Africa's Future Is Young!

Young People's Priorities for Their Reproductive and Sexual Self-Determination

Africa’s Future Is Young!

Young People’s Priorities for Their Reproductive and Sexual Self-Determination

Imprint

Original edition
August 2024

© Berlin Institute for Population and Development

The work is protected by copyright. All rights reserved.

Published by
Berlin Institute for Population and Development
Schillerstraße 59
10627 Berlin
Germany
Phone: +49 (0)30 22 32 48 45
Email: info@berlin-institut.org
www.berlin-institut.org

You can find the Berlin Institute on Facebook, Instagram and LinkedIn.

Authors: Colette Rose, Kristin Neufeld, Constantin Wazinski, Catherina Hinz
Project Support: Nele Disselkamp, Walabe Dimiti, Hannah Weiss, Hannah Krenzel
Editor: Christine Hieb
Translation: Melody Makeda Ledwon
Design and Layout: Jörg Scholz
Cover illustration: Elena Sunagatova
Printing: Heenemann

ISBN: 978-3-946332-74-9

This study was funded by the German Federal Ministry for Economic Cooperation and Development (BMZ) and supported by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), Sector Initiative Population Dynamics, Sexual and Reproductive Health and Rights. The Berlin Institute for Population and Development is responsible for the content of the study.

The views expressed in the study do not necessarily reflect those of the BMZ.

Funded by

The Authors

Colette Rose, Master of Science in Political Sociology at the London School of Economics. Project Coordinator, International Demography at the Berlin Institute for Population and Development.

Kristin Neufeld, Master of Arts in International Studies / Peace and Conflict Research at the Goethe University Frankfurt. Researcher at the Berlin Institute for Population and Development.

Constantin Wazinski, Master of Arts in Urban Geographies – Human Geography at the Humboldt University of Berlin. Researcher at the Berlin Institute for Population and Development.

Catherina Hinz, M. A. in German Literature, History and South Asian Studies at the Universities of Hamburg and Heidelberg. Executive Director at the Berlin Institute for Population and Development.

TABLE OF CONTENTS

EXECUTIVE SUMMARY 4
LIST OF ABBREVIATIONS 6

1. AFRICA'S YOUTH, AFRICA'S FUTURE 7
WHAT IS SRHR? 11

2. THE STATE OF YOUNG PEOPLE'S SRHR IN AFRICA 12

3. TALKING TO YOUNG PEOPLE ON THE GROUND 18

3.1. WHEN GIRLS BECOME MOTHERS 20
3.1.1. MAJOR GAPS IN SEXUALITY EDUCATION 20
3.1.2. ARE YOUTH-FRIENDLY SERVICES REALLY YOUTH-FRIENDLY? 24
3.1.3. PREJUDICES BY MEDICAL STAFF 26
3.1.4. WHO IS LEFT BEHIND? 29
3.1.5. ADDRESSING POVERTY: THE EFFECTS OF PRECARIOUS LIVING CONDITIONS ON SRHR 32

3.2. TAKING A CLOSER LOOK AT THE FOCUS COUNTRIES 36
3.2.1. NIGERIA: THE SRHR OF YOUNG IDPS ARE AT A GREAT RISK 36
3.2.1. TANZANIA: YOUNG MOTHERS NEED SUPPORT 39
3.2.3. ZAMBIA: THE IMPACT OF LEGISLATION ON YOUNG PEOPLE'S ACCESS TO HEALTHCARE 42

4. HOW CAN THESE ISSUES BE ADDRESSED? 44

4.1. IDENTIFYING WHAT WORKS: BEST PRACTICES 44

4.2. RECOMMENDATIONS 48

METHODOLOGY 50
ACKNOWLEDGMENTS 52
GLOSSARY 54
REFERENCES 56

EXECUTIVE SUMMARY

Africa is home to the largest youth population in the world today, representing almost 60 percent of the total population, or approximately 890 million children and young people under the age of 25. Based on UN estimates, this number will rise to over 1.2 billion by 2050. The youth population on the continent will continue to grow throughout the 21st century.

As a result, generations of young people will have a decisive impact on the future of the region. As tomorrow's business leaders, policymakers, doctors, farmers, as well as parents, they determine how Africa's 54 countries are going to change during this century, both socioeconomically and demographically. What actions must be taken today to ensure that young people can make informed and empowered decisions for themselves, their families and their communities?

Achieving sexual and reproductive health and rights (SRHR) is a key factor in ensuring young people lead healthy and empowered lives. SRHR, in turn, are an important foundation for sustainable and equitable development. Particularly for girls and young women, SRHR are a prerequisite for completing their education and job training, growing up free from gender-based violence, and leading empowered lives.

African governments face significant challenges in ensuring SRHR for all young people on the continent. Africa has made significant strides in recent decades, yet there is still room for improvement. For example, statistics show, that gender-based and sexual violence, child marriage, unintended pregnancies and early motherhood remain prevalent among young people.

Where do we need to invest most urgently? How can we best strengthen the SRHR of young people? There are numerous projects and initiatives at local, national, and regional levels, which promote young Africans' SRHR. However, too often, projects for young people are designed, planned and implemented without them. Especially marginalised young people, including youth with disabilities, LGBTQI+ people and refugees face exclusion. Therefore, not all initiatives always help those most in need. This study aims to help bridge the gap between programming and the needs of target groups.

What do young people think?

We conducted interviews with youth activists, youth organisations and other experts in the following three focus countries: Nigeria, Zambia and Tanzania. Our conversations about the priorities, needs and desires of young Africans regarding their SRHR revealed various gaps in provision. Interviewees also discussed potential solutions to these issues.

Sexuality education is inadequate

Comprehensive sexuality education is a key element to ensuring individuals have the knowledge and skills to make informed and responsible decisions about their body and sexual and reproductive health. However, due to existing cultural and religious taboos surrounding the topic of sexuality, young people in Nigeria, Tanzania and Zambia usually receive little or no sexuality education at school and at home. Young people therefore lack the necessary information about sexual and reproductive health, including protection from HIV and unwanted pregnancy, and preparation for their first menstrual cycle. Addressing the urgent need to expand sexuality education programmes is crucial.

There are major gaps in youth-friendly healthcare services

To ensure young people can get preventive health check-ups and medical treatment, including contraception, it is essential that services and facilities are designed in a youth-friendly way. Despite the existence of national guidelines for youth-friendly healthcare provision in all three focus countries, often such services are either not actually youth-friendly or non-existent. To gain young people's trust, healthcare facilities must provide care that is tailored to their specific needs, is confidential and private, and offers services by trained healthcare workers who have actively engaged in understanding young people's needs.

Provider bias is a significant barrier to quality healthcare

In all three focus countries, healthcare providers often have prejudiced and condescending attitudes towards young patients, particularly as it relates to their sexual and reproductive health. Provider bias is a major contributor to the lack of youth-friendly healthcare. If young people feel judged and stigmatised by medical staff, they may be discouraged from returning to a clinic for other health problems, including sexually transmitted infections (STIs) or irregular menstrual cycles. Providing targeted training to healthcare workers is an effective approach to raising their awareness about respectful interactions with adolescents in health facilities.

Marginalised youth are left behind

While many groups, including young people with disabilities, young LGBTQI+ people and young people living with HIV face discrimination and marginalisation, they do not experience this in the same ways. For example, it is not uncommon for queer or HIV-positive people to be left in the waiting room of a health clinic for long periods, while young people with disabilities may not even be able to enter the clinic as a result of physical barriers in most facilities. Including marginalised young people and focusing on their needs should be part of the planning phase of new projects or facilities. Ideally, there should be a direct consultation with members of marginalised groups.

No empowerment without poverty reduction

Addressing the gaps in young people's sexual and reproductive health provision must include the issue of poverty. Adolescents should not be forced to choose between purchasing a STI test, pads or a bag of rice. They deserve the opportunity to earn a living and lead independent lives. We therefore recommend integrating SRHR services and economic empowerment.

Recommendations

To meet the needs and demands of young people in Africa, development institutions and other funding agencies should consider the following:

- Support partner countries to better adapt their health facilities to the needs of young people
- In conversation with partner countries, highlight the intersections between SRHR, girls' education, job training for young women and support in promoting employment
- Promote the inclusion of marginalised young people in projects and funding decisions at all levels
- Consult and work with local youth experts and organisations before developing priorities to identify the greatest needs and the most promising local solutions
- Ensure sustainable funding for local organisations and projects
- Simplify funding applications and reporting and provide support to local African organisations in navigating complicated funding processes
- Promote partnerships between international and local NGOs, consider imbalances of power and proactively support the fair distribution of power
- Address evidence gaps, invest in community-led research and strengthen local analytical capacity to assess the need for SRHR health services, especially among marginalised young people
- Offer long-term support to local youth organisations which focus on advocacy work

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
AU	African Union
BMZ	Federal Ministry for Economic Cooperation and Development (Germany) Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung
CSE	Comprehensive Sexuality Education
DHS	Demographic and Health Surveys
FGM	Female Genital Mutilation
GBV	Gender-Based Violence
GIZ	German Development Cooperation Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
LGBTQI+	Lesbian, Gay, Bisexual, Trans, Queer, Intersex and additional, unnamed identities
MSM	Men who have sex with men
NGO	Nongovernmental Organisation
PrEP	Pre-Exposure Prophylaxis
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UN DESA	United Nations Department of Economic and Social Affairs
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
WHO	World Health Organization

1 | AFRICA'S YOUTH, AFRICA'S FUTURE

"Young people cannot fully enjoy a happy and healthy life if their right to sexual and reproductive health is not realised."

Cotonou Youth Action Agenda[1]

It is common for young people across the world to talk to their friends about sex or the first menstrual cycle, experience their first romantic relationships and express their gender identity. These topics, among many others, are part of young people's lives and describe the transition from childhood to adulthood, also known as adolescence (see glossary). During this period, they may become curious about physical changes in puberty, and explore their sexuality and identity more intensely.[2]

To make healthy, empowered and responsible decisions about their bodies, their sexual lives and family planning, young people need comprehensive sexuality education and access to youth-friendly health services. Reliable information and a supportive environment allow youth to protect their sexual and reproductive health and rights (SRHR). Particularly for girls and young women, SRHR are a prerequisite for graduating from high school and vocational training, growing up free from gender-based violence (GBV) (see glossary) and leading empowered lives.

While universal SRHR are not yet a reality in any region or country in the world, there has been a growing recognition in recent years that sexual and reproductive self-determination are the foundation for sustainable development, gender equality, and demographic change. SRHR is therefore a key issue in (German) development policy today.

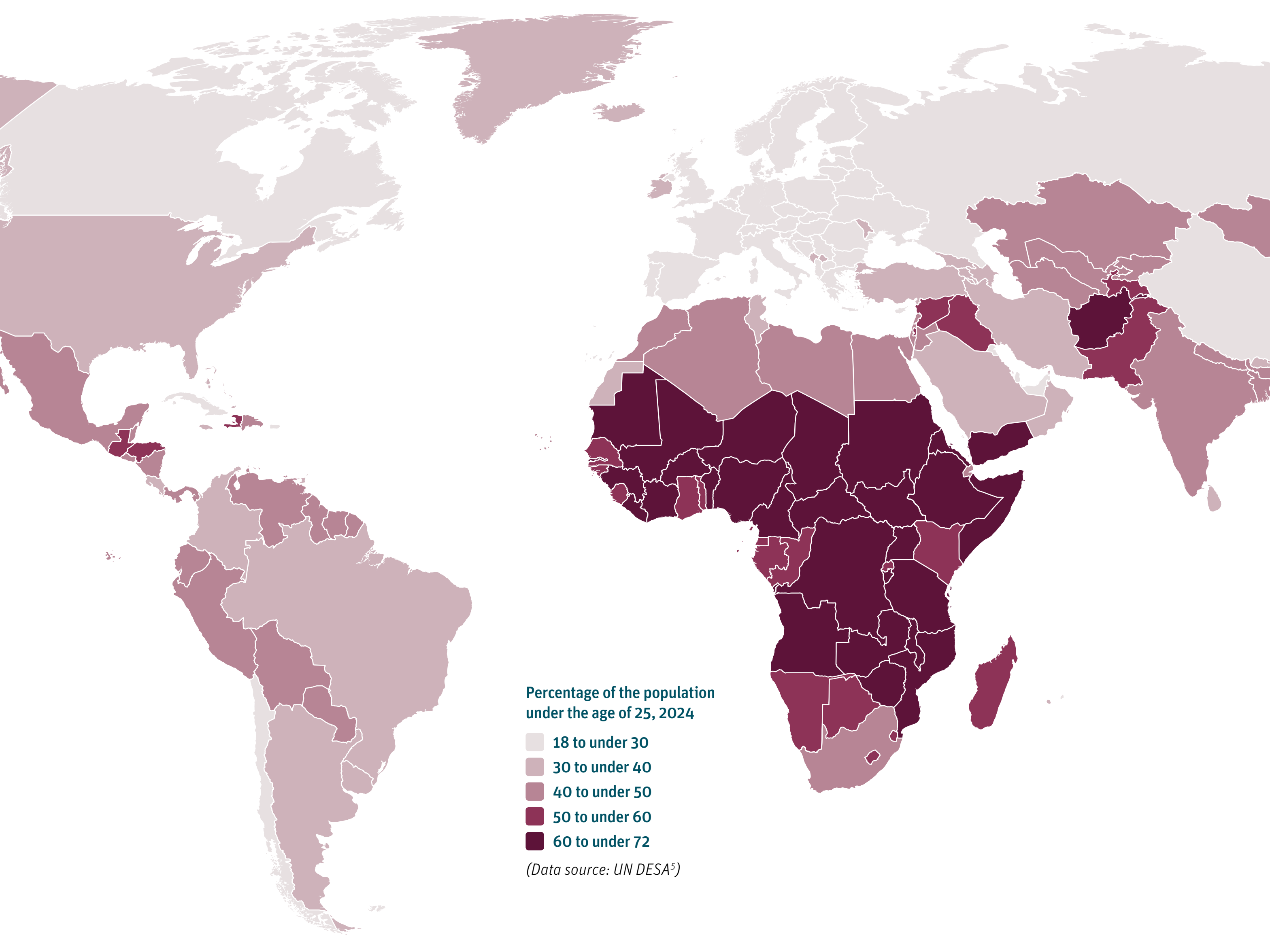
Africa's Youth Generation

Africa has the largest generation of young people in the world. Nearly 60 percent of Africa's population is under the age of 25. By comparison, in Europe only one in four people is under 25. And unlike other regions of the world, Africa's population of young people will continue to grow until the end of the century.[3] Approximately 890 million children and youth[a)] live on the African continent today and the UN estimates that by 2050, it will be more than 1.2 billion.[4]

[a)] In accordance with the United Nations definition, this study refers to girls and boys aged 0 to 18 as children and 15 to 24-year-olds as youth.

A Note on Gendered Language

In this study we often use the words girls and women when discussing issues such as pregnancy, menstruation and GBV because the available data on these topics largely consists of surveys and studies in which participants are identified as girls or women. When we quote from interviews, we reproduce the language used by our interviewees. However, trans and nonbinary people also experience pregnancy, menstruation and GBV. In fact, trans and nonbinary people are disproportionately affected by GBV, discrimination and other barriers to healthcare.



Africa has the world's youngest population

Walking through Africa's streets, the majority of faces you see are young – especially in Western, Central and Eastern Africa. Overall, six out of ten people in Africa are under the age of 25. Worldwide, it is four in ten, with strong regional differences: In strongly ageing populations such as South Korea, Japan or Italy, only 20 percent of the population is younger than 25, compared to around 70 percent in Niger and the Central African Republic.

Africa's Youth in International and Regional Agreements

African governments as well as organisations operating on the African continent have already recognized the opportunities as well as the challenges of a large teenage population. For example, the United Nations' 2030 Agenda for Sustainable Development, with its goals on health, gender equality (see glossary) and education, commits to investing precisely in the areas that are central to both demographic and socio-economic development.[6] The African Union (AU) has also developed strategies to build on the potential of its young population for the continent's socio-economic development. The *AU Roadmap on Harnessing the Demographic Dividend through Investments in Youth* explicitly highlights the need to invest in young people's sexual and reproductive health.[7] Goal 6 of *2063: The Africa We Want* through which the AU aims to drive socio-economic development on the continent, also explicitly addresses the prospects of young people in Africa.[8]

These generations of young people will have a significant impact on the future of the region. As tomorrow's business leaders, policymakers, doctors, farmers, and also parents, they determine how Africa's 54 countries are going to change, both socioeconomically and demographically, during this century. The challenge we currently face is to identify the most effective ways to ensure that moving forward young people can make empowered, informed, and healthy choices for themselves, their families and their communities.

There Is No Future Without a Greater Investment in Young People

African countries face significant social and economic challenges. The continent's rapid population growth alone, which could continue until the end of the century[9], is already making it difficult for many governments to provide their people with adequate schools, hospitals, food, clean water or even jobs. These challenges are further complicated by the global climate crisis, health crises such as the COVID-19 pandemic and a growing number of armed conflicts on the African continent.[10] Furthermore, the legacy of European exploitation of Africa and its people through the Transatlantic Slave Trade and colonisation continues to have a detrimental impact on many African countries.[11,12,13] Global inequities of power persist, leaving many African countries in a debt trap with annual international debt repayments exceeding the amount they invest in their healthcare systems.[14,15]

Overcoming these significant challenges is not the sole responsibility of young Africans. Rather, it is essential that young people are empowered by decision-makers to help shape solutions and have a voice in politics. Furthermore, it is important that teachers prepare students for the workforce and help them build self-confidence and develop critical thinking skills. Young people need to have access to vocational training and to jobs that will give them the opportunity to pursue a career and then to earn an adequate income. It is also important that they have access to medical advice and care from trained and respectful staff, so that they can understand their own bodies and prevent illnesses and unwanted pregnancies.

In this way, advancing SRHR remains a core element in achieving young people's empowerment and self-determination and therefore sustainable and socially just development for future generations. Strengthening SRHR also drives demographic change: When girls and young women are given the freedom to choose if, when and how many children they have, the number of children they have tends to decline. Healthcare and sexuality education for young people therefore urgently require more investment and scaling up of effective approaches.

What Are the Priorities?

Where do we need to invest most urgently? How can we best strengthen the SRHR of young people? There are numerous projects and initiatives at local, national, and regional levels, which promote young Africans' SRHR. However, too often, projects for young people are designed, planned and implemented without young people. This is especially the case for marginalised young people, including youth with disabilities, LGBTQI+ people, refugees, or those who sell sex (see glossary). As a result, not all initiatives always help those most in need. Furthermore, people, committees, or organisations often set priorities for development cooperation projects without consulting the target groups. For example, this could lead to a new 'youth-friendly' health centre being built that is not accessible to people with disabilities, or where young people's privacy is not guaranteed.

This study aims to help bridge the gap between programming and the needs of the target groups. The following chapter provides an initial overview of the current state of sexual and reproductive health among young people in Africa. It covers a range of topics, from contraceptive care to HIV treatment, as well as harmful traditional practices and sexual violence.

To gain insight into service gaps and potential solutions from young people's perspectives, we spoke to youth activists, youth organisations and other experts in three focus countries about young people's priorities, needs and aspirations in relation to their SRHR.[a)] During our consultations in Nigeria, Zambia and Tanzania in early 2024, young interviewees working on SRHR issues answered the following questions: What do young people learn and think about gender roles, family planning, contraception and sexuality? What is their assessment of current health services and policy frameworks focused on SRHR for young people? Key findings from these interviews are discussed in Chapter 3.

These interviews with diverse groups of youth experts enabled us to identify best practices that can be used to better meet the needs of young people. The resulting recommendations are summarised in Chapter 4.

[a)] See methodology section for further explanation of our approach

WHAT DOES *SRHR* MEAN?

In this report, we refer to the *Guttmacher-Lancet Commission's* integrated definition of **s**exual and **r**eproductive **h**ealth and **r**ights, as excerpted below.[b), 16]

Sexual and reproductive health is a state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust and communication in promoting self-esteem and overall well-being. All individuals have a right to make decisions governing their bodies and to access services that support that right.

[b)] In its 2018 report published in *The Lancet*, the Guttmacher-*Lancet* Commission for Sexual and Reproductive Health and Rights – an international consortium of global health, development and human rights experts – presented an evidence-based agenda for universal SRHR and an integrated, new definition of SRHR.

Achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy and personal autonomy respected
- freely define their own sexuality, including sexual orientation and gender identity and expression
- decide whether and when to be sexually active
- choose their sexual partners
- have safe and pleasurable sexual experiences
- decide whether, when and whom to marry
- decide whether, when and by what means to have a child or children, and how many children to have
- have access over their lifetimes to the information, resources, services and support necessary to achieve all the above, free from discrimination, coercion, exploitation and violence

Essential sexual and reproductive health services must meet public health and human rights standards, including the "Availability, Accessibility, Acceptability, and Quality" framework of the right to health. The services should include:

- Comprehensive sexuality education
- Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods
- Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care
- Safe abortion services and treatment of complications of unsafe abortion
- Prevention and treatment of HIV and other sexually transmitted infections
- Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence
- Prevention, detection and management of reproductive cancers, especially cervical cancer
- Information, counselling and services for subfertility and infertility
- Information, counselling and services for sexual health and well-being[17]

2 THE STATE OF YOUNG PEOPLE'S SRHR IN AFRICA

As a region, Africa has made some great strides in recent decades in terms of young people's SRHR. For example, the number of girls and young women undergoing female genital mutilation (FGM) (see glossary) or being married as children has declined.[18, 19] However, progress has been uneven across countries, has stalled in some cases, or has not benefited all young people equally.[20] Furthermore, ongoing population growth in many African countries means that the absolute number of pregnancies and births among teenage girls aged 15 to 19 continues to rise, even as the birth rate (see glossary) in this age group declines.[21] A review of regional data and statistics reveals the current status of sexual and reproductive health among young women and men in Africa.

