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YOUNG PEOPLE TODAY. TIME TO ACT NOW.

Why adolescents and young people need comprehensive sexuality education and sexual and reproductive health services in Eastern and Southern Africa

In partnership with:

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Pupils at a school in Chipata, Zambia, where sexual and reproductive health and rights is taught as part of the curriculum

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PROLOGUE

This report is dedicated to the memory of Douglas Bernard Kirby, PhD – formerly a Senior Research Scientist at ETR Associates – who died on 22 December 2012 while climbing Cotopaxi in Ecuador. He was 69.

Dr Kirby was one of the world's leading experts on sexuality education. He wrote over 150 articles, chapters and monographs and worked with national governments, civil society and UN agencies to strengthen sexuality education programmes throughout the world. As a founding member of UNESCO's Global Advisory Group on Sexuality Education, he was a principal developer of the *International Technical Guidance on Sexuality Education: An evidence-informed approach for schools, teachers and health educators* (UNESCO, 2009a) and he helped to shape a wide-ranging global programme of work on all aspects of sexuality education that revitalized the education sector response to HIV and AIDS. He also worked closely with United Nations (UN) partners and ministries of education on capacity building and providing intensive support aimed at scaling up sexuality education in Eastern and Southern Africa, the region most affected by the HIV epidemic.

Dr Kirby received his PhD in Sociology from the University of California, Los Angeles (UCLA) in 1975. For the past 25 years he served as Senior Research Scientist at ETR Associates in California, USA. During his professional career, he published the most definitive systematic reviews on the effectiveness of sex, relationships and HIV education in schools and is widely recognized as the leading world expert on sex, relationships and HIV education curriculum standards. He painted a more comprehensive and detailed picture of the risk and protective factors associated with young people's sexual behaviour, contraceptive use and pregnancy, and identified important common characteristics of effective sexuality education and HIV education programmes.

On another level, he was a passionate, thoughtful and inspiring advocate for education, health and the needs of young people. He will be remembered for his professional integrity, his infectious love for life, and his dedication to making the world a better place.

For more information on Dr Kirby's work, please visit
http://www.etr.org/more-about-doug-kirby#obit.

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-retroviral therapy
ASRH	Adolescent sexual and reproductive health
AU	African Union
BMZ	German Ministry for Economic Cooperation and Development
CEDAW	Convention on Elimination of Discrimination Against Women
CPD	Commission on Population and Development
CRC	Convention on the Rights of the Child
CSE	Comprehensive sexuality education
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
EAC	East African Community
EC	Emergency contraceptives
ECOSOC	Economic and Social Council
EFA	Education for All
EMIS	Education Management and Education Systems
ESA	Eastern and Southern Africa
FGM	Female genital mutilation
FP	Family planning
GBV	Gender-based violence
GEFI	Global Education First Initiative
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
HIV	Human Immunodeficiency Virus
HTC	HIV testing and counselling
IATT	Inter-Agency Task Team
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
LGBTI	Lesbian, gay, transgender and intersex
MDGs	Millennium Development Goals
M&E	Monitoring and evaluation
MoE	Ministry of Education
MoH	Ministry of Health
MSM	Men who have sex with men
NGO	Non-governmental organization
OFID	OPEC Fund for International Development
OVC	Orphans and vulnerable children
PLHIV	People living with HIV and AIDS
PMTCT	Prevention of mother-to-child transmission
REC	Regional Economic Community
SACMEQ	Southern and Eastern Africa Consortium for Monitoring Educational Quality
SERAT	Sexuality Education Review and Assessment Tool
SIDA	Swedish International Development Cooperation Agency
SRH	Sexual and reproductive health
SADC	Southern African Development Community
STI	Sexually transmitted infection
UIS	Institute for Statistics (UNESCO)

UN	United Nations
UNAIDS	United Nations Joint Program on HIV/AIDS
UNECA	United Economic Commission for Africa
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNGASS	UN General Assembly Special Session
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VMMC	Voluntary male medical circumcision
WHO	World Health Organization
YFS	Youth-friendly services
YPLHIV	Young people living with HIV and AIDS

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This draft has also benefitted from a wide range of inputs received during a Technical Coordinating Group meeting held in Johannesburg from 31 January to 1 February 2013. Partners at that meeting included regional representatives of the United Nations Joint Program on HIV/AIDS (UNAIDS), UNFPA, UNICEF and WHO, as well as the Church of Sweden, East African Community (EAC), Ford Foundation, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), Health and Development Africa Ltd, INERELA+, International Planned Parenthood Federation (IPPF) – Africa Regional Office, Rebranding HIV, Swedish International Development Cooperation Agency (SIDA) and Southern African Development Community (SADC).

Following two successful sub-regional civil society consultations in Johannesburg and Dar es Salaam, at which the report was reviewed in detail, a number of important revisions were incorporated. Important additional contributions were gathered at a meeting of the High Level Group in Botswana in July 2013 under the leadership of Prof Sheila Tlou (UNAIDS). A list of civil society organizations consulted is included in the full report.

UNESCO gratefully acknowledges the involvement and financial support of Germany's Ministry for Economic Cooperation and Development (BMZ), the OPEC Fund for International Development (OFID), the governments of Sweden and Norway, UNFPA, UNICEF, the Ford Foundation and IPPF.

1. INTRODUCTION

This report is the summary of an in-depth *Regional Report* into the education and sexual reproductive health status of adolescents and young people in Eastern and Southern Africa. The full report can be accessed online at the following link: www.unesco.org/aids.

1.1. Background

Adolescents and young people[1] represent the future of every society. Better education and public health measures can be hugely beneficial to their health and development (*Lancet*, 2012). For most adolescents and young people, this period of their lives is a time of enormous vibrancy, discovery, innovation and hope. Adolescence is also the time when puberty takes place, when many young people initiate their first romantic and sexual relationships, when risk-taking is heightened and 'fitting in' with peers becomes very important. It can also be a challenging time for young people, who are becoming aware of their sexual and reproductive rights and needs, and who rely on their families, peers, schools and health service providers for affirmation, advice, information and the skills to navigate the sometimes difficult transition to adulthood. This transition may catalyse a range of challenges including HIV infection, other sexually transmitted infections (STIs), unintended pregnancy, low education attainment or dropping out of education and training. These problems relating to physical health and other non-health issues may also be associated with a set of psycho-social problems that can impact negatively on the development and welfare of young people, particularly for young women. While boys and young men gain rights and social power in this transition to adulthood, in contrast, girls and young women growing up in many societies lose their rights and struggle to build the assets they need for later life.

In a global context, sub-Saharan Africa remains the region that is most affected by the HIV epidemic, despite positive signs that HIV prevalence is declining overall among young people in the region (UNAIDS, 2011, p. 53). The high numbers of new infections among young people in Eastern and Southern Africa (ESA) remain a serious concern, as is the fact that the majority of adolescents and young people living with HIV are growing up in the same region. HIV-related stigma and discrimination – including attitudes based on laws and policies – continue to hamper the region's responses to the epidemic, by preventing young people from accessing a range of key sexual and reproductive health (SRH) services. Despite being the region with the highest HIV prevalence among adolescents and young people, HIV knowledge levels remain persistently low. Common practices such as early sexual debut and child marriage in adolescent girls, high primary school dropout rates and low transition to secondary school, age disparate and transactional sex, coupled with weak protection and SRH systems, as well as weak adolescent health services overall, combine to create a daunting challenge in impacting the rights to education and health of adolescents and young people in the region.

In the recent past, a number of global and regional commitments and policy level statements have repeatedly underscored the linkages between SRH, education and services in terms of fulfilling the rights and meeting the development needs of adolescents and young people. Importantly, these declarations have come from both the education and health sectors and promote the roll-out of comprehensive sexuality education (CSE) and full access to necessary SRH services. The programme of action developed at the International Conference on Population and Development (ICPD) in 1994 underlines the importance of sexuality education 'both in and out of school' as part of the basic life skills that all young people require. Furthermore, it called for transparent and participatory accountability mechanisms to monitor the implementation of sexuality education

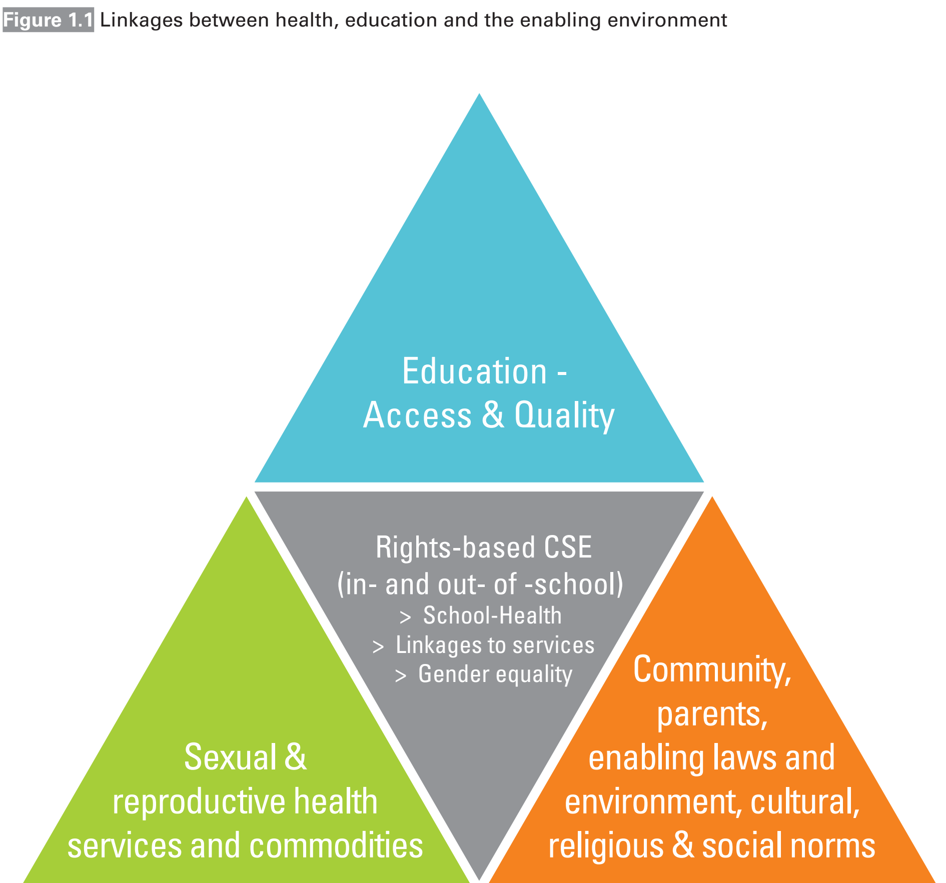
1 This report focuses on adolescents and young people who are defined as age 10–24 in most cases. At the same time, it recognizes the important differences in evolving capacity over this period in any young person's life cycle and the need to adapt accordingly.

programmes. More recently, the Commission on Population and Development (CPD) and a range of African-focused commitments and declarations clearly outlined a rights-based argument from young people on the need for SRH education (Commission on Population and Development, 2012). The African Commission-led Maputo Plan of Action (2006) and Maseru Declaration on the Fight Against HIV/AIDS in the SADC Region (2003) are two examples of particular relevance that focus on the region. Furthermore, the UN Secretary General's Global Education First Initiative (GEFI) made it clear that good quality education (including education on HIV) was fundamental to improving health outcomes, progress towards gender equality, economic opportunities and sustainable development. Global citizenship education is one of the three pillars of GEFI: empowerment of young people, promoting human rights and gender equality is a building block of citizenship education to which CSE makes a significant contribution. The Global Consultation on Education in the post-2015 debate has identified reproductive health as an important right and demonstrated linkages with education achievement and SRH status. The report highlighted the importance of CSE's contribution to the prevention of unintended pregnancy, violence and abuse, and gender-based violence.

At the same time, there are increasing demands from young people in the region for access to good quality CSE and health services, as articulated in the Mali Call to Action, the Bali Youth Forum Declaration and the post-2015 regional consultations on education and many other platforms.

While the mandates of the health sector and the education sector are clearly different, there are natural points of convergence around the needs of adolescents and young people, which include the issue of school health, the critical role that education plays in developing healthy populations and the joint responsibility of both sectors to ensure that poor health is not a barrier to achieving education. Linkages between these sectors are critical for ensuring a holistic approach. Other sectors also play an influential role in establishing an enabling environment for the SRH of young people.

Figure 1.1 Linkages between health, education and the enabling environment



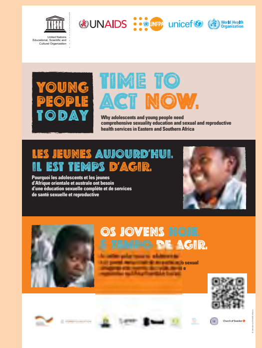
1.2. The ESA Commitment Process

In late 2011, under the leadership of UNAIDS and with the support of Germany's Ministry for Economic Cooperation and Development (BMZ) and the Regional Economic Communities (EAC and SADC), UNESCO initiated a process that aimed to develop and implement a commitment around the needs and rights of adolescents and young people, focusing on their sexual and reproductive health, education and services. Subsequently, the initiative has expanded and now includes core UN partners and civil society organizations from across the region with significant financial and technical support from Sweden, Norway, UNFPA, UNICEF, the Ford Foundation and the International Planned Parenthood Federation (IPPF). This initiative was inspired by a similar process that was led by the government of Mexico prior to the 2008 International AIDS Conference and that led to a ministerial-level declaration paving the way for sexuality education as a vehicle for responding to the HIV epidemic and re-affirming the linkage to services.

Figure 1.2 The ESA Ministerial Commitment Process

The ESA Ministerial Commitment Process is led by Professor Sheila Tlou, Director, UNAIDS Regional Support Team, with support from a Technical Coordinating Group including UN partners, civil society and bilateral partners.

A High Level Group, chaired by Professor Tlou, and including regional leaders such as former President Festus Mogae (Botswana) and Mama Salma Kikwete (First Lady of Tanzania), as well as a number of regional experts and leaders, will steer this process at a political level, culminating in a ministerial-level signing event planned for ICASA 2013 in Cape Town, South Africa.



Since the inception, the partners have completed two successful sub-regional civil society consultations, as well as a number of country-level validation meetings that have reviewed country-specific reports and provided recommendations for action.

More information on the Eastern and Southern Africa Ministerial Commitment Process is available at: http://www.unesco.org/new/en/hiv-and-aids/our-priorities-in-hiv/sexuality-education/east-and-southern-africa-commitment/

The partners involved in this process are aiming to secure a commitment from ministers of health and education from 21 countries in Eastern and Southern Africa. In order to bring together the two sectors around a common agenda, this report attempts to provide an up-to-date scan of the major trends in data, evidence and issues impacting on the education and health needs of adolescents and young people in the region. It is expected to inform discussion at regional and country level across 21 countries, as well as informing the response by all the partners involved in this initiative and supportive country-level actions thereafter.

1.3. Purpose and structure of this summary report

The full report (*Young People Today. Time to Act Now*) was developed in support of the ESA commitment process, to provide a regional assessment of the current status of HIV and sexuality education and SRH services for adolescents and young people, and to provide an evidence base for discussion related to policy change and programming for adolescents and young people in the Eastern and Southern Africa (ESA) region.

The report looks at the challenges facing adolescents and young people, and the policies and programmes that affect their futures – in terms of health, education and global citizenship. Far too often, the health and education needs of adolescents and young people are treated as mutually exclusive issues. As this report shows, it is time to break that artificial divide and instead focus and combine our efforts around a unifying vision – *a young African, a global citizen of the future*

who is healthy, resilient, socially responsible, an autonomous decision-maker and one who has the capacity to reach their full potential and contribute to the development of their community, country and the region.

This summary presents the synthesized findings of the regional report. It covers the health and social status of adolescents and young people in the region including access to education, HIV knowledge, HIV and unintended pregnancy prevalence, and key gender and human rights indicators. The report also presents an analysis of the responses under three thematic headings: sexuality education; sexual and reproductive health services; and gender, rights and contextual issues. Ten key recommendations offer guidance on how to move forward (see Chapter 6 – Recommendations).

Table 1.1 Countries included in the ESA Commitment Process

Angola	Madagascar	South Africa
Botswana	Malawi	South Sudan
Burundi	Mauritius	Swaziland
DR Congo	Mozambique	Tanzania
Ethiopia	Namibia	Uganda
Kenya	Rwanda	Zambia
Lesotho	Seychelles	Zimbabwe

Figure 1.3 Map of countries involved in the ESA Commitment Process

Note: Map is indicative and does not reflect official boundaries

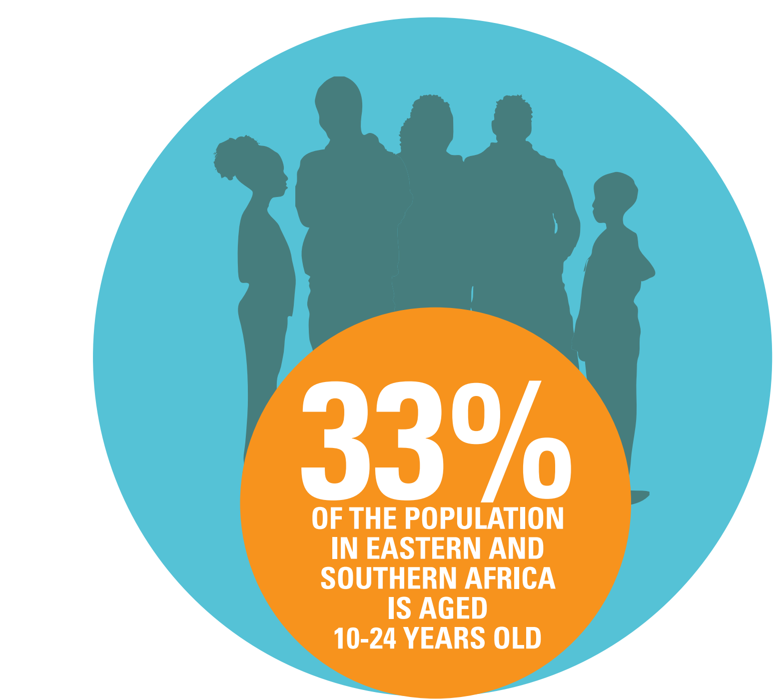
2. FINDINGS

This section presents findings on the health and social status of adolescents and young people in the region across 11 thematic areas.

2.1. Population

Adolescents and young people aged 10–24 make up an estimated 33 per cent of the population in Eastern and Southern Africa (UNFPA, 2012c). This population of 158 million is expected to grow to 281 million by 2050. In demographic terms, the region is experiencing a youth bulge, which has major implications for education, health and economic development overall. Young people will drive the development of the region over the next two decades – a demographic dividend in the making.

Figure 2.1 The Youth Bulge



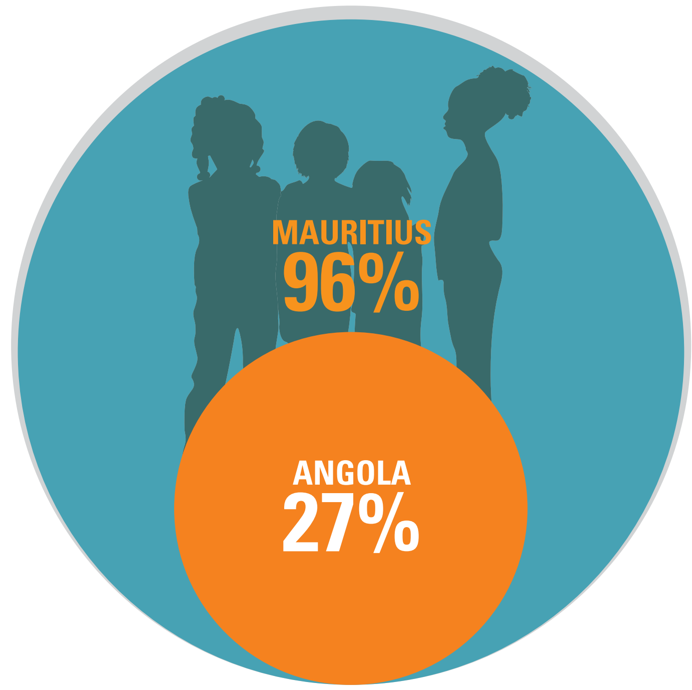
Source: UNFPA, 2012c

2.2. Access to education

The rewards of investment in expanded access to basic education across the region are visible in almost all countries in ESA. The official primary net enrolment rate stands at 87 per cent for both boys and girls, although there are regional variations (UNICEF, 2012). However, the completion rates of primary schooling remain a concern in a number of countries, and secondary school enrolment rates are not only considerably lower than primary school but show a gender disparity

(average for boys is 32 per cent and for girls is 28 per cent, with considerable country variations). For example, in Angola an estimated 27 per cent of girls were expected to complete the last grade of primary school.[2]

Figure 2.2 Girls expected to reach the last grade of primary school (2007-2009 data)

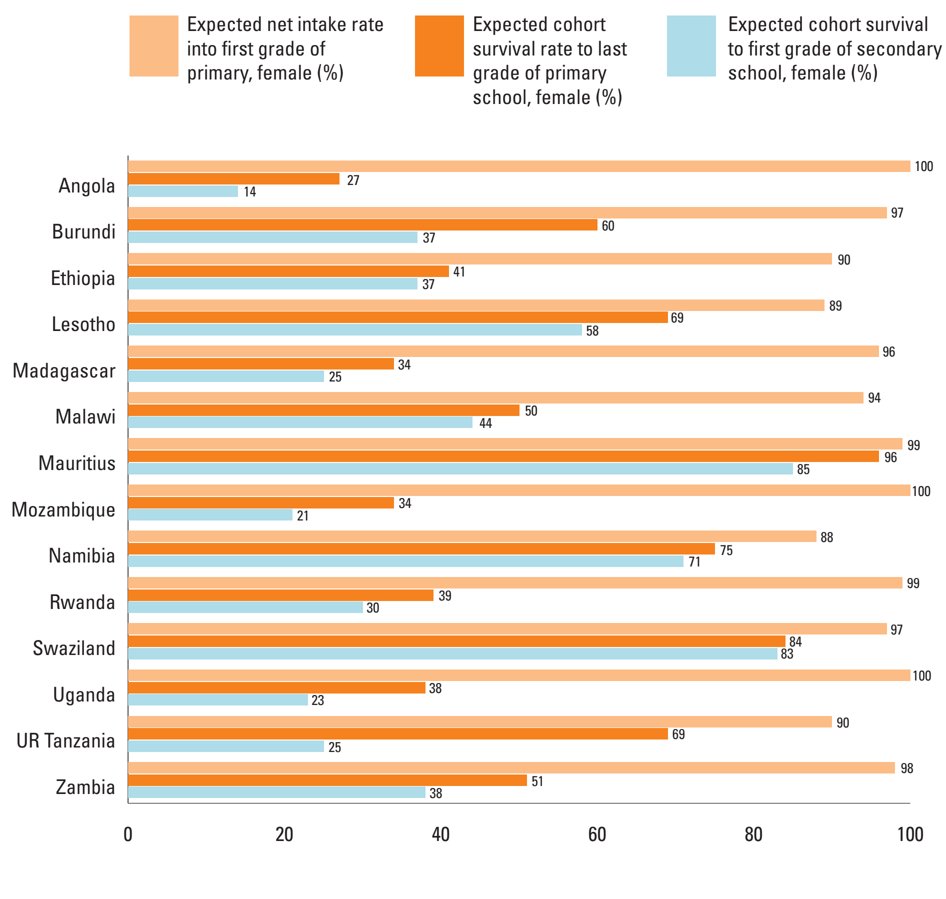


Source: UIS Database, 2012

In the majority of countries, secondary school completion is at very low levels – below 20 per cent. Again, using the Angolan example, only 14 per cent of girls in the same cohort were expected to make the transition to secondary school.[3] This sharp drop-off in school enrolment at secondary level is mirrored in a number of countries, including those where primary school access has improved considerably. As a result, most children and young people in the region are completing less than 6.5 years of education, which is inadequate in terms of the cognitive and other skills needed for the transition to young adulthood or the world of work. There is considerable variation across ESA in the numbers of adolescents who are out of school and their access to non-formal, vocational or informal education varies widely. The context of school can be quite diverse in secondary education. For example, in many countries secondary schools are established and managed by faith-based or private providers, which means access is based on the ability to pay fees and other entrance criteria, which can limit the potential for interventions. Figure 2.3 illustrates the chances girls have across the region of completing primary school, reaching secondary school and the likelihood of dropping out.

2 UNESCO Institute for Statistics (UIS) Database. Data for 2007–2010, depending on country (accessed 2012).
3 UNESCO Institute for Statistics (UIS) Database. Data for 2007–2010, depending on country (accessed 2012).

Figure 2.3 Expected cohort retention rate to last grade of primary school and first grade of secondary school among girls in selected ESA countries, 2010



Source: UIS, 2010

The number of out-of-school adolescents in some parts of the region is a concern – for example, Ethiopia has an estimated 3.1 million young people who are not in school. Bearing in mind that some children never make it to school in the first place, what are the reasons for drop out? To give just one example, girls in Tanzania cited economic hardship, aspirations for a better life and forced marriage as the factors behind their decisions to leave school (Restless Development, 2013).

The impact of limited educational opportunities and poor quality education on health and well-being is wide-ranging; a number of commitments have, and are being made, to increase primary school retention, to reduce costs for poor families, to improve the quality of education and to improve the transition from primary to secondary school for all learners. While recognizing the gains in access, there are still concerns about quality in the region. In this report, quality is looked at in the context of teaching and learning, and learning outcomes in sexuality education.

2.3. Adolescents and young people out of school

Overall, sub-Saharan Africa has high school drop-out rates, but there is considerable variation across ESA in the numbers of adolescents who are out of school. Most early school leaving occurs between the first and second grades. Across the region, about one in six pupils (17 per cent) leaves school before reaching Grade 2. The factors affecting dropout in Africa vary widely and include school safety and teenage pregnancy in the case of girls in higher grades. Overall in Eastern Africa, a recent report highlighted the following trends: despite progress, millions of children are still denied the chance to go to school; late entry and dropouts are major challenges

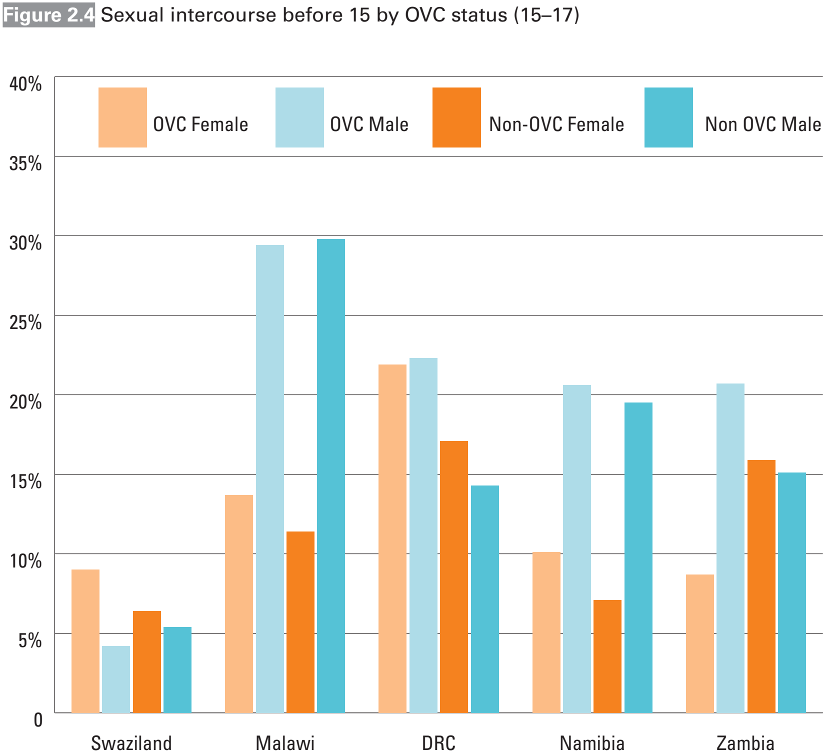
to achieving universal primary education; once in school, many pupils are not learning the basics; and progress in education is not reaching the marginalized (EFA Global Monitoring Report, 2013).

2.4. Children affected by HIV and AIDS

Despite the overall decline in AIDS mortality in the region, there are an estimated 10.5 million children living in the ESA region who have lost one or both parents to AIDS (UNAIDS, 2013). Despite increased access to treatment, numbers of orphans due to AIDS will continue to increase particularly in parts of sub-Saharan Africa[4]. The strain this imposes on families, carers and children themselves is well documented. HIV and AIDS continue to impoverish families, threaten children's schooling, nutrition and mental health, and increase children's risk of abuse and exploitation[5]. Global analysis of HIV related vulnerability show that double orphans usually have worse educational attendance than non-orphans and that poverty intensifies the impact of HIV and AIDS on children's lives. Research from South Africa shows that children orphaned by AIDS and those living with a parent with AIDS, face greater risks of emotional and physical abuse and sexual exploitation than other children.[6]

Figure 2.4 highlights the risks facing OVC – among a range of other challenges that children face in terms of SRH.

Figure 2.4 Sexual intercourse before 15 by OVC status (15–17)



Source: Country DHS reports

4 Belsey, M. & Sherr, L (2011) The definition of true orphan prevalence: Trends, contexts and implications for policies and programmes. Vulnerable Children and Youth Studies, 6:3.

5 United Nations Children Fund (2011) Taking Evidence to Impact, making a difference for vulnerable children living in a world with HIV and AIDS. UNICEF, New York

6 Cluver, L. Orkin, M. et al (2011) Transactional sex amongst AIDS orphaned and AIDS affected adolescents predicted by abuse and extreme poverty, Journal of Acquired Immune Deficiency Syndromes.

2.5. Child marriage

In Eastern and Southern Africa, UNFPA estimates that 34 per cent of women aged from 20–24 years old were married or in union by the age of 18 (UNFPA, 2012a). Many countries in the region are making some progress towards eradicating child marriage, including Ethiopia, Lesotho, Rwanda, Tanzania Uganda and Zimbabwe (UNFPA, 2012a). Despite this trend, however, the practice remains prevalent in some parts of the region and has direct negative consequences for the health, education and social status of girls and young women. In Mozambique, for example, an estimated 52 per cent of women were married or in union by age 18 over the period 2000–2011.

Box 2.1

In 2004, the Ethiopian government made it illegal for girls under 18 to marry. Despite the law, tens of thousands of girls are married every year by the age of 15. Many girls are forced to marry in secret ceremonies. This is Melka's story:

"I was 14. I'd just come home from school and there were so many people at my house. Everyone was dressed up and I asked my mother what was going on but no one would tell me. More and more people just kept coming. Then my mother brought me a dress and said 'Here. Put this on. You're getting married.' After the wedding, they took me to his house in the next village. He was so old. He started pushing me towards the bedroom. I didn't want to go inside but no one would listen to me. I woke up in the hospital (…) The nurses told the police what happened. My stepfather and the man they forced me to marry went to jail, my mother did too. The marriage was annulled. It was hard, but I've come out stronger. Before this happened I was shy and couldn't look people in the eye. Now, I'm not scared of anything."[7]

2.6. Sexuality, risk and decision-making

The age at sexual debut is a key indicator when considering health outcomes, particularly when making programming choices about education or services. There is considerable variation between countries and self-reported figures in Demographic Health Surveys (DHS) show higher average ages (around 17–18 in many countries) than other evidence, for example, on adolescent pregnancy. In Kenya, Lesotho, and Malawi adolescent males are more likely to report being sexually active before the age of 15 than girls (UNFPA/PRB, 2012). Significant numbers of girls are childbearing by the age of 15. By the age of 17, at least 10 per cent of young women in 10 countries in the region have started childbearing. It is important to recognize that, for many girls and young women, the first sexual encounters are forced, an issue that is dealt with in greater detail later in the report (see Section 2.11).

The types of relationships that adolescents and young people are engaged in also have an important impact on their sexual and reproductive health. Multiple and concurrent partnerships and inter-generational sexual relationships are both recognized as drivers of the HIV epidemic in the region; in three countries (Lesotho, Madagascar and Swaziland) more than one in four young men aged 15–24 report being involved in multiple concurrent sexual relationships (DHS data). In four countries in the region, more than 10 per cent of young women report being involved in a relationship with a man more than 10 years their senior, presenting a range of challenges, particularly around the ability to negotiate condom use, and the longer sexual history of the male partner. In some countries, women most at risk of engaging in inter-generational sex are young women of school-going age. Transactional relationships (for money, gifts such as school provisions or shelter and protection) are also common and further disempower the receiving partner, usually girls or young women. Studies have found that, the greater the economic gift or transfer, the less likely it is for safe sex to be practised (Luke, 2008).

7 Girls Not Brides (n.d.) Melka's Story, Ethiopia (http://www.girlsnotbrides.org/girls-voices/melkas-story/).

Positive changes in high-risk sexual behaviour are evident in Kenya, Malawi, Mozambique, Namibia and Zambia, but increases in sexual risk behaviour have been found in the Democratic Republic of Congo (DRC) and Rwanda (Luke, 2008).

2.7. HIV knowledge levels

A trend in the region has shown that knowledge about HIV prevention is increasing among young women and young men. In Rwanda, for example, the proportion of young women with comprehensive knowledge of HIV prevention rose from 23 per cent in 2000 to 51 per cent in 2009. However, in general, young people's knowledge levels regarding HIV remain low, with less than 40 per cent of young people in the ESA region having sufficient knowledge about HIV prevention.[8] The regional average of comprehensive knowledge of HIV and AIDS stands at 41 per cent for men and 33 per cent for women. The average for sub-Saharan Africa is 26 per cent for females aged from 15–24, which is still far below the 2010 target of 95 per cent comprehensive knowledge set at the United Nations General Assembly Special Session on HIV/AIDS in 2001.[9]

Figure 2.5 Comprehensive knowledge about HIV and AIDS among youths aged 15–24 years

Male
Female

Burundi
Ethiopia
Kenya
Lesotho
Madagascar
Malawi
Mozambique
Namibia
Rwanda
Swaziland
Tanzania
Uganda
Zambia
Zimbabwe

0% 10% 20% 30% 40% 50% 60% 70%

Source: UNICEF, 2013

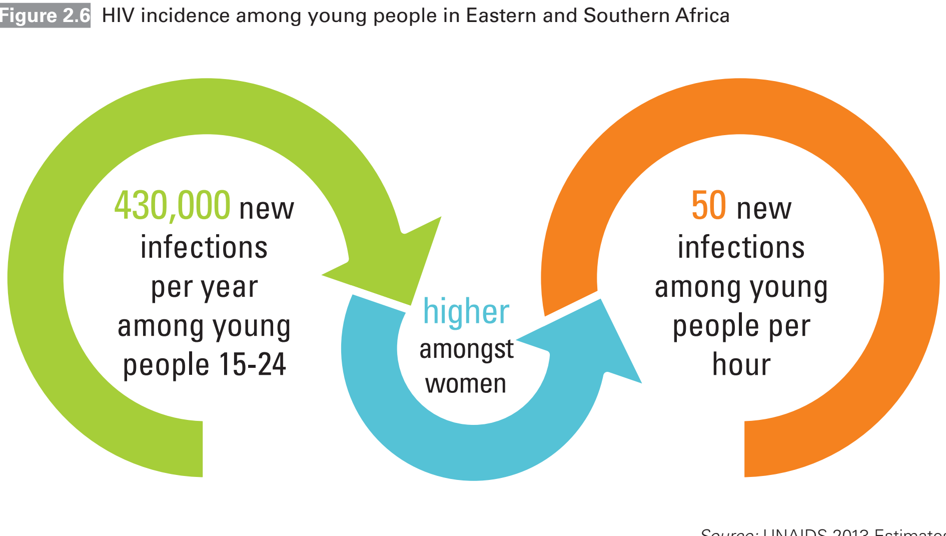
8 UNAIDS Country Data from 2010 (http://www.aidsinfoonline.org).
9 UNAIDS Country Data from 2010 (http://www.aidsinfoonline.org).

2.8. HIV and other sexually transmitted infections

Overall, the Eastern and Southern African region remains the epicentre of the global HIV epidemic, with 18.5 million people living with HIV and prevalence rates among young people ranging from 0.2 per cent (Eritrea) to 15 per cent (Swaziland). It is estimated that 2.6 million young people aged from 15–24 years old were living with HIV in 2012 in the ESA region. The regional HIV prevalence among young women aged 15–24 years old is 4.3 per cent, which is two and a third times higher than among men of the same age.

While recent data show a levelling off in HIV incidence in the ESA region, the reality is that young people currently, and for the foreseeable future, will need to deal with the complex and multi-dimensional factors that drive the epidemic. Adolescents are more vulnerable to HIV infection because of their age, biology and legal status. Thanks to better access to affordable treatment, adolescents and young people living with HIV are living longer, healthier and more productive lives. However, like most other adolescents and young people, they face continuing obstacles in terms of education and health (Baryamutuma and Baingana, 2011).

Figure 2.6 HIV incidence among young people in Eastern and Southern Africa



Source: UNAIDS 2013 Estimates

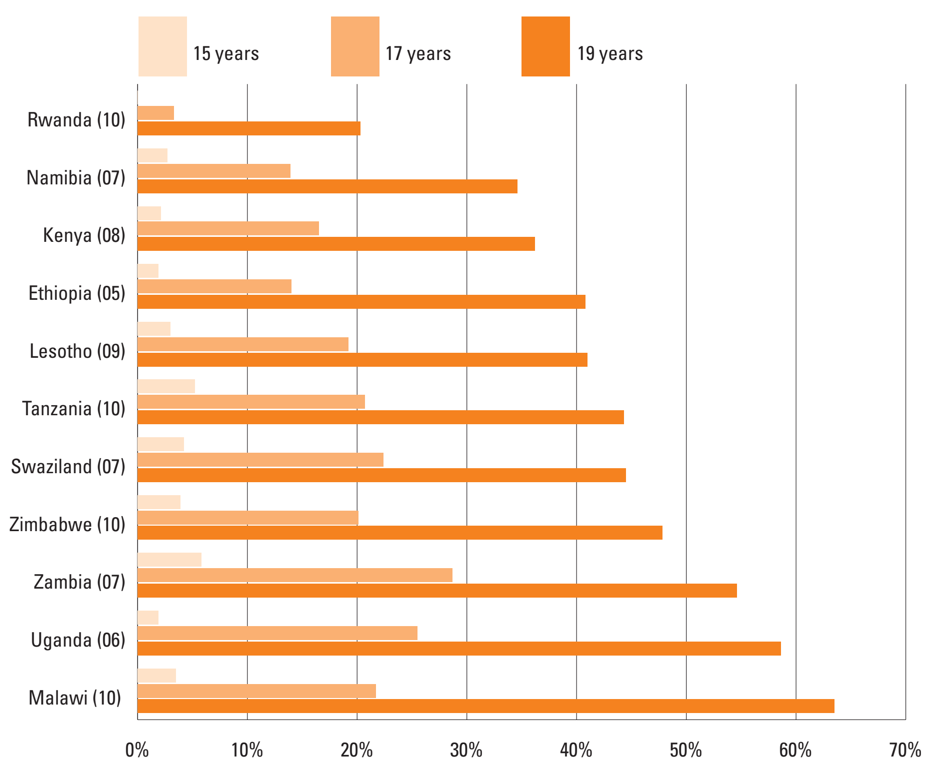
2.9. Teenage pregnancy

By age 17, at least 20 per cent of young women in six countries in the region have started childbearing. This rises to over 35 per cent among 19 years olds in 10 countries.

Data from across the ESA region show that adolescent fertility rates remain persistently high at 108.2 live births per 1,000 girls aged 15–19. This is two times higher than the world average, which is 53.4 per 1,000 girls.[10] The rates are especially high in Uganda, Zambia, DRC, Malawi and Mozambique. In Malawi, for example, more than 50 per cent of women had given birth by the age of 20 (EQUINET, 2012, p. 14). Adolescent pregnancy often brings detrimental social and economic consequences for a girl, her family and the broader community (Global Campaign for Education, 2010), especially if it leads to a girl dropping out of school. The health risks for adolescents are also greater, with higher risks of birth complications and maternal mortality.

