Adolescent Sexual Health in West Africa: Rights, Realities, Responses
Plan in West Africa

Plan was founded in 1937 by a British journalist, John Langdon-Davies, and a refugee worker, Eric Muggeridge, to support children whose lives had been disrupted by the Spanish Civil War. Since then, Plan has become one of the largest international, child-centred development organisations in the world.

Over the past seven decades, Plan’s focus has shifted from wartime relief to long-term community development. However, children and their well-being still remain at the centre of everything we do. Plan operates in 49 countries in Asia, Latin America and Africa, twelve of which are situated in West and Central Africa1. Our programmes use children’s rights as a key concept in promoting their development, survival, participation and protection.

Plan’s work on the African continent is guided by our Strategic Framework for Africa. (Plan 2008) At its core are the UN Convention of the Rights of the Child (UN 1989) and the African Charter on the Rights and Welfare of the Child. (OAU 1990)

The right to development

Plan in West Africa is dedicated to achieving education for all through projects promoting:

- early childhood care and development ensuring a strong foundation for good health, growth and success in education and life;
- quality education for all children;
- girls’ enrolment and success at school;
- rapid education for children in countries experiencing conflicts.

Plan also supports non-formal education, learning and opportunities for self-employment and finance for youth. We advocate against all forms of violence in schools.

The right to protection

Plan supports community-based and national initiatives to stop child abuse, exploitation and trafficking and to strengthen national and regional legal frameworks and policies. We facilitated children’s participation in the follow up of the UN study on violence against children, and also work to abolish female genital cutting as a form of violence against children. We insist on the need to provide children who have been victims of violence, abuse and exploitation with appropriate psycho-social support. We support programmes to improve the economic security of households and particularly of women in order to create a protective environment for children.

The right to survival

Ensuring equal access to affordable and quality primary health services is the aim of Plan’s interventions in the health domain. Its focus is on the reduction of maternal and child mortality through the support of programmes for integrated management of childhood illnesses in the community and in health facilities, youth-friendly sexual health services, school health and hygiene services, the provision and use of clean water, and the promotion of safe sanitation and hygiene at community level.

The right to participation

Plan aims at increasing children’s space in civil society through supporting existing and emerging children and youth organisations, child media work (www.plan-childrenmedia.org) and the inclusion of children in decision and policy making processes at community and national level. Plan also supports child and youth participatory research on childhood and child poverty issues across the region.

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1 Benin, Burkina Faso, Cameroon, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Niger, Senegal, Sierra Leone, Togo
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Who is this publication for?

This publication is addressed to people who work with adolescents in West Africa, be it as teachers, nurses or social workers, as activists, politicians or bureaucrats, in national institutions or in international organisations. It draws attention to the rights and needs of a demographic group that is often neglected in social development initiatives. The publication is part of Plan’s effort to refocus the lens used to view the African continent.” International development cooperation is not about problems, it is about people.” (Plan 2008)

Placing adolescents and their rights into the centre of programming and policy decisions is different from focusing on the problems and diseases of adolescents. It requires more than just new wording in project and programme documents. It requires a different way of seeing. It requires a cultural change that is particularly difficult when it comes to the sensitive area of sexuality. We therefore hope that this publication will be widely used by the media and the general public to promote a vision inspired by the words of Nelson Mandela:

“My dear young people: I see the light in your eyes, the energy in your bodies and the hope that is in your spirit. I know it is you, and not I, who will make the future. It is you, not I, who will fix our wrongs and carry forward all that is right in the world”

(Mandela 2002).

Why is this publication necessary?

In 2010, the population of the African continent will pass the mark of one billion. About one in five of these people will be adolescents aged 10 to 19. The African continent has the fastest growing population of adolescents, expected to reach 300 million in 2050. (UNFPA 2003) These young people are going through a complex transition at a breathtaking speed. One of these transitions is the maturation of their sexuality. Industry has long taken note of the commercial potential of this large demographic group. Adolescents are an important market for fashion and entertainment products, in Africa as in the rest of the world. But when it comes to the provision of social services, adolescents are often neglected. One day they are children, developing parental instincts to protect themselves and their future children. The next day they are young adults asserting themselves, questioning adult values, threatening established order (and disturbing peace and quiet with their loud music!) This transition is not sudden, it is relentless but occurs almost imperceptibly, and it is strongly influenced by local culture. Anybody who has raised children is aware of the difficulties and conflicts that arise during this transition. Many of these conflicts are related to the start of adolescent sexuality.

In the second decade of their lives, children make the adult world feel insecure, and the response to this insecurity by public institutions may be dogmatism and excessive control; but more commonly it is neglect. Children are important because “they are our future”, adults are important because they are “economically productive”, adolescents simply do not exist. Or rather, they do exist but only in the expression of the problems they create. They become pregnant before society thinks they are ready, they engage in unsafe sexual
behaviour, they act out their energy as “hooligans”, or they serve as child soldiers.
This jaded view of adolescence is reflected in the ambivalence of social institutions, and it deprives young people of appropriate services and support during one of the most critical stages of their development. This publication aims to change this view. Adolescents live through a period of sexual transition that may be among the most exciting but also the most disturbing periods of their lives. Rather than seeing this as a problem, this publication attempts to analyse this process from the perspective of the rights of young people to live and develop to their full potential.

Adolescent population by region (2003 – 2050)

Source: UNFPA 2003
Adolescent Sexual Health in West Africa: Rights, Realities, Responses

The period between infancy and adulthood is a time of growth and change. It is a time when experiences are collected and beliefs, attitudes and behaviours are formed that will leave their mark throughout life. There can be no doubt that the foundation of how women and men experience and express their sexuality is established during this period. In many West African communities the sexual behaviour of adolescents continues to be a taboo subject. It is sometimes regarded as appearing suddenly after puberty or after a marriage ceremony. Many parents and teachers believe that sexuality is best not talked about in order to protect young people from information that may lead to sexual experimentation.

The period from birth to adulthood is categorised and labelled in many different ways. We all know that these labels are only indicative. A 17 year old mother of two in Niger can hardly be called a “child”, and yet a “youth” may be as old as 34 according to the African Youth Charter (AU 2006). The illustration below shows the labels that are most commonly applied to people at different ages in their pre-adult and early adult development.

Some demographic labels applied to the period of growth and development

A discussion of sexual health is relevant for each of these demographic groups. At some point in their development most of them engage in sexual intercourse. However, sexual behaviour is not restricted to the act of intercourse, and sexuality is forming long before it is expressed in this way.

Most of the recent interest in sexual health is sparked by renewed attention to reproductive health and to HIV prevention. Publications on these issues usually target the “Youth” or “Young People” age categories. In the context of West Africa this is problematic. Starting at age 15 with the “Youth” category leaves out almost half the girls in Mali and Niger who at that age are already married, many of them with children. And using the “Young People” category groups children who have not yet started puberty with the majority of men and women who already have children of their own. Furthermore, there is child protection legislation in all countries that applies to those in the younger age group of the “Young People” category but does not apply to those at the other end of the scale. Most countries have laws protecting a 13 year old girl that do not apply to a 23 year old woman, at least in the text of the law if not always in practice.

Sexual behaviour does not start with the first act of sexual intercourse, but this event is a convenient marker to understand gender differences, regional differences and historical changes. Among boys in West Africa, the median age of first sexual intercourse is later than among boys in industrialised countries; among girls it is usually a little earlier. In five of eleven West African countries from where we have data, one third of today’s adult women experienced their sexual initiation by the time they reached the age of 15. There is, however, a major difference between West Africa and the industrialised countries of Europe and North America. For many West African girls sexual initiation is with a stable partner within marriage, while early sexual intercourse among girls in industrialised countries is almost exclusively premarital. The median age of first marriage for girls is as low as 15 years in Niger and as high as 25 years in the USA. (Wellings 2006).
Over the last ten years, significant changes in the age of sexual initiation have been observed in all countries. In West Africa, the age of first sexual intercourse among girls and boys is rising. This is illustrated by successive surveys from Ghana.

### Age of first sexual intercourse among young women aged 20-24 in Ghana in successive Demographic and Health Surveys

![Graph showing the decrease in the proportion of girls having sexual intercourse before age 15 from 1988 to 2003.](image)

![Graph showing the decrease in the proportion of boys having sexual intercourse before age 15 from 1988 to 2003.](image)
Whatever the trends, it is clear that the great majority of girls and about half of the boys start to become sexually active during adolescence before they reach the age of 20 years. At the same time, the age of first marriage is rising even faster. The consequence is an increase in pre-marital intercourse among both boys and girls in West Africa. Paradoxically, this shift may be advantageous for girls’ sexual health because sexual initiation outside marriage is generally followed by less frequent sexual activity than sexual initiation within marriage, and they are also more likely to be protected from unwanted pregnancies and sexually transmitted infections by the use of a condom (Dixon-Mueller 2008). While condom use by adolescent married girls in West Africa can be assumed to be near zero, condom use by young people outside marriage is increasing. West African reports on condom use by young unmarried women during their last intercourse range from a low of 14 percent in Mali in 2001 to a high of 54 percent in Burkina Faso in 2003. (WHO 2008-2).