Teenagers' First Sexual Experiences

Worldwide, including in Africa, many young women and men become sexually active during their teenage years.[22, 23] Therefore, it is important that girls and boys receive comprehensive sexuality education before their first sexual experiences, so that they can make healthy and empowered decisions about their lives.[24]

Recent *Demographic and Health Surveys* (DHS)[a] studies of young people aged 20 to 24 show that on average, teenage girls in most regions of Africa have sexual intercourse for the first time between the ages of 16 and 20, and in most countries before the age of 19. In Burundi, the average age at first sexual intercourse is 20, but in Mozambique it is much lower at 16.[25] In some countries in sub-Saharan Africa, such as Liberia or Sierra Leone, surveys conducted in recent years suggest that about one in four women had sex for the first time before they turned 15.[26] Among men aged 20 to 24, the average age at first sexual intercourse is similar to that of women. In some countries, however, young men are much older than women when they first have sex. In Mali, for example, the average age for young men is just under 20, compared with about 17 for women.[27]

There is no definitive indicator that can be used to measure how much sexuality education young people receive. However, the DHS do provide some relevant data regarding knowledge about individual SRHR topics. For example, they measure the number of young people aged 15 to 24 with comprehensive and accurate knowledge about HIV.[b] DHS data from 35 countries in sub-Saharan Africa show that, on average, only slightly more than one of three men and women aged 15 to 24 have adequate knowledge about HIV. There are significant differences between countries. In Mauritania, less than 10 percent of young people are educated on this subject, compared to almost two in three young people in Rwanda.[28]

[a] The *Demographic and Health Surveys (DHS) Program* regularly collects detailed, representative data on population and health in over 90 countries using surveys. Funded by the *U.S. Agency for International Development* (USAID), the DHS Program is particularly suited to providing a statistical overview of SRHR among young people in African countries because of its comprehensive and small-scale data availability on the health situation in this region of the world.

[b] The DHS surveys define comprehensive, accurate knowledge about HIV as the ability to: correctly name the two most important ways to protect oneself from HIV during sexual intercourse (using condoms and only having sex with a faithful, uninfected partner), reject the two most common local misconceptions about HIV transmission, and understand that a healthy-looking person can be HIV positive.

Child Marriage Is Widespread, Especially in Western and Central Africa

A marriage is considered a child marriage (see glossary) if at least one spouse is under the age of 18. Therefore, child marriage is a violation of human rights and a threat to the health and rights of young women. The issue tends to affect girls more than boys because in most cases a girl is married to an older man.[29] Women who are married as children have a greater risk of becoming pregnant before they are physically or mentally ready. They are also more likely to contract HIV and other sexually transmitted infections.[30]

United Nations Children's Fund (UNICEF) estimates that 127 million women and girls were married before age 18. A global comparison reveals that the risk of being married as a child is higher in sub-Saharan Africa than in any other region of the world.[31] In West and Central Africa, child marriage is most prevalent, with almost four in ten girls marrying before they reach 18 years of age.[32] While the number of women married as children has been slowly declining in all parts of Africa since the 1990s, the positive impact of this change has disproportionately benefited girls from wealthier households. When the statistics are disaggregated by household income, the number of children married in the poorest households is actually increasing in some regions of Africa.[33]

Percent

50

40

30

20

10

Richest fifth
Poorest fifth
Secondary or higher
Primary education
No schooling
Urban
Rural
Total

Wealth
Education
Residence

Poverty is one of the main causes of child marriage

In sub-Saharan Africa, almost four million teenage girls get married every year. Even though the practice of child marriage is increasingly losing support worldwide, in sub-Saharan Africa almost one in three girls under the age of 18 is forced into marriage – one in ten before the age of 15. The risk of getting married is particularly high for girls who are affected by poverty or live in rural regions.[34,35]

Percentage of women aged 20 to 24 who were married before the age of 18, 2023, by socio-demographic characteristics
(Data source: UNICEF[36])

One in Two Pregnancies Is Unintended

It is estimated that 43 percent of pregnancies among women aged 15 to 49 in Africa are unintended. This equates to about 27 million unintended pregnancies per year, of which about four million are among teenage girls aged 15 to 19.[37] On average, almost half of all pregnancies in this age group are unintended, although there are vast regional differences. In Northern Africa, for example, only one in three pregnancies among teenagers aged 15 to 19 is unintended, compared to three in four in Southern Africa.[38]

An unintended pregnancy at a young age can negatively impact a young woman's life in many ways, including her educational opportunities, career prospects, and her ability to lead an independent life and make autonomous decisions. Pregnancy also poses significant health risks for teenagers. Compared to women aged 20 to 24, teenage pregnancy and childbirth are associated with increased health risks such as eclampsia[c)] or severe injuries such as obstetric fistula[d)]. Furthermore, complications related to pregnancy and childbirth are the second leading cause of death for girls aged 15 to 19 globally.[39,40]

[c)] Eclampsia is a life-threatening disease that can cause seizures. It only occurs during pregnancy. Adequate antenatal care allows medical professionals to diagnose the preliminary stage of the disease, pre-eclampsia, and monitor it.

[d)] Obstetric fistulas are a preventable, serious birth injury, resulting in a hole between the vagina and bowel and/or vagina and bladder. Obstetric fistulas are the result of a difficult labour that often lasts for days without medical assistance. In many instances, the injury leads to lifelong physical ailments, depression and social exclusion.

Despite Restrictive Laws, Abortion Is Common

Despite the legal restrictions on abortion in many African countries[41], eleven million pregnancy terminations occur on the continent every year. Of these, 75 percent — approximately eight million — are unsafe.[42] The fact that most abortions are unsafe is directly related to restrictive laws. If abortion is legal, carried out according to the medical standards set by the World Health Organization (WHO) and performed by a professional, it is a safe and simple medical procedure.[43]

A significant number of abortions worldwide are the result of unintended pregnancies, including in Africa. Approximately half of all unintended pregnancies among girls aged 15 to 19 result in a pregnancy termination. There are also regional differences: In Eastern, Central and Northern Africa, for instance, more than 30 percent of pregnancies are unintended, compared to 50 percent in Southern Africa and almost 60 percent in Western Africa.[44] Nearly nine out of ten abortions are performed in unsafe conditions in Western Africa.[45] Given that abortions in Africa are more common among young women than older women, experts believe that young women are also at increased risk of unsafe abortion.[46]

High Unmet Need for Modern Contraception

One of the primary reasons for the high number of unintended pregnancies in Africa is young women's particularly high unmet need for modern contraception[a]. This means that women who are sexually active (whether married or unmarried) would like to avoid a pregnancy, but for various reasons either do not use a modern contraceptive method or use a traditional, less effective method.[47]

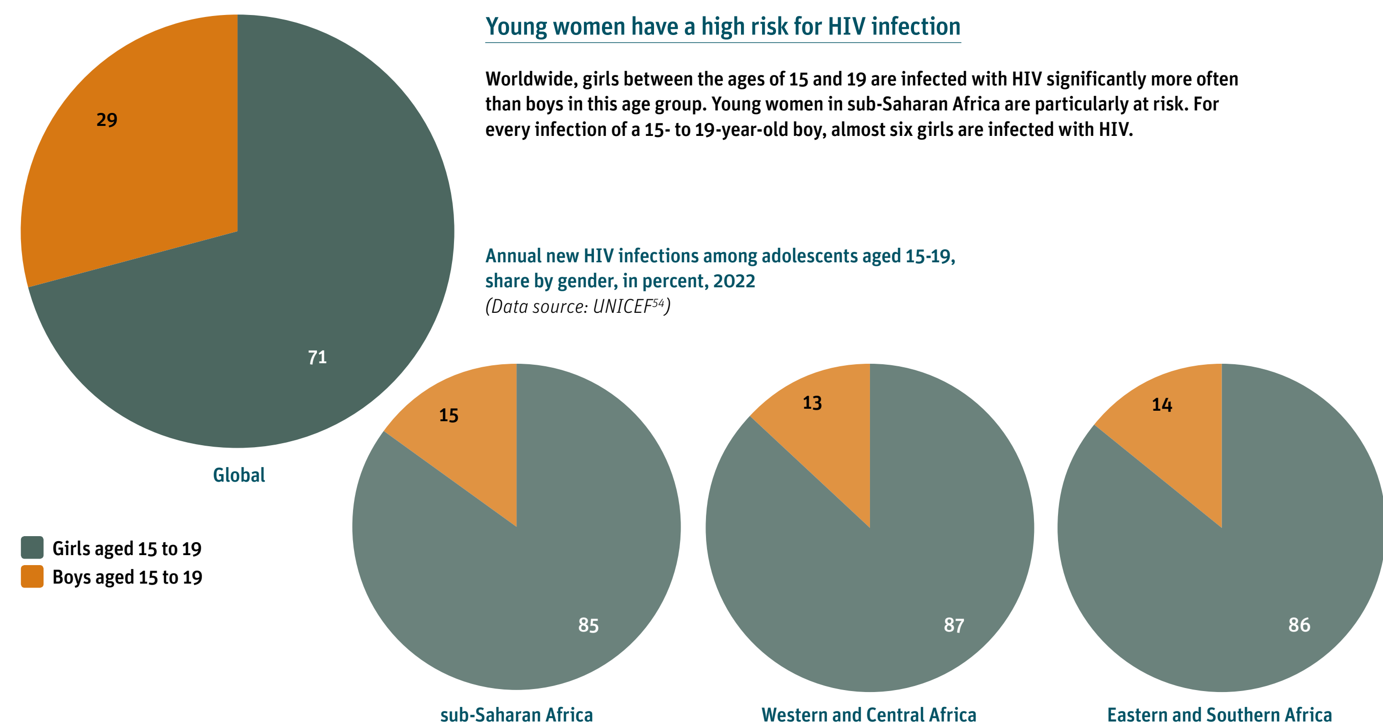
On average, 42 percent of African women aged 15 to 49 who wish to avoid pregnancy, have an unmet need – among teenage girls aged 15 to 19 it is 55 percent.[48] This implies that millions of young women are unable to adequately protect themselves against unintended pregnancies. The situation for young people is most dire in Western and Central Africa, where two in three 15- to 19-year old girls have an unmet need, compared to only one in five in Southern Africa.[49]

[a] Modern contraceptive methods include hormonal pills, implants, injectables, IUDs, condoms (male and female), emergency contraceptive pills, diaphragms, sterilisation and the lactational amenorrhea method.

Early Motherhood Is a Widespread Phenomenon

On average, women in Africa have more children than in any other region of the world. According to the most recent estimates, the average number of children born to women in Africa is approximately four, which is nearly twice the global average.[50] This is partly because many of them have their first child at a very young age. In sub-Saharan Africa, one in four women gives birth to their first child before turning 18. In 2022, eleven million African girls under the age of 18 gave birth.[51]

In addition to the health risks of early pregnancy and childbirth for young women themselves, the children of teenage mothers also face higher health risks than children of women who have their first child in their twenties.[52] Moreover, pregnant teenagers and teenage mothers in Africa frequently face social marginalisation, which significantly impacts their physical and mental health, social life and economic situation.[53]



Not Enough Progress in Reducing HIV and Other STIs

Sexually transmitted infections (STIs) are infections that are primarily transmitted through sexual contact. Some STIs, such as HIV and syphilis, can also be transmitted from mother to child during pregnancy and birth. Many STIs can be treated effectively in the long term, and some can even be cured with medical treatment. However, left untreated, STIs can have serious consequences, including infertility, cervical cancer or even the death of a newborn child.[55]

Recent estimates from the WHO indicate that the number of new cases of STIs, such as syphilis, is increasing worldwide, including in Africa.[56] While there is limited data on the exact age distribution of these new cases, it is very likely that young people in Africa are also affected.[57]

The number of new HIV infections is decreasing worldwide. However, the proportion of young people living with HIV is increasing. Sub-Saharan Africa is home to 85 percent of the world youth population aged 10 to 19 living with HIV. This equates to 1.4 million children and adolescents (600,000 boys and 810,000 girls).[58, 59] Young women are especially vulnerable to HIV infection.

Girls and young women account for more than 75 percent of new infections among young people aged 15 to 24. In sub-Saharan Africa, young women aged 15 to 24 were more than three times as likely to be infected with HIV as their male counterparts. Worldwide, about 4,000 young women in this age group become infected with HIV each week, and 3,100 of these infections occur in sub-Saharan Africa.[60]

However, the data on young people living with HIV need to be viewed in a more nuanced way. Estimates indicate that only 25 percent of girls aged 15 to 19 and 17 percent of boys aged 15 to 19 in Eastern and Southern Africa have been tested for HIV in recent years, although these regions are most impacted by HIV globally.[61] In sub-Saharan Africa, only 10 percent of men and 15 percent of women aged 15 to 24 are aware of their HIV status.[62]

It is also concerning that there has been little progress in the treatment of HIV among children and young people. Despite the significant progress in HIV treatment through antiretroviral therapy (ART) in many countries in recent years, children below the age of 15 with HIV are considerably less likely to be undergoing treatment than adults. This is true for all regions in Africa. The most significant discrepancy is in Western and Central Africa, where over 80 percent of individuals aged 15 and above with HIV are undergoing treatment, but less than 40 percent of children under the age of 15 are receiving the same.[63] The data available about young people aged 15 to 19 are limited but estimates from 21 countries in sub-Saharan Africa indicate that only 55 percent of young people in this age group received treatment in 2021.[64]

One in Three Women Experiences GBV

Gender-based violence (GBV) represents one of the most widespread human rights violations worldwide. Globally, one in three women experience GBV in their lifetime, most commonly in the form of intimate partner violence or sexual violence.[65] GBV has a profound impact on women's physical, mental, sexual, and reproductive health.[66]

One in three women in Africa will also experience GBV in her lifetime. According to the available data, most physical and sexual violence is perpetrated by women's partners. Intimate partner violence has a significant impact on the physical and mental health of women and their children, both in the short and long term. This includes physical injuries, depression, anxiety, unwanted pregnancies, STIs and even death.[67]

In sub-Saharan Africa, more than one in five girls aged 15 to 19 who have been in romantic relationships have experienced physical and/or sexual violence from a current or former partner in the past year.[68] The Democratic Republic of Congo has the highest number of cases: Around 40 percent of girls aged 15 to 19 and 50 percent of women aged 20 to 24 have experienced partner violence.[69] Furthermore, surveys conducted in other countries in sub-Saharan Africa, including Rwanda and Gabon, showed that approximately 10 percent of women between the ages of 18 and 29 had experienced sexual violence before the age of 18.[70]

Female Genital Mutilation Still Exists in Some Countries

Female genital mutilation (FGM) is a particularly harmful traditional practice that is widespread in approximately 30 countries in Africa, Asia and the Middle East. FGM can be carried out in various ways and, according to the WHO, is a traditional harmful practice that involves the "partial or total removal of external female genitalia, or other injury to female genital organs for non-medical reasons."[71] FGM is mostly carried out on girls between birth and age 15. It represents a serious violation of the right to physical integrity. The procedure causes both short-term and long-term physical and psychological damage.[72]

In Africa the practice is particularly prevalent in several countries from the Atlantic coast to the Horn of Africa, from Mauritania to Somalia. A total of 144 million girls and women are affected by FGM.[73] In some countries, such as Somalia, Guinea and Mali, most women aged between 15 and 49 have experienced FGM.[74] A review of the younger generation indicates that the prevalence of FGM among girls in many countries has declined in recent decades. However, while many countries are making progress, FGM rates are stagnating in Somalia and some countries in Western Africa.[75]

Blind Spots in SRHR Data

While commonly used indicators can provide an initial assessment of young people's SRHR in Africa, there are often significant gaps in the data. The statistics are presented in a simplified and aggregated manner, which lack detail regarding specific population groups. While the surveys on which the statistics are based, particularly the Demographic Health Surveys, contain some information about young people, most public data fails to adequately distinguish between different sociodemographic characteristics and living conditions. There is also a lack of comparable data for groups of young people with specific characteristics across different regions. To identify differences in SRHR status by gender, educational status, area (urban or rural) or income, further analysis is required.[76] For example, to obtain information on the SRHR status of young mothers, young internally displaced individuals or people with disabilities, additional studies must be considered. Furthermore, the lack of recent comprehensive data is also rooted in the impact of the COVID-19 pandemic, which has led to less of surveys in some African countries.

In the following chapter we attempt to address some of these blind spots and fill in the gaps to provide a more comprehensive understanding of the issues. By conducting in-person interviews with local experts in the three focus countries, we were able to gain a more complex understanding of the respective SRHR situation and hear the stories behind the numbers. What are the needs and perspectives of young people?

3 TALKING TO YOUNG PEOPLE ON THE GROUND

What exactly does SRHR mean to young people in Africa? What are their key concerns? What are they learning about sexuality and where do they get contraception? How do they rate healthcare services where they live? Where would they like to see improvements?

To address these questions, we conducted field research in Tanzania, Zambia and Nigeria in January and February 2024. Our aim was to engage with experts on the ground and gain insight into their perspectives. Our qualitative survey is designed to supplement where quantitative data are insufficient. We met with young people and employees of non-governmental organisations (NGOs) involved in youth work. In Lagos and Dar es Salaam we met with our interview partners at a fixed location. From Dar es Salaam we took the ferry to Zanzibar to meet local experts on the island. In Lusaka we took a car across town to meet young peer educators at a local health facility and met other interviewees at their offices or local coffee shops.

We tried to capture a diverse range of perspectives, interviewing individuals from both urban and rural areas, as well as large, international organisations and small initiatives started by university students. Our interviewees included LGBTQI+ activists, sex workers and young people with disabilities, who provided insights on their experiences and recommendations to improve healthcare services.[a]

The Three Focus Countries: An Overview

In all three focus countries, more than 60 percent of the population is under the age of 25. Zambia, with a population of 21 million, and Tanzania, with around 69 million, are small compared to Nigeria, which is the most populous country in Africa with 233 million people with one of the continent's largest economies.[77] Lagos, a so-called megacity, is situated in the south of the country with 16 million inhabitants. Dar es Salaam, in Tanzania, has also seen a significant population growth: Its population has more than doubled from 3.8 million in 2010 to 8.1 million today. The largest city in Zambia, Lusaka, is also estimated to grow by two million inhabitants in the next ten years, reaching a total of over five million in 2035.[78] The legacy of British colonialism is evident in Nigeria's, Zambia's and Tanzania's legislation. The Tanzanian mainland was also under German colonial rule for over 30 years (from 1885 to 1918) as part of the German colony of German East Africa.[79]

[a] The methodology section provides details on the selection of our focus countries, the process of identifying interview partners, and the manner in which the interviews were conducted.

Mainland Tanzania and Zanzibar

The United Republic of Tanzania was founded in 1964, merging Tanganyika and Zanzibar.[80] To this day Zanzibar continues to function as a semi-autonomous state and differs in many ways from Mainland Tanzania. For instance, Zanzibar's population is estimated to be 99 percent Muslim, compared to only 34 percent of the total Tanzanian population. About 63 percent are Christian, while five percent belong to other faiths.[81]

Socio-demographic overview of the focus countries Nigeria, Tanzania and Zambia
(Data source: UN DESA[82,83], World Bank[84])

		AFRICA	Nigeria	Tanzania	Zambia
Total population	**2024** (millions)	**1,515**	**233**	**69**	**21**
	2050 (millions)	**2,466**	**359**	**130**	**38**
Growth of total population (2024–2050) (percent)		**63**	**54**	**89**	**79**
Young population (under the age of 25)	**2024** (millions)	**890**	**143**	**43**	**13**
	2050 (millions)	**1,217**	**180**	**70**	**19**
Percentage of young population	**2024**	**59**	**62**	**63**	**62**
Average number of children per woman	**2024**	**4.0**	**4.4**	**4.5**	**4.0**
Percentage of people living in extreme poverty*		**37**** (2019)	**31** (2018)	**45** (2018)	**64** (2022)
Percentage of urban population	**2024**	**45**	**55**	**38**	**47**

* under $2.15 per capita per day, purchasing power parity 2017 ** Sub-Saharan Africa

3.1 When Girls Become Mothers

Despite their differences, all three countries face similar challenges when it comes to SRHR for young people. This includes, for example, the high number of teenage pregnancies. According to the United Nations, over one million girls between the ages of 15 and 19 had a child in Nigeria in 2023, just under 500,000 in Tanzania and around 135,000 in Zambia.[85] Based on recent surveys, it is reasonable to assume that in Nigeria and Tanzania one in six, and in Zambia one in four teenage girls aged 15 to 19 is already a mother.[86]

Just recently, in early 2024, Zambia's high number of teenage pregnancies attracted media attention. The authorities in Eastern Province reported almost 3,000 teenage pregnancies in January alone.[87] However, these numbers do not tell the whole story. For instance, they do not indicate how many girls became pregnant as a result of rape, contracted sexually transmitted infections (STIs), will have an unsafe abortion, and will not return to school after giving birth. In Zambia, this prompted a media debate,[88] as part of which a men's network[a] called on the police to imprison the alleged male "perpetrators".[89] Such a response, however, would not address, structural problems, such as poverty and a lack of comprehensive sexuality education in schools, which are known to contribute to the high numbers of unplanned pregnancies, remain.

[a] *Zambia National Men's Network for Gender and Development*

Especially in rural Africa, it is not uncommon for teenagers to already have several children, according to interview partners in each focus country. In rural regions in particular, girls continue to be married young or do not use contraception. As a result, many have unintended pregnancies and become mothers at an early age, which our interview partners identified as a central problem.

