Adolescent Sexual and Reproductive Health and Rights (ASRHR)

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Students at LEAP academy in Langa Cape Town commit to a menstrual health campaign under the guidance of Chantelle Goliath, executive director of New Heritage Foundation. Photo: Colleen Lowe Morna

Key points

- Adolescent sexual and reproductive health and rights (ASRHR) are critical for the well-being and development of young people in Southern Africa who face high rates of HIV, child marriages and adolescent fertility.
- Comprehensive Sexuality Education (CSE) equips young people with the knowledge, attitudes, and skills to make informed decisions about their health, well-being, and relationships.
- Nine countries have laws and policies that allow adolescents to access SRH services, including contraception, without third-party authorisation.
- A study by the Stop Stock-outs Project (SSP), '*Contraceptive Supply Chain: Stock-outs and their Causes*', revealed that stock-outs of contraceptives are prevalent in South Africa.[1]
- The region's health systems need to be strengthened to be able to withstand emergencies such as potential pandemics and continue to provide adolescent friendly services.
- An example of such strengthening is a cutting-edge mobile app to provide adolescent and youth-friendly health services (AYFHS) and information that has been launched by South Africa's Department of Health.
- Adolescents girls and young women generally have high unmet need for contraception. In South Africa, for instance, there is a higher unmet need (31% among adolescent girls aged 15-19 and 28% among young women aged 20-24 years)[2] than amongst all women where the unmet need is about 20%.
- Mozambique has the region's highest adolescent fertility rate (AFR), with 165 births per 1,000 women aged 15 to 19. High AFR correlates with high rates of child marriages and early pregnancies.

[1] Nqumako, P. (no date) Study finds a decline in access to contraceptives in SA. Available at: https://www.iol.co.za/dailynews/news/study-finds-a-decline-in-access-to-contraceptives-in-sa-b501f311-7477-43ac-b3da-3fea77a77df8 (Accessed: 20 January 2025).

[2] The HERStory Series: Access, use, and perceptions of contraception services among adolescent girls and young women in South Africa | SAMRC (no date). Available at: https://www.samrc.ac.za/policy-briefs/herstory-series-access-use-and-perceptions-contraception-services-among-adolescent (Accessed: 20 January 2025).

Introduction

Adolescent girls receiving sanitary pads. Photo: Gender Links

Adolescent Sexual and Reproductive Health and Rights (ASRHR) are critical for the well-being and development of young people in Southern Africa. The region faces significant challenges, including high rates of HIV among adolescents, child marriages, adolescent pregnancies, and violence against children. Adolescents aged 10-19 comprise 23% of the population in sub-Saharan Africa (SSA).[3] with over 80% of HIV-infected adolescents in the world living in this region. The adolescent pregnancy rate stands at 19.3%, the highest globally.[4] Child maltreatment is widespread, often rooted in the low societal status of children and influenced by cultural, social, and religious beliefs.[5]

The state of ASRHR in the region is still recovering from the severe impact of the COVID 19 pandemic which complicated the delivery of ASRHR services. School closures and strained healthcare systems disrupted access to education and essential health services, exacerbating existing inequalities. Adolescents faced increased barriers to accessing contraception, HIV testing, and mental health support. Countries like South Africa and Namibia have taken steps to integrate mental health services into primary healthcare and launch awareness campaigns. Still, more resilient health systems are needed to ensure continuous access to care.

Comprehensive Sexuality Education (CSE) is essential in improving ASRHR. CSE equips young people with the knowledge, attitudes, and skills to make informed decisions about their health, well-being, and relationships. It promotes gender equality, challenges harmful cultural norms, and empowers young people to exercise their rights fully. Effective CSE is age-appropriate, scientifically accurate, and culturally relevant, providing a foundation for healthy and respectful relationships.

Despite the clear benefits of CSE, its implementation in Southern Africa faces numerous obstacles. Political resistance, cultural beliefs, and institutional challenges hinder the widespread adoption of CSE programmes. Some strategies that are being employed to overcome these barriers are: involving local communities in adapting CSE to integrate indigenous knowledge; enhancing the roles of teachers, parents, and students; improving funding and training, and fostering political support.

It is critical that all countries have legislation and policies that enable the provision of SRH services to adolescents. This chapter shows that not all countries have such policies in place. It also shows that there are variations in the age at which adolescents can legally access contraceptives without third party authorisation.

These gaps contribute to high adolescent fertility and early and unintended pregnancy rates. Girls who experience early and unintended pregnancy are at risk of unsafe abortions as well as poor physical and mental health, their babies are at risk of low birth weight. Many girls who become pregnant drop out of school which limits their economic opportunities.

In conclusion, investing in ASRHR is vital for the future of Southern Africa. Governments can foster a generation capable of contributing to the region's economic and social development by ensuring that young people are educated, healthy, and empowered. Comprehensive policies and programmes that support ASRHR will help create a brighter and more prosperous future for all SADC member states.

[3] Wangamati, C.K. (2020) 'Comprehensive sexuality education in sub-Saharan Africa: adaptation and implementation challenges in universal access for children and adolescents', Sexual and Reproductive Health Matters, 28(2), p. 1851346. Available at: https://doi.org/10.1080/26410397.2020.1851346.
[4] ibid
[5] ibid

Table 3.1: Key Adolescent Sexual and Reproductive Health and Rights (ASRHR) indicators

Indicators	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
CSE curriculum reflects international standards	Yes[6]	Partial	N/A	No	Yes	Yes	N/A	Yes	N/A	Yes	Yes	N/A	Yes	Yes	Yes	Partial
Age of access to contraceptives[7]	16	12	No data	18	15	No data	12	16	16	16	12	15	12	12	16	16
Legal age to consent to sex (M)[8, 9]	18	18	13	18	18	16	14	16	16	18	14	18	16	18	16	18
Legal age to consent to sex (F)[10, 11]	16	18	13	14	18	16	14	16	16	18	14	18	16	15	16	18[12]
Existence of laws and policies that allow adolescents to access SRH services without third-party authorisation	No	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	No	No
Adolescent fertility rate (births per 1000 women, 15-19 years of age)[13]	136	48	56	107	68	89	118	117	24	165	63	52	61	123	116	93
Adolescent birth rate (births per 1000 women, 15-19 years of age by %)[14]	58	44	32	109	87	206*	111	10	20	180	82	47	39	112	24	108

*Note this is the figure in the 2023 SADC SRHR score card. In the 2021 score card this was 55. It is very unlikely that such dramatic change occurred within two years and is more likely that the difference is the result of a data quality issue.

Table 3.1 shows:

- Botswana, Madagascar, Namibia, South Africa and Tanzania provide access to contraceptives to adolescents from the age of 12 years.
- Mozambique has the region's highest adolescent fertility rate (AFR), 165 births per 1000 women aged 15 to 19. Six other countries have AFRs which are above 100 births per 1000 adolescents.
- Nine countries have laws and policies that allow adolescents to access SRH services without third-party authorisation.
- Set at 13 years for both girls and boys, Comoros has the lowest age of consent for sex in the region, followed by Namibia and Madagascar at age 14 each.
- The minimum age for consent to sex is lower than the age for access to contraceptives in the DRC.

ASRHR and life after COVID-19 pandemic

The COVID-19 pandemic significantly disrupted adolescents' access to education in the SADC region. Extended school closures led to substantial learning losses and widened educational inequalities. Many students, especially those from disadvantaged backgrounds, struggled with remote learning as they did not have digital devices and internet connectivity. Although some SADC countries distributed learning materials and provided radio and television lessons, these efforts were insufficient to fully mitigate the impact, leaving many adolescents at risk of falling behind academically.

The response to the pandemic strained health-care systems, making it difficult for adolescents to access essential services, including sexual and reproductive health care. A study in South Africa

6 UNFPA regional data, https://www.unfpa.org/data/AO Accessed 10 June 2021.
7 Gender Links, Audit of SADC ASRHR Policies and Laws 2021.
8 https://esaro.unfpa.org/sites/default/files/pub-pdf/lates_technical_brief_harmonization_2.pdf
9 List of Ages of Consent in Africa (no date). Available at: https://www.ageofconsent.net/continent/africa (Accessed: 13 November 2024).
10 https://esaro.unfpa.org/sites/default/files/pub-pdf/lates_technical_brief_harmonization_2.pdf
11 List of Ages of Consent in Africa (no date). Available at: https://www.ageofconsent.net/continent/africa (Accessed: 13 November 2024).
12 UNICEF Statement on Zimbabwean law raising the age of consent to 18 years (no date). Available at: https://www.unicef.org/zimbabwe/press-releases/unicef-statement-zimbabwean-law-raising-age-consent-18-years (Accessed: 13 November 2024).
13 World Bank Open Data. Available at: https://data.worldbank.org (Accessed: 13 November 2024).
14 SADC SRHR SCORECARD 2023 (no date) Tableau Public. Available at: https://public.tableau.com/app/profile/sadc.srhr.scorecard2239/viz/SADCSRHRSCORECARD2023/2023English (Accessed: 13 November 2024).

showed that the pandemic response shifted healthcare resources towards combatting COVID-19, affecting the quality and availability of HIV services, particularly for adolescents living with HIV (ALHIV)[15]. Adolescents faced increased barriers to accessing contraception, HIV testing, and mental health support, exacerbating existing health challenges. Countries like South Africa and Namibia integrated mental health services into primary healthcare and launched awareness campaigns to address these issues. Despite these efforts, the pandemic highlighted the need for more resilient health systems to ensure adolescents can access the care they need, even during crises.

