Adolescent Sexual and Reproductive Health and Rights (ASRHR) 3

Youth in Botswana take part in a campaign event at a mall in Gaborone in 2020 as part of the Botswana Family Welfare Association (BOFWA) Youth Action Movement. Photo: Mboy Maswabi

KEY POINTS

- Except for Tanzania, 15 of the region's member states adopted a phased approach to re-opening schools following COVID-19 pandemic lockdowns, with standard operating procedures to ensure the safety of learners and staff.
- COVID-19 vaccine trials for adolescents form part of universal health coverage, which means that all persons must be able to access health services, medicines, and the vaccines they require regardless of age.
- Learning should integrate Comprehensive Sex Education (CSE) curriculum with indigenous African knowledge and practices on sexual education to provide legitimacy to CSE in the region.
- CSE refers to the provision of age-appropriate, culturally relevant, scientifically accurate, realistic, non-judgmental information about sex and relationships.[1]
- In February 2020, Angola and Mozambique updated their CSE programmes to meet international standards.
- Gender Links (GL), the SADC Gender Protocol National Alliance partners, and local governments with youth leads conducted the Youth Rapid Assessment Study in eight out of 16 SADC countries between 2019 and 2021.
- In and out of school, adolescents and young people must have access to good quality CSE, with linkages to youth-friendly sexual and reproductive health (SRH) and HIV services.
- Drivers of teenage pregnancies are context specific and can include child marriage, poverty, lack of access to ASRHR and effective CSE.

[1] SADC-SRHR-Strategy Publication 2019-2030. Available at https://hivpreventioncoalition.unaids.org/wp-content/uploads/2020/07/SADC-SRHR-Strategy-2019-2030-for-public.pdf, accessed 21 June 2021

Introduction

Despite considerable progress since the International Conference on Population and Development (ICPD) more than 25 years ago, millions of people especially youth, who constitute 60% of the population of SADC, still lack access SRHR information and services.

Zimbabwean gender activists take part in the Million Pads campaign in Harare in July 2019.
Photo: Tapiwa Zvaraya

Punitive policies and restrictive laws against vulnerable groups create barriers to their access to SRHR services.

Key SRHR concerns relating to youth include:

- Significant percentages of sexually active adolescents below the age of 16;
- Multiple concurrent sexual relations;
- Increasing trends of inter-generational 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,
- High levels of GBV.
- Child marriages remain a huge concern with an increasing number of adolescent girls faced with the challenge.

National, regional, sub-regional and global instruments and frameworks guide CSE and ASRHR. Several indicators assess the advancement of CSE and ASRHR in SADC member states.

Table 3.1: Key CSE and Teenage Pregnancy Indicators

Countries/Indicators	Angola	Botswana	Comoros	DRC	Eswatini	Lesotho	Madagascar	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Tanzania	Zambia	Zimbabwe
CSE curriculum reflects international standards	Yes[2]	Partial	N/A	No	Yes	Yes	N/A	Yes	N/A	Yes	Yes	N/A	Yes	Yes	Yes	Partial
Age of access to contraceptives	N/A	12	N/A	18	15	N/A	12	16	16	16	12	15	12	12	16	16
Legal age to consent to sex (M)	18	16	13	18	16	16	14	16	16	18	14	18	16	18	16	16
Legal age to consent to sex (F)	16	16	13	14	16	16	14	16	16	18	14	18	16	15	16	16
Adolescent fertility rate (per 1000 women, 15-19 years of age)[3]	151	46	70	124	77	93	110	133	26	149	64	62	68	118	120	86
Adolescent birth rate (births per 1000 women, 15-19 years of age by %)[4]	163	51	70	109	87	91	151	137	23	180	64	68	41	139	135	108

Source: UNFPA regional data, World Bank, WHO Global Health Observatory.

2 UNFPA regional data, https://www.unfpa.org/data/AO, accessed 10 June 2021.
3 World Bank, 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, accessed 16 June 2021.
4 World Health Organisation, Global Health Observatory, https://www.who.int/data/gho/data/indicators/indicator-details/GHO/adolescent-birth-rate-(per-1000-women-aged-15-19-years), accessed 16 June 2021.

Table 3.1 illustrates some important ASRHR indicators in the SADC region, with new data this year that confirms very high adolescent birth rates for young women between the ages of 15-19. In the 2020 Barometer, this table showed only adolescent fertility rates. Birth rates speak to the number of live births out of 1000 in a certain age cohort, in this case ages 15-19.

Table 3.1 shows that:

- Eleven out of 16 SADC countries have higher teen birth rates than teen fertility rates. Those highlighted in red indicate a higher rate, while those in green indicate lower birth rates compared to fertility rates.
- Age of consent to sexual activity should align to the age of access to contraceptives, yet in DRC the age of access to contraceptives is 18 while age of consent to sex for females is 14.
- There is need to harmonise the age of consent to sex for boys and girls: they should have the same minimum age. Angola, DRC and Tanzania require legal reforms to make this happen.
- In February 2020, Angola and Mozambique updated their CSE programmes to meet international standards. Several other countries still need to do so.

The global pandemic has disrupted school-based Comprehensive Sexual Education (CSE) and sexual services provision. High COVID-19 infection and mortality rates have resulted in some in and out of school programme suspensions, while others closed entirely.

In this third edition of the #VoiceandChoice Barometer, the Adolescent Sexual Reproductive Health and Rights (ASRHR) chapter documents and profiles the impact of delayed (CSE) on teenage sexual behaviour and decision-making. According to a United Nations Educational, Scientific and Cultural Organisation (UNESCO) report, Sub-Saharan Africa is home to more out-of-school children than any other region in the world.[5] The COVID-19 school closures and re-openings exacerbated challenges accessing SRHR, especially for youth who rely on these services within school systems.

CSE provides young people with knowledge, skills and attitudes to develop and sustain positive, healthy relationships and protect themselves from unsafe situations. Yet access to CSE programmes remains a critical challenge. Over the last three years, SADC has seen growing contention about, and resistance to, CSE curriculum changes in the region, with the Zambian government leading a proposed removal of CSE from school curriculums. For consultation and transparency, the Zambian government formed a Technical Review Committee for CSE in May 2021 to investigate proposed bans to potential changes.

Matters related to sexuality, reproductive health and decision-making might include access to CSE and contraceptive information and services: all human rights linked to bodily autonomy and reproductive decision-making.[6] As such, the proposed ban in Zambia provides evidence that legislators continue to deem critical SRH services as "less essential." These services have suffered under SADC governments that divert capacity and funding, both of which become even more critical during times of crisis such as a global pandemic. When delivered effectively, CSE can help prevent gender-based violence (GBV), HIV and AIDS among young people.

This chapter will provide recommendations of how governments can position CSE within the anticipated rollout of vaccines in the region. Current COVID-19 research shows that the younger generation has the lowest mortality rate when infected.[7]

This year for the first time, this chapter explores the preliminary findings of the eight-country Youth Rapid Assessment surveys conducted by Gender Links (GL), Alliance partners, and local government municipalities with a youth lead. This

[5] UNESCO Institute for Statistics Database 2020. Available at http://data.uis.unesco.org/, accessed 10 June 2021
[6] UNFPA State of World Population Report 2021. My Body is my Own: Claiming the Right to autonomy and self-determination, page 55
[7] Bhopal, Sunil S et al. 2021 "Children and young people remain at low risk of COVID-19 mortality. Lancet Child Adolescent Health Publication.

includes the Young Women Alliance, junior councillors and other youth formations in the GL Centres of Excellence (COE) programmes.

This chapter explores the many dimensions of youth-friendly health education and services especially those linked to teenage pregnancy and teen fathers. In keeping with the tradition of the SADC Gender Protocol Barometer #VoiceandChoice publications, the chapter will also provide an update on progress made in ASRHR Alliance campaigns. In addition, it gives CSE updates for all SADC member states.

ASRHR during COVID-19

In March 2021, world leaders met at the World Health Assembly (WHA) Global Education Coalition high-level ministerial meeting to take stock of lessons learnt and discuss possible education strategies required in the second year of COVID-19. Two representatives from the South African Department of Basic Education stressed the crucial role of teachers in the context of the pandemic, noting that states should prioritise vaccination campaigns and distributions for teachers.[8] Fewer young people and adolescents die from COVID-19 infection compared to adults, so education and health experts noted the importance of preserving the custodians of education, especially linked to CSE and ASRHR delivery.

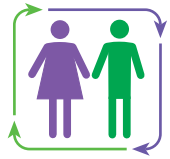
Because digital content can influence knowledge, attitudes and practices of adolescents and young people, leaders considered using these tools to disseminate COVID-19 information -including around vaccination rollout - alongside CSE and ASRHR education. When harnessed safely and thoughtfully, access to Information and Communication Technologies (ICTs) and digital spaces can add value to CSE delivery. At the WHA meeting, ministers commended innovative new teaching methods that prioritise learner wellbeing and psychosocial support in the pandemic context.

