YOUTH FACT SHEET

SEXUAL REPRODUCTIVE HEALTH AND RIGHTS FOR ADOLESCENTS IN SUB SAHARAN AFRICA

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There are approximately 157 million young adults ages 15-24 in Sub Saharan Africa. By 2015, this number is expected to increase to 198 million.

As growing numbers of young people enter their reproductive years, they will need significantly expanded reproductive health services. Adolescents in Sub Saharan Africa (SSA) have particular reproductive health vulnerabilities such as high adolescent birth rates , this group contributes to over 50% of the global proportion of births taking place in adolescence and to over 23% of the burden of disease due to pregnancy , child and maternal health, with severe implication for their access to education and livelihood options.

This advocacy brief provides the most recent review on the sexual and reproductive health and rights (SRHR) of adolescents in nine Sub Saharan African countries, namely Angola, Benin, Ethiopia, Rwanda, Kenya, Nigeria, Sierra Leone, Tanzania and Zambia.

A HARSH REALITY: THE CURRENT CONTEXT

Young people ages 15-24 account for an estimated 45 percent of new HIV infections worldwide, with young women disproportionately affected.

In Nigeria, for example, 21% of sexually active young women ages 15-17 had at least one partner 10 years older than they were.

Young pregnant women are at greater risk of death from pregnancy-related causes than adult women.

Female genital mutilation (FGM) threatens the health of 3 million girls each year in Africa.

In Ethiopia, 62% of young women have undergone the procedure.

The adverse consequences of FGM include:
- Complications in childbirth
- Tetanus
- Urinary incontinence
- Maternal death.

1. OUR VISION

It is critical to have safe spaces in communities in Sub Saharan Africa, which ensure adolescents, especially girls, have access to a safe environment that enables them to learn, communicate and foster healthy relationships with their peers. Many girls face the threat of violence and transactional sex due to poverty, traditional settings and cultural norms that limit their mobility and access to reproductive health services. They need economic empowerment to improve their reproductive health outcomes. This would ensure they have access to education, life skills, and income to overcome the unequal power relations which put them at risk of domestic violence and judgemental attitudes that drive them to make unsafe choices. Access to comprehensive sexuality education would also increase their knowledge of their bodies, availability of youth friendly services and ability to protect themselves from sexual abuse and exploitation. Hence access to safe spaces with correct information will enable adolescents to make informed choices on a range of SRH services, including contraception, STI/HIV testing and treatment; antenatal, delivery and postnatal care; and clinical care for sexual assault survivors.

2. ADOLESCENT FERTILITY RATE

Table 1:
Adolescent Fertility Rate

COUNTRY	BIRTH RATE PER 1,000 WOMEN AGES 15-19
Angola	175
Benin	93
Ethiopia	81
Rwanda	35
Kenya	95
Nigeria	120
Sierra Leone	104
Tanzania	124
Zambia	128

The demographic health surveys of the countries in this study indicate that there are countries in Sub Saharan Africa where adolescent fertility rates have declined faster than the average regional rate. These include Benin, Ethiopia, Kenya, Nigeria, Rwanda and Tanzania, however, even in these countries, the rates are high by world standards, with half above 100 births per 1,000 women.

Source: World Bank 2009-2013

The adolescent fertility rate is defined as the number of births per 1,000 women ages 15-19.

Sub Saharan Africa has the world's highest level of adolescent birth rates, which poses serious consequences to the health and development of young girls. The risk of maternal death and disability is higher for adolescents than for women in their 20s. At the same time, early childbearing often limits girls' opportunities for education, training and livelihood opportunities. The demographic health surveys of the countries in this study indicate that there are countries in Sub Saharan Africa where adolescent fertility rates have declined faster than the average regional rate.

3. CONTRACEPTIVE USE AMONG ADOLESCENTS IN SUB SAHARAN AFRICA

According to the 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, a significant percentage, 68%, of sexually active unmarried adolescents have an unmet need for modern contraception. In the nine SSA countries under review, contraceptive use among young unmarried women is higher in comparison to married women of the same age. 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. This is probably due to the widespread HIV intervention programmes where the predominant method of prevention advised is condoms; they do not seem to have access to a range of contraceptive methods. The pattern of limited contraceptive use poses challenges for both married and unmarried young women 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 norms which put emphasis on fertility[1].