The situation remains challenging as COVID-19 continues to circulate globally. Dr Maria Van Kerkhove of WHO emphasised that "COVID-19 is still very much with us and circulating in all countries".[16] The WHO's third round of the Global Pulse Survey[17] on the continuity of essential health services during the pandemic revealed that 92% of participating countries, including all 16 SADC countries, reported service disruptions, particularly in primary care, emergency care, and elective surgeries. The report underscores the need for long-term strategies to build resilient health systems and improve preparedness for future public health emergencies, including technical assistance in health worker recruitment, community engagement, and access to essential medical supplies.

New viruses like human metapneumovirus (HMPV) are emerging, adding to possible pandemic challenges. As HMPV surges in Asia and Europe, the WHO has called for reinstating restrictions implemented during the COVID-19 pandemic. These warnings suggest that SADC countries must remain vigilant and make concerted efforts to ensure pandemic preparedness in all forms. Using technology to enhance ASRHR is one way of preparing against pandemic restrictions, which often limit access to information. The following example shows how South Africa is using a tailored mobile app to enhance access to youth-friendly services.

South Africa: A progressive web App for youth-friendly health services

The Department of Health in South Africa has officially reactivated its B-Wise platform by launching a cutting-edge mobile app tailored to provide adolescent and youth-friendly health services (AYFHS) and information.

B-Wise is an interactive digital platform developed by the Department of Health in partnership with stakeholders, including the President's Emergency Plan for Aids Relief (PEPFAR), to improve the uptake of health services among adolescents and young people in South Africa, especially HIV prevention, mental health, family planning, and contraceptive use, to make informed choices about their sexual and reproductive health. This development reinforces the South African government's commitment to empowering young people with accessible, reliable, and youth-centred appropriate health resources.

The B-Wise app brings innovative features, including interactive tools for sexual and reproductive health and rights, health and wellness promotion, education, and HIV and TB prevention. Young people in South Africa continue to face healthcare access and information barriers. The reactivation of B-Wise and the introduction of this innovative app addresses these challenges head-on, providing a digital space where youth can access life-saving health information and services without stigma or barriers.[18]

[15] Van Staden, Quintin, Laurenzi, Christina A, and Toska, Elona. Journal of the International AIDS Society, vol. 25, issue 4 (2022), e25904e: https://healtheducationresources.unesco.org/library/documents/two-years-after-lockdown-reviewing-effects-covid-19-health-services-and-support, accessed 29 September 2022

[16] COVID-19 making worrying comeback WHO warns, amid summertime surge | UN News (2024). Available at: https://news.un.org/en/story/2024/08/1152866 (Accessed: 17 January 2025).

[17] Global pulse survey on continuity of essential health services during the COVID-19 pandemic. Available at: https://www.who.int/publications/m/item/global-pulse-survey-on-continuity-of-essential-health-services-during-the-covid-19-pandemic-Q4 (Accessed: 16 January 2025).

[18] Department of Health Launches New B-Wise App to Empower Youth Health Access | Health Devdiscourse. Available at: https://www.devdiscourse.com/article/health/3174214-department-of-health-launches-new-b-wise-app-to-empower-youth-health-access (Accessed: 28 November 2024).

Comprehensive sexuality education (CSE) frameworks and indicators

Sustainable Development Goal (SDG) 4: Ensure inclusive and equitable education and promote lifelong learning opportunities for all.

SDG 5.6.2 measures the "number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education."

International Conference on Population and Development (ICPD) paragraphs 4.29, 7.37, 7.41, and 7.47: Sexuality education to promote the well-being of adolescents specifies key features of such education.
- Education should occur in schools and at the community level, be age-appropriate, begin as early as possible, foster mature decision-making, and aim to improve gender equality.
- Such programmes should address specific topics, including gender relations and equality, violence against adolescents, responsible sexual behaviour, contraception, family life and sexually transmitted infections (STIs), and HIV and AIDS prevention.

The East and Southern Africa (ESA) Ministerial Commitment: 15 SADC countries signed the Commitment, which 20 countries endorsed and affirmed in 2013 (the ESA-CSE commitment). Education and health ministers from these countries are committed to accelerating access to CSE and health services for young people in the region. Comoros is the only SADC country that is not part of this commitment.

SADC Gender Protocol Article 11: Ensure that the girl and the boy child have equal access to information, education, services and facilities on sexual and reproductive health and rights. Adopt laws, policies, and programmes to ensure the development and protection of the girl and the boy child.

The SADC SRHR Strategy for ensuring CSE notes that member states should accelerate and improve the delivery of quality comprehensive sexuality education for in and out-of-school youth by the education and youth sectors. The strategy further specifies:
- Member states should ensure that young people and adolescents are prepared, supported, and provided with education and all the information and skills to make safe and healthy decisions about their lives and futures. This includes ensuring that adolescents and young people in and out of school access quality, comprehensive, age-appropriate, scientifically accurate life skills-based CSE with linkages to youth-friendly SRHR services and the youth sector more broadly.
- The importance of strengthening the capacity of educators at all levels, specifically to provide age, gender and culturally appropriate rights-based CSE that includes core elements of knowledge, skills and values as preparation for adulthood and, wherever possible, the creation of intra-curricula school CSE programmes.
- There is a need to build and strengthen the skills of those working in broader youth and community interventions to expand capacity within member states to reach out-of-school youth.
- Stakeholders should explore creative approaches to build the capacity of media, including radio, to reach out-of-school youth.

Knox Thumbumuzi Cup Launch in Mbabane, Eswatini. Photo: Thandokuhle Dlamini

The urgent need for comprehensive sexuality education in Southern Africa is highlighted by the high rates of HIV among young people, child marriages, adolescent pregnancies, unsafe abortions, and violence against children[19]. Adolescents aged 10-19 comprise 23% of the sub-Saharan African (SSA) population[20], with over 80% of HIV-infected adolescents in the world living in this region. The adolescent pregnancy rate is 19.3%, the highest in the world.[21] Child maltreatment is widespread, often stemming from the low societal status of children and influenced by cultural, social, and religious beliefs.

Effective CSE equips children and young people with crucial decision-making skills to navigate challenges related to relationships and sexuality. It addresses gender inequality and power dynamics within communities, challenging cultural norms that perpetuate violence. CSE empowers young individuals to protect their health, well-being, and dignity by providing them with a comprehensive knowledge, attitudes, and skills toolkit. It is essential for exercising full bodily autonomy, which includes the right to make choices about one's body and having the information necessary to make those choices meaningfully.[22]

CSE aims to equip children and adolescents with the knowledge, skills, and values that they need for sexual and reproductive health. However, implementing and adapting CSE in sub-Saharan Africa remains challenging. Despite progress in policy development and implementation, significant barriers persist, including political resistance, cultural beliefs, and institutional challenges.[23] It is important that political support is mobilised so that sufficient funding is allocated and training conducted. Teachers, parents, and students all play crucial roles for effective CSE implementation. The involvement of local communities in the adaptation process makes a crucial contribution to integrating indigenous knowledge. Communities play a vital role in ensuring that youth are educated, healthy, and empowered, contributing to a brighter future for all SADC member states.

To clarify CSE, the UNFPA has identified ten common myths and truths. These demonstrate the impact that CSE has on ASRHR. They are:

1. *Myth:* Sexuality education grooms children for sexual abuse.
   Truth: It teaches children about threats such as predation and sexual abuse, empowering them to seek help.
2. *Myth:* Abstinence-only education is more effective than sexuality education.
   Truth: Research shows that abstinence-only education does not reduce adolescent birth rates or sexually transmitted infections, rather, it is associated with higher risks regarding these issues.
3. *Myth:* Sexuality education encourages children to have sex early or to have more sexual partners.
   Truth: Research shows that it often leads young people to delay having sex, as well as to have safer sex and fewer sexual partners.

[19] Wangamati, C.K. (2020) 'Comprehensive sexuality education in sub-Saharan Africa: adaptation and implementation challenges in universal access for children and adolescents', Sexual and Reproductive Health Matters, 28(2), p. 1851346. Available at: https://doi.org/10.1080/26410397.2020.1851346.
[20] ibid
[21] ibid
[22] Comprehensive sexuality education | United Nations Population Fund. Available at: https://www.unfpa.org/comprehensive-sexuality-education (Accessed: 20 January 2025).
[23] Wangamati, C.K. (2020) 'Comprehensive sexuality education in sub-Saharan Africa: adaptation and implementation challenges in universal access for children and adolescents', Sexual and Reproductive Health Matters, 28(2), p. 1851346. Available at: https://doi.org/10.1080/26410397.2020.1851346.
[24] 10 myths - and truths - about comprehensive sexuality education (no date). Available at: https://www.unfpa.org/stories/10-myths-%E2%80%93-and-truths-%E2%80%93-about-comprehensive-sexuality-education (Accessed: 20 January 2025).

