Adolescents and young people in Sub-Saharan Africa (SSA) will constitute 19.6% (224,432,000) of the region’s population by 2015. The region is characterized by unemployment particularly among youth with an employment to population ratio at 45.8%. Employment for young people age 15-24 has remained stagnant and youth in particular face lack of productive employment and decent jobs. Too many young people are employed in the informal and vulnerable employment sectors. While the 45 countries that comprise SSA show steady economic growth, this progress is not reflected in the socioeconomic and health indicators for its young population. The region is yet to achieve the ICPD goals as well as the MDG targets and indicators. Poverty is highest in SSA compared to all the other regions, with 47.5% of people living on less than a $1.25 PPP/day.

The ICPD PoA states that education is a key factor in sustainable development. The PoA calls for universal access to quality education and achieving the widest and earliest possible access by girls and women to secondary education. At the same time the MDG 2 calls for universal primary education for boys and girls alike by 2015. Young people in SSA share common dreams about their education, health, and work; however the experience of being a young woman or man is as diverse as the cultures of the communities they live in.

SSA has progressed with promoting gross enrolment in primary education for both boys and girls, however low retention and high dropout rates caused by poverty, gender discrimination, poor hygiene and sanitation facilities, and sexual harassment by teachers and male pupils, hinder completion of primary education.
The ICPD PoA calls for the promotion “to the fullest extent” of the health of young people and provision of services that are of good quality and sensitive to the needs of the young and “safeguarding the rights of adolescents to privacy, confidentiality, respect and informed consent.”

3. Access to sexual and reproductive health (SRH) information and services

The ICPD PoA calls for the promotion “to the fullest extent” of the health of young people and provision of services that are of good quality and sensitive to the needs of the young and “safeguarding the rights of adolescents to privacy, confidentiality, respect and informed consent.”

3.1 Comprehensive sexuality education (CSE)

Overall there is limited data on sexuality education status in the region. A Guttmacher study emphasised the need for sexuality education both in school and out of school in SSA, given the magnitude of HIV, unintended pregnancies and the vulnerabilities of adolescent and young girls. Despite policies in place many adolescents do not receive any form of sexuality education. The entry point for most of the sexuality education curricula is through HIV and AIDS programmes. According to a 2004 survey, HIV and AIDS were part of the primary school curriculum in 19 of 20 African countries with a high prevalence of HIV. Life skills are integrated into the curricula in 17 of the 20 countries, however implementation of the programmes have not been effective. At the same time school-based sex education programmes do not cater to youth (the majority of them adolescent girls and young women) who are not in school. Addressing out-of-school adolescents is another big challenge in the region.

Sexuality education is not comprehensive, mostly takes a biological perspective and religious groups and parent associations define the parameters and content for its age appropriateness. Some NGOs have established adolescent friendly reproductive health services in Tanzania and Zambia to provide the population age 10-24 with sexual and reproductive health information. Other barriers include teachers who are perpetrators of sexual harassment and violence thus parents are not comfortable with them handling the programmes. The low number of female teachers in rural schools and poor infrastructure also limit young women’s access to quality information.

3.2 Contraceptive use among adolescents and young people

According to Guttmacher brief Facts on the Sexual and Reproductive Health of Adolescent Women in the Developing World only 21% of married adolescents in sub-Saharan Africa are using a modern contraceptive method and 67% of married adolescents who want to avoid pregnancy for at least the next two years are not using any method of contraception. At the same time significant percentage- 68%- of sexually active adolescents have an unmet need for modern contraception.

In the nine SSA countries, as part of the Global South ICPD+20 review, contraceptive use among young unmarried women is higher in comparison to married women of the same age. This situation might have arisen due to strong HIV intervention programmes as the predominant method of contraception used by this group is condoms and this group does not seem to have access to range of contraceptive methods.

