Adolescent Sexual and Reproductive Health and Rights 3

Students attending the launch of Womens day ceremony at Jwaneng, Botswana. Photo: Keletso Serole

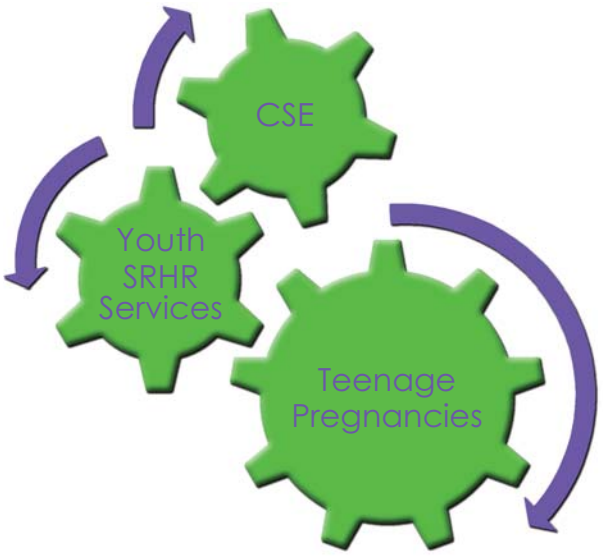
KEY POINTS

- Most SADC countries have a Comprehensive Sexuality Education (CSE) programme in place that meets or is in the process of being aligned to international standards but implementation, monitoring and evaluation is still weak.
- Where CSE is implemented, young people are able take advantage of educational and other opportunities that will impact their lifelong well-being; avoid unwanted pregnancies and unsafe abortions; improve their sexual and reproductive health and protect themselves against STIs, including HIV.
- Young people who are not in schools are harder to reach with CSE, requiring different approaches and greater effort.
- Only six SADC countries (DRC, Lesotho, Madagascar, Malawi, South Africa and Zambia) have stand alone Adolescent Sexual and Reproductive Health and Rights (ASRHR) policies or strategies. Only five countries (Madagascar, Mozambique, Namibia, South Africa and Tanzania) in SADC do not require parental consent for adolescents to access SRHR services.
- The age of access to contraceptives in SADC ranges from 12 in five countries to 18 in one.
- Adolescent fertility ratios in the region range from 27 per 1000 women in Mauritius to 152 per 1000 women in Angola.
- Tanzania's President John Magufuli has banned readmission of girls who get pregnant in school. He has also urged women to stop using contraception so that they can increase the country's population.

Introduction

Sixty percent of SADC's population is below the age of 25. It follows that youth should be the major focus of any SRHR campaign. Yet, to quote Save the Children: "As adolescents around the world enter puberty, taboos, discomfort and fear prevent parents and other trusted adults from teaching relevant information to help adolescents navigate the complexities of their emerging sexuality."[1]

Key SRHR concerns relating to youth in Southern Africa include significant percentages of sexually active adolescents below the age of 16; high levels of teenage pregnancies; multiple concurrent sexual relations; increasing trends of intergenerational sexual relations; low levels of consistent condom usage during sex; high levels of maternal mortality amongst young mothers; compromised quality of antenatal care to young mothers compared to older mothers; high levels of HIV and AIDS among young people, especially young women, and high levels of GBV. Child marriages remain a huge concern with an increasing number of adolescent girls faced with the challenge (see Chapter seven).



As adolescents around the world enter puberty, taboos, discomfort and fear prevent parents and other trusted adults from teaching relevant information to help adolescents navigate the complexities of their emerging sexuality

This chapter covers the efforts made in different Southern African countries in implementing the SADC Gender Protocol articles that relate to three interlinked areas: Comprehensive Sexual Education (CSE), access to SRHR services for young people and teenage pregnancies.

The United Nations Education, Scientific and Cultural Organisation (UNESCO) defines CSE as a "curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to realise their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and understand and ensure the protection of their rights throughout their lives."[2]

The term "comprehensive'"emphasises an approach to sexuality education that encompasses the full range of information, skills and values to enable young people to exercise their sexual and reproductive rights and to make decisions about their health and sexuality.[3] CSE is a rights-based approach to sexuality education. It promotes the acquisition of knowledge, skills and positive values of sexuality and reproductive health.

1 https://www.savethechildren.org/us/what-we-do/global-programs/health/adolescent-sexual-and-reproductive-health
2 https://en.unesco.org/news/why-comprehensive-sexuality-education-important
3 Ibid

Table 3.1: Key CSE and Teenage Pregnancy Indicators

INDICATORS	Angola	Botswana	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
CSE curriculum that reflects international standards[4]	Partial	Partial	No	Yes	Yes	N/A	Yes	N/A	Partial	Yes	N/A	Yes	Yes	Yes	Partial
Age of access to contraceptives	N/A	12	18	15	N/A	12	16	16	16	12	15	12	12	16	16
Legal age to consent to sex (M)[5]	18	16[6]	18	16	16	14[7]	16	16	18	14	18	16	18	16[8]	16
Legal age to consent to sex (F)[9]	16	16	14	16	16	14	16	16	18	14	18	16	15	16	16
Adolescent fertility rate (births per 1000 women, 15-19 years of age)[10]	152	30	124	77	90	110	140	27	135	74	57	43	115	83	104

Source: Gender Links, 2018.

Table 3.1 shows that:

- Most SADC countries have a CSE programme in place that meets or is in the process of being aligned to international standards.
- The age of access to contraceptives in SADC ranges from 12 in five countries to 18 in one.
- The legal age of consent to sex ranges from 14 to 18. It is higher for men in three countries - Angola, Tanzania and DRC. This parameter is important because sex before the legal age of consent is statutory rape. Lowering the age for women essentially lowers the bar for statutory rape for women and is discriminatory. Coerced sex is a major contributory factor to high rates of teenage pregnancy.
- Adolescent fertility ratios in the region range from 27 per 1000 women in Mauritius to 152 per 1000 women in Angola. There is a directly inverse correlation between levels of development and levels of adolescent fertility; this reflects the importance of socio-economic factors in bringing down adolescent fertility.

In a region which has over 158 million young people aged between 10-24 a strengthened CSE curriculum with age appropriate and sensitive information will help improve adequate knowledge on the matter among children and adolescent groups. Although school-based sexuality education and HIV prevention are not enough by themselves to prevent HIV and ensure the rights of young people to sexual and reproductive health, school-based programmes are a very cost-effective way to contribute to these aims.[11]

Inadequate access to comprehensive and age-appropriate information about sex and sexual health among adolescents is recognised as a contributing factor to high teenage pregnancy rates. Teenage pregnancies are often a contentious socio-political issue. As the ones disproportionately affected girls' access to education during pregnancy and thereafter is often jeopardised.

Multiple laws and policies have been put in place reflecting the intersection between sexual education and teenage pregnancy, yet some of these laws and policies undermine girls' right to education. UNESCO states that the education sector has an obligation to minimise teenage pregnancies by providing adequate knowledge, information and skills and by ensuring that pregnant girls and adolescent mothers have the right to continue their education.

Low educational levels are themselves responsible for high rates of teenage pregnancies. For example, a 2018 *Situation Analysis on Early and*

4 UNESCO, Emerging Evidence, Lessons and Practise in Comprehensive Sexuality Education, a Global Review, 2015
5 https://www.up.ac.za/media/shared/10/ZP_Files/harmonizationoflegalenvironment-digital-2-2.zp104320.pdf
6 https://www.youngpeopletoday.org/wp-content/uploads/2018/06/ESA_Commitment_Report_2015.pdf
7 https://www.youngpeopletoday.org/wp-content/uploads/2018/06/ESA_Commitment_Report_2015.pdf
8 https://www.youngpeopletoday.org/wp-content/uploads/2018/06/ESA_Commitment_Report_2015.pdf
9 https://www.up.ac.za/media/shared/10/ZP_Files/harmonizationoflegalenvironment-digital-2-2.zp104320.pdf
10 https://data.worldbank.org/indicator/SP.ADO.TFRT?locations=BW-CD-AO-LS-MG-MW-MU-NA-MZ-ZA-SC-SZ-TZ-KM-ZM-ZW
11 Review of the evidence on sexuality education: report to inform the update of the UNESCO International technical guidance on sexuality educationhttps://unesdoc.unesco.org/ark:/48223/pf0000264649?posInSet=12&queryId=222e6166-0557-4ca6-98d3-46d3f2315ca3

Unitended Pregnancies in East and Southern Africa[12] carried out by UNESCO shows that in Tanzania, Malawi and Zambia, more than 50% of girls with no education had experienced a pregnancy. Furthermore, school dropout (including due to pregnancy) is linked to fewer livelihood options, limited economic independence, and a lack of any additional potential benefits of school attendance, such as increased self-confidence and life skills.[13] Therefore, education - including CSE - needs to be considered as both an instrument to prevent teenage pregnancy and a means towards better life chances.[14]

CSE is empowering: **#VoiceandChoice** workshop in Mbabane, Eswatini.
Photo: Thandokuhle Dlamini

The United Nations Population Fund (UNFPA) notes that where CSE is implemented, young people are able take advantage of educational and other opportunities that will impact their lifelong well-being; avoid unwanted pregnancies and unsafe abortions; improve their sexual and reproductive health and protect themselves against STIs, including HIV; understand and question social norms and practices and contribute to society.[15] This shows that CSE is interlinked with the broader aspects of adolescents' life and contributes to them becoming active and empowered citizens.