4. *Myth:* Sexuality education goes against culture and religion.
   Truth: The content of comprehensive sexuality education is tailored to fit local contexts and is taught with the support of cultural leaders in the community.
5. *Myth:* Sexuality education promotes LGBTQIA+ "lifestyles" among students.
   Truth: It does not endorse or campaign for any "lifestyle" other than promoting health and well-being for everyone, everywhere. That said, it also acknowledges the need to safeguard the rights of gender-diverse and LGBTQIA+ people.
6. *Myth:* Sexuality education sexualises children and deprives them of their "innocence".
   Truth: Children will confront issues related to sexuality at some point, whether we like it or not, so they must be informed and prepared to deal with them. CSE provides them with age-appropriate knowledge and skills that help them avoid teen pregnancy, understand consent, make responsible choices, and recognise predation and abuse.
7. *Myth:* Sexuality education introduces sexually inappropriate material to young people too early.
   Truth: CSE must be scientifically accurate, non-judgemental, age and developmentally appropriate. Without such education, children will be vulnerable to conflicting and damaging messages from their peers, social media and other sources.
8. *Myth:* Sexuality education promotes masturbation.
   Truth: CSE does not encourage masturbation. Children start to explore their bodies through sight and touch at a very early age. Educators let them know that this is standard practice.
9. *Myth:* Sexuality education is trying to legalise paedophilia.
   Truth: CSE protects children and never calls for the decriminalisation of adults having sex with children or the abolition of the age of consent. The sexual abuse of children is a crime that CSE helps to defeat.
10. *Myth:* Sexuality education is not relevant for children.
    Truth: Sexuality is inherent to human experience throughout a person's life. CSE is a lifelong process that is relevant to all ages. Long before younger children think about having sex, this type of education can help them learn about their bodies, emotions, family life, relationships, the basic principles of consent and what to do if they experience or see abuse.

Source: UNFPA.[25]

Here are some examples of CSE work in the SADC region:

CSE in Namibia: achievements, barriers, and future directions

Comprehensive sexuality education has been mainstreamed in Namibia since independence in 1990 through government programmes, such as the School Health and Life Skills Education programmes[26]. High rates of adolescent pregnancy, increasing HIV infections, high levels of discrimination against people living with HIV, and stigmatisation, motivated the adoption and rollout of CSE in the school Life Skills Education curriculum. In addition, with 66% of the population below the age of 30 and 43% of new HIV infections occurring among young people aged 15-24, the scale-up of the programme in schools was considered necessary. The Government also introduced 'My Future is My Choice' as an extra-curricular programme in the late 1990s in response to the impact of HIV and AIDS in the education sector. This reinforced and deepened related content in teaching life skills, biology and life science.

[25] ibid
[26] Wekesah, F.M. et al. (2019) 'Comprehensive Sexuality Education in Sub-Saharan Africa. Nairobi, Kenya: African Population and Health Research Center (APHRC), Accessed 17 November 2024

Information on sexual health, which was designed to reach young people at a secondary level and develop their skills to make safe choices related to their sexual health, included themes such as risky behaviours. In 2004, the 'Window of Hope' programme was developed for primary school students as an after-school activity to increase their self-esteem, build their knowledge and skills to protect themselves against HIV and develop compassion for those living with the virus. The official scale-up of the Life Skills Education programme started in 2012/13 through the curriculum review and was boosted following the signing of the Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern Africa (also referred to as the ESA Commitment) in December 2013. Scaling-up initiatives included strengthening and refining the curriculum; developing teaching and learning materials; teacher training; the appointment of Life Skills Education teachers; integrating sexual and reproductive health services and Life Skills Education components into the School Health programme; awareness raising among key stakeholders, and strengthening the monitoring of Life Skills Education in the national Education Management Information System (EMIS).

However, in 2021, resistance from faith-based organisations claiming that the programme was 'promoting sexual promiscuity among young people' pressurised the Government into rejecting the Ministerial Commitment. Some life-skills teachers have expressed a lack of confidence and discomfort in dealing with sensitive sexuality-related topics, and some parents are resistant to communicating with their children about these themes. Following negative publicity and misinformation about the Life Skills Education programme, the Ministry of Education, Arts and Culture organised a special meeting, inviting over 120 faith-based and religious leaders to clarify any misconceptions around CSE, to ensure better understanding and to gain their support. The government has been committed to engaging with partners to advocate for CSE.

Source: UNESCO.[58]

While many SADC countries have adopted the East and Southern Africa[28] (ESA) Ministerial Commitment, which emphasises CSE and youth-friendly health services, Comoros has not joined this initiative.

Comoros: Approach to CSE

Comoros differs from other SADC countries in its approach to CSE and youth-friendly sexual and reproductive health services. Comoros focuses on integrating ASRHR within its broader health and education strategies, which are often influenced by cultural and religious contexts. This difference highlights the need for tailored strategies that respect cultural contexts while ensuring that young people receive comprehensive and accurate information to make informed decisions about their health and well-being.

Comoros differs from other SADC countries... it focuses on integrating ASRHR within its broader health and education strategies

[27] Namibia | Comprehensive Sexuality Education | Education Profiles (no date). Available at: https://education-profiles.org/sub-saharan-africa/namibia/~comprehensive-sexuality-education (Accessed: 17 November 2024).
[28] Fulfilling our promise to girls in Eastern and Southern Africa | UNICEF Eastern and Southern Africa (no date). Available at: https://esaro.unfpa.org/en/news/fulfilling-our-promise-girls-east-and-southern-africa-will-give-voice-and-secure-their-equal (Accessed: 19 January 2025).

The country's approach tends to be more conservative, emphasising abstinence and traditional values.[29] This can limit the scope and effectiveness of CSE programmes, as they may not fully address young people's diverse needs and realities. With a long history of political instability, Comoros has had fewer dedicated ASRHR programmes and resources[30] compared to other SADC countries that have embraced the ESA Commitment. The government also lacks sufficient youth-friendly health services, making it difficult for teens to access sexual and reproductive health care.[31] Thus, access to youth-friendly health services in Comoros has been limited.

The UN 2021 country programme document[32], reveals that sexually transmitted infections remain a concern among youth (2020 prevalence and behavioural survey); the HIV prevalence rate among young people aged 15-24 years is 0.07 per cent, slightly higher than the national rate of 0.05 per cent. Many challenges remain, including:

- gaps in young people's access to accurate and comprehensive information and services, leading to unsafe sexual practices;
- the absence of a multi-sectoral youth policy which would promote an enabling environment for adolescent sexual and reproductive health;
- weak adolescent-friendly health services;
- a lack of capacity among duty bearers to effectively promote adolescent sexual and reproductive health;
- gaps in school programmes that focus on life skills, including comprehensive sexuality education and bodily autonomy, and
- gaps in leadership and peace-building skills to navigate the complexities of adolescence.

A notable effort is collaboration between local NGOs and international organisations to provide youth-friendly health services and education in the Comoros. Some of the key organisations working to improve youth-friendly health services in Comoros include:

1. Médecins Sans Frontières (MSF) - Known for its work in providing medical care, MSF also engages in health education and awareness campaigns, including those related to sexual and reproductive health.[33]
2. UNAIDS - This organisation focuses on HIV prevention and treatment, advocating for comprehensive health education and services for adolescents.[34]
3. Maeecha is a local NGO that works on education, literacy, and health care services, including water, sanitation, and hygiene (WASH).[35]
4. AIDS and Rights Alliance for Southern Africa (ARASA) promotes human rights and HIV and AIDS education, improving young people's access to health services and information.[36]

These organisations collaborate with local communities and government agencies to enhance the delivery of CSE and ensure that adolescents have access to the necessary health services and information.[37] These programmes aim to increase awareness about sexual and reproductive health, promote gender equality, and reduce the incidence of STIs and unintended pregnancies. Additionally, community-based initiatives engage parents, religious leaders, and educators to support the delivery of CSE in a culturally sensitive manner.

[29] A secret pregnancy in the Comoros: One teen's story | United Nations Population Fund (no date). Available at: https://www.unfpa.org/news/secret-pregnancy-comoros-one-teens-story (Accessed: 20 January 2025).
[30] Mohamed, K.S. et al. (2021) 'An Overview of Healthcare Systems in Comoros: The Effects of Two Decades of Political Instability', Annals of Global Health, 87(1). Available at: https://doi.org/10.5334/aogh.3100.
[31] A secret pregnancy in the Comoros: One teen's story | United Nations Population Fund (no date). Available at: https://www.unfpa.org/news/secret-pregnancy-comoros-one-teens-story (Accessed: 20 January 2025).
[32] https://www.unfpa.org/sites/default/files/portal-document/ENG_DP.FPA_.CPD_.COM_.7%20-%20Comoros%20CPD%20-%20Final%20-%202Jul21.pdf
[33] List of Ngos, Charities and non-profits in Comoros (no date). Available at: https://ngobase.org/c/KM/comoros-ngos-charities (Accessed: 19 January 2025).
[34] ibid
[35] ibid
[36] ibid
[37] Ibid

Zimbabwe: Women in Communities (WICO)

Women in Communities, a Voice and Choice Southern Africa Fund (VCSAF) grantee, is implementing a project designed to bridge the generational gap in addressing sexual and reproductive health and rights (SRHR) and HIV in Shurugwi district, Midlands, Zimbabwe. The initiative, titled "I Am My Daughter's Keeper," focuses on addressing teenage pregnancies, school dropouts, HIV and STI transmission, as well as period poverty. The goal is to foster community participation and improve communication between adolescents and their parents and guardians on SRHR and HIV issues. Key strategies include:

- Involving parents and guardians in school discussions on SRHR and HIV.
- Creating one-on-one platforms for intimate discussions between learners and parents.
- Engaging community-based organisations (CBOs) and media partners to reach target groups.

