West and Central Africa Commitment for educated, healthy and thriving adolescents and young people

"Listen, Understand, Act"

LISTEN, UNDERSTAND, ACT

WCA COMMITMENT

Situation analysis
July 2021

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Contents

Summary

With a growing population of adolescents and young people, the West and Central Africa region faces an unprecedented opportunity to reap a demographic dividend if this population is educated, healthy, and employed. However, major obstacles – including lack of access to quality education and high rates of school dropout, gender-based violence (GBV), and early and unintended pregnancies (EUPs) – will need to be overcome to achieve this. Meeting these needs forms part of the priorities of the African Union's Agenda 2063 and of the Sustainable Development Goals (SDGs) pertaining to health, education, and gender equality. Leaders from the health and education sectors within the region have echoed the urgency of addressing young people's needs at various forums. Notably, more than 120 representatives from 22 WCA countries agreed on a roadmap for the establishment of a *West and Central Africa Commitment for Educated, Healthy and Thriving Adolescents and Young People (WCA Commitment)* to promote access to both quality comprehensive education and information (CEI) and sexual and reproductive health and rights (SRH) for adolescents and young people.

This report presents evidence on the status of adolescents and young people in WCA with respect to key indicators affecting their wellbeing. The thematic areas covered include education, health and gender inequity. Significant progress has been made in the education sector to reduce the number of children out-of-school, however, progress is not uniform, and disparities between genders and countries remain, usually at the expense of girls. Birth rates in the region for girls aged below 18 years are among the highest in the world, contributing to early school-drop outs and serious health complications.

Low levels of correct knowledge on HIV and of the fertile reproductive period indicate the urgency of comprehensive education and information for adolescents and young people. In addition, inaccessibility, unaffordability or unsuitability of existing services for the specific needs of adolescents and young people serve as obstacles preventing uptake of Sexual and Reproductive Health Services.

Gender inequality is an important cross-cutting issue as gender and other social norms bring about health risks during adolescence, a time when adolescents have the least access to preventive and curative services. Child marriage in particular is a risk factor for early pregnancy with associated health complications for adolescent girls and young women. It is also linked to school dropouts, depriving girls from the protective effects of education. ICTs are increasingly important and access to social networks (via mobile phones) and the media (television, radio) is expanding, although there are disparities in access between urban and rural areas. While girls and young women have less digital access than their male counterparts, ICTs represent an opportunity to provide adolescents and young people with critical information.

Finally, the report presents opportunities that the region can exploit to meet the needs of adolescents and young people comprehensively and effectively. It demonstrates how even with limited resources, it is possible for the region to achieve positive outcomes in the health, education and wellbeing of adolescents and young people. The *WCA Commitment* will be a much-needed catalyst for unlocking resources, fostering inter-sectorial collaboration and scaling up effective educational programmes and health services that will drive the development of the region towards the shared vision of a prosperous African continent.

Summary

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Background

In West and Central Africa (WCA),[1] 64% of the population is currently below the age of 24 years,[2] with the adolescent population (10-19 years) expected to jump by 37%, from 120 million to 164 million, by 2030.[3] Ensuring this population is educated, healthy, and employed could benefit the region from the demographic dividend. However, major obstacles – including lack of access to quality education and high rates of school dropout, gender-based violence (GBV), and early and unintended pregnancies (EUPs) – will need to be overcome to achieve this.

Meeting these needs forms part of the priorities of the African Union's Agenda 2063[4] and of the Sustainable Development Goals (SDGs) 3, 4 and 5 pertaining to health,[5] education, and gender equality.[6] Agenda 2063, which works towards "*An integrated, prosperous and peaceful Africa, driven by its own citizens, representing a dynamic force in the international arena*" has set the following goals for the region (among others):

- A high standard of living, quality of life and well-being for all citizens.
- Well-educated citizens and a skills revolution underpinned by science, technology and innovation.
- Full gender equality in all spheres of life.
- Engaged and empowered youth and children.

SDG targets, by 2030:

3.7 Ensure universal access to sexual and reproductive health care services.

4.1 Ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes.

4.7 Ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes.

5.2 Eliminate all forms of violence against all women and girls.

5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilations.

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[1] The report will generally cover the 25 countries in the region, namely Benin, Burkina Faso, Burundi, Central African Republic (CAR), Cabo Verde, Cameroon, Chad, Côte d'Ivoire, Democratic Republic of Congo (DRC), Equatorial Guinea, Gabon, the Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Republic of Congo, Sao Tomé and Principe, Senegal, Sierra Leone, and Togo.
[2] United Nations Population Fund West and Central Africa Regional Office (UNFPA WCARO). Transforming and Uplifting Lives. One Region One Mission. Annual Report 2015. UNFPA WCARO (2015).
[3] UNICEF . May 2019. Adolescent girls' health and well-being in West and Central Africa.

[4] https://au.int/en/agenda2063/overview (Consulted on 18 May 2020).
[5] https://www.un.org/sustainabledevelopment/ (Consulted on 18 May 2020).
[6] A number of other regional documents are also relevant: Pan-African High-Level Conference on Education: The Nairobi Declaration and Call for Action on Education (2018); Addis Ababa Declaration on Population and Development in Africa beyond 2014 (2013); African Common Position on Ending Child Marriage in Africa; and the Maputo Plan of Action for the Operationalisation of the Sexual and Reproductive Health and Rights Continental Policy Framework.

Background

Expected impacts of the WCA Commitment

- Impetus for scaling up education and access and use of quality services programmes in response to EUPs, HIV, GBV, and substance use.

- Strengthened advocacy.

- Accelerated mainstreaming and institutionalization of CEI in national and sub-regional strategies.

- Better collaboration between the education and health sectors – including the simultaneous implementation of CEI and SRH services – and between stakeholders in general.

- Increased mobilization of partners, including donors, around a common agenda.

- Annual workplans per country, with regular monitoring of outcomes.

Conscious of the challenges facing adolescents and young people in the region, and in line with several other international commitments and WCA government programmes centring on education and well-being, representatives from 17 WCA countries agreed on the Dakar Call to Action at a regional conference in Senegal in 2015,[7] calling for high-level political commitment action to scale up education on HIV, adolescent pregnancies, and gender-based violence and increase the quality and coverage of reproductive health education in WCA. Similarly, at a conference on SRH and comprehensive education and information[8] (CEI) in November 2018, which brought together more than 120 representatives from 22 WCA countries, the link between health and educational outcomes, as well as school dropout, were discussed and the causes identified. Recognizing that the promotion of access to both quality comprehensive education and information, and SRH for adolescents and young people requires

stronger political will and increased efforts, the conference culminated in a roadmap for establishing a *West and Central Africa Commitment for Educated, Healthy and Thriving Adolescents and Young People (WCA Commitment)*.

The WCA Commitment envisages a generation of adolescents and young people that are healthy, educated, responsible, and are actors in the development of their families, communities, and countries. It addresses EUPs, child marriage, HIV and other sexually transmitted infections (STIs), substance use, sexual and gender-based violence (SGBV), and poor educational outcomes. By underscoring adolescents' and young people's education, health, gender equality, equity, and empowerment, the Commitment will drive the implementation of the African Union Roadmap on harnessing the demographic dividend (2016), and the Continental Education Strategy for Africa.

[7] Regional conference addressing education issues related to HIV prevention, sexual and reproductive health and gender equality, Dakar, 7-9 October 2015.
[8] The International Technical Guidance on Sexuality Education refers to to the term 'comprehensive sexuality education (CSE)', while recognizing that orientation should be adapted to the context of programme implementation.

This report will therefore use the term 'comprehensive education and information (CEI)', which all countries in West and Central Africa have adopted in the Political Declaration on HIV and AIDS: Ending Inequalities and Taking Action to Overcome AIDS by 2030, in 2021.

Photo credit: ©Plan International

In addition to the sizeable health and education budgets in the region, which attest to the importance of these sectors in meeting the needs of adolescents and young people, all WCA countries have health, CEI, and SRH programmes in place. The WCA Commitment supports these existing national efforts, while creating an environment conducive to their scaled-up implementation.

The WCA Commitment is all the more important because the region's population grows exponentially, albeit at different paces from country to country, depending on their rates of fertility and life expectancy. Niger, for example, with a fertility rate of seven children per woman, will see the highest growth (nearly three times the current population by 2050), followed by Mali, Burkina Faso, and Benin, while Nigeria, despite having a lower growth rate, could nevertheless become the third most populous country in the world after India and China, with 401 million inhabitants.[9]

Given a high proportion of their populations are adolescents and young people, countries in the region hope to benefit from this demographic dividend – but, for this to happen, this group of citizens must be healthy, educated, and have decent jobs, failing which, in a context of limited human and financial resources, population growth will have an impact on the ability of governments in the region to deliver essential services, such as health and education.

> **Demographic dividend** is the economic growth potential that can result from shifts in a population's age structure, mainly when the share of the working-age population (15 to 64 years) is larger than the non-working-age share of the population (14 years and under, 65 years and older).[10]

Photo credit: ©Plan International

## Education and health – essential building blocks for sustainable development

An educated population is one of the prerequisites for economic growth and poverty reduction.[11] Non-enrolment and lack of skills worsen social inequalities and vulnerability, which in turn hamper economic growth and slow down poverty reduction. It is estimated that achieving universal primary and secondary education would help lift more than 420 million people out of poverty (see adjacent graphic), and that the effects would be especially substantial in sub-Saharan Africa.[12] On average, it is estimated that one year of schooling increases earnings by 12% in the region (14.5% for women).[13]

Importantly, contributing to a country's development requires not only improving access to quality education, but also keeping children, adolescents, and young people in the educational system and improving their capacity to learn. However, among adolescents and young people, health-related issues (often linked to poor nutrition, EUPs, GBV, and child marriage) are the main causes of school absenteeism, dropout, and diminished learning, and thus low educational outcomes. The combined effects of deficiencies in health and education, together with poverty, and a country's development, jeopardize attainment of the demographic dividend.

Moreover, adolescents and young people's health and educational outcomes are influenced by social determinants at all levels, from personal and family, to community and national.[14] A wide range of factors, including poverty, access to education and health services, legal and policy frameworks, access to information and knowledge, gender inequalities, relationships within families, communities and among peers, violence, and substance abuse, as well as sociocultural standards and values affect health and education.[15] Other factors also have

an impact, such as access to infrastructure and services, geopolitical instability, and humanitarian conflicts and crises. It is therefore imperative to give adolescents and young people the resources – through knowledge, attitudes and skills – they need to better manage these determinants in everyday life, within their families and communities, with their peers and in school.

Estimated effect of universal secondary completion on the number of poor
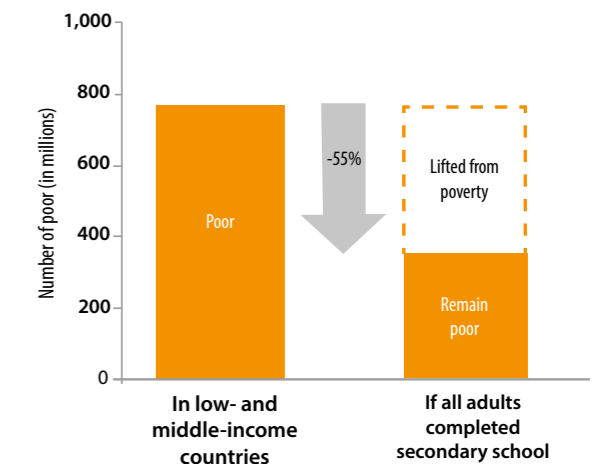
> "During adolescence, an individual acquires the physical, cognitive, emotional, social, and economic resources that are the foundation for later life health and wellbeing."[16]

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[9]   UN DESA. World Population Prospects 2019.

[10] https://www.unfpa.org/demographic-dividend (Consulted on 30 March 2020).

[11] The UNESCO Institute of Statistics and Global Education Monitoring (GEM) Report. Reducing global poverty through universal primary and secondary education. Policy Paper 32 /Fact Sheet 44. June 2017.

[12] Ibid.

[13] Montenegro and Patrinos, 2014. Policy Research Working Paper 7020. Comparable Estimates of Returns to Schooling around the World. The World Bank, Education Global Practice Group. September 2014.

[14] Patton, G. C. (2012). Health of the world's adolescents: a synthesis of internationally comparable data. The Lancet, 379: 1665-75.

[15] Russell M Viner, E. M. (2012). Adolescence and the social determinants of health. The Lancet, 379: 1641–52.

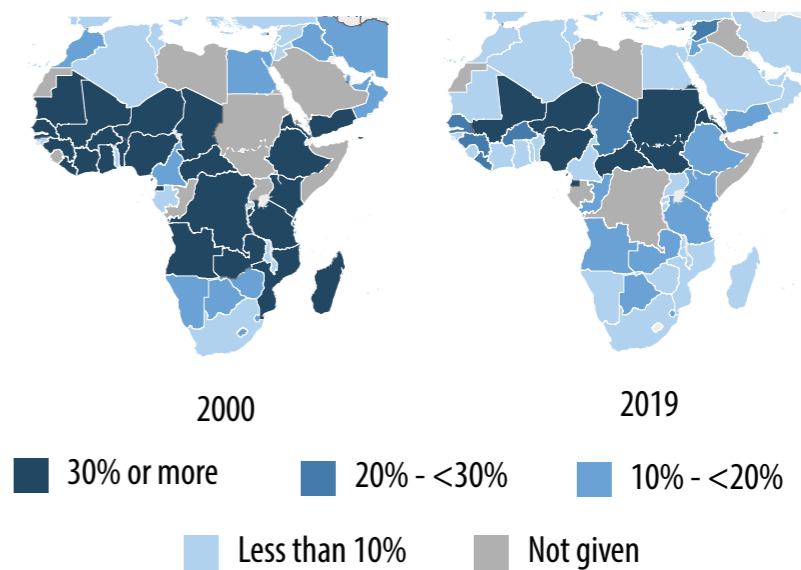[16] Patton, G.C.; et al. 2016. Our future: A Lancet commission on adolescent health. The Lancet. 2423-2478.