Comprehensive Sexual Education

SDG 4 Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all. SDG 5.6.2 indicator measures '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'.

ICPD paragraphs 4.29, 7.37, 7.41, and 7.47 Sexuality education to promote the well-being of adolescents; it specifies key features of such education.

- Education should take place both in schools and at the community level, be age-appropriate, begin as early as possible, foster mature decision-making, and specifically aim to improve gender inequality.
- 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), HIV and AIDS prevention.

The East and Southern Africa (ESA) Ministerial Commitment 15 Southern African countries have also signed the East and Southern Africa (ESA) Ministerial Commitment which was endorsed and affirmed in 2013 by 20 countries. Education and Health Ministers in SADC committed to accelerate access to CSE and health services for young people in the region. The only SADC country which is not part of the commitment is Comoros.

[12] UNESCO. 2018. Situational analysis on early andunintended pregnancy in Eastern and Southern Africa
[13] https://www.youngpeopletoday.org/wp-content/uploads/2019/04/Unesco_EUP_Report_2018_LOW_RES.pdf
[14] https://en.unesco.org/news/early-and-unintended-pregnancy-what-role-education
[15] https://southafrica.unfpa.org/sites/default/files/pub-pdf/UNFPA_CSE_report_web.pdf

SADC 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 Comprehensive Sexuality Education (CSE) is that Member States should accelerate and improve delivery of quality comprehensive sexuality education for in and out of school youth by the education and youth sectors. The strategy further specifies that;

- 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 life and future. This includes ensuring that adolescents and young people in-school and out-of-school have access to quality, comprehensive, age-appropriate, scientifically accurate life skills-based comprehensive sexuality education (CSE) with linkages to youth-friendly sexual and reproductive health (SRH) services and the youth sector more broadly.
- 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, making in school CSE programmes intra-curricula and examinable is key.
- Building and strengthening the skills of those working in wider youth and community interventions will expand the capacity within Member States to reach out-of-school youth.
- Creative approaches should be explored to build the capacity of different forms of media, including radio, to reach out-of-school youth.

The right to sexuality education is grounded in universal human rights - including the right to education and to health - as established in numerous international agreements. SADC countries have signed up to various international and regional agreements including the UN Convention on the Elimination of All forms of Discrimination Against Women (CEDAW, 1979); the International Conference on Population and Development (ICPD, 1994); and the Maputo Plan of Action.

The importance of CSE is recognised in the Sustainable Development Goals (SDG) monitoring framework under SDG 5, global indicator 5.6.2 which refers to "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'.[16]

It is also recognised in the SADC Gender Protocol Article 11 which encourages state parties to adopt laws, policies and programmes that ensure the girl and boy child have equal access to information, education services and facilities on SRHR and that state parties shall develop concrete measures to prevent teenage pregnancies.[17] This article of the Protocol also calls on member states to "ensure that the girl and the boy child have equal access to education and health care, and are not subjected to any treatment which causes them to develop a negative self-image."

The right to sexuality education is grounded in universal human rights

[16] https://sustainabledevelopment.un.org/sdg5
[17] SADC Gender Protocol Barometer 2018

Students in Zimbabwe discuss SRHR during a GL workshop.
Photo: Tapiwa Zvaraya

The Gender Responsive Assessment (GRA) survey of constitutions and laws found that in **Malawi**, there are differences in treatment accorded to boys and girls which negatively affects their access to education and health care, girls being the ones largely affected. **Mozambique** noted that there are policies on equal access for girls and boys to education, but there is still a need to intensify this action in rural communities, where girls are still facing cultural barriers in accessing education. **Zambia** noted that there are usually more girls enrolled in primary school, but the concern is retention. The reviewers noted the need to take into consideration the different needs of girls and boys. **Angola** noted that in rural and peri-urban areas girls' access to education favours the boy child. Differential access to education for boys and girls may mean that girls have lower chances of receiving CSE as they may not be in school or are not remaining in school.

The SADC SRHR Strategy has strong provisions for ensuring that Member States provide CSE in primary and secondary schools. The roll-out of CSE, with a strong emphasis on integrating rights into the curriculum while linking with AYSRHR services, is a critical element of an accelerated response to SRHR in SADC[18]. This will increase the voice and choice, and promote better information and greater freedom for adolescents and young people about their sexuality in and out of schools. This will ultimately increase levels of knowledge of HIV infection among adolescents and young people, reducing early and unintended pregnancies, and will raise awareness and response to the sexual exploitation of children and adolescents.

UNESCO and partners developed international technical guidelines[19] on sexuality education in 2009 which were revised in 2018. These seek to assist national education authorities and stakeholders in the development and implementation of CSE programmes and materials. This provides a roadmap for countries to develop context relevant CSE strategies as they move towards achievement of country, regional and international CSE goals.

Policies and practice

In 2015, UNESCO conducted a global review of CSE in 48 countries across the world. The sample included 12 SADC countries. The review excluded Comoros, Madagascar, Mauritius and Seychelles. The findings were published in a report titled, *'Emerging Evidence, Lessons and Practice in Comprehensive Sexuality Education - A Global Review 2015'*.

[18] SADC Strategy 2019-2030
[19] https://www.unaids.org/sites/default/files/media_asset/ITGSE_en.pdf

Table 3.2: Breakdown of CSE in 12 SADC countries[20]

Country	National policy	CSE place in the curriculum	Reflects international standards	Offered at		Mandatory or optional	Teacher training
				Primary	Secondary		
Angola	Yes	In progress - stand-alone	Under review to meet standards	Yes	Yes	Mandatory	Yes
Botswana	Yes	Integrated	Under review to meet standards	Yes	Yes	Integrated into mandatory subjects	Yes
DRC	Yes	Integrated	No	Yes	Yes	Mandatory and examinable	Yes
Eswatini	Yes	Stand alone	Yes	Yes	Yes	Mandatory and examinable	Yes
Lesotho	Yes	Integrated - primary Stand-alone - secondary	Yes	Yes	Yes	Mandatory	Unknown
Malawi	Yes	Stand-alone	Yes	Yes	Yes	Mandatory and examinable	Yes
Mozambique	Yes	Integrated	Under review to meet standards	Yes	Yes	Mandatory and examinable	Unknown
Namibia	Yes	Stand-alone	Yes	Yes	Yes	Mandatory and assessment	Yes
South Africa	Yes	Stand-alone	Yes	Yes	Yes	Mandatory and examinable	Yes
Tanzania	Yes	Integrated	Yes	Yes	Yes	Mandatory and examinable	Yes
Zambia	Yes	Integrated	Yes	Yes	Yes	Mandatory and examinable	Unknown
Zimbabwe	Yes	In progress	Under review to meet standards	Yes	Yes	Mandatory and examinable	Yes

Source: Emerging evidence, lessons and practice in comprehensive sexuality education: A global review, 2015.

Table 3.2 shows that:

- 12 SADC countries have national CSE policies in place and offer mandatory CSE in primary and secondary schools.
- All except DRC reflect international standards. In four countries, (Angola, Botswana, Mozambique and Zimbabwe) CSE is under review to reflect international standards.
- Teacher training is provided in nine countries, but could not be verified in Lesotho, Mozambique and Zambia. Without CSE as a compulsory subject in teacher training programmes, or compulsory quotas for CSE teachers in schools, effective delivery cannot be guaranteed. It was also noted that most curricula did not mention access to guidance, supervision or reporting requirements for teachers who encountered disclosure of sexual abuse during delivery of sexuality education programmes, pointing to a critical lack of supervision and support.[21]

Within SADC, CSE goes by several different names such as prevention education, relationships and sexuality education, sexual and reproductive health (SRH) education, population and family life education (FLE), healthy lifestyles and the basics of life safety in other Southern African countries. The **Zimbabwe** School Health Policy (2018) defines CSE as a formal curriculum that is part of a comprehensive school health education approach that addresses age-appropriate physical, mental, emotional and social dimensions of human sexuality.[22] The **Zambia** Education Curriculum Framework (ZECF) identifies CSE as a cross-cutting issue, and the vehicle through which topics such as Population and Family Life Education and Reproductive Health and Sexuality are to be implemented. The ZECF states that "Learning institutions should, therefore, equip learners with knowledge, skills, values, and positive attitudes about their reproductive health and sexuality for their benefit and that of society."[23]

[20] https://unesdoc.unesco.org/ark:/48223/pf0000243106
[21] https://unesdoc.unesco.org/ark:/48223/pf0000243106
[22] https://hivhealthclearinghouse.unesco.org/sites/default/files/resources/zshp_final_signed_march_2018_reduced.pdf
[23] https://unesdoc.unesco.org/ark:/48223/pf0000247268

Zambia: Challenges in delivering CSE[24]

Having a CSE policy is just the start. According to Matildah Mhango, 30, a teacher at Petauke Day Secondary School in Eastern Province lack of teaching materials is a challenge in the delivery of sexuality education.

"Teachers, especially in rural areas, face challenges in delivering CSE to pupils because of cultural barriers and lack of appropriate CSE materials to teach the subject across different grades," she said. Mhango said while teachers were perceived by pupils as the most credible and trustworthy people who can talk about anything, including sexuality, it is difficult to share the right information with them when the teachers themselves are ignorant about sex education.

She said there is a need for sufficient and proper training programmes on how to teach CSE in schools as well as social support from community members. Mhango explained that most of the pupils at her school come from homes where it was traditional for sex related issues to be taught to them only by their grandparents or traditional counsellors. "Pupils find it really difficult to learn, especially if the teacher is of the opposite sex, because their culture does not allow. It is disrespectful for them.