Poverty, inadequate sexuality education and difficulties accessing contraception and other healthcare services frequently result in unintended pregnancies among adolescent girls. In Africa, almost 50 percent of pregnancies among 15- to 19-year-olds are unintended, with a significant number of these pregnancies ending in unsafe abortions.[90, 91]

Teenage mothers are more likely to experience complications during pregnancy and childbirth, and many do not complete their secondary education.[92] According to national data from Zambia, less than half of young mothers return to school after giving birth.[93] Teenagers who do not complete secondary education are at a higher risk of not having a secure income as adults. In the worst case, poverty is passed on from one generation to the next.[94]

3.1.1. Major Gaps in Sexuality Education

Sexuality Education Is a Prerequisite for Bodily Autonomy

Throughout their lives, individuals make decisions that impact their own sexual and reproductive health, as well as that of others. Comprehensive sexuality education is a key factor in enabling individuals to make autonomous and responsible decisions regarding their body and their sexual and reproductive health.

The United Nations Educational, Scientific and Cultural Organization (UNESCO) recommends comprehensive and age-appropriate sexuality education to begin in primary school. This enables children to understand their bodies, their families and social relationships, and recognize child abuse before reaching puberty. To make informed decisions about safer sex (see glossary), contraception and consensual sexual relationships, teenagers require information and sexuality education before they become sexually active.[95] Young people worldwide are often sexually active from an early age, including in Africa. In the focus countries, almost one in ten girls have their first sexual intercourse before their 15th birthday, and more than half before their 18th birthday.[96] Furthermore, in Nigeria and Tanzania, one in five teenage girls becomes a mother for the first time between the age of 15 and 19, in Zambia almost one in three.[97]

To counteract concepts of sexuality that are based on the oppression of women, it is important to implement a human rights-based and gender-sensitive approach to sexuality education. Some harmful traditional practices, such as FGM, are aimed in part at depriving women of sexual desire and pleasure.[98] In this context, sexuality education that discusses sexual pleasure for both women and men can help to dismantle harmful gender norms.[99]

Young People Lack Information

However, due to prevailing cultural and religious taboos around sexuality, young people in Nigeria, Tanzania and Zambia typically receive little or no sexuality education. At school and at home, young people do not receive the necessary information about sexual and reproductive health, including how to protect themselves from HIV and unwanted pregnancy, or how to prepare for the onset of menstruation. A nationwide survey of young people aged 15 to 24 in Nigeria, Zambia and Tanzania found that less than 50 percent of respondents had comprehensive knowledge of how to protect themselves from HIV infection.[101, 102, 103]

One of our interview partners in Tanzania shared her personal experience of her first menstruation:

> *“The only thing that [my mother] told me [was] ‘Do not play with boys. You will get pregnant.’ So, in my thoughts, I was thinking maybe when I play, even normal play with [boys], I’ll get pregnant.”*

Additionally, young people frequently lack sufficient knowledge about the healthcare services they can access. For example, they may be unaware about where they can get condoms or contraceptives, HIV tests, treatment for STIs or post-abortion care (medical care following an unsafe abortion).

1 Relationships

2 Values, Rights, Culture and Sexuality

3 Understanding Gender

4 Violence and Staying Safe

5 Skills for Health and Well-being

6 The Human Body and Development

7 Sexuality and Sexual Behaviour

8 Sexual and Reproductive Health

Key topics of comprehensive sexuality education based on UNESCO guidelines, 2018
(Data source: UNESCO[100])

Comprehensive sexuality education is multifaceted

The United Nations Educational, Scientific and Cultural Organization (UNESCO) first published international guidelines for comprehensive sexuality education (CSE) in 2009 and last updated them in 2018. The guidelines affirm that CSE is inseparable from human rights, gender equality and a commitment to social diversity. This is based on the aspiration to enable positive, affirmative learning that is geared towards the interests of young people. UNESCO formulates specific age-appropriate learning objectives for all key topics, which are to be considered equally important and interlinked. Such guidelines provide authorities and other stakeholders in the education system with support in creating curricula that have a positive impact on the health and well-being of young people.

There Is Insufficient Sexuality Education in Schools

The Tanzanian government adopted its most recent *National Accelerated Action and Investment Agenda for Adolescent Health* in 2021. This plan identifies increased access to information on sexual and reproductive health as an important step for reducing the number of teenage pregnancies.[104] However, in discussions with youth activists in Tanzania, we were repeatedly informed that sexuality education in schools only focuses on basic biological aspect of sexuality, excluding topics related to sex and contraception.

In contrast, Zambia for many years was a leader in the region as it relates to sexuality education, having introduced a comprehensive sexuality education curriculum in 2014. The Zambian government worked closely with various stakeholders on this matter and managed to avoid opposition from religious institutions by distancing itself from LGBTQI+ issues within the official curriculum.[105] However, there are recent challenges in implementing sexuality education in Zambia (see box: Zambia Abolishes Comprehensive Sexuality Education). Some of our respondents in Zambia indicated that teachers often decide individually which aspects of the curriculum they will teach. This approach allows them to avoid discussing subjects that they find uncomfortable. Taboo subjects, such as contraception and STIs, are generally not discussed openly in Zambian society and are therefore ignored.

In Nigeria, many interviewees emphasised that sexuality education in schools was limited in scope and focused on abstinence. In 2004, the government introduced the national *Family Life and HIV Education* curriculum for sexuality education in schools. Earlier drafts of the curriculum had proposed more comprehensive sexuality education, but following opposition from conservative political and religious forces, certain elements and topics were removed.[106] Some interview partners were also dissatisfied with the lack of national efforts to provide sexuality education programmes for out of school children and adolescents. The United Nations Population Fund (UNFPA) shares this concern, noting that some 18 million children in Nigeria are out of school.[107]

Zambia Abolishes Comprehensive Sexuality Education

Recently Zambia experienced a setback in sexuality education. Following rumours and disinformation about the alleged content of sexuality education in schools, which circulated on social media, there was a public outcry in 2020.[108, 109] Criticism of the existing curriculum for comprehensive sexuality education came mainly from Christian actors, who urged the government to abolish sexuality education in schools altogether. In response, the Zambian government established an interministerial committee to review the curriculum. As a result, the original curriculum, based on UNESCO guidelines, was replaced with a significantly reduced version in 2023, entitled *Life Skills and Health Education.*[110]

Prevailing Cultural Norms Prevent Open Dialogue on Sexual and Reproductive Health

In Nigeria, Zambia and Tanzania, as in many other countries and cultures worldwide, topics relating to reproductive and sexual health, sexuality and female bodies particularly, are regarded as taboo. As a result, many parents and older family members find it difficult to talk openly with their children and adolescents about their sexual and reproductive health and rights.

Young people in all three countries provided several reasons why it is difficult to discuss these topics within the family. Some parents feel ashamed to talk openly about sexuality, while others lack the information to explain HIV or contraception to their children. In addition, some adults believe that comprehensive sexuality education will encourage their children to become sexually active. Interviewees also reported that many parents lack the time to have such conversations with their children. In households experiencing poverty, securing food for the family is a daily, time-consuming challenge.

Menstruation is also a taboo subject. Some of our interview partners reported that many young women are taken by surprise when they menstruate for the first time. Often, neither family members nor sexuality education teachers prepare girls for the onset of menstruation and how to manage it. The limited information provided to adolescents about the menstrual cycle often lacks key aspects about menstrual hygiene, such as how to prevent infections.

A Lack of Information Creates Opportunities for Myths and Misinformation

"I think one thing is most [young people] want to have sex as much as they can – safer, pleasurable sex – but that information is not there, it's not out there, and most of them are probably struggling to find what are the right sorts of information, and it's so easy to be misinformed in such a context because maybe you depend to get information from a friend or you depend to get information from an auntie or a cousin, brother or a cousin, sister, and normally the information is not very right information."

Employee at a youth-led organisation, Tanzania

If young people do not receive adequate sexuality education at school or from their parents, where do they get information about safer sex, contraception and menstruation? In all three countries, our interviewees identified their friends and peers, the internet and social media as key sources of information on sexuality. However, they also cited traditional leaders, religious community centres, NGOs and health facilities as important resources.

While NGOs working on SRHR issues and health centres can be expected to provide accurate and comprehensive information to young people, this is not always the case with friends, churches or mosques, or on the internet. Myths about menstruation, conception and contraception are likely as old as humankind itself but continue to be widespread today. In the mining regions of Tanzania, for example, some people believe that if a woman walks past a mine while she is menstruating, the ore will disappear from the mine. In Zambia, Nigeria and Tanzania, we were told that some women and men believe that modern contraceptives cause infertility. A youth activist in Nigeria described the attitude of many young men towards condoms as follows:

"Condoms are for fools. Condoms are for people who are not strong enough. Pull-out gives me strength. If you're good in pulling out, you don't need to worry about condoms."

Without corrective action, the absence of information provides space for the spread of misinformation. Conservative actors who advocate against SRHR have exploited this void to advance their agendas. For instance, comprehensive sexuality education is sometimes disparaged as foreign or 'Western' propaganda for the rights of LGBTQI+ people. In conversations with interviewees in all three countries, we heard about influential Christian leaders who have been using misinformation to fuel fear of sexuality education, family planning and LGBTQI+ rights in their communities.

The Internet and Social Media: A Gift and a Curse

Compared to previous generations, young people in the 21st century have a significant advantage: The internet. While not all young people have internet access or smartphones, especially in remote rural areas, young people across Nigeria, Zambia and Tanzania use the internet frequently.[111, 112] Our consultations suggest that most young people in major urban areas such as Dar es Salaam and Lagos have access to both the internet and social media. In Nigeria and Tanzania, activists reported that young people can access comprehensive and accurate information about their SRHR online. In all three countries, the internet and social media also represent an important lifeline for LGBTQI+ youth. They provide a vital source of reliable and accurate information on SRHR, tailored to their specific needs, and offer a sense of community and belonging.

However, social media also enables the spread of misinformation. In all locations, many of our interview partners reported that young people often encounter inaccurate information on the internet. For both teenagers and adults, it can be challenging to recognise reliable sources of information online.

GOOD PRACTICE

Talking About Taboos

'Join-In Circuit on AIDS, Love and Sexuality' (JIC) is an interactive tool to facilitate discussion among young people about HIV/AIDS, relationships and sexual and reproductive health. The German Development Cooperation (GIZ) is implementing JIC as part of its work in different countries. In cooperation with the *National AIDS Council* and the NGO *Afya Mzuri*, the programme was first introduced in **Zambia** in 2015.

The course consists of eleven mobile and interactive learning stations that can be selected and combined individually for use in health centres and schools. Through a variety of methods, including images, role play and storytelling, participants learn about GBV and the transmission of STIs, among other topics. In recent years, the learning stations have been adapted several times to ensure the course is accessible, inclusive and gender-sensitive.

Several evaluations have shown that JIC has a positive impact on young people's sexual and reproductive health knowledge and behaviour. For example, young people were more likely to be tested for HIV and developed more critical attitudes towards traditional gender roles and GBV after participating in the JIC programme.[113, 114]

3.1.2 Are Youth-Friendly Services Really Youth-Friendly?

For adolescents to receive screenings, medical treatment and contraceptive care, services and facilities must be youth friendly. But what exactly does "youth-friendly" mean? A few years ago, the Nigerian Ministry of Health published national standards for youth-friendly healthcare: For example, it is crucial that young people are aware of the services and treatment options available at their nearest health facility, that they can reach this facility easily, and don't face barriers accessing treatment. In addition, the environment and design of healthcare facilities should be appropriate for young people, ensuring they enjoy privacy and receive confidential care.[115] In Zambia, too, youth-friendly healthcare is on the agenda. The government has published a policy paper on the subject outlining its plans to establish youth-friendly areas in health centres in all districts by 2026. To date, however, areas referred to as youth-friendly corners are not sufficiently available.[116]

The Ministry of Health in Tanzania recognises the need for improvement and identifies gaps in the health system in its *National Accelerated Action and Investment Agenda for Adolescent Health and Wellbeing*. These include a lack of adequately trained staff at health centres to meet the needs of young people, lack of educational materials and contraceptives, and limited opening hours.[117]

What are the characteristics of youth-friendly healthcare?

This word cloud illustrates characteristics of youth-friendly healthcare and healthcare facilities. Some characteristics relate more to healthcare staff, others to low-threshold access. It is also noticeable that the atmosphere of healthcare provision is a key factor in ensuring youth-friendliness.

(Data source: Interviews of this study, inspired by CHOICE for Youth and Sexuality[118])

What Are the Experiences of Young People on the Ground?

As ambitious as some of the national guidelines in Tanzania, Zambia and Nigeria are on paper, there has been limited implementation in practice. In reality, many youth-friendly corners are not really youth-friendly, or they simply do not exist. In some health centres, the areas for young people are only open on specific days of the week or during school hours. If a young person wants to consult with a doctor, it is often not possible to do so after school hours because the centre is closed in the evenings. Furthermore, health centres are widely dispersed, particularly in rural areas. For some individuals, the nearest clinic is 20 or even 40 kilometres away from their home. Even in larger cities, especially in rapidly growing urban areas, the journey to the nearest clinic can take time. The cost of transportation to a health centre or clinic is an additional financial burden for many young people, who may lack the financial resources to purchase a bus ticket.

Our experts have reported that in some cases, there is only one healthcare professional on site in health centres, serving large populations. This means they are forced to prioritise. According to one interviewee, treating a case of malaria is often considered more important than talking to a teenager about 'putting on a condom'. Furthermore, existing youth-friendly corners do not offer comprehensive services. Particularly in rural areas, the range of available medical products is limited. For instance, when one of our interviewees visited a centre in eastern Zambia, it had condoms, but no HIV or pregnancy tests. Similarly, in Nigeria, young people cannot always choose between a range of contraceptive methods because often only one specific method is available at the health centre. In other centres, staff do not distribute any products, but instead provide information and counsel on family planning.

Health commodities, such as condoms and pregnancy and HIV tests, are often out of stock at local health centres, which means that medical staff cannot provide patients with the products they need. Instead, they may write prescriptions for young people to purchase these health items at a pharmacy. However, this is not an option for those with limited financial resources. In Tanzania, many important treatments are also subject to a charge or hidden costs. For example, patients are required to pay for the treatment of various STIs or cancer screening themselves (see Chapter 3.1.5).

Even if a young person has the time to walk or drive to a health centre during opening hours and has the money to pay for transportation, treatment and medications, the question of remains: Can they receive confidential care?

A significant number of facilities that claim to be youth-friendly lack a separate entrance or waiting area. Our interview partners reported that benches under trees are often the only available seating. This raises concerns about unwelcome encounters with young people's neighbours or family members also seeking care at the only health centre in the area. The taboos around teenage sexuality represent a significant barrier to healthcare. The fear of encountering familiar faces at the health centre can lead a young person to avoid going to a health clinic altogether. Furthermore, many interviewees indicated that the privacy of young people and adolescents is not always protected in healthcare facilities. The ability to consult with a healthcare professional in private and behind closed doors is not guaranteed. In some instances, consultations occur in the hallway. Consequently, young people often travel to distant clinics to avoid running into someone they know. Young patients with HIV also prefer to travel to more distant healthcare facilities as they fear stigmatisation. The additional costs of transportation can be a significant financial burden, even if the antiretroviral therapy itself is free.

It is therefore crucial that designated areas in healthcare facilities are not only designed with young people in mind, but that they are exclusively for young people and have separate entrances and waiting areas.

Young People's Health Is Not Prioritised

The needs of adolescents and young people are often not given the priority they deserve. As recent years have shown, healthcare services that are specifically designed for young people are frequently de-prioritised during pandemics or other crises. In Zambia, or example, youth-friendly corners were closed in the early years of the COVID-19 pandemic or used to treat patients during the cholera outbreak in late 2023. No alternatives were offered to young people. Consequently, millions of people lost access to contraception in early in the COVID-19 pandemic and mobile clinic staff reported a significantly higher demand for family planning services among teenage girls and a rise in teenage pregnancies.[119]

Another significant issue with existing health services and youth-friendly corners, as identified by interviewees, is the lack of inclusivity. As a result, young people with disabilities and LGBTQI+ youth are frequently unable to utilise the services provided, or only to a limited extent (see chapter 3.1.4).

In conclusion, youth-friendly corners should be places that are specifically designed to meet the needs of young people, offering them confidentiality and privacy, and inclusive care by trained staff. This also includes designing areas that are appealing to youth to make them feel comfortable. If young people do not utilise youth-friendly services, this is a clear indication that the services are not meeting the needs of young people.

GOOD PRACTICE

How an App Can Improve Healthcare for Youth

The organisation *SafAIDS* has developed an app that allows young people in **Zambia** and five other countries in Southern Africa to submit complaints and report problems in healthcare facilities. For example, if a young person visits a clinic for HIV counselling and the facility is closed despite information stating otherwise, or has no HIV tests in stock, they can submit a report directly via the app. The report is read and processed by a staff member at the clinic. The anonymised data collected through the app can be used to identify the most common problems in adolescent and young adult healthcare and eliminate them. It can also be used to support advocacy campaigns and improve health policies.[120, 121]

3.1.3 Prejudices by Medical Staff

In all focus countries, healthcare providers often have biased and patronising attitudes towards young patients, particularly regarding their sexual and reproductive health. This phenomenon, known as *provider bias*, is a significant contributor to the lack of youth-friendly healthcare. Several interview partners identified provider bias as one of the main challenges in realising young people's SRHR.

Focusing on Personal Convictions Instead of Young People's Needs

In every focus country, interviewees reported that medical staff generally treated youth unprofessionally, both in terms of the pillars of medical ethics and specific needs of young patients. When staff members step into the health clinic in the morning, they carry their personal beliefs and opinions with them. These personal beliefs then frequently influence the treatment and counselling process. This is not uncommon, as people worldwide act according to their personal beliefs and values. However, it becomes concerning when these values and beliefs have a negative impact on young people's health and freedoms.[122]

Interview partners in all three focus countries emphasised that the religious and cultural beliefs of health workers often influence the counselling and treatment they provide to young people. Often young people feel that medical staff condemn and stigmatise them for their concerns. A study on the stigmatisation of young women in Zambia found that prejudices and stigmas frequently arise unintentionally and without conscious reflection. The social environment and deeply rooted social attitudes play a significant role in this.[123]

Young People Are Often Humiliated in Healthcare Facilities

For a young woman who has just fallen in love and is considering contraception, it can be a significant challenge to seek counselling. Once she meets with a healthcare professional for contraceptive counselling, she may instead receive a stern lecture about having sex at her age. Consequently, a consultation at a health centre can feel like an interrogation by young people. Our interviewees shared that young patients are often confronted with comments and questions, such as: You are so young, why are you thinking about having sex? Why do you need condoms? Does your mother know you are here? Sitting in the waiting room and anticipating such intrusive questions can understandably cause young people considerable distress.

"Some of the health providers understand that they are health providers and not moral officers or moral police, but not all."

Youth activist, Nigeria

For example, if a teenage patient discloses they are sexually active by requesting an STI test, it is not uncommon for a healthcare provider to lose their temper. This is a result of societal perceptions that sexual activity among young people is morally wrong, particularly among unmarried women.

The interviews conducted in all three countries revealed a lack of professional boundaries among medical staff, with health workers treating young patients as if they were their own children. Young people therefore feel as if they were being reprimanded and scolded by their parents when asking for condoms or a pregnancy test in health centres. In some cases, health workers even violated the confidentiality agreements by contacting their patients' parents to inform them about their child's visit to the clinic.

As one interviewee in Zambia reported, in some instances healthcare providers also refuse to perform medical procedures because of their religious beliefs. For example, health workers may refuse to perform abortions, even though they have been instructed to do so by their supervisors.[124] Similarly, some health workers refuse to provide contraception to young people, leaving them without the care they need.

Negative Experiences Erode Trust in the Healthcare System

Pervasive provider bias not only affects the quality of medical care negatively, but it also discourages young people from visiting health clinics altogether. The medical personnel's interaction with young people impacts if teenagers are satisfied with their care. It also determines whether they will return to seek medical care in the future.[125, 126]

For example, if medical providers accuse a young woman of being promiscuous and immoral for asking about contraceptives, she will leave the health centre humiliated and perhaps angry. Should she need counselling regarding a potential pregnancy in the future, it is unlikely that she will return to the same health centre. It is possible that she may look for a different clinic, farther away from her home, but she may also decide to only use healthcare services in an emergency. As reported by several respondents in all focus countries, many young people avoid professional health services for fear of being judged and discriminated against.

In Zambia an interview partner shared that, as a result, some pregnant young women decide to give birth at home without assistance, which is riskier than giving birth in a health facility. An interview partner in Nigeria told us about a young woman who relied on medical advice from an untrained provider because she feared stigmatisation at the local hospital. She later died from complications of an unsafe abortion. Provider bias can therefore not only have harmful but also fatal consequences.

"In some cases, the people who run those service points sometimes are not well-trained. And so, they don't know how to handle those young people and make them come back. So, for instance, maybe a young girl wants to come for family planning, and she is maybe 16, 17 or 18. And then the nurse will tell her 'You should abstain from sex!'. [...] The girl will go home and never come back! And that's a lost opportunity."

A youth organisation representative, Nigeria

Healthcare Personnel Lack Sufficient Training

Many of our interviewees believe that inadequate training contributes to the lack of quality care young patients receive from healthcare workers. Comprehensive training to help healthcare workers contextualize their personal beliefs within a healthcare setting through *Values Clarification and Attitude Transformation* workshops, for example, would therefore be beneficial (see box: Successfully Reducing Stereotypes). Furthermore, healthcare providers frequently lack sufficient knowledge about the specific concerns young people have about sexual and reproductive health. This should also be incorporated more fully into the training programme.

Finally, the age difference between young patients and older healthcare professionals is a significant barrier. Young people often associate older healthcare professionals with narrow-minded and stigmatising attitudes, which can lead to a lack of trust. Several interviewees stated that younger patients would be more likely to open up and build trust with healthcare professionals who were younger or of a similar age.

