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Actions in follow-up to the recommendations of the International Conference on Population and Development

Monitoring of population programmes, focusing on adolescents and youth

Report of the Secretary-General

Summary

Responding to decision 2010/101 of the Commission on Population and Development (E/CN.9/2010/9), adopting "Adolescents and youth" as the theme for its forty-fifth session, the report provides an overview of development issues related to young people's sexual and reproductive health, with particular emphasis on the needs of girls and young women.

It reviews actions by Governments, NGOs and the United Nations Population Fund and its partners that create a supportive environment for young people as they make the transition to adulthood; invest in young people; promote their rights and gender equality; provide access to sexual and reproductive health information and services; encourage their education and social integration; ensure protective measures and safe spaces for the most vulnerable among them, including those in humanitarian situations, and support an enabling policy and legal framework for young people's participation in policymaking.

It concludes by drawing attention to further actions required to promote and secure young people's sexual and reproductive health and reproductive rights as a development priority to meet internationally-agreed goals, and contribute to countries' broad development aims.

[1] E/CN.9/2012/2.

Contents

I. Introduction

1. The present report on adolescents and youth has been prepared in response to the decision 2010/101 of the Commission on Population and Development (E/CN.9/2010/9), in which the Commission decided to adopt "Adolescents and Youth" as the special theme for its forty-fifth session.[2]

2. There are over 1.8 billion young people aged 10 to 24 today, the largest generation of young people in history. Close to 90 per cent of all young people live in developing countries where they tend to make up a large proportion of the population. In Uganda, Zimbabwe and Swaziland, the proportion is more than 50 per cent, and in 67 other developing countries, they comprise more than 40 per cent of the population aged 10 and over.

3. In recent years, countries have made considerable progress in the formulation of national youth policies with the guidance of the World Programme for Action on Youth. Yet many elements of these policies do not have budgets attached to them and do not result in the mainstreaming of young people's issues in national policy agendas.

4. Some regions, including Central and Eastern Europe and Central Asia, have ensured near-universal primary and secondary education. Elsewhere, especially in sub-Saharan Africa and South Asia, secondary education still remains out of reach for most young people, especially girls. Countries that have managed to expand access to primary education now face greater demand for secondary education; ensuring equitable access and quality education remains a challenge.[3]

5. Youth employment remains a challenge. The formal sector offers too few openings and most young people living in poverty lack education and skills to take advantage of the opportunities that exist. By the end of 2010, there were about 75.1 million young unemployed people.[4] Around 152 million employed youth still live in extreme poverty, doing low-paid and unsafe work.

6. Young people as much as all people share the human right to health, including sexual and reproductive health: but there are also compelling policy reasons for investing in young people's health and development.[5] Nearly two-thirds of premature deaths and a third of the total disease burden in adults are associated with conditions or behaviours that began in youth.[6]

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[2] UNFPA uses the following terms: adolescents: 10-19 year olds (early adolescence 10-14; late adolescence 15-19); youth: 15-24 year olds; young people: 10-24 year olds. Adolescence and youth is a period of transition to adulthood, but young people are highly diversified by age, sex, marital status, schooling level, residence, and socio-economic status, among other considerations.

[3] For detailed discussion see: UNESCO. 2011. *Global Education Digest 2011: Comparing Education Statistics Across the World.*

[4] Global Employment Trends for Youth: 2011 Update, International Labour Organization

[5] WHO, Geneva, 2010. *Child and Adolescent Health and Development: Progress Report 2009.*

[6] World Bank, 2008. *World Development Report 2007.*

7. The first study of global patterns of mortality in young people found that 2.6 million young people aged 10-24 die every year, 97 per cent in low- and middle-income countries. Complications during pregnancy and childbirth, gender-based violence and AIDS are among the leading causes of mortality for young people.[7] Maternal mortality and morbidity accounts for 16 per cent of all disability-adjusted life years (DALYs), the sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability, among women aged 15–29 in developing countries.[8]

8. Between 2000 and 2009, 31 per cent of young women aged 20-24 in least developed countries gave birth before age 18.[9] In low- and middle-income countries, complications from pregnancy continue to be the leading cause of mortality among adolescent girls aged 15-19. Most adolescent girls, whether married or unmarried give birth with insufficient information, health care or support. Among the main risks faced by the youngest mothers are prolonged labour, fistula, post-partum infection, being infected by HIV and mother-to-child transmission.

9. Adolescent girls and young women face high levels of morbidity and mortality as a result of unsafe abortion. In 2008, there were an estimated three million unsafe abortions in developing countries among girls aged 15-19.[10] Because many adolescent pregnancies are unintended, rates of unsafe abortion among young women are high, especially in sub-Saharan Africa where girls aged 15-19 account for one in every four unsafe abortions.[11]

10. Unmet need for modern contraception remains at historically high levels especially in developing countries. Demand will continue to rise because today's young people are entering their reproductive years and many will wish to have smaller families than their parents.

11. Limited access to information, quality and affordable adolescent and youth sexual and reproductive health services is one of the main factors contributing to the high unmet need for contraceptives. An in-depth study of four sub-Saharan African countries found that 60 per cent or more of adolescent men and women did not know how to prevent pregnancy; one-third or more did not know of a source for contraceptives.[12]

12. Young people aged 15-24 account for 41 per cent of all new HIV infections in the 15-49 age group, which means 3000 young people are still newly infected with HIV every day.[13] Young women are more vulnerable than young men: in Kenya for example women 15-24 are four times more likely to have HIV than males of the same age.[14] Only 34 per cent of youth (24 per cent of

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[7] Patton, George C et. Al., *The Lancet*, Volume 374, Issue 9693, Pages 881 - 892, 12 September 2009. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2809%2960741-8/fulltext.

