Adolescent Sexual and Reproductive Health and Rights (ASRHR)

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Youth take part in an ASRHR campaign march in Beitbridge, Zimbabwe, in 2021. Photo: Tapiwa Zvaraya

KEY POINTS

- Eleven SADC countries now have ASRHR policies but many need an update.
- A recent study[1] highlighted the impact of COVID-19 on adolescents in six SADC countries. It shows that 92% of young respondents reported facing difficulties in accessing appropriate healthcare.
- Three quarters of young people report experiencing loneliness, and many have made suicide attempts due to loss of income, limited prospects for employment and months of pandemic-related confinement.[2]
- The COVID-19 pandemic has driven an increase in early pregnancies by as much as 65% in some SADC member states.[3]
- A new study[4] in South Africa shows the pandemic response shifted healthcare resources towards combatting COVID-19, affecting the quality and availability of HIV services, especially for vulnerable populations, such as adolescents living with HIV (ALHIV).
- Seychelles has the worst coverage of all SADC countries for Comprehensive Sexuality Education (CSE) in primary school.
- Inadequate information about the nature, aim, and intended outcomes of CSE means policymakers continue to see pushback and opposition to it in some parts of the region.[5]
- Angola has the highest adolescent fertility rate (AFR) in the SADC region at 143 live births per every 1000 women aged 15 to 19. Mauritius is lowest at 24.

1 MIET AFRICA (2021) The Impact of COVID-19 on Adolescents and Young People in the SADC Region. South Africa. MIET AFRICA, https://mietafrica.org/wp-content/uploads/2021/07/REPORT-Impact_COVID_19_AYP_SADCRegional.pdf, accessed 29 September 2022.
2 ibid.
3 ibid.
4 Van Staden, Quintin, Laurenzi, Christina A, and Toska, Elona. Journal of the International AIDS Society, vol. 25, issue 4 (2022), e25904e: https://healtheducationresources.unesco.org/library/documents/two-years-after-lockdown-reviewing-effects-covid-19-health-services-and-support, accessed 29 September 2022
5 The journey towards comprehensive sexuality education - Global status report, https://www.unfpa.org/publications/journey-towards-comprehensive-sexuality-education-global-status-report, accessed: 29 September 2022.

Introduction

In the 28 years since policymakers adopted a Programme of Action at the 1994 International Conference on Population and Development (ICPD), the Southern African Development Community (SADC) region has made significant progress on sexual and reproductive health and rights (SRHR). The ICPD centred reproductive health and the empowerment of women and introduced the concepts of SRHR.

Yet millions of people - especially young people, who comprise more than 1.2 billion of the world population and up to 60% of SADC's population - still do not have access to SRH information and services. Further, in recent years, the COVID-19 pandemic has highlighted the fragility of gains made in this area over the past three decades.

To address widening ASRHR gaps, the World Health Organisation (WHO) has increased its research portfolio, set norms and standards, encouraged country support and advocacy - all of which it sets out in the first report in a new series on adolescent health, titled *Working for a Brighter, Healthier Future*. Alongside the challenges, the report highlights how people around the world have been coming together to improve the health and well-being of adolescents. WHO has also broadened the scope of its work at regional and country level.[6] In terms of data, the WHO collects and analyses data by age and sex; supports the creation of national strategies and plans that take into account the needs of adolescents; and helps shape high-level policies to address the environmental, economic, and other factors that affect adolescents' health.[7]

Regionally, the SADC SRHR Policy advocates for early access to adolescent SRHR (ASRHR) as a means of postponing sexual debut. At the national level, SADC countries have ASRHR programmes and policies that, while often outdated, promote adolescent sexual health. Punitive policies and restrictive laws against vulnerable groups, including youth, create barriers to their access to ASRHR services across the region. This chapter highlights these and other regional ASRHR challenges, including:

- The significant number of sexually active adolescents younger than 16;
- High numbers of multiple concurrent sexual relations;
- Increasing instances of inter-generational sexual relationships;
- Low levels of consistent condom usage;
- High levels of maternal mortality amongst young mothers;
- Compromised quality of antenatal care for young mothers compared to older mothers;
- High levels of HIV and AIDS among young people, especially young women;
- High levels of violence against women and girls (VAWG);
- Increasing numbers of child marriages;
- High adolescent fertility rates; and
- High unmet need for contraception.

[6] First WHO report highlights efforts to improving health and well-being of adolescents worldwide, https://www.who.int/news/item/18-01-2022-first-who-report-highlights-efforts-to-improving-health-and-well-being-of-adolescents-worldwide, accessed: 30 September 2022.
[7] ibid.

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[8]	Partial	N/A	No	Yes	Yes	N/A	Yes	N/A	Yes	Yes	N/A	Yes	Yes	Yes	Partial
Age of access to contraceptives[9]	16	12	No data	18	15	No data	12	16	16	16	12	15	10	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)[10]	143	44	61	119	92	92	104	131	24	142	58	60	62	114	115	77
Adolescent birth rate (births per 1000 women, 15-19 years of age by %)[11]	104	43.7	32	109	87	55	103	4	24	153.8	82	56	46.2	123	29	69

Table 3.1 highlights important ASRHR indicators in the SADC region and incorporates new data for adolescent birth rates obtained from the SADC Scorecard[12] and based on 2019 baseline figures for each country.

Countries calculate 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. The data continues to show very high birth rates among young women between the ages of 15 and 19. Other noteworthy findings include:

- Only South Africa adheres to the SADC SRHR Strategy 2019-2030 target on contraception, which notes that states should provide for it from age 10. This is a best practice in the region and South Africa's National Contraception Clinical Guidelines enshrine it.[13]
- Four out of 16 SADC countries have higher adolescent birth rates than fertility rates. Those highlighted in red indicate a higher rate, while those in green indicate lower birth rates compared to fertility rates.
- The data on age of consent to sexual activity and the age of access to contraceptives remains much the same as past years. Overall, there is a need to harmonise the age of consent to sex for boys and girls: they should have the same minimum age. Another gap requiring action is in the DRC, where legislators have yet to align the age of access to contraceptives (18) and the age of consent to sex for females (14). All other countries make contraceptives available at the same age or earlier than the age of consent.
- The low birth rate figure for Malawi requires further analysis as it is drastically lower than the country's adolescent fertility rate, shown as 131 per 1000 live births.