Challenges faced include low male participation and the sensitivity of the topics. However, the project saw improved learner participation, reduced absenteeism, better behaviour among boys, reduced stigma, and increased confidence among learners. Parents gained insights into ASRHR and HIV, enhancing their ability to guide their children.

The project emphasises the importance of developing comprehensive ASRHR policies, training school health masters, and engaging the community.

Results

The initiative has significantly improved learner participation by providing sanitary ware for girls, which has reduced absenteeism. This provision has encouraged attendance and fostered a more supportive environment for female students. School heads have reported enhanced student behaviour, noting increased respect toward girls from male peers.

Moreover, the project has successfully reduced the stigma surrounding menstruation, allowing learners, particularly girls, to feel more confident and open about discussing their menstrual hygiene and using sanitary pads. This newfound confidence has been further bolstered by empowering parents with insights into ASRHR and HIV topics. As a result, parents are better equipped to guide and support their children in making informed health decisions.

The initiative has also provided a sustainable model for addressing ASRHR and HIV issues through collaborative efforts involving parents, demonstrating its potential for long-term impact. The project has specifically boosted girls' confidence and assertiveness, enabling them to navigate challenges more effectively.

Parent involvement has been remarkably high, with active participation in the campaign. This engagement has been highlighted in the Sun Newspaper and on WICO's social media platforms, showcasing families' commitment to this cause. Additionally, twelve School Health Masters have been trained to create stigma-free school environments, further promoting inclusivity and respect.

Results from the monitoring and evaluation have shown positive changes in behaviour and attitudes towards SRHR and HIV. These include:

- Initial baseline surveys and interim project reviews highlighted issues like high absenteeism due to periods.
- The WICO programme has contributed to positive changes, such as reduced absenteeism related to menstrual periods.
- The evaluation showed that girls are now more comfortable discussing their periods and using sanitary pads, even with boys.
- Parents and guardians have embraced the programme, appreciated the dialogues and become more supportive.
- School authorities noted positive changes in learners' behaviour, with students focusing more on their schoolwork rather than on their physical changes.

Source: WICO.[38]

Overall, comprehensive sexuality education is essential for the health and well-being of adolescents in the SADC region. While significant progress has been made, challenges remain in ensuring that all young people have access to high-quality CSE. By addressing these challenges and building on successful models, SADC countries can improve the sexual and reproductive health outcomes of their adolescents and promote their rights and empowerment.

Access to contraceptives and age of consent to sex

Adolescents in the SADC region have the same reproductive health rights as adults, which means they should have access to reproductive health services without any barriers. However, requiring third-party authorisation to access adolescent sexual and reproductive health services, such as contraceptives and information, prevents young people from exercising their fundamental human rights. Adolescents are vulnerable to rape and other sexual violence as well as to early sexual debut, including within the context of child marriage. This means that they are vulnerable to contracting HIV and other sexually transmitted infections (STIs) as well as to unsafe abortions and early childbearing.

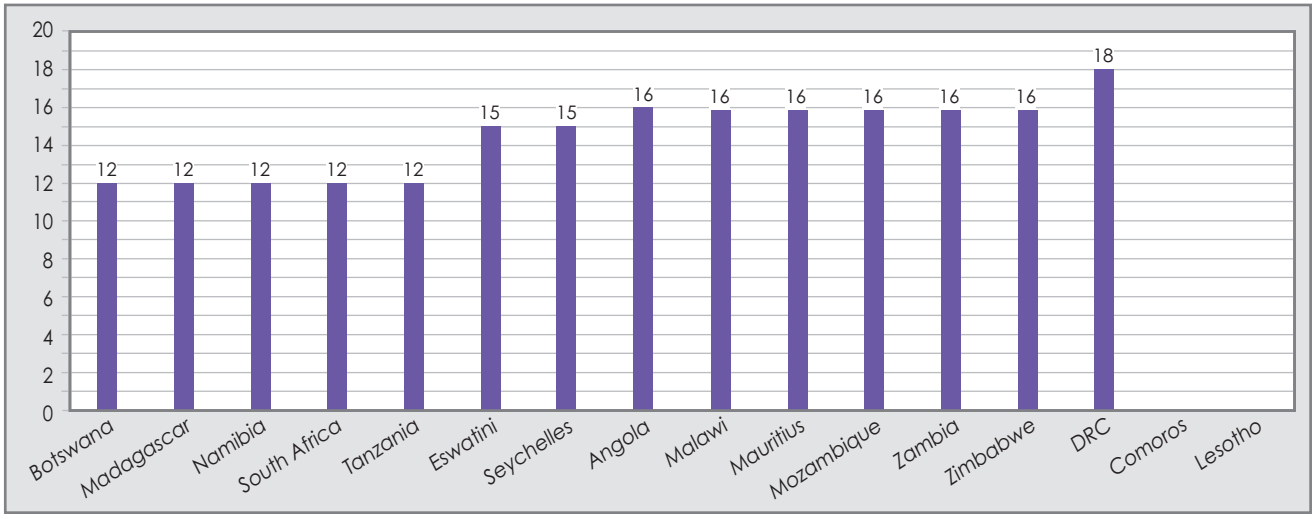
Promoting sexual health is essential for achieving Sustainable Development Goal (SDG) 3: Ensure healthy lives and promote well-being for all ages.

Specifically, **Target 3.7** aims to ensure universal access to sexual and reproductive healthcare services, including family planning, information, and education, and the integration of reproductive health into national strategies and programmes by 2030.

To achieve this SDG, countries must align their laws and policies regarding access to contraceptives and the age of consent to sex. Creating a supportive legal and policy environment is vital for preventing early and unintended adolescent pregnancies and fatherhood, thereby safeguarding the health and rights of young people in the SADC region.

[38] Women in Communities presentation at the Voice and Choice Zimbabwe Summit November 2024:

Figure 3.1: Age of access to contraception



Source: GL Mapping of SRHR Policies and Laws updated 2021

Figure 3.1 shows that five SADC countries- Botswana, Madagascar, Namibia, South Africa and Tanzania-provide contraceptives to young people from the age of 12. Seychelles and Eswatini begin at age 15. The remaining countries permit contraception from age 16, with the Democratic Republic of Congo (DRC) as an outlier, allowing it only from age 18. In the case of DRC, this creates a significant gap since the legal age for girls to consent to sex is 14, resulting in a four-year delay in accessing this fundamental right.

No data is available for Lesotho and Comoros on the age of consent to contraceptives. However, the 2023 SADC 2nd Milestone Score-card[39], indicates that the unmet contraceptive need among individuals aged 15-49 in these countries was 18% in Lesotho and 32% in Comoros. Legislators must urgently review the age of consent for contraception to address the rising incidence of early pregnancies in the region.

According to data published in 2024 by Track 20, which assesses opportunities for family planning programming among adolescents and youth in **Comoros**, adolescents or youths in Comoros who use a modern method of contraception are 2% of all women, while adolescents or youth who have an unmet need for modern contraceptives are 7.3% of all women.[40]

Contraceptive methods, Lesotho. Photo: Ntolo Lekau

[39] SADC SRHR SCORECARD 2023 (no date) Tableau Public. Available at: https://public.tableau.com/app/profile/sadc.srhr.scorecard2239/viz/SADCSRHRSCORECARD2023/2023English (Accessed: 13 November 2024).
[40] https://www.track20.org/download/pdf/Youth%20Briefs/English/Comoros%20Youth%20Opportunity%20Brief.pdf

The largest group of adolescents and youth with an unmet need for modern contraception are married youth (20-24), who comprise 4% of women of reproductive age (WRA). Programming focused on this population, therefore, has the potential to make a significant contribution to increased national contraceptive prevalence.[41]

In **South Africa**, about one in five women of reproductive age (15-49 years) have an unmet need for contraception, and among Adolescent Girls and Young Women (AGYW), there is an even higher unmet need (31% among adolescent girls aged 15-19 and 28% among young women aged 20-24 years)[42]. The following case study illustrates, however, that there are many barriers in access to contraceptives.

South Africa: Study finds a decline in access to contraceptives

A study by the Stop Stock-outs Project (SSP), *'Contraceptive Supply Chain: Stock-outs and their Causes'*, revealed that stock-outs of contraceptives were prevalent across the country. The study focused on the Eastern Cape, KwaZulu-Natal, and the North West provinces between April 2022 and June 2023.

The study examined the availability of various types of contraceptives. SSP, together with the Ritshidze project, surveyed public health users to assess their experiences of accessing contraceptives. In the Eastern Cape and KwaZulu-Natal provinces, almost all women and girls who were surveyed did not receive the contraceptives they requested.