The pandemic has negatively affected and killed many more elderly people than young people. However, vaccine research suggests that youth and adolescents aged 15 to 19 years are more prone to COVID-19 infection and to transmitting the virus as adults. At the time of publication, many governments had authorised Pfizer's vaccine for youth aged 12 and older, with the Moderna and Johnson & Johnson vaccines available to those aged 18 and older.[9] Officially, because researchers only tested vaccines on

[8] Ibid.
[9] Salazar, J.C. (2021). When Will the COVID-19 Vaccine Be Available for Kids, and Will It Be Safe for Your Family? https://www.connecticutchildrens.org/coronavirus/when-will-the-covid-19-vaccine-be-available-for-kids-and-will-it-be-safe-for-your-family/, accessed 17 July 2021.
[10] WHO, 2021. The Pfizer BioNTech (BNT162b2) COVID-19 vaccine: What you need to know, https://www.who.int/news-room/feature-stories/detail/who-can-take-the-pfizer-biontech-covid-19--vaccine#:~:text=The%20vaccine%20has%20only%20been,high%2Drisk%20group, accessed 24 June 2021.
[11] Archyde, 2021. Delta variant virus is most vulnerable to infection in children and young people with different symptoms | Anue Ju Heng-International Politics and Economics https://www.archyde.com/delta-variant-virus-is-most-vulnerable-to-infection-in-children-and-young-people-with-different-symptoms-anue-ju-heng-international-politics-and-economics/, accessed 11 July 2021.

children older than 12, the World Health Organisation (WHO) has not recommended vaccination of children younger than 12, even those in high-risk groups.[10] Scientists continue to research the medical impact of COVID-19 on youth and children as emerging variants of the pandemic seem to pose a greater threat to the younger generation. Many European countries, India, the United States and Africa, specifically South Africa, were struggling against the Delta variant at the time of publication. It is 60% more infectious than the SARS-CoV-2 Alpha variant and reportedly manifests in different symptoms in children and youth.[11]

CSE frameworks and indicators



Sustainable Development Goal (SDG)-4: Ensure inclusive and equitable quality 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 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 SADC countries signed the Commitment, which 20 countries endorsed and affirmed in 2013 (the ESA-CSE commitment). Education and health ministers from these countries committed to accelerate 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 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 life and future. This includes ensuring that adolescents and young people both in and out of school have access to 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.
- The need to build and strengthen the skills of those working in wider youth and community interventions to expand capacity within member states to reach out-of-school youth.
- That stakeholder should explore creative approaches to build the capacity of media, including radio, to reach out-of-school youth.

Lack of basic SRHR education increases gender inequalities and leads to poor sexual and reproductive health outcomes, including sexually transmitted infections (STIs), unintended pregnancies and HIV and AIDS, to mention a few. Adolescents and young people represent the region's best opportunity for economic and social development; they form the foundation for growth and stability in all SADC countries. To realise the potential of youth, decision makers must educate them, keep them healthy, and maximise their potential to participate in national and regional economic growth and development. Regional and national policies that champion CSE and ASRHR help ensure that the educated, healthy and empowered youth of today become productive and thoughtful adults of tomorrow who contribute to positive futures for all SADC nations.

The Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS), the SRHR Cluster led by the SADC Gender Protocol Alliance, mobilises civil society and youth organisations in the region. It also supports the Eastern and Southern African (ESA) Ministerial Commitments, including those on CSE and SRH services for adolescents and young people agreed to by 21 SADC and East African countries in 2013 that expired in 2020. With support from UNESCO under the Secure the Future project, SAfAIDS recently began work to increase support for new Ministerial Commitments beyond 2020. SAfAIDS supports this work through television and radio programmes on CSE and radio listening clubs formed to enlighten citizens about sex education.

Table 3.2 illustrates highlights from all 16 national policy frameworks as well as monitoring and evaluation strategies for CSE. This 2021 data includes Angola, DRC, Mauritius and Seychelles, which all revisited monitoring and evaluation of CSE in late 2020 and early 2021. Two countries have stand alone policies; nine have integrated these into other policies or strategies; in two countries CSE is fragmented, or found in several different places. In Zimbabwe, a CSE policy is in progress.

Adolescent girls and boys deserve an opportunity to learn about their bodies

The table provides a short description of how various countries conduct monitoring and evaluation and assess the impact of specific SRHR health indicators, including prevention of new HIV infections, prevention of child marriages, and other areas. Child marriages remain a huge concern with an increasing number of adolescent girls facing this challenge. A key variable of ASRHR that curriculum in the DRC recognises the inclusion of SRH outcomes such as knowledge, perceptions and behaviour. While named differently by each country, the function of ASRHR policies or programmes remains the same: to provide school-based sexual health education in both primary and secondary schools.

Table 3.2: CSE national policy frameworks in SADC[12]

Country	Approach to CSE	M&E and CSE strategies
Eswatini	Stand alone	The policy and curriculum have a monitoring, feedback and evaluation strategy that aligns with, and ensures the effective implementation of Life Skills Education (LSE). The Sexual Offences and Domestic Violence Act (SODV) enactment in 2018 supports better outcomes in reduced GBV among adolescents, mostly advocated by youth.
Malawi	Stand alone	The government, with support from UNESCO, has developed a CSE monitoring tool that ensures trained teachers receive regular support and supervision. Malawi has seen improved outcomes in reduction of child marriages and community leaders have taken on the fight through initiatives such as "One community."
Namibia	Stand alone	Namibia has made limited progress in reduction of teenage pregnancy, which is a government priority.
South Africa	Stand alone	South Africa has a four-pronged approach to curriculum assessments, monitored by curriculum specialists and governed by the Curriculum Assessment and Policy Statement. This includes annual monitoring visits to provinces and schools by the national coordinator of the Life Skills programme.
Botswana	Integrated	CSE content is age-appropriate and taught within the context of culture.[13] CSE is compulsory and examinable, although examination tends to concentrate on core competency requirements.
Comoros	Integrated	Integrated provision for CSE, however mostly civil society and international institutions deliver it. The Association Comorienne pour le Bien-Être Famille (ASCOBEF) delivers a comprehensive range of school SRH programmes and services in collaboration with the government.
DRC	Integrated[14]	The National Sexuality Education curriculum has other sex education courses taught in schools in DRC.
Lesotho	Integrated	The Ministry of Education and Training introduced the Curriculum and Assessment Policy of 2009 in Lesotho schools.[15] Although it is a slow and ongoing process, knowledge levels have increased because of the advanced Life Skills syllabus.
Madagascar	Integrated	The Direction des Curricula et des Intrants' (DCI's) M&E plan integrates key performance indicators about supervision and evaluation of activities, as well as impact on learners starting at the primary school level. In addition, the DCI and Institut National de Formation Pédagogique (INFP) have plans to monitor the rollout of training.[16]
Mozambique	Integrated	The Department of School Health (Departamento de Saúde Escolar) has ensured widespread dissemination of SRHR and HIV and AIDS materials.
Seychelles	Integrated[17]	Personal, Social and Civic Education Programme (PSCE) offered in public schools from year 1 to year 15.
Tanzania	Integrated	While outcome evaluations of CSE programmes frequently focus on measuring results, such as increased knowledge, the Ministry of Education Science and Technology made a commitment in March 2020 to reach more than 6.5 million secondary school students with specific mention of non-discrimination of pregnant girls. Additionally, school heads have been trained how to monitor and report on CSE.
Zambia	Integrated	Zambia commissions and undertakes research studies to monitor delivery and quality of CSE, including tracking of progress made towards policies such as the National AIDS Strategic Framework (2011-2016 and 2017-2021) and the Adolescent Health Strategic Framework (2010-2016 and 2017-2021).
Angola	Fragmented[18]	CSE appears in the National Strategy for HIV, TB and Malaria for the Education Sector (2013-17). In 2020, Angola began integrating it into curricular materials within the scope of the Curriculum Adequacy Program for the period 2018-2026.
Mauritius	Fragmented[19]	Collaboration between the ministries of education and health includes drafting of the Sexual Education National Curriculum Framework. The Mauritian Institute for Education leads on this.
Zimbabwe	In progress	Guidance and Counselling (G&C) has tools to monitor implementation of life skills, which include the evaluation of the National Adolescent Sexual and Reproductive Health Strategy (2010-2015).

Source: GL Mapping of SRHR Policies and Laws updated 2020, APHRC, UNESCO, UNFPA.

[12] Gender Links conducted SRHR Research audit of laws and policies, researcher in 15 SADC countries conduct the research May 2020
[13] MIET together with SADC Secretariat as its implementing partner, Review Meeting of Future Life Now, CSTL project 2020.
[14] APHRC, 2019 report https://aphrc.org/wp-content/uploads/2020/03/CSE-in-DRC.pdf, accessed 21 June 2021
[15] Gender Links (2019), https://genderlinks.org.za/casestudies/lesotho-demystify-sexual-education-in-secondary-schools/
[16] 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
[17] Gender Links 2020 SRHR policy and laws audit by Benjamin Vel
[18] UNFPA Report February 2020, https://angola.unfpa.org/en/news/international-workshop-comprehensive-sexual-education-hosted-ministry-education-inide-and-unfpa, accessed 20 June 2021
[19] Emambokus, W.B.S., Oogarah-Pratap, B. (2019). Exploring Parents' and Teachers' Perspectives about School-Based Sexuality Education in a Multicultural Context: A Case Study in Mauritius. Educational Process: International Journal, 8(3), 185-195.