Local council teams take part in ASRHR action planning at Victoria Hotel in Maseru, Lesotho, in 2022. Photo by Ntolo Lekau

[8] UNFPA regional data, https://www.unfpa.org/data/AO Accessed 10 June 2021.
[9] Gender Links, Audit of SADC ASRHR Policies and Laws 2021.
[10] 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 26 September 2022.
[11] Score Card for Sexual and Reproductive Health and Rights in the SADC Region Fast tracking the Strategy for SRHR in the SADC Region 2019 - 2030, accessed: 10 September 2022.
[12] Score Card for Sexual and Reproductive Health and Rights in the SADC Region Fast tracking the Strategy for SRHR in the SADC Region 2019 - 2030, Workbook: SADC SRHR SCORECARD 2021_EN_FR_PO (tableau.com), accessed: 10 September 2022.
[13] South Africa National Contraception Clinical Guidelines, 2019. https://www.knowledgehub.org.za/system/files/elibdownloads/2021-03/National%20Contraception%20Clinical%20Guidelines_Final_2021.pdf, accessed 30 September 2022.

According to the United Nations Educational, Scientific and Cultural Organisation (UNESCO) 2021 Global report, resistance to comprehensive sexuality education (CSE) remains a challenge in some settings. The report provides a snapshot of progress toward school-based CSE around the world. Resistance to CSE often stems from misunderstandings about the nature, purpose, and outcomes of this type of education. When delivered properly, CSE aids in the prevention of GBV and HIV among young people.

ASRHR and COVID-19

> Limited access to mobile phones and internet connectivity is widening the education gap for girls in rural and remote areas

The COVID-19 pandemic, which wreaked global havoc between 2020 and 2022, left an indelible imprint on national health and education response systems. While most countries have contained the virus through ongoing vaccination and hygiene efforts, the severity and scale of the crisis affected adolescent access to reproductive health care - a critical area of health care that challenged policymakers even before the pandemic. Once again, ASRHR fell off the list of top priorities as governments shifted funding and attention to COVID-19 vaccination and containment and healthcare staffing shortages. Meanwhile, local movement restrictions limited the cohort's ability to access contraception or attend school. Many young people who normally have easy access to SRHR within school settings faced even greater barriers to care due to frequent and unpredictable school closures over the past two years.

In response, this year's chapter delves into youth-friendly health education and services, particularly as the region recovers from the pandemic. In keeping with the tradition of the SADC Gender Protocol Barometer #VoiceandChoice publications, it also includes case studies of how local governments have stepped up their efforts to promote CSE and adolescent sexual health.

Regional: Youth face numerous health and education setbacks linked to COVID-19

Significant and worrying gaps in education and healthcare provision have left millions of young people behind in Southern Africa as the region struggles to address the fallout from the COVID-19 pandemic, according to a 2021 study conducted by the Media in Education Trust (MIET) Africa. [14]

Researchers carried out the study on the impact of COVID-19 on adolescents and young people in the SADC region in six countries: Lesotho, Madagascar, Malawi, Namibia, Zambia, and Zimbabwe.

[14] MIET AFRICA (2021) The Impact of COVID-19 on Adolescents and Young People in the SADC Region. South Africa. MIET AFRICA, https://mietafrica.org/wp-content/uploads/2021/07/REPORT-Impact_COVID_19_AYP_SADCRegional.pdf, accessed 29 September 2022.

A young woman receives a COVID-19 vaccination in Madagascar in 2021. Most governments shifted funding and attention to COVID-19 vaccination and containment, which negatively affected ASRHR in the region. Photo: Zoto Razanadratefa

Other key findings on adolescent education and health during the COVID-19 pandemic include:

- School closures affected 127 million learners in Eastern and Southern Africa.
- COVID-19 led to a huge increase in early pregnancies: as much as 65% in some SADC member states. Around one million girls in sub-Saharan Africa got pregnant during COVID-19, which means many may not return to school.
- The weeks of school closures in SADC meant that learning declined and dropouts increased, especially among the most disadvantaged. Projected school dropouts could wipe out recent gains made in reducing the number of out-of-school young people.
- Most (92%) young respondents reported that the pandemic affected their access to healthcare.
- Mental health and psychological wellbeing are a concern in the region: 74% of youth reported feelings of loneliness, distance, or suicide attempts due to loss of income, limited prospects for employment and months of confinement.
- The pandemic added to the number of those dealing with drug and substance abuse and it accelerated the growth of cyberbullying.
- Three out of five learners lost access to important SRHR services.
- Routine measles and other immunisations have fallen far behind, increasing the risk of young people acquiring secondary diseases. At least 14 million children in sub-Saharan Africa will miss routine immunisation: 60% of these children live in the SADC region.
- Due to the disruption of SRHR supply chains, the region struggles with shortages of antiretroviral treatments (ART), condoms and other contraceptives, which will increase disease burdens (including higher risks of HIV infections), and unintended pregnancies in the SADC region.

For the most vulnerable young people, including those with disabilities and those living in poor or marginalised communities, education represents a life-changing and often life-saving opportunity. Beyond the classroom, schools provide spaces of support, offering young people nutrition through school meals and critical psychosocial and SRHR support for their wellbeing and healthy development.

Researchers found that linking education with SRHR support has proved a useful model, with "youth corners" or spaces for young people providing a safe and enabling environment. CSE provided in schools is also a critical support and service for adolescents and young people. In the absence of these in-person opportunities, the report noted that governments and civil society organisations should invest in innovative, digitally based and remote SRH information and services for adolescents and young people.

Bridging the digital divide is crucial for SADC's development. The study found that limited access to mobile phones and internet connectivity continues to widen the education gap, particularly for girls living in rural and remote areas. Governments should improve e-governance by investing in modern ICT infrastructure and supporting the education sector to use blended approaches to teaching and learning to suit learner needs.

As the COVID-19 infection curve flattens, governments must urgently and safely open schools, focusing on equity-based access to education to ensure that SADC truly builds back better by leaving no one behind.

Source: MIET AFRICA .[15]

[15] MIET AFRICA (2021) The Impact of COVID-19 on Adolescents and Young People in the SADC Region. South Africa. MIET AFRICA, https://mietafrica.org/wp-content/uploads/2021/07/REPORT-Impact_COVID_19_AYP_SADCRegional.pdf, accessed 29 September 2022.

Across the region, the COVID-19 pandemic disrupted ASRHR services and limited access to HIV and AIDS prevention services, including condoms and pre-exposure prophylaxis. As the MIET Africa study and others have noted, this is especially challenging for at-risk groups like adolescents living with HIV (ALHIV).

South Africa: COVID-19 healthcare shifts affecting adolescents living with HIV

The Joint United Nations Programme on HIV and AIDS (UNAIDS) 95-95-95 global targets for epidemic control aim to ensure by 2030 that 95% of HIV-positive people know their HIV status, 95% of people diagnosed with HIV receive sustained ART and 95% of people on ART have viral suppression.

South Africa's progress towards the 95-95-95 goals has been significantly slower among adolescents living with HIV (ALHIV), according to the Journal of the International AIDS Society. Among this group, ART adherence, retention in care and viral suppression remain a concern.