Table 2:
Percentage of currently married women and sexually active unmarried women age 15 to 24 who have used any contraceptive method

COUNTRY	AGES 15-19			AGES 20-24		
	Any method	Modern method	Traditional method	Any method	Modern method	Traditional method
Benin (2006)	19.7	11.9	6.1	45.0	24.5	12.0
Ethiopia (2011)	5.3	5.2	0.3	23.3	22.2	1.1
Kenya (2008/9)	14.1	13.2	2.9	57.3	52.2	17.9
Nigeria (2008)	10.5	9.1	4.1	30.2	25.7	17.1
Rwanda (2010)	2.1	1.9	6.0	19.5	16.5	16.6
Tanzania (2010)	10.7	9.4	6.1	29.2	24.0	24.0
Zambia (2007)	21.9	19.9	7.1	67.9	60.9	29.9

Source: The most recent country DHS reports[2]

4. HIV PREVALENCE RATE

Across Sub Saharan Africa, diverse countries have achieved notable reductions in HIV prevalence among young people (15-24 years). In 2009 it was estimated that HIV prevalence among youth in SSA was an estimated 1.4% in males and 3.4% in females[3]. In this region, changes in sexual behaviour patterns among adolescents — such as waiting longer to become sexually active, having fewer multiple partners and increasing condom use — have resulted in reductions in HIV prevalence. For instance, previously high-burden countries such as Ethiopia, Kenya, Tanzania and Zambia achieved a significant decline of more than 25 per cent in HIV prevalence among young people. These declines are essential for curbing the AIDS epidemic in Sub Saharan Africa[4]. While there are efforts to reduce new HIV infections in the region, HIV is still a big problem among some communities in SSA. Girls are two to four times more likely to become infected than boys. Persistent gender discrimination, poverty and inequality place adolescent girls at an especially high risk for contracting HIV. HIV infection rates in teenage girls in some urban areas in Sub Saharan Africa are more than five times higher than those among teenage boys. In addition, HIV prevalence is higher in the 20-24 year-old age group (both male and female) compared to the 15-19 year-old age group, suggesting that more efforts are needed to strengthen HIV prevention for young adults, their partners and their children.

Table 3:
HIV prevalence rate among adolescents ages 15-19 in 2014 (%)

COUNTRY	AGES 15-19		AGES 20-24		YEAR OF DHS
	Male	Female	Male	Female	
Ethiopia	0.1	0.7	0.4	1.7	2011
Kenya	1.7	2.7	1.5	6.4	2009
Nigeria					
Rwanda	0.3	0.8	0.8	2.4	2008
Sierra Leone	0.0	0.8	1.3	1.5	2008
Tanzania					
Zambia	3.6	5.7	5.2	11.8	2007

Source: most recent country DHS reports[5]

5. EARLY, CHILD AND FORCED MARRIAGE

Marriage is a formalised, binding partnership between consenting adults. Child marriage involves either one or both spouses being children and may take place under civil, religious or customary laws with or without formal registration. Under the Convention on the Rights of the Child, marriage under the age of 18 is a violation of rights. Sub Saharan Africa has the second highest rate of child, early and forced marriage. In countries where the legal age of marriage differs by sex, the age for women is always lower. For example in Benin, which has one of the highest child marriage prevalences in the world[6], the legal age of marriage is 18 for males and only 15 for females. The causes of early and forced marriage are complex, interrelated and dependent on individual circumstances and context. This practice is driven by different factors such as gender inequality, poverty, and negative traditional or religious practices. In many countries the importance of preserving family 'honour' and girls' virginity is such that parents push their daughters into marriage well before they are ready. There is a belief that marriage safeguards against 'immoral' or 'inappropriate behaviour'. Failure to enforce laws on conflicts, disasters and emergencies which increase economic pressures on households result in many families that would not previously have considered early marriage to use it as a last resort measure of survival.

Child, early and forced marriage contributes to driving girls into a cycle of poverty and powerlessness. These girls are likely to experience violence, abuse and forced sexual relations, poor sexual and reproductive health, illiteracy and a lack of education.[7]

6. FEMALE GENITAL MUTILATION

Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.

