



ACERWC

African Committee of Experts on
the Rights and Welfare of the Child



TEENAGE PREGNANCY IN AFRICA

Status, Progress
& Challenges



2022

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LIST OF ACRONYMS

ACERWC	African Committee of Experts on the Rights and Welfare of the Child
ACPF	African Child Policy Forum
ACRWC	African Charter on the Rights and Welfare of the Child
AU	African Union
CAR	Central African Republic
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
CSE	Child sexual exploitation
CSO	Civil society organisation
CSE	Child sexual exploitation
DALY	Disability-adjusted life year
DHS	Demographic and Health Surveys
DRC	Democratic Republic of Congo
FGD	Focus group discussion
IDPs	Internally displaced persons
IEC	Information education communication
LBW	Low birth weight
MICS	Multiple indicator cluster surveys
NGO	Non-governmental organisation
SDGs	Sustainable Development Goals
SRH	Sexual reproductive health
SRHR	Sexual and reproductive health rights
STD	Sexually transmitted disease
STI	Sexually transmitted infection
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations Refugee Agency
UNICEF	United Nations International Children's Emergency Fund
VAC	Violence against children
WHO	World Health Organization
YFS	Youth-friendly service

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FOREWORD

The African Committee of Experts on the Rights and Welfare of the Child (ACERWC/ Committee) has been at the forefront of championing child rights across Africa. For more than two decades, it has made a major impact on the African socio-economic, legislative and political landscape by urging governments to place children at the centre of the policy-making agenda. Thanks to the Committee's multifaceted efforts, the concept of child rights has permeated public discourse and practice. Acting as a custodian of the African Charter on the Rights and Welfare of the Child, the Committee has advised governments to make greater commitment to improving law, policy and practice on child rights, and it has charted the way forward in this regard by providing knowledge resources, guidelines and frameworks.

At its 35th and 36th Ordinary Sessions, the ACERWC considered the issue of teenage pregnancy at the request of partner organisations including Plan International, the Centre for Reproductive Rights (CRR) and the African Child Policy Forum. The Committee has noted from its interaction with State Parties that although teenage pregnancy is a continental issue that affects many countries, few have specific laws and policies for addressing it; indeed, on the contrary, some of them have regressive measures that neglect pregnant teenage girls. The Committee has noted, too, that little attention is paid to the notion of prevention through education and the provision of contraception.

Accordingly, at its 36th Ordinary Session, held on 23 November – 4 December 2020, the Committee decided to undertake a study to assess the situation of teenage pregnancy in Africa. The current study – ***Teenage Pregnancy in Africa: Status, Progress and Challenges*** – is the result of that initiative. It provides the necessary evidence base for the Committee's engagement with State Parties to address the issue; more specifically, it identifies a range of solutions that the Committee can adopt in continental frameworks or guidelines for national action.

As such, the Committee commits itself to encouraging national governments, regional economic communities and civil society to make thorough use of the findings and recommendations of this report. The Committee recognises that teenage pregnancy is a multi-sectoral issue requiring the involvement of multiple actors and sectors. Therefore, we urge all relevant stakeholders to join with us in taking the results of the study to the next level through the technical and financial collaboration which is necessary for implementing its recommendations and raising awareness of its findings.

Hon. Joseph Ndayisenga
Chairperson of the ACERWC

CHAPTER 1: BACKGROUND TO THE STUDY

1.1 Context

Many African countries, aware of the gravity of the problem of teenage pregnancy, have taken steps at the legal, policy and administrative levels to prevent it and to seek to ensure that pregnant girls and young mothers have access to appropriate sexual and reproductive health (SRH) information and services and can continue with their education. Progress has been reported, for instance, in access to contraception, in antenatal and postnatal care services, and in ensuring that schools remain accessible to pregnant teens and teenage mothers. Thanks to these efforts, many countries in Africa have seen a general decline in teenage pregnancy.

Nevertheless, as this report reveals, the current level effort towards preventing and responding to teenage pregnancy leaves much to be desired. Teenage pregnancy has a prevalence rate of more than 25% in 24 African countries, a rate that reaches as high as 48% in Niger, 44% in Chad, and 43% in Equatorial Guinea.¹ It is estimated that one in every five adolescent girls in Africa becomes pregnant before reaching the age of 19.² Teenage pregnancy affects girls of all backgrounds and in every part of the world; but girls from African countries are at a greater risk due to factors such as poverty, low levels of education, economic status, family and community attitudes, and lack of access to reproductive health services and information.³

Pregnant teens and teen mothers in Africa endure a litany of ills that compromise not only their own survival and development but that of their babies. They are often stigmatised, rejected or subjected to violence by partners, parents and friends,⁴ while health-care and education service providers shun them as an embodiment of sexual immorality or as a living contradiction – of a child bearing a child. Services that cater for their medical needs are either non-existent or inaccessible, and so they are often forced to give birth outside the safety of health-care systems and in the absence of skilled attendants. This often results in either death for the mother and/or baby, or long-term health complications. According to the World Health Organization (WHO), pregnancy and childbirth complications are the leading cause of death among girls aged 15–19 years globally, while young mothers aged 10–19 years face a higher risk of contracting multiple and systemic infections than women aged 20–24 years.⁵ Moreover, it is estimated that about 3.9 girls between 15 and 19 years of age who decide not to carry their pregnancies to term resort to unsafe abortions every year. These result in high maternal mortality rates, increased

1 See Fig 2.1 below.

2 Kassa, M.G. et al. Prevalence and determinants of adolescent pregnancy in Africa: A systematic review and meta-analysis. *Reproductive Health*, 2018, 1–17. See also Centre for Reproductive Rights Africa Program. Available at: <https://reproductiverights.org/our-regions/africa/> (accessed on 20 July 2022).

3 Raj, A. and Bohemer, U. Girl child marriage and its association with national rates of HIV, maternal health, and infant mortality across 97 countries. *Violence against Women*, 2013, 19(4): 536–51.

4 Darroch, J. et al. (2016). *Adding it up: Costs and benefits of meeting the contraceptive needs of adolescents*. Guttmacher Institute.

5 WHO (2020). *Adolescent pregnancy*. Available at: <http://www.who.int/mediacentre/factsheets/fs364/en/> (accessed on 20 July 2022); WHO (2016). *Global health estimates 2015: Deaths by cause, age, sex, by country and by region, 2000–2015*.





morbidity, and lasting health problems.⁶

Teenage pregnancy is thus a major factor in negative health outcomes for both mother and child. In addition, it not only places a huge economic burden on families and communities, but also affects the educational outcomes of pregnant teens, teen mothers and their children, as they miss schooling opportunities. Ultimately, it inhibits their future educational and employment opportunities.⁷

1.2 Rationale for the study

Although there are many studies on teenage pregnancy (most of which are national in scope or focus only on aspects of the issue), the continent still lacks a comprehensive report that identifies Africa-wide patterns and serves to provide comparative cross-country evidence. Both of these aspects are crucial ingredients for triggering a Pan-African policy discourse on the issue, including by the ACERWC and other African Union (AU) organs and Regional Economic Communities (RECs). Teenage pregnancy has been on the agenda of the ACERWC for some time, with the Committee considering the issue at its 35th and 36th Ordinary Sessions. In addition to noting that teenage pregnancy is a problem that, to varying degrees, affects the entire continent, the Committee has consistently highlighted the gravity of the issue in its interactions with State Parties as well as in its concluding observations and recommendations to them. With these and other considerations in mind, the ACERWC, at its 36th Ordinary Session (23 November to 4 December 2020), decided to undertake a study to assess the situation of teenage pregnancy in Africa – one that could provide comparative evidence and Africa-wide analysis.

1.3 Scope, objectives and methodology of the study

Given its Pan-African scope, this study of teenage pregnancy in Africa sets out to document the status, prevalence, drivers and consequences of teenage pregnancy across the continent. It makes use of a desk-based review of available secondary data and case studies from selected countries. It also examines the state of current efforts to respond to teenage pregnancy. The evidence it gathers will be used to inform the development of Pan-African frameworks on the subject, including those under the mandate of the ACERWC. The main objectives of the study are to:

- ① assess the situation of teenage pregnancy in terms of, inter alia, age, rate, and sub-regional variations;
- ② identify factors that lead to teenage pregnancy in Africa;
- ③ examine the consequences of teenage pregnancy in the African context;
- ④ examine the interplay between teenage pregnancy and the rights provided in the African Charter on the Rights and Welfare of the Child (ACRWC);
- ⑤ examine the laws and policies of African States relating to teenage pregnancy as well as

6 Darroch, J. et al. (2016). Adding it up: Costs and benefits of meeting the contraceptive needs of adolescents. Guttmacher Institute.

7 WHO (2015). Global standards for quality health care services for adolescents.

- the access pregnant teenagers or teen mothers have to services;
- examine laws and policies relating to the retention of pregnant girls and teen mothers in schools and the measures of additional support that are in place to enable them to sustain themselves; and
 - make recommendations for the way forward.

METHODOLOGY

The study involved qualitative research seeking to gain in-depth understanding of the causes and effects of teenage pregnancy in Africa. This included analysis of the legal and policy environment and related issues at various levels. The research also used case studies as a means of ascertaining the situation in selected countries. The study defines teenage pregnancy, in the words of Demographic and Health Surveys (DHS), as a situation in which 'a girl, usually within the ages of 13-19, becom[es] pregnant'. In regard to rates of teenage pregnancy, the study follows the definition used by the DHS, namely the 'percentage of women aged 15-19 who have given birth or are pregnant with their first child at the time of the study'.

Data-collection tools and techniques

Secondary data

Relevant literature, including country case studies and peer-reviewed journals

- Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), and surveys by UNICEF and other organisations

Primary data

A **standardised questionnaire** with both open-ended and closed questions was circulated to all AU Member States so as to obtain first-hand information from governments. The questions related, inter alia, to the scale of the problem; the adequacy of laws and policies; the availability and accessibility of services; good practices in preventing and responding to teenage pregnancy; and challenges to addressing the problem. Responses were received from seven Member States and integrated within the report.

Country case studies were conducted in the Central African Republic (CAR), Chad, Malawi, Mali, Mozambique, Niger, Mauritania and Uganda. The study undertakes an in-depth analysis of the issue by zooming in on countries selected on the basis of the high prevalence of teenage pregnancy and regional representation. Accordingly, eight countries with a relatively higher prevalence of teenage pregnancy and representing each of the five geographic regions of Africa were selected.

In-depth interviews were conducted in selected countries with selected pregnant teenagers and teen mothers aged 13–19 years.

Key informant interviews were conducted with selected policy- and law-makers; service providers; experts from a local civil society organisation (CSO); and representatives of UNICEF, UNFPA and Plan International country offices.

Focus group discussions (FGDs) were held with groups of six to seven teenage mothers aged 13–19 years, as well as with traditional or religious leaders and community members.



1.4 Limitations of the study

The absence of primary data in some countries necessitated reliance on secondary data, while aggregate data on specific themes proved to be unavailable in certain countries. Several countries were found not to have updated their demographic and health surveys; however, even when data is up to date, the range of data provided in such surveys is not extensive enough to enable an in-depth and cross-sectional analysis of all the issues. Furthermore, analysis of countries that were not the subject of field studies are less than fully substantive. To address these limitations, recent peer-reviewed journals and national surveys focusing on those countries were consulted. In addition, the study was conducted amid the COVID-19 pandemic. As a result, access to pregnant teenagers and other stakeholders proved challenging, and at times impossible, due to travel restrictions.

1.5 Structure of the study

This study is divided into eight chapters. This introductory chapter presents the context of the study; its rationale; and its objectives, scope and methodology.

- ④ Chapter Two briefly discusses the prevalence of teenage pregnancy in Africa, including its urban-rural variations.
- ④ Chapter Three examines factors that drive teenage pregnancy, including poverty, low levels of education, economic status, family and community attitudes, age, lack of or limited access to reproductive health services, early sexual debut, sexual risk taking, child marriage and media influence.
- ④ Chapter Four addresses the situation of teenage pregnancy among the most vulnerable groups: the disabled; those living and/or working on the street; ethnic minorities; girls in refugee camps, or in emergency and humanitarian situations; trafficked girls; and girls in child-headed households.
- ④ Chapter Five examines the (un)availability of SRH information and services and their accessibility to teenage girls and boys, including the role of relevant laws and policies.
- ④ Chapter Six discusses the rights of pregnant teens and teen mothers in international and regional human rights instruments and the extent to which national laws and policies are harmonised with these instruments. It also discusses the contextual application of the four general principles of children's rights and their role in preventing teenage pregnancy and advancing the rights of pregnant teens.
- ④ Chapter Seven discusses the short- and long-term impacts of teenage pregnancy on the health, education, income and standard of living of mothers, children, families and communities.
- ④ Chapter Eight concludes the discussion and makes recommendations. These emphasise the need to approach teenage pregnancy in a holistic manner as a public health emergency, a human rights issue, and a predicament borne out of gender imbalance.

CHAPTER 2: THE PREVALENCE OF TEENAGE PREGNANCY IN AFRICA

2.1 Introduction

This chapter discusses the extent of teenage pregnancy in Africa. It analyses the demographic data of countries with high prevalence, in the course of which it looks closely at regional disparities and identifies trends across the continent. Furthermore, it examines urban-rural and in-country variations in teenage-pregnancy prevalence, with a view to aiding the development of context-based responses.

2.2 Extent and magnitude of teenage pregnancy

Teenage pregnancy has been a major challenge on the continent for some time. Although it declined in recent years, it remains a significant problem affecting millions of girls throughout Africa. The United Nations Population Fund (UNFPA) estimates that each day 20,000 girls under the age of 18 give birth in developing countries. Regional averages for the prevalence of teenage pregnancy stand at 25% for Eastern and Southern Africa and 27% for West and Central Africa – these are significantly higher than the global average of 15%. Hidden within the regional averages are the very high rates in particular countries. In Niger, the percentage of women aged 20-24 years who gave birth before the age of 18 is 48%; in Chad, it is 44%; in the CAR, 43%; and in Equatorial Guinea, 42%. Nearly half of the countries in Africa have a teenage-pregnancy prevalence rate equal to, or more than, 25%.

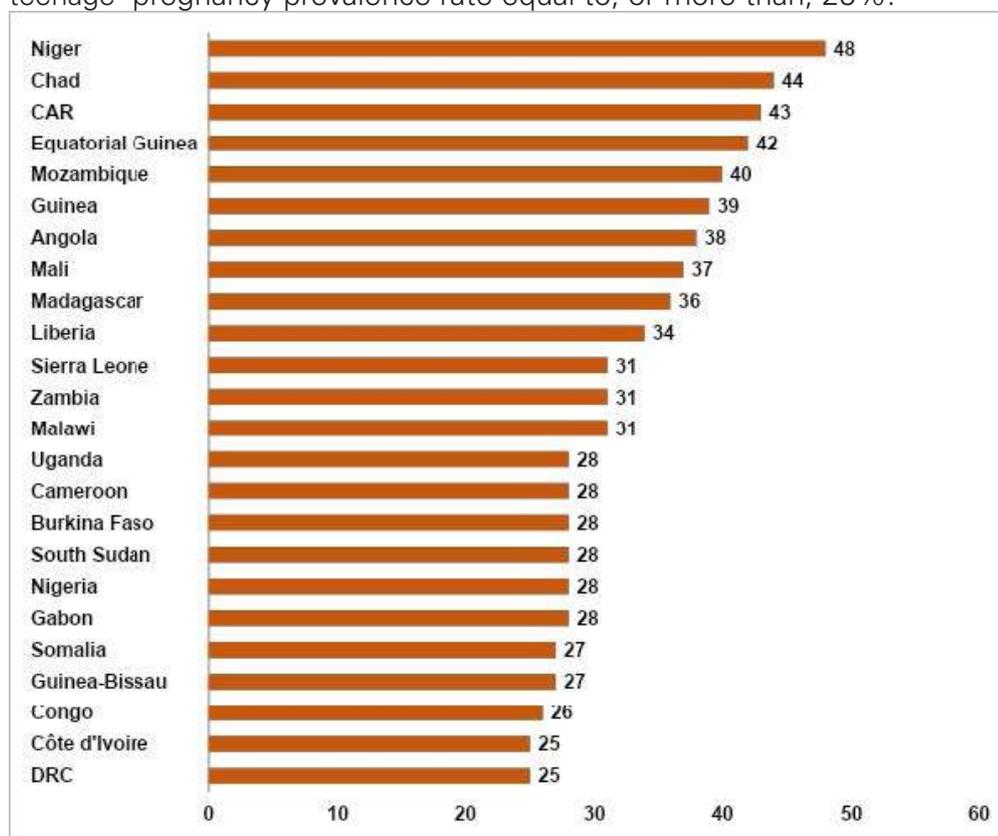


Figure 2.1: African countries with prevalence of teenage pregnancy >25%

Source: DHS and MICS surveys



However, it is important to note that there has been a decline in the prevalence of teenage pregnancy both globally and in Africa. The Southern African region has had the most significant decline, of about 23% (from 119 to 92 per 1,000 births among girls aged 15–19), while the West and Central African region has seen a drop of about 15%. One of the possible reasons for this variation could lie in the increasing availability of SRH and family-planning services in the Southern African region compared with the other regions; another reason, though, could be that teenage pregnancy is underreported in some parts of Southern Africa.

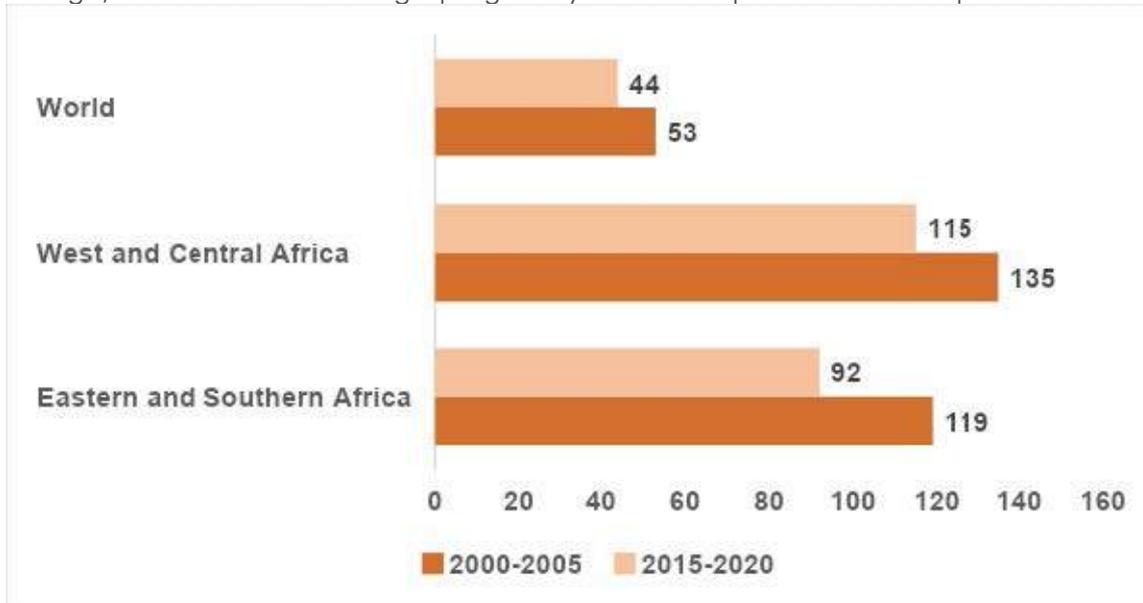


Figure 2.2: Rate of decline of births per 1,000 births among girls 15–19 years

Source: United Nations, Department of Economic and Social Affairs, Population Division (2021).

2.3 Urban-rural and in-country variations in teenage pregnancy prevalence

Studies have shown strong interprovincial variations within countries due to variations in cultural and religious belief systems, differing degrees of access to information and services, and the relative strength or weakness of the relevant laws, especially in those countries with decentralised systems of government. A study in Zambia found strong regional differences in the prevalence of teenage pregnancy, with the highest rates recorded in the Western and North Western provinces, followed by the Eastern and Southern provinces.

In Nigeria, the prevalence of teenage pregnancy ranged from 29% in North–West Zones to 5.5% each in the South–West Zones (with teenage pregnancy as high as 32% in Sokoto and 31% in Kaduna states, but as low as 5% and 1% in Imo and Lagos states, respectively).

Teenage pregnancy is generally a greater problem in rural than urban areas. This is due to a number of factors, including child marriage, lack of access to SRH information and services, and cultural belief systems and attitudes. According to DHS data, there is a 12% increase in the likelihood of teenage pregnancy for girls living in rural areas than those in urban areas (though it remains higher for those living in urban slums). Aggregated analysis of DHS data from 33 countries shows that rural girls start sexual relations 1.3 years earlier, and marry 2.7 years earlier, than urban girls. For instance, the prevalence

of teenage pregnancy is almost twice as high in the rural areas than it is in the urban areas of Zimbabwe, Zambia, Togo, the Democratic Republic of Congo (DRC), Madagascar, Mali, Guinea-Bissau and Guinea; and it is higher by about 10% in the CAR, Ghana and Madagascar. Furthermore, DHS surveys also show that rural girls have their first birth almost 2 years earlier than urban girls.

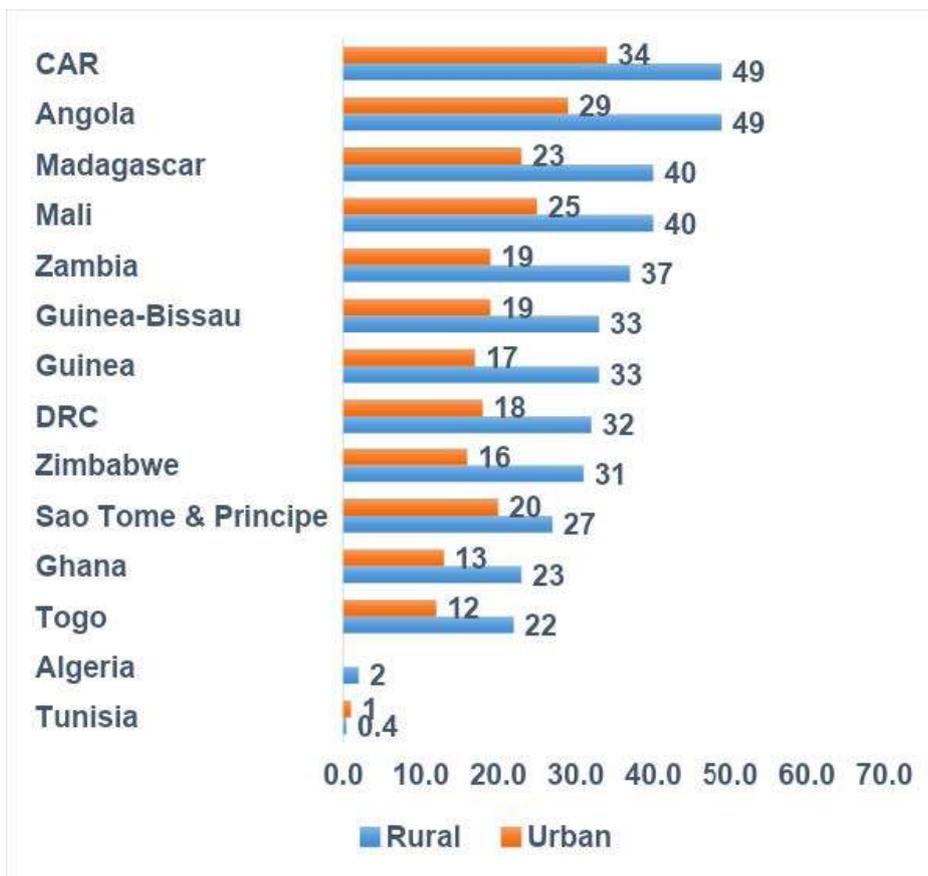


Figure 2.3: Urban-rural variation in teenage-pregnancy prevalence (selected countries)

Source: DHS and MICS surveys

2.4 Summary

Despite a decline in its global prevalence, teenage pregnancy remains a huge challenge in Africa. Teenage pregnancy has a prevalence of more than 25% in 24 of Africa’s 55 countries, and reaches figures as high as 48% in Niger, 44% in Chad and 43% in the CAR. Its prevalence is consistently higher in rural than in urban areas, and almost twice as high in the rural areas than in the urban areas of Zimbabwe, Zambia, Togo, DRC, Madagascar, Mali, Guinea-Bissau and Guinea. This prevalence is mainly attributable to limited access to SRH services; lower levels of literacy; early sexual debut; and the higher rates of child marriage in rural areas. Related to this is the stark variation in prevalence seen across provinces within countries, where it is found to be higher in provinces with limited urbanisation (which usually translates to a limited availability of relevant services).



CHAPTER 3: CAUSAL FACTORS IN TEENAGE PREGNANCY

3.1 Introduction

This chapter examines the several factors that influence teenage pregnancy in Africa. These include those that are rooted in culture and societal attitudes; drivers related to economic status; restrictive or discriminatory laws and policies on sexual and reproductive health rights (SRHR); and media influence. Some of the factors tend to be universal in scope, while others are specific to the African context. In addition, the chapter discusses how these factors are inter-connected and work to put girls in Africa at greater risk of teenage pregnancy. Identifying the causes with sufficient clarity is important for devising appropriate intervention mechanisms at all levels.

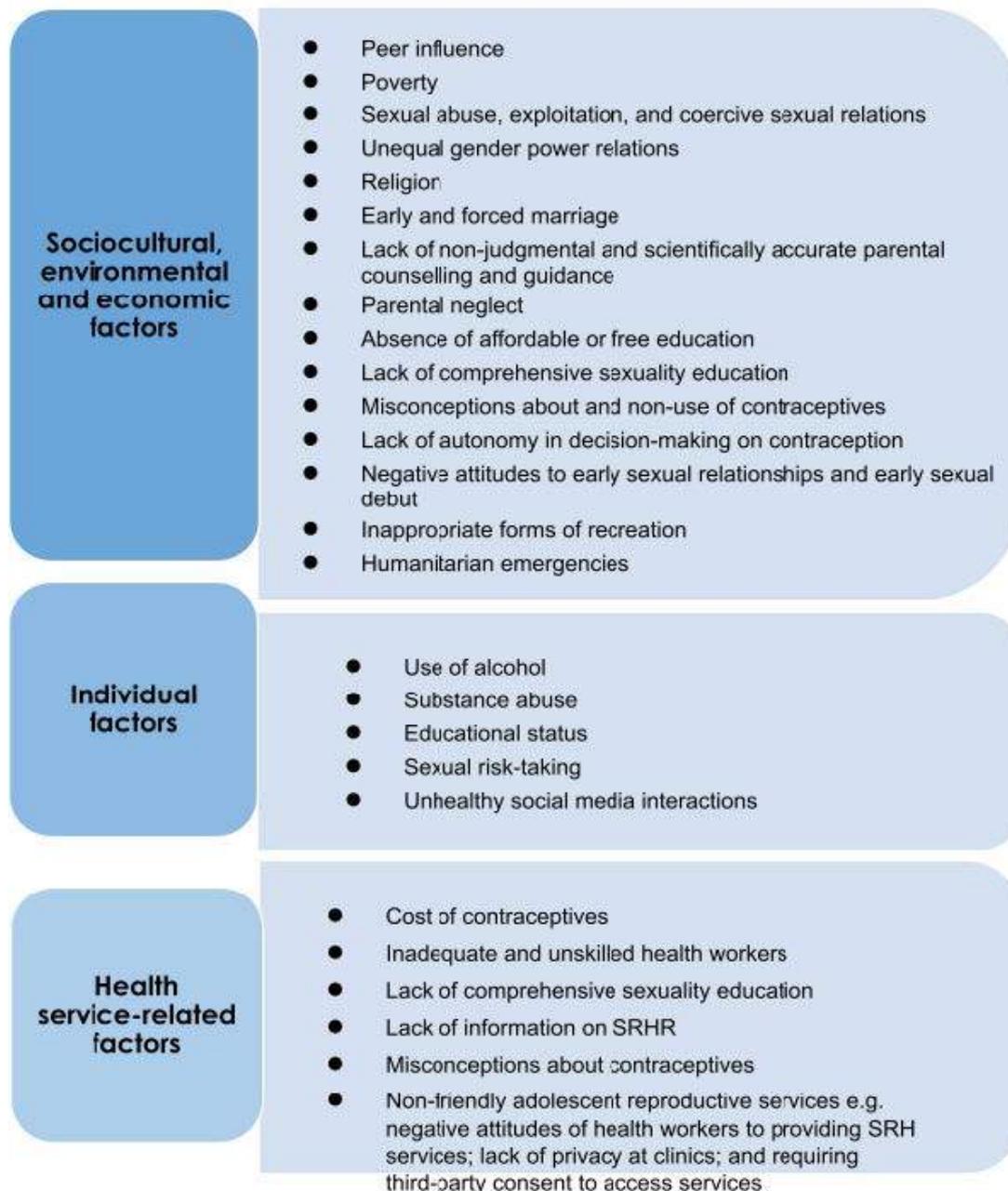


Diagram 3.1: Factors in teenage pregnancy

Adapted from Yakubu, I. and Salisu, W.J. Determinants of adolescent pregnancy in sub-Saharan Africa: A systematic review. Reproductive Health, 2018, 15(15)
Table 1: Causal factors in teenage pregnancy across countries

Factor	CAR	Chad	Madagascar	Malawi	Mali	Mauritania	Mauritius	Mozambique	Niger	Rwanda	Senegal	Togo	Uganda
Low socioeconomic status	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Low level of education	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Child/forced marriage	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NR*	Yes	Yes	Yes	Yes	Yes
Risky sexual behaviour	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NR	Yes	Yes	Yes	Yes	Yes
Lack of supportive family environment/poor parent-child interaction	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Lack of open family discussions about sexuality	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Family patterns of sexual experience/history of teenage pregnancy in the family	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NR	Yes	Yes	Yes	Yes	Yes
Living in a community where early child-bearing is encouraged	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Lack of access to SRH information and services	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Negative attitudes of health-care service providers	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sexual abuse and exploitation	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Negative media influence/access to pornography	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Peer pressure	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NR	Yes	Yes	Yes	Yes	Yes
Girls' lack of sexual agency and autonomy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NR	Yes	Yes	Yes	Yes	Yes

Source: Primary data collected in selected countries as part of the present study (October – December 2021)

8 □ No response





3.2 Attitudinal and cultural factors

Negative behaviours and attitudes which influence teenage pregnancy are rife in Africa and are found among parents, community members, and even service providers such as teachers and health-care workers. Some of these attitudes are the result of gender narratives that regard pregnancy and motherhood among children as a contradiction and consequently associated only with deviant teenage girls.

Decisions teenagers make about their lives, including personal decisions about sexuality and reproduction, are influenced by societal attitudes that are themselves rooted in cultural and religious beliefs. Several factors entrenched in social customs and traditions contribute directly or indirectly to teenage pregnancy. For example, studies in South Africa have shown that the high value given to children and fertility in many African cultures is one of the factors that push female teenagers to engage in sexual activities and prove their ability to bear children.

Although infertility is essentially a biomedical issue, in traditional thinking, as research in Africa demonstrates, infertility is considered a woman's problem, and women shoulder the highest burden of social stigma and suffering caused by infertility. As such, teenagers are pressured by stereotypes to prove to society that they are capable of bearing children. For instance, one South African study demonstrates that teenagers seek to get pregnant in order to prove their fertility. Hence, wrong societal attitudes place teenagers in a situation that forces them to engage in sexual activities and eventually get pregnant before they even acquire the level of maturity and physical readiness necessary for giving birth to a child.

Another factor driving teenage pregnancy is societal perception of the use of contraceptives. As a study conducted in Ethiopia and Kenya shows, the use of contraceptives by men and women in these countries is influenced more by the perception of societal approval or disapproval than by any personal preference. A further study shows that in many African countries, society labels women and girls as promiscuous if they use contraceptives. Due to such misconceptions, teenagers who are interested in the use of contraception fear being seen as promiscuous by their community, and, as a result, engage in unprotected sexual intercourse.