[8] Lule E et al. (2006) Adolescent health programs, in: Jamison D.T. et al., eds., *Disease Control Priorities in Developing Countries*, New York: Oxford University Press; and Washington, DC: World Bank.

[9] UNICEF. 2011. "Adolescence: An Age of Opportunity". State of the World's Children Report.

[10] World Health Organization. 2011, *WHO guidelines on preventing early pregnancy and poor reproductive health outcomes among adolescents in developing countries.*

[11] World Health Organization, 2009. *Women and Health: Today's Evidence Tomorrow's Agenda.*

[12] AGI, 2010. *Facts on the Sexual and Reproductive Health of Adolescent Women in the Developing World.*

[13] UNAIDS, Geneva. Report on the Global AIDS Epidemic 2010

[14] UNGASS (2010) Country progress report - Kenya

young women and 36 per cent of young men for low and middle income countries) can answer correctly the five basic questions about HIV and how to prevent it.[15]

13. Child marriage is a human rights issue in itself, which often entails the denial of many other human rights, including education and health.[16] Most countries have a legally-established minimum age of marriage, but the enforcement of laws varies and traditional practice often prevails. Child marriage is still widespread, especially in least developed countries, where 30 per cent of women aged 15-19 are married or in union.[17] If present patterns continue, in the next decade around 100 million girls will be married as children.[18]

14. Across all economic strata and across the world, adolescent girls and young women live under the threat of sexual violence and abuse, including from an intimate partner. Up to 50 per cent of sexual assaults are committed against girls under age 16. It is estimated that one in two adolescent girls in the Caribbean are forced into sexual initiation. Central American women also suffer high rates of violence. Studies in sub-Saharan Africa found that partner's violence and the fear of abuse stopped girls from saying "no" to sex and jeopardized condom use.[19]In sub-Saharan Africa, young women make up 71 per cent of young people living with HIV.

15. Female genital mutilation/cutting (FGM/C) is still widespread. Between 100 and 140 million women and girls have experienced FGM/C in Africa.[20] Although the proportion of women undergoing FGM/C is decreasing significantly in Burkina Faso, Egypt, Eritrea, Kenya, Nigeria and Senegal, over 3 million girls worldwide remain at risk of the procedure every year.

16. It is estimated that one in every five adolescents experiences a mental health or behavioural problem each year. Gender-based violence increases three- to fourfold the risk of depression and anxiety in adolescents, especially those in emergency settings. Mental health problems often lead to risky behaviours, including unsafe sex, substance abuse and failure to seek care.[21] In low- and middle-income countries, access to mental health services in generally limited: services that address adolescents' needs are especially inadequate.

17. Overall, young people continue to face poverty, unemployment and underemployment, inadequate education, poor health outcomes and violence. Poor, rural and girls especially are vulnerable to unwanted sexual contact and gender-based violence, including child- and forced marriage. They lack access to sexual and reproductive health services to avoid unintended

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15 UNAIDS (2011). *AIDS at 30: Nations at the Crossroads*.

16 Using the Convention on the Rights of the Child as a framework, these rights include the right to life, health, education, participation, protection from harmful practices, and freedom from abuse and exploitation. It is a violation of Article 16(2) of the Universal Declaration of Human Rights, which provides: "Marriage shall be entered into only with the free and full consent of the intending spouses."

17UNICEF. 2011. "Adolescence: An Age of Opportunity". State of the World's Children Report.

18International Center for Research on Women. http://www.icrw.org/child-marriage-facts-and-figures. Accessed 26 January 2012

19 Population Reference Bureau. 16 March 2009. *Family Planning Saves Lives.*

20 World Health Organization estimates 2011.

21 UNICEF, WHO, and GWU. April 2011. Round Table on Adolescent Mental Health: Bridging the Mental Health Gap and Reaching the World's Adolescents.

pregnancies, unsafe abortions and sexually transmitted infections (STIs), including HIV. Unmet need for contraception remains high, and demand is rising. The ICPD Programme of Action and Key Actions for further implementation is still an unfinished agenda for young people in most regions of the world.

II. Policies, Programmes and Participation

18. The sheer size of today's young generation will cause significant population growth in the coming decades, even if each young woman has only two children. However, falling fertility and smaller families will ease the burden of health care and education costs, and release resources for investment. Many countries in Asia and Latin America have already reaped this demographic dividend. Ensuring that this opportunity becomes available in those countries that have not yet done so, notably in South Asia and sub-Saharan Africa, requires appropriate policies and urgent investment in young people. Failure to respond will entrench poverty for generations.

19. As experience shows and research indicates, successful policies are based on enabling young people to make choices and take the lead in encouraging others to do the same.[22]Such a policy framework reflects universal human rights and young people's right to a fair share of national investment. It includes a legal and social environment that respects and encourages young people's evolving capacities for decision-making, removes barriers to gender equality, enables later marriage and combats gender-based violence. Policies investing in developing the human capital of young people should be complemented by integrated strategies for growth and job creation, developing specific interventions to reach disadvantaged youth.

20. Policy frameworks should reflect the understanding that poverty, education, sexual and reproductive health and gender equality are linked in complex ways and across generations. For example, poverty is one of the main causes of unequal access to education, creating a compound disadvantage for girls of secondary-school age. Among the poorest household quintile, only 63 per cent of girls attend lower secondary school, compared to 90 per cent of boys from the richest household quintile.[23] Her lack of education combined with her already low economic status reduces her autonomy and self-esteem, so she is at enhanced risk for sexual exploitation, STIs, including HIV, unintended pregnancy and gender-based violence. She is likely to remain poor and powerless, and pass on her disadvantages to her children.

