reclaiming and redefining rights: setting the adolescent and young people SRHR agenda beyond icpd+20

GLOBAL SOUTH OVERVIEW

These Global South Adolescent and Young People Fact Sheets, have been developed as part of the ICPD+20 Global South SRHR Monitoring and Research Initiative steered by ARROW in partnership with Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights (ASTRA), Latin American and Caribbean Women's Health Network (LACWHN), Egyptian Initiative for Personal Rights (EIPR) and the World YWCA. The fact sheets provide the most recent data and analysis on adolescent and young people SRHR across the Global South regions. The recommendations to respective governments, donors, UN agencies take into consideration the evidence and lived realities of adolescent and young people in Asia and the Pacific, Eastern Europe, Latin America and the Caribbean, and the Middle East and Northern Africa and Sub-Saharan Africa.

arrow
asian-pacific resource & research centre for women

1. Context[1]

People under 25 comprise 43% of the world's population and roughly 88% of adolescents live in developing countries.[2] Of the 620 million young people in the labor force, almost 13% were unemployed in 2009, which is the highest number ever.[3] Many girls and boys enter adolescence in a malnourished state of health. About 16 million adolescent girls give birth every year globally and in any given year at least 20% of adolescents suffer from mental illnesses such as depression or anxiety.[4] Approximately, 430 young people die from interpersonal violence every day.[5] While 40% of men and 38% of women have accurate knowledge about HIV transmission, an estimated 40% of new HIV infections occur in young people age 15-24.[6]

2. Universal access to quality education

The ICPD Programme of Action calls for universal access to quality education, including the elimination of gender disparities and achieving the widest and earliest possible access by girls and women to secondary education.[7] While many countries have made progress towards gross enrollment of children in primary school, gaps still exist in the Sub-Saharan Africa, Middle East and Northern Africa, and Eastern Europe regions.

The secondary gross enrolment ratios are far from universal with Sub-Saharan region listed in the bottom rung with only 35.3 % of children enrolled in secondary education. This is followed by South Asia with 55.9% and Arab States at 66.5%.[8]

Gender gaps continue to persist in access to quality education. Specific population groups within regions and across countries, such as indigenous populations, disabled, and marginalised and vulnerable populations such as Roma communities in Eastern Europe, face much more difficulty in access to quality primary, secondary and tertiary education.

Poverty significantly impacts access to education at all levels. Other barriers including high dropout rates, lack of sanitation facilities and sexual harassment by teachers impede access to education, especially for young girls. High unemployment and under employment for educated youth persists across the regions.

This fact sheet has been published by ARROW with funding support from FORDFOUNDATION and Sida

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

3.1 Comprehensive sexuality education (CSE)

Sexuality education is varies in content and how it is implemented throughout the five global south regions. Regional trends and global variations demonstrate the necessity for country-level agendas that incorporate internationally agreed upon commitments regarding sexuality education.

While surveys and studies reveal that there is high demand for sexuality education, the provision by countries of comprehensive sexuality education both in and out of school is far from being realised.

Even when mandated for implementation, sexuality education curriculum faces serious challenges while traversing from national to local levels, with local communities and local governments interfering with materials related to course content or needed for teacher trainings as in the case of Latin America. In the event that policies do exist for sexuality education, such as in Sub-Saharan Africa and in Latin America and the Caribbean, lack of financial resources present as barriers to dissemination and proper implementation of policies.

Comparisons of curriculum content and availability can be made across the regions. While sex education is provided in most of the countries in the global south regions, the content and the comprehensiveness of these courses, and the avenues by which the curriculum is delivered varies and is not meeting the standards of comprehensive sexuality education definition (refer to box1). The provision of out-of-school sex education has been documented in Asia and the Pacific region.

Box 1: Sexuality education is defined as education about all matters relating to sexuality and its expression. Sexuality education covers the same topics as sex education, but also includes issues such as relationships, attitudes towards sexuality, sexual roles, gender relations and the social pressures to be sexually active and it provides information about SRH services. It may also include training in communication and decision making skills.[9]

Data on sexuality education in Africa is limited. Given poor enrolment ratios in primary and secondary schools it is very important for the region to focus efforts both in school and out of school. With the exception of Mexico, sexuality education in countries reviewed for the ICPD+20 global south monitoring report for Latin America and the Caribbean, does not include contraception until at least the secondary level with the Dominican Republic introducing it only at the tertiary level and Nicaragua excluding it altogether.

Evidence shows that school curricula include limited information on reproductive health. In addition, teachers usually overlook this information during classes either out of embarrassment or unpreparedness. In the MENA region, Tunisia is the only country that has instituted school-based sexuality education since 1960, however it is yet to be comprehensive.

Data from the Central and Eastern Europe region countries in the ICPD+20 global south monitoring report shows that 6 of the 10 countries provide sex education at the primary level and by the secondary level 9 of the 10 countries provide sex education.

3.2 Contraceptive Use among Adolescents and Young People

Adolescent and young people's right to contraceptive information and services is recognised within the ICPD PoA. The right to highest attainable standard of sexual and reproductive health, the right to decide the number and spacing of one's children, the right to information and the right to quality sexual and reproductive health services enshrined at ICPD PoA stipulate that adolescents and young people have access to contraceptive information and services in an enabling environment.

Global estimates by Guttmacher show that 52 million never-married women, mostly adolescents and young women aged 15-24 in the developing world, are sexually active and in need of contraceptives in 2012. A recent Guttmacher report notes that there is a steady long-term trend towards increased levels of sexual activity among this group, due to reasons such as the declining age of menarche, the rising age at marriage and changing societal values.[10]

This trend emphasises the growing need to ensure all adolescents and young women have access to sexual and reproductive health services, including contraception suitable to their needs, as envisaged in the ICPD PoA.[11]

In Latin America and the Caribbean, young women age 15-24 have the highest rates of dissatisfaction with contraceptive methods compared to all regions in the world. Contraception discourses and services in the South Asia sub-region lie mostly within the context of marriage.

Among the countries reviewed in the ICPD+20 global south monitoring report for the Asia Pacific region, Cambodia and the Philippines have the lowest CPR rates among those age 15-19 in the region, followed by Nepal and Pakistan. For young women aged 20-24, Pakistan, Cambodia, and the Philippines

remain among the countries with the lowest CPR rates in the region. The highest CPR rates are recorded in Bangladesh and Indonesia. It is difficult for adolescents in the MENA region to obtain contraceptives regardless of whether or not they are married due to various social and cultural reasons.

Despite information and the existence of sex education in primary and secondary schools, CPR rates in Eastern Europe are relatively low.

Withdrawal and abortion are the primary means of family planning and contraceptive use in some of the countries in the region. In the region, the condom is the most popular method of contraception and this raises questions on the availability of a range of contraceptive methods to adolescents and young people. Service providers can also create barriers in accessing contraceptive methods, contributing significantly to the problem.

In the Sub-Saharan Africa region only 21% of married adolescents are using a modern contraceptive method, and this is more pronounced.[12] In this region the overall levels of unmet need is higher for all women, and this more pronounced among adolescents at 68%.[13]

Across the global south regions, the pattern of contraceptive use poses challenges for both married and unmarried young women to Young married women who might be under pressure to conceive right after marriage due to socio-cultural motives which put emphasis on fertility.

Never-married women, including adolescents and young women, have a great disadvantage in obtaining contraceptives largely due to stigma attached to being sexually active before marriage. Among women in need of contraceptives, use of modern methods is 31 percentage points lower among never-married women than among married women in Asia; this difference is 10 percentage points in Latin America and the Caribbean.

However, the situation is reversed in Sub-Saharan Africa, where the proportion of never-married, mostly adolescents and young women in need using modern contraceptives is 19 percentage points higher than among their married counterparts.[14]

3.3 Adolescent pregnancies

Adolescent pregnancies epitomise many of the sexual and reproductive health problems prevalent among the adolescents across the global south countries. The ICPD Programme of Action calls for a substantial reduction in adolescent pregnancies, and to address the sexual and reproductive health issues of adolescents in a manner consistent with the evolving capacities of adolescents.[15]

About 16 million adolescent girls aged 15-19 give birth each year, roughly 11% of all birth worldwide, with 95% of the births occurring in developing countries.[16] Half of these births occur in just 7 countries: Bangladesh, Brazil, Democratic Republic of Congo, Ethiopia, Nigeria, India and the United States. Four of these countries fall into the Global South ICPD+20 Monitoring and Research Initiative, being steered by ARROW

Table 1: Regional adolescent birth rates 2011

Region	Adolescent Birth Rate
Arab States	44.4
East Asia and the Pacific	19.8
Europe and Central Asia	28.0
Latin America and the Caribbean	73.7
South Asia	77.4
Sub-Saharan Africa	119.7

Source: Human Development Report 2011

In 2010, the global adolescent birth rates stood at 53 births per 1,000 women. An examination of the above table shows that Sub-Saharan Africa region has a very high rate of adolescent births (119.7), almost double the global adolescent birth rate, followed by South Asia at a rate of 77.4, and Latin America following closely at 73.7.

According to the ICPD+20 global south monitoring report for the Asia Pacific region, adolescent birth rates vary significantly. It is highest in Bangladesh, Lao PDR, Afghanistan, Nepal and Papua New Guinea especially in rural areas. The adolescent birth rate is comparatively lower in China and Malaysia.[17] The adolescent's birth rates are high in the Oceania sub-region. A trend analysis of the adolescent fertility rates in the Latin American region shows an increase in the adolescent fertility rates over time.[18] In the Middle East and Northern Africa region, countries such as Yemen have an adolescent birth rate of 80 per 1000 women, which is much higher than the regional average.

The adolescent birth rates in Bulgaria and Romania, Georgia, Azerbaijan are higher than in the Eastern Europe regional average.[19] Although the rate remains high in Armenia, it is the country with the biggest improvement in reducing its adolescent pregnancy rate, with a drop from 66.6 births per 1000 women in 1995 to near 30 in 2009.

Complications arising from adolescent pregnancies

An examination of the characteristics of young adolescent mothers in the global south regions shows that they are mostly from lower income groups, in rural dwelling and with poor

education.[20] Adolescents and young girls who get pregnant tend to enter into the vicious cycle of poverty because early motherhood often compromises their educational attainment, economic potential and their social well-being.

Young adolescents face a higher risk of complications, with adolescents under 16 facing four times the risk of maternal death as women over age 20.[21] Factors such as poor socio-economic status, education, violence, and lack of access to SRH information and services contribute to high adolescent birth rates.

In Africa, high levels of maternal mortality and the prevalence of HIV and AIDS are largely responsible for higher mortality among young women. In Nigeria, the high rate of adolescent pregnancies is prevalent with 23% of young women aged 15-19 who have begun childbearing.[22] It needs to be noted that more than 25% of fistula patients in Ethiopia and Nigera had become pregnant before the age of 15 and more than 50% before age of 18, showing a definite co-relation between adolescent pregnancy and morbidity conditions of fistula. Adolescent girls face severe morbidity, as well as psychological problems and social isolation as a result of this condition.[23]

In South Asia, early marriage, early childbearing and insufficient access to health services are the main causes for the relatively high mortality among adolescent and young women.[24] The proportion of women under the age of 20 giving birth in Bangladesh yearly is one of the highest in the world.[25] The number of deaths among adolescent mothers is double the national average.[26]

In Eastern Europe, early marriage is a problem in Armenia, Azerbaijan, Georgia, and some parts of the Russian Federation. Of girls between 15 and 19 years of age, 13% were married, divorced or widowed in Azerbaijan and 11% in Russian Federation.[27] Moreover, in Bulgaria, Hungary and Romania, early marriage and childbirth forces Roma girls to drop out of school.[28]

It needs to be noted that a significant proportion of adolescent pregnancies result from non-consensual sex, and most take place in the context of teen marriage. Most of the marriages among adolescent girls occur well below the legal age of marriage, as a result of customary and religious laws.

Early and child marriages violates both international commitments and national laws. Tunisia has one of the lowest adolescent birth rate, 6 per 1000 women for 2007, partially due to the high minimum age of marriage, which is 20 years old for both sexes.[29]

3.4 Access to abortion information and services among adolescents and young women

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

Adolescent girls age 10-19 account for at least 2.2-4 million unsafe abortions in developing countries.[30] Young women under the age of 25 account for almost half of all abortion deaths[31] and this group is seriously affected by the consequences of unsafe abortion .

Adolescent girls and young women living in developing countries account for a significant proportion of unsafe abortions. These countries have abortion permitted on restrictive grounds, and where abortion is permitted, access to safe abortion services especially for adolescents and young girls remains a challenge.

In Sub-Saharan Africa, adolescent girls account for a quarter of all unsafe abortion and almost 60% of unsafe abortions are among young women aged less than 25 years.[32] About 10,000 adolescent girls in Nigeria die due to unsafe abortions each year.[33] Abortion is permitted on at least one ground in all the countries reviewed.

The latest estimates from WHO indicate that there are more than 3 million unsafe abortions performed in 2008 in the MENA region, accounting for 14% of maternal mortality.[34] Abortion access is politicized in countries in the ICPD+20 global south monitoring report for the MENA region due to the inclination of religious institutes, international organisations and national legal norms. Abortion is permitted on at least one ground in Egypt and Yemen and it is permitted on all grounds in Turkey and Tunisia.

Abortion policies in countries in the ICPD+20 global south monitoring report for Latin America and the Caribbean are heavily influenced by religious and cultural norms. In Mexico, abortion is legal on all grounds only in the Federal District. Other states in Mexico either have restrictions or totally ban abortion. Abortion is restricted on all grounds in Nicaragua and Dominican Republic. [35]

In Asia, 30% of unsafe abortions are among women under 25 years of age.[36] Vietnam, Nepal, Cambodia and China have abortion permitted on all grounds. Abortion is permitted at least on one ground in the ICPD+20 global south monitoring report Asia-Pacific region countries. Eastern Europe region has higher abortion rates in comparison to all of the Europe.

The countries under review in the region have abortion permitted on all grounds, with the exception of Poland. Poland has one of the most restrictive abortion regulations in Europe. Moreover, in 2012, the initiatives to restrict access to abortion appeared in Azerbaijan, Bulgaria, Hungary, Poland, Russian Federation and Ukraine.[37] Adolescents face more barriers accessing abortion and among these laws are clauses that require young girls to obtain parental consent for the procedure prior to performing it.

Gestational limits, parental and spousal consent, mandatory waiting periods and counseling, and lack of information on the legality of abortion among both adolescents and young people and service providers, stigma and religious influence impede abortion access for adolescents and young women. As a result this group is more like to suffer from abortion-related complications, including immediate and long-term disability and death.[38]

3.5 Sexually Transmitted Infections (STI) and HIV and AIDS

It is estimated that 80-90% of the global burden of sexually transmitted infections occurs in developing countries. These countries have limited screening, diagnostic and treatment options. Adolescents and young women are at greatest risk for almost all STIs, with one in 20 young people contracting a curable STI each year, and one in four sexually active adolescent women is diagnosed with an STI every year. Adolescents mostly contract gonorrhoea, *Chlamydial* infection, syphilis, trichomoniasis, chancroid, genital herpes, genital warts, HIV infection and hepatitis B infection.[39]

STIs result from unprotected sex, and sometimes sex resulting from coerced, force, violence and transactional sex, especially among marginalised adolescent and young girls.[40]

It is generally observed that STIs are more prevalent among African and Caribbean adolescents than in other regions of the world, partly because sexual debut comes as early as 10-11 years in some African and Caribbean countries. Studies on gonorrhoea in selected Middle East and African countries found that STI levels were highest among 15-19 year olds. Meanwhile, STIs are also high among Pacific Island young people: the prevalence of chlamydia among under-25-year old pregnant women is 40.7% in Samoa and 40% in Fiji.[41]

Comprehensive and correct knowledge about HIV among both young men and young women has increased slightly since 2008 globally, but at only 34%, as against the UNGASS target of 95%.[43]

Globally, young women aged 15-24 are more vulnerable to HIV with infection rates twice as high as in young men, and accounting for 22% of all new HIV infections. Data in the table below shows the HIV prevalence among young women is much higher to that of young men globally, and in the Sub-Saharan region, Oceania, Eastern Europe and Central Asia, Middle East and Northern Africa and the Caribbean.

In sub-Saharan Africa, it is observed that young women aged 15–24 years are as much as eight times more likely than men to be living with HIV. Five countries—Botswana, South Africa, United Republic of Tanzania, Zambia, and Zimbabwe—showed a significant decline in HIV prevalence among young women or men in national surveys. [44] In the Caribbean, young women are approximately two and a half times more likely to be infected with HIV than young men.

Table 2: Estimated percentage of young women age 15-24 living with HIV in 2009

Region	Young women (15-24) prevalence percentage	Young men (15-24) prevalence per-centage
Global	0.6 (0.5-0.7)	0.3 (0.2-0.3)
Sub-Saharan Africa	3.4 (3.0-4.2)	1.4 (1.2-1.7)
East Asia	<0.1 (<0.1-<0.1)	< 0.1 (< 0.1-< 0.1)
Oceania	0.2 (0.2-0.3)	0. 1 (0.1-0.3)
South and South-East Asia	0.1 (0.1-0.1)	0.1 (0.1- 0.1)
Eastern Europe and Central Asia	0.2 (0.2– 0.3)	0.1 (0.1-0.1)
Western and Central Europe	0.1 (<0.1-0.1)	0.1 (0.1-0.2)
Middle East and North Africa	0. 2 (0.2-0.3)	0.1 (0.1-0.1)
Caribbean	0.8 (0.6-1.0)	0.4 (0.3-0.7)
Central and South America	0.2 (0.1-0.3)	0.2 (0.2-0.5)

Source: UNAIDS Global Report 2010

In Asia, the proportion of women living with HIV compared to men has stabilised at 35%. Sex is a key driver of HIV in Asia and at least 50 million women in Asia are at risk of acquiring HIV from their male intimate partners who engage in high-risk behaviour, including paid sex, injecting drug use and unsafe male to male sex. In Eastern Europe and Central Asia, young women are especially at risk. HIV prevalence is twice as high amongst young women as amongst young men in this region.

The evidence points to decreasing incidence of HIV among young people with at least seven countries across the globe showing statistically significant decline of 25% or more in HIV prevalence. However, many young people still continue lack knowledge and tools they need to prevent HIV, including ready access to condoms and lubrication, and people who inject drugs also lack sufficient access to sterile needles.[45]

4. Traditional and harmful practices

The most common discriminatory traditional practices that occur across the global south regions include child marriage (Asia-Pacific, Sub-Saharan Africa and MENA regions), female circumcision (Asia-Pacific, Sub-Saharan Africa, MENA, and Latin America and the Caribbean specifically in Colombia), and honour killings (Asia-Pacific and MENA regions).

Young women, who may not have full agency over decisions concerning their bodies and sexualities, find themselves caught between the burden of harmful traditional practices and the dangers of newly emergent practices such as gang harassment and human trafficking.

The ICPD Programme of Action called for the total elimination of Female Genital Mutilation (FGM), defined as the partial or total removal of the female genitalia or other injury to the female genital organs for non-medical reasons.[46]

There are an estimated 130–140 million girls and women who have been subjected to FGM and 3 million girls are at risk of it every year. Most women who have experienced FGM live in one of the 28 countries in Africa and the Middle East – nearly half of them in just two countries: Egypt and Ethiopia.

Countries in which FGM practice has been documented include: Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Cote d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Togo, Uganda, United Republic of Tanzania and Yemen. The prevalence of FGM ranges from 0.6% to 98% of the female population.

In the Asia-Pacific region, female circumcision or female genital mutilation is most commonly practiced in Indonesia and traditionally practiced by eight ethnic groups within the country.[47] It is also prevalent among the Bohra Muslim communities in Pakistan and India.[48]

5. Homophobia and Transphobia

As of 2012, at least 40% of UN Member States have legislations criminalising same-sex sexual acts.[49] In comparison to 2011, the number of countries persecuting people rose from 76 to 78.[50] Interesting developments are seen in Botswana, Mozambique, Mauritius and Seychelles where legislation have been adopted that "prevent discrimination on grounds of sexual orientation in workplaces." At the same time Russia has introduced legislation punishing homosexual propoganda.[51]

Stigma and discrimination against people's sexual diversity and against young people living with HIV in the region is one of the common practices that clearly poses a risk to the young people, who are victims of violence in this situation, affecting their dignity, health and development.