The situation of adolescents and young people in West and Central Africa

Education

Percentages of primary-age out-of-school children[17]

2000   2019

- 30% or more
- 20% - <30%
- 10% - <20%
- Less than 10%
- Not given

There has been notable progress in the education sector in WCA. Between 2000 and 2019, the rate of primary-age out-of-school children significantly reduced (see graphic above), while secondary school enrolment increased. For example, data for 1996-2004 shows that 25% of boys and 21% of girls were attending secondary school.[18] These rates increase to 39% and 36%, respectively, for 2010-2016.[19]

However, at least 23 million[20] children, adolescents, and young people are still out of school in WCA (bearing in mind that this figure could double if all WCA countries were included in these statistics). While the estimates of the United Nations Educational, Scientific and Cultural Organization (UNESCO) Institute for Statistics (UIS) on rates of out-of-school adolescents (both genders) show an improvement over time, for instance Niger made more progress between 2010 and 2020 than between 1975 and 2000 (see graphic on the next page), population growth has resulted in the number of out-of-school adolescents in this country increasing sharply from 493,000 in 1981 to 1.3 million in 2017.

[17] Data and graph from the UNESCO Institute for Statistics. https://tellmaps.com/uis/oosc/#!/tellmap/-528275754? (Consulted on 20 April 2020).
[18] UNICEF. 2006. State of the World's Children Statistical Tables.
[19] Ibid.

[20] UNESCO Institute for Statistics. http://data.uis.unesco.org/index.aspx?lang=en&SubSessionId=&themetreeid=-200 (Consulted on 18 May 2020).

The situation of adolescents and young people in West and Central Africa

Countries with high rates of out-of-school children of lower-secondary age

Legend:
- Central Africa, Rep
- Niger
- Guinea
- Senegal
- Chad
- Equatorial Guinea
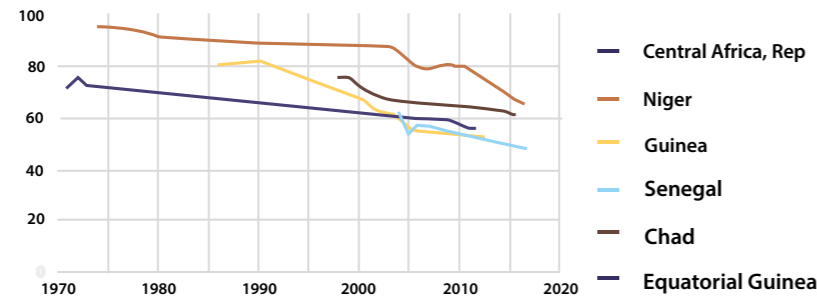
Furthermore, the graphic below reveals that progress in the education sector is not uniform, and disparities between genders and countries remain. For example, in two countries in the region, only one in three girls reaches the third year of primary school compared with 50% of boys, while in another country in the region, in contrast, 95% of girls and 93% of boys complete primary school. There are some countries in which the disparity favours girls, such as Burkina Faso, Burundi, Cabo Verde, Mauritania, Sao Tome and Principe, and Senegal, but in most cases, it favours boys. Cabo Verde, Ghana, Sao Tome and Principe, and Togo have the highest enrolment rates and the lowest gender disparities.

Gender disparity also widens with age. In WCA, the disparity, an 8 percentage point gap, is more marked in the first and second cycles of secondary education (versus 4 points in primary education), and only 33% of girls in the region complete their studies. This gender disparity in completion rates affects youth (15-24 years) literacy rates as well, which in 2019 was 73% for boys and 60% for girls.[21]

Rates of school completion in WCA
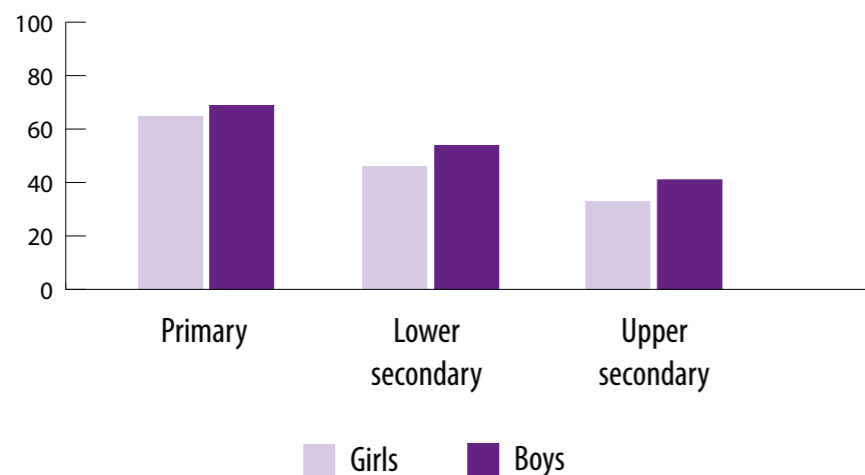
Legend: Girls, Boys

"It's the girl who pays the price for pregnancy. The boy goes to school and she doesn't."

Pasteur Jumien Aye Yapi, ARSIP, Côte d'Ivoire

Photo credit: ©UNESCO

Also in 2019, WCA had the highest out-of-school rate for adolescents of lower-secondary age in the world.[22] Girls are disproportionately represented in this regard, with school dropout often occurring as a result of GBV, including within the school setting, child marriage, EUP, social norms on the role of the girl child within the family group, and the precarious situation of humanitarian crises. Of note, only four countries in the region have strong national legislation on the right to education for pregnant girls and mothers, and just three others allow pregnant girls to remain in school and do not prescribe mandatory absence after delivery.[23] The lack of explicit measures protecting the right to education for pregnant girls and mothers means a large number of these girls will be expelled from school in these countries.

Although this situation analysis did not cover non-formal education and technical and vocational education and training (TVET), all WCA countries do implement these education programmes. TVET not only plays a key role in providing learners with the skills they need to enter the job market, it also, like formal education, offers a good opportunity to deliver CEI and SRH services to adolescents and young people. Some countries have already started integrating skills-based content into TVET and therefore, in addition to formal education, non-formal education and TVET should be an integral part of a country's response to the CEI and SRH needs of adolescents and young people.

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[21] UNICEF. 2019. State of the World's Children Statistical Tables.

[22] https://apiportal.uis.unesco.org/visualization-out-of-date#!/tellmap/-1522571971? (Consulted on 20 April 2020).
[23] Human Rights Watch. 2018. Leave No Girl Behind in Africa. Discrimination in Education against Pregnant Girls and Adolescent Mothers. https://www.hrw.org/report/2018/06/14/leave-no-girl-behind-africa/discrimination-education-against-pregnant-girls-and (Consulted on 20 April 2020).

Health

A large proportion of young people become sexually active in adolescence
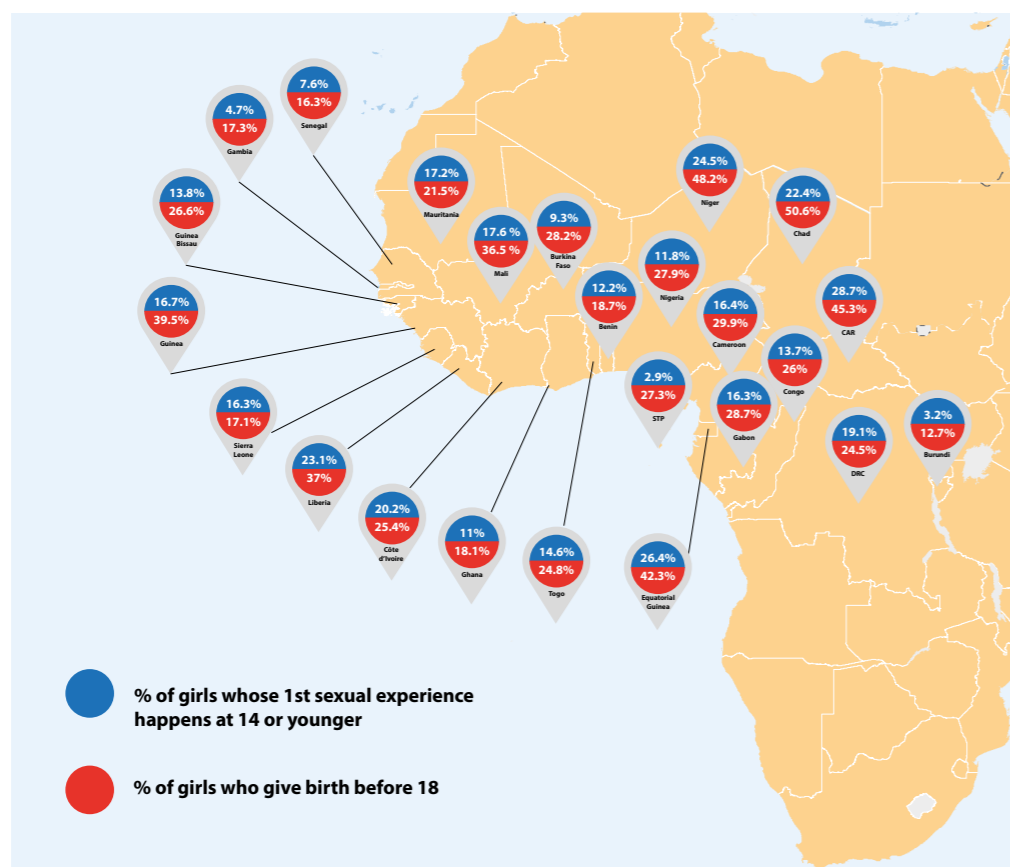
The high percentage of adolescents and young people who started their sexual life before turning 18 calls not only for better access to and better use of SRH services suited to their needs and quality CEI provided as early as primary school, but also for the establishment of a legal, policy and social context suitable for programmes in this area. No less than 16% of girls and 12% of boys aged 15-24 becoming sexually active before the age of 15,[24] and the percentage of girls who have had sex before the age of 18 varying, from between 36% in Senegal and 84% in Liberia.[25]

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Photo credit: ©Plan International

- 4.7% / 17.3% — Gambia
- 7.6% / 16.3% — Senegal
- 13.8% / 26.6% — Guinea Bissau
- 17.2% / 21.5% — Mauritania
- 24.5% / 48.2% — Niger
- 22.4% / 50.6% — Chad
- 9.3% / 28.2% — Burkina Faso
- 17.6% / 36.5% — Mali
- 16.7% / 39.5% — Guinea
- 11.8% / 27.9% — Nigeria
- 12.2% / 18.7% — Benin
- 16.4% / 29.9% — Cameroon
- 28.7% / 45.3% — CAR
- 16.3% / 17.1% — Sierra Leone
- 13.7% / 26% — Congo
- 2.9% / 27.3% — STP
- 23.1% / 37% — Liberia
- 16.3% / 28.7% — Gabon
- 20.2% / 25.4% — Côte d'Ivoire
- 11% / 18.1% — Ghana
- 14.6% / 24.8% — Togo
- 26.4% / 42.3% — Equatorial Guinea
- 19.1% / 24.5% — DRC
- 3.2% / 12.7% — Burundi

● % of girls whose 1st sexual experience happens at 14 or younger

● % of girls who give birth before 18

A high rate of early and unintended pregnancies

EUPs are responsible for many girls dropping out of school, as well as for health complications, such as a higher than the norm rate of neo-natal mortality. EUPs also significantly contribute to the high rate of maternal mortality in some countries in the region. In WCA, 33% of women gave birth before the age of 18 years, and 3.5% of adolescents before the age of 15 years. Of the 10 countries in the world with the highest percentages of pregnancies before the age of 18 years, seven are in WCA.[26] Further, birth rates in the region for girls aged 10-14 years[27] are the highest in the world, and have increased between 2000 and 2017 in some countries, such as Cameroon, Congo, Guinea, and Nigeria. There has been progress in others, for example, Sierra Leone.

EUPs are closely correlated to a number of interconnected factors, such as economic and education status, knowledge of SRH, child marriage, and access to and use of SRH services. These factors can reduce or amplify risks. For instance, only two WCA countries have more than 50% of women who think that they are fertile in the middle of the menstrual cycle. In the region, rates vary between 5% and 57%,[28] showing that adolescents and young people are in urgent need of reproductive health education. Moreover, prevention of child marriage, which leads to early pregnancies, is imperative. In the countries representing the majority of child marriages and early childbearing globally, 84% of children born to mothers aged under 18 are likely to be born from a child marriage,[29] while in six WCA countries, a girl who marries at 13 years will, on average, have 26% more children in her lifetime than if she had married at 18 years or later.[30]

[24] UNFPA WCARO. 2018. Adolescents and Youth Report: West and Central Africa. This statistic does not cover all WCA countries.
[25] Natacha Stevanovic Fenn et al. Child marriage, adolescent pregnancy and family formation in West and Central Africa. Patterns, trends and drivers of change. UNICEF 2015.