There are also countries where teenage pregnancy arises from societal attitudes that stem from religious beliefs about children and contraception. For instance, a study in Guinea finds that adolescents and youth (15–24 years) believe that having a child is a gift from God and that the use of contraceptives to avoid pregnancy is an act of homicide. Similarly, belief in the religious prohibition of contraceptives exists in countries such as Uganda and Nigeria where contraception is regarded as an abominable interference with the will of God. As a result, teenagers who grow up and/or live in areas where contraception is stigmatised will either not consider the use of contraceptives or, where they do consider it, refrain from using contraceptives for fear of societal disapproval.

An equally important factor in the prevalence of teenage pregnancy is the simple fact that

discussions around sexuality are considered taboo across African countries. Adults avoid discussion of sexual matters in the presence of children, and even amongst themselves. In some communities, there is little or no communication between adults and children about reproductive health. For instance, studies show that in Zambia and Kenya there is limited parent-child communication on sexuality and that even when it does take place, it is in an environment clouded by the fear that such discussion might itself lead children into early sexual debut. As a result, the fact that discussions about sexuality are taboo in Africa hinders teenagers from receiving age-appropriate information about sexuality and reproduction from their parents. It consequently leaves them in a situation where they can all too easily make ill-informed decisions that result in pregnancy.

Other studies indicate that negative behaviours from health-care workers discourage women and girls from seeking antenatal care, or from attending clinics and follow-up visits. Respondents from Uganda, Chad and Malawi (interviewed as part of this study) all lamented the negative attitudes, at community level, that stand in the way of governmental and civil society efforts to address teenage pregnancy. One teenage mother (19 years old) in Uganda had this to say:

I am personally requesting that the health-service providers should stop judging us when we go for their services. They ask us many questions. For example, they ask us where our boyfriend is. We tell them he has run away. They become too inquisitive on us and they condemn us a lot.

The negative attitudes of health-care providers to contraception thus sometimes impede access to services by adolescents. For instance, a study in Nigeria shows that health-care providers believe that providing contraceptives to unmarried adolescents promotes promiscuity and that Nigerian culture does not support premarital sex. Consequently, they are often hesitant to advise girls on the benefits of contraception. Such stigma is a result of limited knowledge of contraception. A study in South Africa demonstrates that health-care providers' knowledge of modern contraceptive methods shapes their perceptions and thereby affects how they render services to children, especially in the case of girls. In the broader community, uninformed notions about teenage sex and teens' use of contraceptives exist among health-care providers.

Ironically, teachers' and health-care workers' negative attitudes towards pregnant teens mean that such teens are less likely than non-pregnant ones to receive SRH information from these sources. The media was found to be a more accessible source of information for pregnant teens than for their non-pregnant peers. According to a study in Ghana, pregnant teens were five times more likely to access pregnancy-prevention information from the media than their non-pregnant counterparts. Non-pregnant teens were about two times more likely to have access to pregnancy-prevention services from health facilities than their pregnant peers. In the same vein, non-pregnant teens were twice as likely to receive information on pregnancy prevention from school than from pregnant teens among their peers. Typical to the African context, the availability of parental or grandparental support in child care is a critical factor that mitigates some of the consequences that pregnant teenage girls have to worry about (such as the financial implications of pregnancy and the need for general support in parenting).



3.3 Poverty and family circumstances

Poverty, low income and lack of employment opportunities are important contributors to teenage pregnancy in countries such as Ethiopia, South Africa, Ghana, and Malawi. Poverty is closely linked to early sexual debut, as is the involvement of girls in unwanted or coercive sex for survival or for cash or various transactional favours. Studies have established a clear link between poverty and sexual exploitation. Teenage pregnancy was as high as 66.3 % among teenagers in the poorest quintile compared with only 37.4% among teenagers in the richest quintile (see Figure 3.1 below).

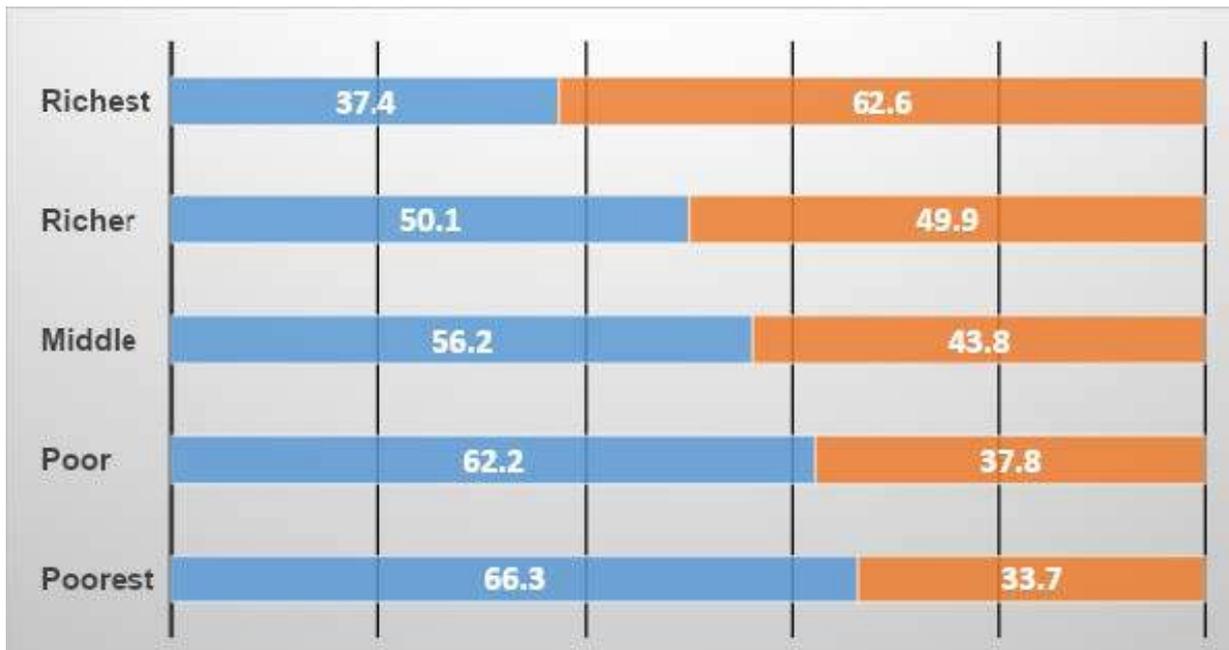


Figure 3.1: Prevalence of teenage pregnancy in Africa by wealth quintiles

Source: Relationship between individual and contextual variables and first pregnancy in adolescents who had ever had sex (DHS 2010–2018)

A case-control study conducted in Ethiopia found that teenagers in the poorest category were 3.09 times more likely to get pregnant than those in the wealthiest category. In Nigeria, teens from the lowest wealth quintile represented about 32% of all pregnant teens compared to just 3.4% from the highest wealth quintile. In Zambia, the percentage of teenagers who began childbearing was highest (45%) among respondents from the lowest wealth quintile, and lowest (10%) among respondents from the highest wealth quintile.

For every 1% increase in a community's level of poverty, the likelihood of teenage pregnancy increased by 1% in West and Southern Africa and by 2% in East Africa. Poverty and unemployment are strong determining factors of teenage pregnancy. Every 1% increase in the level of unemployment among women increased the likelihood of teenage pregnancy by one percentage point in Southern Africa, while in East Africa, every 1% increase in community-level unemployment among women decreased the odds of teenage pregnancy by one percentage point (though this was not so in West Africa). The unusual inverse relationship between community-level unemployment among women and teenage pregnancy in East Africa can be explained partly by the fact that unemployment would

have created a situation where mothers could stay home and provide proper guidance for their children.

Poverty also leads to teenage pregnancy due to the fertile ground it creates for sexual exploitation. This has been evidenced by a reduction in certain aspects of sexual exploitation following the introduction of cash transfer programmes in some countries. For example, Zimbabwe’s Harmonized Social Cash Transfer Programme led to a reduction in the likelihood of youth experiencing coerced sex, while Malawi’s Social Cash Transfer Programme led to a reduction in child marriage and early sexual debut among youth.

The other pathway through which poverty leads to teenage pregnancy is transactional sex. This occurs when sexual relations are undertaken for money or gifts, and is common among adolescents. A study in South Africa noted that the facilitators of sexual exploitation offered girls money, drugs, clothes and other material goods to lure them into sex with strangers; similarly, there were reports that modelling jobs and entry into modelling competitions were offered with the aim of tricking girls into sex. On many occasions, parents were said to have connived in these transactions.

Violence against children (VAC) surveys estimate the prevalence of transactional sex to be as high as 18% in Kenya, 15% in Malawi and 12% in Tanzania. The exploitation of children through transactional sex can involve forms of compensation other than cash, such as the provision of drugs and alcohol. In Addis Ababa, the sexual exploitation of children through transactional sex most frequently involves an exchange of money or *khat* (a local herbal stimulant) and other drugs. Studies in Kenya, Senegal and South Africa found that male teachers solicit sex from girl pupils in exchange for grades, academic favours, and money.

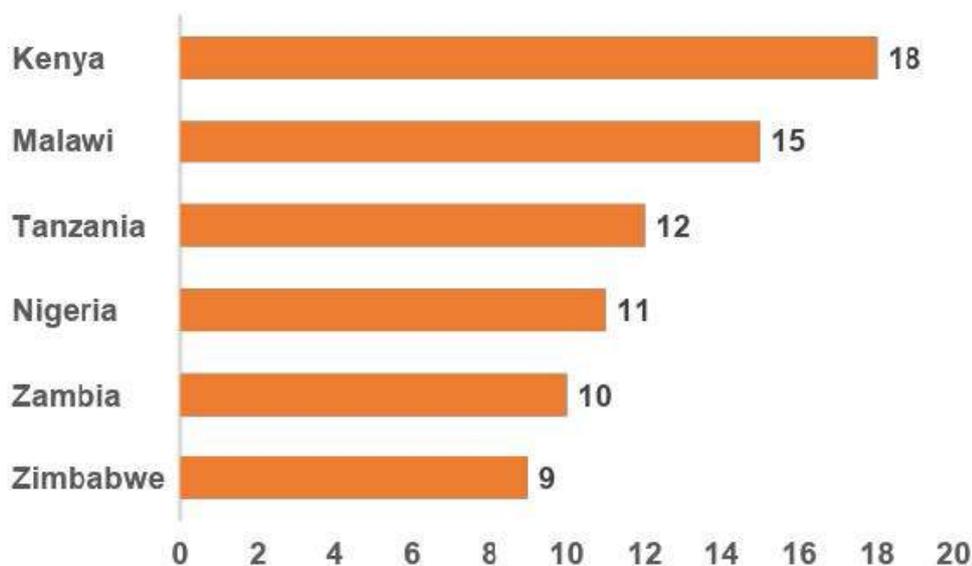


Figure 3.2: Prevalence of transactional sex in selected countries, 2012–2017

Source: VAC Country Surveys in Kenya, Malawi, Nigeria, Tanzania, Zambia, Uganda and Zimbabwe (2012–2017)



Transactional sex is usually age-disparate, and most often occurs between a younger woman and an older man, which thus means that the dynamics of the relationship are dominated by the man. This puts girls in a situation where they are unable to negotiate the timing of sex, or the use of contraceptives and practice of safe sex, as they are often not able to voice their opinions about sex in these relationships. A study in South Africa revealed that girls who engaged in age-disparate sex were more than twice as likely to have reported pregnancy. In addition to sexual risk-taking, girls' engagement in age-disparate relationships with older men – so called 'sugar daddies' – tends to compromise their autonomy in making decisions about safe sex.

'Those who sexually abuse us, especially those older men, undermine and disrespect us after impregnating us. They usually do not want to associate with us anymore because they feel like we are shaming them. Once you get pregnant with a married man, he will not even want to come near you and they deny responsibility because they already have their wives'
- A teen mother, 19, Uganda

Box 3.1: Sex offenders on the move and transactional sex: A risk factor in teenage pregnancy

Sexual exploitation is a major problem in the travel and tourism sector in Africa. Tourists often feel that 'the normal rules' in their home country do not apply when they travel to a foreign place. Reliable data on child sexual exploitation (CSE) in this sector is patchy, but the few available studies based on primary research paint a gloomy picture:

- In Egypt, a study showed that some parents from poor backgrounds facilitated transactional sex, or 'tourism marriages', between their daughters and male tourists (predominantly from Gulf states). Here the parents receive financial payments, including *moakher*, which is financial compensation the male tourist pays to the family of the girl to end the 'tourism marriage'. Such exploitative sexual arrangements are often facilitated by a broker who receives payment for his or her services. A study in Kenya on the state of sexual exploitation in travel and tourism showed that bar owners/managers accounted for 53% of the players involved in mediating and facilitating sexual exploitation in the sector, while peers/friends accounted for a further 27%. Other active exploiters include individuals well known to and trusted by children, including police officers, teachers, lecturers, religious leaders, doctors, watchmen, and relatives.
- South African research among law enforcement officials and social workers suggested that organised criminal networks played a facilitatory role in CSE through 'transactional sex,' and that some tourists, both foreign and local, had interacted with such networks to gain access to children for sexual purposes.

The worrying trend is that age-disparate sexual relations between teens and older men are generally regarded with indifference or even a degree of tolerance. Such sexual relationships are often characterised by lower condom use among girls.

3.4 Early sexual debut, sexual risk-taking and peer influence

Sexual activity and sexual curiosity among adolescents are a normal part of their physiological development and maturation. During puberty, children enter a stage where their sexual organs develop fully and they start responding to sexual impulses, including sexual intimacy and love.

However, this normal response to sexual urges among teenage boys and girls might take a risky dimension and lead to an early sexual debut, especially when it involves alcohol and drug abuse and unsafe sexual experimentation.

Participants in a Zambian study highlighted early sexual debut as a key driver of teenage pregnancy, and reported that sexual debut occurred at ages as early as 9 and 10 years. They also said that certain ways of dressing and behaving were regarded as 'signs' that young women have started having sexual relations. Teenage dating is viewed as acceptable behaviour, as highlighted by more than two-thirds of the participants in a study in a township in Gauteng province, South Africa. Sixty-two percent of the respondents in another South African study reported having begun engaging in sexual activities between the ages of 13 and 15. Similarly, one in three girls in Chad, and one in four in Guinea, the CAR, and Niger, had their first sexual encounter at the age of 15, which is a significant risk factor.

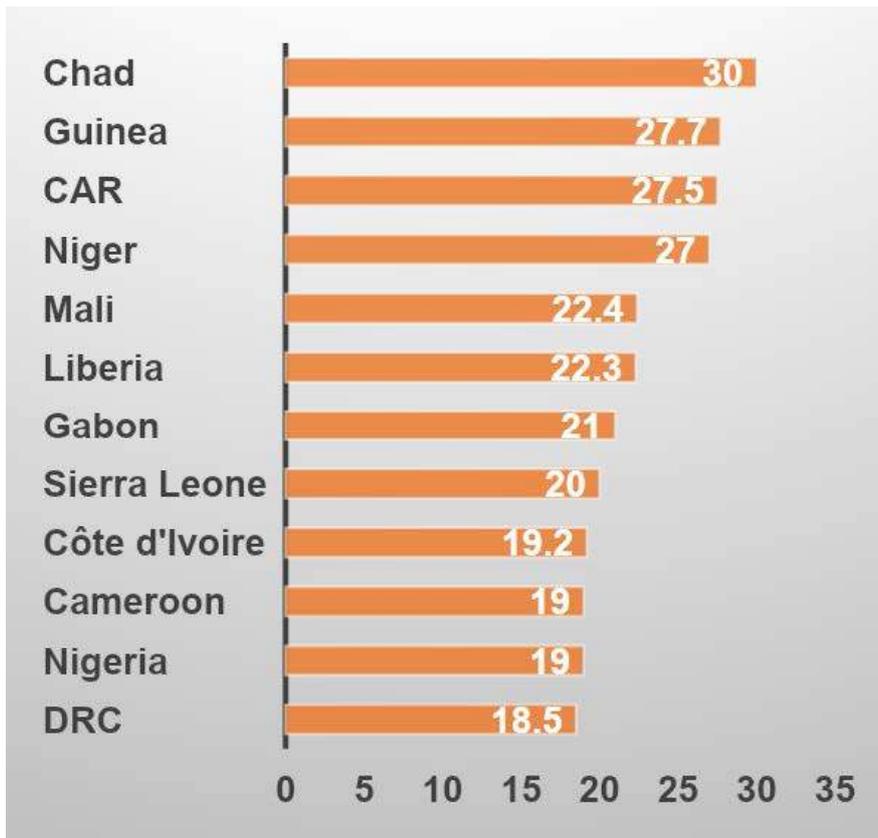


Figure 3.3: Countries with high percentage of women (20–24 years) who had first sex by age 15

Source: UNICEF (2015). *Child marriage, adolescent pregnancy and family formation in West and Central Africa: Patterns, trends and drivers of change*

Sexual intercourse and, more particularly, sex with multiple partners were prevalent, and strongly correlated with substance use, among in-school adolescents in some African countries. Teenagers with multiple sexual partners are at greater risk of teenage pregnancy. A study on secondary and high school students in Tiko Health District in Cameroon found that girls with multiple partners were four times more likely to get pregnant than those without.

A study among university students in South Africa showed that risk behaviours of illicit sex – which included going to discos, clubs or parties (45.6%), smoking cigarettes (14.6%), drinking alcohol (nearly 30%) and smoking marijuana (9.7%) – are associated with unwanted pregnancies. Similarly, 38.5% of respondents in a study in Tanzania attributed sexual urges to engaging in unprotected sex, hence the risk of teenage pregnancy.

In a study in Ghana, 25% of respondents attributed teenage pregnancy to drug abuse among adolescents. A South African study on school-going adolescents showed that,





from a sample of teen girls, about 50.4% of them have used alcohol one or more times in their lives, while 13.1% of them never used alcohol before sex. About 29.7% used drugs of one type or another, and about 35% had two or more sexual partners.

In an FGD with traditional leaders in a Ugandan rural community, it was noted that alcohol abuse by parents, and subsequently by teens, within the household is a factor in teenage pregnancy. A pastor in a local church said that ‘some parents spend much of their time taking alcohol, to the extent of neglecting their responsibility of family leadership and guidance’. As shown in Figure 3.4, about 25% of respondents in a study in Seychelles reported having drunk alcohol, while 10% reported having had multiple sexual partners.

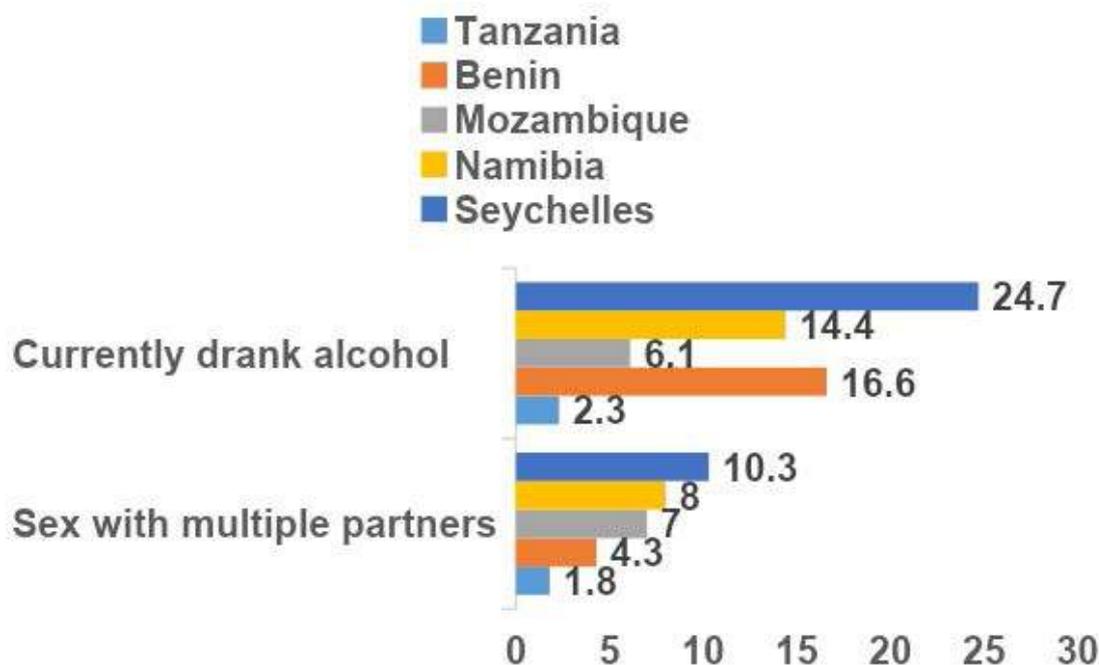


Figure 3.4: Prevalence of sexual and non-sexual risk-taking behaviours among in-school female adolescents (selected countries)

Source: Shayo, F.K and Kalomo, M.H. Prevalence and correlates of sexual intercourse among sexually active in-school adolescents: An analysis of five sub-Saharan African countries for the adolescent’s sexual health policy implications, BMC Public Health, 2019,19(1):1285.

Sexual risk-taking is largely a function of the influence of peers and friends. More than 30% of respondents in a Tanzanian study said peer pressure was the most significant factor contributing to teenage pregnancy, while in a study in the DRC, 73% of respondents cited peer pressure as the cause of teenage pregnancy. About 15% of respondents in a Rwandan, and about 27% in a Zambian study said much the same thing. In a study in Ghana, 41% of the participants cited peer pressure by friends and classmates as a contributing factor to teenage pregnancy. More than half (52%) of the respondents in a study in Nigeria indicated that peer pressure influenced their sexual activities.

3.5 Level of education and teenage pregnancy

There is an inversely proportional relationship between levels of education and teenage pregnancy. On the one hand, the higher the level of education a girl attains, the less the likelihood of her becoming pregnant early; on the other, children who are pregnant are less likely to return to school and/or complete school. In Africa, among teenagers with no education, teenage pregnancy was about 68.6% compared with about 41.6 among those with secondary/higher education, hence significantly decreasing with an increase in the level of education (see Figure 3.5). In one study conducted in Ghana, among surveyed pregnant teens, 68.1% were out-of-school compared with just 18.8% who were in-school.

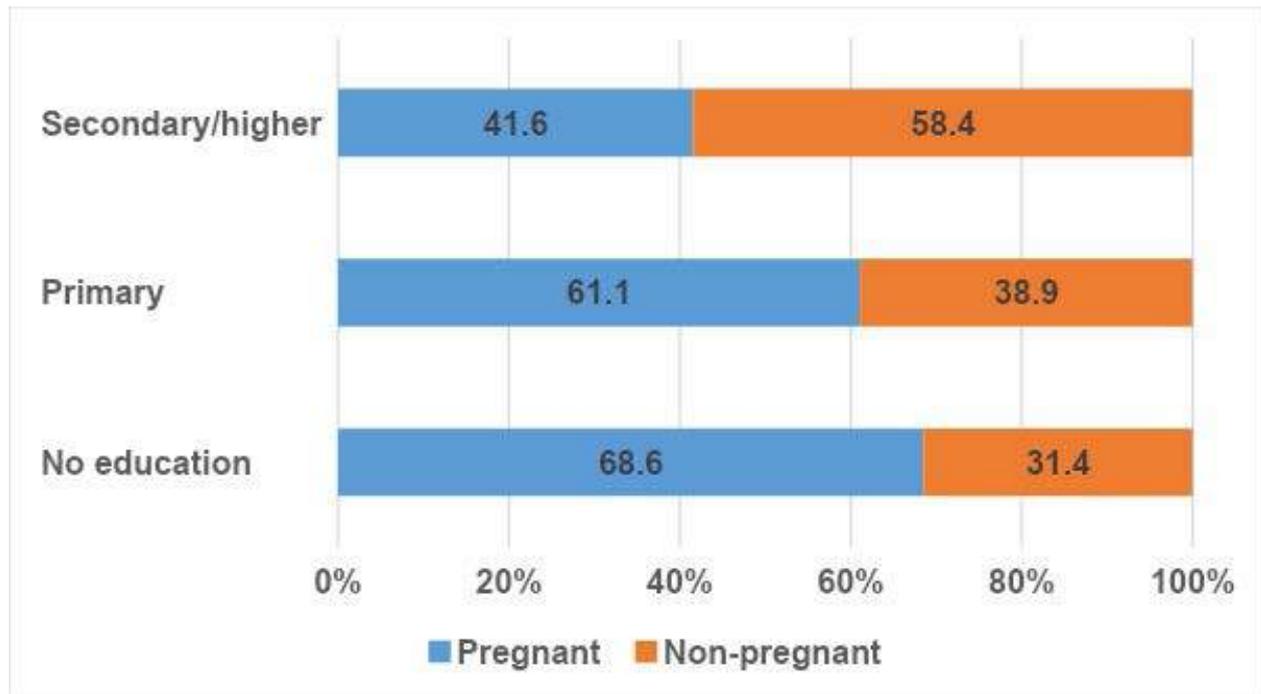


Figure 3.5: Prevalence of teenage pregnancy by level of education in Africa

Source: Relationship between individual and contextual variables and first pregnancy in adolescents who have had sex (DHS 2010–2018)

A study in Zambia showed that 47% of teenagers with no education had teenage pregnancies, compared to 36% of those with primary education, 23% with secondary education and 12% of those with higher than secondary education. The study found the ability to read and write to be an important factor. In Nigeria, half of adolescent women with no education have begun childbearing, compared with 2% of women with a level of education above secondary.

In Namibia, having secondary and higher education reduced the odds of teenage pregnancy by 30%.

A study in rural Ethiopia showed that the prevalence of teenage pregnancy was about 34.0% for those with no formal education, 11.5% for those with primary education and 6.7% for those with secondary education and above.

In Malawi, teenagers who have secondary and higher education were 0.53 times less likely to be pregnant compared to teenagers who have primary and or no education.



Level of education also plays a role in enhancing contraceptive use and therefore reducing the risk of teenage pregnancy. In many African countries, in-school teenagers were 51.2% less likely than those out of school to report ever having had sexual intercourse. Those in school were also 20.5% more likely to have used a condom in their last sexual encounter, and 4.1% more likely to communicate with their parents about SRH issues. Furthermore, those in school were 32.6% more likely than those out of school to report unmet needs for health care, 7.9% more likely to have visited a primary care clinic, and 30.1% less likely to have visited a traditional healer in the past 12 months. In Chad, girls in secondary school used contraceptives nearly four times more than those in primary school. From the evidence, it is clear that there is a correlation between low levels of education and teenage pregnancy.

3.6 Lack of knowledge of and access to SRH information and services

Studies across Africa reveal that teenagers have very limited knowledge of sex, pregnancy prevention, and other reproductive matters. Lack of knowledge about SRH was cited by 87.3% of respondents as the cause of teenage pregnancy in a study in the DRC. Limited knowledge of SRH issues, including awareness of risk factors as well as lack of information about contraceptives, has also been reported in, among others, Ethiopia, Ghana, Kenya, Nigeria, Tanzania, and Uganda.

The results of a study in South Africa showed that 65% of participants agreed that teenage pregnancy could be prevented by using contraceptives such as pills and injections, while 83% said that teenage pregnancy could be prevented through the use of condoms. Surprisingly, 11% of the participants agreed that teenage pregnancy could be prevented by bathing after sex. While 28% of the participants agreed that teenage pregnancy can be prevented by oral sex, about 50% disagreed that oral sex could prevent it and 22% were unsure. Even though the findings show that the majority of participants believed that oral sex cannot prevent teenage pregnancy, it is evident that teenagers still need more information about the prevention of pregnancy. Finally, the study showed that 79% of the participants disagreed with the statement that having sex when standing could prevent pregnancy.

Another South African study revealed that 88% of participants were knowledgeable about the use of contraceptives and 12% were not. Those who were knowledgeable about contraception chose not to use it or kept the use of any contraceptive a secret. This can be attributed to the stigma and negative societal attitudes attached to the use of contraceptives.

The level of knowledge about contraceptives is even lower when it comes to emergency contraceptives, which can prevent unintended pregnancy if taken within a defined period following unprotected sex—whether coerced or not—or in the event of incorrect contraceptive use. Knowledge of emergency contraceptives was found to be below 10% in Senegal and Zambia. A study in Nigeria found that only 28% of the respondents had good knowledge of emergency contraception, while, encouragingly, about 55% of study participants in Ethiopia said that they had heard about it.

Moreover, teenagers face individual, structural, cultural, legal, policy and religious barriers to accessing SRH services. The challenges are multidimensional and mutually reinforcing. For instance, individual barriers include lack of knowledge and misconceptions about SRH services and fear surrounding utilising SRH services.

A study conducted in Uganda shows that teenagers are afraid to seek SRH

information and services from facilities shared with older community members.

Structural barriers include lack of a dedicated space for young people at the facilities, health workers' attitudes to teenage use of SRH services, and limited numbers of skilled health workers to offer youth-friendly SRH services. Studies from the DRC and South Africa affirm that teenagers' access to SRH services is affected by all these structural barriers.

Furthermore, studies from several countries point out that cultural stigma and religious prohibition of the use of contraceptives remain among the major barriers that hold teenagers back from accessing and utilising SRH services.

Although there is a significant increase in teenage access to and utilisation of SRH information and services across Africa, it is still essential to scale up the coverage of such services, enhance their quality, and make them child-friendly.

As indicated in Box 3.2, the Committee and the African Commission on Human and Peoples' Rights have provided guidance on what State Parties should do to ensure access to comprehensive sexuality education and SRH information and services.

Box 3.2: Comprehensive sexuality education and SRH information and services as captured in General Comments of the ACERWC and ACHPR

Joint General Comment of the African Commission on Human and Peoples' Rights (ACHPR) and the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) on Ending Child Marriage, para 36

To encourage the uptake of sexual and reproductive health services, State Parties should develop and implement comprehensive sexuality education and information programmes. Age appropriate information about sex, sexuality, sexual and reproductive health rights and sexually transmitted infections ... should form part of the formal school curriculum and should also be disseminated widely among the general public, including in non-school settings and in media which reaches rural and remote settings.

African Committee of Experts on the Rights and Welfare of the Child, General Comment No. 7 on Article 27 of the African Charter on the Rights and Welfare of the Child 'Sexual Exploitation', para 161

Children should receive age-appropriate and child-sensitive information. Children at all levels of the educational system must receive comprehensive sexuality education. School children should receive appropriate materials to learn about the risks of sale, sexual exploitation and sexual abuse as well as the means to protect themselves offline and online. The provision of sexuality education for in and out of school adolescents must be comprehensive and scientifically accurate. In line with this, States should develop a clear policy and curriculum for the delivery of the subject and provide adequate training and tools for teachers. Educational programmes should always include information on concrete and practical ways for children to seek help and support, and to signal sexual abuse safely and confidentially. Educational materials tailored to those in marginal and hard to reach situations should be prioritised (e.g. children in street situations, migrant children and children with a disability, and out of school children, for instance).

The (un)availability and (in)accessibility of SRH information and services to teenagers are discussed in depth in chapter seven of the study. As is seen in section 7.2 of this report, schools are the main source of knowledge and information about SRH matters, and out-of-school girls are excluded from such knowledge and information. This exclusion from school-based sexual education might partly explain the high prevalence of teenage pregnancy among girls with no formal education. This is a strong indication that education on SRH matters needs to be extended





to community-wide platforms, rather than provided just in schools.

3.7 Sexual abuse and teenage pregnancy

Studies in numerous settings have shown that sexual abuse is a factor that contributes to teenage pregnancy. Studies in Ghana, Tanzania, Nigeria and South Africa found that sexual violence was a factor contributing to teenage pregnancy. Existing evidence on young women whose first sexual experience was forced or due to other forms of sexual abuse shows that sexual violence against children is a widespread problem.

Studies have also revealed that rape has led to an increase in the prevalence of unintended pregnancy among teenage girls, which is as high as 34% in Zimbabwe, 33% in Malawi, 31% in Tanzania, and 30% in Kenya.