Homophobia is a wide problem in Latin America and youth face difficulties with self-expression and integration in their communities. In Asia, more than half the countries in the region still criminalise homosexuality, and countries in the Pacific are at different stages when it comes to legal frameworks around sexual orientations and gender identities.[52]

The situation in Africa for Lesbian, Gay, Bisexual, Trans and Intersex (LGBTIQ) has not seen much progress in recent years. Regionally, 36 countries have laws criminalizing homosexuality. Punishments include imprisonment and the death penalty. The laws on homosexuality are rooted in colonial era laws, religious conservatism, political climates, cultural beliefs, heterosexual family values and patriarchy.[53]

The recognition of diverse sexual and gender identities is still problematic in Eastern Europe.

6. Recommendations

The recommendations for governments in respective regions are captured in the regional factsheets. The global factsheet captures the cross-cutting recommendations for Donors, UN agencies, international organizations and civil society and draw from the regional ICPD meeting outcomes in 2012 - KL Call to Action, Warsaw Call to Action.

We the adolescents and young people of the Global South countries call upon Donors, UN agencies, international organizations to:

1. Given that data on the sexual and reproductive behaviour and access to SRH services of adolescents and young people is limited across global south countries, it is important to allocate funding and support for ethical and gender-sensitive research to provide evidence for policy making and programming related to SRHR of adolescents and young people. Data should be disaggregated according to age, sex and other socio economic indicators.

2. Ensure that accountability mechanisms are in place and adhere to the highest standards of transparency in order to monitor progress in achieving SRHR, social equality and equity, and acheiving universal access to sexual and reprodutive health.

3. Unequivocally endorse, sustain and scale up resources and official development aid (ODA) for the implementation of comprehensive SRHR interventions for adolescents and young people in the Global South regions.

4. Ensure universal access to quality education and eliminate gender disparities in both primary and secondary education.

5. Provide universal acess to comprehensive sexuality education and youth-friendly sexual and reproductive health services.

6. Address the unmet need for contraception among adolescent and young people through the provision of contraceptive information, as well provide access to range of contraceptive methods. Make all efforts to substantially reduce the number of adolescent pregnancies.

7. Provide access to safe abortion information and services and remove barriers such as gestational limits, parental and spousal consent, mandatory waiting periods and counseling.

8. Put mechanisms in place to eliminate all forms of harmful practices such as child marriages, FGM, Honour Killing impacting adolescents and young girls.

9. Advocate for ensuring universal access to youth friendly SRH services and CSE in the Secretary General's Report and other outcome documents in the lead-up to ICPD+20.

10. Review, amend and implement laws, policies and programmes to address the needs and realities of adolescents, young people and LGBTIQ persons and at all times uphold the principles of human rights , gender equality, and equity and push for progressive rights based SRHR laws and policies.

11. Ensure the capacity enhancement of young people and civil society to effectively engage with governments and participate in the ICPD Beyond 2014 processes at country, regional level and global level; Young people's SRHR issues are genuinely and cross-sectionally integrated across all UNFPA-proposed thematic meetings and regional meetings in the lead-up to the ICPD+20 review processess.

12. Address the vulnerabilities of women and young people due to migration, climate change, disasters, conflict and displacement, and adopt concrete measures to mitigate their impact.

To Civil Society Organizations

1. Advocate to Governments to ensure adolescents and young people's increased access towards sexual and reproductive health information and services, commodities including HIV Testing and Counselling, medical male circumcision, contraceptives, Anti-Retroviral Therapy and maternal health care.

2. Prioritize advocacy and education on reform of laws and policies on traditional and cultural practices and norms that threaten the sexual and reproductive health and rights of young people including female genital mutilation/cutting, traditional sexual initiation rites, child-marriage, gender-based violence and all other forms of sexual exploitation.

3. Create spaces where civil societies can engage meaningfully, and share existing platforms with young women and girls, as these are influential in shaping the post 2015 development framework. Their participation should be part of a whole, comprised of multi-layered partnership building with other actors in the movement.

4. Actively engage in monitoring governments in their international commitments to SRH and hold them accountable

5. Monitor national budgets to ensure that the appropriate funds are allocated for SRH services of young people and adolescents.

reclaiming and redefining rights: setting the adolescent and young people srhr agenda beyond icpd+20

Endnotes

1 This global south adolescent and young people SRHR factsheet is based on the five regional (Asia and the Pacific; Eastern Europe; Middle East and Northern Africa; Latin America and the Caribbean and Sub-Saharan Africa) .

2 United Nations Population Fund (UNFPA) . (2011). Young people: forging the future. New York, NY: United Nations. Retrieved from http://www.7billionactions.org/uploads/browser/files/7b_factsheets_youth_v5.pdf.

3 United Nations Population Fund (UNFPA) . (2011). Young people: forging the future. New York, NY: United Nations. Retrieved from http://www.7billionactions.org/uploads/browser/files/7b_factsheets_youth_v5.pdf.

4 World Health Organization (WHO). (2011). Young people: health risks and solutions. Geneva, Switzerland: WHO. Retrieved from http://www.who.int/mediacentre/factsheets/fs345/en/index.html.

5 World Health Organization (WHO). (2011). Young people: health risks and solutions. Geneva, Switzerland: WHO. Retrieved from http://www.who.int/mediacentre/factsheets/fs345/en/index.html.

6 United Nations Population Fund (UNFPA) . (2011). Young people: forging the future. New York, NY: United Nations. Retrieved from http://www.7billionactions.org/uploads/browser/files/7b_factsheets_youth_v5.pdf.

7 ICPD Para4.18; 6.7c, 11.5

8 United Nations Development Programme (UNDP). (2011). Human Development Report 2011, Sustainability and Equity: A Better Future for All. New York, NY: United Nations.

9 Glossary Browser. (2009). Retrieved September 29, 2009, from International Planned Parenthood (IPPF) Web site: http://glossary.ippf.org/GlossaryBrowser.aspx

10 Singh, S. and Darroch, JE. (2012). Adding It Up: Costs and Benefits of Contraceptive Services—Estimates for 2012, New York, NY: Guttmacher Institute and United Nations Population Fund (UNFPA) Retrieved from < http://www.guttmacher.org/pubs/AIU-2012-estimates.pdf>.

11 Presler-Marshall, E. and Jones N. (2012). Charting the future: empowering girls to prevent early pregnancy. London, UK: Overseas Development Institute. Retrieved from http://www.savethechildren.org.uk/sites/default/files/docs/Charting_the_Future.pdf

12 Guttmacher Institute. (April 2010). Facts on the Sexual and Reproductive Health Of Adolescent Women in the Developing World. New York, NY. Retrieved from (http://www.guttmacher.org/pubs/FB-Adolescents-SRH.pdf).

13 Guttmacher Institute. (April 2010). Facts on the Sexual and Reproductive Health Of Adolescent Women in the Developing World. New York, NY. Retrieved from http://www.guttmacher.org/pubs/FB-Adolescents-SRH.pdf

14 Singh, S. and Darroch, JE. (2012). Adding It Up: Costs and Benefits of Contraceptive Services—Estimates for 2012, New York, NY: Guttmacher Institute and United Nations Population Fund (UNFPA) Retrieved from < http://www.guttmacher.org/pubs/AIU-2012-estimates.pdf>.

15 ICPD Programme of Action

16 World Health Organization (WHO). (2008). Adolescent Pregnancy. Making Pregnancy Safer Notes, 1(1). Geneva, Switzerland: WHO. Retrieved from <www.who.int/maternal_child_adolescent/documents/mpsnnotes_2_lr.pdf>.

17 Jahanath, S; Mushtaq, N; Ajao, J. (2012). Reclaiming & Redefining Rights-ICDP+20: The Status of Sexual & Reproductive Health and Rights in Asia and the Pacific (draft, unpublished). Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW).

18 Yoval, N; Ajao, J. (2012). Reclaiming & Redefining Rights-ICDP+20: Latin America and the Caribbean region SRHR youth fact sheet (draft, unpublished). Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW).

19 Szostak, M; Pabijenek, K. (2012). Reclaiming & Redefining Rights-ICDP+20: Central and Eastern Europe region SRHR youth fact sheet (draft, unpublished). Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW).

20 Growing up global: The Changing Transitions to Adulthood in Developing Countries (National Research Council, 2005

21 World Health Organization (WHO). (2012). Maternal mortality. Geneva, Switzerland: WHO. Retrieved from <http://www.who.int/mediacentre/factsheets/fs348/en/index.html>.

22 National Population Commission (NPC) [Nigeria] and ICF Macro. (2009). Fertility Levels, Trends, and Differentials. In Nigeria Demographic and Health Survey 2008 (pp. 60-1). Abuja, Nigeria: National Population Commission and ICF Macro.

23 World Health Organization (WHO). (2009). Adolescent pregnancy: a culturally complex issue. Bulletin of the World Health Organization, 87(6), 405-484. Geneva, Switzerland: WHO. Retrieved from <http://www.who.int/bulletin/volumes/87/6/09-020609/en/>.

24 United Nations Commission on Population and Development. (2011). Report of the secretary general at the forty-fifth session adolescents and youth. New York, NY: UN.

25 Racherla, S.J. (Ed.). 2011. Reclaiming & Redefining Rights - Thematic Studies Series 4: Maternal Mortality & Morbidity in Asia. Kuala Lumpur, Malaysia: ARROW. http://arrow.org.my/publications/ICPD+15Country&ThematicCaseStudies/MaternalMortality&MorbidityinAsia.pdf

26 United Nations Children's Fund (UNICEF). (2009). Maternal and neonatal health in Bangladesh. New York, NY: UNICEF. Retrieved from <http://www.unicef.org/bangladesh/Maternal_and_Neonatal_Health.pdf>.

27 Pabijanek, K. (2012). Reclaiming & Redefining Rights - ICPD+20: Status of sexual and reproductive health and rights in Central and Eastern Europe. Warsaw, Poland: Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights (ASTRA

28 Szostak, M; Pabijenek, K. (2012). Reclaiming & Redefining Rights-ICDP+20: Central and Eastern Europe region SRHR youth fact sheet (draft, unpublished). Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW).

29 Abd El-Hameed, D.; Abdelaty, S. (2012). Reclaiming & Redefining Rights-ICDP+20: Middle East and North Africa region SRHR youth fact sheet (draft, unpublished). Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW).

30 Ipas. (2012). Retrieved from <http://www.ipas.org/en/What-We-Do/%20Youth.aspx>.

31 Department for International Development. (2011). Safe and unsafe abortion (Practice Paper). London, UK: DFID. Retrieved from <http://www.dfid.gov.uk/Documents/publications1/pol-2010-safe-unsafe- abort-dev-cntries.pdf>.

32 Advocates for Youth. (2011).Youth and unsafe abortion: a global snapshot. Washington, DC. Retrieved from <http://www.advocatesforyouth.org/storage/advfy/documents/youth-and-unsafe-abortion.pdf>.

33 Department for International Development. (2011). Safe and unsafe abortion (Practice Paper, DFID Policy July 2011). London, UK: DFID. Retrieved from <http://www.dfid.gov.uk/Documents/ publications1/pol-2010-safe-unsafe- abort-dev-cntries.pdf>.

reclaiming and redefining rights: setting the adolescent and young people srhr agenda beyond icpd+20

This fact sheet is written by Sivananthi Thanenthiran, Sai Jyothirmai Racherla, and Janet Ajao
Asian-Pacific Resource and Research Centre for Women (ARROW)

34 Abd El-Hameed, D.; Abdelaty, S. (2012). Reclaiming & Redefining Rights-ICDP+20: Middle East and North Africa region SRHR youth fact sheet (draft, unpublished). Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW).

35 Yoval, N; Ajao, J. (2012). Reclaiming & Redefining Rights-ICDP+20: Latin America and the Caribbean region SRHR youth fact sheet (draft, unpublished). Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW).

36 Advocates for Youth. (2011).Youth and unsafe abortion: a global snapshot. Washington, DC. Retrieved from <http://www.advocatesforyouth.org/storage/advfy/documents/youth-and-unsafe-abortion.pdf>.

37 Szostak, M; Pabijenek, K. (2012). Reclaiming & Redefining Rights-ICDP+20: Central and Eastern Europe region SRHR youth fact sheet (draft, unpublished). Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW).

38 Postabortion Care Consortium. (2006). Technical guidance on youth-friendly postabortion care. Watertown, MA: Pathfinder International. Retrieved from <http://www.pathfinder.org/publications-tools/Technical-Guidance-on-Youth-Friendly-Postabortion-Care.html>.

39 Advocates for Youth. (2010). Adolescents and sexually transmitted infections. Washington, DC. Retrieved from <http://www.advocatesforyouth.org/publications/456?task=view>.

40 Advocates for Youth. (2010). Adolescents and sexually transmitted infections. Washington, DC. Retrieved from <http://www.advocatesforyouth.org/publications/456?task=view>.

41 WHO. 2006. Second Generation Surveillance Surveys of HIV, Other STIs and Risk Behaviour in Six Pacific Island Countries. Geneva: WHO. Cited in Spratt, J. (2009). Youth SRHR in the Pacific: Deserving Urgent Attention. ARROWs for Change, Vol. 15 Nos. 2 & 3. Kuala Lumpur: ARROW. http://arrow.org.my/publications/AFC/V15n2&3.pdf

42 Sexually Transmitted Infections in Adolescents Kazhila C. Chinsembu. The Open Infectious Diseases Journal, 2009, 3, 107-117 University of Namibia, Faculty of Science, Department of Biological Sciences, P/B 13301, Windhoek, Namibia

43 Joint United Nations Programme on HIV/AIDS (UNAIDS). (2010). UNAIDS Report on the global aids epidemic 2010. New York, NY: United Nations. Retrieved from <http://www.unaids.org/globalreport/global_report.htm>.

44 Joint United Nations Programme on HIV/AIDS (UNAIDS). (2010). UNAIDS Report on the global aids epidemic 2010. New York, NY: United Nations. Retrieved from <http://www.unaids.org/globalreport/global_report.htm>.

45 Joint United Nations Programme on HIV/AIDS (UNAIDS). (2010). UNAIDS Report on the global aids epidemic 2010. New York, NY: United Nations. Retrieved from <http://www.unaids.org/globalreport/global_report.htm>.

46 World Health Organization. (2011). An update on WHO's work on female genital mutilation (FGM) (Progress report) Retrieved from (http://whqlibdoc.who.int/hq/2011/WHO_RHR_11.18_eng.pdf).

47 Thanenthiran, S.; Racherla, S. (2011). In Reclaiming and Redefining Rights-Thematic Studies Series 1: Sexuality & Rights in Asia (p. 19). Kuala Lumpur, Malaysia: Malaysia

48 Female Genital Mutilation in Pakistan, and Beyond.(2011).Retrieved October 11, 2012, from Tribune Web site: http://blogs.tribune.com.pk/story/7523/female-genital-mutilation-in-pakistan-and-beyond/

49 Ottosson, D. (2007). State Sponsored Homophobia. A World Survey of Laws Prohibiting Same Sex Activity between Consenting Adults. Retrieved October 12, 2012, from the International Lesbian and Gay Association (ILGA) Web site: http://ilga.org/historic/Statehomophobia/State_sponsored_homophobia_ILGA_07.pdf

50 Ottosson, D. (2007). State Sponsored Homophobia. A World Survey of Laws Prohibiting Same Sex Activity between Consenting Adults. Retrieved October 12, 2012, from the International Lesbian and Gay Association (ILGA) Web site: http://ilga.org/historic/Statehomophobia/State_sponsored_homophobia_ILGA_07.pdf

51 Ottosson, D. (2007). State Sponsored Homophobia. A World Survey of Laws Prohibiting Same Sex Activity between Consenting Adults. Retrieved October 12, 2012, from the International Lesbian and Gay Association (ILGA) Web site: http://ilga.org/historic/Statehomophobia/State_sponsored_homophobia_ILGA_07.pdf

52 Ottosson, D. (2007). State Sponsored Homophobia. A World Survey of Laws Prohibiting Same Sex Activity between Consenting Adults. Retrieved October 12, 2012, from the International Lesbian and Gay Association (ILGA) Web site: http://ilga.org/historic/Statehomophobia/State_sponsored_homophobia_ILGA_07.pdf

53 Itaborahy, LP (2012). State-sponsored Homophobia: A world survey of laws criminalising same-sex sexual acts between consenting adults. Brussels, Belgium: The International Lesbian, Gay, Bisexual, Trans and Intersex Association. Retrieved from (http://old.ilga.org/Statehomophobia/ILGA_State_Sponsored_Homophobia_2012.pdf).

reclaiming and redefining rights: setting the adolescent and young people SRHR agenda beyond icpd+20

ASIA AND THE PACIFIC REGION FACT SHEET

These Global South Adolescent and Young People Fact Sheets, have been developed as part of the ICPD+20 Global South SRHR Monitoring and Research Initiative steered by ARROW in partnership with Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights (ASTRA), Latin American and Caribbean Women's Health Network (LACWHN), Egyptian Initiative for Personal Rights (EIPR) and the World YWCA. The fact sheets provide the most recent data and analysis on adolescent and young people SRHR across the Global South regions. The recommendations to respective governments, donors, UN agencies take into consideration the evidence and lived realities of adolescent and young people in Asia and the Pacific, Eastern Europe, Latin America and the Caribbean, and the Middle East and Northern Africa and Sub-Saharan Africa.

arrow
asian-pacific resource & research centre for women

1. Context[1]

By 2015, the Asia and the Pacific region is estimated to be home to approximately 1,834,205 young people.[2]

This dynamic group contributes directly to the development of society, both in terms of innovation and entrepreneurship. They are heterogeneous, and come from all walks of life.

They are students, migrant workers, working young women and girls, and unemployed. They are of diverse sexualities and gender identities, they live with HIV, they are sex workers, and they have disabilities.

They are young girls and boys who have limited access to education due to many contributing factors. They face multiple challenges, such as the issues of poverty, migration, religious fundamentalisms, education, employment and health that intersect with harmful traditional and cultural norms.[3] It is therefore especially crucial that this diverse group fully realises their rights, especially those that impact their sexual and reproductive health(SRH).

2. Universal access to quality education

The region is close to achieving universal primary education however, the gross secondary enrolment ratio is 76.9% in East Asia and the Pacific while in South Asia it is at a low 55.9%.[4] Significant disparities exist between female and male secondary school enrolment across the region and this is most pronounced in the South Central Asia subregion with 54% of females and 60% males enrolled in secondary school.

In 13 of the 21 countries monitored in Asia and the Pacific region, less than 30% of the female population has secondary education.[5] This gender gap is especially worrying in the South Asian sub-region with countries like India, Pakistan, Nepal, and Afghanistan, showing poor enrolment rates in secondary schools.[6]

The total percentage of the population age 15-24 years that could both read and write by 2010 is 99.4% in East Asia and 93.4% in West Asia, while South Asia and South-East Asia are

This fact sheet has been published by ARROW with funding support from FORDFOUNDATION and Sida

reclaiming and redefining rights: setting the adolescent and young people srhr agenda beyond icpd+20

80.5% and 97.7% respectively.[7] Oceania has the lowest literacy rate in Asia and the Pacific region with 75.5%.[8]

3. Access to sexual and reproductive health (SRH) Information and Services

The ICPD PoA calls for the promotion "to the fullest exent" of the health of young people and provision of services that are of good quality and sensitive to the needs of the young and "safeguarding the rights of adolescents to privacy, confidentiality, respect and informed consent."[9]

There are two clear strains of thinking about adolescents in the 21 countries surveyed. In South Asia, where the age of marriage is rather low, adolescents are often married early and their rights to services are recognized within this context. In South-east Asia, where the age of marriage is comparatively higher, adolescent sexual activity is often perceived as being outside the context of marriage.

As SRH services have been so often subsumed within the context of reproduction, access to these services and to information becomes problematic for adolescents.

3.1 Comprehensive sexuality education (CSE)

There are vast differences in the interpretation of what constitutes sexuality education and some governments in the region have already begun to address incorporating sexuality education into the general education curriculum. In addition to this, the scope and coverage of sexuality education curriculums differ significantly within the countries and current emphasis seems to be on biology rather than health and rights. NGOs in the region have been working on creating awareness about the demand for sexuality education.