21. Attention to young people's rights and needs has been growing, but has not always translated into effective investments. In 2010, a review of national poverty reduction strategies showed that three out of four poverty reduction strategies did not identify young people as a major group experiencing poverty despite evidence to the contrary.[24] Further, only 33 per cent of them consulted young people during the process of preparing poverty reduction strategies.

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[22] Bruce, J. and John Bongaarts (2009). *The New Population Challenge.* From Laurie Mazur (ed.), *A Pivotal Moment: Population, Justice, and the Environmental Challenge*. Washington, DC: Island Press.
[23] UNESCO. 2011. *Global Education Digest 2011: Comparing Education Statistics Across the World.*
[24] UNFPA (2010). *The Case for Investing in Young People.*

22. There are good practices that illustrate meaningful youth participation. Throughout the International Year of Youth 2010-11, young people mobilized in over 30 countries to put young people's rights at the heart of development. In Latin America, young people are leading efforts to promote the implementation of the *Carta de Bahia*, an important outcome for the region from the International Year of Youth. In Africa, youth-led organizations have continued to mobilize to promote the ratification of the African Youth Charter and the implementation of the Maputo Plan of Action. In Belize, young people host a radio show designed to address issues facing youth in the country with support from the United Nations country programme. In Honduras, the United Nations Inter-Agency Programme has supported a policy roadmap for children and youth called *Ruta Social para un Buen Gobierno.*

23. In Viet Nam, the 2009 population and housing census helped identify marginalized youth groups, which are now the focus of the United Nations country programme and national policy. Youth-led participatory research has incorporated young people's perspectives in data collection and analysis, for example in Zambia and Afghanistan's Bamyan Province. Myanmar addressed young people's lack of capacity by developing youth leadership training on health and development. In Nicaragua, PLAN International created a diploma course on sexual and reproductive health and governance.

24. Effective laws are essential in creating a supportive environment. For example, in 2010, 102 countries reporting on UNGASS indicators had non-discrimination laws and regulations protecting young people. However, this is insufficient by itself to ensure access. In practice young people, particularly young women, find frequently that requirements of parental or spousal permission, disapproval from the family or the community, and negative attitudes among service providers curtail their access to sexual and reproductive health services.

III. Gender Equality and Investing in Adolescent Girls

25. The ICPD Programme of Action and Key Actions for Further Implementation highlighted greater equality for the girl child as a right in itself as well as a necessary first step for women to realize their full potential and become equal partners in development. Investing in girls benefits not only the girls themselves, but also their families, communities, and countries over many generations. Educated and healthy adolescent girls equipped with life skills will stay in school longer, marry later, delay childbearing, have healthier children, and earn higher incomes.[25] Investing in their rights and empowerment will help to accelerate the achievement of internationally-agreed development goals, including the Millennium Development Goals (MDGs).

26. The United Nations Adolescent Girls Task Force, co-chaired by UNFPA and UNICEF, and including ILO, UNESCO, UNHCR, UN Women and WHO, now joined by more than 20 countries, provides a platform for collective action. Through the task force, the UN system is promoting a comprehensive evidence-based model that gets girls into school and helps them stay there; guarantees their access to health information and services, including sexual and

[25] Ibid.

reproductive health, and gives them control over their life decisions while ensuring successful transition into adulthood. Particular attention is given to reaching the most marginalized girls.

27. This model was successfully put into practice by UNFPA, the Population Council and its partners in the *Berhane Hewan* programme in Ethiopia.[26] The programme aims to delay marriage and increase school attendance, while promoting functional literacy and life skills, and providing social support, including mentoring, and reproductive health information for married and unmarried girls.[27] A similar approach supported by UNFPA and the Population Council, *Abriendo Opportunidades* in Guatemala is helping to create a cadre of young women advocating for their rights in rural Mayan communities. The programme uses a mapping exercise which reflects girls' own perspectives on health and safety, and encourages them to share their ideas about ways to improve health services. Sharing the maps with the community builds local buy-in for girls' programmes.

28. Delaying the age of marriage not only protects girls' rights, but can, under certain circumstances, help offset population momentum and slow down the pace of population growth.[28] Effective interventions include keeping girls in school; providing them with livelihood education; identifying socio-economic alternatives; addressing cultural norms and working with parents; and advocating for policy change, including the enforcement of child marriage laws.[29] In Pakistan, research on vulnerable girls led by UNFPA will be the first step in a joint initiative to help girls affected by harmful practices; it will also ascertain whether these girls can find programmes to help them. In Malawi, UNFPA's work with youth councils on the legal age of marriage has evolved into a UN joint programme that reaches out to girls at risk of child marriage.

29. UNFPA and UNICEF work together in supporting communities to put an end to FGM/C. Through partnerships with governments, NGOs, religious leaders and community groups, in four years, more than 8,000 communities in Ethiopia, Egypt, Kenya, Mali, Mauritania, Senegal, Burkina Faso, the Gambia, Guinea, Guinea Bissau, Djibouti, Eritrea and Somalia have abandoned the practice. These countries are able to change the social norms and cultural practices, and communities are uniting to protect the rights of girls.

30. The UN in Egypt will support a comprehensive model emphasizing marginalized adolescent girls' active citizenship and participation in their communities. *Ishraq* is a programme in Upper Egypt, now being scaled up, to improve the health, social and education opportunities of out-of-school girls. *Ishraq* trained teachers, engaged parents, worked with NGOs and community leaders, and established institutional ties with formal schooling systems.

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[26] Temin, Miriam and Levine, Ruth , 2009. *Start With a Girl: A New Agenda for Global Health*. Washington, DC: Center Centre for Global Development.
[27] Ibid.
[28] Bruce and Bongaarts, op. cit.
[29] Temin and Levine, op. cit.