Throughout the monitoring period, injectable contraception was reported as the least accessible, followed by external condoms and the implant. The study investigated the relationship between the supply chain and contraceptive stock-outs. It found that medicinal stock-outs are widespread across South Africa.

The study used interviews with public health facility managers to establish the causes of poor access and the mitigation measures in place. The project reported that when facility managers were interviewed about the measures implemented to address stock-outs, most Eastern Cape and KwaZulu-Natal managers reported receiving guidance on how to respond to stock-outs. However, managers in the North West said they had not received such advice.

The survey showed that healthcare providers made efforts to ensure that healthcare users did not leave facilities without medicines. It also stated that healthcare providers offered users alternative medicines or referred users to facilities with stock. The survey also highlighted the unavailability of termination of pregnancy services. Most of the surveyed facility managers in all three provinces reported that they referred health-care users seeking these services to other facilities.

> Poor national procurement planning continues to be the main driver of contraceptive shortages and stock-outs

"Our findings are that poor national procurement planning continues to be the main driver of contraceptive shortages and stock-outs. At the provincial level, causes of stock-outs included budgetary limitations, dependence on manual paper-based systems, and poor management of stock controls. The report recommends that the national and provincial health departments urgently address the use of manual data systems for payment and stock management.

Source: IOL.[43]

[41] Ibid
[42] The HERStory Series: Access, use, and perceptions of contraception services among adolescent girls and young women in South Africa | SAMRC (no date). Available at: https://www.samrc.ac.za/policy-briefs/herstory-series-access-use-and-perceptions-contraception-services-among-adolescent (Accessed: 20 January 2025).
[43] Nqumako, P. (no date) Study finds a decline in access to contraceptives in SA. Available at: https://www.iol.co.za/dailynews/news/study-finds-a-decline-in-access-to-contraceptives-in-sa-b501f311-7477-43ac-b3da-3fea77a77df8 (Accessed: 20 January 2025).

In South Africa, young people are taking bold steps to improve adolescent sexual and reproductive health, breaking down stigma and advocating for better services. Veronica Molefe's journey from a 17-year-old seeking information to a passionate health advocate exemplifies youth challenges and triumphs in this critical area.

South Africa: Breaking the stigma: Improving SRHR services for youth

Veronica Molefe, a young woman and leader in providing sexual and reproductive health services through Shout-It-Now in South Africa, shares her journey, highlighting the challenges young people face in South Africa to access to SRHR services. Despite her proactive approach at age 17, when seeking information about contraception and HIV prevention, she experienced judgement and stigma from healthcare providers, a reality that persists for many adolescents today.

"One of my friends became pregnant, and it wasn't clear whether she had used contraception or not. It got me thinking I wasn't sexually active yet, but I wanted to be prepared for when the time came. So, I went to my local clinic, just a street away from my home, to ask for information on contraception and HIV prevention options. What followed was disheartening. The nurse asked me invasive questions: "Why do you want those things? Are you sleeping around? Children like you should be in school, not here." "I felt judged and ashamed. All I wanted was information, but I left empty-handed. Fortunately, my mom stepped in, and we found another clinic that provided the support I needed," Molefe explained. She added: "That was 10 years ago, but sadly, this is still the reality for many young people in South Africa today."

The statistics are alarming, with 150,000 girls aged 10 to 19 experiencing unintended pregnancies in 2022/2023, compounded by high HIV infection rates, particularly among young women. The stigma surrounding sexual health often prevents youth from accessing available services, with many health facilities lacking a welcoming atmosphere. Molefe emphasises the need for youth-friendly health services that respect and support young people, as offered by Shout-It-Now, which recruits younger staff and utilises peer ambassadors to foster a non-judgemental environment. The call to action stresses the importance of collaborative efforts across society to destigmatise sexual and reproductive health, leading to open discussions and empowering youths to take charge of their health.

Source: MSN news.[44]

It is essential that all countries have progressive laws and policies that support the availability of SRHR services to youth, enabling adolescents to access sexual and reproductive health services independently, without the need for third-party authorisation.

[44] Madwantsi, V. (1732532372) Breaking the stigma: improving sexual and reproductive health services for youth in South Africa. Available at: https://www.msn.com/en-za/news/other/breaking-the-stigma-improving-sexual-and-reproductive-health-services-for-youth-in-south-africa/ar-AA1ul8QB?ocid=msedgntp&pc=DCTS&cvid=6535064e8e724db58d8f6deeaebcb780&ei=14 (Accessed: 25 November 2024).

Table 3.2: Existence of laws and policies that allow adolescents to access SRH services without third-party authorisation

Botswana	Yes
Eswatini	Yes
Lesotho	Yes
Madagascar	Yes
Malawi	Yes
Mozambique	Yes
Namibia	Yes
South Africa	Yes
United Republic of Tanzania	Yes
Angola	No
Comoros	No
Dem. Rep. of Congo	No
Mauritius	No
Seychelles	No
Zambia	No
Zimbabwe	No

Source: SADC Scorecard 2023.[45]

Table 3.2 illustrates which SADC countries have legal and policy frameworks providing adolescent access to sexual and reproductive health (SRH) services without requiring third-party authorisation and which do not. It shows that Botswana, Eswatini, Lesotho, Madagascar, Malawi, Mozambique, Namibia, South Africa, and Tanzania have laws supporting this access. In contrast, it shows that Angola, Comoros, the Democratic Republic of Congo, Mauritius, Seychelles, Zambia, and Zimbabwe do not have similar laws and policies.

Extracts of laws from Lesotho and South Africa show a progressive shift toward prioritising children's and adolescents' autonomy and rights in health-related matters.

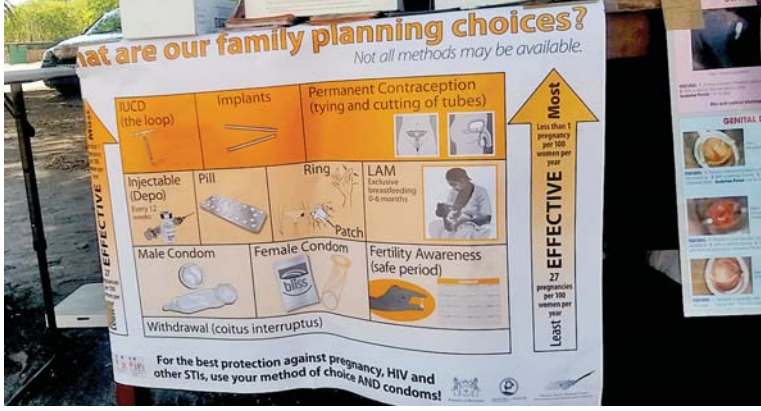
Figure 3.2: Examples of progressive laws on adolescent health matters

The Lesotho Children's Protection and Welfare Act 2011 provides at:	The South African Children's Act 38 of 2005 includes provisions on consent to medical treatment and surgical procedures, HIV testing and counselling, and access to contraceptives:
Section 232(2): ***A child may consent to medical treatment provided the child is -*** (a) at least 12 years of age; and (b) of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment or operation. ***Section 233(2):*** ***Consent for HIV test on a child may be given by -*** (a) the child, if the child is 12 years or older.	***Section 129*** ***(2) states that a child may consent to his or her own medical treatment or to the medical treatment of his or her child if -*** (a) the child is over the age of 12 years; and (b) the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment. ***(3) A child may consent to the performance of a surgical operation on him or her or his or her child if -*** (a) the child is over the age of 12 years; and (b) the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation; and (c) the child is duly assisted by his or her parent or guardian. ***Section 134 states that:*** ***(1) No person may refuse -*** (a) to sell condoms to a child over the age of 12 years; or (b) to provide a child over the age of 12 years with condoms on request where such condoms are provided or distributed free of charge. ***(2) Contraceptives other than condoms may be provided to a child on request by the child and without the consent of the parent or caregiver of the child if -*** (a) the child is at least 12 years of age; (b) proper medical advice is given to the child; and (c) a medical examination is carried out on the child to determine whether there are any medical reasons why a specific contraceptive should not be provided to the child. ***(3) A child who obtains condoms, contraceptives or contraceptive advice in terms of this Act is entitled to confidentiality in this respect, subject to section 105.***

Source: The extract was taken from The Lesotho Children's Protection and Welfare Act 2011 and the South African Children's Act 38 of 2005

[45] SADC SRHR SCORECARD 2023 (no date) Tableau Public. Available at: https://public.tableau.com/app/profile/sadc.srhr.scorecard2239/viz/SADCSRHRSCORECARD2023/2023English (Accessed: 13 November 2024).

Figure 3.2 shows that The Lesotho Children's Protection and Welfare Act 2011 and the South African Children's Act 38 of 2005 outline specific provisions regarding children's rights concerning medical treatment and contraceptive access. Both Acts allow children aged 12 and above to consent to medical treatments and surgical procedures, provided they demonstrate sufficient maturity and mental capacity to understand the implications involved. The legislation specifies that children can consent to their medical treatment, including HIV testing and the provision of contraceptives, without requiring parental consent, as long as they are given appropriate medical advice and a medical examination has been conducted. Additionally, it mandates confidentiality for children seeking information and services related to contraceptives, ensuring their rights are respected in health matters. These Acts highlight a shift towards recognising children's autonomy in significant health-related decisions and reinforce the importance of informed consent.