The pattern of contraceptive use poses challenges for both married and unmarried young women to access contraception, and is more aggravated in the case of young married women who might be under pressure to conceive right after marriage due to socio-cultural motives which put emphasis on fertility. Among the contraceptive methods, condom use is high among sexually active unmarried women as STI and pregnancy prevention is the major motive among this group. Contraceptive services need to be made more accessible, for all women but especially adolescents and young women, through investments both in contraceptive information as well as services.

3.3 Adolescent pregnancies

The ICPD PoA calls for a reduction in adolescent pregnancies. The SSA region accounts for the highest adolescent fertility rate at 119.7 compared to the global average of 58.1. Half of
services. It calls for women’s access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions.\(^{18}\)

The annual number of induced abortions in Africa rose between 2003 and 2008, from 5.6 million to 6.4 million. In 2008, the most abortions occurred in Eastern Africa (2.5 million), followed by Western Africa (1.8 million), Northern and Middle Africa (0.9 million), and Southern Africa (0.2 million).\(^{19}\)

Of the 6.4 million abortions carried out in 2008, only 3% were safe. The condition for the legality of abortion varies among countries in the region. Every country in Africa has at least one ground on which abortion is permitted.\(^{20}\)

The African charter on the Protocol on Women of Rights (Maputo Protocol), signed by most of SSA countries, has explicitly articulated a woman’s right to abortion. Article 14(2) of the Protocol calls upon states to “provide adequate, affordable and accessible health services” to women. It also urges governments to protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health or life of the pregnant woman or life of the foetus.

Despite this most of the countries still retain harsh laws on abortion, inherited from colonial regimes and borrowed from other countries with similar religious barriers. One quarter of unsafe abortions occur among adolescents age 15-19 in Africa, which is the highest of all the world regions.\(^{21}\) Young women account for a significant proportion of the number of unsafe abortions\(^{22}\) with almost 60% under age 25 and 80% under age 30.\(^{23}\) Even where abortions are legal, young women face barriers in accessing safe abortions, including gestational limits, the need for parental consent, mandatory waiting periods or counseling, and lack of knowledge on the legality of abortions.\(^{24}\)

### 3.4 Access to abortion information and services among adolescents and young people

The ICPD PoA calls upon governments and all stakeholders to “deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. It calls for women’s access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions.”\(^{18}\)

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In most Sub-Saharan countries legal restrictions on abortion increases the risk of unsafe abortion among young women, particularly in countries where sex education is also restricted on moral grounds. This environment places young women in a complex situation where they are stigmatised for seeking unsafe abortion following unintended pregnancies. Many of them are poor, cannot access services and have limited access to contraception as well. (see table 2)

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Women and girls disproportionately bear the burden of HIV infections. The knowledge on HIV among both young men and women has slowly increased over the years (34%), which is behind the 2015 UNGASS target of 95%. In SSA, more women than men are living with HIV. Young women age 15-24 are almost eight times more likely than men to be HIV positive. The estimated percentage of HIV prevalence among young women and men shows increasingly higher levels of prevalence among young women in all the countries. In Kenya, Tanzania and Zambia the prevalence rates for both young men and women are higher than the regional average for SSA.

HIV infection rates among young women in the region are reflective of the impact of social and gender constructs, with increasing infection rates for young women age 15-24. Factors such as biological susceptibility, older male sexual partners, transactional sex, as well as harmful and discriminatory traditional practices, contribute to higher levels of HIV infection among adolescents and young women. (see table 3)

**4. Harmful Traditional Practices (HTPs) in Sub-Saharan Africa**

Some of the HTPs that affect young women in SSA include female genital mutilation and cutting (FGM/C), early marriages in the form of abduction, widow cleansing, inheritance rights, breast massage in (Rwanda and Cameroon), sexual initiation practices and rites, and other practices and taboos preventing women from controlling their fertility.