FGM is usually carried out by traditional circumcisers who often play other central roles in communities such as attending childbirths. It is recognised internationally as a violation of the human rights of girls and women. The procedure has no health benefits for girls and women as it can cause severe bleeding and problems urinating, later cysts, infections, infertility as well as complications in childbirth and increased risk of new-born death. FGM is typically carried out on young girls sometime between infancy and age 15.[10] Over 3 million girls under the age of 18 across the African continent are at risk of being cut. Globally, female genital mutilation is recognised as a violation of reproductive health rights, but Africa has been identified as the region where the practice is most prevalent. The United Nations Convention on Rights of the Child (CRC) Article 24: 3 calls upon state parties to take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children. FGM is a traditional practice which is harmful to girls' health but it can additionally be the source of the denial of many other rights prescribed in the CRC, including the right to protection (Article 19), the right to education (Articles 28 and 29) and freedom from sexual abuse (Article 34). FGM is linked with early marriage which can be a sanctioned form of child sexual abuse.[11]

Table 4:
Legal and median marriage for adolescents in Sub Saharan Africa

COUNTRY	LEGAL AGE OF MARRIAGE	MEDIAN AGE OF MARRIAGE FOR WOMEN	
	MALE	FEMALE	
Angola	18	18	
Benin	18	15	18.5 (DHS 2006)
Ethiopia	18	18	16.5 (DHS 2011)
Kenya	18	18	20.1(DHS 2008/09)
Nigeria	18	18	18.3 (DHS 2008)
Rwanda	21	21	21.4 (|DHS 2005)
Sierra Leone	21	21	17.0 (DHS 2008)
Tanzania	18	18	18.8 (DHS 2010)
Zambia	21	21	18.2 (DHS 2007)

Source: UN Data (2013) Legal age of Marriage[8]. Median age of marriage: most recent country DHS[9]

Estimates based on survey data suggest that **in Africa, 91.5 million girls and women aged 10 years and above have been subjected to FGM**. Of these, 12.4 million are between 10 and 14 years of age. In some communities, and in some situations, women are subjected to FGM later in life; including when they are about to be married, or after marriage, during pregnancy and after childbirth, or when their own daughters undergo the procedure. Most women who have experienced FGM live in one of the 28 countries in Africa – nearly half of them in just two countries: Egypt and Ethiopia.[12] 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.

COUNTRIES WHERE FGM HAS BEEN DOCUMENTED		
Benin	Cameroon	Djibouti
Burkina Faso	Chad	Kenya
Eritrea	Ghana	Ethiopia
Gambia	Liberia	Guinea
Guinea Bissau	Niger	Mali
Mauritania	Sierra Leone	Nigeria
Senegal	Uganda	Somalia
Sudan	Central African Republic	Togo

The most common short-term consequences of FGM include:
- severe pain
- shock caused by pain and/or excessive bleeding (hemorrhage)
- difficulty in passing urine and faeces because of swelling
- oedema and pain
- infection
- Death can be caused by hemorrhage or infections, including tetanus & shock.[13]

Women who have undergone FGM have been found to be 1.5 times more likely to:
- experience pain during sexual intercourse
- experience significantly less sexual satisfaction
- have less sexual desire
- Experience complications during childbirth.

7. COMPREHENSIVE SEXUALITY EDUCATION

More and more, adolescent and young people face increasing pressure about sex and sexuality, including conflicting messages and norms due to lack of adequate information, skills and awareness on their rights, especially around sex, sexuality and gender expectations.[14]

Comprehensive Sexuality Education (CSE) programmes work to delay the initiation of sex, reduce the number of sexual partners, and increase the use of condoms and other forms of contraception. Some programmes also seek to increase testing and treatment for HIV and other STIs. They can be implemented both in schools and in other community settings for the out-of-school adolescents.[15]The High Level Taskforce for ICPD recommended in its recent report that all young people should have access to comprehensive sexuality education and related services in order to enable them to exercise their rights, understand their bodies, make informed decisions about their sexuality and better plan their lives.[16] This recommendation encapsulates the reality of youth and underscores the need to heighten the focus on CSE for young people. Access to comprehensive sexuality education, including family planning, is an essential element of youth sexual and reproductive health and rights programming in Africa, as seen in major frameworks such as the Maputo Plan of Action (Maputo PoA) for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights, the African Youth Charter and the ICPD Programme of Action.[17]

"A number of programmatic approaches have been identified as effective avenues towards CSE. Such approaches include programmes implemented in organised settings such as schools, youth organisations, clinics and communities in general. In addition to these are programmes which directly involve young people themselves in programme development and implementation. Some of the approaches which have shown programmatically meaningful results include: curriculum based programmes delivered in school and out of schools and life skills training. These approaches have been found to reach a significant number of young people – with positive outcomes, and are empirically grounded. They can therefore be scaled-up within reasonable timeframes and cost effectively. For example, sexuality education programmes delivered through school curriculum have the potential to reach a large number of young people and have been found in evaluations to have significant effects on young people's behavioural outcomes."[20]