ASRHR teenage pregnancy and parent child materials in Kgotla, Botswana.
Credit: Kgalalelo Gambule

SADC countries need to ensure adolescent autonomy and access to essential health services. This includes providing comprehensive sexual and reproductive health education, promoting mental health awareness, and removing barriers to accessing care. By empowering young people to make informed decisions about their health, SADC countries can foster a healthier, more informed generation. Investment in youth-friendly health services and policies that respect adolescents' rights will improve individual well-being and contribute to the overall development and resilience of communities throughout the region.

Enhancing ASRHR

Although most adolescent health issues are preventable or treatable, adolescents face multiple barriers to accessing health care and information. ASRHR experts consider a society or community youth-friendly when its health systems provide services based on an in-depth understanding of the desires and requirements of the young people living in that society or community. For instance, Guttmacher lists several indicators of effective youth-friendly services.

Effective Youth-Friendly Services

Whether services are provided in a clinical setting, a youth-oriented site, in schools or in the community, specific youth-friendly characteristics are essential for effective services.

- Providers should be trained to work competently, sensitively and respectfully with adolescents and young people on their sexual and reproductive health needs.
- Services must be confidential, non-judgemental and private.
- Clinic opening hours should be convenient for adolescents and young people: Late afternoons (after school), evenings and weekends.
- Services should be accessible to all adolescents and young people, regardless of age, marital status, sexual orientation or ability to pay.
- Effective referral systems should be in place.
- Adolescents and young people should have opportunities to be involved in designing, implementing, and evaluating the programme.
- Services should seek to involve and gain the support of those critical in young people's lives and the local community, such as partners, parents/ guardians and schools.

Source: Guttmacher.[46]

[46] https://www.guttmacher.org/sites/default/files/report_downloads/demystifying-data-handouts_0.pdf

Lesotho YWCA: Promoting the right to health for young women and girls

The Lesotho Young Women's Christian Association (YWCA) has launched a project to enhance young women's health rights through CSE and improved access to SRHR services. This initiative addresses several critical issues observed in the community, including:

- Lack of understanding regarding gender-based violence and limited awareness of sexuality education.
- Limited knowledge and awareness among students about comprehensive sexuality education.
- Under-reporting of child protection issues and gender-based violence, as confirmed by child and gender reports.
- Ineffective implementation of laws and policies by various stakeholders.

The project targets communities in three districts: Mafeteng, Maseru, and Berea. Its primary focus is on creating a safe environment for promoting SRHR, particularly for adolescent girls and young women. The YWCA's objectives include reducing gender-based violence, improving health outcomes, and ensuring access to quality health services through community empowerment and advocacy.

To achieve these objectives, the YWCA has undertaken several key activities. Six school dialogues on SRHR were conducted in high schools, with two sessions held in each district. Three community dialogues and three dialogues with community leaders and stakeholders were organised on SRHR, with one of each kind of dialogue per district. Information, education, and communication (IEC) materials were developed and distributed, including brochures and flyers. Surveys were administered to assess initial knowledge and attitudes. Furthermore, clubs were established in each district to engage males in promoting gender equality and SRHR.

The YWCA has achieved several milestones to date. School dialogues were conducted in five schools across Mafeteng, Maseru, and Berea. Three district dialogues were held with District Child Protection Teams (DCPTs) in these districts. Two community dialogues were organised to promote the rights and health of young women and girls. Men's and boys' clubs were established and trained using the male engagement model to transform boys into men who support gender equality. Additionally, two radio slots were secured to raise awareness about SRHR issues.

Nonetheless, the project has faced several challenges. Less than half of the targeted beneficiaries were reached, falling short of the goal to reach 2,730 individuals. Low turnout at community gatherings required aligning activities with existing events on the chiefs' timetables, causing delays. Collaboration with private schools was delayed due to slow responses to suggested dates. To address these challenges, the YWCA proposed several solutions. Despite their low enrolment rates, they plan to work with more private schools to reach the target number of beneficiaries. Project activities will be aligned with other planned community events to increase attendance. Meetings with school committees and principals will be held to explain the project's relevance to their curriculum, generating more interest and securing more time for activities in schools. The project's reach within the designated districts will be broadened to meet target numbers.

Conclusion

The Lesotho YWCA's project demonstrates a comprehensive approach to promoting the right to health for young women and girls through CSE and improved access to SRHR services. Despite facing challenges, the project has made significant strides in community engagement, education, and advocacy. Continued efforts to address barriers and expand the project's reach will be crucial for its success and sustainability. This case study highlights the importance of community-based initiatives in addressing SRHR issues and the need for ongoing support and collaboration among stakeholders to achieve lasting impact.

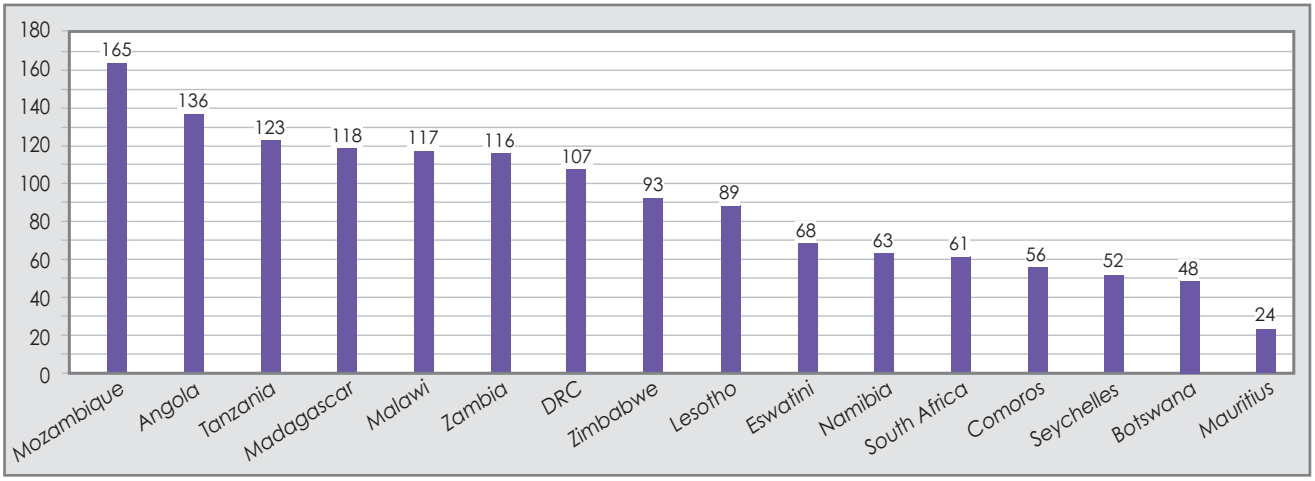
Source: VCSAF.[47]

[47] Southern Africa: Young women call for a safe future - VCSA Fund' (2024), 23 October. Available at: https://vcsafund.org/2024/10/23/wosso-fellows-submission-to-sadc-pf-hearing/ (Accessed: 19 November 2024).

Early unintended pregnancy in the SADC region

Early unintended pregnancy remains a significant challenge in the SADC region, profoundly impacting the lives of adolescents.[48] Early pregnancies often result from limited access to comprehensive sexuality education, contraceptives, and reproductive health services. These early pregnancies can lead to adverse health outcomes, disrupt educational and career opportunities, and perpetuate cycles of poverty and gender inequality. Addressing this issue requires targeted interventions to improve access to sexual and reproductive health services and empower young people with the knowledge and resources to make informed decisions about their reproductive health.

Figure 3.3: Adolescent fertility rates (per 1000 women 15-19)



Source: World Bank 2022 Statistics.[49]

Figure 3.3 illustrates the state of adolescent fertility in the SADC region using the most recent data from 2022 provided by the World Bank. Mozambique has the region's highest adolescent fertility rate (AFR), with 165 births per 1,000 women aged 15 to 19. Several other countries also exhibit high fertility rates, including Angola, Tanzania, Madagascar, Malawi, Zambia, and the Democratic Republic of Congo (DRC). High adolescent fertility rates are often associated with elevated rates of child marriages and early pregnancies.[50] These factors contribute to a cycle of poverty and limited educational and economic opportunities for young women.

Addressing these high fertility rates requires comprehensive strategies, including improving access to education, enhancing reproductive health services, and implementing policies that protect the rights of adolescents.

High adolescent fertility rates are often associated with elevated rates of child marriages and early pregnancies

[48] Wangamati, C.K. (2020) 'Comprehensive sexuality education in sub-Saharan Africa: adaptation and implementation challenges in universal access for children and adolescents', Sexual and Reproductive Health Matters, 28(2), p. 1851346. Available at: https://doi.org/10.1080/26410397.2020.1851346.
[49] World Bank Open Data. Available at: https://data.worldbank.org (Accessed: 13 November 2024).
[50] WHO, 2012. Early marriages, adolescent and young pregnancies. https://apps.who.int/gb/ebwha/pdf_files/WHA65/A65_13-en.pdf

Teenage pregnancy in Seychelles. Photo: Gender Links

By understanding these dynamics, policymakers and stakeholders can better target interventions to reduce adolescent fertility rates and improve the well-being of young people in line with the SADC SRHR Strategy 2019-2030 goals. These figures suggest that bold steps need to be taken to reduce the high AFR in the region. Lessons from other countries show that the implementation of sexual and reproductive health policies, educational and vocational programmes, empowerment initiatives, training activities, school retention programmes and behaviour change campaigns significantly contribute to addressing high adolescent fertility.[51]

Studies suggest that inter alia, socio-economic status, lack of parental communication and support, early marriage, religion, and low educational status of adolescents are contributing factors to high adolescent fertility rates.[52] The following case study illuminates the challenges of teenage pregnancies in Mozambique.