10 UN Population Division, 2012.

Figure 2.7 Percentage of females (15, 17 and 19 years of age) who have started childbearing (DHS data)



Source: Olson, R, 2012

However, there are important socio-cultural factors that influence adolescent decision-making about pregnancy, with many young women choosing parenthood and many young women getting married. Unintended pregnancies are a challenge: despite high levels of knowledge about modern methods of contraception, a large cohort of young people do not use contraception and many use it inconsistently and incorrectly.[11] Access to termination of pregnancy is extremely limited in most countries in this region. The most restrictive laws are those that either permit abortion only to save a woman's life or ban the procedure entirely, which are applied in 9 out of the 21 ESA countries.[12] According to the World Health Organization (WHO, 2008b):

- In 2008, there were an estimated 5.5 million unsafe abortions in sub-Saharan Africa, including 2.4 million in Eastern Africa and 120,000 in Southern Africa.
- In sub-Saharan Africa, women under the age of 25 account for 60 per cent of all unsafe abortions.
- 14 per cent of maternal deaths in Africa (including Northern Africa) are the result of unsafe abortion.
- It is estimated that, in several African countries, up to 70 per cent of all women who receive treatment for complications of abortion are under 20 years old.

There is a notable jump in childbearing between girls aged 17 and 19 in many countries in the region – suggesting that age 17–18 is a critical age for young women making choices about, or requiring access to, contraception.

11 See http://www.who.int/gho/maternal_health/reproductive_health/family_planning_text/en/index.html.
12 The World Abortion Laws 2012.

2.10. Maternal mortality

Medical complications from pregnancy and childbirth are among the leading causes of death for girls aged 15–19 globally. By investing in overall strengthening of peri-natal care programmes and, in particular, focusing on the way that adolescents and young women can be reached, rates of maternal mortality and complications such as fistula can be significantly reduced.

A combination of factors impacts on adolescent women. For example, in Zimbabwe, 4 per cent of girls are married by the age of 15, which increases to 30 per cent by the age of 18. An estimated 38 per cent of maternal deaths are related to AIDS (Africa Public Health Info., 2012). Remaining in education, delaying marriage and pregnancy and access to services will make the biggest difference in this scenario.

2.11. Sexual and gender-based violence

In most ESA countries, the age of consent for sex is above 16 years and the minimum legal age for marriage is above 18 years. Despite these restrictions, however, over 10 per cent of girls had their sexual debut before the age of 15. By comparison, adolescent girls in developed countries may initiate sexual activity at the same age or younger – the difference is in the protective factors in their environment, including education and health services. For many adolescent girls in the ESA region, sex, marriage and pregnancy remain neither voluntary, consensual nor informed.

A high percentage of women report having experienced sexual violence at some point in their lives: between 15–35 per cent in the nine countries for which data are available. The rates are higher for women aged 20–24 than those aged 15–19. A Southern and Eastern Africa Consortium for Monitoring Educational Quality (SACMEQ) study on violence in primary schools across 15 education systems in the region provides evidence that violence of various forms (including sexual harassment) is pervasive and increased during the period 2000– 2007 (Saito, 2011). Cultural traditions and weak legal infrastructures for preventing or reporting violence play a key role.

3. Sexuality Education

Defined and often labelled in many different ways, sexuality education usually involves teaching and learning on issues relating to human sexuality. Comprehensive sexuality education (CSE) emphasizes a holistic approach to human development and sexuality (IPPF, 2011). UNESCO identifies the primary goal of sexuality education as follows: "children and young people become equipped with the knowledge, skills and values to make responsible choices about their sexual and social relationships in a world affected by HIV" (UNESCO, 2009a, p. 3).

Evidence has shown that CSE that is scientifically accurate, culturally and age-appropriate, gender-sensitive and life skills-based can provide young people with the knowledge, skills and efficacy to make informed decisions about their sexuality and lifestyle (UNESCO, 2009a). Research points to the fact that CSE can effectively delay sex among young people, as well as increasing condom and overall contraceptive use among sexually active youth (Boonstra, 2007, p. 5).

3.1. A supportive legal and policy environment for implementation

Strong international agreements exist to promote the roll-out of CSE. These include the Convention on the Rights of the Child (CRC) and the Committee on the Elimination of Discrimination Against Women (CEDAW). The International Conference on Population and Development (ICPD) in 1994, the Fourth World Conference on Women in 1995 and the World Summit on Children in 2002 have extended the scope of the CRC, by affirming the right of all children and adolescents to receive SRH information, education and services in accordance with their specific needs (WHO, 2011a). The Framework for Action in Sub-Saharan Africa, the Maputo Plan of Action, the African Youth Charter and a range of other regionally focused declarations and strategies further stress the need for education on HIV, reproductive health and gender. Concrete progress has been made in the legal protection of women's rights. However, the adoption and domestication of regional instruments by many member states has been slow, and implementation is often not systematic or harmonized. Across countries in the ESA region, gaps remain between the numerous agreed legal instruments and policies that are in place and actual implementation on the ground.

All countries in the region report having a policy or strategy to promote life skills-based HIV education for young people, but many face challenges in the implementation. The limited evidence available indicates that few of these policies or strategies are fully operationalized and costed. Very few countries stipulate explicitly that private and faith-based schools also have to provide sexuality or HIV education. Despite policies or frameworks, the teaching of sexuality education may still be selective, with some topics being excluded as teachers respond to cultural and religious norms and their own personal attitudes.

3.2. Content, teaching and delivery of CSE programmes

Sexuality education in Africa has largely focused on stemming the growing AIDS epidemic. Most countries have reported that they provide life skills-based HIV education in the curriculum at primary and secondary level as well as during teacher training. However, the results of a regional curriculum scan carried out by UNICEF, UNFPA and UNESCO in 2011 highlight that gaps or concerns are found in over 70 per cent of the topics or areas of the curricula reviewed for 10 ESA countries. The scan reviewed existing curricula according to six core learning areas, namely: generic life skills; adolescent and reproductive health; sexuality education; gender equality and empowerment; HIV and AIDS and other STIs; and stigma and discrimination. Overall, the content was found to be generally age appropriate, and addressed communication skills effectively. However, certain gaps were noted, including information on key aspects of sex and sexual health, information about condoms and contraception, and insufficient or contradictory messages about gender and human rights. Finally, it was noted that references to sexuality tended to be negative and based on fear.

Table 3.1 Overview of 10-country sexuality education curriculum scan: identifying gaps in content and approach

Countries and curricula	Topics						Topics & approach			Teaching methods		
	A	B	C	D	SRH E	SRH F	G	H	I	J	K	L
Botswana (Pre-Secondary, 2010)	grey	orange	orange	light orange	orange	orange	grey	grey	light orange	light orange	grey	light orange
Kenya (Primary & Secondary, 2008)	orange	orange	orange	orange	orange	grey	orange	orange	grey	light orange	orange	light orange
Lesotho (Standard 4, Form C)	grey	orange	orange	orange	orange	light orange	orange	light orange	grey	grey	light orange	light orange
Malawi (Primary & Secondary)	light orange	grey	orange	orange	orange	light orange	light orange	light orange	orange	orange	grey	grey
Namibia	grey	orange	orange	orange	orange	orange	orange	grey	orange	grey	orange	light orange
South Africa	orange	orange	orange	orange	orange	orange	orange	orange	light orange	grey	grey	light orange
Swaziland	grey	light orange	grey	orange	orange	light orange	light orange	grey	orange	grey	grey	grey
Uganda (LPS for Prim. & Sec. 2009)	orange	orange	orange	grey	grey	orange	grey	grey	light orange	grey	orange	orange
Uganda (ASRH/LPSO-Level, 2009)	orange	light orange	orange	orange	orange	grey	light orange	orange	light orange	orange	orange	orange
Zambia (Life Skills Framework, 2010)	grey	light orange	orange	orange	orange	grey	light orange	grey	orange	grey	grey	grey
Zambia (BE Syllabi Grades 1-7, 2003)	orange	orange	orange	orange	light orange	orange	orange	orange	orange	grey	grey	grey
Zimbabwe (HIV&AIDS/LSE Prim., 2003)	light orange	orange	grey	orange	orange	light orange	orange	orange	light orange	grey	grey	light orange

Topics:

A. Self and others; relationships, incl. power in relationships
B. Human development; puberty, body and reproduction
C. Sexuality and sexual behaviour
D. Communication, negotiation and decision-making skills
E. Gender focus, human rights base
F. Age appropriateness
G. Empowering YP/amplifying YP's voices
H. STIs/HIV/AIDS: Prevention, incl. condoms
I. Treatment and care
J. Pregnancy, contraception and abortion
K. Critical thinking skills
L. Personalizing content, diverse methods

(grey) No significant gaps or concerns

(light orange) Topics or areas that are missing or weak – minor to moderate

(orange) Topics or areas that are missing or weak – moderate to serious

Adapted from: UNFPA, UNESCO, UNICEF, (2013). *Sexuality Education Curricula in East and Southern Africa: Results of a 10-Country Review.*

Training and orientation of teachers on essential topics of sexuality education are reported in most ESA countries. Effective teaching is a critical part of the success of sexuality education and all educators require appropriate training and support. Good policy and practice in pre-service teacher training is documented in by UNESCO (UNESCO, 2011c).

However, significant gaps in teacher confidence and classroom delivery have also been noted in the region. Lack of confidence in the subject matter and social norms preventing talking about sensitive subjects such as relationships or sex have been cited by teachers as barriers to delivering certain topics. Equally, teaching approaches such as a focus on affective (emotional) learning and critical thinking, and participatory teaching methodologies require strengthening before it is possible to deliver CSE effectively.

Significant challenges remain in the preparation and capacity development of teachers, and there is a lack of national-level costed strategies, coordinated mechanisms and monitoring and

evaluation (M&E) for most countries to address the challenges for teacher training and education. Lack of teaching and learning materials and excessive teacher workload are also reported as key barriers.

"Ministries of education are responsible and accountable for what gets through to learners – it is important that that the Ministry leads [in the process of HIV and sexuality education], and that others come to complement and support."

Jemimah Nindo, Teacher Service Commission (Kenya)

Regional and country-level efforts are underway to review and improve the curriculum content in most countries in the region, and in some countries there are actions to strengthen teacher training and support.

Delivery of sexuality education can be found in a variety of modalities in different settings. In the school setting, 12 out of 13 ESA countries reported having made HIV and related life skills issues a compulsory part of the curriculum, and eight of them made it examinable. However, CSE components are often not taught as planned, either because it is 'not taken seriously', or because other topics take priority.

Out-of-school young people are generally reached through peer education and youth-friendly, centre-based education interventions. However, the effectiveness of peer education programmes in achieving health-related behaviour change has not always been clearly demonstrated. Very few countries have made systematic efforts to mobilize parent and community support (UNESCO, 2012c), despite this activity being instrumental to the success of implementing comprehensive sexuality education.

3.3. Coverage and quality of CSE

Rapid progress towards universal primary education is being made across the ESA region. However, the high drop-out rates between primary school and secondary school, especially for girls, are still of concern in some of the countries (as discussed in Section 2.2 above). This has significant implications for efforts to scale up sexuality education. Whereas school-based programmes can be cost-effective for reaching adolescents and young people, a large number of adolescents will miss out on this educational opportunity until secondary enrolment rises. It is therefore critical that school-based CSE starts early, at primary school level, to reach adolescents before puberty, before sexual debut and before they are lost to the formal education system. Non-formal education programmes should be strengthened within the community, using the same content guidelines proposed for in-school programmes. As with in-school programmes, non-formal programmes should be adapted to the age and development of participants and should be specially tailored to the needs of hard-to-reach or vulnerable young people.

Non-formal, and formal education, may benefit from harnessing increasing access to and the evolving capabilities of new information communication technologies. Country reports indicate a high percentage of coverage by school in most countries, regardless of the content and quality of the programmes. The success of reaching out-of-school young people with HIV and life skills programmes has been estimated at below 50 per cent for the majority of the countries reviewed.[13]

The persistently low levels of HIV knowledge among adolescents and young people suggests an urgent need to improve the quality of the delivery of HIV and sexuality education in most ESA countries. A 2009 study of learner and teacher knowledge of HIV and related health issues by SACMEQ[14] found that two thirds of Grade 6 learners did not have the minimal level of knowledge about HIV and AIDS required to preserve and promote their health. However, teachers generally had high levels of knowledge about HIV. The study concluded that teachers lacked both the mandate and the skills (including confidence) to transmit this knowledge to learners.

13 The estimations were made by the national-level education officials and civil society representatives who participated in a roundtable meeting to respond to the Global Progress Survey on Education Sector Responses to HIV and AIDS, commissioned by the UNAIDS Inter-Agency Task Team on Education in 2011–2012. The survey covered 39 countries globally, of which 14 came from the ESA region.

14 The Southern and Eastern Africa Consortium for Monitoring Educational Quality (http://www.sacmeq.org/reports.htm#policy_series).

One aspect of sexuality education that is often considered particularly challenging is the teaching of condoms as contraception or HIV prevention. Condom education for young people is often a controversial issue because issues of sex, sexuality and condom use are rooted in complex social and inter-personal dynamics. Across the ESA region, attitudes towards sex and condoms associate condom use with promiscuity and unfaithfulness, as well as interfering with pleasure, fertility and the meaning and purpose of sex (Maticka-Tyndale, 2012, p. 66). However, among adolescents and young people, evidence shows that eliminating information about condoms in favour of abstinence-only messages can lead to a higher incidence of unprotected sex at first intercourse and unfavourable attitudes towards condoms in the future. Evidence on sexuality education in general shows that abstinence-only messages are the least effective for young people (UNESCO, 2009a), and that education, as well as services, must focus on increasing health behaviours, which includes condom use.

Monitoring of the delivery and quality of CSE is still limited, with less than one third of ESA countries having established monitoring systems for CSE. Serious efforts are now underway in some countries to integrate HIV-sensitive indicators in Education Management and Information Systems (EMIS), including systems to measure the process and outcomes of life skills-based HIV and sexuality education.

Donor investment in CSE is increasing, with new initiatives focused on scale up in at least six countries, including Lesotho, Malawi, Mozambique, Tanzania, Uganda and Zambia, expected to reach 35,000 schools, 74,000 teachers and 15 million learners across the region over the next two and a half years.

3.4. Impact, cost and cost-effectiveness of CSE

Existing evidence, although very limited, suggests that sexuality education programmes have improved the knowledge level of learners that may have contributed to behaviour change, when these programmes are well implemented.

No systematic efforts have been made to analyse or document the cost or cost-effectiveness of the national comprehensive sexuality education programmes in the region. However, evidence available from international country case studies has shown that:

1) CSE programmes can have significant health outcomes and non-health benefits (for example, the potential to reduce gender inequality and gender-based violence); and
2) can be delivered at reasonable cost in low-, medium- and high-income country contexts, and thus calls for policymakers to seriously consider investing in sexuality education programmes in order to improve the sexual health of their populations and make a positive impact on non-health outcomes (UNESCO, 2011b).

3.5. Conclusions

The review of the status of HIV and sexuality education in Eastern and Southern Africa has revealed both positive trends and gaps and challenges in ensuring that adolescents and young people have full access to quality HIV and sexuality education. These are summarized below:

- Evidence shows that CSE programmes can improve the knowledge level of learners, which contributes to behaviour development and change for better health outcomes, and can be highly cost-effective, especially when compulsory, adapted from existing models and integrated into the mainstream school curriculum.
- Progress has been achieved by most countries in developing political and policy support for CSE, integrating sexuality education in school curricula; building the capacity of teachers and educators; and working with non-governmental and civil society organizations, including

youth networks, to reach out-of-school adolescents and young people with appropriate HIV and sexuality education.

- While a number of relevant policies and commitments exist, gaps and challenges remain in translating these political commitments and policy frameworks into costed operational strategies and plans supported with nationwide coordination and monitoring mechanisms for enforcing/reinforcing multi-sectoral implementation. Specific barriers have been noted in: mobilizing parent and community support; improving the existing curriculum and learning materials so that they are comprehensive enough to address all the health and development needs of adolescents and young people; building the capacity of teachers and educators; and expanding the evidence base of coverage and quality, cost and cost-effectiveness, outcomes and impact of comprehensive HIV and sexuality education.

- Barriers against scaling up CSE could also have reflected issues within the broader educational system that are not unique to this field. These include: the philosophy of education whereby sexuality education and health issues are seen as subordinate to more 'cognitive' subjects, and thus are not examinable; teachers and curriculum are overloaded; teacher shortage, low pay, absenteeism/illness (particularly in high HIV-prevalence settings) and transfer; uneven distribution of teachers; large class sizes within some settings; reduction in educational funding translates into difficulty in securing resources to establish curricula, train teachers and provide materials; and weak systems for monitoring and evaluation/supervision.

A strong political commitment in the region is therefore required to operationalize many of the existing policy frameworks and to accelerate the progress towards clearly defined and time-bound targets in terms of coverage and quality of CSE for all adolescents and young people in the region.

4. SEXUAL AND REPRODUCTIVE HEALTH SERVICES

In order to fully exercise their right to health, including sexual and reproductive health (SRH), all adolescents and young people require safe, effective, affordable and acceptable access to a range of services – particularly services related to pregnancy, HIV and STI prevention, testing and treatment. These essential SRH services and commodities include, but may not be limited to:

- modern contraception (female and male condoms, hormonal contraception such as pills or injectables, implants, intrauterine devices (IUD) and diaphragm);
- abortion (where legal);
- post-abortion care; pregnancy advice and care;
- prevention of mother-to-child transmission of HIV (PMTCT);
- safe delivery and post-partum care;
- voluntary medical male circumcision;
- diagnostic testing and treatment for STIs; and

- confidential testing and counselling for HIV, as well as treatment and care services for young people living with HIV.

"Young people have the right to access the highest attainable standard of health which requires removing of the legal, social, and policy barriers that prevent them from accessing the health information and services that they need."

Rishita Nandagiri and Rinaldi Ridwan, youth representatives and co-chairs, International Steering Committee
Opening Speech, ICPD Global Youth Forum, Bali
December 2012

There is widespread recognition that there are SRH services that effectively improve adolescent health (WHO, UNFPA, UNICEF, 1999). There is also evidence to show that young people of varying ages are involved in sexual relationships and therefore need services. However, the delivery of SRH services to adolescents and young people is made complex by legal, cultural and religious norms.

4.1. Legal and policy support for sexual and reproductive health services

A broad range of international and regional commitments, agreements and plans of action exist that explicitly recognize the rights of adolescents and young people to exercise their right to health and to access SRH services. The International Conference on Population and Development (ICPD, 1994) was a critical milestone in creating the link between sexuality education and SRH services for young people. Equally, policymakers in the ESA region have been increasingly focusing on this issue. The African Union (AU) has contributed to advancing human rights protections, and worked closely with regional structures such as the Southern Africa Development Community (SADC) and Eastern Africa Community (EAC) to strengthen norms, provide mechanisms for peer review, and assist countries in codifying human rights stipulations within domestic policies and institutions.[15] The array of treaties establishing standards for human rights commitments is broad. Guided by continental and regional SRH and rights policies and strategies, member states have a clear mandate to develop, implement and evaluate effective policies and strategies related to sexuality education and SRH leading to the improvement of related health outcomes for young people. A number of protocols and commitments have been established to which the majority of countries in the ESA region have signed up.

However, the evidence presented in the full diagnostic report suggests that many of these commitments remain partially or wholly unrealized, often due to policy gaps, lack of budget or a lack of monitoring, among other issues. One major issue is the lack of harmonization between legislation and policy. A number of existing legislative and policy frameworks that are in place in many ESA countries serve as barriers to young people wanting to access SRH information and services.

4.2. Age of consent and evolving capacity

In order to develop services for adolescents and young people, there needs to be an appropriate balance between protection and autonomy. Laws on the age of consent are designed to protect children. These relate to the age at which children can consent to sex, marriage and access to SRH services such as HIV testing and contraception. As such, the law is an important part of protecting children and young people from abuse. However, these protective laws may also have important limiting effects on access to services. Legislation relating to the SRH of adolescents and young people, including the age of consent to sex and to services, should be reviewed to ensure that the appropriate balance between protection and autonomy is achieved.

The legal and social status of young people as individuals who lack the full autonomy of adults but are also rights holders creates a unique dichotomy that many health professionals, youth workers, legislators, educators and parents find difficult to navigate. Nowhere is this dichotomy

15 Council on Foreign Relations (http://www.cfr.org/human-rights/global-human-rights-regime/p27450).

more pronounced than in relation to children and young people's access to SRH services and information. Services are often withheld from young people because of their age, thereby exacerbating the vulnerabilities they face and violating the rights afforded to them under international and regional human rights law (IPPF, 2012b).

▶ Age of consent to services

Access to services such as contraception, post-abortion care or HIV testing will be limited if a young person requires adult (usually parental) consent. In some countries, modified laws reflect the evolving capacity of young people and allow access to services focusing on the public health benefits. Significant progress has been made in the ESA region in promoting HIV testing and counselling (HTC). However, challenges still remain related to consent to HTC, especially among young people. In a review by the Centre of Human Rights at the University of Pretoria in South Africa, five out of six countries in Southern Africa were found to have policies on the minimum age for independent access to HIV testing.[16] This is an important issue for adolescents in the ESA region, as the lack of consensus on the legal age of self-consent to HTC means that the need for parental or guardian consent becomes a barrier for some adolescents in obtaining testing.

▶ Age of consent to sexual intercourse

The age of consent for sexual intercourse varies widely between countries, and sometimes between sexes. One of the public health implications of a low age of consent to sex is that relevant services or laws may need to be aligned so that young people may access SRH services legally. However, aligning sexual health services with a specified age can be problematic. Viewing sexual health service delivery on a 'by need' basis can ensure that those who are sexually active, or those individuals who are more at risk, can access services independently. For example, in South Africa the age of consent for HIV testing is 12 years old, but the age of consent for sex is 16 years. Viewing service delivery on a by need basis allows medical professionals to exercise their discretion on the capacity of the child or young person, which is an important part of achieving a needs-based approach that balances protection and autonomy, while promoting good health. Training for medical professionals to ensure that they are able to serve the best interests of adolescents through the exercise of this discretion is critical.

4.3. HIV and the law

The Global Commission on HIV and the Law[17] recommends that sexually active young people should have confidential and independent access to health services in order to protect themselves from HIV. The Commission calls on countries to reform relevant laws to ensure that the age of consent for autonomous access to HIV and SRH services is equal to or lower than the age of consent for sexual relations (Global Commission on HIV and the Law, 2012).

The Commission reviewed six areas of legislation that directly impact on HIV services for both prevention and care and found that a range of laws that specifically criminalize certain behaviours in relation to HIV are very prominent in this region. The majority of countries criminalize HIV transmission, consensual sexual activities between people of the same sex, and sex work. These laws all limit the ability of HIV prevention or care services to reach the most vulnerable populations, and create an environment of fear and stigma that will limit the uptake of general HIV services that may be available.

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16 Legal and policy issues related to HIV and young people in selected African countries. Preliminary information, compiled by the Centre for Human Rights, Faculty of Law, University of Pretoria as part of the African Human Rights Moot Court Competition, 2010.

17 The Global Commission on HIV and the Law is an independent, global process led by law-makers and designed to analyse and generate evidence on rights and law in the context of HIV, increase awareness among constituencies and develop rights-based and evidence-informed recommendations. The Commission published its landmark report, *HIV and the Law: Risks, Rights and Health*, in 2012.

4.4. Sexual and reproductive health services

SRH services offer a range of health, social and economic benefits for young people.[18] They can help to reduce unwanted pregnancies, maternal mortality and unsafe abortions (Bongaarts, 2008), as well as preventing STIs including HIV.

Many of the essential SRH services needed by adolescents and young people already exist in the ESA countries and are delivered through a mixture of public, private and non-governmental organization (NGO) providers. However, coverage of services is usually mixed, with rural areas less well served than urban and peri-urban areas. Costs of services vary widely and services have usually been designed for the general population and not specifically for adolescents and young people. If services are provided in an appropriate way, they can offer important positive impacts for young people.

4.5. Contraceptive access, use and availability

Modern contraceptive use among adolescents is generally low. Despite high levels of knowledge about these methods, many young people do not use contraception and some use contraceptives inconsistently and incorrectly. On average, modern methods of contraception meet approximately 50 per cent of young people's family planning demands, with wide country variations (see Figure 4.1).

Contraceptive use rates also tend to decrease with economic status. Fewer than 5 per cent of the poorest young people use modern contraception (UNFPA, 2012b). Some of the obstacles that adolescents face in obtaining contraceptives are related to availability, accessibility and acceptability (WHO, 2012b). Even if supplies or services are available to the general public, they may not be available to young people because of the law, or because of the personal value judgements of service providers. Actions to overcome these barriers to contraceptive use at various levels have recently been recommended by WHO and include: reforming laws and policies to enable all adolescents to obtain contraceptives and information; reducing the cost of contraceptive services; educating adolescents about contraceptive use; and, increasing community support for contraceptive provision to adolescents (WHO, 2011b).

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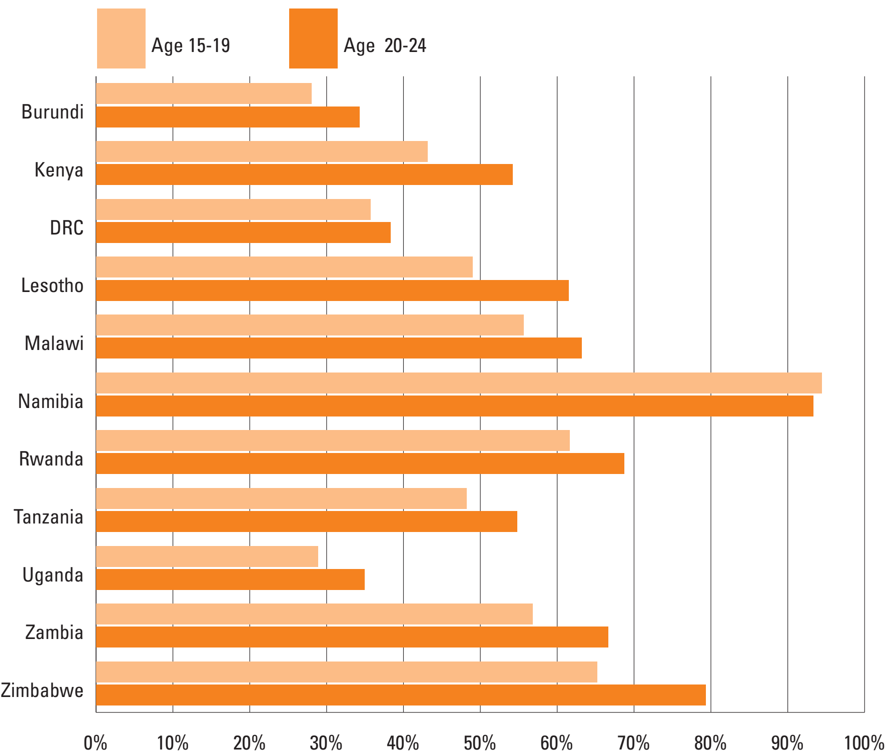
18 UNFPA, (2008) Outlook 25th Anniversary Issue. *Reducing unmet need for family planning: Evidence-based strategies and approaches* 12 (1), p. 1. November 2008

Figure 4.1 Percentage of demand satisfied by modern family planning methods (all women)



Source: Country DHS data, 2006–2011

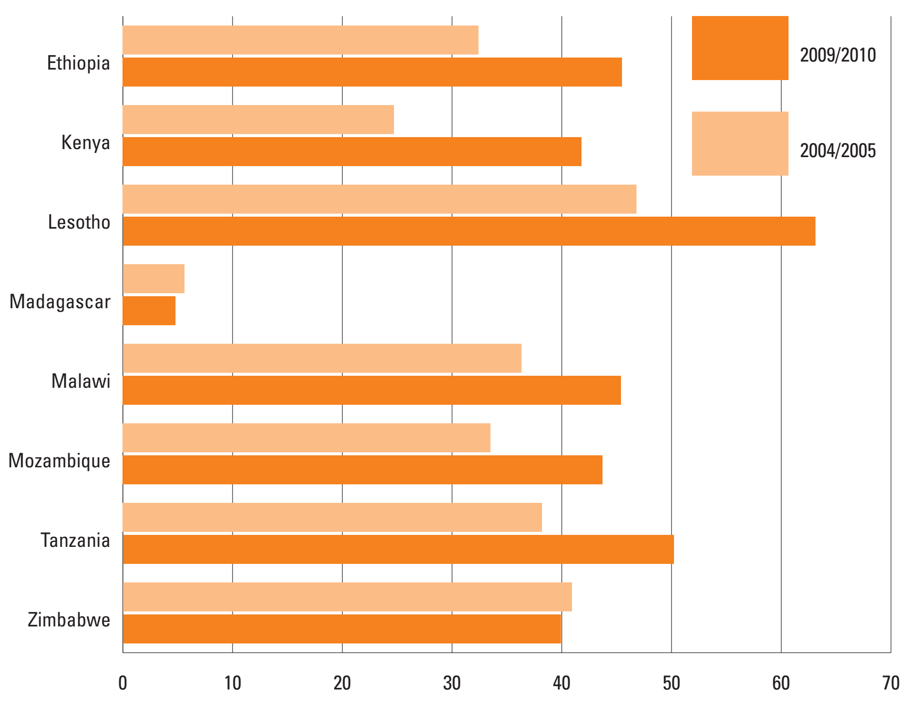
Levels of reported condom use are increasing in several countries in the region, although rates remain below 50 per cent in many instances (see Figure 4.2). A decline in condom use has been noted in a minority of settings, such as in Uganda and Rwanda. In addition, knowledge about condoms remains low in several of the high-prevalence countries, especially among young women (UNAIDS, 2012).

Aiming to increase correct and consistent condom use among both sexes is critical, as condoms offer dual protection from both pregnancy and STI (including HIV) and as such may be the most appropriate method for young people. Improving both supply and demand is critical. In 2011, donor support contributed to making only nine male condoms available for every adult male aged 15–49 in sub-Saharan Africa. Female condom availability is still extremely poor.

"At one point [I] did research on teenage pregnancy, I had all the knowledge I needed to avoid it from happening to me, yet at the age of 16, I fell pregnant. Knowledge on its own is not adequate."

Participant, Country validation meeting, Botswana

Figure 4.2 Use of condoms by sexually active females (15-19) at last sex



Source: DHS data (www.hivdata.measuredhs.com)

In most countries, the public sector, the private sector and other players like NGOs are the main sources of contraceptives. In countries like Ethiopia, Lesotho, Malawi, Tanzania, Zambia and Zimbabwe, the role played by the public sector in contraceptive distribution is considerably wider than that played by any other providers. The involvement of other players is vital in complementing the efforts of governments in trying to satisfy demand for contraceptives. For countries like Uganda, the role played by the private sector in contraceptive distribution is almost equal to the role played by the public sector.

% of young people aged 15–24 with multiple partners who reported condom use at last sex

Regional average:
Females: 34%
Males: 45%

Range among females:
High: Namibia – 74%
Low: Madagascar – 3%

Source: DHS Data

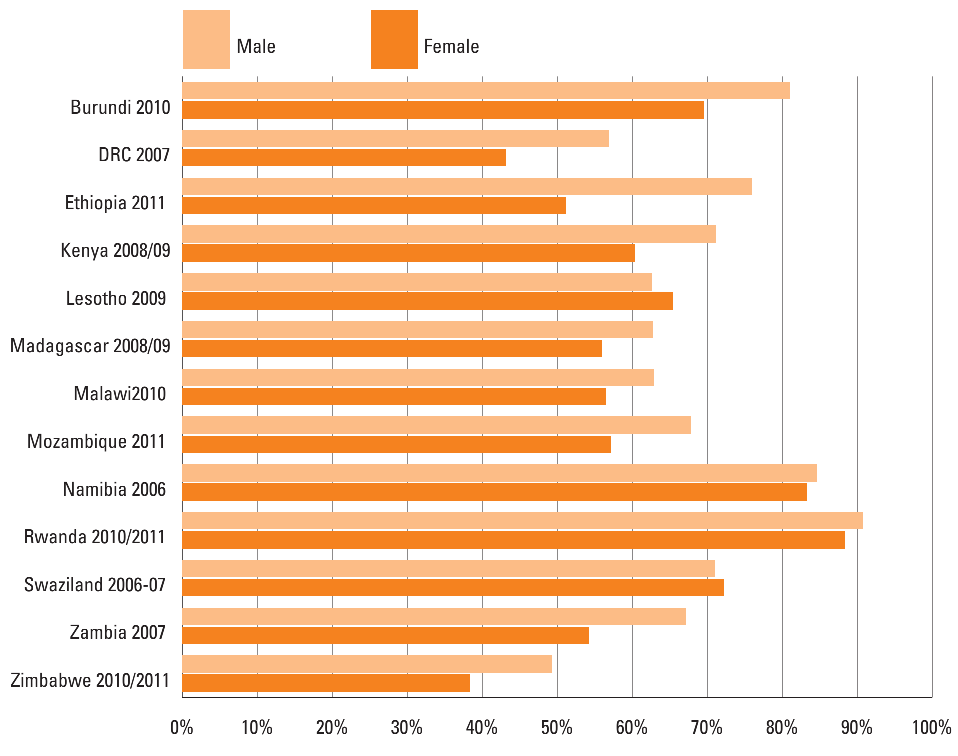
Condom education for young people is often controversial. However, among adolescents and young people, evidence shows that eliminating information about condoms in favour of abstinence only messages can lead to a higher incidence of unprotected sex at first intercourse and unfavourable attitudes towards condoms (UNESCO, 2009a).

Parental support for teaching adolescents about condoms in this region is high. In at least nine countries where data are available (Burundi, Ethiopia, Kenya, Malawi, Namibia, Rwanda, Swaziland, Uganda and Zambia), over 60 per cent of adults agree that children aged between 12 and 14 should be taught about condoms. Concerns regarding possible parental and/or community opposition to teaching information about condoms as part of sexuality education are likely to be based on perceived opposition rather than a real and generalized opposition.

Emergency contraception (EC) provides an option to reduce the risk of pregnancy after contraceptive failure or after unprotected sex. Women have the right to information and services about emergency contraception, just as with all other safe and effective methods of family planning. EC is currently registered (or licensed and available) through health facilities

or pharmacies in all countries in the region,[19] although knowledge and uptake varies between countries.

Figure 4.3 Percentage of adult aged 25-49 who agree that children 12–14 years should be taught about condoms



Source: Doyle, A et al, 2012

4.6. Voluntary male medical circumcision

Voluntary male medical circumcision (VMMC) reduces men's risk of acquiring HIV infection through vaginal sex, making it a core component of a comprehensive HIV prevention strategy in this region. WHO and UNAIDS recommend VMMC should be promoted alongside other prevention interventions including risk reduction counselling, access and use of condoms and HTC. Adolescent boys are a core target group for national male circumcision programmes although they currently have limited interaction with health services. Engaging adolescent boys in VMMC programmes will not only reduce HIV risk but will also provide a strategic opportunity to engage adolescent boys with other SRH services and to integrate complementary HIV prevention interventions. Scale up of VMMC is underway in 14 countries in the ESA region.

19 Consortium for Emergency Contraception Information (http://www.cecinfo.org/country-by-country-information/status-availability-database/), accessed 25 April 2013.

4.7. Unintended pregnancy and responses

Across sub-Saharan Africa, the unintended pregnancy rate among adolescents continues to place a huge burden of responsibility on girls and young women. Health risks for adolescent pregnancy are high and include higher rates of maternal mortality. The social and financial costs of early motherhood are high and include dropping out of school, the beginning of a new life of adulthood and financial pressures.

Despite restrictive laws on termination of pregnancy in this region,[20] a large number of women are nonetheless accessing abortion services. However, because of a lack of regulation, these are often unsafe and can result in lifelong health complications or even death. The majority of women undergoing unsafe abortion are under 24 years of age and the rates are particularly high across Africa. Among the 3.2 million unsafe abortions in women aged 15–19 years old globally, almost 50 per cent are in the Africa region. Almost 54 per cent of unintended adolescent pregnancies in sub-Saharan Africa occur among married women.

The question of termination of pregnancy is a complex rights issue, with countries in the ESA region characterized by a spectrum of legislative positions on the issue.[21] The most restrictive laws are those that either permit abortion only to save a woman's life or ban the procedure entirely. Many countries in this category such as Uganda, Mauritius and Malawi explicitly permit abortion when a pregnancy threatens a woman's life. The least restrictive abortion laws are those that allow abortion without being restricted to specific reasons, as in South Africa.

Where abortion is not legal, it is nonetheless in demand and is being provided in non-regulated environments. This may result in complications such as excessive bleeding, infections or more severe effects such as perforation and in some cases, death. In several African countries, it is estimated that up to 70 per cent of all women who receive treatment for complications related to abortion are younger than 20.

"Adolescents who seek PAC [post-abortion care] services often have very different needs and experiences than their adult counterparts. Young women and girls are vulnerable to unwanted pregnancy and unsafe abortion because of social and economic circumstances, lack of comprehensive sexual education, and reproductive health services that do not meet their needs. They are more likely to experience coerced or forced sex and to have inadequate knowledge of, and access to, contraception."

Post-Abortion Care Consortium
www.pac-consortium.org

4.8. Maternal mortality and complications

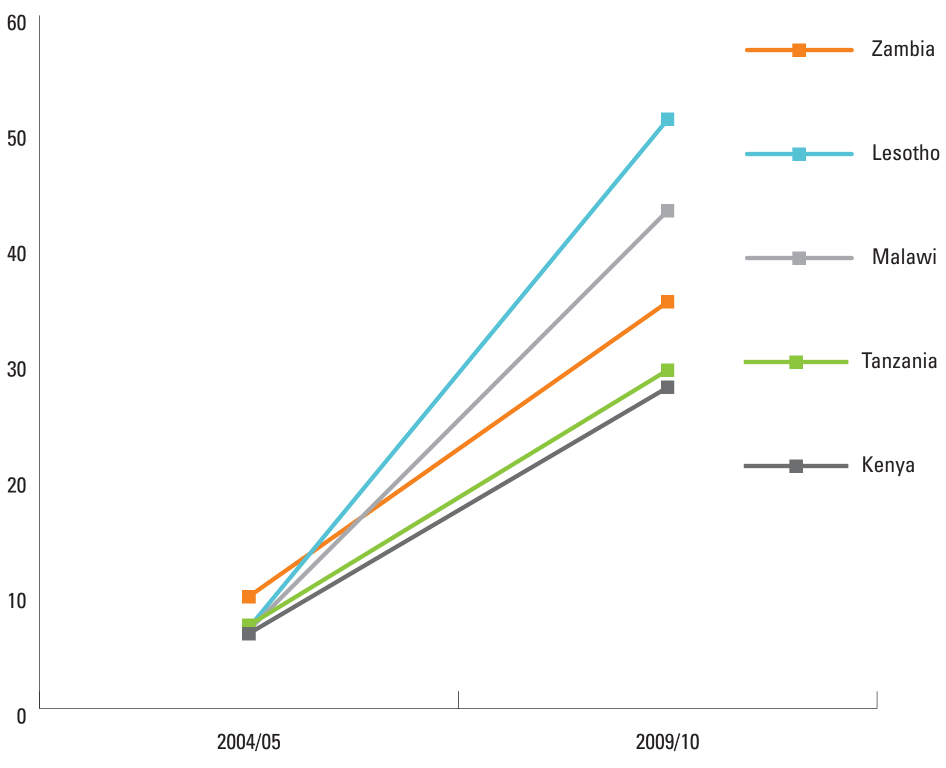
Pregnancy among adolescent girls has a higher rate of mortality than pregnancy among other age groups. Due to the immature physical development of adolescent girls, other complications can also arise. Obstetric fistula is a devastating childbirth injury that can affect any woman or girl who suffers from prolonged or obstructed labour without timely access to an emergency Caesarean section. By investing in overall strengthening of peri-natal care programmes and focusing on the way adolescents and young women can be reached, rates of maternal mortality and complications such as fistula can be significantly reduced.