After two years of living with COVID-19, policymakers need to examine the direct and indirect effects of the pandemic on healthcare resources, access to HIV services and availability of support structures, to assess their impact on HIV care for ALHIV.

The COVID-19 response in South Africa has shifted healthcare resources towards combatting COVID-19, affecting the quality and availability of HIV services. The healthcare system's response to COVID-19 has threatened to diminish fragile gains in engaging ALHIV with HIV services, especially as this group relies on overburdened public health facilities for their HIV care.

Reallocation of limited health resources utilised by ALHIV disrupted healthcare workers' capacity to form and maintain therapeutic relationships with ALHIV and monitor ALHIV for ART-related side effects, treatment difficulties and mental health conditions, affecting their ability to retain ALHIV in HIV care.

Prevailing declines in HIV surveillance meant missed opportunities to identify and manage opportunistic infections and HIV disease progression in adolescents. Lockdown restrictions have also limited access to healthcare facilities and healthcare workers for ALHIV by reducing clinic appointments and limiting individual movement. ALHIV have had restricted access to social, psychological and educational support structures, including national feeding schemes. This limited access, coupled with reduced opportunities for routine maternal and sexual and reproductive health services, may place adolescent girls at greater risk of transactional sex, child marriages, unintended pregnancy and mother-to-child HIV transmission.

Policymakers often overlook adolescent HIV care in South Africa; however, ART adherence among ALHIV in South Africa is particularly susceptible to the consequences of a world transformed by COVID-19. Disruptions to health structures, new barriers to access health services and the limited available education and psychosocial support systems have reshaped the current structures in place to support HIV testing, ART initiation and adherence. Reflecting on these limitations can drive considerations for minimising these barriers and retaining ALHIV in HIV care.

Source: Journal of the International AIDS Society.[16]

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

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.

CSE helps young people to protect and advocate for their health, well-being and dignity by providing them with a necessary toolkit of knowledge, attitudes and skills. It is a precondition for exercising full bodily autonomy, which requires not only the right to make choices about one's body but also the information to make these choices in a meaningful way.[17]

[17] Comprehensive sexuality education, United Nations Population Fund, https://www.unfpa.org/comprehensive-sexuality-education, accessed: 28 September 2022.

The International Technical Guidance on Sexuality Education is a technical tool that presents the evidence base and rationale for delivering CSE to young people to achieve the global Sustainable Development Goals (SDGs).[18] It states that CSE must be scientifically accurate; incremental; age and developmentally appropriate; curriculum-based; comprehensive; based on a human rights approach; based on gender equality; culturally relevant and contextually appropriate; transformative; and able to help develop life skills needed to support healthy choices.

The lack of basic SRHR education exacerbates gender inequities and contributes to negative SRH outcomes, such as STIs, unwanted pregnancies, and HIV and AIDS. Adolescents and youth have the biggest chance for economic and social development in the region as they represent the basis for progress and stability in all SADC countries. To maximise youth participation in national and regional economic growth and development, decision-makers must ensure their education, health, and participation potential. Regional and national policies that promote CSE and ASRHR ensure that today's educated, healthy, and empowered youth will become tomorrow's productive and intelligent adults who contribute to the bright futures of all SADC member states.

Table 3.2: Status of CSE in SADC[19]

Country	Education policies on life skills-based HIV and sexuality education in both primary and secondary	Gender responsive life skills-based HIV and sexuality education forms part of the curriculum in primary and secondary education	Mandatory curriculum for both primary and secondary education	Coverage of primary schools (%)	Coverage of secondary schools (%)	Teacher training policy/programme/ curriculum
Angola	Yes	Yes	Yes	76-100	76-100	Yes
Botswana	Yes	Yes	Yes	76-100	76-100	Yes
Comoros	Yes	No data	No data	51-75	51-75	Yes
Democratic Republic Of Congo	Relevant legal frameworks, laws, decree, acts and policies (levels of education are not specified)	Yes	Yes	76-100	76-100	Yes
Eswatini	Yes	Yes	Yes	76-100	76-100	Yes
Lesotho	Yes	Yes	Yes	76-100	76-100	Yes
Madagascar	Yes	Yes	Optional curriculum for both primary and secondary education	51-75	51-75	Yes
Malawi	Yes	Yes	Mandatory curriculum for primary education only	76-100	76-100	Yes
Mauritius	Education policies on life skills-based HIV and sexuality education in secondary education only	No data	No data	No data	76-100	Yes
Mozambique	Yes	Yes	Optional curriculum for both primary and secondary education	76-100	76-100	Yes
Namibia	Yes	Yes	Yes	51-75	76-100	Yes
Seychelles	Yes	No data	No data	26-50	51-75	Yes
South Africa	Yes	Yes	Yes	76-100	76-100	Yes
Tanzania	Yes	Yes	Yes	51-75	51-75	Yes
Zambia	Yes	Yes	Yes	76-100	76-100	Yes
Zimbabwe	Yes	Yes	Yes	76-100	76-100	Yes

Source: UNESCO Journey towards Comprehensive Sexual Education, 2021 Global Status Report.

[18] International technical guidance on sexuality education, United Nations Population Fund, https://www.unfpa.org/publications/international-technical-guidance-sexuality-education, accessed: 28 September 2022.
[19] The journey towards comprehensive sexuality education - Global status report, https://www.unfpa.org/publications/journey-towards-comprehensive-sexuality-education-global-status-report, accessed: 29 September 2022.

Table 3.2 uses data from the UNESCO (2021) Global Status Report on CSE[20] to show the state of CSE among SADC states. It illustrates that many countries have committed to CSE in primary and secondary curriculum, teacher training, and monitoring and evaluation. It also shows that:

- All 16 SADC countries have CSE included in their teacher training curriculum;
- Madagascar and Mozambique make their curriculum optional, while Malawi mandates it in primary only.
- At between 26-50% of use in primary schools, Seychelles has the least coverage of CSE.

Factors affecting the implementation of CSE

Resistance to CSE is frequently the result of incorrect information about its nature, purpose, and outcomes.[21] Anti-CSE activists in SADC member states continue to disagree on the definition of CSE and the language surrounding it. The following examples demonstrate the nature and forms of resistance to CSE.