Both sex education and sexuality education are controversial issues in the region, especially in the countries where conservative religious parties are in positions of power in the parliament. In the countries where sex education has been initiated, challenges remain with regards the comprehensiveness of the curriculum. The increased acceptance in the countries for sex education is attributed to combating the HIV epidemic rather than providing sex education to adolescents. In countries like Thailand and Vietnam, mostly NGO-led programmes have reconceptualised sexuality education as sexuality education, and incorporate safe sex, sexual expression, negotiation and communication. (see table 1)

According to the UNESCO publication,[10] controversies persist on whether SRH education and services need to be extended to adolescents in the country and this has implications on the implementation of the policy. Indonesia, Malaysia, Pakistan, Bangladesh, Bhutan, the Philippines and Samoa have not started providing sex education in schools as part of the school curriculum.

Still, Indonesia has a policy to extend information and reproductive health education to adolescents, to be implemented by the National Family Planning Coordinating Board and the Department of Education. Similarly, in Malaysia and Pakistan, sex education has not been integrated into the school curriculum, although the demand for sex education among adolescents has been documented by NGOs.

In Bangladesh, sex education is not taught by teachers in schools although some basic reproductive health topics are included in the school curriculum. In the Philippines, adolescent reproductive health (ARH) education is mostly community-based.[11] In Vietnam, Afghanistan, India and Nepal, there are attempts to introduce sex education but limitations exist.[12] Papua New Guinea shows consistent mainstreaming of sexuality and HIV/AIDS education in policy documents.[13]

3.2 Contraceptive use among adolescents and young people

Each year, adolescent women account for 12% of all births in South Central and Southeast Asia.[14] However, data on contraceptive prevalence for adolescents and young people in the 21 countries monitored is scarce and, in fact, only Bangladesh, Cambodia, Nepal, Pakistan, India, Indonesia, Maldives, and the Philippines, have CPR data for adolescents and young people. In India data is available for currently married women and sexually active unmarried women.

Any modern method of contraception use for currently married women and sexually active unmarried women aged 15-19 years is 6.9 and 9.0 respectively. Similarly any modern method of contraception use for currently married women and sexually active unmarried women aged 20-24 is 26.1 and 11.5 respectively.

In the other countries, the highest CPR is recorded in Indonesia and Bangladesh. The CPR is very low in the Philippines and Cambodia. The CPR for among those 15-19 is comparatively lower than CPR among 20-24. The use of contraception for young girls in Bangladesh occurs mainly within the context of marriage for married adolescents. Contraception is the best way to prevent unintended pregnancy, and also to reduce the need for abortion, and the prevalence of unsafe abortion, especially for young people. However, data on CPR is limited, and very often, this has less to do with the law, and more to do with the discrimination and social stigma around adolescents and young people having pre-marital sex.

Table 1: The status of sexuality education curricula in the 21 countries monitored

Country	National Curriculum: Primary	National Curriculum: Secondary	National Curriculum: Tertiary	Actions for Informal/ Out-of-School Education on SRH & HIV	Teacher Training
Afghanistan	No	Yes		Yes	No
Bangladesh	Planned for 2011	Yes		Yes	Yes
Bhutan	Yes	Yes		Yes	Planned
Burma	Yes	Yes			Yes
Cambodia	Yes	Yes	No	Yes	Yes
China	No	Yes	Yes	Yes	Yes
Fiji	Yes	Yes	Yes	Yes	Yes
India	No	Yes		Yes	Yes
Indonesia	Yes	Yes	Yes	Yes	Yes
Kiribati					
Lao PDR	Yes	Yes		Yes	Yes
Malaysia	Yes	Yes		Yes	Yes
Maldives	No	Yes			Yes
Nepal	No	Yes		No	Yes
Pakistan	No	No		No	No
Papua New Guinea	Yes	Yes	No	Yes	Yes
Philippines	No	Yes		Yes	Yes
Samoa	No	Yes	Yes	Yes	No
Sri Lanka	No	Yes		Yes	Yes
Thailand	Yes	Yes	Yes	Yes	Yes
Vietnam	Yes	Yes	Limited	Yes	Yes

Source: Review of Policies and Strategies to Implement and Scale Up Sexuality Education in Asia and the Pacific (p 32). UNESCO

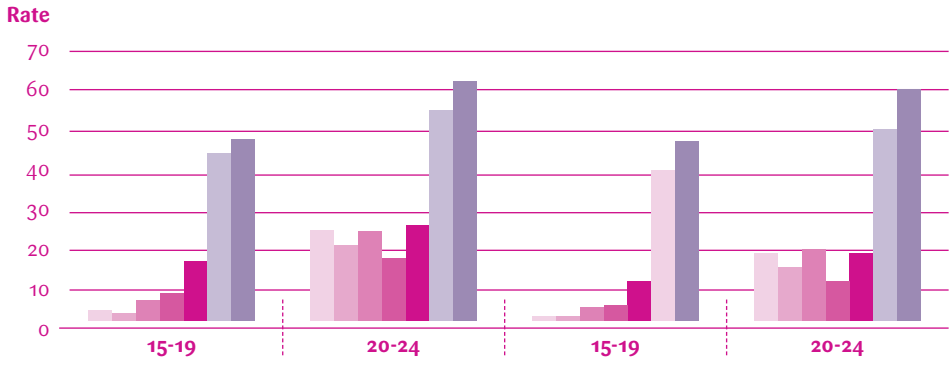
3.3 Adolescent Pregnancies

The ICPD PoA calls to "substantially reduce all adolescent pregnancies".[15]

In 2009, Oceania recorded the highest number of adolescent births in the region, with 62.1 per 1000 women age 15–19, while the lowest number is from East Asia with 6 per 1000 women age 15-19. South Asia, South East Asia and West Asia are also relatively high, with 46, 44.8 and 48.1 per 1000 women age 15-19, respectively.. Adolescent birth rates vary quite significantly across the region, as evidenced in the 21 countries monitored. It is highest in Bangladesh (133.4) in South Asia and 110 in Lao PDR. These are followed closely by Afghanistan (90.0), Nepal (81.1) and Papua New Guinea (70), all in stark contrast to the lowest numbers, which are found in China (6.2), Malaysia (16) and Pakistan (16.1).

reclaiming and redefining rights: setting the adolescent and young people srhr agenda beyond icpd+20

Fig 1: Contraceptive prevalence rate among adolescents and young women



	Any Method 15-19	Any Method 20-24	Modern Method 15-19	Modern Method 20-24
Philipines	3.1	23.1	1.6	16.3
Cambodia	2.1	19.1	1.4	12.9
Nepal	5.1	22.8	4.2	18.4
Pakistan	6.7	15.4	4.2	10.6
Maldives	1.5	23.2	9.6	16.8
Bangladesh	41.8	52.4	37.6	47.5
Indonesia	45.4	59.5	44.8	57.9

Source: Available Country Demographic Health Surveys

In Bangladesh and Afghanistan, early childbearing among women age 15 – 19 is more prominent in rural areas, compared with urban areas,[16,17] while in Nepal, 17% of adolescent women aged 15-19 are already mothers or pregnant with their first child although adolescent pregnancy rates have dropped by 10% over the last five years.

Despite some great improvements in terms of lowering the adolescent birth rates in the region, adolescent fertility is still a major concern.

3.4 Access to abortion information and services among adolescents and young women

In 2008, there was an estimated 10.8 million unsafe abortions in Asia,[18] and it was reported that in 2006, due to the sheer size of Asia's population, the region accounted for 45.7% of all unsafe abortions annually among women age 15-24 that occur in the developing world.[19]

Abortion is a debate plagued with ideological and morality-based arguments, therefore, with the exception of Vietnam, all other countries monitored have put some sort of clause on limiting the access and availability of abortion to women, even where abortion is generally permitted or available upon request.

For example, although Cambodia, China and Nepal have legalized abortion across the board, Cambodia and Nepal have set gestational limits of 14 weeks[20] and 12 weeks[21], respectively. While in China and Nepal, it is illegal to have an abortion for sex-selection purposes[22].

Even in countries where abortion is legal, young women face numerous barriers to accessing safe abortion services. Gestational limits, the need for parental or spousal consent, and mandatory waiting periods or counselling can also be barriers, as well as the lack of information about the legality about abortion in the countries.[23]

Table 2: Adolescent birth rate

Country	Adolescent birth rate per 1000 girls age 15-19
Afghanistan	90.0 (2008)
Bangladesh	133.4 (2004)
Bhutan	59.0 (2009)
Burma	17.4 (2001)
Cambodia	48.0 (2008)
China	6.2 (2009)
Fiji	31.1 (2004)
India	38.5 (2009)
Indonesia	52.3 (2005)
Kiribati	39.0 (2005)
Lao PDR	110.0 (2005)
Malaysia	14.0 (2009)
Maldives	18.5 (2009)
Nepal	81.0 (2010)
Pakistan	16.1 (2007)
Papua New Guinea	70.0 (2000)
Philippines	53.0 (2006)
Samoa	28.6 (2006)
Sri Lanka	24.3 (2006)
Thailand	46.7 (2009)
Vietnam	35.0 (2009)

Source: UN MDG Indicators Database

3.5 HIV/AIDS

There was an estimated 4.9 million people in Asia living with HIV in 2009, including the 360,000 who became newly infected that year. In the Pacific, the number of people living with HIV is 57,000 , almost double from 28,000 in 2001, although the number of people newly infected with HIV has begun to decline from 4700 in 2001 to 4500 in 2009. [24]

According to UNAIDS, the general trends in the Asian region "hide important variation in the epidemics, both between and within countries."[25] According to the report, most HIV epidemics in the region appear to be stable, although in a number of countries in the region, the epidemic is concentrated in a few provinces in the region. New infections in the region are mostly attributed to injecting drug users, sex workers and their clients and men who have sex with men.[26]In the Pacific region, the epidemic is mostly attributed to sexual transmission. [27]

The estimated prevalence of HIV/AIDS among young women aged 15-24 in 2011 in East Asia is <0.1, while Oceania as well as South and Southeast Asia both have an estimated prevalence rate of 0.2 and 0.1 respectively.[28] Notably, while most countries monitored had rates of 0.1 or less, rates in Papua New Guinea, Burma and Lao PDR are higher at 0.8, 0.3 and 0.2 respectively. [29]. Treatment and care of HIV/AIDS prevention across the 21 countries monitored, paints a mixed picture.

Some countries in the region have addressed the HIV/AIDS epidemic in a comprehensive manner. Cambodia in particular, has utilized this approach and in doing so made significant progress in bringing down the rates of HIV cases within its borders. Few governments in the region have successfully addressed stigma and discrimination via laws, policies and programmes. Stigma, especially for the vulnerable populations among adolescents and young, people hinders their access to HIV treatment and care.

There is a need to expand the reach awareness programmes, and to make voluntary counselling and testing for HIV/AIDS widely available in the region. Data on access to HIV/AIDS treatment and care among adolescents and young people is difficult to obtain.

4. Traditional and harmful practices

The most common discriminatory traditional practices that occur across the region include female circumcision, honour killings and some that are specific to the various cultures around the region.

In the region, the practice of female circumcision or female genital mutilation is most commonly practiced in Indonesia and traditionally practiced by eight ethnic groups within the country.[30] It is also prevalent among the Bohra Muslim communities in Pakistan and India.[31]

Honour killings are common in Afghanistan and Pakistan.[32] Young women and girls who express the desire to marry someone of their own choosing and to further their education are victims of honour killings.

Table 3: Abortion polices in the Asia and the Pacific region

Country	To save woman's life	To preserve physical health of the woman	To preserve mental health of the woman	Rape or Incest	Foetal impairment	Economic or Social Reasons	On request
Afghanistan	√	-	-	-	-	-	-
Bangladesh	√	-	-	-	-	-	-
Burma	√	-	-	-	-	-	-
Bhutan	√	√	√	√	-	-	-
Cambodia	√	√	√	√	√	√	√
China	√	√	√	√	√	√	√
Fiji	√	√	√	√	√	-	-
India	√	√	√	√	√	√	-
Indonesia	√	-	-	-	-	-	-
Kiribati	√	-	-	-	-	-	-
Lao PDR	√	√	-	-	-	-	-
Maldives	√	√	-	-	-	-	-
Malaysia	√	√	√	-	-	-	-
Nepal	√	√	√	√	√	√	√
Pakistan	√	√	√	-	-	-	-
Philippines	√	-	-	-	-	-	-
Papua New Guinea	√	√	√	-	-	-	-
Sri Lanka	√	-	-	-	-	-	-
Samoa	√	√	√	-	-	-	-
Thailand	√	√	√	√	√	-	-
Vietnam	√	√	√	√	√	√	√

Source: The World Abortion Laws 2012

In Afghanistan, 14 cases of honour killings were recorded between 2010 and 2011.[33] In Pakistan, at least 791 women and young girls were murdered in the name of 'honour.'[34] It is likely that this figure much higher but cases are under-reported due to the social stigma and culture that surrounds the practice.

Other discriminatory practices that are harmful to young women and girls include but are not limited to the practices of *Deuki* and *Jhuma* in Nepal, where young girls are offered to the temple and then forced into sex work. In Pakistan, the religious lobby is of the view that a girl's puberty is indicative of her maturity; *jirgas* force little girls to be exchanged as 'compensation' between warring groups or tribes.

On the island of Tanna in Vanuatu, the tradition of *kastom,* where the family of a murderer gives a girl child to the family of the victim for the purposes of marriage as a gesture of apology.

These practices greatly affect the full realisation of sexual and reproductive health and rights of young women and girls.[35]

Child Marriages

While there exists a legal minimum age of marriage throughout most of the region, girls in some countries may be getting married very early. This is likely a major contributing factor to adolescent pregnancies in the region. Child marriages are the

most widespread in South Asia. Fifty-four percent of young girls are forced into early marriages in Afghanistan, while in Bangladesh one in three adolescents have already begun child-bearing. In the Pacific, Kiribati's data shows that 5% of married women between 20 to 49 years of age were married by the age of 15, and 26% were married before age 18.

The legal age of marriage varies for women and men in the 21 countries. Even though the legal age of marriage for women in Bangladesh is 18, data on the median age of marriage for women shows that girls get married as early as 15 years old. Similarly, in Nepal the legal age of marriage for women is 20 years yet the median age of marriage is 17 years, demonstrating the need to enforce the law on legal age of marriage in the respective countries.

5. Homophobia and Transphobia

In Asia, more than half the countries in the region still criminalise homosexuality, and countries in the Pacific are at different stages when it comes to legal frameworks around sexual orientations and gender identities.[38] Same-sex sexual relations are illegal in Afghanistan, Bangladesh, Bhutan, Burma, Kiribati, Malaysia, Maldives, Pakistan, Papua New Guinea, Samoa and Sri Lanka.[39]

In Vietnam, the government has passed a law criminalising same-sex marriages in Vietnam although there is no specific legal framework against same-sex sexual preferences or relations. In Cambodia in 2004, former King Sihanouk called for the legalization of gay marriage, yet any policy is yet to be issued.[40]

The most progressive country in the region is Nepal. In 2008, the Supreme Court of Nepal recognized lesbians, gays, bisexuals, transgenders, and inter- sexed (LGBTIs) persons as natural persons.

The Court issued directive orders to the government of Nepal to ensure rights to life according to their own identities and to introduce laws providing equal rights to LGBTIs and amend all the discriminatory laws against them. The Supreme Court also ordered the government to formulate an act on same-sex marriage.[41]

6. Recommendations

We, the adolescents and young people of Asia and the Pacific call upon our governments to:

1. Review, amend and implement national policies that are relevant to the sexual and reproductive health and rights of adolescents and young people. These policies need to be strengthened to provide access to SRH services, which includes but is not limited to access to quality and affordable contraception, safe abortion services, information services an HIV/STI services. The policies need to also repeal stigma and discrimination by stating clearly the measures that will be taken against such acts. The diversity of adolescents and young people in the countries need to be considered and taken seriously into account when reviewing existing policies, and implementing new ones, in order to fully achieve universality of rights.

2. Have more research and data collection on adolescent and young people's sexual and reproductive health and rights needs, in order to paint an accurate and holistic picture surrounding the SRHR needs of young people and adolescents in each country and the region.

3. Make available data on adolescent and young people's access to ART needs, in order to capture accurately the numbers of adolescents and young people who are not only infected with HIV, but also receiving treatments

4. Provide Comprehensive Sexuality education (CSE) to adolescents and young people, focusing not only on reproduction and biology, but include the rights aspect as well. CSE needs to be provided at different levels of education. Educators need to be given the training needed on sex and sexuality education, in order to accurately educate adolescents and young people with regards to sex and sexuality. The training needs to not just focus on the biology of reproduction and transmission of sexually transmitted diseases, but also include the different aspects of sexual rights - dimensions, communication and negotiation.

5. Tighten laws that are relevant to traditional practices that are harmful to adolescents and young people, with policies stating clearly the measures that will be taken against such acts.

reclaiming and redefining rights: setting the adolescent and young people srhr agenda beyond icpd+20

6. Allocate funds for the sexual and reproductive health and rights of adolescents and young people specifically in the national budgets, and not subsumed under the general health budgets.

7. Meaningfully engage non-governmental organisations and social movements that are youth-led and progressive at all levels, ensuring an environment that is positive and enabling for their work.

8. Reorient service providers' attitudes towards young women and adolescents who need SRH services to be holistic, ensuring affordability, accessibility and free from discrimination. Gender sensitive approaches need to be incorporated, ensuring that the service providers be cognisant and receptive to the diverse sexualities, gender identities, and socio-economic classes of adolescents and young people.

reclaiming and redefining rights: setting the adolescent and young people srhr agenda beyond icpd+20

Endnotes

This fact sheet is written by
Suloshini Jahanath
Asian-Pacific Resource and Research Centre for Women (ARROW)

1 In this Factsheet, Asia and the Pacific region (AP) is used to represent the region in general. Specific references are made to Afghanistan, Bangladesh, Bhutan, Cambodia, China, Fiji, India, Indonesia, , Kiribati, Lao PDR, Malaysia, Maldives, Nepal, Pakistan, Papua New Guinea, , Philippines, Samoa, Sri Lanka, Thailand and Vietnam which comprise the 21Asia and the Pacific countries monitored for the ICPD+20 Global South Monitoring Report.

2 United Nations Department of Economic and Social Affairs. (2012). World Population Prospects [Data File]. New York, NY: United Nations. Retrieved from (http://esa.un.org/unpd/wpp/unpp/panel_indicators.htm)

3 Nandagiri, R.; Judhistari, R.A. (2012).Young Activists and Advocates from Asia Pacific Demand Full Recognition of Young People's Sexual and Reproductive Rights for the 45th Session of the Commission on Population and Development.

4 United Nations Development Programme (2011). Human Development Report 2011, Sustainability and Equity: A Better Future for All. New York, NY: United Nations

5 For the AP section citation 5 should be: United Nations Development Programme (2011). Human Development Report 2011, Sustainability and Equity: A Better Future for All. New York, NY: United Nations

6 World's Women and Girls. Population Reference Bureau 2011 Data Sheet

7 United Nations (UN). 2012. Indicator 2.3, Statistical Annex. In The Millennium Development Goals Report 2012. New York, USA: UN

8 United Nations (UN). 2012. Indicator 2.3, Statistical Annex. In The Millennium Development Goals Report 2012. New York, USA: UN

9 ICPD PoA == paras 6.7(a), 6.7(b), 6.15, 7.45

10 United Nations Educational, Scientific and Cultural Organisation (UNESCO). (2012). Review of Policies and Strategies to Implement and Scale Up Sexuality Education in Asia and the Pacific. Retrieved October 11, 2012, from UNESCO Web site: http://unesdoc.unesco.org/images/0021/002150/215091e.pdf

11 World Health Organization. (2005). Sexual and Reproductive Health of Adolescents and Youth in the Philippines. A Review of Literature and Projects. 1995-2003. Manila, Philippines: WHO.

12 Save the children fund US and MOET. (2005). A qualitative study on the education reproductive health and HIV/AIDS prevention within school system in Vietnam. Hanoi, Vietnam: SC US.

13 United Nations Educational, Scientific and Cultural Organisation (UNESCO). (2012). Review of Policies and Strategies to Implement and Scale Up Sexuality Education in Asia and the Pacific. Retrieved October 11, 2012, from UNESCO Web site: http://unesdoc.unesco.org/images/0021/002150/215091e.pdf

14 Guttmacher Institute. (2010). Facts on the Sexual and Reproductive Health Of Adolescent Women in the Developing World. Retrieved October 12, 2012, from Guttmacher Institute Web site: http://www.guttmacher.org/pubs/FB-Adolescents-SRH.pdf

15 United Nations Population Fund (UNFPA). (2004).Chapter 7: Reproductive Rights and Reproductive Health, Paragraph 7.44(b). In Programme of Action, Adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994 (p. 59). New York, USA: UNFPA.