31. Programmes in Rwanda focus on the empowerment of adolescent girls through sexuality education, particularly prevention of HIV infection and unwanted pregnancies. Many schools are providing girls-only toilets and sanitary supplies and designating rooms in boarding schools just for girls. Recently, a national HPV vaccination programme reached 97 per cent of adolescent girls.

32. In Liberia, UNFPA led an assessment of the reach of youth-centred programmes, which became a benchmark for holistic multi-sectoral programming for young people. UNFPA also supported a focused mentorship programme for younger adolescents. Sexual violence against girls is a grave violation of human rights with severe health and social consequences.

33. Approximately 150 million girls under the age of 18 are estimated to have experienced some form of sexual violence.[30] Together-for-Girls, a public-private partnership which involves five United Nations agencies, aims to eliminate sexual violence against children, with a focus on girls. It supports evidence-based prevention programmes and services for survivors of sexual violence in Kenya, Swaziland, Tanzania, and Zimbabwe. Most recently, in Tanzania, a national survey on violence against children spurred government commitment to develop a national action plan to reduce violence against children and support survivors.

IV. Sexual and Reproductive Health and Reproductive Rights

34. The ICPD Programme of Action 1994 and the Key Actions for Further Implementation 1999 clearly state the right of adolescents to the highest attainable standards of health, including sexual and reproductive health. This includes providing "appropriate, specific, user-friendly and accessible services to address effectively their reproductive and sexual health needs."

35. The Committee on the Rights of the Child and the Committee on the Elimination of Discrimination against Women have recognized adolescents' right to contraceptive information and services.[31] However, barriers remain, and lead to increased risk of HIV and other STIs and high rates of unintended pregnancy and abortion.

36. The Convention on the Rights of the Child recognizes the "evolving capacities" of adolescents to make decisions in matters affecting their lives; but many states still require parental consent for adolescents to access contraceptive information and services, which can deter adolescents from seeking them. Even where parental consent is not required, stigma around adolescent sexuality may deter adolescents or may result in denial of service. Cost can be a significant obstacle for adolescents.

37. While the importance of a comprehensive and integrated package of adolescent sexual and reproductive health information and services is widely recognized, there is enormous variety in what countries are supporting. There are many examples of national or smaller-scale action by

[30] Together-for-Girls website. http://www.togetherforgirls.org/#/home/3 accessed 27 January 2012

[31] For full citations, see: UNFPA and Center for Reproductive Rights, 2010. *Briefing Paper: The Right to Contraceptive Information and Services for Women and Adolescents.*

governments and NGOs to encourage safer sexual and reproductive health behaviours and a positive community and policy environment. Some of these programmes work through the health system, others outside it; the most effective are led by the health sector with complementary actions in education, protection, and employment. Historically sexual and reproductive health programmes tend to be separate from HIV and AIDS prevention and treatment, and adolescent sexual and reproductive health services may be separate from other services for young people, although there is an encouraging trend towards integrated services.

38. There are good examples of programmes that deliver integrated health services, including sexual and reproductive health services, which are focused on young people's unique needs and expectations. They typically feature extended hours of service, confidentiality and privacy, personnel trained to work effectively with adolescents, and reduced costs. An example is Mozambique's *Geração Biz* which reaches more than four million young people in schools and community centres, using seven thousand peer educators and health providers trained on youth-friendly services. *Geração Biz* is managed in rotation by the Ministries of Education, Health, and Youth, ensuring a cross-sectoral approach.

39. South Africa's National Adolescent-Friendly Clinic Initiative (NAFCI) aims to make health services more accessible and acceptable to young people, establish national standards and criteria for adolescent health care in accredited clinics throughout the country, and develop the capacity of health care workers to deliver quality services.[32] In Zambia, the Ministry of Health and its partners are building the capacity of community-based groups to provide integrated reproductive health information and services for young people, especially young rural girls.

40. In Mongolia, adolescent health centres provide reproductive health information, education and services while increasing adolescents' capacity to make decisions for their own well-being and health. Operated by district health alliances and provincial health departments, the service package integrates prevention and management of reproductive tract infections and STIs. Access is encouraged by messages in the media and through sexuality education in schools.

41. In India, the Ministry of Family Health and Welfare with its partners is implementing a core adolescent sexual and reproductive health (ASRH) package for both married and unmarried adolescents at all levels of the national health system. One strategy is to set up special stalls during village fairs to reach both adolescents and the larger community of adults who interact with them.

42. Egypt has established an integrated national programme to educate adolescents about reproductive health and offer them guidance about services. Another component raises community awareness, breaking cultural and social barriers and encouraging adolescents to speak out about sensitive issues.

[32] WHO (2009). *Evolution of the National Adolescent-Friendly Health Clinic Initiative in South Africa*. http://whqlibdoc.who.int/publications/2009/9789241598361_eng.pdf

43. In Bolivia the *Mamas Jovenes* project held group peer support sessions at health-care centres for pregnant adolescents and their families. The centres provided a safe and private location for prenatal and postnatal check-ups and family planning.[33]

44. The *Plan Andino de Prevencion del Embarazo Adolescente* (PLANEA) is an initiative of the six Andean countries, combining the work of health and education ministries to prevent adolescent pregnancy. Colombia, for example, is building health workers' capacity to work with adolescents, and promoting social mobilization and communications in support of young people's access. The 2011 Medellin Declaration places efforts to reduce adolescent pregnancy at the heart of the fight against intergenerational poverty.

45. In Georgia, UNFPA pioneered a model that engages the private sector to deliver services. Youth-friendly centres throughout the country provide services free of charge.