GOOD PRACTICE

Successfully Reducing Stereotypes

One effective method of reducing provider bias are trainings, such as *Values Clarification and Attitudes Transformation* (VCAT). In VCAT formats, facilitators guide participants through a process in which they critically reflect on their personal values, attitudes and actions.[127] Since 2015, the organisation *MSI **Tanzania*** has been offering VCAT workshops with the aim of increasing awareness among health workers, identifying hidden obstacles to the treatment of young people and, in the long term, improving contraceptive provision for adolescents. Workshop evaluation results demonstrate that these formats effectively reduce prejudice and biased attitudes, thereby enhancing the quality of counselling services for contraception and family planning for young people.[128]

GOOD PRACTICE

A Guide to Working Without Discrimination

The 'MakeWay' project is working to promote an intersectional (see glossary) perspective on SRHR in five African countries, as well as at the regional and global level. The project's goal is to reduce barriers for individuals affected by multiple forms of discrimination based on their gender, religion, disability, ethnicity, class or other identity markers. The project is funded by the Dutch Ministry of Foreign Affairs and is implemented in collaboration with six organisations in Ethiopia, Kenya, Rwanda, Uganda and **Zambia**. One aspect of the project is the development of intersectional guidelines, which are freely available on the MakeWay website. The guidelines provide NGOs, trainers and any other interested parties with guidance on how to, for example, develop an accessible, intersectional communication strategy or design a training course.[129]

3.1.4 Who Is Left Behind?

One recurring theme in our conversations with interview partners was the lack of inclusion in healthcare. Various groups, including young people with disabilities, young LGBTQI+ people and young people with HIV, who are disproportionately affected by gender-based violence, face discrimination and marginalisation.

Young LGBTQI+ People

Our interviewees reported that the Ugandan government's 2023 drastic new legislation against LGBTQI+ people[130] also had a significant impact on neighbouring countries. Tanzania, Zambia and Nigeria also have laws on the books criminalising homosexuality. Therefore, sexual and reproductive health and rights are particularly thorny issue for young queer people. In all three countries, same-sex sexual activity is illegal. In Zambia and Tanzania, same-sex intercourse can be punishable with a life sentence, while in Nigeria, prison sentences can vary between 14 and 21 years depending on the state.[a), 131] In all focus countries, such laws stem from British colonial rule and remained in place after independence.[132, 133] In Tanzania, the government has enacted further restrictive legislation in recent years. Members of parliament have been known to express their contempt for LGBTQI+ people in the media,[134] announcing that those who discriminate against sexual minorities need not fear legal consequences.[135, 136] In Zambia, a 2022 a fashion show prompted a heated media debate: Religious organisations accused the organisers of 'violating national values' after men walked the runway in feminine clothing.[137]

The restrictive political and legal environment has resulted in the exclusion of young queer people from SRHR projects and discrimination against LGBTQI+ individuals by staff in health centres. Several of our interview partners reported that health centres and medical services are not inclusive in general, particularly in terms of gender-sensitivity. Some interviewees added that LGBTQI+ people are aware of health centres in the big cities where they are treated well and share this information within their communities. However, most marginalised people regularly experience discrimination when seeking medical treatment. For example, one interviewee in Tanzania reported that as a young mother, queer person, or youth living with HIV, one might be left in the waiting room the entire day, or even asked to come back the next day. This could occur, for instance, if someone who is perceived as male displays characteristics typically associated with women.

It is often the case that medical staff lack adequate training to appropriately address the specific needs of individuals with diverse gender identities. In Zambia, we heard that trans people were unable to obtain medication to affirm their gender identity. In Nigeria, interviewees indicated that discrimination and inadequate healthcare for trans people prompted them to purchase medication illegally without receiving professional medical guidance.

Young people with HIV

Young people who have been living with HIV since birth are frequently overlooked in SRHR projects. They are often reluctant to openly communicate their status. A significant number of people continues to hold prejudices and are misinformed about HIV. Some young people are even unaware they have HIV because their parents don't tell them for fear of stigmatisation.

The lack of information about sexually transmitted infections (STIs) and the limited availability of pre-exposure prophylaxis (PrEP) are leading to an increase in HIV rates, particularly among young people.[138] If taken as prescribed, PrEP is just as effective as a condom or antiretroviral therapy in preventing infection with HIV.

HIV treatment can be particularly difficult for LGBTQI+ people. If they test positive for HIV or another STI, they are usually asked to come back with their partner so both can receive treatment. The threat of long prison sentences for homosexuality and the hostile environment makes it difficult for LGBTQI+ people to comply with this request.

a) In the southern states of Nigeria, the *Criminal Code Act* (2004) is the primary legislation applied, whereas in the northern region, the *Penal Code* (1959) is the prevailing legal framework. Moreover, 12 states in the north of the country apply the *Sharia Penal Code*. The severity of the laws in question determines the punishment for same-sex sexual intercourse. Such acts are punishable by flogging or even the death penalty. (Source: ILGA World (2024). Legal Frameworks. Criminalisation of consensual same-sex sexual acts (ILGA World Database). https://database.ilga.org/criminalisation-consensual-same-sex-sexual-acts (28.06.24).)

In the HIV response, cisgender *men who have sex with men* (MSM) are considered a *key population*.[139] However, the needs of MSM are only partially addressed by this distinction in the health system, especially in countries where homosexuality is criminalised. If NGOs explicitly provide health services to gay men beyond those defined as MSM, they risk legal problems. For example, the Tanzanian government de-registered one of the largest NGOs in this field for offering services to gay men, contrary to international agreements.[140, 141]

Young People with Disabilities

Worldwide, an estimated 10 percent of children under the age of 18 have a disability, and in Western and Central Africa it is 15 percent.[142] However, young people with disabilities are often not a clearly defined population group. The concept of disability is fluid, and there are a variety of different types of disabilities that can be experienced for different lengths of time, including temporary and lifelong disabilities. Due to societal prejudices and stigma, families with disabled family members are often reluctant to participate in household surveys. As a result, the true number of people with disabilities is likely significantly higher.[143]

In most cases, buildings and information are not accessible or barrier-free, which makes it particularly difficult for young people with disabilities to receive information on topics related to sexuality and to receive medical care. Furthermore, healthcare professionals often hold negative attitudes towards people with disabilities and lack the necessary training to provide adequate care.

In particular older healthcare facilities are often inaccessible for individuals with disabilities. For example, there might be no ramps or lifts to enter the building in a wheelchair, and often signs or written information are not available in Braille. Additionally, few if any healthcare professionals are proficient in sign language, which severely limits communication with deaf patients. As a result, young people with disabilities must rely on support from others for information and counselling. Particularly when it comes to matters of sexuality this can create a significant barrier to receiving care.

Asking for contraception can also be a very uncomfortable experience, as medical staff often are prejudiced against people with disabilities and assume that they are not sexually active. Many parents also believe that young people with disabilities do not and will not have sex and therefore do not educate them about sex. However, people with disabilities are just as likely to be sexually active as people without disabilities.[144, 145] The provision of sexuality education and access to health services for young people with disabilities depends not only on accessible materials and infrastructure, but also on the involvement of legal guardians, caregivers and support persons.[146]

Several interviewees reported that doctors and nurses ignore young people with disabilities. They can decide which patients to see first, and young people with disabilities are often not welcome. Conversations and counselling sessions sometimes take place over the disabled person's head, addressing only their support person. An accompanying person who interprets for a disabled patient holds power, which they could use to abuse patients, thus reproducing violence.

Missing Data on Marginalised Groups

It is unclear how many people are affected by these issues due to a lack of official data. Disaggregated data on many groups who are in urgent need of support is lacking. For example, the estimated number of trans and intersex young people in all three countries is significant,[147] yet there is no national data collected on these groups. Given the lack of research about the subgroups within the LGBTQI+ community, even NGOs working on SRHR are unaware of their needs. While there are estimates at the UN level of the size of the aforementioned marginalised groups, this is insufficient. Lack of official data makes it more challenging for NGOs to advocate for the needs of marginalised people, and easier for government representatives to ignore certain groups.

Other vulnerable groups include sex workers and young people in prisons. These individuals are particularly vulnerable to contracting STIs. In Zambia, for instance, one interviewee told us that distributing condoms in prisons is prohibited. Furthermore, there is also no official data on young people in prison. Therefore, for example, the number of young women incarcerated for terminating a pregnancy is not known.

In a nutshell, the key concern according to a young person with a disability is: 'We are left behind'. Many health centre staff are not trained to effectively interact with people with a wide range of disabilities and needs. A simple example shows how important Braille is not only for informational materials, but also for health products. There is no Braille print on condom packaging, which presents a challenge for blind teenagers who are learning to use condoms for the first time. The expiration date on condom packaging is also illegible to them.

GOOD PRACTICE

Safe Shelter for LGBTQI+ Youth

The youth- and LGBTQI-led organisation *Improved Sexual Health and Rights Advocacy Initiative* (ISHRAI) offers support to LGBTQI+ people in **Nigeria**. It provides a range of services, including psychological and legal support, advocacy work, and education on SRHR topics. Temporary accommodation for LGBTQI+ individuals who are seeking protection from violence and discrimination and require a supportive environment is also provided by ISHRAI. The 'Safe Shelter' programme,[148] operated by ISHRAI, provides two shelters for about 25 individuals each for up to three months, or longer in exceptional cases. In this way, the organisation addresses the insecurity and violence that LGBTQI+ people in Nigeria face.

"For me, as a blind person, the main issue is not getting information in a way that I can access – in Braille."

Youth activist, Zambia

In addition, the cost of contraceptives represents a significant barrier for many young people with disabilities. Many are unemployed and don't have an income, so they often lack the financial resources to purchase contraceptives from pharmacies.

At the policy level and in international development programmes, there are too few initiatives to integrate young people with disabilities into sexual and reproductive health and rights initiatives.[149] A significant challenge is that every person with a disability has different needs and requirements for support. Consequently, there is no single solution that works for all people with a disability.

GOOD PRACTICE

Nurturing the Next Generation of Activists

The *Young and Alive Initiative* is a youth organisation in **Tanzania** that provides training for the next generation of youth activists.[150] Through the 'Young and Alive Fellowship', it promotes the leadership skills of young activists, with an emphasis on youth from marginalised communities. Through this programme, young people learn about SRHR topics and advocacy strategies. The aim is to ensure that young people can participate in political processes in the long term and shape their own futures by training in 'SMART advocacy'[151] methods.

GOOD PRACTICE

Strengthening the Voices of Young Marginalised Women

The international project 'We Lead', led by the organisation *Hivos*, supports civil society organisations in nine countries to strengthen SRHR for severely marginalised young women. As part of this project, the youth organisation *Sustainable Impact and Development Initiative (SID)* in Lagos, **Nigeria**, organised a two-day workshop for young women with disabilities and young women living with HIV. In the first phase, experts provided young women with knowledge about SRHR. In the second phase of the workshop, participants were trained how to collectively advocate for their interests. Through group discussions, they developed recommendations for improved and inclusive access to SRHR services. The outcome was a jointly developed strategy paper that is now being used for advocacy purposes.[152, 153]

3.1.5 Addressing Poverty: The Effects of Precarious Living Conditions on SRHR

Those concerned with improving the sexual and reproductive health of young people must also acknowledge the issue of poverty. Many of our interview partners in all three focus countries highlighted this issue. After all, those who experience daily hunger and struggle with meeting basic needs cannot afford to wait for hours in a health clinic for a counselling appointment. Poverty can therefore have a negative impact on sexual and reproductive health, as well as on young people's ability to exercise their sexual and reproductive rights. The socio-economic circumstances of young people result in a wide range of SRHR needs. For instance, single mothers who sell only a few bags of fruit a day at a market stall to make ends meet face different challenges than young mothers with a secure job or a spouse who has a stable income.

The World Bank's most recent estimates indicate that approximately one-third of the population in sub-Saharan Africa lives below the poverty line, which means that they are affected by extreme poverty.[a), 154, 155] This figure is considerably higher than in any other region of the world and is above the global average. The COVID-19 pandemic has led to a further increase in the number of people affected by extreme poverty, which is the first increase in the global poverty rate in decades. [156]

[a] According to the World Bank, a person living below the international poverty line, or in extreme poverty, has less than 2.15 US Dollars per day at their disposal (based on purchasing power parity in 2017).

In Nigeria, just under one-third of the population lives in extreme poverty, in Tanzania about half of the population and in Zambia almost two-thirds.[157]

Recent estimates suggest that a significant number of the global youth population (ages 15 to 24) living in extreme poverty is concentrated in sub-Saharan Africa. Extreme poverty affects tens of millions of young people in the region (80 million in 2019).[158] In the coming years, the issue is likely to become more acute in several countries in sub-Saharan Africa. Nigeria is the country in the world where the absolute number of young people living in extreme poverty is likely to increase the most by 2030, driven by population growth and the lack of progress in poverty reduction.[159]

Many of our interview partners stressed that economic empowerment is a prerequisite for young people to be able to secure their SRHR. They should not have to choose between spending their income on a bag of rice or an STI test. Young people must be able to secure their livelihood and lead a self-determined life.

Healthcare Is a Financial Burden for Young People

The high costs of health services and products can be a heavy financial burden for young people. Most of our interviewees expressed concern that health services and essential products such as sanitary towels or condoms are not affordable for young people. Although public institutions in all focus countries offer many health services – including counselling related to family planning and contraception – free of charge, there are still many costs that can put a strain on young people's finances.

In more than one focus country, interviewees reported that services or products that are usually provided free of charge in public health facilities must sometimes be purchased for a fee. If a patient wants to move up in line, they can give the attending staff a banknote for 'faster service'. The typically long waiting times in public clinics can lead some young people to pay to get expedited service – if they have the extra money.

Patients often wait all day to be seen by a health professional. Depending on the treatment, they may be forced to wait many hours over several days. Or they might wait in vain for days without ever receiving the care they need. One interviewee described daily queues of up to 500 people. With such long waiting times, young people may have to choose between several days' wages or necessary healthcare. As a result, some people living in poverty cannot even afford to get the care they need at a public clinic, while those who are wealthier go to expensive private medical providers.

Furthermore, respondents in all focus countries shared that basic health commodities are often in short supply in public facilities, forcing young people to rely on private providers. However, several experts in Nigeria and Tanzania reported that products in private health centres are unaffordable for most young people. Financial constraints may therefore dictate a young woman's choice of contraceptive method if her preferred method is not available in a public clinic. If she has sufficient financial resources, she can obtain the contraceptive method of her choice from a private clinic or pharmacy. But if she does not, she might switch to an alternative method that causes her adverse side effects, or she might stop using contraception altogether.

Interviewees in all three focus countries also reported that in many rural areas the nearest clinic is located many kilometres away from patients' homes, which means there may be significant travel costs. Even in Lagos, one of Africa's largest metropolitan areas, the trip to the clinic can be a financial barrier, even though health facilities are more widely available than in rural areas. This results in additional costs for health services that should be free, such as contraceptive counselling. There are also many life-saving health services, such as cervical cancer screening, that are not free in all countries. The same applies to the treatment of STIs, which are subject to a fee in both Tanzania and Nigeria.

Unintended Pregnancy, Young People, and the Cycle of Poverty

These different cost barriers to accessing counselling and care makes it challenging for many young women and girls who experience poverty to avoid an unintended pregnancy. And there are only limited support services available for young people have an unintended or unwanted pregnancy. It is difficult or even impossible to legally terminate a pregnancy in all focus countries. In Nigeria and Tanzania, abortion is only permitted in cases where the pregnant person's life is at risk.[160] In Zambia, the law is much more liberal, but there too access to a legal abortion is associated with many barriers (see Chapter 3.2.3.). The only options for most young women are to have a child or to have an illegal and potentially unsafe abortion.[161, 162, 163] Illegal safe abortions might also be available, but, according to our interviewees, they are not affordable for most women.[164] The case of Tanzania shows that on paper all health services related to pregnancy and childbirth – including post-abortion care following an unsafe abortion – are provided free of charge. But in reality, half of all post-abortion care patients are required to pay for this care.[165]

Young women need poverty reduction and educational opportunities

A comparison of young women in Zambia, Tanzania and Nigeria who become mothers at an early age reveals the same trends in our three focus countries. In rural regions, adolescents often bear children earlier than in urban regions. The higher the level of education, the less often young women are already mothers. Differences in wealth have a particularly strong impact on early motherhood: adolescents affected by poverty are significantly more likely to have a child than those who are wealthier.

Percentage of women aged 15 to 19 who are mothers, by socio-demographic characteristics
(Data source: ICF[166])

Several interviewees reported that young people who are already affected by poverty are often unable to escape the cycle of poverty due to unplanned early motherhood. In part this is due to young pregnant women and mothers having to leave school and often being unable to return. Experts estimate that more than half of young mothers in Zambia never return to school. Although young mothers can legally attend school in all three focus countries,[167] this is often not reflected in reality. Young women without secondary education face significant challenges in gaining employment and generating sufficient income. They are also difficult to reach with comprehensive sexuality education outside of school, as one interviewee from Tanzania reported.

When young mothers cannot afford to send their children to school, the cycle of poverty continues from one generation to the next. Although public schools in Tanzania are free, there are indirect costs such as school uniforms and school meals.[168] Some schools require parents to give their children the equivalent of 50 cents (in Euros) every day for school cafeteria meals. For a young mother living in extreme poverty, this is often unaffordable.

Selling Sex to Survive

In all three focus countries, interviewees reported that young people, particularly girls and young women, engage in sex work to meet their basic needs or to provide for their families.

In Nigeria, experts shared that some girls have sex with strangers for 200 Nigerian Naira (less than 20 cents in Euros) – the cost of a small bottle of water. In some cases, parents even encouraged their children to engage in sexual activities in exchange for money to contribute to the family income. In Tanzania, interviewees explained that some young women exchange sexual activities for hygiene products that they otherwise cannot afford, such as sanitary towels. In regions where the journey to school is particularly long, sometimes students exchange sexual activities for a lift. For young mothers who lack both an education and a supportive partner, sex work is often the only viable option for meeting the basic needs of their children (see Chapter 3.2.2.).

Selling sex can be dangerous for young people. They are particularly at risk of contracting STIs, unintended pregnancy or experiencing violence, robbery or extortion. In all three countries, interview partners reported that survivors of sexual violence often do not get support from the police and perpetrators often are not prosecuted. Studies have confirmed the high levels of violence[169, 170] and that young sex workers are at a higher risk of contracting HIV or having an unintended pregnancy.[171, 172, 173]

Since sex work is criminalised in a variety of ways in all focus countries[174] and sex workers experience discrimination by healthcare workers[175], they are often afraid to seek care when they experience health problems.

GOOD PRACTICE

Support for Girls With Incomplete Education

In the three-year ‘Adolescent Girls Initiative’ pilot project in two districts of the Shinyanga region of **Tanzania**, *UNFPA* worked with local authorities and the NGO *Kiota Women’s Health and Development* to improve the sexual and reproductive health (SRH) for female adolescent school dropouts. The project achieved this goal in conjunction with measures such as writing and literacy education as well as vocational training. The aim was to enable girls to enter the labour market. In addition, young women were supported in obtaining micro-credits for entrepreneurship. Evaluations show that the project led to both an increase in the use of SRH services and greater financial independence for more young women. The provision of vocational training and business start-up support in conjunction with SRHR education and services also increased community acceptance of SRHR programmes.[176, 177]

Period Poverty: Poverty Makes Menstrual Hygiene Difficult

Those experiencing poverty are often unable to practice adequate menstrual hygiene. In all three focus countries, we were informed that a significant number of girls and young women lack the financial resources to purchase menstrual hygiene products such as sanitary pads. One possible solution is the use of reusable menstrual pads, but currently only a few projects make them available.

Many young people are unable to purchase pads from stores because they cannot afford to buy them. Therefore, they use improvised alternatives that are unsanitary and often lack absorbency. This not only increases the risk of preventable infections, but also has a negative impact on mental health and well-being. Students often feel uncomfortable about attending school during their period, fearing that they may be mocked and rejected by their classmates if a bloodstain becomes visible on their clothes. Furthermore, many educational institutions lack the necessary facilities to provide clean water and private toilets for students to change their pads or wash their hands.[178] As a result, many students stay home during their period if they do not have access to adequate menstrual products, and thus miss many days of school.

"For students from really disadvantaged backgrounds it becomes inconvenient to purchase one packet or two packets of sanitary pads each month. And so they usually end up using the unsafe like just a piece of cloth or socks or just different methods. [...] And that is what actually leads some girls to end up missing school. Because when you wear socks, when you wear a cloth that is not of absorbent nature, at the end of the day it's guaranteed that your skirt or your dress will be soiled. So to avoid that embarrassment and shame they would rather stay at home during their periods."

Youth activist, Tanzania

GOOD PRACTICE

"Every Girl Deserves a Dignified Period Experience"

This is how the founder of the *Whisper A Dream Foundation* in **Zambia** describes the mission of her organisation. In rural areas of the country, many girls do not have access to sanitary pads, or their families cannot afford them. Instead, they often use cloth or other materials that are not always hygienic. The *Whisper a Dream* team travels to remote areas of the country to educate young people about menstrual hygiene and distribute reusable pads. They also run workshops in villages to teach girls and young women how to sew reusable cloth pads from everyday materials and how to clean them to prevent infection.[179]

GOOD PRACTICE

Art as Therapy

In the southern province of **Zambia**, the 'Art Beyond Schools' project, run by the *Contact Trust Youth Association*, provides art therapy in schools and health centres. The aim is to improve young people's mental health, which can have a positive impact on their SRHR. Art therapy is helping them learn in an easy way to express the feelings and thoughts they may find difficult to put into words. The unique aspect of the project is its peer-to-peer teaching approach. Art lessons are given by young people for young people but, if necessary, trained medical professionals specialising in art therapy are available to support the young trainers. In 2023 alone, the project reached almost 1,000 young people between the ages of ten and 24.[180]

3.2 Taking a Closer Look at the Focus Countries

In previous chapters, we highlighted five key priorities our interview partners in Nigeria, Zambia and Tanzania emphasised: expanding sexuality education, youth-friendly healthcare and inclusion, and reducing poverty and provider bias. Our findings demonstrate that the needs and perspectives of young people on SRHR are strikingly similar in all countries.