20 Advocates for Youth. (2011) (see http://www.advocatesforyouth.org/publications/1901-youth-and-unsafe-abortion-a-global-snapshot).
21 See http://worldabortionlaws.com/map/

4.9. Access to HIV testing and counselling

Significant progress has been made in many ESA countries to expand access to HIV testing and counselling (HTC) for the general population (see Figure 4.3), and these services are also being taken up by young people. Of all the major HIV prevention indicators among young people, access to HTC has seen the most dramatic increase across the region – higher than increases in knowledge levels or condom use. In many countries, investing in the expansion of HTC services has been the major component of HIV prevention with concerted HIV testing campaigns in a number of countries and an impressive scale-up of HTC sites. In Malawi and Zimbabwe, young people aged 15–24 are the largest cohort using HTC services, representing approximately 40 per cent of all clients.

Figure 4.4 Percentage of women and men aged 15–24 who know where to get an HIV test and the percentage ever tested for HIV



With the expansion of treatment programmes in the region, education and health planners can optimize HTC as both a programme entry point to primary prevention and as a way of identifying young people who need further care and support. However, the importance of HTC is premised on the ability of health services to ensure that there is adequate provision of good quality, easily accessible and responsive youth-friendly HTC services connected to diagnosis, treatment and care services.

Many countries in the region have developed HTC guidelines that include components addressing the specific needs of children, adolescents and young adults. These are further underpinned by global guidelines, such as the forthcoming WHO *Guidance for HIV testing and counselling (HTC) for adolescents and treatment and care for adolescents living with HIV: Recommendations for a public health approach (WHO, 2013)*.

There are a range of barriers that prevent young people from accessing HTC, varying from availability of services, worries about confidentiality, inaccurate risk perceptions, fear of being stigmatized and perceptions of the consequences of living with HIV. Research in South Africa has found that fear of stigmatization may be one of the most important barriers to HTC uptake (Meiberg et al., 2009).

A survey of health facilities in all nine provinces of Zambia reported that, despite HTC services being integrated across almost all health facilities in the country, only 15 per cent provided youth-friendly HTC/PMTCT services, varying from 32 per cent in Northern to 7 per cent in Southern Province, with Lusaka at 16 per cent. Youth-friendly services (YFS) were reported to be more available in government facilities than in NGO facilities. Of the facilities providing YFS, 75 per cent had at least one provider trained in YFS guidelines. The reasons for limited availability of YFS include lack of funds and space to provide separate services to young people.

Disclosure of HIV status is a particularly challenging issue for young people testing positive, or already living with HIV (UNICEF, 2011). The WHO guidance (2013) further clarifies issues around ethical and effective service provision for adolescents, along with operational guidelines. This guidance recommends that *"adolescents be counselled about the potential benefits and risks of disclosure of their HIV status and empowered and supported to determine if, when, how and to whom to disclose. Disclosure must always be a choice, and laws or practices requiring disclosure, including laws governing access to education, must be removed".* Depending on whether HIV transmission occurred peri-natally or during adolescence, the experience of learning of an HIV-positive diagnosis and the management of that diagnosis will be very different.

Further guidance from UNESCO and GNP+ (the Global Network of People Living with HIV/AIDS) outlines the responsibility of the education sector in meeting the needs of young people living with HIV, with a focus on confidentiality and ensuring that disclosure of HIV status is not a prerequisite for access to education (UNESCO, 2012b).

4.10. Access to HIV treatment

According to latest estimates, 2.6 million young people aged 15–24 (UNAIDS 2013) and between 1.8 and 2.4 million adolescents aged 10–19 (UNICEF, 2011) are living with HIV in Eastern and Southern Africa. Young women in the ESA region are over two times more likely to be living with HIV than their male peers, making access to SRH education and services such as pregnancy prevention or PMTCT even more critical.

Young people living with HIV face a number of challenges: access to HIV treatment, breaches of confidentiality, stigma and discrimination from families, communities, schools and service providers. Young people living with HIV have limited access to information regarding decision-making about sexual relationships and disclosure of status. Their rights to access education and employment may also go unrecognized.

Attrition rates between HIV testing and treatment services are high and further clients are lost to follow-up. In one multi-country study in the region (Lamb et al., 2012), adolescents aged 14–19 had the highest rates of 'loss to follow-up' of all groups, with over 50 per cent being lost in the pre-ART phase. Thirty per cent of 15–24 year olds were lost to follow-up once initiated on ART. Strategies and guidance are under development to meet the special needs of adolescents and young people living with HIV to ensure their integration and retention in testing, care and treatment. Recognizing the different stages of disease progression between people peri-natally infected and those infected behaviourally during adolescence or youth is also an important component of HIV care and treatment provision.

The considerable gaps in SRH services for young people in this region are particularly important for the increasing numbers of adolescents and young people living with HIV in the region who wish to safely fulfil their right to health and to engage in sexual relationships in full safety.

Evidence from qualitative studies with young people living with HIV (YPLHIV) who access HIV treatment through care clinics shows a striking need to address HIV and SRH jointly. In Uganda and Kenya, YPLHIV aged 15–24 report wanting children and relationships on a par with non-HIV

infected peers. More than 1 in 10 adolescent girls (HIV status unspecified) over 17 years old become pregnant (rising to more than 1 in 5 by age 19). Safe conception and safe delivery, with a focus on life-long access to treatment and PMTCT, must be a priority in this region. The majority of young people entering into HIV care in the ESA region are girls, referred through PMTCT services and further efforts must be made to increase voluntary HTC and other routes into care and treatment for all adolescents and young people. Equally, numbers of perinatally infected young people are growing with improved access to paediatric ART.

In 2012, approximately 6.2 million people in the region were receiving ART, increasing from 625,000 in 2005 and representing 64 per cent coverage of ART for all those requiring treatment (UNAIDS, 2013). At the end of 2011, Botswana, Namibia, Rwanda, Swaziland and Zambia had all achieved coverage of over 75 per cent and coverage levels in Kenya, Malawi, South Africa and Zimbabwe were between 60 per cent and 80 per cent.

However, there are gaps in coverage of ART among all people in this region, which remains a significant issue. Certain countries achieved overall coverage of below 40 per cent (Madagascar, Angola, Mauritius and South Sudan). Coverage exceeds 50 per cent in only four countries: Botswana, Namibia, South Africa and Swaziland. Treatment coverage among children under the age of 15 was 'unacceptably low' overall in 2011, at an average of 33 per cent. Men in the region are less likely to initiate ART treatment than women. Further data disaggregation is required to understand the patterns of ART access among adolescents and young people.

A number of adolescent and youth-specific ART treatment clinics exist in the region, providing a critical service that bridges the gap between paediatric and adult services. However, adolescents and young people will require continued ART services tailored to their needs, reflecting the length of time already spent on treatment and possible access to second or third line treatment regimens.

As young people increase as a proportion of the total population of HIV patients, retaining them in HIV care and on treatment will require that these services become more relevant to the needs of young people.

4.11. Provision of youth-friendly services

For the majority of young people in this region, access to modern forms of contraception, condoms, safe abortion, STI/HIV testing and counselling or HIV treatment is severely hampered. Reviewing inconsistencies in policy or legislation will reduce many of the barriers that have been outlined above and provide a clear framework for health providers to receive adolescent and young clients according to their need and based on good public health policy.

The delivery of SRH services through appropriate venues, at appropriate times and by staff that is sensitive to the needs of their clients is a key element in reaching adolescents and young people. Youth-friendly services are those that specifically seek to be open at times that are suitable for young people, and are located in places where young people feel safe and comfortable accessing it. Most importantly, young clients should not face judgement or stigma from staff, and they should be able to trust that their confidentiality will be respected.

"Providers are often biased and do not feel comfortable serving youth who are sexually active; youth do not feel comfortable accessing existing services because they are not 'youth-friendly' and may not meet their needs; and, often, community members do not feel that youth should have access to sexual and reproductive health services."

EngenderHealth, 2002

Such services may be established in an existing youth-focused location (e.g. a youth centre) or they may be a specially designed aspect of an existing health service (e.g. a youth clinic held on a certain day outside school hours).

The provision of youth-friendly services does not necessarily entail a separate service and, in fact, this approach is shown to be unsustainable in many instances. Training service providers (e.g.

nurses, doctors and community health workers) in issues related to adolescents and maintaining overall quality standards on confidentiality in mainstream services will be key to scaling up and maintaining adolescent and youth-friendly services.

With ever increasing numbers of people in the 10–24 age band, all SRH providers must seek to deliver services that are appropriate for young people as a core part of their client base. Any service that is not catering to their particular needs or taking steps to ensure that the service is accessible is missing a large and critical segment of the population. Investments in staff training, medical protocols and service protocols that focus on the specific needs of adolescents should increase the numbers of young people who are accessing, and being retained, in health services.

4.12. Linkages to education

Little evidence is available from the region on efforts between the education and health sectors for joint programming, monitoring and evaluation of SRH education and services for adolescents and young people. Discussions and some pilot projects for school-based HIV testing have been undertaken in South Africa and Zimbabwe, for example. However, the complex issues around consent and confidentiality have given pause to these actions.

4.13. Conclusions

Addressing gaps in services requires a combination of approaches:

- Increasing demand for services among adolescents and young people, particularly through increased sexuality education.
- Increasing the supply of key commodities, particularly condoms for dual protection (HIV and pregnancy), and improving attitudes towards condom use.
- Removing or clarifying legal barriers to access, such as age of consent for services, and increasing awareness among young people of these changes.
- Improving youth-friendliness of existing services with a particular focus on reducing stigma and discrimination faced by young people, and improving service provider attitudes.
- Facilitating integration and referrals across service areas, linking SRH services with HIV services.
- Ensuring that the full range of combination prevention services for HIV, including condoms, VMMC, HTC and treatment are available and specifically tailored and targeted for adolescents and young people.
- Improving linkages between education and health services, for example, through referral mechanisms between schools and health services, health personnel participation in education services, greater support from schools for HIV treatment literacy, treatment support and overall confidentiality.
- Further improved coordination between public, private and NGO sectors to ensure coverage of appropriate and necessary services in any given location.
- Strengthening the monitoring and reporting of service data on adolescents and youth and strengthening the feedback loop to inform service planning.

5. GENDER, RIGHTS AND CONTEXTUAL ISSUES

Gender, rights, cultural practices, poverty and other structural factors are all cross-cutting issues that must be recognized when addressing the sexual and reproductive health of adolescents and young people.

5.1. Gender

Gender inequality and gender-based violence are a matter of grave concern for the ESA region. The SADC Protocol on Gender and Development (2008) sets important targets to be achieved by 2015 in terms of education, health and gender equality – all of which have direct relevance to the ESA Commitment Process. This legally binding protocol was seen as a significant milestone in the journey towards the empowerment of women, the elimination of discrimination and the achievement of gender equality and equity in the region. In health and services, the differential impacts on boys and girls, men and women, are clearly visible in many instances. The importance of gender in effective CSE programmes is increasingly under the spotlight. A programme that incorporates gender analysis is likely to be more effective at changing health outcomes than a programme focusing on individual behaviours only. Current content may address some elements

that are relevant to gender but most programmes require rethinking to adequately address gender inequality, gendered norms and gender-based violence. Gender equality is currently being championed in the ESA region through a number of initiatives and high-level task forces.

Girls' worlds are often circumscribed during adolescence as they are withdrawn from school and experience a stark decline in their friendship networks and general freedom. Without this social capital and the confidence that goes with it, girls do not establish themselves as decision makers even within their families, nor as citizens in their communities, and are unlikely to succeed as economic actors.

Not only do boys and girls have very different trajectories, but there are growing differences among young people within and across countries; some young people progress while others are left behind.

Source: Population Council (2004)

The most recent monitoring update from the SADC region captures keys trends in the broader context in the region in terms of progress towards realizing the rights of girls and women and gender equality (see Table 5.1).[22]

Table 5.1 Progress towards the implementation of the SADC Protocol on Gender and Development, 2013

Challenges	Successes
Patriarchal attitudes still abound, reflected in gender stereotypes in schools; the workplace and the media; as well as predominantly male decision-making structures in all areas. Customary law contracts constitutional provisions with few ramifications in many countries. The case of a Lesotho woman denied the right to take over the chieftaincy after her father died is a chilling reminder of deeply entrenched patriarchal values. Hate crimes against lesbian women (widely publicized in South Africa) serve as another reminder of the lethal combination of homophobia and misogyny that still plague many countries in the region. **Gender violence remains the most telling indicator of women's lack of rights and agency:** The shockingly high levels of gender violence revealed by recent prevalence surveys (from 25% in Mauritius to nearly 80% in four districts of Zambia) shows that at least one in three women have experienced some form of gender violence over their lifetime. **Backward movement in elections:** With few exceptions, the last set of elections have been disappointing: the decrease in women's representation both at national and local level in Angola and Swaziland last year; persistent low levels of women's representation in the DRC; and the marginal increase in women's representation in the Lesotho national elections in May 2012 serve as a reminder of the fragile gains made by women in the political sphere.	**Education is still the bright star of the SADC region:** Gender parity is rapidly being achieved at all levels. The gender division of labour in subjects is slowly changing, and this will eventually result in a change in the gender division of labour in the workforce. **Tangible benefits of Constitutional Reviews:** One of the major alliance successes over the last year has been getting gender onto the agenda of Constitutional Reviews in 10 countries, notably Mauritius, Zimbabwe and Zambia. As witnessed over the past year, this is beginning to yield benefits. In Mauritius, the constitutional amendment paved the way for a quota in local government that led to a fourfold increase in women at the local level in the December 2012 elections. The new Zimbabwe Constitution does away with claw-back clauses and guarantees women 22% of the seats in the national assembly. **50/50 campaigns go for the bulls eye:** There are 10 elections in the SADC region between August 2013 and December 2015. Detailed projections in the SADC Gender Protocol Barometer show that, if the re-launched 50/50 campaign is rigorously pursued, the region should achieve the original target of 30% of women in decision-making at local and national level, with four countries coming close to or exceeding the 40% mark.

22 Excerpted from SADC Gender Protocol Barometer 2013 (see http://www.genderlinks.org.za/page/sadc-research).

Challenges	Successes
The economy is still a male preserve: Women still lack access to economic decision-making (26%), land, credit and other means of production. They constitute the majority of the poor; the unemployed; the dispossessed and those who work in the informal sector. **Women lack a say in the decisions that affect their lives:** Whether in the bedroom or the board room, women are effectively rendered voiceless. They have little say, for example, in the use of male condoms that are essential for preventing the spread of HIV and AIDS. Women's lack of 'voice' is reflected in the media, where the proportion of female sources has risen only marginally from 17% in 2003 to 22% in a self-monitoring exercise covering 76 media houses in the region. **HIV and AIDS continues to threaten the fragile gains that have been made:** Young women remain the majority of those newly infected by HIV and AIDS as well as those who bear the burden of caring for people living with AIDS.	**Good news on HIV for the first time:** The 2013 barometer carries good news on HIV for the first time. AIDS-related deaths in the region have reduced by 32% since 2001 due to the expansion of ART. In seven SADC countries, PMTCT is higher than 80%. Although gender disparities continue to be a major driver of the pandemic, there is some evidence of changes in sexual behaviour patterns leading to a reduction in HIV and AIDS. **A better understanding and more holistic approach to GBV:** Six Violence Against Women Baseline Studies have helped to establish the disparity between police and actual GBV figures. The studies also show that the highest levels of violence – psychological and economic – are the most underreported. These findings have accelerated the campaign for routine surveys of this nature to strengthen National Action Plans to End Gender Violence.

Source: Excerpted from SADC Gender Protocol Barometer 2013 (see http://www.genderlinks.org.za/page/sadc-research).

5.2. Rights, stigma and discrimination

HIV national strategic plans for most ESA countries commit to a rights-based response to HIV. Increasingly, countries are introducing laws and policies that can help to eliminate stigma and discrimination. The need to defuse HIV-related stigma and discrimination is widely recognized across the ESA region. However, actual programmatic steps to address HIV legislation and human rights violations are not being implemented everywhere. The latest UNAIDS regional survey noted that *"the region needs extraordinary leadership and efforts to tackle the issues related to human rights, stigma and discrimination against people living with HIV. The people centred character of the HIV response is a distinctive quality in this region and elsewhere"* (UNAIDS, 2013).

Stigma, discrimination and criminalization of certain key populations such as men who have sex with men (MSM), sexually exploited adolescents and young people who use drugs limit the effectiveness of programmes to improve their SRH, including HIV risk. Key populations are even further marginalized for being both young and at risk. Adolescents and young people who are lesbian, gay, transgender or otherwise gender non-conforming (LGBTI) are a vulnerable population in ESA that require specific responses from both health, education and institutions charged with protecting the rights of young people. In particular, a number of studies have noted the high rates of HIV prevalence among adult MSM.

5.3. Gender-based violence

Gender-based violence is prevalent in the ESA region. It takes many forms and includes sexual violence (e.g. rape, forced sex, marital rape) and a range of other well-documented practices (e.g. domestic violence, sexual coercion, intimate partner violence). More recently, the phenomenon of school-related gender-based violence has received increasing attention in terms of its impacts not only on girls and young women, but also on boys and young men. A study shows that one

in five young adolescents in Southern African countries have been victims of sexual violence in the region (Andersson et al, 2008). Homophobic bullying is an increasingly recognized form of gender-based violence in both school and community settings. Extreme examples of violence have emerged in the form of targeted attacks on young women identified as lesbian or gender non-conforming. Education and health services, as well as other partners, have key roles to play in the response to violence, particularly in relation to the increased risk of HIV faced by victims.

5.4. Parents and families

Studies have repeatedly shown that favourable parental attitudes influence children's attitudes, whether this is related to acceptance of sexuality education and uptake of HIV testing or contraceptives. Parents often rely on teachers or health workers to respond to young people's developmental needs, particularly those considered more private, gender specific or culturally defined. Contrary to popular belief, adults are increasingly more supportive in the ESA region, even on sensitive issues like condom education.

Parents and families play a key role in shaping attitudes, norms and values related to gender roles, sexuality and the status of adolescents and young people in the community. Values related to the centrality of the family, life affirming approaches and solidarity are also central tenets in faith-based sources of learning for young people. Indeed for many communities, sexuality is a gift that needs care and protection. Faith-based approaches in the response to the HIV epidemic have demonstrated considerable power, innovation and value. Those qualities can make a decisive difference in removing barriers to better health and education outcomes for adolescents and young people – specifically in making sexuality education and services more accessible and better supported.

5.5. Conclusions

This section aims to highlight the common threads and inter-linkages across a range of contextual issues through the lens of gender and human rights. All of the issues require responses that fundamentally address the rights of girls and young women, gender inequality and gender norms. Young men and boys too are part of the equation in that the empowerment of girls and young women will require their active engagement in changing the status quo.

The recommendations of the High Level Panel on the post-2015 agenda (UN, 2013) signal very clearly where the ESA Commitment Process can and should make a decisive impact on the life chances of girls and young women in the region in the years ahead:

- **Gender and rights** – make gender and rights a non-negotiable component of any response to the needs of adolescents and young people.
- **Vulnerable young people** – protect the human rights of vulnerable young people and use all available means to ensure access to prevention and care services.
- **Gender-based violence** – enforce existing zero tolerance policies and laws effectively and support children and young people, particularly girls and women.
- **School-related gender-based violence** – eradicate the culture of violence in and around schools.
- **Structural factors including poverty** – enable girls to complete primary education, make the transition to secondary school and complete at least 10 years of basic education.
- **Religion** – engage with religious and cultural leaders to support access to SRH education and services and protection of the rights of girls and young women.

- **Parents and families** – engage with parents to strengthen their involvement in the transition to healthy adulthood.
- **Child marriage** – identify the 'hot spots' in the region and use the law and existing policy to protect the rights of girls and young women.

6. RECOMMENDATIONS

Eastern and Southern Africa is a region with enormous potential, reflected in a population bulge of 158 million adolescents and young people (33 per cent of the region's population) who will reap the benefits of better education and better health. Young people will drive development in the next two decades. Currently adolescents and young people in the ESA region face a range of challenges in health, education and the social and economic realities that impact on their families and community life. Bold leadership, bold actions and deliberate steps that eliminate barriers to progress are required to accelerate the pace of change. These changes in health and education need to happen now and young people's involvement in shaping their own futures is key.

The ESA Commitment aspires to achieve a vision for the future – *a young African, a global citizen who is empowered, educated, healthy, resilient and socially responsible, an autonomous decision-maker and one who has the capacity to reach their full potential and contribute to the development of their community, country and the region.*

How can we get closer to achieving this vision?

1. Bold leadership and bold actions are needed

Commitments to improving SRH and gender equality through education and services already exist in the ICPD Programme of Action (1994) and subsequent international conventions. However, 20 years after the first of these pledges, levels of unintended pregnancy, STIs including HIV and many other adverse health outcomes affecting young people are still a cause for concern in the ESA region. At the same time, there are urgent demands from young people across the region for better access to good quality CSE and health services, as articulated in the Mali Call to Action, the

Bali Youth Forum Declaration and the post-2015 regional consultations. Governments in the ESA region have an opportunity to show leadership and to build on the support of young people, civil society and development partners. Now is the time for a commitment by the education and health sectors to bold actions that scale-up the core elements of ICPD and key regional conventions including the Maputo Plan of Action and the SADC Gender and Development Protocol.

2. Recognize the changing realities in the lives of adolescents and young people

Globalization, access to new communications technologies, rapid urbanization and changes in social norms are all factors confronting the region's adolescents and young people with new realities. They are not passive followers. Indeed, many are also at the leading edge of change in their communities and among their peers. These changing realities are reflected in relationships, decisions about sexual behaviour and the transition to adulthood.

The majority of young people in the region become sexually active only after the age of 18. However, a significant minority of over 42 per cent of adolescents in more than half the countries in the region are already sexually active by the age of 18. In Mozambique, an estimated 25 per cent of adolescents are sexually active by age 15. It is evident that significant numbers of adolescents and young people between the ages of 15 and 20 are engaged in a variety of relationships and are sexually active, both within and before marriage. Regardless of marital status, it is essential that this population has access to the education, services and commodities they need in order to prepare for adulthood and maintain their health. Necessary services must include, but are not limited to, safe modern forms of contraception, condoms, HIV testing, HIV treatment, safe delivery and PMTCT.

Despite a range of policy-level commitments on reproductive health in general, there is value in having an open, frank and evidence-informed discussion that examines the realities facing young people and recognizes the opportunities and challenges this brings.

Excerpt from Outcome Document of the Regional Consultations on the Post-2015 Development Agenda [African region]

United Nations Economic Commission for Africa (UNECA)/ African Union (AU), 2013

Human development must be an integral part of the post-2015 development agenda. The following priority areas of human development were identified:

Education and Human Capacity Development

The following areas were prioritized:

Improved quality of teaching:

> Access to quality primary, secondary and technical and vocational education

> *Strengthened curricula for primary and secondary education to include life skills, civic, sexuality and reproductive health education.*

Universal and equitable access to quality healthcare

Low life expectancy and equitable access to quality healthcare, particularly for the most vulnerable groups, continue to be a major concern in Africa.

In this regard, participants highlighted the following priorities:

> Improved maternal, newborn and child health

> *Enhanced access to sexual and reproductive health and rights, including family planning*

> Special focus on vulnerable groups, including children, the youth, the unemployed, the elderly and people with disabilities.

Source: UNECA, 2013

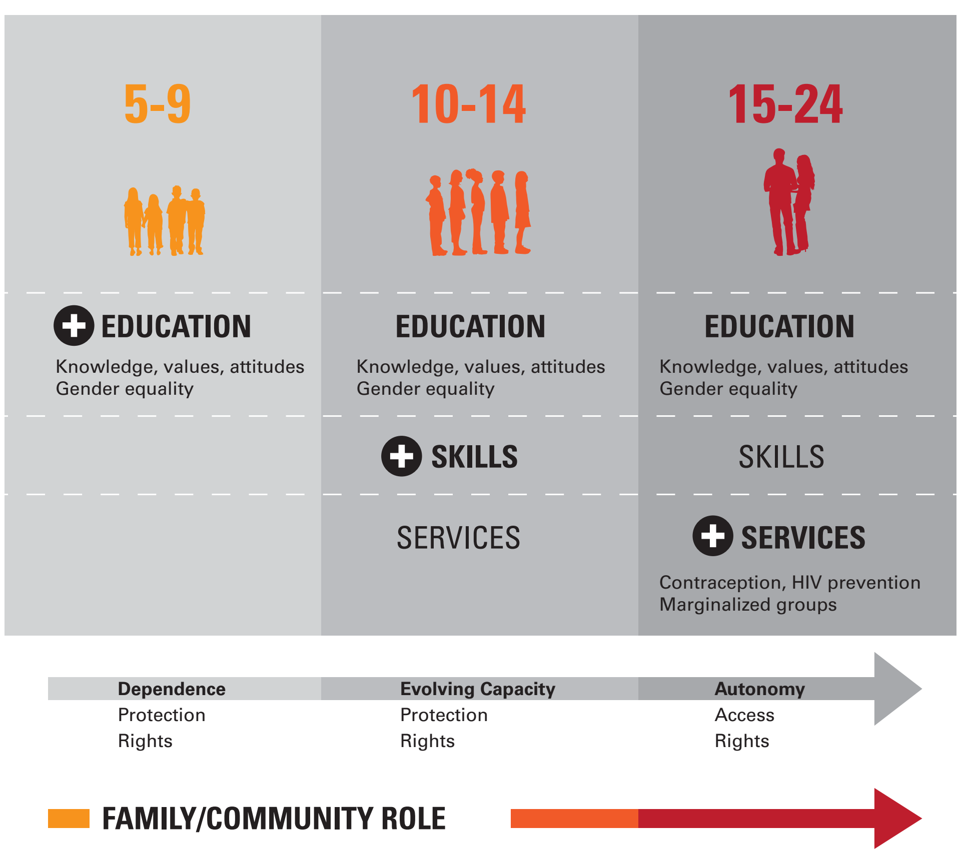
Good quality CSE creates the space for that dialogue in education settings, in health facilities, between peers, within the family and in the community. Combining CSE and access to health services in a way that is age-appropriate and within a supportive environment can make a positive impact on adolescents and young people when they need it most. Furthermore, this needs to be understood as part of the life cycle of children and young adults as they move from dependence to full autonomy.

- **The building blocks – childhood and pre-puberty:** The education sector can play a leading role in the development of positive norms around gender and rights, understanding of health, communications, values and attitudes.

- **Early adolescence:** Before puberty all young people should learn about puberty, sex and sexual health and develop the skills needed to negotiate their emerging sexuality, while increasing awareness of gender, violence and rights.

- **Mid-adolescence and before sexual debut** is the key age to the formation and adoption of healthy behaviours and the skills to manage relationships of all forms. Some young people will also need to be reached with services; it is also critical to develop a safe environment, free from gender violence or rights violations.
- **Older adolescence and young adulthood:** On-going skills and behavioural-based education should be connected closely to appropriate services. Services for specific vulnerable groups will be required (e.g. young married women, sexually exploited young women, young men who have sex with men).

Figure 6.1 Evolving needs of adolescents and young people corresponding to the life cycle



3. Scale up comprehensive sexuality education

Just 30 per cent of girls and boys in the region have adequate knowledge of HIV in ESA. Education has the responsibility, authority and ability to reach every adolescent and young person in the region with a minimum package of good quality HIV and sexuality education that can make a difference to knowledge and skills levels and the uptake of services. A number of countries are making progress towards improving curricula, teacher training and increasing coverage. On-going curriculum reviews in many ESA countries offer a window of opportunity to strengthen content on CSE. The last five years have witnessed growing international and regional support for CSE, as well as investment in programming and technical support. Countries in the ESA region have an opportunity to capitalize on this wave of support and also demonstrate their leadership at continental level.

Where there is opposition, education and health must demonstrate leadership by acting on the evidence of what works. *Good quality comprehensive sexuality education does no harm – it does not lead to early sexual debut.* On the contrary, it builds knowledge, healthy social norms, skills and values that are essential to preparing young people for adulthood, choices about sexuality, relationships and ultimately citizenship. Concerted action is needed now to translate the various commitments into action and to integrate the real needs of adolescents into curricula and ensure that teachers are equipped, and communities are supportive.

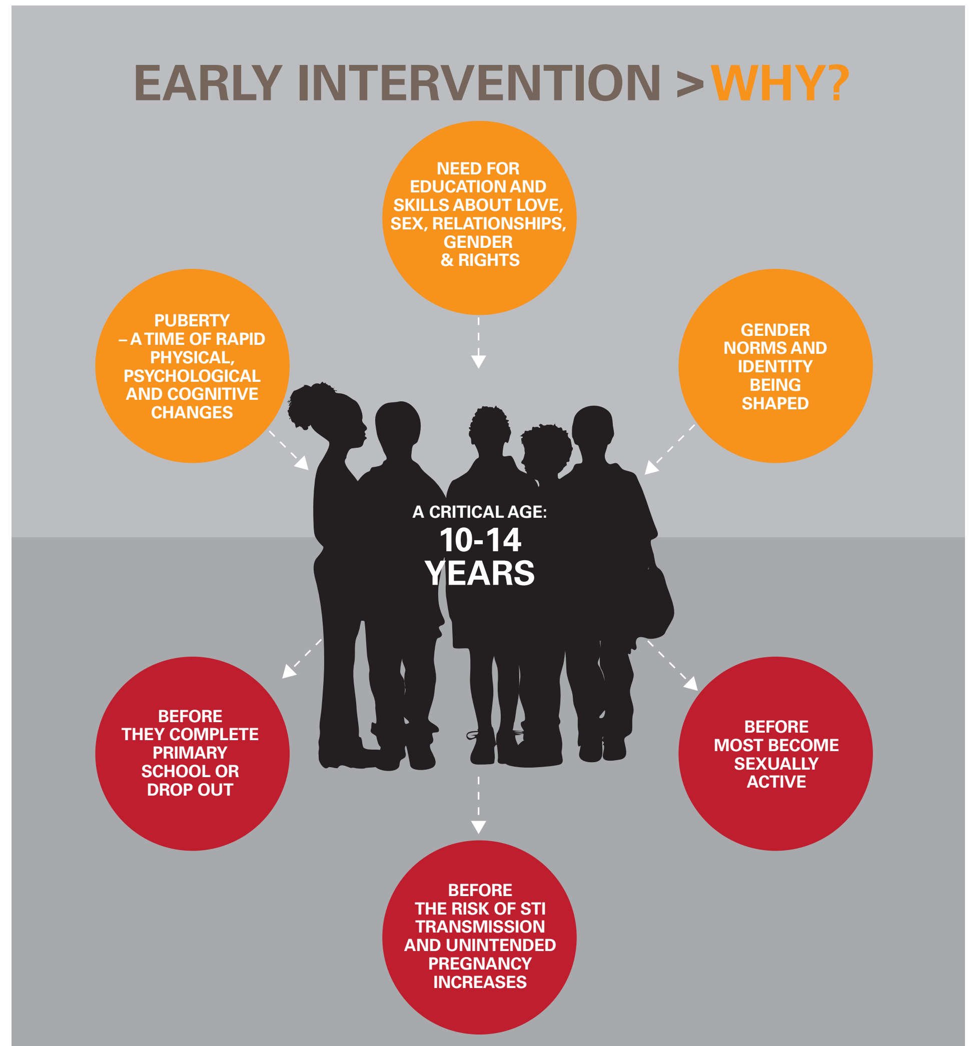
Too many of the existing curricula tend to avoid honest and open discussion of sexuality, sexual behaviour and safer sex. There is an opportunity to strengthen CSE content in curricula to build skills and knowledge in these core topics to address gender inequality and power dynamics.

For sexuality education to have maximum impact, it has to reach all adolescents and young people in and out of school. Scale up across three critical dimensions makes a difference: coverage (number of schools reached/teachers trained); quality (programme fidelity); and depth (political and community support). It will be important to reach both practising and pre-service teachers with training, support supervision and the materials they will need.

4. Take action early through education

Early adolescence (age 10–14) is a key stage in the life cycle and in terms of the entry points for education that will make a difference to key health and social outcomes. In education terms, this highlights three issues: 1) the necessity of sexuality education at upper primary school level (if it has not already started); 2) the importance of reaching adolescents before and during puberty; and 3) before they leave the education system altogether. Successful interventions at this stage have the potential to impact positively on social norms (e.g. gender equality and norms) as well as sexual decision-making (if and when to become sexually active or refusing sex), as well as the skills to protect themselves against HIV transmission or other STIs and prevent pregnancy. More broadly, this intervention also has the potential to create the confidence young people need to access services when they need them.

Figure 6.2 Rationale for early intervention on HIV/sexuality education and SRH



5. Maximise the protective effect of education through EFA

Education protects. It is a key determinant of a number of health and social outcomes, including reduced HIV risk, reduced maternal mortality and improved gender equality. Low completion rates in primary school mean that not all children and young people are being reached with the necessary formal education and many of them will not have access to HIV or sexuality education before they become sexually active. In Angola, for example, nearly three out of every four girls does not reach the last grade of primary school. The transition to secondary school is equally challenging for many girls in the region. For example, 14 per cent of girls in Angola make it to the first grade of secondary school. While there is progress in this indicator in other countries, the overall imperative is that keeping adolescents and young people in education is necessary to realize its protective effects. Ensuring that girls complete primary school and make the transition to secondary school has even greater benefits, including delaying sexual debut, preventing early marriage and postponing childbearing (Plan, 2011). If girls leave school at the end of primary education and have their first children from age 15 onwards, they will do so without having received any preparation. More and better schooling means not only better education outcomes, but also better health outcomes.

6. Integrate and scale up youth friendly HIV and SRH services

For most young men and women, preventing pregnancy is more of an immediate concern than preventing themselves from HIV infection. However, the high rates of HIV as well as high rates of unintended pregnancy mean that dual protection and programmes that address both SRH and HIV together are critical. . These issues apply equally to the two million young people living with HIV in the region in a context where access to access to ART is improving but still inadequate; where stigma remains a very divisive issue; condoms access is unreliable and the threat of criminalization is a possibility. Integration of SRH and HIV services makes sense from a young person's perspective; youth friendly services must respond to that need. There is strong support for youth friendly services in the region, however the real challenge is often the implementation gap. The advantages of integration are now beyond doubt: allowing young people access both HIV and SRH services under the same roof or in the same facility increases the opportunities for a continuity of care without being referred elsewhere; expansion means a wider range of clinical services provided beyond HIV treatment and care to include management and treatment of any other STIs, family planning, PMTCT and other related services; reducing the frequency and cost of reaching a health facility (e.g. transport costs) means greater accessibility and affordability for more young people; and stigma and discrimination are reduced as well as increased coverage for marginalised and most at risk/under-served populations.

7. Eliminate barriers to access for all young people

Contradictory and outmoded policy, laws and practice concerning access to services and commodities for adolescents and young people are a major barrier to better health. This report re-affirms that legal restrictions, particularly around the age of independent consent to services, constitute a major barrier in access to those services. Universal access goals for young people require changes in these laws and policies, where they still exist. Advances have been made in lowering the age of consent in some countries (e.g. Malawi and South Africa) and the lessons learnt need to better understood and replicated more broadly.

Identifying those populations that are most marginalized and most at risk is a necessary first step to developing appropriate and accessible services. These groups may include, but are not limited to: rural communities, particularly girls within these communities, where school access and health services are most sparse; married adolescent girls who are often 'invisible' to mainstream SRH services; adolescent key populations, including young men who have sex with men, sexually exploited adolescents and young adults who sell sex who have a heightened risk of contracting HIV.

8. Make an AIDS free future a reality

The HIV epidemic in the region is changing – for the better. There have been declines of 25 per cent or more in HIV prevalence among young people in six countries across the region (Botswana, Ethiopia, Kenya, Malawi, Namibia and Zimbabwe). The challenge is to sustain and increase these declines in a context where 51 young people in the region are newly infected with HIV every hour. The decline in HIV prevalence and the falling number of new HIV infections among young people worldwide, and especially in sub-Saharan Africa, are occurring simultaneously with behavioural changes such as waiting longer to become sexually active, having fewer multiple partners and increased use of condoms among young people with multiple partners. However, progress could be faster. HIV prevention efforts must be increased with a focus on building the foundations through CSE and linking this to a range of services, particularly condoms, VMMC and HTC aimed at young people. Concerted efforts to achieve universal access for treatment need to focus heavily on access for adolescents and young people, and the transition from paediatric to adult care.

9. Strengthen gender and rights within education and services

Deeply held norms around gender in the region are a strong barrier to improving sexual and reproductive health for young people. Early marriage, social expectations of girls' behaviour, higher school drop-out rates and inequality within relationships all create a dynamic where girls and women are often not in control of their own sexuality and health. A recent study shows that one in five young adolescents and 30 per cent of women under 24 have been victims of sexual violence in the region (Country DHS data, 2007-2011). Gender norms, in particular prevailing patriarchal norms, continue to have a negative impact on the overall well-being and development of girls in the region.

Policies and public awareness about regional efforts to address gender inequality and gender-based violence are increasing. However, public leadership (political, religious and cultural) must tackle what is harmful while celebrating what is positive and affirming. Education and health need to intensify their focus on reducing violence in and around school contexts, where it remains a defining feature of life for too many girls and young women. This includes addressing more than sexual violence to tackle the less obvious forms of abuse, harassment or discrimination that makes a classroom or school playground unsafe. Structural interventions that reduce risk and vulnerability, especially for girls and young women, should be supported.

10. Work together around a common agenda for adolescents and young people

The education and health sectors must take the joint lead and mobilize their common strengths to develop, plan and deliver CSE and SRH services that will make a decisive change. Some of the challenges outlined in this report fall clearly within the mandate of the education or health sector. Others will require action that is broader than both sectors and calls for involvement by agencies responsible for youth, community development, gender or the justice system. What is clear is that joint leadership is needed by the two arms of government that, along with civil society, are most immediately involved in the development and well-being of adolescents and young people. Strengthening efforts for young people to receive appropriate education about HIV prevention and treatment in schools should emphasize the need to increase accessibility to information and tools/commodities for HIV prevention through linkages and referrals between the schools and health facilities.

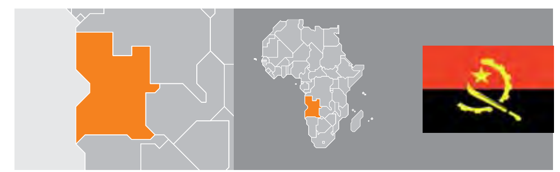
It is time for bold decisions and bold actions that fulfil the promise of ICPD, that realize the rights of young people in the region and that set out a new path in the post-2015 world towards a generation defined by good health and choices in reproductive health, not by avoidable outcomes such as HIV or unintended pregnancy.

The country profiles present a summary of key data and analysis for each country based on available published sources.

Angola (English and Portuguese)
Botswana
Burundi (English and French)
DR Congo (English and French)
Ethiopia
Kenya
Lesotho
Madagascar (English and French)
Malawi
Mauritius (English and French)
Mozambique (English and Portuguese)
Namibia
Rwanda (English and French)
Seychelles (English and French)
South Africa
South Sudan
Swaziland
Tanzania
Uganda
Zambia
Zimbabwe

Data have been collected, reviewed and approved through consultation processes in each country but may not reflect the views or carry the full endorsement of all partners in this publication.