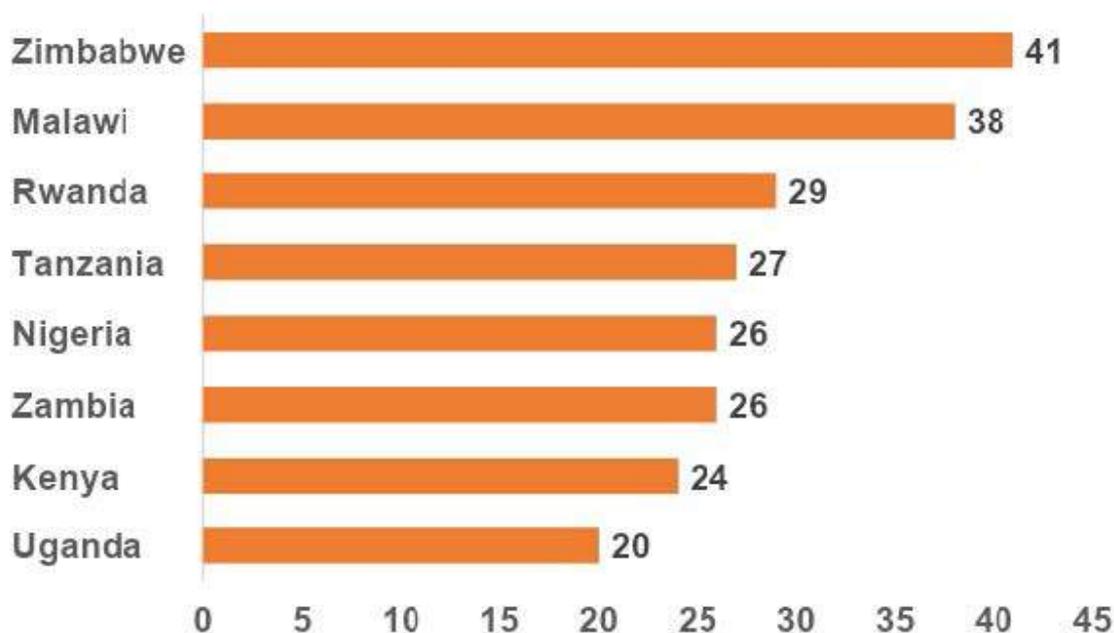


Figure 3.6: Percentage of females aged 18–24 whose first sexual experience was forced

Source: VAC National Surveys

Nearly one in four females (23.3%) aged 13–24 years who were subjected to rape in Zimbabwe became pregnant as a result of the first or most recent incident. In Rwanda, 29% of females indicated that their first sexual experience was rape, a situation increasing the likelihood of unwanted pregnancies. An earlier study in South Africa showed that 11–20% of adolescent pregnancies were due to rape.

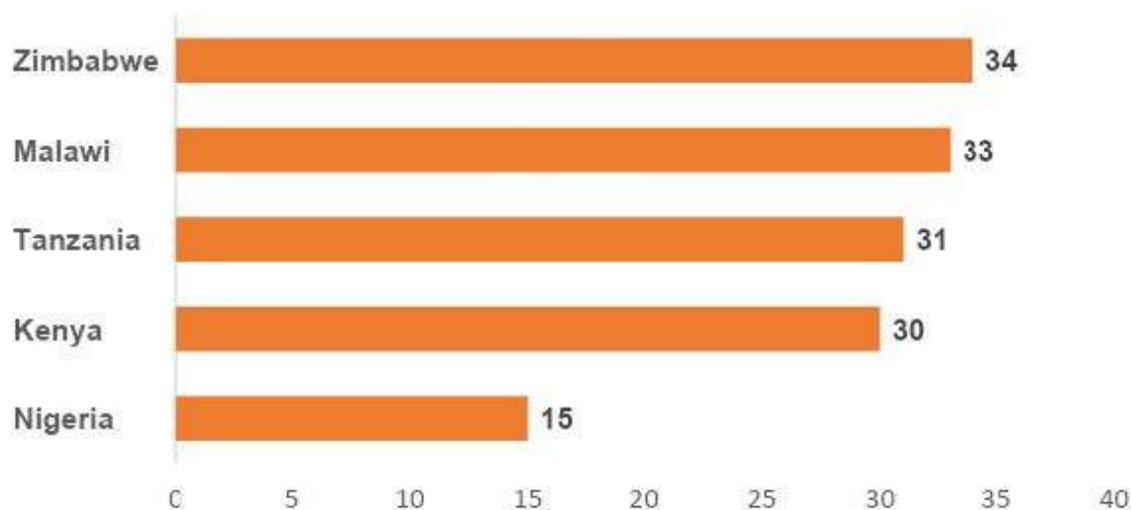


Figure 3.7: Prevalence of unintended pregnancy among women aged 18–24 resulting from forced sex

Source: Together for Girls (undated). 'Girls experience sexual violence at staggering rates'. Available at: <https://www.togetherforgirls.org/identifying-the-issue/>

Apart from sexual abuse, the manner in which the survivors of such abuse and violence are treated afterwards may contribute to either the increase or reduction of teenage pregnancy. The provision of various services, including emergency contraception, in one-stop centres helps in preventing teenage pregnancy. A study in Malawi indicates that one-stop centres – where health practitioners, police and social workers coordinate their efforts closely – are an effective strategy for improving the health, safety and wellbeing of survivors of sexual and physical violence.

Conversely, the absence or ineffectiveness of reporting, referral and one-stop care and support systems for survivors of sexual abuse can undermine efforts to tackle teenage pregnancy. In many African countries, child sexual abuse cases are either unreported or underreported. For instance, a study from South Africa establishes that most survivors of sexual violence neither officially report incidents of rape, nor mention them to other people.

Even when survivors of sexual abuse and violence do come out and report the matter, they might not be able to get the services they need. The existence of one-stop centres alone cannot guarantee the prevention of teenage pregnancy. The kind and quality of service provided by such centres plays an important role in determining their effectiveness. For instance, a study in Ethiopia indicates that the capacity and quality of a one-stop centre is affected by budget constraints and limited human resources. As observed by the WHO, survivors of rape and sexual abuse should be offered emergency contraceptives within 120 hours of sexual violence. Noting that many countries do not have child- and adolescent-friendly health services (which include the provision of emergency contraceptives and the safe abortion services necessary to address teenage pregnancies), the Committee stresses that States should ensure that victims of sexual violence and exploitation have access to free contraceptive services, including emergency contraceptives.

Unfortunately, not all one-stop centres provide comprehensive services to teenage survivors of sexual abuse and violence. For instance, a survey in 2012 in Kenya and Zambia showed that only three out of five one-stop centres offered emergency contraceptive pills to survivors of sexual assault. Thus, it is not only the presence but the effectiveness of one-stop centres that matters in addressing teenage pregnancy.



3.8 Media influence and teenage pregnancy

The media, and especially the film industry, has played a role in exposing children to incorrect information about sex and sexual relations, notably in regard to the notion that engaging in sex without contraception and prior screening for sexually transmitted infections (STIs) carries little risk.

Lack of SRH information and knowledge, coupled with parental negligence and the fact that adolescence is characterised by rapid brain development and the onset of puberty and sexual awareness, means that adolescents are likely to follow the model of behaviours they see in the media without considering whether these behaviours are appropriate for them, given their particular capacities, or whether these behaviours are safe and healthy.

Sexual behaviours in certain contexts – which may be unacceptable in others – are often transmitted through the media. The impact of globalisation and the lack of parental guidance and accurate SRH information to navigate it, have all played a part in encouraging teenage pregnancy. Media influence was attributed to be a cause for teenage pregnancy by 78.5% of the respondents in a study in the DRC.

Online sexual abuse and exposure to sexual content online have also played a significant role in driving teenage pregnancy. Exposure to sexually explicit messages in the media was cited as a predictor of teenage pregnancy in Ghana and South Africa.

An analysis of a large sample of online conversations revealed that teenage girls were on average exposed to sex-related content every minute and an obscenity every two minutes. This relentless exposure to sexual content can influence sexual behaviour.

The role played by social network sites cannot be underestimated in allowing teenage boys and girls to explore sexual relationships with little input from parents and significant others. Sexting – the sending and receiving of sexually explicit cell phone text or photo messages – is another phenomenon that forms part of a culture of risky sexual behaviours among teenagers.

It is important to note that it is not the media in and of itself that is the problem. Rather, it is the misuse of media and teenagers' exposure to age-inappropriate content that increases teenage pregnancy. In fact, if used properly, media can be an instrument capable of contributing to the prevention and reduction of teenage pregnancy, as evidence shows. For instance, a study from Zambia indicates that teenagers who have access to media with age-appropriate information on matters of sexuality and reproduction are less likely to become pregnant than those with no or limited access.

Another study, from Uganda, establishes that the use of mass media and community dialogue help in reducing the risk of teenage pregnancy by equipping teenagers with knowledge of pregnancy prevention and influencing behaviour on contraceptive use.

In this regard, it is worth noting the attention some States are giving to the media in the effort to reduce teenage pregnancy. For example, the government of Sierra Leone, in its national strategies, has emphasised the crucial role of the media in reducing teenage pregnancy.

Media can play a key role in preventing and reducing teenage pregnancy in Africa; it is hence essential to call for more investment in this sector to advance girls' rights to SRH information and services.

From the evidence above, it is apparent that the media plays an important role in either decreasing or increasing the likelihood of teenage pregnancy. Much depends on whether children are exposed to inaccurate information and explicit sexual content that could influence their understanding of sexuality and reproduction. Therefore, the solution lies partly in empowering parents or caregivers to offer adequate guidance to their children – both online and offline – to

prevent children’s access to material that is neither age-appropriate nor consistent with their evolving capacities. Furthermore, media platforms, including online social media sites, should be legally required, and monitored in this regard, to ensure that children do not have access to information which is insensitive to their needs and rights or that encourages them to engage in sexual activities at an early age.

3.9 Teenage pregnancy and child marriage

The connection between child marriage and teenage pregnancy is well-established. It is underscored by the fact that 80% of teenage mothers in most African countries are married or co-habit with a male partner or have already been married.

When a girl gets pregnant, it is often the case that she is forced into marrying the person who made her pregnant. Half of the pregnant teens and teenage mothers interviewed in Mauritania for this study reported having been married immediately following their pregnancy. Out-of-court family negotiations with the perpetrator of the sexual violence and rape that resulted in pregnancy often lead to the child’s marriage to the perpetrator. This is a source of considerable emotional distress. According to community-member participants in an FGD in Uganda, ‘The idea of living with the person who raped you is an unbearable situation.’⁹

Most of the parents in my community, once their girls get pregnant, they tell them to go and marry those men who impregnated them and they chase them away from home whether they like it or not’ – a teen girl, 14, Uganda

Once married, girls are expected to get pregnant. Girls who are trapped in early or forced marriages run a very high risk of pregnancy. Generally, marital status remains significantly associated with teenage pregnancy, and adolescent girls who are not married are less likely to become pregnant than those who are.¹⁰ This has been established in countries such as Ethiopia, Ghana and Malawi.¹¹

Young married girls are often under pressure from their partners (and, in some cases, their in-laws) to conceive soon after marriage. In many instances, marriages between young girls and older men are entered into for procreation and to take advantage of a young girl’s long reproductive life. Accordingly, many girls get pregnant soon after marriage even though their bodies might still be physiologically underdeveloped.¹² This is because the use of contraception among married teenage girls is extremely low. There are, in turn, several reasons for this, including the girls’ inability to give or withhold sexual consent – most of them are married to older men, and lack the power to negotiate over reproductive rights or birth control.¹³ As shown

9 Data from Uganda country case study, as part of this research.

10 Ochen, A.M. et al. Predictors of teenage pregnancy among girls aged 13–19 years in Uganda: A community based case-control study. BMC Pregnancy Childbirth, 2019, 19.

11 Kaphagawani N.C., Kalipeni E. Sociocultural factors contributing to teenage pregnancy in Zomba district, Malawi. Global Public Health, 2017, 12(6): 694–710.

12 African Union (2013). Campaign to end child marriage in Africa: Call to Action 3.

13 According to Barua and Kurz, ‘Evidence based research has shown that child brides’ lack of knowledge about reproductive health matters, the high pressure they feel to give birth soon after marriage, and their limited autonomy to





in Figure 3.8, countries with the highest prevalence of child marriage are also the countries with the highest prevalence of teenage pregnancy.

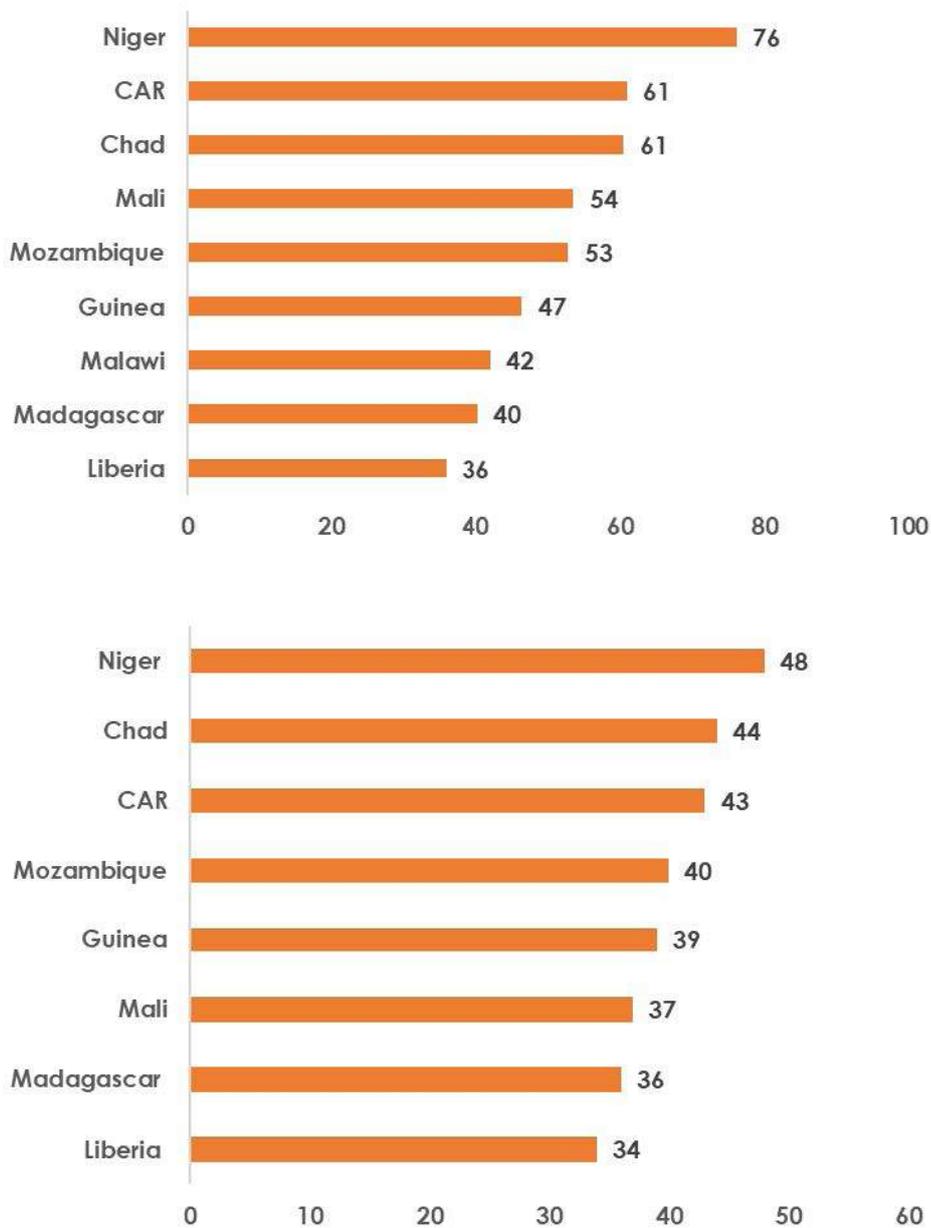


Figure 3.8: Countries with high prevalence of child marriage and teenage pregnancy.

Source: DHS and MICS surveys

As noted in the SADC Model Law on Eradicating Child Marriage and Protecting Children already in Marriage (hereafter 'Model Law'), there is a close association between child marriage and early pregnancy, as girls are pressured to demonstrate their fertility.¹⁴ In a 2018 study in Ethiopia, adolescent girls expressed feelings of powerlessness in negotiating contraceptive use due to fears of offending or disappointing their partners and in-laws.¹⁵ Also, a study in Tanzania

make reproductive decisions often cause teenage pregnancy? See Barua, A. and Kurz, K. Reproductive health-seeking by married adolescent girls in Maharashtra. *India Reproductive Health Matters*, 2001, 9(17): 53–62.

14 SADC Model child marriage law, 11.

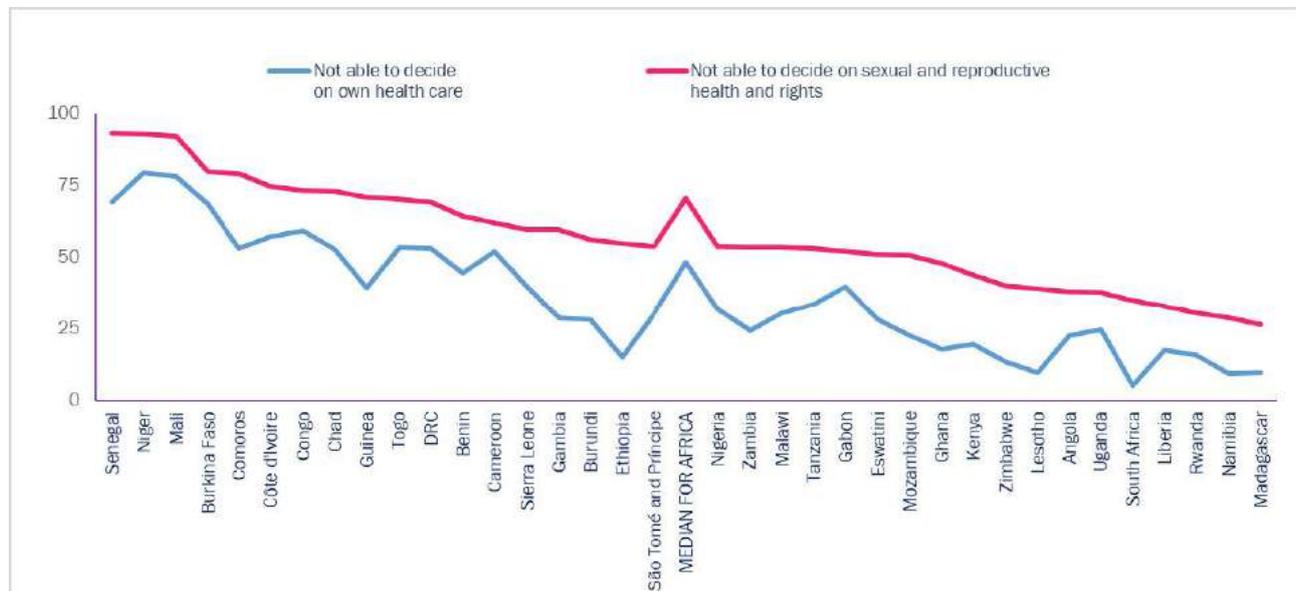
15 McClendon, K.A. et al. Intersections of girl child marriage and family planning beliefs and use: Qualitative findings from Ethiopia and India. *Culture, Health & Sexuality*, 2018, 20(7): 799–814.

observed that high bride prices exert immense pressure on married girls to start childbearing immediately upon marriage.¹⁶ There is considerable social pressure on girls who get married early to get pregnant quickly. In extreme instances, this pressure sees partners and in-laws resorting to violence against girls. Scared of divorce and the stigma associated with it, girls generally acquiesce to demands for them to give birth as soon as possible after marriage,¹⁷ thereby propelling the prevalence of teenage pregnancy.¹⁸ This phenomenon is closely related to young brides' unawareness of their reproductive rights and their lack of agency or autonomy in matters relating to pregnancy, delivery and contraception.

In many communities, if a girl becomes pregnant, an arrangement is made for the father of the child to marry off the girl with a view to protecting the honour of the pregnant girl and her family.¹⁹

3.10 Girls' lack of agency or autonomy in SRH decisions

Apart from the factors above, a critical factor that leads to teenage pregnancy is women and girls' lack of autonomy and agency in regard to their SRH choices. For example, more than half of the women in 11 African countries said that they cannot make their own health-related decisions. On average, a third of women in Africa are denied the right to make decisions about their health and about 54% are unable to make decisions on their sexual and reproductive health rights. A very high percentage of girls in Senegal, Mali, Comoros and Congo Republic have no or very limited power to make their own SRH decisions.



16 Centre for Reproductive Rights (2013). Forced out: Mandatory pregnancy and the expulsion of pregnant students in Tanzanian schools.

17 See UNFPA-UNICEF Global Programme to End Child Marriage (2021). Evolution in the evidence on child marriage: 2000–2009, 53.

18 Ketema, H. and Erulkar, A. Married adolescents and family planning in rural Ethiopia: Understanding barriers and opportunities. *African Journal of Reproductive Health*, 2018, 22(4): 26–34. See also Rahman, M.M. and Kabir, M. Knowledge of adolescents on contraception and dynamics of its use. *Health and Population: Perspectives and Issues*, 2005, 28(4): 164–177.

19 UNICEF (2015). Qualitative study of child marriage in six districts of Zambia.

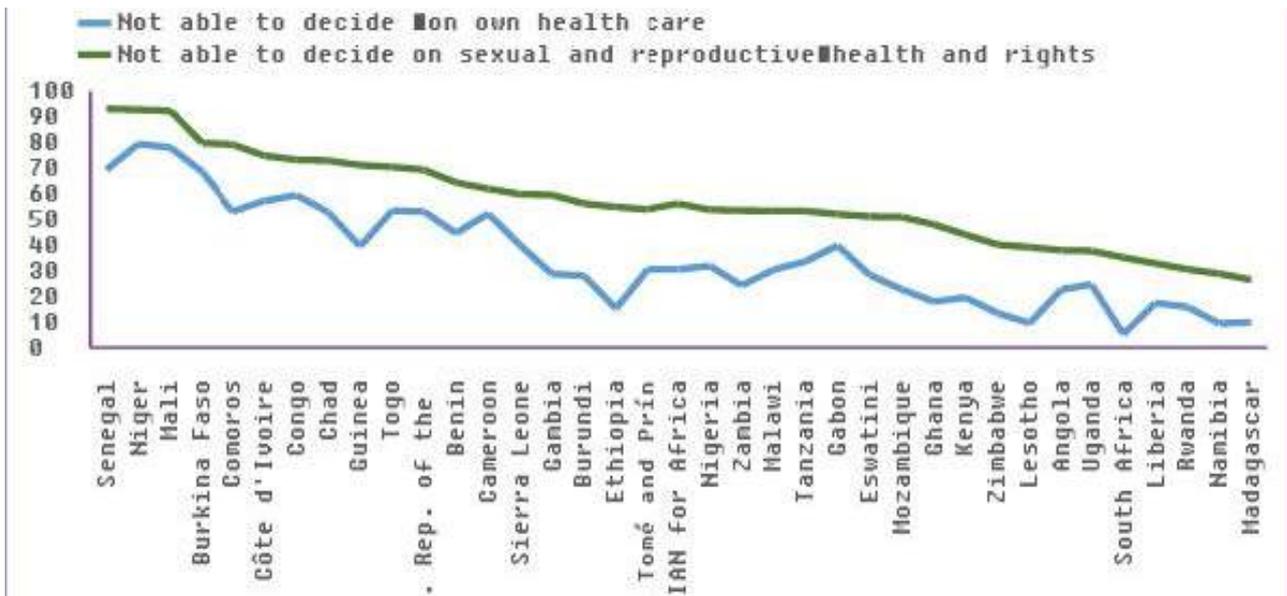


Figure 3.9: Proportion of women (aged 15–49) in African countries who cannot make health and SRHR decisions

Source: Based on data from UNFPA 2020

Children asserting autonomy in reproductive decision-making are often confronted by counterclaims of legitimate intervention by parents or guardians responsible for caring for the child. So, on the one hand, restrictive laws and policies take away the autonomy of girls over sexual life (see Chapter 6); on the other, just as importantly, traditional beliefs about parental responsibilities serve to do much the same. The unintended effect is that girls might experiment in secret without appropriate information, knowledge and understanding, thereby exposing themselves to the risk of teenage pregnancy.

3.11 Summary

Teenage pregnancy is triggered by a number of factors, some of which are universal and others of which are specific to the African context. Girls from Africa are at a greater risk of teenage pregnancy due to factors such as poverty, low levels of education, economic status, child marriage, family and community attitudes, sexual exploitation, and lack of or limited access to SRH information and services.

Parents, community members, and health-care and education service providers often display negative attitudes towards girls who seek SRH information and services. In most African societies, where virginity before marriage is celebrated, using contraceptives – a sign of sexual experience – is culturally shunned. Gender-discriminatory practices that deny girls the autonomy to make their own SRH choices is a particularly important factor, and one which is often neglected in discussions of teenage pregnancy.

Household poverty is a major factor in teenage pregnancy in Africa. Overall, teenage pregnancy was found to be about 37% in the richest quintiles compared to 66% in the poorest quintiles in many African countries. Transactional sex, sexual exploitation, and age-disparate sex are all fuelled by household poverty. The sexual exploitation of girls in the travel and tourism sector, as

well as in armed conflict and humanitarian emergencies, is an ever-increasingly important factor in teenage pregnancy.²⁰

Furthermore, one of the most significant determinants of teenage pregnancy in Africa is girls' level of education. Girls with lower levels of education are consistently at greater risk of pregnancy than those with primary and secondary education. This is due partly to their low levels of knowledge about SRH matters and services.

Girls from families characterised by domestic violence and alcohol and drug abuse are at greater risk of teenage pregnancy. Perhaps the greatest of all factors is child marriage. Countries with the highest prevalence of teenage pregnancy are also countries with the highest prevalence of child marriage.

20 Yakubu, I. and Salisu, W.J. Determinants of adolescent pregnancy in sub-Saharan Africa: A systematic review. *Reproductive Health*, 2018, 15(15): 5–6; Human Rights Watch (2018). *Leave no girl behind in Africa: Discrimination in education against pregnant girls and adolescent mothers*.



CHAPTER 4: **SPECIAL VULNERABILITIES AND RISK FACTORS**

4.1 Introduction

This chapter discusses the situation of teenage pregnancy for girls who live in especially vulnerable circumstances. While teenage pregnancy affects all girls, some groups are disproportionately affected by this problem. These include girls with disabilities; those living and/or working on the streets; those belonging to ethnic minority groups; refugees, or those living in emergency or other situations requiring humanitarian assistance; girls who have been trafficked; and girls in child-headed families and other groupings.²¹ As well as discussing all of this, the chapter examines the additional vulnerabilities that arose from the COVID-19 pandemic.

4.2 Girls living in especially vulnerable circumstances

Although all girls are vulnerable to teenage pregnancy, there are certain groups who are especially vulnerable to it. While the risk of and exposure to teenage pregnancy varies, girls in vulnerable situations often find themselves forced into sexual relations due to poverty and transactional sex, among other things. They tend to have very limited access to SRH services.

The primary data collected from selected countries for the purposes of this study (Chad, Madagascar, Mauritania, Togo, Niger, Senegal, and Rwanda) indicated that many groups are particularly vulnerable to teenage pregnancy. They include girls with disabilities; girls living on the street and in urban slums; domestic workers; those deprived of parental care; girls on the move; and girls living in humanitarian and conflict situations. Respondents attributed this vulnerability to a range of factors: the existence of limited legal protection; and broader individual and community factors, including negative social attitudes and restrictive cultural practices. All of these factors increased the possibility of teenage pregnancy.

4.2.1 Pregnancy- and SRH-related challenges for girls with disabilities

According to an African Child Policy Forum (ACPF) research report, sexual violence inflicted on children with disabilities is high in many countries, ranging from two incidents of sexual violence per child in Senegal to about four incidents per child in Cameroon. These include rape (52%); forced involvement in transactional sex (30%); and indecent touching (43%). Among children with disabilities, those with speech and language difficulties are three times more likely to suffer sexual abuse than other children. For children with behavioural disorders, the risk is between five and seven times higher than for children without disabilities.²² A study in Ghana found that 13 was the average age for teenagers with disabilities to first have sexual relations. It was also found that about 77% of sexually active respondents did not use contraception. The study revealed that school teachers were the major sources of information for adolescents with disabilities (63.9%), followed by parents (12.2%). Participants with visual impairments were 2.3 times more likely to have good knowledge of sexual health than those with intellectual disabilities.²³

21 CRC Committee, General Comment No.13, para 72(g).

22 Dhai, A. (2003). Ethical & societal issues in the care and management of the intellectually disabled child as they grow up. Presented at a workshop of the South African Association for Scientific Study of Mental Handicap. Johannesburg General Hospital.

23 Obasi, M. et al. Sexual and reproductive health of adolescents in schools for people with disabilities Mercy. Pan African Medical Journal, 2019, 14(33): 299.

Limited access to SRH and family planning services is a major driver of teenage pregnancy among girls with disabilities. Studies in Cameroon, Ethiopia, Ghana, Kenya, Namibia, Rwanda, South Africa, Uganda, Zambia and Zimbabwe all reported on the general physical inaccessibility of the health-care system for the disabled. They noted the lack of disability-friendly transportation as a significant impediment barring teenagers with disabilities from accessing SRH and family-planning services. Lack of adjustable hospital beds in delivery wards for women giving birth was cited as a barrier in Uganda. Lack of knowledge on the part of health-care providers about disability, as well as negative attitudes towards the disabled and adolescents who are pregnant or seeking SRH information and services, were also cited as significant drivers of teenage pregnancy in most of the studies, notably so in Ethiopia, Ghana, Namibia, Senegal, Zambia and Zimbabwe. Negative perceptions of the disabled – including the widely held assumption that the disabled are asexual, often trigger an extremely adverse reaction when a pregnant woman or adolescent who is disabled is encountered.

Significant barriers to effective communication with the disabled include the absence of information about SRH in alternative formats such as braille, enlarged print or audio compact disks, and the complete lack of sign language interpreters. All of these have been reported to impede accessibility of SRH services to adolescents with disabilities in Cameroon,²⁴ Ethiopia,²⁵ Ghana,²⁶ Kenya,²⁷ Namibia,²⁸ South Africa,²⁹ Uganda,³⁰ and Zimbabwe.³¹ In Nigeria, there is a failure to cover the sexual and reproductive needs and rights of adolescents with disabilities in the national curriculum, along with a correlative lack of teaching materials. What is also notable is the absence or inadequate capacity of educators on the topic of sexuality and disability, which has been cited as another important factor in teenage pregnancy.

Reports have also shown that, in many African countries, lack of SRH education means that adolescents with disabilities tend to engage in sexual intercourse without any form of contraception. Ethiopia records that only about 35% of young people with disabilities did use contraceptives during their first sexual encounter.³²

24 Bremer, K. et al. Reproductive health experiences among women with physical disabilities in the Northwest Region of Cameroon. *International Journal of Gynaecology Obstetrics*, 2010, 108(3): 211–3.

25 Yimer, A.S. and Modiba, L.M. Modern contraceptive methods knowledge and practice among blind and deaf women in Ethiopia. A cross-sectional survey. *BMC Women's Health*, 2019, 19(1): 151.

26 Tun, W. et al. Limited accessibility to HIV services for persons with disabilities living with HIV in Ghana, Uganda and Zambia. *Journal of International AIDS Society*, 2016, 19: 1–7.

27 Tanabe, M. et al. Intersecting sexual and reproductive health and disability in humanitarian settings: Risks, needs, and capacities of refugees with disabilities in Kenya, Nepal, and Uganda. *Sexual Disability*, 2015, 33(4): 411–27.

28 Van Rooy, G and Mufune, P. Experiences and perceptions of HIV/AIDS and sex among people with disabilities in Windhoek, Namibia. *Sexuality and Disability*, 2014, 32(3): 311–21.

29 Mavuso, S.S. and Maharaj, P. Access to sexual and reproductive health services: Experiences and perspectives of persons with disabilities in Durban, South Africa. *Agenda [Internet]*, 2015, 29(2): 79–88.

30 Yousafzai, A.K. et al. HIV/AIDS information and services: The situation experienced by adolescents with disabilities in Rwanda and Uganda. *Disabil Rehabil*, 2005, 27(22): 1357–63.

31 Peta, C. Disability is not asexuality: The childbearing experiences and aspirations of women with disability in Zimbabwe. *Reproductive Health Matters*, 2017, 25(50): 10–9.