Adolescents

According to stereotypes, adolescents are immature, take risks with their lives and the lives of others, and do not know how to behave properly unless they are under strict adult control. This is reinforced by the image of adolescents projected in the media and by the way the term adolescent is used in the public health literature, especially in publications on HIV prevention. The images of adolescents projected in these publications include the "unknowledgeable or ill-informed adolescent", the "high-risk adolescent", the "adolescent who unduly conforms to peer-pressure", and the "tragic but innocent adolescent" who inadvertently becomes infected with HIV. (Warwick 1990) The projected image is that of either villains or victims.

In fact, the characteristics of the adolescent age group are very heterogeneous. The behaviours of adolescents vary widely between individuals, across cultures, across social and economic backgrounds, and between

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Child victims are newsworthy

In a study published under the title ‘Children: dying to make the news’, the Empowering Children & Media Project analysed 22,000 news items of 36 different media published over a two-month period in South Africa (Media Monitoring Project 2004). Among the news stories featuring children, 59 percent were about adolescents aged 10 to 18.

About half of the stories were negative. Crime, violence, child abuse and disasters were the main topics. While it is a common feature of news to report “bad news”, the study found that the representation of children in these stories was very limited. The most common role of children in news stories is that of victims. In stories about HIV and AIDS, the three top roles for children were victim (30%), orphan (21%) and sick child (14%).

What are the stories with children about? Top 12 topics (90% of all stories)

- Crime 18%
- Disasters and accidents 10%
- Child Abuse 10%
- Health 8%
- Arts, entertainment 7%
- Personalities, profiles and families 4%
- Social welfare 3%
- HIV/AIDS 3%
- Human Rights 3%
- Sport 12%
- Education 11%
- War, conflict and violence 11%

Source: Children Media Monitoring Project 2004
genders and include non-normative sexual orientation and gender identity e.g. same sex attraction. Some adolescents are taking risks; others are more responsible and reflective than their parents. In West Africa, many adolescent girls are mothers caring for their children. The majority of boys and girls in their late adolescence have significant economic responsibilities within their families.

What adolescents throughout the world have in common is the fact that they are going through puberty and therefore experiencing dramatic changes in body and mind. Adolescent girls especially experience a period of heightened vulnerability, not the least due to the norms in many West African societies that treat them as children in terms of their cognitive development, restricting their choices and expressions of personality, while considering them physically as women, ready for marriage. Also, adolescents share the fact that, at least on paper, they are protected from sexual abuse and exploitation by most national legislations, although the enforcement of these laws varies from country to country.

How young is too young?

A key concept in Article 5 of the UN Convention of the Rights of the Child is the duty of parents and guardians to provide appropriate guidance to children consistent with their “evolving capacity.” (UN 1989) This is a critical concept when it comes to the issue of adolescent sexuality. When are adolescents old enough to learn about sex? When are they old enough to express their opinions about sex? When are they old enough to make their own decisions about their sexual behaviour? What kind of guidance do they need, and when is their capacity “evolved”? It must, however, be understood that “appropriate guidance” can never mean pre-empting the decisions of adolescents by forcing girls into marriage, by coercing them to engage in sexual intercourse, or by placing them into situations where they are exposed to such coercion. Unfortunately this is the experience of too many West African girls.

There are two important dimensions of the evolving capacity of adolescents: the physical maturity and the cognitive maturity - the capacity to voluntarily make informed decisions. The ages of attaining these levels of maturity are highly variable. Girls reach physical maturity approximately two years earlier than boys. The age of their first menstruation is usually between 11 and 14 years. Girls in rural areas tend to have their menarche about two years later than urban girls. The average age of menarche in rural Senegal, for instance, is around age 15. Menarche, however, does not equate with physiological maturity for sexual intercourse. The reproductive tract at time of menarche is still immature. Adolescent boys reach their physical sexual maturity generally around age 16 to 17, but there are also large variations. There are no physical signs that signal when adolescents have fully developed the capacity to make informed decisions about key aspects of their sexual and reproductive behaviour. There are many factors that determine the age at which this level of maturity is reached, including access to good quality sexual education. There is a general consensus that by the age of 18 most adolescents have the physical and mental capacity to make their own decisions about sex and marriage. Whether they have the skills to do so and whether they are free to make voluntary choices depends on the guidance they have received since early adolescence, and in a family and community environment that respects their rights to make choices.

Following these arguments, it is useful to look at adolescents’ sexual rights in three distinct age groups. Between the ages of 10 and 14 sexual maturation begins. Adolescents in this group are physically and mentally too young to have sex, but they have the right to appropriate education and information to prepare them for the impending changes in their bodies and in their emotions. Between the ages of 14 and 17 most adolescents go through a period of sexual maturation. Adolescent girls in this age group are highly vulnerable to sexual coercion, exploitation and violence, and they have the right to be protected. By age 18 most adolescents are physically and emotionally mature to make choices about their own sexuality and they have the right to express these choices and be taken seriously about the choices they make.

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1 This section draws extensively on a review paper under the same title written by Ruth Dixon-Mueller. (Dixon-Mueller 2008)
2 See also the text box on page 15
What is sexual health?

In 1975, the World Health Organization published the first internationally accepted definition of sexual health (WHO 1975). Since then, several national and international institutions have proposed alternate definitions. In 2002, the World Health Organization convened a panel of international experts to re-define sexual health. The working definition proposed by the experts was as follows:

“Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled” (WHO 2002).

The fundamental difference of this definition to the one accepted in 1975 was the clear reference to sexual rights. The panel of experts suggested the following definition of sexual rights:

Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- seek, receive and impart information related to sexuality;
- sexuality education;
- respect for bodily integrity;
- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when, to have children;
- pursue a satisfying, safe and pleasurable sexual life.

A number of organisations and governments, for instance the Government of Canada, have adopted these definitions (Government of Canada 2003) but the World Health Organization continues to stress that it does not represent an official position. While the concept of reproductive rights has been widely endorsed since the 1994 International Conference on Population and Development in Cairo, governments and international agencies are much more reluctant to refer to sexual rights in their official documents.

The interest in sexual health is driven by two prominent public policy issues. The first is the effort to control excessive population growth. In the 1990s, the focus of international population policy shifted from the provision of stand-alone family planning programmes to the promotion of sexual and reproductive health through integrated primary health-care services. The second is the international response to HIV. The mainstay of effective HIV prevention is success in changing sexual behaviours and attitudes through behaviour change communication. Invariably, this has led to a renewed interest in understanding human sexuality and in defining the concept of

* It also acknowledged girls’ education as a key causal factor, as well as access to financial and physical assets as viable alternatives to relying on children as social security for families.
sexual health. But while population control and HIV prevention have sparked the interest in sexual health, they are also responsible for hindering the direction of discussion.

- In September 1994, at the International Conference on Population and Development in Cairo, representatives of 184 governments agreed on an agenda for action that, among others, included the objective to address adolescent sexual and reproductive health by promoting “responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counselling specifically suitable for that age group” (UN 1994). While it opened the floor to discussion on adolescent sexual health, it placed it firmly into the context of reproduction. It also left the question of how to define “healthy sexual behaviour” open to interpretation. Many of the programmes and policies that followed the Cairo consensus focus on reproductive health, overlooking the fact that reproduction is only one aspect of sexual behaviour.

- In the context of HIV prevention, sexual behaviour, especially the sexual behaviour of adolescents, is primarily discussed in terms of its risk for the transmission of disease. Sex is considered something that has to be “made safe” or should be avoided altogether. In its most narrow interpretation, sexual health promotion in HIV prevention programmes means the promotion of sexual abstinence, the provision of information about HIV, and the social marketing of condoms to prevent sexually transmitted infections. Whilst this focus on the “absence of disease” is obviously an important aspect of sexual health, it is nonetheless a very limiting focus.

Discussing the sexual health of adolescents beyond the thematic limits of safe reproduction and the control of sexually transmitted infections is difficult. Acceptable sexual behaviour and relationships are subject to local norms and religious teaching. It is not unusual that behaviours outside these norms are labelled as “unhealthy” or even criminal. There are many examples of individuals suffering grievous bodily harm in the name of maintaining sexual norms. This includes state sanctioned imprisonment, torture and sometimes even the murder of men who have sex with men in several African countries. Women who have sex with women in parts of Africa are often targets of sexual violence because of their sexual orientation. Defining “health” as a value-free concept overriding all local norms would be a form of cultural imperialism that is neither functional nor feasible. The discussion moves to somewhat firmer ground when the issues of sexual and reproductive health and rights are discussed within a framework of universally accepted human rights which take precedence over cultural values.

What are the sexual rights of adolescents?

The 1989 UN Convention on the Rights of the Child defines children as people up to the age of 18 thereby including the great majority of adolescents. It is a legally binding international instrument ratified by 193 national governments (UN 1989). It is silent on the issue of sexual rights beyond the right of protection from sexual exploitation (Articles 19 and 34). There are, however, articles that apply indirectly such as Article 12 affirming the freedom of expression and Article 24 dealing with the abolition of harmful traditional practices, some of which directly interfere with sexual health. Furthermore, an “optional protocol” of the Convention came into force in 2002 providing additional protection to children from pornography, child prostitution, and human trafficking (UN 2002).


Beyond these two international legal instruments, there is no consensus on the rights of adolescents. In many societies, adolescence is not even recognised as a distinct developmental stage. The 2006 African Youth Charter (AU 2006) is still awaiting ratification by the majority of African governments. It addresses some sexual rights, but the Charter defines its target as “youths” between the ages of 15 and 35 and it qualifies many statements as applying only to those “of full age”. It thus largely fails to address the situation of adolescents.