16 The Asian-Pacific Resource & Research Centre for Women (ARROW). (2011). Reclaiming & Redefining Rights - Thematic Studies Series 4: Maternal Mortality Morbidity in Asia. Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW)

17 Afghan Public Health Institute, Ministry of Public Health (APHI/MoPH), Central Statistics Organization (CSO), ICF Macro, Indian Institute of Health Management Research (IIHMR), and World Health Organization Regional Office for the Eastern Mediterranean (WHO/EMRO). 2011. Fertility, Marriage and Family Planning. In Afghanistan Mortality Survey 2010 (p. 50). Calverton, Maryland, USA: APHI/MoPH, CSO, ICF Macro, IIHMR and WHO/EMRO.

18 World Health Organisation (WHO). 2011. Unsafe Abortion. Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008 (Sixth edition). Geneva, Switzerland: WHO

19 Ganatra B. (2006). Young and Vulnerable: The Reality of Unsafe Abortion among Adolescent and Young Women. ARROWs for Change 12(3), 1-2.

20 Center for Reproductive Rights(CRR). (2012). The World's Abortion Laws 2012. Retrieved October 13, 2012, from World Abortion Laws Web site www.worldabortionlaws.com

21 Center for Reproductive Rights (CRR). (2011. Abortion Worldwide: Seventeen Years of Reform. Retrieved October 13, 2012, from CRR Web site: http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bp_17_years.pdf

22 Center for Reproductive Rights(CRR). (2012). The World's Abortion Laws 2012. Retrieved October 13, 2012, from World Abortion Laws Web site www.worldabortionlaws.com

23 Bayer, L; Cheetham, N; Robbins, S. (2011). Youth and Unsafe Abortion. A Global Snapshot. Washington DC, USA: Advocates for Youth.

24 Joint United Nations Programme on HIV/AIDS (UNAIDS). (2012). Asia and the Pacific. Retrieved October 12, 2012, from UNAIDS Web site: http://www.unaids.org/en/regionscountries/regions/asiaandpacific/

25 Joint United Nations Programme on HIV/AIDS (UNAIDS). (2012). Asia and the Pacific. Retrieved October 12, 2012, from UNAIDS Web site: http://www.unaids.org/en/regionscountries/regions/asiaandpacific/

26 Joint United Nations Programme on HIV/AIDS (UNAIDS). (2012). Asia and the Pacific. Retrieved October 12, 2012, from UNAIDS Web site: http://www.unaids.org/en/regionscountries/regions/asiaandpacific//

27 Joint United Nations Programme on HIV/AIDS (UNAIDS). (2012). Asia and the Pacific. Retrieved October 12, 2012, from UNAIDS Web site: http://www.unaids.org/en/regionscountries/regions/asiaandpacific/

28 Joint United Nations Programme on HIV/AIDS (UNAIDS). (2010). Annex 1: HIV & AIDS estimates and data, 2009 and 2001. In Global Report. UNAIDS Global Report on the Global AIDS Epidemic 2010 (p. 190).Geneva, Switzerland: UNAIDS

29 Joint United Nations Programme on HIV/AIDS (UNAIDS). (2010). Annex 1: HIV & AIDS estimates and data, 2009 and 2001. In Global Report. UNAIDS Global Report on the Global AIDS Epidemic 2010 (p. 190).Geneva, Switzerland: UNAIDS

30 Thanenthiran, S.; Racherla, S. (2011). In Reclaiming and Redefining Rights-Thematic Studies Series 1: Sexuality & Rights in Asia (p. 19). Kuala Lumpur, Malaysia: Malaysia

31 Female Genital Mutilation in Pakistan, and Beyond.(2011).Retrieved October 11, 2012, from Tribune Web site: http://blogs.tribune.com.pk/story/7523/female-genital-mutilation-in-pakistan-and-beyond/

32 Defining "honour" crimes and "honour" killings.(2012). October 11, 2012,from UN Women Web site: http://www.endvawnow.org/en/articles/731-defining-honourcrimes-and-honour-killings.html

33 "Honour Killings" Rising in Afghan West. (2011). Retrieved October 11, 2012, from UNHCR Web site: http://www.unhcr.org/refworld/topic,45a5fb512,45a608be2,4e1c657d2,0,,,AFG.html

34 Human Rights Commission of Pakistan.(2010). State of Human Rights in 2010.HRCP. Retrieved October 11, 2012, from HRCP Web site: http://www.hrcp-web.org/Publications/AR2010.pdf

35 Jahanath, S; Mushtaq, N, Ajao, J.(2012). Reclaiming & Redefining Rights-ICDP+20: The Status of Sexual & Reproductive Health and Rights in Asia and the Pacific (draft, unpublished). Kuala Lumpur, Malaysia: The Asian-Pacific Resource & Research Centre for Women (ARROW)

38 Ottosson, D. (2007). State Sponsored Homophobia. A World Survey of Laws Prohibiting Same Sex Activity between Consenting Adults. Retrieved October 12, 2012, from the International Lesbian and Gay Association (ILGA) Web site: http://ilga.org/historic/Statehomophobia/State_sponsored_homophobia_ILGA_07.pdf

39 Ottosson, D. (2007). State Sponsored Homophobia. A World Survey of Laws Prohibiting Same Sex Activity between Consenting Adults. Retrieved October 12, 2012, from the International Lesbian and Gay Association (ILGA) Web site: http://ilga.org/historic/Statehomophobia/State_sponsored_homophobia_ILGA_07.pdf

40 Cambodian King Backs Gay Marriage. (2004). Retrieved August 10, 2009, from BBC News Web site: http://news.bbc.co.uk/2/hi/asia-pacific/3505915.stm

41 National AIDS/STD Programme (NASP) Ministry of Health and Family Welfare. (2008). 2008 UNGASS Country Progress Report: Nepal (January 2006 - December 2007). Retrieved July 28, 2009, from UNAIDS, Uniting the World Against AIDS Web site: http://data.unaids.org/pub/Report2008/nepal_2008_country_progress_report_en.pdf

reclaiming and redefining rights: setting the adolescent and young people SRHR agenda beyond icpd+20

EASTERN EUROPE REGION FACT SHEET

These Global South Adolescent and Young People Fact Sheets, have been developed as part of the ICPD+20 Global South SRHR Monitoring and Research Initiative steered by ARROW in partnership with Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights (ASTRA), Latin American and Caribbean Women's Health Network (LACWHN), Egyptian Initiative for Personal Rights (EIPR) and the World YWCA. The fact sheets provide the most recent data and analysis on adolescent and young people SRHR across the Global South regions. The recommendations to respective governments, donors, UN agencies take into consideration the evidence and lived realities of adolescent and young people in Asia and the Pacific, Eastern Europe, Latin America and the Caribbean, and the Middle East and Northern Africa and Sub-Saharan Africa.

1. Context[1]

In Eastern Europe adolescents and young people age 15-24 constitute 10,9%[2] of the population, approximately 31,729,000 people. Young people, despite being well educated and highly qualified, are confronted with the consequences of the financial crisis of 2008 and the subsequent fiscal challenges facing countries around Eastern Europe. Across the region, young people are far more likely than other groups to struggle with finding employment and, when they do, the work is likely to be low-paying, precarious and insecure. Increasing migration from Eastern to Western Europe eases potential social tensions among jobless young people in their country of origin, but young migrants face greater barriers than young people from the majority population in destination countries.

The Eastern Europe[3] region, with EU member states Bulgaria, Hungary, Poland and Romania, is often perceived as a group of middle income countries where there are vast economic disparities. The disparities within the region and among different groups within the individual countries, are neglected and this is reflected in the fact that in the last decade most donors in the region have redirected their funds towards new hotspots outside of the region.

The rise of religious extremism is a major obstacle to the realisation of the SRHR of women and youth in Eastern Europe. Religious and conservative forces oppose sexuality education, contraception, abortion services and same sex unions.

2. Universal access to quality education

Adolescents and young people of both sexes experience equal chances for entering the education system across Eastern Europe and all analysed countries are moving towards universal access to education. Although, the gross enrolment rate of primary education exceeds 98%[4] in the region, the gross secondary enrolment ratio is 90.7% and the gross tertiary enrolment ratio is 57.1%.[5] The literacy rate adds up to 99.6%[6] of young people and adolescents being able to read and write. Girls usually outnumber boys in general programmes, whereas the opposite is true in vocational programmes. This gender gap is also reflected in tertiary education: women are usually more numerous than men in the first stage of tertiary education and in certain fields of education (arts, education and humanities). Problematic situations arise in Azerbaijan and some areas of the Russian Federation where girls may drop out from the education system due to gender bias and early marriage, and

This fact sheet has been published by ARROW with funding support from FORDFOUNDATION and Sida

reclaiming and redefining rights: setting the adolescent and young people srhr agenda beyond icpd+20

Table 1: Sexuality education component in the school curriculum

Country	Term used	Age at which SE officialy begins	Minimum standards	Voluntary organisations involved	Is the SE curriculum comprehensive according to WHO standards?	Staff
Armenia	Healthy Lifestyle	13	Yes	N/A	N/A	Q
Azerbaijan	Basics on Reproductive Health	13	N/A	Yes	No	Q
Bulgaria	Sexuality Education	13	No	Yes	No	N/A
Croatia	Health Education (not yet implemented)	9	N/A	Yes	N/A	N/A
Georgia	Integrated in biology subject of reproductive health issues and importance of healthy life style	12	No	Yes	N/A	N/A
Hungary	Education for Family Life	7	Yes	Yes	No	Q
Poland	Education for Family Life	12	Yes	Yes	No	Q
Romania	Education for Health	7	No	Yes	No	Q
Russian Federation	Developed programmes not yet implemented	N/A	N/A	Yes	N/A	N/A
Ukraine	Basics of Health (+ other elective subjects)	7	Yes	Yes	No	Q

Source: WHO, UNESCO, IPPF
Q - questionable

also in Roma communities of Bulgaria, Hungary, and Romania where the rate of girls dropping out of lower secondary school is between 5% and 15%.[7]

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

The ICPD PoA calls for the promotion "to the fullest exent" of the health of young people and provision of services that are of good quality and sensitive to the needs of the young and "safeguarding the rights of adolescents to privacy, confidentiality, respect and informed consent."[8]

3.1 Comprehensive sexuality education (CSE)

Sexuality education is a contentious issue in Eastern Europe. While today's adolescents and young people face increasing pressure regarding sex and sexuality with conflicting messages and norms, sexuality remains taboo and official institutions tend to expect families to take care of sexuality education.

Inadequate sexuality education programmes and the inability of parents to provide necessary information leave the burden of filling this gap on the few volunteer groups and initiatives whose capacities and outreach are limited. Existing sexuality education programmes present a one-sided, biased view of sexuality which harbours myths, misconceptions, fears,

discrimination, gender stereotypes and a harmful lack of information which can lead to HIV, sexually transmitted infections, unwanted teen pregnancies as well as misinformed perceptions of gender and sexuality.

The table 1 presents the existing programmes and describes the situation in ten countries of the region taking into consideration the WHO standards[9]. Sexuality education is a mandatory subject in Armenia, Ukraine, and Croatia though it is yet to be implememted in these countries.

Armenia and Ukraine are among the countries which have a strongly incorporated sexuality education component in their school curriculum. However, these programmes are mostly influenced by the HIV prevention agenda. The sexuality component in Poland and Croatia is strongly influenced by the Catholic Church which condemns contraception and sex outside of marriage. Bulgaria and the Russian Federation have failed to implement already developed educational programmes into the school curriculum.

There is no common regional framework on sexuality education that all the countries adhere to. The lack of comprehensive sexuality education is the most burning issue of the region and is reflected in adolescent pregnancy rates and high HIV/AIDS prevalence among young people. (see table 1)

3.2 Contraceptive use among adolescents and young people

Despite a visible improvement, the use of modern contraception remains generally low in the region with heavy reliance on withdrawal and abortion as means of avoiding pregnancy.[10] Of all women age 15-49 (either married or in a union), 74.9% use some method of contraception, and only 54.3% use a modern method.[11] The condom is the most widely available method of preventing pregnancies and is accessible in pharmacies, shops and clubs. It is also the most popular contraceptive among adolescents and young people.

Young people face many barriers to accessing modern contraception. Even in countries of the European Union such as Bulgaria, Hungary, Poland, and Romania access to modern contraception remains an issue.

The most blatant example is Poland where the use of conscientious objection by doctors and pharmacists obstructs access to modern contraceptives, including emergency contraception. Throughout the region, lack of sexuality education pushes young people to turn to alternative sources of information like the internet and their peers. High costs of modern contraceptives and lack of subsidies from health insurance systems, along with requiring parental consent, further limit young people's access to pregnancy prevention methods.

Stereotypes and lack of knowledge, including that on the part of health professionals, obstruct access to modern contraceptive methods in the Caucasus. Lack of gender equality is also a determining factor, particularly in relationships in which women experience difficulties with negotiating condom use with their partners. There is a pressing need for research on young people and adolescents and contraceptive use in Eastern Europe. The data available is very scarce and incomplete, making it almost impossible to provide a bigger and more comprehensive picture.

3.3 Adolescent pregnancies

The ICPD PoA calls for a reduction in adolescent pregnancies. Reasons for early pregnancies vary across the region and follow two unique trends: where pregnancies occur within marriage, and the other being a marker for early sexual debut. The adolescent birth rates remain high throughout the region, averaging 23.4 births per 1000 girls age 15-19[12].

The largest numbers of adolescent pregnancies are observed in Bulgaria, Romania and the Caucasus countries of Georgia and Azerbaijan (the only country in the region where the numbers have remained stagnant over the years). Moreover, in Armenia, the Russian Federation and Ukraine the number of adolescent pregnancies is high and above the mentioned average for this region. Lack of CSE in schools and many barriers in access to modern and effective contraception contribute to this situation.

Adolescent birth rates below the regional average are observed in Croatia (12.8), Hungary (19.3) and Poland (16.1). Since 1995 the level of adolescent births dropped by almost 33% in Georgia and the Russian Federation. Although the rate remains high in Armenia, it is the country with the biggest improvement in reducing its adolescent pregnancy rate, with a drop from 66.6 births per 1000 women in 1995 to near 30 in 2009. This might have resulted from a lower number of early marriages compared to the 90s, but also from the fact that there are much fewer girls than boys in the population.

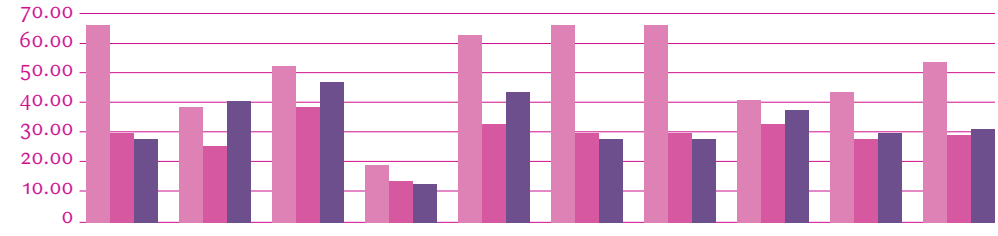
Early marriage is a problem in Armenia, Azerbaijan, Georgia, and some parts of the Russian Federation. Among girls between 15 and 19 years of age, 13% were married, divorced or widowed in Azerbaijan, and 11% in the Russian Federation.[13] In Bulgaria, Hungary, and Romania, early marriage and childbirth force Roma girls to drop out of school.

3.4 Access to abortion information and services among adolescents and young women

Abortion rates remain high in Eastern Europe compared to the Western part of the continent. The annual regional estimate

reclaiming and redefining rights: setting the adolescent and young people srhr agenda beyond icpd+20

Fig 1: Adolescent birth rates per 1000 women



	Armenia	Azerbaijan	Bulgaria	Croatia	Georgia	Hungary	Poland	Romania	Russia	Ukraine
1995	66.60	39.00	52.90	18.80	64.20	31.40	22.440	42.00	43.90	54.30
2003	29.40	26.40	39.00	13.90	33.20	20.70	14.70	33.00	27.90	29.50
2009	29.40	40.70	47.60	12.80	4380	19.30	16.10	40.70	29.80	29.90

Source: UN MDG Indicators Database

of unsafe abortions is 360,000[14] and, even though 30% of all pregnancies in Europe are terminated with abortions, a higher proportion of abortion procedures occur in Eastern Europe.[15] Lack of available data regarding the rates of adolescent abortions, resulting from the diversity of methodological approaches to data collection, makes it very difficult to describe current developments regarding the use of reliable information.

Liberal abortion laws remain in place in almost all countries of Eastern Europe and these recognize a woman's right to abortion without restrictions up to 12 weeks of pregnancy. The striking exception is Poland where the law criminalises abortion unless: the woman's life or health is in danger; the fetus is incurably deformed; or the pregnancy resulted from a criminal act. Poland has one of the most restrictive abortion regulation in Europe and, even within the legal framework, access to abortion services is difficult. As a result, many women are forced to rely on underground abortion services. Although the table presents liberal grounds on which abortion is permitted in the region, women, and especially young women, face significant barriers accessing safe abortion services.

Adolescents face even more barriers accessing abortion services and among these are laws requiring young girls to receive parental consent for the procedure prior to performing it. This is generally the case for all of Eastern Europe.

Moreover, in 2012, initiatives to restrict access to abortion appeared in Azerbaijan, Bulgaria, Hungary, Poland, the Russian Federation and Ukraine. (see table 3)

3.5 HIV/AIDS

Unemployment, poverty and increased substance use, especially among adolescents and young people, contribute to the spread of HIV/AIDS.

Eastern Europe is one of two regions in the world where the incidence of new HIV infections is on the rise. Until 10 years ago HIV was almost nonexistent in the region. However, the number of people living with HIV has almost tripled since 2000 and reached an estimated 1.4 million in 2009 (1.3 million – 1.6 million with the incidence rate below 0.1). There were 130,000 new infections in 2009. New infections in Ukraine and the Russian Federation constitute 90% of new infections in the region[16]. HIV positive young people and adolescents account for less than 0.1% in Armenia, Azerbaijan, Bulgaria, Croatia, Georgia, Hungary, Poland and Romania. In the Russian Federation and Ukraine the rates are 0.3% among young women and 0.2% among young men.[17]

Although injection drug use remains the primary route of HIV transmission, the rapid growth in the number of heterosexual transmissions poses the risk that HIV/AIDS will turn into a general pandemic in this region.[18] In 2007, heterosexual transmission was the source of 42% of newly diagnosed HIV infections in Eastern Europe.

Feminisation of the HIV epidemic is yet another regional characteristic, with the proportion of women living with HIV growing rapidly. By 2009 women represented 45% of people

Table 2: Grounds on which bortion is permitted under 12 weeks of pregnancy

COUNTRY	To save woman's life	To preserve physical health	To preserve mental health	Rape or incest	Foetal impairement	Economic or social reasons	On request
Armenia	✓	✓	✓	✓	✓	✓	✓
Azerbaijan	✓	✓	✓	✓	✓	✓	✓
Bulgaria	✓	✓	✓	✓	✓	✓	✓
Croatia	✓	✓	✓	✓	✓	✓	✓
Georgia	✓	✓	✓	✓	✓	✓	✓
Hungary	✓	✓	✓	✓	✓	✓	✓
Poland	✓	✓	✓	✓	✓	--	--
Romania	✓	✓	✓	✓	✓	✓	✓
Russian Federation	✓	✓	✓	✓	✓	✓	✓
Ukraine	✓	✓	✓	✓	✓	✓	✓

Source: World Abortions Policies 2011. United Nations Department of Economic and Social Affairs Population Division

living with HIV in Ukraine when in 1999 the number was estimated at 37%.[19]

Data shows that women and young people, along with injection drug users, sex workers, migrants, men who have sex with men, and Roma people, belong to the most at-risk groups. Members of these groups are not only vulnerable to infections but they also face discrimination in access to testing, counselling and care services. Because of the widespread stereotypes associating AIDS with social pathologies, people living with HIV/AIDS in the region experience stigma and discrimination.