In most African countries, CSE is not part of the school curriculum and there is reluctance or even resistance among adults to openly discuss sexuality with young people, thereby leaving at risk of negative outcomes. As a result, the provision of adequate and comprehensive sexuality education is critical in order to enable young people to make informed decisions regarding their SRHR. Given the current high rates of unintended pregnancies and incidence of STIs, including HIV, among youth owing to lack of knowledge on basic prevention methods, it is imperative to invest in age, gender and culturally appropriate, rights based comprehensive sexuality education that empowers young people to make informed choices, build healthy relationships and acquire necessary life skills.[18] Contrary to beliefs in many African societies, evidence shows that CSE does not contribute to increased rates of sexual activity among young people. Rather, it results in positive outcomes such as assisting young people to better understand their sexual and reproductive rights, preventing HIV/STI infections, contributing to delayed sexual debut, resulting in reduction of number of sexual partners and increasing the use of contraception. In addition, it provides young people with the knowledge and information needed to negotiate safer sex and delay the onset of sexual activity.[19]

8. POVERTY AND REPRODUCTIVE HEALTH FOR ADOLESCENTS

MDG 1 draws attention to the pervasiveness of extreme poverty and the need to eliminate it. In most of the profiled countries, young women and men are poor, living on less than $2 per day, and represent a sizable portion of the unemployed and underemployed. Most employed young people engage in agriculture and face declining arable land and farm sizes. International investment is needed to build the skills and capacity of both young women and young men for productive employment in other sectors within their own countries. Such investment will contribute to the health of individuals, families, communities and national economies, as well as to the stability and security of the region.[21]

Sub Saharan Africa has experienced very high rates of unemployment and poverty among young people aged 15 to 24. Poverty and reproductive health are intricately related. Poverty is associated with high-risk behaviours, such as rape and unsafe sex in exchange for monetary incentives. These behaviours put young women at risk of unintended pregnancy and sexually transmitted infections such as HIV, which in turn affect their reproductive health (USAID, 2009). Poverty and inadequate healthcare systems compound the vulnerability of young women to sickness and early death. Young teen mothers are at high risk of experiencing serious complications during pregnancy and childbirth because their bodies often have not yet fully matured (Bernstein & Hansen, 2006). Poverty increases risky behaviours to HIV such as transactional sex and substance abuse. Fewer opportunities for employment and education prevent empowerment of women. On a broader, national scale, lack of finances can restrict development, educational opportunities, access to health care and employment creating a favourable setting for the spread of HIV. These traditional gender norms place women at increased risk as they have less freedom in choosing their partners, initiating and pacing sexual activity and negotiating on safer sex. In addition, some customs and beliefs also place women at increased risk of HIV, such as wife inheritance and having sex with a virgin as a cure for HIV.[22]

9. AVAILABILITY, ACCESSIBILITY AND AFFORDABILITY OF REPRODUCTIVE HEALTH SERVICES IN SUB SAHARAN AFRICA

The health of women and children in Africa has not seen a significant improvement over the last two decades with regard to sexual and reproductive health (SRH). The adoption by Member States of the Regional Strategy for Sexual and Reproductive Health in 1998 was a landmark in the movement towards health for all on the continent. It introduced a high level of regional and global collaboration not achieved before and became the umbrella for several initiatives addressing thematic areas or promoting innovative and comprehensive approaches to reproductive health care covering maternal and perinatal health, adolescent sexual and reproductive health, unintended pregnancies, control of sexually transmitted infection and HIV/AIDS, prevention of cervical cancer, and reduction of rates of female genital mutilation and domestic and sexual violence.[23]

In Sub Saharan Africa, the health system is built around curative services and it is mostly concentrated in urban areas. **In most countries, less than half of the population, mostly those living in major urban centres, have access to health services.** Even if the assertion of health officials in many countries that family planning is integrated into their primary health system is true, it is still unavailable for the vast majority of the population who live in rural areas. The unmet need for family planning in Africa is still enormous. **It is estimated that almost 30 million married women of reproductive age would like either to stop childbearing or space the birth of their next child, but cannot do so because they have no access to family planning services.** The real unmet need for family planning may be even greater if one includes women who are not married but are sexually active and wish to adopt a family planning method.

