STRENGTHENING RIGHTS, ERADICATING POVERTY

Why Germany should invest more in sexual and reproductive health and rights

Berlin Institute for Population and Development

DSW Deutsche Stiftung Weltbevölkerung youth can

Imprint

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Foreword

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The African continent is young: around 60 per cent of the continent's population is under 25 – nearly 900 million children, adolescents, and young adults. This demographic momentum brings both opportunity and responsibility. If governments and international partners mobilise sufficient resources and align health, education, and employment systems with this generation, Africa can unlock unprecedented progress.

Sexual and reproductive health and rights (SRHR) are central to that livelihood agenda. When people are educated and empowered, they can make informed choices about schooling, livelihoods, and family planning – breaking cycles of poverty and dependency. This study shows that progress in SRHR, gender equality, poverty reduction, and sustainable population dynamics go hand in hand. Where comprehensive sexuality education, modern contraception, and youth-friendly services are missing, potential for individual development is held back; where they are available, prosperity and equality grow.

In particular, in East Africa – where population growth is projected to continue beyond 2080 – social security systems must expand quickly. This means not only clinics but a whole ecosystem: schools and training centres, social protection, and inclusive labour markets. In short, sub-Saharan Africa needs less control and more investment in systems that enable young people to thrive.

Our findings also underscore how strongly young women are still affected by discrimination, gaps in SRHR, school drop-out, and limited income prospects– and how much they gain when barriers are removed and autonomy is strengthened. Investing in SRHR is therefore also an investment in economic development, climate resilience, and social justice.

Yet just when more funding is needed, further cuts are looming. We call on policymakers, the private sector, and civil society in Germany and Europe to step up support for rights-based, multisectoral programmes and to engage with African partners on fair terms. Economic self-reliance grows where resources are shared equitably and systems are financed reliably.

I thank the Berlin Institute for Population and Development for its evidence-rich analysis, and the young experts from Ethiopia, Kenya, Tanzania, and Uganda whose voices are at the heart of this publication. May this study help ensure that everyone in Africa – and worldwide – can live freely, in good health, and with the power to decide over their own lives.

Angela Bähr
DSW Chief Programme Officer (CPO)

1 Sexual and reproductive health and rights and poverty eradication are inseparable

Sexual and reproductive health and rights (SRHR) are inextricably linked to human rights, gender equality, sustainable development, and poverty eradication. The global community acknowledges these links in the 2030 Agenda for Sustainable Development with its 17 Sustainable Development Goals (SDGs), adopted by 193 states.[1] The Agenda emphasises that the SDGs are closely interconnected and can only be achieved together. Nevertheless, SRHR remains politicised and contested worldwide – a reality that threatens the entire SDG Agenda.[2] This summary report[i] explores why SRHR and poverty eradication must be addressed together and situates the analysis in the current development funding crisis.

Over the past 30 years, significant progress has been made worldwide in both areas: the proportion of people living in extreme poverty fell from 38 per cent (1990) to 8.5 per cent (2024),[3] HIV infections have dropped by 60 per cent since 1995,[4] and birth rates among teenage girls have declined significantly.[5] These advances demonstrate that investments in SRHR work. But they are under grave threat today – due to political backsliding, funding gaps, and mutually reinforcing crises such as the COVID-19 pandemic, the climate crisis, and a growing number of armed conflicts and humanitarian crises.[6, 7, 8] As a result, extreme poverty is once again on the rise and food insecurity is increasing in sub-Saharan Africa.[9, 10] In addition, development funding cuts by the United States and Europe are jeopardising the SRHR of millions of people – especially on the African continent.[11, 12, 13] For many young people in African countries, poverty has become a more immediate threat than an unintended pregnancy or HIV infection: daily survival often takes precedence over preventive health care.

SRHR and poverty are also closely interlinked with education. For girls and young women in particular, completing secondary school is both a right and a prerequisite for a self-determined life: the longer girls remain in education, the later they get

WHAT EXACTLY DOES SRHR MEAN?