ANGOLA



Population: 20 820 525 (2012)

47.6% of Angola's population is under the age of 15.[1]

Public Expenditure on Education:

3.5% of GDP (2010)[2]

Public Expenditure on Health education: 4.6% of GDP (2009)[1]

Proportion of orphans aged 10-15: 10%

Population[1]	Male	Female	Total
% children 0-14 years	22.4%	21.51%	43.9%
% Adolescents/ young people 15-24 years	10.2%	9.9%	20.1%

Education: Secondary school attendance needs to be supported and encouraged. This means that to ensure that young people are reached there should be programmes that target out-of-school young people. Education attainment is in generally low, this is reflective of the 20 year civil war that Angola has emerged from. The progression rate to secondary school is low particularly for females. Among women age 15-49, 25 percent have never been to school, 57 percent have had some primary education, and 19 percent have had secondary or higher education. There are large differences between rural and urban areas: 40 percent of urban women have completed secondary school or higher, yet only 2 percent of rural women have attained a similar level. Five percent of women in urban areas and 40 percent of women in rural areas have had no education.[3]

Education[2]	Male	Female	Total
Adult literacy rate (2011)	82.6%	58.6%	70.4%
Youth (15-24) literacy rate	80.1%	66.1%	73.0%
Net enrolment rate primary	93 %	78%	86%
Net enrolment rate secondary	15%	12%	13%
Survival to last grade of primary	37%	27%	32%

Trained teachers (primary)		Teacher-student ratios[2]	
Male	Female	Primary	Secondary
No data	No data	1:46	1:39

Gender parity index for net enrolment rate[2]	Primary	Secondary	Tertiary
	0.84	0.81	No data

Sexuality education: There has been an effort in Angola towards providing sexuality education (SE) for young people dating back to 1991 with the establishment of a programme that promoted sexuality and reproductive health (SRH) education in schools. Specificity around HIV and AIDS was introduced after 2000 and educators were trained on this component during that time, however, the HIV and AIDS training seems to be less integrated. The United Nations Children's Fund (UNICEF) and United Nations Population Fund (UNFPA) played a key role in providing support to both learners and educators with regard to strengthening knowledge around sexually transmitted infections (STIs) and HIV and AIDS. Informally, programmes have been rolled out in the 18 Angolan provinces and information disseminated through theatre, dance, singing and discussions between learners and community. The Ministry of Education's strategy (2013-2017) includes the need to promote less risky behaviour and attitudes in relation to sexuality education, STIs and HIV and AIDS.

Curriculum available	Curriculum type	Examinable
-	-	-

Curriculum content				
Topic covered	Inclusion in core curriculum			
	Low/P	Up/P	Low/S	Up/S
Generic life skills	Yes	Yes	Yes	-
Adolescent and reproductive health	Yes	Yes	Yes	-
Sexuality education	Yes	Yes	Yes	-
Gender equality and empowerment	Yes	Yes	Yes	-
HIV and AIDS and other STIs	Yes	Yes	Yes	-
Stigma and discrimination	Yes	Yes	Yes	-
Family life and interpersonal relations	Yes	Yes	-	-

Sexual and reproductive health: Data collected from women attending antenatal clinics suggest the intensity of the HIV epidemic varies among Angola's different provinces, with the highest rates of infection occurring in the areas bordering Namibia, along the transport route to Luanda, and along the border of the Democratic Republic of Congo; the lowest rates are found in the centre of the country. The provinces with the highest rates are Cunene and Benguela, with a prevalence of 4.4%, closely followed by Lunda Norte, Cuando Cubango and Huambo, each at 4.2%, according to the 2010-2014 National Strategic Plan.

SRH	Rural	Urban	Total
Adolescent fertility rate (aged 15-19)[3]	23.9%	12.6%	19.1%
Youth fertility rate (aged 20-24)	32.6%	19.0%	26.1%
HIV prevalence (aged 15-24)[4]	Male: 0.6%	Female: 1.6%	Total: 1.1%
Incidence of SGBV (aged 15-19)[5]	-	19.5%	-
Incidence of SGBV (aged 20-24)[5]	-	30.4%	-

Behaviour indicators: With an estimated 2% of the adult population living with HIV, Angola has one of the lowest HIV prevalence rates in sub-Saharan Africa.

Behavioural indicators	Male	Female	Total
Prevalence of young people living with HIV (aged 15-24)[4]	0.6%	1.6%	1.1%
Sex before age 15 (aged 15-24)[5]	17.2%	21.2%	19.5%
Multiple partners (aged 15-24)[5]	4.5%	0.2%	2.1%
Condom use at last high-risk sex (aged 15-24)[5]	80.6%	18.9%	45.4%

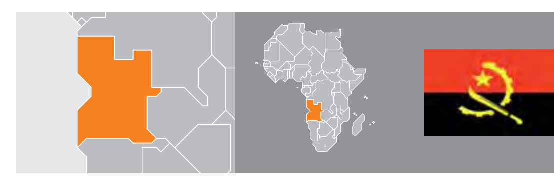
Services: There are attempts by the government to provide adequate services. Currently there is access to HIV testing and counselling (HCT) and post-abortion services, however, these are limited to specific geographic locations at the present time. The government has indicated an additional roll-out to remote areas, although there is still an issue around the technical staff and their capacity.

Access to services	Male	Female	Total
Married women using all family planning methods	-	-	-
15- 19-year-olds using contraception	-	-	-
Access to HIV testing and counselling	Yes	-	-
Access to post-abortion care	-	Yes	-
Availability of young people-friendly services	-	-	-

Notes:

1 The World Bank. World Development Indicators Data. (http://databank.worldbank.org/data)
2 UNESCO Institute for Statistics Data Centre
3 ICF International. 2012. Angola 2011 Malaria Indicator Survey. Calverton, Maryland, USA
4 UNICEF. 2013. *The State of the World's Children 2013: Children with disabilities.* United Nations Children's Fund
5 Ministério da Saúde. Relatório sobre o Progresso do País para dar Seguimento aos Compromissos da Sessão Especial sobre VIH e SIDA da Assembleia Geral das Nações Unidas, periodo 2010-2011

ANGOLA



População: 20 820 525 (2012)

47,6% da população de Angola tem idade inferior a 15 anos.[1]

Despesa Pública em: 3,5% do PIB (2010)[2]

Despesa Pública em despesa com Saúde: 4,6% do PIB (2009)[1]

Proporção de órfãos com idades 10-15: 10%

População[1]	Homens	Mulheres	Total
% de crianças com idades 0-14	22,4%	21,51%	43,9%
% de adolescentes/ jovens com idades 15-24	10,2%	9,9%	20,1%

Educação: A frequência do ensino secundário necessita de ser apoiada e incentivada. Isto significa que, para assegurar que se chega aos jovens, deveria haver programas direcionados aos jovens que não frequentam a escola. Os níveis de educação são, em geral, baixos, como reflexo da guerra civil que durou vinte anos e da qual Angola emergiu. A taxa de progressão para o ensino secundário é baixa, em particular das mulheres. Entre as mulheres com idades entre 15-49, 25 por cento nunca frequentaram a escola, 57 por cento receberam algum tipo de instrução primária e 19 por cento frequentaram o ensino secundário ou superior. Existem grandes diferenças entre as áreas rurais e as áreas urbanas: 40 por cento das mulheres dos centros urbanos concluíram o ensino secundário ou superior, no entanto apenas 2 por cento das mulheres das zonas rurais conseguiram atingir um nível semelhante. Cinco por cento das mulheres das áreas urbanas e 40 por cento das mulheres das áreas rurais não frequentaram qualquer tipo de ensino.[3]

Educação[2]	Homens	Mulheres	Total
Taxa de literacia de adultos (2011)	82,6%	58,6%	70,4%
Taxa de literacia da população jovem (15-24)	80,1%	66,1%	73,0%
Taxa líquida de matrícula no ensino primário	93 %	78%	86%
Taxa líquida de matrícula no ensino secundário	15%	12%	13%
Progressão para o ensino secundário	37%	27%	32%

Professores formados (primário)[i]		Rácios Professor-aluno[i]	
Homens	Mulheres	Primário	Secundário
Dados inexistentes	Dados inexistentes	46%	39%

Índice de paridade de género para a taxa líquida de matrícula[ii]	Primário	Secundário	Superior
	0,84	0,81	Dados inexistentes

Educação sexual: Em Angola, têm sido desenvolvidos esforços para oferecer educação sexual (ES) aos jovens. Estes esforços remontam a 1991, ano em que foi criado um programa de promoção da educação para a saúde sexual e reprodutiva (SSR) nas escolas. A partir de 2000, começou a ser dada mais atenção ao VIH e à SIDA e, durante esse período, os professores receberam formação sobre esta componente, mas a formação sobre o VIH e a SIDA parece ter sido menos bem conseguida. O Fundo das Nações Unidas para as Crianças (UNICEF) e o Fundo das Nações Unidas para a População (UNFPA) desempenharam um papel fundamental no apoio a alunos e professores com vista ao reforço dos conhecimentos sobre as doenças sexualmente transmissíveis (DSTs), o VIH e a SIDA. Informalmente, foram implementados programas nas 18 províncias de Angola e divulgadas informações através do teatro, da dança, do canto e de debates entre os alunos e a comunidade. A estratégia do Ministério da Educação (2013-2017) prevê a necessidade de promover comportamentos e atitudes menos arriscados relativamente à educação sexual, às DST e ao VIH e SIDA.

Currículo disponível	Tipo de currículo	Testes de avaliação
-	-	-

Conteúdo curricular				
Temas abrangidos	Inclusão no currículo nuclear			
	P/1º grau	P/2º grau	S/1º ciclo	S/2º ciclo
Habilidades genéricas para a vida	Sim	Sim	Sim	-
Saúde adolescente e reprodutiva	Sim	Sim	Sim	-
Educação sexual	Sim	Sim	Sim	-
Igualdade de género e capacitação	Sim	Sim	Sim	-
VIH e SIDA e outras DST	Sim	Sim	Sim	-
Estigmatização e discriminação	Sim	Sim	Sim	-
Vida familiar e relações interpessoais	Sim	Sim	-	-

Saúde sexual e reprodutiva: Os dados fornecidos por mulheres que frequentam clínicas pré-natais indicam que a intensidade da epidemia de VIH varia entre as diferentes províncias de Angola, sendo que as taxas mais elevadas de infeção se verificam junto à fronteira com a Namíbia, ao longo da rota de transportes para Luanda e ao longo da fronteira com a Republica Democrática do Congo; as taxas mais baixas registam-se no centro do país. As províncias com as taxas mais elevadas são Cunene e Benguela, com uma prevalência de 4,4%, seguidas de perto por Lunda Norte, Cuando Cubango e Huambo, cada uma com 4,2%, de acordo com o Plano Estratégico Nacional para 2010-2014.

SSR	Rural	Urbano	Total
Taxa de fertilidade adolescente (idades 15-19)[3]	23,9%	12,6%	19,1%
Taxa de fertilidade jovem (idades 20-24)	32,6%	19,0%	26,1%
Prevalência do VIH (idades 15-24)[4]	Homens: 0,6%	Mulheres: 1,6%	Total: 1,1%
Incidência de violência sexual e baseada no género (idades 15-19)[5]	-	19,5%	-
Incidência de violência sexual e baseada no género (idades 20-24)[5]	-	30,4%	-

Indicadores comportamentais: Estimando-se que 2% da população adulta vive com VIH, Angola regista uma das mais baixas taxas de prevalência de VIH na África subsariana.

Indicadores comportamentais	Homens	Mulheres	Total
Prevalência de jovens que vivem com VIH (idades 15-24)[4]	0,6%	1,6%	1,1%
Sexo antes dos 15 (idades 15-24)[5]	17,2%	21,2%	19,5%
Múltiplos parceiros (idades 15-24)[5]	4,5%	0,2%	2,1%
Uso de preservativo no último encontro sexual de elevado risco (idades 15-24)[5]	80,6%	18,9%	45,4%

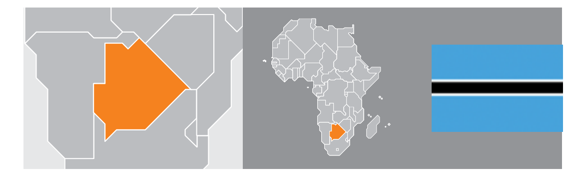
Serviços: O governo tem feito tentativas para prestar os serviços adequados. Atualmente, existe acesso a aconselhamento e testes de VIH, bem como a serviços de cuidados após-aborto, embora a cobertura geográfica seja limitada de momento. O governo assinalou o prolongamento de tais medidas para zonas mais remotas, mas continuam a verificar-se dificuldades relativamente ao pessoal técnico envolvido e à sua capacidade de resposta.

Acesso a serviços	Homens	Mulheres	Total
Mulheres casadas que usam todos os métodos de planeamento familiar	-	-	-
Jovens de 15-19 anos que usam contracetivos	-	-	-
Acesso a aconselhamento e testes de VIH	Sim	-	-
Acesso a cuidados após-aborto	-	Sim	-
Disponibilidade de serviços de apoio à juventude	-	-	-

Notas:

1 Banco Mundial. Indicadores do Desenvolvimento Mundial. (http://databank.worldbank.org/data)
2 UNESCO Institute for Statistics Data Centre
3 ICF International. 2012. Angola 2011 Malaria Indicator Survey. Calverton, Maryland, USA
4 UNICEF. 2013. The State of the World's Children 2013: Children with disabilities. Fundo das Nações Unidas para as Crianças
5 Ministério da Saúde. Relatório sobre o Progresso do País para dar Seguimento aos Compromissos da Sessão Especial sobre VIH e SIDA da Assembleia Geral das Nações Unidas, período 2010-2011

BOTSWANA



Population[1]**:** 2 million

Of the population, 33.5% is under the age of 15.

National poverty line: 30.6%[2]

Public Expenditure on Education: 7.8% of GDP[3]

Public Expenditure on Health: 3.1% of GDP[4]

Population[2]	Male	Female	Total
% children 0-14 years	17%	16.4%	33.5%
% adolescents/ young people 15-24 years	10.8%	11.%	21.9%

Education: Net enrolment rates for primary school education are almost universal in Botswana, with higher enrolment rates for females than males. Net attendance rates for primary school are high, with girls outperforming boys.[5] There is a 50% decline in secondary school attendance for both males and females, which indicates that this needs to be further supported and encouraged. The drop off in attendance should inform an increase in life skills/sexuality education for out-of-school young people. Educational attainment in Botswana is relatively high compared to other countries in the region; the mean number of school years completed is 8.9 out of an expected 12.2.

Education[5]	Male	Female	Total
Adult literacy rate	84.1%		
Net enrolment rate primary	92.6%	93.5%	93.17%
Net enrolment rate secondary	36%	44%	40%

Trained teachers (primary)		Teacher-student ratios[5]	
Male	Female	Primary	Secondary
na	na	1: 27	na

Gender parity index (ratio girls/boys)	Primary	Second	Tertiary
	0.96	1.06	na

Sexuality education: Both primary and secondary school levels have a life skills education curriculum and non-governmental organizations (NGOs) work together with government to provide HIV and sexuality education (SE). The second Botswana National Strategic Framework 2010-2016 highlights the need to reach the younger population with HIV prevention programmes, with a key component of this being the scaling-up of HIV education programmes and curricula in all educational institutions, as well as increasing participation by community-based organizations (CBOs) and NGOs. The Ministries of Youth, Health and Education, together with NGOs, can play an important role in reaching out-of-school young people with HIV prevention messages and education.

Curriculum available	Curriculum type	Examinable
Yes	Life skills Education	No

Curriculum content

Topic covered	Inclusion in core curriculum			
	Lower primary	Upper primary	Lower secondary	Upper secondary
Generic life skills	Yes	Yes	Yes	Yes
Adolescent and reproductive health	No	No	No	Yes
Sexuality education	No	No	Yes	Yes
Gender equality and empowerment	Yes	Yes	Yes	Yes
HIV and AIDS and other STIs	No	No	Yes	Yes

Sexual and reproductive health[6]**:** Various sexual and reproductive health (SRH) services are provided in Botswana and most women, particularly young women, have access to them.[7] One of the pivotal components of SRH services for young people is family planning and contraceptive provision. The comprehensive provision of SRH services is impeded by a lack of skilled personnel to provide the services, as well as a scarcity of adolescent-friendly SRH services. Ministries of Education and Health are making efforts to provide Family Life Education (FLE) in varying arenas, including schools.

SRH[8]	Male	Female	Total
Adolescent fertility rate	146.8 per 1 000 live births		
STI rate (aged 15-24)	3.5%	2.4%	2.9%
HIV prevalence (aged 15-19)[9]	2.4%	5%	3.7%

Behavioural indicators: At a rate of 17.6%, Botswana has the second highest HIV prevalence globally. In the 15-24 age band, females have double the prevalence of their male counterparts, at 11.8% and 5.2% respectively.[10] Condom use among youth with irregular partners is quite high in Botswana, at 78.4%, which tells us that young people have some access to services. Comprehensive and correct knowledge of HIV remains fairly low, at 42.1%.[10] This indicates that there needs to be a more concerted effort to increase HIV and life skills education among young people.

Behavioural indicators[8]	Male	Female	Total
Sex before age 15 (aged 15-19)	6.8 %	4.2%	5.5%
Prevalence of multiple sexual partners (aged 15-24)	17.5%	17%	17.25%
Prevalence of child marriage	0.1%		
Condom use at last sex with irregular partner (aged 15-24)	78.4%		

Services: Botswana's antiretroviral drug (ARV) access is widely lauded as a best practice in the region. According to the World Health organization (WHO) guidelines, 95% of people eligible for treatment have access to it.[7] Prevention of mother-to-child transmission (PMTCT) therapy is available to all pregnant women at a government facility free of charge. The PMTCT programme has coverage of 95% of women who require it. The safe male circumcision programme was introduced in 2009 to increase the uptake of male circumcision.[11] During July and September 2007, nearly 1.9 million male condoms were distributed by government health facilities, while Population Services International sold and distributed more than 6.8 million condoms.

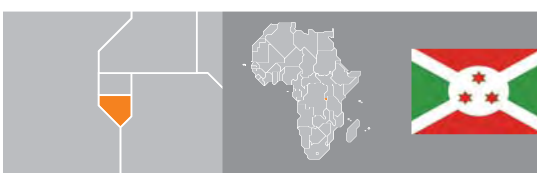
Access to services[5]	Male	Female	Total
Access to HIV counselling and testing (aged 15-49)	60%		

Availability of young people-friendly services: The policy environment for adolescent/ young people programmes is highly supportive in Botswana. NGOs (BOFWA and YWCA) have been providing information and services on SRH to young people in partnership with the Ministries of Education and Health in providing FLE in varying arenas, including schools. There is a good network system of health facilities at different levels in the country within a 15 km radius from home (referral hospitals, district hospitals, mine hospitals, private hospitals, clinics, health posts, mobile stops and NGO young people centres).

Notes:

1 Botswana Census 2011
2 International Poverty Centre (UNDP) and Botswana Institute for Development Policy, 2005, *Poverty Status Report for Botswana: Incidence, Trends and Dynamics*
3 UNESCO Institute for Statistics Data Centre.
4 The World Bank. World Development Indicators Data. (http://databank.worldbank.org/data)
5 Botswana Ministry of Education and Skills Development, 2012, Education Ministry Information System Annual Report
6 WHO Regional Office for Africa, 2008, Botswana Factsheets of Health Statistics
7 MOH 2012
8 Botswana Global AIDS Response Report (GARR), 2012
9 BAIS III 2008
10 HCT
11 MOH 2013

BURUNDI



Gross Domestic Product[1]	102 $ (RMDH 2011)
Education spending[2]	9,2% of GDP
Health spendin[9]	4,4 % of GDP
Proportion of OVC (per thousand) **0 to 18 years**	Data not available by age-group

Population: 8 053 574 (Census 2008)

47% of the population is between 0 and 14 years old, making Burundi a particularly young country.[3]

Population[3]	Male	Female	Total (average)
% children 10-14 yrs	13.6%	13,0%	13.3%
% adolescents 15-19 yrs	10.9%	11.5%	11.2%
% youth 20-24 yrs	8.0%	8.7%	8.4%

Education[4]**:** The literacy rate among adults is 43.2%. Primary school access is almost universal, and is equal for boys and girls. Burundi has a high net enrolment rate for primary level of 90.7% (average male and female). Access to secondary school is considerably lower with 20.4% for the lower secondary and 17.2% in upper secondary (average for both sexes). Whilst primary school attendance rates are high, the drop out rate in lower secondary school is quite high, with an average of 5.9% among boys and girls. The formal school system is the major route through which children receive sexuality education. In order to increase the chances of reaching older children and adolescents, it would be appropriate to increase out of school sexuality education provision.

Education[5]	Male	Female	Total (average)
Adult literacy rate (RGPH 2008)	48.1%	38.4%	43.2%
Literacy rate 10 – 14 yrs	55.2%	54.0%	54.6%
Literacy rate 15 – 19 yrs	61.8%	52.7%	57.1%
Literacy rate 20 – 24 yrs	52.8%	42.9%	47.6%
Net enrolment rate - primary	89.9%	91.5%	90.7%
Net enrolment rate - secondary	Lower 22.6%	Lower 18.4%	Lower 20.4%
	Upper 19.5%	Upper 15.2%	Upper 17.2%
Drop out rate in Grade 8	5.8%	5.9%	5.9%

Trained teachers (primary)		Teacher-student ratios	
Male	Female	Primary	Secondary
93,2%		45/1	Data not available

Sexuality Education: In 2009, with support from INEE and pressure from NGOs (sometimes with donor funding) and barely four years after the end of the conflict, the Ministry of Education of Burundi began developing a more robust civics education curriculum which included practical skills, including peace-building. The government of Burundi works in partnership with IPPF, ISP and UNICEF to develop sexuality education interventions targetted at young people. Teaching appraoches for HIV and sexuality education include peer-education, practical skills, communication and awareness raising, and, establishment of STOP AIDS clubs in schools. Some sexuality education activities are included in the National Strategic Plan for HIV. It is well recognised in Burundi that the country must address HIV among young people.

Curriculum available	Curriculum type	Examinable
Yes	Practical skills development	No

Curriculum content				
Topics covered	Inclusion in core curriculum			
	Lower primary	Upper primary	Lower secondar	Upper secondary
General Life Skills	Yes	Yes	Yes	Yes
Adolescent and reproductive health	No	No	No	No
Sexuality Education	No	No	No	No
Gender equality	No	No	No	No
HIV / AIDS and other STIs	No	No	No	No
Human rights	No	No	Yes	No

Sexual and reproductive health:

The national youth stragegy is currently under revision before being integrated into the national strategic plan for poverty reduction. The major challenges identified in the plan are: mismatch between training that youth receive and the reality of the job market; high levels of youth unemployment; lack of coordination between the various youth services and organisations; weak capacity of youth focussed organisations and services; increase in HIV prevalence among young people. HIV rates are relatively low but rates among women are twice as high as among men (women 0.8%, men 0.2%[6])

Sexual and Reproductive health		
Adolescent Fertility Rate (15-19 yrs) [6]	18,6%	
Pregnancy / birth rate among adolescent girls[6]	30/1000 births	
STI rate (15-24 yrs) including HIV[6]	40%	
HIV Prevalence 15-24[6]	**Male**	**Female**
	0.2%	0.8%
Incidence of gender-based violence among young women (15-24 yrs)[7]	Higher rates reported in the school environment than elsewhere	
Young women (15-24 yrs) victims of sexual violence[7]	13,7%	

Behavioural indicators :

The national HIV prevalence is 2.97% and among young people aged 15-24 the prevalence among women is 0.8% – four times that of men. Condom use data among young men is higher than among women, of whom only 26.9% report having used a condom at last sex with a non-regular partner. Adolescent fertility rate (15-19 years) remains low, at 30 live births per 1,000 adolescent girls. However, 18.6% of young women aged 15-19 have already had a pregnancy.

Sexual violence is widespread: 17.7% of young women under 15 and 13.7% of women 15-24 reported having been victims of sexual violence. Rates of intergenerational sexual relationships are low at 0.6%. These data reveal that young women are particularly vulnerable to HIV infection as a result of sexual violence: in order to be effective, sexuality education and programmes for HIV must reflect these vulnerabilities by specifically addressing gender equality. [6]

Behavioural indicators [6]	Male	Female
Sex before 15 (15-24 yrs)	8.4%	3.3%
HIV knowledge levels	46.5%	44.5%
Multiple sexual partners (15-24 yrs)	6.0	0.7
Child marriage (<18 yrs)	26% of women (20-24) report having been married before the age of 18.	
	Male	**Female**
Condom use at last sex with a non-regular partner	46%	26.9%

Services :

Two thirds of the population are under the age of 25. A large number of adolescents do not have easy access to sexual and reproductive health information or services which explains the levels of unintended pregnancy, unsafe abortions and the high levels of maternal mortality, of HIV and STIs. With a rate of 1,000 deaths per 100,000 live births, maternal mortality rates consitute one of the most serious public health problems. Approximately 80% of all births take place at home, without assistance from trained health professionals.

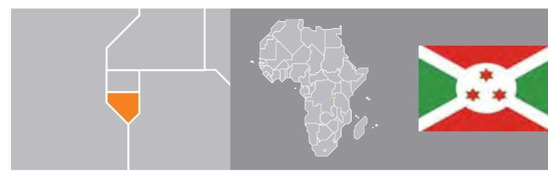
Access to services[6]	Male	Female	Total
Contraceptive use among married women	22%		
Contraceptive use among adolescents (15-19 yrs)	57.7%	56.3%	57%
Contraceptive use among adolescents (20-24 yrs)	83.6%	79%	81.3%
Acces to HIV counselling and testing (15-24 yrs): Yes			
Access to post-abortion care	N/a		

Availability of youth-oriented services : The Kamenge Youth Centre has bee operational since 1991. During and after the 1994 crisis, the centre provided a space for young Tutsis and Hutus to come together for sporting and cultural activities. In the past 15 years, the Kamenge Youth Centre has welcomed youth from all social backgrounds, ethnic groups and religious to engage in activities aimed at promoting peace and coexistance. These activities include workshops on peace, HIV awareness raising camapaigns, literacy activities, and IT training. According to a UNAIDS situational report on Burundi published in 2007, 4000 young people had benefitted from practical skillls training on HIV and 972 Stop AIDS clubs had undertaken education and communication activities reaching 23,354 school students. Additionally, since 2007, school-based Stop AIDS clubs and other youth centres have been established across the country.

Notes:

1 Plan National de Développement Sanitaire 2011-2015 (PNDS 2011-2015)
2 Human Development Report, 2013
3 Recensement Générale de la population et de l'habitation 2008 (RGPH 2008)
4 RGPH 2008
5 RGPH 2008
6 Enquête Démographique et de Santé 2010 (EDS 2010)
7 Rapport SWAA, SERUKA, NTURENGAHO

BURUNDI



Produit intérieur brut[1]	PPA 102 $ (RMDH 2011)
Dépenses d'éducation[2]	9,2 % du PIB
Dépenses de santé[2]	4,4 % du PIB
Proportion d'orphelins (pour mille) de 0 à 18 ans	Non disponible par tranche

Population : 8 053 574 (Recensement 2008)

47 % de la population a entre 0 et 14 ans, ce qui fait du Burundi un pays particulièrement jeune.[3]

Population[3]	Masculin	Féminin	Tx Moyen
% enfants 10-14 ans	13,6 %	13,0 %	13,3 %
% adolescents 15-19 ans	10,9 %	11,5 %	11,2 %
% jeunes 20-24 ans	8,0 %	8,7 %	8,4 %

Éducation[4] : Au Burundi, Le taux d'alphabétisation des adultes est de 43,2 %. La scolarisation à l'école primaire est presque universelle, et ce tant pour les filles que pour les garçons. Le taux net de scolarisation dans le primaire atteint 90,7 % en moyenne pour les deux sexes, ce qui est élevé. Les taux de fréquentation dans l'enseignement secondaire sont bien inférieurs, avec une moyenne de 20,4 % pour le premier cycle et 17,2 % pour le second cycle chez les deux sexes. Alors que les taux de fréquentation de l'école primaire sont élevés, le taux de déperdition dans l'enseignement du premier cycle du secondaire est assez élevé, avec une moyenne de 5,9 % pour les filles et les garçons. Le système scolaire est le premier vecteur par lequel les jeunes enfants ont accès à l'éducation sexuelle complète. Cela étant, pour atteindre les élèves plus âgés du secondaire, il serait opportun de multiplier les occasions de recevoir une éducation sexuelle en-dehors du système scolaire.

Éducation[5]	Masculin	Féminin	Tx moyen
Taux d'alphabétisation des adultes (RGPH 2008)	48,1%	38,4%	43,2 %
Taux d'alphabétisation 15-24 ans			
Taux d'alphabétisation 10-14 ans	55,2 %	54,0 %	54,6 %
Taux d'alphabétisation 15-19 ans	61,8 %	52,7 %	57,1 %
Taux d'alphabétisation 20-24 ans	52,8 %	42,9 %	47,6 %
Taux net de scolarisation dans le primaire	89,9 %	91,5 %	90,7 %
Taux net de scolarisation dans le secondaire	1er cycle 22,6 %	1er cycle 18,4 %	1er cycle 20,4 %
	2e cycle 19,5 %	2e cycle 15,2 %	2e cycle 17,2 %
Taux de déperdition en 8e année	5,8 %	5,9 %	5,9 %

Enseignants formés (primaire)		Proportion élèves/enseignants	
Masculin	Féminin	Primaire	Secondaire
93,2 %		45/1	Données non disponibles

Éducation sexuelle : Grâce au réseau de l'INEE et à la pression des ONG (parfois soutenues par des financements de donateurs), le ministère de l'Éducation du Burundi a entamé dès 2009, soit quatre ans à peine après la fin du conflit, la préparation d'un programme étoffé d'éducation civique et de compétences pratiques qui incluera des compétences en matière d'édification de la paix. Le gouvernement du Burundi travaille de concert avec la FIPF, l'ISP et l'UNICEF pour proposer des services d'éducation sexuelle adaptés et destinés aux jeunes. Les stratégies d'enseignement en matière de VIH et d'éducation sexuelle comprennent notamment l'éducation par les pairs, les compétences pratiques, des programmes de sensibilisation et de communication et la création de clubs STOP SIDA dans les écoles. Certaines activités liées à l'éducation sexuelle des jeunes figurent dans le Plan stratégique national pour le VIH. Le Burundi est conscient qu'il faut s'attaquer au problème du VIH chez les jeunes.

Programme disponible	Type de programme	Examinable
Oui	Acquisition des compétences pratiques	Non

Contenu du programme				
Sujet couvert	Inclusion dans les programmes de base			
	Inf/ P	Sup/P	Inf/S	Sup/S
Compétences pratiques génériques	Oui	Oui	Oui	Oui
Santé adolescente et procréative	Non	Non	Non	Non
Éducation sexuelle	Non	Non	Non	Non
Égalité des sexes et autonomisation des femmes	Non	Non	Non	Non
VIH/SIDA et autres IST	Non	Non	Non	Non
Socle des droits de l'homme	Non	Non	Oui	Non

Hygiène sexuelle et santé reproductive : La Stratégie nationale pour la jeunesse est en cours de révision en vue d'être intégrée au Cadre stratégique national de lutte contre la pauvreté. Les principaux problèmes identifiés dans la stratégie sont les suivants : inadéquation entre la formation donnée aux jeunes et la réalité du marché du travail ; niveau élevé du chômage des jeunes ; manque de coordination entre les différentes structures d'encadrement des jeunes ; faibles capacités d'encadrement des associations de jeunesse ; augmentation de la prévalence du VIH parmi les jeunes. La prévalence du VIH est assez faible (0,8 %[6] chez les femmes et 0,2 %[6] chez les hommes), mais les femmes connaissent un taux de prévalence deux fois plus élevé.

Hygiène sexuelle/santé sexuelle et reproductive		
Taux de fécondité des adolescentes (15-19 ans)[6]	18,6%	
Taux de grossesse/ natalité chez les adolescentes[6]	30/1000 naissances	
Taux d'IST (15-24 ans) y compris VIH[4]	40%	
	Masculin	**Féminin**
Prévalence du VIH 15-24 ans [6]	0,2 %	0,8 %
Incidence des violences basées sur le genre chez les jeunes femmes 15-24 ans [7]	Les e violences sexuelles sont plus déclarées en milieu scolaire que dans d'autres milieux	
Jeunes femmes (15-24 ans) victimes de violences sexuelles[7]	13,7%	

Indicateurs de comportement : Le taux national de prévalence du VIH est de 2,97 %. Dans la tranche d'âge des 15-24 ans, la prévalence chez les femmes est de 0,8 %, c'est-à-dire quatre fois plus que chez les hommes. L'utilisation des préservatifs est plus élevée par les jeunes hommes, seulement 26,9 % des jeunes femmes déclarent avoir utilisé un préservatif lors de leur dernier rapport sexuel avec un partenaire non régulier. Le taux de fécondité des adolescentes (15-19 ans) demeure assez faible, avec 30 naissances vivantes pour 1 000 adolescentes. Cependant, 18,6 % des jeunes femmes de 15 à 19 ans ont déjà entamé une grossesse. La violence sexuelle est répandue, 17,7 % des jeunes filles de moins de 15 ans ayant déclaré avoir été victimes de violences sexuelles, ce taux étant de 13,7 % pour les jeunes femmes de 15 à 24 ans. Le taux de rapports sexuels intergénérationnels est faible, soit 0,6 %. Ces statistiques démontrent que les jeunes femmes sont particulièrement vulnérables à l'infection par le VIH, à la suite de violences sexuelles ; il va de soi que, pour être pertinents, l'éducation sexuelle et les programmes de sensibilisation au VIH doivent tenir compte de ces vulnérabilités en adoptant une approche fondée sur l'égalité des sexes.[6]

Indicateurs de comportement[6]	Masculin	Féminin
Rapports sexuels avant 15 ans (15-24 ans)	8,4 %	3,3 %
Connaissance approfondie du VIH	46,5 %	44,5 %
Prévalence de partenaires sexuels multiples (15-24 ans)	6,0	0,7
MGF	Non applicable	
Prévalence du mariage des enfants (<18 ans)	26 % des femmes (20-24 ans) indiquent avoir été mariées avant l'âge de 18 ans.	
	Masculin	**Féminin**
Utilisation d'un préservatif lors du dernier rapport sexuel	46 %	26,9 %

Services : Les deux tiers de la population ont moins de 25 ans. De nombreux adolescents n'ont pas facilement accès à l'information et aux services en matière d'hygiène sexuelle et de santé sexuelle et reproductive, ce qui explique les grossesses non désirées, les avortements à risque, ainsi que les taux élevés de mortalité maternelle, de VIH/SIDA et d'infections sexuellement transmissibles. Avec 1 000 décès pour 100 000 naissances vivantes, le taux de mortalité maternelle constitue l'un des plus graves problèmes de santé publique. Environ 80 % des accouchements ont lieu à domicile, sans l'aide de professionnels de santé formés.

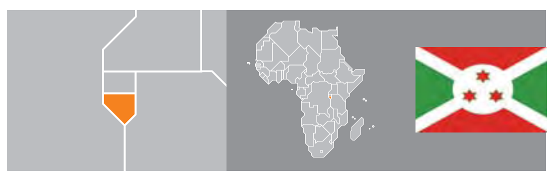
Accès aux services[6]	Masculin	Féminin	Total
Femmes mariées utilisant une quelconque méthode de planification familiale		22 %	
15-19 ans utilisant des contraceptifs	57,7 %	56,3 %	57 %
20-24 ans utilisant des contraceptifs	83,6 %	79 %	81,3 %
Accès au dépistage/consultation VIH (15-24 ans): Oui			
Accès aux soins post-avortement	n.d		

Disponibilité des services adaptés aux jeunes : Le Centre de la jeunesse de Kamenge existe dans la région depuis 1991. Pendant et après la crise de 1994, il a permis d'organiser des rencontres entre jeunes Hutus et Tutsis dans le cadre d'activités sportives et culturelles. Au cours des 15 dernières années, le Centre de la jeunesse de Kamenge a rassemblé des jeunes de tous les milieux sociaux, ethniques et religieux, pour les impliquer dans différentes activités visant à promouvoir la paix et la coexistence. Parmi ces activités figurent des ateliers sur la paix et la réconciliation et des actions de sensibilisation au SIDA, des activités d'alphabétisation, des sessions de travail et des formations informatiques. Selon un rapport de situation sur le Burundi publié en 2007 par ONUSIDA, 4 000 jeunes avaient à cette date reçu une formation aux compétences pratiques, et 972 clubs Stop SIDA avaient entrepris des activités d'information, d'éducation et de communication qui avaient touché 23 354 élèves. Il faut noter également que ces derniers temps, des clubs Stop SIDA au sein des écoles secondaires et d'autres centres pour jeunes ont été créés partout dans le pays.

Notes:

1 Plan National de Développement Sanitaire 2011-2015 (PNDS 2011-2015)
2 Rapport sur le développement humain 2013
3 Recensement Générale de la population et de l'habitation 2008 (RGPH 2008)
4 RGPH 2008
5 RGPH 2008
6 Enquête Démographique et de Santé 2010 (EDS 2010)
7 Rapport SWAA, SERUKA, NTURENGAHO

DEMOCRATIC REPUBLIC OF CONGO



National Poverty Rate[1]	71.3%
Public spending : Education[i]	6.2%
Public spending : Health[i]	1.1%
School attendance rate among orphans age 10 - 14 yrs[2]	63.3%

Population : 65 705 093

Population estimations take into consideration increased mortality rates caused by HIV and AIDS, which has led to lowering of life-expectancy, higher rates of infant mortality and reductions in overall population growth.[3]

Population[4]	Male	Female	Total
% children aged 10 to 14 yrs	14.3%	13.0%	13.6%
% adolescents 15 to 19 yrs	10%	9%	9.5%
% youth 20 to 24 yrs	8.3%	10%	9.1%

Education :

Overall levels of access to primary schooling are reasonably high, however, there is a considerable drop-out rate between primary and secondary level schooling. There are also differences between girls and boys' access to school: girls have lower school enrolment at both primary and secondary school.

Primary and secondary school completion rates are very low, particularly among girls, and this will impact negatively on the implementation of any HIV-related programmes. On average, only 3.5 years of schooling are being completed of a possible 8.5 years. The low levels of school-completion suggest that a significant number of young people are not in education.

Education	Male	Female	Total
Adult literacy rateiv	86%	59%	66.8%
Literacy rate15 to 24 yrs	68%	62%	65%
Primary enrolment rate (net)[5]	53%	46%	49.5%
Net school attendance rate primary[2]	78%	72%	75%
Net school attendance rate secondary[2]	35.1%	28.3%	42.2%
Primary school completion rates	15.4%	13.5%	14.4%
Secondary school completion rates	85.3%	89.7%	87.2%

Trained Teachers (primary)[6]			Teacher / learner ratio[7]	
Male	Female	Total	Primary	Secondary
-	-	93.4%	37.4%	15.2%

Gender parity index (ratio girls /boys)[2]	Primary	Secondary	Tertiary
	0.93	0.81	-

Sexuality Education : The school curriculum includes HIV and AIDS, sexuality education and a wide range of practical skills. However, teaching materials are not available for all levels. The "Life skills and HIV" curriculum is spread across the seven core subjects. It is implemented in primary and secondary school and is in the process of redevelopment for further education. The HIV curriculum is obligatory and is examinable in primary and secondary schools. It is estimated that 80% of all primary and secondary schools include HIV/AIDS and life skills education based on this curriculum. Young people out of school are also targeted through non-formal education programmes. The option of parental engagement is included in the HIV curriculum, on an ad-hoc basis. The long term impact of the programme has not yet been evaluated.

Curriculum available	Type of curriculum	Curriculum examinable
Yes	Life Skills	Yes

Curriculum content[8]				
Topic covered	Included in core curriculum			
	Primaire 1	Primaire 2	Secondaire 1	Secondaire 2
General Life Skills	Yes	Yes	Yes	N/a
Adolescent and reproductive health	No	Yes	Yes	N/a
Sexuality education	No	Yes	Yes	N/a
Gender equality and empowerment	Yes	Yes	Yes	N/a
HIV and AIDS and other STIs	Yes	Yes	Yes	N/a
Stigma and discrimination	Yes	Yes	Yes	N/a
Family life and personal relationships	Yes	Yes	Yes	N/a

Sexual and reproductive health : HIV prevalence across the country is low, particularly in comparison with other countries in the region. HIV prevalence is lower among young people than the adult population Fertility rates among adolescents are quite high, a fact which can be partly attributed to early sexual debut: 21.4% of girls have their first sexual experience before the age of 15 years. In addition, pregnancy related complications are more common among adolescents and contribute to a higher maternal mortality rate.