32 Kassa, T.A. et al. Sexuality and sexual reproductive health of disabled young people in Ethiopia. *Sexually Transmitted Diseases*, 2014, 41(10), 583–588; Aderemi, T.J. et al. Predictors of voluntary HIV counselling and testing services utilisation among people with disabilities in Addis Ababa, Ethiopia. *AIDS Care*, 2014, 26(12), 1461–1466.





4.2.2 Pregnancy- and SRH-related challenges for girls living on the street and in urban slums

Girls living and/or working on the street are particularly vulnerable to sexual violence and exploitation.³³ They often find themselves engaging in transactional sex without the appropriate access to SRH information and services. More than 74% of girls living and/or working on the street surveyed in Uganda, 70% in Kenya and 62% in Malawi were subjected to at least one form of sexual harassment or violence. Twenty-five percent of girls living on the street in Kenya had experienced rape.³⁴

Egypt is home to more than a million children who are living and/or working on the street. A study by National Centre for Social and Criminological Research (NCSCR) found that at least 20% of them (most between the ages of 6 and 11) were victims of trafficking who were exploited by a third party for sexual purposes as well as for earning income through begging. Among the sexually active 15–17-year-olds living on the street, 54% reported having multiple sexual partners and 52% reported having never used condoms. Furthermore, 53% of the girls contacted for the study in Greater Cairo, and 90% of respondents in Alexandria, had experienced sexual abuse.³⁵

Urban slums are the other main setting where girls are at greater risk of teenage pregnancy. Evidence from slum communities in Nairobi indicates that adolescents living in slums engage in riskier sexual behaviours than their peers in non-slum areas. These behaviours include early sexual debut; transactional sex; and multiple sexual partnerships.³⁶ In slum communities, adolescents' knowledge of contraception is inadequate, and their access to contraceptive methods is limited, impacting an adolescent girl's ability to control her reproductive life.³⁷ In Kenyan urban slums, 41% of adolescents in a study reported having been victims of unintended pregnancy, with 26% of them reporting that their pregnancy was mistimed and 15% reporting that it was entirely unwanted.³⁸ These findings suggest not only limited knowledge, availability and use of SRH information and services in urban slums; they also indicate that there is weak law enforcement in these areas, resulting in sexual violence and teenage pregnancy.

4.2.3 Teenage pregnancy in the context of conflict, humanitarian and refugee settings

In conflict, emergencies and humanitarian situations, the risk of sexual abuse and violence is omnipresent. Girls are subjected to sexual abuse and exploitation by some members of the armed forces, family members, strangers and even humanitarian

33 CRC Committee, General Comment No. 21 (2017) on children in street situations (CRC/C/GC/21), para 58.

34 VAC survey data from Uganda, Kenya and Malawi.

35 Nadaa, K.H. and Suliman, E.D.A. Violence, abuse, alcohol and drug use, and sexual behaviors in street children of Greater Cairo and Alexandria, Egypt. *AIDS*, 2010, 24 (suppl 2): S39–S44.

36 Kabiru, C.W. et al. Transition into first sex among adolescents in slum and non-slum communities in Nairobi, Kenya. *Journal of Youth Studies*, 2010, 13: 453–471.

37 Ezeh, A.C. et al. Reaching the urban poor with family planning services. *Studies in Family Planning*, 2010, 41: 109–116.

38 Beguy, D. et al. (2014). Unintended pregnancies among young women living in urban slums: Evidence from a prospective study in Nairobi City, Kenya.

aidworkers(peacekeepersanddevelopment aid staff).³⁹ The risk is everywhere: at home, in detention camps, and in the everyday activities of the community, where girls perform daily activities such as collecting water and firewood or going to school.⁴⁰ In conflict areas, for example, girls are taken as brides by warlords or offered by their families to authority figures in exchange for protection from violence or death.⁴¹ Teenage girls are also offered to combatants, fighters or warriors as a way of negotiating peace and harmony among conflicting communities. All in all, girls are the objects of multiple forms of violence, including abduction, sexual violence, prostitution, forced impregnation, forced termination of pregnancy, and forced marriage.⁴² As a standard military tactic, girls are systematically used as sexual objects as a way of humiliating communities, exerting domination over them, and instilling fear.⁴³

According to the UN:

- Since 2009, Boko Haram has, in Nigeria, recruited and used more than 8,000 children, abducted at least 4,000 girls, boys and young women, and sexually exploited more than 7,000 girls and women.
- In South Sudan, more than 17,000 children have been recruited and used in the war over the years, with a further 3,090 children abducted and 1,130 children sexually exploited by armed forces and armed groups.
- In Somalia, militants from groups such as Al-Shabaab and Ahl al-Sunna wal-Jama'a, and soldiers of the National Army, are reported to have forced girls into sexual slavery and/or forced marriages.⁴⁴

In all these situations, where they are deprived of the power to exercise their will and autonomy over their sexual life and reproductive health, teenage girls get pregnant.

Another major concern in emergencies, conflicts, and humanitarian situations is the lack of health-care services, facilities and other psychosocial support services for girls. Conflicts and strife, whatever their nature, result in the destruction of health facilities (through bombing or burning) and the displacement of health and other professionals who could otherwise provide services. At the same time, the supply of medical equipment and stocks is often badly affected, meaning that sexually abused girls are unable to obtain the medical advice and assistance they would need to stop pregnancy. For those already pregnant, regular access to health facilities and antenatal care is made difficult if not impossible. Female refugees in the Osire refugee

39 A survey in Liberia, Guinea and Sierra Leone observed: 'Agency workers ... are among the prime sexual exploiters of children often using the very humanitarian assistance and services intended to benefit refugees as a tool of exploitation. Male national staff ... trade humanitarian commodities and services, including medication, education courses, school supplies [amongst others], in exchange for sex with girls under 18. The practice appeared particularly pronounced in locations with significant and established aid programmes.' See United Nations High Commissioner for Refugees and Save the Children – UK (2002). *Sexual violence and exploitation: The experience of refugee children in Liberia, Guinea and Sierra Leone* 9. Available at: <https://bit.ly/3b6Juc5> (accessed on 20 July 2022).

40 See CEDAW Committee, General Recommendation No. 30 on Women in Conflict Prevention, Conflict and Post-Conflict Situations 2013 (CEDAW/C/GC/30), para 34.

41 AU Campaign to End Child Marriage in Africa, 4.

42 UN Report of the Secretary-General on Conflict-related Sexual Violence (2018) S/2018/250.

43 CEDAW Committee, General Recommendation No. 30 on Women in Conflict Prevention, Conflict and Post-Conflict Situations 2013 (CEDAW/C/GC/30), para 35.

44 UN (2017). Joint report of the Special Rapporteur on the sale and sexual exploitation of children, including child prostitution, child pornography and other child sexual abuse material and the Special Rapporteur on trafficking in persons, especially women and children, A/72/164, Seventy-second session, Distr.: General 18 July 2017.



camp in Namibia stated that they feel undermined and deprived of agency, specifically in regard to accessing contraceptive services for teenage girls.⁴⁵

In Malawi, research conducted in the Dzaleka refugee camp shows that early pregnancy is a common issue for refugees from different countries, including Ethiopia, Burundi, Rwanda, Somalia, and the DRC. Teenage pregnancy is a serious issue for Burundian refugees in Rwanda. A research study in two Congolese refugee camps in Rwanda-Kiziba and Gihembe indicates that the top four issues among encamped refugees are prostitution, early pregnancy, out-of-school children, and delinquency. Among these, teenage pregnancy is regarded as the most prevalent (45%) source of refugees' problems.⁴⁶

Many adolescents with refugee status have reproductive health issues that put their health and lives at risk. The United Nations Refugee Agency (UNHCR) affirms that the foremost reproductive issue in refugee status or crisis situations is unintended pregnancy.⁴⁷

The Special Rapporteur on the human rights of internally displaced persons (IDPs), in his 2017 report on Nigeria, described the extent of sexual exploitation and abuse in IDPs as an 'an epidemic', further noting that 'sexual exploitation and sexual violence, including demands for transactional sex to access food and non-food items, are commonplace'.⁴⁸ Refugees often resort to sex as a means to ensure their survival. This, coupled with the tendency by some personnel in the camps to abuse their positions of power and control to take sexual advantage of teenage girls, can lead to unintended pregnancies.⁴⁹ One study notes that 'sexual acts can be demanded in exchange for protection and material support, with peacekeepers and aid workers withholding food, shelter, and other services until their sexual demands are met'.⁵⁰

The Special Rapporteur on the human rights of IDPs noted that in nearly all the camps surveyed, women and girls reported engaging in 'survival sex' in exchange for food, money, and permission to leave camps with restrictive movement policies.⁵¹ Women and girls who suffer unintended pregnancy through rape and sexual exploitation have limited or no access to contraception, including emergency contraception, and often resort to unsafe abortion.⁵²

45 Pinehas, N. L. et al. Healthcare needs of displaced women: Osire refugee camp, Namibia. *International Nursing Review*, 2016, 63(1): 139–47.

46 Prickett, I. et al. (2013). Community-based child protection mechanisms in refugee camps in Rwanda: An ethnographic study. *Child Protection in Crisis-Network for Research, Learning & Action*.

47 Okanlawon, K. et al. (2010). Contraceptive use: Knowledge, perceptions and attitudes of refugee youths in Oru refugee camp, Nigeria.

48 Human Rights Council, Thirty-fifth session 6-23 June 2017 Agenda item 3. Report of the Special Rapporteur on the human rights of internally displaced persons on his mission to Nigeria.

49 Nanette, E. Where there is no village: Teaching about sexuality in crisis situations. *SIECUS Report*, 1998, 26(5): 7–10.

50 Sieff, K. (2016). UN says some of its peacekeepers were paying 13-year-olds for sex. *The Washington Post*. Available at: <https://wapo.st/3q7qphU> (accessed on 20 July 2022).

51 Human Rights Council, Thirty-fifth session 6-23 June 2017 Agenda item 3. Report of the Special Rapporteur on the human rights of internally displaced persons on his mission to Nigeria.

52 Centre for Reproductive Rights and Legal Defence and Assistance Project (2020). *The Conflict in Northeast Nigeria: Impact on the Sexual and Reproductive Rights Conflict of Women and Girls*.

4.3 COVID-19 and teenage pregnancy

There is growing evidence that COVID-19 impacted greatly on children in Africa, specifically girls given their unique vulnerabilities. Numerous studies reveal that COVID-19 and measures in response to it increased the incidence of sexual violence and transactional sex, leading in turn to increased levels of teenage pregnancy. Furthermore, child marriage, closure of schools, household deprivation and the disruption in protective services meant that girls were exposed to unintended pregnancy, especially in rural areas. To cite a few examples from the available data:

- In Uganda, teenage pregnancy was reported to have shown a sharp increase since the COVID-19 pandemic. It is estimated that more than 17,000 girls have risen by 30% since the outbreak of COVID-19. Another estimate put the number of girls who were made pregnant in the eight districts of northern Uganda during the first two months of the 2020 COVID-19 lockdown at over 17,000, some of them as young as 12 years.⁵³ In the Luuka district, it was reported that over 40 primary school girls have been made pregnant within the space of just two months.⁵⁴ In another district called Nwoya, the number of adolescent pregnancies reportedly doubled within three months, between April and June 2020 compared to January to March of the same year.⁵⁵
- In Kenya, available evidence suggests that more than 150,000 teenage girls became pregnant over a three-month-period during the COVID-19 lockdown, representing a 40% increase on the pre-COVID-19 period. A rise in teenage pregnancy of 80% or more was reported by a number of counties between March and June 2020 compared to the same period in 2019.⁵⁶
- In Malawi, in July 2020, the Health Principal Secretary predicted a 35% increase in the number of pregnancies in girls between the ages of 10 and 19 years in the first half of 2020 compared to 2019.⁵⁷

Child marriage served to increase teenage pregnancy during the pandemic. Many families facing economic hardships felt they had no choice but to marry off their daughters quickly to reduce the dependents in the household. School closures created fertile ground for large numbers of child marriages due to the lack of scrutiny by child protection workers.

For example, in early 2020, 766 planned child marriages were averted by authorities in the northern part of Ethiopia. A news report in July 2020 said that in Kitgum, Uganda, 2,300 school girls became pregnant and 128 were married in the course of the pandemic. Likewise, a household survey of refugees in Kampala and settlements indicated that teenage pregnancies and child marriage had increased by 21% and 18%, respectively, during the pandemic.⁵⁸ In Malawi, between April and June, Child Helpline recorded 669 cases of child marriage (an increase

53 Ojulu, E. Pandemic leads to surge of child mothers in Uganda. *New African*, 2021.

54

55 Save the Children (2020). *Protect a generation: The impact of COVID-19 on children's lives*.

56 UNOCHA Kenya. 'Kenya situation report'. 10 August, 2020.

57 Davies, P. 'Teen pregnancies rise in Malawi amid coronavirus pandemic'. *AfricaNews*, 4 September, 2020.

58 UNHCR, UN Women, Government of Uganda et al. (2020) *Inter-agency rapid gender analysis – COVID-19*.





of more than 80% compared to 2019).⁵⁹ In Uganda, according to police reports, the number of child marriage cases more than doubled when comparing the three-month periods before and after the lockdown in the first half of 2020.⁶⁰

COVID-19 also affected the distribution of contraceptives and availability of medical staff to provide family-planning services. According to 2020 predictions by UNFPA, were the lockdown to have continued for a further six months, stock-outs of many contraceptive methods were expected in more than a dozen of the lowest-income countries, resulting in an additional 7 million unintended pregnancies.⁶¹ Estimates on the impact of the pandemic on contraceptive access and use among adolescents in Ethiopia showed a decline of roughly 3.5% in the numbers of adolescents receiving modern contraceptive care and those giving birth with the assistance of a skilled health worker. The estimate also found a 6.5% drop in the number of 15–19-year-olds receiving post-abortion care and a 9% rise in the use of safe abortion care. According to the estimates, an additional 20,738 adolescents had their contraception needs unmet in Ethiopia, resulting in an additional 8,884 unintended pregnancies over the course of a year. This increase in unintended pregnancies cost the Ethiopian health system an additional 10.1 million Ethiopian birr for pregnancy-related and new-born care in 2020 (the equivalent of approximately USD 255,920).⁶² On the whole, the COVID-19 pandemic has exposed girls to teenage pregnancy driven by increased poverty; sexual violence and abuse; child marriage; and limited or lack of access to SRH information and services, including contraception.

4.4 Summary

Although it affects all girls, teenage pregnancy is a problem experienced with particular acuteness by girls who fall into one or more categories of vulnerability. For instance, among those with disabilities, major drivers of early pregnancy include their limited access to SRH service and heightened risk of sexual abuse and exploitation.

Girls living and/or working on the street and those living in urban slums have also been found to be at greater risk of teenage pregnancy due to higher risks of coercive sex, early sexual debut and transactional sex stemming from poverty and limited access to SRH and protection services. Girls living in conflict, emergency and humanitarian situations are exposed to often extremely high risks of pregnancy, due to sexual exploitation perpetrated by some members of the armed forces, family members and even humanitarian aid workers.

Another formidable challenge exacerbating the challenge of teenage pregnancy is the COVID-19 pandemic. The pandemic has driven incidences of child marriage, sexual violence and transactional sex, all leading to teenage pregnancy. Furthermore, child marriage, closure of schools, household deprivation and the disruption of protective services meant that girls became exposed to the possibility of unintended pregnancy, particularly in rural areas.

59 Rigby, J. 'Child marriages skyrocket in Malawi as COVID-19 closes schools'. The Telegraph, August 14, 2020.

60 Edwards, J. (2020). *Protect a generation: The impact of COVID-19 on children's lives*. London: Save the Children.

61 UNFPA (2020). *Impact of the COVID-19 pandemic on family planning and ending gender-based violence, female genital mutilation and child marriage*. Interim Technical Note Information.

62 Seme, A. et al. (2021). *Impact of the COVID-19 pandemic on adolescent sexual and reproductive health in Ethiopia*. New York: Guttmacher Institute.

CHAPTER 5: THE IMPACT OF TEENAGE PREGNANCY

5.1 Introduction

This chapter examines the wide-ranging impact of teenage pregnancy. It focuses on how the phenomenon affects the lives, survival and development of pregnant teens and teen mothers. It begins by analysing the links between teenage pregnancy and mother-and-child morbidity and mortality. Thereafter, the chapter discusses other impacts arising from teenage pregnancy, such as unsafe abortions, school dropouts, and emotional and social effects. Equally importantly, it demonstrates the negative impact that teenage pregnancy has on national development and the economic costs arising from inaction.

Table 5.1: Impact of teenage pregnancy in selected countries

Impact	CAR	Chad	Mada-gascar.	Egypt	Ma-lawi	Mali	Mau-rita-nia	Mau-ritius	Mo-zam-bique.	Niger	Rwan-da	Sen.	Togo	Ugan-da
On teen mother														
Dropping out of school	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Future economic disadvantage	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Forced/early marriage	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Unsafe abortion	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	NR	Yes	Yes	Yes	Yes	Yes
Increased risk of pregnancy and birth complications	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
High risk of contracting HIV and STDs	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Risks of obstetric fistula	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mental ill-health	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Repeat pregnancy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Stigma and rejection by family and community	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
On child														
Retarded foetal growth	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Low birth weight	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes



Increased risk of developmental delay and disability	Yes													
Increased risk of anti-social behaviour and being incarcerated	Yes	Yes	Yes	No	Yes		Yes							
Less prepared to enter kindergarten	Yes	Yes	Yes	Yes	Yes		Yes							
Risks of neglect and abuse	Yes	Yes	Yes	No	Yes		Yes							

Source: Primary data collected in selected countries as part of the present study, October – December 2021

5.2 Morbidity and mortality in mother and child

In the litany of adverse effects that teenage pregnancy has, what stands out is its impact on the health of the mother and child. Higher rates of morbidity and mortality among mothers and infants are associated with teenage pregnancy. Global estimates show that adolescents aged 15–19 years are twice as likely to die during pregnancy or childbirth as those over the age of 20, with girls under 15 years being five times more likely to die. Due to the underdevelopment of their reproductive organs for pregnancy and birth, pregnant teens also face an increased risk of both prolonged labour and ruptured uteruses during birth, which results in cases of fistula.

A further study shows that babies born to adolescent mothers in low-income countries face a 50% risk of stillbirth or death before they are 1 month old in comparison to those born of mothers aged over 20. A study in eSwatini found that about 16% of babies born to teenage mothers died, compared to the 9% death rate in babies born to adult mothers. In the Western Cape province of South Africa, 5.3% of the total perinatal deaths in South Africa in 2015 occurred among girls under 20 years of age.

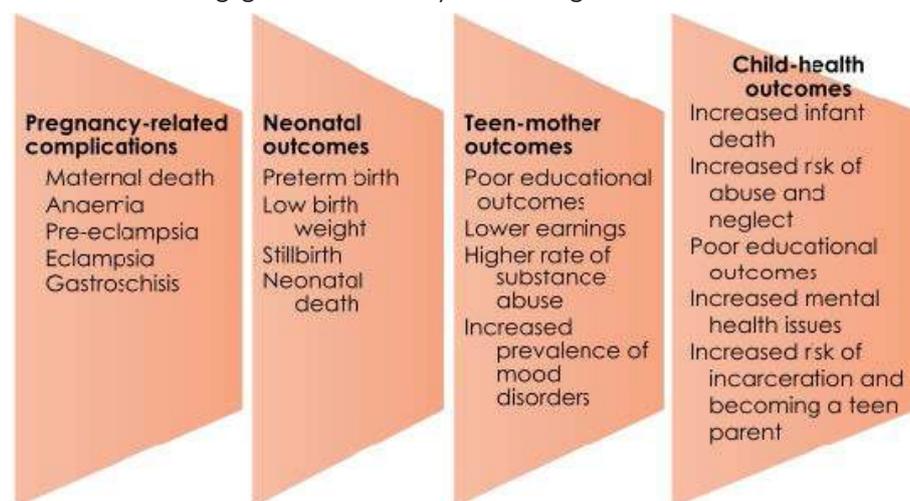


Diagram 5.1: Health-related impacts of teenage pregnancy

Source: Molokoane, F. Teenage pregnancy considerations: Maternal and foetal subspecialty. Obstetrics & Gynaecology Forum, 2018, 2

In addition to its effect on maternal and infant mortality, teenage pregnancy is associated with a host of medical complications. These include premature birth; pregnancy-induced hypertension; anaemia; urinary tract infection; post-partum haemorrhage; preeclampsia; mental disorders (e.g. depression); and sexually transmitted diseases (STDs). In an Egyptian study, stillbirths were reported for 3.2% of mothers in the 10–19-year age group compared to 3.4% in the 20–35-year age group. Preterm labour and preterm delivery were reported in 18.2% of the 10–19-year age group, compared with 14% in the 20–35-year age group. Preeclampsia and eclampsia were reported at 12.4% and 0.7% of mothers aged 10–19, and at 8.2% and 0.9% for mothers aged 20–35 years.

The other health-related impact of teenage pregnancy is anaemia. This is found to be nearly three times higher for teen mothers. Anaemia was reported among 24% of teenage mothers in Eritrea, 25% in Senegal and 13% in Nigeria. Complicated births such as caesarean section deliveries and obstructed labour are also common among adolescents, mainly due to their underdeveloped reproductive organs. For instance, 11% of pregnant teens in a Nigerian study underwent obstructed labour compared to 2% of adults.

The fact that medical services for caesarean sections are not widely available in Africa means that pregnant teens also face a greater risk of infant mortality and maternal death (see Chapter Six for detailed discussion of access to SRH services). In a study in Nigeria, 32% of teens underwent caesarean sections compared to 23% of adults, while in Eritrea, 35% of teens gave birth through caesarean section compared to only 9% of adults.

A study in Egypt showed that 58.1% of the study sample had antepartum complications; 12.9% suffered antepartum haemorrhage; 5.7% suffered from anaemia; 18.5% had preterm labour pains; and 19.4% suffered rupture of membranes. Data from a 2014 study (which covered a number of African countries) showed that four leading causes account for 71.7% of maternal deaths among South African pregnant teenagers: hypertension (22.8%); non-pregnancy-related infections (HIV/AIDS-related, such as TB or pneumonia) (21.1%); obstetric haemorrhage (14.2%); and a range of other medical and surgical disorders (13.6%). The higher postpartum morbidities among teenagers than older women could be due partly to their inexperience, causing them to neglect early symptoms of complications during pregnancy, and hence predisposing them to adverse post-partum events.

The impact of teenage pregnancy does not stop with the mother: it also has serious adverse effects on the child's survival and health. Perhaps the most common of these is low birth weight, due to low maternal weight and body mass index at conception or delivery. As teen mothers may be undernourished or have incomplete physical development, their infants have an increased risk of suffering from stunting, diarrhoea and anaemia. Very young maternal age (≤ 16 years) at time of delivery was the variable with the highest risk for the delivery of a low birth-weight infant (16%) compared to 9% for adult mothers aged 20–30 years.

A study in eSwatini revealed that 13% of teenage mothers of ages 11–16 years gave birth to underweight babies compared to 9% of mothers aged between 22 and 25 years.





By the end of the neonatal period, almost two-thirds of the new-borns admitted to a South African hospital were still in clinical care and 2% had died. Furthermore, about 82% of the admitted babies born to teenage mothers were premature and 83% were classified as of low birth weight. Children who were born to mothers less than 18 years old were more likely to be diagnosed with sepsis (14.7%) than children born from mothers above 18. They were also about six times more likely to be anaemic, and four times more likely to suffer from congenital pneumonia, than those born to older women. All these negative health outcomes are likely to have effects on maternal and child morbidity and mortality, as well as on the child's development and intellectual growth.

5.3 Teenage pregnancy and unsafe abortions

Given that most teenage pregnancies are unwanted and/or unplanned, girls often resort to abortion. However, most of these are unsafe, unhygienic and unprofessional abortions, taking place at home and likely to lead to injuries and deaths due to excessive blood loss, sepsis, and the like.

Nearly four in 10 (38%) of unintended pregnancies in Africa end in abortion. The continent accounts for 29% of the global average of unsafe abortions. According to 2015 estimates, in many African countries the maternal death rate associated with unsafe abortion is 37 deaths per 100,000 live births, while the risk of maternal death from an unsafe abortion is one in every 150 procedures. In a study in rural Nigeria, about 50% of respondents had had induced abortions, with 72.7% of these taking place at home or at the chemist and with at least 68.2% performed by nurses and others. About 81.8% of respondents suffered post-abortion complications.

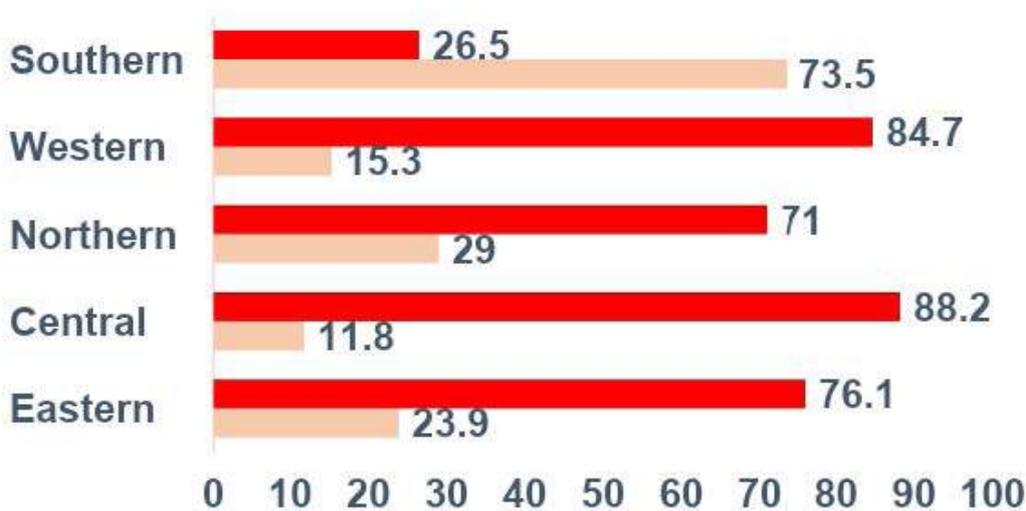


Figure 5.1: Distribution of annual number of safe and unsafe abortions in Africa, 2010–2014

Source : Ganatra, B. et al. 2017. Global, regional, and sub-regional classification of abortions by safety, 2010–14 : Estimates from a Bayesian hierarchical model. The Lancet, 2017, 390

In 2010–2014, an average of about three in four abortions in Africa were unsafe. In Eastern Africa, unsafe abortions are estimated to account for almost one out of five maternal deaths (18%), the highest rate in the world, while in Western Africa, the figure stands at one out of eight (12%). Southern Africa has the lowest rate on the continent, that of about one out of 10 maternal deaths (9%). In Nigeria, complications from unsafe abortion account for 72% of

all deaths in young women under the age of 19. Usually performed in unsafe conditions, a significant number of abortions end in the death of the pregnant girl. In South Africa, abortions (a large majority of which were induced and unsafe) accounted for 17.60% of deaths in 2006–2012.

In Africa as a whole, the proportion of safe abortions was 25% or less (with the exception of Southern Africa). The highest proportion of least-safe abortions occurred in countries where there are both legal and cultural barriers to it, namely in the Central African region, followed by Western Africa and Eastern Africa. Fewer than 1% of abortions are classified as least-safe in countries with the least restrictive laws, compared with 31% of those in countries with the most restrictive laws.

In the absence of proper facilities and given the fact of legal restrictions, girls in many countries resort to traditional (often unsafe) avenues to terminate pregnancy. In a Tanzanian study, 67% of the women recorded having had an unsafe abortion and 45% of these women had resorted to either a traditional service provider or a relative for the termination of their unintended pregnancy. In addition,

22% of the women self-administered plant species orally (in teas or by chewing leaves), while 13% administered them via the genitals to induce the abortion. About 8% of the women reported having induced abortion by using plants to mechanically rupture the membranes. A study in Western Kenya found that the most common unsafe methods used for induced abortion were ingesting herbs and drugs meant for other prescriptions, and inserting various types of objects into the uterus through the genitals. Similarly, a cross-sectional study involving 278 women in rural and urban Tanzania found that herbs, roots and catheters are the most common unsafe abortifacients used for induced abortion.

'I contemplated terminating my pregnancy because I was scared of my mother finding out since she said that if I ever get pregnant in her home, she would strangle me. I also felt that I was not ready to give birth because I was still young to be a mother' – A teenage mother, 19, Uganda

About 88% of respondents in Uganda and 70% of respondents from Malawi (with these coming predominantly from rural areas) said that, to terminate pregnancy, they would resort to a local healer or traditional birth attendant, or take traditional herbs and medicines.

Half of the respondents in Uganda said they would go to private clinics as opposed to public ones, apparently to ensure confidentiality. In Mauritania, most of the respondents expressed revulsion at the idea of having an 'abortion' and said that it is strictly against Islam. However, a few said that, in the unlikely event of having to terminate their pregnancy, they would resort to traditional birth attendants and local healers.

'I once tried to terminate my pregnancy outside of a health-care centre and it did not go well and I had complications. I had to be assisted by a doctor to conceive after that' – A teenage mother, 18, Nampula City, Mozambique

Respondents among teenage mothers in Chad said that, to terminate pregnancy, they would consider going to a local healer or a traditional birth attendant rather than to a public hospital. This was due both to lack of money, but also the possibility of being able to maintain secrecy. A similar response came from respondents in Uganda, although some of them said they





would prefer to have a doctor or a nurse for terminating pregnancy, no matter the consequences. The adoption of unsafe methods by teenagers often results in serious health complications (including death). In Africa, in a significant majority of cases, abortion services are viewed as sinful and immoral.

5.4 Impact of teenage pregnancy on mental health

Teenage pregnancy affects not only the physical health of adolescents, but so too their mental health. Pregnancy is at times associated with depression. Global estimates put the prevalence of depression during the perinatal period at about 11–18% generally, but as high as 30–50% in low-income countries. This is higher among young mothers, who experience a two- to nine-fold increased prevalence of perinatal mental health illness compared to adults.

The negative attitudes adopted towards a pregnant teen or a teen mother – manifested in stigmatisation, exclusion and rejection – exacerbate her vulnerability to mental illness. Studies have shown that mental illness may lead to increased risky behaviour such as unprotected sex, which may, in turn, result in teenage pregnancy and/or postnatal HIV infection. Likewise, teenage pregnancy may contribute to parental mental illness, something which also affects the developmental outcomes of the children.

In Rwanda, one study showed that about 89% of respondents reported low self-esteem, with the same percentage of respondents noting feelings of discrimination against them. Forty-four percent reported rejection by their family members.

***‘In my family, there’s a girl who got pregnant at 15 years of age. She was depressed and she almost went mad, to the extent of removing her clothes. It cost us a lot to get her back into shape’
– Teeso community member, Uganda***

About 37% of respondents

in a Nigerian study reported experiencing a sense of shame; 27%, a sense of guilt; 28%, feelings of loneliness; while 15% lived with a sense of helplessness. About 34% of respondents reported continuous stigmatisation by their surrounding social world.

In Tanzania, rates of common mental illnesses amongst pregnant teens (covering both the pregnancy period and the postpartum period [0–36 months]) ranged from 8.8% to 21.6%. Other studies find a strong link between the mental illnesses suffered by teenage mothers and the behaviour of their spouses. A Zimbabwean study found that psychological morbidity among mothers was associated with having an older spouse.

Meanwhile, a further study from Tanzania showed that mental health conditions among mothers are associated with experiencing verbal or physical abuse; having a partner who does not assist with child care; being in a polygamous relationship; having a partner with lower levels of education; and having a partner who smokes.