In this report, we refer to the Guttmacher-Lancet Commission's integrated definition of sexual and reproductive health and rights (SRHR), which asserts:

> "Sexual and reproductive health is a state of physical, emotional, mental, and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity."[14]

Achieving sexual and reproductive health relies on the realisation of the sexual and reproductive rights of every person.[15] Sexual and reproductive rights include the right to bodily integrity, to decide freely whether, when, and with whom to be sexually active, to marry, and to have children. They encompass the freedom to define one's own sexuality, sexual orientation, and gender identity, as well as to freely choose sexual partners. In addition, there is the right to lifelong access to information, resources, and health services.[16]

A NOTE ON GENDER-SPECIFIC LANGUAGE

In this study, reference is often made to girls and women. This is because the available data on SRHR is largely collected with girls or women as respondents. However, trans and non-binary people also experience pregnancy, menstruation, and gender-based violence (GBV). Trans and non-binary people are disproportionately affected by GBV as well as by discrimination and other barriers to health care.

[i] *For a full analysis, see the German-language report: RECHTE STÄRKEN, ARMUT BEENDEN. Warum Deutschland stärker in sexuelle und reproduktive Gesundheit und Rechte investieren sollte. Deutsche Stiftung Weltbevölkerung (DSW)/Berlin Institut für Bevölkerung und Entwicklung, 2025. Available at: https://www.dsw.org/wp-content/uploads/2025/09/SRGR-Studie_web.pdf*

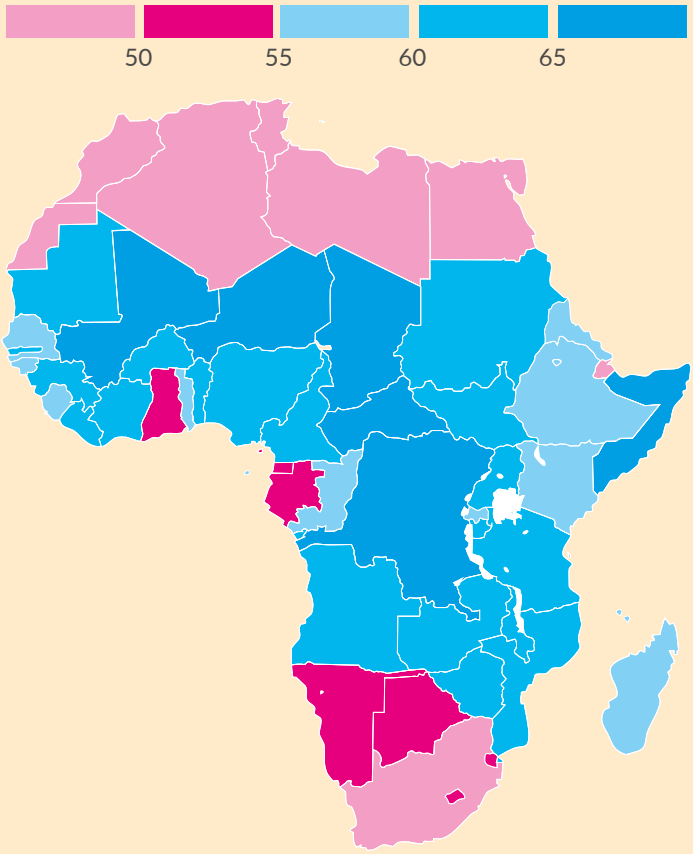
married and have their first birth; and the better their economic prospects as adults. Yet poverty makes it harder to realise one's SRHR and to complete secondary education. Early and forced marriage, teenage pregnancy, early motherhood, and gender-based violence are major barriers to women's participation in public, social and economic life. Exclusion from these spheres of life is frequently compounded by other forms of marginalisation, for example due to extreme poverty, displacement, sexual orientation, gender identity, disability, and/or homelessness.

In this study, we take a closer look at Africa, home to the largest youth generation in the world today. Sixty per cent of the population is under the age of 25.[17] In order to secure the hard-won progress of recent decades and to give Africa's youth a healthy and self-determined future, it is now more important than ever for European development cooperation to invest more heavily in SRHR and poverty reduction. Investment in these areas is essential for the realisation of the 2030 Agenda.