Sexual and reproductive health	Male	Female	Total
Fertility rate among adolescents 15 to 19 yrs[2]	-	135‰	-
Contraceptive prevalence rate among 15-49 yrs[2]	-	18%	-
STI prevalence among 15 to 24 yrs[4]	4.9%	4.1%	4.5%
HIV prevalence among young people 15 to 24 yrs[9]	**15 to 19**	**20 to 24**	**Total**
	2.6%	3.0%	3.0%
Incidence of gender-based and sexual violence among young women 15 to 24 yrs[4]	16 % report having ever experienced sexual intercourse without their consent (forced sex) Younger women in particular are at risk: the prevalence of women who have ever experienced forced sex is 21% among girls 18-19 yrs and 14% among women aged 40-49. In areas affected by conflict, 76% of women accept gender-based violence as 'normal'.		
Unmet family planning needs among 15 to 49 yrs[6]	Birth spacing	Birth control	Total
Aged 15-19 yrs	25.2%	0.9%	26.1
Aged 20-24 yrs	22.2%	1.8%	24%

Behavioural indicators :

HIV knowledge levels among young people are very low. This presents a potential risk of increased HIV and STI transmission even if current prevalence levels are relatively low. These risks for young people are heightened by low levels of condom use across the whole adult population. Condom use is currently the most effective way of reducing the risk of STIs and of unintended pregnancy.

Behavioural indicators	Male	Female	Total
Sex before age 15 (aged 15-19) (among youth aged 20 to 24 yrs)[4]	17.7%	18.2%	18%
Prevalence of multiple sexual partners (aged 15-24)[4]	14.3%	3.3%	8.8%
Prevalence of FGM among women 15-24 yrs	-	No data	-
Condom use at last sex 15 to 24 yrs[4]	25.6%	16.4%	21%
Child marriage (among women 20 to 24 yrs)[10]	**Married by 15 yrs**		**Married by 18 yrs**
	8%		39%

Services : The ministry of health works with other ministries to integrate issues related to youth, education and sexual and reproductive health. Some studies show that, for young people, health services are a second choice, after self-medicating or traditional healers, which are viewed as more easily accessible. IN DRC, some programmes have been developed to improve the delivery of services to adolescents and young people. The country is, however, vast and the scale of the challenges that remain in sexual and reproductive health are also vast: DRC has some of the world's worst SRH outcomes worldwide.

Access to services[4]	Male	Female	Total
Young women aged 15-19 yrs reporting difficulty in accessing health care	-	85.1%	-
Young people aged 15-19 who use contraception	27.8%	6.6%	17.2%
Young people aged 20-24 who use contraception	18.9%	9.6%	14.3%
Access to HIV testing and received a result from a test in the previous 12 months	**15 to 19 yrs**		**20 to 24 yrs**
	5.5%		13 %
Access to post-abortion care	Data not available		
Availability of youth friendly services	Limited		

Notes:

1 UNDP. Human Development Report 2013
2 RDC, Ministère du plan, (2010), Enquête par Grappe à Indicateurs Multiples (Mics4 /2010)
3 The World Bank. World Development Indicators Data. (http://databank.worldbank.org/data)
4 RDC, Ministère du plan, (2007), Enquête Démographique et de Santé, Kinshasa
5 Annuaires statistiques de l'EPSP 2009-2010
6 IDH, 2005-2010
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8 Country summary report for the Global Progress Survey on Education Sector Response to HIV and AIDS (2011)
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10 UNICEF SOWC : La situation des enfants dans le monde 2005-2010, UNICEF

RÉPUBLIQUE DÉMOCRATIQUE DU CONGO

Taux national de pauvreté[1]	71,3 %
Dépenses publique d'éducation[1]	6,2 %
Dépenses publique de santé[1]	1,1 %
Taux de fréquentation scolaire des orphelins de 10 à 14 ans[2]	63,3 %

Population : 65 705 093

Les estimations prennent en compte les effets de la surmortalité due au SIDA, qui se traduit par une espérance de vie moins longue, une mortalité infantile plus forte et un taux de croissance démographique moins élevé[3].

Population[4]	Hommes	Femmes	Total
% d'enfants de 10 à 14 ans	14,3 %	13,0%	13,6%
% d'adolescents de 15 à 19 ans	10%	9%	9,5%
% de jeunes de 20 à 24 ans	8,3%	10%	9,1%

Éducation : Le taux de fréquentation scolaire net dans le primaire est assez élevé mais, parmi les élèves qui sont passés dans le secondaire, ce taux est très faible. On observe aussi certaines différences entre les sexes dans la fréquentation des écoles primaires et secondaires, le taux net de fréquentation des filles étant moins élevé que celui de leurs homologues masculins. Le taux d'achèvement des études dans le primaire et le secondaire est très faible, et cela aura sans doute des incidences négatives sur la mise en place d'un programme relatif au VIH et au SIDA. Cela est encore exacerbé par le fait que, parmi les jeunes scolarisés, le taux d'achèvement des études dans le primaire et le secondaire est malheureusement très bas, en particulier parmi les filles. Sur un nombre moyen possible de 8,5 années de scolarité, seules 3,5 années sont effectivement achevées. Cet indicateur confirme l'impression qu'un nombre important de jeunes ne suivent pas la scolarité formelle.

Éducation	Hommes	Femmes	Total
Taux d'alphabétisation des adultes[4]	86 %	59 %	66,8 %
Taux d'alphabétisation 15 à 24 ans[4]	68 %	62 %	65 %
Taux net d'admission dans le primaire[5]	53 %	46 %	49,5 %
Taux net de fréquentation dans le primaire[2]	78 %	72 %	75 %
Taux net de fréquentation dans le secondaire[2]	35,1 %	28,3 %	42,2 %
Taux d'achèvement de la scolarité dans le primaire[2]	15,4 %	13,5 %	14,4 %
Taux d'achèvement de la scolarité dans le secondaire[2]	85,3 %	89,7 %	87,2 %

Enseignants formés (primaire)[6]			Proportion élèves/enseignants[7]	
Hommes	Femmes	Total	Primaire	Secondaire
-	-	93,4 %	37,4	15,2

Indice de parité des sexes (ratio filles/garçons)[2]	Primaire	Secondaire	Supérieur
	0,93	0,81	-

Éducation sexuelle : Des questions portant sur un large éventail de compétences pratiques, le VIH/SIDA et l'éducation sexuelle sont incluses dans le programme scolaire. Cependant, il n'existe pas de matériels pédagogiques pour toutes les classes. Le programme « Compétences pratiques/VIH » recoupe les sept principales matières scolaires. Il est appliqué dans les écoles primaires et secondaires et est en cours de réexamen dans l'enseignement supérieur. Le programme sur le VIH est obligatoire et donne lieu à un examen dans les écoles primaires et secondaires. On estime qu'environ 80 % des écoles primaires et secondaires dispensent un enseignement sur le VIH/SIDA et les compétences pratiques en s'appuyant sur le programme. Les jeunes non scolarisés sont également visés dans l'application de ce programme au moyen d'initiatives d'éducation non formelle. Une option pour les parents est prévue dans le programme sur le VIH, mais seulement sous une forme ponctuelle. L'impact à long terme du programme sur le VIH n'a encore fait l'objet d'aucune évaluation.

Programme disponible	Type de programme	Programme donnant lieu à examen
Oui	Compétences pratiques	Oui

Contenu du programme[8]				
Sujets traités	Prise en compte dans le curriculum commun			
	Primaire 1	Primaire 2	Secondaire 1	Secondaire 2
Compétences pratiques générales	Oui	Oui	Oui	Pas de réponse
Santé des adolescents et santé de la reproduction	Non	Oui	Oui	Pas de réponse
Éducation sexuelle	Non	Oui	Oui	Pas de réponse
Egalite des sexes et autonomisation des femmes	Oui	Oui	Oui	Pas de réponse
VIH/SIDA et autres IST	Oui	Oui	Oui	Pas de réponse
Stigmatisation et discrimination	Oui	Oui	Oui	Pas de réponse
Vie familiale et relations interpersonnelles	Oui	Oui	Oui	Pas de réponse

Santé sexuelle et reproductive : La prévalence du VIH dans l'ensemble du pays est assez faible, notamment en comparaison avec d'autres États subsahariens. La prévalence globale du VIH est aussi plus faible parmi les jeunes que dans l'ensemble de la population adulte. Le taux de fécondité des adolescentes est assez élevé, et s'explique sans doute en partie par le commencement précoce de l'activité sexuelle, 21,4 % des filles ont eu leurs premiers rapports sexuels avant l'âge de 15 ans. En outre, les complications de santé sont fréquentes chez les adolescentes pendant la grossesse, facteur qui contribue à l'augmentation de la mortalité maternelle.

Santé sexuelle/reproductive	Hommes	Femmes	Total
Taux de fécondité des adolescentes de 15 à 19 ans[2]	-	135 ‰	-
Taux de prévalence des contraceptifs chez les personnes de 15 à 49 ans[2]	-	18 %	-
Prévalence des IST chez les jeunes de 15 à 24 ans[4]	4,9 %	4,1 %	4,5 %
Prévalence du VIH chez les jeunes de 15 à 24 ans[9]	**15 à 19 ans**	**20 à 24 ans**	**Total**
	2,6 %	3,0 %	3,0 %
Incidence des cas de violence sexuelle et sexiste (VSS) chez les jeunes femmes de 15 à 24 ans[4]	16 % ont déclaré avoir déjà eu des rapports sexuels contre leur volonté. Les jeunes filles, en particulier, sont les plus exposées. En effet, l'incidence des violences sexuelles varie de 21 % chez les jeunes filles de 18-19 ans à 14 % chez les femmes de 40-49 ans. Dans les zones de conflit, 76 % des femmes considèrent la violence sexiste comme normale.		
Besoins non satisfaits de planning familial chez les personnes de 15 à 49 ans[6]	Espacement	limitation	Total
15 à 19 ans	25,2	0,9	26,1
20 à 24 ans	22,2	1,8	24

Indicateurs comportementaux : Le niveau d'information approfondi des jeunes sur le VIH est très faible. Cela induit potentiellement un risque élevé de transmission de maladies sexuellement transmissibles parmi les jeunes, même si actuellement la prévalence du VIH et d'autres IST est assez peu élevée. Les risques de santé élevés pour les jeunes sont renforcés par la faible prévalence de l'usage de préservatifs dans l'ensemble de la population adulte. L'utilisation de préservatifs est aujourd'hui probablement le moyen le plus sûr de réduire les maladies sexuellement transmissibles et les grossesses involontaires.

Indicateurs de comportement	Hommes	Femmes	Total
Rapports sexuels avant 15 ans (chez les jeunes de 20 à 24 ans)[4]	17,7 %	18,2 %	18%
Partenaires multiples chez les jeunes de 15 à 24 ans[4]	14,3 %	3,3 %	8,8 %
Prévalence des MGF chez les jeunes femmes de 15 à 24 ans	-	Pas de données	-
Usage de préservatif lors du dernier rapport sexuel chez les jeunes de 15 à 24 ans[4]	25,6 %	16,4 %	21 %
Prévalence du mariage des enfants (chez les femmes de 20 à 24 ans)[10]	**Mariage à 15 ans**		**Mariage à 18 ans**
	8 %		39 %

Services : Le ministère de la Santé travaille avec d'autres ministères à l'intégration des questions qui concernent la jeunesse, l'éducation et la santé sexuelle et de la reproduction. Certaines enquêtes montrent que, pour les jeunes, les services de santé sont considérés comme une option secondaire venant après l'automédication et les traitements traditionnels, perçus comme plus facilement accessibles. En RDC, des programmes ont été élaborés à l'intention des adolescents et des jeunes, afin de répondre aux besoins actuels et d'améliorer la fourniture de soins. Le pays, cependant, est vaste et les défis à surmonter en matière de santé sexuelle et reproductive sont de ce fait énormes, la RDC affichant certaines des statistiques les plus défavorables au niveau mondial dans ce domaine.

Accès aux services[4]	Hommes	Femmes	Total
Jeunes femmes de 15 à 19 ans ayant des difficultés à accéder à des soins de santé	-	85,1 %	-
Jeunes de 15 à 19 ans utilisant la contraception	27, 8%	6,6 %	17,2 %
Jeunes de 20 à 24 ans utilisant la contraception	18,9 %	9,6 %	14,3 %
Accès au dépistage VIH / résultats du dernier test VIH pendant les 12 mois précédents	**15 à 19 ans**		**20 à 24 ans**
	5,5 %		13 %
Accès aux soins après avortement	Pas de données		
Disponibilité de services adaptés aux jeunes	Réduite		

Notes:

1 UNDP. Human Development Report 2013
2 RDC, Ministère du plan, (2010), Enquête par Grappe à Indicateurs Multiples (Mics4 /2010)
3 The World Bank. World Development Indicators Data. (http://databank.worldbank.org/data)
4 RDC, Ministère du plan, (2007), Enquête Démographique et de Santé, Kinshasa
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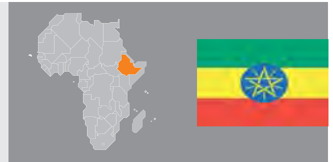
10 UNICEF SOWC : La situation des enfants dans le monde 2005-2010, UNICEF

ETHIOPIA



Population: 91 728 849 (2012)[1]

Approximately 43.9% of the population is less than 15 years of age.[2]

National poverty line: 38.9%[3]

Public Expenditure on Education (2010): 4.7% of GDP[3]

Public Expenditure on Health (2011): 2.6% of GDP

Population[2]	Male	Female	Total
% children 10-14 years	15.4%	13.8%	14.6%
% adolescents 15-19 years	9.3%	11%	10.2%
% young people 20-24 years	7.7%	8.3%	8.0%

Education: Net enrolment rates for primary school have seen a marked increase over the last decade. Ethiopia has made significant strides in universal primary school education. The gender parity index illustrates a gender bias in education which increases by education level. Primary attendance and enrolment is high, however, this is not the case with secondary attendance. This should inform programming and initiatives to reach young people. Continued efforts should be made to target out-of-school young people so that they can access sexuality and life skills education. Mean years of schooling is 1.5 years out of an expected 8.5 years, one of the lowest educational attainment levels in the Eastern and Southern African (ESA) region.

Education[4,5]	Male	Female	Total
Adult literacy rate (2007)	49.1%	28.9%	39.0%
Literacy rates 15-24 years (2007)	63%	47%	55%
Net enrolment rate primary	86.8%	83.9%	85.4%
Net enrolment rate secondary	16.9%	17.6%	17.3%
Trained teachers (Lower primary)	27.3%	34.7%	30.4%
Trained teachers (Upper primary)	89.3%	93.8%	90.8%

	Primary	Secondary
Teacher-pupil ratios	55	40
Gender parity index	0.95	0.88

Sexuality education: There is a cross-curricula HIV and AIDS syllabus which is compulsory and examinable and the component on sexuality education (SE) is in the process of being developed. An estimated 38.4% of primary and secondary schools provide life skills education, which includes HIV and AIDS. The Ethiopian curriculum also orientates parents on HIV and AIDS education on a yearly basis. Efforts have been made to include traditional leaders in the discussion as well, however, this is being done on an ad hoc basis.[6]

Curriculum Available	Curriculum Type	Examinable
Yes	Life Skills Education	Yes

Curriculum content[6]

Topic covered	Inclusion in core curriculum			
	Lower primary	Upper primary	Lower secondary	Upper secondary
Generic life skills	Yes	Yes	Yes	Yes
Adolescent and reproductive health	Yes	Yes	Yes	Yes
Sexuality education	Partial	Partial	Partial	Partial
Gender equality and empowerment	Yes	Yes	Yes	Yes
HIV and AIDS and other STIs	Yes	Yes	Yes	Yes
Human rights base	Yes	Yes	Yes	Yes

Sexual and reproductive health: The HIV and AIDS Education Strategic Plan For Intensifying Multi-sectoral HIV and AIDS Response in Ethiopia II (SPM II) recognizes the importance of reaching young people in programming and educating them on HIV and AIDS and sexuality. SPM III employs a number of strategies to promote SE and young people-friendly sexual and reproductive health (SRH) services through peer education programmes, anti-AIDS clubs and girls clubs, which provide young people with educational information on sex and sexuality. The National Reproductive Health Strategy (2006-2015) recognizes the importance of education in achieving positive reproductive health outcomes for the country, and for young people in particular.

SRH[2]	Male	Female	Total
Adolescent fertility rate (aged 15-19)		7.9%	
Adolescent fertility rate (aged 20-24)		20.6%	
STI rate (aged 15-24)	1.9%	0.7%	1.3%
HIV prevalence (aged 15-24)	0.1%	0.55%	0.325%
Unmet need for FP (aged 15-19)		32.8%	
Unmet need for FP (aged 20-24)		21.8%	

Behavioural indicators: In comparison with the rest of the ESA region, Ethiopia has low prevalence of HIV and AIDS and sexually transmitted infections (STIs), however, knowledge and condom use are equally low. There is a 10% difference in the knowledge levels of young men and women. Women also experience higher prevalence of HIV and AIDS, STIs and age at first sex. The gendered nature of the HIV and AIDS is quite pervasive in the Ethiopian indicators, but the epidemic is quite generalized in Ethiopia, which masks the risks some key populations face as compared to others.[2]

Behavioural indicators[2]	Male	Female	Total
Sex before age 15 (aged 15-19)	1.2%	7.1	-
Sex before age 15 (aged 20-24)	1.3%	16%	8.65%
Prevalence of multiple sexual partners (aged 15-24)	1%	0.4%	0.7%
Prevalence of female genital cutting (aged 15-49)		74%	
Prevalence of child marriage (women aged 20-24 married before age 18)		36.5%	
Condom use at last sex among unmarried youth (aged 15-24)	60.9%	45.5%	

Services: In 2010/11, 173 million condoms were distributed. The National Reproductive Health Strategy stipulates the incorporation of emergency contraception as an integral part of the national contraceptive method mix. A total of 5.85 million people (53% male and 47% female) receiv ed HIV counselling and testing (HCT) in 2008/09. In Ethiopia, male circumcision is a culturally embedded practice and therefore, 89.1% of young men aged15-24 report being circumcised.[2]

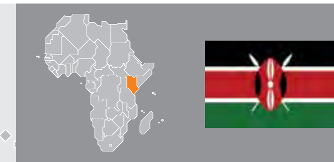
Access to services			
Currently married women using FP methods (aged 15-19)		23.8%	
Currently married women using family planning methods (aged 20-24)		34.8%	

Access to HTC (aged 15-24)	Male	Female
Know where to get tested	69.2%	78.8%
Have ever tested	40.5%	35.6%
Have received testing results	37.3%	32%
Access to post-abortion care	Abortion is illegal in Ethiopia except in specific circumstances	

Notes:

1 The World Bank. World Development Indicators Data. (http://databank.worldbank.org/data)
2 EDHS 2011
3 Human Development Report 2013
4 UNESCO Institute for Statistics Data Centre
5 Ministry of Education. September 2012. Education Statistics Annual Abstract 2004 E.C (2011/2012) Addis Ababa, Ethiopia
6 Selected 2011 GPS Key Results: Ethiopian Ministry of Education

KENYA



Population[1]: 38.6 million

A total of 43% of the population is below the age of 15 and 78% of Kenyans currently live in rural areas, with 60% of households engaged in farm work.

National poverty rate[2]: 45.9%

Education expenditure[2]: 17.2% of government expenditure

Health expenditure[2]: US $37 per capita

Ratio of school attendance of orphans aged 10-14[2]: 0.93 (2007)

Population[3]	Male	Female	Total
% children 10-14 years	13.8%	13.7%	27.5%
% adolescents 15-19 years	10.6%	9.5%	20.1%
% young people 20-24 years	8%	9.3%	17.3%

Education[4 5]: The education system is centralised, and includes eight years in primary school, four years in secondary school and four years in a general university degree programme. The completion rate remains relatively low, and in secondary school in particular, a huge discrepancy between the number of girls and boys who complete school exists. This necessitates the development of gender-specific programmes for out-of-school young people. The Kenyan government has provided orphans and vulnerable children (OVC) the opportunity to access education.

Education[4]	Male	Female	Total
Adult literacy rate	90.5%	83.5%	87%
Literacy rates 15-24 years	87.2%	72.3%	83.9%
Net enrolment rate primary	95.9%	95.6%	95.7%
Net enrolment rate secondary	32.9%	32.6%	32.7%
Primary school completion rate	81.9%	78.6%	80.3%

Trained teachers (primary)[4]		Teacher-student ratios[4]	
Male	Female	Primary	Secondary
96%	92.5%	1:47	1:30

Gender parity index (ratio girls/boys)	Primary	Second	Tertiary
	0.98	0.90	0.70

Sexuality education[6]: The Life Skills Education Syllabus series are an improved version of the 2002 ones. The purpose of the 'Let Us Talk About AIDS' series, which are designed for children in and out of school, is to teach young people how to form healthy relationships so that they can avoid being infected with HIV and other sexually transmitted infections (STIs). There is no data about the existence of special training for life skills education teachers.

Curriculum available	Curriculum type	Examinable
Yes	Life Skills	No

Curriculum content[7]

Topic covered	Inclusion in core curriculum			
	Lower primary	Upper primary	Lower secondary	Upper secondary
Generic life skills	Yes	Yes	Yes	Yes
Adolescent and reproductive health	-	Yes	Yes	Yes
Sexuality education	-	Yes	Yes	Yes
Gender equality and empowerment	Yes	Yes	Yes	Yes
HIV and AIDS and other STIs	Yes	Yes	Yes	Yes
Stigma and discrimination	-	Yes	Yes	Yes
Family life and interpersonal relations	Yes	Yes	Yes	Yes

Sexual and reproductive health (SRH)[8 9]**:** HIV and AIDS, maternal and child health are priority areas for the government. Kenya is characterized by a high unmet need for family planning, a low level of contraceptive use (it is, however, high if compared to other African countries' contraceptive use levels), as well as high rates of unintended pregnancy. Kenya has one of the highest child marriage rates in the world, which impacts negatively on the state of young women's health.

SRH[8]	Male	Female	Total
Adolescent fertility rate (aged 15-19)	-	17.7%	17.7%
Contraceptive prevalence (aged 15-19)	-	25%	25%
Contraceptive prevalence (aged 20-24)	-	30%	30%
STI prevalence (aged 15-24)	1.3%	1.6%	1.5%
HIV prevalence (aged 15-24)	1.8%	4.1%	3.8%
Incidence of sexual gender-based violence (SGBV) (aged 15-24)	-	15.4%	15.4%
Unmet need for family planning (aged 15-24)	-	30%	30%

Behavioural indicators[8]**:** Gender-based violence (GBV) is common in Kenya: 39% of women aged 15-49 report having been physically or sexually abused by their husbands or partners. A total of 35% of men and 18% of women are likely to engage in higher–risk sex, defined as sex with non-marital, non-cohabitating partners.

Behavioural indicators[8]	Male	Female	Total
Sex before age 15 (aged 15-19)	22.3%	11.5%	16.9%
Sex before age 15 (aged 20-24)	22%	10.4%	16.2%
Multiple partners (aged 15-24)	7.7%	1.6%	4.7%
Prevalence of female genital cutting (aged 15-49)	-	32%	32%
Prevalence of child marriage	-	26%	26%
Condom use at last sex (aged 15-24)	64%	40%	53.4%

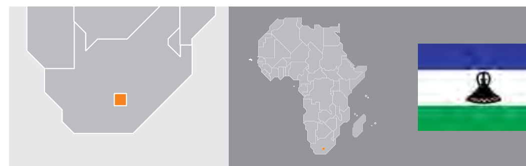
Services[8]**:** As a result of the existence of multiple opportunities for HIV testing and counselling (HTC), there has been a significant increase in the number of HIV-tested people. Prevention of mother-to-child transmission services are provided for free. They include various interventions, such as HTC, preventive treatment with antiretroviral drugs (maternal and infant), counselling, information about correct infant feeding, access to safe obstetric care and family planning services. Access to post-exposure prophylaxis (PEP) is increasing.

Access to services[8]	Male	Female	Total
Married/sexually active unmarried women aged 15-24 using all family planning methods	-	16.7%	16.7%
15- 24-year-olds using contraception	67%	37%	52%
	Aged 15-19	**Aged 20-24**	
15- 24-year-olds eligible for HIV testing	84%	84%	
Access to post-abortion care	Unclear how widely the new legal status of abortion is understood or being implemented		
Availability of young people-friendly services	7% of health facilities offer young people-friendly services		

Notes:

1 Population Reference Bureau and National Coordinating Agency for Population and Development, 2011, *Kenya Population Data Sheet 2011*.Washington, DC: PRB
2 UNDP, 2011, *Human Development Report - Sustainability and Equity: A Better Future for All*. UNDP: New York
3 Kenyan National Census, 2009
4 MoE 2009
5 MoE, 2012, *End of Decade Assessment*
6 Kenya Institute of Education, 2002, *Life Skills Education for the Youth*. Nairobi
7 Kenya Institute of Education, 2008, *Ministry of Education Secondary School Curriculum: Life Skills Education Syllabus*. Nairobi
8 DHS 2008-9
9 National AIDS/STI Control Programme, 2009, *Kenya AIDS Indicator Survey: Final Report*. Nairobi, NASCOP

LESOTHO



Population: 2 051 545 (2012)[1]

36.8% of the population is aged below 15.[2]

National poverty line: 43%[3]

Public expenditure on education: 13% of GDP[4]

Public expenditure on health: 8.5% of GDP[5]

Population[3]	Male	Female	Total
% children 10-14 years	15.8%	13.6%	29.4%
% adolescents 15-19 years	12%	10.4%	22.4%
% young people 20-24 years	9%	9%	18%

Education: The proportion of trained teachers is only about 60%, which might result in a significant compromise of the delivery of quality of education. Furthermore, while net attendance rates for primary school look good at 87% and 91% for males and females respectively, the same is not the case with secondary attendance rates at 23% and 37% for young men and women respectively.[6] These attendance rates suggest there is a lot of absenteeism from school among young people, especially at secondary level. There is therefore a need to monitor and ensure consistent school attendance by young people. School attendance rates for females are higher, which suggests the country could be doing much more to ensure gender equality.

Education[7]	Male	Female	Total
Adult literacy rate	83%	96%	90%
Literacy rates 15-24 years	86%	98%	92%
Net enrolment rate primary	72%	75%	74%
Net enrolment rate secondary	23%	37%	30%
Progression to secondary	71%	73%	74%

Trained teachers (primary)[8]		Teacher-student ratios[8]	
Male	Female	Primary	Secondary
11%	59%	34	39

Gender parity index (ratio girls/boys)	Primary	Second	Tertiary
	1.04	0.91	0.62

Sexuality education: The HIV and AIDS and Life Skills Education (LSE) curriculum was introduced in 2005 and piloted in 2007. It is taught in primary school grades 4 to 7 and secondary school forms A to C. In terms of content[11,8], the LSE curriculum includes themes highly relevant to HIV and pregnancy prevention education, such as gender, human rights, identity, HIV transmission and prevention, and AIDS treatment and care. However, it either misses, or inadequately addresses the issue of understanding sexually transmitted infections (STIs), as well as information about condoms, condom use negotiation and contraception. Despite the fact that the curriculum addresses bodily changes occurring during the teen years, there is no mentioning of the connection between sex and pregnancy. Sexuality is presented in an entirely negative light through focusing on sexual abuse, the need to abstain, and the risks of sex. Self-efficacy and communication skills are also inadequately addressed. The issues of avoiding multiple-concurrent partnerships and intergenerational sexual relationships are only rarely mentioned.[8] Almost all of the above-mentioned courses are offered at each level of education from primary to tertiary. The curriculum has been made mandatory in all educational institutions. Efforts have also been made to include out-of-school young people in life skills and HIV and AIDS awareness efforts.

Curriculum available	Curriculum type	Examinable
Yes	Life Skills	No

Curriculum content[8]				
Topic covered	Inclusion in core curriculum			
	Lower primary	Upper primary	Lower secondary	Upper secondary
Generic life skills	Yes	Yes	Yes	No
Adolescent and reproductive health	No	No	No	No
Sexuality education	No	No	No	No
Gender equality and empowerment	No	No	No	No
HIV and AIDS and other STIs	Yes	Yes	Yes	No
Stigma and discrimination	Yes	Yes	Yes	No
Family life and interpersonal relations	Yes	Yes	Yes	No

Sexual and reproductive health: Prevalence of STIs is estimated at 14%, while HIV prevalence for young people aged 15-24 is estimated at 18.5% and is very high among females at 28.2% compared to 8.9% of their male counterparts[6]. A likely contributing factor is high prevalence of early sexual debut among this age group, with 8.5% of males and 21.5% of females having had sex before 15 years old[9]. Condom use among young people is high, estimated at 62% for females and 54% for males during sex with an irregular partner.[9] This, together with increased levels of comprehensive knowledge, seem to correlate with the decrease of HIV prevalence among young people aged 15-22 (10.8% among females and 6.1% among males from 2004 to 2009).[6]

SRH	Male	Female	Total
Adolescent fertility rate[9]		96 births per 1000 women	
Teenage pregnancy rate[9]		20%	
STI rate (aged 18-49)[10]	13%	15%	14%
HIV prevalence (aged 15-24)[6]	8.9%	28.2%	18.5%
Unmet need for family planning (aged 15-24)[9]	-	28%	28%

Behavioural indicators: The incidence of HIV is high at 23%, although it is slightly lower in the 15-24 age group.[9] The high prevalence of child marriage in Lesotho exposes young girls to the risk of early pregnancy, HIV and STIs. Teenage pregnancy, child marriage and the lower status of girls leads to higher school attrition rates for girls.

Behavioural indicators[9]	Male	Female	Total
Sex before age 15 (aged 15-19)	9%	25%	17%
Sex before age 15 (aged 20-24)	8%	18%	13%
Multiple partners (aged 15-24)	21%	4%	12.5%
Prevalence of female genital cutting (aged 15-24)		2%	
Prevalence of child marriage			9%
Condom use at last sex (aged 15-24)	54%	62%	58%

Services: Not available.

Access to services[9]	Male	Female	Total
Married women using all family planning methods	-	46%	-
15- 19-year-olds using contraception	27.7%	20.5%	24.1%
20- 24-year-olds using contraception	64.2%	70.7%	67.5%
Access to HIV testing and counselling in the past 12 months	13.6%	11.8%	12.7%
Access to post-abortion care	Only where a woman's life is at risk		
Availability of young people-friendly services:	-		

Notes:

1 Bureau of Statistics, 2006, Population and Housing Census, Government of Lesotho
2 National AIDS Commission, 2011, National HIV and AIDS Strategic Plan 2011/12-2015/16
3 UNDP, 2010, Human Development Report – The Real Wealth of Nations
4 UNESCO Institute for Education Data Centre
5 UNDP. Human Development Report 2013.
6 UNICEF, 2011, *Opportunity in Crisis: Preventing HIV from Early Adolescence to Young Adulthood.* New York: UNICEF.
7 MoE, 2012, Education Statistics Bulletin 2011
8 Population Council, 2011, Sexuality Education Curriculum Review: Lesotho
9 DHS 2009
10 GOL, 2012, Global AIDS Response Country Progress Report January 2010-December 2011

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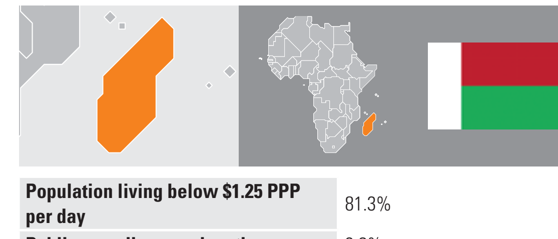

Population living below $1.25 PPP per day	81.3%
Public spending on education	3.2%
Public spending on health	2.3%
Proportion of orphans 10-15 yrs	11%

Population: 22 293 914 (2012)

42.4% of the population is below the age of 15.

Population	Male	Female	Total
% children 10-14 yrs	–	–	24%
% adolescents 15-19 yrs	10.1%	10.1%	10.1%
% youth 20-24 yrs	7.0%	7.1%	7.0%

Education:

More than 25% of children between 6 and 10 years of age are not enrolled in primary school. Girls have a higher national net enrolment rate than boys in this age band. The low net enrollment rates at secondary level show a low internal efficiency within the system. In fact only 23% of 11-14 year olds that should be in secondary school are enrolled. Significant drop outs are recorded at the primary education especially in recent years. In contrast, women over 15 are less literate than men. However this national average masks regional variations.

Education	Male	Female	Total
Adult literacy rate	74,9	68%	71,4%
Literacy rates 15-24 yrs			-
Net enrolment rate primary	72,4%	74,5%	73.4%
Net enrolment rate secondary	21%	24.5%	22.5%
Progression to secondary	-	-	-

Trained teachers (primary)		Pupil / Teacher Ratios	
Male	Female	Primary	Secondary
-	-	44	

Gender parity index (ratio girls/boys)	Primary	Second	Tertiary
	-	-	-

Sexuality Education: The duration of primary education in Madagascar is 5 years. The elementary education is provided to the children of the age group of 6 to 10. The duration of secondary education in Madagascar is 7 years. The secondary education is divided into a junior secondary stage and a senior secondary stage when sexuality education is offered. Children from 11 to 14 years attend the junior secondary stage and children from 15 to 17 years attend the senior secondary stage. The duration of the junior secondary stage is 4 years and for senior secondary stage, the duration is 3 years. After the completion of junior level, certificates are received by the graduates. Life skills training which is expected to equip young people with skills to help protect themselves against challenges like HIV infections, is provided through schools.

Curriculum Available	Curriculum Type	Examinable
Yes	Life Skills – stand alone	From Grade 8

Curriculum Content				
Topic Covered	Inclusion in core curriculum			
	Low/ P	Up/P	Low/S	Up/S
Generic life skills	Yes	Yes	Yes	Yes
Adolescent & reproductive health	No	Yes	Yes	Yes
Sexuality education	No	Yes	Yes	Yes
Gender equality & empowerment	Yes	Yes	Yes	Yes
HIV/AIDS and other STIs	Yes	Yes	Yes	Yes
Stigma & discrimination	Yes	Yes	Yes	Yes
Family life & inter-personal relations	yes	Yes	Yes	Yes

Sexual and Reproductive Health: There is a high birth rate among young people estimated at 147 births per 1,000 adolescents (UNICEF, 2010). This means approximately 147 female adolescents out of a 1,000 are at risk of contracting HIV and/or other STIs, as research has identified the practice of sexual intercourse at tender age to be associated with increased risk of HIV infection. The risk is likely to increase as comprehensive correct knowledge of HIV is also quite low among young people (*State of the World's Children*, 2012).

Sexual/ Reproductive Health	Male	Female	Total
Adolescent fertility rate	-	4.65%	-
Teenage pregnancy rate 15-19 yrs	-	31.7%	31,7%
STI rate 15-24 yrs	2%	4,6%	0.2%
HIV prevalence 15-24 yrs	0.2%	0.1%	0.2%
Incidence SGBV young women 15-24 yrs	-	55%	-
Unmet need for FP 15-24 yrs	-	21.2%	21.2%

Behavioural indicators:

HIV prevalence is very low in Madagascar but there is a significant high percentage of young people who are sexually active before the age of 15. There is high prevalence of child marriage in Madagascar.

The rate of teenage pregnancy between 15 and 19 years is quite high: 31% indicating early onset of sexual activity. 17% of girls in this age group have had sex before age 15. Among boys, however, sexual debut occurs later as only 8.4% have had sexual intercourse before age 15. However, once sexually active boys are more likely to have multiple partners. More than 74% of boys and girls do not have comprehensive knowledge of HIV and over 75% do not practise protective behaviour during sex as condom use is low.

Behavioural Indicators	Male	Female	Total
Knowledge of HIV 15-24 yrs	26%	23%	-
Sex before 15 15-24 yrs	9,1%	17,6%	-
Multiple partners 15-24 yrs	30.7 %	4.4%	-
FGM	-	-	0.9%
Prevalence of child marriage	-	-	48%
Condom use at last sex 15-24 yrs	9.7%	5.2%	-

Services: Most of sexually transmitted infections are treated in both public and private health facilities. These facilities also provide sexual and reproductive health services to adolescents and the Youth.

Access to services	Male	Female	Total
Married women using all FP methods	-	39.9%	
Unmarried sexually active population using any modern contraception	17.9%	14.1%	28.6%
20-24 year olds using contraception	-	-	-
Access to HIV testing/counselling	Available both in public and private health facilities		
Access to post abortion care	-		
Availability of YF Services	Available both in public and private health facilities		

Notes:

The World Bank. World Development Indicators Data. (http://databank.worldbank.org/data)
Enquête auprès des Ménages 2010
Plan intérimaire pour l'éducation 2013-2015
Enquête démographique et de Santé 2008-2009
Bureau des Statistiques pour Madagascar
Projet de plan national stratégique : "Projet stratégique de lutte contre le VIH et le SIDA 2013-2017"
La situation des enfants dans le monde, 2012
Fonds d'urgence de l'UNICEF 2010

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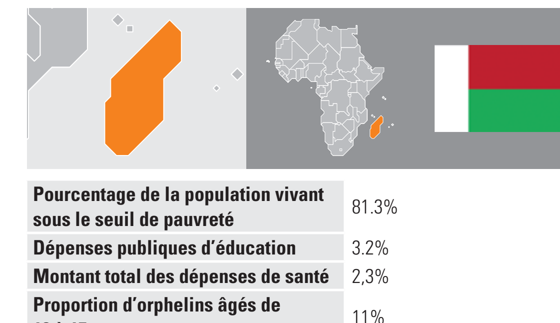

Pourcentage de la population vivant sous le seuil de pauvreté	81.3%
Dépenses publiques d'éducation	3.2%
Montant total des dépenses de santé	2,3%
Proportion d'orphelins âgés de 10 à 15 ans	11%

Population: 22 293 914 (2012)

42,4 % de la population a moins de 15 ans.

Population	Masculin	Féminin	Total
% enfants 0-14 ans	–	–	24 %
% jeunes 15-24 ans	10,1 %	10,1 %	10,1 %
% 25 ans et plus	7 %	7,1 %	7 %

Éducation : Plus de 25 % des enfants entre 6 et 10 ans ne sont pas inscrits dans le primaire. Le taux net de scolarisation est plus élevé pour les filles que pour les garçons parmi cette tranche d'âge. Le faible taux de scolarisation dans le secondaire indique une faible efficacité interne au sein du système. Seuls 23 % des 11-14 ans qui devraient être dans le secondaire sont inscrits. D'importants abandons scolaires ont été enregistrés dans l'enseignement primaire, surtout au cours de ces dernières années. À l'inverse, les femmes de plus de 15 ans sont moins instruites que les hommes, mais cette moyenne nationale dissimule des disparités régionales.

Éducation	Masculin	Féminin	Total
Taux d'alphabétisation des adultes	74,9 %	68 %	71,4 %
Taux d'alphabétisation des 15-24 ans			-
Taux net de scolarisation dans le primaire	72,4 %	74,5 %	73,4 %
Taux net de scolarisation dans le secondaire	21 %	24,5 %	22,5 %
Passage au secondaire	-	-	-

Enseignants formés (primaire)		Proportion élèves/enseignants	
Masculin	Féminin	Primaire	Secondaire
-	-	44	

Indice de parité des sexes (ratio filles/garçons)	Primaire	Secondaire	Supérieur
	-	-	-

Éducation sexuelle: À Madagascar, la durée de l'enseignement primaire est de 5 ans. L'enseignement élémentaire est dispensé aux enfants de la tranche d'âge allant de 6 à 10 ans. La durée de l'enseignement secondaire est de 7 ans, et celui-ci est divisé en un premier cycle du secondaire et en un deuxième cycle du secondaire durant lequel l'éducation sexuelle est dispensée. Les enfants de 11 à 14 ans fréquentent le premier cycle du secondaire tandis que les enfants de 15 à 17 ans fréquentent le deuxième cycle du secondaire. La durée de l'enseignement du premier cycle du secondaire est de 4 ans, et elle est de 3 ans pour le deuxième cycle du secondaire. Après l'achèvement du premier cycle, un diplôme est remis à ceux qui réussissent aux examens. Une formation sur les compétences nécessaires à la vie courante visant à doter les jeunes de compétences pour les aider à se protéger contre des fléaux comme les infections par le VIH, est proposée dans le cadre des institutions scolaires.