46. In the Russian Federation, the Ministry of Health and Social Development and UNICEF have developed an easily accessible range of age-appropriate health, social, psychological and information services. To date, 117 facilities have been established in 28 regions, serving approximately 1.5 million young people.[34] To ensure scaling-up, a training centre was established for health and social service providers.

47. Part of Moldova's strategy to promote and safeguard the health of young people has been to establish youth-friendly health centres. The Ministry of Health is now working on scaling-up youth-friendly services and integrating them in the national health system.

48. A strategy known as demand-side financing provides vouchers directly to girls who need services, overcoming household barriers.[35] In Nicaragua girls were able to use vouchers for reproductive health care at the clinic of their choice. In Zambia, health workers made vouchers available for emergency contraception.[36]

49. Gaps in laws and regulations, poor application in practice, and inadequate enforcement prevent many adolescents from reaching SRH information and services. WHO's tool for conducting rights-based national SRH law and policy assessments includes a module on barriers to adolescents' access; Sri Lanka and Tajikistan have carried out adolescent sexual and reproductive health assessments, to be followed by legislative reform.

50. A growing number of countries have established service quality standards. WHO has supported countries to define, standardize and improve the quality of health service provision to adolescents, and to expand the coverage of health services, for example in Tanzania, where the Ministry of Health and Social Welfare has made good progress in standardizing and

33 Save the Children (2011) *Adolescent Reproductive and Sexual Health Update*. Washington DC.
34 WHO (2010). *Youth-friendly Health Policies and Service in the European Region: Sharing Experiences.*
35 Temin and Levine, op.cit.
36 Skibiak, John (2001). *Testing Alternative Channels for Providing Emergency Contraception to Young Women*. Washington DC: Population Council.

institutionalizing adolescent-friendly services at national level. The focus is now on supporting health management teams and facility managers at regional, council and local levels.

51. Addressing girls' sexual and reproductive health calls for action outside the health system to change social norms; create empowering community resources for girls, and increase the health-related benefits of schooling and other investments. Communications media strongly influence young people's knowledge, attitudes, and behaviours, and can be a channel for sexuality education. The TV drama *Soul City* is credited with a shift in attitudes and norms in South Africa about intimate partner violence and domestic relations.[37] Providing safe spaces permits girls to socialize with peers; learn how to protect their health and manage their money, and develop relationships with mentors and role models in their community. Using these tools they can begin to exert some control and autonomy over their lives.[38] For example, the *Biruh Tesfa* programme in Ethiopia provides safe spaces for girls who have migrated to urban areas and are at risk of coerced sex and exploitative labour. Over 35,000 girls have participated in *Biruh Tesfa* groups in the poorest areas of 17 cities.[39]

52. In Nepal, a new project provides safe spaces for workshops, discussion forums, and role-playing to engage girls and their parents. The programme works with community leaders, teachers, and peers and supports local health facilities to provide adolescent-friendly services.[40]

V. HIV and Young People

53. In 2001, member states at the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS unanimously adopted the Declaration of Commitment on HIV/AIDS. This commitment was renewed five years later with the Political Declaration on HIV/AIDS.[41] Member States agreed to further their commitment to addressing the rising rate of new HIV infections among young people and to implement comprehensive, evidence-informed prevention programmes that promote responsible sexual behaviour, including the use of condoms; evidence-informed and skills-based HIV education through mass media, schools and other settings; and the provision of youth-friendly sexual and reproductive health services, including HIV services.

54. The trajectory of the disease worldwide has been bending downwards among young people. The UNAIDS 2011 World AIDS Day Report indicated a decline in HIV prevalence among young people in at least 21 of 24 countries with national HIV prevalence of 1 per cent or higher. These declines in new infections in young people are being spurred by changes in sexual behaviour (waiting longer to become sexually active, choosing to have fewer partners, and using condoms) and increased access to treatment.

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37 Speizer et al. (2003). The effectiveness of adolescent reproductive health interventions in developing countries: A review of the evidence. *Journal of Adolescent Health* 33:324-48.
38 Ibid.
39 http://www.popcouncil.org/projects/41_BiruhTesfaSafeSpaces.asp
40 Save the Children (2011). *Adolescent Reproductive and Sexual Health Update*. Washington DC.
41 Resolution 60/262. Political Declaration on HIV/AIDS. United Nations General Assembly Sixtieth Session. New York, United Nations, 2006.

55. In the recent 2011 Political Declaration on HIV/AIDS[42], United Nations member states recommitted to working towards reducing sexual transmission of HIV by 50 per cent by 2015 including among young people. Three bold results have been agreed upon in order to move towards achieving the overall goal, namely: At least 80 per cent of young people in and out of school will have comprehensive knowledge of HIV; and doubling of young people's use of condoms, as well as of HIV testing and counselling services.

56. A recently published report of national AIDS spending[43] found that three categories of spending focused on young people–in school, out of school and orphans and other vulnerable children. Strategies for young people are included in national multisectoral strategies to respond to HIV in 151 of 172 countries. However, few country progress reports provide detailed information on HIV among young people and the programmes that engage them. Of 90 plans reviewed by UNAIDS, 73 mentioned programmes and activities for young people, but only 34 provided specifics.

57. A study of HIV-positive young people receiving anti-retroviral therapy (ART) in Uganda and Kenya found that most were sexually active, yet contraceptive use was low and there were high rates of unintended pregnancies. Even among young pregnant women receiving ART, the use of some maternal health services, including prevention of mother-to-child transmission, was low.[44]

58. Many young people have limited or no access to HIV prevention programmes. Legal restrictions, the structure of services, community resistance and local customs present considerable barriers. In the most severely affected countries, very few young people have accessed HIV testing and counselling services. All countries, with the exception of Namibia, report that less than 20 per cent of young people have been tested and counselled in the last year.