5 E.g. Article 8.2: “Young men and women of full age who enter into marriage shall do so based on their free consent and shall enjoy equal rights and responsibilities.” African Youth Charter (AU 2006)
Girls in many West African societies are catapulted out of childhood into adult roles. One day they are schoolgirls, the next they are wives and mothers. Their rights as adolescents simply disappear in this rapid change of roles. Yet many of their adolescent rights, including their sexual rights, can be derived from the universal child rights set out in the UN Convention.

The right to education: Adolescents have the right to education that prepares them to make informed decisions about their own sexuality, and to know how to judge the consequences of these decisions. This education can be provided in schools, churches, by parents, through peer education programmes or by the media. The importance is that the information provided is based on evidence, that it is appropriate to age and gender, and that it is delivered in a way that allows girls and boys to act on it within the context of their society and community. Education that only focuses on information about sexually transmitted infections or only on the biology of reproduction is insufficient if it does not also transmit the life skills and the system of values that are necessary to engage in a relationship based on equality and mutual respect.

The right to health: Adolescents have the right to receive services that respond to their specific physical and psychological health needs. These are distinct from the needs of children and adults. Child health clinics ignore the growing sexuality of young adolescents. Maternal health clinics ignore the psychological needs of young married mothers. Unmarried adolescents who are sexually active are completely excluded from health and family planning services. More often they are treated as delinquents rather than individuals in need of care. Adolescents have the right to receive professional care and services where they can discuss matters of major importance in their lives free of judgement and moral reproach.

The right to be safe and protected from injury: Frequent and severe punishment is a reality in the lives of a large number of adolescent girls and boys in West Africa. In 2007, Plan and Family Health International interviewed more than 1,000 children in communities experiencing difficulties in five countries of West Africa. More than 80% of them reported that they had suffered significant physical abuse, verbal abuse or neglect in their homes (Decosas 2009). Female genital cutting continues to be a practiced in many parts of the region. It is a complex cultural practice performed in different forms for different reasons. But it is always a grievous injury to the body of a young girl, an injury that may have long-lasting impact on her sexual life (Plan WARO 2007). These are just two examples of failures to provide adequate safety and protection from injury to adolescents. These rights are clearly inscribed in the Convention of the Rights of the Child and there should be no question about their application to adolescents. Application of these rights should, among other things, include access to a juvenile justice system that can effectively protect adolescents who have come in conflict with the law and who are especially vulnerable to injury and abuse.

The right to be protected from sexual abuse and exploitation: The trafficking of children and adolescents continues to be an issue in many West African countries. The majority of these young people are sold to work as farm labourers or domestic servants under conditions resembling slavery. But a significant number of them, girls as well as boys, are forced into prostitution, exploited for child pornography, or exposed to repeated sexual abuse (Davies 2005; Behrendt 2007). Sexual abuse of adolescents is not restricted to the context of child trafficking. Child sexual abuse and exploitation, defined as “the imposition of sexual acts, or acts with sexual overtones, by one or more persons on a child” is an alarmingly common occurrence in the daily lives of adolescent girls in West Africa (Jones 2008). A discussion of the issue and increased attention to protective legislation started in the South of the African continent in the late 1990s. In West Africa the issue is still very much shrouded in silence.

The right to be heard: Too many decisions about adolescents are made without ever asking the young people
themselves. How should they express their growing sexual feelings? What services do they require and what information should they have? What rights do they have to freely choose their sexual partner – of the opposite or the same sex? Girls in many West African societies are treated as immature children until the moment of marriage. Their adolescence is over before they have any chance to experience one of the most important periods of their own development. Adolescents have the right to be able to identify and express their opinions about issues that affect their lives, including issues related to their sexuality. There are an increasing number of initiatives such as youth fora and youth parliaments to listen to young people, but these initiatives should not exclude a discussion of information, services, standards and regulations that affect the sexual lives of adolescents.

The fact that governments do not pay sufficient attention to the rights of adolescents was noted with concern by the UN Committee on the Rights of the Child. In 2003, it issued a “general comment” entitled “adolescent health and development in the context of the Convention on the Rights of the Child” (UN 2003). The comment provides guidance on how to balance the sexual rights of adolescents with the rights of parents. Paragraph I.7 of the document states:

“The Committee believes that parents or other persons legally responsible for the child need to fulfil with care their right and responsibility to provide direction and guidance to their adolescent children in the exercise by the latter of their rights. They have an obligation to take into account the adolescents’ views, in accordance with their age and maturity, and to provide a safe and supportive environment in which the adolescent can develop. Adolescents need to be recognised by the members of their family environment as active rights holders who have the capacity to become full and responsible citizens, given the proper guidance and direction.”

The sexual rights of adolescents can thus be derived from existing accepted principles of human rights and child rights. There will always be areas of friction between parental responsibility and adolescent rights. Parents are obliged to act in the best interest of their children according to their “evolving capacities”. As societies change, “best interests” change. Defining what exactly is in the best interest of the adolescent should be a subject of constant review and negotiation.

Evolving Capacity

Article 5 of the Convention on the Rights of the Child states that governments must respect the “responsibilities, rights and duties of parents or … other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognised in the present Convention” (UN 1989). Therefore parental rights and responsibilities are not unbounded. By inserting the word ‘appropriate’, Article 5 removes the possibility that parents or other carers have carte blanche to provide, or fail to provide, whatever guidance and support they deem suitable. Similarly, Article 18 of the Convention imposes certain boundaries on the upbringing and development of children, stressing that “the best interests of children will be (the parents) basic concern”.

The concept of evolving capacities of children needs to be understood in three dimensions:

- **As a developmental concept**: It recognises the extent to which children’s development, competence and emerging personal autonomy are promoted through the realisation of their rights.
- **As an emancipatory concept**: It asserts the rights of children to respect for their capacities and transfers rights from adults to children in accordance with their level of competence.
- **As a protective concept**: Because children’s capacities are still evolving, they have rights to protection by parents and by governments from harm. The levels of protection they require will diminish in accordance with their evolving capacities.

(Adapted from G. Lansdown 2005)

Why focus on the sexual health and rights of adolescents?

The majority of adolescents in West Africa, as in many other regions of the world, have had sexual intercourse before age 18 while they are still “children” as defined by the Convention on the Rights of the Child. Early sexual initiation of girls in West Africa occurs primarily within the context of marriage while this is rare for
boys. Whether married, in informal union, or single, the services and the access to information for these young people are severely restricted by current practices in the education and health services, and by the common perception that they are “too young to have sex”. Furthermore, forcing girls into marriage, or refusing them permission to marry, severely limits the ability of young women and men to make informed decisions about their sexual and reproductive lives, even after they have passed the age of adolescence.

The fact that young people during late adolescence become sexually active should not be a cause of alarm. This was pointed out by experts convened in Mexico by the International Union for the Scientific Study of Population (IUSSP): “It is not “teenage sex,” “early marriage” or “adolescent childbearing” “per se that is problematic, but the extent to which such events contribute to or reflect a lack of opportunities; occur with inadequate protection due to lack of choice, knowledge, skills or relevant services; or constitute a violation of young people’s health and human rights.” The participants of the seminar concluded that “policies and programs should build on the positive elements of adolescents’ lives to ensure that their sexual, marital and reproductive transitions are fully informed, voluntary, and safe both for themselves and their partners.” (Dixon-Mueller 2007)

What is a cause for alarm is that the fact that the HIV pandemic is increasingly affecting young poor women. Adolescence is a critical moment when, for many girls, risk of HIV infection is heightened by social isolation, particularly if they have married young, as well as economic vulnerability and fragile family structures. There is concern that health, social development, livelihoods, and youth programs are failing to reach the most vulnerable girls and young women at risk of HIV infection.

Opinions about the age when young people are “ready” to responsibly engage in sex, marriage or parenthood are as entrenched as they are variable. They differ between generations, genders, rural or urban habitat, religious conviction, ethnicity, and social background. Against this background of firmly held beliefs, the difficult task is to move the discussion from one that purely focuses on age, and move it to one about the ability of young people to make strategic life choices. This ability includes having freedom of movement, knowing their community, being able to participate in decision making, appreciating the equality of genders, and having the necessary information about sexuality and reproduction. Today, a large proportion of West African adolescents engage voluntarily or involuntarily in sexual intercourse without having acquired this ability, regardless of whether their parents, their teachers, their clerics or their communities consider them to be old enough to have sex or not.

Plan’s programmes to promote adolescent sexual health and rights aim to bridge this gap. We believe that we have the social responsibility to open eyes to the evolving sexuality of adolescents. Communities have their own norms and standards for age-appropriate sexual behaviour. The adolescents in these communities, however, have a right to age-appropriate guidance and services, and they have the right to be heard when these norms and standards are discussed. Adolescent sexual health programmes should do everything possible to ensure that young people are equipped to responsibly engage in sexual intercourse when they are ready to do so; because we all know that they will, whether they are ready or not.

Experiencing and surviving sexual violence

The use of physical force to compel a person to perform a sexual act, usually called rape, is only one form of sexual violence and abuse (CDC 2008). For adolescent girls it is the most traumatic form of initiation into their sexual life, an initiation that may have a life-long impact. The rape of adolescent boys is less common, but it nevertheless occurs.