[26] UNFPA WCARO. 2018. Adolescents and Youth Report: West and Central Africa. Based on data from 18 WCA countries.
[27] UN DESA. 2020. Fertility among young adolescents aged 10 to 14 years. ST/ESA/SER.A/448. Advance Copy. It should be noted that actors report problems with data collection (especially for girls aged 10-12 years).
[28] Data source: Country briefs. UNESCO, 2021.
[29] Wodon, Q., C. Male, and A. Onagoruwa. 2017. A Simple Approach to Measuring the Share of Early Childbirths Likely Due to Child Marriage in Developing Countries. Education Global Practice. Washington, DC: The World Bank. Cited on page 4 of Wodon, Q., C.Male, A.Nayihouba, A.Onagoruwa,

A.Savadogo, A. Yedan, J.Edmeades, A.Kes,N. John, L. Murithi, M. Steinhaus and S.Petroni (2017). Economic Impacts of Child Marriage: Global Synthesis Report, Washington, DC: The World Bank and International Center for Research on Women.
[30] Statistics created from data table 3.1: Marginal and National Impacts of Child Marriage on Total Fertility p32 in Wodon, Q., C.Male, A.Nayihouba, A.Onagoruwa, A.Savadogo, A. Yedan, J.Edmeades, A.Kes,N. John, L. Murithi, M. Steinhaus and S.Petroni (2017). Economic Impacts of Child Marriage: Global Synthesis Report, Washington, DC: The World Bank and International Center for Research on Women.

Access to adolescent and youth-friendly SRH services

There are numerous obstacles to access to and use of SRH services in the region, in particular:
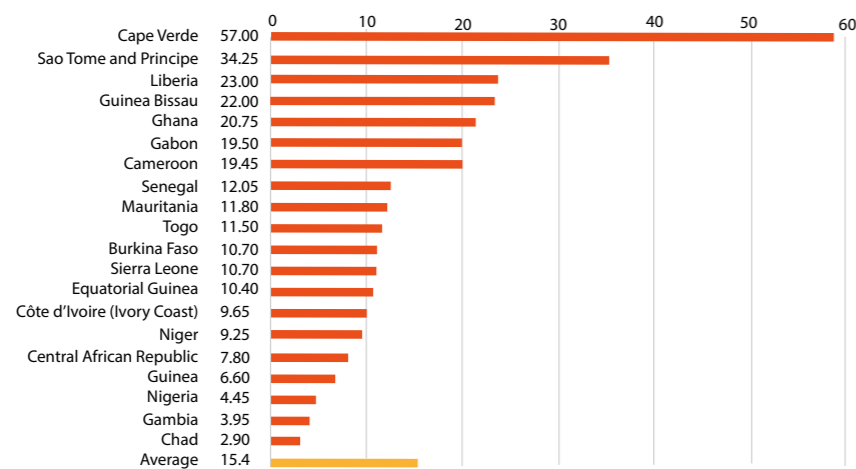
- Services that are often virtually non-existent or not easily accessible without means of transport (especially in rural areas).
- High costs of services in certain countries/ points of service that make them unaffordable for adolescents and young people.
- Negative attitudes of some healthcare providers or lack of training, supervision, and support for them.
- The culture and attitude of parents and the community, where the adolescent or young person needs consent from a parent or husband before accessing services.
- Services that are not adapted to the specific needs of adolescents and young people or service standards[31] that are not implemented.
- Weaknesses in reproductive health commodity procurement, storage, and distribution systems.
- A legal, policy, and social context that does not sufficiently safeguard the rights to education,

health, and protection of adolescents and young people.

- A legal and policy framework that is not always aligned with countries' national and regional commitments (Convention on the Elimination of All Forms of Discrimination against Women, African Charter on the Rights of the Child, etc.) As a result, local laws do not provide enough protection for the rights of the child and adolescents (especially girls), including the rights to education and to SRH.
- Limited information and knowledge on the part of adolescents and young people about their needs, SRH services, and how to access them.
- Stigma and discrimination of adolescents and young people.

The outcome of these obstacles is that only 15%[32] (unweighted average) of young women aged 15-24 who are married or in a union, or their sexual partner, use at least one contraceptive method, and all countries in the region, except Cabo Verde, have a rate of contraceptive use that is below 50%. Two-thirds of countries have a rate below 12%.[33]

Gaps also exist between age brackets, with the needs of adolescents aged 15-19 years being the least met. In Ghana, demand for contraception is met for 27% of those in the 20-24 years age bracket, but drops to 10% for those aged 15-19 years.[34] Rates also drop for women who are not in a union. In the Republic of Congo, for instance, the demand for contraceptives of 69% of married women aged 20-24 years is met, however, this rate drops to 33% for all women in this age bracket when unmarried women are included in the figure. Nevertheless, there has been progress. Of the 10 countries in the world that saw the highest increase in their rates of contraceptive use for the 15-49 age range, four are in WCA.[35]

High-impact interventions to reduce the prevalence of pregnancies among adolescents are necessary to improve maternal and child health and, generally, health and education outcomes. Effective interventions (refer to the section on programmes) include implementing quality CEI beginning in primary school, improving access to and use of SRH services adapted to adolescents and young people, and creating demand within this group.

Modern contraceptive prevalence rate among young women 15-24 years

Country	Value
Cape Verde	57.00
Sao Tome and Principe	34.25
Liberia	23.00
Guinea Bissau	22.00
Ghana	20.75
Gabon	19.50
Cameroon	19.45
Senegal	12.05
Mauritania	11.80
Togo	11.50
Burkina Faso	10.70
Sierra Leone	10.70
Equatorial Guinea	10.40
Côte d'Ivoire (Ivory Coast)	9.65
Niger	9.25
Central African Republic	7.80
Guinea	6.60
Nigeria	4.45
Gambia	3.95
Chad	2.90
Average	15.4

Source of data: ICF Macro, Demographic and Health Surveys 2005-2016 and UNICEF Multiple Cluster Indicator Surveys 2010-2016.

Photo credit: ©Plan International

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[31] For example, WHO and UNAIDS, Global standards for quality health-care services for adolescents. A guide to implement a standards-driven approach to improve the quality of health-care services for adolescents (Geneva, WHO, 2015).
[32] Data based on 20 countries in the region.

[33] UNFPA WCARO (2018). Adolescents and Youth Report: West and Central Africa.

[34] Ibid.
[35] Burkina Faso, Liberia, Senegal, and Sierra Leone. UN DESA, Population Division (2020). World Fertility and Family Planning 2020: Highlights (ST/ESA/SER.A/440).

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Maternal health

The same obstacles in terms of access to and use of SRH services exist for prenatal care, thereby affecting maternal health of adolescents. There is a direct connection between maternal mortality and access to health services, as seen in Gabon, which has one of the region's lowest maternal mortality rates for the 20-24 years age range, correlating with the highest percentage of childbirths in the presence of a trained health provider and access to prenatal care. In the rest of the region, the maternal mortality rate among adolescents aged 15-19 varies vastly from country to country, with only 8% of adolescent deaths linked to pregnancy in Burundi, for example, but more than 50% in Chad.[36] Giving birth in a care setting and in the presence of a trained health provider, whereby quality emergency obstetrical care can be received if necessary, also reduces the risk of obstetric fistulas, another maternal health-related complication. Fistula prevalence rates in the region are generally high, ranging from between 0.2 to nearly six women in 1,000, with three countries in the region having some of the highest rates in the world.[37]

EUP and child marriage – impacts and linkages[38,39]

- Complications during pregnancy and childbirth are the main cause of death among young girls aged 15-19 in the world.

- Adolescent mothers (10-19 years) are more exposed to eclampsia, puerperal endometriosis and systemic infections than women aged 20-24.

- The babies of adolescent mothers are more exposed to risks of low birth weight, premature delivery, and serious neonatal conditions.

75% of early pregnancies are associated with early marriage.
*Ending child marriage could reduce the fertility rate by 11%.*

Child marriage and EUP are linked to school dropout for girls.
Every additional year of secondary schooling can reduce the risk of child marriage by 6%.

Child marriage reduces the earnings of adult women by 9%.
Ending child marriage could reduce population growth and could generate more than 500 billion US dollars in benefits per year globally.

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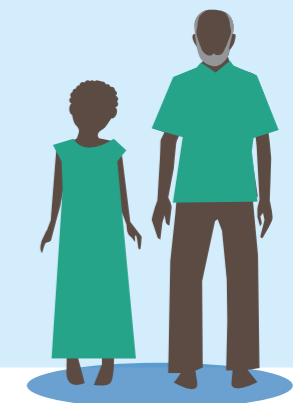
[36] Data source: Country briefs. UNESCO, 2021.
[37] Saifuddin Ahmed Erin Anastasi. Prevalence of Obstetric Fistula in 55 UNFPA Priority Countries. Johns Hopkins University UNFPA. Presentation.
[38] WHO. Global health estimates 2015: Deaths by cause, age, sex, by country and by region, 2000–2015. Geneva: WHO; 2016.

[39] Wodon, Q., C.Male, A.Nayihouba, A.Onagoruwa, A.Savadogo, A. Yedan, J.Edmeades, A.Kes,N. John, L. Murithi, M. Steinhausand S.Petroni (2017). Economic Impacts of Child Marriage: Global Synthesis Report, Washington, DC: The World Bank and International Center for Research on Women.

HIV and young people

Young people are continuing to acquire HIV in WCA. The total number of new HIV infections among young people aged 15-24 in the region was estimated to be 69,000 in 2019 and among these young women remain disproportionately affected (48,000 women aged 15-24 are infected versus 21,000 men).[40]

New infections among young people are the result of limited knowledge about HIV and limited access to preventive and care services, as well as to the context in which the youth live and interact (in particular culture, social norms, and peer pressure). In WCA, only 24% of boys and 22% of girls aged 15-19 have comprehensive HIV knowledge.[41]

The low level of knowledge (none of the countries in the region scored above 50% in terms of comprehensive HIV knowledge), and the fact that this knowledge is not improving over time in certain countries, highlights the need for good quality CEI starting at the primary level.
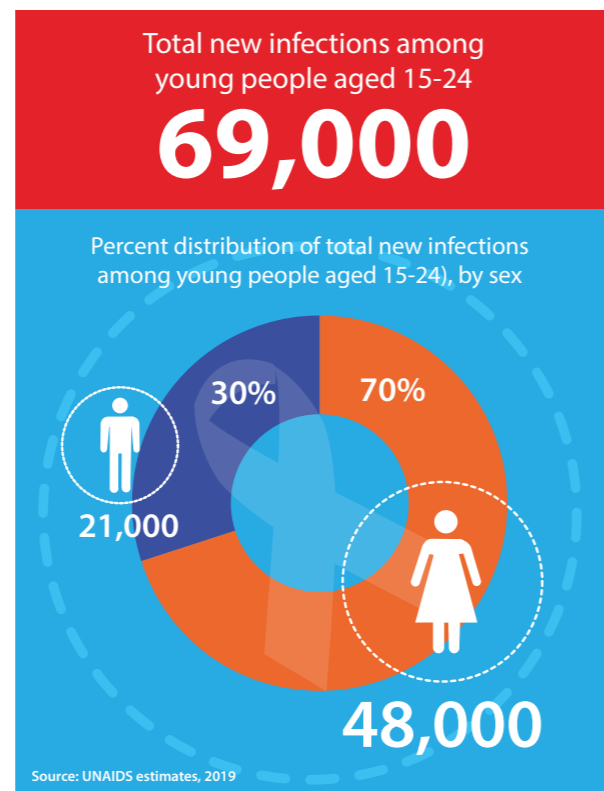
Total new infections among
young people aged 15-24

69,000

Percent distribution of total new infections
among young people aged 15-24), by sex

30%   70%

21,000

48,000

Source: UNAIDS estimates, 2019

Photo credit: ©Plan International

[40] https://aidsinfo.unaids.org/ (Consulted on 20 April 2020).
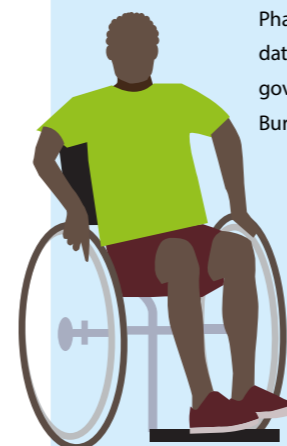[41] UNICEF. State of the World's Children. Statistical Tables 2019.

Adolescents and young people with disabilities – increased risk

Adolescents and young people with disabilities are among the most vulnerable and marginalized groups. They are less likely to be in school, have access to health services (due to physical and financial obstacles and lack of providers with training on disability), be empowered, or see their needs taken into account. Moreover, it is estimated that 80% of people with disabilities live below the poverty line.[42]

While adolescents and young people with disabilities also wish to engage in romantic and sexual relationships, they have a greater unmet need for health, nutrition, and welfare services, and are more likely to be stigmatized and discriminated against, and even excluded from SRH and other national health and education programmes and services.

Based on the limited data available, conclusions can be drawn about the vulnerability of people with disabilities, whatever their age. A survey[43] conducted in Burkina Faso, Cabo Verde, Guinea-Bissau, and Niger notes that HIV prevalence among people with disabilities was higher than that of the general population, and that people in this group also engaged in unsafe sexual practices. Other data points to socio-economic inequality, limited access to and use of health services, and an increased risk of violence for those with disabilities, including:

- Less frequent school attendance (48%).
- Difficulties getting jobs (38% of men and 49% of women are without their own income).
- A lack of financial resources, including access to services (66% have foregone care because they lack sufficient resources).
- Difficulties accessing information and preventive and care services (Barely 14% participated in an HIV prevention activity).
- Only 27% have taken an HIV test in their lifetime and only 55% have access to a condom if needed.
- 25% of women (14% of men) have been forced into having sexual intercourse.
- 75% of victims suffer from recurring violence.