59. An estimated 10 billion male condoms are needed every year to cover all risky sex acts. Yet, in 2010, only nine male condoms were available for every adult male of reproductive age in Sub-Saharan Africa. One female condom was distributed for every 50 women worldwide or one female condom for every 13 women of reproductive age in Sub-Saharan Africa. Low- and middle-income countries rely heavily on the donor community, mainly UNFPA and USAID, which provided 3.2 billion male condoms in 2007 to developing countries but only 2.8 billion in 2010.[45]

60. Prevention efforts in Zimbabwe have expanded since 2000, though under-funded in comparison to other countries in the region. Extensive education among young people resulted in

[42] 2011, Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS A/65/277
[43]UNAIDS (2011), Securing the Future Today: Synthesis of Strategic Information on HIV and Young People
[44]Birungi H., Mugisha JF., Nyombi J., Obare F., Evelia H., and Nyinkavu H. (2008) "Sexual and reproductive health needs of adolescents perinatally infected with HIV in Uganda." FRONTIERS Final Report. Washington DC, Population Council.
[45]UNFPA Issues brief: Comprehensive Condom Programming – Rev. Oct 2011.

high levels of knowledge about HIV prevention, increasing male and female condom use and substantial decline in non-regular or casual sexual partners.[46]

61. In Uganda, with a prevalence of 4.9 per cent for young people aged 15-24 years, the AIDS Commission has included young people in the national strategic plan on HIV/AIDS. The plan emphasises HIV prevention amongst the vulnerable and most at risk. National policy is to integrate HIV services with reproductive health services.

62. In Indonesia, programmes have been successful in reaching out to most at-risk young people by partnering with NGOs and providing vital education and health services through tailor-made programmes based on the characteristics and needs of the targeted population.

63. In Iran, the Government is partnering with UNICEF in a pilot project to empower young people to prevent HIV. It provides information, education, counselling and referral services in health centres and the community, and will develop models for effective interventions. Based on experience and lessons learned, the programme will in future respond to the vulnerabilities of young women, strengthen the capacity of service providers and increase the use of services by at-risk children, youth and women. At the policy level, adolescent-friendly HIV prevention services will be integrated into the new national strategic plan.

VI. Comprehensive Sexuality Education

64. In line with the ICPD Programme of Action and the Key Actions for Further Implementation, UNFPA among other United Nations agencies supports countries to provide age-appropriate information about sexuality and reproductive health, in a manner consistent with young people's evolving capacities and the parental rights and responsibilities. Sexuality education includes structured opportunities for young people to explore their attitudes and values and to practice decision-making, communication and other life skills necessary for making informed choices about their sexual and reproductive lives. Extensive research shows that comprehensive sexuality education does not lead to increased risk behaviour among adolescents and does not promote early sexual activity.[47] To the extent that programmes provide adolescents with full and correct information, they explode myths and misunderstanding, clarify values and reinforce positive attitudes.

65. The cooperation and support of parents, families and other community leaders and actors should be sought from the outset of the programmes. Ministries of Education play a critical role in building consensus on the need for sexuality education through consultation and advocacy with key stakeholders, including young people, parents, policy makers and politicians.

66. Research and international technical guidance supported by UNESCO, UNAIDS, UNFPA, UNICEF and WHO demonstrates the characteristics of effective programmes and confirms their

[46] Gregson S et al: HIV Decline in Zimbabwe due to declines in risky sex? Evidence from a comprehensive epidemiological review. *International Journal of Epidemiology*, April 2010.
[47] UNESCO(2009), *International Technical Guidance On Sexuality Education*

importance of comprehensive sexuality education that address gender and sexuality norms.[48] Unequal power in intimate relationships is associated with earlier sexual initiation; more sexual partners; more frequent unprotected sexual intercourse; lower rates of condom and contraceptive use, and higher incidence of HIV. Increasingly education programmes address male behaviour, coercion and violence, but they should also take into account the root causes that reinforce such behaviour.

67. Despite increased support to comprehensive sexuality education at the secondary school level, sexuality education is generally unavailable to older school-age children, and out-of-school programmes are limited. In Indonesia, in some pilot districts, sexuality education has been introduced at the junior high school level, either mainstreamed into existing subjects or as a stand-alone subject. The Ministry of Education and Culture, the Indonesia Planned Parenthood Association and UNFPA are working with teachers and young people to develop relevant guidance and tools for locally-appropriate teaching. UNFPA is collaborating with the Ministry of Education and Culture to include sexuality education in the national education system.

68. Since 1998, the Government of Mongolia has provided sexuality education in schools from the third through the tenth grades. With UNFPA support and technical assistance from Margaret Sanger International, national experts were trained to develop a sexuality education curriculum, which was rolled out across the country in 2004.

69. UNFPA partners with government and NGOs to support youth peer education at summer camps in Georgia. Since 2006, more than 39,500 young people have attended interactive sessions conducted by trained peer educators on sexual and reproductive health and reproductive rights, HIV prevention, and gender and a healthy lifestyle.

70. In Togo, *L'Association Togolaise pour le Bien-Être Familial* (ATBEF), has promoted sexuality education in partnership with DANIDA and the Government, with radio and TV programmes, round-table meetings, reflection days with religious leaders, youth workshops and meetings with district authorities. ATBEF also assembled a coalition of national NGOs and local associations which produced a new national curriculum for pre-school and primary schools, and a self-learning manual and module for teachers.