The West African Region has suffered a number of recent wars and armed conflicts, notably in Côte d’Ivoire, Guinea, Guinea-Bissau, Liberia and Sierra Leone. The systematic rape of women and girls has been a feature in many of these conflicts. There are claims, for instance, that in Liberia about 40% of all girls and women have suffered sexual violence (M’Jid 2008). The euphemism “bush wife” was used in these conflicts to “normalise” the serial rape or gang rape of young girls by male fighters on both sides. During the Plan study of the need for psychosocial support of children in West Africa, we heard many testimonies such as this one from a 16 year old girl in Liberia:
“My mother used to be with a man before the war started, but she left him. He joined the rebels and came back to kill her. My mother managed to escape, but he kidnapped me instead. I was nine years old. The rebels took me as bush wife whenever they wanted.” (Morgan 2009)

But sexual violence occurs under much less dramatic circumstances. There are indications that it may be very common in West Africa, but there are few studies or official statistics to confirm this suspicion. As the UNICEF Special Rapporteur on the Sale of Children, Dr Najat Maalla M’Jid points out in her report:

"Today, there is no country in West and Central Africa that can pretend to be free of the sexual exploitation of children. But there is also no country that can report accurate information about the number of children who are victims of this exploitation because it is to the largest part clandestine, and a method to estimate its extent does not exist. The statistical data are insufficient, and the means that are mobilised to prevent the sexual exploitation of children and to fight against it are therefore limited and have little impact."

(M’Jid 2008) (Translation: the author)

The impact on a young girl who experiences sexual violence is severe and long lasting. There are the immediate risks of pregnancy and of sexually transmitted infections, and there are the long-term psychological effects of the trauma.

The Plan study in Liberia found that children who had been associated with the fighting forces during the war had significantly higher rates of depressive illness and thoughts of suicide. Most of the girls among them had survived multiple and repeated episodes of rape or gang rape. They were also exposed to different forms of violence and had witnessed many forms of brutality. But the experiences of sexual violence were nevertheless major traumatic events in their lives (Behrendt 2008).

The Plan study also found that girls who had experienced sexual violence were much more likely to be engaged in transactional sex later in their lives. This has also been reported in other studies (Castle 2008). It appears that some girls who had been raped viewed themselves and their bodies differently. One method of protecting themselves from their traumatic memory may be to trivialise sexual intercourse and use it more readily for survival and income.

The story of Zinabu, 16 years old, Ghana
(Child Research and Resource Centre 2009)

There was this teacher in my school who was the husband of the headmistress. This man usually enticed the school girls with money and had sex with them. I was in Grade 3 of Junior Secondary School when the headmistress sent me home to do her laundry. I was doing the washing alone in the house when the husband came in. He went straight to the living room and called me in. As soon as I got there, he moved towards me and pushed a Cedi 20,000 note (approximately 2 US Dollars) he was holding through my breast into my dress and pushed me down. He forcibly had sex with me in spite of my protests. I wept bitterly after the incident and reported it to my mother.

The matter went to the queen mother for settlement. The teacher was asked to apologise to me and my mother and also to pay cash compensation of Cedi 50,000 (approximately 5 US Dollars) a month towards my education cost until I complete Junior High School. I was not happy the way the case was handled but my mother said that was the decision of the queen mother.

6 female traditional leaders
Many countries have laws that define the age at which young people are allowed to consent to sexual intercourse. In some countries separate age limits exist for heterosexual intercourse and for same-sex intercourse between men or between women. In all West African countries with exception of Burkina Faso and Côte d’Ivoire same-sex intercourse is illegal at any age (AVERT 2009). Sexual consent laws are meant to protect adolescents from exploitation by adults. Sexual intercourse by an adult with a girl or boy younger than the age of consent is legally considered to be rape, even if the younger person claims to have participated voluntarily. In West Africa, the legal age of consent to intercourse ranges from 13 years in Nigeria and Burkina Faso to 16 years in Ghana and Mali. Several countries, for instance Benin, Niger and Senegal do not have a legally defined age of consent (AVERT 2009). Generally the laws have no more than symbolic significance and are rarely enforced. In Cameroon, for instance, the legal age of consent to intercourse is 21 years (INTERPOL 2009). However, girls are permitted to marry without parental consent at age 15 and boys at age 18. In the 2004 Demographic and Health Survey, 76 percent of young men and 86 percent of young women aged 20-24 reported that they had sexual intercourse before age 20 (Measure DHS 2009). Most national laws limiting the age of consent to sexual intercourse do not apply to intercourse within marriage. For instance the sexual intercourse of a polygamous adult man in his 40s with one of his wives in her early teens is not considered abusive in about half of the West African countries where polygamy is legal.

The right to marry and to enter into marriage with the “free and full consent” of both spouses is set out in the 1948 Universal Declaration of Human Rights (UN 1948). Later UN Conventions and Resolutions established a legal minimum age of marriage to stop the practice of child marriages. The 1990 African Charter on the Rights and Welfare of the Child states that the minimum age of marriage shall be 18 years (OAU 1990). It entered into force in November 1999. In West Africa, however, many countries continue to have legislation that allows marriage without parental consent for girls of young age, ranging from 15 years in Cameroon, Mali and Niger to 17 in Burkina Faso, Guinea, and Togo. Few countries have accepted the standard of 18 years for girls, although this is the generally accepted legal age for boys. Sierra Leone has set the legal age limit for boys and for girls at 21 years (UN 2007).

As for consent to sexual intercourse, the laws limiting the right to marriage are full of loopholes. They do not apply to marriage with parental consent, and they also do not apply to the majority of marriages in rural areas that are sealed in traditional or religious ceremonies. The practice of girls as young as 12 being given in marriage by their parents to older, often polygamous men continues to be widespread in many West African countries despite legal prohibition. It is a major violation of the sexual rights of these girls.

Equally problematic is legislation that requires parental consent for marriage up to early adulthood, as for instance 21 years for men and women in Sierra Leone, or 20 years for men in Togo (UN 2007). Many young women and men reach the maturity to enter into a stable relationship in their late adolescence. Having to depend on parental consent about whom and when to marry is an unreasonable restriction of their sexual rights.
Sexual rights in a polygamous society

Polygamous marriages are illegal in Benin, Guinea, Côte d’Ivoire and Cape Verde. In all other West African countries polygamous marriages are recognised under civil or under customary law. But even in the countries where polygamy is illegal, the practice continues and the laws are rarely enforced.

Polygamy is defined as “the maintenance of conjugal relations by more than two persons” (Government of Canada 2006). In practice, with very few exceptions, it means the marriage of a man to several wives. This form of polygamy is also referred to as polygyny to distinguish it from polyandry - the marriage of one woman to several husbands. The marriage of a man to up to four wives is permitted under Islamic law, which is the main foundation of its legal status in most West African countries. Polygyny is however also practiced in most traditional non-Islamic African cultures, usually without limits in the number of wives.

The United Nations’ Human Rights Committee has demanded that polygamy be abolished on the grounds that it is an inadmissible discrimination against women and violates their dignity (UN 2000). In this publication, we are only looking at the impact of the practice of polygamy on the sexual health and rights of adolescents.

The demographic trap

Most societies have about an equal number of men and women. Distortions of this equilibrium occur locally or temporarily because of labour migration or as a consequence of wars, but on a national scale these distortions disappear in the longer run. If the practice of polygamy is widespread, many men will not find sexual partners of equal age. However if the population distribution is in the form of a pyramid as it is in all African countries, there will at any time always be more younger women than older men. An “adequate supply” of marriageable women can therefore be maintained if husbands are generally much older than their wives. This may not be the only reason why child marriages and the early sexual initiation of girls continue to be so widespread in West Africa, but it is certainly a major one.

At the same time, young men who reach their sexual maturity may find that there are few female partners available for marriage. The young women in their peer group are already married to older men. Sexual initiation of young men on the basis of an equal and consensual formation of partnerships is therefore severely restricted, favouring the expansion of commercial sex and predatory sexual behaviour often involving coercion and violence.

Africa’s population structure in 2008

Source: Population Reference Bureau 2009
The gender equality trap

There are many anecdotal reports of women who are happily married in polygamous unions, who feel equal to their husbands in all respect, and who would be very annoyed about the suggestion that they are victims of gender discrimination. But these reports are exceptions that hide the systemic discrimination underpinning a traditional system of social organisation that is essentially unfair to women. In polygamous societies, the perception that a man may have many wives but a woman may only have one husband is instilled at an early age. As the youth researchers of a Plan project in Benin have found, both young girls and boys accept that men are entitled to several concurrent sexual partners, but they believe that women should only have one (see page 25). As a consequence, young boys grow up with the perception that women are a commodity to be conquered and possessed, and young girls are often resigned to a future of becoming the property of men. Social assumptions about gender identity and sexuality are re-enforced: Women should concentrate on motherhood and should not take pleasure in sexual activities. Men, on the other hand, need to demonstrate their self-worth and power through sexual conquests. Clearly, this is not the basis on which to assert the rights of adolescent girls and boys to sexual health as defined by a “positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence” (WHO 2002).

The story of Fifonsi, 23 years old, Benin.

I was only 17 when I graduated from high-school. I wanted to complete my studies at a secretarial college (brevet de technicien supérieur (BTS) en secrétariat) quickly and find work to help my parents with our household finances. I worked during my holidays to help pay my tuition of nearly 400,000 Francs (1 US Dollar = approximately 450 Francs).

I found a job as a maid with a young couple at 50,000 Francs per month. After just a few days on the job, my employer’s husband started to pay a lot of attention to me, gave me presents and also a lot of money. I was overwhelmed by his charm and his kindness and started to sleep with him. Three months later I was pregnant.