Adolescents and young people with disabilities are further at risk in humanitarian and fragile situations, where access to and use of services are further limited.

"People do not think that the disabled are sexually active. It's a double taboo. Education, employability, sexuality, and even acceptability are a constant struggle for disabled youth."

Phadylatou Gouem, a young leader and data and information officer with a non-governmental organization (NGO), Burkina Faso.

[42] WHO and World Bank. 2011. World report on disability. Geneva: WHO.
[43] Humanity & Inclusion. HIV & Disability in West Africa: A combined analysis of 4 surveys conducted in Burkina Faso, Niger, Guinea Bissau and Cap Vert. 2019.
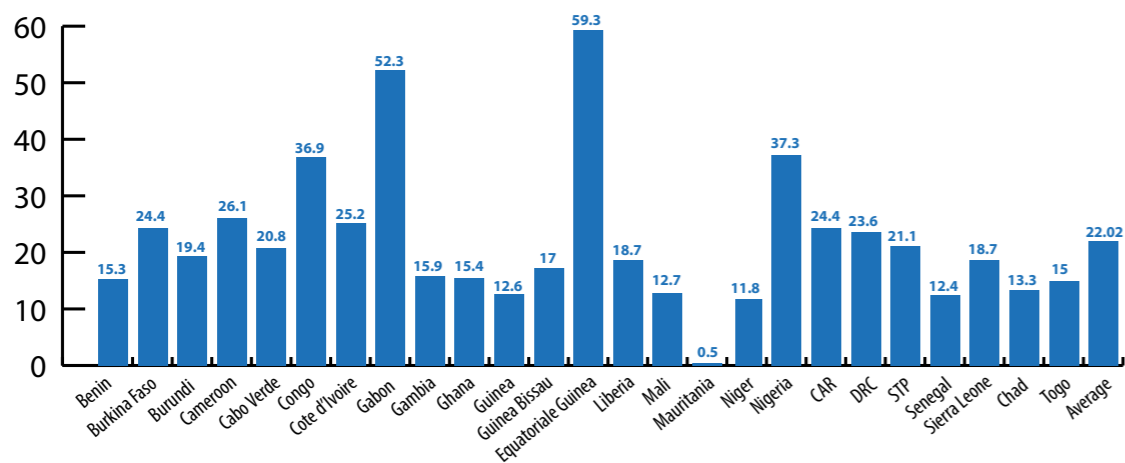
Substance use

In WCA, alcohol and tobacco use among adolescents and young people is higher than that of illegal drugs. Adolescents aged 15-19 tend to consume less alcohol than the total population, but this gap disappears for and, in sub-Saharan Africa, increases for those in the 20-24 age range.[44] Alcohol consumption rates in WCA in countries where alcohol sale is allowed) among 15-19-year-olds vary from 11.8% to 59%.

Tobacco is often the first substance used by adolescents and young people. In sub-Saharan Africa, 18% of youth aged 15-24 (21% of boys and 13% of girls) used tobacco in the previous month,[46] while the percentage of adolescents aged 13-15 who use tobacco varies between 8% and 26%.[47]

Although there are gaps in the data on substance use in WCA, cannabis is the substance most used by the youth (and the general population) across all regions of the world, after alcohol and tobacco, with the highest prevalence in WCA, North America, and Oceania.[48] Nevertheless, use rates vary considerably across regions and countries.[49] In one of the countries in the region, for instance, it is estimated that 24% of young people used cannabis in the past month,[50] while student surveys in the region show that between 1% and 9% of adolescents aged 13-17 have used marijuana one or more times in their life.[51] There is very limited data on the use of other substances, but it is estimated that at least 5-10% to 19% of boys aged 13-15 have already used amphetamine-type stimulants.[52]

WHO, alcohol consumption over the past 12 months, % of 15-19-year-olds[45]

Country	Value
Benin	15.3
Burkina Faso	24.4
Burundi	19.4
Cameroon	26.1
Cabo Verde	20.8
Congo	36.9
Cote d'Ivoire	25.2
Gabon	52.3
Gambia	15.9
Ghana	15.4
Guinea	12.6
Guinea Bissau	17
Equatoriale Guinea	59.3
Liberia	18.7
Mali	12.7
Mauritania	0.5
Niger	11.8
Nigeria	37.3
CAR	24.4
DRC	23.6
STP	21.1
Senegal	12.4
Sierra Leone	18.7
Chad	13.3
Togo	15
Average	22.02

[44] WHO. 2018. Global status report on alcohol and health 2018.
[45] https://www.who.int/data/gho/data/indicators/indicator-details/GHO/15-19-years-old-current-drinkers-(-) (Consulted on 10 April 2020).
[46] WHO AFRO. 2014. Towards Tobacco Free Young People in the African Region.
[47] Global Youth Tobacco Survey: Togo 2013 and Sao Tomé-and-Principe 2010.
[48] UNESCO. 2018. Good Policy and Practice in Health Education. Booklet 10 Education sector responses to the use of alcohol, tobacco and drugs.
[49] UNODC. 2015. Word Drug Report 2015. Vienna: UNODC.
[50] https://dataunodc.un.org/drugs/prevalence_youth-2017 (Consulted on 07 April 2020).
[51] Global Student Health Survey Benin 2016 and Ghana 2012.
[52] UNESCO. 2018. Good Policy and Practice in Health Education. Booklet 10 Education sector responses to the use of alcohol, tobacco and drugs.

Photo credit: ©FFMuskoka/V.Tremeau

Impact of substance use (alcohol, tobacco and others)

Substance use is detrimental not only to health but also to education. Among others, tobacco is linked to breathing problems, cannabis to respiratory diseases and mental health issues, alcohol to health challenges such as alcoholic cirrhosis, hepatitis, and cancer in adulthood, as well as to cognitive effects. Globally, substance use is associated with school failure and dropout or failure to complete secondary and post-secondary education. Moreover, risky health behaviours (including sexual risks), as well as delinquency and violence, are linked to alcohol and drug use among adolescents and young people in low- and middle-income countries.[53]

Although non-communicable diseases generally do not affect adolescents and young people, the risk factors for these diseases, such as smoking, harmful alcohol and drug use, unhealthy eating, and physical inactivity, often start in adolescence. The risk of non-communicable diseases is growing worldwide (today they are the leading cause of mortality among adults), and it is during adolescence that preventive measures are most effective and health behaviours are adopted.

Photo credit : ©FFMuskoka/V.Tremeau

Mental health

The World Health Organization (WHO)[54] notes that self-destructive behaviours (including suicide) are the second cause of mortality among older adolescents. Although the impact and prevalence of mental and behavioural disorders have not been properly quantified in Africa, and even less so in WCA, global estimates point to an increase in cases of mental disorders.

Given that mental disorders also affect adolescents and young people and that they can be linked to increased substance use and risky sexual and non-sexual behaviours, a holistic response to the needs of adolescents and young people is required. This is particularly important in light of the WHO estimate that half of mental health problems start at age 14 and for the most part go undetected and untreated.[55] Childhood and adolescence are therefore key moments in the development of an individual to equip them, through life skills-based education, with resilience and the tools they need to stay healthy.

Impact of endemic diseases on the education and health of adolescents and young people

Adolescents and young people's education is affected both by their own health and by the national health situation, such as the presence of endemic diseases such as COVID-19 and Ebola. These can have a major impact on the education system, as is the case with COVID-19, which resulted in, among other things, school closures, the interruption of school feeding programmes, a reduction in likelihood of continuing their studies for the most vulnerable, greater inequalities, reduced learning, and increased risk of EUP, child marriage,[56] violence, and school drop-out for economic reasons, while affecting the physical and mental health of students.

Photo credit: ©Plan International

In May 2020, during the COVID-19 epidemic, 23 WCA countries closed their Early Childhood Development (ECD) centres, primary and secondary schools, and universities, leaving more than 114 million learners affected.[57] Distance learning is only accessible to those who have internet access and whose school and teachers have the resources to work in this manner, however, for the most part, the region's education systems have limited resilience and have neither the resources nor the capacity to quickly put in place an alternative system. Even without digitalization, distance learning, for example through homework, is complicated for students without access to essential resources such as textbooks. Moreover, many will be penalized and will fall behind if their families or relatives are unable to assist them. COVID-19 has highlighted the importance of planning and being prepared for all contingencies, which is why it is so important to identify alternative processes, including through digitalization. In a globalized world, risks do not disappear; they increase. A large number of those interviewed for this report also note the impact of COVID-19 on their own activities and at the organizational level. The pandemic has not only reduced the funding available for activities, but also prevents gatherings, trainings, and participation.

[53] UNESCO. 2018. Good Policy and Practice in Health Education. Booklet 10 Education sector responses to the use of alcohol, tobacco and drugs.

[54] WHO. 2018. Global accelerated action for the health of adolescents (AA-HA!) Guidance to support country implementation.
[55] https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health (Accessed 15 June 2019).
[56] Plan International and Girls Not Brides. August 2020. Joint Policy brief. COVID-19 and child marriage in West and Central Africa. https://plan-international.org/publications/covid-19-child-marriage-west-central-africa.

[57] Does not include Burundi, which did not shut down its educational institutions, and Benin, which was partially open in that month. Data from 14/05/2020. https://en.unesco.org/covid19/educationresponse (Consulted on 27 January 2021).

Gender Equality

> "Gender inequality is a major obstacle. Society is still biased in favour of men. Social and cultural norms stigmatize women as being the 'weaker' sex and, in some cases, still consider that the woman's place is in the kitchen."

Mr. Francis Aniagyei, Teacher, Ghana

The Organization for Economic Cooperation and Development's (OECD's) Social Institutions and Gender Index (SIDI),[58] which measures discrimination against women, taking into consideration laws and social norms and practices, shows high and very high levels of discrimination in the region. In WCA, gender inequalities[59] affect access to information and health services and access to education and school retention. It also affects health and well-being through, among other things, social norms and peer pressure. Discrimination within families, attacks on the physical integrity of girls, limited access to productive and financial resources, and restrictions on civil liberties are manifestations of discrimination,[60] and all underscore the importance of reducing gender inequality to promote equality and improve the health and well-being of girls as well as boys.[61]

"**Gender norms**[62] are a subset of social norms that relate specifically to gender differences. They are informal, deeply entrenched, and widely held beliefs about gender roles, power relations, standards or expectations that govern human behaviours and practices in a particular social context and at a particular time. They are ideas or 'rules' about how girls and boys and women and men are expected to be and to act.

People internalize and learn these 'rules' early in life.[63] Gender norms sustain a hierarchy of power and privilege that typically favours what is considered male or masculine over that which is female or feminine, reinforcing a systemic inequality that undermines the rights of women and girls and restricts opportunity for women, men, and gender minorities to express their authentic selves."[64]

Photo credit: ©Plan International

Adolescence is a period of human development when norms related to gender are reinforced, and when these gender and other social norms bring about increased health risks (peer pressure, toxic masculinity, GBV, among others), at the very time when adolescents usually have the least access to preventive and curative services.

Child marriage

Child marriage further exposes girls to domestic violence, STIs, including HIV, and reduces access to education and jobs. It is also closely linked to early pregnancies in WCA. In the region, marrying young is associated with reduced use of modern contraceptives, as well as with higher fertility.[65] A number of factors affect the rate of child marriage, including the historical and cultural dimension of marriage, as well as economic and social contexts. These include gender norms and roles, as well as social expectations and obligations. Poverty, education costs, and the need to ease the financial load of a child and supplement household income are major contributory factors to the high rate of child marriage as well.[66]

[58] Social Institutions and Gender Index - OECD's SIDI.
[59] Gender equality refers to the equal rights, responsibilities and opportunities of women and men and girls and boys. Equality does not mean that women and men will become the same but that women's and men's rights, responsibilities and opportunities will not depend on whether they are born male or female. UN Women, Training Centre Glossary. (Consulted on 4 November 2020).
[60] UNICEF (May 2019). Adolescent girls' health and well-being in West and Central Africa.
[61] For more details, see Viner, R. M., et al. (2012). Adolescence and the social determinants of health. The Lancet, 379: 1641–52.
[62] UNICEF Technical Note on Gender Norms. https://www.unicef.org/

media/65381/file/GP-2020-Technical-Note-Gender-Norms.pdf.
[63] UN Women Training Centre, 'Gender Equality Glossary', https://trainingcentre.unwomen.org/mod/glossary/view.php?id=36.
[64] Heise, Lori, Greene, Margaret E, Opper, Neisha, Stavropoulou, Maria, Harper, Caroline, Nascimento, Marcos, and Zewdie, Debrework, on behalf of the Gender Equality, Norms, and Health Steering Committee, 'Gender inequality and restrictive gender norms: Framing the challenges to health', The Lancet, vol. 393, pp.2440–2454, 2019, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)30652-X/fulltext.