"Some parents, especially in the rural areas, have a myth that educating children in the area of sexual behaviour and morality should belong to parents alone," Mhango said. The integration of CSE into both optional and compulsory subjects at higher grade levels raises questions about whether the "dose" of CSE offered varies especially with the continuous cases of child pregnancies.

Panos Institute Southern Africa Executive Director Lillian Keifer said CSE is an important aspect of the curriculum because it enables young people to make sound decisions and take the right actions in relation to sexuality. Keifer said for this to be possible, CSE must be taught in a manner that is open and enables the learners to open up, and freely discuss issues such as HIV prevention, human rights, sexual and reproductive health, relationships and human rights.

"Age appropriateness is therefore critical and must be taken into account in the administration of CSE to young people," she said. Keifer said the implementation of CSE must not take a one-size-fits-all approach, but needs to take into account the socio-cultural and economic factors at play in each context, which, if not properly addressed, may result in people withholding information.

Keifer said the materials and methodologies used for CSE must be simplified so that learners are able to relate with the subject." The implementation of CSE should also not be confined to learners at schools, but should also be extended to the wider community through structures like parent teacher associations, and church or religious groups, among others," Keifer said. Chief Mkanda of the Chewa people in Eastern Province said parents should be the first teachers in sexuality education apart from teachers at school. The chief said sexuality education, which is taught in school, is enough such that parents should take it up from there in sensitising the children.

Source: Dorothy Chisi, Gender Links News Service, 2019

[24] https://genderlinks.org.za/news/zambia-cse-boosts-school-success/

The **Eswatini** Education and Training Sector Policy, 2011 and the National HIV Prevention Policy, 2012 make provision for CSE but the National Policy on Sexual and Reproductive Health (2013) and National Youth Policy fall short of mentioning sexuality education in school. However, the Ministries of Education and Training; Health; Sports, Culture and Youth Affairs developed a draft Cabinet Paper for the implementation of Comprehensive Sexuality Education (CSE) and Sexual and Reproductive Health (SRH) activities following the ESA Commitment Conference in December 2013. This has strengthened the government's capacity to jointly collaborate on CSE issues for young people.

Secondary School in Bricaville, Madagascar.
Photo: Razanandrateta Zotonantenaina

The **Madagascar** Ministry of Education decided that CSE would be infused into all subjects, from Malagasy to Physical Education. It would also cover all levels and ages, from early childhood to adolescence. It is divided into four age brackets: 5-8 years, 9-12 years, 12-15 years, and 15+, in accordance with the official education programme.[25] In Seychelles, sexual education is included in the curriculum of Personal and Social Education (PSE) taught in state schools from primary to secondary levels.[26] Finally, UNFPA has documented that there is an absence of a CSE curriculum in Comoros, which when combined with the lack of a legal framework for adolescent SRHR services and the inadequacy of existing youth-friendly centres to provide these services, has resulted in the country continuing to face early sexual debut and unprotected sexual activity expose young girls to unwanted pregnancies, sexually transmitted infections, including HIV/AIDS, abortions and higher rates of maternal mortality.[27]

In **Seychelles**, sexuality education is covered under the Personal, Social and Civic Education (PSCE) curriculum. Schools have both PSCE teachers and counsellors. While the counsellors are more at ease talking to students about sexuality, sexual health, contraceptives and relationships, the PSCE teachers purposely avoid these topics when they are meant to teach them. They prefer to use the PSCE lessons to catch up on maths, language and science lessons. The students are thus not taught what is clearly in the curriculum. Adults, on the other hand, being of a different generation have not been sufficiently exposed to information on sexual and reproductive health and rights. Therefore, there is a need for action to engage children, youth, adults, parents, teachers and the public in general about SRHR.

Resistance to CSE

A lack of understanding and knowledge on CSE has resulted in many viewing CSE in schools as radical sexualisation of children, mainly encouraging young people to engage in premature sexual activity. This misperception has influenced the emergence of some counter campaigns on CSE in the region.

A lack of understanding and knowledge... encouraging young people to engage in premature sexual activity

[25] https://hivhealthclearinghouse.unesco.org/sites/default/files/resources/cse_scale_up_in_practice_june_2017_final_.pdf
[26] http://www.seychellesnewsagency.com/articles/8134/Sexologist+in+Seychelles+wants+comprehensive+sex+education%2C+sex+positive+society.
[27] https://www.unfpa.org/sites/default/files/portaldocument/DP.FPA_.CPD_.COM_.6Finalcountryprogrammedocumentfortheomoros.pdf

Malawi's Life Skills Education suffers setbacks[28]

Deep-rooted conservatism, misconceptions, culture, and religious beliefs appear to be some of the factors currently throwing off the track efforts to improve young people's access to correct and comprehensive sexuality information through Life Skills Education in Malawi. With stunning revelations indicating that between 2010 and 2017 close to 30,000 female learners dropped out of secondary schools due to early marriage or pregnancy, commentators are questioning the effectiveness of Life Skills education in the country.

First introduced in primary schools in the 1990s, Life skills education was meant to be a way of empowering children with appropriate information and skills in the fight against HIV infections and AIDS and for them to deal with various other everyday social and health problems affecting them, including early pregnancies.

> Life skills education was meant to be a way of empowering children

Findings suggest that the teaching of life skills in the country's schools is generally constrained by a variety of social and structural contextual factors. For example, rural communities consider life skills education estranges their children from their cultural roots by discouraging the children to attend initiation schools. Parents in rural communities oppose the use of illustrations on sexual development in the learning material and discourage learners from reading such content.

One parent said, "I think some of the materials using in teaching Life Skills education arouse the learners' sexual feelings and end up having a sexual relationship and getting pregnant." Some students believe that cultural beliefs also dilute school learning by allegedly reinforcing sexual relationships, the very issues which life skills education confronts.

"Some church-run schools think the subject goes against the church's moral teaching, but SAFE's view is that some teachers in church-run schools believe the subject goes against the church's moral," Makala said.

There is another challenge: A study on the implementation of Life Skills Programme in public secondary schools in Malawi conducted in the South Eastern Educational Division (SEED) showed that lack of teaching and learning materials, non-examinability of the subject and inadequate teacher training were, among others, major factors that are hindering effective implementation of the programme.

There is a shortage of trained CSE teachers at secondary level and in some countries at primary level. Research shows that many teachers do not hold the same beliefs as to what to teach on sexuality, when it should be taught and at what age learners should be introduced. Cultural sensitivities are also often a barrier.

Source: Winstone Mwale, Gender Links News Service, 2019

[28] https://genderlinks.org.za/news/malawis-life-skills-education-inadequate/

Recently news broke out that the **South Africa** Department of Basic Education (DBE) had introduced "sex lessons for modern grade 4s in new life orientation curriculum" which includes "...yoga, masturbation and LGBTI+ all part of a new curriculum." This caused an uproar on mainstream and social media of what kind of education system the government will be offering.[29] Although the department distanced itself from the article,[30] this response shows how short-sighted most conversations on CSE can become. Such responses also overlook that children and young people get information about sex from many places, some of which may be ill-informed and more promotive of sexualised activity. There has been a boom of sexualised imagery in the media where young people may get ideas of sex and relationships. Young people also turn to other children for information, and speaking amongst themselves about sex may influence peddling of inaccurate information.

In **Lesotho** a study by Dr Khau (2012) found that sexuality education is hindered by the beliefs of teachers. Another study by Rakolobe (2017) shows that sexuality education is negatively affected by religious and cultural believes of teachers as sex is taboo and religion encourages abstinence and does not allow for the education on the use of condoms and other contraceptives. Malawi finds itself in a similar situation to Lesotho the article above details how beliefs and misconceptions are impacting negatively on delivery of CSE. The Government of Lesotho, through the Ministry of Education and Training (MOET) is a signatory to the SADC Comprehensive Education Policy. MOET introduced Life Skills education in the curriculum at both primary and secondary schools levels. In addition, a new textbook has been introduced to secondary schools in Grade 8. This encourages the teaching of body parts in Sesotho to demystify sex and sexual education among Basotho learners[31].

Marching for equality: Bonhomme High School children. Photo: Ntolo Lekau

In **Botswana** the political and legal environment has been conducive to the implementation of CSE because of the synergies with existing strategies and programmes including:

- The Ministry of Education and Skills Development HIV and AIDS Strategic Framework (2011-16), which provides for CSE to be introduced from pre-school through to tertiary education. Specific reference is also made to the integration of Sexuality and Life Skills Education into teacher education.
- The National Strategic Framework for HIV and AIDS (2009-2016), which has prioritised the prevention of new infections, especially among young people.
- The ASRH Implementation Strategy (2012-2016) and the SRH Policy Guidelines and Service Standards. The ESA Commitment, which Botswana endorsed in December 2013 and adopted in January 2014, provides a policy framework with set short- and long-term targets to facilitate the scale up of CSE.[32]

[29] https://www.timeslive.co.za/sunday-times/news/2019-05-12-sex-lessons-for-modern-grade-4s-in-new-life-orientation-curriculum/
[30] https://www.education.gov.za/Newsroom/MediaReleases/English/tabid/2322/ctl/Details/mid/8493/ItemID/6885/Default.aspx
[31] Kelello Rakolobe, SADC Protocol@Work case study
[32] https://hivhealthclearinghouse.unesco.org/sites/default/files/resources/cse_scale_up_in_practice_june_2017_final_.pdf

Monitoring and Evaluation of CSE

Monitoring and Evaluation (M and E) is an essential mechanism to track performance of countries on their implementation of CSE. Countries are undertaking various efforts in integrating M and E frameworks from local to national levels. Table 3.3 details the measures being taken in SADC countries to monitor CSE, where this is integrated into existing curriculum as well as where it is stand alone.