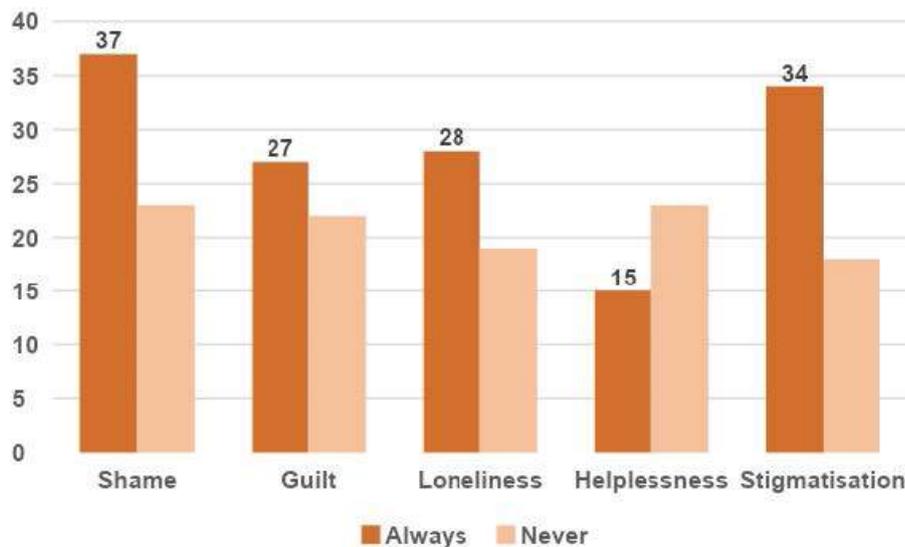


Figure 5.2: Mental health challenges among pregnant teens in Nigeria

Source: Aanuoluwapo, O. et al. *Stress and resilience among pregnant teenagers in Ile-Ife, Nigeria*, *European Journal of Midwifery*, 2021, 5: 9

Focus group discussion with participants in Uganda noted that teenage pregnancy brings shame both to the family and to the girls themselves. It affects their self-esteem and confidence and leads to stress and depression (and might well affect pregnant girls’ readiness to socialise with family and community members). They also noted that teen mothers tend to lose the confidence necessary to associate and mix with other girls, since they see themselves as failures and consider their future as unpredictable and their dreams shattered. They become hopeless and feel they can never fulfil their ambitions. They also noted that other girls are likely to stay away from them, as they are now seen as bad influences. Similar sentiments were expressed by teens interviewed in Malawi who stated that they are seen as ‘bad company’ by community members, school personnel and other children in school, with this acting as a powerful restraint on their socialising.

5.5 Impact of teenage pregnancy on education

It is increasingly common to see pregnant teens in schools across Africa: in 2019, there were 77 pregnant teens at one secondary school in Mpumalanga province, while 74 attended another secondary school in the Eastern Cape province of South Africa.

Numerous studies have established the impact of teenage pregnancy on educational outcomes for both mother and child. Teenage pregnancy is a key factor pushing adolescents to drop out of school. It is thus likely to affect children’s school completion rate. One study found that giving birth while still a teen leads to a 50% reduction in the likelihood of high school completion. In Kenya, the free secondary education policy led to a 5.3% reduction – approximately a 12% drop – in teenage motherhood.

A sector review of girls’ primary and secondary education in Malawi notes that pregnancy was thought to account for 27% of dropouts from secondary school.

A study on school re-entry policies in Kenya for girls who are mothers states that girls’ dropout rates due to pregnancy are 23% nationally and 39% in the Emuhaya District.^w



Meanwhile, a South African study found that women who had their first child in their teens are 10% more likely to drop out of school. The study showed that teenage pregnancy increases the probability of grade failure by 55.7 percentage points and causes girls to lag behind their non-pregnant peers by 0.284 years. The drop-out hazard is equal to a 0.097 additional likelihood of grade failure. Teenage pregnancy decreases the number of years of completed schooling by 1.05; the likelihood of sitting for the matric exam by 0.233 percentage points; and post-secondary education by 4.3 points.

A study from Uganda estimates that a quarter of secondary school dropouts among girls are due to early marriage, while more than half (59%) are due to pregnancy. In a Nigerian study, 60% of adolescents felt that teenage pregnancy leads the adolescent to drop out of school. A study in South Sudan showed that 54% of respondents believe that teenage pregnancy is a cause for dropping out of school.

In many African countries, restrictions on school re-entry policies have effectively excluded pregnant teens and teenage mothers from continuing their education (see section 6.4 for a detailed discussion of school re-entry policies for teenage mothers). In Malawi, for instance, pregnant students face a one-year suspension, following which they can apply for readmission only by sending requests to the Ministry of Education as well as to the school in question. In Senegal, teen mothers are required to present a medical declaration that they are healthy enough to attend school before they are allowed to return. Similarly, in Botswana, pregnant students are allowed to re-enter school after giving birth only after a year's suspension, while all girls are required to agree to regular pregnancy testing at school.

In some situations, the sociocultural beliefs within communities are likely to have a greater impact on pregnant students' access to and participation in education than official school policies.

Girls expelled from school might stand no further chance to pursue their education in the future and are exposed to child marriage, abuse and dependency. This constitutes gender-based discrimination: boys who impregnate girls often remain in school while the girls are expelled, with substantial effects on their development. Thus, even where school readmission policies do exist, other factors stand in the way of teen mothers returning to school. Sixty percent of the respondents in a Kenyan study agreed that girls were ashamed of going back to the same school after teenage pregnancy. A further 53.7% strongly agreed that peer pressure discouraged girls from readmission after pregnancy. About 47.7% and 46.2% agreed that girls are not accorded proper prenatal and postnatal attention in their schools.

In many countries, there is also a marked reluctance among school personnel to accept school re-entry policies where they do exist. This is a formidable obstacle to policy implementation. In a study in Namibia, about 76% of teachers contacted felt that the country's pregnancy policy is promoting the increase of pregnancy among school going children. It is also worth noting that, where there are restrictive laws in terms of school attendance during pregnancy, pregnant learners are likely to maintain secrecy about their pregnancy so as to avoid disruption to their schooling, behaviour which may prove dangerous both to themselves and to their babies.

There is a further dimension to the link between education and teenage pregnancy: this relates to the children born to teen mothers. In South Africa, average educational attainment was found to be the lowest for children born to young teen mothers (under 18 years of age), with the difference increasing with the children's age. Overall, in the 7–12-year age group, the educational attainment difference between children born to mothers under 18 versus mothers over 21 years is 0.15 of a grade. This increases to half (0.51) a grade for 13–15-year-olds and exceeds a third (0.69) of a grade for the 16–19 age group.

The negative impact of teenage pregnancy on access to education and educational attainment undermines the child's right to development, which is part of the four pillars of children's rights under international law (see section 6.3.1).

5.6 Emotional and social impact

In most African communities, the sight of an unmarried pregnant teen might generally generate a sense of unease and discomfort as it can be perceived as the 'embodied confirmation of uncontained and unconstrained adolescent sexuality'. In many instances, societies also struggle with the apparent ambiguity of seeing a child as a mother, which might confuse the child as she is treated like a child and yet expected to act like an adult. This often leads to stigmatisation and exclusion, which, if not accompanied by proper counselling, might trigger in the pregnant teen feelings of guilt and emotional distancing from family and friends. It is possible too that these reactions might lead the teen to adopt unhealthy coping mechanisms, such as engaging in unsafe sexual acts that can lead to repeated pregnancies.

The value given to fertility in African cultures can also influence female teenagers into engaging in sexual activities to prove their ability to bear children.

Evidence links traditional gender norms, unequal power in sexual relationships and intimate partner violence with negative SRH outcomes. These include teenage pregnancy, unsafe abortion and death.

In addition, socially constructed beliefs about femininity often encourage virginity and discourage sexual activity by young women, while beliefs about masculinity often encourage sexual virility and high incidences of sexual activity by young men. In traditional communities, societies not only hold

teenage girls responsible for pregnancy, but also stigmatise them as immoral and deviant in ways that rarely apply to men and boys. In some African countries (such as Sudan and Morocco), pregnant unmarried girls may be legally charged with adultery, indecency, or extramarital sex.

'In my opinion, teenage pregnancy should be condemned seriously by the government. Young girls who keep their virginity and avoid pregnancy should be recognised. In other words, virginity should be promoted among young girls. As a mother, I am also against young girls accessing contraceptives and family planning services while still very young' – A mother from Teeso community, Uganda

During pregnancy, teenage girls are more likely to be rejected by their family members, who may feel ashamed, while male partners are likely to deny their involvement for fear of incurring

'We face pressure from parents, including insults and a lot of stigmatisation from schoolmates' – A pregnant teenage girl (19) from the CAR

parental responsibility for the child (including financial responsibility). It is interesting to note that a significantly higher number of pregnant teens and teenage mothers in rural areas contacted in the country case study of Mauritania, conducted as part of this research, faced more stigma and blaming and shaming by parents, neighbours and teachers than those in urban areas.



In communities where sexual chastity is a virtue and girls are expected to maintain their virginity until marriage, pregnant teens and teenage mothers and their children experience stigma. In Zulu culture, for example, they are called **amaqhasha**, which means being sexually active and immoral, and their children are called **imilanjwana** or **ingane yesihlahla** (pejorative terms connoting that a child is born out of wedlock).⁶³ In some countries, teen mothers who return to school are stigmatised and bullied by their teachers. In a study of one South African secondary school, teen mothers reported being branded 'baby mama' and taunted in front of their classmates by teachers.⁶⁴ School personnel often believe that pregnant girls and/or teenage mothers have a corrupting influence on other learners, especially learners whom they categorised as being 'innocent'.⁶⁵ A similar sentiment was echoed in an FGD in Uganda where participants noted that 'teenage pregnancy sets a bad example to other girls in the community – when girls get pregnant, many other young girls in the community might think that pregnancy is normal [for teens] and then also get pregnant'.⁶⁶

In Tanzania, teachers often support the country's policy on expelling pregnant girls from school because, in their view, not to do so could 'contaminate' or 'corrupt' other female students and bring them to engage in sexual behaviour and potential early pregnancies. Though this policy was recently revoked, the associated attitudes are yet to change. In some communities and cultures, there is a widespread belief that permitting pregnant girls and adolescent mothers to continue their education could normalise extramarital pregnancy, excuse the girls of their 'wrongdoing', and create a 'domino effect' in which more girls will become pregnant.⁶⁷

In a Nigerian study which captured parents' perceptions about teenage pregnancy, 93% of parents said that a pregnant teen is a deviant, while 84% believed that a pregnant teen has no future. Close to 86% of them said that teenage pregnancy has a devastating effect on parents, while about the same percentage attributed teenage pregnancy to parental failure. Interestingly, more than 70% believed that teenage pregnancy is the result of Western education. About 63% of parents in the study said they would give their daughter away in marriage were she to become pregnant.⁶⁸

Other studies, however, offer an entirely different picture. According to one of these, mothers of pregnant adolescents who had also experienced adolescent pregnancy showed more sympathy towards and understanding of the experiences of their daughters. Such mothers indicated that they accept the situation and give their daughters the required support.⁶⁹ Although parents initially react negatively to the pregnancy, they often accept it and continue affording emotional and financial support to their daughters and grandchildren.⁷⁰

63 Shange, T. (2012). Indigenous methods used to prevent teenage pregnancy: Perspectives of traditional healers and traditional leaders.

64 Malatji, H. et al. 'Every time when I make a mistake in class, educators would say, you baby mama you must keep quiet': Challenges confronting teenage mothers when re-engaging with secondary school education in a Johannesburg secondary school, South Africa. *Journal of Human Behaviour in the Social Environment*, 2020, 30(3), 306–318.

65 Shefer, T. et al. (2013). 'Young parents talk of their school experiences' in R. Morrell, D. Bhana, & T. Shefer (eds.), *Books and babies: Pregnancy and young parents in schools*. Cape Town: HSRC.

66 Data from Uganda country case study, as part of this study.

67 Vision Mondiale Internationale (2020). Répercussions de la Covid-19: L'accès Refusé les Grossesses Précoces Chez les Adolescentes Risquent D'empêcher Un Million de Filles En Afrique Subsaharienne de Retourner À l'école.

68 Mgbokwere, D. et al. Perception and attitudes of parents towards teenage pregnancy in a rural community of cross river state, Nigeria. *Global Journal of Pure and Applied Sciences*, 2015, 21: 181–172.

69 Health Direct. 2012. Teenage pregnancy: Pregnancy birth and baby.

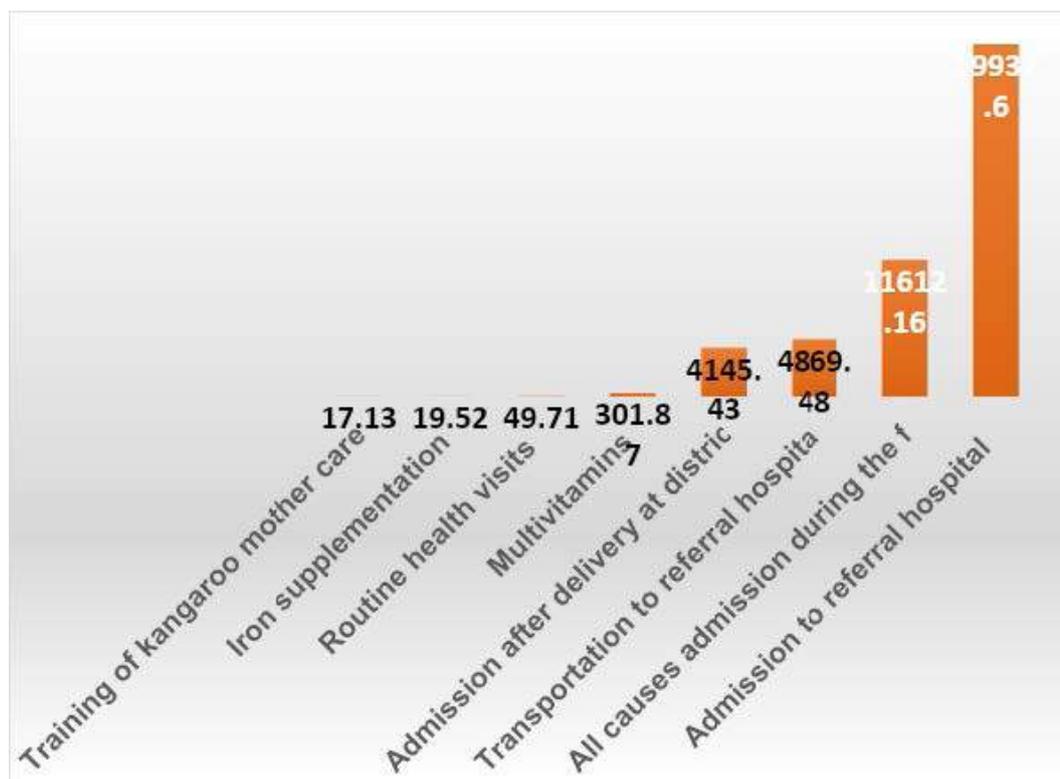
70 Fernandes, A.O. et al. Adolescent pregnancy: Perceptions of mothers of young pregnant women. *Acta Paul Enferm*, 2012, 25(1): 55–60.

5.7 Economic impact of teenage pregnancy: The cost of inaction

In addition to its sociocultural impact, teenage pregnancy entails significant economic costs. Besides the short-term health-care costs at household and system levels, teenage pregnancy, in the long-term, has an effect on national wealth and human development. Without losing sight of the fact that addressing teenage pregnancy is primarily to be understood as a human rights obligation that governments have, the huge economic cost entailed by response interventions points to the need to make greater investment in prevention efforts: these are not only less expensive but also more effective.

A study in Mozambique reported that the cost of raising a low-birth weight (LBW) baby was estimated at USD 24.12 due to hospitalisation and care for the baby, while the health system incurred USD 169,957.⁷¹ Household costs for routine health care would decrease by 53% for each 100 gram increase in birth weight, while avoiding deaths associated with LBW per 1,000 live births would save a significant amount of disability-adjusted life years (DALYs). All in all, the average costs associated with each non-LBW baby is USD 121, whereas the incremental cost per LBW baby is, on average, USD 425. Thus, the average cost per LBW baby is USD 546, 4.5 times higher than the cost per non-LBW baby.

The study in Mozambique also found that the incremental costs of admission due to low birth weight after hospital delivery at the referral tertiary hospital and at Manhica District Hospital were USD 29,937.60; incremental hospital admission costs due to excess morbidity during the first year of life were USD 11,612.16. About 10% of the total cost was attributed to transportation to the referral hospital, which amounts to USD 4,869.48



71 Sicuri E. et al. Costs associated with low birth weight in a rural area of Southern Mozambique. PLoS ONE, 2011, 6(12): e28744.



Figure 5.3: Health-system costs and DALYs due to LBW in Manhiça (Mozambique) (USD)

Source : Sicuri, E. et al. Costs associated with low birth weight in a rural area of Southern Mozambique. PLoS ONE, 2011, 6(12): e28744

A study in Ghana estimated that the cost of medication for pregnant teens is in the order of USD 238.05, with laboratory or diagnostics costs standing at about USD 93.95. These figures represented 66.2% and 26.1%, respectively, of the total medical cost to the household. The total direct cost was estimated at USD 15,867.14 and the total indirect cost at USD 1,616.32. The study also showed that the household heads absented themselves from work to travel with their pregnant girls to the medical facilities. The valued waiting time cost the household heads as much as USD 259.03, while the valued travel time cost the household heads USD 44.65 every month. In addition, the analysis pointed out that teenage mothers and household heads spent, on average, three hours at the health facility and about 10 minutes travelling to the health facility.⁷²

In Kenya, in 2012, the treatment of complications arising from unsafe abortions cost the public health system a total of Ksh 432.7 million (about USD 5.1 million) in health personnel salaries and in medical supplies. The average financial cost of treating unsafe abortion complications in public health facilities stood at 4,943 Kenyan shillings (Ksh) or 58 US dollars (USD). The personnel costs for treating severe complications amounted to Ksh 5,653 (USD 67).

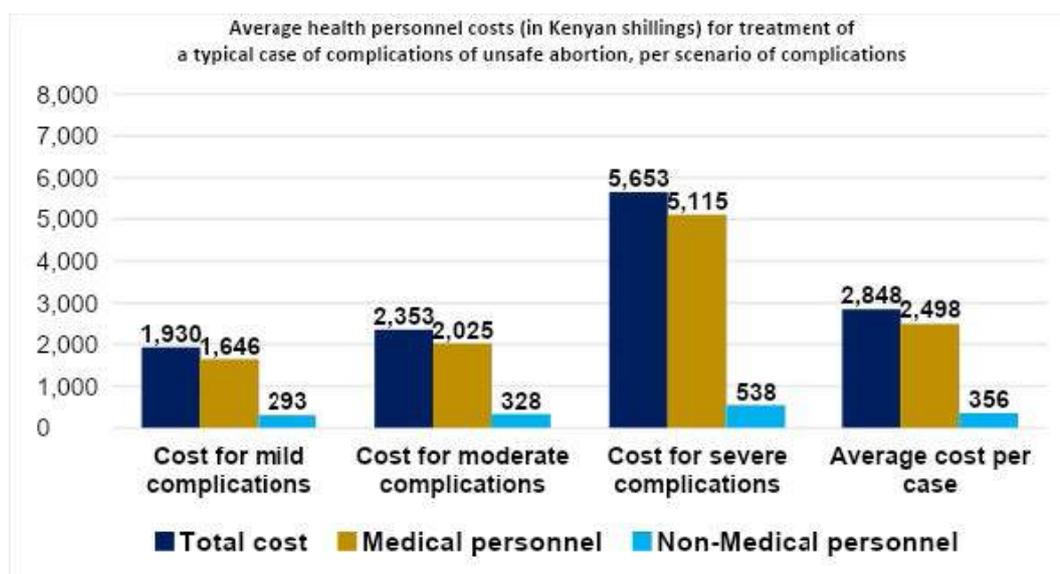


Figure 5.4: Average health personnel costs (in Kenyan shillings) for treatment of complications of unsafe abortion

Source: Ministry of Health (2018). The costs of treating unsafe abortion complications in public health facilities in Kenya. Republic of Kenya

In eSwatini, on average, the government pays E577 per pupil through the Free Primary Education policy, meaning for every pregnant school dropout, the government loses E577. Thus, in the 2010–2015 period the government lost a total of E863,769 due to teenage pregnancy dropouts, along with E65,243,626.13 on health expenditure due to these pregnancies. With the 82,978 teenage pregnancies between 2001–2017, the government of eSwatini lost an estimated E511,467,572.72 in health expenditure.⁷³

⁷² Narh, M.T. (2017). Economic burden of teenage pregnancy on households in Elmina community. Master’s thesis: University of Ghana.

⁷³ Dlamini, N. (2019). The implication of teenage pregnancies in Eswatini: A trend and spatial analysis. Eseparc

At the same time, another study estimated that the gains in earnings and productivity that would have been observed today if women had not married early for a core set of 15 countries are estimated at USD 26 billion.⁷⁴ The welfare cost of early childbirths due to population growth (order of magnitudes at the global level for more than 100 countries) is estimated at USD 187 billion, which in 2030 would equate to a staggering USD 707.5 billion.⁷⁵

5.8 Summary

Teenage pregnancy has huge adverse effects on the life of a pregnant teen or a teenage mother and her child. In terms of its health-related impacts, it can cause higher rates of morbidity and mortality, due to complications during pregnancy and both during and after birth. A significant proportion of maternal and child deaths results from unsafe abortion, procured in unsafe and unhygienic conditions and practised through unprofessional methods. Unsafe abortion is the result mainly of a lack of access to safe medical services. Moreover, one of the most common adverse effects of teenage pregnancy is low birth weight, which is due to low maternal weight and body mass index at conception or delivery. Teenage pregnancy is associated too with a host of medical complications, including premature birth, pregnancy-induced hypertension, anaemia, urinary tract infection, post-partum haemorrhage, and preeclampsia.

Another direct and very significant impact of teenage pregnancy relates to the education of pregnant teens, teenage mothers and their children. Once pregnant, girls are often forced to drop out of school, usually permanently. Restrictive laws that prohibit school re-entry for pregnant teens and teenage mothers mean that most will never re-enter school. Even where the laws do allow re-entry, pregnant teens and teenage mothers suffer humiliation and discrimination from school personnel and their peers. These challenges, coupled with limited time to study, often lead to poor educational outcomes, which in turn entail both loss of individual earnings and loss of national income. The economic cost of teenage pregnancy includes significant government and individual health-care costs related to care and treatment of health complications.

Working Paper 012/SZL.

74 Savadogo, A. and Wodon, Q. (2017). Impact of child marriage on women's earnings across multiple countries. Education Global Practice.

75 World Bank (2017). Economic impacts of child marriage: Global synthesis report.



CHAPTER 6: LEGAL AND POLICY FRAMEWORKS

6.1 Introduction

This chapter unpacks the scope of the legal and policy frameworks relating to teenage pregnancy and examines the reproductive health rights of adolescents under international law. It begins with a discussion of the relevant provisions of international and regional human rights instruments such as the Convention on the Rights of the Child (CRC), the Convention on the Elimination of Discrimination against Women (CEDAW), the ACRWC and African Women's Rights Protocol. The chapter also examines the general principles of children's rights (namely life, survival and development; the best interests of the child; non-discrimination; and child participation) and what is required of States in the context of teenage pregnancy. Treaty monitoring bodies have provided guidance on the scope of State Parties' obligations in preventing teenage pregnancy, advancing girls' reproductive health care, and supporting pregnant teenagers during pregnancy, childbirth and beyond. Finally, this chapter discusses how adolescents' access to SRH information and services is treated in national laws and policies and the extent to which the latter are harmonised with international and regional child-rights laws.

6.2 International and regional law and policy frameworks

The most ratified of all child-rights instruments, the CRC, does not make explicit reference to 'teenage(r), pregnancy or teenage pregnancy'.⁷⁶ By contrast, while likewise making no reference to 'teenage(r)', the ACRWC⁷⁷ explicitly uses the term 'pregnant' in the context of access to education. Article 11(6) of the ACRWC underscores that

State Parties to the present Charter shall take all appropriate measures to ensure that children who become pregnant before completing their education shall have an opportunity to continue their education on the basis of their individual ability.

The express mention of State Parties' obligation to take considered and appropriate measures and steps to ensure that girls who become pregnant complete education elevates their legal protection in Africa and guarantees access to education.

Two noteworthy issues emerge from the above. First, while there is no explicit mention of 'teenage pregnancy' in the CRC, the protection and promotion of the rights and wellbeing of pregnant teens could be advanced within the spirit and letter of the CRC, specifically the need to ensure the provision of health-care services and the promotion of preventive health care.

Secondly, the CRC and ACRWC do not compete with each, but are complementary in content, scope and reach in ensuring the rights and wellbeing of teen girls. Moreover, given the interdependence and indivisibility of child rights, the CRC and ACRWC should be read alongside other international and African human rights instruments that promote the reproductive health rights of teen girls. For instance, CEDAW⁷⁸ defines women to include girls and urges State Parties to ensure to women (including girls) appropriate services in connection with pregnancy, confinement and the postnatal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation. Similarly, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) urges State Parties to

76 Convention on the Rights of the Child. Adopted 20 November 1989. GA Res 44/25(1989), UN Doc. A/RES/44/25 (1989).

77 African Charter on the Rights and Welfare of the Child (1990). OAU Doc. CAB/LEG/24.9/49 (1990), entered into force 29 November 1999.

78 CEDAW (Convention on the Elimination of All Forms of Discrimination against Women), 1979. UN Resolution 34/180.

[e]stablish and strengthen existing prenatal, delivery and postnatal health and nutritional services for women during pregnancy and while they are breast-feeding; c) Protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus.

In sum, there is a wide range of legal provisions that ensure the respect, protection and promotion of the physiological and psychological wellbeing of teenage girls during pregnancy and after giving birth. Treaty monitoring bodies provide guidance on how States should construe international and African regional laws that protect the rights of girls. For instance, the CEDAW Committee⁷⁹ has recommended that State Parties should

[p]rovide universal, free and compulsory primary education that is girl friendly, including in remote and rural areas, consider making secondary education mandatory while also providing economic incentives for pregnant girls and adolescent mothers to complete secondary school and establish non-discriminatory return policies.

Furthermore, in the context of education, the CEDAW Committee recommends that State Parties should take practical measures to respect, protect and fulfil the rights of girls. They should:

- ***Review and/or abolish laws and policies that allow the expulsion of pregnant girls and teachers and ensure that there are no restrictions on their return following childbirth.***
- ***Formulate re-entry and inclusive education policies enabling pregnant girls, young mothers and married girls under 18 years of age to remain in or return to school without delay and ensure that such policies are disseminated to all educational establishments and administrators, as well as among parents and communities.***

Protective measures and response services for pregnant teens should take into account their individual needs and circumstances. In the case of girls who were victims of harmful cultural practices, such as female genital mutilation, the management of their pregnancy and childbirth and other interventions should factor this into medical treatment or surgical interventions, if any. In the context of conflict and humanitarian settings, taking into account the pervasive sexual violence that occurs in those settings, States must ensure that pregnant teens have access to safe and legal abortion and post-abortion care services, available and accessible emergency contraception, and quality maternal health care and psychosocial support.⁸⁰

Sexual and reproductive health rights of girls: ACERWC perspectives

Access to confidential SRH services, including termination of any pregnancy caused by sexual violations, must be regarded as an essential right in ensuring victims' survival and development (para 41).

States should ensure that girls who become pregnant because of sexual violence have ac-

79 UN (2014). Committee on the Elimination of Discrimination against Women. Joint General Recommendation No. 31 of the Committee on the Elimination of Discrimination against Women and No. 18 of the Committee on the Rights of the Child on harmful practices.

80 African Committee on Experts on the Rights and Welfare of the Child, General Comment on Article 22 of the African Charter on the Rights and Welfare of the Child: Children in Situations of Conflict (202), para 66–71.





cess to SRH information and services, including safe abortion services, and [that] those who choose to continue with the pregnancy have access to maternal health services and are allowed and supported to continue with their education (para 114)

States must also ensure that victims of sexual violence and exploitation can access post-abortion services and are not accused of or prosecuted for terminating a pregnancy outside of the law. For those who might carry forward the pregnancy, States must guarantee access to affordable and quality maternal health services (para 146)

Source: General Comment No. 7 on Article 27 of the ACRWC

The right of adolescents to access SRH information has been further affirmed in the Joint General Comment on Ending Child Marriage issued by the African Commission on Human and Peoples’ Rights and the ACERWC, which states that governments must implement comprehensive sexuality education programmes that provide ‘age-appropriate information about sex, sexuality, sexual and reproductive health rights and sexually transmitted infections including HIV and AIDS’.⁸¹

Article 22 of the ACRWC obligates State Parties to respect and ensure respect for rules of international humanitarian law applicable in armed conflicts, emergencies and strife; this includes the protection of girls from sexual abuse and exploitation.⁸² Furthermore, international humanitarian law places an obligation upon States to protect girls as part of the civilian population in armed conflicts by taking all practical, strategic and programmatic measures and interventions.⁸³ Similarly, the law protects internally displaced girls, as well as asylum and refugee girls, from sexual abuse and exploitation (which invariably results in pregnancies). For instance, the ACRWC requires States to take ‘all appropriate measures’ to protect girls seeking refugee status, whether accompanied or unaccompanied by parents, legal guardians or close relatives. The duty includes providing girls with the ‘appropriate protection’, on the one hand, and ‘humanitarian assistance’, on the other, in particular relating to the sexual abuse and exploitation that results in their getting pregnant.⁸⁴

Table 6: References to teenage pregnancy in human rights instruments

Human rights instrument/ policy	Reference to teenage pregnancy
ACRWC	<ul style="list-style-type: none"> • Makes reference to the right of pregnant teens to continue their education (art 11(6)) • Makes reference to access to health facilities, family life education and services (art 14)
CRC	<ul style="list-style-type: none"> • Does not make explicit reference to teenage(r), pregnancy or teenage pregnancy
CEDAW	<ul style="list-style-type: none"> • Mentions that women (including girls) should get access to appropriate services in connection with pregnancy, confinement and the postnatal period, and be provided with free services where necessary, as well as adequate nutrition during pregnancy and lactation

81 ACHPR and ACERWC, Joint General Comment on Ending Child Marriage (2017), para 36.

82 Article 1(k), Maputo Protocol.

83 Article 22(3), ACRWC.

84 Article 23(1), ACRWC.

CEDAW Committee	<ul style="list-style-type: none"> • Mentions the need to provide economic incentives for pregnant girls and adolescent mothers to complete secondary school and establish non-discriminatory return policies • Refers to the need for a review and/or repeal of laws and policies that allow the expulsion of pregnant girls and teachers and ensure that there are no restrictions on their return following childbirth • Recommends that States formulate re-entry and inclusive education policies enabling pregnant girls, young mothers and married girls under 18 years to remain in or return to school without delay, and ensure that such policies are disseminated to all educational establishments and administrators, as well as among parents and communities
Maputo Protocol	<ul style="list-style-type: none"> • Requires States to eliminate all forms of discrimination, to guarantee equal opportunity in education, and to promote enrolment and retention of girls in school and organise programmes for girls who leave school prematurely • Refers to the establishment and strengthening of existing prenatal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding; and to the protection of the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus⁸⁵
Agenda 2040	<ul style="list-style-type: none"> • Notes that no girl child should be denied education as a result of becoming pregnant

At the policy level, the African Union Commission adopted the Sexual and Reproductive Health and Rights Continental Policy Framework – a key tool to mainstream and accelerate the issue of sexual and reproductive health rights of women and girls. While the Continental Policy Framework was adopted to achieve health-related Millennium Development Goals, it applies equally to the health-related Sustainable Development Goals (SDGs), such as SDG 2 which aims to ‘end all forms of malnutrition and address the nutritional needs of adolescent [pregnant and lactating] girls’.

In turn, Agenda 2040 is explicit about the protection of the rights of pregnant girls. It notes that, in the context of education, ‘boys and girls have equal opportunities and access to primary and secondary school education; no girl child is denied education as a result of becoming pregnant’. Additionally, Agenda 2063 of the African Union, under Aspiration No. 6, envisions an Africa that is inclusive and where no child or woman is left behind or excluded on the basis of his or her gender, age or other factors, while barriers to quality education and health care for women and girls are eliminated.⁸⁶

While not exhaustive, the above demonstrates that pregnant teenage girls are equally and fully protected under international and African regional laws and policies. One of the critical challenges lies in the interpretation and implementation of these laws and policies in the domestic sphere across Africa. The other equally critical issue is the existence of inadequate and, in some cases, gender-discriminatory laws and policies, as the next section shows.

85 These progressive provisions of the Protocol notwithstanding, some countries that have ratified the Protocol have done so with reservations on key provisions on sexual and reproductive rights. Examples include Kenya on article 14(2)(c) and Uganda on article 141(2)(a) and 14(2)(c).