To my surprise, he proposed that I keep the baby and become his second wife. I needed to use all my powers of persuasion and enlist the help of his friends to finally convince him to take me to the hospital for an abortion.

I could continue my studies and he even supported me financially during the three years. In the end this turned out very fortunate for me, but it could have destroyed my life.
Entry Ways through HIV prevention

The majority of sexual health programmes for adolescents in West Africa are part of the national or international response to HIV. This should not come as a surprise. The pandemic of HIV continues to be described as a “global emergency”. This raises expectations of immediate massive action backed by large sums of money. There are many high level international declarations that place the response to HIV in a preeminent position. To name just a few: The 2000 UN Millennium Declaration (UN 2000-2), the 2001 UN General Assembly Declaration on commitment to HIV/AIDS (UN 2001), and the 2001 Abuja Declaration of African Heads of State (OAU 2001). Although the overall resource needs for HIV programmes outstrip current available commitments, the financial support to national HIV programmes has increased rapidly, and a number of high volume international funding mechanisms were created in the last ten years. Of the 22 billion US dollars spent on official development assistance for health, water and sanitation in 2007, one third (7.4 billion) was allocated to the international response to HIV (Kates 2009).

Programmes for HIV prevention among adolescents in West Africa primarily aim to change behaviour, specifically to delay the age of sexual initiation, to reduce the numbers of sexual partners, and to increase condom use. Over the last 25 years, HIV prevention programmes have become more sophisticated and more complex. There is, however, a continued dominance of educational approaches, based on social science theories that emphasise knowledge as a main motivator of behaviour. In 2006, a panel of experts reviewed the evidence for the effectiveness of 23 different types of interventions for HIV prevention among young people. The only programmes judged to provide “very strong evidence” for a beneficial impact were “[school] curriculum-based interventions with characteristics that have been found to be effective in developed countries and are led by adults” (Ross 2006).

Educating children and adolescents about HIV and sexuality should be a relatively simple task, but interventions from parents, community leaders and organised religion often subverts frank discussion of sexual behaviour in class rooms. Once children leave school and become responsible for their own and their families’ economic survival, basic livelihood concerns and their economic future move to the top of their list of priorities. The results of HIV education can be measured in knowledge, attitude and behaviour surveys, however epidemiological impact is harder to determine. This makes funding of HIV prevention education interventions attractive to international agencies. Many of them have subscribed to the approach of “results-based management”: Programmes set measurable targets and work towards achieving these targets. Improving knowledge about HIV, self-reported changes in attitudes towards people living with HIV, and self-reported changes in sexual behaviour are convenient parameters for target setting. It is therefore not surprising that an approach that addresses a well defined captive audience and uses a limited set of easily measured indicators to monitor outputs is found to provide the strongest evidence for benefit. Low-hanging fruits are easy to pick. But the adolescents in West Africa who are most in need for information about HIV risk and sexual health and rights are the vast majority who are not in school and who are not reached by these targeted programmes.
Whose priorities?
There is no doubt that HIV prevention programmes among adolescents in Africa have generated positive results. The prevalence of HIV among young people in some African countries continues to decline. The age of girls’ sexual debut in some countries has increased by as much as two years. These results are primarily observed in the countries experiencing a high HIV prevalence in East and Southern Africa. There are few observations from West Africa, and the profile of HIV in this part of Africa is patchy. There are a few localities with high HIV prevalence, there are some population groups such as female sex workers and men who have sex with men who are severely affected by HIV, but for most adolescents in the region HIV is a rare phenomenon that they only know about from education and information programmes.

Even when HIV is rare, there is a need to prevent HIV infection and stay ahead of the curve of long term impact projections in all regions of Africa. Within the West African context it is worth asking whether HIV prevention programmes are meeting the wider needs to address adolescents’ sexual health and sexual rights. Do these programmes adequately address other issues of significant concern in regards to adolescents in the region? These issues, of course, vary from community to community but two that are quite specific to West Africa are the continuing practice of female genital cutting and the persistence of child marriages in many countries of the region. It has been noted that child marriage leaves young women vulnerable to HIV infection from their older partners. These issues require additional international attention:

In Sierra Leone, practically all girls in rural areas undergo a very painful and potentially dangerous excision of parts of their external genitalia at the age of puberty. Plan research carried out on this issue in 2005 found that there was a high incidence of physical complications due to excision, that the associated initiation rites often include other forms of severe child abuse, and that a large number of women interviewed in the study reported persistent physical, psychological and emotional difficulties related to the experience of excision. HIV prevention in Sierra Leone is a national priority supported by large sums of international aid. A seropositive prevalence survey conducted in 2005 indicates that Sierra Leone has 1.5% prevalence rate. Compared to previous surveys, AIDS is on the increase

Tackling female genital cutting must also become a national political priority. In 2005 the Minister of Social Welfare, Gender and Women’s Affairs was quoted as saying: “We will do something [to prohibit the practice] if the women themselves ask for it”. The Gender Equality Strategy endorsed by the Global Fund Board in November 2008 will allow countries like Sierra Leone which are grant recipients to request funds to “Address and reduce the risks and vulnerabilities that increase women’s and girls’ susceptibility to infection by the three diseases7, and mitigate the impact for those already infected (including, gender-based violence, female genital mutilation, early or forced marriage, lack of access to education, wife inheritance, increased risk due to pregnancy, discrimination in employment.)”

(source: http://www.theglobalfund.org/documents/board/18/GF-B18-04_ReportPSC_Addendum.pdf)

In Niger, HIV prevention is a national priority with a focus on those vulnerable to HIV, marginalization and social instability outlined in the Strategic Plan for the Fight against HIV/AIDS infection. They include young men and women, particularly those with little or no education, sex workers, prison inmates, mobile populations, truck drivers and mine workers. These populations as identified in the Strategic Plan were also targets for priority actions in terms of prevention, communication for behavioral change and, if infected, medical and psychological care within Niger’s successful Global Fund Round 7 grant. More than one third of young women in Niger are married by the time they are 15 years old. A survey in a rural area carried out by Plan Niger in 2003 found that more than two thirds of women were married before their first menstruation, and more than half gave birth before the age of 16. Most of the child marriages in Niger are arranged by the family. The future brides have no say in the choice of spouses or in the timing of their marriage. Serious complications of early pregnancy, including uterine rupture, vaginal fistula, post-partum infections and maternal death were recorded by the Plan research. Research by the Population Council indicates that married adolescent girls have limited control over their reproductive health and represent a sizeable fraction of adolescents at risk for HIV infection and experience some of the highest rates of HIV prevalence of any group.

(source: http://www.popcouncil.org/pdfs/CM.pdf)

The legal age of marriage without consent for girls in Niger is 15 years, but this is immaterial in a country where the majority of marriages are arranged by families. The legislation is nevertheless in contravention of the 1990 African Charter on the Rights and Welfare of the Child.

These two examples illustrate that international support for adolescent sexual health programmes seeking outcomes in terms of HIV prevention must be integrated and linked to SRHR interventions to address multiple vulnerabilities. What can be measured easily and rapidly is an increase in knowledge, especially among school children. And because it can be measured and also reported, the provision of knowledge often takes precedence over all other objectives. Achieving changes in community and behavioural norms – for instance in the reduction of child marriages or the reduction of systemic gender discrimination in sexual relationships – is difficult to measure, and the results are difficult to attribute to one specific project. Interact Worldwide has been committed to challenging the existence of largely separate, compartmentalised HIV/AIDS and reproductive health responses which address separate target populations and have different policy goals and is committed to integration and linkage of SRH and HIV responses in its policy and advocacy and programme interventions.


Raising interest and funds for the promotion of adolescent sexual rights is even more difficult. Rights are not there to produce results; rights set standards for desired programme outcomes. Being better able to exercise and enjoy rights is the result of good programming. But assessing progress in this area is often beyond the type of performance monitoring frameworks imposed by international donors. Those working with young people in West Africa find it difficult to retain a perspective on adolescent rights when it is neither shared nor appreciated by the institutions that provide financial assistance.

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7 HIV, Malaria and Tuberculosis
Sexual and Reproductive Health Rights
Sexual and Reproductive Health
A human rights approach to adolescent sexual health

A rights-based approach to health, according to the World Health Organization, includes “making human rights an integral dimension of the design, implementation, monitoring and evaluation of health-related policies and programmes in all spheres, including political, economic and social” (WHO 2002-2). One is tempted to add “sexual” to this list, but when it comes to the issue of sexual health, there is considerable reluctance to affirm that sexual rights are integral to programming decisions; especially the sexual rights of adolescents. The publication of the World Health Organization nevertheless outlines the elements of a rights-based approach to health. These include, among others:

- Safeguarding human dignity;
- paying attention to population groups considered most vulnerable in society;
- ensuring that health services are accessible to all;
- ensuring that policies and programmes address differences between genders;
- ensuring equality and freedom from discrimination;
- disaggregating health data to detect underlying discrimination;
- ensuring free, meaningful, and effective participation of beneficiaries of health programmes in decisions that affect them;
- promoting and protecting the right to education and information;
- making explicit linkages to international human rights norms and standards; and
- articulating government obligations to respect, protect and fulfil human rights.
In a generic fashion, the application of these elements to sexual health programmes for adolescents would go very far in assuring a rights-based approach. What is lacking are detailed and explicit statements on how these principles apply to the issue of adolescent sexual health. The World Health Organization plans to publish its strategy on health and human rights in 2009 (WHO 2008). It remains to be seen to what extent the sexual rights of adolescents will be recognised in the strategy.