Table 3.3: Monitoring and Evaluation strategies across SADC[33]

Country	Approach to CSE	How M and E conducted
Botswana	Integrated	• Adapted 11 out of the 15 HIV core indicators into the Annual School Census (ASC) in Botswana to enable them to monitor CSE delivery. • Training of 30 education officers EMIS regional officers to form regional teams to coordinate the process.
Lesotho	Integrated	• Assessment packages have been developed for each of the grades where CSE is taught; • HIV-related indicators have been incorporated into the EMIS; • HIV and AIDS knowledge indicators have been incorporated into the National Education Assessment. There are also plans to include CSE-related indicators in inspection tools.
Mozambique	Intergrated	• Joint planning and monitoring of activities with government takes place on a regular basis. The main departments involved are the Department of School Health (Departamento de Saúde Escolar) and the National Directorate of Teacher Training (Direcção Nacional de Formação de Professores).
Tanzania	Integrated	• School inspectors have been trained as district CSE trainers and 8 were oriented on CSE indicators. • 10 indicators for measuring the education sector's response to HIV have been integrated into the EMIS.
Zambia	Integrated	• Zambia conducts an ASC which contains some directly relevant CSE indicators, based in part on the global HIV and AIDS indicators developed by UNESCO.
Eswatini	Stand alone	• The regional education officers routinely visit schools to monitor and support the teaching of LSE. • There are classroom and school-based monitoring tools in the form of LSE lesson attendance registers, as well as feedback sessions by learners and teachers through focus group discussions. • Baseline and end-line knowledge, attitude and practice (KAP) studies.
Malawi	Stand alone	• Joint planning and monitoring of government and stakeholder activities is taking place. In addition, the inclusion of staff from the Department of Inspectorate and Advisory Services in all training activities ensures that division managers are involved. Six division inspectors have been trained so far. This ensures that trained teachers are regularly supported and supervised. To improve supervision, the MoE, with support from UNESCO, has developed a CSE monitoring tool.
Namibia	Stand alone	• Sexuality education indicators are integrated in the EMIS, and responsible officers are trained in the collection and reporting of these indicators. In addition, the school health programme is monitored through the Ministry of Health monitoring systems.
South Africa	Stand alone	• The Life Skills and Life Orientation curricula are assessed and monitored by curriculum specialists within DBE and through the implementation of the Curriculum Assessment and Policy Statement. • Regular training and capacity-building is provided to teachers to ensure quality implementation and up-to-date information and methodology are used. • The DBE provides quarterly monitoring visits to provinces and schools through the national coordinator of the Life Skills Programme. • Inter-provincial meetings are held on a six-monthly basis to share information and best practice, and to assess progress and gaps on implementation.
Zimbabwe	In progress	• Periodic joint field visits and supporting integration of HIV indicators into EMIS (ongoing).

[33] UNESCO.2017 CSE Scale Up in Practice : Case studies from Eastern and Southern Africa. https://hivhealthclearinghouse.unesco.org/library/documents/cse-scale-practice-case-studies-eastern-and-southern-africa.

Engaging out-of-school youth

Young people who are not in school are harder to reach with CSE, requiring different approaches and greater effort. Although schooling offers the best possibility to reach massive numbers of young people, many children in the region, especially girls, are out of school. For example, in DRC more than 50% of primary school-aged children are not in primary school, and there are low levels of enrolment in secondary school.[34]

> Out-of-school children and youth are a population that needs to be engaged

Out-of-school children and youth are a population that needs to be engaged if CSE programmes are to work. Lack or non-delivery of CSE to this population may influence increasing proportions of teenage pregnancy, as well as other poor SRHR outcomes for young people. UNFPA notes that having an out-of-school CSE framework will complement the in-school CSE curriculum and by so doing, support a holistic approach to ensuring consistency of rights-based and gender-sensitive information provided to all young people.[35]

UNESCO has documented different approaches taken by countries to engage out-of-school youth. For example in Madagascar the Ministry of Employment, Technical Education and Vocational Training, the Ministry of Youth and Sports, and the Ministry of Agriculture and Farming (MAE) integrate CSE as a cross-cutting issue in their vocational training for reaching out-of-school youth with sexuality education. In Tanzania, community radio is used to broadcast CSE programmes that enable rural and hard to reach young people including out-of-school youth to hear information about sexual and reproductive health. In Malawi, the Ministry of Youth, with support from UNFPA, developed a CSE manual for out-of-school youth, and district youth officers were trained on CSE to enable them to deliver CSE to out-of-school youth.[36]

EmaSwati Youth Pledge towards a GBV free Eswatini during the Walk in her Shoes Campaign.
Photo: Thandokuhle Dlamini

[34] SADC Gender Protocol Barometer 2018
[35] https://esaro.unfpa.org/en/news/empowering-out-school-youth-cse
[36] https://hivhealthclearinghouse.unesco.org/sites/default/files/resources/cse_scale_up_in_practice_june_2017_final_.pdf

Seychelles championing SRHR through social media[37]

The Sexual and Reproductive Health Seychelles has been active since its creation in the Ministry of Health, conducting outreach activities in schools, public places, and communities. Its Facebook page is active, with weekly posts which include pictures of their local activities and links from organisations, such as the World Health Organisation (WHO). The ministry officers reach students, young people and adult employees of various workplaces to inform them of their sexual and reproductive health and rights. They do lively interactive presentations, using props and visual aids. They also distribute male and female condoms, lubricating gel and leaflets. SRHR issues are still taboo in Seychelles; young people especially, do not have ready access to correct information about their bodies, their sexual health, contraceptives, abortion, sexual diversity, and dating.

SRHR issues are still taboo in Seychelles

Sexual and Reproductive Health Seychelles has thus been conducting sessions and running a Facebook to reach as many people as possible, in a friendly, engaging and non-threatening manner. The aim is to inform for better personal decision-making. Direct sessions and social media are used to reach a diverse population through three main approaches:

- Conduct sessions in schools, communities, workplaces and with specific population groups, e.g., drug users, and sex workers. These sessions usually last one hour with brief presentations and time for questions and answers.
- Roadshows or outreach activities in workplaces or in specific outdoor sites. These outreach activities are sometimes combined with a promotion being done by a private company. While the company is promoting its products, the Sexual and reproductive health Seychelles give customers information and offer voluntary HIV testing and counselling. Sometimes, the HIV tests are combined with other health issues, such as diabetes, hypertension and cardiovascular problems. These activities are engaging and fun for the public who willingly participate as the tests are done freely and the results given immediately.
- Using social media, such as the Facebook page, to send links from other sites (WHO, for example) and to give information about sexual and reproductive health and rights. The page also gives information about world days and weeks, such as World AIDS Day, World Hepatitis Day, World Health Day. The three methods allow the organisation to reach a wide variety of people and to tailor their information and messages to the target audiences. Therefore, the information given to secondary school students differ slightly in content, context and emphasis to the ones given to adults in their workplaces.

The use of social media has also helped to ensure that the programme of activities is successfully implemented; reaching a wide variety of populations. These include young people, students, parents, employers, employees and even policy-makers as they read and monitor the content of the Facebook page.

Source: Benjamin Vel, SADC Protocol@Work case study

[37] https://genderlinks.org.za/casestudies/seychelles-championing-sexual-and-reproductive-health-through-social-media/

Youth friendly SRHR Services

Adolescents and young people face many barriers in accessing sexual and reproductive health services, ranging from the judgmental attitudes of staff towards sexually active unmarried youth, inconvenient opening times and locations, lack of privacy, fear of lack of confidentiality, to costs.[38]

To be effective, CSE must be accompanied by access to youth friendly services. These in turn need to be provided for in stand along youth SRHR policies. UNFPA reports that the majority of countries in the region do not have laws and policies that determine the age of consent to medical treatment, including access to contraceptives, HIV counselling and testing and termination of pregnancy.

This creates challenges along the chain from the individual who wants to seek the service right up to the health care provider who may end up making their own judgement to provide or not to provide the service. A clear age of consent to access treatment and service is important in improving access to SRHR services by adolescents.

Table 3.4: SADC countries with adolescent and youth SRHR policies across SADC[39]

Country	Stand-alone ASRHR Policy or Strategy
DRC	Yes, National Strategic Plan for Health and Wellbeing of Adolescents and Youth 2016-2020
Lesotho	Yes, National Health Strategy for Adolescents and Young People 2015-2020
Madagascar	Yes, Adolescent and Youth Health Strategy (2016-2020)
Malawi	Yes, National Youth Friendly Health Services Strategy 2015-2020
South Africa	Yes, Adolescents and Youth Health Policy *2016 - 2020*
Zambia	Yes, National Adolescent and Youth Health Strategy (2016-2020)
Angola	No
Botswana	No
Eswatini	No
Mauritius	No
Mozambique	No
Namibia	No
Seychelles	No
Tanzania	No
Zimbabwe	No

Source: African Health Observatory.

Table 3.4 shows that only six SADC countries (DRC, Lesotho, Madagascar, Malawi, South Africa and Zambia) have stand alone ASRHR policies or strategies. Thirteen countries have institutionalised youth-friendly SRH service training programmes for health and social workers and ten countries offer the standard minimum package of AYFSRH services[40].