86 Africa Union, Agenda 2063, paras 47–58.





6.3 General principles of children's rights

This section discusses the principles governing the implementation, monitoring and enforcement of child-rights instruments and how, in particular, these principles should guide efforts to address teenage pregnancy.

6.3.1 Life, survival and development

The principle of life, survival, and development requires safeguarding the child's right to life and ensuring the child's development (which encompasses the physical, psychological, emotional, social and spiritual aspects of the child's life). In accordance with Article 5 of the ACRWC, State Parties need to apply their resources to the maximum extent possible, and seek to ensure that sufficient financial and institutional resources and skilled personnel are available to support and develop children's capacities and opportunities in life.⁸⁷ Member States should ensure that their laws, policies, and practices on SRHR – including measures relating to the prevention of or response to teenage pregnancy – are consistent with the child's right to life, survival and development.⁸⁸

Teenage pregnancy endangers the normal growth and physical, psychological and emotional development of adolescent girls. It also poses a considerable threat to their survival and development, and especially of those living in situations of vulnerability. As noted by the Committee, teenage pregnancy is often associated with significantly higher rates of maternal morbidity, maternal mortality and infant mortality.⁸⁹

To minimise high rates of teenage pregnancy among adolescents globally, the CRC Committee requires that States ensure that health systems and services are able to meet the specific SRH needs of adolescents, including the provision of family-planning and safe abortion services.⁹⁰ The implications of teenage pregnancy for adolescent girls' rights to health, life, survival and development are fully explored in Chapter Seven (7) of this study.⁹¹ On the whole, teenage pregnancy curtails the right to development, as those who marry young are often forced to drop out of school find themselves precluded from participating in economic, political, social and other activities.

6.3.2 The best interests of the child

The best interests of the child constitute one of the four fundamental principles of children's rights. The CRC and ACRWC set out that in all actions concerning children – whether undertaken by a public or private institution or by individuals – the best interests of the child shall be a primary consideration.⁹² The CRC Committee stipulates that the best interests principle is a threefold concept that stands as a substantive right, an interpretative legal principle and as a rule of procedure.⁹³ Furthermore, it is a flexible and adaptable concept the scope of which must be

87 ACERWC, Guidelines for Child Participation, para 14.

88 ACERWC, 37th Session, Outcome statement of the day of general discussion on the SRHRs of adolescent children (2021), para 16(iv).

89 ACRWC and ACERWC, General Comment on Ending Child Marriage (2018).

90 CRC Committee, General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24) (CRC/C/GC/15), para 56.

91 Sections 7.2; 7.3 and 7.4 of this study.

92 Article 3(1), CRC; Article 42(1), ACRWC.

93 CRC Committee, General Comment No. 14 (2013) on the right of the child to have his or her best interests taken

determined on a case-by-case basis and in relation to the specific circumstances of the particular child.⁹⁴ The ACERWC has noted that no conditions are attached to the principle of the best interests of the child so as to dilute its scope, reach or standard of application.⁹⁵ Moreover, the principle of the best interests of the child aims at ensuring the full and effective enjoyment of all children's rights,⁹⁶ and there are no limitations to the domains or sectors to which it applies.⁹⁷ It runs through all children's rights recognised by international and regional instruments.

Accordingly, the principle of the best interests of the child applies to all matters concerning a pregnant girl. For instance, in its Concluding Recommendations to Liberia, the ACERWC noted that access to SRH services was very limited, the prevalence of teenage pregnancy was alarmingly high, and clandestine abortions by teenage girls were common. To address these concerns, the ACERWC recommended that Liberia develop and adopt a national strategy on the prevention of teenage pregnancy and revise its legislation on abortion, notably with a view to guaranteeing the best interests of pregnant teenagers and avoiding the need for teenage girls to resort to unsafe abortions, often at the risk of their lives.⁹⁸ Hence, State Parties are obliged to invest in the prevention of teenage pregnancy and, when pregnancy does occur, to give paramount consideration to what is best for the pregnant girl according to the particular circumstances of each case.

In addition, the best interests of the child require State Parties to take all necessary measures to prevent all forms of sexual violence and its consequences by eliminating the root causes of such violence against children. It is in the best interests of the child, and also incumbent upon State Parties, to provide victims of sexual violence with (among other things) access to pregnancy tests, emergency contraception that prevents conception, safe medical abortions for grounds stipulated in the law,⁹⁹ post-abortion care, and psychological support.¹⁰⁰ Therefore, it is imperative to mainstream the principle of the best interests of the child in all actions – public or private – related to teenage pregnancy.

6.3.3 Non-discrimination

Non-discrimination is another cardinal principle of children's rights guaranteed by child-rights instruments. State parties have the obligation to ensure that children enjoy their rights and freedoms without any discrimination based on their own or their parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, fortune, birth or other status.¹⁰¹ Thus, all children, including pregnant teenagers, have the right to enjoy their rights free from discrimination of any kind.

Pregnant teenagers face multifaceted discrimination. Such discrimination has significant impacts not only on their immediate and present needs, but also on their future in ways which

as a primary consideration (art. 3, para. 1) (CRC/C/GC/14), para 6.

94 CRC Committee, General Comment No. 14 (2013), para 32.

95 ACERWC, General Comment No. 5 on state party obligations under the African Charter on the Rights and Welfare of the Child (Article 1) and systems strengthening for child protection, para 4(3).

96 CRC Committee, General Comment No. 14 (2013), para 4.

97 ACERWC, General Comment No. 5, para 4(3).

98 Concluding Recommendations by the ACERWC on Liberia report on the status of implementation of the ACRWC, 9.

99 Provision of abortion service at least should follow the grounds listed under Maputo Protocol, Article 14(2)(c).

100 Guidelines on Combating Sexual Violence and its Consequences in Africa (2017) (Niamey Guidelines), para 28.

101 Article 2(1), CRC; Article 3, ACRWC.



ultimately hinder them from reaching their full potential in various spheres of life. For example, in many African countries, pregnant teenagers face discrimination in access to health and reproductive information and services and access to education. In this regard, the Committee has made several observations relevant to many a State Party. For instance, the Committee was concerned by reports which show that teenage girls who get pregnant were deprived of free birth delivery in Burundi. It therefore recommended that Burundi prohibits such differential treatment and ensure that pregnant girls get free medical services from the prenatal to the post-delivery period.¹⁰² It is one thing to eliminate discrimination in law and policy, but quite another to ensure non-discriminatory service delivery practices: States are, however, obliged to ensure both.

The Committee has given similar recommendations regarding the prohibition of discrimination against pregnant teenagers in schools in countries such as Benin, Kenya, Lesotho, Mozambique, Namibia, Sierra Leone, Tanzania, and Uganda, and it remains necessary to ensure that pregnant teenagers do not face any discrimination in the enjoyment of their rights. In this regard, the CEDAW Committee recommends that States review and/or abolish laws and policies that allow the expulsion of pregnant girls from schools and ensure that there are no restrictions on their return following childbirth.¹⁰³ In addition, it is crucial that States adopt non-discriminatory continuation policies that allow teenagers to return to school after pregnancy.¹⁰⁴ Therefore, States are required to take preventative and responsive measures that aim at eliminating the discrimination which pregnant teenagers face in exercising their right to education.

The multiple vulnerabilities and intersectional discrimination faced by the most marginalised children cannot be overlooked. For instance, a teenager may be pregnant, with a disability, and also living in an armed-conflict zone where there are strong cultural beliefs against teenage pregnancy; or, a pregnant teenager may be an unaccompanied migrant from an ethnic minority group. These intersecting vulnerabilities can make discrimination against pregnant teens a complex matter. Noting the particular vulnerabilities caused by such intersections, the CRC Committee recommends that States invest heavily in preventative policies that address the underlying causes of such vulnerabilities.¹⁰⁵ Hence, States should adopt a holistic approach and give high priority to preventative measures which address the multiple and overlapping discrimination that pregnant teenagers can face.

6.3.4 Child participation

In terms of articles 4(2) and 7 of the ACRWC, children have the right to express their views, to be heard, and to have their views taken into consideration in all judicial and administrative proceedings concerning them. This principle, which highlights the role of the child as an active participant in the promotion, protection and monitoring of his or her rights, applies equally to all measures adopted by State Parties in their overall efforts to implement the Charter.¹⁰⁶ Respect for the views of the child should be enshrined in all national legislation. Furthermore,

102 Concluding Recommendations by the ACERWC on the initial report of the Republic of Burundi on the status of implementation of the ACRWC, para 30.

103 CEDAW Committee, General recommendation No. 36 (2017) on the right of girls and women to education (CEDAW/C/GC/36), para 24(g).

104 CEDAW Committee and CRC Committee, Joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women/general comment No. 18 of the Committee on the Rights of the Child (2019) on harmful practices. (CEDAW/C/GC/31/Rev.1–CRC/C/GC/18/Rev.1, paras 63 and 69).

105 CRC Committee, General Comment No. 4 (2003), para 34.

106 ACERWC, General Comment No. 5 on state party obligations under the African Charter on the Rights and Welfare of the Child (Article 1) and systems strengthening for child protection (2018), para 4.4.

government processes which are aimed at securing children's rights – including teenage pregnancy and access to health care – should be transparent and accessible to children so as to enable their participation, consistent with their age and evolving capacities.¹⁰⁷ Children have a right to participate in the design and implementation of interventions that prevent or address teenage pregnancy. Health-related interventions have been found to benefit children the most when children are actively involved in assessing needs, devising solutions, shaping strategies and carrying them out rather than being seen as passive objects for whom decisions need to be made by others.¹⁰⁸

A variety of measures are likely to be necessary to ensure the participation of children from all sectors and classes of society, including measures targeted at amplifying the voices of girls, pregnant teens and teen mothers from marginalised and hard-to-reach remote areas. As the ACERWC has noted, State Parties should make efforts to involve children in legislative drafting, policy development and evidence-building in matters affecting them, including ensuring that children's views are considered without discrimination.¹⁰⁹

The CRC Committee is of the view that States are under a duty to find proper means of providing sexual and reproductive information which is adequate and sensitive to realising the rights of children taking into account the specificities of their many and varied situations.¹¹⁰ In efforts to ensure access to SHR information and thereby close gaps created or perpetuated due to inequalities, priority should be given to children – in this instance, pregnant children – in the most vulnerable situations.

In its recently adopted Guidelines on Child Participation, the ACERWC emphasises that to effectively involve a child in a participatory process, the child must be granted access to sufficient and child-friendly information on the matter concerning the child. In terms of Article 7 of the ACRWC, the objectives of child participation will not be fulfilled if a child is not given access to all the necessary and applicable information required for the child to freely formulate and communicate an opinion.¹¹¹ This includes providing legislative backing to accessing sexual and reproductive information and services for children.¹¹² Key aspects of child participation, such as the age at which children can consent to contraception, also need to be stipulated in law.¹¹³

During the 37th Session of the Committee, it was emphasised that AU Member States need to craft laws and policies which allow adolescent children to access SRH services and information without the requirement of third-party consent or approval (taking into consideration the child's evolving capacity). Furthermore, participants emphasised the need to ensure that their laws, policies, and practices on SRHR are in line with the four general principles of the ACRWC, including child participation.¹¹⁴ In other official documents, the Committee observes that States

107 ACERWC, General Comment 5, para 4.4.

108 CRC Committee, General Comment No. 3: HIV/AIDS and the rights of the child (2003), para 12.

109 ACERWC, General Comment No. 7 on Article 27 of the ACRWC: Sexual Exploitation (July 2021), para 45.

110 CRC Committee, General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child (2003), para 24.

111 ACERWC, Guidelines on Child Participation (February 2022), para 17.

112 ACERWC, General Comment No. 5, para 5.3.4.

113 See generally ACERWC, General Comment No. 5, para 5.3.4.

114 ACERWC, 37th Session, Outcome statement of the day of general discussion on the sexual and reproductive health and rights of adolescent children (2021), para 16(iii)-(iv).



should ensure that third-party authorisation, including the need to obtain parental consent, are not requirements for adolescents to access SRH services.¹¹⁵ States should guarantee that any laws that prescribe the age of consent to reproductive health services are not an impediment to adolescents' gaining access to the above health services.¹¹⁶

In terms of its Guidelines on Child Participation, the Committee is bound to seek children's views and opinions when collecting the primary data necessary to draft and validate studies on the rights and welfare of the child. It is also required to coordinate with State Parties and CSOs to develop child-friendly data collection tools that collect the views of children during research without discrimination. There is also a need to ensure that researchers (adults) consulting with children have the necessary training and resources to carry out field consultations in an age-appropriate, disability- and gender-sensitive manner.¹¹⁷ The Guidelines stipulate that special considerations should be made to ensure that all children irrespective of their vulnerability and those affected by the subject matter of the research participate. Furthermore, children shall be provided with adequate space and opportunities to reflect and provide their insights on the results of the study, as well as the policy and programmatic implications of the continental report on State Parties' obligations.¹¹⁸ Accordingly, the Committee, in conducting the study on teenage pregnancy, created safe spaces for pregnant teens and teen mothers to freely express their views, to be heard, to have their views considered, and to influence the findings of the study.¹¹⁹ This was done through both one-on-one interviews and focus-group discussions.

Member States, AU and United Nations (UN) agencies, and civil society organisations (CSOs) need to provide girls, pregnant teens and teen mothers with a supportive and enabling environment to participate in the design, implementation, coordination and review of strategies and plans of action to combat teenage pregnancy at all levels. Where appropriate, the involvement of children – including those who became pregnant before reaching their 18th birthday – in SRHR education and awareness-raising activities is critical for both effective teenage pregnancy prevention and reducing stigmatisation and discrimination. It enables adolescents to share their experiences (with their peers) in preventing or coping with teenage pregnancy and its impacts, thereby creating a rich platform for peer-to-peer support. State Parties should ensure that girls, pregnant teens and teen mothers who participate in these initiatives do so voluntarily, after being advised, and that they receive the necessary social support and legal protection to allow them to lead normal lives during and after their involvement in SRHR and pregnancy prevention or response activities.¹²⁰

6.4 National laws and policies

While there is commendable progress in the harmonisation of national laws and policies with international and African regional children's rights law,¹²¹ the challenges remain that a restrictive law and policy landscape limits adolescents' access to SRHR information and services. The challenges are evident in that laws and policies are premised on the idea that children lack the

115 ACERWC, General Comment No. 7, para 148.

116 ACERWC, General Comment No. 7, para 148.

117 ACERWC, General Comment No. 7, para 25.

118 ACERWC, Guidelines on Child Participation, para 26.

119 For more information on child participation in the study, see para 1.3 above.

120 See generally CRC Committee, General Comment No. 3, para 12.

121 ACPF. 2021. Harmonisation of laws on children in Africa.

capacity to give informed and full consent on matters relating to their bodies and SRH services. Generally, law and policy frameworks are framed to ensure the protection of children without catering for the SRH agency of children, in particular girls. Examples of such laws are those which set the minimum age for sexual consent and the age for marriage without following the internationally accepted standards and those which prohibit access to contraceptive services and sexuality education for children.

In many African countries, the minimum age for consenting to sexual intercourse is spelt out and codified in criminal laws.¹²² The intention is to ensure the protection of girls (and boys too) from sexual predators by criminalising the act and penalising every person who engages in sexual intercourse with 'minors' (the term used in many statutes across Africa). The presumption underlying a minimum age is that young people lack the maturity to fully comprehend the nature and long-term consequences of sexual intercourse. Hence, legally, they are incapable of 'consenting' to intercourse. The criminalisation of sexual intercourse with girls and boys of a specified age group who lack the legal competency to consent takes different descriptions across African countries (such as rape, defilement, statutory rape, felonious intercourse, and aggravated indecent assault, amongst others).¹²³ Yet, these laws leave a grey area in the protection of girls insofar as it concerns the prevention of teenage pregnancy.

The setting of a minimum age is not always reflective of the consent to sexual activities of minors. Despite the fact that the theoretical concern of the law is to protect, treat, and rehabilitate children, thereby minimising adolescent sexual risk-taking, many sexually active girls are not protected by the law. Social perceptions of children, particularly girls, who are sexually active, are that they are 'promiscuous' or 'incorrigible', rather than as persons in need of support, legal protection, health care and guidance.¹²⁴ A study by UNFPA which reviewed 23 countries in East and Southern Africa on the harmonisation of the legal frameworks for adolescent SRHRs, noted that the setting of an appropriate age of consent to sexual activity requires a balance of the rights to protection and the recognition of the evolving capacity and autonomy of adolescents as they grow up.¹²⁵

Moreover, historically, early age at marriage has been associated with high fertility and its attendant health consequences.¹²⁶ In Africa, societies have traditionally encouraged early marriage for girls, before or shortly after puberty (see discussion on the intersection of child marriage and teenage pregnancy below). While most laws and policies provide for access to family-planning services to adults or married people, unmarried sexually active adolescents experience stigmatisation when seeking such services. Indeed, in some countries and states, laws and regulations prevent them from accessing them at all. For example, the current laws in Zimbabwe, particularly the Public Health Act, restrict children under the age of 16 from accessing SRH services such as contraceptives and emergency family-planning pills because they are below the age of consent.¹²⁷ While the law is undergoing review to align it with the

122 See the legal age for consent by country. Available at: <https://worldpopulationreview.com/country-rankings/age-of-consent-by-country> (accessed on 12 June 2021).

123 Paxman, J.M. and Zuckerman, R.J. (1987). *Laws and policies affecting adolescent health*. WHO: Geneva.

124 Ibid.

125 UNFPA (2017). *Harmonising the legal environment for adolescent sexual and reproductive health and rights*. Available at: https://esaro.unfpa.org/sites/default/files/pub-pdf/2017-08-Laws%20and%20Policies-Digital_0.pdf (accessed on 14 June 2021).

126 Ibid.

127 FP Family Planning (2019). 'Zimbabwe should promote adolescent access to sexual health services.' Available





children’s rights standards set by the 2013 Constitution, such restrictiveness still stands in the way of access to SRHR.

A number of African countries continue to set the minimum age of marriage below the internationally accepted standards. Ten countries still have minimum ages for marriage that discriminate between girls and boys, while many other countries have a minimum age of marriage which is lower than 18 years for both girls and boys. Although there are encouraging attempts by countries to set the minimum age of marriage in line with international standards, the problem is exacerbated by exceptions in law that weaken the prohibition. These exceptions include allowing parental consent or customary or religious laws with lower minimum ages to take precedence over national law.

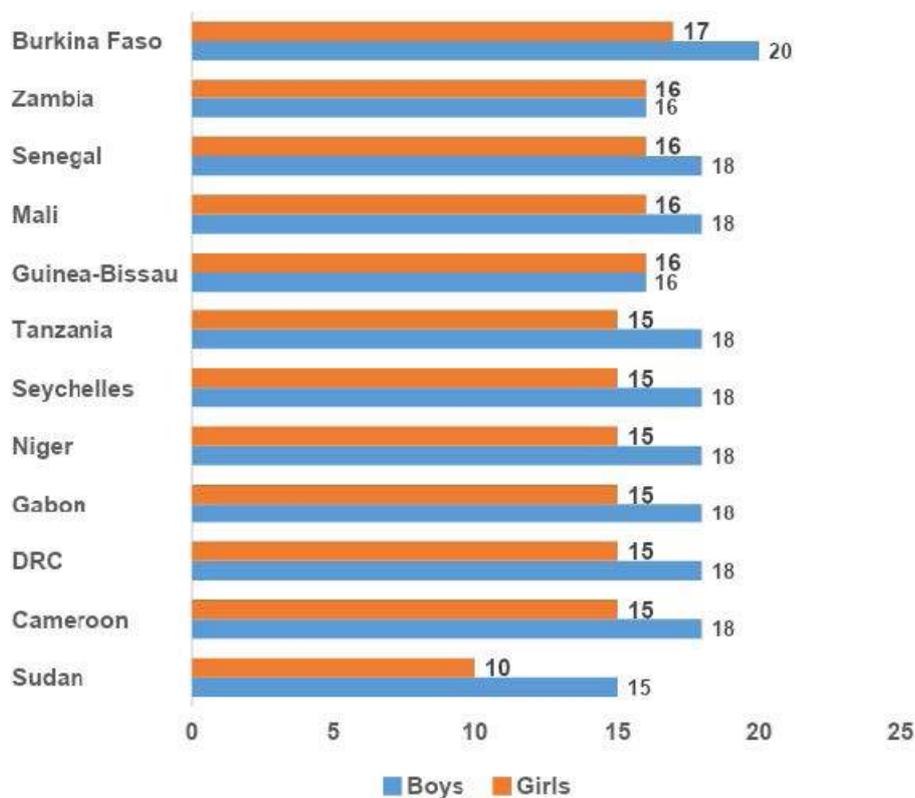


Figure 6.1: African countries with gender-discriminatory minimum ages of marriage and/or a minimum age of marriage below 18 years

Source: Compiled by ACPF from the laws and policies of African countries; ACPF 2019

On a more positive note, Malawi’s Gender Equality Act domesticates the provisions of the Maputo Protocol. Section 19(1) of the Act reaffirms the right to adequate SRH information and services. It includes the rights to

- access sexual and reproductive health services;
- access family-planning services;

at: <https://familyplanning2020.org/news/zimbabwe-should-promote-adolescent-access-sexual-health-services> (accessed on 14 June 2021).

- ☉ be protected from STIs;
- ☉ obtain self-protection from STIs;
- ☉ choose the number of children one wishes to have, and when to bear those children;
- ☉ control fertility; and
- ☉ choose an appropriate method of contraception.

Section 20 of the Malawi's Gender Equality Act imposes a number of obligations on service providers relating to SRH, including the duty to respect the rights of every person to SRH without discrimination.

Rwanda has enacted various laws that have either a direct or indirect impact on girls' rights to SRH information and services. These include a standalone law on reproductive health, Law No. 21/05/2016 of 20/05/2016 relating to human reproductive health. Article 7 thereof provides that every person of majority age has the right to decide for themselves when it comes to reproductive health issues. By contrast, Article 11 of Law No. 49/2012 (on medical professional liability insurance) does not allow minors to seek health-care services without the prior consent of either their parents or legal guardians. The requirement for parental consent, therefore, has the effect of preventing girls younger than 18 from deciding for themselves in relation to their reproductive health. These provisions can be construed to mean that the age of consent for issues related to reproductive health is 18 years. Although the law does not specifically set the age of consent to sex, children aged at least 14 may engage in consensual sex with peers in the same age category without sanction, provided there is no violence, abuse or exploitation involved.

On the other hand, Article 14 of the Law 21/05/2016 of 20/05/2016 relating to reproductive health provides that every biological parent or guardian has the duty to discuss reproductive health issues with his or her children. As far back as 2000, Ghana adopted a National Adolescent Reproductive Health Policy that 'provides a context for addressing teenage pregnancies, adolescent sexuality, early marriage, infant mortality, maternal mortality, fertility rate, family planning and sex education'.

Laws that prohibit or criminalise the use of certain medical procedures and services are also a barrier to access to SRH for girls. The legal restrictions may prevent access to certain facilities needed for SRH (such as contraceptives and/or termination of pregnancy). In some instances, restrictive laws criminalise the use of services such as the termination of pregnancy.¹²⁸ Six countries, namely the Congo Republic, Egypt, Madagascar, Mauritania, Senegal and Sierra Leone, have prohibited termination of pregnancy on all grounds. While Morocco requires spousal authorisation alone and Mauritius requires parental authorisation alone, Equatorial Guinea requires both spousal and parental authorisation. Conversely, countries such as Ethiopia, Rwanda and Zambia allow abortion after taking into consideration the woman's socio-economic circumstances. However, Zambia also requires the authorisation of three medical health professionals for the provision of safe abortion services.¹²⁹ The Gambia and Niger permit abortion only when there is a risk to the foetus. Only Cape Verde, Guinea-Bissau, Mozambique,

128 World Health Organization (2015). Sexual health, human rights and the law. Available at: https://apps.who.int/iris/bitstream/handle/10665/175556/9789241564984_eng.pdf (accessed on 14 June 2021).

129 Section 3, Termination of Pregnancy Act (CAP 304).





São Tomé and Príncipe, South Africa and Tunisia lay no restrictions on abortion. The majority of countries allow abortion on grounds of saving the woman’s life and preserving physical health, or in cases of rape.

Table 6.2: Laws relating to abortion by country and grounds for abortion

Country	Grounds for abortion			Country	Grounds for abortion		
	To preserve health	Rape	To save woman’s life		To preserve health	Rape	To save woman’s life
Algeria	x			Côte d’Ivoire		x	
Angola	x	x		Kenya			x
Benin	x	x		Lesotho	x	x	
Botswana	x	x		Liberia	x	x	
Burkina Faso	x	x		Libya			x
Burundi	x			Malawi			x
Cameroon		x		Mali		x	x
CAR	x	x		Namibia	x	x	
Chad	x	x		Nigeria			x
Comoros	x	x		Seychelles	x	x	
Djibouti	x	x		Somalia			x
DRC	x	x		South Sudan			x
Eritrea	x	x		Sudan		x	
eSwatini	x	x		Tanzania			x
Gabon		x	x	Togo	x	x	
Ghana	x	x		Uganda			x
Guinea	x	x		Zimbabwe	x	x	

Source: Center for Reproductive Rights. The world’s abortion laws. Available at: <https://maps.reproductiverights.org/worldabortionlaws>

For example, the Cameroonian Act No. 80/10 of 14 July 1980 expressly prohibits encouraging abortion by the sale or distribution of abortion equipment or through the provision of written materials. Also, the Cameroonian Act No. 90/035 of 1990, on pharmacy practice in Cameroon, prohibits contraceptive ‘propaganda’.

In most of the above laws, the intention is to protect the interests of younger people whom, it is feared, will be corrupted in some way if reproductive information reaches them. However, the direct consequence is that it constitutes a legislative barrier to a successful policy on adolescent sexual education. It can also lead to unjustified arrests of girls for seeking abortion services. This further discourages girls (including those eligible by law to do so) from accessing SRH information and services, hence driving them to resort to unsafe abortion practices. It also dissuades health-care professionals from providing services and information because they fear incurring criminal liability. Some 33 countries have developed adolescent and youth health

policies or strategic plans, while 25 countries have developed adolescent-friendly health service standards along with implementation plans.¹³⁰

Another area of concern in terms of law and policy relates to the restrictions imposed on pregnant teens and teen mothers with regard to returning to school. Despite the constitutional and legislative obligations of governments to ensure access to education without discrimination based on any ground, in practice, pregnant teens and teen mothers are usually denied the right to pursue their education or re-enter the school system after delivery. This substantially limits their chances of engaging in meaningful employment later in life or in achieving socio-economic independence. Research reveals that in some African countries access to education is regarded as a privilege that can be withdrawn as a punishment inflicted upon teenagers for the immoral act of getting pregnant out of marriage.¹³¹

Although the majority of African countries have made human rights commitments on the policy level to protect pregnant teens and teen mothers' right to education, in practice adolescent mothers are often treated very differently, depending on which country they live in. Some governments have focused on addressing barriers to education as well as the root causes of teenage pregnancies and school dropouts, which include the provision of social and financial support for adolescent mothers. A good example is the child support grant in South Africa. Cape Verde and Senegal adopted special arrangements for teenage mothers, including the provision of time for breast-feeding or time off when babies are ill, or for attendance at health clinics. Zambia has granted flexibility in class shifts, thereby providing teenage mothers with choices. In Gabon, efforts have been made to establish nurseries close to schools to facilitate frequent, easy contact between teenage mothers and their children.¹³²

Despite the positive steps by some African countries, a significant number of countries have laws and policies that directly discriminate in education against pregnant girls and adolescent mothers. In Equatorial Guinea, Sierra Leone, and Tanzania, the legal and policy landscape requires authorities to expel pregnant girls from school and deny teen mothers the right to study in public schools. In Tanzania, pregnancy testing is practised in schools as a measure recommended by the country's Education and Vocational Training Toolkit for curbing teenage pregnancies.¹³³

According to Human Rights Watch, 24 African countries lack a re-entry policy or law to protect pregnant girls' right to education, which leads to irregular enforcement of compulsory education at the school level. It equally reports that countries in North Africa generally lack policies related to the treatment of pregnant teens in school, but impose heavy penalties and punishments on girls and women who are reported to have had sexual relations outside wedlock. Morocco and Sudan apply morality laws that allow them to criminally charge adolescent girls with adultery, indecency, or extramarital or premarital sex. Mozambique issued a decree stating that pregnant girls should be transferred to night school. Although it allows school re-entry, the decree has the potential to reinforce the message that pregnant girls should not mix with other students.

130 Ibid.

131 Human Rights Watch (2018). *Leave no girl behind in Africa: Discrimination in education against pregnant girls and adolescent mothers*. Available at: <https://www.hrw.org/report/2018/06/14/leave-no-girl-behind-africa/discrimination-education-against-pregnant-girls-and> (accessed on 14 August 2021).

132 Ibid.

133 Ministry of Education and Vocational Training, 'School Improvement Tool Kit: Practical guide for head teachers and head of schools,' July 2013. Available at: <http://www.moe.go.tz/index.php?> (accessed on 14 August 2021).



In fact, increased rates of dropouts were reported following the decree, with girls finding it difficult to attend classes at night-time due to lack of child care and concerns about safety at night-time.¹³⁴

Table 6.3: Treatment of school re-entry of teen mothers in laws and policies

Countries with national laws on pregnant girls and teen mothers' right to education	Countries with policies on continuation
Benin	Cape Verde
Democratic Republic of Congo	Gabon
Lesotho	Ivory Coast
Mauritania	Rwanda
Nigeria	
South Africa	
South Sudan	
Zimbabwe	
Countries with policies on re-entry that set conditions for adolescent mothers	
Botswana	Namibia
Cameroon	Mozambique
Burundi	Rwanda
Kenya	Senegal
Gambia	Seychelles
Gabon	South Africa
Liberia	Swaziland
Madagascar	Uganda
Malawi	Zambia
Mali	

Source: Human Rights Watch (2018). Leave no girl behind in Africa: Discrimination in education against pregnant girls and adolescent mothers

Table 6.4: Summary of policies on teenage pregnancy (selected countries)

Country	Policy title	Target group	Teenage pregnancy-related issues addressed	Scope of activities

134 Salvi, F. In the making: Constructing in-school pregnancy in Mozambique. *Gender and Education*, 2018, 30(4): 494–512.