Seychelles offers CSE curriculum in both primary and secondary school. Called the Personal, Social and Civic Education Programme (PSCE), public schools deliver it from year 1 to the last year in school. It includes tailored training and advocacy to close ASRHR gaps, offered in partnership with UNFPA. The hallmark of the CSE implementation is support in the reduction of teenage pregnancies and advocacy for youth-friendly services and life-skills education. Together with supportive laws and policies, the programme assists in extending HIV testing and counselling and strengthens the monitoring of HIV and AIDS patients. However, the fact that some teachers do not take it seriously presents a challenge, as teachers sometimes opt out to use the time to cover other subjects. Others seek the help of nurses to conduct these sessions in secondary schools and others do not teach it at all because they feel ill equipped or uncomfortable. This is a common complaint of students: teachers often skip sessions on SRHR.

Mauritius has taken a fragmented approach to CSE with no formal sex education in its primary and secondary school curricula. It also has a high-unmet need for CSE, as noted in its National Sexual and Reproductive Health Policy, which also highlights the high teenage pregnancy and child marriage rates in the country. Implementation of CSE and SRH services in schools for adolescents and youth does not occur regardless of policy provision. In the past, Mauritius Family Planning Association (MFPA) launched sex education in selected primary schools. However, according to GL 2020 desktop research, the Ministry of Education has shown a willingness to introduce sex education in schools but this intention has been subject to much controversy. Thus, no formal CSE exists for youth, mainly because legislators have neglected to implement a common approach in the multi-ethnic and multi-religious "rainbow nation"[20] of Hindus (48%), Muslims (20%), Christians (27%) and Chinese (3%). In 2020, UNFPA prioritised delivering adolescent SRH services, especially for very young adolescent girls. It also emphasised the need for increased availability of CSE.

DRC has taken an integrated approach in that the National Reproductive Health Programme and the National Adolescent Health Policy both provide for CSE. However, sex education and CSE in DRC face patriarchal cultural limitations. For one, the issue of condom use as a contraceptive method remains frowned upon in traditional Congolese cultural settings. The Union Congolaise des Femmes des Medias (UCOFEM), a #VoiceandChoice Alliance partner, campaigns against the patriarchal structures that lead to high rates of GBV. While the national policy and CSE programme encourage condom use and multiple contraceptive methods, cultural resistance remains strong. According to GL desktop research on SRHR policies and laws in 2020, DRC faces challenges and gaps in youth-friendly services and facilities. The National Reproductive Health Programme ensures that pregnant adolescents have the same rights as adults to antenatal, natal and postnatal care in all health zones, but challenges abound in ensuring a uniform client-focused approach by healthcare specialists. Girls in DRC need community-based psychosocial care to prevent cases of backstreet abortions. DRC has the fourth lowest contraceptive prevalence, which explains its high teenage pregnancy rates, according to the Guttmacher Institute.[21]

The definition of CSE and language around it remains a matter of contention among SADC member states. Conservative movements and organisations such as the **South Africa**-based online group #LeaveOurKidsAlone have rejected CSE outright. The anti-CSE group took the Department of Basic Education in South Africa to task on the newly implemented CSE lesson tools in 2019 and 2020. The group formed to oppose the implementation of CSE and scripted lessons in schools. The group's founder said, "Our children are being sold out to organisations like the United Nations, who want the resources of

[20] Rambaree, K., Mousavi, F., Magnusson, P. and Willmer, M., 2020. Youth health, gender, and social media: Mauritius as a glocal place. Cogent Social Sciences, 6(1), p.1774140.
[21] Guttmacher Institute, 2021. https://www.guttmacher.org/report/unintended-pregnancy-abortion-kinshasa-drc, accessed 22 June 2021

our country."[22] Due to COVID-19 lockdowns, parents had to teach much of the 2020 educational curriculum as a strategy to help their children continue to learn despite school closures.

Similarly, anti-CSE groups in **Zambia** have claimed that CSE runs counter to the country's religious and cultural norms. Churches and church-related entities have made submissions against CSE to parliament and the education department, leading in some cases to petitions and protests. Their main argument is that Zambia signed the ESA Ministerial Commitment on CSE and SRH services for adolescents and young people without consulting Zambian society and communities.[23] Despite this, educators and activists in Zambia have successfully used innovative approaches to delivering CSE via mass and digital media. This includes the Zambian Alliance network member Women in Law Southern Africa Zambia (WILSAZ), whose programmes have campaigned for CSE through mass and social media.

The definition of CSE and language around it remains a matter of contention among the member states

Zambians remain divided over CSE

Members of the Zambia parliament recently shot down a regressive motion that sought to suspend the teaching of CSE in schools pending wider consultations by stakeholders.

News reports indicate that most MPs voted against this proposed suspension, with some members of civil society and teacher unions collaborating under the banner "Pro-CSE." These groups welcomed guidance provided by Vice President Inonge Wina on the floor of the National Assembly on 2 October 2020 that government would initiate wide consultation with key stakeholders to inform its review of CSE framework.

Lenganji Nanyangwe, Zambian director of the Sexual Reproductive Health and Rights Africa Trust, noted that the Private members' motion to suspend CSE in schools proposed by MP Sebastian Kopulande "was not consistent with the executive order by the Vice President of Zambia. Wina rightly commissioned a review of CSE curriculum prior to the withdrawing of CSE from current implementation in Zambian schools.

Zambian society fully supports CSE, says Lenganji Nanyangwe, Zambian director of the Sexual Reproductive Health and Rights Africa Trust.
Photo courtesy of Twitter

"Society fully supported the introduction of CSE in Zambia and incorporated into the school curriculum only after extensive and inclusive consultations led by the CSE Task Force. It was premised on a strong national legal and policy framework and in the context of regional, continental and indeed global protocols, such as the Education Act No. 23 of 2011, the Maputo Protocol, The SADC Gender Protocol and the Sustainable Development Goals 3,4 and 5, all of which Zambia is party to. It demands

[22] Kiewit, L. (2020). Online group wants new curriculum to make a #sexit, Feb 2020.
[23] Kachikoti, C. (2021). Zambia Times, Sunday 12 June 2021

therefore that the review of CSE in Zambia is done in cognisance of broader commitments made as a country and importantly should be domesticated in the context of the health and educational needs of our children and the community at large."

Anti-CSE proponents claim that CSE in schools erodes Christian values and cultural norms, arguing that the CSE curriculum in its current state should be more accurately called "abortion, promiscuity and gay rights education."

Speaking at a regional SRHR virtual meeting, Lubna Bhayani of Frontline AIDS noted that, "CSE is essential for young people to be able to protect themselves from unintended pregnancies and HIV - the two biggest killers of young women and adolescent girls in Sub-Saharan Africa. Integrating CSE into school curricula provides the opportunity for young people to engage in discussions on sex, gender, rights, sexuality and sexual orientation and is a key strategy to guaranteeing bodily autonomy and ensuring sexual and reproductive health and rights upheld."

Conservatives often cite CSE as a reason for young people becoming more promiscuous, especially in conjunction with high teenage pregnancy rates.

CSOs, faith-based organisations and community members need to be educated and involved in advocacy regarding the scientific evidence of the benefits of CSE, as well as what it sets out to achieve. Zambia has a history of commissioning and undertaking research studies to monitor delivery and quality of CSE, including tracking of progress made towards policies such as the National AIDS Strategic Framework (2011-2016 and 2017-2021) and the Adolescent Health Strategic Framework (2010-2016 and 2017-2021).

A lesson learned as schools have reopened in these COVID-19 pandemic times is that continued commitment and evidence-based research remains critical for tackling the misconceptions about CSE. It is crucial that CSE and ASRHR advocacy and awareness raising goes beyond passing of motions that reverse progress made to actual countering challenges beliefs and perceptions and ensuring age appropriate CSE benefits young people.

Source: Shamiso Chigorimbo, Gender Links
Opinion piece as part of a submission for the
SADC Protocol @ Work Media articles October 2020

In May and June 2021, Eswatini and Mozambique represented the only two SADC countries to sign a draft resolution alongside other countries at a meeting at WHA, the decision-making body for the WHO. The resolution, *Ending violence against children through health systems strengthening and multisectoral approaches*, aims to end violence against children and calls for changes and improvements to existing sexual education curricula. The resolution urged all member states to "provide accessible gender-sensitive, free from gender stereotypes, evidence-based and appropriate to age and evolving capacities sexuality education to children. With appropriate direction and guidance from parents and legal guardians, with the best interests of the child as their basic concern to empower and enable them to realise their health, well-being and dignity, build communication, self-protection and risk reduction skills, as a fundamental part of the efforts to prevent, recognise and respond to violence against children."[24] Activists see the commitment as a bold move to creating a more enabling environment for protection against child abuse.