With a more limited scope, but in a more practical way, the United Nations Fund for Population Activities (UNFPA) and the International Planned Parenthood Federation (IPPF) have compiled ten advocacy messages for HIV prevention among girls and young women.

The three axes of this agenda – services, social and economic empowerment and protection – demonstrate that it is possible to frame HIV prevention in a comprehensive rights-based programme. But the document outlines an advocacy agenda rather than a programme strategy; it is limited to HIV prevention and does not address all issues of sexual health; and it is specific to girls. However the agenda demonstrates a very tangible approach to rights-based health programming for adolescents.

### 10 key advocacy messages to prevent HIV in girls and young women

1. **Goal 1: Improve the accessibility of sexual and reproductive health services for girls and young women**
   - **Key message 1**: Expanded provision of sexual and reproductive health policies and programmes.
   - **Key message 2**: Scale up key HIV prevention services, especially the provision of voluntary counselling and testing and female condom contains.
   - **Key message 3**: Expand ‘positive prevention’ services for people living with HIV.
   - **Key message 4**: Make sexual and reproductive health services youth-friendly and gender-sensitive.
   - **Key message 5**: Provide tailor-made, non-stigmatising, accessible and reproductive health services for “key populations”.

2. **Goal 2: Expand socio-economic opportunities for girls and young women**
   - **Key message 7**: Increase economic options, including shifting gender partnerships.
   - **Key message 8**: Reduce the number of people living with HIV.
   - **Key message 9**: Strengthen leadership skills and involvement in decision-making.

3. **Goal 3: End child marriage**
   - **Key message 10**: Outline child marriage in all areas of national legislation, promote supportive services and work with communities to change social norms.

*Source: IPPF 2007*
Plan Ghana – a steep learning curve

Plan Ghana started its first adolescent sexual health project in three rural areas in 1999. The project used many approaches that were considered to be quite innovative at the time, including peer to peer education, folk media, and the use of the Stepping Stones training method to generate discussions about sexual health among young people.

Stepping Stones (Wellbourne 1995)

Stepping Stones is a training package on HIV, communication and relationship skills, sexual and reproductive health and rights, gender relations, and community mobilisation. Since it was developed by Alice Welbourne in 1994 in Uganda, it has been adopted by over 5,000 organisations and is used around the world. In formal evaluations it was found to be a powerful tool for individual and social change. Participants have reported reductions in gender violence and in alcohol consumption, as well as improved relationships and communication between the genders and generations.

In the style of its time and to generate the results expected by its financial donor, the project focused primarily on transmitting knowledge about HIV. After two years, the evaluation of the project did indeed show a remarkable increase in knowledge about how to prevent HIV infection and unwanted pregnancy. It was, according to the terms of reference of the project, a success. (Plan Ghana 2001)

However, like many similar projects in West Africa, the project was not able to reach adolescents who were out of school. Their attendance of peer group meetings was irregular. The young people moved frequently in search of employment or of training opportunities. Survival was their first priority. A programme to promote sexual health and rights has to take this into consideration and establish a link between guidance and support for livelihood as well as for sexual health. This issue has been taken up by Plan projects in Niger, Senegal and Sierra Leone. (see page 28)

The story of Alex, 19 years old, Sierra Leone

“I lost my father and my mother lives in a rural village. I am practically alone in Freetown and I take care of myself. Before the Plan project, I spent most of my time in game arcades and bars, especially at night. I smoked and even sold drugs. I was an outlaw.”

“Then I was contacted to be part of the project’s savings and credit group in our neighbourhood. I have to say that I wasn’t a believer at the beginning, but agreed to go along because of the persuasion of other youths and the project extension agent. I told myself that trying wouldn’t cost me anything.

“The group started with meetings, small contributions and learning about savings and a code of conduct that all we youths had to conform to. Not only did I save, but over time I began to realise that I was undergoing change. For example, I started paying more attention to the way I expressed myself, because our code of conduct did not allow abusive language. This caused me to treat my friends with more respect. I started going out less at night, because I needed to be fresh during the day for my activities and the group meetings. With the money I borrowed from the group I bought and sold costume jewellery and made a profit.”

“I stopped smoking and drinking and changed my way of life. I also realised that other people started looking at me in a more favourable way. Suddenly I was recognised and respected. My life started to have meaning. I started thinking about the future and began thinking about starting a family. The Good Lord returned to my spirit and I became balanced and happy. And I said to myself, ‘I’ll never again be the way I was.’ I promised myself to no longer smoke or drink. I resolved to change. Now I think of my future because I have rediscovered hope and self-confidence.”
The other “missing link” noted by the evaluators was the absence of adolescent-friendly health clinics. Information about HIV and other sexual health issues is not useful if there are no services to support young people when they are confronted with real-life problems. The evaluation noted that “adolescent sexual and reproductive health interventions that are not supported by good referral services are unlikely to significantly protect adolescents from unwanted pregnancies, sexually transmitted infections and other reproductive health risks.” Plan Ghana has learned the lessons of this first project. Adolescent sexual health and rights issues are increasingly being addressed in its child rights and livelihood programmes.

- In the project area where it was most difficult to bring about changes in gender relationships, an initiative to support girls’ football teams is showing promising results in building the self-confidence of girls. Issues of sexuality are discussed in the team meetings without prompting.
- In collaboration with the Ghana Health Service, a number of adolescent-friendly health clinics have been established.
- Following a study that reported a high prevalence of sexual abuse of school girls by their male peers (Child Research and Resource Centre 2009), Plan Ghana has started a large-scale advocacy campaign involving adolescents to change attitudes and behaviours in order to make schools safe for girls and boys.

How to provide adolescent-friendly sexual health services:

- Show young people that you enjoy working with them.
- Counsel in private areas where you cannot be seen or overheard. Ensure confidentiality and assure the young client of confidentiality.
- Listen carefully and ask open-ended questions such as “How can I help you?” and “What questions do you have?”
- Use plain language and avoid medical terms.
- Use terms that suit young people. Avoid terms such as “family planning” which may seem irrelevant to those who are not married.
- Try to ensure that girls and young women attend voluntarily to seek care that they consider important, rather than being pressured by their partner or their family to undergo medical examinations related to their sexual health.
- Speak without expressing judgement (for example say “You can” rather than “You should”). Do not criticize even if you do not approve of what the young person is saying or doing. Help them make decisions that are in their best interest.
- Take time to fully address questions, fears and misinformation about sex, sexually transmitted infections and contraceptives.
- Be prepared to answer common questions about puberty, monthly bleeding, masturbation, sexual attraction to the opposite or the same sex, nocturnal emission and genital hygiene.
- Be prepared to respond to reports of sexual abuse and violence in a substantive manner, offering counselling and effective protection with the level of urgency that is required.

Adapted from Johns Hopkins 2007
Plan Benin – exploring adolescent priorities

The rural Couffo District in the South West of Benin is one of the poorest areas of the country, a zone of heavy out-migration to urban areas and to neighbouring countries. The rate of unwanted pregnancies, HIV infection, and other signs of poor sexual health among adolescents in Couffo indicate that these young people live under a greater-than-average threat to their health and well-being.

Plan Benin started from the premise that effective promotion of sexual health among adolescents has to be based on their real-life situations. It therefore embarked on a process of assisting young people in developing a project that would meet their needs and priorities.

Plan organised village meetings of young people to select a team of youth leaders. Thirty boys and girls aged between 10 and 19 years were selected. In a series of workshops they learned leadership skills, basic principles of sexual health and rights, and research methods. Thus equipped, they conducted their own situation analysis of the factors influencing the sexual health and rights of adolescents in their community.

The result of this research was remarkable. These were some of the findings reported by the young researchers:

- Boys and girls of all ages have considerable knowledge about sexual and reproductive health. Sexuality and the issue of HIV are, however, surrounded by stigma and gender discrimination. Young people, for instance, find it acceptable that boys have several concurrent sexual partners, but they consider it unacceptable for girls.
- Sexual behaviour of young people in Couffo is strongly influenced by television and video clubs and by peers. There is little communication with parents. Boys and girls alike expressed a strong desire for more and better sex education and advice on issues of sexuality.
- Young people hardly ever use health services. The services are too far away, too expensive, too unfriendly, and lack privacy. Furthermore, use of the services often requires parental permission.
- Parents acknowledge that they have problems communicating with their children, and that they lack the means to support and to control them. Some compensate by being overly protective, others disengage themselves from their children, and others even exploit them.
- The social and financial status plays a central role in the sexual behaviour and the risks to sexual health among young people in Couffo. Boys need money to afford a girlfriend and to support a family in the future. If they do not have money, they cannot assume their responsibilities as fathers when their girlfriends become pregnant. For many girls, boyfriends are the only means to obtain consumer goods. The young researchers concluded that the main underlying cause for risks to their sexual health is the clash between the moral standards and the bleak economic situation of their communities.
- A particularly vulnerable group are girls who sell sex in order to pay their school fees, finish their vocational training or even just survive. Sex sold in order to survive earns a very low rate of exchange. The girls are not only abused by adults, but also stigmatised by their own peers.
Following their research, the young people formulated a project proposal under the title Miaglo Vevisese (let us combat persistent suffering). The main objective of the project was to empower adolescents in the District of Couffo to make choices that positively influence their future health and well-being. Specifically, they asked for a project that would:

- Establish spaces for young people where boys and girls can interact and organise themselves around their own concerns and priorities;
- Help bring about positive engagement and support from local leaders, parents, teachers and other adult duty bearers on issues affecting the health and well-being of adolescents;
- Provide integrated youth-friendly sexual and reproductive health services;
- Provide protection and support to adolescents (mainly girls) who are especially vulnerable to threats to their sexual and reproductive health through initiatives of social and economic support, such as school meals, access to micro-credit loans, etc.