This study sheds light on the multifaceted interactions between poverty and SRHR, with a special focus on the perspectives and needs of young people in Africa. To do so, the authors combined a review and analysis of current literature and data with quantitative findings from interviews with young adult SRHR activists and NGO staff in Ethiopia, Kenya, Tanzania and Uganda.[ii]

AFRICA'S POPULATION IS PREDOMINANTLY YOUNG

Percentage of the population under the age of 25, 2025



Map: Berlin-Institute for Population and Development
Source: UN DESA – World Population Prospects 2024 [18]
Created with Datawrapper

Overall, six out of ten people in Africa are under the age of 25. Worldwide, the figure is four out of ten, with strong regional differences: in rapidly ageing countries such as South Korea, Japan, and Italy, only 20 per cent of the population is younger than 25. In Niger and the Central African Republic, however, the figure is around 70 per cent.[19]

[ii] *The authors conducted ten semi-structured virtual interviews with twelve young adult SRHR activists and NGO staff in Kenya, Tanzania, Uganda and Ethiopia. The four countries were selected in line with DSW's programme priorities, and DSW facilitated contact with interviewees. All participants provided informed consent. With permission, the interviews were recorded, then anonymised, and their insights were used to complement and validate the desk research.*

2 An unprecedented crisis in development financing

2025: THE END OF THE US AGENCY FOR INTERNATIONAL DEVELOPMENT

January 20: On the first day of his second term, President Donald Trump orders a 90-day freeze on all US government development funds.

January 27: Hundreds of employees of the US Agency for International Development (USAID) are dismissed.

February 2: The USAID website is taken offline.

March 28: Secretary of State Marco Rubio announces that USAID will be dismantled.[20]

July 1: USAID ceases to directly implement foreign assistance, and Rubio announces that future "foreign assistance programs that align with administration policies – and which advance American interests – will be administered by the State Department."[21]

Historically, the United States (US) has been among the most important donor countries in international development cooperation, particularly in the health sector. Its contribution to combating HIV (63 per cent of all bilateral funding) and to family planning (40 per cent) has been especially significant.[22, 23] The disruption of US development financing at the beginning of 2025 has particularly severe consequences in Africa, where many national health systems depend on financing from international donors.[24] In the case of HIV, dependence on the US is particularly extreme for some countries: in Malawi, Zimbabwe, and Mozambique, national HIV prevention programmes were until recently almost entirely funded by the US.[25]

2.1. Dramatic consequences

In 2024 alone, US government funding provided 47.6 million women and couples with modern contraceptive care and prevented 17.1 million unintended pregnancies.[26] After the US funding freeze in January 2025, clinics and projects were forced to cease operations, thousands of health workers lost their jobs, and countless patients had to – at least temporarily – go without essential and life-saving medication and vaccines.[27, 28, 29, 30, 31] Scientists warn that a complete cut in US funding for HIV programmes could result in millions of preventable deaths.[32] In Mozambique, South Africa, Tanzania, Uganda and Zambia alone, an additional 9.3 million people could die from AIDS within the next 15 years.[33] Tuberculosis cases could also rise sharply due to reduced access to antiretroviral therapy (ART).[34] When we spoke to youth activists in Uganda and Kenya in early April, they reported that the interrupted access to ART for young people was disastrous. One Kenyan interviewee shared that there had already been shortages of ART supplies before January, but afterwards ART became completely unavailable in many clinics.

Also impacted by the cuts is the Demographic and Health Surveys (DHS) programme[iv] – a vital source of standardised representative data on population health largely funded by USAID. Its discontinuation endangers the data foundation for health planning and policy-making in many African countries.[35] In this respect, the USAID cuts affect Africa in two ways: on the one hand, essential funding for health systems is lost, and on the other hand, future needs remain unknown.