4. Homophobia and transphobia

The recognition of diverse sexual and gender identities is still problematic in the region, and homophobia and transphobia starts as early as primary school. At the societal level, homophobia and transphobia are generally accepted and there is need for general action to promote tolerance towards LGBTIQ communities including young people.

References to "traditional values" to justify homophobic and transphobic actions, as well as support of patriarchal values and gender-stereotypical patterns of behaviour, are widely used in the media and reinforced at the political level all over the region.[20] This has a negative impact on the lives and everyday experience of LGBTIQ youth in the region.[21]

reclaiming and redefining rights: setting the adolescent and young people srhr agenda beyond icpd+20

5. Recommendations

We, adolescents and young people of Eastern Europe, call governments to:

1. Collect data on young people's access to sexual and reproductive health and rights and address gaps in implementation of the International Conference on Population and Development Programme of Action;

2. Review, amend and implement laws and policies to address the needs and realities of young women and men, girls and boys, and to uphold human rights, including sexual and reproductive rights;

3. Address the impact of religious extremism on Sexual and Reproductive Health and Rights for women, young people, Lesbian, Gay, Bisexual, Transgender, Queer and Intersex persons and other vulnerable groups by removing legal and policy barriers pertaining to young people's Sexual and Reproductive Health and Rights based in political and cultural conservatism;

4. Unequivocally endorse, sustain and scale up domestic resources for the implementation of comprehensive Sexual and Reproductive Health and Rights interventions for adolescents and young people in the region;

5. Fulfill the right of adolescents and young people to universal access to a continuum of quality care and comprehensive sexual and reproductive health services, supplies and information, through all levels of healthcare and public provisioning;

6. Provide universal comprehensive sexuality education and youth friendly health services. Ensure full participation of young people in the process of developing such programmes and insitutions. Create a system of accountability and transparency to monitor the status of comprehensive sexuality education in respective countries and develop mechanisms to ensure that these initiatives reflect needs of young people and adolescents;

7. Improve all levels of education and training systems and invest stronger policy efforts in order to improve youth employment;

8. Meaningfully engage non-governmental organisations and progressive social movements as equal partners in development at all levels, particularly youth-led groups, and ensure an enabling environment for their work.

reclaiming and redefining rights: setting the adolescent and young people srhr agenda beyond icpd+20

Endnotes

This fact sheet is written by Marta Szostak and Katarzyna Pabijanek
Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights (ASTRA)

1 In this Factsheet, Eastern Europe is used to represent the region in general. Specific references are made to Armenia, Azerbaijan, Bulgaria, Croatia, Georgia, Hungary, Poland , Romania, Russia, and Ukraine as they comprise the ten Eastern Europe countries monitored for the ICPD+20 Global South Monitoring Report.

2 United Nations Department of Economic and Social Affairs. (2012). World Population Prospects [Data File]. New York, NY: United Nations. Retrieved from <http://esa.un.org/unpd/wpp/unpp/panel_indicators.htm>.

3 Eastern Europe is used here to refer to the post-communist European countries of Croatia, Bulgaria, Hungary, Poland and Romania, and five countries of the former Soviet Union: Armenia, Azerbaijan, Georgia, Russian Federation, and Ukraine. The shared history of subjugation to the former Soviet Union and experience of "transition" from communism to democracy hold the group together. As a consequence of political and economic transformation and global economic crisis, socio-economic inequities have grown alarmingly and access to public resources has declined all over the region.

4 Human Development Report 2011 http://hdr.undp.org/en/reports/global/hdr2011/

5 United Nations Development Programme (UNDP). (2011). Human Development Report 2011, Sustainability and Equity: A Better Future for All. New York, NY: United Nations

6 United Nations. (2012). The Millennium Development Goals Report, 2012. New York, NY: UN. Retrieved from <http://www.un.org/millenniumgoals/pdf/MDG%20Report%202012.pdf>.

7 United Nations Educational, Scientific and Cultural Organisation (UNESCO). (2012). World atlas of gender equality in education. Paris, France: United Nations.

8 ICPD PoA == paras 6.7(a), 6.7(b), 6.15, 7.45

9 The WHO Regional Office for Europe released the guidelines in March 2010. The guidelines were developed by a group of 20 experts from 9 European countries under the guidance of the Federal Centre for Health Education (BZgA) in Cologne, Germany and the WHO Regional Office for Europe. They provide step-by-step instructions and a detailed matrix to support health and education professionals in their efforts to guarantee children accurate and sensitively presented information about sexuality. http://www.euro.who.int/en/what-we-publish/information-for-the-media/sections/latest-press-releases/new-european-guidelines-on-sexuality-education-experts-say-sexuality-education-should-start-from-birth

10 Pabijanek, K. (2012). Reclaiming & Redefining Rights - ICPD+20: Status of sexual and reproductive health and rights in Central and Eastern Europe. Warsaw, Poland: Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights (ASTRA).

11 United Nations Department of Economic and Social Affiars (UNDESA). (2011). World Contraceptive Use 2011. New York, NY: United Nations Population Division.

12 United Nations. (2012). The Millennium Development Goals Report, 2012. New York, NY: UN. Retrieved from <http://www.un.org/millenniumgoals/pdf/MDG%20Report%202012.pdf>.

13 Pabijanek, K. (2012). Reclaiming & Redefining Rights - ICPD+20: Status of sexual and reproductive health and rights in Central and Eastern Europe. Warsaw, Poland: Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights (ASTRA).

14 World Health Organization, (2011). Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008, 6th Edition. Geneva, Switzerland: Department of Reproductive Health and Research. Retrieved from <http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241501118/en/index.html October, 2012>.

15 Guttmacher Institute. (2012). Facts on Induced Abortion Worldwide. New York, NY: Guttmacher Institute and World Health Organisation (WHO). Retrieved from <http://www.guttmacher.org/pubs/fb_IAW.html>.

16 Joint United Nations Programme on HIV/AIDS. (2010). UNAIDS Report on the global aids epidemic 2010. Geneva, Switzerland: United Nations. Retrieved from <http://www.unaids.org/globalreport/global_report.htm>.

17 Joint United Nations Programme on HIV/AIDS. (2010). UNAIDS Report on the global aids epidemic 2010. Geneva, Switzerland: United Nations. Retrieved from <http://www.unaids.org/globalreport/global_report.htm>.

18 Pabijanek, K. (2012). Reclaiming & Redefining Rights - ICPD+20: Status of sexual and reproductive health and rights in Central and Eastern Europe. Warsaw, Poland: Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights (ASTRA).

19 Joint United Nations Programme on HIV/AIDS (UNAIDS). (2010). UNAIDS Report on the global aids epidemic 2010. New York, NY: United Nations. Retrieved from <http://www.unaids.org/globalreport/global_report.htm>.

20 Pabijanek, K. (2012). Reclaiming & Redefining Rights - ICPD+20: Status of sexual and reproductive health and rights in Central and Eastern Europe. Warsaw, Poland: Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights (ASTRA) and Ottosson, D. (2007). State Sponsored Homophobia. A World Survey of Laws Prohibiting Same Sex Activity between Consenting Adults. Retrieved October from the International Lesbian and Gay Association (ILGA) Web site: <http://ilga.org/historic/Statehomophobia State_sponsored_homophobia_ILGA_07.pdf>.

21 Pabijanek, K. (2012). Reclaiming & Redefining Rights - ICPD+20: Status of sexual and reproductive health and rights in Central and Eastern Europe. Warsaw, Poland: Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights (ASTRA) and Ottosson, D. (2007). State Sponsored Homophobia. A World Survey of Laws Prohibiting Same Sex Activity between Consenting Adults. Retrieved October from the International Lesbian and Gay Association (ILGA) Web site: <http://ilga.org/historic/Statehomophobia State_sponsored_homophobia_ILGA_07.pdf>.

reclaiming and redefining rights: setting the adolescent and young people SRHR agenda beyond icpd+20

LATIN AMERICA AND THE CARIBBEAN REGION FACT SHEET

These Global South Adolescent and Young People Fact Sheets, have been developed as part of the ICPD+20 Global South SRHR Monitoring and Research Initiative steered by ARROW in partnership with Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights (ASTRA), Latin American and Caribbean Women's Health Network (LACWHN), Egyptian Initiative for Personal Rights (EIPR) and the World YWCA. The fact sheets provide the most recent data and analysis on adolescent and young people SRHR across the Global South regions. The recommendations to respective governments, donors, UN agencies take into consideration the evidence and lived realities of adolescent and young people in Asia and the Pacific, Eastern Europe, Latin America and the Caribbean, and the Middle East and Northern Africa and Sub-Saharan Africa.

1. Context [1]

It is estimated that by 2015, the population aged 15 to 24 years in Latin America and the Caribbean will be 107,660,000, or 17% of the total region.[2] Young women account for 51% of the young population, so it is essential to continue with actions to address gender gaps including growing numbers of adolescent pregnancies. Young people are the key to the development of the region, however in most LAC countries there are no legal frameworks that recognize the young people as subjects of rights, or policies that address their specific needs.

It is important to recognize that many of the problems in the region are rooted in economic disparities and social exclusion. These problems limit access for youth – young women, indigenous youth, youth of African descent and youth with diverse gender identities and sexual orientations – to access sexual and reproductive health services, quality education, decent work, and opportunities for effective participation. It is worrying that almost 20 years after governments signed and committed to the ICPD PoA some public policies, especially those in education and sexual and reproductive health pertaining to adolescents and young people, are suffering setbacks.

2. Universal access to quality education

The ICPD PoA set out to achieve the goal of universal primary education by 2015. According to the database of indicators of the Millennium Development Goals (MDGs), the literacy rate of young people in the region in 2010 was 97.2%, higher than the literacy rate in all developing regions and the world, 88.1% and 89.6%, respectively.[3]

Data shows that gross primary enrolment is almost universal in the Latin America and Caribbean region. According to the Economic Commission for Latin America and the Caribbean (ECLAC), Mexico reached a net rate of 98% for men and women (2007) and Nicaragua reached 96% (2007).[4]

While literacy and primary enrollment rates for girls and boys are high and nearly achieving the stated goals of the Human Development Index 2011,[5] girls still have lower rates of enrollment than boys. The gross secondary enrolment ratio for the region is 90.7% with girls outnumbering boys.[6]

Efforts to improve quality education will need to take into account coverage area and social inequities. It is critical to

This fact sheet has been published by ARROW with funding support from FORDFOUNDATION and Sida

attend to the educational needs of all youth groups, especially the those that constitute some of the most vulnerable segments of the youth population, which includes indigenous youth, black youth and youth with disabilities.

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

The ICPD PoA calls for the promotion "to the fullest exent" of the health of young people and provision of services that are of good quality and sensitive to the needs of the young and "safeguarding the rights of adolescents to privacy, confidentiality, respect and informed consent.[7]" In order for young people to access health services, it is necessary to develop policies and programs governing the negative impact of stereotypes, prejudices, dogmas and fundamentalism that limit universal access to sexual and reproductive health services.

3.1 Comprehensive sexuality education (CSE)

Many of the countries in the region have programmes or curricula that comprise compulsory sex education, however conservatism and the involvement of the Catholic Church in some cases makes it difficult to prevent their implementation.

In the case of Mexico it is important to note that there has been progress made beyond specific legislation on sex education. Sex education is integrated into the Health Act and since 2006 there has been a program designated to provide this education.

The fact that the body responsible for education in Mexico is not in charge of this program greatly hinders implementation. In the years 2007 and 2008 educational materials devoid of scientific content but teeming with religious values about contraception and condom effectiveness were purchased and distributed in parallel to official textbooks with religious valuations, in clear defiance of the legal framework. (see table 1)

Another factor that is important for implementation is the provision of resources and materials themselves. In the case of Mexico, Brazil and the Dominican Republic there are no financial resources for sexuality education and in Colombia and Argentina there are no clear and secure logistical processes for its implementation. Civil society has focused their efforts towards disseminating information to youth and adolescents and as such it has played an important role in the face of complex or difficult governmental policies and government programs on sex education curricula.

3.2 Contraceptive use among adolescents and young people

The total contraceptive prevalence rates for all sexually active young women age 15 to 19 years ranges from 14.6% (2001) in Nicaragua to 26.5% (2010) in Colombia. The Dominican Republic and Nicaragua, both are in Central America and the Caribbean have traditionally had poorer health indicators than the remainder of the Latin America region. The CPR is higher for young women age 20 to 24 years across all the countries, but even in the best case it remains below 59.1% (Colombia). Based on the latest LACDC data for Brazil, the contraceptive prevalence rate is 66% among young women 15-19 and 77% among 20-24%.[9]

Despite comparatively high CPR, the unmet need for modern contraception is 22% in Latin America and the Caribbean. . The latest data shows that in Latin America and the Caribbean, young women aged 15-24 have the second highest rate of dissatisfaction with contraceptive methods in the world.[10] Evidence in Columbia (13.5%), Nicaragua(10.9%), and the Dominican Republic(13.5%) shows adolescent girls have begun sexual activity as early as age 15.[11] If the goal is to achieve access to SRH information and services for youth and adolescents, it is necessary to strengthen public policies that guarantee access to contraceptives, including the female condom and emergency contraception and safe abortion services.

3.3 Adolescent Pregnancies

Adolescent pregnancy is a serious problem for the region, where 78.9 per 1000 births are attributed to young women between the ages of 15 and 19 years.[12] The situation is more complex for Latin America where rates range from a minimum of 50.1 in the case of Cuba (2008) to a maximum of 108.5 births per 1,000 teens in Nicaragua (2005). In the Caribbean this number is 69 per 1000 births, which is not drastically lower than the regional average of 79.7.

The trend in this region is contrary to the global trend of declining adolescent birth rates, as there have been increases in rates in several of the countries. In Mexico the rate increased by 6.4, from 80.8/1000 in 2006 to 87.4/1000 in 2007. In Brazil, between 2008 and 2009, there was an increase from 86.5/1000 to 90/1000, constituting a change of 3.5, and in Colombia the rate increased from 91.9/1000 in 2002 to 96.2/1000 in 2005, a change of 4.3.

This characteristic of the region, where the adolescent birth rates have increased over time is closely linked to socioeconomic status, low levels of education, and violence against women and young women.[14] This disproportionately affects the most vulnerable populations, including indigenous and rural youth.[15] Acceleration of menarche combined with early sexual initiation and violence again women are key factors

Table 1: Sex Education for HIV prevention in Latin America and the Caribbean

Specific aspects of the program (or curriculum) official levels: primary (A), secondary (B) and high (C) on sexual education and HIV prevention [8]																		
Country	**Aspects the biological reproduction human**			**Self Esteem**			**Stigma and discrimination**			**Equality the sexes (roles gender)**			**STIs**			**Contraception**		
	A	**B**	**C**	**A**	**B**	**C**	**A**	**B**	**C**	**A**	**B**	**C**	**A**	**B**	**C**	**A**	**B**	**C**
Argentina	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓		✓	✓
Brazil	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓		✓	✓
Colombia	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Dominican Republic	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓
Mexico	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nicaragua		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			

Source: Sex education for HIV prevention in Latin America and the Caribbean: Regional diagnosis. Available online: http://bvs.minsa.gob.pe/local/MINSA/1641.pdf

contributing to adolescent pregnancy in the region.

Considering that the region has serious problems with access to health, education and employment, we find that adolescent mothers face a lack of opportunities to advance their education and secure employment.[16] This precarious situation ultimately forces many young women in the region into poverty.

3.4 Access to abortion informaiton and services among adolescents and young women

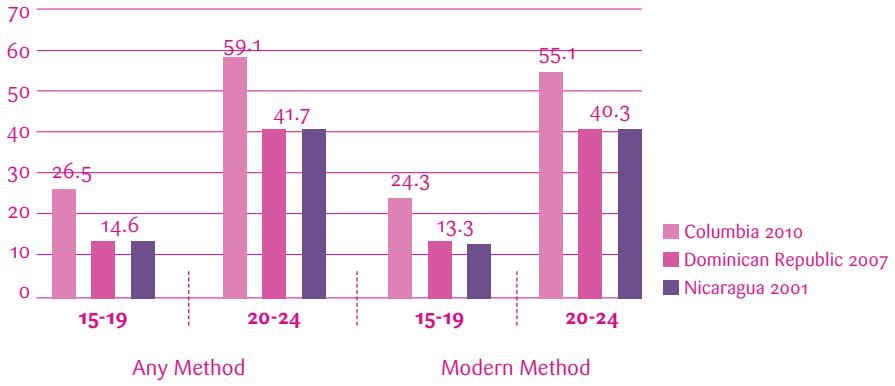
Abortion policies in Latin America have long been controversial issues and remain heavily influenced by religious and cultural constructs. The status of abortion policies in the region has resulted in prominent international human rights cases and lawsuits against governments whose legislations restrict even life-saving abortion procedures. Health workers have also been documented for refusing to provide even the most basic of comprehensive reproductive health services, deferring to conscientious objection or hiding behind the ability to ambiguously interpret some laws. There was such a case in Peru in which a 17-year-old woman was forced to carry to term her pregnancy with an anencephalic fetus and made to breastfeed for the four days that the fetus survived.[17] The fact of the matter is that abortion is an issue of access to healthcare, and so secular states must respect this as a necessary and essential framework for ensuring that young people have the right to make decisions on the matter.

Overall, the region has very restrictive laws on abortion, particularly in the South America and Central America sub regions. (see table 3)

Policies vary dramatically between countries; while some countries attempt to define the circumstances in which abortion is legal others have adopted precarious laws that have caused public documents be manipulated and used to misinform or deliberately hide information from the public. This legality of abortion may also vary drastically within any single country. In Mexico, abortion is legal only in the Federal District and is allowed in all of the cases indicated in the table above. Only 18 states outside of the Federal District permit abortion with restrictions and the remaining 18 have banned abortion altogether on the grounds of conservative desires to protect religious determinations of when life after conception begins. In March of 2012, the Argentine Supreme Court took a landmark decision holding that abortion is legal in all cases of rape.[20]

Access to safe abortion is a state responsibility. Young women undoubtedly suffer the most devastating effects of inconsistent

Fig 1: Contraceptive prevalence rate among young people



Source: Available Country DHS Reports

rhetoric among policy makers and service providers, as well as the effects of varying interpretations of sexual and reproductive health legislation. Currently, there are women in Mexico who are subject to criminal proceedings in the states where abortion is criminalized under the penal code[21].

The situation faced by young people in rural areas is further complicated because access to general health services in these areas is in itself a huge shortfall within the region for the general population, the repercussions of which affect primarily young women. Recognizing sexuality as an integral part of health policy and law will be a major step in improving conditions young women in the region face daily with regard to decision making that impacts their bodies.

3.5 Sexually transmitted infections (STIs) and HIV/AIDS

In Latin America, the lack of data and statistics makes it difficult to form a general picture of the prevalence of STIs in young people between 15-24 years. Available studies show that the incidence of STIs varies dramatically from country to country and, even within any single country, it varies from one geographic area to another.

Contraceptive use has increased in many parts of the world, especially in Asia and Latin America, but there is still much to be done in order to achieve sufficient coverage. Information about STIs, prevention of STIs or condom use (male or female) depends on political will and often conservative contexts represent a greater risk of infection.

Sexual and economic inequality, gender inequality and societal values in a patriarchal culture are the most important causes explaining why young women are most affected by STIs. In the Dominican Republic, for example, the percentage of women age 15- 24 who have had an infection is 21.1% while the percentage for their male counterparts is only 2.9%. [22]

3.5.1 HIV/AIDS

According to the 2011 UNAIDS Global Report, HIV prevalence rates amongst young men and women vary considerably from country to country. The highest rates of HIV are concentrated in the Caribbean region, where young women and men have an HIV prevalence rate of 0.8 and 0.4, respectively. This is higher than the Global average of 0.6 and 0.3, respectively[23].

The rate of HIV amongst men in the Dominican Republic is 0.3, which is less than half of that of women. For the countries of interest, Mexico and Nicaragua have the lowest HIV rates for women (0.1 in both countries), and men (0.2 in Mexico and 0.1 in Nicaragua, respectively), which are also lower than the global estimates. The variations in prevalence rates can be explained most immediately by lack of access to sexual and reproductive health services for youth and low rates of contraceptive use.