**Female Genital Mutilation (FGM)**

The ICPD PoA calls for the total elimination of FGM, defined as the partial or total removal of the female genitalia or other injury to the female genital organs for non-medical reasons. This practice is rooted deeply in tradition and exists in 28 countries in Africa. There are an estimated 130-140 million girls and women who have been subjected to the operation and 3 million girls are at risk of undergoing the practice every year.

The current trends with regards to FGM include the lowering of the average age at which girls are subjected to the procedure and the medicalisation of FGM where parents are increasingly seeking health care providers to perform FGM on their daughters.

Most women who have experienced FGM live in one of the 28 countries in Africa and the Middle East – nearly half of them concentrated in two countries: Egypt and Ethiopia. Countries in which FGM practice has been documented include: Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Cote d’Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Togo, Uganda, United Republic of Tanzania and Yemen. The prevalence of FGM ranges from 0.6% to 98% of the female population.

FGM has many consequences including negative psychological outcomes such as post-traumatic stress disorder, anxiety, depression, and psychosexual problems. Women who have undergone FGM have been found to be 1.5 times more likely to experience pain during sexual intercourse, experience
significantly less sexual satisfaction, and have less sexual desire, and experience complications during childbirth. While there are efforts to curb this practice, in many countries the reduction in prevalence is not as substantial as hoped for, and in a few, no decline has been noted. Although some countries in SSA have addressed these issues, there is need for greater effort to combat HTPs in the region.

### 5. Homophobia and Transphobia

The situation in Africa for lesbian, gay, bisexual, trans, intersex and queer (LGBTIQ) persons has not seen much progress in recent years. Regionally, 36 countries have laws criminalizing homosexuality. Punishments include imprisonment and the death penalty. The laws on homosexuality are rooted in colonial era laws, religious extremism, political climates, cultural beliefs, heterosexual family values and patriarchy.

At the UN Assembly in Geneva on the Joint Declaration to decriminalise homosexuality in 2011, the number of African countries who signed rose from 6 to 11 with 13 countries who abstained and 28 who opposed Joint Statement on Sexual Orientation and Gender Identity (SOGI). These developments will have implications for the exercise of SRH rights of LGBTIQ persons.

#### Table 2: Grounds on which abortion is permitted

<table>
<thead>
<tr>
<th>Country</th>
<th>To save the woman’s life</th>
<th>To preserve physical health</th>
<th>To preserve mental health</th>
<th>Rape or incest</th>
<th>Foetal impairment</th>
<th>Economic or social reasons</th>
<th>On request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
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<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Benin</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>—</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>—</td>
</tr>
<tr>
<td>Kenya</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>—</td>
<td>✓</td>
<td>✓</td>
<td>—</td>
</tr>
<tr>
<td>Nigeria</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Rwanda</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Sierra Leone</td>
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<td>✓</td>
<td>✓</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Tanzania</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Zambia</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>—</td>
<td>✓</td>
<td>✓</td>
<td>—</td>
</tr>
</tbody>
</table>


#### Table 3: Young women and men HIV prevalence

<table>
<thead>
<tr>
<th>Country</th>
<th>Young women (15-24) prevalence (%)</th>
<th>Young men (15-24) prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global</td>
<td>0.6 [0.5 - 0.7]</td>
<td>0.3 [0.2 - 0.3]</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>3.4 [3.0 - 4.2]</td>
<td>1.4 [1.2 - 1.7]</td>
</tr>
<tr>
<td>Angola</td>
<td>1.6 [1.1 - 2.2]</td>
<td>0.6 [0.4 - 0.9]</td>
</tr>
<tr>
<td>Benin (2006)</td>
<td>0.7 [0.5 - 1.1]</td>
<td>0.3 [0.2 - 0.4]</td>
</tr>
<tr>
<td>Ethiopia (2011)</td>
<td>No data</td>
<td>No data</td>
</tr>
<tr>
<td>Nigeria (2008)</td>
<td>2.9 [2.3 - 3.9]</td>
<td>1.2 [0.9 - 1.6]</td>
</tr>
<tr>
<td>Rwanda (2010)</td>
<td>1.9 [1.3 - 2.3]</td>
<td>1.3 [0.9 - 1.6]</td>
</tr>
<tr>
<td>Sierra Leone (2008)</td>
<td>1.5 [0.9 - 2.5]</td>
<td>0.6 [0.3 - 1.0]</td>
</tr>
<tr>
<td>Tanzania (2010)</td>
<td>3.9 [3.1 - 5.3]</td>
<td>1.7 [1.3 - 2.3]</td>
</tr>
<tr>
<td>Zambia (2007-08)</td>
<td>8.9 [7.3 - 12.0]</td>
<td>4.2 [3.2 - 5.5]</td>
</tr>
</tbody>
</table>