[24] WHO (2021), Ending Violence against children through health systems strengthening and multi-sectoral approaches. Available on. https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_ACONF8-en.pdf, accessed on 24 June 2021.

CSE e-tools ensure ongoing learning during pandemic school closures

The region has seen an increase in digital learning platforms for school-age children, starting from early childhood education (ECD) up to tertiary education. Due to the pandemic, learning platforms moved to the internet, and the need to incorporate ASRHR and CSE curriculum into online platforms increased. Given improvements in internet accessibility on smart phones and various other technological advances, local and international research indicates that more young people rely on the internet and other online sources for information.[25] Likewise, advances in CSE and adolescent SRH knowledge and services must transition to include internet-based curriculum and awareness raising. While this is an overall positive development, it can worsen education inequalities and accessibility for learners living in remote areas with limited internet access or for those who cannot afford it.[26]

As a rights-based approach to adolescent sex education, CSE seeks to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality. The UNESCO curriculum development and review department in 2020 made improvements to the Sexuality Education Review and Assessment Tool (SERAT). SERAT helps collect data on school-based sex education programmes. Zambia and Zimbabwe accompanied its implementation with the International Technical Guidance on Sexuality Education. CSE aims to help young people develop positive sexual behaviours so, when used effectively, the SERAT tool reviews school-based CSE programmes against international standards. Users can customise it to fit the context and specific programmes of each country.

Schools, youth-friendly health facilities and youth centres usually deliver CSE, with instruction from teachers, health providers and trained peers. With the limitations and concerns of COVID-19 infections and physical distancing, regional regulations resulted in school interruptions, closures and re-openings, moving CSE and other curriculum to online platforms. The SERAT tool, housed on the UNESCO Health and Education Resource Centre, provides an online library with access to more than 6000 downloadable resources. It includes research papers, evaluations, tools and guidance to support ministries and other stakeholders. Social and economic challenges to accessing online learning have arisen as a substantial concern and limitation to continued access to learning while students remain at home in many parts of the region. To mitigate this, ministries of education and partners have developed further resources to support both learners and teachers.

Schools, youth-friendly health facilities and youth centres usually deliver CSE

New resources include a combination of printed curriculum materials for home use and scripted lesson plans for TV and radio learning.[27] Digital spaces offer new options for learning that include reaching marginalised young people along with new possibilities to influence knowledge creation and sharing. Access to digital sex education offered by such tools helps fill gaps in places without sufficient or effective sex education in

[25] Ubisi, L. (2020), Analysing the hegemonic discourses on comprehensive sexuality education in South African schools, Durban, Journal of Education UKZN.
[26] The Impact of COVID-19 on Young People and Adolescents in the SADC Region - Report Out Now, MIET and HSRC 2021 report, https://mietafrica.org/the-impact-of-covid-19-on-young-people-and-adolescents-in-the-sadc-region-report-out-now/, accessed 17 July 2021.
[27] SADC-Webinar-Reopening-Schools-in-the-time-of-COVID19-Record-Report. 2020 available on https://www.mietafrica.org/wp-content/uploads/2020/10/SADC-Webinar-Reopening-Schools-in-the-time-of-COVID19-Record-Report.pdf, accessed 24 June 2021.

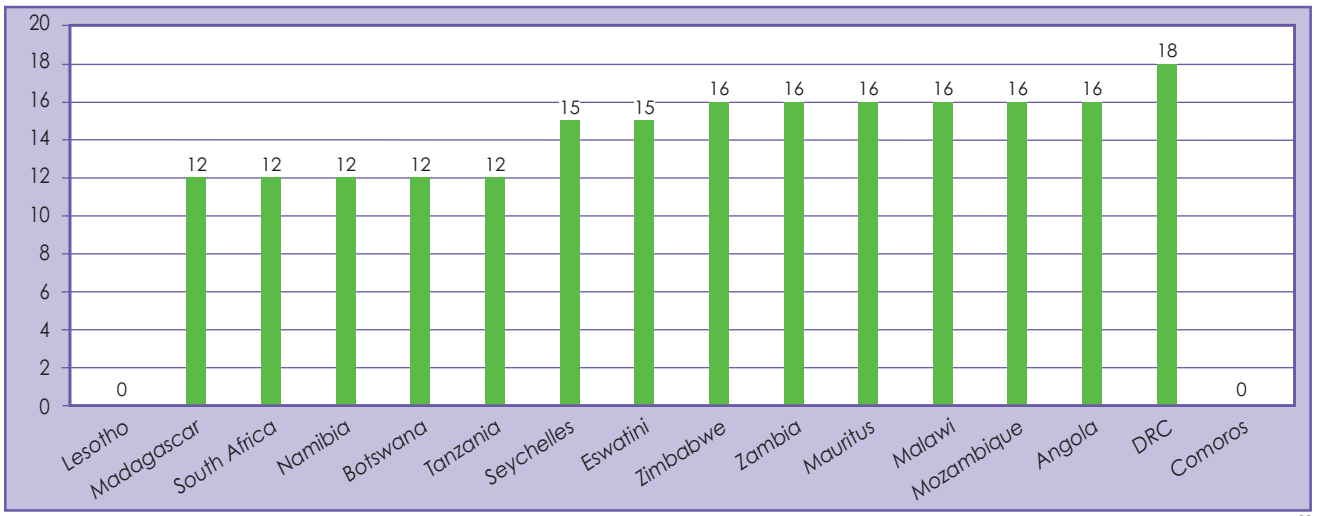
schools. It can also complement and strengthen school-based sex education. However, technological interventions must not completely replace interpersonal and traditional education methods. A 2020 UNESCO report warns that sex education for young people should translate to digital spaces alongside the safe and age appropriate continuation of other CSE.[28]

In **South Africa**, organisations such as the Earth Child Project have devised strategies to reach young girls within marginalised and impoverished communities. This includes providing digital training on life skills and SRHR. South African Women in Development (SAWID), a GL Alliance partner, has engaged in numerous discussions and dialogues together with Young Women Alliance on the topic. SAWID demonstrated that lockdowns led to heightened levels of GBV, which affected young girls. It is clear from the discussions that schools provide places of escape and solace for many children. School closures left vulnerable children stuck in households with their abusers in many cases. Some case studies show that, due to poverty, food insecurity and abuse, children had to bargain with abusers to receive food during the pandemic. Lack of emergency contraception and post-exposure prophylaxis (PEP) treatment led to many of these children falling pregnant and contracting HIV. World Vision International indicated that more than one million girls across Southern Africa might not return to schools in 2022 due to teenage pregnancy.

Access to contraceptives and age of consent to sex

Policies on access to contraceptives and age of consent to sex directly influence teenage pregnancy rates. Synergies in policies can ensure better decision-making and avoidance of teenage pregnancy and fatherhood. An enabling legal and policy environment is critical to the promotion of sexual health.

Figure 3.1: Age of access to contraception



Source: UNAIDS Select data 2020.[29]

[28] UNESCO (2021), One year into COVID-prioritizing education recovery to avoid a generational catastrophe available at https://events.unesco.org/event?id=3620682418&lang=1033, accessed 24 June 2021
[29] UNAIDS, 2017-2020, http://lawsandpolicies.unaids.org/jointanalysis?id=young_people&a=LSO&lan=en, accessed 12 July 2021

Figure 3.1 shows age of access to contraceptives in SADC as of 2020 and illustrates that Lesotho has no specification on minimum age of access to contraception. No data currently exists on the minimum age of contraceptives in Comoros.

According to UNAIDS, the unmet contraceptive need in the 15 to 49 age cohort for Lesotho and Comoros stands at 16% and 35%, respectively, in 2020.[30]

Table 3.3: Requirements for parental consent for ASRHR in SADC[31]

Country	Not required	Yes, if younger than 14	Yes, if younger than 16	Yes, if younger than 18	Data not available
Madagascar	✗				
Mozambique	✗				
Namibia	✗				
South Africa	✗				
Tanzania	✗				
Angola					✗
Comoros					✗
Lesotho		✗			
Malawi		✗			
Mauritius		✗			
Botswana			✗		
Zambia			✗		
Zimbabwe			✗		
DRC[32]				✗	
Eswatini				✗	
Seychelles				✗	

Source: UNAIDS, 2020.[33]