The following section will take a closer look at each of our focus countries. We discuss the specific issues our Nigerian interview partners identified as priorities and provide an overview of the current policy landscape impacting young people in Zambia. We also look at one of the most commonly discussed topics in Tanzania.

This chapter will look closely at one of the most urgently raised issues in each country. For instance, the situation of internally displaced persons (IDPs) in Nigeria, restrictive laws in Zambia or the challenging circumstances faced by young mothers in Tanzania.

The priorities in this chapter reflect our impressions from the country interviews. They should not indicate that, for example, the policy landscape is only a challenge in Zambia and not in Nigeria or Tanzania. Similarly, young mothers in Nigeria and Zambia face significant obstacles too, and not just in Tanzania.

3.2.1 Nigeria: The SRHR of Young IDPs Are at a Great Risk

In our interviews in Nigeria, young IDPs were frequently mentioned. Many of them have been living in IDP camps in the north-east of the country for the past decade due to violent conflict.[181] Around the world, the number of people who have had to flee to another place within their country of origin has been increasing for years. This is also the case in sub-Saharan Africa. At the end of 2022, 31.7 million people in the region were internally displaced. With 4.5 million IDPs, Nigeria has the third highest number of IDPs in sub-Saharan Africa, after to the Democratic Republic of Congo and Ethiopia.[182] In 2023, the *International Organization for Migration* (IOM) identified nearly 2.3 million IDPs in north-eastern Nigeria alone, 58 percent of whom were under the age of 18.[183]

Inadequate Sexual and Reproductive Health Provision

Organisations working to provide health services for young internally displaced people in Nigeria reported that people in the camps are isolated and have very limited access to any kind of care. Many camps are in remote rural areas, which contributes to the fact that the SRHR of girls and young people in the camps are particularly at risk, in particular when they require medical care after experiencing sexualised violence or experiencing an unintended pregnancy. Interviewees reported that although makeshift health facilities were available in the camps, they were inadequately equipped, and many essential health services were not available at all. When the camps' emergency humanitarian aid supplies of health products like pads or condoms are used up, "women and girls are left to themselves again and go back to square one", stated a representative of a Nigerian youth organisation. There is also a lack of adequate sanitation facilities.

Extreme Poverty in the IDP Camps

IDPs face great challenges generating income and making ends meet. Addressing IDPs' precarious living conditions is key to ensuring SRHR for young people. When health and menstrual commodities run out in the make-shift clinics, teenagers are forced to purchase these products with their own money. However, many are not even able to afford pads, let alone more expensive health products.

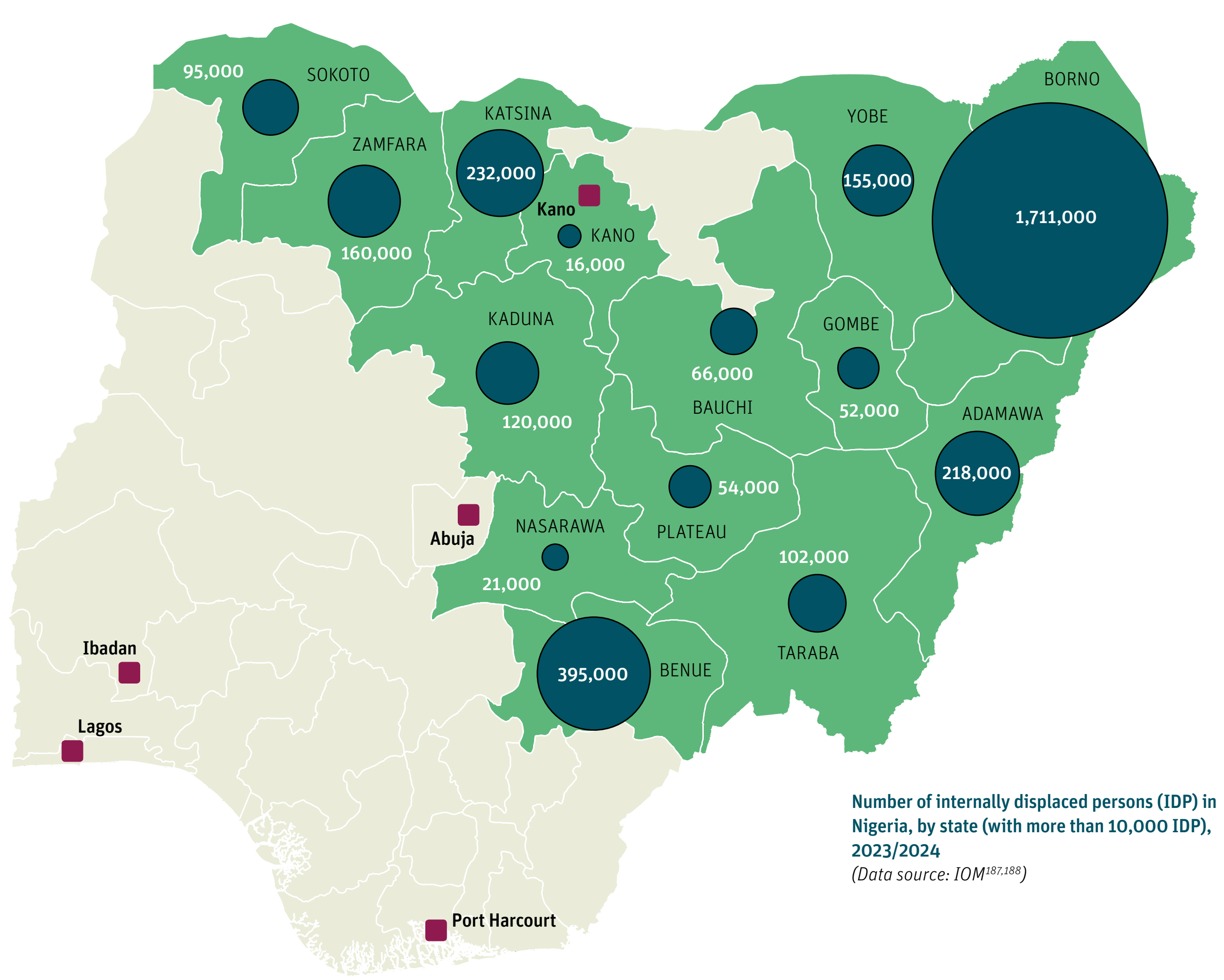
A study on the SRHR situation of young women in an IDP camp in north-eastern Nigeria shows that many young IDPs live precariously. Ninety percent of 500 girls interviewed stated that they did not have enough food. One in five teenagers used old clothing to make pads.[184]

Due to extreme poverty and inadequate healthcare in the IDP camps teenage girls are often dependent on men to ensure their survival. For example, by getting married to secure their livelihood. Studies also indicate that some young women in refugee camps in north-eastern Nigeria engage in sex work in exchange for food or money.[185]

According to a Nigerian youth activist, child marriages occur more frequently in IDP camps. Some parents force their underage daughters to marry because they cannot afford to take care of all their children. Studies confirm that children and women in humanitarian contexts, such as north-eastern Nigeria, are particularly vulnerable to child marriage, but also unintended pregnancy, unsafe abortions, STIs and GBV.[186]

Where young internally displaced persons need support

Hundreds of thousands of adolescents in Nigeria have had to flee their place of origin due to violent conflicts. In the north-east and north-west of the country and in north-central Nigeria, there is an urgent need to address the particularly disadvantaged living conditions of displaced persons. The north-eastern state of Borno stands out, as it has the highest number of IDP in Nigeria at 1.7 million.



Number of internally displaced persons (IDP) in Nigeria, by state (with more than 10,000 IDP), 2023/2024
(Data source: IOM[187,188])

GBV Is a Major Problem

In Nigeria, numerous experts reported that GBV was widespread. Gender-based and sexual violence affects many teenage girls, particularly in the IDP camps in north-eastern Nigeria. That said, GBV is also a serious issue in Zambia and Tanzania.

A representative from an NGO providing support to young people in camps in north-eastern Nigeria reported that the number of cases of GBV and sexual violence, including rape, is alarming. Young female IDPs are particularly vulnerable to these forms of violence and physical attacks in the IDP camps. There is a lack of safe spaces for girls and young women where they can spend time with other women, talk and be at ease. Furthermore, reports from other organisations in north-eastern Nigeria, as well as other studies, confirm that young women and girls in humanitarian settings are at high risk of experiencing GBV. Therefore, violence prevention and providing support for women after they experience violence is a priority for humanitarian organisations – in Nigeria and across the world. [189, 190, 191,]

GOOD PRACTICE

Targeted Support for Young Women in Humanitarian Contexts

The NGO *Action Health Incorporated* (AHI) provides SRHR support to young people in **Nigeria**, including in the north-eastern region of the country affected by violent conflicts. For instance, from 2018 to 2019 AHI implemented the 'Sustaining Care' project in the region, providing targeted support for internally displaced girls and young women in IDP camps. Funded by the *United Nations Office for the Coordination of Humanitarian Affairs* (UNOCHA), the project's objective was to enhance the provision of reproductive healthcare services for girls, adolescents and young mothers. Given the prevalence of GBV among IDPs, health workers were specially trained to provide youth-friendly emergency care, for example, in cases of rape. Psychosocial counsellors provided support to girls and young women in designated safe spaces to assist them in processing their experiences of gender-based and sexual violence. The AHI projects represent an important approach to promoting SRHR among young people in humanitarian crisis contexts and to countering the effects of gender-based discrimination and violence.[193]

GOOD PRACTICE

A Critical Examination of GBV Through Artistic Expression

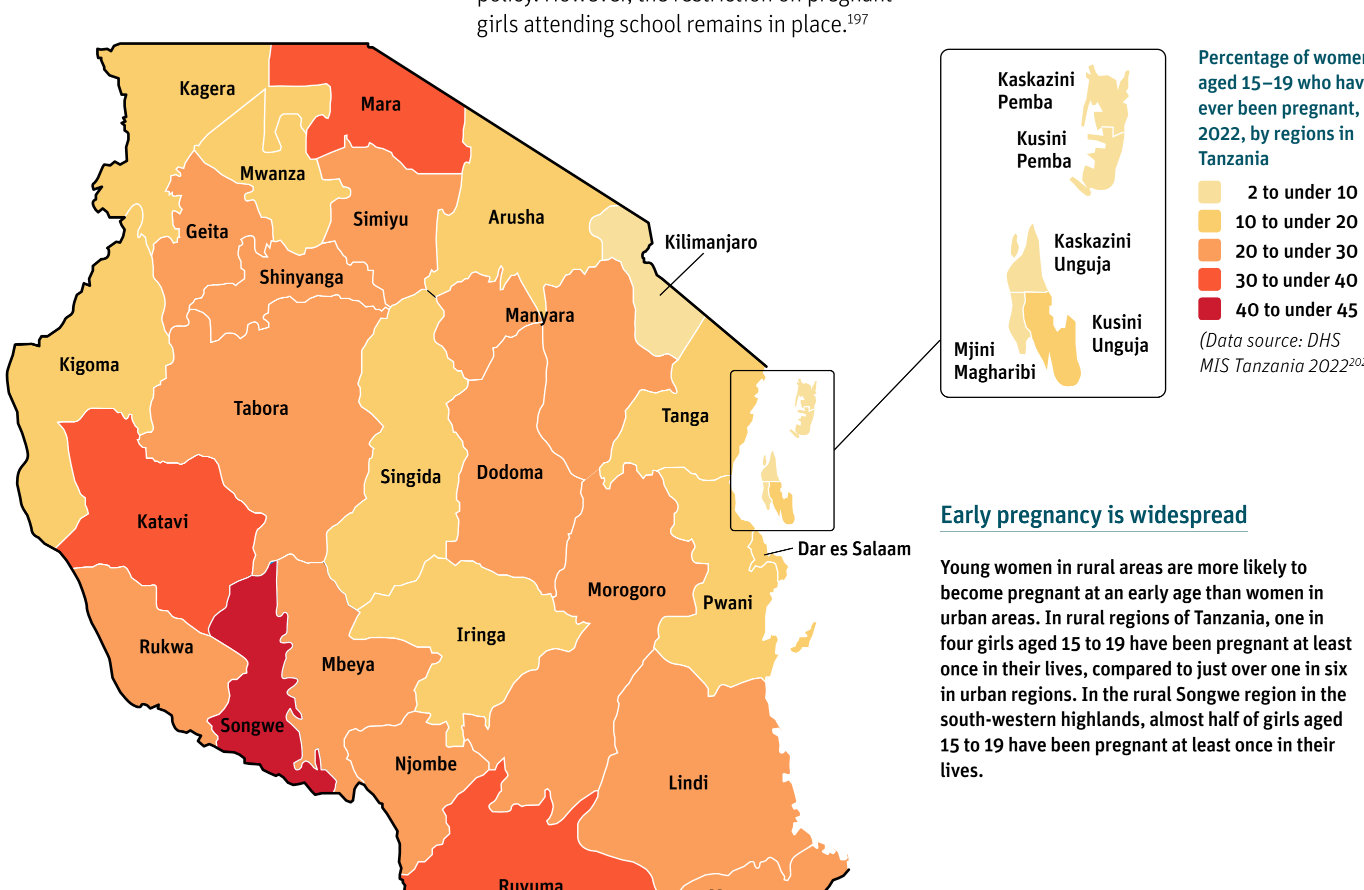
Through the performing arts the **Tanzanian** youth-led organisation *Theatre Arts Feminists* raises awareness about GBV, particularly in rural areas and challenges prevailing norms.[194] The objective is to challenge the normalisation of violence through theatre and traditional dance performances. The target audience is children, both girls and boys. The productions are also designed to disrupt the cycle of trauma that can result from experiences of violence. The performances can support young people who have experienced GBV to name their experiences for the first time, thereby demonstrating that they share their experiences with many others.

3.2.2 Tanzania: Young Mothers Need Support

'Young mothers are in a really tough situation' summarised an employee of an international organisation, which runs projects for young people in Tanzania. Poverty and early motherhood are closely linked. The greater the poverty, the greater the likelihood that girls between the ages of 15 and 19 will become pregnant.[195] Pregnant teenagers are often forced to drop out of school either during pregnancy or after giving birth. This deprives them and their children of the opportunity to earn an income and contributes to the cycle of poverty continuing from one generation to the next.[196]

For many years pregnant girls and young mothers in Tanzania were barred from attending school. Following years of advocacy by civil society organisations, the Tanzanian government made a partial change to this policy at the end of 2021. The new policy allows girls to return to school within two years of giving birth, thanks to a re-entry policy. However, the restriction on pregnant girls attending school remains in place.[197]

Meanwhile, the African Union's *African Committee of Experts on the Rights and Welfare of the Child* has called on Tanzania to lift the ban on pregnant girls attending school.[198] Even so, civil society experts argue that the re-entry policy alone is not enough.[199] Without additional social and financial support, it is impossible for most young mothers to care for their young children and attend school at the same time.[200, 201]



Early pregnancy is widespread

Young women in rural areas are more likely to become pregnant at an early age than women in urban areas. In rural regions of Tanzania, one in four girls aged 15 to 19 have been pregnant at least once in their lives, compared to just over one in six in urban regions. In the rural Songwe region in the south-western highlands, almost half of girls aged 15 to 19 have been pregnant at least once in their lives.

Sex Work as a Last Resort

Young mothers living in poverty in Dar es Salaam told us that they face significant challenges in providing for themselves and their children. They often receive no financial support from their children's fathers. Although many young mothers live with their parents or grandparents, they are also expected to contribute to the household income. Without a degree or vocational training, it is difficult for them to find a job to make ends meet or contribute to the household income. For many, the only way to earn money is through sex work. This work is often associated with physical violence and does not guarantee a sufficient income, yet it is often the only viable survival strategy available to them. One young mother shared that, as a young sex worker, she was regularly exploited by men. On occasion, men refused to pay her, and when she insisted on being paid, she was beaten with beer bottles.

Financial support is the most important need to ensure young mothers' survival and that of their children. The mothers we met with expressed the need for more assistance in finding ways to continue their education, given the difficulty of securing employment without it. Most had only completed primary school. Many mentioned the desire to start a small business, but lacked the necessary education and skills to do so.

The Cycle of Intergenerational Poverty

For young Tanzanian mothers living in poverty, breaking the cycle of intergenerational poverty can be difficult, if not impossible. Good health and education would be a prerequisite to do so. The young mothers we met are working hard to achieve this goal. Although many health services, such as childhood vaccinations, contraception and HIV treatment, are provided free of charge in public facilities in Tanzania, they remain out of reach for many marginalised people.

The biased treatment that young people often experience in health facilities increases when health workers realise during a consultation that a young unmarried woman is pregnant or a mother, living with HIV or working as a sex worker. Interviewees reported waiting for days to get a vaccination for their child, having to pay bribes or 'fast-service fees' to get long-term contraceptives, such as IUDs or implants, and being verbally reprimanded by health workers in specialised HIV clinics if they are a few days late for their antiretroviral treatment.

A young mother told us that she wants to vaccinate her child, despite the significant daily challenges she faces accessing health services. Challenges include the need to budget for transportation, waiting an entire day without food, and experiencing bias from healthcare workers. The last time she took her child to the community health centre for a third and final vaccination, she reached her breaking point. Staff demanded a bribe of 1,000 Tanzanian Shillings (approximately 40 cents) for the child's vaccination and given that the young mother was unable to pay the requested amount, her child did not receive the recommended routine vaccinations. A significant number of children born to young mothers are unable to receive all their vaccinations for similar reasons.

Such discrepancies in immunisation rates for children are also reflected in national statistics. In 2022, just over half of all children aged 12 to 23 months had received basic antigens. When analysed by household poverty level, the figures for fully vaccinated children in the poorest 20 percent of the population are below the national average at just 42.5 percent.[203] Overall, childhood vaccinations have greatly declined during the COVID-19 pandemic. Statistics for 2015 to 2016 show that before the pandemic, on average, 75 percent of all Tanzanian children had received the necessary vaccinations, as well as 65 percent of all children from the poorest households.[204] These numbers show the alarming gaps in basic healthcare provision, which will have long-term effects on children's health and well-being, families, communities and the entire country.

Child Marriage and Early Motherhood Are Prevalent in Rural Areas

In discussions with activists and staff from organisations operating in rural Tanzania, we learned that child marriages and early motherhood are still more common in these areas than in urban regions. The latest data from the Demographic and Health Surveys indicate that both men and women in rural areas marry at an earlier age than their urban counterparts. However, child marriage disproportionately impacts girls, regardless of their location. Nationally, nearly one in five girls gets married etween the ages of 15 and 19, while less than one percent of men marry at this age.[205]

The differences between urban and rural areas are particularly evident in pregnancy and birth rates. In urban areas of the country, one in six young women aged 15 to 19 has been pregnant at least once, compared with one in four in rural areas.[206] The birth rate for 15- to 19-year-olds is twice as high in rural areas as in urban areas.[207]

One interviewee from a youth-led organisation told us in rural areas she often encounters teenage girls who already have more than one child. Since the Tanzanian government aims to reduce teenage pregnancies[208], it is also common, particularly for young teenagers, to give birth at home without medical assistance to conceal pregnancies and births from the government. In addition, our interviewees reported that the health infrastructure and services for pregnant young women are worse in rural areas. Recent surveys show that significantly fewer women in rural areas attend at least four antenatal care visits or are cared for by qualified health professionals during childbirth than in urban areas. Among pregnant adolescents under the age of 20, one third do not receive adequate antenatal care, adding to the existing health risks of teenage pregnancy.[209, 210]

GOOD PRACTICE

Specialised Health Facilities for Young Pregnant Women and Mothers

In Lagos, **Nigeria**, the *Lagos State Ministry of Health*, with support from *UNFPA*, runs four public 'Young Mum's Clinics'. These offer comprehensive support to pregnant teenagers and young mothers: free medical care for pregnant women, mothers and their babies, education on sexual and reproductive health and family planning, and psychological counselling. Participating hospitals help to ensure professional healthcare for pregnant women and mothers through regular home visits. The facilities also support young women's secondary education and refer them to job training programmes.[211, 212, 213, 214]

3.2.3 Zambia: How Laws Impact Young People's Access to Healthcare

Restrictive or outdated laws are one of the biggest barriers to SRHR for young people. What needs to be done to improve SRHR and healthcare for young people? Particularly in Zambia, most people believe that the legal situation needs to be improved. The legal age at which young people can receive healthcare without parental consent and the regulation of abortion were repeatedly identified as key issues.

There are many obstacles to legal abortion

Abortions are legal in Zambia under certain conditions, yet many young women and girls have unsafe abortions. In 2020, authorities in Zambia's Eastern Province reported more than 1,000 cases of complications from unsafe abortions.[215] Unsafe abortions not only result in a high number of complications requiring treatment, but are also one of the main causes of maternal mortality in Zambia.[216] What factors contribute to the high number of unsafe abortions despite the relatively liberal abortion law?

As early as 1972, the Zambian government regulated access to abortion in the *Termination of Pregnancy Act*. The law states that an abortion is legal if it is carried out by a trained and registered doctor in a hospital and two other doctors confirm that the pregnancy either endangers the life of the pregnant person, her physical or mental health, or threatens the well-being of existing children. Another reason for a legal abortion can be a serious illness or disability of the unborn child.[217]

"All it puts are barriers."