Teenage pregnancy in Mozambique

Mozambique has one of the highest adolescent fertility rates in the SADC region and the world, with approximately 165 births per 1,000 women aged 15-19.[53] This high prevalence is influenced by various socio-economic, cultural, and educational factors, making it a significant public health concern. Some of these factors are:

- Poverty is a significant driver of teenage pregnancies. Many adolescents engage in early sexual relationships due to economic pressures and the need to support their families[54].
- Low levels of education are strongly associated with higher rates of teenage pregnancies. Girls who drop out of school are more likely to become pregnant[55].
- In many communities, early marriage and childbearing are culturally accepted and even encouraged. This cultural acceptance leads to high rates of teenage pregnancies[56].
- Limited access to contraceptives and reproductive health services is a significant barrier. Adolescents often face challenges in obtaining contraceptives due to stigma, lack of information, and healthcare provider biases.[57]

[51] Cadena K, Hernandez PB, Inchauste G. Preventing teenage pregnancy: a priority for the well-being of women in Mexico. Available from: https://www.
[52] https://blogs.worldbank.org/latinamerica/preventing-teenage-pregnancy-priority-well-being-women-mexico (Updated April 13, 2022; Accessed October 19, 2022).
Maharaj, N.R. (2022) 'Adolescent pregnancy in sub-Saharan Africa - a cause for concern', Frontiers in Reproductive Health, 4. Available at:
[53] https://doi.org/10.3389/frph.2022.984303.
Maharaj, N.R. (2022) 'Adolescent pregnancy in sub-Saharan Africa - a cause for concern', Frontiers in Reproductive Health, 4. Available at:
[54] https://doi.org/10.3389/frph.2022.984303.
Mekonen, E.G. (2024) 'Pooled prevalence and associated factors of teenage pregnancy among women aged 15 to 19 years in sub-Saharan Africa: evidence from
[55] 2019 to 2022 demographic and health survey data', Contraception and Reproductive Medicine, 9(1), p. 26. Available at: https://doi.org/10.1186/s40834-024-00289-5.
[56] ibid
[57] ibid
Jonas, K. et al. (2016) 'Teenage pregnancy rates and associations with other health risk behaviours: a three-wave cross-sectional study among South African school-going adolescents', Reproductive Health, 13(1), p. 50. Available at: https://doi.org/10.1186/s12978-016-0170-8.

Effects of teenage pregnancy

The effects of teenage pregnancy in Mozambique and the rest of SADC are profound and multifaceted, impacting the health, education, and socio-economic status of young mothers:

- Teenage mothers face higher risks of complications during pregnancy and childbirth, including preterm birth, low birth weight, and maternal mortality than older women do[58]. These health risks are exacerbated by inadequate prenatal care and poor health infrastructure.
- Teenage pregnancy often leads to school dropout, limiting educational and career opportunities for young mothers. This disruption perpetuates the cycle of poverty and reduces the socio-economic mobility of young women. In Mozambique, 70 per cent of pregnant girls, of whom many were still enrolled in primary school past puberty due to late enrolment, dropped out of school.
- The economic burden of teenage pregnancy is significant. Young mothers are less likely to complete their education and secure stable employment, leading to long-term financial instability.[59]
- Teenage mothers often face social stigma and discrimination, which can lead to social isolation and mental health issues. The stigma associated with teenage pregnancy can also affect the self-esteem and prospects of young mothers.[60]

A secret pregnancy in the Comoros: One teen's story

Sara* was 17 when she found out she was pregnant. Living in a rural village in the Comoros, she carried the entire pregnancy in secret and then gave birth in a hospital bathroom. "Our society does not accept getting pregnant out of wedlock," she explained recently to UNFPA. "I was going out with a young man who was 20 years old," she recalled. They rarely used condoms, she said. "My cycles were regular, and I was happy to calculate the day of ovulation to take precautions. But it was not effective." In November of last year, she realised that she was pregnant. "I did not know what to do," she said. "I was completely lost… My father is a religious man and would not accept that it happened to his eldest daughter. I thought he would kill me."

**Not her real name* *Source: UNFPA.*[61]

Across SADC, the struggle of pregnant girls and adolescent mothers to stay in school is fraught with challenges. The story of Constância, a once high-achieving student who faced insurmountable barriers after becoming a mother in Mozambique, highlights the systemic and social obstacles many young girls encounter in their pursuit of education.

[58] Amoadu, M., Hagan, D. and Ansah, E.W. (2022) 'Adverse obstetric and neonatal outcomes of adolescent pregnancies in Africa: a scoping review', BMC Pregnancy and Childbirth, 22(1), p. 598. Available at: https://doi.org/10.1186/s12884-022-04821-w.
[59] ibid.
[60] ibid
[61] A secret pregnancy in the Comoros: One teen's story | United Nations Population Fund (no date). Available at: https://www.unfpa.org/news/secret-pregnancy-comoros-one-teens-story (Accessed: 20 January 2025).

Mozambique: Pregnant girls and adolescent mothers struggle to stay in school

Constância had an unblemished academic record. She never failed a grade and reached the 12th grade at age 17, a milestone that few adolescent girls achieve in Mozambique because of the many systemic and social barriers they face to attend school. But in grade 12, Constância had a child. She started missing classes because she had to breastfeed her daughter and had no one to support her with childcare. As a result, she failed some exams and dropped out without completing the grade. When she found out she was pregnant, she moved in with her boyfriend, a 25-year-old man. Once she gave birth to their daughter, she started taking contraceptives to avoid getting pregnant again. Her boyfriend was against this, so she hid it from him. When her menstrual period became irregular, he accused her of having an abortion. He became angry and threatened to stop giving her money for the household and her expenses, including the money she used to pay for her education.

Constância decided to leave her boyfriend's home and returned to her family's home with her daughter. In 2021, at 18, she could not re-enrol in school because she no longer had money to pay for fees and other costs. Her parents committed to getting the money to pay for her enrolment in the 2022 academic year. "I want to return to the same school where I was already studying because I'm used to it," she said. "The school is far, and I spend much money on transportation." Like other adolescent girls and women who spoke with Human Rights Watch, Constância, now 19, hoped her circumstances would improve. "The child's father will take on his responsibilities again, and the baby will stay with my mom," she said.

Source: Human Rights Watch.[62]

Addressing teenage pregnancy

Mozambique has implemented several initiatives to address the high rates of teenage pregnancy and to mitigate its effects:

- The Mozambican government has integrated CSE into the school curriculum to provide adolescents with accurate information about sexual and reproductive health. This education aims to reduce the incidence of teenage pregnancies by promoting safe sexual practices.
- Efforts have been made to establish youth-friendly health services that provide confidential and non-judgemental care to adolescents. These aim to improve access to contraceptives and reproductive health information.
- Programmes that engage community leaders, parents, and adolescents are crucial for changing cultural norms and reducing stigma. Community education initiatives help create a supportive environment for young people to make informed decisions about their reproductive health.
- Financial support and educational opportunities for young mothers can help them continue their education and improve their socio-economic status. Programmes that offer scholarships, childcare support, and vocational training are essential for empowering young mothers.

Conclusion

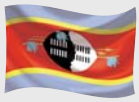
The prevalence of teenage pregnancy in Mozambique, as well as in other countries of SADC, highlights the need for comprehensive strategies to address the underlying socio-economic, cultural, and educational factors. By implementing effective interventions and creating a supportive environment, Mozambique and other countries can reduce the incidence of teenage pregnancies and improve the health and well-being of young people.

[62] Martínez, E. (2024) '"Girls Shouldn't Give Up On Their Studies"', Human Rights Watch [Preprint]. Available at: https://www.hrw.org/report/2024/02/13/girls-shouldnt-give-their-studies/pregnant-girls-and-adolescent-mothers-struggles (Accessed: 19 November 2024).

SADC Gender Protocol Alliance work on ASRHR in the region

The Southern Africa Gender Protocol Alliance, coordinated by Gender Links, is a regional network that advocated for adopting the SADC Protocol on Gender and Development in 2008. Since then, the Alliance has produced an annual Barometer to monitor progress toward achieving gender equality across the SADC region, aligning its findings with the Protocol's targets. It operates through six thematic clusters: Governance and Constitutional and Legal Rights; Sexual and Reproductive Health; Economic Justice and Education; Climate Change and Sustainable Development; Media, Information, and Communications; and LGBTIAQ+. One notable partner within the Alliance's SRHR cluster is the Southern Africa Aids Dissemination Service (SAfAIDS), which promotes SRHR rights through various regional and local programmes. The work of the Alliance and its partners demonstrates a strong commitment to advancing gender equality and SRHR in the region.