[65] ICRW, UNICEF: Child marriage, Adolescent Pregnancy and Family Formation in West and Central Africa- Patterns, Trends and Drivers of Change. UNICEF, 2015.
[66] Ibid. et, Malhotra, A., et al. (2011). Solutions to end child marriage: What the evidence shows. The International Center for Research on Women, Washington DC.
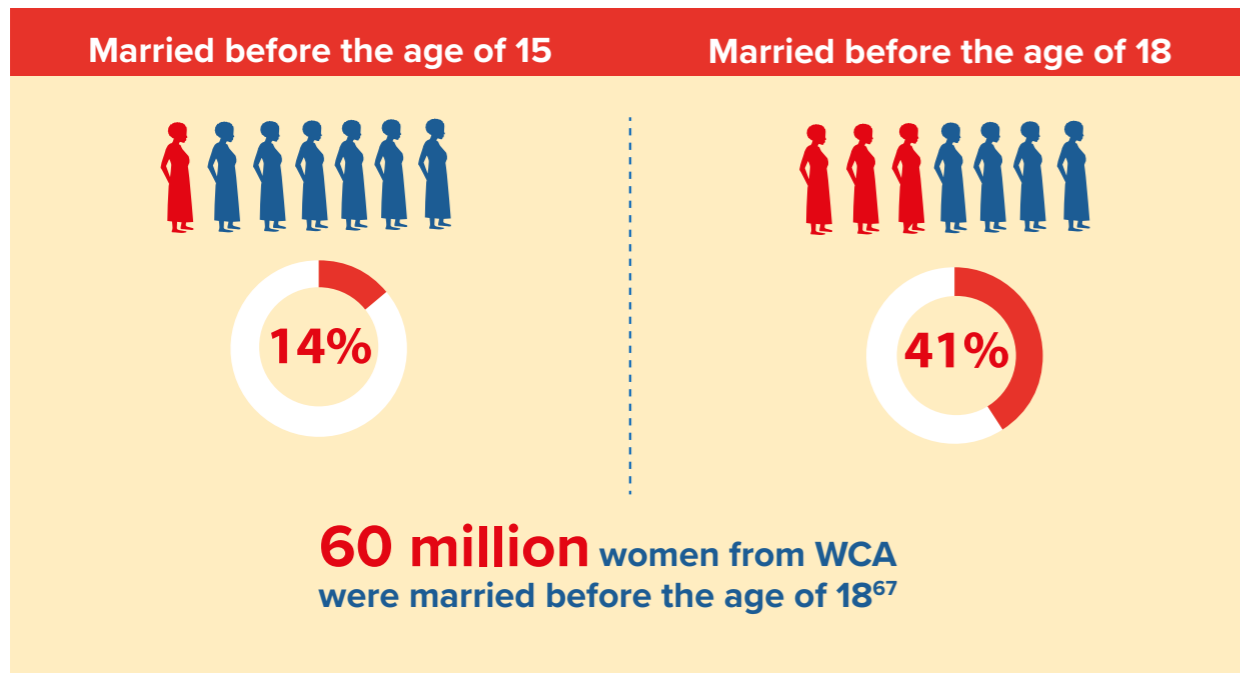
Married before the age of 15

14%

Married before the age of 18

41%

60 million women from WCA were married before the age of 18[67]

Girls in WCA face the highest risk globally of marrying in childhood,[68] with six of the 10 countries with the highest prevalence of child marriage in the world located in the region.[69] However, there is a wide disparity in rates between countries. For example, the rate of girls who marry at 14 or younger varies between 2% and 30%. Furthermore, even though there has been a slow decline in the prevalence of child marriage in the region since 1990, from 52% to 41%, population growth will lead to an increase in the number of girls married before the age of 18. Indeed, it is estimated that if the current prevalence is maintained, the number of girl-brides will reach 20.8 million by 2050.[70]

Photo credit: ©FFMuskoka/V.Tremeau

Child marriage – progress in the region[71]

Gabon, the Gambia, Ghana, Guinea Bissau, and Togo have all seen declines in the rates of child marriage. Based on measures adopted in several countries and the progress made, lessons can be drawn on what is effective and what the key success factors are.

Effective interventions
- Girls' empowerment (providing them with knowledge, developing their skills, and building a support network).
- Educating and mobilizing parents and members of the community.
- Improving access to, and the quality of, education.
- Interventions aimed at promoting education, including: money transfer, scholarships, free school uniforms, fees reduction, teacher training, and life skills education.
- Economic assistance to girls and their families.
- A legal and policy framework conducive to and more protective of health and reproductive rights.

Success factors
- A strong political commitment at the national and regional levels, such as the *African Union Campaign to End Child Marriage*.
- At the national level, a legal and policy framework that is protective, fully implemented, and harmonized with regional and international human rights treaties.
- A national strategy and a detailed action plan.
- Investments in the education and health of adolescents and young people, in particular young girls.
- Large-scale implementation of interventions based on best practices.

[67] UNFPA/UNICEF WCARO. Child marriage in West and Central Africa. At a Glance September 2018.
[68] UNICEF (May 2019). Adolescent girls' health and well-being in West and Central Africa.

[69] UNFPA/UNICEF WCARO. Child marriage in West and Central Africa. At a Glance September 2018.
[70] Ibid.

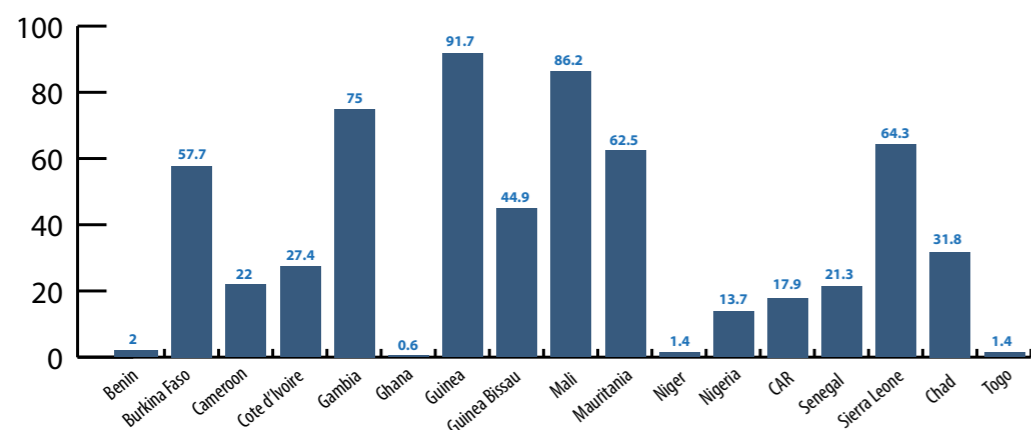[74] Data source: Country briefs. UNESCO, 2021.

Female genital mutilation and cutting

The region is home to 18 countries that practice female genital mutilation or cutting (FGM/C). In some countries, only certain ethnic groups practice FGM/C and at variable levels of intensity.[72] In others, FGM/C prevalence has declined, including Côte d'Ivoire, Mali, Niger, and Nigeria. Furthermore, the United Nations Children's Fund (UNICEF) notes that in some countries "the generational trend is clearly towards ending the practice". This trend is noted in Benin, Burkina Faso, Côte d'Ivoire, Niger, Nigeria, and, to a lesser extent, Sierra Leone.[73]

> **The term FGM/C refers to all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for cultural or other non-medical reasons.**

FGM/C prevalence rate in WCA

Country	Prevalence
Benin	2
Burkina Faso	57.7
Cameroon	22
Cote d'Ivoire	27.4
Gambia	75
Ghana	0.6
Guinea	91.7
Guinea Bissau	44.9
Mali	86.2
Mauritania	62.5
Niger	1.4
Nigeria	13.7
CAR	17.9
Senegal	21.3
Sierra Leone	64.3
Chad	31.8
Togo	1.4

Nevertheless, data from the region's 17 countries on the prevalence of FGM/C still shows a very high rate in some countries, especially in rural areas. In six countries, prevalence exceeds 50%, and in one country nearly 92% of girls aged 15-19 are subjected to FGM/C.[74]

UNICEF[75] notes that FGM/C is rooted in cultural conventions linked to gender, sexuality, marriage, and family, and influences how the practice is considered and tolerated in different contexts. For instance, FGM/C is often considered as a necessary step in the education and protection of the girl child, allowing her to marry. This explains the importance of an approach that goes beyond presenting the practice in a negative and critical light. In countries like Guinea and Nigeria, for example, FMG/C is often associated with child marriage, with those who marry after 18 less at risk.[76] The daughters of women with no education or those who tend to justify violence are also at higher risk, showing the link between education, poverty, and FGM/C.

Declining rates of FGM/C

A decline in the prevalence of FGM/C among children aged 0-14 is evident across the continent, showing the effectiveness of certain interventions. This is clearly demonstrated in West Africa, where FGM/C rates dropped sharply from 74% in 1996 to 25% in 2017.[77] The interventions that drove this decline include the passing of national laws against the practice (for example in Benin, Guinea-Bissau, and Togo), as well as strong political will and high-level spokespersons (such as in Nigeria, where the national response was launched by the vice-president's wife on behalf of the office of the first lady, and at the regional level by the wives of five state governors).

A number of lessons can be drawn[78] from the regional experience, such as:
- Target investments/interventions based on evidence about patterns of FGM/C and the specific locations where it is practiced (understanding local variations in FGM/C).
- Focus abandonment efforts on family and community members who decide whether girls are subjected to FGM/C, including fathers, health workers, traditional cutters, traditional birth attendants, and religious and community leaders.
- Strengthen the capacity of health care and law enforcement professionals to address FGM/C effectively.
- Prevent the medicalization of FGM/C.
- Strengthen linkages among the legal, education, and health sectors, and develop multi-sectoral responses that rely on existing institutions and functions, and are implemented at decentralized levels.

- Put in place an appropriate legal framework. Laws are necessary but require social legitimacy to be effective and continued efforts to ensure that their provisions are known and enforced.
- Support local research capacities to guarantee that FGM/C responses are rooted in reliable evidence and suited to the local context.

FGM/C and its social and cultural bases are evolving. In many countries, young women and men are less likely than their elders to believe that FGM/C should continue, that it is required by religion, or that the practice is necessary to maintain a woman's chastity and fidelity.[79] Continuous efforts are required to strengthen this generational trend.

Photo credit: ©Plan International

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[72] UNFPA technical division: Demographic Perspectives on Female Genital Mutilation, page 21; UNFPA New York.
[73] UNICEF: West and Central Africa - Overview of cutting/female genital mutilation. Consulted in October 2017.
[74] Data source: Country briefs. UNESCO, 2021.
[75] UNICEF Innocenti Research Centre. November 2010. Dynamics of social

change towards the abandonment of cutting/female genital mutilation in five African countries.
[76] UNFPA technical division: Demographic Perspectives on Female Genital Mutilation, page 21; UNFPA New York.

[77] Kandala N-B, Ezejimofor MC, Uthman OA, et al. Secular trends in the prevalence of female genital mutilation/cutting among girls: a systematic analysis. BMJ Glob Health 2018;3:e000549. doi:10.1136/bmjgh-2017-000549.
[78] Evidence to End FGM/C. Reflections from Five Years of Research. https://www.popcouncil.org/uploads/pdfs/2020RH_FGMC_ReflectionsFiveYears.pdf.

[79] UNICEF Innocenti Research Centre. November 2010. Dynamics of social change towards the abandonment of cutting/female genital mutilation in five African countries.

Harassment, violence, and GBV – a widespread problem

Harassment, violence, and GBV are prevalent in WCA and happen anywhere: at school, at home, online, or in the community. It should be noted that available data falls far short of real cases. This is mainly because it is a taboo topic, there is a culture of silence, and reporting mechanisms are ill-adapted. Of grave concern, the prevalence of harassment at school is 48%,[80] and sub-Saharan Africa is one of the only regions in the world where rates of harassment at school have in fact increased. Sexual violence in schools continues to be a problem in several countries across the region as well.

- In Nigeria, 27% of boys reported that their first instance of sexual violence was perpetrated by a classmate or schoolmate (versus 13% of girls).

"Those who turn a blind eye or deaf ear saying, it's a private matter, know that you too are accomplices to violence... Because of these attitudes, millions of women and girls face the threat of violence and rape every day."

UN Deputy Secretary General
Amina Mohammed

- In Central Africa, the prevalence of women reporting that their first non-consensual sexual act was committed by a teacher is between 0% and 7%. It is much lower in West Africa, at between 0.3% and 1.9%.
- More than 6% of women aged 15 years and older in WCA reported having suffered physical violence perpetrated by a teacher.[81] Of note, however, is that in nearly half of the countries in WCA, corporal punishment in school is not prohibited.[82] While data for the region is incomplete, the prevalence of physical violence perpetrated by teachers is high in sub-Saharan Africa, generally, although there is significant variation between countries.

GBV, an endemic problem in the region, is aggravated by permissive gender norms. For instance, the percentage of adolescents who claim that a husband is justified in beating his wife is 37% for men and 45% for women[83] in WCA. This is borne out by the fact that of the five countries in the world with the highest rates of women aged 18-29 who have had forced sex before the age of 18, four are in WCA (Cameroon, DRC, Gabon, and Ghana).

Photo credit: ©FFMuskoka/V.Tremeau

Individuals aged 10-24 are especially at risk in humanitarian conflict or fragile contexts, and are often the target of violence. One survey found, for example, that 60% of children were under 15 years and 10% under 12 years when they were recruited into an armed group.[86] With regard to sexual violence specifically, the rate in the DRC (18% of girls under the age of 22 have suffered sexual violence) is one of the highest in the region.

In terms of online bullying, a rapidly increasing global problem, there is very limited data for WCA (see table below). Most of the data is from Europe and the United States and show that this type of bullying affects up to one in 10 children, with older students being more exposed than younger ones. Moreover, the problem is growing: the share of children aged 11-16 who use the internet and have already suffered online bullying increased from 7% in 2010 to 12% in 2014.[87] It is likely that with accelerating access by youth to information and communications technologies (ICTs) in the region (see section on ICTs below), these levels of bullying will increase.