Botswana	Revised National Youth Policy (Botswana, 2010)	Youth (15–35 y)	Poverty, unemployment	Information education communication (IEC) (peer education, youth life skills, youth and health empowerment programmes), health services (youth friendliness, including vulnerable groups), institutional support (supportive legal environments)
Ghana	National Gender Policy (Ghana, 2015)	Boys and girls	Poverty, sexual violence	IEC (education, school retention programmes), institutional support (welfare department, trafficking secretariat, human rights court)
	Adolescent Health Service Policy and Strategy (Ghana, 2016)	Young people (10–24 y)	Access to family planning services, coerced sex, concurrent partners, child marriage, contraceptive use, early sexual initiation, multiple sexual partners, sexual violence	IEC (social and behavioural change communication strategy), health services (increasing access for adolescents), training (needs assessment of staff, and capacity-building of staff)
Kenya	National Adolescent Sexual and Reproductive Health Policy (Kenya, 2015)	Adolescents (10–19 y) Additional sub-groups of adolescents	Availability of SRH services, child marriage, coerced sex or sexual abuse, early sexual initiation, low self-confidence, multiple sexual partners, poverty	IEC (parents, communities, adolescents, professionals, CSE, digital platforms to access information), health services (strengthen capacities to provide information and services), training (build the capacity of health-care providers), institutional support (ensure attainment of ASRH rights), research (data management and analysis)
Malawi	National Youth Policy (Malawi, 2013)	Youth (10-35 y)	Unemployment, early marriage	IEC (youth involvement in programme design, CSE, target school dropouts, vulnerable youth), health services (adequate and accessible youth-friendly health services), institutional support (advocating for increase in the legal age of marriage, regulations and enforcement of laws that advance youth reproductive health)





Namibia	National Health Policy Framework (Namibia, 2010)	Young people and adolescents	Low contraceptive prevalence rate, unmet need for family planning	IEC (community, adolescents), health services (adolescent-friendly), training (staff of health services)
	Education Sector Policy for the Prevention and Management of Learner Pregnancy (Namibia, 2010)	Learners of schoolgoing age	Early sexual debut, forced sex, gender inequity	IEC (CSE), health services (counseling)
Seychelles	Reproductive Health Policy (Seychelles, 2012)	Adolescents and youth	Early sexual debut, sexual abuse, sexual violence, unprotected sex, intergenerational sex	Health services (access to SRH), training (teachers, counsellors, professionals), Institutional support, (school health programme)
Sierra Leone	Reproductive, Maternal, Newborn, Child & Adolescent Health Policy (Sierra Leone, 2017)	Adolescents	Prevention of teenage pregnancy and child marriage, health care, sexual education	IEC (CSE, adolescents), health services (adolescent-friendly, increased uptake), training (health workers), institutional support (address legal and sociocultural barriers to health services), advocating for elimination of harmful practices
	National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage 2018–2022	Adolescents and youth		Increasing demand for and ensuring access to adolescent and youth-friendly health-care services, ensuring access to comprehensive sexual education, ensuring an enabling learning environment for adolescent girls and boys to thrive
South Africa	Integrated School Health Policy (South Africa, 2012)	Youth	Low contraceptive use, early sexual debut	IEC (CSE)
	National Adolescent and Youth Health Policy (South Africa, 2017)	Adolescent and youth (10–24 y)	Lack of access to SRH services	IEC (CSE), health services (access to youth-friendly services)

South Sudan	National Family Planning Policy (South Sudan, 2012)	Adolescents Youth	Illiteracy, early marriage, access to contraceptives, spacing or limiting childbirth	IEC (adolescents); health services (provision of accessible services)
	National Reproductive Health Policy (South Sudan, 2013)	Adolescents	Inadequate access to SRH services, early marriage, gender-based violence	Health services (increase availability, ensure equity of access, improve facilities), Institutional support (eradicate gender-based discrimination and violence)
eSwatini	National Policy on Sexual and Reproductive Health (eSwatini, 2013)	Youth, adolescents	Inadequate access to SRH services	IEC (schools, community), health services (enable resources)
Tanzania	National Health Policy (Tanzania, 2017)	Adolescents	Low supply of family-planning methods, limited knowledge	Health services (ensure quality services to adolescents, strengthen services), institutional support (ensure law enforcement re gender-based violence)
The Gambia	Gender and Women Empowerment Policy 2010-2020 (The Gambia, 2010)	Boys and girls	Early marriage, limited access to SRH information	IEC (schools, out-of-school, community)
	Gambia National Gender Policy 2010-2020 (The Gambia, 2010)	Boys and girls	Early sexual debut, school drop-out	IEC (schools, community), institutional support (school retention, reporting sexual abuse)

6.5 Summary

The express recognition of the rights of pregnant teens in international and African-regional human rights instruments is far from uniform. Some instruments make only implicit reference to such rights, while others are detailed and explicit with regard to them. In terms of national laws and policies, a good number of countries have made attempts to harmonise their laws and policies with the instruments. Some have enacted laws, policies and strategies on health or gender equality that pay sufficient attention to teenage pregnancy. Other countries have developed national policies or strategies on SRH, but with generic application that lacks an SRH policy specifically targeting adolescents.

However, huge challenges remain in terms of the availability of laws and policies that provide unfettered access to SRH information and services to adolescents. In many countries, the minimum ages of marriage and sexual consent do not follow international standards. In a significant number of countries, laws criminalise abortion unless it is for the sake of preserving



the health of the mother or the child, or in cases of rape. Six countries (Congo Republic, Egypt, Madagascar, Mauritania, Senegal and Sierra Leone) have prohibited termination of pregnancy on all grounds.

Another area of concern relates to the restrictions imposed on pregnant teens and teen mothers to continue with and return to school. Twenty-four countries reportedly lack a re-entry policy or law to protect the right of pregnant girls to education, which leads to irregular enforcement of compulsory education at the primary school level. Meanwhile, North African countries generally lack policies on the treatment of pregnant teens in school but impose heavy penalties and punishments on girls and women who are said to have had sexual relations outside wedlock.

CHAPTER 7: AVAILABILITY AND ACCESSIBILITY OF SRH INFORMATION AND SERVICES

7.1 Introduction

This chapter examines the availability and accessibility of SRH information and services across the continent. Adolescents' access to SRH information and services plays an important role in reducing teenage pregnancy in Africa. Conversely, lack of information and knowledge about SRH matters can result in children harbouring misconceptions about contraception, sexuality and reproduction, thereby increasing levels of teenage pregnancy. Apart from demonstrating how SRH information and services impact on the prevalence of teenage pregnancy, this chapter highlights the importance of coordination among stakeholders to ensure adolescents have access to accurate, age-appropriate information and services.

7.2 Access to SRH information

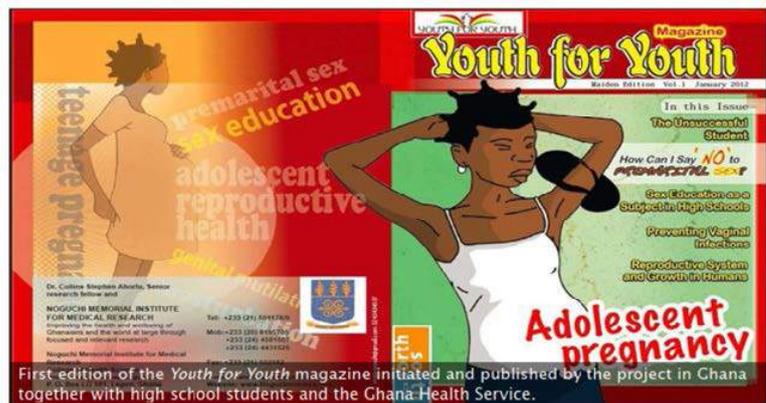
Teenage girls and boys access SRH information from various sources, including schools, family members, peers and the media. In Zambia, a study showed that 58% of children learn about SRH health from radio and 48% from teachers. In addition, 38% report having heard about sexual and reproductive issues from health-care service providers and 27% from peers.

Among all female and male respondents, 64% have knowledge about modern contraception and 88% said they know how to prevent pregnancy. One South African study showed that the majority (30.8%) of children received information about sexuality and reproduction from friends; 27.7% received it from school; 20% were informed by their parents; and 21.5% had information from media, including TV, radio, newspapers and the internet.

In a study from Ghana, peers were cited by about 33% of respondents as the source of information on SRH, while 33% also named parents or guardians as the source.

Lack of knowledge about sexual and reproductive matters means that girls suffer from many misconceptions. These include beliefs that contraceptives lead to sterility; condoms disappear within the woman's body; and contraceptives cause cancer, prolonged menstruation, heart palpitations, and excessive weight gain or weight loss. A Tanzanian study found a high level of ignorance about SRH issues among teenagers (about 53% of the study participants said, for instance, that menstruation is a sure sign of pregnancy).

A typical example of this ignorance is the limited knowledge girls have about the ovulatory cycle, which is associated with a higher rate of use of contraceptives and hence a reduction in teenage pregnancy. In a review covering 29 African countries, it was found that more



First edition of the Youth for Youth magazine initiated and published by the project in Ghana together with high school students and the Ghana Health Service.

'When I gave birth to my first child, the doctor did not tell me about family planning, but after giving birth to my second child, he told me that it is good to space my birth because I gave birth again when my first child was just one-year-old. So, he advised me to use family planning and told me about different family-planning methods and that I had to make a choice ... I am currently using [an] implant' – A 19-year-old teenage mother in Uganda, who had recently given birth to her second child



women with correct knowledge of the ovulation phase (30%) used contraceptives than those who did not (21.9%). In Chad, the rate of utilisation of contraceptives was 9.5% for those with the correct knowledge of their ovulatory cycle compared with 3% for those with no or limited knowledge of the same.

In a number of countries, there is limited knowledge about the ovulatory system: this is as low as 10.4% in São Tomé and Príncipe and under 16% in Angola, Liberia and Zimbabwe (see Figure 7.1).

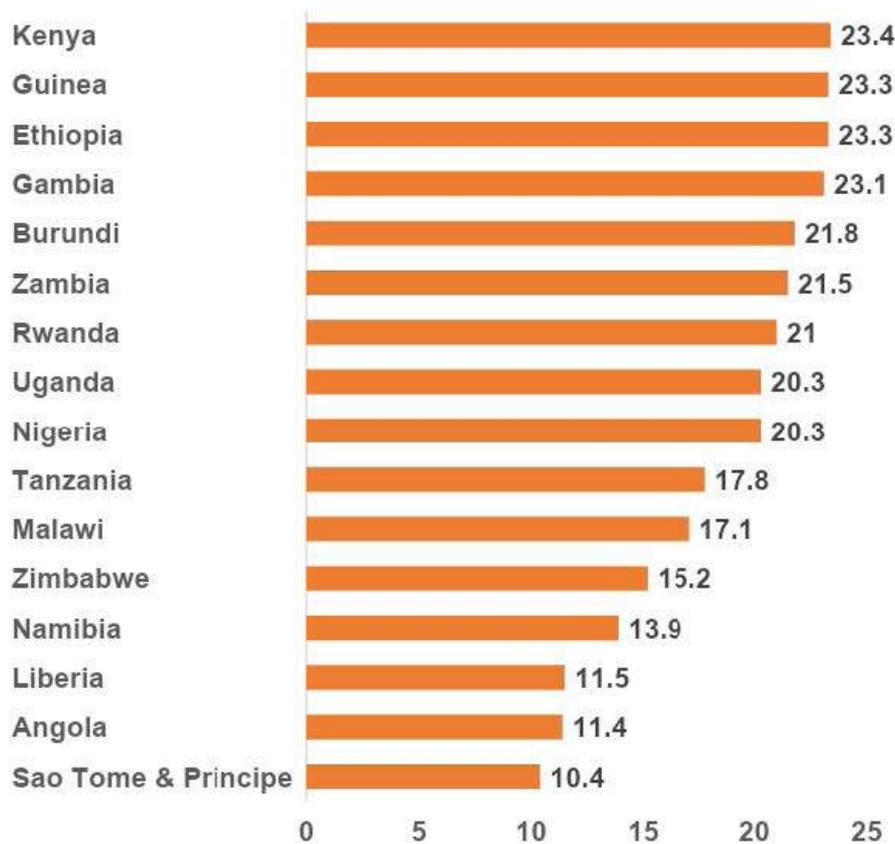


Figure 7.1: Countries with low prevalence of ovulatory knowledge (<25%)

Source: Iyanda, A.E. et al. Fertility knowledge, contraceptive use and unintentional pregnancy in 29 African countries: A cross-sectional study. *International Journal of Public Health*, 2020, 65(4): 445–455

Studies in Malawi and Ghana point out that women with knowledge of their ovulatory cycle had a 75% higher chance of using contraceptives than counterparts with no such knowledge.

It is also worth noting the variation between urban and rural women aged 15–24 in terms of this knowledge (63.3% of rural women lack it compared to 36.7% of urban women). Limited knowledge of the ovulatory cycle can lead, even among those who use contraceptives, to their irregular and/or incorrect use, as is shown by studies in Nigeria, South Africa and Malawi.

Families matter when it comes to influencing a teenager’s sexual behaviour and the risk of early pregnancy. Open communication within the family about sex and sexual matters is associated with positive outcomes for sexual behaviour. These include delay in sexual activity; greater responsibility in the course of a sexual act (including use of contraception); and the rejection of attitudes that encourage sex and sexual risk-taking.

Mothers have a particularly important role in passing on knowledge to their daughters in

the light of their own experiences, fears or expectations and rules regarding the sexual behaviour of children. They are also best placed to provide their daughters with information about child care, including the importance of proper nutrition and good parenting. One study revealed that teenagers who live in households where there is limited parent-daughter interaction regarding issues of sexuality, love and pregnancy were 3.7 times more likely to experience pregnancy than those who live in conditions with good parent-daughter interaction.

Despite the crucial role parents could play in passing on knowledge about SRH issues, parent-daughter communications on sex-related issues have generally been lacking.

Studies from across the continent have established the critical role of schools in imparting information and knowledge on sex-related matters as well as SRH issues such as abstinence, birth control, contraception, sexually transmitted diseases, and other aspects of sexual behaviour. Schools can provide instruction for children on issues relating to human sexuality such as human sexual anatomy, the sexual reproduction system, sexual intercourse, reproductive health, emotional relations, and reproductive rights and responsibilities. Many countries have been able to integrate sexual education into the school curriculum, although with varying degrees of depth. There is, overall, good coverage of issues related to contraceptives, reproduction and reproductive anatomy and physiology, but with some conveying negative views about teenage sexuality and sexual relationships.

'Government needs to convince parents to permit their daughters to use contraceptives to prevent pregnancy in our community, and it should also create a social group who could help the teenage mothers and pregnant teens in the country' – A teen mother, 19, Nampula province, Mozambique

A UNESCO and UNFPA study that examined school curricula on sexual education in 10 African countries made the following observations.¹³⁵

- Content was generally age-appropriate, although in some instances the issue of puberty was covered only after the fact in later classes. There was also a concern that the discussions of puberty focused on its biological dimensions, to the detriment of its social and environmental implications.
- There was little emphasis on avoiding risky situations.
- There is an over-emphasis on abstinence; discussions of emergency contraception are rare; and, generally, discussions about sexuality are based on fear and resonate negative overtones about sexual relationships.
- The power dynamics that underlie age-disparate sex, gender-based violence, and engagements in multiple concurrent sexual partnerships are mostly avoided.

Table 7.1: Scan of sexuality education curricula (selected countries)

Country	Human development, puberty, body and reproduction	Sexuality and sexual behaviour	SRH	
			STIs/HIV/AIDS; prevention, including condoms and treatment and care	Pregnancy, contraception and abortion

135 UNESCO and UNFPA (2012). Sexuality education: A ten-country review of school curricula in East and Southern Africa.





Botswana (pre-school, second.)	Reproductive anatomy and physiology, reproduction	Sexual relationships	STIs, unsafe practices	Contraception, adolescent pregnancy
Kenya (prim. & second.)	Reproductive anatomy and physiology, reproduction	Fear-based, negative about sexuality and all sexual relationships	HIV information (all aspects), condoms, STIs	Contraception, abortion
Lesotho (Std. 4, Form C)	Reproduction	Fear-based, negative about sexuality and all sexual relationships	Condoms, STIs	Contraception
Malawi (prim. & second.)		Fear-based, negative about sexuality and all sexual relationships	Coverage on condoms missing, weak on HIV	Contraception
South Africa	Anatomy and physiology, reproduction	Hardly addressed	STIs too brief, condoms missing, HIV section weak	Contraception, unintended pregnancy
Uganda (adolescent SRH/ life-planning skills, O-level)	Reproduction	Negative about sexuality and all sexual relationships	Condoms missing except in Islamic study; HIV information inadequate	Contraception missing, except in Islamic study, content on abortion and teenage pregnancy inaccurate
Zambia (basic education syllabi; grades 1 –7)	Anatomy and physiology, reproduction	Missing	Discussion of HIV prevention not thorough	Adolescent pregnancy

Source: UNESCO and UNFPA (2012). *Sexuality education: A ten-country review of school curricula in East and Southern Africa*

In many countries, the traditional ways of initiating girls and boys into adulthood continue. These initiation rituals often involve sex education, induction into appropriate sexual conduct, respect for marriage and the sanctity of virginity, among other things. Most of the rituals are drawn from the sexual beliefs, conceptions, norms, value judgments and practices that are deeply connected to other aspects of African cultural values. The following examples of traditional sex education from Ghana and South Africa illustrate this.

Box 7.1: Traditional methods of teenage pregnancy prevention: Examples from Ghana and South Africa

Initiation rites in Ghana: Initiation or puberty rites – such as *bragoro* for Ashanti girls, *dipo* for Krobo girls and others, in some Ghanaian communities – equip the initiates with some useful advice on sex. The rites aim to prevent promiscuity and pre-marital sex among adolescents. Young people who underwent the rites successfully were described as decent, and received the praise of their parents and elders.

Virginity testing (*ukuhlolwa kwezintombi*) is one of indigenous ways used, mostly in rural areas, to prevent teenage pregnancy. In this practice, young women are examined either at home or in an open space by older women to determine if they are still virgins. Some say that the practice, through the reward of social prestige, protects girls by encouraging them to remain sexually inactive until they get married and provides positive reinforcement for abstinence. But human rights organisations have criticised this practice, first, because it is done in public, and, secondly, if a young girl fails the test, she will find herself labelled, stigmatised and classified as a prostitute.

Thigh sex (*ukusoma*) is a form of pre-marital sexual intercourse which makes use of the thighs to satisfy sexual desires without incurring the loss of virginity. It is a non-penetrative sexual practice done by young people who do not want to engage in penetrative sex before marriage. This practice is, however, not widely practised even in traditional societies.

The Nomkhubulwane ritual is a ritual performed in traditional Zulu culture by traditional healers, virgin girls

and parents in KwaZulu-Natal at Impendle in honour of the Zulu goddess Nomkhubulwane. It is claimed that the absence of the goddess can lead to social crises such as droughts and great storms during which only virgin girls – whom the goddess considers as her daughters – have powers to communicate with Nomkhubulwane and reverse the crises. This provides a strong incentive for a girl to maintain her virginity and delay sexual activities so as to take part in this festival.

The Royal Reed Dance festival (*umKhosi womhlanga*) takes place at the Royal Zulu Palace, called Kwabulawayo, and is supported by thousands of Zulus, including the King of the Zulus, traditional leaders, traditional healers and ordinary people. The Royal Reed Dance festival has been viewed as one of the indigenous methods for promoting the protection of girlhood. During this ceremony, the reed ritual is performed only by virgin girls – this is ensured by means of virginity testing prior to, as well as at, the ceremony.

In traditional Zulu culture, *ukukhuliswa* is a ritual ceremony that takes place during adolescence. During the ceremony, adults educate teenagers about the meaning of the changes in their bodies and the importance of abstinence. 'During ritual ceremonies relating to the stage of *ukukhula* (the beginning of puberty) for boys and girls, the community openly addresses sexual matters through educational talks, songs, dances and the offering of advice.'

Source: Shange, T. (2012). *Indigenous methods used to prevent teenage pregnancy: Perspectives of traditional healers and traditional leaders*

It is worth noting that while the above practices have cultural significance and enjoy some measure of success in preventing teenage pregnancy, some of them include dimensions that are discriminatory and inconsistent with adolescents' right to comprehensive, non-judgemental information on SRH and their right to privacy. Others also have dimensions that are inconsistent with adolescents' right to freedom from discrimination on the basis of age and gender, as well as with their right to autonomy in accordance with their evolving capacities. Thus, there is a need to explore how these cultural practices could evolve to observe such rights.

7.3 Access to SRH services

The question of access to information on SRH is crucial. There has been a significant increase in the accessibility of SRH information and services (especially regarding contraceptives) across Africa. Fourteen countries have already achieved coverage of more than 80% in access to contraceptives among women aged 15–24 years, while Guinea and Lesotho have achieved more than 90% access for women aged 15–24 years. However, according to the WHO, about 47 million women and girls in Africa still have no access to modern forms of contraception.



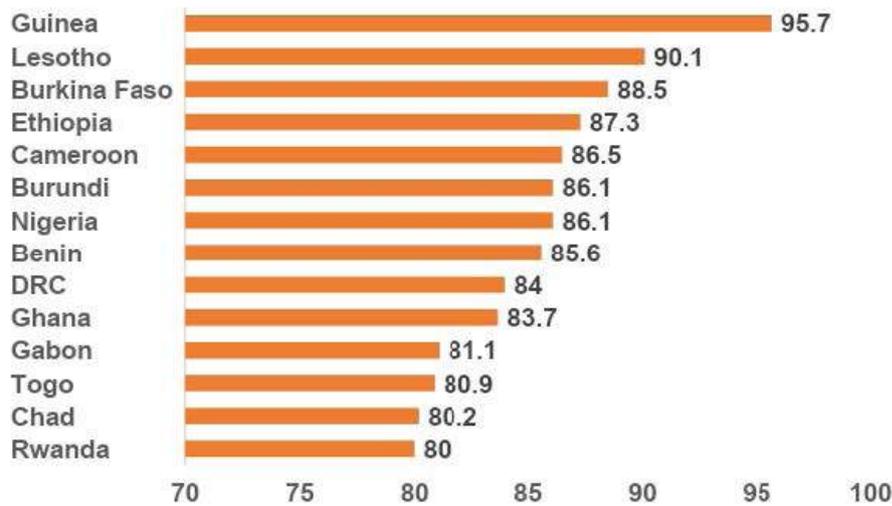


Figure 7.2: Countries with the highest (>80%) coverage of contraceptive use among women aged 15–24, 2008–2017

Source: Iyanda, A.E. et al. Fertility knowledge, contraceptive use and unintentional pregnancy in 29 African countries: A cross-sectional study. International Journal of Public Health, 2020, 65(4): 445–455

In terms of the types of contraception used, in Zambia, condoms were mentioned by 56% of respondents but the most mentioned form of pregnancy prevention was abstinence (75%). A Namibian study showed that 39% of the participants reported using contraceptives, with the majority of them (72%) using injections, about 17% using condoms, and 9.4%, pills.

Most teenage girls reported that the contraception method they used at first intercourse was a male method – either male condoms or withdrawal. In a study in Cameroon, the most commonly used contraceptive method was the male condom, used by 49.1% of secondary school students and 49.2% of high school students. **Coitus interruptus** was the second-most popular method, cited by 12.7% of secondary students and 15.9% of high school students; the least popular method was the use of contraceptive pills (by only 3.6% of secondary school students and 3.1% of high school students). About 34.5% of secondary students and 31.7% of high school students reported not having used any birth control methods.

In Tanzania, 83.5% of respondents cited pills as a pregnancy prevention method; 81%, condoms; 79%, injection; and 3%, traditional medicine. It is important to note that since most teenage girls cited the male condom as a contraceptive device, this practice forces them to rely on the decision of their male partner with regard to safe sex.

The use of contraceptive pills by teens is constrained by a multitude of interrelated factors. These include knowledge; access; motivation; and influences from peers, partners, parents and other social and public influences. Teenagers face numerous challenges in accessing contraceptives: the need to visit a health-care provider to obtain a prescription; getting to a pharmacy to issue the prescription; and paying for the medical visit as well as the pills. They also face the challenge of taking a pill each day at the right time; obtaining refills; stopping and starting cycles at the correct moment; as well as interpreting side-effects correctly and taking the proper action to resolve any problems. For teens living in rural communities, these challenges are compounded by the unavailability of health-care centres or nearby pharmacies; the significant lack of family-planning services; and the distance to the urban centres where these are available.

In some countries, restrictive laws and policies that require contraceptives to be sold solely in pharmacies or in specific health-care centres further preclude teenagers from accessing them because most rural areas lack these services.

The country case studies which were conducted in Uganda, Malawi and Mauritania as part of this study revealed a strong resistance among community members to the provision of contraceptives to adolescents. For instance, community leaders in Mkanda and Kwale in Malawi insisted that the provision of contraceptives, and even sex education, to teenage girls only increases teenage pregnancy and should not be encouraged. They also expressed concern that these initiatives are run by schools or NGOs without the knowledge or permission of parents.

Most of the FGD participants from Mauritania objected to the authorisation of contraceptives for, and access to reproductive health-care centres by teenage girls because they believe that such access and provision will encourage immorality and bad behaviour.

In Uganda, FGD participants in one rural community argued against access to contraceptives for teenage girls. They were of the view that contraceptives are meant to achieve child spacing among adult married couples and not to promote sex among young unmarried girls. They also said that such access would encourage sex work and multiple sexual partners for girls. Some of the FGD participants believed, furthermore, that the use of contraceptives would lead to infertility.

'Parents should be given the confidence to open up to their children and tell them facts instead of myths about sex' – A government expert, Uganda

A South African study found that teens stop using condoms when they feel that their relationships have stabilised and replace them with non-barrier methods of contraception (such as the pill and the injection).

Pregnant teens need access to health care that encompasses antenatal care, skilled birth delivery care, and postnatal care. There is a significant positive impact on pregnancy outcomes associated with the provision of these services, especially when provided by formally trained and accredited health care professionals. In comparison to women who did not receive skilled maternal health care, those who received such services experienced fewer complications and discomfort during pregnancy; underwent less invasive biomedical intervention during birth; and adjusted better to postnatal life and childrearing. Despite the critical importance of antenatal care, skilled birth delivery and postnatal care, access to these remains very low in many countries. Twenty-two countries in Africa have less than 50% coverage of antenatal health care for pregnant girls aged 15–19 years. The coverage is as low as 4% in Somalia and 21% in South Sudan, and below 35% in Morocco, Niger and Chad.

The low coverage of antenatal care services in many countries may be due primarily to the unavailability of the services. But it is also due to judgmental attitudes towards, lack of training in, and understanding of, adolescents' reproductive needs by health workers. The general lack of respect and absence of privacy within the health-care system, coupled with fear of humiliation and having to respond to unpleasant questions and procedures during antenatal care, complicates the picture.



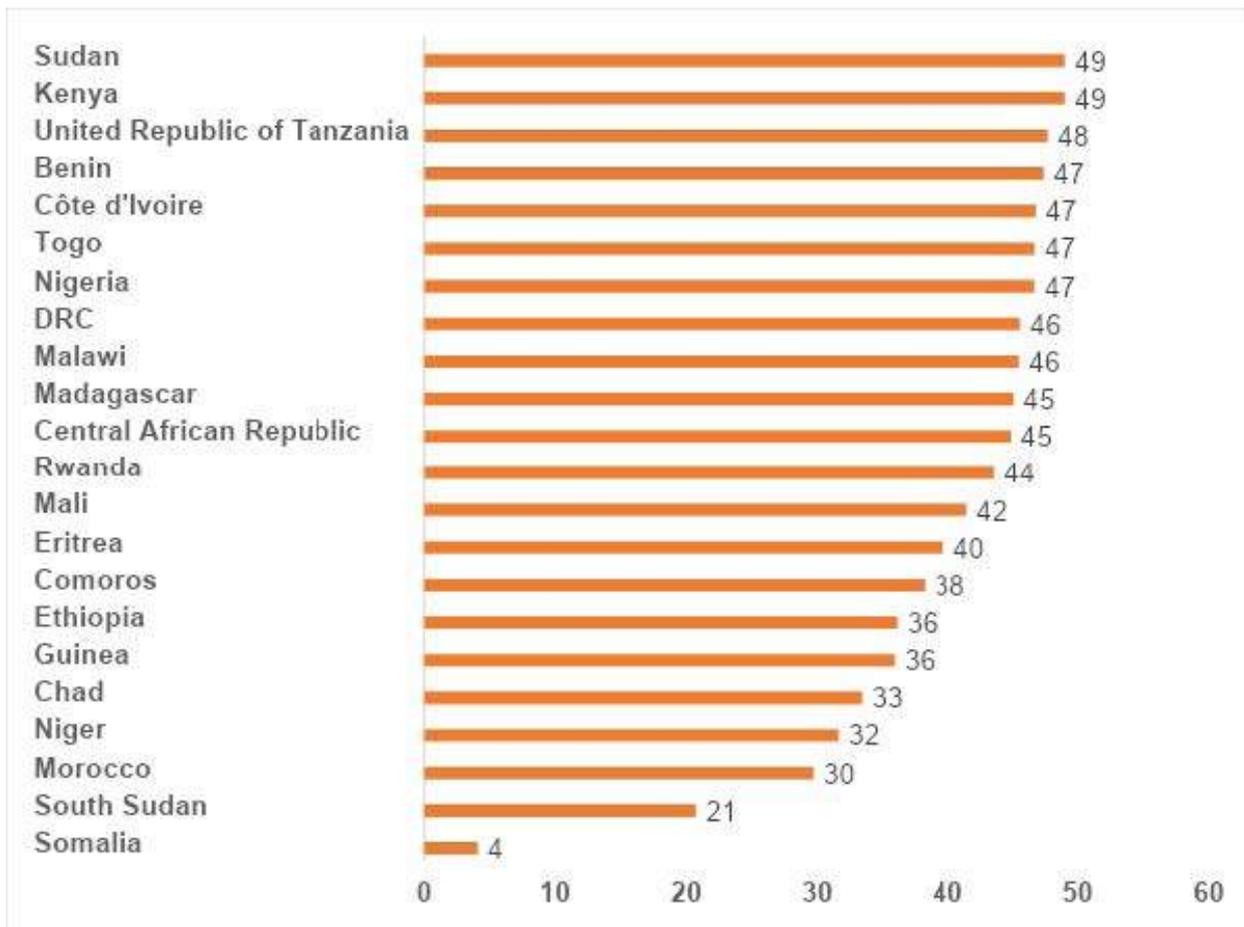


Figure 7.3: Countries with antenatal care coverage <50% for pregnant girls aged 15–19

Source: UNICEF global databases, 2021, on antenatal care, based on MICS, DHS and other nationally representative household survey data

Despite this grim picture, it is encouraging to note that several countries have a very high coverage of antenatal care. Egypt has achieved near-universal coverage of antenatal care for pregnant teens aged 15–19, while Liberia, Sierra Leone, Guinea-Bissau and São Tomé and Príncipe enjoy more than 80% coverage.

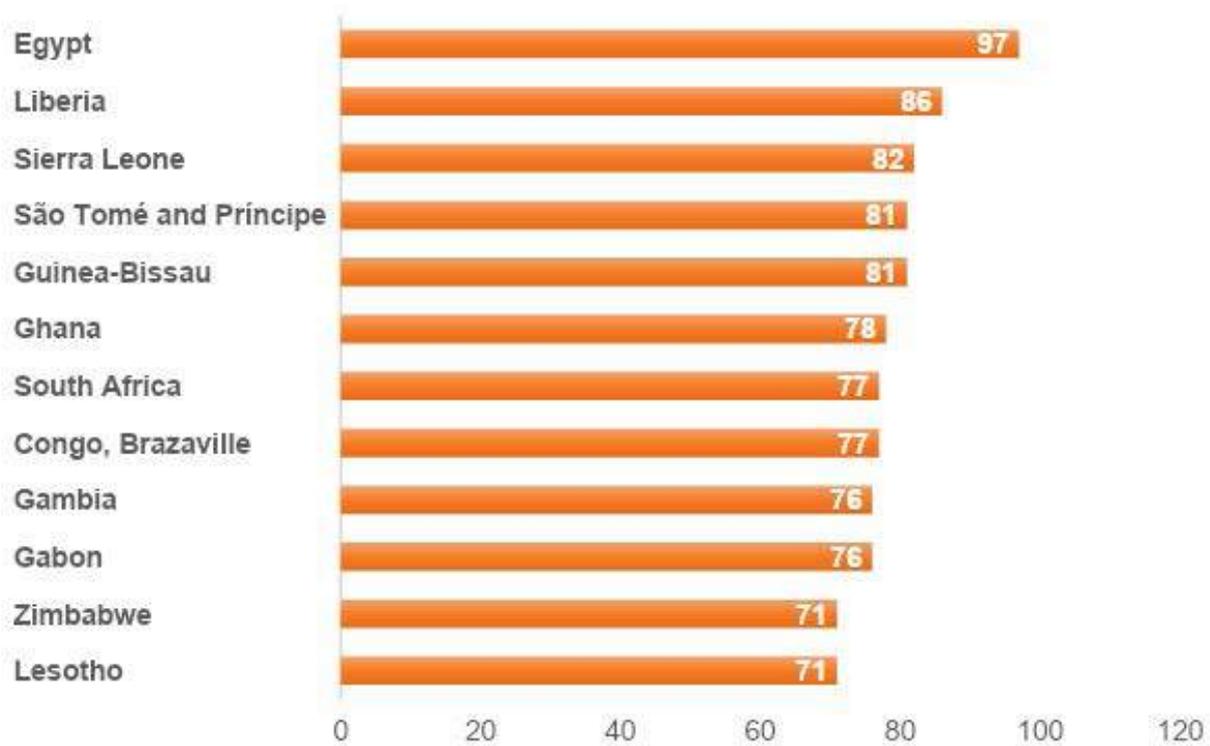


Figure 7.4: Countries with antenatal care coverage >70% for pregnant girls aged 15–19

Source: UNICEF global databases, 2021, on antenatal care, based on MICS, DHS and other nationally representative household survey data

In comparison to antenatal care, there is relatively better coverage in terms of birth delivery in a health-care facility by a skilled attendant. From the available data, there are only six countries with less than 50% coverage of the service: Chad, South Sudan, Sudan, Nigeria, Niger and Angola.