Problems facing the availability and accessibility of family planning in Africa include:

- Lack of strong government commitment
- Medical barriers
- Socio-cultural barriers
- Lack of communication between urban centres and rural areas
- Lack of adequate resources

10. CONCLUSIONS

For young women in Sub Saharan Africa to benefit from longer schooling, gain productive experience in the labour market before marriage and childbearing, and develop readiness for parenthood, they need access to contraceptives and reproductive health services that will enable them to protect their health and avoid unintended pregnancies. Meeting the contraceptive needs for married and sexually active unmarried adolescents would help reduce unintended pregnancies (including those that end in unsafe abortion), thereby also reducing maternal deaths and ill health. Contraceptive services should be responsive to the special needs of adolescent women, be provided in a manner that does not stigmatise sexually active adolescents and be offered in a respectful and confidential way. The provision of information to young people needs to be improved and expanded using a variety of methods—including providing CSE to young people in schools and also reaching out to those who are not attending school.[24]

RECOMMENDATIONS

1. Put young people at the centre of the post-2015 development agenda.
2. Scale-up or integrate a skills based, age - appropriate, gender-sensitive and quality comprehensive sexuality education for both in and out of school youth, and mobilise support among community gatekeepers, i.e. parents, religious and traditional leaders.
3. Increase access to comprehensive and youth friendly health information and services for young people including marginalised and most at risk groups such as Persons with Disabilities, people in rural areas and the urban poor through a rights based approach regardless of sex, age, HIV status or sexual orientation.
4. Governments should revise policies and laws that criminalise safe abortion services and implement programmes that ensure young women's access to safe and comprehensive abortion care.
5. Ensure young people's universal access to high quality comprehensive SRH services through the provision of modern family planning methods, including condoms and emergency contraceptives, maternal health services and cervical and breast cancer screening.
6. Formulate, review and adapt laws and policies that accelerate the implementation of SRH services for all young people in line with the Maputo Plan of Action and the African Youth Charter.
7. Remove all legal barriers that hinder young people's universal access to comprehensive SRH information and services, such as parental and spousal consent.
8. Recognise that young people have autonomy over their own bodies, pleasures, and desires. Cultural and religious barriers such as harmful traditional practices must be eliminated.
9. Governments needs to promote gender equality and empowerment of young women and girls in aspects recognising their vulnerability, eliminate discrimination against them and also recognise the role of young men and boys in ensuring gender equality.

11. CASE STUDIES

EARLY, CHILD AND FORCED MARRIAGE: The Case Of Mereso Kiluso, A Masaai Girl from Tanzania

In traditional Maasai communities like mine, marrying off girls is very common. I was married at 13 to a man in his 70s. I gave birth to my first child within a year. I had no professional prenatal care and no trained medical assistance during delivery. I had to depend on my husband and his other wives for guidance. It was a very painful experience and this happened every time I got pregnant. Because of all these difficult births I have a hard time controlling my bladder and it is sometime painful to urinate. Today, I am a mother of five at 29 years old. In communities like mine, age is not understood as a number. Our traditional values dictate girls are meant for marriage, and when the men decide we are biologically ready, we are married.

In my community marriage is a way of earning money as my family had been paid a price for me, I was not welcome home. It wasn't until six years ago that I was able to take charge of my own destiny. I ran away to the city of Arusha where I attended counseling and workshops. This helped me gain confidence and I learned to support myself. I returned to my village and found a neighbour who quietly supports girls that are survivors of forced marriages. He was inspired to know there was a safe space at the YWCA where girls could go to seek shelter. My community now understands that girls have value beyond marriage and that we can earn money and contribute more to our communities when we stay in school.

My brother used to think I was wrong to leave my husband. But seeing how well I am doing selling traditional Maasai jewelry and clothing he is starting to respect my choice. Thankfully, I have supporters in my community who help give me other options to grow food for my children. I believe my relationship with my brother will get better with time. I am still working on it. My

mother is very proud. She used to fear my disobedience to my husband would reflect poorly on her and she would be cast out of the community. But now she sees I am welcome and respected and she is so happy to have me back in her life. In the fight against child marriage, the biggest battle is finding those who are ready for change and giving them the courage to speak to others.