In **South Africa**, #LeaveOurKidsAlone[22] is one of several group that has publicly condemned CSE. The South African Department of Basic Education came under fire from anti-CSE activists in 2020 for using CSE-focused teaching materials. Other organisations in the country have gone as far as proposing their own models of sexual health education that they claim are both safe and credible.[23]

In the **DRC**, the National Reproductive Health Programme and the National Adolescent Health Policy both cover CSE. This highlights the DRC's integrated approach to CSE. However, patriarchal attitudes and structures make it hard to teach about sexuality and CSE. For example, some traditionalists in the country still frown on the use of condoms as a method of birth control. DRC has one of the highest adolescent fertility rates (119 per 1000 women 15-19) in the region. The Guttmacher Institute found that the DRC has the fourth lowest use of birth control in the world, which helps explain the high number of teens who get pregnant there.[24]

Despite significant opposition to CSE, the UNESCO (2021) Global Status Report on CSE[25] finds that communities everywhere, including parents, school administrators, religious leaders, the media, and young people themselves, have helped foster a conducive atmosphere for CSE.

> Resistance to CSE is frequently the result of incorrect information about its nature, purpose, and outcomes

[20] The journey towards comprehensive sexuality education - Global status report, https://www.unfpa.org/publications/journey-towards-comprehensive-sexuality-education-global-status-report, accessed: 29 September 2022.
[21] ibid.
[22] #LeaveOurKidsAlone: Leader of anti sex ed group says they'll bring the country to a standstill, https://www.news24.com/parent/Learn/Learning-difficulties/leaveourkidsalone-anti-sex-ed-group-gathers-over-50-000-fb-members-in-just-two-weeks-20191113, accessed: 5 October 2022.
[23] Admin (2020) 'Breakthrough Against CSE - Major Doors Open At United Nations!', JOY! News, 29 September. Available at: https://joynews.co.za/breakthrough-against-cse-major-doors-open-at-united-nations/ (Accessed: 29 September 2022).
[24] Guttmacher Institute, 2021. https://www.guttmacher.org/report/unintended-pregnancy-abortion-kinshasa-drc [accessed 22 June 2021]
[25] The journey towards comprehensive sexuality education - Global status report, https://www.unfpa.org/publications/journey-towards-comprehensive-sexuality-education-global-status-report, accessed: 29 September 2022.

Zimbabwe: Local council rolls out comprehensive plan to expand ASRHR support

Youth in Rimuka, a suburb of Kadoma, take part in sex education classes coordinated through the city council. Photo: Alfred Maruma

Recent findings that show knowledge gaps among youth and low uptake of ASRHR services have spurred policymakers at the City of Kadoma to embark on a drive to ensure more adolescents learn about SRHR, ideally through CSE.

Evidence drawn from a rapid assessment of ASRHR conducted by GL in 2020 suggests that adolescents in the community lack sexual reproductive health knowledge and do not make good use of ASRHR services such as contraception. For instance, the assessment showed that just 35% of young people requested contraceptives, 29% of young women had requested a pregnancy test, and 5% of those were pregnant at the time.[26]

In response to these challenges, Kadoma lawmakers have employed multiple strategies to educate adolescents on SRHR. These included conducting SRH awareness campaigns in the local authority's health centres, schools, and communities; forming adolescent school health clubs; and establishing adolescent and youth-friendly centres. The City also works with some churches to provide SRHR information to their congregations. It runs the activities in partnership with the Ministry of Health and Child Care, and the Ministry of Youth; both groups represent critical partners for sharing information on legislative policies and other health-related policies.

Junior councillors help implement the city's youth-led SRHR campaigns on teenage pregnancies, HIV and AIDS, and GBV. Critically, the council used the media and arts to spread awareness to adolescents, including a partnership with Berina Community Radio to publicise issues on ASRH. Local dramas have also proved effective in raising awareness: 1142 youths benefitted from these engagements (girls comprised 55% of the total).

"As adults and community members we need to empower and protect our children and youths from all forms of gender-based violence, including sexual violence, and equip them for a better tomorrow," said Raphael Nyadenga, a member of the Budiriro youth arts group.

The City hopes its awareness campaigns lead to a decline in teenage pregnancies, STI infections and new cases of HIV. Despite its early successes, staff faced numerous challenges in implementing the project. These include religious and cultural barriers associated with SRHR; limited political support and will; and in some instances, poor coordination between partners. The council, however, leveraged its institutional strength to overcome some of these challenges.

Source: Sikhanyisiwe Moyo, Gender Focal person, Kadoma City Council, Zimbabwe.

[26] GL Rapid Assessment of ASRHR 2019-2020- Zimbabwe Pamphlet.

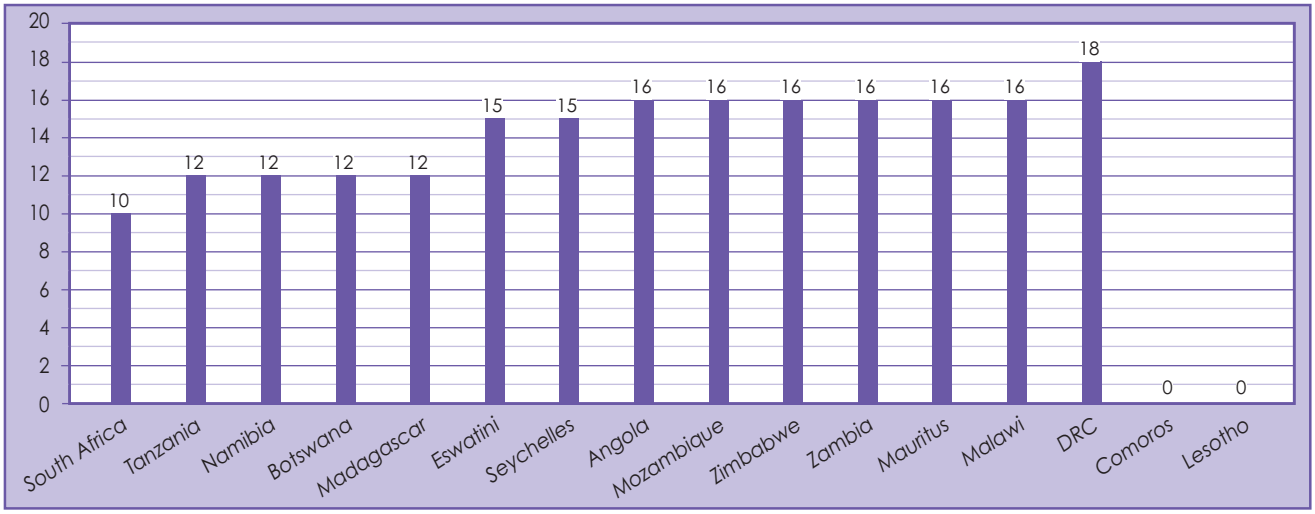
Access to contraceptives and age of consent to sex

Adolescents have reproductive health rights just as adults do, entitling them to reproductive health needs without any barriers. Adolescents are particularly vulnerable to early marriages, early child bearing, rape and sexual violence, unsafe abortions and risk of contracting HIV and AIDS. Requiring third party authorisation for ASRHR services and information prevents adolescents from exercising their basic human rights.