Employee at an NGO, Zambia, about the Termination of Pregnancy Act

The requirement for three doctors to provide written consent for a woman to receive an abortion poses a huge challenge, especially for women in rural areas. Getting three signatures when there is only one small health centre nearby can prove next to impossible. In addition, many women and girls are unaware that abortions are legal, or the conditions under which they are permitted. Because the subject is taboo, it is not discussed openly. Even medical professionals are often unaware that abortion is part of free healthcare.

"Zambia has a patient-doctor ratio of 1 to 12,000. Imagine, a woman wants to access an abortion in a rural area in a population of a doctor-to-patient ratio of 1 to 12,000. Where are they going to get that doctor to sign that?"

Project Coordinator at an NGO, Zambia

In our conversations on the ground, interviewees repeatedly emphasised that Zambia is "is a Christian country". Many people believe abortion to be morally wrong. Young women who have an unintended pregnancy are particularly fearful of being judged. As with other healthcare services, additional obstacles include financial costs, distance from the nearest hospital, and the insensitive conduct of medical professionals. Furthermore, reports indicate that women experiencing an unwanted pregnancy are often denied treatment because there is no more misoprostol (see glossary) available. This means that young people often turn to unsafe methods to terminate an unintended pregnancy.[218]

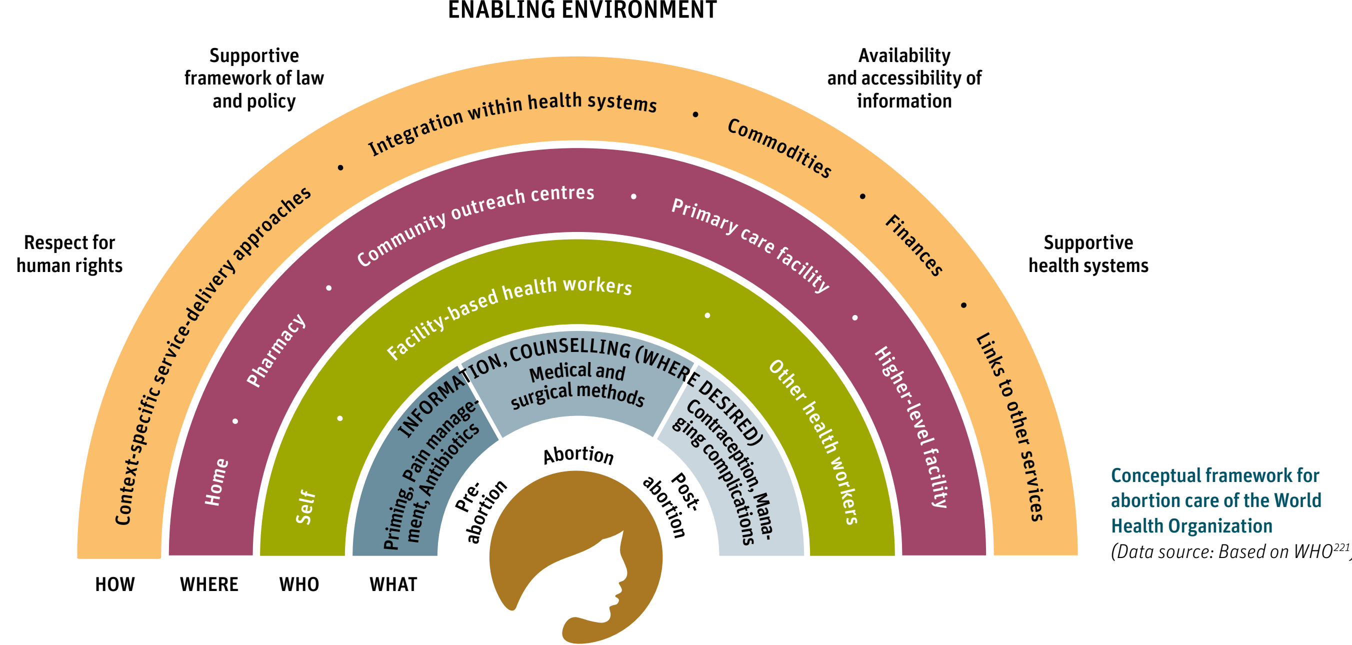
Women who have terminated a pregnancy illegally in Zambia may face up to 14 years in prison.[219] The number of women currently in prison for an having an illegal abortion is unclear.

GOOD PRACTICE

24-Hour Hotline

The 'Aunty Tasha Helpline' is accessible 24 hours a day, offering guidance to young people in **Zambia** who have questions related to sexual health, contraception and STIs. Counsellors who have received the relevant training are available to provide callers with information and support on sexual and reproductive health topics. They counsel women who have experienced an unplanned pregnancy and then refer them to the appropriate medical professionals. Those who contact the helpline can be assured that their data will be treated confidentially and that they will not be judged or discriminated against. The hotline is funded by the *MAMA Network* (**M**obilising **A**ctivists around **M**edical **A**bortion), a network of activists and feminist organisations in sub-Saharan Africa.[220]

Aspects included in comprehensive abortion care



Conceptual framework for abortion care of the World Health Organization
(Data source: Based on WHO[221])

Age of Consent Is a Barrier

In Zambia (like in Tanzania and Nigeria), children and adolescents require the consent of their legal guardians to access healthcare. The age of consent presents a significant barrier for many youth seeking preventive medical check-ups or contraceptives independently. Although this problem has existed for a long time, the legal framework in Zambia was recently further restricted. In 2022, the Zambian government passed the *Children's Code Act*, which defines a child as anyone younger than 19 years old.[222] In practical terms, this means that many young people under the age of 19 are unable to receive medical care without the consent of their legal guardians.[223]

Interviewees reported multiple times that many health workers find it difficult to understand the legal situation. They are allowed to provide information and counsel but are sometimes unsure if they are permitted to give 16-year-old condoms without parental consent. The law is unclear, even misleading, and contradicts other legislation.[224] For young people, it typically depends on which medical professional they are interacting with and how that person handles the situation.

Let us imagine the following scenario: A 17-year-old student would like a check-up and STI testing. To do so, she requires the consent of her mother or father. However, sex is a highly taboo subject within her family, and she is reluctant to tell her parents that she has been having sex with her boyfriend. As a result, she does not get tested for STIs.

Although almost 70 percent of girls and almost half of all boys in Zambia have sex for the first time before their 19th birthday[225], they are not allowed to purchase contraceptives or receive HIV testing until they are 19.

An interview partner in Nigeria reported that the age of consent in Nigeria varies based on the medical treatment. Furthermore, different laws apply depending on the state.[226] Consequently, the legal situation is unclear and inconsistent. Yet, there are few advocacy initiatives working to adapt or lower the age of consent.

4 HOW CAN THESE ISSUES BE ADDRESSED?

What are the most effective ways to support young Africans' sexual and reproductive self-determination? What strategies can be employed to bridge the gaps in healthcare provision for young people? How can socio-cultural norms be modified so that young people can openly discuss their questions, concerns and hopes about gender roles, sexuality and contraception? And how can international development cooperation align with the growing demand by young people for greater participation and inclusion?

There are numerous solutions to address these challenges. The question is: which of these solutions are effective and which are not? Despite the best of intentions from international development organisations, many well-intentioned projects and initiatives have had limited success. This is often due to a lack of communication with local experts and communities about what is actually needed, or because development organisations employ outdated strategies that do not meet the needs of younger generations. However, there are also countless effective programmes, whether implemented at the national level by international organisations or at the local level by a community-based organisation and volunteers.

In each consultation, we asked our interviewees in Nigeria, Zambia and Tanzania what they think needs to be done to improve SRHR for young people in their country. We also inquired if any existing projects or initiatives were particularly effective or should be expanded and receive more support. Ultimately, those on the ground are best positioned to understand their community's needs, identify what works and to address current gaps. This chapter outlines effective strategies, recommendations and best practices, based on the insights provided by our respondents. The term best practices refers to solutions and examples of successful projects in diverse contexts in the three focus countries (and often in many others). These solutions should be implemented more broadly by organisations working on the ground. The following recommendations are directed towards decision-makers in politics, international development and the donor community.

4.1 Identifying What Works: Best Practices

1 Expand Sexuality Education in a Creative Manner

In all educational institutions sexuality education should align with the current UNESCO guidelines and become the norm. Simultaneously, it is important to expand outside the classroom, including for young people who are (still) in school and those who are out of school. For instance, extracurricular sexuality education programmes often represent the only way girls and young women who are not (or no longer) in school can access information about safer sex, contraception and bodily autonomy. The most effective strategies for disseminating crucial and accurate information about sexual and reproductive health and rights (SRHR) to young people are those that combine education with recreational activities and are led by young people themselves or in tandem with them.

A Winning Combination: Education and Recreation

Sexuality education that centres games, sports and other recreational activities is much more attractive to young people. Especially in rural communities, where young people have little access to information via the Internet, it is important to engage them with in-person activities. Free drinks or snacks and reimbursement of any travel expenses can also encourage young people to participate.

Many SRHR programmes address the needs of girls and young women. However, it is also important to reach boys and young men, address their needs and teach them responsible and respectful behaviour in relationships. In many countries, reaching boys through football clubs has proven to be particularly effective. They are provided with an attractive recreational activity, of which there are often few, and learn about sexual and reproductive health in the breaks between games.

Peer Education Is the Gold Standard

Experience shows that peer-to-peer learning is the most successful way to reach young people. Young people tend to trust other young people more than adults and can talk more openly with them about sensitive topics that are considered taboo in society. In peer education projects, selected teenagers are trained on SRHR issues and to answer any questions their peers may have. In some cases, they receive additional training so that they can counsel their peers on condoms and contraceptives and distribute them to teenagers in their communities. Peer educators can quickly and effectively disseminate information to their peers, answer their questions, recommend other sources of information and refer them to youth-friendly clinics.

Connecting With Youth Digitally

The use of the internet and access to social media via cell phones and smartphones is widespread among young people in Africa today, especially in urban areas.[227] Consequently, it is easy to reach them through these platforms. Many regional and national organisations have developed apps to provide young people with information on sexual and reproductive health in youth-friendly formats. Young interviewees in all three focus countries repeatedly emphasised the importance of disseminating simple, short messages via modern, youth-friendly channels. To respond to the short attention span of young people, organisations can use digital options such as videos and cartoons or interactive digital formats. It is also crucial to ensure accessibility for young people with disabilities. For example, videos should be produced with subtitles.

"I can't be everywhere at the same time, but an app can."

Peer Educator, Zambia

2 Make Healthcare More Youth-Friendly

In general, doctors and other health workers receive insufficient training on how best to interact with young patients, communicate effectively with them and how to set aside personal views in the consulting room. During our interviews, we learned that training in youth-friendly healthcare, if it is provided at all, is far too short and infrequent. Therefore, it is important to extend these training courses to all healthcare workers who see and interact with young people. However, individual training courses on appropriate interaction with young people are not a long-term solution.

Reducing Provider Bias Through Awareness-Raising

The *Values Clarification and Attitude Transformation* (VCAT) process is a proven method for reducing the stigma associated with sexually active young people among healthcare workers. In a VCAT workshop, participants are asked to consider their attitudes towards young people's sexuality and to reflect on their role in providing healthcare for young people. In this way, the workshops help participants to identify their own prejudices and ingrained attitudes towards young people's SRHR and can contribute to changing them.[228]

Planning Youth Clinics and Programmes Together With Young People

Interviewees repeatedly emphasised the importance of involving young people in the planning of youth health centres and programmes. They highlighted that it was particularly crucial to build youth-friendly spaces with input from young people. Building trust with staff and feeling comfortable in healthcare facilities is especially important for young people. To respond to this need, young people must be part of the planning process. They should not have to lead on their own, but they should be given a role and a say in the planning process of a health centre or the implementation of a project from the conception phase to the implementation and evaluation phase.

To gain an understanding of young people's many and diverse perspectives, it is important to organise regular community dialogues where young people can openly talk about what is important to them. For example, when the director of a youth organisation in Zanzibar, Tanzania, launched a programme on menstrual hygiene and health, she organised dialogues with girls and young women in the community to identify their key needs. This approach enabled her to set the right priorities for the organisation's new programme.

Accessibility Is Not Optional

It should be standard practice that hospital and community clinic buildings are accessible for individuals with disabilities, regardless of whether they use a wheelchair, are blind and/or are deaf. Accessibility is essential in every new clinic. To ensure this, young people with disabilities should be consulted directly to understand their needs. It is also important to consider accessibility in the design of SRHR information materials and campaigns. This could include the use of image descriptions in the form of 'alt text' online, printed materials in Braille for people with visual impairments or accompanying videos in sign language for people who are deaf.

"Let young people co-create these programmes. Young people understand their lived realities better."

NGO worker, Zambia

3 Connect the Eradication of Poverty and GBV With SRHR Services

Adapting SRHR programmes to the realities of young people's lives is essential. Poverty represents a major challenge for young people in Africa and is often linked to limited prospects for higher education and secure employment. Many women and girls have already experienced GBV, including sexual violence. Therefore, the most effective SRHR initiatives for young people integrate economic empowerment, and measures for the prevention of GBV and sexual violence.

Integrating Economic Empowerment into SRHR Services

Many activists and NGO staff highlighted the challenge of encouraging young people to prioritise their sexual and reproductive health and follow safer sex recommendations when they lack access to education and employment opportunities. For some young people, such as young mothers, it is often difficult to ensure their basic needs are met, including food for themselves or their children. They do not have enough time to attend a workshop on SRHR. This is why the integration of SRHR services and economic empowerment is repeatedly cited as a best practice. The objective is not necessarily job placement, but a first important step includes providing young people, particularly women, with fundamental financial skills to empower them to become financially independent.

Many young women already possess relevant skills with which they could earn a living as a seamstress or cook, for example. However, they often lack the know-how to start their own small business. Besides young mothers, the most important target groups for such initiatives include young people experiencing extreme poverty, homeless youth and teenagers who are out of school.

> *"[...] you can give people knowledge [about SRHR] but if they're not economically stable, [...] it's really a challenge to achieve what we want to achieve."*

Employee at a youth organisation, Tanzania

Linking SRHR, Poverty and GBV

Projects that address SRHR among young people must also address the issue of gender-based and sexual violence. Again, poverty often facilitates sexual violence. For example, when a large family lives in close quarters or in one room, the risk for rape or incest increases. It is essential to counter the social normalisation of these forms of violence. As part of SRHR programmes young people of all genders should receive education that helps them identify sexual and other forms of violence within the family or in relationships – and emphasises that such violence is not normal. Trusting environments in which young people, especially girls and women, can talk about their experiences of violence and receive support and protection is also essential. In addition to the physical consequences, experiences of violence are often traumatic for children and young people. Including psychosocial support in projects that promote young people's sexual and reproductive health can therefore be very beneficial.

> *"When a woman is financially independent she can make decisions for herself because she is not under authority like deprived [women] are. For instance, a woman who is facing gender-based violence in her home: Because she cannot survive on her own [...] and she doesn't have a source of income, she continues in that."*

Representative of an NGO, Nigeria

4 Promote Community Dialogues to Counter Cultural and Religious Resistance

Religious and traditional leaders play a significant role in many African communities, and their opinions are held in high regard.[229] Their views on issues such as girls' education, child marriage or sexuality education therefore often set the tone for the entire community. It is important to collaborate with them to dismantle harmful practices, norms and taboos. Community Dialogues play a key role in this process because they can bring about important changes within the community. Engaging in dialogue with parents, teachers, community leaders as well as government representatives is also crucial to facilitate a more open approach to SRHR topics such as menstruation and sexuality education, and to create a youth-friendly environment in the entire community.

Working with Traditional and Religious Leaders

Particularly in rural communities, working with traditional and religious leaders and village elders at the outset of any project is essential. An organisation that launches a project on taboo subjects such as sexuality education, menstruation, contraception for adolescents or GBV without consulting community leaders and elders will quickly be met with resistance. But if project organisers first set up dialogues with local decision-makers to describe the project, its objectives and goals, this can lead to greater acceptance and a higher chance of success. Especially as it relates to SRHR issues, it is crucial to address possible prejudices and myths. For instance, there are many misconceptions surrounding the concept of comprehensive sexuality education. Through open dialogue with traditional or regional authorities, however, it is possible to respond to their questions, clarify any misconceptions and demonstrate how sexuality education can benefit young people, their families and communities.

Fostering Dialogue With the Whole Community

While it is important to engage community leaders, Community Dialogues should be approached more broadly and extended to the entire community. Interviewees in all three focus countries reported that a community-focused approach to sensitive issues such as SRHR for young people is crucial to understand the concerns and expectations of different community members. Dialogues with young people, parents, teachers and other civil society and government representatives can also support the community in finding solutions for their own specific context.

Teaching Parents to Talk Openly About SRHR

Given that most parents have grown up in families where it was not possible to talk openly about SRHR issues, they too need to learn how to talk to their daughters or sons about menstrual hygiene or STIs without stigmatising them. This can be achieved through special dialogue formats – training parents on how to have an open, non-judgemental exchange with their children about different SRHR issues. It is important to include men in this process because, among other things, it can increase the acceptance of sexual and reproductive health services for both men and women. Finally, in Community Dialogues with parents it is possible to discuss gender roles, expose power relations and to gradually reduce the power imbalance between men and women.

"[...] We also have to change the mindset of men, because at the end of the day we are working in the families where men are the bread earners and the one who makes decisions. So because of that, we also have to transform the mindset of men and also change the practices that are going on in the rural areas mostly, and after we do that, it will help us to create places where there is openness, culture of openness, where parents can talk to their children about their menstruation, about their adolescence, about their sexuality."

Youth activist, Tanzania

4.2 Recommendations

The challenges African countries are facing in the 21st century are significant and require a multifaceted approach to ensure sustainable development and social and gender equality. It is essential that all Africans can realise their sexual and reproductive health and rights (SRHR) to achieve these goals. Young people on the continent are increasingly asserting their rights in this regard. They are demanding sexual and reproductive self-determination, full participation in social, political and economic life, and a future filled with opportunities. It is therefore imperative that the promotion of SRHR for young people remains a priority in development cooperation, and continues to be reflected in international and national agreements on sustainable development. To meet the needs and demands of young people in Africa, development cooperation institutions and other funders should consider:

- **Supporting partner countries to better adapt their health facilities to the needs of young people.** Prioritising investments in accessible infrastructure, targeted training of (additional) health workers and a sustainable supply of key commodities for youth-friendly healthcare is critical. A goal of these investments should be that young people are treated with respect, clinic waiting times are reduced and public healthcare services are provided free of charge.

■ **Highlighting the intersections between SRHR, girls' education, job training for young women and support in promoting employment in dialogues with partner countries**. It is crucial that SRHR-related barriers that prevent girls from remaining in school and complete their education – such as unintended pregnancy, early motherhood, lack of access to adequate menstrual products and necessary hygiene facilities at school – are reduced as quickly as possible to achieve gender equity and sustainable development.

■ **Strengthening measures that promote the inclusion and participation of marginalised young people** in projects and funding decisions **at all levels**. This includes supporting youth-led organisations led by young people from marginalised groups, including young people with disabilities, LGBTQI+ youth or young people living with HIV, who advocate for the SRHR of their communities.

■ **Consulting and working with local youth experts and organisations before developing funding priorities** to identify the greatest needs and the most promising local solutions. Furthermore, coordinating with other funders to avoid duplication of efforts is recommended. Stakeholder mapping is helpful in this regard to ensure that similar projects are not carried out simultaneously in one region of the country while other regions are neglected.

■ **Ensuring sustainable financial support** for local organisations and projects. This means more funding for existing successful projects and local youth-led organisations, as well as long-term funding beyond the duration of individual projects. To be effective and sustainable, organisations need more funding overall, as well as continuous and flexible funding. Flexibility in funding must allow for individual adjustments to programmes. This makes projects and organisations more resilient to crises.

■ **Simplifying funding applications and reporting**, and providing support to local African organisations in navigating complicated funding processes. This is crucial for small NGOs and youth organisations that do not have sustainable, flexible funding.

■ When promoting partnerships between international and local NGOs, it is important to consider the balance of power and **proactively support a just distribution of power**. Otherwise, localisation efforts run the risk of only superficially involving local youth organisations and not empowering them as long-term, independent partners.

■ **Addressing evidence gaps, investing in community-led research and strengthening local analytical capacity** are key to assessing the need for SRHR health services, especially among marginalised young people. Without representative and disaggregated data on marginalised populations, it is difficult to convince governments or funders of the importance of projects that support, for example, trans youth, young sex workers or homeless young people, and to identify real needs.

■ **Supporting local youth organisations that primarily engage in long-term advocacy work**. This work is time-consuming but necessary to improve legislation and policy, including in relation to sexuality education, the legal regulation of abortion and the rights of young LGBTQI+ people. Past funding levels for advocacy work have been insufficient, but it is important for young people to be able to participate in political decision-making processes in areas that affect them. Building advocacy and leadership capacity among young people is also key so that they can hold their country's policymakers to account.

METHODOLOGY

Our Approach

This study comprises online literature reviews, data research, as well as qualitative data collection through guided interviews in three focus countries.

Selecting Focus Countries

Based on three selected African countries, the study examines in detail whether the existing provision of sexual and reproductive healthcare aligns with young people's preferences and their attitudes towards issues around sexuality, pregnancy and contraception. To identify three countries, we conducted an analysis of the existing literature and data sources on the sexual and reproductive health of young people (aged 15 to 24) in Africa. We carried out this research using a variety of literature as well as databases, including from the DHS Program, the United Nations, the World Health Organization and international research institutions such as the US-based *Guttmacher Institute*.

The Statistical Data Used

We used key statistical data to provide an overview and comparative analysis of the current sexual and reproductive health and rights situation of young people in Africa. An important source of statistical data is the *Demographic and Health Surveys Program* (DHS), which collects and presents representative SRHR-relevant data in several countries.