Lesotho uses the Adolescent Health Policy to address issues of Teenage pregnancy. The policy aims to:

- Reduce maternal mortality rates among adolescents by 30%.
- Reduce genital fistulae of obstetric origin in adolescents by 80%.

[38] https://esaro.unfpa.org/sites/default/files/pub-pdf/SYP%20Annual%20Report%202017%20V2.pdf
[39] aho.afro.who.int/profiles_information/index.php/
[40] UNESCO Fulfilling our Promise to Young People Today 2013 - 2015 Progress Review - The Eastern and Southern African Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people 2016

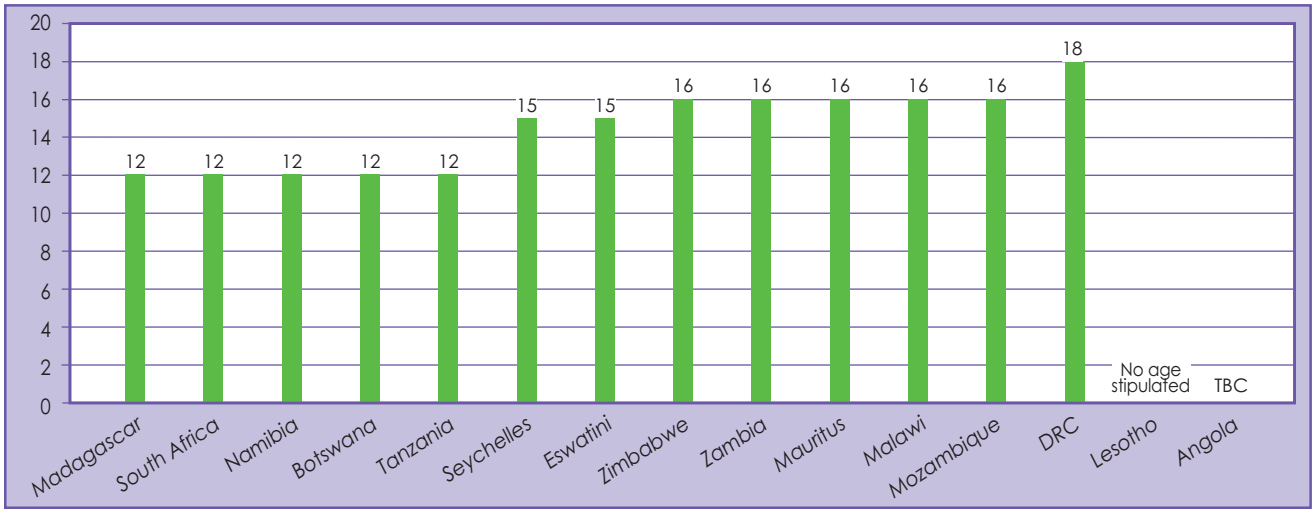
- Reduce prevalence of anemia among expectant adolescents by 20%.
- Increase post-natal care attendance among adolescents by 50%.
- Reduce maternal deaths, resulting from unsafe abortions among adolescents, to less than 10% of the national maternal mortality rates.
- Reduce teenage pregnancies by 30% of the current national levels.
- Provide adolescent couples and individuals with the knowledge and tools of reproductive health to ensure appropriate spacing of births.
- Raise the contraceptive use in sexually active adolescents by 20%.

The Ministry of Education and Training has introduced sexuality education in the curriculum by making Life Skills a compulsory subject in schools. There are adolescent health corners in some health facilities that are meant to cater for the health of adolescents especially their health in relation to sexual and reproductive health rights. The Lesotho Education Act also states that there should be continuation of education after a girl becomes pregnant, meaning that pregnant girls and school going mothers should continue with their education. However research shows that, despite the act, there appears to be no guidelines in terms of how school-going mothers should be treated. What is prominent in the policy is that they must return to continue with their education.[41]

... everyone's but nobody's responsibility

Malawi's National Youth Policy of 2013[42] seeks to ensure the provision of comprehensive sexuality education that promotes abstinence, mutual faithfulness and condom use, uptake of family planning services amongst the youth sexual and cultural practices that promote the spread of STIs including HIV and AIDS, early marriages and teenage pregnancies are discouraged. It also advocates for increase in the legal age of marriage, regulations and enforcement of laws that advance youth reproductive health including sexual violence. However, research shows that Malawi's re-entry policies, are in a form of government circulars with little direction on rights and responsibilities of different actors to facilitate effective re-entry. Therefore this leaves the implementation to chance making it everyone's but nobody's responsibility.

Figure 3.1: Age of access to contraceptives across SADC countries



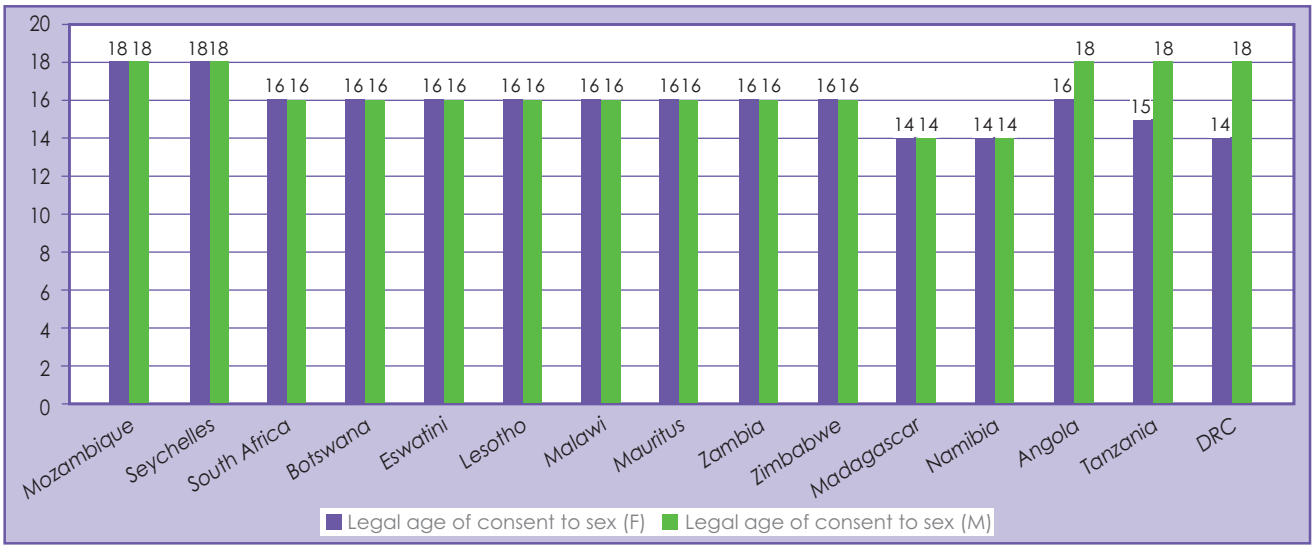
Source: Gender Links.

[41] C.M. Molapo J. D. Adams Miss S P Zulu Schooling-Going Mothers' Experiences in Relation to Teachers: A Case of High Schools in Leribe District, Lesotho https://www.mcser.org/journal/index.php/mjss/article/viewFile/3859/3776
[42] http://www.youthpolicy.org/national/Malawi_2013_National_Youth_Policy.pdf

Figure 3.1 shows that five SADC countries (Madagascar, South Africa, Namibia, Botswana and Tanzania) provide contraceptives to young people from the age of 12. The Seychelles and Eswatini start at age 15.

Five countries (Zimbabwe, Zambia, Mauritius, Malawi and Mozambique) allow for contraception from age 16 and the DRC at 18. Data for Angola needs to be confirmed and Lesotho does not stipulate any age.

Figure 3.2: Legal age of consent to sex in SADC



Source: Audit of SRHR laws and policies in SADC, 2018.

Figure 3.2 shows that the legal age of consent to sex in SADC ranges from 14 for young men and women in Madagascar and Namibia, to 18 for young men and women in Mozambique and Seychelles. In the majority of SADC countries (eight), the age of consent for young men and women is 16. In three SADC countries (Angola, Tanzania and DRC), the age of consent for young men is higher than for young women. The biggest gap is in DRC, where the age of consent is 18 for young men and 14 for young women. According to the SADC Gender Strategy: "This perpetuates gender inequality and reinforces unhealthy gender norms that disempower girls."

The gap in between age of access to contraceptives and legal age of consent to sex is a contentious point in many countries. In six SADC countries (Botswana, Madagascar, Mozambique, Namibia, South Africa and Tanzania) contraceptives are legally available to adolescents younger than the legal age of consent. This is in recognition of the fact that young people below the age of legal consent are having sex. The dilemma that arises is that sex below the age of consent is by definition statutory rape. But what if this is consensual, and occurs between two persons below the age of consent?

In **South Africa** Parliament has adopted the Criminal Law (Sexual Offences and Related Matters) Amendment Act which states that consensual sex of teenagers older than 12 years is legal. The Amendment Bill does not change the age of consent to have sex, which remains at 16. Welcoming the amendment, Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN), an organisation dedicated to children's rights said: "The Bill is a call to action to support adolescents to make informed life choices especially in relation to sexual decision making."

SAFAIDS Launches Mobile SRHR App[43]

SAfAIDS is empowering adolescents and youths to engage in social accountability monitoring of Sexual Reproductive Health (SRH) services through MobiSAfAIDS, an innovative mobile application.