Promoting sexual health is a building block to the attainment of SDG 3: *Ensure healthy lives and promote well-being for all at all ages, and, specifically, Target 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.*

This requires that countries align their laws and policies on access to contraceptives and the age of consent to sex. This legal and policy environment is critical in avoiding adolescent pregnancy and fatherhood.

Figure 3.1: Age of access to contraception



Source: GL Mapping of SRHR Policies and Laws updated 2021.

Figure 3.1 shows that only South Africa follows the SADC SRHR Strategy 2019-2030, which provides for contraception from age 10. This represents a best practice in the region and South Africa's National Contraception Clinical Guidelines 2019 include it.[27] Four SADC countries (Botswana, Madagascar, Namibia and Tanzania) provide contraceptives to young people from the age of 12. Seychelles and Eswatini start at age 15. The remaining countries allow for contraception from age 16, with DRC as the outlier at 18. In the case of DRC, this highlights a significant gap of four years between this basic right and the legal age for girls to consent to sex in the country, at 14 years.

[27] South Africa National Contraception Clinical Guidelines, 2019. https://www.knowledgehub.org.za/system/files/elibdownloads/2021-03/National%20Contraception%20Clinical%20Guidelines_Final_2021.pdf, accessed 30 September 2022.

While there is no data for Lesotho and Comoros, the SADC Scorecard shows that the unmet contraceptive need in the 15-49 age cohort in both countries stood at 18% and 32%, respectively, in 2021.[28] Given the increasing numbers of early pregnancies in the region, legislators should urgently lower the age of consent for contraception to help address this challenge.

Table 3.3: Existence of laws and policies that allow adolescents to access SRH services without third party authorisation

Country	Yes	Yes, if 12 and older	Yes, if 14 and older	Yes, if 15 and older	No laws and policies	Data not available
DRC	✗					
Lesotho	✗					
Madagascar	✗					
Malawi	✗					
Namibia	✗					
Tanzania	✗					
Eswatini		✗				
South Africa		✗				
Mauritius			✗			
Seychelles				✗		
Angola					✗	
Comoros					✗	
Botswana					✗	
Zambia					✗	
Zimbabwe					✗	
Mozambique						✗

Source: SADC Scorecard.[29]

Table 3.3 shows that the DRC, Lesotho, Madagascar, Malawi, Namibia, and Tanzania have laws and policies that allow adolescents to access SRH services without third party authorisation. Other countries have laws that allow access to ASRHR services only at certain ages. For instance, South Africa and Eswatini require third party authorisation for youths younger than 12; the same applies in Mauritius for those younger than 14 years. Meanwhile, adolescents in Seychelles must be 15 or older to access SRHR without third party authorisation. No laws and policies exist on this in Angola, Botswana Comoros, Zambia and Zimbabwe, and there is no data for Mozambique.

Requiring third party authorisation for ASRHR services and information prevents adolescents from exercising their basic human rights

[28] Score Card for Sexual and Reproductive Health and Rights in the SADC Region Fast tracking the Strategy for SRHR in the SADC Region 2019 - 2030, Workbook: SADC SRHR SCORECARD 2021_EN_FR_PO (tableau.com), accessed: 10 September 2022.
[29] SADC SRHR SCORECARD 2021_EN_FR_PO. https://dev-www.sadc.int/srhrscorecard/, accessed: 10 September 2022).

Enhancing ASRHR

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

According to the International Planned Parenthood (IPP), elevating youth-friendly services should include the following:

- Trained providers who work competently, sensitively and respectfully with adolescents and young people on their sexual and reproductive health needs;
- Confidential, non-judgmental and private services;
- Convenient clinic opening hours for adolescents and young people: such times include late afternoons (after school), evenings and weekends;
- Accessible services for all adolescents and young people irrespective of their age, marital status, sexual orientation or ability to pay;
- An effective referral system;
- Opportunities for adolescents and young people to be involved in designing, implementing and evaluating the programme; and
- Services should seek to involve and gain the support of those important in the lives of young people and in the local community, such as partners, parents/guardians and schools.

Adolescents and young people may not get the care they need because of strict rules, laws and policies, parental or partner control, lack of knowledge, distance, cost, lack of privacy, and provider bias. GL's rapid assessment in Botswana, Eswatini, Lesotho, Madagascar, Mauritius, South Africa, Zambia, and Zimbabwe from November 2019 to December 2020 showed how these factors affect access and quality of care for ASRHR in each of the countries under investigation.

Young girls take part in a 2022 campaign to promote SRHR services in churches in Zimbabwe's Zibagwe district. Photo: Tapiwa Zvaraya

Some of the key findings from these assessments include:

Cost of ASRHR services

- The average fee is $2 across the four countries (Eswatini, Lesotho, Madagascar, and Zimbabwe) in which respondents pay fees.
- Fees for health services range from $1 in Lesotho to $3 in Zimbabwe.
- In Zimbabwe, where respondents paid the highest fees, this represents 15% of the average daily income (and 5% of the average daily income in Lesotho).
- In Eswatini, the $2 fee constitutes 22% of the average daily income of $9, while the $2 in Madagascar constitutes 18%.

Quality of care

- In Lesotho, 62% of respondents did not receive services because they arrived without an adult third party present.
- Between 46% and 57% of respondents did not receive services in Zimbabwe, South Africa, Zambia and Zimbabwe.
- Lower proportions of respondents in Madagascar and Botswana did not receive services without third party authorisation.
- In Eswatini, only 13% reported not receiving services without third party authorisation.

The relatively high fees for ASRHR services and the requirement for parental consent, among other factors, limit the voice and choice for adolescents. They represent a disincentive to young people seeking out help and critical information from these facilities.

Lesotho: Siloe Council introduces youth-friendly SRH infrastructure

Some members of the Siloe Council in Lesotho described the recent Gender Links ASRHR rapid assessment as a wake-up call that immediately spurred them to respond.

GL conducted the study, which uncovered several barriers for youth trying to access SRH services, in nine Centres of Excellence for Gender in Local Government (COEs), including the Siloe Council.

It covered three clinics - Liphiring, Mofumhali oa Rosari and Mohalinyane Health Centre - with 61 respondents: 49% female and 51% male.

The report found that Mohalinyane and Mofumahali oa Rosary clinics do not open after school hours or on weekends: a worrying finding that likely prevents many young people from accessing their services.

Following the results of the study, Siloe Council worked with clinics to prioritise young people's access and ensure they receive reliable health-care advice.

The council also turned one of its offices into a youth corner where young people can come after school and on weekends for all their health needs. Young people seem to appreciate the initiative as many have used the facility since it opened. Tlotliso Mosala, a local youth, said the youth corner provides an alternative space within the council for those youth who worry about the stigma of visiting an SRH clinic.