Given that DHS data only covers individual countries and cannot be retrieved for regions combining multiple countries, we also used data and projections from the United Nations Population Fund (UNFPA), the United Nations Department of Economic and Social Affairs (UN-DESA), the World Health Organization and other institutions.

These sources provide SRHR data on young people with varying levels of detail and thematic focus. Therefore, we used a variety of different data sources as required. In specific instances, we also sourced data from relevant thematic collections, for example, from the Joint United Nations Programme on HIV (UNAIDS), or used scientific articles, and performed our calculations based on these assembled data.

Our selection of focus countries is based on multiple criteria, including demographic indicators and SRHR-related policies. Following an initial data analysis based on the catalogue of criteria developed by our research team, seven countries were considered as focus countries: Cameroon, Malawi, Niger, Nigeria, Zambia, Tanzania and Togo. They were narrowed down to three final destinations: **Zambia**, **Tanzania** and **Nigeria**.

The selection was made based on several key factors. 1) Robust evidence base for all three countries as well as DHS data from 2018 or later, including data from 2022 in the case of Tanzania. 2) The representation of several regions of Africa: Western Africa (Nigeria), Eastern Africa (Tanzania) and Southern Africa (Zambia). 3) Differing legal context in each country regarding SRHR issues such as abortion or sexuality education in schools. Furthermore, a projected population growth in Nigeria and Tanzania coupled with a high unmet need for modern contraceptives among girls and young women in Nigeria were additional key considerations in the selection process.

Selection of Interview Partners

The qualitative component of the data collection comprised interviews with experts in our focus countries: Nigeria, Tanzania and Zambia. We define experts as young people who are involved in SRHR, activists and staff at local and international NGOs. Even though this project explores the needs and perspectives of adolescents and young adults aged 15 and above, due to time and resource constraints we were only able to conduct interviews with adults aged 18 and over. We are aware that this means valuable perspectives from younger people are not included in the study.

Potential interview partners were identified through internet research as well as professional and private contacts. Based on the resulting list of contacts, we attempted to bring together a broad spectrum of perspectives on SRHR. We contacted both large international organisations, as well as smaller volunteer initiatives and specifically reached out to organisations that advocate for the rights of LGBTQI+ youth and people with disabilities. The organisations we engaged, all have different priorities. These include advocacy, leadership and empowerment for young people, mental health, menstruation, family planning and healthcare delivery. In Tanzania and Nigeria, two local consultants provided invaluable support, assisting us in selecting interviewees, coordinating interview schedules, and providing us with an interview space in Dar Es Salaam and Lagos.

Conducting the Interviews and Analysing the Results

We conducted a total of 66 interviews with 111 interviewees, each lasting between 30 and 90 minutes. Of these, we conducted 58 interviews during project trips in January and February of 2024, and an additional eight virtually in February and March of 2024. In Tanzania, our research team travelled to Dar es Salaam and Zanzibar, and in Zambia, to Lusaka and Livingstone. In Nigeria, our team was based in Lagos. We also conducted virtual interviews to connect with organisations located outside of the places we visited, for example, in rural areas of Zambia and north-eastern Nigeria.

The interviews were conducted in pairs with one to six interviewees. We used an interview guide with several core questions, which we adapted according to the context, interview flow and time. One organisation in each country reviewed and commented on the interview guide before we arrived. All participants provided informed consent to be interviewed and interviewees were not compensated or given any other incentives in exchange for their participation. Most interviewees gave their informed consent to recording their interview. We also took detailed notes during each interview. We anonymised all information from the interviews. Based on the detailed notes, we analysed the results and identified several key themes (see chapter 3). The key findings and recommendations have been discussed and validated with select experts the three focus countries.

ACKNOWLEDGMENTS

The Berlin Institute for Population and Development would like to extend its gratitude to the many individuals and organisations whose assistance, input, valuable insights and comments have been instrumental in making this study a success.

We would like to extend special thanks to Innocent Grant (*Young and Alive Initiative*, Tanzania) and Elizabeth Talatu Williams (*Sustainable Impact and Development (SID) Initiative*, Nigeria) for their invaluable support in the lead-up to and during our visits to Tanzania and Nigeria.

We would also like to thank the following organisations:

AfriYAN Tanzania

Association of Young People living with HIV/AIDS in Nigeria (APYIN)

Contact Trust Youth Association

Copper Rose Zambia

DAI/TEENSMATA

Deaf Women Aloud Initiative (DWAI)

Deutsche Stiftung Weltbevölkerung

Equality Triangle

Family Health Trust

FAWEZA

Girls Pride Zambia

GIZ Zambia

Improved Sexual Health and Rights Advocacy Initiative (ISHRAI)

KVP Forum Zanzibar

Learners Corner Education Tech Hub Lagos

Love in Colours Foundation Zanzibar

MSI Reproductive Choices

Planned Parenthood Association of Zambia

Positive Movement Zambia

REPSSI

SAfAIDS Zambia

Sustainable Impact and Development (SID) Initiative

Transbantu Association Zambia

Whisper A Dream Foundation

WOMEN'S GLOBAL NETWORK FOR REPRODUCTIVE RIGHTS AFRICA

Young and Alive Initiative

Young Mothers Mbagala Network

Zanzibar Fighting Against Youth Challenges Organization (ZAFAYCO)

We would like to thank the following individuals:

A young person living with HIV sharing her story positively

Aanuoluwapo Owoseeni, Vision Spring Initiatives

Abiola, Youth Development and Empowerment Initiative (YEDI)

Adek Bassey Ozaveshe, Today for Tomorrow Foundation

Adesegun Fatusi

Alice Ahadi Magaka from The Pink Box Initiative

Aluwa Mkilindi, Theatre Arts Feminists

Ankita Mehta

Bamidele Oyewumi, Program Manager, HACEY Health Initiative

Benetius Boniphace, Program Coordinator, Restless Development

Besa Mwansa, Young Women in Action

Bibian Chibelushi, Copper Rose Zambia

Bwalya Mukuka, Senior Program Officer, Young Women in Action

Cecilia Lesho of Bakashana Organization, Kasama, Northern Province

Chilekwa Chisanga, Head of Programmes, Regional Psychological Support Initiative (REPSSI)

Chilundika Mwiinga

Christabel Hanongo, Contact Trust Youth Association

Christabel Mambwe, Technical Advisor: Youth, Disability & Gender, MSI Zambia

Dalitso Mvula

David Sinkamba, Cofounder/Media GenHope Foundation

Dogo Caleb, Today for Tomorrow Initiative

Dr. Walusungu Mtonga

Drosin M. Mulenga, Population Council Zambia Office, Program Officer

Edward Sibeene

Elizabeth Senkoro

Esther Ezem, Center for Health Education and Vulnerable Support

Eva Raphael Mkane, VSO

Florence Tembo, Young Women in Action

Frances Nwankwo, Queer Advocate

George Adjete, SRHR Youth Advocate/Activist

George Dexters Hara, Peer Educator, Copper Rose Zambia

Getrude Clement, Youth advocate SRHR Tanzania

Gift Giovanni Banda, Peer Educator

Halima Lila, Independent Consultant

Hannah Haynes

Innocent Chansa, Adolescent Responsive Health Systems Expert

Inonge Wina-Chinyama, Operations Director, MSI Zambia

James Mdala, MSI Zambia

Joseph Sewedo Akoro

Kevin Squash, Young and Alive Initiative Tanzania

Kiki

Lilian Sanga, Young and Alive Initiative

Mashingo Lerise, Adolescent & Youth SRHR expert, MSI Tanzania

Mauton Akoro, Program Officer, The Initiative for Equal Rights

Michael Hanshya

Mike Mbizvo

Mirriam Syamakata, Peer Educator at Contact Trust Youth Association

Ms. Tuponege Donald, Youth coordinator

Ms. Walta Carlos, Youth SRHR Program Officer, Women's Global Network for Reproductive Rights (WGNRR Africa)

Mubika Mukobeko

Mubita Simonda, Programme Designer/ Health Expert, Afya Mzuri

Mulenga Ching'ambo, Programmes Manager, Centre for Reproductive Health and Education

Myles Mwansa, Zambia Network of Young People Living with HIV

Nancy Chilufya

Natasha Okpara, Population Council

Noah Daka, Public Health Nurse

Ogechi Onuoha, MSI Nigeria Reproductive Choices

Oladimeji Ibrahim, AfriYAN Nigeria

Oluwafunso Bukoye, Action Health Incorporated

Omar Mussa Omar, Chairperson of KVP Forum Zanzibar

Onikepe Owolabi

Peer Educator, CTYA

Public Health Nurse

Rabson Sakala

Ronnie Jere, Executive Director, Contact Trust Youth Association

Stephanie Mulamata, Project Coordinator, Contact Trust Youth Association

Swide Riwa

Tessar Maryam Chitalo, Family Health Trust

Thelma Banda, Advocate for sexual and reproductive health and rights, employed by the Ministry of Health in Zambia, who is also a nurse by profession

Treasures Uchegbu, Convener CEO, Speaking Fingers Network, and Lead Facilitator, LifeWorkReady Program and Camp for Deaf Adolescents and Youths

Usen Asanga, Youth Development and Empowerment Initiative (YEDI)

Vivien Bwembya, Young Women in Action, Lusaka

Wisdom Omokaro, Youth Development and Empowerment Initiative (YEDI)

Zahra Salehe, Integrating Capacity and Community Advancement Organisation (ICCAO)

Zirose Mumba, Family Health Trust

GLOSSARY

Adolescence – The period between childhood and adulthood, which is characterised by significant physical, psychological, and social developmental changes. It begins with the onset of puberty, which typically occurs between the ages of 10 and 13, and ends in young adulthood, which generally occurs between the ages of 18 and 21.

Birth rate – The number of live births per 1,000 inhabitants in a given year.

Child marriage – a marriage in which at least one spouse is under the age of 18. Once girls begin menstruating and are considered marriageable, they are often impacted by child marriage. In some countries, adolescents are legal adults before the age of 18. In such instances, marriages would be referred to as 'early marriages'. Forced marriage, on the other hand, refers to a marriage to which one or both partners have not consented freely (regardless of age).

Cis/Cisgender – A person whose gender identity is the same as the sex they were assigned at birth.

Female genital mutilation (FGM) – This term describes all procedures involving the partial or total removal or cutting of the external female genitalia for non-medical reasons. The World Health Organization has classified four categories: Partial or total removal of the clitoris and/or clitoral hood (Type I), partial or total removal of the clitoris and vulval labia minora, with or without removal of the vulval labia majora (Type II), narrowing of the vaginal opening by joining and stitching the vulval labia minora and/or majora (Type III), and all other harmful procedures on the female genitalia for non-medical reasons, such as piercing, cutting, scraping and etching (Type IV). FGM is a serious human rights violation that can result in a range of immediate and long-term complications and in some cases, even death. In the long term, it can cause significant damage to the urinary, reproductive and sexual organs, increasing the risk of birth complications and significantly impairing sexual pleasure.

Fertility rate – The average number of children born to women during their reproductive years (between the ages of 15 to 49).

Gender-based violence (GBV) – Gender-based violence is a human rights violation. It includes all forms of violence and abuse, including physical, sexual, psychological and economic violence inflicted on an individual because of their gender or perceived gender roles and expectations. Women, girls and people who do not conform to traditional gender norms are disproportionately affected by GBV.

Gender Equality – Equality means that everyone has the same rights, obligations, and opportunities. Equality is primarily concerned with legal equality (being equal before the law). However, legal equality does not always mean actual equality. Therefore, equality can be defined as a political process or set of measures designed to achieve equal treatment existing in real life. This means that every person can exercise their rights and participate in political, economic, and social activities equitably without discrimination. Gender equality is a key prerequisite for sustainable development.

HIV/AIDS – The Human Immunodeficiency Virus (HIV) is a virus that damages the immune system. Without the right treatment, it can lead to the Acquired Immune Deficiency Syndrome (AIDS), a life-threatening disease. HIV medication suppresses the virus and prevents the outbreak of AIDS, allowing those affected to live long and fulfilling lives.

Intersectionality – is a metaphor to describe how systems of discrimination based on identity markers such as race, age, sex, gender, sexual orientation, disability, socio-economic status, ethnic or religious affiliation, real or perceived, can intersect and reinforce each other, creating new forms of discrimination.

LGBTQI+ – Lesbian, gay, bisexual, trans, inter and queer. The plus sign represents an open space and placeholder for additional, unnamed identities.

Marginalisation – Describes how systems of discrimination based on (perceived) identity markers, including sexual orientation, race, ethnicity, religion, social class, educational level, economic status and/or disability, result in the geographical, economic, social and/or cultural displacement of a person or group to the margins of society. Consequently, marginalised individuals and groups are treated as less important or inferior by society, which leads to a loss of resources, influence and status, and negatively impacts their health.

Misoprostol – A drug used together with mifepristone in medical abortions. It is also used for a number of other gynaecological indications. The WHO has listed misoprostol on its 'essential list' of the most effective and safe drugs.

Modern contraceptives – Modern contraceptives include hormonal pills, contraceptive implants, contraceptive injectables, IUDs, condoms (male or female), the emergency contraceptive pill, diaphragms, sterilisation and the lactational amenorrhoea method.

Patriarchy – A social system in which men dominate and determine values, norms and behaviour. It encompasses control over resources, traditions, laws, the division of labour and the role of women. Patriarchal structures can exist in supposedly equal societies.

Queer – The term 'queer' challenges normative concepts about gender and sexuality. It is also a term used to self-identify and convey an inviting stance towards non-binary genders, non-normative sexual practices and politicise the diversity of sexual identities.

Reproductive age – The years in which women can have children, usually between the ages of 15 and 49.

Safer sex – The practice of safer sex involves the use of dental dams and female and male condoms to prevent the transmission of STIs, particularly HIV. It also includes HIV treatment to stop the spread of the virus and prevent infection, as well as pre-exposure prophylaxis (PrEP). PrEP is a medication that protects individuals at risk of HIV prior to potential exposure. The preferred term in this context is safer sex given that there is always a small risk of contracting STIs during sex.

Sex worker – A sex worker is a person of legal age who works in the sex industry and offers sexual services in exchange for money or goods. Sex work is a source of income for millions of people worldwide. The term 'young people who sell sex' is used to describe individuals under the age of 18 who engage in sex work.

Trans/Transgender – An umbrella term to describe several different gender identities. It unites a range of identities and ways of living, including those who do not wish to choose a gender identity. The term 'transgender' refers to people whose gender is not the same as the gender they were assigned at birth.

REFERENCES

1 UNFPA (2024). Cotonou Youth Action Agenda. 30 Years Strong: Youth-built Futures for Population and Development. www.unfpa.org/resources/cotonou-youth-action-agenda (27.06.24).

2 McCarthy, K. et al. (2016). Investing when it counts: Reviewing the evidence and charting a course of research and action for very young adolescents. Population Council, New York.

3 UN DESA, Population Division (2024). World Population Prospects: The 2024 Revision. Custom data acquired via website. https://t1p.de/khs8q (12.07.24).

4 see endnote 3.

5 see endnote 3.

6 United Nations (2015). Transforming our World: The 2030 Agenda fo Sustainable Development. New York.

7 African Union Commission (2017). AU Roadmap on Harnessing the Demographic Dividend through Investments in Youth. Addis Ababa.

8 African Union Commission (2015). Agenda 2063: The Africa We Want. Addis Ababa.

9 see endnote 3.

10 Obermeier, A. M. (2023). Conflict Trends in Africa, 1989–2022 (PRIO Policy Brief, 5). www.prio.org/publications/13677 (27.06.24).

11 Debt Justice (2022). Colonialism and debt. How debt is used to exploit and control. https://t1p.de/xdr4b (27.06.24).

12 Graeber, D. (2012). Debt. The first 5,000 years. New York.

13 French, H. W. (2021). Born in Blackness. Africa, Africans, and the making of the modern world, 1471 to the Second World War. New York.

14 United Nations (2023). Africa Spends More on Debt Servicing than Health Care, Secretary-General Tells High-level Policy Dialogue, Urging Financing, Investment in Continent. https://press.un.org/en/2023/sgsm21809.doc.htm (27.06.24).

15 Amnesty International (2023). On Zambia, health, and public debt: Alternatives to austerity. https://t1p.de/a34sj (27.06.24).

16 Starrs, A. M. et al. (2018). Accelerate progress – sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission. The Lancet Commissions. 391(10140), pp. 2642-2692.

17 see endnote 16.

18 Akwara, E. & Chandra-Mouli, V. (2023). Good progress in a number of areas of ASRH, but there is much more that needs to be done. Sexual and Reproductive Health Matters, 31(1).

19 UNICEF (2024). Female genital mutilation (FGM). https://t1p.de/un37k (27.06.24).

20 Melesse, D. Y. et al. (2020). Adolescent sexual and reproductive health in sub-Saharan Africa: who is left behind? BMJ Global Health, 5(1).

21 Chandra-Mouli, V. et al. (2019). The Political, Research, Programmatic, and Social Responses to Adolescent Sexual and Reproductive Health and Rights in the 25 Years Since the International Conference on Population and Development. Journal of Adolescent Health, 65, pp. S16-S40.

22 Van Nguyen, K. & Eaton, J. W. (2022). Trends and country-level variation in age at first sex in sub-Saharan Africa among birth cohorts entering adulthood between 1985 and 2020. BMC Public Health, 22(1120).

23 Sully, E. A. et al (2020). Adding It Up: Investing in Sexual and Reproductive Health 2019-Appendix Tables. Guttmacher Institute, New York. https://t1p.de/01svd (27.06.24).

24 see endnote 2.

25 ICF (2024). STATcompiler. The DHS program (Median age at first sexual intercourse). www.statcompiler.com/en/ (27.06.24).

26 UNFPA (2024). Population Data Portal (Early sex before age 15 among women aged 20-24). https://t1p.de/sd0x1 (27.06.24).

27 see endnote 25.

28 ICF (2024). STATcompiler. The DHS program (Comprehensive correct knowledge about AIDS among young women/men age 15-24). www.statcompiler.com/ (27.06.24).

29 UNICEF (2023). Child marriage. https://data.unicef.org/topic/child-protection/child-marriage/ (27.06.24).

30 UNFPA (2022). Child Marriage. www.unfpa.org/child-marriage (28.06.24).

31 UNICEF (2023). Is an End to Child Marriage within Reach? Latest trends and future prospects. 2023 update. New York.

32 see endnote 29.

33 see endnote 31.

34 see endnote 31.

35 UNICEF (2024). Are we on track to end child marriage by 2030? (The Child Marriage Data Portal). https://childmarriagedata.org/global-trends/ (28.06.24).

36 see endnote 35.

37 see endnote 23.

38 see endnote 23.

39 WHO (2024). Adolescent pregnancy. https://t1p.de/x990q (04.07.24).

40 UNICEF (2024). Early Childbearing. https://data.unicef.org/topic/child-health/adolescent-health/ (27.06.24).

41 Center for Reproductive Rights (2024). The World's Abortion Laws. https://t1p.de/7bj8c (27.06.24).

42 Guttmacher Institute (2021). Adding It Up: Investing in Safe Abortion Services in the African Union. https://t1p.de/4gdf3 (27.06.24).

43 WHO (2024). Abortion Fact Sheet. www.who.int/news-room/fact-sheets/detail/abortion (27.06.24).

44 see endnote 23.

45 see endnote 23.

46 Bankole, A. et al. (2020). From Unsafe to Safe Abortion in Sub-Saharan Africa: Slow but Steady Progress. Guttmacher Institute, New York.

47 Guttmacher Institute (2021). Adding It Up: Investing in Contraceptive Services in the African Union. https://t1p.de/eben4 (27.06.24).

48 see endnote 47.

49 see endnote 23.

50 see endnote 3.

51 see endnote 40.

52 see endnote 39.

53 Ajayi, A. I. et al. (2023). Lived experiences of pregnant and parenting adolescents in Africa: A scoping review. Reproductive Health, 20(113).

54 UNICEF (2023). Key HIV epidemiology indicators for children and adolescents aged 0-19, 2000-2022. https://t1p.de/a6rgl (27.06.24).

55 WHO (2024). Sexually transmitted infections (STIs) Fact Sheet. https://t1p.de/ozlgr (27.06.24).

56 WHO (2024). Implementing the global health sector strategies on HIV, viral hepatitis and sexually transmitted infections, 2022–2030. Report on progress and gaps 2024. Geneva.

57 Du, M. et al. (2022). Increasing incidence rates of sexually transmitted infections from 2010 to 2019: an analysis of temporal trends by geographical regions and age groups from the 2019 Global Burden of Disease Study. BMC Infectious Diseases, 22(1): 574.

58 UNICEF (2023). Adolescent HIV prevention. https://t1p.de/lzctb (27.06.24).

59 UNAIDS (2023). The path that ends AIDS: UNAIDS Global AIDS Update 2023. Geneva.

60 UNAIDS (2023). Factsheet Global HIV statistics. https://t1p.de/loy27 (27.06.24).

61 see endnote 58.

62 WHO (2024). Adolescent Health. Factsheet. www.afro.who.int/health-topics/adolescent-health (28.06.24).

63 see endnote 60.

64 WHO, UNICEF & UNAIDS (2022). The Global Alliance to End AIDS in Children. https://t1p.de/9jzte (28.06.24).

65 WHO (2024): Violence against women. https://t1p.de/mc2hn (28.06.24).

66 Beyene, A. S. et al. (2019). Gender-based violence among female youths in educational institutions of Sub-Saharan Africa: a systematic review and meta-analysis. Systematic Reviews, 8(59).

67 see endnote 65.