6. Recommendations

We, the adolescents and young people of Sub-Saharan Africa on call upon our governments to:

1. Scale-up investments in quality education and seamless progression to employment and self-employment for young people, especially adolescent girls and young women.

2. In order to sustain the progress and accelerate the Sub-Saharan, countries achievement of MDG2 targets, governments need support to increase investment in education. They also need to reduce user fees, improve infrastructure train more female teachers and build capacity of communities to be responsible for ensuring young women and girls accessing education. The lack of access to quality education has implications for young women and men not only in seeking gainful employment but also seeking SRH services.

3. Deliberately allocate funds for sexual and reproductive health programmes in line with regional and global commitments including the Abuja Declaration, the Maputo Programme of Action which calls on a minimum allocation of 15% of the national budget to health,

4. Support the formulation, integration, and implementation of laws, policies and programmes that protect the sexual and reproductive health of young people, in addressing harmful traditional practices.

5. Remove legal barriers to access SRH services, and implement policies to uphold the sexual and reproductive health of adolescents and young people to the highest attainable standards.


7. Urgently expand provision of youth friendly sexual and reproductive health services to all adolescents and young people by enabling affordability, acceptability and availability of these services especially for marginalized and underserved young people. These services include access to a range of comprehensive contraceptive methods, access to safe abortion services, prevention treatment of STIs and HIV and a host of other sexual and reproductive health services to meet their needs.

8. Call for effective implementation of Art. 5 of the Maputo Protocol on the Rights of women and HTPs at the national level in the sub-Saharan countries.

9. Education reduces the risk of pregnancy among adolescents and accurate information on sexuality also enables them to make relevant choices. There is also a need to invest in research to get more data on the trends of adolescent pregnancies in Sub-Saharan Africa to address cultural drivers of adolescent fertility and to meaningfully include the youth in defining their SRH needs.

10. Government should develop programmes that provide access to comprehensive reproductive health services that include contraception, safe abortion and post abortion care counselling and treatment.

11. Hold our governments accountable to their commitments concerning young people’s access to evidence-based comprehensive sexuality education and youth friendly services.

12. Mobilize young people to seize all opportunities within their families, in schools, communities and reproductive health-care centres, to obtain the appropriate sexual and reproductive health information and services.

13. Educate young people on their sexual reproductive health and rights, as well as how to protect these rights in the context of supportive legal and development frameworks.

14. Ensure the meaningful participation of young people in the operational review of the ICPD Programme of Action, ICDP Beyond 2014 and Millennium Development Goals post 2015 in defining the future they want.
In this factsheet, Sub Saharan Africa (SSA) is used to represent the region in general. Specific references are made to Angola, Benin, Ethiopia, Kenya, Nigeria, Rwanda, Sierra Leone, Tanzania and Zambia, as they comprise the nine SSA countries monitored for the ICPD+20 Global South Monitoring Report.


For the purposes of this factsheet, the countries included in this region are: Angola, Benin, Ethiopia, Kenya, Nigeria, Rwanda, Sierra Leone, Tanzania and Zambia.


1 ICPD Programme of Action para 8.25


3 Global South ICPD+20 Africa regional report (Draft)