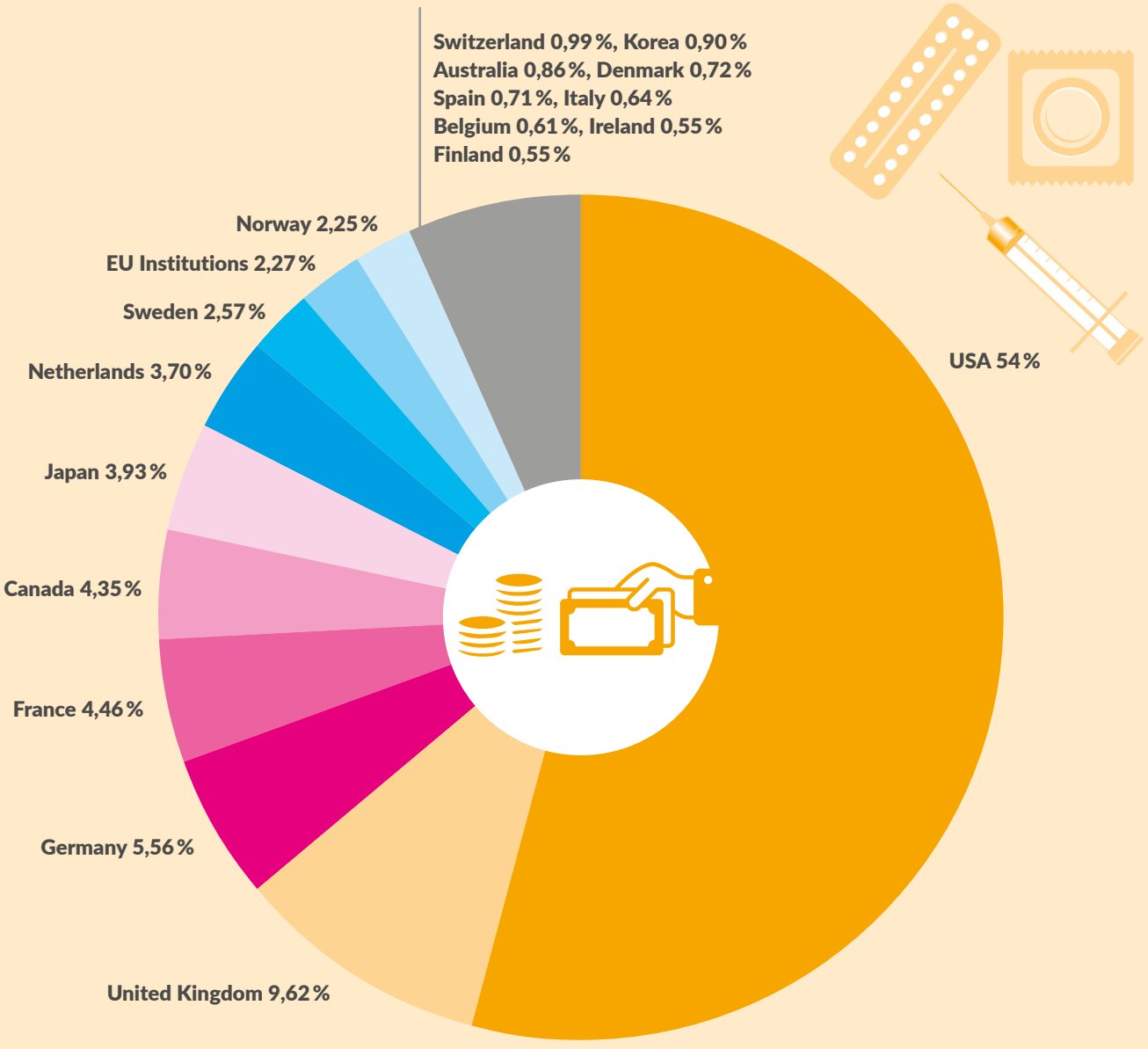
2.2. Who will step in to close the gap?

As the US withdraws from development financing, several European governments – including Germany – as well as the European Union are also planning cuts. Between 2025 and 2029, up to 30 billion euro could be lost.[36] In Germany, funding for SRHR has already been declining since 2021.[37] Despite political commitments in the current government's coalition agreement,[38] the Federal Government plans to cut the budget of the Federal Ministry for Economic Cooperation and Development (BMZ) by nearly 1 billion euro for 2025, which will inevitably affect SRHR.[39]

[iv] *The Demographic and Health Surveys (DHS) Programme is a long-running international survey initiative funded primarily by USAID that collects comparable, nationally representative data on key population and health indicators in low- and middle-income countries. DHS surveys generate detailed information on fertility, maternal and child health, family planning, sexual and reproductive health, gender-based violence, HIV, nutrition, and mortality. Governments, donors, and global health agencies use DHS data to plan health services, allocate resources, and track progress toward national and international commitments.*

THE US WAS PREVIOUSLY THE LARGEST DONOR TO SRHR WORLDWIDE

Donor share of total Official Development Assistance (ODA) to global SRHR, 2023 (in per cent)



An analysis of all Official Development Assistance (ODA) for SRHR in 2023 demonstrates how influential US government funding has been to date. For years, family planning, HIV and AIDS, and reproductive health have been high on the US development cooperation agenda for both Democrats and Republicans.