68 UNICEF (2023). Violent unions. https://t1p.de/vjd44 (01.07.24).

69 WHO (2021). Global Database on the Prevalence of Violence Against Women. https://t1p.de/jfft4 (01.07.24).

70 UNICEF (2023). Sexual violence. https://t1p.de/c3tgv (01.07.24).

71 WHO (2024). Female genital mutilation. https://t1p.de/5gdfn (01.07.2024).

72 see endnote 71.

73 see endnote 19.

74 UNICEF (2024). Female genital mutilation (FGM) (Percentage of girls and women aged 15-49 years who have undergone FGM). https://t1p.de/un37k (02.07.24).

75 see endnote 19.

76 see endnote 20.

77 see endnote 3.

78 UN DESA (2018). World Urbanization Prospects 2018: The 2018 Revision. Custom data acquired via website. https://t1p.de/uk30d (02.07.24).

79 Collins, R. O. & Burns, J. M. (2013). A History of Sub-Saharan Africa. (2. edition). Cambridge.

80 Vice President‘s Office (2024). Home. Union Matters. www.vpo.go.tz/ (02.07.24).

81 U.S. Department of State (2021). 2020 Report on International Religious Freedom: Tanzania. https://t1p.de/w9l9f (02.07.24).

82 see endnote 3.

83 see endnote 78.

84 World Bank (2024). Poverty and Inequality Platform (Poverty rate). https://pip.worldbank.org/poverty-calculator (28.06.24).

85 see endnote 3.

86 ICF (2024). STATcompiler. The DHS programm (Teenagers who are mothers). www.statcompiler.com/en/ (02.07.24).

87 ZNBC Today (2024). Eastern Province has recorded 2, 946 teen pregnancies within the month of January 2024. https://t1p.de/j6wpu (02.07.2024).

88 Miti, C. (2024). “Arrest the men Impregnating under age girls in EP”. https://t1p.de/dvjmo (02.07.24).

89 Banda, N. (2024). ZNMNGD CALLS ON THE POLICE TO ARREST MEN BEHIND THE OVER 2800 TEEN PREGNANCIES IN EASTERN PROVINCE. https://t1p.de/s1cs1 (02.07.24).

90 see endnote 23.

91 see endnote 39.

92 Copper Rose Zambia (2022). The Impact of Teenage Pregnancy on Gender Equality in Zambia. https://t1p.de/ah09t (02.07.24).

93 Ministry of Education Republic of Zambia (2022). Education Statistics Bulletin 2020. Lusaka. https://t1p.de/gbmye (02.07.24).

94 World Bank (2022). The Social and Educational Consequences of Adolescent Childbearing (Gender Data Portal). https://t1p.de/yqb1s (02.07.24).

95 UNESCO (2019). Facing the facts: the case for comprehensive sexuality education. Policy Paper, 39.

96 ICF (2024). STATcompiler. The DHS programm (Sex before the age of 15/18). www.statcompiler.com/en/ (02.07.24).

97 ICF (2024). STATcompiler. The DHS programm (Teenagers who have begun childbearing). www.statcompiler.com/en/ (04.07.24).

98 UNFPA (2024). Female genital mutilation (FGM) frequently asked questions https://t1p.de/q2y54 (02.07.24).

99 Mills, R. et al. (2023). Opening a portal to pleasure based sexual and reproductive health around the globe; a qualitative analysis and best practice development study. Sexual and Reproductive Health Matters, 31(3).

100 UNESCO (2018). International technical guidance on sexuality education. An evidence-informed approach (2. revised edition). Paris.

101 Ministry of Health, Tanzania Mainland et al. (2022). Tanzania Demographic and Health Survey and Malaria Indicator Survey 2022 Final Report. Dodoma, Tanzania & Rockville, Maryland, USA.

102 National Population Commission (NPC) Nigeria & ICF (2019). Nigeria Demographic and Health Survey 2018. Abuja, Nigeria & Rockville, Maryland, USA.

103 Zambia Statistics Agency et al. (2019). Zambia Demographic and Health Survey 2018. Lusaka, Zambia & Rockville, Maryland, USA.

104 Ministry of Health, Community Development, Gender, Elderly and Children, United Republic of Tanzania (2021). National Accelerated Action and Investment Agenda for Adolescent Health and Wellbeing 2021/22 - 2024/25. https://t1p.de/ki5dy (02.07.24).

105 African Population and Health Research Center (APHRC) (2019). Comprehensive Sexuality Education in Sub-Saharan Africa. Implementation of CSE in Zambia. Nairobi.

106 UNESCO (2023). Nigeria: Comprehensive Sexuality Education. https://t1p.de/yvkk2 (02.07.24).

107 UNFPA (2023). Delivering Comprehensive Sexuality Education for Out-of-school Young People. Country Case Studies on UNFPA‘s Global Programme on Out-of-school CSE. Nigeria. https://t1p.de/zepxg (02.07.24).

108 Maseko, M. (2020). UN Press Release on Comprehensive Sexuality Education (CSE). UN Zambia. https://t1p.de/tpj4f (02.07.24).

109 Hamusunga, G. (2020). ZANEC PRESS STATEMENT ON COMPREHENSIVE SEXUALITY EDUCATION. Zambia National Education Coalition. https://t1p.de/m8wqh (02.07.24).

110 Lusaka Times (2023). Ministry of Education clarifies misinformation on Comprehensive Sexuality Education books circulating on social media. https://t1p.de/x8go1 (02.07.24).

111 ITU (2024). Facts and Figures 2023: Youth Internet Use. https://t1p.de/ysfoo (02.07.24).

112 GSMA (2023). The Mobile Economy Sub-Saharan Africa 2023. London.

113 American Institutes for Research (2018). Impact Evaluation of the Join-In-Circuit in Schools in Zambia. Final Evaluation Report. Washington.

114 Syspons (2022). Effectiveness Study on the „Join-In Circuit“ in Zambia. Berlin.

115 Fatusi, A. O. (2018). Nigeria National Standards & Minimum Service Package for Adolescent & Youth-Friendly Health Services (2018). https://t1p.de/t0p51 (02.07.24).

116 Ministry of Health, Republic of Zambia (2023). 2022-2026 Strategic Plan National Health. “Towards Attainment of Quality Universal Health Coverage Through Decentralisation”. Lusaka.

117 see endnote 104.

118 CHOICE for Youth and Sexuality (2024). Youth-Friendly Services. https://t1p.de/atm2e (19.06.24).

119 Kons, K. et al. (2022). Factors Associated with Adolescent Pregnancy in Sub-Saharan Africa during the COVID-19 Pandemic: A Review of Socioeconomic Influences and Essential Interventions. International Journal of Sexual Health, 34(3), pp. 386-396.

120 SafAIDS (2022). MobiSAfAIDS App for Sexual and Reproductive Health and Advocacy. https://t1p.de/sxl7k (03.07.24).

121 UNICEF (2022). Social Accountability Monitoring of Young People‘s SRH Services: Partnering for better SRHR outcomes among Young People. Conference Report. https://t1p.de/u5sir (03.07.24).

122 Solo, J. & Festin, M. (2019). Provider Bias in Family Planning Services: A Review of Its Meaning and Manifestations. Global Health: Science and Practice, 7(3), pp. 371-385.

123 Meek, C. et al. (2022). Health worker perceptions of stigma towards Zambian adolescent girls and young women: a qualitative study. BMC Health Services Research, 22.

124 Freeman, E. & Coast, E. (2019). Conscientious objection to abortion: Zambian healthcare practitioners‘ beliefs and practices. Social Science & Medicine, 221, pp. 106-114.

125 Arije, O. et al. (2022). “They will judge you more like a parent instead of like a health practitioner”: Perceptions and preferences of young people regarding sexual and reproductive health services in Southwest Nigeria. Dialogues in Health, 1.

126 Corley, A. G. et al. (2022). Exploring and Monitoring Privacy, Confidentiality, and Provider Bias in Sexual and Reproductive Health Service Provision to Young People: A Narrative Review. International Journal of Environmental Research and Public Health, 19(11).

127 Turner, K. L. et al. (2018). Values clarification workshops to improve abortion knowledge, attitudes and intentions: a pre-post assessment in 12 countries. Reproductive Health, 15.

128 MSI (2018). Values clarification: transforming attitudes to adolescent contraceptive use in Tanzania. https://t1p.de/xrkmo (03.07.24).

129 Make Way (2024). Make Way Zambia. www.make-way.org/make-way-zambia/ (03.07.24).

130 Human Rights Watch (2023). Uganda’s President Signs Repressive Anti-LGBT Law. https://t1p.de/k6wyc (03.07.24).

131 ILGA World (2024). Legal Frameworks. Criminalisation of consensual same-sex sexual acts (ILGA World Database). https://t1p.de/z324g (03.07.24).

132 d’Adesky, A.-C. (2023). Updates on anti-LGBTQ legislation and impact on LGBTQ+ civil rights in Tanzania (Briefing Paper).

133 Southern Africa Litigation Centre & Transbantu Association Zambia (2021). Key issues related to sexual orientation, gender identity and expression identified by a community consultation in Zambia. Johannesburg.

134 see endnote 132.

135 Laukkanen, S. (2024). Sexual and Reproductive Rights. Tanzania. GFMER. https://www.gfmer.ch/srr/Tanzania.htm (03.07.24).

136 ILGA World (2024). Tanzania. (ILGA World Database) https://database.ilga.org/tanzania-lgbti (03.07.24).

137 Silimina, D. (2022). LGBTQI rights remain sensitive issue. https://t1p.de/atgzq (03.07.24).

138 see endnote 58.

139 UNAIDS (2024). Key Population Atlas. https://kpatlas.unaids.org/dashboard (03.07.24).

140 see endnote 132.

141 Human Rights Watch (2020). “If We Don’t Get Services, We Will Die”. Tanzania‘s Anti-LGBT Crackdown and the Right to Health. https://t1p.de/a3nev (03.07.24).

142 UNICEF (2021). Seen, Counted, Included. Using data to shed light on the well-being of children with disabilities. New York.

143 Mesiäislehto, V. (2023). Sexual and Reproductive Health and Rights through the Lens of Belonging. Intersectional Perspectives on Disability, Gender, and Adolescence in Tanzania (JYU Dissertations, 671). Jyväskylä.

144 Mesiäislehto, V. et al. (2021). Disparities in Accessing Sexual and Reproductive Health Services at the Intersection of Disability and Female Adolescence in Tanzania. International Journal of Environmental Research and Public Health, 18(4).

145 UNFPA & Women Enabled International (2021). The Impact of COVID-19 on Women and Girls with Disabilities. A Global Assessment and Case Studies on Sexual and Reproductive Health and Rights, Gender-Based Violence, and Related Rights. https://t1p.de/fkewx (03.07.24).

146 see endnote 144.

147 UNAIDS (2024). Key Population Atlas. (Transgender People: Population Size Estimate). https://kpatlas.unaids.org/dashboard (03.07.24).

148 ISHRAI (2023). Safe Shelter. www.ishraing.org/safe-shelter/ (03.07.24).

149 Bassey, A. E. et al. (2022). Are youth-friendly reproductive health services accessible for young people with disabilities during the COVID-19 pandemic in Nigeria? Annals of Medicine & Surgery, 84.

150 Young & Alive Initiative (2019). Home. https://www.youngandalive.org/ (03.07.24).

151 Johns Hopkins University (2023). SMART Advocacy. https://smartadvocacy.org/ (03.07.24).

152 SID Initiative (2024). 2023 Annual Report. Lagos.

153 Hivos (2024). We Lead. https://hivos.org/program/we-lead/ (03.07.24).

154 World Bank (2024). Measuring Poverty. www.worldbank.org/en/topic/measuringpoverty (03.07.24).

155 Castaneda Aguilar, R. A. et al. (2024). March 2024 global poverty update from the World Bank: first estimates of global poverty until 2022 from survey data. https://t1p.de/sp8sl (03.07.24).

156 see endnote 155.

157 World Bank (2024). Poverty and Inequality Platform. https://pip.worldbank.org/poverty-calculator (03.07.24).

158 Hamel, K. & Di Nucci, C. (2019). More than 100 million young adults are still living in extreme poverty. https://t1p.de/dhx1g (03.07.24).

159 see endnote 158.

160 see endnote 41.

161 Väisänen, H. et al. (2021). Sexual and Reproductive Health Literacy, Misoprostol Knowledge and Use of Medication Abortion in Lagos State, Nigeria: A Mixed Methods Study. Studies in Family Planning, 52(2), pp. 217-237.

162 Akinyemi, A. et al. (2022). Quality of information offered to women by drug sellers providing medical abortion in Nigeria: Evidence from providers and their clients. Frontiers in Global Women‘s Health, 3.

163 Lince-Deroche, N. et al. (2021). The health system costs of post abortion care in Tanzania. BMC Health Services Research, 21.

164 Leone, T. et al. (2016). The individual level cost of pregnancy termination in Zambia: a comparison of safe and unsafe abortion. Health Policy and Planning, 31(7), pp. 825-833.

165 see endnote 163.

166 ICF (2024). STATcompiler. The DHS program (Teenage pregnancy). https://www.statcompiler.com/en/ (03.07.24).

167 Human Rights Watch (2024). A Brighter Future: Empowering Pregnant Girls and Adolescent Mothers to Stay in School. Education Access across the African Union: A Human Rights Watch Index. https://t1p.de/68fu4 (03.07.24).

168 Shukia, R. (2021). Fee-free Basic Education Policy Implementation in Tanzania: A ‘Phenomenon’ Worth Rethinking. Huria: Journal of the Open University of Tanzania, 27(1).

169 Baleta, A. (2015). Lives on the line: sex work in sub-Saharan Africa. The Lancet, 385(9962), pp. e1-e2.

170 Ayamah, P. et al. (2023). Multiple indicators of violence against female sex workers and its associated factors in Ghana: Evidence from the 2015 integrated bio-behavioral surveillance survey cross-sectional study. Health Science Reports, 6(5).

171 Wamoyi, J. et al. (2016). Transactional sex and risk for HIV infection in sub-Saharan Africa: a systematic review and meta-analysis. Journal of the International AIDS Society, 19(1).

172 Ranganathan, M. et al. (2016). Transactional sex among young women in rural South Africa: prevalence, mediators and association with HIV infection. Journal of the International AIDS Society, 19(1).

173 Austrian, K. et al. (2019). „When He Asks for Sex, You Will Never Refuse": Transactional Sex and Adolescent Pregnancy in Zambia. Studies in Family Planning, 50(3), pp. 243-256.

174 NSWP - Global Network of Sex Work Projects (2021). Global Mapping of Sex Work Laws. www.nswp.org/sex-work-laws-map (03.07.24).

175 see endnote 169.

176 Lugalla, J. et al. (2016). Endline Evaluation of Adolescent Girls Initiative Project in Kahama-Shinyanga.

177 CREMES International (2021). Documentation of Best Practices for the Adolescent Girls Initiative Project (AGI) Implemented in Shinyanga Region 2013-2015. Study Report. https://t1p.de/qtvgo (03.07.24).

178 Tadesse, A. G. et al. (2023). Prevalence of school absenteeism during menstruation and associated factors in sub-Saharan Africa: A systematic review and meta-analysis. https://www.researchsquare.com/article/rs-3700784/v1 (03.07.24).

179 Whisper a dream Foundation (2024). Whisper a dream Foundation - Facebook Page. https://t1p.de/o4wb0 (03.07.24).

180 Contact Trust Youth Association (2024). Art Beyond Schools. Interim Progress Report (December 31, 2022, to December 31, 2023).

181 IOM (2024). Nigeria. https://dtm.iom.int/nigeria (03.07.24).

182 IDMC (2023). 2023 Global Report on Internal Displacement. Internal displacement and food security. Geneva.

183 IOM (2023). Nigeria - IDP and Returnee Atlas. North-East - Round 46 (December 2023). Abuja. https://t1p.de/nfb7b (03.07.24).

184 International Center for Research on Women (2022). The Sexual and Reproductive Health Needs and Challenges of Adolescent Girls and Young Women in Humanitarian Settings in Nigeria and Uganda. Washington, DC.

185 Marlow, H. M. et al. (2021). The Sexual and Reproductive Health Context of an Internally Displaced Persons' Camp in Northeastern Nigeria: Narratives of Girls and Young Women. Frontiers in Reproductive Health, 3.

186 see endnote 184 and 185.

187 see endnote 183.

188 IOM (2024). IDP Atlas - March 2024. Mobility Tracking - North-Central and North-West Nigeria. https://t1p.de/bfu2c (28.06.24).

189 UNFPA (2022). UNFPA Nigeria Humanitarian Situation Report: Focus North-East Crises (3/2022). https://t1p.de/u50ed (03.07.24).

190 see endnote 184.

191 UNHCR (2024). Gender equality and gender-based violence. https://t1p.de/2uuyt (04.07.24).

192 Klugman, J. (2022). The Gender Dimensions of Forced Displacement. A Synthesis of New Research. https://t1p.de/0rgyn (04.07.24).

193 Action Health Incorporated (2020). Building Resilience and Hope: Working with Adolescent Girls in the Midst of Crisis in North-Eastern Nigeria. Lagos.

194 Theatre Arts Feminists (2024). Theatre Arts Feminists - Instagram Page. https://www.instagram.com/theatreartsfeminists/ (04.07.24).

195 see endnote 101.

196 Msichana Initiative (2023). Implication of Re-Entry Policy in Tanzania. https://t1p.de/b7m0s (04.07.24).

197 McCool, A. (2021). Tanzania to lift ban on teenage mothers returning to school. The Guardian. https://t1p.de/7o46r (04.07.24).

198 Center for Reproductive Rights (2022). African Committee Recommends Tanzania Reform Policies That Barred Pregnant Girls from School. https://t1p.de/2w80f (04.07.24).

199 see endnote 196.

200 Omondi-Adeitan, T. (2022). School re-entry policies must be effective for teenage mothers in Africa https://t1p.de/ys2cx (04.07.24).

201 Ngaza, B. & Mwila, P. M. (2022). Secondary school re-entry programme of teenage mothers: views of stakeholders in Zanzibar, Tanzania. Journal of Educational and Management Studies, 12(4), pp. 65-78.

202 see endnote 101.

203 see endnote 101.

204 Ministry of Health, Community Development, Gender, Elderly and Children, Tanzania Mainland et al. (2016). Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) 2015-16. Dar es Salaam, Tanzania & Rockville, Maryland, USA.

205 see endnote 101.

206 see endnote 101.

207 ICF (2024). STATcompiler. The DHS program (Age specific fertility rate: 15-19). https://www.statcompiler.com/en/ (04.07.24).

208 see endnote 104.

209 see endnote 101.

210 see endnote 39.

211 Hello Lagos (2024). HELLO LAGOS - Facebook Page. www.facebook.com/hellolagosikeja (04.07.24).

212 UNFPA (2024). A wish for every mother: A safe birth and a promising future. https://t1p.de/eyu1p (04.07.24).

213 UNFPA (2024). Teen Moms become peer mentors. Nigeria. www.unfpa.org/8billion/8stories/nigeria (04.07.24).

214 Guardian Nigeria (2023). How Lagos youth friendly initiative is improving lives of young Nigerians. The Guardian. https://t1p.de/8toqo (04.07.24).

215 Siamabule, B. (2022). Copper Rose Zambia: Increasing awareness on safe abortion in Zambia. https://t1p.de/f96r1 (04.07.24).

216 Ministry of Health, Republic of Zambia (2017). Standards and Guidelines for Comprehensive Abortion Care in Zambia. https://t1p.de/600bv (04.07.24).

217 Republic of Zambia (1996). The Termination of Pregnancy Act, 1972. https://t1p.de/z1ydg (04.07.24).

218 Copper Rose Zambia (2023). Exploring the Challenges and Barriers Faced by Young People in Accessing Abortion Services at Health Facilities in Zambia. https://copperrosezambia.org/download/sap-publication/ (04.07.24).

219 see endnote 216.

220 Aunty Tasha (2023). Aunty Tasha Helpline. Empowering Adolescent Girls for a Healthy Future. https://auntytashazm.com/ (04.07.24).

221 WHO (2022). Abortion care guideline. Geneva.

222 National Assembly of Zambia (2022). The Children's Code Act, 2022 (Act No. 12 of 2022). https://t1p.de/y1vgn (04.07.24).

223 Kangaude, G. et al. (2020). Adolescent sexual and reproductive health and universal health coverage: a comparative policy and legal analysis of Ethiopia, Malawi and Zambia. Sexual and Reproductive Health Matters, 28(2), pp. 211-225.

224 see endnote 223.

225 Zambia Statistics Agency et al. (2019). Zambia Demographic and Health Survey 2018. Lusaka, Zambia & Rockville, Maryland, USA.

226 CIA (2024). Nigeria (The World Factbook). https://t1p.de/auh50 (04.07.24).

227 see endnote 111 and 112.

228 see endnote 128.

229 Katenda, L. M. (2022). For religious leaders in Africa, popular trust may present opportunity, challenge in times of crisis (Afrobarometer Dispatch No. 536).

About the Berlin Institute

The Berlin Institute for Population and Development is an independent think tank working on issues related to regional and global demographic change. The Institute was established in 2000 as a non-profit foundation. We raise awareness for demographic changes, promote sustainable development, introduce new ideas into political debates and develop evidence-based solutions to meet diverse demographic challenges in Germany and around the globe. Our studies and policy papers are freely available on our website for anyone with an interest in current demographic challenges and solutions. You can find more information at www.berlin-institut.org/en/

Support the independent work of the Berlin Institute.

The Berlin Institute is a non-profit foundation. We do not receive public institutional or core funding of any kind. Ongoing research is financed through grants for individual projects, research contracts and private donations. Unrestricted funds enable us to continually develop new ideas and identify future trends, which is why individual contributions are particularly valuable for our work. Please find more information at www.berlin-institut.org/en/donations.

Berlin Institute
for Population and Development
Schillerstraße 59
10627 Berlin
Germany

www.berlin-institut.org

ISBN: 978-3-946332-74-9