Plan Benin is still in the process of mobilising sufficient financial support to start this project. The young researchers, however, did not wait. All of them continued to work with their peers on important sexual health issues. Their parents and teachers reported that the 30 youth leaders had become effective communicators and respected spokespeople for youths in their communities.

In April 2006, Sophie Gbesso, then a 19 year old high-school student who was a member of the research team, wrote to the international medical journal The Lancet. The following is an excerpt (Gbesso 2006):

“You ask me what our problems are? I will tell you. Our schools are far from our homes. I walk to school every morning for over an hour at the break of daylight and back again in the afternoon under the burning sun. Our parents are poor, and we often leave the house without breakfast, and without food or money for the rest of the day. When we have a holiday to rest or to catch up with our studies, we have to work on our family farm. We have no place where young people can meet and have a social life or where we could maybe do some cooperative business to earn money for our own needs. Our schools are not safe. Sexual harassment of girls in schools is common. Many former colleagues have left school because of pregnancy. There are no health or social services for young people in our community. Whenever we try to speak out, we find that our opinion does not count. Nobody ever asks us what we need and what we want.”

“What can we do about this situation? We first of all need to get together as a group and claim our rights. We want parents in our communities to stop abusing their children. We want them to give us the freedom to express ourselves. We need NGOs and we need the government to assist us. They should help us secure our rights and they should develop programmes that address our real issues. HIV prevention and sexual health promotion are all very interesting but they are only a small part of the problems we face as adolescents growing up in rural Benin.”
Plan Togo – putting it into action
In Togo, Plan worked in partnership with the Togolese Family Planning Association (ATBF) in a project to support youth clubs dedicated to the promotion of sexual health and sexual rights of adolescents aged 15 to 19. Over a period of three years, twenty clubs were supported by the project, each with a membership of approximately thirty high school students or apprentices, the membership including girls and boys. Each club was led by a female and male volunteer facilitator, generally a young person recruited from the community where the club was located. These were small towns in the Central and Plateau Regions of Togo. After three years, the pilot project was evaluated by an independent research organisation (SOTED 2008).

The impact of the project is readily palpable. All twenty clubs are firmly established in their community. They have contributed to the personal development of their members and have built their confidence. A health worker in Elavagnon, one of the project communities, said: “We now have adolescents and young people who are able to discuss their sexuality openly and with professional clarity.”

One of the main issues related to adolescent sexuality in this area of Togo is unwanted pregnancy among schoolgirls. Official statistics are not available, but it is generally known that many schoolgirls resort to clandestine and illegal abortions, and many leave school because they are expecting a baby. One of the underlying reasons is a high level of ignorance among adolescents about the fundamentals of sexuality and reproduction. Talking about sex is considered a taboo among young people. As a result, the first sexual encounter is an almost accidental event, an experience entered into without negotiation and without knowledge of the consequences. The activities of the clubs have changed this situation, not only for club members but also for their school colleagues. A high-school teacher in Kparatao said: “Yes, the activities of our school club have had an impact. Before this club was created, I was aware of at least two pregnancies among schoolgirls each year. Since the club has started its activities, I have not noted a single pregnancy”.

One of the most important lessons of the pilot project in Togo is the realisation that once you create the opportunity for young people to take charge of their own issues and concerns, these concerns can no longer be compartmentalised into ‘sexual health issues and other problems.’ The project’s intention was to create clubs that address pre-defined sexual health issues: early unwanted pregnancy, sexual violence and sexually transmitted infections including HIV. But once the young people felt confident that they were in charge of their own agenda, they rapidly expanded the range of activities. They started to discuss all their concerns about growing up in a community where they felt under-valued and marginalised. The impact of this empowering process is expressed as follows in the evaluation report:

*We conclude that the young club members constitute a dynamic local force breathing new life into their communities. Our analysis clearly shows that the involvement of the clubs in the development of their community has introduced new actors in the process of local democratisation. The youth clubs have become part of the process of empowering communities to take charge of their own development.*

This is an important observation. It underlines the fact that sexual health is not just being informed about reproductive functions and sexually transmitted infections. It also requires being in charge of your life and being able to meaningfully contribute to the decisions and the standards that prevail in your family and your community.

Plan West Africa – scaling up what we have learnt
For the twelve country offices that form Plan’s West Africa Region, the experiences in Ghana, Togo and Benin have developed our understanding of good sexual reproductive health programming. All twelve offices have been engaged for many years in projects and activities for reproductive health and for HIV prevention. All of them have a significant portfolio of activities to promote the rights of children. But the challenge was to bring these two types of activities together. This challenge is far from overcome, but the concept of adolescent sexual health and rights that emerged from these experiences offers a new programme platform.
In 2007, Plan started an initiative to create savings and loan associations and provide business training for young people in Senegal, Sierra Leone and Niger. By July 2009, a total of 3,706 young people participated in more than 200 associations created under this initiative, three quarters of them girls and young women aged 15 to 24. The project in Senegal and Niger was developed in partnership with the African Movement of Working Children and Youth (AMWCY), a youth-led movement that makes young people positive actors in their own development and advocates against child exploitation and poor working conditions.

Another lesson learnt has been the scale-up of youth-centred micro-finance and business development projects to reach an increasing number of adolescents who are not in school. Successful initiatives were started by Plan in Niger, Sierra Leone and Senegal, reaching more than 3000 boys and girls in these countries. Initial evaluations indicate that the economic empowerment achieved through these initiatives generates major changes in the capacity of adolescent participants to take charge of their lives in all aspects, including their sexual health and the realisation of their sexual rights.

This is reflected in the 2010-2012 HIV programme strategy adopted by Plan for the West Africa Region. The overall goal of Plan’s response to HIV over these two years will be to strengthen the sexual health and rights of children and youth. The response to HIV will be embedded in a wider approach for the promotion of sexual health and rights.

Making financial services and business skills available to children and youth in West Africa

In 2007, Plan started an initiative to create savings and loan associations and provide business training for young people in Senegal, Sierra Leone and Niger. By July 2009, a total of 3,706 young people participated in more than 200 associations created under this initiative, three quarters of them girls and young women aged 15 to 24. The project in Senegal and Niger was developed in partnership with the African Movement of Working Children and Youth (AMWCY), a youth-led movement that makes young people positive actors in their own development and advocates against child exploitation and poor working conditions.
RECOMMENDATIONS

To Governments in West Africa:

- Where such legislation does not already exist, governments in West Africa should immediately adopt legislation to end child marriages, to outlaw female genital cutting, and to protect adolescent girls from sexual harassment, coercion and forced marriage. All governments should take effective action to enforce these laws and to support the necessary attitude and behaviour change of the populations which sustain these practices.
- Governments in West Africa should ensure that each and every school in the country include age-appropriate curriculum on sexual education, which is appropriately tailored to meet the needs of adolescents. Specifically, the curriculum should focus on strengthening their life skills as well as incorporating human rights, gender equality and sexual rights and responsibilities.
- Social services provided by governments in West Africa should include the provision of youth centres and/or community based facilities managed with a high level of youth participation, offering a wide range of services and opportunities for the development of adolescent girls and boys.
- Governments in West Africa should ensure that all primary health care services have the capacity and the facilities to provide services specifically for adolescents where they can receive care and counselling that is confidential, non-judgemental and professional. These services should include the provision of counselling and support, specifically for contraception and the prevention of sexually transmitted infections, as well as for adolescent victims of sexual abuse, and care and support for pregnant adolescent girls, including the provision of safe termination of pregnancy within the existing legal framework of the country.
- Member States of the African Union who have not yet ratified the Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa and the African Charter on the Rights and Welfare of the Child should do so immediately to strengthen the promotion and protection of the rights of girls and women in their countries.
- Governments in West Africa must take effective measures to ensure that adolescent boys and girls are protected from all forms of violence, abuse, neglect and exploitation. In particular, governments should adopt special measures to ensure the physical, sexual and mental integrity of adolescents with disabilities and other groups particularly vulnerable to abuse and neglect.
- Governments in West Africa should live up to their commitment made in the “Abuja Declaration on HIV/AIDS, Tuberculosis and other infectious diseases” (2000) to allocate 15% of their national budgets to the health sector; national health budgets should clearly identify budget lines for adolescent sexual health.

To the African Union:

- The African Union should recognise adolescence as a distinct life period in the African Youth Charter and develop related program and policy recommendations on this basis.
- The African Committee of Experts on the Rights and Wellbeing of the Child should lobby for the inclusion of information on the situation of sexual health and rights of adolescents in States’ Parties’ reports and alternative reports.
To civil society organisations in West Africa

- Civil society organisations should expand their mobilisation efforts on the issue of HIV to include adolescent sexual health and rights. Specifically, these mobilisation efforts should include advocacy for a government response in the education, health, social service and criminal justice sectors to achieve:
  - Effective protection of adolescent girls and boys from sexual violence, harassment and coercion;
  - Effective support of adolescent girls and boys during their period of sexual transition to develop their ability to freely and responsibly express their sexuality in ways that foster personal and social wellbeing.