"Gender-based violence: Violence against someone based on gender discrimination, gender role expectations and/or gender stereotypes; or based on the differential power status linked to gender that results in, or is likely to result in, physical, sexual or psychological harm or suffering."[84]

"There are many forms of violence, including (but not limited to) physical, verbal, sexual, psychological, and socio-economic violence."[85]

Online bullying – a growing problem

• 45% of women aged 18-45 have already experienced a form of gender violence while using social media.	• 34% of participants report that they have been victims of online bullying. • 39% say they know private online student groups in which kids share information about others in order to bully them.	• 54% of participants in Africa report that they have been victims of online bullying. • One in four girls bullied online feel they are in physical danger.
A survey of women aged 18-45 on Facebook and Twitter.[88]	U-report poll of 170,000 U-Reporters aged 13-24[89] in 30 countries (including eight in WCA).	Poll[90] of 14,000 girls in 31 countries (including four in WCA, 10 for the entire region) on several continents.

80 UNESCO. 2019. Behind the numbers: ending school violence and bullying.
81 UNICEF. 2019. State of the World's Children Statistical Tables.
82 UNICEF A Familiar Face: Violence in the lives of children and adolescents, UNICEF, New York, 2017.

83 Data source: Country briefs.

84 UNESCO. 2018. Revised edition. International guidelines on sexuality education. An evidence-informed approach.
85 UN Women, UN Women, Training Centre Glossary (Consulted on 10 November 2020).
86 A survey conducted by the ILO in cooperation with UNICEF in four countries, including Congo-Brazzaville, cited by UNFPA WCARO (2018). Adolescents and Youth Report: West and Central Africa.
87 UNESCO. 2019. Behind the numbers: ending school violence and bullying.
88 Covering the following countries: Benin, Burkina Faso, Cameroon, Côte d'Ivoire, DRC, Gabon, the Gambia, Ghana, Guinea Conakry, Liberia, Mali,

Mauritania, Niger, Nigeria, Republic of Congo, Senegal, Sierra Leone, and Togo. 2019. Internet Without Borders https://internetwithoutborders.org/jif2019-les-cyberviolences-sexistes-touchent-45-de-femmes-sur-les-reseaux-sociaux-en-afrique-centrale-et-occidentale/ (Consulted on 10 April 2020).
89 UNICEF https://www.unicef.org/press-releases/unicef-poll-more-third-young-people-30-countries-report-being-victim-online-bullying (Consulted on 10 April 2020).
90 Plan International. 2020. Free to be online? Girls' and young women's experiences of online harassment. https://plan-international.org/publications/freetobeonline.

Humanitarian conflict and fragile contexts

Adolescents and young people are especially vulnerable in health crises (epidemics), and humanitarian, conflict and fragile contexts. They are at higher risk of being exposed to STIs, including HIV, GBV, child marriage, and various forms of violence. Adolescents are especially at risk of sexual exploitation, rape, and human trafficking.[93] Adolescents and young people are also at risk of being recruited into an armed group. Access to education in these contexts is especially difficult and often results in school dropout or failure. Often, in these contexts, adolescents and young people find themselves in a situation of vulnerability and precariousness without the necessary skills to make sound decisions, and without resources (intellectual, material, and financial) that would enable them to support themselves. Access to health services in these contexts is also limited and quality is often affected, while an increased rate of mental disorders, with limited services that are adapted to the needs of individuals aged 10-24 years, is common.

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Access to and use of ICTs

Currently, only a quarter of the sub-Saharan African population has internet access.[91] Furthermore, the low rate of cell phone ownership limits mobile internet adoption and there is a gender gap in internet access. However, it should be noted[92] that in West Africa, mobile phone is the main platform used to access the internet, and by the end of 2018 the region had 185 million mobile phone subscribers, which is equivalent to 48% of the population. This number is projected to reach 248 million by 2025. The region also had nearly 100 million mobile internet users, which is projected to reach 183 million by 2025. Moreover, future growth will largely be driven by young consumers owning a mobile phone for the first time (more than 40% of the region's population are aged under 18 years), which will lead to a shift in consumer mobile engagement (voice-centric engagement for older users, and data-centric services such as gaming, streaming, etc. for younger consumers).

Photo credit: ©Plan International

[91] GSM Association. 2019. The State of Mobile Internet Connectivity 2019.
[92] GSM Association. The Mobile Economy West Africa 2019. https://www.telepin.com/gsma-report-the-mobile-economy-west-africa-2019/.

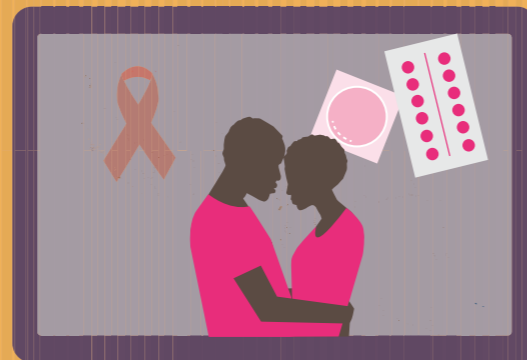[93] Plan International. 2018. Adolescent Girls in Crisis: voices from the Lake Chad Basin. https://plan-international.org/publications/adolescent-girls-crisis-lake-chad-basin.

Effective programmes

There are wide variations between countries on most of the indicators and on implementation of responses adapted to the needs of adolescents and young people. These variations should not obscure the fact that these indicators reveal concerns common to most, if not all, countries. The variations can show progress or the realities on which to build, strengthen or encourage action, through (inter alia) stronger political commitment.

Whatever the context, responses must be based on convincing evidence. International research has identified many interventions that are effective, and others that are not,[94] when it comes to having an impact on behaviour change and the use of SRH services by adolescents and young people (10-24 years.

Effective interventions include:
- Health services adapted to the needs of adolescents and young people.
- A policy of pre-service and continuing training of healthcare providers focused on the health of adolescents and young people.
- Training health care providers on SRH services adapted to the needs of adolescents and young people, combined with formative supervision and support to providers.
- Integration of HIV and SRH services, including contraception and family planning.
- CEI in and out of schools.
- CEI training for teachers, combined with onsite formative supervision and support for staff.
- Participation of adolescents and young people, parents/guardians, the community, and religious and community leaders in programmes for CEI and SRH services.

Others, such as service provision in youth centres, peer education, and one-off public meetings have generally been ineffective in facilitating young people's access to SRH services, changing their behaviours, or influencing social norms around adolescent SRH.[95]

A review of interventions notes that the approaches that have been found to be effective when well implemented, such as CSE and youth-friendly services, have tended to flounder as they have considerable implementation requirements that are seldom met.[96] There are other obstacles too, for example the social, legal, and political environment. However, evidence in the region does provide a range of possible solutions.

Sexual and reproductive health services adapted to adolescents and young people

> "Healthcare providers are not trained, young people do not receive services, there are problems of access, confidentiality, and communication is ill-adapted. Young people are considered as a homogeneous group, disregarding their differences and specific characteristics. It is therefore very difficult for a disabled youth."
>
> Phadylatou Gouem, a young leader and data information officer with an NGO, Burkina Faso.

[94] Venkatraman Chandra-Mouli et al., "Twenty years after International Conference on Population and Development: where are we with adolescent sexual and reproductive health and rights?", Journal of Adolescent Health, vol. 56, S1eS6 (2015); Venkatraman Chandra-Mouli et al., "What does not work in adolescent sexual and reproductive health: a review of evidence on interventions commonly accepted as best practices", Global Health: Science and Practice, vol. 3, No. 3 (2015), pp. 333–340; World Health Organization (WHO) and Joint United Nations Programme on HIV and AIDS (UNAIDS), Global standards for quality health-care services for adolescents. A guide to implement a standards-driven approach to improve the quality of health-care services for adolescents (Geneva, WHO, 2015).

[95] Venkatraman Chandra-Mouli et al., "What does not work in adolescent sexual and reproductive health: a review of evidence on interventions commonly accepted as best practices", Global Health: Science and Practice, vol. 3, No. 3 (2015), pp. 333–340.

[96] Ibid.

Effective programmes

Although, most countries in the region have adolescent and youth policies or strategies, most of these are not implemented because of limited human and financial resources. However, all countries in the region are working to improve quality, access to, and use of SRH services. On the whole, national responses are driven by global standards developed[97] by the WHO to improve service quality, as well as by implementation criteria for health centres that take in adolescents and young people.

SRH services should, among other things, be accessible, acceptable, equitable, appropriate, and effective. In a recent study[98] on the key elements for the implementation of SRH services adapted to adolescents and young people in WCA, evidence, promising practices, and key components are identified, along with three essential aspects, namely creating an enabling environment, the need for demand creation, and technical considerations.

Creating an enabling environment requires:
- Ownership and leadership from the government.
- An appropriate and enabling legal and policy environment, which implies ensuring the dissemination and full implementation of laws and legal instruments.

Photo credit: ©FFMuskoka/V.Tremeau

- Proper coordination and collaboration within and across sectors and with development partners, NGOs) at the national, regional and local levels, university and research institutions, the private sector, and communities.

Demand creation requires:
- Participation, awareness-raising, and empowerment of adolescents and young people.
- CEI implemented on a large scale and linked to SRH services.
- Referral systems to service delivery points.
- Awareness-raising and mobilization of parents, communities, and community and religious leaders.
- Use of ICTs.

Technical considerations cover:
- Which service delivery points (SDP) will implement services.
- The minimum package of services for adolescents and young people to be implemented at each level and for each SDP type.
- Development of norms and standards per SDP type.
- Building the capacities of healthcare providers through training, supervision, and support.
- Information, education, and social and behavioural change communication (SBCC) campaigns. The need to change attitudes is essential, and includes the need to address gender inequalities; socio-cultural barriers; the reasons why adolescents and young people do not use services; and preconceived ideas about contraceptives and family planning and their side effects.
- Efficient supply and management of commodities.
- Monitoring and evaluation (M&E).

Quality CEI in and out of schools

Adolescents and youth, parents, the community and religious and community leaders

Integrated and quality adolescent and youth-friendly SRH services

Enabling legal and policy environment

Comprehensive education and information

In WCA, as in other regions of the world, education systems are evolving. Many countries are initiating national reforms to develop skills-based approaches aimed at ensuring that adolescents and young people acquire the skills necessary to meet the demands of a changing work and social environment.[99] CEI is part of this shift towards a student-centric and transformation-driven approach to education. It helps develop, among others, critical thinking, problem-solving, decision-making, negotiating, and communication skills, as well as resilience, respect for diversity, and equality that empower students to take responsibility for and control their actions and help them become healthy, responsible, productive citizens.[100] CEI

therefore meets the needs of students in the 21st century. It is one of the key components of health education and well-being, and of school health programmes and policies.

> "Silence in the name of modesty can lead to suicide; let's break the taboo and discuss sexuality with young people."
>
> Imam Talouta Dioni, Burkina Faso

97 WHO and UNAIDS, Global standards for quality health-care services for adolescents. A guide to implement a standards-driven approach to improve the quality of health-care services for adolescents (Geneva, WHO, 2015).

98 UNFPA WCARO. 2019. Adolescent and Youth Sexual and Reproductive Health and Rights Services Key elements for implementation and scaling up in West and Central Africa.

99 While this vision to transform the education sector is well entrenched in national policy papers, its translation into practice for the purpose of changing teaching and learning methodologies is still in its infancy in most countries, and in others yet to be considered.

100 Global Education Monitoring Report, UNESCO. June 2019. Policy Paper 39. Facing the facts: the case for comprehensive sexuality education.

Photo credit: ©FFMuskoka/V.Tremeau

WCA countries have been teaching different components of CEI for decades through programmes often referred to as "family life education", "life skills education" or "prevention education". These programmes were developed to respond to specific needs such as HIV prevention. Nevertheless, data, for instance on comprehensive knowledge of HIV, shows the scant progress made. Consequently, most governments in the region have initiated, in cooperation with national stakeholders, a process to update and improve these programmes.