The organisation is empowering disadvantaged adolescents and youths in rural Hwange District with knowledge and skills on how they can engage health service providers towards enhancing SRH services delivery for young people. This is meant to promote youth participation in SRH services policy transformation conversation.

The regional organisation in partnership with the Sweden (Sida) and Buwalo Matalikilo Trust (BMT) launched a Youth Friendly Corner at Lukosi Hospital in Hwange where they are piloting a Mobile Social Accountability Monitoring [MobiSAfAIDS] Platform for Sexual Reproductive Health services in rural Hwange. The pilot initiative is also being done in Lesotho, Malawi, Eswatini, South Africa and Zambia.

The MobiSAfAIDS application is available for download on Google play store and there is also a desktop version. Users have to register in order to access the application, once one registers they can interact with a health facility administrator who has been trained to deal with issues being raised via the mobile application. This is being supported under the Regional Transforming Lives Programme.

Promoting use of technology for Social Accountability Monitoring for young people through the use of the MobiSAfAIDS application. Photo: SAFAIDS

Percy Ngwerume a Social Accountability Specialist with SAfAIDS said their interest is around prevention of early unplanned pregnancy among young women, sexual and gender based violence and also tackling issues of unsafe abortion."We might not have statistics on unsafe abortion, it's something that is a reality in our communities, it's happening but we are not talking much about it so we want to say let's have this conversation so that we can prevent unsafe abortion and unplanned pregnancies," said Mr Ngwerume.

Ngwerume says a research that they carried out in Hwange District revealed that only 7% of young people have had an opportunity to engage or interact with service providers. The application will thus provide a safe and anonymous environment for young people to engage with health service providers. Were service issues warrant policy transformation, young people have been equipped with the skills to analyse data from the application and package this for further policy advocacy.

"Our young people do not really have the confidence to engage health service providers around issues to do with services being provided," he said.

Anna Mandizha Ncube the executive director for BMT said cases of unsafe abortion, school drop outs due to teen age pregnancies are a cause of concern in Ward 20 that they chose to work in.

"We are targeting the ages between 10 to 24 years because this is when a lot of abortions are taking place and this is when early sexual debut are happening. Some parents in the community are complaining that we are concertizing young children on Sexual Reproductive Health issues but the truth of the matter on the ground is children as young as 10 years old are engaging in sexual activities and the constitution of the country allows them to access information on Sexual Reproductive Health," said Mrs Ncube.

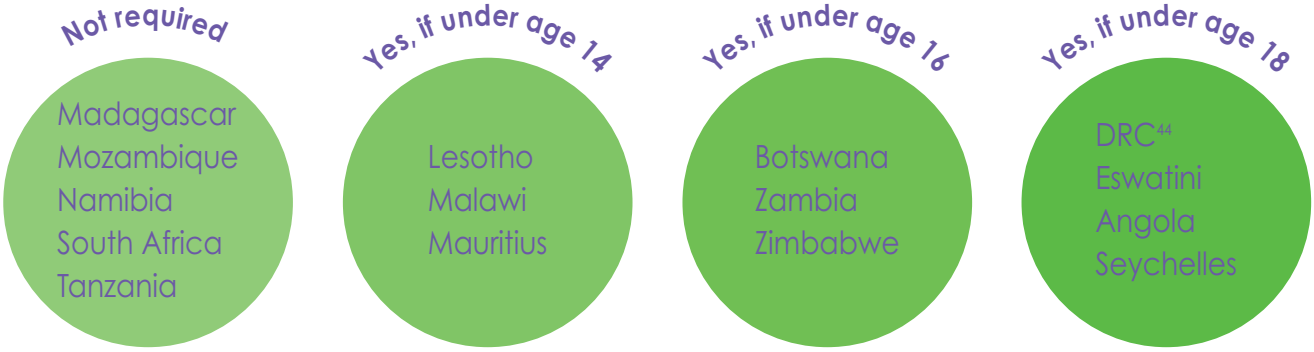
"Our mobile application (MobiSAfAIDS) will allow the young boys and girls to put across complains or compliments in a private way as compared to suggestion boxes," said Mrs Ncube.

Hwange District Medical Officer Dr Wisdom Kurauone, speaking on behalf of the Ministry pf Health and Child Care (MoHCC), welcomed the initiative. "The community does not have access to a lot of things that urban young people are exposed to, we welcome the initiative and we hope to have more youth friendly facilities in Hwange District," said Dr Kurauone.

BMT supported by SAfAIDS trained 20 young boys and girls, known as Social Accountability and Monitoring [SAM] champions, in Hwange District. The champions are drawn from seven villages namely Chilanga, Bangale, Iubwedile, Dicki, Change, Mpongola and Gamba 1 & 2. Under the guidance of Buwalo Matalikilo Trust, SAM Champions will act as key deliverers of SRH information to their peers in the community as well as Social Accountability Monitors. They will facilitate engagement with service providers and policy makers to advocate for policy transformation in SRH service delivery based on evidence generated through the MobiSAfAIDS.

Source: Health Times, 2019

Figure 3.3: Requirements for Parental consent for ASRHR in SADC[44]



Source: UNAIDS.

As illustrated in Figure 3.3, only five countries (Madagascar, Mozambique, Namibia, South Africa and Tanzania) in SADC do not require parental consent for adolescents to access SRHR services. In Lesotho, Malawi and Mauritius parental consent is required if you are under age 14. This applies to Botswana, Zambia and Zimbabwe if you under age 16. In Angola, DRC, Eswatini and Seychelles anyone under the age of 18 cannot access SRHR services without parental consent.

Laws and policies that require parental consent to access sexual and reproductive health services discourage adolescent girls from accessing the services they need to stay healthy. Removal of these requirements is needed, as is the rapid scale-up of intensive combination prevention programme packages, including elements that improve school attendance and empower young women to mitigate their own risk.[46]

Lobbying for unrestricted access to SRHR services by adolescents is an important strategy to address key challenges such as increasing HIV infections amongst young people, early pregnancies and early marriages, menstrual health and unsafe abortions.

[43] https://healthtimes.co.zw/2019/04/23/safaids-launches-mobile-srhr-app/
[44] http://www.unaids.org/sites/default/files/media_asset/unaids-data-2018_en.pdf
[45] https://www.who.int/bulletin/volumes/97/1/BLT-18-212993-table-T1.html
[46] https://www.unaids.org/sites/default/files/media_asset/unaids-data-2018_en.pdf

Teenage pregnancy

With the increasing rates of teenage pregnancy in the region[47], one of the SADC Strategy outcomes is to reduce the rates of teenage pregnancies by ensuring that:

- All stakeholders work collaboratively to define a national minimum package of social, behavioural, structural, and biomedical interventions that will reduce early and unintended adolescent pregnancies, unsafe abortion, unsafe abortion, STIs and HIV among adolescent and youth, and to scale up this package of interventions.
- Member States to consider policies on the readmission and retention of pregnant girls in schools so that they can reach their full potential.
- Tracking adolescent fertility rate.
- Comprehensive sexuality education.
- Counselling and services for a broad range of modern contraceptives.

The levels of teenage pregnancies amongst adolescent girls remain a public health concern in Southern Africa exacerbated by lack or limited CSE, low use of contraceptives, limited access to services, early sexual debut, child marriages, Gender Based Violence (GBV) as well as intergenerational and transactional relationships fuelled by poverty.

According to the UNFPA, every day in developing countries, 20 000 young girls under 18 give birth. This amounts to 7.3 million births a year. With an average of 101 births per 1000 woman between the ages Southern Africa has the highest level of adolescent pregnancy.

> The levels of teenage pregnancies amongst adolescent girls remain a public health concern