Graphic: Deutsche Stiftung Weltbevölkerung (DSW)
Source: DSW, Donors Delivering Report 2025 [40]

This crisis illustrates how development cooperation is still reproducing structural dependencies that have clear colonial continuities. African experts emphasise the urgent need for independence from development funding – especially in the health sector.[41, 42, 43] But in the meantime, transitional financing for SRHR will be essential for countries that have received a large share of their health-system funding from the US.[44, 45]

Overall, the numerous long-term consequences of the drastic US funding cuts for the health systems and societies of individual African countries are not entirely foreseeable. What the future looks like depends on whether national governments can redistribute existing resources and whether other donor countries step in to help close the gaps.

> *Global solidarity and renewed commitment from funding partners will be needed as countries plan and lead sustainable transitions towards self-financing.*
>
> *Winnie Byanyima, Executive Director, UNAIDS*

3 Poverty and SRHR: a vicious cycle

3.1. Poverty shapes the daily lives and health of many

According to Afrobarometer, poverty is rising again in Africa. In the latest surveys across 39 countries, 81 per cent of respondents reported having had no income at least once in the previous year, and 66 per cent reported at least one occasion when they could not pay for medication or medical care.[46] While regular income is, strictly speaking, not a basic need, it is necessary to purchase essential goods such as clean water, food, and health products. Around one in four people reported they periodically had to go without such basic necessities.[47] This severely limits access to SRHR: those living hand-to-mouth cannot afford contraception, preventive care, or skilled birth attendants. Interview partners in Ethiopia, Kenya, Tanzania, and Uganda reported that for young people, poverty often poses a more immediate threat than an unintended pregnancy or HIV infection. Relatively high youth unemployment in sub-Saharan Africa (an average of 9 per cent among 15- to 24-year-olds) and the normalisation of precarious jobs further reduce the ability of young people to invest in their education and health, including SRHR services.[48]

> *"Poverty is a key driver of some of the challenges (such as teenage pregnancy or getting HIV) that girls are going through."*
>
> *Employee, Action 4 Health Uganda*

How precarious living conditions affect sexual and reproductive health

In rural regions of Africa, there is often a lack of youth-friendly health services and reliable sexual education. Girls from poor households tend to have earlier sexual contacts, marry, and have children sooner. The costs and the need to earn an income make it harder to avoid unintended pregnancies. Many young mothers drop out of school and later have poorer job prospects. An interview partner in Ethiopia confirmed: women can neither limit the number of their children nor work – a poverty cycle that continues across generations.

Efforts to reduce poverty must also address SRHR – and vice versa. Economic empowerment is crucial for young people to afford SRHR: the preferred contraceptive method, menstrual products, or a visit to a clinic are often too expensive. Some young people affected by extreme poverty – especially girls and young women – may sell sex simply to meet basic needs or support their families.[49]

In many rural areas of Africa, it is not uncommon for teenage girls to already have one or more children.[50] This is often driven by structural factors such as poverty, prevailing social norms, and a lack of comprehensive sexuality education (CSE) in schools. Young people in remote regions may have limited access to reliable information on menstruation, safer sex and contraception, and youth-friendly health centres are scarce and hard to reach. Girls and young women from the poorest households face particularly high barriers to realising their SRHR; statistically they tend to have their first sexual experiences earlier, marry earlier and have their first child earlier than their peers from wealthier households.[51] Cost barriers related to counselling and contraception, together with the need to earn an income, make it harder to avoid unintended pregnancy. The consequences are far-reaching: many young mothers do not complete school and later struggle to gain a foothold in the labour market. [52]

One interviewee in Ethiopia explained to us what the scientific literature repeatedly confirms: many women are unable to limit the number of their children.[53] The responsibilities associated with pregnancy and motherhood, domestic labour, and care work can prevent young women from finishing secondary school or taking up paid work, perpetuating an intergenerational cycle of poverty. Without an independent income, escaping extreme poverty can be impossible. Investments in SRHR are therefore both a matter of human rights and a key lever for poverty reduction: SRHR open up education, decent work, and self-determination for girls and young women.