CEI is a curriculum-based process of teaching and learning about the cognitive, emotional, physical, and social aspects of sexuality. CEI must be scientifically accurate and be based on human rights and gender equality. It should be delivered systematically to students over the long term, from an early age, with age-appropriate learning objectives. International guidelines on CEI[101] identify the eight key concepts that should be covered: relationships; values, rights, culture and sexuality; understanding of the concept of gender; violence and staying safe; skills for health and well-being; human body and development;
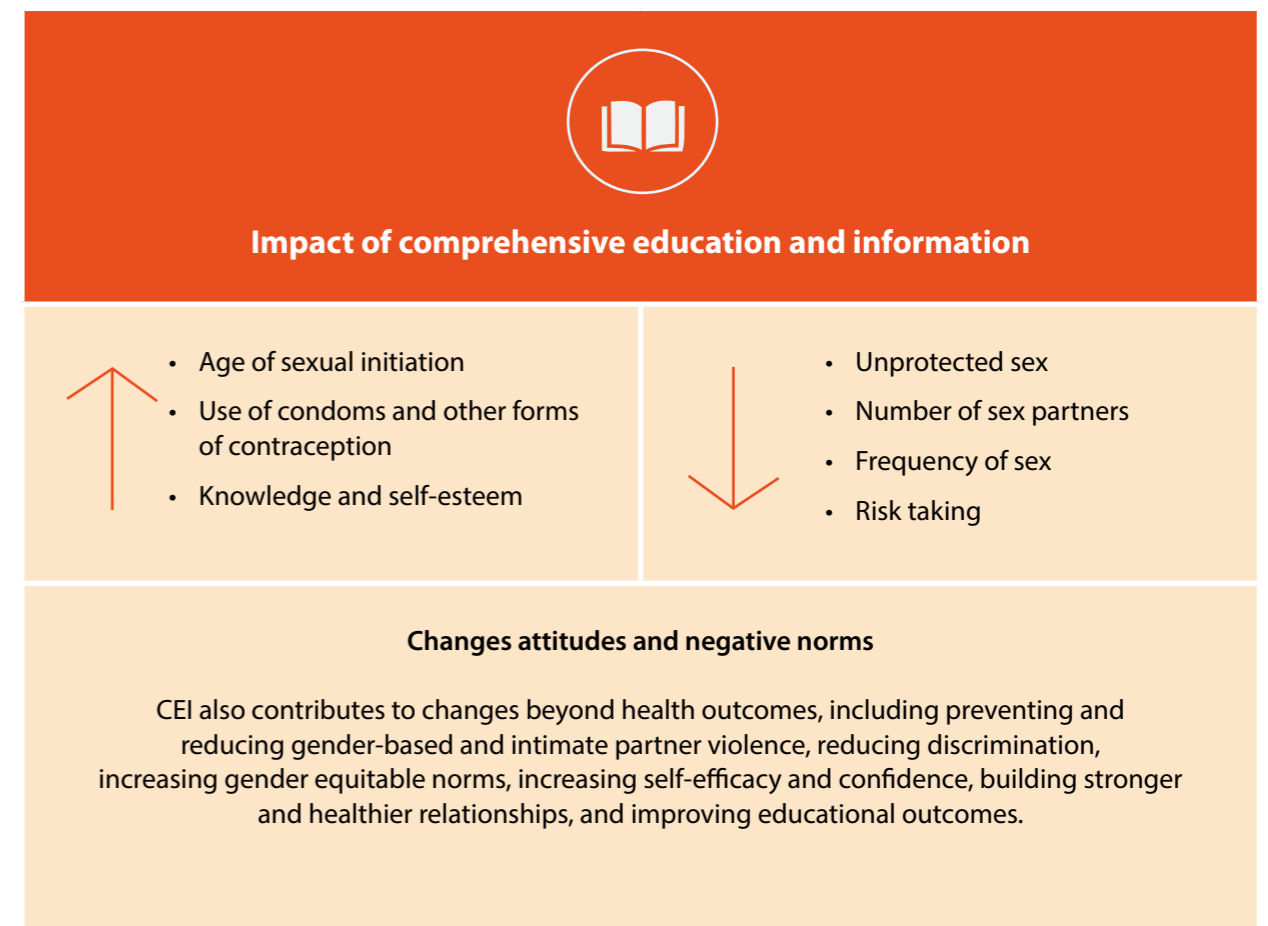
sexuality and sexual behaviour; and SRH. It is up to each country to adapt them to the local context, in accordance with national laws and policies in force. Experience has shown that a national consensus between the main actors, including education, health, religious and traditional authorities, teachers, parents and young people, is crucial to the implementation of these programmes.

Countries in the region are building on their existing programmes to improve their effectiveness and relevance. The new programmes aim to develop the knowledge, skills, attitudes, and values that will enable adolescents and young people to thrive – with respect to their health, well-being and dignity –develop respectful social and sexual relationships, reflect upon the consequences of their choices for their own and others' well-being, and understand and defend their rights.

A growing number of surveys[102,103] show that well-implemented CEI can have numerous positive effects. It limits misinformation and increases relevant knowledge; reduces risky behaviours; increases the rate of adoption of responsible behaviours; develops the ability to make informed decisions and comply with them; and promotes communication with parents or trusted adults.

Impact of comprehensive education and information

- Age of sexual initiation
- Use of condoms and other forms of contraception
- Knowledge and self-esteem

- Unprotected sex
- Number of sex partners
- Frequency of sex
- Risk taking

Changes attitudes and negative norms

CEI also contributes to changes beyond health outcomes, including preventing and reducing gender-based and intimate partner violence, reducing discrimination, increasing gender equitable norms, increasing self-efficacy and confidence, building stronger and healthier relationships, and improving educational outcomes.

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[101] UNESCO. 2018. Revised edition. International guidelines on sexuality education. An evidence-informed approach.

[102] UNESCO. International Technical Guidance on Sexuality Education: An evidence-informed approach for schools, teachers and health educators. UNESCO, Paris, December 2009. NB: The technical guidance is being revised and will be available in late 2017.

[103] UNFPA Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender. UNFPA, New York, 2014.

A review of CEI programmes in 23 sub-Saharan African countries[104] identified the strengths and weaknesses of each country's response. In eight countries the Objectives and Principles component of the programmes was the strongest, followed in seven countries by a strong Institutional Context. But in 10 countries, the greatest weakness is content. For example, it was found that programmes covered human development and youth empowerment better than SRH and relationships. In addition, more attention was paid to life skills than to social norms or gender. Programmes designed for 15-18-year-olds were less developed. Nonetheless, the identified strengths – the component on Objectives and Principles – demonstrates that many ministries of education are interested in making CEI effective. The authors of the review note, however, that paying more attention to content on SRH and relationships, as well as social norms and gender, will be required to make life skills more relevant and effective.

Photo credit: ©Doug Linstedt/Unsplash

Levers of success of CEI implementation

One study[105] on the factors and actions conducive to the introduction or implementation of CEI identified a number of "levers of success", in particular:

Creating an enabling environment
- Political will and high-level support.
- Advocacy to sustain political and budgetary support.
- Identification and active involvement of "allies" among decision-makers.
- Ownership of the programme by the government and national leadership.
- Commitment from government to respond to HIV and AIDS, EUPs, and GBV.
- High-level and high-profile ministerial declaration in support of CEI.

Stakeholder involvement and support
- Building a national coalition of actors in support of CEI.
- Identification of allies within religious and local communities that can express public support for the programme.
- Active involvement of teachers, parents, and adolescents and young people in the promotion and development of the CEI programme.

Advocacy and sensitization
- Ongoing sensitization, information, communication, advocacy, and consensus-building activities to overcome resistance and create and sustain support from all actors, including parents, school administration, religious leaders, and government.
- Production and dissemination of evidence illustrating the impact of CEI.

- Using education data on enrolment, dropouts, and educational attainment disaggregated by sex and age to justify the wide-spread introduction of CEI in schools.
- Making the link between school-based CEI and improving the quality of education and retention, particularly for girls.

National response
- Development of a national strategic plan for scale-up prior to rollout of the CEI programme. Development of appropriate training modules or teaching guides and student textbooks (primary and secondary levels).
- Implementation of locally-developed national programmes that recognize and respect cultural and religious beliefs, while factoring in current changes in lifestyle and ensuring that the programmes maintain most of the essential components that make them effective.
- Collaborative processes of curriculum review and content development.
- Willingness to accept a change in terminology/programme name in order to make it more politically and culturally acceptable.
- Sufficient technical support.
- Effective partnerships (through formal mechanisms), for example, between ministries of education and health and between public institutions and civil society organizations (CSOs).
- Mobilization of domestic and external resources to support implementation of CEI.

[104] Hospital, X., Herat, J., Machawira, P, Ngué, W., Castle, C. Can we make comprehensive sexuality education more effective? A review of 23 school-based comprehensive sexuality education programmes in sub-Saharan Africa. Poster presented at the 22nd International AIDS Conference (2018)- Amsterdam, the Netherlands.

[105] Adapted from: UNESCO. 2016. Levers of success. Case studies of national sexuality education programmes. UNESCO, Paris.

"When I reached puberty, I could not discuss it with my mother. We did not have that kind of relationship. I preferred to discuss it with my teacher."

Patricia Agyepong, Akosua's mother, #CSEandMe, Ghana

Comprehensive education and information – Advancing programmes

Together with national stakeholders, most governments in the region have initiated a process to update and improve CEI programmes. The overviews below do not represent comprehensive case studies for each country, nor do they identify the significant obstacles in some countries, but they do highlight certain key actions that contribute to the implementation and scaling of CEI.

Bénin – A review of different CEI projects and a study on EUPs in Benin drew attention to needs and opened discussion on a topic previously considered taboo. All stakeholders got together to identify reservations and obstacles, develop a common understanding of CEI, and develop the programme. On this basis, the country produced teaching guides, textbooks, and a communication plan. An app, known as *"Ma vie Mon Choix"* (My life, My choice), was designed to raise awareness of sexuality and gender issues.

Cameroon – The teaching of CEI in Cameroon has been institutionalized by an inter-ministerial order since 2006 in the curricula of primary and secondary schools, as well as in teacher training institutes. In addition, teaching and learning materials for teachers and students and a training and teaching curriculum have been developed. Self-study materials in the form of DVDs and radio programmes build the capacities of teachers and facilitate the introduction of CEI in the main carrier subject.

Niger – Political will, leadership, and ownership of CEI were key factors for the progress recorded in implementation in Niger. A working group and a steering committee were set up thanks to the strong involvement of the secretary general of the Ministry of Secondary Education and one of the ministry's departments. A common roadmap involving all partners guides the implementation of CEI and suitable health services. The programme relies on secondary education teaching modules, a module for "School Health Clubs", and multimedia resources. The process benefited from the involvement of religious leaders, and a ministerial order facilitated coordination around the roadmap.

Nigéria – *The Family Life/HIV Education* (FLHE) curriculum in Nigeria is integrated into carrier subjects such as English and Civics from primary to secondary school, and in initial teacher training, including an online in-service training programme currently being developed. The content of the FLHE curriculum is being revised, and will be updated. The success of scale-up varies across states. The curriculum was fully implemented in Lagos State at an estimated cost of USD6.90 per student.

DRC – A national family life education programme was endorsed in the DRC by all education sector actors and resulted in the development of student textbooks and teaching guides. A ministerial order requires all schools to implement the curriculum. An SRH and CEI coordination group is operational, and an annual inter-sectoral roadmap to which all stakeholders adhere, contributes to the effectiveness and complementarity of interventions. Due in particular to TV lessons on SRH, parents and other members of the community are increasingly supportive of family life education.

Senegal – A coalition of key stakeholders (ministries, young people, CSOs, the United Nations, and others) is coordinating the development of the CEI curriculum in Senegal. The coalition has laid emphasis on a common understanding of CEI, and has organized a series of workshops resulting in the development of an CEI framework (key concepts and learning objectives) based on international standards, taking into account the socio-cultural context, and in line with the technical requirements of the Ministry of National Education. The involvement of religious organizations such as the *Réseau Islam et Population*, which trains Imams and highlights verses from the Koran that are supportive of SRH, is helping change social and cultural norms affecting access to information and SRH services.

Togo – An CEI programme has been in implentation in Togo since 1987. In addition, in 2009, two ministerial orders institutionalized School Health Education for the Prevention of AIDS and STIs. One hour per week is devoted to this separate lesson in secondary schools. Educational materials have been revised, teacher training launched, and SRH was added a few years later. Different projects have been implemented by partners, but none has been scaled up. A National Programme Against Child Marriage and Teenage Pregnancy 2015-2019 was developed and implemented. School violence, a related subject, is covered through a specific module on which all primary school head teachers have received training.

"My friends and I talked nonsense about sexuality. We thought for instance that during your first sexual experience, you don't necessarily need to use a condom because you can't contract an STI and the girl can't become pregnant. But now I can confidently tell them that even during your first sexual experience you can become pregnant. I was lucky to join a health club where I got some information that opened my eyes about some stuff I was dealing with that was going to spell my doom if I didn't stop. At the beginning I had no information."

Paul Philippe N'Guessan, Côte D'Ivoire, testimony from the #JeVeuxSavoir campaign

Opportunities for a comprehensive and effective response

"I want to talk about my little sister… who could not complete the first cycle of sewing school because she had an early pregnancy at 14… (That's the outcome) due to the fact that in primary school no information is provided about sexuality, especially in rural areas… So, you go through primary school and leave without any information on sexuality; it's only in the second to last year of high school that sexuality is actually discussed. But it's merely about the menstrual cycle and all, plus lessons on reproductive health in the last year of high school. But basically, you aren't told anything, meaning you go through adolescence without any information on sexuality. And the information you receive, as in the case of my little sister, is "Stay away from boys!" "Don't hang around with boys!"

Euphrasie Coulibali, Côte D'Ivoire, testimony drawn from the #JeVeuxSavoir campaign

A regional response

Regional priorities such as combating child marriage and FGM/C, including through African Union campaigns, have received regional and national support and recognition, resulting in significant progress in many countries. Regional (or global) campaigns and commitments allow for the identification of priorities, consensus on effective approaches, and the development of a roadmap. They make it possible to coordinate stakeholders around clear and measurable targets, and can catalyse financial resource mobilization. Moreover, regional recognition fosters dialogue on a topic that is often considered taboo. A *West and Central Africa Commitment for Educated, Healthy and Thriving Adolescents and Young People* would demonstrate the emphasis the region places on education, health, and the development of adolescents and young people, and would mobilize partners as well as the financial and human resources needed to better meet their needs.

Photo credit: ©FFMuskoka/V.Tremeau

> "The region needs a holistic and common approach. WCA's Commitment would encourage the sharing of information and strategy, and would tackle the current lack of synergy. WCA's Commitment would foster decision-making at the national level and promote mutual assistance and support in the region."