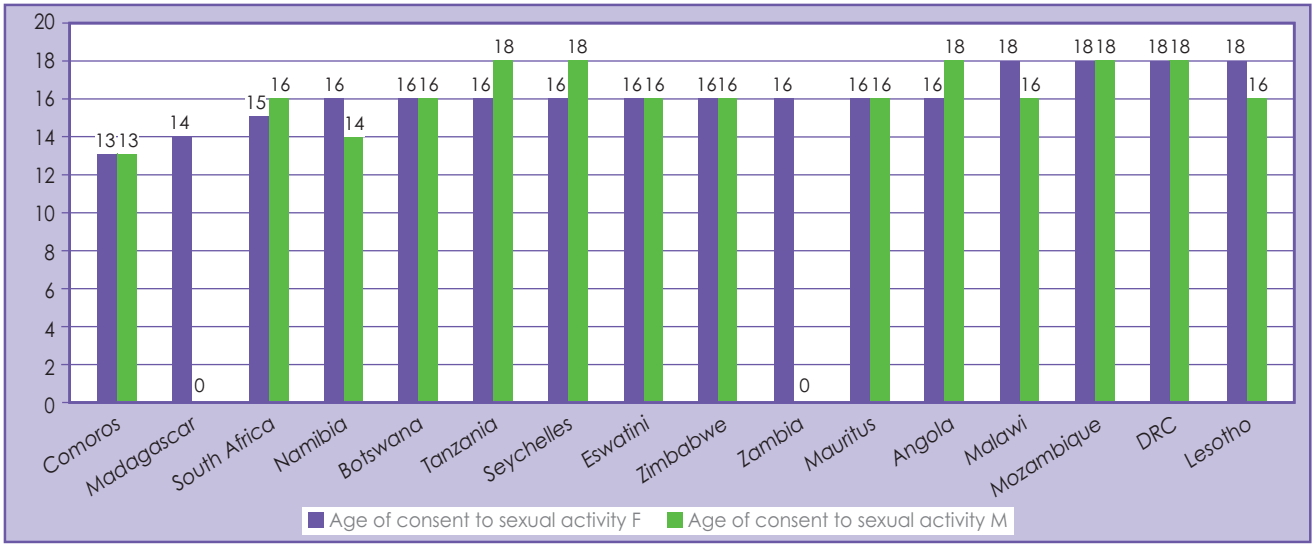
Table 3.3 maps laws in all SADC countries on age of parental consent for adolescents to access SRH services. Lesotho, Malawi and Mauritius require parental consent for youth younger than 14; the same applies in Botswana, Zambia and Zimbabwe for those younger than 16. Meanwhile, citizens of DRC, Eswatini and Seychelles must be 18 or older to access SRHR without parental consent.

Allowing young people to access ASRHR services without parental consent removes a critical barrier to youth getting information about their health, such as HIV status and information on STIs. Requiring parental consent for ASRHR services and information prevents adolescents from exercising their basic human rights.

Allowing young people to access ASRHR services without parental consent removes a critical barrier to youth getting information about their health

[30] Family Planning Organisation 2020 https://www.familyplanning2020.org/lesotho, accessed 21 June 2021
[31] Lowe Morna, C et al (eds) (2020) Adolescent Sexual and Reproductive Health, in SADC Gender Protocol 2020 Barometer, Gender Links, Johannesburg, pp 22
[32] World Bank, 2020, https://www.who.int/bulletin/volumes/97/1/BLT-18-212993-table-T1.html, accessed 28 April 2020
[33] UNAIDS, 2017-2020, http://lawsandpolicies.unaids.org/country?id=MOZ&lan=en UNAIDS Laws and Policies Analytics, accessed 20 June 2021

Figure 3.2: Age of consent to sexual activity by sex



Source: GL Mapping of SRHR Policies and Laws updated 2020.

Figure 3.2 shows differing legal age of sexual consent for males and females in Angola, Lesotho, Malawi, Namibia, Tanzania, South Africa and Seychelles. The data also illustrates a large range between countries, with the age of consent as young as 13 years in Comoros.

The minimum age of consent to sexual activity protects adolescents and children against sexual exploitation. The African Charter on the Rights and Welfare of the Child, 1990, Article 27: Sexual Exploitation obligates member states to:

1. Undertake to protect the child from all forms of sexual exploitation and sexual abuse and shall in particular take measures to prevent:

(a) The inducement, coercion or encouragement of a child to engage in any sexual activity;

as such, it is paramount that the implementation of age of consent legislation, to protect young people, both female and male, from sexual abuse and sexual exploitation by predatory adults.

Countries that do not have the same age of consent for males and females have not used a gender-neutral approach to age of consent to sexual activity. Varying arguments and debates accompany this issue, with many noting that females mature earlier than males, making them more vulnerable to sexual exploitation.

Youth-friendly services

The International Planned Parenthood Federation (IPPF) provides guidelines on youth-friendly services and the key elements that should be included for effective service delivery. Youth-friendly service delivery is about providing health services based on a comprehensive understanding of what young people in any given society or community want and need. It bases these on an understanding of, and respect for, the realities of young people's diversity and sexual rights. A youth-friendly approach requires offering young people a wide range of SRH services, including:

- Sexual and reproductive health counselling;
- Contraceptive counselling and provision (including emergency contraception);
- Abortion services;

- Prevention, testing and counselling services for HIV and other STIs;
- Prenatal and postpartum services;
- Sexual abuse counselling; and
- Relationship and sexuality counselling.

Youth-friendly service delivery should also take into account the special needs of young people including:

- Where possible, facilities should provide services in an integrated manner at the same delivery point to allow for ease of access for young people.
- Recognising the financial barriers that young people can face, services should be free of charge or provided at a discounted rate to young clients.
- Services are only truly youth-friendly if young people themselves help determine the content, scope, and monitoring and evaluation of such services.

Youth-friendly health services work hand-in-hand with meaningful CSE services for all adolescents and youth. Access to information, education and adolescent-friendly comprehensive services requires adequate policy provision. Ensuring quality and timely services for youth so they can make free and informed decisions and choices about their sexuality and reproductive lives starts from the policy level before implementation at institutional and community levels.

Table 3.4: SADC countries with adolescent and youth SRHR policies[34]

Country	Stand-alone ASRHR policy or strategy
Botswana	Yes, Adolescent Sexual and Reproductive Health Strategy
DRC	Yes, National Strategic Plan for Health and Wellbeing of Adolescents and Youth 2016-2020[35]
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
Zimbabwe	Yes, National Adolescent and Youth Sexual and Reproductive Health Strategy 2015-2020
Angola	No
Comoros	No
Eswatini	No
Mauritius	No
Mozambique	No
Namibia	No
Seychelles	No
Tanzania	No

Source: African Health Observatory, Gender Links Policies Audit updated 2021.

Table 3.4 shows that half of all SADC countries do not have stand-alone ASRHR policies. However, all 16 countries committed to the International Conference on Population and Development (ICPD), which informs provisions in national ASRHR and other general SRHR policies in all member states. Gender activists want to address the challenges youth face in accessing SRHR services, including age limitations.

South Africa has its Adolescent Sexual and Reproductive Health and Rights Framework Strategy (ASRH&R, 2018) and the National Integrated Sexual and Reproductive Health and Rights Policy (2018). Both provide for Adolescent SRH and youth-friendly services. Five priority areas underpin the ASRH&R policy, accompanied by a set of objectives focusing on coordination, colla-

[34] Updated 2021 to include Botswana ASRHR strategy and DRCs Plan Strategique National de la Sante et du Bien Etre des Adolescents 2016-2020.
[35] National strategic plan for adolescent and youth health and wellbeing 2016-2020, implemented since March 2016 by Ministry of Health Secretary General DRC

boration, information, and knowledge sharing. ASRHR knowledge sharing between stakeholders includes developing innovative approaches to SRHR information, education, and counselling for adolescents. This includes provisions to strengthen ASRHR service delivery and support various health concerns. These policies aim to create effective community support networks for adolescents while formulating evidence-based revisions of legislation, policies, strategies and guidelines on ASRHR.

Namibia has a standalone approach to CSE, but no standalone ASRHR policy. The National Policy on Sexual, Reproductive and Child Health provides for adolescent SRH. The policy requires the government to promote adolescent friendly health services in collaboration with other stakeholders, committing health facilities in Namibia to provide "All sexually-active adolescents, regardless of age, shall have the right to confidential handling of all aspects of their personal health information, including testing behaviour, risk behaviour, and diagnoses."[36] With pandemic travel and trade restrictions and border closures, Namibia faced a contraceptive shortage. The Education Sector Policy for the Prevention and Management of Learners Pregnancy review report of 2020 reported an increase in teenage pregnancy following the initial lockdown in March 2020. Adolescents in Namibia typically have access to contraceptives at age 12.

Malawi has a standalone ASRHR policy, the National Youth Friendly Health Services Strategy, as well as a standalone approach to CSE. Its national SRHR policy ensures strategies for sexual education services for adolescents and the youth. The policy aims to improve access and availability to youth-friendly health services and strengthened behavioural change interventions in the Youth Friendly Health Services (YFHS). Under the family planning section, the policy addresses teenage pregnancies aligned with their contribution to maternal and child mortality rates. The issue of teenage pregnancies addressed as one element of a larger problem of unmet needs for family planning for women does not tackle economic and cultural challenges. However, the policy is progressive in terms of male involvement, encouraging male participation in reproductive health and highlighting the challenges in ensuring male involvement in maternal and neonatal health care.