A nurse observes a participant learning about the female condom at a workshop in Lesotho in 2020. Photo: Ntolo Lekau

The centre offers antenatal services, HIV testing and counselling, prevention and treatment of STIs, and sexuality and contraception education. Apart from these services, many activities at the centre help young people release stress and share leisure time together. The Council regularly trains its healthcare workers to ensure they understand how to deliver better services to young people and evaluate the impact of their service delivery on youth SRH outcomes.

The Government of Lesotho, along with United Nations Children's Fund (UNICEF) and other partners, has also responded to the ASRHR gaps by introducing other innovative projects to provide young people an opportunity to shape the healthcare services they receive. This includes a tool that allows them to rate the services they receive at healthcare facilities.

Source: Ntolo Lekau Gender Links Lesotho.

The health centre in Anjozorobe, **Madagascar**, where GL conducted an ASRHR rapid assessment in 2020, provides youth-friendly ASRHR services to adolescents including, counselling, ASRHR information, orientation, education, advice, free access to contraception, quality care and treatment, as well as referrals to other nearby hospitals in the event of HIV positive tests. In addition, health teams work closely with schools within the districts to run an annual campaign called Proximity Care. During this campaign, health workers share information about ASRHR and explain the importance of prenatal consultation. In 2021, thanks to their involvement in this campaign, 90 young pregnant women aged 18 and younger gave birth without complications.

Enhancing ASRHR through policy provisions

Providing youth with high-quality, timely services that allow them to make free and informed decisions about their sexuality and reproductive lives begins at the policy level and progresses to the institutional and community levels. Countries in the SADC region need adequate policy provision to ensure access to information, education, and adolescent-friendly comprehensive services.

Table 3.4: SADC countries with adolescent and youth SRHR policies[30]

Country	Stand-alone ASRHR policy or strategy reported in 2021	Additional ASRHR policies or strategies updated in 2022
Botswana	Adolescent Sexual and Reproductive Health Implementation Strategy (2012-2016)	
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)	
Zimbabwe	National Adolescent Sexual and Reproductive Health Strategy (2016-2020)	
Angola	No	The National Strategy on Comprehensive Healthcare for Adolescents and Youth, Family Planning and Reproductive Health
Mozambique	No	Integrated Package of Services for Youth (2010)
Tanzania	No	SRHR guidelines and National Adolescent Reproductive Health Strategy (2011-2015)
Comoros	No	No
Eswatini	No	No
Mauritius	No	No
Namibia	No	No
Seychelles	No	No

Source: GL Mapping of SRHR Policies and Laws updated 2021, and MIET AFRICA 2021.[31]

Table 3.4 provides an updated review of SADC countries, showing those with stand-alone ASRHR policies and strategies. The previous Barometer reported that eight out of 16 countries had ASRHR policies. Further research and desktop reviews over the past year concluded that 11 countries have ASRHR policies, adding Angola, Mozambique and Tanzania to the list. Comoros, Eswatini, Mauritius, Namibia, and Seychelles do not have stand-alone SRHR policies or guidelines. Updating ASRHR policies represents a critical step to improving ASRH outcomes because it enables member states to conform to the provisions of their national, regional, and global ASRHR obligations.

[30] Updated 2022 to include Angola ASRHR strategy, Mozambique's integrated package for Youth 2010, and Tanzania's SRHR guidelines and National Adolescent Reproductive Health Strategy 2011-2015.

[31] MIET AFRICA (2021) The Impact of COVID-19 on Adolescents and Young People in the SADC Region. South Africa. MIET AFRICA, https://mietafrica.org/wp-content/uploads/2021/07/REPORT-Impact_COVID_19_AYP_SADCRegional.pdf, accessed 29 September 2022.

Eswatini: Civil society groups celebrate new policies to address ASRHR gaps

A concerted advocacy push to pressure government and community leaders to improve ASRHR in Eswatini bore fruit over the past year, says the Eswatini Young Women's Alliance (EYWA).

Members of the group met with representatives from the ministries of justice, health, and social welfare, as well as UN bodies, the Eswatini National Youth Council, and others to understand and advocate for ASRHR policy and legislative provisions for Eswatini.

They also took part in several debates on the National Youth Policy (2020) and the Education Sector Policy for the Prevention and Management of Learner Pregnancy (2021). The government later adopted both policies along with a new bill to address safe abortion services.

EYWA says consultations with various stakeholders suggested that policymakers must align legal frameworks to implement the new legislation. The Ministry of Health highlighted ASRHR gaps in hospitals, including inadequate youth-friendly clinics.

The group also saw positive change stemming from their discussions with community leaders, during which their members requested that local leaders play a bigger role in preventing illegal child marriages. The Ministry of Education has completed a draft policy on adolescent pregnancy and is finalising a policy to allow pregnant girls to continue attending school without interruption. EYWA says it will conduct follow-up checks to monitor the implementation process.

According to the Eswatini National Youth Council, along with the new policies, the government has integrated some health services, trained new health workers, and introduced mobile clinics (known as Dreams on Wheels) in rural areas. Initially, the health ministry mandated the Dreams on Wheels clinics exclusively for HIV prevention services, but they have since expanded their offerings to include all health services, including SRHR. In addition, the Ministry of Health began providing school SRHR services as part of its school health programming.

Members of the Eswatini Young Women's Alliance march against GBV in 2019. The group recently appealed to policymakers to improve SRH services and access to safe abortion.
Photo: Gender Links

UNICEF worked with the Ministry of Education to develop the Education Sector Policy for the Prevention and Management of Learner Pregnancy (2021) and support life skills education. Furthermore, they began assisting pregnant girls with financial support when they return to school to prevent girls from dropping out.

Meanwhile, the Ministry of Health is conducting a survey to determine the extent of abortion on the ground at the constituency level. Civil society groups hope it will use the findings to make policy decisions based on evidence rather than the views of a few individuals. During the policy tracking meetings, government stakeholders emphasised the importance of legal and safe abortion.

The Southern Africa HIV and AIDS Information Dissemination Service (SAFAIDS) said that, despite the government's evolving stance on safe abortion, backstreet abortion increased during COVID-19. The group has engaged champions (advocates) and conducted training for policymakers and health practitioners in response to this challenge.

Source: Eswatini Young Women's Alliance.