- Civil society organisations should include the protection of adolescent girls from sexual violence, forced marriage, unwanted pregnancy and genital cutting in their portfolio of youth programmes and lobby their governments for a stronger focus on adolescents as a specific demographic group in their national health policies and programs.

- Civil society organisations should provide increased opportunities for youth-led groups and organizations to contribute and should include youth as partners. By including youth as partners, NGOs can support them by strengthening their capacities, expanding their advocacy reach and providing funding opportunities for projects concerning sexual and reproductive health and other issues of priority to them.

- Civil society organisations should dedicate the resources necessary to increase the capacity of their staff to facilitate the participation of children and youths in program design, implementation and evaluation, especially for programming that directly affects those under the age of 18.

- Civil society organisations should improve documentation and information sharing on innovative and successful programs targeting adolescent boys and girls with sexual and reproductive health programming.

To the institutions of the UN family:

- The institutions of the UN family, and particularly the World Health Organization, should increase their efforts to promote and support the sexual rights and the sexual health of adolescents in West Africa. UN institutions should also adopt explicit and clear positions on these issues.

- The institutions of the UN family that have the mandate to work with children and adolescents should jointly commission research and conduct expert consultations to generate clear, evidence-based guidelines for parents and educators balancing the need for protection and the right to autonomy for children. The objective of these guidelines should be a better understanding of the concept of “best interest of the child” in the area of sexual health and rights that is specific to the West African context.

- The institutions of the UN family participating in the global response to HIV should develop distinct and specific strategies for adolescents and routinely collect and publish data that are specific to the adolescent age group of 10 to 18, rather than their current focus on “youth” aged 15 to 24.

- The CEDAW Committee should elaborate a general comment on the issue of adolescent girls’ sexual health.

- CEDAW and CRC Committees and the NGO community should promote the inclusion of information on the situation of sexual health and rights of adolescents in States’ Parties’ reports and alternative reports.
To international aid agencies working in West Africa

- Aid agencies should use the opportunity of available funds for HIV prevention to support initiatives that advance and protect the sexual health and rights of adolescent boys and girls.
- The international development cooperation should invest in sexual health and rights of youth and give priority to support the development of national plans of sexual health and rights in the country and programs that focus on the empowerment of adolescents, providing them with opportunities to access adequate information and to participate in the design, implementation and monitoring of projects, policies and services concerning their sexual and reproductive health rights.
- Donor agencies should include in their policy and strategy frameworks the cross cutting issue of “children and youth”. When negotiating national budget support, donors should demand a mechanism of accountability for adolescents and youth from the recipients’ country.
- Donor agencies should allocate funding opportunities to research on adolescent sexual health and rights, both as operations research within youth oriented programming, and stand alone research to fill the existing evidence gap.
- Donor agencies should incorporate targets and indicators for adolescents’ health (health outcomes and service utilization) as a requirement in program design for grants; data collection and indicators for adolescent and youth health should be disaggregated by sex and age group (10 - 14, 15 - 18, 19 - 24 years).

To the European Union:

- The EU should foster a strengthened, concerted and inclusive right to health dialogue from the local up to the global policy level. The EU should make a greater effort to contribute to the development of well-defined health sector policies in beneficiary countries while actively engaging with civil society - including organizations of children and youth - in this process.
- The European Commission (EC) and EU government states should fully integrate a human rights approach to programming in their policymaking and program implementation.
- The EC should consider increasing its aid to the health sector in developing countries to support its commitment to the health Millenium Development Goals (MDGs); The EC also needs to establish clearer guidance on when each aid instrument should be utilised and how they can best be used in combination; EU donor governments should allocate 0.1% of their gross domestic income to official development assistance for health.

To Adolescents:

- Adolescents should organize themselves into equitable groups and organizations to debate issues that concern their wellbeing, including their sexuality. They should also seek partnerships with qualified NGOs and government institutions which can help strengthen their capacity as a group and amplify their voices from community to policy making level.
African Charter on the Rights and Welfare of the Child

The African Charter on the Rights and Welfare of the Child was adopted by the Organisation of African Unity (OAU) in 1990 (in 2001 the OAU became the African Union). The charter entered into force in 1999. As of the end of 2008 it has been ratified by 43 of the 53 African Union member states. The Charter is considered an important addition to the UN Convention on the Rights of the Child as it specifically addresses some of the traditional and cultural values of the African continent. It includes, for instance, a clear prohibition of child marriage.


African Youth Charter

The African Youth Charter was adopted by the 7th Ordinary Session of the Assembly of the African Union held in Banjul, the Gambia, in July 2006. It creates a legally binding framework for governments to develop supportive policies and programmes for young people. However, as of June 2009, only Gabon, the Gambia, Mali and Rwanda have ratified the Charter. Another constraint of the Charter is its definition of "youth and young people" as being in the age group between 15 and 35. The full text of the Charter can be accessed at http://www.africa-union.org/root/au/Documents/Treaties/Text/African_Youth_Charter.pdf.

Child marriage

The term 'child marriage' in this document refers to the marriage of girls below the age of 18 years. This is with reference to the African Charter on the Rights and Welfare of the Child which states in Article 21: “Child marriage and the betrothal of girls and boys shall be prohibited and effective action, including legislation, shall be taken to specify the minimum age of marriage to be 18 years” (OAU 1990). In practice, this is rarely, if ever, an issue for boys in West Africa. However a large number of girls in West Africa continue to get married at a very young age, many of them under pressure from their families, and many of them against their will.

Convention on the Rights of the Child

The Convention on the Rights of the Child was adopted by the United Nations’ General Assembly in November 1989 and came into force in 1990 after it had been ratified by the required number of UN Member States. The 193 countries that have ratified the Convention as of December 2008 are bound to it by international law. Compliance is monitored by the United Nations Committee on the Rights of the Child which is composed of members from countries around the world. In May 2000, two optional protocols were adopted by the UN General Assembly, prohibiting the participation of children in military conflicts and the sale of children, child prostitution and child pornography (UN 2002).

Both protocols have been ratified by more than 120 states. The full text of the Convention can be accessed at http://www2.ohchr.org/english/law/pdf/crc.pdf.

International Conference on Population and Development

The International Conference on Population and Development (ICPD) was held under the auspices of the United Nations in September 1994 in Cairo, Egypt. It was attended by 11,000 delegates. A representative of more than 180 countries negotiated a Programme of Action in the area of population and development for the next 20 years. It endorsed a new global population strategy that links population issues to social and economic development and focuses on the needs of women and men, rather than on achieving demographic targets. The Programme of Action can be accessed at the following link:

Menarche

Menarche refers to the time in a girl’s life when menstruation begins. The age of menarche usually varies between 11 and 15 years and is influenced by body weight as well as genetic and environmental factors. A downward trend of the age of menarche has been observed in most developing countries. (Dixon-Mueller 2008)

Polygamy

The term polygamy refers to a conjugal relationship between more than two spouses. By far the most common situation is the marriage of a man to several wives, known as polygyny or polygynous polygamy. There are a few societies where a woman may marry several husbands, referred to as polyandry or polyandrous polygamy. Under Islamic law, a man may have up to four wives. In many traditional cultures, however, there is no limitation on the number of women a man may marry. (Government of Canada 2006)
Sexual violence
Sexual violence is divided into three categories: 1) use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed; 2) attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, e.g., because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure; and 3) abusive sexual contact (CDC 2008).

Social marketing
Social marketing is the systematic application of marketing techniques to achieve behavioural outcomes that are of benefit to individuals and society, such as giving up smoking, using condoms or employing insecticide-treated bed-nets in malaria-endemic areas. It is sometimes forgotten that the targeted result of social marketing is behaviour change rather than increased consumption of specific commodities (such as condoms), even if these commodities are considered to be good for society.

Transactional sex
Transactional sex refers to sexual relations in exchange for money, goods or services, including sex with teachers in exchange for exam marks. We distinguish transactional sex from sex work, commercial sex and prostitution as the former is conducted on an informal level, usually at a very low level of reward. Adolescent girls who engage in transactional sex in West Africa are often grasping at opportunities to ensure their survival, and they are frequently pressured into these exchanges. This is hardly a commercial activity, therefore these girls cannot be described as “sex workers”.

UN Human Rights Committee
The Human Rights Committee is a body of independent experts that monitors the implementation of the International Covenant on Civil and Political Rights by the Member States of the United Nations. All states’ parties are obliged to submit regular reports to the Committee on how the rights are being implemented. The Committee meets in Geneva or New York and normally holds three sessions per year. The Committee also publishes its interpretation of the content of human rights provisions, known as general comments on thematic issues or its methods of work. (http://www2.ohchr.org/english/bodies/hrc/)

UN Millennium Declaration
The UN Millennium Declaration was adopted as a result of the United Nations’ General Assembly in September 2000, also known as the Millennium Summit. The actions agreed upon in the declaration were later reformulated into eight goals and 21 targets to be monitored by following 60 indicators. International attention is largely focused on the goals (the Millennium Development Goals) rather than on the Declaration, although it is the Declaration rather than the Goals that represents the international consensus. The Declaration can be accessed under the following link: http://www2.ohchr.org/english/law/millennium.htm
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Overview on Girls’ legal protection in Africa

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2 Source: WILDAF
3 Source: http://www.mutengo.co.za/publications.htm - guide to the African Charter
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