Traditionally, women in Malawi serve as custodians of maternal health, hence maternal and post-natal health care services have focused on women with very little male involvement. The policy puts forward strategies to improve male involvement in reproductive health and encourages the empowerment of men to promote and support SRHR services. In addition, the policy encourages women to invite their husbands to support and utilise SRHR services.[37] Successfully tackling traditional and conservative mind-sets involves mobilising communities and increasing awareness of the importance of male involvement through information, education and communication. The policy also challenges harmful practices deeply rooted in traditional and cultural conservatism. Despite its strong feminist activism, Malawi remains a deeply conservative society in which sexual activity, contraceptives, and SRHR remain taboo topics for open discussion in most places. However, civil society organisations, health care providers and the government continue to carry out campaigns to raise awareness, increase SRHR conversation and grow community.

Zimbabwe has both CSE and reproductive health policies, but no standalone ASRHR policy. Its health policy includes guidelines on youth-friendly clinical SRH service provision developed under the National Standard Training Manual on ASRH. It guides the work of health facilities and provides a framework for SRHR for adolescents. The country is currently reviewing age of access to contraceptives alongside proposals to harmonise age of sexual consent and marriage to 18 years. Women's organisations and the Ministry of Health

[36] Government of Namibia, 2012, National Policy on Sexual, Reproductive and Child Health Sexual & RH Policy Zero Draft (who.int), accessed 20 June 2021
[37] Government of Malawi, 2015-2020, Malawi policy National Youth Friendly Health Services https://surveygizmoresponseuploads.s3.amazonaws.com/fileuploads/382553/5541426/168-50a5b3c1cd6bc46489185d76ea47e10e_National_Youth_Friendly_Health_Services_Strategy.pdf, accessed 20 June 2021

suggest leaving age of consent at 16 years because of anticipated challenges in getting contraceptives to adolescents due to the mismatch in age to access and age of consent. They worry that unmet need for contraceptive use in adolescents will remain high, exacerbating existing challenges faced by sexually active girls younger than 16 in accessing contraceptives. The debate around age of consent remains contentious and legislators paused some discussions on this because of the COVID-19.

In **Angola**, which does not have a formal ASRHR policy or strategy, the government partners with Acção Angolana para a Mulher (AAM) and other organisations to provide comprehensive SRHR policies and services, especially to reach underserved areas and population groups.[38]

Botswana has an Adolescent Sexual and Reproductive Health Strategy that allows adolescents to access SRHR services without restrictions. Botswana's CSE policy provides for an integrated approach, and the guidance and counselling division of each school delivers it. This ensures a standalone approach in a specific allocated school programme.

Youth led ASRHR research 2020 to 2021

Nearly two fifths of young people who sought Sexual and Reproductive Health (SRHR) Services in eight Southern African countries were denied these services because they were not accompanied by a parent or family member. More than two thirds had to pay a fee for the health services they received. These services cost an average of $2, which is 9-20% of the daily income in the countries surveyed. But 81% of the those who accessed services said that health personnel treated them confidentiality. These are among the findings of the Adolescent Sexual and Reproductive Health and Rights (ASRHR) Rapid assessment undertaken in Botswana, Eswatini, Lesotho, Madagascar, Mauritius, South Africa, Zambia and Zimbabwe from November 2019 to December 2020.

The purpose of this research is to strengthen youth-led and focused efforts to promote ASRHR through gender and youth responsive local governance. The research included 13395 adolescents between ages 10 and 19 in eight countries, 6916 (52%) females and 6445 (48%) males and 34 people identifying as gender non-confirming (GNC). The survey is being carried out with the Centres of Excellence for Gender in Local Government with the support of HIVOS and Amplify Change.

As part of the study, junior councils and other youth formations in the GL COEs conducted a survey on ASRHR services, with results showing that providers denied two-fifths of young people access to services because an adult did not accompany them. The Young Women's Alliance leads advocacy on ASRHR in the 15 national country campaigns.

South Africa conducted the research in the highest number of clinics (168) and Zimbabwe had the most respondents at 2998. Lesotho, with only nine clinics, had the fewest respondents at 585.

[38] SRHR Internal Audit Gender Links and Angola researcher Isabel de Almeida, 2020

Table 3.5: Key findings of the GL ASRHR Rapid Response Survey 2019-2020

Indicator/country	Botswana	Eswatini	Lesotho	Madagascar	Mauritius	South Africa	Zambia	Zimbabwe	Overall
Logistic information on health facilities (% yes)									
Health facility within 10 km from your home	78	29	68	65	95	75	89	67	73
Does the facility open after school?	22	27	43	77	57	86	76	63	57
Does the facility open on weekends	59	45	41	74	59	44	93	77	71
Comfortable waiting area?	70	92	80	82	90	78	80	77	80
Proportion of respondents who paid a fee?	0	87	42	83	0	2	80	72	35
How much is the fee in USD?	0	2	2	2	0	2	2	4	$2
Quality of care (% yes)									
Are peer counsellors available?	61	16	56	77	13	65	62	71	64
Young people are treated with respect	97	96	69	91	90	88	94	82	89
Young people have privacy and confidentiality	85	95	67	73	92	87	98	74	81
Young people are treated without parental consent	71	88	38	68	57	53	49	55	60
Health workers spend sufficient time with young people	54	95	42	80	84	81	94	68	75
Young people receive appropriate information	47	91	86	80	54	84	75	73	72
Sexual and reproductive health services (% yes)									
Young people requested contraceptives	36	16	50	40	3	42	28	26	31
Young people received contraceptives	94	95	77	82	21	90	84	80	84
Young women requested a pregnancy test	31	22	35	37	2	36	27	24	30
Young women received a pregnancy test	74	92	65	82	33	88	71	57	75
HIV and AIDS (% yes)									
Requested HIV test	30	81	69	22	2	46	59	37	41
Received HIV test	87	98	95	90	15	92	99	83	92
Requested sexually transmitted infection (STI) test	21	4	24	18	0	31	15	14	18
Received STI test	98	89	87	86	0	89	92	74	89
Requested anti-retrovirals (ARVs)	2	2	7	8	0	19	3	8	7
Received ARVs	100	43	59	68	0	80	90	84	78
Follow up and referral (%yes)									
Made a follow up appointment	6	79	80	77	29	68	45	54	53
Referred to a relevant facility	9	57	68	84	56	64	61	62	59

Source: GL ASRHR Rapid Response Survey 2019 to 2020.

- 73% of the sample had a health facility within 10 km of their homes. This ranged from 29% in Eswatini to 89% in Zambia.
- 64% of the respondents reported meeting peer counsellors in the health facilities they visited. This ranged from 16% in Eswatini to 77% in Madagascar.
- 31% of the sample requested contraception and 84% of these received contraception. Lesotho (50%) had the highest proportion of young people requesting contraceptives. South Africa has the highest percentage (90%) of youth asking for, and receiving contraceptives.
- 30% of the female respondents requested a pregnancy test and 75% received one. Madagascar (37%) had the highest percentage of those requesting a pregnancy test. Eswatini (92%) had the highest percentage of those asking for a pregnancy test receiving one.
- 41%, of respondents requested an HIV test and 18% requested a sexually transmitted infection (STI) test; most received these tests.
- 72% of the sample received materials tailor made for their needs. About a quarter of the sample did not receive youth friendly information that is relevant and responds to their needs.
- 53% of the sample received follow up appointments and 59% received a referral to another facility. Lesotho (80%) had the highest proportion of those receiving follow up referrals.

These findings point to some good practises in the region, but also the need for youth-led policy and advocacy for consistent policies and standard setting on ASRHR across the region, consistent with the SADC SRHR Strategy 2019-2030.

Young activist hopes to inspire Lesotho youth to learn about SRHR issues

One young woman in Lesotho has energetically taken the reins from older gender activists to lead on SRHR empowerment and education in her community.

Participants, SRHR public gathering - Maoa Masaoana Village, Sephokong Council, Leribe in September 2020. Photo: Ntolo Lekau

Ntsoaki Mosala, 20, a participant in SRHR outreach activities hosted by Sephokong Council from Maoa-Masooana in Lesotho's Leribe district, said she is never afraid of new challenges. Therefore, it is no surprise that Mosala embraced local activism following her participation in a public gathering for SRHR activities in her village. She says it changed her life.

Mosala vividly remembers the very first time she encountered Gender Links at the SRHR action planning for councils. The Sephokong Council had invited her to represent youth and she took part in training objectives to deepen local government SRHR plans, facilitate better service delivery, and increase awareness on SRHR.

Additionally, the programme aimed to inspire youth involvement in SRHR campaigning and advocacy, which affected her directly. The council came up with the action plan, which clearly showed the need for a joint collaboration with youth and community members. Mosala did not waste any time. Immediately after the training, she talked to her councillor and local chief to get their help to mobilise youth in her village. After sharing the action plan with the youth, they drafted a strategy to implement ASRHR awareness-raising tasks and activities.

Mosala then led a focus group to create a youth strategy and she visited different ministries to canvass support. Leading the whole process, she consulted with representatives from Lesotho's Ministry of Health and shared how they could improve youth services at various different clinics. She also convinced a local clinic to create a youth health day and a youth corner. In addition, her campaign successfully advocated for the distribution of sanitary pads and towels at the local clinic.