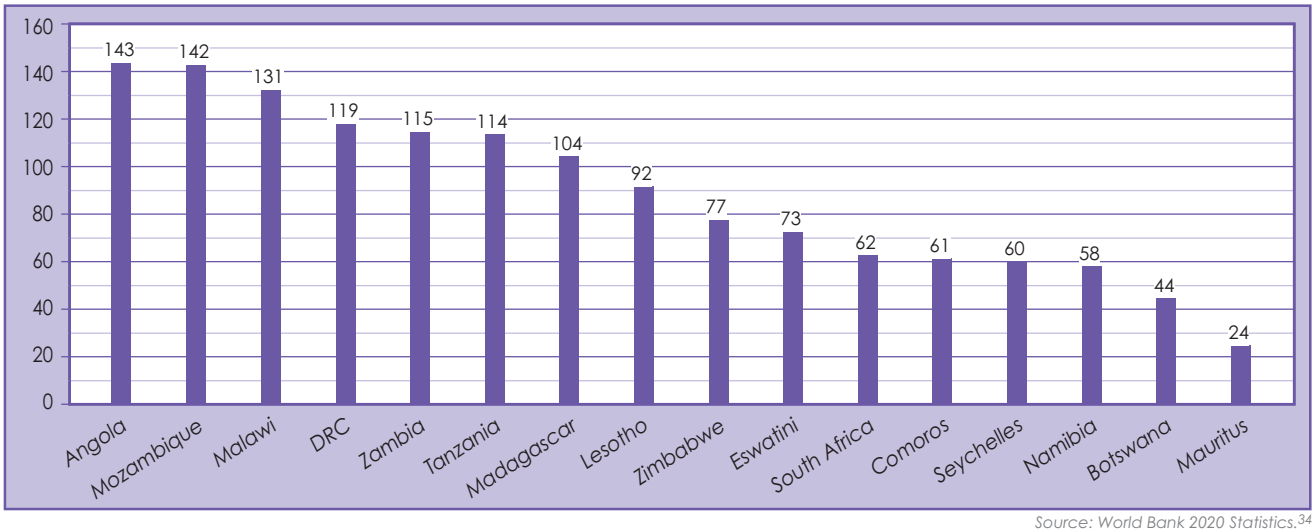
Early unwanted pregnancy

A low adolescent fertility rate (AFR) can indicate a country's dedication to reproductive health and family planning

One of the most important indicators of a nation's reproductive health is the adolescent fertility rate (AFR). The AFR assesses the prevalence of early pregnancy at the national level. A low AFR can indicate a country's dedication to reproductive health and family planning, while a high AFR indicates a country's low level of social and economic development, as well as its lack of access to reproductive health care.[32]

Gender activists use the AFR to monitor Goal 3.7.2 of the SDGs, which includes a target to reduce adolescent birth rates.[33] Countries determine their AFR, measured in births per 1000 women, by dividing the number of live births to women aged 15-19 in a given year by the total female population of the same age group.

Figure 3.2: Adolescent fertility rate (per 1000 women 15-19)



Source: World Bank 2020 Statistics.[34]

Figure 3.2 shows the state of adolescent fertility in the region using the most recent figures for each country. Angola has the highest adolescent fertility rate in the SADC region at 143 live births per every 1000 women aged 15 to 19. Fertility rates remain high in several other countries, including Mozambique, Malawi, DRC, Zambia, Tanzania and Madagascar. A high AFR also corresponds to high rates of child marriages and early pregnancies. At least one in ten girls (14%) in Mozambique has given birth before the age of 15, with this indicator rising to 57% before the age of 18.[35] With 24 live births per every 1000 women aged 15 to 19, Mauritius has the lowest

[32] Collins, I. (2022) 'Adolescent Fertility Rate Definition | You Getting Pregnant', 30 June, https://www.yougettingpregnant.com/adolescent-fertility-rate-definition/, accessed: 28 September 2022.
[33] SDG Goal 3.7.2 Adolescent Birth Rate, Global SDG Indicator Platform, https://sdg.tracking-progress.org/indicator/3-7-2-adolescent-birth-rate/, accessed: 7 October 2022.
[34] 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 26 September 2022.
[35] 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

adolescent fertility rate in the region, showing the country's dedication to addressing ASRH concerns.

These figures highlight the urgent need for accessible, youth-friendly SRH programmes that include contraceptive education. Increasing CSE and youth access to contraceptives are two solutions activists suggest for addressing the high incidence of adolescent fertility. The following case study illuminates the challenges of teenage pregnancies in South Africa's Free State Province.

South Africa: Officials respond to early pregnancy spike in Free State

The Free State Health Department has recorded an alarming 150 births in just four months of 2022 for girls between age 10 and 14. Statistics show that more than 4 700 teens aged between 15 and 19 gave birth in 2021. In the same year, the department recorded 2 100 pregnancy terminations among girls between ages 10 and 19.

The South African Medical Research Council reports that, even before the COVID-19 pandemic, 16% of young women aged 15 to 19 had given birth to a child. The figure ranges between 11% in urban and 19% in rural areas. In the Free State, the Thabo Mofutsanyana District recorded the highest cases of early pregnancies.

In June 2022, Lindiwe Zulu, Minister of Social Development, called on government departments to work together to address the scourge of high early unwanted pregnancies.

Social Development Minister Lindiwe Zulu has urged government departments to enhance collaboration to reduce high rates of early unwanted pregnancy.

Credit: SA Government

A spokesperson for the Free State Department of Health, Mondli Mvambi, noted that youth-friendly zones and clinics cater for sex education for young people. Mvambi says the department encourages contraceptive use to avoid unwanted pregnancies, noting, "We've got a high rate of children that are having children, from 10 to 16 years of age."

But Buyiswa Mpini, a national programme officer for UNESCO, says this age group faces many challenges in accessing SRH services, which should concern decision makers. "Let's talk to young men and men in general and ask what role you can play to protect our girls from falling pregnant, which is don't rape our girls. If you are engaging in relationships with our girls, make sure you allow them to protect themselves."

Meanwhile, Bukelwa Qwelane, director of the Life Skills prevention programme in the province, notes that rape and abuse often contribute to high teenage pregnancies. "You will agree that social and economic issues render learners vulnerable to pregnancies where learners are being abused and raped. The numbers that we see are statutory rapes where learners do not consent to sexual engagements."

Reproductive healthcare expert Sebabatso Tsaoane says teenagers face elevated pregnancy risks. "So in pregnancy, what happens is that the women's body has to cater for the needs of the growing foetus. So in the case of early unwanted pregnancy, nutrients that are supposed to be used for the development of this specific teenager now have to be diverted to the growing foetus."

Source: Konelo Lekhafola, SABC News.[36]

[36] Teenage pregnancies on the rise in Free State: Health Dept stats (2022) SABC News, https://www.sabcnews.com/sabcnews/teenage-pregnancies-on-the-rise-in-free-state-health-dept-stats/, accessed: 7 October 2022.