Table 2: Adolescent birth rate[13]

Country	Year	Rate
World	2009	48.6
Latin America and Caribbean	2009	78.9
Caribbean	2009	69.0
Latin America	2009	79.7
Nicaragua	2005	108.5
Dominican Republic	2004	98.0
Mexico	2008	87.4
Colombia	2007	85.1
Brazil	2008	71.4
Argentina	2009	68.2

Source: The Millennium Development Goals indicators. http://mdgs.un.org/unsd/mdg/Data.aspx

Different youth populations have unique difficulties and challenges. Violence and sexual abuse, along with stigma against LGBTIQ persons and people living with HIV also contribute to high prevalence rates within these populations. While data shows that young girls in Latin America and the Caribbean, are not particularly more vulnerable to HIV infection when compared to their male counterparts[24], circumstances impacting them disproportionately impacts young girls .

Before reaching age 19, the combined impact of biology, low HIV knowledge and risk perception, early sexual debut, and social norms that perpetuate gender inequality – will have tremendously impacted adolescent girls[25]. Although there are many different communities of young people, young women and men in Latin America and the Caribbean have common experiences that further fuel the problem.

Combining to exacerbate the situation is the reality that prevention services are few and drug use, particularly in the Central America and Caribbean sub regions, is high. Young people who engage in drug use and who sell sex are at an increased risk for contracting HIV than their peers who do not[26].

4. Traditional and harmful practices

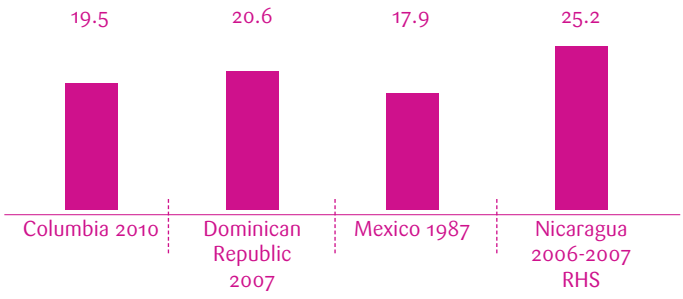
Young women are the most affected by traditional practices and patriarchal culture in the region because it is still far from achieving recognition of women's rights and gender equality and it is reflected in its double-discrimination against women particularly regarding gender and age status.

Access to education and forced marriages for girls and young women are examples of harmful gender-based customs that especially impact young women and girls in indigenous communities and rural areas.

Another complex situation linked with traditions and customs, especially in indigenous communities across all countries in the region, is access to education for women. In some countries such as Colombia, there still exists the practice of FGM. In 2011, a project by the Ministry of Health and Welfare, UNFPA-UN Women, community leaders were consulted and it was agreed that this practice would be eliminated.

However, there are still a few reports of isolated cases within the same ethnic groups living in the forest areas of the Colombian Pacific. Although such practices are difficult to document, women's organizations working in the region primarily on issues of violence and gender equity in rural indigenous communities, have testimonials and evidence of this occurring.

Fig. 2: Percentage of women age 15-19 who are mothers or pregnant with the first child.



Source: Available Country DHS Reports

reclaiming and redefining rights: setting the adolescent and young people srhr agenda beyond icpd+20

Table 3: Grounds on which abortion is permitted

Grounds on which abortion is permitted[18]							
Country	**To save woman's life**	**To preserve a woman's physical health**	**To preserve a woman's mental health**	**In case of rape or incest**	**Because of fetal impairment**	**For economic or social reasons**	**On request**
Argentina	✓	-	-	-	-	-	-
Brazil	✓	-	-	✓	-	-	-
Colombia	✓	✓	✓	✓	✓	-	-
Mexico[19]	✓	✓	✓	✓	✓	✓	✓
Nicaragua	-	-	-	-	-	-	-
Dominican Republic	-	-	-	-	-	-	-

Source: World Abortions Policies 2011. United Nations Department of Economic and Social Affairs Population Division

5. Homophobia and Transphobia

Stigma and discrimination against people's sexual diversity and against young people living with HIV in the region is one of the common practices that clearly poses a risk to the young people who are survivors of violence in this situation. This affects their dignity, health and development.

The rights of youth in the region remain a sensitive issue, particularly in the area of adolescent sexuality and self-expression. Homophobia is a wide problem in Latin America and youth face difficulties with self-expression and integration in their communities. Consequently efforts have been made to address this and conventions have been developed and signed to improve the quality of life of youth within their communities.

The Iberoamerican Convention on the Rights of Youth is an international human rights treaty, signed on October 11, 2005 whose scope of application is limited to 21 of the Iberoamerican countries but has so far only been ratified by 7 countries[27], with another 9 currently in the process of being ratified. Six countries are yet to sign the treaty and these countries include Argentina and Brazil. The document highlights the importance of family and parents while stating that youths have a right to peace, gender equality, life, personal integrity, and protection against sexual abuse." The Convention also holds that youth are entitled to "equal rights before law and all the guarantees of the corresponding procedure" stressing also "the right to assert their own identities, including sexual orientation; be free of discrimination; and pursue social connections, including having a life partner and entering into marriage. Because of the specificity of the sexual rights it asserts, the document is yet to be ratified in much of Latin America as religiously backed political conservatism does not support many of its assertions.

6. Recommendations

We, the adolescents and young people of Latin America and the Caribbean call upon our governments to:

1 Promote a legal framework that recognizes and guarantees the rights of young people, including sexuality as a human right. Sexual and Reproductive Rights should include free access to safe abortion, youth friendly quality sexual health services and mandatory comprehensive sexuality education.

2 Ratify the Ibero-American Convention on the Rights of the Youth

3 Develop public policies that guarantee and upholds affirmative and pleasure, ensuring protection against all kinds of violence and promoting youth autonomy over their bodies.

4 Develop public programmes that include access to quality, friendly and free sexual and reproductive health services and to contraception (such as the female condom and emergency contraception). Young people living with HIV should be provided appropriate care and free medication.

5 Ensure access to effective, secular, and scientific information is provided in the implementation of comprehensive sexuality education programmes and curricula.

6 Designate public funding to ensure the development and implementation of public policies for the effective practice of sexual and reproductive rights.

7 Ensure efficient and sustained increase in State spending to ensure quality secular education, including comprehensive sexuality education, as well as improving conditions for access to higher education, as a way of reducing social inequalities.

8 Create mechanisms to ensure the effective participation of young people in the development, implementation and evaluation of public policies, with attention focused on their specific needs, especially those related to the full practice of their sexual and reproductive rights.

9 Provide funding and gather statistics and data that are disaggregated by age and sex to get a better understanding of the reality of youth.

10 Sex education for HIV prevention in Latin America and the Caribbean: Regional diagnosis. Available online: http://bvs.minsa.gob.pe/local/MINSA/1641.pdf

11 World Abortions Policies 2011. United Nations Department of Economic and Social Affairs Population Division

reclaiming and redefining rights: setting the adolescent and young people srhr agenda beyond icpd+20

Endnotes

This factsheet is written by Nayeli Yoval
Latin American and Caribbean Women's Health Network (LACWHN)
and Janet Ajao
Asian-Pacific Resource and Research Centre for Women (ARROW)

1 In this Factsheet, Latin America and the Caribbean (LAC) is used to represent the region in general. Specific references are made to Argentina, Brazil, Colombia, Dominican Republic, Mexico, and Nicaragua as they comprise the six LAC countries monitored for the ICPD+20 Global South Monitoring Report.

2 United Nations Department of Economic and Social Affairs. (2012). World Population Prospects [Data File]. New York, NY: United Nations. Retrieved from (http://esa.un.org/unpd/wpp/index.htm).

3 United Nations. (2012). The Millennium Development Goals Report, 2012. New York, NY: UN. Retrieved from <http://www.un.org/millenniumgoals/pdf/MDG%20Report%202012.pdf>.

4 CELADE, División de Población. (2002). Indicadores para el Seguimiento Regional del Programa de Acción de la CIPD. Comisión Económica para América Latina y el Caribe (CEPAL). Retrieved from <http://www.eclac.cl/cgi-bin/getProd.asp?xml=/publicaciones/xml/5/9735/P9735.xml&xsl=/celade/tpl/p9f.xsl&base=/celade/tpl/top-bottom.xsl>.

5 United Nations Department of Economic and Social Affiars (UNDESA). (2011). World Contraceptive Use 2011. New York, NY: United Nations Population Division.

6 United Nations Department of Economic and Social Affiars (UNDESA). (2011). World Contraceptive Use 2011. New York, NY: United Nations Population Division.

7 ICPD PoA == paras 6.7(a), 6.7(b), 6.15, 7.45

8 Sex education for HIV prevention in Latin America and the Caribbean: Regional diagnosis. Available online: http://bvs.minsa.gob.pe/local/MINSA/1641.pdf

9 Indicators for monitoring regional PoA ICPD. Latin American & Caribbean Demographic Centre (LACDC)

10 Rosen, J. (2010). Position paper on mainstreaming adolescent pregnancy in efforts to make pregnancy safer. Washington, DC: World Bank.

11 Information Processing of Demographic and Health Surveys using Statcompiler, Measure DHS, Macro International IMC, [Online]: http://www.measuredhs.com

12 United Nations. (2012). The Millennium Development Goals Report, 2012. New York, NY: UN. Retrieved from <http://www.un.org/millenniumgoals/pdf/MDG%20Report%202012.pdf>.

13 The Millennium Development Goals indicators. http://mdgs.un.org/unsd/mdg/Data.aspx

14 Regional Population Report in Latin America and the Caribbean 2011. Investing in Youth. CEPAL-UNFPA

15 Regional Population Report in Latin America and the Caribbean 2011. Investing in Youth. CEPAL-UNFPA

16 Regional Population Report in Latin America and the Caribbean 2011. Investing in Youth. CEPAL-UNFPA

17 Center for Reproductive Rights. 12/10/2008. http://reproductiverights.org/en/case/kl-v-peru-united-nations-human-rights-committee

18 United Nations Department of Economic and Social Affairs. (2011). World Abortion Policies 2011. New York, NY: Population Division. Retrieved from (http://www.un.org/esa/population/publications/2011abortion/2011abortionwallchart.html).

19 Each state adopts its own abortion laws. The table reflects abortion laws in the Federal Criminal Code. Some states allow abortion for the following reasons: to preserve the woman's physical health, to preserve the woman's mental health, in case of fetal malformation or economic or social reasons. In 2007, the Federal District approved the legal termination of a pregnancy up until 12 weeks of gestation with no justification required.

20 Center for Reproductive Rights. 03/19/2012. http://reproductiverights.org/en/press-room/argentina-decriminalizes-abortion-in-all-cases-of-rape

21 CEDAW Committee, Consideration of reports submitted by States parties: Mexico, May 17, 2011, [CEDAW/C/MEX/7-8], párrafo 170, p. 52.

22 Demographic and Health Survey. Dominican Republic 2007

23 Joint United Nations Programme on HIV/AIDS (UNAIDS). (2011). Securing the future today: synthesis of strategic Information on HIV and young people. Geneva, Switzerland: UNAIDS.

24 United Nations Children's Fund (UNICEF), June 2011. Opportunity in Crisis: Preventing HIV from early adolescence to young adulthood. New York, NY

25 United Nations Children's Fund (UNICEF), June 2011. Opportunity in Crisis: Preventing HIV from early adolescence to young adulthood. New York, NY

26 Monasch, Roeland, and Mary Mahy, 'Young People: The centre of the HIV epidemic', in Preventing HIV/AIDS in Young People: A system- atic review of the evidence in developing countries, edited by D. Ross, et al., World Health Organization Technical Report Series 938, WHO, Geneva, 2006; Uuskula, A, et al., 'Emergent Properties of HIV Risk among Injecting Drug Users in Talinn, Estonia', Sexually Transmitted Infections, vol. 86, suppl. 3, 2010, iii79-iii84.

27 Convención Iberoamericana de Derechos de los Jóvenes. Retrieved from <http://www.laconvencion.org/index.php?secciones/mapa>.

global south adolescent and young people fact sheets, have been developed as part of the icpd+20 global south srhr monitoring and research initiative steered by arrow in partnership with central and eastern european women's network for sexual and reproductive health and rights (astra), latin american and caribbean women's health network (lacwhn), egyptian initiative for personal rights (eipr) and the world ywca. the fact sheets provide the most recent data and analysis on adolescent and young people srhr across the global south regions. the recommendations to respective governments, donors, un agencies take into consideration the evidence and lived realities of adolescent and young people in asia and the pacific, eastern europe, latin america and the caribbean, and the middle east and northern africa and sub-saharan africa.

reclaiming and redefining rights: setting the adolescent and young people SRHR agenda beyond icpd+20

MIDDLE EAST AND NORTHERN AFRICA REGION FACT SHEET

These Global South Adolescent and Young People Fact Sheets, have been developed as part of the ICPD+20 Global South SRHR Monitoring and Research Initiative steered by ARROW in partnership with Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights (ASTRA), Latin American and Caribbean Women's Health Network (LACWHN), Egyptian Initiative for Personal Rights (EIPR) and the World YWCA. The fact sheets provide the most recent data and analysis on adolescent and young people SRHR across the Global South regions. The recommendations to respective governments, donors, UN agencies take into consideration the evidence and lived realities of adolescent and young people in Asia and the Pacific, Eastern Europe, Latin America and the Caribbean, and the Middle East and Northern Africa and Sub-Saharan Africa.

EGYPTIAN INITATIVE FOR PERSONAL RIGHTS

المبادرة المصرية للحقوق الشخصية

1. Context[1]

Adolescents and young people in the Middle East and Northern Africa (MENA) region constitute the majority of the population and, according to UNFPA in 2007, one in five persons in the MENA region is between 15-24 years old . Striking similarities persist between the young people across the region. Most youth in the region share an increasing level of education, high percentages of unemployment especially among university graduates, and delays in the age at which they are married. While waiting for opportunities for employment and marriage, youth in the MENA region enter into a phase of waiting adulthood, or "wait-hood,"[2] characterized by a period of stagnation and dependency.

Countries across the MENA region differ in their socio-economic contexts; however, they share similar cultural backgrounds. In the past twenty years, the MENA region has witnessed various political changes that influenced the status of sexual and reproductive health and rights for all populations and for women in particular.

2. Universal access to quality education

The ICPD Program of Actions calls for universal access to quality education and achieving the widest and earliest possible access by girls and women to secondary education. At the same time the Millennium Development Goal 2 calls for universal primary education for boys and girls alike by 2015.

In the MENA region, relative improvements in literacy rates among youth have been reported between 2000 and 2010. Most of the improvement has been attributed to Northern Africa where the percentage increased from 79.4% in 2000 to 87.9% in 2010, while Western Asia's literacy rate- which was already quite high - increased only by approximately 2%, from 91.6% in 2000 to 93.4% in 2010.[3]

In the Arab region, the gross enrolment ratio for primary education has reached 95% however the gross secondary enrolment ratio is 66.5%.[4] However gender gaps still persist with female enrolment in Northern Africa and Western Asia at

This fact sheet has been published by ARROW with funding support from FORDFOUNDATION and Sida

Table 1 : Status of sex and sexuality education in the region

	Egypt	Kuwait	Palestine	Tunisia	Turkey	Yemen
Terms used for sexuality education	No school based sex ed program	No school based sex ed programs	No school based sex ed program	Reproductive health education (within science)	No school based sex ed program	No school based sex ed program
Minimum Standards for Sexuality Education	Basic information about the anatomy of the reproductive system and information on STIs including HIV/AIDs[9]	N/A	N/A	Information on reproductive health in the science curricula	Data on maturation, family planning and human reproduction is introduced in science, biology and health classes	Scarce information on human biology
Remarks	Teachers are not prepared to discuss these issues with students and students know very little on sexuality.	There was a ministerial decree to start school based sex ed which was later dropped by the minister	The ministry of health tries to introduce sex ed in primary and secondary but not materialized yet	Tunisia was one of the first countries in the region to introduce information on reproduction and FP during the Sixties,	Lately turkey provided school with "Puberty project" where students receive sexual health book and health expert visits them regularly to answer their questions, such an initiative has not been evaluated yet	Illiteracy rate deprives many young women from access to the limited information

68 and 71 percent respectively.[5] Furthermore, girls' share of enrollment compared to boys' continues to decrease in higher education levels in some countries in the region including Egypt, Yemen and Turkey.[6] Generally, levels of education have increased in the region but posed further challenges related to unemployment among university graduates.[7]

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

The ICPD PoA calls for the promotion "to the fullest extent" of the health of young people and provision of services that are of good quality and sensitive to the needs of the young and "safeguarding the rights of adolescents to privacy, confidentiality, respect and informed consent".[8]

3.1 Comprehensive sexuality education (CSE)

Lack of CSE is a common characteristic among different countries in the region. Evidence shows that school curricula include limited information on reproductive health. In addition, teachers usually overlook this information during classes either out of embarrassment or unpreparedness.

There lack of political will from the governments to mainstream CSE programmes. This has resulted in NGOs and other initiatives playing a pivotal role in raising awareness among youth and young people in issues related to puberty, body changes, contraception, and prevention of STIs and HIV.

Efforts implemented by NGOs are limited and cannot be replicated on a national level without governments taking the lead. Additionally, NGOs have limited access to schools and permission to research and communicate with young people, as governments in the region place many barriers on working with adolescents and young people. There is no school-based sexuality education curriculum in any of the countries, with the exception of Tunisia. Sexuality education is mandatory only in Tunisia, where reproductive health education is incorporated within the science curriculum. In all the countries there is scarce data on the age at which sexuality education begins. (see table 1)

With the new political changes in the region after the "Arab Spring", many sex education initiatives are taking place using social media but at the same time many activists are worried about which direction this may move because the new ruling elites in the region are from right wing parties with a regressive agenda on women's rights and sexuality.

3.2 Contraceptive use among adolescents and young people

Data pertaining to use of contraception among youth is hard to access since most of the national surveys and DHS ask only ever married women about contraception use, this excludes those who are involved in premarital sexual activities. Even in surveys focusing on unmarried youth, it is noticeable that young women are less likely to report their sexual activities compared to young men for cultural reasons.[10]

It remains difficult for youth and young people in the Middle East and North Africa to access contraception regardless of whether they are married. As for married women, the high value placed on women's fertility urges newly married couples to have children early. Young married women typically do not use contraception until after their first child and they are less likely to use modern contraception than older age groups. [11] From the data in the following table, it should be noted that contraceptive use by ever married women age 15-19 is almost 50% less than the use of women age 20-24. (seee table 2) The introduction of services such as contraception to unmarried youth is widely unacceptable, and some reports have even described these services as "nonexistent".[12] The stigma attached to sex outside of marriage and the desires of young people to be accepted by the society further deters them from seeking information about contraception and safe sex.[13] This is reflected in the low use of condoms and contraceptives by youth in the whole region.[14]

Youth Friendly Services in the region tend more to adopt an information-based approach rather than service provision; this is especially the case for Egypt and Yemen. Another important factor to highlight is the lack of state efforts to provide SRH services to youth, requiring that NGOs bear the brunt in service provision with limited geographical coverage and unsustainability. The private sector is then one of the few remaining alternatives for youth seeking contraceptives and SRH services,[15] this poses further difficulties in terms of access for poorer and rural youth already experiencing many inequalities.

It is worth noting that emergency contraception is not available in all countries in the MENA region. Moreover, service providers are not adequately trained to prescribe it and young people's knowledge about it is limited.[16] Condom use is also very low in the region with the exception of Turkey and Iran. This also reflects that women are the main users of contraception in the region.[17]

3.3 Adolescent pregnancies

Adolescent fertility epitomises many of the problems prevalent amongst the adolescent population in the MENA region. Although adolescent birth rates are not as high as Sub-Saharan Africa, it is still considered a health risk for female adolescents.[18] While Northern Africa has 29.1[19] per 1000 women (2010), the adolescent birth rate is even higher in Western Asia, 48.1.[20] Adolescent birth rates vary significantly across the region, where it has been recorded to be as low as 13.6 for

Table 2: Contraceptive prevalence among ever married women

Contraceptive Prevalence among ever married women					
	15 - 19 Years		20 - 24 years		
Country	Any Mehod	Modern Method	Any Method	Modern Method	Reference Year
Egypt	23	20	45	41	2008
Palestine	10	7	36	24	2006
Tunisia	20	20	42	38	2006
Turkey	40	18	63	37	2008
Yemen	10	6	25	16	2006

Source: Respective Country DHS reports

reclaiming and redefining rights: setting the adolescent and young people srhr agenda beyond icpd+20

Table 3: Adolescent Birth Rate[23]

Country	Year	Rate
World	**2009**	**48.6**
Middle East and North Africa Region		
Egypt	2005	49.5
Kuwait	2008	13.6
Palestine	2005	59.8
Tunisia	2007	6
Turkey	2006	38
Yemen	2005	80

Source: The Millennium Development Goals indicators. http://mdgs.un.org/unsd/mdg/Data.aspx

Kuwait (2008) and as high as 80 in Yemen (2005), and 59.8 in Palestine (2006).[21]

Numerous factors affect the adolescent birth rates; among them are the minimum legal age of marriage and, consequently, the median age of marriage. The minimum legal age of marriage is adversely proportionate to the adolescent birth rate, for example, Tunisia has one of the lowest adolescent birth rates at 6 / 1000 women for 2007, partially due to a higher minimum age of marriage being enforced in the country, which is 20 years old for both sexes.