"The workshop was an eye opener and boosted my self-confidence and knowledge," said Mosala.

Sadly, COVID-19 delayed her work and limited visits to district hospitals. Once the spread of COVID-19 decreases, Mosala hopes to visit other clinics and influence young leaders to join her and lead similar campaigns across the country.

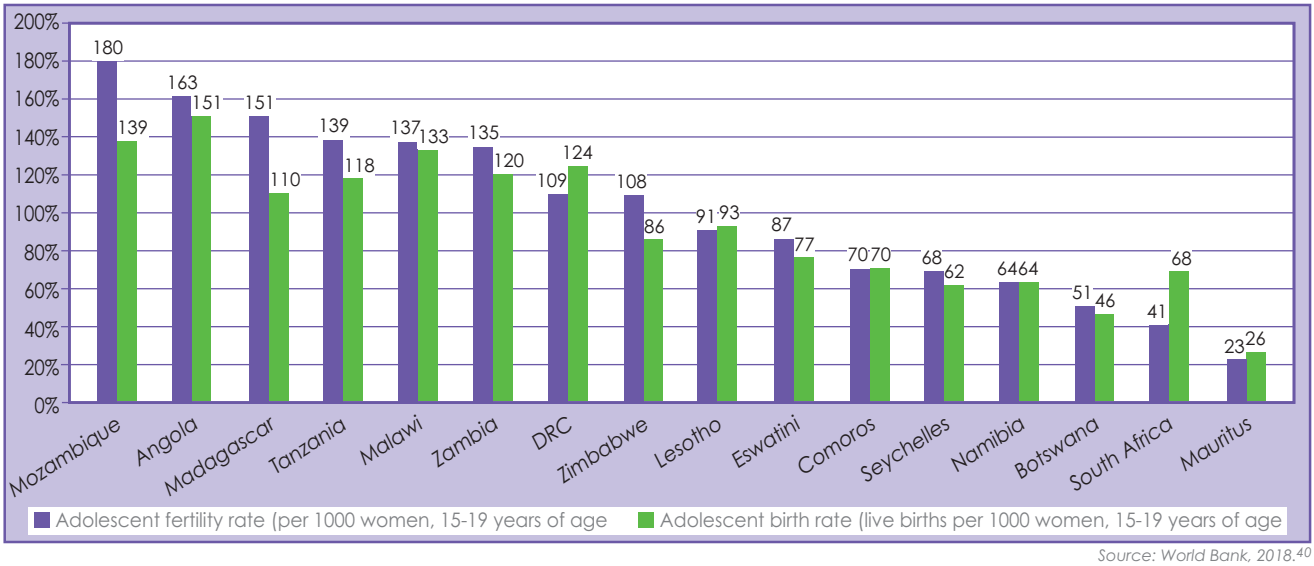
Source: Ntsoaki Mosala, Lesotho Youth Award as part of a submission for the SADC Protocol@Work Gender Links Summit case study 2020

Teenage pregnancy

Teenage boys engage in a menstrual health workshop in Kitwe City Council in Zambia in May 2021. Photo: Samuel Biemba

Two indicators measure the prevalence of teenage pregnancy: country level adolescent fertility rates per every 1000 women between the ages 15 to 19 and adolescent birth rates representing the number of live births per 1000 females aged 15 to 19. Women and girls younger than 19 years old are twice as likely to die during childbirth compared to women older than 20.[39] Complications of pregnancy, abortions and childbirth represent the leading causes of death among adolescent women between the ages 15 to 19. Researchers calculate adolescent birth rate (BR) as total live births (for a specific area and time), divided by the total population (for the same area and time) multiplied by 1000. While the fertility rate (FR) represents the total number of pregnancies (for a specific area and time) divided by the female population at the ages specified.

Figure 3.3: Teenage pregnancy indicators



Source: World Bank, 2018.[40]

[39] UNFPA and ERASO teenage pregnancy data.
[40] World Bank, 2018, 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, accessed 16 June 2021

Figure 3.3 compares teenage pregnancy indicators of adolescent fertility and birth rates from 2018, the most recent figures. Mozambique has the highest adolescent fertility rate in the SADC region at 180 live births per every 1000 women aged 15 to 19. Both fertility and birth rates remain high in several other countries, including Angola, DRC, Madagascar, Malawi, Tanzania and Zambia. Goal 3.7.2 of the SDGs represents a target toward the reduction of adolescent birth rates, commonly reported as the age-specific fertility rate for ages 15-19 years in the context of calculation of total fertility estimates.[41] Some researchers also label birth rates as adolescent fertility rates in other contexts. A related measure is the proportion of adolescent fertility measured as the percentage of total fertility.

These rates underscore a critical need for accessible youth-friendly SRH services that cater for family planning knowledge. Mozambique is one of six countries in the world in which at least one in ten girls (14%) has had a child before they turn 15, and 57% before age 18.[42] To tackle high rates of adolescent fertility, activists recommend improving CSE and adolescent access to contraceptives.

COVID-19 leads to increase in child abuse and teenage pregnancy in Malawi

Learners at the Mphangala Primary School in Kasungu district in Central Malawi in May 2019. Photo: Thokozani-Matewe

School closures due to COVID-19 led to an increase in teenage pregnancies in Malawi, with 7274 teenage girls reportedly pregnant in Mangochi District alone, according to one recent report.

A 16-year-old secondary school student from that region shared her experience becoming pregnant after her stepfather raped her. "I've resisted him for years," she said. "He took advantage of the absence of my mother and my not going to school to force me in to bed with him; now look, here I am, seven-months away from giving birth."

She lamented that her dream of completing her education and the prospect of a promising future now seem dim. Sadly, she is one of many victims of sexual assault and abuse in the COVID-19 pandemic.

Recent statistics back up such stories from survivors and paint a gruesome picture of the extent of violence against women and girls, according to Stephano Joseph, social welfare officer for Blantyre District, whose jurisdiction has registered a record 77 GBV cases between March and May 2020.

"The month of April alone my office received 23 cases, whilst in May we received 30 cases and 24 cases in June," said Joseph. "Factually, the figures have tripled as the same period last year we recorded an accumulative figure of

[41] UN, 2018, https://sdg.tracking-progress.org/indicator/3-7-2-adolescent-birth-rate/, accessed 19 June 2021
[42] Ministério da Saúde (MISAU), Instituto Nacional de Estatística (INE), e ICF. 2019. Inquérito de Indicadores de Imunização, Malária e HIV/SIDA em Moçambique 2015: Relatório Suplementar Incorporado os Resultados de Biomarcadores de Antiretrovirais. Maputo, Moçambique. Rockville, Maryland, EUA: INS, INE, e ICF. Online: https://www.dhsprogram.com/pubs/pdf/AIS12/AIS12_SP.pdf

20 cases, which is an unprecedented record being registered since schools were closed to help combat the spread of COVID-19."

In an interview, the district's traditional leader Senior Chief Malemia warned of stiffer punishment for offenders inflicting harm on girls and women. "I will tell you this; desperate times need desperate solutions. As a traditional leader, I will not sit and watch this rot happening in my district. It's now time to put in place legislation at local levels in form of by-laws to tame these evil injustices against girls," he said.

People Serving Girls at Risk, an advocate group, blames Malawi's government for its failure to create policies and safeguards to protect children. Caleb Ng'ombo, the group's executive director, worries that adults have taken advantage of the crisis to abuse the fragile and vulnerable in Malawian society.

"What we are calling for from government is that first they must ensure full implementation of the laws and policies the country has, like the Child Care and Justice Protection Act, which is very clear about child protection and safe guarding their rights," Ng'ombo said.

In an interview with GL, human behaviour psychologist Moses Muotcha suggested that it is time Malawi strengthened its psychosocial support base to help victims of social injustices. Patricia Kaliati, Malawi's minister of gender, community development and social welfare, committed to deploy a team of social warfare officers to Mangochi District to investigate the rapid rise in cases of teen pregnancies.

Tamanda Matebule is a journalist from MIJ FM in Malawi. This story is part of the GL News Service Gender and COVID-19 news series

Teenage pregnancy has increased in **Angola** in part due to a lack of contraceptives. According to a 2019 Guttmacher Institute report, the country has a 67% unmet need for contraceptives among women and girls between the ages 15 and 49. The US-based institute conducts country-level research that estimates adolescent pregnancy rates and documents adolescent access to SRH information and services. Ensuring that young women and girls have support and access to family planning services allows them to exercise their reproductive rights. Unintended pregnancies arise from unprotected sexual intercourse and, while CSE reduces the likelihood that youth engage in unprotected intercourse, some will still practice riskier sexual behaviours even after acquiring knowledge. Access to contraceptive methods reduces risk and provides options for young women and girls.