71. Colombia piloted a comprehensive approach to sexuality education on 2005. With technical assistance from UNFPA, the Ministry of Education has scaled up the programme to the national level, engaging the health sector, universities and NGOs. In November 2010, the Ministry launched a new four-year plan that prioritizes education in sexuality and citizenship. Similarly, Argentina is implementing a nation-wide initiative on sexuality education.

72. *ProMundo* in Brazil has done innovative campaigns and programmes to address gender stereotypes and early socialization, and to promote healthier, more equitable relationships among young men and women. The programme has been adapted for other countries, including Mexico and India.

[48] Ibid.

73. In Nigeria, the national family life and HIV and AIDS education curriculum has broadened access to sexuality education for young people. It is a result of a Government-NGO partnership. An electronic version of the curriculum is now available as a resource for parents, teachers, and young people.[49] The Girl Power Initiative, an NGO partner, also conducts outreach programmes for girls.

74. In Egypt, the main modality for sexuality education is peer education, in-school as well as out-of school. UNFPA Egypt collaborates with the National Council for Childhood and Motherhood on a peer education programme in 14 districts to reach out-of-school youth. In addition, UNFPA has collaborated with a prestigious religious centre to produce a guide on reproductive health topics for religious leaders, addressing topics such as female genital mutilation and contraception.

VII. Humanitarian Settings

75. The ICPD Programme of Action and the Key Actions for Further Implementation recognize the situation of refugees and internally displaced people, and highlight the need to ensure "effective protection of and assistance to refugee populations, with particular attention to the needs and physical security of refugee women and refugee children" Conflicts and disasters disrupt familial and social structures and have a dramatic impact on young people's safe and healthy development. Young people in humanitarian crisis situations are at risk of unwanted pregnancy, unsafe abortion, and STIs, including HIV. Boys as well as girls are vulnerable to rape and sexual exploitation and abuse – a reality that the Security Council has recognized through several resolutions on sexual violence.

76. Empowering young people and promoting their leadership and participation in conflict and post-conflict settings requires political support and concerted efforts. With support of UNFPA, countries have increasingly incorporated young people's SRH needs in their national emergency preparedness plans.

77. UNFPA and Save the Children published the *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings*.[50] The Toolkit includes user-friendly tools for ensuring priority SRH interventions; assessing adolescent needs; fostering participation with communities and parents, and identifying ASRH entry points in health programmes. It also contains tools for service providers to work more effectively with adolescents at the clinic and community level.[51]

78. With the Women's Refugee Commission, UNFPA supported an advocacy video entitled Youth Zones – *Voices from Emergencies*.[52] Screenings raised attention among policy makers, donors and programme managers to the challenges and capabilities of young people in emergency settings.

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[49] Temin and Levine, op.cit.
[50] https://www.unfpa.org/public/global/publications/pid/4169
[51] http://www.rhrc.org/resources/arh/player.html
[52] www.youthzones.org

79. UNFPA and UNDP[53] have been working closely with United Nations and other partners to address HIV and gender based violence among female combatants and young girls associated with armed forces and armed groups. Programmes are being implemented successfully in Sudan, Cote d'Ivoire, Comoros, Indonesia and Nepal.

80. In Haiti, after the 2010 earthquake, young people conducted post-disaster rapid needs analyses, including camp assessments to find pregnant women and provide them with extra food supplies. Young people also ensured condom availability and conducted HIV/AIDS awareness sessions.

81. In response to the recent events in Egypt, UNFPA convened an inter-agency United Nations task force to coordinate activities and initiatives that focus on young people. The task force provides volunteer opportunities for young people to share information, coordinate activities, and engage in policy and programmatic decision-making.

VIII. Major Partnerships and Networks

82. Young people have a right to participate in programmes that affect them and with training and assistance; they can become powerful advocates for positive change. Opportunities for youth participation are important both for the development of individuals and for the social, political and economic stability of the larger society. Young people's experience of citizenship and community involvement affects the extent and kind of civic participation throughout their lives.

83. Governments and the United Nations are working in partnership with youth-led organizations to promote youth engagement and participation. The YPEER programme is one example of youth participation in programming. YPEER networks promote sexual and reproductive health and provide peer counselling and information across the Arab States and East Europe. YPEER aims to build the capacity of young people to be activists and educators in their communities, involving them directly in programming for increasing young people's knowledge of SRH issues. In the Occupied Palestinian Territories, YPEER is being expanded within disadvantaged youth groups, supported by the Ministry of Social Affairs. Over 300 peer educators have been trained, including about 100 in Gaza. The approach is being expanded and adopted by other youth NGOs.

84. In Nepal, UNFPA and Restless Development co-chair the inter-agency working group on youth, and closely collaborate with the government on youth policy. UN working groups work closely with youth-led organizations at regional level in Latin America and the Arab States. At the global level, the Inter-Agency Task Team on Young People and HIV, co-chaired by UNFPA and UNICEF, includes youth-led organizations as members, an example of good practice in youth-adult partnership. The Inter-Agency Network on Youth Development includes over 30 entities within the United Nations and cooperates closely with youth organizations. The United Nations Adolescent Girls Task Force calls for greater investments in girls' rights, education,

[53] UNFPA and UNDP are co-chairs of the Gender, HIV-DDR sub-working group of the inter-agency working group on DDR (Disarmament Demobilization and Reintegration).

health, and development as part of an essential strategy for breaking the inter-generational cycle of poverty.

85. At all levels, youth organizations are working in partnership to develop joint priorities and actions. In Afghanistan, Youth in Action Association provides a platform for youth organizations across the country to develop common advocacy messages and strategies. During the International Year of Youth, a coalition of youth organizations in partnership with UNFPA developed an advocacy and communications strategy that produced blogs by youth journalists on youth participation in decision-making processes, art contests on HIV prevention, workshops and training activities, including a campaign under the theme "10 Days of Activism".