Mohamed Zeidane, Secretary General, Ministry of Secondary Education, Niger

Political will, leadership and ownership

Experience with CEI and SRH programmes have shown that the ones that are most successful and sustainable are those that were implemented in the context of strong and firm political will. This already exists in some countries, but in others, advocacy will be needed at all levels to ensure a common understanding and the prioritization of the needs of adolescents and young people. Leadership and ownership by politicians and decision-makers in key ministries such as education, health, youth, social, and gender affairs are key to encouraging open discussion of the issue and effective implementation of programmes. Without leadership from the government, these programmes will stagnate and it will be harder to scale them up nationally. Political leadership can catalyse resource mobilization, open a dialogue on adolescent and youth sexuality, and help bring about a shift in gender and other social norms that pose health risks.

Adolescents and young people

There is wide consensus on the importance of asking adolescents and young people about their needs and the best way to meet those needs. Similarly, research has shown the importance of the participation of individuals from this age bracket in the development, implementation, and M&E of CEI and SRH programmes, as well as in advocacy efforts. The young people interviewed for this report emphasize the importance of recognizing that this group is not homogenous and that their specific characteristics must be acknowledged and taken into account in programmes. These

specific characteristics include, in particular, diversity in age, gender, disability, context (urban, rural, humanitarian, etc.), educational level, socio-economic level, religion, and culture. The participation of different adolescent and youth groups is therefore necessary, and the specific characteristics of these groups must be taken into account when developing programmes to ensure that they meet the needs of all adolescents and young people.

Overcoming socio-cultural barriers

> "The health and well-being of adolescents and young people clash with values, customs, and traditions to which we are attached and which are becoming major barriers."

Patrick Alain Fouda, RéCAJ+, Cameroon

Sexuality is a taboo topic in many societies, and socio-cultural restrictions make it difficult to have discussions and debates about sexuality, and can erect barriers to CEI and access to and use of SRH services. Moreover, information about sexuality provided by schools, parents, friends, religious leaders, and others can be contradictory. A Social and Behaviour Change Communication programme that raises the awareness of parents, the community, and religious and community leaders about adolescent and youth SRH and negative social norms and societal attitudes would help overcome these barriers.

Photo credit: ©FFMuskoka/V.Tremeau

Parents and the community

Scientific research shows that the participation of parents, guardians, the community, as well as religious and traditional leaders in the development and implementation of CEI and SRH programmes is very helpful in overcoming obstacles and increasing their impact. When consulted and informed about programme content, most of these key stakeholders support the implementation of an CEI programme and access to SRH services. However, some of them may have reservations, raise questions about

the content of curricula, or feel uncomfortable around a topic that is considered taboo. These are normal feelings. A number of stakeholders noted the importance of developing communication strategies and interventions which address these concerns that are rooted in a response to a specific problem identified by the community (such as HIV or EUP), use appropriate language, and demonstrate scientific research findings in an understandable way (such as that CEI can delay the age of first sex). It is therefore crucial to recognize and understand these reservations so as to craft a suitable response.

"We need to differentiate customs from religion. Religion is not a barrier to health services and to the reproductive and sexual health education of adolescents and young people."

Iman Mohamed Lamine Camara, Côte D'Ivoire

Photo credit: ©Annie Spratt/Unsplash

Religious and traditional leaders as key partners in creating an enabling social environment

Given the importance of the social environment to the health and education of adolescents and young people, it is essential to involve religious and community leaders in the development of CEI programmes and SRH services. A shared understanding of what CEI and access to SRH services is, as well as endorsement and support for these services from leaders, are helpful in overcoming many barriers to access.

Religion and religious texts are not, in themselves, barriers, and in some cases could even support the implementation of CEI and SRH services. Sex is not taboo in Islam, and menstruation, puberty, and sexual violence are covered in Surates. In fact, religious texts of Islam and Christianity emphasize the importance of knowledge and understanding, thus reinforcing the importance of giving adolescents and young people the knowledge and skills they need to protect themselves.

Religious leaders interviewed for this report underscore that an insufficient knowledge of original texts can result in poor understanding and a reductive interpretation of religion and taboos. To address this situation, many countries in the region have started developing a rationale, from both Muslim and Christian perspectives, to support the interpretation of religious texts. A common and reliable rationale that could be adapted by each country in the region could be used to train religious leaders as well as inform and raise awareness among their faithful. Translation into local languages would also allow a better understanding and dissemination of knowledge and messages about CEI and SRH.

An enabling legal and political environment

An enabling legal and political environment is key to implementing and expanding SRH and CEI coverage. A review[106] in five West African countries notes that although SRH services adapted to adolescents and young people are included in policies, laws, and strategies, legal ambiguities surrounding the age of consent and access to contraceptives and SRH services mean that service delivery depends on the healthcare provider and can therefore be affected be the latter's bias. Moreover, laws and policies are not harmonized and there is limited dissemination and implementation of laws and legal texts. The situation is similar for CEI. Many countries in the region have a policy framework that is conducive to CEI, but implementation has not followed. Countries that have signed implementing decrees or ministerial orders and have put in place systems of accountability are the most successful.

A dynamic civil society

WCA has a dynamic civil society at the regional, national, and local levels. At the regional level, different coalitions such as family planning advocacy group *Coalition Régionale des Organisations de la Société Civile pour le repositionnement de la Planification Familiale en Afrique de l'Ouest Francophone* (CROSC-PF) and religious group *Alliance des Religieux de l'Afrique de l'Ouest pour la promotion de la Santé et le Développement* (ARAO-SD), build the capacities of national CSOs. At the national and local levels, many organizations are active in this area and are key stakeholders crucial to the implementation and scaling of programmes.

The engagement of adolescents and young people to resolving their own problems is also a key element. Overall experience has shown that the effectiveness of SRH interventions is much stronger when adolescents and young people participate in the development, implementation, evaluation of, and advocacy for, interventions.[107] This participation is greater in some countries in the region than in others. Moreover, the false perception that young people constitute a homogenous group persists and affects the quality of their commitment. It is crucial to ensure that a range of ages, genders, disabilities, context (urban and rural), educational levels, socio-economic groups, and cultural (including religious) identities are represented.

Access to and use of ICTs

ICTs are becoming more important in the lives of adolescents and young people most have access to social networks (via mobile phones) and the media (television, radio), although there are disparities in access between urban and rural areas. ICTs allow simple and anonymous access to information (for instance about SRH) and create social bonds. Unfortunately, ICTs can also spread false information and the internet can be a source of bias and bullying. Too often, young people do not know the difference. Misinformation, cyber-bullying, and sexting (among others) continue to grow worldwide. The negative impact of ICTs can in turn affect self-confidence and mental health. Life skills-based education is therefore essential to empower young people to filter information and protect themselves against risks inherent in internet use.

Online information on the current COVID-19 pandemic highlights both the positive and negative aspects of the internet. While a large amount of inaccurate information and conspiracy theories are an obstacle to an effective response in certain contexts, digital technology also allows the rapid transfer and updating of reliable information. Moreover, in countries where ICTs are well developed and there were school closures, children and adolescents were able to continue their studies. It should, however, be noted that ICTs could also increase educational inequalities if only one segment of the population has access to them.

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[106] Papworth, E. and Nelson, N., Review of Adolescent and Youth Policies, Strategies and Laws in Selected Countries in West Africa (Dakar, UNFPA, 2017).

[107] UNFPA WCARO. Adolescent and Youth Sexual and Reproductive Health and Rights Services, Key elements for implementation and scaling up in West and Central Africa. https://wcaro.unfpa.org/sites/default/files/pub-pdf/EN-UNFPA-WCARO-MUSKOKA-ECS-AYSRHR-Report-WEB_1.pdf.
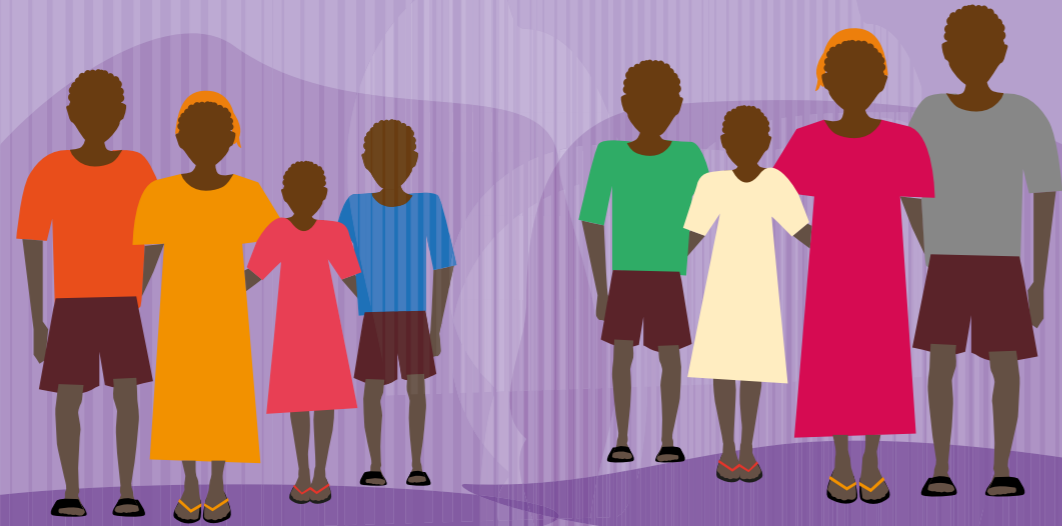
Conclusion

Adolescence is a key moment in a person's development. *During adolescence, an individual acquires the physical, cognitive, emotional, social, and economic resources that are the foundation for later life health and well-being.*[108] This is also when healthy behaviours are adopted and bad habits like harmful alcohol and drug use, unhealthy eating, physical inactivity, and unsafe sexual behaviours start.

Regional and global experience has shown that a positive impact on the health, education, and well-being of adolescents and young people even with limited human and financial resources. There are many successes in the region, from SRH and CEI programmes to campaigns against child marriage and FGM/C, which demonstrate this.

The regional experience[109] highlights some key elements of an effective national response:
- Data and studies, such as those on EUPs, make it possible to identify problems, start a discussion about topics that are often taboo, and develop an effective response.
- Leadership and ownership by the government are key for an effective, scaled-up and sustainable implementation.
- The target – adolescents and young people – need be taken into consideration. They must participate in the development, implementation, evaluation of, and advocacy for, programmes.
- Participation in and support from communities, starting with parents and religious and traditional leaders, is crucial to the success of CEI and SRH programmes.
- The preparation of a national roadmap in consultation with key stakeholders lays the foundation for a common understanding and shared goals, and ensures that activities align with national priorities.

- The preparation of a detailed and approved national action plan that includes a M&E framework, clearly defines responsibilities, puts in place an accountability system, and ensures its application will facilitate implementation.
- A multi-sectoral cooperation and coordination system is essential to effective implementation.
- The implementation of a comprehensive advocacy plan targeting amongst others parents as well as religious and community leaders reduces prejudice about programmes and increases their legitimacy.
- Putting in place a suitable legal, policy, and strategic framework creates a conducive environment for the implementation of programmes and the protection of the health and well-being of adolescents and young people.
- Programme effectiveness depends on the establishment of linkages between CEI and SRH services that are adapted to adolescents and young people.
- A discussion on sustainability is crucial. Projects with a defined budget and duration can accomplish a great deal, but progress is often jeopardized when funding disappears. Integration into state budgets and plans is therefore key.

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[108]Patton, G.C.; et al. 2016. Our future: a Lancet commission on adolescent health. The Lancet. 2423-2478.
[109]Among others: UNFPA WCARO. Adolescent and Youth Sexual and Reproductive Health and Rights Services: Key elements for implementation and scaling up in West and Central Africa; and Comprehensive Sexual Education: Key considerations for implementation and scaling up in West and Central Africa.

It is the responsibility of countries in the region to develop coordinated and multi-sectoral national responses that meet the needs of all adolescents and young people. This comprehensive response calls for the implementation and scaling-up of CEI programmes and SRH services that are adapted to their needs. A *West and Central Africa Commitment* *for Educated, Healthy and Thriving Adolescents and Young People* would demonstrate the value the region places on adolescents and young people, and would mobilize financial and human resources needed to better meet their needs. The opportunities are there; it is what we do with them that matters.

"It is clear that the problems of dealing with young people's sexuality are still relevant today. They profoundly affect, and will continue to affect, the quality of life of our children, and therefore that of our families and society in general, if we do not address them. We need to respond in a way that is in proportion to the challenges at hand. We need to redouble our efforts, pool our resources and adjust our strategies for greater effectiveness and efficiency."

Prof Patrick Mouguiama-Daouda, Minister of National Education, Gabon

LISTEN, UNDERSTAND, ACT

WCA

COMMITMENT

The West and Central Africa (WCA) region has a growing population of adolescents and young people. This population represents an unprecedented opportunity to capitalize on the demographic dividend if they are educated, healthy and thriving. However, major obstacles, including lack of access to quality education and high dropout rates, gender-based violence, and early and unintended pregnancies, must be overcome to achieve this. Addressing these needs is a priority of the African Union's Agenda 2063 and the Sustainable Development Goals on health, education, and gender equality.

This report presents data on the status of adolescents and youth in WCA with respect to key indicators affecting their well-being. The thematic areas covered are education, health, and gender equality. The **West and Central Africa Commitment for Educated, Healthy, and Thriving Adolescents and Young People** will be a critical catalyst for unlocking resources, fostering cross-sectoral collaboration, and developing effective education programs and health services that will drive the region's development toward the shared vision of a prosperous African continent.