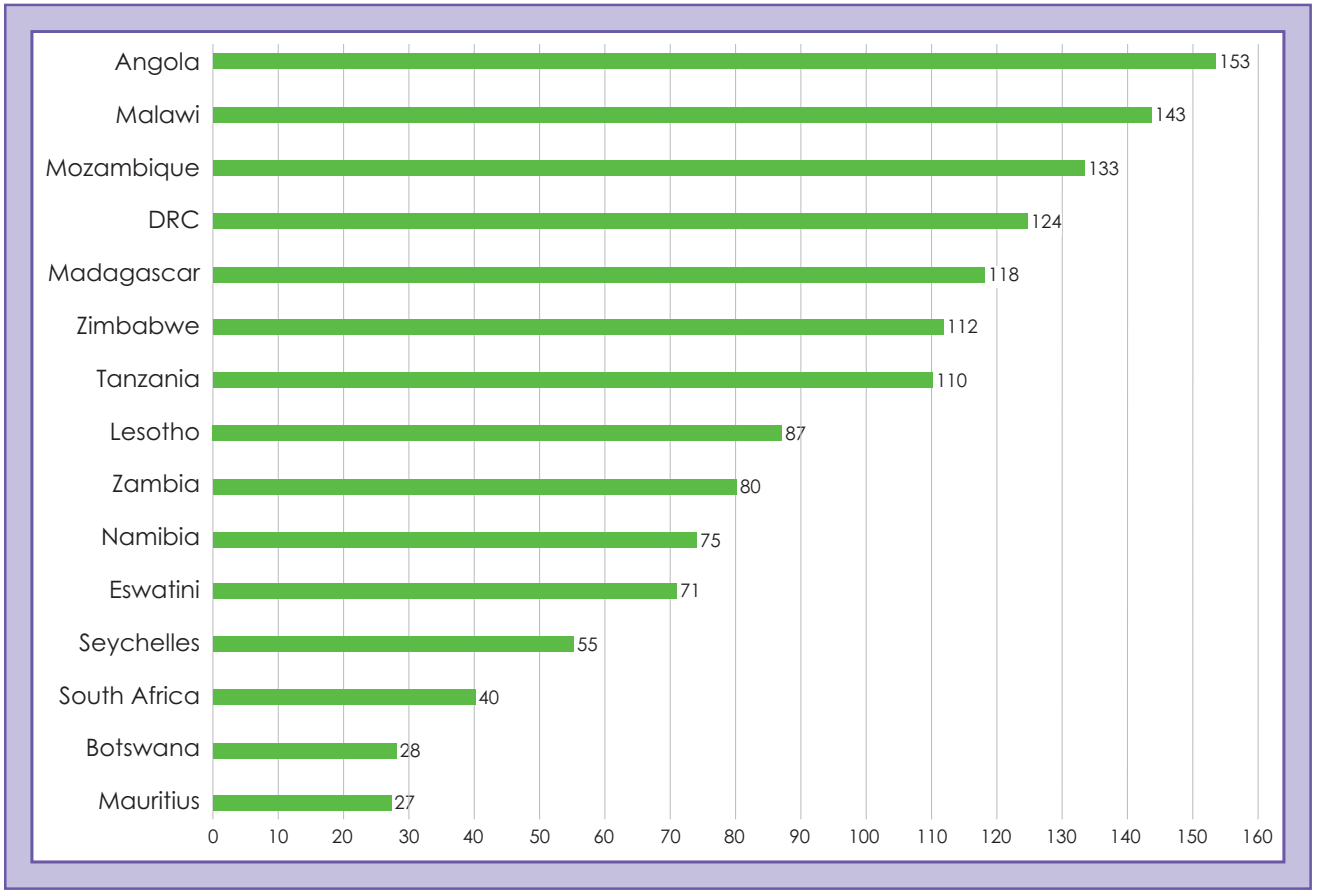
Teenage pregnancies burden female and male youth with obligations beyond their ability to manage, both financially and psychologically. For teenage fathers, the financial expectation to provide economic support is an added obstacle in their completion of secondary education. On the other hand, teenage mothers, who are expected to take care of the child, are more likely to stay home after childbirth, thus impacting their ability to access secondary education or complete it.

When a girl becomes pregnant, her life can change radically. Her education may end and her job prospects diminish. She becomes more vulnerable to poverty and exclusion, and her health often suffers. Complications from pregnancy and childbirth are the leading cause of death among adolescent girls.

Adolescent pregnancy is generally not the result of a deliberate choice - these girls often have little say over decisions affecting their lives. Rather, early pregnancy is a consequence of little or no access to school, information or health care.[48] Teenage pregancnies are also a result of an unmet need for contraception. The Guutmacher institute reports that in Southern Africa, 32% of sexually active adolescents have an unmet need for contraception.[49] It is important to include access to services such as contraceptive methods that could prevent teenage pregnancies in the CSE curriculum to enable adolescents to make informed decisions. The response to teenage pregnancies by the education sector through policies and laws becomes important if girls are to stay in school.

[47] SADC Gender and Development Monitor 2016
[48] https://www.unfpa.org/adolescent-pregnancy
[49] https://www.guttmacher.org/fact-sheet/adding-it-meeting-contraceptive-needs-of-adolescents-sub-saharan-africa

Figure 3.4: Adolescent live births per 1000 population



Source: Southern Africa Gender Protocol Alliance mapping of SRHR Policies and Laws, 2018.

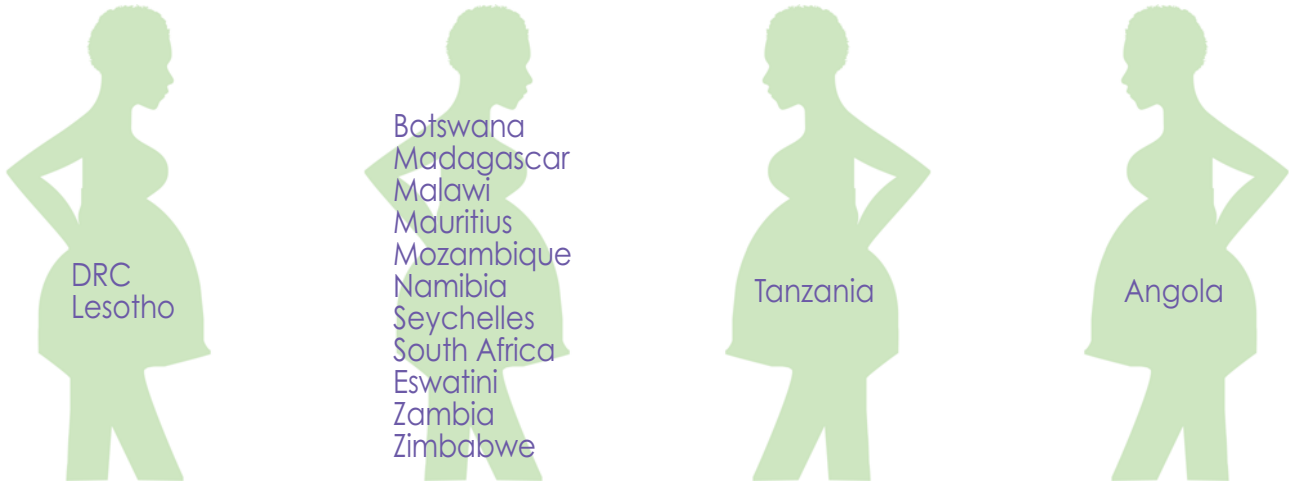
Figure 3.4 shows that in seven SADC countries (Tanzania, Zimbabwe, Madagascar, DRC, Mozambique, Malawi and Angola) over 100 out of 1000 (10%) of adolescent girls are having children. Although lower, the figures Lesotho, Zambia, Namibia, Eswatini and Seychelles are also of concern. Teenage pregnancies and girls drop out of school are interlinked with both influencing the other.

Teenage pregnancies compromise young girls futures, urgent action is needed.
Photo: Gender Links

Policies on adolescent pregnancy

Policies on teenage pregnancy deal primarily with the girl with little focus on the father of the unborn child. In addition, while conditional re-entry is possible in most SADC countries, young mothers face many challenges including economic constraints and social barriers. Conditional re-entry creates a situation where although there are provisions for girls going back to school these provisions may not be absolute and are dependent on certain terms being met. All policies on teenage pregnancy must provide for social protections as well as economic support and allow girls to be easily integrated back into the education system.

Figure 3.5: Breakdown of teenage pregnancy and school policies in SADC[50]



Source: Human Rights Watch Report 2018, Leave No Girl Behind in Africa Discrimination in Education against Pregnant Girls and Adolescent Mothers.

The DRC and Lesotho have policies in place that protect pregnant girls' rights to stay in school and do not prescribe any mandatory conditions to be met. However, Lesotho lacks policies on how to enforce that right. Thus, in the absence of guidance, schools may still expel pregnant girls.[51]

Botswana, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Eswatini, Zambia and Zimbabwe have re-entry policies for pregnant girls. Human Rights Watch notes that in Botswana, Eswatini and Zambia, girls are excluded from school for between 6 and 18 months after giving birth. They are often not allowed to return to the same school. Tanzania outrightly expels pregnant girls while Angola has no policies in place for pregnant girls.

Re-entry is extremely difficult for girls on account of factors such as poverty, stigma and discrimination, and limited support mechanisms for the girls to overcome these.[52] The Gender Responsive Assessment (GRA) Survey analysis on whether students and teenage mothers are allowed to continue with their education across different countries. Only Lesotho, Malawi and Botswana scored the maximum point of two per country.

Respondents in the GRA noted that in Lesotho girls are allowed to continue with their education as per the provisions of the Education Act no's of 2010. However, some Christian schools still have a reservation regarding that. In Angola although the Constitution is non-discriminatory, respondents noted the in some school's internal regulations do not allow pregnant girls and adolescents to study in the daytime. Namibian respondents noted that although there is a policy, responsibility in terms of who ensures that the learner returns to school is not legislated. Emotional and financial support is needed in most cases especially in the more rural parts of Namibia.

Re-entry is extremely difficult for girls on account of factors such as poverty, stigma and discrimination, and limited support...

[50] https://www.hrw.org/report/2018/06/14/leave-no-girl-behind-africa/discrimination-education-against-pregnant-girls-and
[51] UNESCO. 2019. Global Education Monitoring Report - Gender Report: Building bridges for gender equality. Paris, UNESCO.
[52] https://www.youngpeopletoday.org/wp-content/uploads/2019/04/Unesco_EUP_Report_2018_LOW_RES.pdf

Tanzania continues to exclude teenage mothers from education[53]

The 2015-2016 Tanzania Demographic Health Survey (DHS) shows that in the teenage child-bearing category the percentage of women aged 15-19 who have either had a birth or are pregnant is 27%.[54] Despite this high proportion of teenage pregnancies, the country banned teenage mothers from continuing their education or returning to any state-run school following child birth. This was a blow to the girl child's right to education.

Tanzania's President John Magufuli reinforced this ban and added that the government should imprison men involved in teenage pregnancies. A few years on there has been no paradigm shift in Tanzania where the policy of expulsion and non-readmission of girls who get pregnant in school regardless of the circumstances they fall pregnant under continued.