Birth delivery in a non-health-care facility and without a skilled birth attendant contributes significantly to maternal and infant morbidity and mortality. For instance, asphyxia, which can easily be avoided in a skilled birth delivery, accounts for about 23% of approximately four million neonatal deaths each year, while 40–70% of new-born deaths are attributed to the absence of interventions such as clean delivery practices, immediate warming of the new-born, umbilical-cord care, and neonatal resuscitation.

The absence of a skilled health attendant can also increase the risk of stillbirths, which are associated with obstetric emergencies, infections and foetal growth restriction.

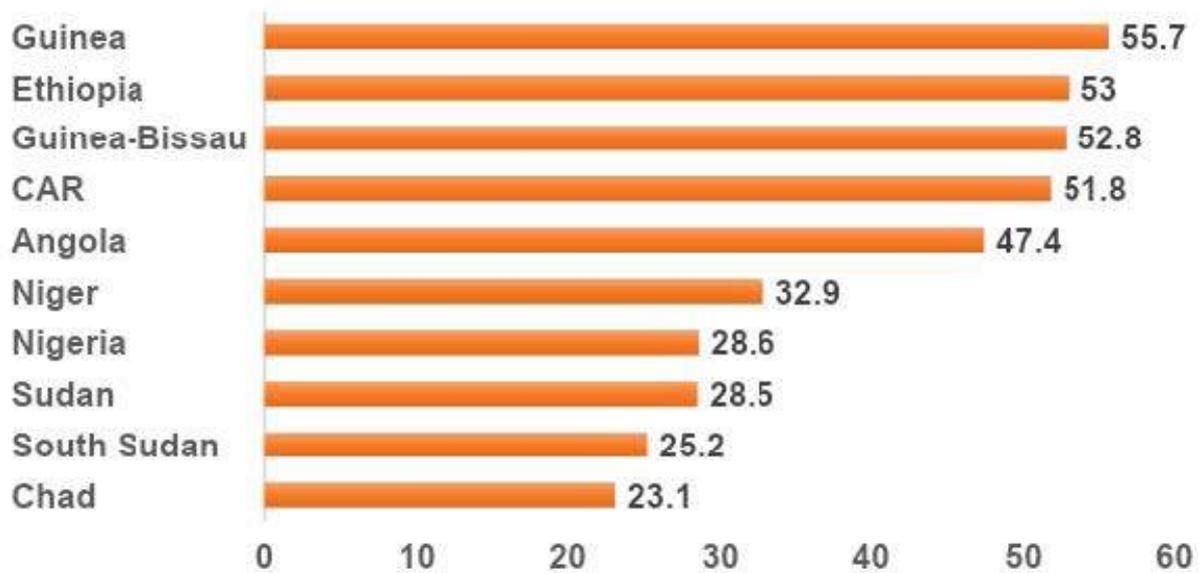


Figure 7.5: Countries with less than >60% of pregnant mothers under 20 years of age who delivered in a health facility

Source: UNICEF global databases, 2021, on coverage of delivery in a health facility, based on MICS, DHS and other nationally representative household survey data

It is encouraging to see, on the other hand, that a number of countries have achieved near-universal coverage in terms of birth delivery in a health-care facility, while 15 countries have reached more than 85% coverage.

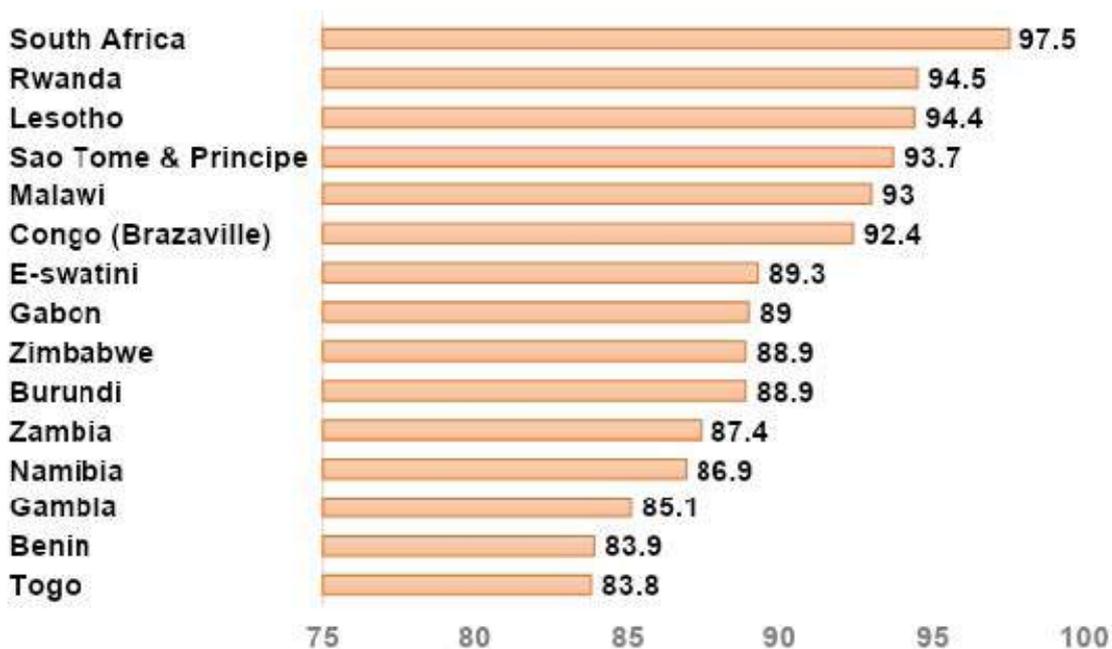


Figure 7.6 Countries with >85% of pregnant teens under 20 years of age who delivered in a health facility

Source: UNICEF global databases, 2021, on coverage of delivery in a health facility, based on MICS, DHS and other nationally representative household survey data

In many countries, initiatives have been put in place to prevent and address teenage pregnancy. These include adolescent peer-education programmes; life skills education programmes; school-based sex education; mass media campaigns; adolescent-friendly clinic initiatives; and community programmes. Below are examples of good practice drawn from selected countries.

Teen-friendly SRH services: Good practices

In the midst of the serious challenge posed by teenage pregnancy, some countries have not only put in place the law and policy frameworks necessary for intervention, but have made commendable efforts to create adolescent-friendly family-planning and SRH information and services. The following good practices from Kenya, Tanzania, Mozambique and South Africa showcase those efforts.

These practices have drawn from some of the standard practices and models in providing teen-friendly SRH services (such as inclusiveness, respect, confidentiality and trust). Experts suggest that SRH and family planning service providers need to take extra steps to make their services teenage-friendly and responsive. This means providing a welcoming environment and ensuring that care is provided in a non-judgmental and supportive atmosphere.

The National Adolescent Friendly Clinic Initiative (NAFCI) in South Africa

The programme was introduced by Limpopo province to address issues related to sexuality among adolescents between the ages of 10–19 years. The goal of the programme is to effect positive behaviour change in adolescents and ensure their access to reproductive health-care services.

The NAFCI has inherent guiding principles which recognise that:

- ☉ Every adolescent is unique and has different needs for health information and services in accordance with age, race, gender, culture, life experiences, social situation, physical and mental wellbeing.
- ☉ Adolescents have SRH rights, including the right to a full range of services. They also have a right to participate in the planning, development and evaluation of services and programmes that address their needs.

To this effect the NAFCI provides the following essential services:

- information, education, and counselling on reproductive health;
- psychosocial and physical assessment;
- contraceptive information, including counselling on emergency contraceptives (both oral and injectable);
- pregnancy testing and counselling;
- antenatal and postnatal care for teenagers;
- STI information, including diagnosis and syndromic management of STIs and partner notification; and





- HIV and AIDS information, pre- and post-test counselling.

Youth Friendly Health Services (Servicios Amigos dos Adolescentes Clinics) (SAAJ) in Mozambique

In Zambezia province, about 55 SAAJs offer their services for youth aged up to about 24 years. The acronym SAAJ stands for 'Youth Friendly Health Services': these are specialised units in health facilities that offer a range of health services from counselling to health tests. In case of positive results, the patient commences treatment immediately, irrespective of whether it is an STD, malaria, or diabetes. The SAAJs provide youth with improved access to adolescent-oriented health information and care, especially with regard to SRH.

The core idea is to offer services for youth in a separate space (often in the backyard of a health facility). This separation reduces waiting times for the target group and allows the use of specially trained staff. It also reduces the fear of being seen by other, often older, relatives or neighbours. There are two types of SAAJ: specific and alternative. While the specific SAAJ is an independent physical ward in a health facility, the alternative SAAJ may refer to just a room, or the availability of specifically trained staff within the health facility. Currently, some alternative SAAJs are being upgraded to become specific SAAJs. This clinical approach is implemented by the health sector with the support of development partners.

Youth-friendly services (YFS) on sexual and reproductive health in Tanzania

This project was implemented in 10 strategically selected districts, targeting 1.2 million youth between 10 and 24 years of age across both urban and rural areas. The objective of the YFS component was to increase the use of quality, youth-friendly adolescent sexual and reproductive health services. The intermediate results from the component were: availability of quality YFS in the project districts increased; supportive environment for YFS provision increased; demand for YFS services increased; and the monitoring and supervision of YFS for clinic and outreach activities established the competence of facilities to deliver and sustain quality YFS activities improved.



Parenting support for teenage mothers: South Africa

The Sinovuyo ('We Have Joy') Teen Parent programme is part of the 'Parenting for Lifelong

Health' initiative. This aims to develop and test evidence-informed parenting programmes that are non-commercial and relevant to lower- and middle- income countries. It is a 14-week parenting programme for at-risk families with 10–18-year-old adolescents. The programme is typically delivered to a pair consisting of the main caregiver and an adolescent from each household within a social learning approach.

One study found that this programme has delivered a range of positive outcomes. From both caregiver and adolescent reports, those receiving the programme recorded reduced abuse (at least in the short term); improved involved parenting and parental supervision; improved household economic welfare and financial management; improved family planning to avoid adolescent violence victimisation in the community; and reduced substance use among caregivers and adolescents. Caregivers also reported reduced depression and stress, a diminution in attitudes condoning corporal punishment, and improved social support.¹³⁶

The Abstinence TV Campaign: 'You think that is Dumb? So is teenage sex. Be smart, abstain': An Example from Kenya¹³⁷

This abstinence campaign is sponsored by the Kenya National Council for Population and Development (KNCPD) in collaboration with UNFPA and targets teenagers in Kenya. The campaign uses the display of a man jumping from a tall building, and a message is put forth in the form of a question: 'You think that is Dumb? So is Teenage Sex. Be Smart, Abstain.' The campaign also appears on television and radio so as to reach the target audience. The campaign message was conveyed using a superhero character, 'Wanna be', who is a teenager. His name is Captain Dumb-dumb. Captain Dumb, dressed in his superhero costume, decides to do a dumb thing by walking on the edge of a tall building and jumping off, copying superheroes that he saw on TV. This portrayal sends a strong message by likening teenage sex to the obvious danger of jumping off a roof. The campaign was meant to delay sexual debut by promoting abstinence among adolescents so that they are likely to have better life-prospects. A study that evaluated the campaign showed that 73.5% of respondents among those who had seen the abstinence advertisement reported that they had observed their peers refraining from sex.

7.4 Coordination of services

In the case-study countries (CAR, Chad, Malawi, Mali, Mauritania, Mozambique, Niger and Uganda) that contributed to this study, a concern regarding coordination was raised by FGD participants and informants from governments and NGOs. Despite the cross-sectoral nature of the issue of teenage pregnancy and access to SRH information and services, there was a lack of collaboration among sectors, as a result compromising the effectiveness of existing initiatives. Even where there are attempts at coordination, the structures are either dysfunctional or functional only in capital cities. As one school director from Mali said, 'No co-ordination. Each government structure makes its own prescriptions and runs with it alone.'

136 Cluver, D.L. et al. Parenting for lifelong health: A pragmatic cluster randomised controlled trial of a non-commercialised parenting programme for adolescents and their families in South Africa. *BMJ Global Health*, 2017, 3(1).

137 Otieno, L.A. (2014). Determining the impact of abstinence campaigns in reducing teenage pregnancy in Mathare North Sub Location: A case study of 'You think that is dumb. So is teenage sex. Be smart abstain' television campaign.



Box 7.2: Good practice in community engagement

Involving community leaders in addressing teenage pregnancy: Sierra Leone

The National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage, 2018–2022, of Sierra Leone stipulates the role of community platforms and ways of ensuring that every chiefdom or ward has a body responsible for the reduction of adolescent pregnancy and child marriage and that it works closely with schools and other service providers. It suggests the following actions:

- Identify bodies and focal points or leaders responsible for adolescent pregnancy and child marriage reduction in each chiefdom or ward
- Develop guidance (terms of reference) for the adolescent-pregnancy and child-marriage reduction bodies (ensuring that key actors such as chiefs, mammy queens, councillors, and religious leaders are involved)
- Provide orientation for bodies responsible for reducing adolescent pregnancy and child marriage
- Hold quarterly meetings with bodies responsible for reducing adolescent pregnancy and child marriage at chiefdom or ward level (with monthly meetings at the village level)
- Identify leaders from chiefdoms and communities as champions to promote adolescent-pregnancy and child-marriage reduction.

Source: Government of Sierra Leone. *The National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage, 2018–2022*

Box 7.3: Multisectoral coordination in addressing teenage pregnancy: Sierra Leone

Office of the President: His Excellency the President provides the overall leadership and chairs biannual meetings to assess and monitor progress in achieving the expected outcomes of the strategy. He also provides overall policy guidance.

The Multi-Sectoral Coordinating Committee (MCC): The MCC is chaired by the Ministry of Health and Sanitation (MoHS) and co-chaired by the Ministry of Social Welfare, Gender and Children's Affairs (MSWGCA). Concerned ministers, heads of UN agencies (UNAIDS, UNDP, UNFPA, UNICEF, WHO, and UN Women), representatives of the donor community, heads of the National Commission for Social Action (NACSA) and the National Aids Secretariat, as well as NGO representatives, are members of the MCC meetings. The role of the committee is to provide policy guidance and direction in the implementation of the strategy, [and] to ensure effective inter-sectoral and inter-ministerial communication, and adequate information sharing among all participating partners. Furthermore, it will oversee the progress of activities undertaken. The committee will meet quarterly, unless otherwise instructed by the chairing ministries.

Multi-sectoral Technical Committee (MTC): The MTC is chaired by the Coordinator of the National Secretariat for the Reduction of Teenage Pregnancy (NSRTP). Ministry focal points and relevant technical officers of the MDAs, UN Agencies, NGOs, civil society organisations and youth associations are members of the MTC. The role of the committee is to provide technical guidance to the implementation of the strategy, ensure complementarity of interventions, facilitate sharing of technical information across sectors and all participating organisations, and monitor the implementation of planned activities and progress towards achievement of expected results. The committee will meet every two months, unless otherwise instructed by the MoHS and MSWGCA.

National Secretariat for the Reduction of Teenage Pregnancy: The secretariat will be responsible for the general coordination of implementation and monitoring. Its role is to support key ministries and participating organisations in initiating policy dialogue, closely monitor programme implementation, ensure progress in achieving the set objectives, and actively engage in the efforts to strengthen national coverage for the implementation of the strategy.

Ministry focal points: All participating ministries will designate a technical staff member to act as focal points. Ministry focal points will participate in the MTC meetings, provide administrative support for meetings, and monitor efforts of the secretariat, as well as keep senior officers updated on programme implementations and discussions of the MTC.

Source: Government of Sierra Leone. The National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage, 2018–2022

7.5 Summary

The availability, accessibility and provision of SRH information and services to teenage girls and boys has always been a challenge in Africa. The challenge associated with accessibility starts with the negative attitudes among health-care providers. Studies in Africa indicate that negative behaviours by health-care workers discourage women and girls from seeking antenatal care, and young people from attending clinics or follow-up visits. Stigmatisation of pregnant teenagers; judgemental and discriminatory approaches; breach of the right to confidentiality; and ill-treatment by health-care workers are among the results of these attitudinal barriers.

The negative attitudes of some health-care professionals extend to discouraging the use of contraceptives by teenagers. While about 57.3% of participants (mainly nurses) in a South African study accepted the fact that teenagers should use contraceptives, more than a third (mainly community members) discouraged their use.





Unmarried teenage girls are often hesitant to access contraceptives, especially in traditional societies in which virginity before marriage is highly valued. Access to contraceptives by these adolescents is reduced both by restricted office hours at health facilities and by the negative attitudes of nurses towards adolescents who seek contraceptive services. This was confirmed in a study in South Africa where health workers felt that teens seeking contraceptives are making an obvious admission of sexual activity.

A study in Ghana showed that young people are not only afraid to ask questions relating to sexual issues, as they think it would be seen as 'disrespectful' and 'disobedient, but they are also inculcated to think that sexual issues are topics only for adult discussion. In another study, girls avoided using contraceptives simply because they did not want to use them.

Among the religious community in Ghana, sex education is seen as a means by which sexually inactive adolescents are converted into those indulging in 'sexual experimentation'.

All the social, cultural and religious norms, values and practices discussed above impede children's access to SRH information and services, thereby fuelling teenage pregnancy.

CHAPTER 8: **CONCLUSIONS AND RECOMMENDATIONS**

8.1 Conclusion: Teenage pregnancy – a three-pronged conundrum

8.1.1 Teenage pregnancy as a public health emergency

Teenage pregnancy has proved to be a multidimensional health crisis, as well as a broader developmental challenge. It compromises children's lives over the entire life cycle, while its public health consequences have intergenerational reach. The causes are manifold. No matter whether due to early sexual debut (often for making ends meet in a poverty-stricken family household); or from being married off at a very young age, or because of being denied access to sexual and reproductive health information (SHR) and services; or simply from unwanted sex, coercion, and exploitation, a long, arduous journey of discrimination and marginalisation is set in motion for any pregnant teen.

The pregnant teen lives a life of deprivation and neglect enjoying very limited access to proper antenatal care, emotional counselling and material support. She might try hard to hide her pregnancy and risk being expelled from school once the pregnancy becomes visible. In the midst of all these grim circumstances, the pregnant teen often resorts to abortion in unsafe places and conditions, often leading to death or lifelong health complications. Even when she manages to access a health-care facility for delivery, she is shunned by some of the doctors and nurses, who harbour the wrong perception of a pregnant teen being an embodiment of sexual immorality.

Pregnant teens – due to their underdeveloped bodies – are also likely to endure considerable physical suffering: obstructed labour; preterm birth; fistula, and a range of other complications. Maternal or foetal death is all too common an occurrence. The effects of teenage pregnancy take their toll on both the mother and her child. Even a child that escapes death is likely to suffer from low birth weight, be deficient in nutrients, and face stunted physical growth and arrested mental development.

The ACERWC recognises that this has long-term effects on Africa's development and economic growth.

8.1.2 Teenage pregnancy as a human rights issue

Human rights, norms and standards focus on women and their rights, and also emphasise the rights of children. But girls in general, and pregnant teens and teen mothers in particular, tend to elude the existing norms. The pregnant teen is all too often seen as a contradiction in terms – a child bearing a child – and the principles and protective armoury available to adult mothers and pregnant adults do not apply to them. Women's rights activists seldom prioritise the plight of pregnant teens in their agenda for gender equality, while child-rights actors relegate the rights of





these children to the women's agenda. When this happens, pregnant teens and teen mothers fall through the cracks. The ACERWC is of the conviction that, as children, pregnant teens deserve unfettered access to the full spectrum of children's rights while as child-bearing individuals, they too need to enjoy the rights available to pregnant adult women and adult mothers. Denying them sexual and reproductive rights, and seeing their exclusion from contraceptives and antenatal care, delivery services and postnatal care – all of this is unacceptable in our age of human rights.

It is also obvious that pregnant teens and teen mothers do not fare well at school. They are often denied their rights to learn and attend school (in some countries, by law). In school, they are humiliated by their teachers (though some teachers do their best to respond to their emotional and material needs). Teens fall pregnant due to being married off at young ages or due to unwanted sex, or sexual exploitation, or due to lack of services, information and support required to make and take safe and healthy decisions regarding their sexuality. Lenient, patriarchal laws and structures mean that these children are not given sufficient protection from perpetrators of abuse and exploitation and those implicated in child marriage.

The ACERWC understands that teenage pregnancy is a manifestation of deeper issues of community and family deprivation and social injustice – and that it needs to be tackled as such.

8.1.3 Teenage pregnancy as a gender-imbalance predicament

The ACERWC believes that teenage pregnancy is not only a children's rights issue, but a gender-equality issue. There are many factors contributing to the high levels of teenage pregnancy – the institution of child marriage being one, and the reality of sexual violence and exploitation, another. In these circumstances, the pregnant teen and teen mother all too often become victims of a deeply entrenched gendered discourse, one that places greater blame on the female victim than the male perpetrator. Pregnant teens and teen mothers are subjected to the relentless, hostile gaze of a world that struggles to accept the idea of a 'child bearing a child'.

Gender discrimination aggravates the difficulties of pregnant teens. It does so in and through the institution of child marriage, as well in the facts of pure sexual exploitation and violence, and in the denial of access to health-care and education services. Indeed, the reluctance of teenagers to use contraceptives does not arise simply from a lack of knowledge or limited availability of contraceptives: it is heavily influenced by a cultural context in which certain beliefs are embedded, beliefs which all too often patriarchal and endorse male domination. Sexuality and contraception are key dimensions of social life in which women's subordination is played out and legitimised and in which the inequalities between men and women are reproduced, and in which women's rights are frequently violated.

In many societies, the norm is for men to seek and exercise sexual pleasure, but women desiring sex are branded as immoral. Traditionally, sexual experimentation among teenage boys is seen as an important determinant of masculinity and a mark of the transition from boyhood to manhood. In an Africa that idealises women's fertility and their role in reproduction, teenage pregnancy is often considered as a welcome transition from adolescence into adult motherhood, while the most common form of contraceptive used among teenagers is the male condom. At the same time, because of the notorious stigma that attaches to any woman who carries condoms, girls

who want to have protected sex almost always have to rely on the boy or man for the use of such protection. Even when it is the boy or man who fails to be willing to use the condom, it is nonetheless the girl or woman who generally takes the blame for the pregnancy. All these gendered stereotypes create a situation in which girls are forced to refrain from safe and rational sexual practices and do not have the power to negotiate safe sex for themselves.

Many common practices display the continued vigour of patriarchal attitudes: the differences in the minimum ages for marriage for girls and boys; and the practice of virginity testing, often performed in public, violating bodily integrity, and conducted only on girls, never on boys. The latter are just two examples. A third is the widespread exclusion of pregnant teens and teen mothers from returning to school. This is an extension of the gender-discriminatory perception that educating a girl is a waste of family resources. Similar practices continue to favour men – and undermine women.

8.2 Recommendations

‘To prevent teenage pregnancy, it’s important to teach girls about sex and equip them with skills for earning a living’ - A teen mother, 17, Niger

Teenage pregnancy is a multi-dimensional issue that requires collaborative effort from various actors and sectors, including governments, the AU, UN agencies, CSOs, community-based organisations, religious and traditional leaders, and many others.

State Parties should:

- Ensure that law and policy-makers, as well as services providers, families and communities, move away from practices that simply blame girls for teenage pregnancy.
- Review national legislation, as well as customary laws and policies, in the light of international human rights standards to provide for the comprehensive protection of girls and boys, with a special emphasis on pregnant teens and teen mothers.
- Raise awareness about, and enforce, existing laws at the community level, while fostering a child-rights culture among members of the judiciary, legislature, ministries, the police, social workers and other relevant sectors to protect girls from teenage pregnancy and uphold their rights.
- Ensure that legal, policy and regulatory frameworks support the rights of teenage girls and boys to have access to comprehensive, scientifically accurate, age-appropriate SRH information; to enjoy confidentiality and privacy; to have proper access to services and materials; and to enhance the capacity of adolescent girls to make their own SRH decisions.
- Adopt legislation and craft policies that allow adolescent children to access SRH services and information without the requirement of third-party consent or approval, taking into consideration their evolving capacity.
- Decriminalise consensual and non-coercive sexual conduct between adolescent children





- who are closer in age to ensure that they access contraception without fear of prosecution.
- Increase the educational attainment of pregnant teens or teen parents and strengthen school-based health and family life education; promote self-esteem; and foster the agency of teenagers.
 - Integrate comprehensive, age-appropriate and accurate SRHR education in schools and provide SRHR education to out-of-school adolescent children using other for a.
 - Ensure that SRH services are gender- and adolescent-responsive and that health workers are sensitised into obtaining skills to avoid stigmatising or discriminating against adolescent children but to ensure their right to confidentiality and provide services that align with the mental, physical, social and psychological needs and capacities of adolescent children.
 - Promote collaboration among government sectors to ensure adolescent girls' access to the full range of contraceptive options for free, safe legal abortion, and quality maternity care services.
 - Ensure appropriate training for all health professionals in contact with teenage girls and boys, including primary health-care providers.
 - Ensure pregnant teens' access to interventions to reduce mother-to-child transmission of HIV during the antenatal period and during delivery.
 - Develop and enforce policies and programmes to ensure that pregnant teens and teen mothers continue with their education in the mainstream education system, including by making appropriate amenities available in schools for them and particularly by accommodating their lactating and other support needs.
 - Adopt and implement policies and strategies for the retention of pregnant teenagers and their re-entry into mainstream schools after delivery for pregnant girls.
 - Make efforts to change the prevailing attitudes of school personnel towards pregnant teens and teen mothers.
 - Implement protocols for systematic detection of violence as part of the routine antenatal care and train health-care providers accordingly.
 - Put in place policies and programmes that help remove barriers that prevent adolescents from seeking help in cases where they are at risk of being raped or otherwise sexually abused or have suffered such violence.
 - Promote policies of zero tolerance of all forms of violence against women and girls, including harmful practices such as child marriage.
 - Ensure that survivors of sexual abuse receive a one-stop service where they can access emergency contraception as well as other reproductive health services and psychological support.
 - Design and implement policies and programmes that empower parents and caregivers to guide children in accessing age-appropriate information and content that is consistent with their evolving capacities.
 - Formulate and implement laws that require media platforms, including social media websites, to ensure that children do not have access to information that is not sensitive to their needs and rights or that encourages them to engage in sexual activities at an early age.

CSOs, community-based organisations, and religious and traditional leaders should, in collaboration with State Parties:

- Involve boys and men as an important part of the discourse on teenage pregnancy to address their information needs and anxieties about sex, relationships and teenage pregnancy. Sensitise communities about the importance of adolescents' access to SRH information and services by showing the benefit of such services in ensuring that they are able to live healthy lives and realise their potential
- Emphasise the role of boys and men in avoiding unintended pregnancy, and inform them of the contraceptive methods available and how to support their partners' use of contraception, along with providing them related material on their responsibility for the children they father and the importance of fathers in child development.
- Seek to change social norms that undervalue girls and put the blame for teenage pregnancy on girls and thereby reduce the social pressures on families to marry off their pregnant girls at early ages.
- Design and implement programmes to inform and empower girls, in combination with interventions to influence family and community norms, to prevent the marriage of girls under 18 years of age and to develop and communicate consistent messages about safe sexual behaviours and teenage-pregnancy prevention methods and practices.
- Facilitate the establishment of adult-teenage communication programmes with guidelines to give adults, notably parents and caregivers, information and skills to communicate effectively with young people about reducing risky sexual behaviour, including by breaking the taboo surrounding discussions about sex in many communities.
- Implore families, schools and religious institutions to teach adolescents about the danger of alcohol and drug abuse, which are often a factor in teenage pregnancy.
- Wherever appropriate, encourage existing traditional methods that promote virginity and abstinence from sex until marriage, with proper child-protection safeguards.
- Provide information to out-of-school girls and community members about the importance of utilising sufficient antenatal, childbirth and postnatal services, safe abortion, and on the need for avoiding unsafe abortions.
- Provide counselling, medical, social and psychological support to pregnant teens, with special attention to those with unintended pregnancies.
- Make teen-friendly SRH information and services available in schools and develop close collaboration between schools and local health service providers to make such services available.
- Develop and implement parenting programmes for teen mothers, including through home visits, mentoring support, parenting and psychosocial support, to improve health and welfare outcomes for the mother and child.
- Improve access to and the quality of formal education for girls, especially at the post-primary and secondary levels in order to build up girls' economic, health and social assets and address underlying economic motivations.

'Fighting teenage pregnancy can be successful if a bottom-top approach is used. From the lessons learned, community bylaws are being more effective than the national laws. Since they are formulated by the community, it is easy to follow and implement them because they are owned by the community' – An expert from Plan International Uganda





- Provide social protection support to poor and deprived communities and households to alleviate household poverty and to design and implement youth development strategies and vocational training and employment opportunities, including those that are meant to keep girls in school.
- Develop and implement programmes that are specifically designed to focus on the most at-risk and especially vulnerable girls, such as those living and/or working on the street, those with disabilities, notably with intellectual disabilities, those living in rural areas and urban slums, and those in humanitarian, emergency and conflict situations.
- Encourage more adult guidance of adolescents, especially young girls, in order to decrease opportunities for coercive or precocious sexual activity and sexual risk-taking.
- Screen for sexual abuse and exploitation, and be aware of the possibility of coercive relationships when the adolescent is pregnant to an older partner.

The AU and RECs should:

- Develop Pan-African frameworks and strategies that inform state party efforts at addressing teenage pregnancy.
- Facilitate cross-country learning and experience-sharing initiatives in partnership with each other and State Parties, and including the identification and dissemination of good practices.
- Encourage State Parties to ratify relevant human rights instruments such as the African Women's Protocol, withdraw reservations on ratified instruments, and incorporate ratified treaties into domestic laws and policies.
- Provide State Parties with elaborations on the provisions in existing human rights instruments that are directly or indirectly related to teenage pregnancy.
- Encourage State Parties to include teenage pregnancy in their periodic reporting on the implementation of ratified treaties.
- Urge State Parties to repeal laws and revise policies that are detrimental to the SRH and rights of girls and boys.

UN agencies and international organisations should:

- Provide financial and technical support to African governments and civil society organisations to effectively address teenage pregnancy, including through debt relief and emergency borrowing facilities.
- Provide research evidence and knowledge resources for informing law and policy-making and advocacy.
- Support relevant actors to address poverty-related factors that contribute to teenage pregnancy, including through social protection interventions.

The media should:

- Contribute to preventing unintended teenage pregnancy through presenting accurate

material on the dangers of sexual risk-taking and the benefits of safer and healthy sex practices, including the use of contraception and broadening messages about the prevention of STDs.

- Ensure proper classification of and sufficient content warning on films, videos, music and other media to enable parents, guardians, caregivers and teachers to effectively identify media messages that are inappropriate for teenagers.
- Develop and implement programmes to empower and support parents and guardians to better supervise their children's interaction with print and electronic media.
- Investigate and report on the plight of pregnant teenagers and teenage mothers, and call upon responsible bodies and persons to design and implement programmes to offer material and psychosocial support to such teenagers.

8.3 Final Remarks

In undertaking this research, the ACERWC expresses its recognition of the urgency and seriousness of the plight of pregnant teens and teen mothers in Africa. The African continent has witnessed nearly three decades of significant changes in its child-rights landscape. As a continental child-rights treaty body, the ACERWC has undertaken several steps in bringing the plight of especially vulnerable children, including pregnant teens and teen mothers, onto the child-rights radar. This study is yet another indication of the ACERWC's commitment to putting especially vulnerable children on the political agenda. Pregnant teens and teenage mothers find themselves at the junction of both children's rights, on account of their age, and women's rights, due to their sex and child-bearing status. It is essential to recognise that pregnant teens face discrimination both as children and as mothers.

The findings and recommendations in this report will provide us with the materials for developing the frameworks and programmes to inform and guide appropriate levels of national action from governments, CSOs and other stakeholders in the struggle to address the scourge of teenage pregnancy.

TEENAGE PREGNANCY IN AFRICA

Status, Progress
& Challenges



2022



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