In **Eswatini**, limited or no access to healthcare facilities coupled with a high proportion of young women and girls out of school and employment (compared to boys in the age range of 15 to 24) has created a headache for lawmakers.[43] According to a United Nations Statistics Division (UNSD) SDG report released during the COVID-19 pandemic, 41% of women, compared to 30% of men, do not attend school or work in formal employment or training. The report also uses the Sexual, Reproductive, Maternal, Child and Adolescent Health (SRMNCAH) monitoring tool to analyse contraception use among women between the ages 15 and 49. Pandemic school closures restricted access to school nutrition programmes, and information on disease prevention and contraception. This contributed to increased rates of SGBV and teenage pregnancy, according to Lomcebo Dlamini from the group Global Advocacy on HIV Prevention Eswatini (AVAC). She notes that educating adolescents about contraception ensures they make informed choices about their sexual and reproductive health and wellbeing.

In March 2020, **Madagascar** began providing CSE education in a more systematic manner, partially because

[43] World Vision, 2020. Covid19 Aftershocks Access Denied, https://www.wvi.org/sites/default/files/202008/Covid19%20Aftershocks_Access%20Denied_small.pdf

of high rates of teenage marriage and pregnancy in the country. Previously, Madagascar, Mauritius and Seychelles only taught school-based sex education within the curriculum for other subjects such as biology, life-skills and civics education initiatives.[44] A 2019 formative research study in two regions of Madagascar used a socio-ecological lens to explore the influences on first time young parents (FTYPs) including teen fathers at the individual, couple, family, community, and system levels. The study included a combination of 44 interviews and 32 focus group discussions for publication in *African Journal of Reproductive Health*.[45] The findings spoke to the need for services geared towards a critical increasing demographic: first time adolescent mothers and fathers, referred to as young parent couples. It reaffirmed the need for a systematic in- and out-of-school CSE and ASRHR programmes.

Teenage fatherhood

The global pandemic shed light on some perennial challenges for teenage fathers, who faced heightened financial challenges during COVID-19 and pressures around their role as caregivers for their children. CSE gaps on the topic of teenage fatherhood point to a need for increased psychosocial support and education aimed specifically at young fathers. One recent study noted that CSE should consider that "psychological health and well-being can be fragile throughout adolescence and some forms of mental illness, such as anxiety or depression, are more likely to start in adolescence than in later life."[46]

Participant Letlatsa demonstrating male condom use in Quthing, Lesotho Youth Workshop, September 2019. Photo: Ntolo Lekau

Combining national policies, international CSE standards and teacher training will help ensure a holistic approach to adolescent SRHR that incorporates the specific needs of adolescent fathers. Ongoing teacher training in CSE content through participatory methodologies remains an essential ingredient for success. This does not mean all teachers must be experts on sexual health and psychological well-being, but they must be able to bridge the gap on specific CSE topics - for example addressing the topic of puberty in reproduction and biology classes as well as its affects in the daily lives of their students. Teachers are also important role models for adolescents, and their actions and behaviours shape the views and attitudes of young learners. Continued pandemic school closures unfortunately meant reduced access to teachers and peer-to-peer support across the region. As the pandemic evolves, education leaders and policymakers must consider all risks associated with ongoing lockdowns, including the risk of adolescents missing the social and health benefits of being in school.

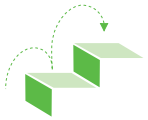
[44] 2020 SRHR Barometer in the time of COVID-19, ASRHR chapter.
[45] 2019 Reaching the youngest moms and dads: a socio-ecological view of actors and factors influencing first-time young parents' use of sexual and reproductive health services in Madagascar, Susan Igras, Melanie Yahner, Haingo Slowdown, Jean Pierre Rakotovao, Rachel favero, Sandrine Andriantsimietry and Justin Ranjalahy Rasolofomanana
[46] Care Knowledge Research Study 2021, https://www.careknowledge.com/media/47368/adolescence_parental-neglect_during_covid-briefing.pdf, accessed 10 July 2021

Backstreet abortion and HIV and AIDS prevention

Infection and prevention rates for HIV and AIDS intertwine with teenage pregnancy and backstreet abortion. A Joint United Nations Programme on HIV/AIDS (UNAIDS) study indicates that 45% of first-time teenage pregnant mothers did not know the risks involved in their actions or did not understand how pregnancy works. The 2019 analysis reveals that young women and girls engage in risky sexual behaviour due to lack of knowledge about STIs or the biology involved in fertility and pregnancy.[47] CSE education thus represents a critical protective factor against HIV infection and teenage pregnancy, especially where teenage pregnancy results in backstreet abortions. UNAIDS found that adolescent young women and girls (AGYW) aged 15-24 account for about 30% of all new HIV infections in Southern Africa.[48]

Findings from the Youth Rapid Assessment Survey research conducted among youth ages ten to 19 illustrate that in six out of eight countries less than 70% of respondents said they had ever requested an HIV test. Moreover, less than 30% of youth in all ten countries reported they had requested an STI test in their lifetimes. Mauritius, at just 2% of respondents that ever requested an HIV test, came in last place on this indicator, while Eswatini led the way, with 81% of youth there saying they had requested an HIV test.

Contraception use and access to emergency contraceptives represent key indicators of adequate SRHR facilities and services for youth. According to Yah et al, unprotected sex, STIs, HIV and pregnancy comprise significant elements of ASRHR and intersect with unsafe abortions and maternal mortality rates in adolescents.[49] Policies should consider age of consent to sexual activity and age of access to contraception, which also link to minimum age of marriage in each member state.



Next steps

Adolescents face many challenges and obstacles as they mature. International CSE standards reviews and tools enable country CSE policies to remain evidence-based and measurable against universal tools such as SERAT, mentioned earlier in the chapter. Even governments committed to CSE must continually work to overcome negative public attitudes and practices. Thus, they should always make the case that CSE forms an essential part of an overall good quality education, helping prepare young people for a fulfilling life in a changing world. It also improves SRH outcomes, promotes safe and gender-equitable learning environments, and improves education access and achievement.

Age of consent to sexual activity should align with age of access to contraceptives

[47] UNAIDS 2019 Women And HIV A Spotlight On Adolescent Girls And Young Women; https://www.unaids.org/sites/default/files/media_asset/2019_women-and-hiv_en.pdf, accessed 22 June 2021
[48] Yah CS, Ndlovu S, et al (2020) The prevalence of pregnancy among adolescent girls and young women across the Southern African development community economic hub: A systematic review and meta-analysis. Health Promote Perspect.
[49] Ibid

Governments must also address capacity and resource constraints that limit the achievement of quality education. This includes ensuring teacher capacity, modern curriculum content and necessary tools for assessment, monitoring and evaluation. When teachers know about policy provision and protection for adolescent rights to contraception and age provisions in their specific countries, youth will be empowered to access the necessary services.

Masvingo City Council junior councillors provide toiletries for distribution at a Zimbabwe school in July 2021. Photo: Tapiwa Zvaraya

As this research has outlined, social, cultural, political, and religious influences affect age of access to contraception, particularly in more conservative countries. Activists must remember this when recommending policies and approaches that enhance ASRHR. For example, policy provision should synergise with the minimum age consent to sexual activity, which for Lesotho is 16 years, and 13 in Comoros. In Lesotho, the National Reproductive Health policy does require the country to provide family planning services for all citizens. The SADC SRHR policy, however, recommends early access to ASRHR as a way to delay sexual debut. Information provides adolescents with the tools and skills they need to make good personal decisions and access necessary SRH measures. Without policies and laws that ensure their education and protection, young people face a greater risk of abuse and are likelier to remain ignorant about SRH issues that could keep them healthy and safe. The intersecting challenges linked to climate change, COVID-19, gender inequality and poverty require gender activists and governments in SADC to redouble their efforts to ensure adolescents throughout the region can realise their rights. Key next steps needed to do this include:

- ***Expand the Gender Links Youth Rapid Response Survey*** to all SADC countries and use the results of this study to spur development of an ASRHR checklist to set standards for the development of policy and legislation.
- ***Vaccinate all eligible teens and educators against COVID-19***: Health systems must prioritise teachers as well as adolescents 12 years and older as part of regional and national vaccination strategies.
- ***Governments need to invest in ICTs*** that offer educational and training opportunities to help educate youth on SRHR issues and ways they can help combat the spread of COVID-19.
- ***Strengthen national policy and legislation*** to assist local authorities to develop protective measures that prohibit and sanction perpetrators of sexual exploitation or abuse against girls during times of crisis.
- ***Continue formal education despite school closures*** and provide safe spaces for CSE, including through online ICT programmes, TV, mobile clinic outreach, or dual approaches.
- ***Align CSE and ASRHR services*** with HIV and AIDS prevention as well as universal health coverage indicators and measures, such as age of consent to SRHR services and age of consent to contraceptives.
- ***Fulfil the unmet*** need for contraceptives to assist in reducing teenage pregnancy and ensure SRHR programmes help young people make well-informed choices.
- ***Consider the risk of not reopening schools and health centres alongside other COVID-19 risks***: Continued pandemic school closures reduce access to teachers and peer-to-peer support. As the pandemic evolves, education leaders and policymakers must consider the risks for adolescents of missing the social and health benefits of being in school.

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