Programme disponible	Type de programme	Sanctionné par un examen
Oui	Compétence pratique	Fin du 1er cycle du secondaire

Contenu du programme				
Sujet couvert	Inclusion dans les programmes de base			
	Inf/P	Sup/P	Inf/S	Sup/S
Compétences pratiques génériques	Oui	Oui	Oui	Oui
Santé de l'adolescent et hygiène procréative	Non	Oui	Oui	Oui
Éducation sexuelle	Non	Oui	Oui	Oui
Égalité des sexes et autonomisation des femmes	Oui	Oui	Oui	Oui
VIH/SIDA et autres IST	Oui	Oui	Oui	Oui
Stigmatisation et discrimination	Oui	Oui	Oui	Oui
Vie familiale et relations interpersonnelles	Oui	Oui	Oui	Oui

Santé sexuelle et reproductive : Un taux de natalité élevé est enregistré chez les jeunes, avec une estimation de 147 naissances pour 1 000 adolescents (UNICEF, 2010). Cela signifie qu'environ 147 adolescentes sur 1 000 sont exposées au risque de contracter le VIH et/ou autres infections sexuellement transmissibles car, selon des recherches, des rapports sexuels à un très jeune âge entraînent des risques accrus d'infection par le VIH. Les risques sont susceptibles d'augmenter, étant donné que les connaissances complètes et correctes sur le VIH sont assez faibles chez les jeunes (*La situation des enfants dans le monde*, 2012).

Santé sexuelle et reproductive	Masculin	Féminin	Total
Taux de fécondité des adolescents	-	4,65 %	-
Taux de grossesse (15-19 ans)	-	31,7 %	31,7 %
Taux d'IST (15-24 ans)	2 %	4,6 %	0,2 %
Prévalence VIH (15-24 ans)	0,2 %	0,1 %	0,2 %
Incidence des violences basées sur le genre chez les jeunes femmes (15-24 ans)	-	55 %	-
Besoins non satisfaits de planning familial (15-24 ans)	-	21,2 %	21,2 %

Indicateurs de comportement : Le taux de prévalence du VIH est très faible à Madagascar mais, à l'inverse, le pourcentage de jeunes sexuellement actifs avant l'âge de 15 ans est extrêmement élevé. La prévalence des mariages d'enfants est élevée. Le taux de grossesses précoces chez les adolescentes entre 15 et 19 ans est assez élevé : 31 % indiquent une activité sexuelle précoce. 17 % des filles appartenant à ce groupe d'âge ont eu des relations sexuelles avant 15 ans. À l'inverse, les premiers rapports sexuels chez les garçons sont plus tardifs, et seulement 8,4 % ont eu des relations sexuelles avant 15 ans. Cependant, dès que les garçons deviennent sexuellement actifs ils sont plus disposés à avoir des partenaires multiples. Plus de 74 % de garçons et de filles ne possèdent pas de connaissances complètes sur le VIH, et plus de 75 % ne se protègent pas pendant les rapports sexuels du fait d'une faible utilisation du préservatif.

Indicateurs de comportement	Masculin	Féminin	Total
Connaissances sur le VIH (15-24 ans)	26 %	23 %	-
Rapports sexuels avant 15 ans (15-24 ans)	9,1 %	17,6 %	-
Partenaires multiples (15-24 ans)	30,7 %	4,4 %	-
Prévalence des mutilations génitales chez les femmes (15-24 ans)	-	-	0,9 %
Prévalence du mariage des enfants	-	-	48 %
Utilisation d'un préservatif lors du dernier rapport sexuel (15-24 ans)	9,7 %	5,2 %	-

Services : La plupart des infections sexuellement transmissibles sont traitées dans des infrastructures sanitaires publiques et privées. Ces infrastructures fournissent aussi des services de santé sexuelle et reproductive aux adolescents et aux jeunes.

Accès au service	Masculin	Féminin	Total
Femmes mariées utilisant une quelconque méthode de planification familiale	-	39,9 %	
Personnes non mariées sexuellement actives utilisant une quelconque méthode de contraception	17,9 %	14,1 %	28,6 %
20-24 ans utilisant des contraceptifs	-	-	-
Accès au dépistage du VIH	Disponible à la fois dans les centres de santé publics et privés		
Accès aux soins post-avortement	-		
Disponibilité des services adaptés aux jeunes	Disponible à la fois dans les centres de santé publics et privés		

Notes:
The World Bank. World Development Indicators Data. (http://databank.worldbank.org/data)
Enquête auprès des Ménages 2010
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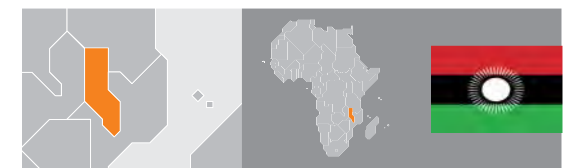

Population[1]**:** 15.3 million

A total of 85% of Malawi's population live in rural areas and almost half of the population is less than 15 years old.

National poverty rate[1]**:** 50.7%

Education expenditure[1]**:** US$8.6 per student in primary

Health expenditure[1]**:** US$26 per capita

Total health expenditure[1]**:** 8.4% of GDP

Proportion of orphans aged 10-15[1]**:** 18.95%

Population[1]	Male	Female	Total
% children 10-14 years	14.2%	13.5%	27.7%
% adolescents 15-19 years	10.1%	10%	20.1%
% young people 20-24 years	7.6%	8.9%	16.5%

Education[1]**:** Malawi follows a formal education system where primary education lasts for 8 years and secondary education for 4. The adult literacy rate in Malawi has witnessed little change since 2005.Urban areas have registered a higher literacy rate (89%) compared to rural areas (61%). Of the population aged 15 years and older, 21% (28% females and 14% males) have never attended school. Of these, only 7% are from urban areas compared to 24% in rural areas.

Education[1]	Male	Female	Total
Adult literacy rate	74.4%	57.2%	65.4%
Literacy rates 15-24 years	78.4%	75.6%	76.9%
Net enrolment rate primary	85%	87%	85%
Net enrolment rate secondary	11%	15%	13%
Progression to secondary	76%	75%	75.5%

Trained teachers (primary)[1]		Pupil-teacher ratios[1]	
Male	Female	Primary	Secondary
95%	97%	79.27	27.8

Gender parity index	Primary	Second	Tertiary
	1.04	0.91	0.62

Sexuality education[2,3]**:** The majority of sexuality education (SE) content is delivered in a stand-alone curriculum at the primary level where the Life Skills Education (LSE) series is delivered from the 2nd till the 8th grade. At the secondary level, Life Skills and Sexual and Reproductive Health Education is delivered from Form 1 to 4. The percentage of Malawi's grade 6 pupils who reached the minimum knowledge level in the 2009 Southern and Eastern Africa Consortium for Monitoring Educational Quality (SACMEQ) test was only 43%. A 2010 study conducted by UNESCO, UNFPA, and UNICEF found that there was a general lack of teaching and learning resources, inadequate training of teachers, accompanied by a lack of knowledge of SRH issues, including HIV transmission, and a discomfort around teaching sex and sexuality. Primary and secondary school teachers receive training on the Life Skills and SRH curriculum.

Curriculum available	Curriculum type	Examinable
Yes	Life Skills – stand alone	From Standard[8]

Curriculum content[4]				
Topic covered	Inclusion in core curriculum			
	Lower primary	Upper primary	Lower secondary	Upper secondary
Generic life skills	Yes	Yes	Yes	Yes
Adolescent and reproductive health	No	Yes	Yes	Yes
Sexuality education	No	Yes	Yes	Yes
Gender equality and empowerment	Yes	Yes	Yes	Yes
HIV and AIDS and other STIs	Yes	Yes	Yes	Yes
Stigma and discrimination	Yes	Yes	Yes	Yes
Family life and interpersonal relations	Yes	Yes	Yes	Yes

Sexual and reproductive health[5,6]**:** The National Standards for Youth Friendly Health Services guide the provision of SRH services to young people. A key national standard is the provision of needs-relevant SRH information to young people. Despite the fact that high awareness of sexually transmitted infections (STIs) and HIV and AIDS exists among young people, only a small percentage have undergone an HIV test.

SRH[5,7]	Male	Female	Total
Adolescent fertility rate per 1,000 births	-	119.2	-
Teenage pregnancy rate	-	25.6%	25.6%
STI rate (aged 18-49)	33.9%	38.9%	36.4%
HIV prevalence (aged 15-24)	3.1%	6.8%	4.9%
Incidence of sexual gender-based violence (SGBV) (aged 15-24)	-	44.9%	44.9%
Unmet need for family planning (aged 15-24)	-	26.2%	26.2%

Behavioural indicators[5]**:** HIV prevalence is high, at 10.6%, but is slightly lower in the 15-24 age group. A significant percentage of young people are sexually active before the age of 15 and there is a high rate of multiple concurrent partnerships among the 15-24-year-olds. The high prevalence of child marriage exposes young girls to the risk of early pregnancy, HIV and STIs. Teenage pregnancy, child marriage and the lower status of girls leads to higher school attrition rates for girls.

Behavioural indicators[5]	Male	Female	Total
Sex before age 15 (aged 15-19)	18%	14.1%	16.1%
Sex before age 15 (aged 20-24)	9.1%	15.5%	12.3%
Multiple partners (aged 15-24)	62.8%	45.5%	54.2%
Prevalence of child marriage	-	49.6%	-
Condom use at last sex (aged 15-24)	51.4%	48.8%	50.1%

Services[8]**:** The National Sexual and Reproductive Health and Rights (SRHR) Policy (2009) was revised to respond to the Maputo Plan of Action, by including the need to incorporate emerging SRHR issues such as basic emergency obstetric/neonatal care, cervical cancer screening, young people-friendly health services, antiretroviral therapy and prevention of mother-to-child transmission. The Malawi National AIDS Policy ensures access to optional HIV testing for all pregnant women. The National Plan of Action for Scaling up SRH and HIV Prevention Initiatives for Young People (2008-2012) combines all major HIV prevention initiatives for young people that are currently ongoing. The National HIV Prevention strategy (2009-2013) promotes HIV-related SRH education through life skills education for young people.

Access to services[7,9]	Male	Female	Total
Married women using all family planning methods		46%	
15-19-year-olds using contraception	27.7%	20.5%	24.1%
20- 24-year-olds using contraception	64.2%	70.7%	67.5%
Access to HIV testing and counselling	28% of sexually active population		
Access to post-abortion care	Only where the woman's life is at risk		
Availability of young people-friendly services	Young people have access to services from over 1600 young people-friendly SRH service sites		

Notes:

1 Government of Malawi, 2010, *RAPID Population and Development*. The Ministry of Development Planning and Cooperation. Lilongwe.
2 UNFPA, 2010, *Sexuality Education: A ten-country review of school curricula in East and Southern Africa. Sexuality Education Curriculum Review: Malawi.*
3 Kalenda, B, 2010, *Life skills and reproductive health education changes behaviour in students and teachers: Evidence from Malawi.* Educational Research and Reviews Vol. 5(4), pp. 169-174.
4 UNFPA, 2010, *Sexuality Education: A ten-country review of school curricula in East and Southern Africa. Sexuality Education Curriculum Review: Malawi.*
5 DHS 2010
6 IPPF, 2010, *Rapid Assessment of Sexual and Reproductive Health and HIV Linkages in Malawi.* Centre for Reproductive Health, University of Malawi, (with IPPF/UNFPA/WHO/UNAIDS). Lilongwe.
7 Government of Malawi, 2012, *Global AIDS Response Progress Report: Malawi Country Report for 2010/2011*. Lilongwe.
8 Government of Malawi, 2009, *National HIV Prevention Strategy 2009-2013.* National AIDS Council. Lilongwe.
9 International Association for National Youth Service, 2010, *National Youth Service Country Profile: Malawi.*

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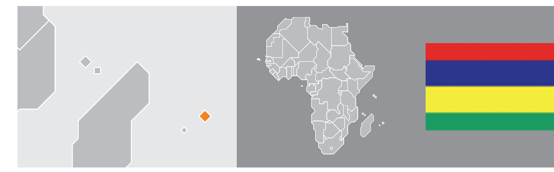


Population: 1.29 million

58% of the population resides in rural areas. The annual population growth rate is 0.5%; almost two-thirds of the population is over 25 years old.[1]

National poverty rate[2]: In 2006/2007, less than 1% of the population lived below US$1 a day

Public Expenditure on Education[2]: 3.2% of GDP

Total Expenditure on Health[2]: 2.3% of GDP

Total health expenditure[1]: 8.4% of GDP

Proportion of orphans 10-17 years[2]: 19 000

Population[1]	Male	Female	Total
% children 0-14 years	10.7%	10.4%	21.1%
% youth 15-24 years	8%	7.8%	15.8%
% 25 years and over	30.4%	32.4%	62.8%

Education[4 5]: The percentage of people who are 15-years-old or over and can both read and write is 88.5%. The minimum school leaving age is 16 years. Access to primary and secondary education is free. Students are also provided with free transportation to school.

Education[3]	Male	Female	Total
Adult literacy rate	90.9%	86.2%	88.5%
Literacy rates 15-24 years	95.7%	97.7%	96.7%
Net enrolment rate primary	93%	95%	94%
Net enrolment rate secondary	-	-	71%
Progression to secondary	96%	96%	96%

Trained teachers (primary)[5]		Teacher-student ratios[5]	
Male	Female	Primary	Secondary
100%	100%	1:22	-

Gender parity index (ratio girls/boys)	Primary	Second	Tertiary
	1.01	1.00	1.24

Sexuality education[6 7]: Life skills education is not yet well defined and is mostly catered for by non-governmental organizations (NGOs) and ministries other than the Ministry of Education (MoE). According to the National Sexual and Reproductive Health Strategy and Plan of Action 2009-2015, sexuality education for young people in and out of school will aim to educate adolescents about issues such as fertility, safe sex, sexually transmitted infections (STIs) and HIV and AIDS, and the implications of an unplanned pregnancy and abortion. There is high unmet need for information, education and sexual and reproductive health (SRH) services for adolescents and young people.

Curriculum available	Curriculum type	Examinable
Yes	-	Not examinable

Curriculum content[8]

Topic covered	Inclusion in core curriculum			
	Lower primary	Upper primary	Lower secondary	Upper secondary
Generic life skills	No	No	Yes	Yes
Adolescent and reproductive health	No	No	Yes	Yes
Sexuality education	No	No	No	Yes
Gender equality and empowerment	No	No	No	No
HIV and AIDS and other STIs	No	No	Yes	Yes
Stigma and discrimination	No	No	No	No
Family life and interpersonal relations	No	No	Yes	Yes

Sexual and reproductive health[7]**:** One of the activities envisioned by the Mauritius Sexual and Reproductive Health Plan for 2009-2015 is a legal and policy review. One of the aims of this review will be to demonstrate the need for enacting laws which protect people providing SRH and family planning services to unmarried adolescents below the age of 18, who have not been given parental consent. Another planned activity is providing young people with accurate information, skills development sessions and user-friendly SRH services.

SRH[3]	Male	Female	Total
Adolescent fertility rate (15-19 yrs) per 1,000 births	-	29.4%	29.4
HIV prevalence (15-24 yrs)	0.34%	0.25%	0.29%
Incidence of sexual gender-based violence (SGBV) (15-49 yrs)	-	22.8%	-

Behavioural indicators[9]**:** HIV prevalence in Mauritius stands at 0.97%. HIV prevalence among young people falling into the 15-24 age group has fallen from 0.67% in 2010 to 0.34% in 2011[10 11]. The percentage of young people engaging in sexual activities at an early age is relatively low.

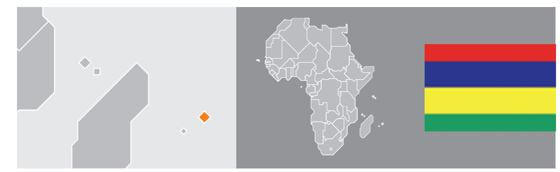
Behavioural indicators[12]	Male	Female	Total
Sex before age 15 (15-24 yrs)	1.3%	0.1%	0.8%
Multiple partners (15-24 yrs)	4.5%	1.3%	3.0%
Condom use at last sex (sex with irregular partners) (15-24 yrs)	90.9%	66.7%	85.7%

Services: The regional hospitals and the community health centres across the island offer an array of health services, including, amongst others, family planning, cancer screening, HIV and AIDS services, emergency contraception provision, dental and ante-natal care.[7] In 2011, the percentage of young people falling into the 15-24 age group who have undergone an HIV test during the past 12 months was 5.7%.[13] Post-Exposure Prophylaxis (PEP) for rape victims is provided in all hospitals. Currently, there are three health facilities offering young people-friendly services; the government is planning on increasing their number to ten.[7] The Criminal Code (Amendment Bill of October 2012), allows the termination of pregnancy in cases where there is risk to the life, or physical or mental well-being of the pregnant woman; where there is a substantial risk of malformation of the foetus; where the pregnancy has not exceeded fourteen weeks and is the result of rape, sexual intercourse with a female under the age of 16 or sexual intercourse with a person who has been reported to the police or to a medical practitioner.[14]

Notes:

1 UNDP, 2011, *Human Development Report (HDR):Human Development Statistical Annex*
2 HDR 2012
3 HDR 2011
4 UNICEF, 2012, *The State of the World's Children*
5 MoE, *National Youth Policy 2010-2014*
6 UNESCO, 2011, *GPS Country Report*
7 MoH, *The National Sexual and Reproductive Health Strategy and Plan of Action 2009-2015*
8 MoE, 2004, *The Development of Education: National Report of Mauritius*
9 UNESCO, 2011, *GPS Key Results*
10 MoH, 2004, *Ante Natal Care surveillance data*
11 MoH, 2011, *Ante Natal Care surveillance data*
12 UNAIDS, 2012, *Global AIDS Response Progress Report Mauritius*
13 *Mauritius HIV, AIDS and STI's Knowledge, Attitude, Practices and Behavior Study (KAPB)*, 2011
14 OECD Development Centre. 2012. Social Institutions and Gender Index: Understanding the Drivers of Gender Inequality

MAURICE



Population : 1,29 million

58 % de la population habite en zone rurale. Le taux de croissance démographique annuel est de 0,5 % ; près des deux tiers des habitants sont âgés de plus de 25 ans[1].

Pourcentage de la population vivant sous le seuil de pauvreté[2] : En 2006-2007, moins de 1 % de la population vivait avec moins de 1 dollar des É.-U. par jour

Dépenses publiques d'éducation[2] : 3,2 % du PIB

Montant total des dépenses de santé[2] : 2,3 % du PIB

Proportion d'orphelins âgés de 10 à 17 ans[2] : 19 000

Population[3]	Masculin	Féminin	Total
% enfants 0-14 ans	10,7 %	10,4 %	21,1 %
% jeunes 15-24 ans	8 %	7,8 %	15,8 %
% 25 ans et plus	30,4 %	32,4 %	62,8 %

Éducation[4, 5] : Le pourcentage de personnes âgées de 15 ans et plus qui savent à la fois lire et écrire est de 88,5 %. L'âge minimum de fin de la scolarité est 16 ans. L'accès à l'enseignement primaire et secondaire est gratuit. Les élèves bénéficient aussi de la gratuité du transport entre le domicile et l'école.

Éducation[3]	Masculin	Féminin	Total
Taux d'alphabétisation des adultes	90,9 %	86,2 %	88,5 %
Taux d'alphabétisation des 15-24 ans	95,7 %	97,7 %	96,7 %
Taux net de scolarisation dans le primaire	93 %	95 %	94 %
Taux net de scolarisation dans le secondaire	-	-	71 %
Passage au secondaire	96 %	96 %	96 %

Enseignants formés (primaire)[5]		Proportion élèves/enseignants[5]	
Masculin	Féminin	Primaire	Secondaire
100 %	100 %	1:22	-

Indice de parité des sexes (ratio filles/garçons)	Primaire	Secondaire	Supérieur
	1,01	1,00	1,24

Éducation à la sexualité[5, 7] : L'éducation aux compétences pratiques n'est pas clairement définie, et elle est assurée pour l'essentiel par des organisations non gouvernementales (ONG) et des ministères autres que le ministère de l'Éducation. Selon la Stratégie et le Plan d'action nationaux pour la santé en matière de procréation 2009-2015, l'éducation sexuelle des jeunes scolarisés ou non scolarisés vise à informer les adolescents sur des questions telles que la fécondité, la sexualité sans risque, les infections sexuellement transmissibles (IST) et le VIH/SIDA, ainsi que sur les conséquences d'une grossesse non planifiée et d'un avortement. D'importants besoins en matière d'information, d'éducation et de fourniture de santé sexuelle et reproductive pour les adolescents et les jeunes ne sont pas encore satisfaits.

Programme disponible	Type de programme	Sanctionné par un examen
Oui	-	Non

Contenu du programme[8]				
Sujet couvert	Inclusion dans les programmes de base			
	Inf/P	Sup/P	Inf/S	Sup/S
Compétences pratiques génériques	Non	Non	Oui	Oui
Santé de l'adolescent et hygiène procréative	Non	Non	Oui	Oui
Éducation sexuelle	Non	Non	Non	Oui
Égalité des sexes et autonomisation des femmes	Non	Non	Non	Non
VIH/SIDA et autres IST	Non	Non	Oui	Oui
Stigmatisation et discrimination	Non	Non	Non	Non
Vie familiale et relations interpersonnelles	Non	Non	Oui	Oui

Santé sexuelle et reproductive[7] **:** Parmi les activités envisagées dans le Plan national pour l'hygiène sexuelle et la santé en matière de procréation 2009-2015 figure un examen de la législation et des politiques. Cet examen permettra notamment de mettre en évidence la nécessité d'adopter des lois qui protègent les personnes fournissant des services d'hygiène sexuelle et procréative et de planification familiale à des adolescents non mariés âgés de moins de 18 ans sans accord parental. Une autre activité planifiée a pour objet de donner aux jeunes des informations exactes, d'organiser à leur intention des séances de développement des compétences et de leur fournir des services d'hygiène sexuelle et de santé procréative qui leur soient adaptés.

Santé sexuelle et reproductive[3]	Masculin	Féminin	Total
Taux de fécondité des adolescents (15-19 ans) pour 1 000 naissances	-	29,4 %	29,4
Prévalence du VIH chez les 15-24 ans	0,34 %	0,25 %	0,29 %
Incidence des violences fondées sur le genre chez les jeunes femmes (15-49 ans)	-	22,8 %	-

Indicateurs de comportement[9] **:** Le taux de prévalence du VIH à Maurice est de 0,97 %. Dans la tranche d'âge 15-24 ans, ce taux a baissé, passant de 0,67 % en 2010 à 0,34 % en 2011[10, 11]. Le pourcentage de jeunes ayant des rapports sexuels précoces est relativement faible.

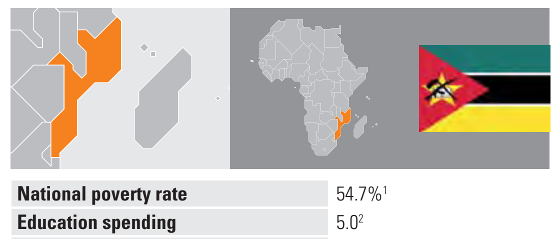
Indicateurs de comportement[12]	Masculin	Féminin	Total
Rapports sexuels avant 15 ans (15-24 ans)	1,3 %	0,1 %	0,8 %
Partenaires multiples (15-24 ans)	4,5 %	1,3 %	3,0 %
Utilisation d'un préservatif lors du dernier rapport sexuel (rapports avec des partenaires irréguliers) (15-24 ans)	90,9 %	66,7 %	85,7 %

Services : Les hôpitaux régionaux et les centres de soins communautaires de l'ensemble du territoire offrent toute une série de services de santé, y compris, entre autres, des services de planification familiale, de dépistage du cancer, des services liés au VIH/SIDA, des services de contraception d'urgence et des soins dentaires et prénataux[7]. En 2011, le pourcentage de jeunes dans la tranche d'âge 15-24 ans ayant passé un test de dépistage du VIH au cours des 12 derniers mois était de 5,7 %[13]. Tous les hôpitaux offrent des soins prophylactiques post-exposition (PPE) aux victimes d'un viol. À l'heure actuelle, il existe trois centres de soins offrant aux jeunes des soins qui leur sont adaptés ; le gouvernement prévoit d'en porter le nombre à dix[7]. Le Code pénal (projet de révision de 2012) autorise l'interruption de grossesse en cas de risque pour la vie ou le bien-être physique ou mental de la femme enceinte, lorsqu'il existe un risque important de malformation du fœtus, jusqu'à la 14e semaine de grossesse, et lorsque la grossesse résulte d'un viol, lorsque la personne enceinte est une mineure de moins de 16 ans ou lorsque les rapports ont eu lieu avec une personne signalée à la police ou à un médecin pratiquant[14].

Notes :

1 PNUD, 2011, *Rapport sur le développement humain, Annexe statistique.*
2 Rapport sur le développement humain 2012.
3 Rapport sur le développement humain 2011.
4 UNICEF, 2012, *La situation des enfants dans le monde.*
5 Ministère de l'éducation, *National Youth Policy 2010-2014.*
6 UNESCO, 2011, *GPS Country Report.*
7 Ministère de la santé, *The National Sexual and Reproductive Health Strategy and Plan of Action 2009-2015.*
8 Ministère de l'éducation, 2004, *The Development of Education: National Report of Mauritius.*
9 UNESCO, 2011, *GPS Key Results.*
10 MoH, 2004, *Ante Natal Care surveillance data.*
11 Ministère de la santé, 2011, *Ante Natal Care surveillance data.*
12 ONUSIDA, 2012, *Global AIDS Response Progress Report – Mauritius.*
13 *Mauritius HIV, AIDS and STI's Knowledge, Attitude, Practices and Behavior Study (KAPB)*, 2011.
14 Centre de développement de l'OCDE. 2012. *Social Institutions and Gender Index: Understanding the Drivers of Gender Inequality.*

MOZAMBIQUE



National poverty rate	54.7%[1]
Education spending	5.0[2]
Health spending	6.6[3]
Proportion of orphans 10-15 yrs	

Population: 23 391 000

In 2007, Mozambique had an estimated population of 20 366 795. The estimated population for 2012 is 23 391 000. Life expectancy at birth in Mozambique has increased by 7.4 years. The life expectancy of the population as a whole is now estimated at 51.78 years (male: 51.01 years; female: 52.57 years) (INE, 2011).

Population[4]	Male	Female	Total
% children 10-14 yrs	15.1%	13.6%	14.3%
% adolescents 15-19 yrs	9.9%	9.2%	9.5%
% young adults 20-24 yrs	6.7%	7.7%	7.2%

Education: The adult literacy rate of 56% has been rising since 2005. Literacy rates for girls are higher in rural areas (64%) than urban areas (35%); this same trend is reflected among boys, with literacy rates of 67% in rural areas and 35% in urban areas. Almost 25% of the Mozambican population aged 15 years and above has never attended school.

Education[5]	Male	Female	Total
Adult literacy rate, regional average	68.1%	50.6%	59.1%
Literacy rate 15-24 yrs, regional average	75.6%	63.7%	69.5%
Net enrolment rate in primary education (2011)	92%	87%	90%
Net enrolment rate in secondary education (2011)	18%	17%	17%
Progression to secondary education			49%

Trained teachers (primary)[5]		Pupil-teacher ratio[v]	
Male	Female	Primary	Secondary
81%	87%	55	33

Gender parity index (girl-boy ratio, 2011)[5]	Primary	Secondary	Tertiary
	0.91	0.87	0.63

Sexuality education: Most content is taught in a stand-alone curriculum at the primary level, where the Life Skills Series is taught in years 2, 5 and 6, and includes a syllabus. Primary education was identified as a crucial access point for HIV-prevention education programmes because primary-school enrolment is high (enabling widespread reach for life skills education) and because of the importance of improving children's knowledge of HIV and AIDS before they become sexually active and/or involved in high-risk behaviours. HIV education has therefore been integrated into the primary curriculum from year 5 and taught through its incorporation into other related subjects, such as moral and civic education and natural sciences. The topics addressed include HIV prevention (modes of transmission and prevention) and combating HIV-related stigma and discrimination.

Curriculum available	Type of curriculum	Examinable
Yes	Life Skills – stand alone	From year 8

Curriculum content				
Topic covered	Inclusion in core curriculum			
	Low/P	Up/P	Low/S	Up/S
Generic life skills	Yes	Yes	Yes	Yes
Adolescent and reproductive health	No	Yes	Yes	Yes
Sexuality education	No	Yes	Yes	Yes
Gender equality and empowerment	Yes	Yes	Yes	Yes
HIV and AIDS and other STIs	Yes	Yes	Yes	Yes
Stigmatization and discrimination	Yes	Yes	Yes	Yes
Family life and interpersonal relationships	Yes	Yes	Yes	Yes

Sexual and reproductive health: In 2009, 292,842 adolescents and young people were served by youth-friendly clinical services (SAAJ); in 2010, this figure increased to 71%, reaching 500,619. 15% of 76 (CNCS, 2012).

The adolescents and young people who benefited from these services were referred by community- and school-based peer educators. In 2010, 22% of sexually active adolescents and young people who attended SAAJ services underwent tests. This is a sharp increase from 2009, when 60,728 adolescents and young people were tested.

Ministry of Health data (2009) shows that the coverage of new family planning service users was 13.5%, while unmet demand for these services was 18.4%. The 2008 multiple indicators survey shows that 83.8% of married woman in the 15-45 age group do not use any contraceptive method.

Sexual/ reproductive health[4]	Male	Female	Total
Fertility rate in the 15-19 age group			167
Teenage pregnancy rate		8.2%	
STI rate (15-24 yrs)	8.3%	4.0%	
HIV prevalence (15-24 yrs)	3.7%	11.1%	7.4%
Incidence of SGBV among young women (15-24 yrs)	15-19 20-24	9.3% 17.5%	
Unmet need for FP (15-24 yrs)		26.2%	23.3%

Behavioural indicators: HIV prevalence is high in Mozambique, at 13.6%, although the level is slightly lower in the 15-24 age group. A significant percentage of young people are sexually active before the age of 15. Mozambique has a high rate of sexual concurrency among young people aged between 15 and 24 years. The high prevalence of child marriage in Mozambique exposes young girls to the risk of early pregnancy, HIV and STIs. Teenage pregnancy, child marriage and the lower status of girls leads to higher school attrition rates for girls.

Behavioural indicators[4]	Male	Female	Total
Sex before 15 (15-19 yrs)	16.8%	21.8%	
Sex before 15 (20-24)	16.9%	27.9%	
Multiple partners (15-24 yrs)	33.2%	4.3%	15.3%
Female genital mutilation			
Prevalence of child marriage			44%
Condom use at last sexual intercourse (15-24 yrs)	45.9%	45.5%	40%

Services: STIs are treated in all health facilities and are integrated into mother and child healthcare, screening, general medicine and youth-friendly clinical services, as well as in the mobile clinics that predominantly operate along rail and road corridors.

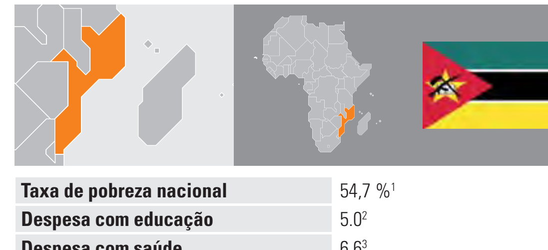
The main concerns are service inefficiency, non-existence of health facilities nearby, attendance hours that are inconvenient for some groups (e.g. sex workers and drivers) and long waiting times to be seen by a health professional. Shortage of medicines and the cost of some medicines are other problems indicated by study participants.

Access to services[4]	Married women	Sexually active but not married	All women
15-19 year olds using contraception	5.9%	26.9%	8.4%
20-24 year olds using contraception	11.7%	38.0	15.3%
Access to HIV testing/counselling	Available to the sexually active population		
Access to post-abortion care	Only where the woman's life is at risk		
Availability of youth-friendly services	Adolescents and young people have access to services from over 1,600 youth-friendly SRH service sites.		

Notes:

1 "Third National Survey of Family Budgets (IOF) 2008/09"
2 UNESCO Institute for Statistics 2013
3 Global Health Observatory 2011
4 Demographic and Health Survey 2011
5 UNESCO Institute for Statistics. Statistics in Brief. Education (all levels) Profile – Mozambique (http://stats.uis.unesco.org)

MOÇAMBIQUE



Taxa de pobreza nacional	54,7 %[1]
Despesa com educação	5.0[2]
Despesa com saúde	6.6[3]
Proporção de órfãos 10-15 anos	

População: 23 391 000

Em 2007, a população estimada de Moçambique era de 20 366 795 habitantes. A população estimada para 2012 é de 23 391 000. A esperança de vida à nascença em Moçambique aumentou 7,4 anos. Estima-se que a esperança de vida da população total seja de 51,78 anos (homens: 51,01 anos; mulheres: 52,57 anos) (INE, 2011)

População[4]	Homens	Mulheres	Total
% crianças 10-14	15,1%	13,6%	14,3%
% adolescentes 15-19	9,9%	9,2%	9,5%
% jovens 20-24	6,7%	7,7%	7,2%

Educação: A taxa de alfabetização de adultos de 56 % tem vindo a aumentar desde 2005. As zonas rurais registaram uma taxa de alfabetização mais elevada (64 %) do que as zonas urbanas (35 %) entre as raparigas e 67 % em zonas rurais e 35 % em zonas urbanas entre os rapazes. Quase 25 % da população com 15 anos ou mais nunca frequentou a escola.

Educação[5]	Homens	Mulheres	Total
Taxa de alfabetização de adultos, média regional	68,1 %	50,6 %	59,1 %
Taxas taxa de alfabetização 15-24, média regional	75,6 %	63,7%	69,5%
Taxa líquida de matrícula no ensino primário (2011)	92%	87%	90%
Taxa líquida de matrícula no ensino secundário (2011)	18%	17%	17%
Progressão para o ensino secundário			49%

Professores formados (primário)[5]		Rácio aluno / professor[5]	
Homens	Mulheres	Primário	Secundário
81%	87%	55	33

Índice de paridade de género (rácio raparigas/ rapazes, 2011)[5]	Primário	Secund.	Superior
	0,91	0,87	0,63

Educação sexual: A maior parte do conteúdo é ministrado num currículo autónomo ao nível primário, em que o módulo Habilidades para a Vida é ministrado na 2.ª, 5.ª e 6.ª classes e inclui um programa de estudos. O ensino primário foi identificado como um ponto de acesso crucial para programas de educação sobre a prevenção do HIV devido à elevada taxa de matrículas nestas escolas (o que permite uma maior disseminação da EHV) e à importância de melhorar o conhecimento das crianças sobre HIV e SIDA antes de se tornarem sexualmente ativas e/ ou envolverem em comportamentos de alto risco. Por este motivo, a educação sobre HIV foi integrada no currículo do ensino primário, sendo ministrada a partir da 5.ª classe através da sua incorporação noutras disciplinas relacionadas com esta questão, tais como educação moral e cívica e ciências naturais. Entre os temas abordados contam-se a prevenção do HIV (modos de transmissão e prevenção) e o combate à estigmatização e à discriminação relacionados com o HIV

Currículo disponível	Tipo de currículo	Testes de avaliação
Sim	Habilidades para a Vida – autónomo	A partir da 8.ª classe

Conteúdo curricular				
Temas abrangidos	Inclusão no currículo nuclear			
	P/1.º grau	P/2.º grau	S/1.º ciclo	S/2.º ciclo
Habilidades genéricas para a vida	Sim	Sim	Sim	Sim
Saúde adolescente e reprodutiva	Não	Sim	Sim	Sim
Educação sexual	Não	Sim	Sim	Sim
Igualdade de género e capacitação	Sim	Sim	Sim	Sim
HIV/SIDA e outras IST	Sim	Sim	Sim	Sim
Estigmatização e discriminação	Sim	Sim	Sim	Sim
Vida familiar e relações interpessoais	Sim	Sim	Sim	Sim

Saúde sexual e reprodutiva: Em 2009, os serviços clínicos amigos dos adolescentes e jovens (SAAJ) tinham atendido 292 842 adolescentes e jovens; em 2010, o número de adolescentes e jovens que tinham beneficiado destes serviços tinha aumentado para 71 %, atingindo 500 619. 15 % de 76 (CNCS, 2012).

Os adolescentes e jovens que beneficiaram destes serviços foram encaminhados para os educadores de pares em bases comunitárias e escolares. Em 2010, 22 % dos adolescentes e jovens sexualmente ativos atendidos em SAAJ foram submetidos a testes. Trata-se de um aumento drástico em comparação com 2009, ano em que foram testados 60 728 adolescentes e jovens.

De acordo com dados do Ministério da Saúde (2009), a cobertura de novos utentes dos serviços de PF era de 13,5 %, enquanto a procura não satisfeita destes serviços se situava em 18,4 %. O inquérito de indicadores múltiplos de 2008 revela que 83,8 % das mulheres casadas na faixa etária dos 15 aos 45 anos não usa qualquer método contracetivo.

Saúde sexual/ reprodutiva[4]	Homens	Mulheres	Total
Taxa de fertilidade 15-19 anos de idade		167/1000	
Taxa de gravidez adolescente		8,2%	
Taxa de IST (15-24)	8,3%	4,0%	
Prevalência do HIV 15-24	3,7 %	11,1 %	7,4 %
Incidência da violência sexual e baseada no género entre mulheres jovens 15-24			
Idades 15-19		9,3%	
Idades 20-24		17,5%	
Necessidade não satisfeita de PF 15-24		26,2 %	23,3 %

Indicadores comportamentais: A prevalência do HIV em Moçambique é elevada, atingindo 13,6 %, embora seja ligeiramente mais baixa na faixa etária dos 15-24 anos. Uma percentagem significativa dos jovens inicia a atividade sexual antes dos 15 anos. Moçambique possui uma elevada taxa de múltiplos parceiros sexuais concomitantes entre os jovens dos 15-24 anos. A elevada prevalência do casamento infantil em Moçambique expõe as jovens raparigas ao risco de gravidez precoce, HIV e IST. A gravidez na adolescência, o casamento infantil e o estatuto inferior das meninas resultam em taxas de abandono escolar mais elevadas entre as raparigas.

Indicadores comportamentais[4]	Homens	Mulheres	Total
Sexo antes dos 15 (15-19)	16,8 %	21,8 %	
Sexo antes dos 15 (20-24)	16,9 %	27.9 %	
Múltiplos parceiros 15-24	33,2%	4.3%[2]	15,3 %
Mutilação genital feminina			
Prevalência do casamento infantil			44 %
Uso de preservativo no último encontro sexual 15-24	45,9 %	45,5 %	40 %

Serviços: As IST são tratadas em todos os estabelecimentos de saúde e integradas nos cuidados de saúde à mãe e à criança, no rastreio, na medicina geral e nos serviços amigos dos adolescentes e jovens (SAAJ), bem como em clínicas móveis que funcionam predominantemente ao longo de corredores ferroviários e rodoviários.

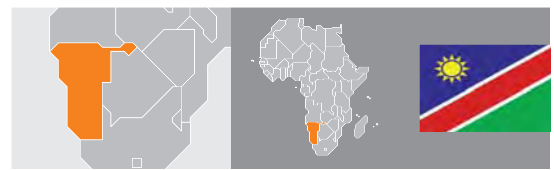
As principais preocupações prendem-se com a falta de eficiência do serviço, a inexistência de estabelecimentos de saúde nas proximidades, horários de funcionamento que não são convenientes para alguns grupos (por ex., trabalhadores do sexo e motoristas) e longas horas de espera para serem vistos por um profissional de saúde. A escassez de medicamentos e o preço de alguns medicamentos são também problemas apontados pelos participantes no estudo

Acesso a serviços[4]	Mulheres unidas	Sexualmente activas, mas não unidas	Todas as mulheres
Adolescentes 15-19 anos que usam contracetivos	5.9%	26.9%	8.4%
Jovens 20-24 anos que usam contracetivos	11.7%	38.0	15.3%
Jovens 20-24 anos que usam contracetivos			
Acesso a aconselhamento/testes HIV	Disponíveis para a população sexualmente activa		
Acesso a cuidados pós-aborto	Apenas quando a vida da mulher está em risco		
Disponibilidade de serviços AAJ	Os adolescentes e jovens têm acesso a serviços prestados em mais de 1 600 clínicas de SSR AAJ.		