86. The Coalition for Adolescent Girls brings together more than 30 international organizations. In 2011, the Clinton Global Initiative continued to encourage discussion on investments and solutions in this area, and the Elders launched "Girls Not Brides", a global partnership of non-governmental organizations to end child marriage, support child brides and raise the profile of this neglected problem.

87. Many global partnerships and networks promote young people's rights and access to sexuality education and sexual and reproductive health. The International Planned Parenthood Federation has catalysed a global youth movement for sexual and reproductive health and strengthened the capacity of its 170 member associations to deliver services. The Interagency Youth Working Group coordinated by Family Health International is a network of NGOs, donors and cooperating agencies with an interest in improving the sexual and reproductive health of young people in developing countries. UNFPA has also mobilized youth-led networks and youth-adult partnerships to promote the ICPD agenda for young people at national, regional, and international levels.

IX. Challenges and the Way Forward

88. Countries have made progress towards the commitments made in the ICPD Programme of Action, the Key Actions for Further Implementation and the MDGs. However, despite the compelling evidence of the importance of young people to countries' prospects for development, investments in young people continue to lag behind.[54] Urgent efforts are needed to protect, promote and fulfil the human rights of young people, especially the right to sexual and reproductive health.

89. Policy frameworks should be multi-sectoral, bringing together relevant ministries, national institutions, donors and stakeholders to initiate an integrated approach to young people's issues, including health, education, employment, social integration, and strategies for sustainable livelihoods.[55]

[54] The Case for Investing in Young People (UNFPA) 2010.

[55] World Programme of Action for Youth, A/RES/50/81 paras.113,114; Outcome document of the High Level Meeting of the General Assembly on Youth, A/RES/65/312 para.9.

90. Adolescent sexual and reproductive health should be included as a development priority as well as a human right, with appropriate budgets. Legal, rights and policy frameworks for adolescent sexual and reproductive health remain generally weak and services inadequate. There continue to be systemic challenges to women's empowerment, gender equality and young people's access to sexual and reproductive health, including social attitudes and practices.

91. There are many barriers that hinder access to an integrated package of SRH and HIV services, especially for vulnerable groups. Among these are legal and policy issues, stigma and discrimination, and social and cultural factors. It is vital to extend coverage of key interventions, including changing social norms and laws. Opportunities exist to reshape the legal and social milieu that compounds vulnerability and marginalization leading to HIV infection.

92. Organizational difficulties include physically inaccessible services, which are not youth-friendly and do not meet the standards of quality, privacy, confidentiality and informed consent. Some countries hoping to move away from standalone ASRH services are experiencing difficulty in scaling-up integrated initiatives. Many services are not youth-friendly. Despite training, many health providers remain judgmental and lack the skills to work with adolescents in a sensitive and confidential way. Commonly, services are oriented to adult women with children and do not reach out to the youngest, including first-time mothers and married adolescents without children. Laws and policies may restrict services available to unmarried adolescents.

93. Health policies, health services delivery systems and financing should ensure access to comprehensive, age-appropriate sexual and reproductive health information and services for both married and unmarried young people, including care in pregnancy and childbirth; safe abortion services in circumstances where it is not against the law; and in all cases access to quality services for the management of complications arising from abortion; post-abortion counselling, education and family planning, contraceptive information and services including male and female condoms for pregnancy and HIV prevention; voluntary HIV counselling and testing linked to antiretroviral treatment, prevention and treatment of sexually transmitted infections, information and counselling on sexual and reproductive health, and gender-based violence screening and services.

94. All services should reach the most marginalized, disabled persons and hard-to-reach youth populations, particularly girls. Improved coordination and referral between health and education systems is needed to provide more integrated support for young people.

95. Girls and young women, both married and unmarried, need protection from all forms of gender-based violence, abuse and exploitation including unwanted and coerced sex. Programmes are needed that build the capacities of young people to protect themselves. Those who experience violence should have prompt access to protection, the requisite services, and justice. Child marriage remains a serious health, social and human rights problem, especially in poor and rural communities.

96. Out-of-school girls in particular need safe spaces to strengthen their health knowledge and life skills, and expand their social networks. Safe spaces should create catch-up schooling opportunities and provide access to services. Programmes should also respond to the needs of boys and young men, to promote concepts of gender equality and mutual respect and offer appropriate role models.

97. Policies should promote gender-sensitive, age-appropriate, life-skills-based comprehensive sexuality education for young people both in and out of school, based on international standards. Curricula should have regard to the evolving capacities of young people at different ages to make their own decisions. Special attention should be paid to the needs of the most marginalized and most at-risk adolescents, including refugee and displaced populations. Young people living with HIV should be engaged to ensure that policies and programmes address their sexual and reproductive health needs and concerns, and eliminate stigma and discrimination against them.

98. Countries should ensure young people’s participation, in particular the most marginalized among them, in policy making and execution, promoting their human rights and their role as agents of social progress and peace-building. They should mainstream young people's needs and perspectives in all post-conflict, peace building, post-disaster and recovery processes and sectors.

99. New technologies should be harnessed to improve access to education, promote youth involvement in governance and to ensure that investments reach marginalized young people, especially adolescent girls. Special efforts are needed on behalf of young people who are internally displaced, refugee or living in difficult humanitarian situations.

100. Investment in data, knowledge generation and capacity development concerning young people is an essential element. Policy strategies should encourage research and systematic generation of data on young people, most particularly the youngest (10-14 year-old) girls. They should ensure that data collection and analysis reflect the priorities of adolescents and youth, are disaggregated by age and sex, and are used to enrich understanding of youth issues, inform policy discussions and interventions, and strengthen the evidence base on the importance of investing in young people.