A country's overall socio-economic status, as well as its political struggles and unrests, contributes to adolescent birth rate. The effect of socio-economic conditions on adolescent fertility is illustrated by comparing Kuwait and Yemen. Although Yemen and Kuwait have very similar minimum ages of marriage – 15 for girls in countries, 16 for boys in Yemen and 17 for boys in Kuwait – the adolescent fertility rate is much higher in Yemen (80) than in Kuwait (13.6).

This may be better understood when looking at the socio-economic conditions in both countries. Kuwait ranks 63 in the Human Development Index, while, Yemen is at 154 in the list of countries.[22]

Kuwait's high ranking likely raised the median age of marriage significantly in the country while child marriage and hence adolescent fertility are still catastrophic in Yemen. (see table 3)

3.4 Access to abortion information and services among adolescents and young women

The issue of abortion in MENA region has been politicized due to the inclination of religious institutes, international organizations and national legal norms.[24] Generally, the region is considered to be home to some of the most restrictive countries when it comes to abortion laws.[25]

While Egypt and Yemen permit abortion only in cases where it is necessary for saving women's lives, Kuwait and Palestine allow abortion on more liberal grounds. Turkey and Tunisia are among countries in the region where abortion laws are most liberalised.[26] (see table 4)

Legal restrictions on abortion lead women to seek it unsafely and the latest estimates from the WHO indicate that more than 3 million unsafe abortions were performed in 2008 in the MENA region, accounting for 14% of maternal mortality.[27] Data on induced and unsafe abortion are severely lacking.

As a result, the issue of unsafe abortion is a silent agony in the MENA region and, as it is illegal in many cases, it is severely underreported and poses great health risks on women. Young women are exceptionally vulnerable for unsafe abortions since they lack access to information, social support and financial resources.

Because most young unmarried women deny involvement in premarital sexual activities due to cultural norms, their knowledge of contraception is limited and their access to it is even more limited. Eighty percent of young women in the MENA region live in countries with restrictive laws on abortion.

One issue to highlight in this area is medical abortion, which presents a better and safer option for women seeking abortion, especially where it is illegal. Many young women seek information about it through various websites and online forums for abortion.

Even in instances where medical abortion pills are taken on an incorrect regimen, it remains a safer option to traditional methods, which involves women inserting foreign objects into their vaginas or drinking large amounts of herbs.

3.5 Sexually transmitted infections(STI) and HIV/AIDS

Youth contribute disproportionately to the disease burden of STIs in MENA. Fifty-nine percent of STI cases in Egypt were among young and predominantly single adults.[28] STI incidence has steadily increased in Kuwait where the most reported STIs among STI clinic attendees were among people age 21–30 .[29]

The dominant profiles of STI clinic attendees in Tunisia were those of young single men with multiple sexual partners.[30] In Yemen, it is estimated that there are 150,000 to 170,000 new STIs per year.[31] In Turkey, 2.9% of sex workers tested in 2010 were seropositive for active syphilis.

Table 4: Grounds on which abortion is permitted in the region

Grounds on which abortion is permitted							
Country	**To save woman's life**	**To preserve a woman's physical health**	**To preserve a woman's mental health**	**In case of rape or incest**	**Because of fetal impairment**	**For economic or social reasons**	**On request**
Egypt	✓	-	-	-	-	-	-
Kuwait	✓	✓	✓	✓	✓	-	-
Palestine	✓	✓	✓	-	-	-	-
Tunisia	✓	✓	✓	✓	✓	✓	✓
Turkey	✓	✓	✓	✓	✓	✓	✓
Yemen	✓	-	-	-	-	-	-

Source: World Abortion Policies 2011

3.5.1 HIV/AIDS

The prevalence of HIV in MENA remains the lowest compared to all other regions worldwide, yet it is only in the MENA and Eastern Europe regions that HIV/AIDS prevalence keeps increasing.[32] The national HIV prevalence among adults in the region is low at 0.2, with the exception Djibouti, Somalia and South Sudan,[33] where the epidemic is becoming generalised with national HIV prevalence exceeding 1%.

Regional estimates for PLHIV for young people (15-19) is 0.2 for young women and 0.1 for young men, further demonstrating the feminization of HIV especially among sex workers and female drug users where the stigma is high and community sympathy is absent.

Young people age 15-24 are at increased risk for HIV in MENA due to lack of information and risky behaviours such as unprotected sex, transactional sex, and injecting drug use. Other factors that contribute to HIV vulnerability include limited access to HIV testing, prevention, and treatment; armed conflict, resulting in disrupted healthcare services and refugees living in poor conditions; and lack of accurate HIV informational materials in Arabic.

Stigma, discrimination, and human rights abuses against HIV positive people and most-at-risk populations (MARPs) are common, driving People Living with HIV/AIDS (PLHIV) underground and preventing them from seeking needed support services.

4. Traditional and harmful practices

Young women in the MENA find themselves caught between the burden of harmful traditional practices like female circumcision, child marriage and honor killings and the dangers of newly emergent practices like gang harassment and human trafficking. Many of the traditional harmful practices disproportionately affect young women since younger women do not have full agency over decisions concerning their bodies and sexualities.

Female circumcision

In 1994, ICPD called on governments to work on the elimination of FGM.[34] FC has been one of the most concerning traditional practices found in the MENA region as well as in other parts of the world. Of the countries examined here, FGM is widely practiced in Egypt and Yemen only. In addition, cases of FGM have been reported in the Occupied Palestinian Territories (OPT) in Gaza.

In the legal arena, Egypt has a law criminalizing FC while Yemen has only a ministerial decree prohibiting the practice.
Source: Social Institutions and Gender Index (SIGI) 2012.
Data on the percentage of women subjected to FGM in the 6 countries between the years 1997 and 2007 show the following trend: there is no evidence to show that FGM is practised in Kuwait, Tunisia, and Turkey.[35] Ninety-six percent of women in Egypt and 23% of women in Yemen age 15- 45 were subjected

reclaiming and redefining rights: setting the adolescent and young people srhr agenda beyond icpd+20

Table 5 : Legislation on FGM

Country	FGM Law
Egypt	After two ministerial decrees banning FC, child law no. 12 for 1996 amended by 126 of 2008 criminalized FC and furthermore incorporated the article in the penal code (242bis). (Official Gazette 1996, 1997. 2008)
Kuwait	N/A
Palestine	N/A
Tunisia	N/A
Turkey	N/A
Yemen	There is no law against FGM/C in Yemen. A ministerial decree made effective on January 9, 2001, however, prohibits the practice in both government and private health facilities (UNHCR 2001). The government banned the practice of female genital mutilation (FGM) in official hospitals, but it is known to continue in private clinics. (SIGI 2012)

to FGM between 1997 and 2007[36]. In Palestine, female genital mutilation is known to be practiced in Gaza, but there are no reports on the number of women affected.[37]

Although the percentages of circumcised women in Egypt are shockingly high (2008 EDHS 91.1% of Egyptian women age 15- 49 have been subjected to FC), yet the percentages among younger generations decreased especially in urban areas. Data gathered on FC between the years 2005 and 2008 revealed that 43.6% of the women age 15- 49 were between ages of 9 and 10 when they were circumcised. UNICEF has reported that the procedure of FGM is usually performed on young Egyptian girls age 9-12. FC has been documented to occur at even younger ages than this. The majority of women circumcised in Yemen by 1997 are recorded as having underwent the procedure some time during their early stage of life, ranging from a few weeks to a few months old.[38]

Honour killing

Honour killings[39] have been among the serious issues facing women in different countries in the MENA region. A 2002 report by the UN Special Rapporteur on Violence against Women listed Turkey, Egypt and Yemen among the countries where honour killing occurs in the region[40]. Although honour killings are considered taboo in Arab society, civil society efforts have helped to shed light on the issue.[41]

In **Egypt**, a non-governmental study shows that murders of women due to suspicion of improper behaviour constituted the majority of honour crimes which occurred between 1998 and 2001.[42] The study stated 34% of the cases were those in which fathers killed daughters. [43] The Egyptian law does not address the issue of honour killing directly.

In Turkey, the 2004 Penal Code criminalised honour killings. [44] Yet this did not stop the practice. In Palestine, honour crimes are committed against women who are suspected of improper behaviour as well as those who have been victims of sexual violence. In Yemen, the law provides reduced sentences to men convicted of murdering their wives or female relatives who committed adultery and this is the case in Kuwait as well.

5. Recommendations

We, the adolescents and young people of Middle East and Northern Africa call upon our governments to:

1. Adopt policies to encourage girls' education and access to education should be guaranteed, especially for disadvantaged young men and women. Accessibility and affordability should not be the only focus of government policies but also the quality and acceptability of education should be prioritised in policies. States have obligations to protect young people's right to work.

2. Combat early marriage and early childbearing for young women and men, States should revise age requirements for marriage. Where minimum age of marriage is below 16, states are highly encouraged to raise the minimum age of marriage and to make them equal for both sexes. Moreover, teenage pregnancy should be considered a major health hazard and in this concern states are recommended to combat cultural norms which encourage pregnancy for young women.

3. Identify abortion as a human rights issue as well as a public health concern. States should seek legal reform to abortion laws and at least guarantee access to safe abortion when pregnancies threaten women's lives and health. Safe abortion should be provided on liberal grounds. States should be held accountable for deaths resulting from unsafe abortions. States are asked for meeting their commitments to address the complications arising from unsafe abortion and provide young women acceptable, affordable and high quality post abortion care.

4. Provide young people access to a full range of affordable, good quality contraceptives, family planning methods and SRH services including condoms and emergency contraception. Young men should be encouraged to positively participate in, use, and be responsible for securing, contraception in a positive participatory way. At the same time all the barriers facing women and youth when accessing contraceptives and SRH services, such as husbands, parents or needing a third party's permission, should be removed.

Service providers should be trained to provide non-judgmental services for young people.

5. Continue prioritising HIV/AIDS in the "Beyond 2014" agenda. Young people should be considered as potential champions of change who are able to stop new infections. Stigma and discrimination, especially against young people who are living with HIV. This should be addressed by states at the legal and community levels. Prioritizing HIV/AIDS should not prevent states from being attentive to other STIs and so states should have solidified policies and services to combat the prevalence of them. Testing, treatment and awareness, especially for youth, should be primary elements in states' policies.

6. To provide young people with comprehensive, rights based sexuality education that enables them to make enables them to make informed and free decisions concerning their sexuality.

7. To enact laws that protects women from violence in private and public spheres. Trafficking and harassment in the workplace, which affect young women disproportionately, should be on the legal agenda of the states on Beyond ICPD negotiations.

8. To adopt a bottom-top approach in issues related to harmful traditional practices affecting women and young women more often. Adding to the legal provisions prohibiting such practices, states should work more with people to dispel myths about such practices and boost mainstream discourse of women's human rights to equality and bodily integrity.

9. Protect people's rights to participate in making policies affecting their lives. Women, young people and marginalized groups have the right to participate in designing, implementing and monitoring policies and laws that affect their daily realities and influence their reproductive and sexual health.

10. Show more transparency in data concerning SRH generally and that pertaining to young people in particular. Disaggregated data should be available on issues of abortion, STIs, HIV/AIDS and contraceptive use. Age groups and target groups in data collection at national levels should be inclusive of unmarried young people and marginalized groups like ethnic and religious minorities.

reclaiming and redefining rights: setting the adolescent and young people srhr agenda beyond icpd+20

Endnotes

1 Middle East and North Africa represents a region of Arab and non-Arab countries like Iran and Turkey. Arab countries consist of Gulf area: Kuwait, Iraq, Qatar, Bahrain, Oman, Yemen and KSA, Levant region: Syria, Lebanon, Palestine and Jordan, Nile valley: Egypt and Sudan, Maghreb: Libya, Morocco, Algeria, Tunisia and Mauritania. For the purpose of this fact sheet we are focusing on Egypt, Kuwait, Tunisia, Turkey, Palestine and Yemen as representatives of the region.

2 Singerman, D. (2007). The Economic Imperatives of Marriage: Emerging Practices and Identities among Youth in the Middle East. (6). Washington, DC, USA: Wolfensohn Center For Development at the Brookings Institution & Dubai School of Government.

3 United Nations. (2012). The Millennium Development Goals Report, 2012 N.B.: The Regional Youth Factsheet for MENA region uses considers MENA region to include: Egypt, Lybia, Tunisia, Alegeria, Morrocow, Muritania, Sudan, Kuwait Yemen, Oma, UAE, KSA, Qatar, Bahrain, Iraq, Syria, Lebanon, Palestine, Jordan, Iran and Turkey.

4 United Nations Development Programme (2011). Human Development Report 2011, Sustainability and Equity: A Better Future for All. New York, NY

5 Population Reference Bureau (2011). The World's Women and Girls: 2011 Data Sheet. Washington, DC.

6 United Nations Educational, Scientific and Cultural Organization. (2010). UNESCO Institute for Statics. [Data Fle]. Montreal, Quebec. Retrieved from http://www.uis.unesco.org/Pages/default.aspx.

7 Singerman, D. (2007). The Economic Imperatives of Marriage: Emerging Practices and Identities among Youth in the Middle East. (6). Washington, DC, USA: Wolfensohn Center For Development at the Brookings Institution & Dubai School of Government

8 ICPD PoA == paras 6.7(a), 6.7(b), 6.15, 7.45

9 Population Reference Bureau. (March 2012). Quality Sexuality Education Needed for Adolescents in Egyptian Schools. Washington, DC: Fatma El-Zaharaa Geel. Retrieved from http://www.prb.org/pdf12/adolescents-egypt-schools-workingpaper.pdf October 2012.

10 Farzaneh Roudi-Fahimi and Shereen El Feki. (2009). Facts of life. Washington, DC: Population Reference Bureau. Retrieved from (www.prb.org/Reports/2011/facts-of-life.aspx).

11 Advocates for Youth. Youth and Unsafe abortion, A Global Snapshot. Washington, DC. Retrieved from http://www.advocatesforyouth.org/storage/advfy/documents/youth-and-unsafe-abortion.pdf October 2012.

12 Sexual and Reproductive Health in the Middle East and North Africa: A Guide for Reporters. Farzaneh Roudi-Fahimi & Lori Ashford, 2009, Population Reference Bureau, Washington USA http://www.prb.org/Reports/2008/mediaguide.aspx

13 Farzaneh Roudi-Fahimi and Shereen El Feki. (2009). Facts of life. Washington, DC: Population Reference Bureau. Retrieved from (www.prb.org/Reports/2011/facts-of-life.aspx).

14 Farzaneh Roudi-Fahimi and Shereen El Feki. (2009). Facts of life. Washington, DC: Population Reference Bureau. Retrieved from (www.prb.org/Reports/2011/facts-of-life.aspx).

15 International Women's Health Coalition. (October 2007). Young Adolescents'sexual and reproductive health and rights in middle east and north Africa. Retrieved from http://www.iwhc.org/index.php?option=com_content&task=view&id=2695&Itemid=1162 October 2012.

16 Farzaneh Roudi-Fahimi and Shereen El Feki. (2009). Facts of life. Washington, DC: Population Reference Bureau. Retrieved from (www.prb.org/Reports/2011/facts-of-life.aspx).

17 youth reproductive health in middle east and north Africa factsheet

18 United Nations Children's Fund (UNICEF). (2001, March). Early Marriage: Child Spouses. Innocenti Digest(7). Florence, Italy: Innocenti Research Center, UNICEF. Retrieved February 28, 2012, from: http://www.unicef-irc.org/publications/pdf/digest7e.pdf

19 United Nations. (2012). The Millennium Development Goals Report, 2012. New York, NY: UN. Retrieved from <http://www.un.org/millenniumgoals/pdf/MDG%20Report%202012.pdf>.

20 United Nations. (2012). The Millennium Development Goals Report, 2012

21 United Nations. (2012). The Millennium Development Goals Report, 2012. New York, NY: UN. Retrieved from <http://www.un.org/millenniumgoals/pdf/MDG%20Report%202012.pdf>.

22 United Nations Development Programme (2011). Human Development Report 2011, Sustainability and Equity: A Better Future for All. New York, NY

23 United Nations Statistics Divisions. The Millennium Development Goals Indicators. New York, NY: Department of Economic and Social Affairs. Retrieved from http://mdgs.un.org/unsd/mdg/Data.aspx

24 Gursoy, A. (1996). Abortion in Turkey: a matter of state, family or individual decision. Soc Sci Med. 42(4): 531-542.

25 Abortion in The middle East and North Africa, Farzaneh Roudi-Fahimi & Lara Dabash 2008, Population Reference Bureau, Gynuity http://www.prb.org/pdfo8/MENAabortion.pdf

26 United Nations Department of Economic and Social Affiars. World Abortion Policies 2011. New York, NY: Population Division. Retrieved from http://www.un.org/esa/population/publications/2011abortion/2011abortionwallchart.html. October, 2012.

27 World Health Organization, (2011). Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008, 6th Edition. Geneva, Switzerland: Department of Reproductive Health and Research. Retrieved from http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241501118/en/index.html October, 2012.

28 Ali et al. (1996). Prevalence of Certain Sexually Transmitted Diseases in Egypt. Journal of the Egyptian Public Health Association 71(5-6) :553-575.

29 Al-Mutairi, N. et al., Clinical Patterns of Sexually Transmitted Diseases, Associated Sociodemographic Characteristics, and Sexual Practices in the Farwaniya Region of Kuwait. Int J Dermatol, Jun; 46(6):594-599.

30 Sellami, A. et al. (2003). Epidemiologic Profile of Sexually Transmitted Diseases (STD) through a Specialized Consultation of STD. Tunis Med.

31 Lambert, L. (2007). "HIV and Development Challenges in Yemen: Which Grows Fastest?" Health Policy and Planning. Jan; 22(1):60-62.

32 Joint United Nations Programme on HIV/AIDS. (2011). UNAIDS Middle East and North Africa Regional Report on HIV/AIDS. Retrieved from http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2257_UNAIDS-MENA-report-2011_en.pdf October 2012.

33 (classified by UNAIDS under MENA)

34 United Nations Population Information Network (POPIN). (1994). Report of the United Nations International Conference on Population and Development, 5-13 September 1994, Cairo, Egypt. Chapter V: The Family, Its Riles, Rights, Composition and Structure, 5.5s Accessed March 21, 2012: http://www.un.org/popin/icpd/conference/offeng/poa.html

35 Progress for Children - A Report Card on Child Protection, No. 8, September 2009; and Social Institutions and Gender Index (SIGI) 2012.

36 Progress for Children - A Report Card on Child Protection, No. 8, September 2009; and Social Institutions and Gender Index (SIGI) 2012.

37 Progress for Children - A Report Card on Child Protection, No. 8, September 2009; and Social Institutions and Gender Index (SIGI) 2012.