In 2018, girls were further disempowered following a public pronouncement by President Magufuli for women to stop using contraception so that they can increase the country's population labelling those who use contraception "lazy". Access to information on SRHR and services was curtailed when government ordered the suspension of family planning advertisements on TV and radio stations in the country.[55]

In a country where CSE is not a standalone subject access to information on contraception was curtailed. This ban has had ripple effects stopping a loan meant to benefit the education sector. In November 2018, the World Bank withheld a US$300 million loan for secondary education in Tanzania, expressing concern over its exclusion of pregnant girls and teenage mothers.[56]

"Evelina," 17, with her 3-year-old daughter "Hope," in Migori county, western Kenya. Evelina is in Form 2, the second year of lower secondary school. After her baby was born, a friend encouraged her to go back to school. Although Evelina cannot afford to pay school fees, the school's head teacher allows her to stay in school. Photo: © 2018 Smita Sharma for Human Rights Watch

Human Rights Watch reports that following discussions between the World Bank and President Magufuli, the government committed to finding ways for the girls to return to school. But the government has not fulfilled this commitment, leaving thousands of girls out of school. On 16 June 2019, the Day of the African Child, the Centre for Reproductive Rights and the Legal and Human Rights Centre (LHRC) turned up the pressure and filed an official complaint before the African Committee of Experts on the Rights and Welfare of the Child challenging the ban on teenage girls in public schools.

Source: Human Rights Watch, 2018

[53] https://www.hrw.org/report/2018/06/14/leave-no-girl-behind-africa/discrimination-education-against-pregnant-girls-and
[54] https://dhsprogram.com/pubs/pdf/FR321/FR321.pdf
[55] https://edition.cnn.com/2018/10/11/health/tanzania-pregnancy-test-asequals-intl/index.html
[56] https://www.theguardian.com/global-development/2018/nov/15/world-bank-pulls-300m-tanzania-loan-over-pregnant-schoolgirl-ban

In the **DRC**, many girls are left pregnant after sexual violence due to war. According to *Girls Not Brides*, the UN estimates that 200,000 girls and women have experienced sexual violence in the DRC since 1998. Military conflict in eastern DRC has increased the vulnerability of young girls being forced into marriage by armed combatants. Some girls who are raped are then forced to marry perpetrators in the hope that it might bring stability to children born out of wedlock.[57] DRC has a policy that protects young mothers' right to return to school, but needs education policies to make sure the laws are enforced.[58]

In **Eswatini**, the policy on teenage pregnancy is vague. It stipulates that a pregnant mother has a right of admission into the school she was attending prior to pregnancy, or any other school. In the inadequate policy environment schools have developed differing approaches to the issue. Some schools allow pregnant pupils to continue attendance until the pregnancy is visible whereupon they stay home and are allowed to return to write examinations. Some schools also allow teenage mothers to return to the same school. However, citing concerns around stigma and negative attitudes towards mothers (including parent concerns about "negative influence" of the teenage mother) some schools recommend a change of school after birth of the child. Eswatini still does not encourage the distribution of condoms in schools although there are campaigns and recommendations by civil society to show the benefits of this including reducing teenage pregnancies.

In October 2017, the Forum for Africa Women Educationalist Swaziland Chapter (FAWESWA) called "upon the government at service delivery level through Ministries of Health and Education to strengthen SRHR and Comprehensive Sexuality Education (CSE) within schools to reach school-attending youth, empower them with knowledge to delay sex in order to ensure they finish school and get better opportunities in life". FAWESWA also urged parents to "talk sexuality and sex with their children at home" and youth "also to take responsibility for their lives."

FAWESWA also urged parents to "talk sexuality and sex with their children at home" and youth "also to take responsibility for their lives

Zimbabwe has drafted an Education Amendment Bill introduced in February 2019. This bill guarantees protection for girls who become pregnant from being excluded. The bill's provision that "no child shall be discriminated against on the basis of pregnancy" is a positive step towards keeping the girl child in school in a country where over 24% of girls between 15 and 19 become pregnant each year. The bill, whose second reading in parliament was in June 2019, has evoked emotionally charged exchanges in parliament. One parliamentarian declared that "Our schools must not be turned into maternity homes… A rotten apple spoils the barrel. I want to say, it will not be good for other pupils as well." Another parliamentarian argued that protecting girls from expulsion encouraged child marriages, and that it meant "we are saying let us let our children get pregnant at school".[59]

[57] https://www.girlsnotbrides.org/child-marriage/democratic-republic-of-the-congo/
[58] https://www.hrw.org/news/2019/06/16/africa-pregnant-girls-young-mothers-denied-school
[59] https://zimfact.org/factsheet-corporal-punishment-pregnancy-and-the-new-education-bill/

In December 2018 the **Mozambique** Ministry of Education revoked a decree of 2003 which ordered all pregnant schoolgirls to attend night classes, and banned them from day classes.[60] The scrapping of the 2003 decree took effect at the start of the 2019 school year. The removal of this decree is a significant step towards keeping the girl child in school.

Botswana utilises a re-entry policy inscribed in the Botswana Education Regulations passed in 1978. In 1995, a government circular standardized the re-entry process per the original guidelines. The policy stipulates that pregnant girls are to be withdrawn from school and re-admitted in the same school or to a different school. Sooner than twelve months after the cessation of the pregnancy pupils are not allowed to sit for examinations while pregnant or within six months of delivery, and their re-entry to school or ability to sit for examinations is contingent upon approval from the Minister of Education.

A pregnant learner at Seme Secondary school in Daggakraal, Mpumalanga, South Africa. Photo: ENCA

In **South Africa** the National Policy on the Prevention and Management of Learner pregnancies represents one of the most progressive and far reaching efforts to prevent teenage pregnancies and support learners who fall pregnant. According to the Statistics South Africa report on *Recorded Live Births* 10.9% of births in 2017 were to adolescent mothers aged 10 to 19. 3 261 girls aged between 10 and 14 and 119 645 were registered as mothers in South Africa in 2017.[61] In the new policy on teenage pregnancies, the Department of Basic Education (DBE) notes that unintended pregnancy amongst learners is not new to the basic education but its scale and impact have reached the point where it requires a systemic policy and structured implementation planning.[62] This policy intends to address:

- high rates of pregnancy among learners;
- the familial and social context within which this occurs;
- options for reduction of unintended and unwanted pregnancies;
- management of its pre-and post-natal implications;
- limitation of associated stigma and discrimination;
- retention and re-enrolment of affected learners in school.

Furthermore, it will ensure the accessible provision of information on prevention; choice of termination of pregnancy (CToP); care, counselling and support; frameworks for impact mitigation; and guidelines for systemic management and implementation. It also places an emphasis on the education systems commitment to role players to providing the CSE which crucial to optimal sexual and reproductive health.

South Africa has relaunched the Mmoho Campaign: a nationwide advocacy campaign that uses a positive, rights-based approach to change the conversation about teenage pregnancy as well as advocating for comprehensive and accessible sexual and reproductive health (SRHR) services for young women and men. The campaign also provide information on SRHR, and documents stories from teens in their own voices, and updates and events from the campaign.[63]

[60] https://allafrica.com/stories/201812240530.html
[61] https://www.iol.co.za/dailynews/news/97-143-teenage-mothers-gave-birth-last-year-says-stats-sa-16813377
[62] https://www.education.gov.za/Portals/0/Documents/Policies/Draft%20Pregnancy%20Policy%202018.pdf?ver=2018-06-26-142235-687
[63] http://www.mmoho.co.za/campaign/

Next steps

Some laws and policies, as well as attitudes and perceptions, continue to create barriers in the realisation of ASRHR in the region. On the other hand, there are now many progressive policies, strategies and legislation in place to support CSE as well as reduce teenage pregnancies. This creates a solid foundation going forward. The best practices, case studies, policies and campaigns detailed in this chapter attest to a changing and more enabling environment for ASRHR. Key next steps include:

- **Strengthen CSE provisions:** Countries need to upscale their CSE provisions and strengthen the CSE curriculum from all angles including training educators, materials policies. Enhance provision of CSE to out-of-school youth.
- **Engage young men in ending early and unintended pregnancies:** Young men have been seldom been part of the equation in ending teenage pregnancies. The involvement of young men has not been considered as a contributing factor to the high teenage pregnancy rate often there is no clear policy in engaging young men who maybe drivers of teenage pregnancy.[64] Therefore, if young men are not involved at different levels in strategies and campaigns to end teenage pregnancies this may be a missed opportunity to create holistic approach to reduce teenage pregnancies.
- **Distribution of condoms:** Governments can remove hindrance on provision of female and male condoms in schools he prevention. Some countries prohibit the distribution of condoms in schools noting that it will encourage early sexual debut and immorality.
- **Creating an enabling and supportive educational environment** where the psychological and physical conditions of the learner is recognised and supported. In Zambia, for example, girls are being provided with a choice of access to morning or evening classes.
- **Strengthen social protection policies:** Governments can remove financial barriers so that girls can go back to school. In South Africa for example the government offers social grants for adolescent mothers which can help girls take care of their children financially as they continue with their education. This should also include child care centers so that girls can remain in school.

[64] Amoo EO, Igbinoba AO, Imhonopi D, et al. Trends, drivers and health risks of adolescent fatherhood in sub-Saharan Africa. SOCIOINT 2017 - 4th International Conference on Education, Social Sciences and Humanities, held in Dubai, United Arab Emirates, 10 - 12 July 2017. Acceshttp://www.scielo.org.za/pdf/sajch/v12nspe/08.pdf