SADC Gender Protocol Alliance takes stock on ASRHR

Southern Africa Gender Protocol Alliance

At its meeting in May 2022, the Alliance undertook a stock taking exercise of its campaign and advocacy work on SRHR in 2021. The SRHR 2021 efforts aimed to amplify the Southern Africa #VoiceandChoice campaign in the face of the COVID-19 pandemic by casting the spotlight on ASRHR and three closely related themes: early unwanted pregnancy, child marriage and unsafe abortion. The meeting reflected on the actual progress, or lack thereof in some cases, in advancing SRHR policy; identified challenges and obstacles; developed strategies to address these; and reviewed country priorities on SRHR. Participants presented on the three themes.

Kevin Chiramba, Gender Links associate, shared the current context of ASRHR policy in the SADC region, as well as findings from the ASRHR rapid assessments. Anne Githuku-Shongwe, director of the UNAIDS regional support team for Eastern and Southern Africa, presented her team's work on ASRHR issues and opportunities to work with Alliance. This includes the Education Plus Initiative, which includes a big push to keep girls in school up to the completion of secondary school; universal access to CSE; fulfilment of SRHR rights; safety from GBV; and school-to-work transitions.

The Alliance meeting highlighted an essential point about language, noting that the term "teenage pregnancy" places a burden on the teenager, especially as many of these pregnancies result from rape and violence. The group agreed to use the term "early unwanted pregnancy" whenever possible. Adolescent mental health represented another critical emerging issue.

The Alliance country partners resolved to work on the following ASRHR priorities over the coming year.

Eswatini

- Integrate ASRHR services with economic development and capacity building on ASRHR for implementers with a focus on adolescents and youth organisations.
- Improve political will on ASRHR through capacity building for the parliament committees on health, youth and gender and ASRHR policies and legislation.
- Sensitise and raise awareness on the importance of CSE.
- Conduct public sensitisation on the new Education Sector Policy for the Prevention and Management of Learner Pregnancy.
- Collaborate with development partners on girl empowerment programmes to eliminate the practice of child marriage.
- Develop a digital media advocacy plan on safe abortion.

The Education Plus Initiative, which includes a big push to keep girls in school up to the completion of secondary school; universal access to CSE; fulfilment of SRHR rights; safety from GBV; and school-to-work transitions

Lesotho

- Renew ASRHR strategies (with a key focus on the age of consent to general health/SRH services).
- Review CSE/Life Skills curricula.
- Review of Penal Code to expand access to safe abortion.
- Increase policy literacy on ASRHR and safe abortion to strengthen demand and access to services and information within the current policy and legal context.
- Improve access to services and quality service delivery (ASRH and safe abortion).

Mauritius

Focus on menstrual health and work with Ripple Association and Raise Brave Girls.

Mozambique

- Lead training on professional health and young women's abortion rights.
- Expand community sensitisation to promote laws about preventing and combatting child marriage.
- Promote actions to engage and empower young women in GBV situations and provide professional and business management advice.

Namibia

- Review the country's SRHR strategy.
- Plan a consultative meeting with parliament to sensitise them on the issues of SRHR and scale up prevention of unsafe abortions through policy review. This includes creating a conducive policy environment that enables positive SRHR outcomes through the provision of judgement-free, safe, legal and effective abortion services and information.
- Advocate for men and boys to support women's desire for autonomy over their bodies and support their decisions on whether to have an abortion or not.
- Work with the Ministry of Education to train teachers on CSE.
- Work with junior majors to lead and take up the campaigns in their towns and villages.
- Intensify youth-led campaigns on social media.

South Africa

- Host community dialogues (churches, traditional leaders, media, social clubs) on early unwanted pregnancy, safe abortion and child marriage.
- Increase stakeholder collaboration.
- Draw up and implement poverty alleviation strategies.

Tanzania

- Improve re-entry guidelines for schools to address the newborn child and teachers.
- Enshrine the re-entry strategy into a policy.

Zimbabwe

- Intensify CSE in schools.
- Advocate for more youth-friendly clinics.
- Assist with the review of the Termination of Pregnancy Act.
- Review the National ASRHR Strategy.

Next steps

Adolescents in SADC face an array of sexual and reproductive health issues. These range from rape, forced prostitution, forced marriage and female genital mutilation to unwanted pregnancies and the risk of contracting STIs such as HIV and AIDS. Policymakers need to recognise, protect and respect their unique needs so adolescents can fully exercise their reproductive health and rights.

CSE is essential for the effective management of adolescent reproductive health issues. It provides them with the knowledge and skills they require to make healthy and responsible decisions in their lives.

Governments must also address the capacity and resource constraints that prevent the achievement of quality education. This includes ensuring teacher capacity, updating curriculum content, and incorporating the necessary assessment, monitoring, and evaluation tools. Youth will be empowered to access necessary services if teachers are aware of policy provisions and protection for adolescent rights to contraception and age provisions in their respective countries.

Social determinants to adolescent health influence the age of access to contraception and the implementation of CSE in many countries. Young people face a greater risk of abuse and are more likely to remain ignorant about SRH issues that could keep them healthy and safe if specific policies and laws that ensure their health, education and protection do not exist or legislators take too long to update them.

The continuous threats of gender inequality, poverty, climate change, COVID-19, and emerging viruses like monkey pox, represent interconnected challenges that require gender activists and governments in SADC to strengthen collaboration to ensure that adolescents throughout the region have voice and choice on their reproductive health. Some important next steps will need to include the following:

- ***Update ASRHR policies:*** Activists should lobby for updated, inclusive and youth-friendly ASRHR policies in all 16 SADC countries that include current information and research.
- ***Governments need to invest in ICTs for CSE education and stop the spread of COVID-19.*** Governments should improve e-governance by investing in modern ICT infrastructure and supporting the education sector to use blended approaches to teaching and learning that suits learner needs. This will help educate youth on SRHR issues and ways they can help combat the spread of COVID-19 and other diseases.
- ***Integrate age of consent to SRH services and contraceptive use*** into universal health coverage metrics and measures, as well as HIV and AIDS prevention strategies.
- ***Restrictions on accessing ASRHR services:*** Member states should remove age restrictions on the right to access services, including contraceptives, HIV testing and other SRH information. All adolescents should be able to access youth-friendly integrated SRHR services, including the full suite of HIV services.
- ***Standardise youth-friendly health facilities:*** Approve a regional set of standards that sets out best practices and approaches for youth-friendly health facilities. These must include accessibility, respect, privacy, provision of peer counsellors, quality SRH services, standards for health worker conduct and follow up care.
- ***Early unwanted pregnancy response:*** Member states need to strengthen multi-stakeholder collaborations to reduce teenage pregnancies. This includes amplifying the role of men and boys in protecting young girls from falling pregnant.

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