38 P. Stanley Yoder, Noureddine Abderrahim and Arlinda Zhuzhuni, Comparative Reports Female Genital Cutting in the Demographic and Health Surveys: A Critical and Comparative Analysis, 2004

39 United Nations Development Fund for Women (UNIFEM). (2007, November). Violence against Women – Facts and Figures. Retrieved March 24, 2012, from: http://www.unifem.org/attachments/gender_issues/violence_against_women/facts_figures_violence_against_women_2007.pdf

40 United Nations Development Fund for Women (UNIFEM). (2007, November). Violence against Women – Facts and Figures. Retrieved March 24, 2012, from: http://www.unifem.org/attachments/gender_issues/violence_against_women/facts_figures_violence_against_women_2007.pdf

41 Honor Killings in Middle East and North Africa: A Systematic Review of the Literature, 2011,, Andrzej Kulczycki and Sarah Windle http://vaw.sagepub.com.library.aucegypt.edu:2048/content/17/11/144

42 Khafagy F.. (2005, May). Honor Killing in Egypt. Paper presented in the expert group meeting: violence against women: good practices in combating and eliminating violence against women, organized by: UN Division for the Advancement of Women in collaboration with UN Office on Drugs and Crime from 17 to 20 May 2005 in Vienna, Austria. Cairo, Egypt: The Association of Legal Aid for Women. Retrieved March 24, 2012, from: P4http://www.un.org/womenwatch/daw/egm/vaw-gp-2005/docs/experts/khafagy.honorcrimes.pdf

43 Khafagy F.. (2005, May). Honor Killing in Egypt. Paper presented in the expert group meeting: violence against women: good practices in combating and eliminating violence against women, organized by: UN Division for the Advancement of Women in collaboration with UN Office on Drugs and Crime from 17 to 20 May 2005 in Vienna, Austria. Cairo, Egypt: The Association of Legal Aid for Women. Retrieved March 24, 2012, from: P4http://www.un.org/womenwatch/daw/egm/vaw-gp-2005/docs/experts/khafagy.honorcrimes.pdf

44 Meline K. (2011, January). Turkey country Profile. Minneapolis, MN, USA: Stop violence against women project - Advocates for Human Rights. Accessed March 29, 2012: http://www.stopvaw.org/turkey.html

This fact sheet is written by Dalia Abd El-Hameed and Soha Abdelaty
Egyptian Institute For Personal Rights (EIPR)

reclaiming and redefining rights: setting the adolescent and young people SRHR agenda beyond icpd+20

SUB-SAHARAN AFRICA REGION FACT SHEET

These Global South Adolescent and Young People Fact Sheets, have been developed as part of the ICPD+20 Global South SRHR Monitoring and Research Initiative steered by ARROW in partnership with Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights (ASTRA), Latin American and Caribbean Women's Health Network (LACWHN), Egyptian Initiative for Personal Rights (EIPR) and the World YWCA. The fact sheets provide the most recent data and analysis on adolescent and young people SRHR across the Global South regions. The recommendations to respective governments, donors, UN agencies take into consideration the evidence and lived realities of adolescent and young people in Asia and the Pacific, Eastern Europe, Latin America and the Caribbean, and the Middle East and Northern Africa and Sub-Saharan Africa.

World YWCA

1.Context[1]

Adolescents and young people in Sub-Saharan Africa (SSA) will constitute 19.6% (224,432,000) of the region's population by 2015.[2] The region is characterized by unemployment particularly among youth with an employment to population ratio at 45.8%.[3] Employment for young people age 15-24 has remained stagnant[4] and youth in particular face lack of productive employment and decent jobs. Too many young people are employed in the informal and vulnerable employment sectors.[5]

While the 45 countries that comprise SSA[6] show steady economic growth, this progress is not reflected in the socioeconomic and health indicators for its young population. The region is yet to achieve the ICPD goals as well as the MDG targets and indicators. Poverty is highest in SSA compared to all the other regions, with 47.5% of people living on less than a $1.25 PPP/day.[7]

2. Universal access to quality education

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

SSA has progressed with promoting gross enrolment in primary education for both boys and girls, however low retention and high dropout rates caused by poverty, gender discrimination, poor hygiene and sanitation facilities, and sexual harassment by teachers and male pupils, hinder completion of primary

This fact sheet has been published by ARROW with funding support from FORDFOUNDATION and Sida

reclaiming and redefining rights: setting the adolescent and young people srhr agenda beyond icpd+20

education especially for girls. The gross secondary enrolment ratio is a mere 35.3% and the gross tertiary enrolment ratio is a dismal 5.9%.[8]

At 32 million, SSA has the highest number of out of school youth, many of them young women in rural areas. Gender disparities are largest in rural poor households, where only 38% of females are enroled in tertiary education[9] The rights of many young women to higher education is dependent on family choices and societal norms. These norms often keep them at home to help with household chores and some are married off early to increase household incomes. They are sexually abused by teachers and peers, and subjected to gender insensitive curriculum with no female role models.

Countries that have abolished school fees over the past decade showed positive results. In Kenya, enrolment increased by 1.3 million in just a matter of weeks.[10] The abolition of fees is partly credited with Tanzania's success in raising the primary net enrolment ratio from a reported 50 % in 1999 to 98 % in 2007.[11]

The percentage of literate young women and men age 15-24, according to 2010 data, is 71.8% in the region, men accounting for higher percentage than women in most countries observed.[12]

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

The ICPD PoA calls for the promotion "to the fullest extent" of the health of young people and provision of services that are of good quality and sensitive to the needs of the young and "safeguarding the rights of adolescents to privacy, confidentiality, respect and informed consent."[13]

3.1 Comprehensive sexuality education (CSE)

Overall there is limited data on sexuality education status in the region. A Guttmacher study[14] emphasised the need for sexuality education both in school and out of school in SSA, given the magnitude of HIV, unintended pregnancies and the vulnerabilities of adolescent and young girls.
Despite policies in place many adolescents do not receive any form of sexuality education. The entry point for most of the sexuality education curricula is through HIV and AIDS programmes. According to a 2004 survey, HIV and AIDS were part of the primary school curriculum in 19 of 20 African countries with a high prevalence of HIV. Life skills are integrated into the curricula in 17 of the 20 countries, however implementation of the programmes have not been effective. At the same time school-based sex education programmes do not cater to youth (the majority of them adolescent girls and young women) who are not in school. Addressing out-of-school adolescents is another big challenge in the region.

Sexuality education is not comprehensive, mostly takes a biological perspective and religious groups and parent associations define the parameters and content for its age appropriateness. Some NGOs have established adolescent friendly reproductive health services in Tanzania and Zambia to provide the population age 10-24 with sexual and reproductive health information. Other barriers include teachers who are perpetrators of sexual harassment and violence thus parents are not comfortable with them handling the programmes. The low number of female teachers in rural schools and poor infrastructure also limit young women's access to quality information.[15]

3.2 Contraceptive use among adolescents and young people

According to Guttmacher brief- Facts on the Sexual and Reproductive Health of Adolescent Women in the Developing World- only 21% of married adolescents in sub-Saharan Africa are using a modern contraceptive method and 67% of married adolescent women who want to avoid pregnancy for at least the next two years are not using any method of contraception. At the same time significant percentage- 68%- of sexually active adolescents have an unmet need for modern contraception.[16]

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

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

3.3 Adolescent pregnancies

The ICPD PoA calls for a reduction in adolescent pregnancies. The SSA region accounts for the highest adolescent fertility rate at 119.7 compared to the global average of 58.1. Half of

Fig 1: Contraceptive use among 15-19 years old currently married and sexually active unmarried women

Source: Most recent country DHS reports

adolescent births occur in seven countries across the world and Democratic Republic of Congo, Ethiopia, and Nigeria are among these countries.

An examination of adolescent fertility rates in Angola (165.0), Zambia (151.1), Sierra Leone (143.0), and Nigeria (123.0) shows high adolescent fertility rates above the regional SSA average of 119.7. Rwanda is the only country that has an adolescent fertility rate that is lower than the regional and the global average. (see table 1)

In the nine SSA countries, as part of the Global South ICPD+20 review, the percentage of women aged 15-19 who have already started child bearing is quite high according to the most recent DHS in the respective countries, 34% in Sierra Leone; 28.6% in Angola; 27.9% in Zambia; 22.9% in Nigeria; 22.8% in Tanzania; 21.4% in Benin; 17.7% in Kenya; 12.4% in Ethiopia. Rwanda has a relatively lower percentage of women aged 15-19 who have already begun child bearing at 6.1%.

Adolescent girls are at risk of early childbearing and the risks are magnified for the youngest mothers.[17] Adolescents under 16 face four times the risk of maternal death and morbidity as women over 20. Pregnancy may limit or even end a teenager's ability to pursue educational or job opportunities.

3.4 Access to abortion information and servcies among adolescents and young people

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

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

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

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

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

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

reclaiming and redefining rights: setting the adolescent and young people srhr agenda beyond icpd+20

Fig 2: Contraceptive use among 20-24 years old currently married and sexually active unmarried women

Source: Most recent country DHS reports

3.5 HIV/AIDS

Women and girls disproportionately bear the burden of HIV infections. The knowledge on HIV among both young men and women has slowly increased over the years (34%), which is behind the 2015 UNGASS target of 95%.[25] In SSA, more women than men are living with HIV. Young women age 15-24 are almost eight times more likely than men to be HIV positive.[26] The estimated percentage of HIV prevalence among young women and men shows increasingly higher levels of prevalence among young women in all the countries. In Kenya, Tanzania and Zambia the prevalence rates for both young men and women are higher than the regional average for SSA.

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

Table 1: Adolescent birth rate per 1000 girls age 15-19

Country	Rate
Angola (2005)	165.0
Benin (2004)	114.3
Ethiopia (2011)	79
Kenya (2007)	106.3
Nigeria (2006)	123.0
Rwanda (2006)	43.0
Sierra Leone (2006)	143.0
Tanzania (2009)	116.0
Zambia (2005)	151.1

Source: MDG official indicators database

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

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

Female Genital Mutilation (FGM)

The ICPD PoA calls for the total elimination of FGM, defined as the partial or total removal of the female genitalia or other injury to the female genital organs for non-medical reasons.[27] This practice is rooted deeply in tradition and exists in 28 countries in Africa. There are an estimated 130–140 million girls and women who have been subjected to the operation and 3 million girls are at risk of undergoing the practice every year.

The current trends with regards to FGM include the lowering of the average age at which girls are subjected to the procedure and the medicalisation of FGM where parents are increasingly seeking health care providers to perform FGM on their daughters.[28]

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

FGM has many consequences including negative psychological outcomes such as post-traumatic stress disorder, anxiety, depression, and psychosexual problems. Women who have undergone FGM have been found to be 1.5 times more likely to experience pain during sexual intercourse, experience

Table 2: Grounds on which abortion is permitted

Country	Grounds on which abortion is permitted						
	To save the woman's life	To preserve physical health	To preserve mental health	Rape or incest	Foetal impairment	Economic or social reasons	On request
Angola	✓	—	—	—	—	—	—
Benin	✓	✓	✓	✓	✓	—	—
Ethiopia	✓	✓	✓	✓	✓	—	—
Kenya	✓	✓	✓	—	—	—	—
Nigeria	✓	✓	✓	—	—	—	—
Rwanda	✓	✓	✓	—	—	—	—
Sierra Leone	✓	✓	✓	—	—	—	—
Tanzania	✓	✓	✓	—	—	—	—
Zambia	✓	✓	✓	—	✓	✓	—

Source: World Abortion Policies 2011 (UN)

significantly less sexual satisfaction, and have less sexual desire, and experience complications during childbirth. While there are efforts to curb this practice, in many countries the reduction in prevalence is not as substantial as hoped for, and in a few, no decline has been noted.[29] Although some countries in SSA have addressed these issues, there is need for greater effort to combat HTPs in the region.[30]

5. Homophobia and Transphobia

The situation in Africa for lesbian, gay, bisexual, trans, intersex and queer (LGBTIQ) persons has not seen much progress in recent years. Regionally, 36 countries have laws criminalizing homosexuality. Punishments include imprisonment and the death penalty. The laws on homosexuality are rooted in colonial era laws, religious extremism, political climates, cultural beliefs, heterosexual family values and patriarchy.[31]

At the UN Assembly in Geneva on the Joint Declaration to decriminalise homosexuality in 2011, the number of African countries who signed rose from 6 to 11 with 13 countries who abstained and 28 who opposed Joint Statement on Sexual Orientation and Gender Identity (SOGI).[32] These developments will have implications for the exercise of SRH rights of LGBTIQ persons.

Table 3: Young women and men HIV prevalence

	Young women (15-24) prevalence (%)	Young men (15-24) prevalence (%)
Global	0.6 [0.5 - 0.7]	0.3 [0.2 - 0.3]
Sub-Saharan Africa	3.4 [3.0 - 4.2]	1.4 [1.2 - 1.7]
Angola	1.6 [1.1 - 2.2]	0.6 [0.4 - 0.9]
Benin (2006)	0.7 [0.5 - 1.1]	0.3 [0.2 - 0.4]
Ethiopia (2011)	No data	No data
Kenya (2008)	4.1 [3.0 - 5.4]	1.8 [1.3 - 2.4]
Nigeria (2008)	2.9 [2.3 - 3.9]	1.2 [0.9 - 1.6]
Rwanda (2010)	1.9 [1.3 - 2.3]	1.3 [0.9 - 1.6]
Sierra Leone (2008)	1.5 [0.9 - 2.5]	0.6 [0.3 - 1.0]
Tanzania (2010)	3.9 [3.1 - 5.3]	1.7 [1.3 - 2.3]
Zambia (2007-08)	8.9 [7.3 - 12.0]	4.2 [3.2 - 5.5]

Source: UNAIDS report on global AIDS epidemic 2010.

reclaiming and redefining rights: setting the adolescent and young people srhr agenda beyond icpd+20

6. Recommendations

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

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

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

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

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

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

6. Ensure evidence-based comprehensive sexuality education for in-and out of school young people through schools and communities.

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

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

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

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

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

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

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

14. Ensure the meaningful participation of young people in the operational review of the ICPD Programme of Action, ICDP Beyond 2014 and Millennium Development Goals post 2015 in defining the future they want.

reclaiming and redefining rights: setting the adolescent and young people srhr agenda beyond icpd+20

Endnotes

This fact sheet was written by Nelly Lukale and Hendrica Okondo
World YWCA
and Sai Jyothirmai Racherla
Asian-Pacific Resource and Research Centre for Women

1 In this factsheet, Sub Saharan Africa (SSA) is used to represent the region in general. Specific references are made to Angola, Benin, Ethiopia, Kenya, Nigeria, Rwanda, Sierra Leone, Tanzania and Zambia, as they comprise the nine SSA countries monitored for the ICPD+20 Global South Monitoring Report.

2 United Nations Department of Economic and Social Affairs. (2012). World Population Prospects [Data File]. New York, NY: United Nations. Retrieved from (http://esa.un.org/unpd/wpp/unpp/panel_indicators.htm)

3 United Nations Department of Economic and Social Affairs (2012). Millennium Development Report 2012, Regional and World Estimates. New York, NY: United Nations.

4 Agbor, J; Taiwo, o; and Smith, J. (2012). Sub-Saharan Africa's youth bulge: A demographic dividend or disaster? In Foresight Africa: Top Priorities for the Continent in 2012. Washington, DC: The Brookings Institute.

5 United Nations Development Programme. (2012). MDG Report 2012: Assessing Progress in Africa toward the Millennium Development Goals. Retrieved from http://web.undp.org/africa/documents/mdg/2012.pdf

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

7 United Nations Development Programme (2011). Human Development Report 2011, Sustainability and Equity: A Better Future for All. New York, NY: United Nations

8 United Nations Development Programme (2011). Human Development Report 2011, Sustainability and Equity: A Better Future for All. New York, NY: United Nations

9 United Nations Department of Economic and Social Affairs. (2012). World Atlas of Gender Equality in Education. New York, NY: United Nations Retrieved from (http://www.uis.unesco.org/Library/Documents/world-atlas-gender-equality-education-2012-en.pdf).

10 Chalasini, R. . Thematic Paper on MDG2: Achieve Universal Primary Education. New York, NY: United Nations Development Group. Retrieved from (http://www.undg.org/docs/11421/MDG2_1954-UNDG-MDG2-LR.pdf).

11 Chalasini, R. Thematic Paper on MDG2: Achieve Universal Primary Education. New York, NY: United Nations Development Group. Retrieved from (http://www.undg.org/docs/11421/MDG2_1954-UNDG-MDG2-LR.pdf).

12 United Nations Development Programme (2011). Human Development Report 2011, Sustainability and Equity: A Better Future for All. New York, NY: United Nations

13 ICPD PoA == paras 6.7(a), 6.7(b), 6.15, 7.45

14 Biddlecom, AE; Hessburg, L; Singh, S; Bankole, A; Darabi, L. (2007). Protecting the Next Generation in Sub-Saharan Africa: Learning from Adolescents to Prevent HIV and Unintended Pregnancy, New York: Guttmacher Institute. Retrieved from (http://www.guttmacher.org/pubs/2007/12/12/PNG_monograph.pdf).

15 Africa Regional Sexuality Resource Centre. www.arsrc.org/index.htm ?

16 Guttmacher Institute. (April 2010). Facts on the Sexual and Reproductive Health Of Adolescent Women in the Developing World. New York, NY. Retrieved from (http://www.guttmacher.org/pubs/FB-Adolescents-SRH.pdf).

17 World Health Organization (WHO). (2008). Adolescent Pregnancy. Making Pregnancy Safer Notes, 1(1). Geneva, Switzerland: WHO. Retrieved from <www.who.int/maternal_child_adolescent/documents/mpsnnotes_2_lr.pdf>.

18 ICPD Programme of Action para 8.25

19 Guttmacher Institute. (2012). Facts on abortion in Africa. New York, NY: Guttmacher Institute and World Health Organisation (WHO). Retrieved from <http://www.guttmacher.org/pubs/IB_AWW-Africa.pdf>.

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

21 Population Reference Bureau (PRB). (2005). Unsafe abortion: facts and figures. Washington, DC. Retrieved from <http://www.prb.org/pdf05/ unsafeabortion.pdf>.

22 Bayer, L; Cheetham, N; Robbins, S. (2011). Youth and Unsafe Abortion. A Global Snapshot. Washington DC, USA: Advocates for Youth.

23 Guttmacher. 2004. Assessing Costs and Benefits Of Sexual and Reproductive Health Interventions. Retrieved from http://www.guttmacher.org/pubs/2004/12/20/or11.pdf

24 United Nations Department of Economic and Social Affairs. (2011). World Abortion Policies 2011. New York, NY: Population Division. Retrieved from (http://www.un.org/esa/population/publications/2011abortion/2011abortionwallchart.html).

25 Joint United Nations Programme on HIV/AIDS (UNAIDS). (2010). Annex 1: HIV & AIDS estimates and data, 2009 and 2001. In Global Report. UNAIDS Global Report on the Global AIDS Epidemic 2010.Geneva, Switzerland: UNAIDS

26 Joint United Nations Programme on HIV/AIDS (UNAIDS). (2010). Annex 1: HIV & AIDS estimates and data, 2009 and 2001. In Global Report. UNAIDS Global Report on the Global AIDS Epidemic 2010.Geneva, Switzerland: UNAIDS

27 World Health Organization. (2011). An update on WHO's work on female genital mutilation (FGM) (Progress report) Retrieved from (http://whqlibdoc.who.int/hq/2011/WHO_RHR_11.18_eng.pdf).

28 World Health Organization. (2011). An update on WHO's work on female genital mutilation (FGM) (Progress report) Retrieved from (http://whqlibdoc.who.int/hq/2011/WHO_RHR_11.18_eng.pdf).

29 World Health Organization. (2011). An update on WHO's work on female genital mutilation (FGM) (Progress report) Retrieved from (http://whqlibdoc.who.int/hq/2011/WHO_RHR_11.18_eng.pdf).

30 Pan-African Conference on Celebrating Courage and Overcoming Harmful Traditional Practices in Africa. (2011). Report on the Pan-African Conference on Celebrating Courage and Overcoming Harmful Traditional Practices, 5-7 October 2011 Retrieved from (http://au.int/en/dp/sa/sites/default/files/English%20Final%20Report%20HTP%20.pdf).

31 Itaborahy, LP (2012). State-sponsored Homophobia: A world survey of laws criminalising same-sex sexual acts between consenting adults. Brussels, Belgium: The International Lesbian, Gay, Bisexual, Trans and Intersex Association. Retrieved from (http://old.ilga.org/Statehomophobia/ILGA_State_Sponsored_Homophobia_2012.pdf).

32 Itaborahy, LP (2012). State-sponsored Homophobia: A world survey of laws criminalising same-sex sexual acts between consenting adults. Brussels, Belgium: The International Lesbian, Gay, Bisexual, Trans and Intersex Association. Retrieved from (http://old.ilga.org/Statehomophobia/ILGA_State_Sponsored_Homophobia_2012.pdf).