Notes:

1 "Third National Survey of Family Budgets (IOF) 2008/09"
2 UNESCO Institute for statistics 2013
3 Global Health Observatory 2011
4 Inquérito Demográfi coe de Saúde 2011
5 UNESCO Institute for Statistics. Statistics in Brief. Education (all levels) Profile – Mozambique (http://stats.uis.unesco.org)

NAMIBIA



Population[1]**:** 2.1 million

Rural-urban migration is prevalent in Namibia; 43% of Namibia's population live in urban areas.

National poverty line[2]**:** 38%

Public expenditure on education[3]**:** 24% of GDP

Total expenditure on health[3]**:** 12% of GDP

Number of orphans 10-17 years[2]**:** 120 000

Population[1]	Male	Female	Total
% children 0-14 years	16.9%	16.5%	33.4%
% young people 15-24 years	11.7%	11.4%	23.1%
% 25 years and over	21.9%	21.7%	43.6%

Education[1,4]**:** The total percentage of people aged 15 years and above in Namibia who can both read and write is 89%. The minimum school leaving age is 16, the rate of survival to last primary grade is 89%. School attendance is 90% or higher for orphans and vulnerable children, as well as for others[5]. Of those of primary school-age, 14% are out of school.

Education[6]	Male	Female	Total
Adult literacy rate[1]	89.5%	88%	88.7%
Literacy rates 15-24 years	93.5%	95.3	94.4%
Net enrolment rate primary	96.9%	98.3%	97.6%
Net enrolment rate secondary	51.3%	62.8%	57%
Progression to secondary	85.1%	86.8%	86%

Trained teachers[6]		Teacher-student ratios[6]	
Primary	Secondary	Primary	Secondary
78%	93%	1:27	1:22

Gender parity index (ratio girls/boys)	Primary	Secondary	Tertiary
	0.99	1.18	1.32

Sexuality education[7,8]**:** Sexual and reproductive health (SRH) education is integrated into the life-skills curriculum, as well as in subjects like Biology and Life Science. Primary and secondary school teachers receive training on the life skills and SRH curriculum. Efforts have been made to ensure that religious, community and/or traditional leaders support the HIV prevention approach adopted by the education sector.

Curriculum available	Curriculum type	Examinable
Yes	Life skills – integrated	Not examinable

Curriculum content[7,9]				
Topic covered	Inclusion in core curriculum			
	Lower primary	Upper primary	Lower secondary	Upper secondary
Generic life skills	Yes	Yes	Yes	Yes
Adolescent and reproductive health	No	Yes	Yes	Yes
Sexuality education	No	Yes	Yes	Yes
Gender equality and empowerment	Yes	Yes	Yes	Yes
HIV and AIDS and other STIs	Yes	Yes	Yes	Yes
Stigma and discrimination	No	No	Yes	Yes
Family life and interpersonal relations	Yes	Yes	Yes	Yes

Sexual and reproductive health[10]: Family planning services are free and available to all Namibians, and all health facilities provide family planning services, counselling and contraceptives. The unmet need for family planning among young people (15-24 years) is 3% and 3.8 % for the 15-19 and the 20-24 age groups respectively. Three in four users get contraceptives from public sources.

SRH[10]	Male	Female	Total
Adolescent fertility rate (aged 15-19) per 1000 births[11]	N/A	74.4	74.4
Teenage pregnancy rate[11]	N/A	15%	15%
STI rate (aged 15-24) (self-reported)	1%	2.6%	1.8%
HIV prevalence (aged 15-24)[10]	2.6%	6.3%	4%
Unmet need for family planning (aged 15-24)[12]	-	3%	3%

Behavioural indicators[12]**:**

The Namibia UNGASS country report indicates that the number of new HIV infections is now declining. Some of the key drivers of the epidemic in Namibia are lack of male circumcision; multiple and concurrent partnerships; inconsistent condom use, especially among married and cohabiting couples; excessive alcohol use; intergenerational sex; transactional sex; and lack of knowledge of status/HIV testing.[13]

Behavioural indicators[12]	Male	Female	Total
Sex before age 15 (aged 15-24)[14]	19.2%	7.4%	13.3%
Multiple partners (aged 15-24)	21.7%	4.2%	12.95%
Prevalence of child marriage	-	8.6%	8.6%
Condom use at last sex (sex with irregular partners) (aged 15-24)	81%	64%	72.5%

Services[15]: The Charter of Rights and the National Policy on HIV & AIDS for the Education Sector both suggest that young people are meant to have access to sexuality education and sexual and reproductive health services. Mobile testing units and young people-friendly testing centres are being implemented. Service providers will be supported to provide friendly and accessible HIV testing and counselling services for the populations most at risk.

Access to services[12]	Male	Female	Total
Married women using all family planning methods	N/A	85.5%	85.5%
15- 19-year-olds using contraception	45.7%	36.3%	41%
20- 24-year-olds using contraception	84.7%	80%	82.35%
Access to HIV testing and counselling[14]	234 800 clients were counselled, tested and received their results		
Termination of pregnancy	Pregnancy termination is permitted only to save a woman's life or health in the event of rape or incest or due to foetal impairment. It is not permitted on request or on social or economic grounds.		
Availability of young people-friendly services	Among the existing facilities with HIV testing systems, only two out of ten provide young people-friendly HIV testing services.		

Notes:

1 Namibia Population and Housing Census, 2011
2 UNDP, 2011, *Human Development Report - Sustainability and Equity: A Better Future for All.* UNDP: New York
3 *Creating Certainty: Namibian Budget Review 2013/2014* (www.pwc.com/na)
4 Namibia Population and Housing Census, 2011
5 *UNAIDS Country Data*, 2009
6 EMIS 2011
7 UNAIDS IATT on Education. 2011. Global Progress Survey (GPS) on Education Response to HIV and AIDS. *Country Summary Report*
8 Republic of Namibia, 2007, *National Policy on HIV & AIDS*
9 Population Council, 2011, *Sexuality Education Curricula in East and Southern Africa: Results of a Ten-Country Review*
10 MoHSS, 2012, R*eport on the National HIV Sentinel Survey*
11 Republic of Namibia, 2010, *National Gender Policy: 2010-2020*
12 DHS 2006-07
13 UNGASS Country Report, 2010, *Republic of Namibia Ministry of Health and Social Services*
14 Global AIDS Response Report, 2012
15 Legal Assistance Centre, 2000

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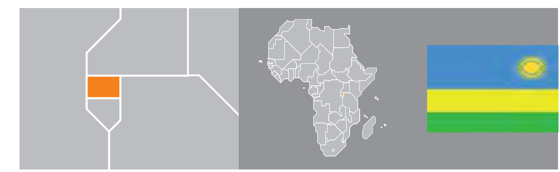

Population: 10.4 million

The majority of the population is comprised of adolescents and young adults, with 67% of all Rwandans under the age of 20.[1]

National poverty rate[2]: 44%

Education expenditure[2]: 16.9% of the national budget

Health expenditure[2]: US$56 per capita

Population[3]	Male	Female	Total
% children 10-14 years	13.7%	12.4%	13%
% adolescents 15-19 years	10.9%	10.1%	10.5%
% young people 20-24 years	8.7%	9.2%	9%

Education[4,5]: The priority areas for the education sector in Rwanda are increasing the coverage and quality of the twelve year-long basic education, increasing access to pre-primary education, strengthening Technical and Vocational Education and Training (TVET) and improving the quality of education throughout the system. Rwanda has sustained a strong political commitment to improve education access and quality, which places the country on a planned trajectory towards achieving quality basic education for all. The efficiency of all education cycles has to be improved, and the disparities in terms of access and attendance based on wealth quintiles and an urban-rural divide, particularly at the secondary level, have to be addressed.

Education[3]	Male	Female	Total
Adult literacy rate	74.8%	67.5%	71.1%
Literacy rates 15-24 years	85.3	85.0%	77.5%
Net enrolment rate primary	94.3%	97.5%	95.9%
Net enrolment rate secondary	24.2%	27.2%	25.7%
Primary school completion rate	75.1%	81.8%	78.6%

Trained teachers (primary)[3]		Teacher-student ratios[3]	
Male	Female	Primary	Secondary
97.5%	99.3%	1:58	1:37

Gender parity index (ratio girls/boys)	Primary	Secondary	Tertiary
	1.03	1.05	0.77

Sexuality education[5,6]: There is no specific curriculum for Sexual and Reproductive Health. Topics on SRH are found in the following subjects: social studies, elementary science and technology, geography and political education. The School Health Policy is still in draft form and has not yet been finalized or adopted by Cabinet. It is now being revised to incorporate nutrition, school feeding and a host of other areas. When it is approved, it will be important to understand how its elements, including sexual education, are delivered through the school system and in the classroom. Unless the formal curriculum incorporates these elements, there is no existing mechanism for their delivery.

Curriculum available	Curriculum type	Examinable
Partially	Integrated	partially

Curriculum content[7]

Topic covered	Inclusion in core curriculum			
	Lower primary	Upper primary	Lower secondary	Upper secondary
Generic life skills	yes	yes	yes	yes
Adolescent and reproductive health	no	yes	yes	yes
Sexuality education	no	yes	yes	yes
Gender equality and empowerment	no	yes	yes	yes
HIV and AIDS and other STIs	no	yes	yes	yes
Stigma and discrimination	no	yes	yes	no
Family life and inter-personal relations	yes	yes	yes	no

Sexual and reproductive health (SRH)[3,8]: The HIV prevalence among adults is 3%, making it a generalized epidemic. The HIV rate among women aged 15-49 (3.6%) is higher compared to men in the same age group (2.3%). In Rwanda, adolescent fertility rate is moderate (6% of young girls aged 15-19)[3]. Unsafe abortion is common, accounting for half of all obstetric complications.

SRH[3]	Male	Female	Total
Adolescent fertility rate (aged 15-19)	-	6%	-
Contraceptive prevalence rate (aged 15-24)	-	21.6%	-
Prevalence of STIs (aged 15-24)	2.1%	3.1%	2.6%
HIV prevalence (aged 15-24)	0.8%	3.2%	2%
	15-19	**20-24**	
Incidence of sexual gender-based violence (SGBV) (female)	12%	23%	
Unmet need for family planning (aged 15-49)		19%	

Behavioural indicators[3,9]: Approximately half of all young people (ages 15-24) in Rwanda can both correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission. Efforts to delay sexual debut have been successful and the median age for debut of sexual activity is 20.7 years among women aged 25-49, and 21.9 years among men falling in the same age group.

Behavioural indicators[3,10]	Male	Female	Total
Sex before age 15 (aged 15-19)	13.3%	4.8%	9.1%
Sex before age 15 (aged 20-24)	8.8%	2.8%	5.5%
Multiple partners (aged 15-24)	1.8%	0.6%	1.2%
Prevalence of female genital cutting (aged 15-24)	-	No data	-
Prevalence of child marriage (by 18)	-	13%	-
Condom use at last sex (aged 15-24)	66.2%	42%	54.1%

Services[3,11]: Young people-friendly centres are not fully meeting the needs of young people; it may be necessary to have young people themselves staffing these centres. For out of school young people, access to SRH services is limited. Only 17 out of 30 districts have functional young people-friendly health centres and these face various challenges. There is weak coordination of activities among community-based organizations/faith-based organizations.

Access to services[3]	Male	Female	Total
Married/sexually active unmarried women aged 15-49 using all family planning methods	-	28.6%	-
15- 19-year-olds using contraception	-	2.1%	-
20- 24-year-olds using contraception	-	19.5%	-
	Aged 15-19	**Aged 20-24**	
Access to HIV testing - results from last HIV test taken in past 12 months	25.6%	44.5%	
Access to post-abortion care	Limited		
Availability of young people-friendly services	Limited, but expanding		

Notes:

1 Population and Housing Census, 2012
2 UNDP, 2011, *Human Development Report - Sustainability and Equity: A Better Future for All.* UNDP: New York
3 DHS 2010
4 MoE, 2012,*Rwanda Education Statistics.* Kigali
5 MoE, 2008, *Education Sector Strategic Plan 2008 – 2012.* Kigali
6 MoH, 2005,*Health Sector Policy.* Kigali.
7 MoE/UNESCO, 2012,*Gaps Analysis of Mainstreaming HIV and AIDS in School Curricula in Rwanda.* Kigali
8 MoH, 2011, *Annual Report 2010-2011.* Kigali
9 MoH, 2011, *Rwanda Health Indicators: Progress 2010 (DHS and EICV) Sector Performance Indicators HSSP I + II and III, 2000 – 2010.* Kigali
10 MoY/UN Rwanda, 2010, *Rwanda Youth Statistical Indicators.* Kigali
11 Bingwayo, A, 2009, *Report on adolescents' health and HIV services in Rwanda, in the context of their Human Rights.* Ministry of Health, Rwanda: Kigali.

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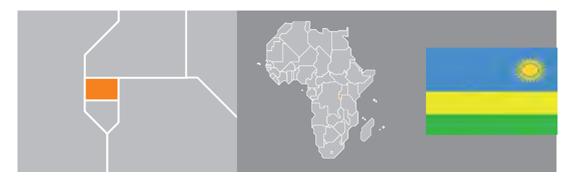

Population : 10,4 millions

La population comprend une majorité d'adolescents et de jeunes adultes : 67 % des Rwandais sont âgés de moins de 20 ans[1].

Pourcentage de la population vivant sous le seuil de pauvreté[2] **:** 44 %

Dépenses d'éducation[2] **:** 16,9 % du budget national

Dépenses de santé[2] **:** 56 $ É.-U. par habitant

Population[3]	Masculin	Féminin	Total
% enfants 10-14 ans	13,7 %	12,4 %	13 %
% adolescents 15-19 ans	10,9 %	10,1 %	10,5 %
% jeunes 20-24 ans	8,7 %	9,2 %	9 %

Éducation[4, 5] **:** Les objectifs prioritaires du secteur de l'éducation au Rwanda sont : accroître la couverture et la qualité du cycle de l'éducation de base, d'une durée de 12 ans, élargir l'accès à l'éducation préprimaire, renforcer l'enseignement et la formation techniques et professionnels (EFTP), et améliorer la qualité de l'éducation dans l'ensemble du système éducatif. Le Rwanda n'a cessé d'être animé par une forte volonté politique d'améliorer l'accès à l'éducation et la qualité de l'éducation, en planifiant la réalisation progressive de l'éducation de base de qualité pour tous. Il faut encore améliorer l'efficacité de tous les cycles de l'enseignement, et réduire les disparités en matière d'accès à l'éducation et de fréquentation scolaire entre quintiles pauvres et riches, ainsi que l'écart entre villes et campagnes, en particulier au niveau de l'enseignement secondaire.

Éducation[3]	Masculin	Féminin	Total
Taux d'alphabétisation des adultes	74,8 %	67,5 %	71,1 %
Taux d'alphabétisation des 15-24 ans	85,3 %	85,0 %	77,5 %
Taux net de scolarisation dans le primaire	94,3 %	97,5 %	95,9 %
Taux net de scolarisation dans le secondaire	24,2 %	27,2 %	25,7 %
Taux d'achèvement dans l'enseignement primaire	75,1 %	81,8 %	78,6 %

Enseignants formés (primaire)[3]		Proportion élèves/enseignants[3]	
Masculin	Féminin	Primaire	Secondaire
97,5 %	99,3 %	1:58	1:37

Indice de parité des sexes (ratio filles/garçons)	Primaire	Secondaire	Supérieur
	1,03	1,05	0,77

Éducation sexuelle[5, 6] **:** Il n'existe pas de programme traitant spécifiquement de la santé sexuelle et reproductive. Des aspects de ces questions sont abordés dans les matières suivantes : études sociales, cours élémentaire de science et de technologie, géographie et éducation politique. La politique de la santé à l'école est à l'état de projet et n'a pas encore été finalisée ni adoptée par le gouvernement. Elle est en cours de révision, pour incorporation de composantes relatives à la nutrition, à l'alimentation scolaire et à un grand nombre d'autres sujets. Une fois qu'elle sera approuvée, il sera important d'analyser comment ses éléments, y compris l'éducation sexuelle, sont mis en pratique dans l'ensemble du système éducatif et dans les salles de classe. Tant que les programmes officiels n'intègrent pas ces éléments, il n'existe pas de mécanisme assurant l'enseignement de ces questions.

Programme disponible	Type de programme	Sanctionné par un examen
Partiellement	Intégré	partiellement

Contenu du programme[7]				
Sujet couvert	Inclusion dans les programmes de base			
	Inf/P	Sup/P	Inf/S	Sup/S
Compétences pratiques génériques	oui	oui	oui	oui
Santé de l'adolescent et de la procréation	non	oui	oui	oui
Éducation sexuelle	non	oui	oui	oui
Égalité des sexes et autonomisation des femmes	non	oui	oui	oui
VIH/SIDA et autres IST	non	oui	oui	oui
Stigmatisation et discrimination	non	oui	oui	no
Vie familiale et relations interpersonnelles	oui	oui	oui	non

Santé sexuelle et reproductive[3, 8] : La prévalence du VIH dans la population adulte est de 3 %, ce qui correspond à une épidémie généralisée. Le taux de séropositivité chez les femmes âgées de 15 à 49 ans (3,6 %) est plus élevé que chez les hommes du même groupe d'âge (2,3 %). Au Rwanda, le taux de fécondité des adolescentes est modéré (6 % des jeunes filles âgées de 15 à 19 ans)[3]. Les avortements non médicalisés sont fréquents, et ils sont responsables de la moitié des complications obstétriques.

Santé sexuelle et reproductive[3]	Masculin	Féminin	Total
Taux de fécondité des adolescentes (15-19 ans)	-	6 %	-
Taux de prévalence de l'utilisation de contraceptifs (15-24 ans)	-	21,6 %	-
Taux de prévalence des IST (15-24 ans)	2,1 %	3,1 %	2,6 %
Prévalence du VIH (15-24 ans)	0,8 %	3,2 %	2 %
Incidence des violences fondées sur le genre chez les jeunes femmes	**15-19**	**20-24**	
	12 %	23 %	
Besoins subsistants en matière de planification familiale (15-49 ans)		19 %	

Indicateurs de comportement[3, 9] **:** La moitié environ des jeunes (15-24 ans) au Rwanda sont capables de nommer correctement les moyens de prévention de la transmission du VIH par voie sexuelle et de rejeter les principales idées fausses concernant la transmission du virus. Les efforts faits pour retarder l'âge du premier rapport sexuel ont été couronnés de succès, et l'âge médian du premier rapport est de 20,7 ans chez les femmes âgées de 25 à 49 ans, et de 21,9 ans chez les hommes du même groupe d'âge.

Indicateurs de comportement[3, 10]	Masculin	Féminin	Total
Rapports sexuels avant 15 ans (15-19 ans)	13,3 %	4,8 %	9,1 %
Rapports sexuels avant 15 ans (20-24 ans)	8,8 %	2,8 %	5,5 %
Partenaires multiples (15-24 ans)	1,8 %	0,6 %	1,2 %
Prévalence des mutilations génitales chez les femmes (15-24 ans)	-	n. d.	-
Prévalence du mariage des enfants (< 18 ans)	-	13 %	-
Utilisation du préservatif lors du dernier rapport sexuel (15-24 ans)	66,2 %	42 %	54,1 %

Services[3, 11] **:** Les centres adaptés aux jeunes ne répondent pas pleinement à leurs besoins ; peut-être serait-il nécessaire que le personnel de ces centres comprenne lui-même des jeunes. Les jeunes non scolarisés ont un accès limité aux services de santé sexuelle et procréative. Seuls 17 districts sur 30 disposent de centres de soins fonctionnels adaptés aux jeunes, et ces centres font face à des difficultés diverses. La coordination des activités entre organisations communautaires et organisations confessionnelles est insuffisante.

Accès aux services[3]	Masculin	Féminin	Total
Femmes mariées/sexuellement actives âgées de 15 à 49 ans utilisant une quelconque méthode de planification familiale	-	28,6 %	-
15-19 ans utilisant des contraceptifs	-	2,1 %	-
20-24 ans utilisant des contraceptifs	-	19,5 %	-
Accès aux résultats du dernier test de dépistage du VIH effectué au cours des 12 derniers mois	**Aged 15-19**	**Aged 20-24**	
	25.6 %	44.5 %	
Accès aux soins post-avortement	Limité		
Disponibilité des services adaptés aux jeunes	Limitée, mais en progression		

Notes :

1 Recensement de la population et des logements, 2012.
2 PNUD, 2011, *Rapport sur le développement humain – Durabilité et équité : un meilleur avenir pour tous.* PNUD, New York.
3 DHS, 2010.
4 Ministère de l'éducation, 2012, *Rwanda Education Statistics.* Kigali.
5 Ministère de l'éducation, 2008, *Education Sector Strategic Plan 2008 – 2012.* Kigali.
6 Ministère de la santé, 2005, *Health Sector Policy.* Kigali.
7 Ministère de l'éducation/UNESCO, 2012, *Gaps Analysis of Mainstreaming HIV and AIDS in School Curricula in Rwanda.* Kigali.
8 Ministère de la santé, 2011, *Annual Report 2010-2011.* Kigali.
9 Ministère de la santé, 2011, *Rwanda Health Indicators: Progress 2010 (DHS and EICV) Sector Performance Indicators HSSP I + II and III, 2000-2010.* Kigali.
10 Ministère de la jeunesse/UN Rwanda, 2010, *Rwanda Youth Statistical Indicators.* Kigali.
11 Bingwayo, A, 2009, *Report on adolescents' health and HIV services in Rwanda, in the context of their Human Rights.* Ministère de la santé, Rwanda: Kigali.

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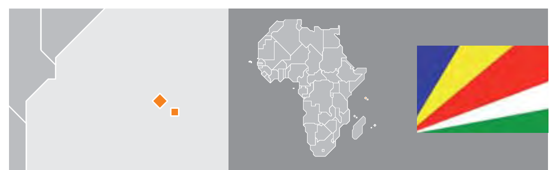

Population[1]**:** 87 441

Of the total population, 23% fall into the 10-24 age group.

National poverty line[2]**:** 17%

Education expenditure[3]**:** 10%

Health expenditure[4]**:** 14.8%

Population[1]	Male	Female	Total
Children 10-14 years	3.088	3.019	6.107
Adolescents 15-19 years	3.686	3.404	7.090
Young people 20-24 years	3.352	2.953	6.305
Total 10-24 years	10.126	9.376	19.502

Education[5]**:** Education is prioritized by government and has the second highest budget allocation. Universal access to education has been achieved.

There are 32 pre-primary schools, 26 primary schools, and 13 secondary schools catering for a student population of about 20,000 students. There is also a school which caters for children with physical and mental disabilities.

Education[5,6]	Male	Female	National
Adult literacy rate	94%	95%	94%
Literacy rates 15-24 years	-	-	99%
Net enrolment rate primary	99%	99%	99%
Net enrolment rate secondary	49%	51%	50%

Sexuality education[7 8]**:** The main vehicle for sexuality education (SE) provision in state schools is the Personal and Social Education (PSE) programme, created by the Ministry of Education. The programme was officially launched in 1998 with the assistance of the United Nations Population Fund (UNFPA). The four main components of the programme are: moral education, career education and guidance, education for citizenship, and family life health education (FLHE). It addresses important life skills and incorporates aspects of growth and development, sexuality education, gender roles and interpersonal and social skills, to name a few. It is a compulsory subject on the curriculum and all primary to secondary schools teach three formal PSE lessons a week. No formal sexuality education programme for out-of-school young people is provided.

Trained teachers[5]		Teacher-student ratios[8]	
Male	Female	Primary	Secondary
80	656	1:13	1:12

Curriculum available	Curriculum type	Examinable
Yes	Personal and Social Education	No

Curriculum content[9]				
Topic covered	Inclusion in core curriculum			
	Lower primary	Upper primary	Lower secondary	Upper secondary
Generic life skills	Yes	Yes	Yes	Yes
Adolescent and reproductive health	Yes	Yes	Yes	Yes
Sexuality education	Yes	Yes	Yes	Yes
Gender equality and empowerment	Yes	Yes	Yes	Yes
HIV and AIDS and other STIs	Yes	Yes	Yes	Yes
Stigma and discrimination	Yes	Yes	Yes	Yes
Family life and interpersonal relations	Yes	Yes	Yes	Yes

Sexual and reproductive health (SRH)[10 11]**:** There is an increase in the number of teenage pregnancies, from 18.7% in 1999 to 29.2% in 2011.[12]

The HIV prevalence among the general population is 0.83%. The HIV pandemic is concentrated in the key populations of injection drug users (IDU) and men who have sex with men (MSM).

SRH[13]	Male	Female	Total
Adolescent fertility rate[14]	-	-	73 per 1 000
Teenage pregnancy rate[15]	-	-	70 per 1 000
HIV prevalence (aged 15-24)	0.8%[16]	0.7%[17]	0.75%
Unmet need for family planning (aged 15-24)			Young people can get access to family planning but those below the age of 18 require parental consent for contraceptives and treatment

Behavioural indicators[18]**:** The results of a child well-being study in 2009 amongst young people falling into the 6-19 age group showed that almost half (46%) of those aged 12-19 have had sex, with 52% of those boys and 40% girls. A quarter of this age group reported having used protection when having had sex.

Behavioural indicators[18]	
Sex before age 15 (aged 15-19)	8 %
Sex before age 15 (aged 20 -24)	25%
Prevalence of child marriage	1%
Condom use:	
At last sex (aged 15-24)	24.7 %
With regular partner	36%
With commercial sex worker	16.7%
With non regular partner	20.7%
Average:	24.7%

Services[19]**:** Health care is free and available to all citizens. *The SRH service is managed by the Programme Development Team in the Public Health Department (PHD) section. Implementation of services is done mainly through the primary health care programme; services are staffed by nurses with the support of other health professionals.*

Access to services[17,20]		
Married women using all family planning methods	General population in government health facilities only	46.2%
20- 24-year-olds using contraception	Data available for government owned SRH centres, but not disaggregated according to age	
Access to HIV testing and counselling (HCT)[21]	Available at one Youth Health Centre, all district Health Centres, all private clinics, and one NGO 94% uptake HCT 5.3% refuse treatment	
Access to post-abortion care	Available but people not made aware and not structured properly	
Availability of young people-friendly services	No minimum package or standard available for young people-friendly services	

Notes:

1 Population and Housing Census, 2011
2 UNDP, 2012, MDG Report: 2010 *Poverty in Seychelles*
3 SOWC, 2009
4 National Statistics Bureau, *Seychelles in Figures: 2012, Edition 1*
5 *Seychelles Millennium Development Goals Status Report*, 2010
6 MoH, 2012, *Population & Development*
7 MoE, 2001, *National Curriculum Framework*
8 Seychelles/UNFPA, *Evaluation report 2008-2011*
9 MoE, 2001, *National Curriculum Framework*
10 MoH, 2009, *Annual Report*
11 MoH, 2011, *Report on the Evaluation of the HIV and AIDS National Strategic Plan 2005 – 2009 and Road Map for the National Strategic Plan 2012 –2016*
12 MoH, Epidemiology and Statistics Section
13 *The Seychelles HIV, AIDS and STI's Knowledge, Attitude, Practices and Behavior (KAPB) and Biological Surveillance Studies*, 2012
14 MoH 2010
15 MoH 2012
16 UNGASS Country Report, 2010
17 UNGASS Country Report, 2008
18 KAPB Survey, 2012
19 *Reproductive Health Policy*, 2012
20 KAPB, 2012
21 Youth Health Centre, 2012, *Strengthening Youth Friendly Services Training Report*

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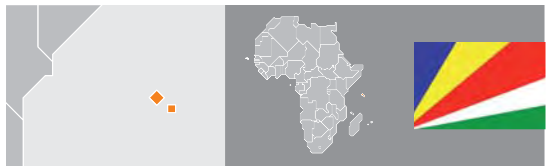


Population[1] **:** 87 441

Le groupe d'âge 10-24 ans représente 23 % de l'ensemble de la population.

Pourcentage de la population vivant sous le seuil de pauvreté[2] **:** 17 %[3]

Dépenses d'éducation[4] **:** 10 %

Dépenses de santé[5] **:** 14,8 %

Population[1]	Masculin	Féminin	Total
% enfants 10-14 ans	3,088	3,019	6,107
% adolescents 15-19 ans	3,686	3,404	7,090
% de jeunes 20-24 ans	3,352	2,953	6,305
Total	10,126	9,376	19,502

Éducation[6] **:** L'éducation est une priorité du gouvernement et le second poste le plus important du budget national. L'objectif de l'accès universel à l'éducation est atteint.

Le pays compte 32 centres d'éducation préprimaire, 26 écoles primaires et 13 écoles secondaires accueillant une population scolaire d'environ 20 000 élèves. S'y ajoute un établissement prenant en charge les enfants physiquement ou mentalement handicapés.

Éducation[5, 7]	Masculin	Féminin	National
Taux d'alphabétisation des adultes	94 %	95 %	94 %
Taux d'alphabétisation des 15-24 ans	-	-	99 %
Taux net de scolarisation dans le primaire	99 %	99 %	99 %
Taux net de scolarisation dans le secondaire	49 %	51 %	50 %

Éducation sexuelle[8, 9] : L'éducation sexuelle est assurée principalement dans les écoles publiques dans le cadre du Programme d'éducation personnelle et sociale (PSE), conçu par le ministère de l'Éducation. Ce programme a été officiellement lancé en 1998 avec le concours du Fonds des Nations Unies pour la population (UNFPA). Il comprend quatre grands volets : éducation morale, formation et orientation professionnelles, éducation à la citoyenneté, et éducation à l'hygiène de la vie familiale. Il traite d'importantes compétences pratiques et aborde des aspects de la croissance et du développement, de l'éducation sexuelle, des rôles assignés aux genres et des compétences relationnelles et sociales, pour ne citer que quelques sujets. C'est une matière obligatoire, qui est enseignée à raison de trois leçons par semaine dans toutes les écoles primaires et secondaires. Il n'existe aucun programme d'éducation sexuelle formel s'adressant aux jeunes non scolarisés.

Enseignants formés[5]		Proportion élèves/enseignants[8]	
Masculin	Féminin	Primaire	Secondaire
80	656	1:13	1:12

Programme disponible	Type de programme	Sanctionné par un examen
Oui	Éducation personnelle et sociale	Non

Contenu du programme[10]				
Sujet couvert	Inclusion dans les programmes de base			
	Inf/P	Sup/P	Inf/S	Sup/S
Compétences pratiques génériques	Oui	Oui	Oui	Oui
Santé adolescente et procréative	Oui	Oui	Oui	Oui
Éducation sexuelle	Oui	Oui	Oui	Oui
Égalité des sexes et autonomisation des femmes	Oui	Oui	Oui	Oui
VIH/SIDA et autres IST	Oui	Oui	Oui	Oui
Stigmatisation et discrimination	Oui	Oui	Oui	Oui
Vie familiale et relations interpersonnelles	Oui	Oui	Oui	Oui

Santé sexuelle et reproductive[11, 12] **:** On note une augmentation du taux de grossesse chez les adolescentes, de 18,7 % en 1999 à 29,2 % en 201113.

Le taux de prévalence du VIH dans l'ensemble de la population est de 0,83 %. La pandémie de VIH se concentre dans les groupes à risques : consommateurs de drogues injectables (CDI) et hommes ayant des relations sexuelles avec les hommes (HSH).

Santé sexuelle et reproductive[14]	Masculin	Féminin	Total
Taux de fécondité des adolescents[15]	-	-	73 pour 1 000
Taux de grossesse chez les adolescentes[16]	-	-	70 pour 1 000
Prévalence du VIH (15-24 ans)	0,8 %[17]	0,7 %[18]	0,75 %
Besoins subsistants en matière de planification familiale (15-24 ans)			Les jeunes ont accès à la planification familiale, mais la fourniture de contraceptifs et de soins est subordonnée à l'accord parental pour les mineurs de moins de 18 ans

Indicateurs de comportement[19] **:** Selon une étude sur le bien-être des enfants réalisée en 2009 auprès des jeunes âgés de 6 à 19 ans, près de la moitié (46 %) des jeunes de la tranche d'âge 12-19 ans avaient déjà eu des rapports sexuels, dont 52 % chez les garçons et 40 % chez les filles. Un quart des jeunes dans cette tranche d'âge déclaraient se protéger lors des rapports.

Indicateurs de comportement[18]	
Rapports sexuels avant 15 ans (15-19 ans)	8 %
Rapports sexuels avant 15 ans (20 -24 ans)	25 %
Prévalence du mariage des enfants	1 %
Utilisation du préservatif :	
Lors du dernier rapport (15-24 ans)	24,7 %
Avec un partenaire régulier	36 %
Lors de rapports sexuels tarifés	16,7 %
Avec des partenaires non réguliers	20,7 %
Taux moyen :	24,7 %

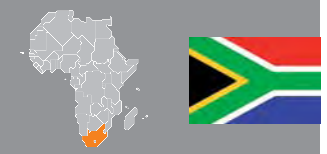
Services[20] : Les soins de santé sont gratuits et accessibles à tous les citoyens. Les services d'hygiène sexuelle et procréative sont gérés par l'équipe d'élaboration du programme de la section compétente du ministère de la Santé publique. Les services sont dispensés principalement dans le cadre du programme de soins de santé primaires par des infirmières secondées par d'autres professionnels de la santé.

Accès aux services[17, 21]		
Femmes mariées utilisant une quelconque méthode de planification familiale	Ensemble de la population dans les centres de soins publics seulement	46,2 %
20-24-ans pratiquant la contraception	Données disponibles pour les centres publics, mais non ventilées par tranches d'âge	
Accès aux tests de dépistage du VIH et de conseils[22]	Service disponible dans un centre de soins pour les jeunes, dans tous les centres de district, dans toutes les cliniques privées et auprès d'une ONG	
	94 % acceptent les tests et les conseils	
	5,3 % refusent le traitement	
Accès aux soins post-avortement	Soins disponibles, mais la population n'est pas informée et les services sont mal organisés	
Disponibilité de services adaptés aux jeunes	Pas de formule globale minimale ou standard disponible pour les services adaptés aux jeunes	

Notes:

1 Recensement de la population et des logements, 2011.
2 PNUD, 2012, *MDG Report: 2010 Poverty in Seychelles*.
3 13 554,00 roupies seychelloises par équivalent-adulte par an (Poverty in Seychelles: Policy Digest, Christophe Muller [consultant auprès du Programme des Nations Unies pour le développement, juillet 2012]).
4 Rapport de l'UNICEF sur la situation des enfants dans le monde, 2009.
5 Bureau national de statistique, *Seychelles in Figures: 2012, Edition 1*.
6 *Seychelles Millennium Development Goals Status Report*, 2010.
7 Ministère de la santé 2012, *Population & Development*.
8 Ministère de la santé, 2001, *National Curriculum Framework*.
9 Seychelles/UNFPA, *Evaluation report 2008-2011*.
10 Ministère de l'éducation, 2001, *National Curriculum Framework*.
11 Ministère de la santé, 2009, *Annual Report*.
12 Ministère de la santé, 2011, *Report on the Evaluation of the HIV and AIDS National Strategic Plan 2005-2009 and Road Map for the National Strategic Plan 2012-2016*.
13 Ministère de la santé, Section de l'épidémiologie et des statistiques.
14 *The Seychelles HIV, AIDS and STI's Knowledge, Attitude, Practices and Behavior (KAPB) and Biological Surveillance Studies*, 2012.
15 Ministère de la santé, 2010.
16 Ministère de la santé, 2012.
17 Session extraordinaire de l'Assemblée générale des Nations Unies sur le VIH/SIDA, Country Report, 2010.
18 Session extraordinaire de l'Assemblée générale des Nations Unies sur le VIH/SIDA, Country Report, 2008.
19 KAPB Survey, 2012.
20 *Reproductive Health Policy*, 2012.
21 KAPB, 2012.
22 Youth Health Centre, 2012, *Strengthening Youth Friendly Services Training Report*.

SOUTH AFRICA



Population: 51.7 million[1]

Young people aged 10-24 number 14.9 million or 30% of the population[2].

National poverty rate: 34.5% (below ZAR 422 per month)[3]

Education expenditure: 4% of GDP per capita (primary and secondary)[4]

Health expenditure: 8.3% of GDP (public and private)[5]

School attendance of orphans aged 10-14: 99.6%[6]

Population[7]	Male	Female	Total
% children 10-14 years	9.3%	8.5%	17.8%
% adolescents 15-19 years	9.9%	9.4%	19.3%
% young people 20-24 years	10.7%	10.1%	20.8%

Education: South Africa has compulsory school attendance from grade 1-9 for all learners. From Grade 10-12, education is not compulsory and learners may decide to drop out or enrol in further education training. Over 95% of children aged 7-14 were attending school in 2011[8]. Enrolment rates fall in secondary schooling and National Senior Certificate (NSC) pass rates are around 70%. Although statistics show high levels of access to secondary education and universal access to primary education, quality of education remains a concern. Major emphasis is being placed on improving quality of education and performance of learners at all levels. Gender indicators show high levels of participation by girls but some gender disparities persist in NSC pass rates. Initiatives to assist in alleviating child poverty and barriers to education access include the Child Support Grant, free access to education and the National School Nutrition Programme.

Education	Male	Female	Total
Adult literacy rate[3]	-	-	79.2%
Literacy rates 15-24 years	98.8%	98.4%	99.2%[9]
Gross enrolment rate primary	95%	91%	93%[10]
Completion of NSC[10]	71.9%	68.6%	70.3%

Trained teachers (primary)		Learner-educator ratio
Male	Female	Primary and Secondary[11]
87% (total)[12]		29.2[10]

Gender parity index (ratio girls/boys)[12]	Primary	Second	Tertiary
	0.96	1.07	na

Sexuality education: Issues related to sex, sexuality and HIV are incorporated in the Health Education curriculum, Integrated School Health Policy (ISHP) and Basic Education Integrated Strategy on HIV, STIs and TB 2012-2016. The ISHP school health package encourages community and learner participation and incorporates health education and promotion into learning areas of the Life Orientation curriculum, which builds on the pre-existing HIV and AIDS Life Skills Education Programme. Supplementary co-curricular activities are also expected, especially in secondary schools. The ISHP Health Education package covers a range of health issues: Grade R - Grade 6 covers abuse, puberty and substance abuse; further sexuality-related topics in Grades 7-12 include abuse, menstruation, Sexual and Reproductive Health (SRH), contraception, sexually transmitted infections (STIs) and HIV, teen pregnancy and terminations, prevention of mother-to-child transmission (PMTCT), HIV counselling and testing (HCT), stigma and substance abuse. In 2008, 65% of learners reported that they had been taught about HIV at school[12].

Curriculum available	Curriculum type	Examinable
Yes	Life Skills/Life Orientation	Yes

Curriculum content[12]

Topic covered	Inclusion in core curriculum			
	Lower primary	Upper primary	Lower secondary	Upper secondary
Generic life skills	Yes	Yes	Yes	Yes
Abuse (sexual, physical, emotional)	Yes	Yes	Yes	Yes
Sexuality and sexual and reproductive health	No	No	Yes	Yes
Gender equality and empowerment	Yes	Yes	Yes	Yes
HIV and AIDS and other STIs	No	No	Yes	Yes
Stigma and discrimination	Yes	Yes	Yes	Yes

Sexual and reproductive health: SRH is a priority in the primary health care approach promoted by health policy. HIV is a major burden, particularly among young women. For example, in 2008, HIV prevalence in women aged 20-24 was 21.1% compared to 5.15% in men[13]. Approximately 60% of South African women aged 15-49 use modern contraception, which is three times sub-Saharan Africa's average. A national PMTCT programme has reduced mother-to-child transmission to less than 4% and access to antiretroviral therapy (ART) has risen dramatically, with 87.1% of HIV positive pregnant women receiving antiretroviral therapy by 2011[6].