FEMALE GENITAL MUTILATION
The Case of Kezia Bianca, A Survivor of FGM from Kenya

My name is Kezia Bianca and I am 23 years old. I come from Kisii which is a place renowned for practicing female genital mutilation and as a girl who grew up here, I was not an exception. I cannot blame my family for making me go through this inhuman act as society dictates it. In my culture it was considered unclean for a girl not to go through the practice. I am a survivor of a clitoridectomy. My community practices FGM type one which is partial or total removal of the clitoris, because they believe that the clitoris is unclean as it makes one sexually active.

I remember the day that it happened as if it was yesterday. The scar still remains fresh in me. I really did not want to go through FGM, but because in my village all the girls of my age set had gone through it, I did not have any option but to follow the community traditions – the community dictates, not you. It was at 5am the morning of the 7th December 1997 when one woman came and told me that it was my day to become a woman. Even though my mum was nowhere to be seen at that time, all I wanted was for her to see the pain in my eyes and tell them to let me go.

Together with me in that group that day was my friend. They sang songs while taking us behind our house where we were made to sit on a very cold stone. They took a piece of cloth, tied it around my eyes and held my head back and then they gave me another piece which they put in my mouth so that I could bite during the whole process to ease the pain. Two women held my legs and hands so tight that I could not move. I could still hear songs which were sang to diffuse the cries. Then I felt a very sharp pain between my legs. This was a turning point in my life. The pain I felt cannot be described; thinking of it brings cold shivers inside me. I was circumcised, I felt incomplete and completely out of control. I could not control the tears from my eyes as they spoke the magnitude of the pain that I was feeling. After that I was taken in a house where I sat in a room crying and cursed. The pain I was going through was unbearable. At the back of my mind so many questions were going through my head: what will happen after this? Will this pain ever leave my life? Will I be able to walk again in my life? I was made to stay in that room for three weeks and was not allowed to shower for the entire three weeks. It was also not good for me to be seen as they believed that I would heal faster if nobody saw me, especially a man, except the special woman who was taking care of us. My life took a complete turn, I felt wasted and hopeless

Because of the pain and agony I went through, it made me take the resolution to stand up and fight for the rights of the girl child. I believe that if by the time I underwent FGM, I had known its dangers I would not have gone through with it. That is why I resolved to join the YWCA of Kenya and advocate for the rights of girls and young women and give them a future without regrets, a future where they can stand up for their rights and the rights of others, a future where they can say "No" and be heard by society.

NOTES

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END NOTES

1. http://www.worldywca.org/YWCA-News/World-YWCA-and-Member-Associations-News/Reclaiming-and-redefining-rights-setting-the-adolescent-and-young-people-SRHR-agenda-beyond-ICPD-20
2. http://dhsprogram.com/Who-We-Are/About-Us.cfm
3. http://www.ncbi.nlm.nih.gov/pubmed/22098766
4. http://www.prb.org/pdf12/status-report-youth-subsaharan-Africa.pdf
5. http://dhsprogram.com/Who-We-Are/About-Us.cfm
6. http://www.devinfo.info/mdg5b/profiles/files/profiles/4/Child_Marriage_Country_Profile_AFRBEN_Benin.pdf
7. http://www.plan-uk.org/early-and-forced-marriage/
8. http://data.un.org/DocumentData.aspx?q=legal+age+of+marriage&id=336
9. http://dhsprogram.com/Who-We-Are/About-Us.cfm
10. http://www.who.int/mediacentre/factsheets/fs241/en/
11. http://www.ohchr.org/Documents/HRBodies/CEDAW/HarmfulPractices/WorldVisionInternational.pdf
12. http://whqlibdoc.who.int/hq/2011/who_rhr_11.18_eng.pdf
13. http://whqlibdoc.who.int/hq/2011/who_rhr_11.18_eng.pdf
14. http://www.ippfar.org/comprehensive-sexuality-education
15. http://www.aidstar-one.com/
16. http://www.icpdtaskforce.org/beyond-2014/policy-recommendations.html
17. www.au.intwww.africa-youth.org
18. UNESCO 2013: Young People Today: Time to Act Now. Why adolescents and young people need comprehensive sexuality education and sexual and reproductive health services in Eastern and Southern Africa
19. www.au.intwww.africa-youth.org
20. www.au.intwww.africa-youth.org
21. http://www.prb.org/pdf10/youthchartbook.pdf
22. http://www.idpublications.com/journals/pdfs/inhe/inhe_editorschoice_1.pdf
23. Accelerating++access+to+sexual+reproductive+health+in+Africa
24. http://www.guttmacher.org/pubs/FB-Adolescents-SRH.pdf

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