Selected SAfAIDS ASRHR programmes in the region



In **Eswatini**, SAfAIDS is implementing the "*Liphimbo Lami*" programme to empower and engage Adolescent Girls and Young Women (AGYW). This initiative focuses on increasing AGYW's access to social protection and economic empowerment programmes and encouraging their involvement in national HIV and SRH programming and policy implementation processes.

It is also running a project titled "*Empowering Adolescent Girls, Young Women, and Men for an Effective, Integrated Gender and Adolescent-Responsive System for HIV Prevention among Adolescents and Young People.*" This project has two key objectives:

- To enhance access to CSE and SRHR for adolescent girls and young women at the community level.
- To improve the integrated delivery of SRHR and HIV services so that they effectively meet the needs of adolescent girls and young women, as indicated by user satisfaction.

In **Zambia**, SAfAIDS[63] works through *Her Future, Her Choice (HFHC)*, a project to strengthen SRHR, targeting adolescent girls and young women in and out of school. The project was developed to respond to the gender inequality and women's rights violations undermining access to comprehensive, rights-based sexual and reproductive health information and services for adolescent girls and young women (10-24 years).

Through the *Gender, Adolescent Pregnancy and Social Norms (GAPS) Programme*, SAfAIDS is collaborating with the Government of Zambia and other partners to create a future where adolescent girls and young people in select geographical areas of the Eastern and Southern Provinces of Zambia can lead empowered and healthy lives. The programme focuses on providing them with access to and opportunities for making their own sexual and reproductive health choices.

Source: SAfAIDS.[64]

[63] 'Our Programmes - SAfAIDS' (no date). Available at: https://safaids.net/our-programmes/ (Accessed: 19 November 2024).
[64] 'Our Programmes - SAfAIDS' (no date). Available at: https://safaids.net/our-programmes/ (Accessed: 19 November 2024).

With funding from the FCDO, Gender Links is working with Women of the South Speak Out (WOSSO) Fellows, a cohort of young women from the global south, to amplify the voices of women and girls and advocate for women's rights. Collaborating with the Voice and Choice Southern Africa Fund grantees, the fellows are making their voices heard by targeting conferences and spaces where discussions and critical decisions about gender equality and women's rights are made. They engage with policymakers, stakeholders, and community leaders to highlight women and girls' challenges in the SADC region and advocate for policies that promote gender equality and protect women's rights. Through these efforts, the WOSSO Fellows are raising awareness and driving tangible change in their communities, ensuring that the perspectives and needs of women and girls are prioritised in regional and global discussions. The following article highlights a recent advocacy initiative.

Southern Africa: Young women call for a safe future[65]

Young women have made an impassioned plea to the Southern African Development Community Parliamentary Forum (SADC PF) to secure a "safe and productive future" for the largest segment of the region's population.

WOSSO Fellows and VCSAF representatives reminded lawmakers that "youth constitute 60% of the population of SADC, and young women are slightly more than half of these youth; in other words, they are the largest single demographic in our region. Yet young women constitute the majority of those who are unemployed, missing in decision-making, and whose rights are violated through GBV."

The submission profiled the harrowing case of a young woman, age 16, who fell pregnant as a result of rape in what is supposed to be a "place of safety" in Lesotho. She HIVE, a Voice and Choice Southern Africa Fund grantee had arranged for her removal from an abusive home situation and placement in the "place of safety", to be safe. In a rare landmark case, She Hive succeeded in winning a court order using existing laws for the young woman to have a safe abortion.

Most women in the region, they noted, "seek unsafe options which include drinking a range of plant or chemical based concoctions or inserting a stick, root or wire into the cervix. Being poor, rural and young are all associated with a higher risk of unsafe abortion." While Africa accounts for about one-quarter of unsafe abortions globally, it accounts for about two-thirds of abortion-related deaths.

The advocacy team included two WOSSO Fellows: Veronika Haimbili, an independent consultant from Namibia, and Vimbai Rugare Nyika, from the Women's Action Group in Zimbabwe, in partnership with Refiloe Harris from She HIVE Association.[66] All three are members of the recently launched Safe Abortion Alliance of Southern Africa (SAASA)[67], a growing network of individuals and organisations campaigning for women's right to voice and choice.

SAASA responded to a call by the SADC PF Standing Committee on Gender Equality, Women's Advancement, and Youth Development (GEWAYD)[68], for submissions to a public hearing on, among others, child marriage and gender-based violence.

[65] 'Southern Africa: Young women call for a safe future - VCSA Fund' (2024), 23 October. Available at: https://vcsafund.org/2024/10/23/wosso-fellows-submission-to-sadc-pf-hearing/ (Accessed: 19 November 2024).
[66] https://shehive.co.ls/
[67] 'SAASA - Safe Abortion Alliance of Southern Africa - VCSA Fund' (no date). Available at: https://vcsafund.org/saasa/ (Accessed: 19 November 2024).
[68] Forum, S.P. (no date) Gender Equality, Women Advancement, & Youth Development - SADC Parliamentary Forum. Available at: https://www.sadcpf.org/index.php/en/plenary-assembly/committees/standing-committees/gender-equality-women-advancement-youth-development (Accessed: 19 November 2024).

The young women asked Members of Parliament (MPs) to make sure that:

- Every member state has a progressive ASRHR policy, which enables us to access youth-friendly SRHR information and services such as contraception.
- Every member state engages in community awareness raising to reduce stigma and protect our rights to comprehensive ASRHR.
- We can access safe abortion - preferably by encouraging member states' parliaments to decriminalise abortion completely and by expanding access to good quality, self-managed, medication abortion.

The chairperson of the hearings congratulated them on the submission and said that this work should be "exposed."

Source: VCSAF.[69]

Junior councillors during an SRHR discussion at a Gender Links workshop in Zimbabwe. Photo: Tapiwa Zvaraya

[69] 'Southern Africa: Young women call for a safe future - VCSA Fund' (2024), 23 October. Available at: https://vcsafund.org/2024/10/23/wosso-fellows-submission-to-sadc-pf-hearing/ (Accessed: 19 November 2024).

Next steps

Improving adolescent sexual and reproductive health and rights in Southern Africa requires a multifaceted approach that addresses the unique challenges faced by young people in the region. Here are some key recommendations that need to be implemented.

Strengthen comprehensive sexuality education programmes

- Member states must ensure that CSE is integrated into school curricula across all SADC countries, making it accessible to all adolescents. This includes providing age-appropriate, scientifically accurate, and culturally relevant information.
- Member states must engage parents, religious leaders, and community members in developing and implementing CSE programmes to ensure cultural sensitivity and community buy-in.
- Member states must invest in training educators to deliver CSE effectively, equipping them with the necessary skills and resources to address sensitive topics confidently.

Enhance health services for adolescents

- Member states must incorporate adolescent-friendly health services into primary healthcare systems, ensuring that young people have access to comprehensive sexual and reproductive health care, including contraception, HIV testing, and mental health support.
- Health ministries must identify and mitigate barriers that prevent adolescents from accessing health services, such as stigma, discrimination, and lack of confidentiality.
- Governments and civil society organisations are encouraged to launch targeted awareness campaigns to inform adolescents about available health services and encourage them to seek care when needed.
- To prevent adolescent pregnancy, stakeholders need to work to reduce socioeconomic inequalities, GBV and alcohol abuse, and improve adolescents' health care and educational status. Issues such as child marriage, unsafe abortions, poor healthcare infrastructure and non-adolescent-friendly health facilities need to be addressed.

Policy development and implementation

- There is a need to encourage countries without specific ASRHR policies to develop and implement stand-alone policies that address the unique needs of adolescents.
- There is a need for continued advocacy for the harmonisation of the age-of-consent laws with access to contraceptives and SRHR services to reduce barriers for adolescents.
- Given the high rates of early pregnancies in the region, legislators must urgently lower the age of consent for contraception to address this challenge.
- Member states must review and strengthen existing policies to ensure they are comprehensive and effectively address the challenges faced by adolescents in the region.
- There is a need to foster political will and commitment to ASRHR by engaging policymakers and advocating for increased funding and resources.

Build resilient health systems

- Member states must ensure adequate allocation of resources to health systems to support the delivery of ASRHR services, even during crises such as the COVID-19 pandemic and to be prepared for emergencies such as future pandemics. Some strategies that can be employed include developing tech solutions.
- Member states must invest in recruiting and training healthcare workers to improve the quality and availability of adolescent-friendly health services.
- Member states must strengthen supply chain systems to supply essential medical supplies and contraceptives consistently.

Monitor and evaluate progress

- Member states must implement robust monitoring and evaluation systems to track ASRHR initiatives' progress and identify areas for improvement.
- There is a need to facilitate sharing of best practices and successful strategies among SADC countries to promote learning and collaboration.
- Member states must ensure regular reporting on ASRHR indicators to maintain accountability and transparency.

By taking these steps, SADC can make significant strides in improving the sexual and reproductive health and rights of adolescents, ensuring that they are educated, healthy, and empowered to contribute to the region's future development in line with the objectives of the Strategy for Sexual Reproductive Health and Rights in the SADC Region (2019 - 2030).

Education, health and empowerment in SADC is the future.
Photo: Colleen Lowe Morna

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