SRH	Male	Female	Total
Teenage pregnancy rate (aged 13-19)	-	4.5%	-
Contraceptive prevalence (aged 15-49)	-	60%	-
Syphilis prevalence (national)[6]	-	-	1.6%
HIV prevalence (aged 15-24)[6]	3.6%	13.9%	8.8%
Prevalence of gender-based violence (GBV) among learners	15% report some GBV by partner[14]		
Unmet need for family planning (aged 15-49)	-	14%[15]	-

Behavioural indicators: There has been a marked change in risk behaviours reported by young people since the 1990s, but they remain high. In the 2008 Youth Risk Behaviour Survey, 38% of learners reported ever having had sex and of these, 13% had their first sex under the age of 14 and 4.4% had had an STI. Among sexually active learners, 40% had more than one sexual partner in their lifetime and 45% used condoms for contraception, but only 31% used them consistently[16]. HIV prevalence in 15- 24-year-olds, a proxy for HIV incidence, remains high but with evidence of a downward trend: in pregnant women aged 15-24, it declined from 21.8% in 2010 to 20.5% in 2011[17]. In 2008, 21% of learners had an HIV test, with no significant gender variation[18].

Behavioural indicators[6]	Male	Female	Total
Sex before age 15 (aged 15-19)	15.1%	10.4%	13.1%
Sex before age 15 (aged 20-24)	8.8%	3.7%	6.1%
Multiple-concurrent partners in the last 12 months (aged 15-19)	9.8%	32.2%	20.6%
Prevalence of female genital cutting (aged 15-24)	-	No data	-
Prevalence of child marriage	-	No data	-
Condom use at last sex (aged 15-19)	93.9%	67.7%	88.1%

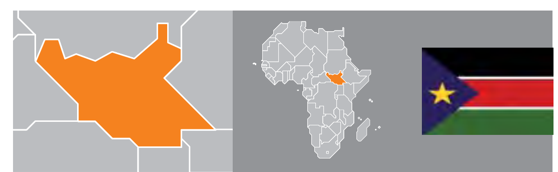
Services: A range of SRH services are available to young people, including contraception, condoms, PMTCT, STI treatment and termination of pregnancy. Historically, they have often been fragmented and not young people-friendly. The ISHP, a joint initiative by the Departments of Education, Health and Social Development, is one key effort to deal with young people's health issues in an integrated way and improve access to services. The ISHP proposes on-site health services in schools, including access to SRH counselling of all learners. For sexually active learners, this should include information on or referral to dual protection contraception and HCT, as well as STI screening. Where services are not available on school premises mechanisms should be in place for ensuring that learners are able to access these services through referrals[6].

Access to services	15-19		20-24	
% young people having more than one sexual partner in last 12 months reporting use of condom at last sex	Male	Female	Male	Female
	-	65.4%	-	77.1%
Access to HIV testing - results from last HIV test taken in past 12 months	15-19		20-24	
	Male	Female	Male	Female
	5.8%	18.1%	19.2%	29.4%
Access to post-abortion care	Yes – but not comprehensive			
Availability of young people-friendly services	ISHP will increase access to SRH and health promotion for young people			

Notes:

1 StatsSA, Census 2011, Statistical Release
2 StatsSA, Census 2011, Methodology and Highlights of Key Results
3 Government of South Africa, 2012, The Presidency, Development Indicators 2011
4 Department of Basic Education, 2013, Action Plan to 2014 - Towards the Realisation of Schooling 2025
5 Department of Health, 2011, National Health Insurance Green Paper
6 Department of Health, 2012, Global AIDS Response Progress Report
7 StatsSA, Census 2011, Census in Brief Stats SA
8 StatsSA, Census 2011,Census in Brief
9 UNESCO Institute for Statistics, UIS data on literacy rates 15-24, 2011 http://stats.uis.unesco.org/unesco/TableViewer/tableView.aspx?ReportId=210
10 Department of Basic Education, 2012, Education Statistics in South Africa, 2011
11 Educations statistics provide a national average for LER in ordinary schools and independent schools (primary and secondary combined)
12 World Bank, Education Data 2009, http://data.worldbank.org/indicator/SE.PRM.TCAQ.ZS
13 This was the last nationally representative general population survey and is the information used by the DoH in the ISHP and in Global AIDS Report Progress Report for South Africa 2012
14 Medical Research Council, 2010, The 2nd South African National Youth Risk Behaviour Survey 2008
15 UNFPA, 2012, State of the World Population
16 Medical Research Council, 2010, The 2nd South African National Youth Risk Behaviour Survey 2008
17 Department of Health, 2011, National Antenatal Sentinel HIV & Syphilis Prevalence Survey in South Africa
18 Department of Health, 2013, Integrated School Health Policy

SOUTH SUDAN



National Poverty Rate[1]	51% (less than US$28 per month)
Education Expenditure[2]	6.9% of domestic spending
Health Expenditure[2]	4.2% of domestic spending (2011/2012 was 2.6%)
Percentage of primary school orphans[2]	10.3%

Population: 8 260 000

South Sudan has a population of 8.26 million, of which 83% live in rural areas and 51% are below the age of eighteen. [2]

Population[3]	Male	Female	Total
% children 10-14 yrs	6.9%	5.9%	12.8%
% adolescents 15-19 yrs	5.6%	5%	10.6%
% youth 20-24 yrs	4.4%	4.4%	8.8%

Education[4]: The education system in South Sudan is embryonic and over-stretched. There is a severe shortage of trained primary school teachers. Only 27% of those above the age of 15 are literate. Literacy levels are higher among men (40%) compared to women (16%) and in urban areas (at 53%) compared to rural areas (22%). Literacy rates are particularly bad amongst the 15-24 year-olds - 55% for men and 28% for women.

Education[4]	Male	Female	Total
Adult literacy rate	40%	16%	28%
Literacy rates 15-24 yrs	55%	28%	41.5%
Net enrolment rate primary	46.2%	35.7%	41.3%
Net enrolment rate secondary	3.3%	2.3%	2.9%
Progression to secondary	69.9%	64.5%	68%

Trained teachers[5]		Pupil / Teacher Ratios[5]	
Primary	Secondary	Primary	Secondary
47.3%	57%	48.7	17.6

Gender parity index (ratio girls/boys)	Primary	Second	Tertiary
	-	-	-

Sexuality Education[6]: Plans are underway for a national curriculum review which will lead towards the incorporation of life skills in the curriculum. A "Life Skills Program" funded by UNICEF is currently being developed by the Ministry of General Education; it will include modules on human rights, gender equality, gender-based violence, reproductive health and sexuality education.

Curriculum Available	Curriculum Type	Examinable
Yes	National P1 to P8	Yes

Curriculum Content[6]

Topic Covered	Inclusion in core curriculum			
	Low/ P	Up/P	Low/S	Up/S
Generic life skills	n/a	n/a	n/a	n/a
Adolescent & reproductive health	n/a	n/a	n/a	n/a
Sexuality education	n/a	n/a	n/a	n/a
Gender equality & empowerment	n/a	n/a	n/a	n/a
HIV/AIDS and other STIs	n/a	n/a	n/a	n/a
Stigma & discrimination	n/a	n/a	n/a	n/a
Family life & inter-personal relations	n/a	n/a	n/a	n/a

Sexual and Reproductive Health[7,8]**:** South Sudan has some of the lowest health indicators in the world. Less than 40% of the population has access to any form of health care. HIV prevalence among the 15-49 years-old is estimated at 3.04% (2009). Approx. 150,000 people are living with HIV (135,000 adults and 14,500 children). An estimated 16,000 new infections occur annually. Knowledge about HIV/AIDS is extremely low. Prevailing cultural and gender norms, and high rates of early marriage and teenage pregnancy exacerbate the situation.

Sexual/ Reproductive Health[8,9]	**Male**	**Female**	**Total**
Teenage pregnancy rate 15-19 yrs		353/1000	
Contraceptive prevalence rate 15-49 yrs	4.5% (all) and 1.7 for modern methods		
	In school youth	**Out of school youth**	
Prevalence of STIs 15-24 yrs (in Juba)	12%	6%	
HIV prevalence rate	3.0%		
	Women 15-19	**Women 20-24**	
HIV prevalence 15-24 yrs (for ANC respondents)	2.3%	3.3%	
Incidence SGBV young women 15-24 yrs	Anecdotal evidence of high rates of gender-based violence and rape		
	Male	**Female**	**Total**
Unmet need for FP 15-49 yrs		24%	

Behavioural Indicators[10]**:** Knowledge of HIV is generally low while the practice of risky sexual behaviour is high. Condom use among the sexually active youth is relatively low, with only 24% of the in-school youth reporting having ever used condoms. More than 10% of both men and women reported having had multiple sexual partners. HIV stigma pervades through all sections of society. More than 10% of the population has had symptoms of an STI; antenatal surveillance and other reports show an extremely high rate of syphilis-positive tests for both men and women.

Behavioural Indicators[10]	**In school**	**Out of school**
Sexually active youth 15-24 yrs (Juba)	44%	65%
First sex by age 15 (Juba)	38%	29%
Multiple partners 15-24 yrs	10%	
Prevalence of FGM 15-24 yrs	No data	
Prevalence of child marriage	48% of all South Sudanese girls between the ages of 15 and 19 are married.	
	15-24 in Rumbek	**15-24 in Yambio**
Condom use at last sex 15-24 yrs	3.5%	13.2%

Services[11]**:** The National Reproductive Health Strategic Plan 2011–2015 calls for the formulation of a National Youth and Adolescent Reproductive Health Strategy to ensure full access of youth and adolescents to quality and comprehensive youth friendly reproductive health services, information and protection.

Access to services[11]	**Male**	**Female**	**Total**
20-24 year olds using contraception	-	29.2%	-
Access to post abortion care	Abortion only to save a woman's life		
Availability of YF Services	Guided by Adolescent SRH Strategy 2010/15		

Notes:

1 5th Sudan Population and Housing Census, 2008
2 UNDP, 2011, *Human Development Report - Sustainability and Equity: A Better Future for All.* UNDP: New York
3 5th Sudan Population and Housing Census, 2008
4 National Baseline Household Survey, 2009
5 EMIS 2011
6 MoE 2011
7 SSAC, 2010, *Universal Access Report: Scaling Up HIV/AIDS Response*
8 Abu Raddad LJ, Akala FA, Semini I, Rieder G, Wilson D, Tawil O, 2010, *Characterizing the HIV/AIDS Epidemic in the Middle East and North Africa.* World Bank Publications
9 UNGASS Country Progress Report on Sudan, 2010
10 Household Health Survey, 2010
11 MoH 2010

SWAZILAND

Population[1]**:** 953 924 (2007)

85% of Swaziland's population lives in rural areas; approx. 48% is below 15 years of age.

National poverty line[2]**:** 60%

Education expenditure[2]**:** 11.1% of GDP

Health expenditure[2]**:** 2.3% of GDP

Proportion of orphans aged 10-15[2]**:** 39.1%

Population[3]	Male	Female	Total
% children 0-14 years	< 5=15.3%	< 5=13.8%	29.1%
	5-9 = 15.2%	5-9=13.2%	28.4%
	10-4=15.7%	10-14=14.6%	30.3%
% adolescents 15-19 years	13.5%	11.6%	25.1%
% young people 20-24 years	9.5%	9.7%	19.2%

Education[4]**:** Net attendance rates for both primary and secondary school levels are relatively high, with girls far exceeding boys in terms of attendance over all. Despite the fact that attrition rates are also relatively high, the formal education institutions continue being one of the most appropriate means through which sexuality education (SE) can be introduced.

Education[4]	Male	Female	Total
Adult literacy rate			90.5%
Literacy rates 15-24 years	91%	94.5%	92.8%
Net enrolment rate primary	82%	84%	83%
Net enrolment rate secondary	55%	74%	65%
School dropout rates	8%	9.4%	8.6%

Trained teachers[4] (primary)		Teacher-student ratios4[4]	
Male	Female	Primary	Secondary
29%	71%	1:45	1:40

Gender parity index (ratio girls/boys):	Primary	Second	Tertiary
Gross enrolment rate	0.90	0.93	
Net enrolment rate	0.95	1.27	N/A

Sexuality education[5]**:** There is a SE curriculum at both the primary and the secondary school level. The 2010 Education Sector Policy initiated the creation of a formal guidance and counselling syllabus which focuses on age-appropriate ways of promoting health at school. HIV and AIDS has been made a compulsory element of SE; teachers receive appropriate training prior to teaching the HIV and AIDS curriculum.

Curriculum available	Curriculum type	Examinable
Yes	Centralised	No

Curriculum content[6]				
Topic covered	Inclusion in core curriculum			
	Lower primary	Upper primary	Lower secondary	Upper secondary
Generic life skills	Yes	Yes	Yes	Yes
Adolescent and reproductive health	Yes	Yes	Yes	Yes
Sexuality education	Yes	Yes	Yes	Yes
Gender equality and empowerment	Yes	Yes	Yes	Yes
HIV and AIDS and other STIs	Yes	Yes	Yes	Yes
Stigma and discrimination	Yes	Yes	Yes	Yes
Family life and interpersonal relations	Yes	Yes	Yes	Yes

Sexual and reproductive health[7]**:** Young people centres provide information and counselling services on HIV, despite the fact that HIV testing has not yet been made available. Young people below the age of 16 require parental consent for HIV testing and counselling (HCT) despite the fact that traditional marriage law allows 13-year-old girls to get married. The rate of unintended pregnancies is 64%. Antiretroviral drugs (ARVs) are available free of charge at public health facilities but only young people, who are 18-years-old or above, can access ARVs without parental consent. HIV prevalence among young people aged 15-24 is 34%.

SRH[7]	Male	Female	Total
Adolescent fertility rate		111 (as per 1 000 women)	
Teenage pregnancy rate		17.3%	
STI rate (aged 15-24)	5.5%	5.2%	
HIV prevalence (aged 15-24)	6.5%	15.6%	
Incidence of sexual gender-based violence (SGBV) (aged 18-24)		Nearly 2 in 3 females	
Unmet need for family planning (aged 15-24)		28.6%	

Behavioural indicators[8]**:** Swaziland has one of the highest HIV rates in the world (25.9%), which can be attributed mainly to the high number of multiple concurrent partners and the high levels of intergenerational sex. Within the 15-24 year age group, 28.5% of young men report having had multiple concurrent partners.

Behavioural indicators[7,9]	Male	Female	Total
Sex before age 15 (aged 15-24)	4.9%	7.4%	6.2%
Multiple partners (aged 15-24)	9%	3.%	6%
Condom use at last sex (aged 15-24)	91.5%	71.5%	81.5%

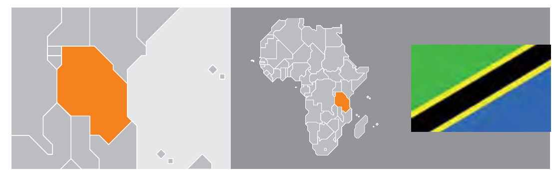
Services[7]**:** Family planning services are provided through governmental, civil society and private sector organizations; these, however, have not been streamlined with HIV and AIDS strategies. Swaziland has been making efforts to combine these with sexual and reproductive health (SRH) services as well. There is no access to safe abortion facilities as abortions are illegal; unsafe abortion is common, accounting for 50% of all obstetric complications and 37% of health facility-based maternal deaths.

Access to services[7]	Male	Female	Total
Married women using all family planning methods		89.2%	
15-19-year-olds using contraception	16.6%	27.6%	22.1%
20- 24-year-olds using contraception	67.1%	78.4%	72.8%
Access to HTC			20%
Availability of young people-friendly services	Available but on a limited scale		

Notes:

1 Population and Housing Census, 2007
2 UNDP, 2011, *Human Development Report - Sustainability and Equity: A Better Future for All.* UNDP: New York
3 Population and Housing Census, 2007
4 MoE, 2011, *Annual Education Statistics Census Report*
5 The Government of Swaziland, *National Strategic Framework on HIV and AIDS 2009–2014*
6 MoE, 2010, *Education and Training Sector Policy*
7 DHS 2010
8 *UNGASS Country Report*, 2010
9 Multiple Indicator Cluster Survey (MICS), 2010

TANZANIA



Population[1]**:** 44.9 million

47% is below 15 years of age; 77.2% live in rural areas.

National poverty rate[2]**:** 33.4%

Public spending on education[2]**:** 6.2% of GDP

Public spending on health[2]**:** 4.0% of GDP

Ratio of school attendance of orphans aged 10-14[3]**:** 0.9%

Population[4]	Male	Female	Total
% children 10-14 years	14.3%	13.8%	28.1%
% adolescents 15-19 years	10.5%	9.3%	19.8%
% young people 20-24 years	6.7%	8%	14.7%

Education: Access to education in Tanzania is improving. Only a small proportion of young people enrolled in primary education are unable to complete it. Literacy rates among young people are quite high.

Education	Male	Female	Total
Adult literacy rate[6]	-	-	69.4%
Literacy rates 15-24 years[5]	78%	76%	77%
Net enrolment rate primary[5]	91%	92%	92%
Net enrolment rate secondary[5]	36%	33%	34%
Progression to secondary[5]	39%	34%	37%

Trained teachers[5] (primary)		Teacher-student ratios[5]	
Male	Female	Primary	Secondary
94% (both)		1:51	1: 34

Gender parity index (ratio girls/boys)	Primary	Secondary	Tertiary
	1.02	1.02	0.82

Sexuality education: Young people receive optional HIV and AIDS life skills education at both lower primary and secondary school levels – negotiations on making the life skills curriculum compulsory are under way. An estimated 15 to 25% of primary and secondary schools cover the main issues of the curriculum. Teachers receive training prior to teaching the curriculum. [7]

Curriculum available	Curriculum type	Examinable
Not as stand alone subject	Integrated into carrier subject	As part of other subjects

Curriculum content[7]

Topic covered	Inclusion in core curriculum			
	Lower primary	Upper primary	Lower secondary	Upper secondary
Generic life skills	No	Yes	Yes	Yes
Adolescent and reproductive health	Yes	Yes	Yes	No
Sexuality education	Yes	Yes	Yes	No
Gender equality and empowerment	No	No	No	No
HIV and AIDS and other STIs	Yes	Yes	Yes	Yes
Stigma and discrimination	No	No	No	No

Sexual and reproductive health: UNESCO provides the Tanzanian government with technical and financial support to strengthen the capacity of teacher training colleges for delivering and monitoring sexual and reproductive health (SRH) and life skills education (LSE). The government has collaborated with non-governmental organizations (NGOs) to provide SRH services to young people.

SRH[8,9]	Male	Female	Total
Adolescent fertility rate (aged 15-19)		116 births/1000 adolescents	
Contraceptive prevalence rate (aged 15-49)		34% (female)	
Prevalence of STIs (aged 15-24)	3.3%	3.2%	3.2%
HIV prevalence (aged 15-24)	1.7%	3.9%	2.8%
Incidence of sexual gender-based violence (SGBV) (aged 15-24)		34.5% (Female)	
Unmet need for family planning (aged 15-49)		18.3% (Female)	

Behavioural indicators[10]: Adolescent fertility levels are very high. The birth rate among young people aged 15-19 years is 116/1000 adolescents. Contraceptive prevalence among young married women is estimated at 34%. Prevalence of multiple and concurrent partnerships among young people is high. The practice is more common among males (35%) than females (23.7%). Less than 50% of young people report condom use at last sexual encounter with a non-regular partner.

Behavioural indicators[10]	Male	Female	Total
Sex before age 15 (aged 15-19)	7.8%	11.3%	9.5%
Sex before age 15 (aged 20-24)	5.5%	14.6%	10%
Multiple partners (aged 15-24)	35.2%	23.7%	29.5%
Prevalence of female genital cutting (aged 15-24)		9%	
Prevalence of child marriage	7% of women were married by age 15		
Condom use at last sex (aged 15-24)	59%	58%	

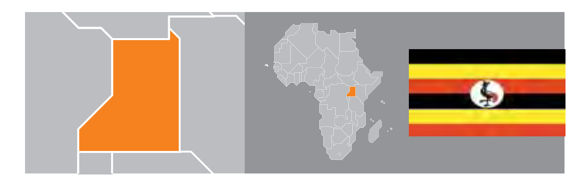
Services[8,11]**:** The National Adolescent Reproductive Health Strategy 2010-2015 makes provision for the creation of an implementation framework designed to support the interventions geared towards increasing adolescents' access to young people friendly sexual and reproductive health information, education and services. More than 27% of young people use modern contraceptives; 7% use traditional ones. A total of 31.6% of females and 36.2% of males have access to condoms.

Access to services[11,12]	Male	Female	Total
Married/sexually active unmarried women aged 15-49 using all family planning methods		28.8%	
15- 19-year-olds using contraception	-	10.7%	-
20- 24-year-olds using contraception	-	29.2%	-
	Aged 15-19	**Aged 20-24**	
Access to HIV testing - results from last HIV test taken in past 12 months	20.5%	37.9%	
Access to post-abortion care	Abortion only to save a woman's life		
Availability of young people-friendly services	Guided by Adolescent SRH Strategy 2010-2015		

Notes:

1 National Population and Housing Census (NPHC), 2012
2 UNDP, 2013, *Human Development Report 2013*
3 National Bureau of Statistics (NBS), 2010
4 NPHC, 2012
5 Basic Statistics in Education (BEST), 2012
6 Household Budget Survey, 2007
7 Tanzania Ministry of Education and Vocational Training. 2011. Selected 2011 GPS Key Results
8 DHS 2010
9 WHO/SOWC 2012
10 Tanzania HIV and Malaria Indicator Survey (THMIS), 2013
11 MoH, *National Adolescent Reproductive Health Strategy 2010-2015*
12 International Conference on Population and Development Beyond 2014, 2012, C*ountry Implementation Profile: United Republic of Tanzania*

UGANDA



Population[1]: 34.1 million

Approx. 21% of the population are young people aged 15-24. The number of young people living in urban areas is slightly higher than the number of those living in rural areas.

National poverty line[2]: 31.1%

Public spending on education[2]: 3.2% of GDP

Public spending on health[2]: 2.0% of GDP

Population of orphans aged 10-17[1]: 1.3 million

Population[1]	Male	Female	Total
% children 0-14 years	24.5%	24.6%	49.1%
% youth 15-24 years	10.5%	10.7%	21.2%
% 25 years and over	14.7%	15.1%	29.8%

Education: The total percentage of people aged 15 years and above in Uganda who can both read and write is 73%.[1] Uganda is among the few African countries which have decentralized their education systems. Net attendance rates for primary schools are 82.5%, for secondary - 17%.[3] These statistics suggest that many young people who are classified as being in school regularly miss classes.

Education[1,4]	Male	Female	Total
Adult literacy rate	79 %	66%	73%
Literacy rates 15-24 (secondary level and above)	87.3%	81.1%	84.2%
Net enrolment rate primary	96.4%	97.2%	96.8%
Net enrolment rate secondary	26%	25%	25.5%
Progression to secondary	60%	57%	-

Trained teachers (primary)[1]		Teacher-student ratios[1]	
Male	Female	Primary	Secondary
90%	89%	1:49	1:19

Gender parity index (ratio girls/boys)	Primary	Secondary	Tertiary
	1.01	0.89	0.78

Sexuality education: Teachers receive training on the Life Skills curriculum and are given a Teacher's Hand Book as a main resource material. The HIV and AIDS/Life Skills curriculum is primarily offered through formal education, which means that young people out of school are usually not reached. The methods of delivery of the HIV and AIDS/Life Skills curriculum are not participatory enough, and thus are unlikely to offer any desirable changes in behaviour. Efforts have been made to ensure that religious, community and/or traditional leaders support the HIV prevention approach adopted by the education sector.

Curriculum available	Curriculum type	Examinable
Yes	Life Skills	No

Curriculum content[5]				
Topic covered	Inclusion in core curriculum			
	Lower primary	Upper primary	Lower secondary	Upper secondary
Generic life skills	No	-	-	-
Adolescent and reproductive health	No	Yes	No	No
Sexuality education	No	Yes	No	No
Gender equality and empowerment	No	Yes	No	No
HIV and AIDS and other STIs	Yes	Yes	No	No
Stigma and discrimination	No	Yes	No	No
Family life and inter-personal relations	Yes	Yes	-	-

Sexual and reproductive health[6]**:** The adolescent fertility and teenage pregnancy rates are high. A number of factors impacting on young people's sexuality and reproductive health (SRH) could possibly explain this.

SRH[8]	Male	Female	Total
Adolescent fertility rate[7] (aged 15-19) per 1000 births	-	134	-
Teenage pregnancy rate (births per 1,000 adolescents)	-	149	-
Self-reported STI prevalence rate (aged 15-24)	14.3%	24.3%	68%
HIV prevalence (aged 15-24)[1]	2.3%	4.8%	-
Incidence of sexual gender-based violence (SGBV) (aged 15-24)	4.1%	12.2%	-
Unmet need for family planning (aged 15-24)	-	-.	33%

Behavioural indicators[8]**:** Condom use with irregular partners among young men aged 15-24 is significantly higher than among females falling into the same age group. Alcohol use during sex amongst young people falling in the 15-24 age group is 14.2% and 11.8% for females and males respectively.

Behavioural indicators[8]	Male	Female	Total
Sex before age 15 (aged 15-24)	12%	13%	12.5%
Multiple partners (aged 15-24)	9.2%	2.8%	6%
Prevalence of child marriage (by 15 years and by 24 years)	-	12% and 24%	-
Condom use at last sex (sex with irregular partners) (aged 15-24)	55%	38%	46.5%

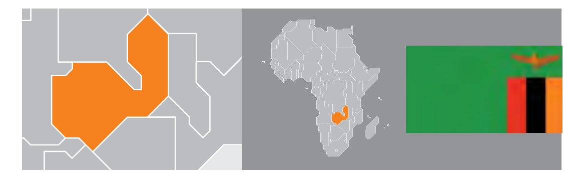
Services[1,8]**:** According to the Health Sector Strategic and Investment Plan, adolescent SRH services are limited in scope and do not really address the needs of adolescents. The proportion of adolescent-friendly health facilities is 10%; the government aims to increase this to 75% by 2015. Some of the interventions planned for the period 2010/11 - 2014/15 include sensitizing and empowering communities regarding their SRH rights, and integrating adolescent SRH in school health programmes. A total of 28% of men aged 15-24 are circumcised.

Access to services[1]	Male	Female	Total
Married women using any family planning methods	-	30%	30%
15- 19-year-olds using contraception	16.3%	19.3%	17.8%
20- 24-year-olds using contraception	60.4%	52.2%	56.3%
Access to HIV testing and counselling	43%	74%	58.5%
Ever tested for HIV and received results (aged 15-24)	35.4%	61.5%	48.5%
Termination of pregnancy	Abortion is illegal unless a woman's health and wellbeing is in danger on the advice of a medical expert.		

Notes:

1 State of Uganda Population Report (SUPRE), 2012
2 HDR 2013
3 Education Policy and Data Center, 2012, *Core USAID Education Profile: Uganda*
4 National Household Survey 2009/2010
5 MoE, 2004, *Report on School Health Programmes and Clubs*
6 DHS 2011
7 *The African Reproductive and Sexual Health scorecard*, 2012
8 Uganda AIDS Indication Survey (UAIS), 2011

ZAMBIA



Population[1]**:** 13 092 666

Of the total population, 25.2% is below the age of 15.

National poverty rate[1]**:** 59.3%

Education expenditure[1]**:** 3.6% of GDP

Health expenditure[1]**:** 1.3% of GDP

Population[2]	Male	Female	Total
% children 10-14 years	15.9%	14.3%	30.2%
% adolescents 15-19 years	9.4%	9.2%	18.6%
% young people 20-24 years	7.3%	8.3%	15.6%

Education[3]**:** Adult literacy stands at 72.8%. Net primary school attendance rates are high, with girls outperforming boys. However, the level of educational attainment remains low, as the mean number of completed school years is 6.5 out of an expected 7.9. The school system is the primary vehicle of comprehensive sexuality education (CSE) delivery. Out-of-school children should be specifically targeted by HIV and sexuality education programming, since their numbers are high.

Education[3,4]	Male	Female	Total
Adult literacy rate	81.9%	63.7%	72.8%
Literacy rates 15-24 years	82.25%	67.15%	74.7%
Net enrolment rate basic (grades 1-9)	94.3%	94.6%	94.5%
Net enrolment rate secondary (grades 10-12)	26.1%	19.9%	23%
Transition rate (grades 7-8)	65%	55%	60%
Transition rate (grades 9-10)	46%	44.8%	45.5%

Trained teachers (primary)[5]		Teacher-student ratios[5]	
Male	Female	Primary	Secondary
65%		1:60	-

Gender parity index (ratio girls/boys)	Primary	Second	Tertiary
	1.01	-	-

Sexuality education[6 7]**:** HIV prevention and sexual and reproductive health (SRH) programmes for young people in and out of school have been implemented over the past two decades. HIV and SE teaching strategies include peer education, life skills, communication outreach programmes, school clubs, young people-friendly corners, media, Edu-sports and theatrical events. In 2012, the Ministry of Education committed to strengthening SE in the formal education curriculum - draft curricula for school-based CSE was developed and piloted in 42 schools in the first quarter of 2013.

Curriculum available	Curriculum type	Examinable
Yes	Life Skills Education and recently, Sexuality Education	Yes

Curriculum content[8]

Topic covered	Inclusion in core curriculum			
	Lower primary	Upper primary	Lower secondary	Upper secondary
Generic life skills	Yes	Yes	Yes	Yes
Adolescent and reproductive health	No	Yes	Yes	Yes
Sexuality education	No	Yes	Yes	Yes
Gender equality and empowerment	Yes	Yes	Yes	Yes
HIV and AIDS and other STIs	No	Yes	Yes	Yes
Human rights base	Yes	Yes	Yes	Yes

Sexual and reproductive health[9]**:** The first draft of the Reproductive Health Policy prioritizes maternal and child health by envisioning continued improvement of the 'Safe Motherhood' programme. It also prioritizes adolescent health and development and highlights the need to increase prevention and management efforts directed towards sexually transmitted infections (STIs) and HIV and AIDS. The Adolescent Reproductive Health Policy seeks to provide accessible, efficient and effective adolescent-friendly health services.[10]

SRH[4]	Male	Female	Total
Adolescent fertility rate (aged 15-19)		146.8 per 1 000 live births	
Percentage of adolescents who have begun childbearing		28%	
STI rate (aged 15-24) excl. HIV	3.5%	2.4%	5.5%
HIV prevalence (aged 15-24)[11]	4.35%	8.75%	6.55%
Incidence of sexual gender-based violence (SGBV) (young women aged 15-24)		16.5%	
Unmet need for FP (aged 15-24) (unmarried)		11.45%	

Behavioural indicators[4,12]**:** Country prevalence of HIV is 14.3%. Among those aged 15-24, females have double the prevalence of their male counterparts. Young men have higher levels of HIV and AIDS knowledge and report higher levels of condom use.

The adolescent fertility rate in the 15-19 years-old age group remains high, at 146.8 per 1,000 live births, with 28% of young women having begun childbearing. Young women are particularly vulnerable to HIV – that is why the HIV and SE programming approach has to be gender-sensitive.

Behavioural indicators[4,13]	Male	Female	Total
Sex before age 15 (aged 15-19)	16.2%	12.3%	14.25%
Sex before age 15 (aged 20-24)	15.7%	14.8%	15.25%
Prevalence of multiple sexual partners (aged 15-24)	4%	<1%	2.5%
Prevalence of female genital cutting		1% of women aged 15-49	
Prevalence of child marriage	26% of women aged 20-24 report being married before the age of 18.		
Condom use at last sex (aged 15-24)	39%	33%	36%

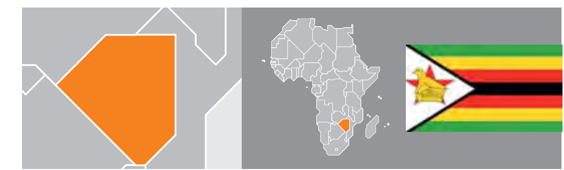
Services[14]**:** Antiretroviral drugs (ARVs) are available free of charge at public health facilities. Family planning (FP) services are provided through governmental, civil society and private sector channels – despite this fact, 70% of women do not have access to them. Efforts for incorporating HIV and AIDS within FP and reproductive health services have been made. Antenatal care is almost universal, with 91% of women receiving it, and 47% of births occurring under the supervision of a skilled provider.

Access to services[4]	Male	Female	Total
Married women using any FP method		77.2%	
15- 19-year-olds using contraception	57.7%	56.3%	57%
20 -24-year-olds using contraception	83.6%	79%	81.3%
Access to HIV testing and counselling (aged 15-24): A total of 82.9% of women know where they can be HIV tested; 30.3% have already been tested. A total of 81.6% of men know where they can be HIV tested; 14.1% of men have already been tested.			
Availability of young people-friendly services[10]**:** Young people-friendly centres have been used as an access point for providing young people-friendly reproductive health and family planning services. However, these have not been particularly effective – there is a shortage of health workers, and most centres are de facto operated by the young people themselves.			

Notes:

1 UNDP, 2011, *Zambia Human Development Report (ZHDR): Service Delivery for Sustainable Human Development.* Lusaka
2 Central Statistical Office, 2010, *2010 Census of Population and Housing Preliminary Population Figures.* Lusaka
3 EMIS 2011
4 DHS 2007
5 EMIS 2011
6 Zambia Education Curriculum Framework, 2013
7 MoH, 2012, *Zambia National Health Policy (NHP).* Lusaka
8 Zambia Education Curriculum Framework, 2013
9 MoH, *Reproductive Health Policy: First Draft.* Lusaka
10 MoH, 2010, *Adolescent Health Strategic Plan 2011-2015 (ADHSP).* Lusaka
11 UN, 2011, UNGASS *Zambia Country Report: Monitoring the Declaration of Commitment on HIV and AIDS and the Universal Access.* Lusaka
12 Zambia Sexual Behaviour Survey (ZSBS), 2009
13 ZSBS 2009
14 MoH 2009

ZIMBABWE



Population[1]**:** 12.97 million

Almost 39.5% of the population is less than 15 years old and 38.3% of Zimbabwe's population live in urban areas.

Population below the poverty line (national)[2]**:** 72%

Public expenditure on education[2]**:** 2,5% of GDP

Public expenditure on health[2]**:** 0.0% of GPD

Life expectancy at birth[2]**:** 52.7 years

Population[3]	Male	Female	Total
% children 0-14 years	20.5%	20.1%	40.6%
% young people 15-24 years	11.2%	12.3%	23.5%
% 25 years and over	17.3%	18.6%	35.9%

Education[4]**:** The Ministry of Education, Sport, Arts and Culture launched the Life Skills, Sexuality, HIV and AIDS Education Strategy (2012-2015) to guide the delivery of life skills-based HIV and sexuality education to learners in schools.

Education[5]	Male	Female	Total
Adult literacy rate	96%	94%	95%
Literacy rates 15-24 years	95.2%	96.2%	95.7%
Net enrolment rate primary	96.4%	97%	96.7%
Net enrolment rate secondary	44.9%	49.5%	47.2%

Trained teachers[5] (primary)		Teacher-student ratios[5]	
Male	Female	Primary	Secondary
89.6% aggregated		1:36.4	1:22

Sexuality education[6]**:** Health and Life Skills education is compulsory in all primary, secondary and tertiary education institutions. HIV and AIDS information is incorporated in all courses. Teachers have been receiving training on the Life Skills and Sexual and Reproductive Health (SRH) curriculum since 1994. Efforts have been made to ensure that religious, community and/or traditional leaders support the HIV prevention approach adopted by the education sector.

Curriculum available	Curriculum type	Examinable
Yes	Life Skills – integrated	Yes

Curriculum content[6,7]

Topic covered	Inclusion in core curriculum			
	Lower primary	Upper primary	Lower secondary	Upper secondary
Generic life skills	Yes	Yes	Yes	Yes
Adolescent and reproductive health	No	Yes	Yes	Yes
Sexuality education	Yes	Yes	Yes	Yes
Gender equality and empowerment	Yes	Yes	Yes	Yes
HIV and AIDS and other STIs	No	Yes	Yes	Yes
Stigma and discrimination	Yes	Yes	Yes	Yes
Family life and interpersonal relations	Yes	Yes	Yes	Yes

Sexual and reproductive health[8]**:** The National Adolescent Sexual and Reproductive Health (ASRH) Strategy (2010-2015) provides a standard framework for SRH rights programming for young people through a multi-sectoral and coordinated approach. The strategy offers three models for addressing SRH issues faced by adolescents and young people: health facility-based; school-based; and community-based models. It builds on the provisions of the National Maternal and Newborn Health Road Map (2007-2015), which aims to increase availability and use of young people-friendly family planning and HIV prevention services. The National Health Strategy for Zimbabwe (2009-2013) has the explicit objective of addressing the SRH rights needs of young people.

SRH[3,9]	Male	Female	Total
Adolescent fertility rate (aged 15-19) per 1,000 births	-	64.6%	64.6%
Teenage pregnancy rate	-	24%	24%
HIV prevalence (aged 15-24)	3.6%	7.3%	5.5%
Incidence of sexual gender-based violence (SGBV) (aged 15-24)	30% of women aged 15-49 have experienced physical violence since age 15		
Unmet need for family planning (aged 15-24)	-	13.1%	13.1%

Behavioural indicators[3,10]**:** Although adult HIV prevalence has shown a consistent decline, it is still high at 15.3%. HIV transmission remains predominantly sexually driven, accounting for over 80% of the infections. The majority of new infections occur in the 20-29 years-old age group. The percentage of young people aged 15-24 who have correct comprehensive HIV knowledge is currently only 52%. Of young women aged 15-19, 15% have had sexual intercourse with a man 10 or more years older.

Behavioural indicators[3]	Male	Female	Total
Sex before age 15 (aged 15-24)	3.9%	3.8%	3.85%
Multiple partners (aged 15-24)	7.7%	1.3%	4.5%
Incidence of child marriage	-	3%	3%
Condom use at last sex (sex with irregular partners) (aged 15-24)	50.5%	38.5%	44.5%

Services[4,11]**:** Since 2004, the Ministry of Health and Child Welfare has implemented the health facility-based model espoused in the ASRH Strategy as one of the three models to reach adolescents and young people with SRH and HIV and AIDS services. Trained male and female peer educators mobilize young people to increase demand for SRH services through community sensitization campaigns. Young women receive services at antenatal classes, and if found to be HIV positive, nurses assist them in enrolling for the prevention of mother-to-child transmission (PMTCT) programme. Notable barriers to access to services include service fees, infrastructural limitations, inconsistencies and contradictions in policies and legal instruments.

Access to services[3]	Male	Female	Total
Married women using all family planning methods	-	58.5%	-
15- 19-year-olds using contraception	-	10.3%	-
20- 24-year-olds using contraception	-	45.0%	-
Access to HIV testing and counselling	The number of testing and counselling sites increased from 1 200 in 2010 to 1 390 in 2011		
Termination of pregnancy	Termination of pregnancy is permitted only to save a woman's life or preserve physical health in the event of rape or incest or due to foetal impairment. It is not permitted on request or on social or economic grounds.		
Availability of young people-friendly services	Young people-friendly corners, which provide a confidential and conducive environment for young people to access SRH services, have been established in 237 health facilities.		

Notes:

1 National Census, 2012
2 UNDP, 2013, *Human Development Report 2013 - The rose of the South: Human progress in a diverse world.* UNDP: New York
3 DHS 2010-11
4 National AIDS Council, 2011, *Zimbabwe National HIV and AIDS Strategic Plan (ZNASP II) 2011-2015*
5 MOESAC, 2012, *Annual Statistical Report*
6 UNESCO, 2012, *Sexuality Education Curriculum Review: Zimbabwe* (unpublished)
7 UNESCO, 2012, *Sexuality Education: A ten-country review of school curricula in East and Southern Africa.* UNESCO Regional AIDS Support Team for East and Southern Africa
8 Ministry of Health and Child Welfare, 2012, *Standard National Adolescent Sexual and Reproductive Health (ASRH) Training Manual for Service Providers*
9 National AIDS Council and UNAIDS, 2012, *Zimbabwe Country Fact Sheet*
10 National AIDS Council, 2011, *Annual Report*
11 Ministry of Health and Child Welfare, 2012, *Standard National Adolescent Sexual and Reproductive Health (ASRH) Training Manual for Service Providers*

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