Health care – but not for everyone

Extensive scientific analysis based on DHS data shows pronounced socio-economic inequalities in access to health care. In South Africa, for example, people from economically disadvantaged households are more likely to postpone medical visits

because they cannot afford treatment or transportation to a clinic.[54] In Kenya, too, preventive care and hospital stays are often unaffordable for people from poorer households.[55] Even where public care is nominally free, indirect costs (e. g., bus fares or time not working) and facility charges can deter use. In Tanzania, our interviewees reported that some clinics demand co-payments or the purchase of a 'patient card' in order to receive treatment. In remote rural areas, young people may be unaware that free services even exist or live too far away from the nearest clinic, while in sprawling urban informal settlements, scarce public transport and the cost of private transport are barriers.

Young people may also avoid public facilities when they are known for a lack of privacy. When it comes to sexual and reproductive health, services such as contraceptive counselling or testing for sexually transmitted infections (STIs) are often unavailable, and young people frequently experience stigmatisation and judgement from health workers for being sexually active at their age. Young women, teenage mothers and young people with disabilities disproportionately experience provider bias for seeking SRH care.[56] One of our interview partners in Ethiopia confirmed that medical providers at private clinics are generally more respectful and discreet, which is why some youth prefer these clinics – if they can afford to go there. Targeted investments in youth-friendly SRH services are urgently needed to ensure all young people – especially those affected by poverty – can receive the care they need.

Contraceptives are often unavailable

In Ethiopia, Kenya, Tanzania, and Uganda, contraceptives such as condoms are generally available free of charge in public clinics. However, inconsistent interpretations of each country's laws and policies regarding whether adolescents under 18 need parental consent to obtain contraceptives in health facilities present a specific challenge for youth.[57] In Kenya, the Ministry of Health allows exceptions for sexually active adolescents, but some clinics still require parental consent, including because health care staff are not sufficiently trained or informed.[58] Similar issues exist in Uganda, where national guidelines allow SRH services for youth without parental consent but adolescents report being denied care.[59] Another major problem is that some modern contraceptives are often unavailable. Frequent stock-outs mean that a young woman may not be able to adopt the method of her choice.[60, 61] Our interview partners reported that some long-acting contraceptive methods are routinely unavailable for weeks or even months in public health facilities. Those who cannot afford private clinics or pharmacies are left with either a less suitable contraceptive or none at all.

HIV prevention and treatment do not reach many adolescents

Worldwide, Eastern and Southern Africa are most affected by the HIV pandemic. The two regions are home to more than half of all people living with HIV.[62] Although significant global progress has been made in prevention and treatment, not

WHAT IS POVERTY AND HOW IS IT MEASURED?

Poverty is not a single, uniform concept. This study draws on multiple data sources that use different poverty concepts and measurements. Perhaps the most commonly used measure is the World Bank's international poverty line. This line defines people who must survive on less than 2.15 US dollar per day (purchasing power parity 2017), as living in extreme poverty. This is a measure of absolute poverty. By contrast, relative poverty assesses living standards in relation to average conditions in a given society, capturing inequality within countries.[63] In countries with limited data on income or consumption, measures such as the DHS Wealth Index uses indicators such as material assets, housing quality, and access to electricity, clean water, and sanitation facilities to rank households into wealth quintiles.[64] Afrobarometer developed the Lived Poverty Index to measure experienced deprivation, i.e. how often people must go without essentials.[65]

Poverty can also be understood as multidimensional. The United Nations Development Programme (UNDP) Multidimensional Poverty Index (MPI) considers a person's entire living situation: in addition to income and employment, it also uses indicators measuring health, education and living standards. In most countries with comparable data, more people live in multidimensional poverty than in extreme poverty using the World Bank definition.[66]

A key limitation of many poverty measures is that they are calculated at the household level, which can mask gendered deprivations within households. Gender-sensitive analyses show higher multidimensional poverty among women and girls, including undernutrition, even in non-poor households.[67, 68]

> *If someone is from a low-income family, his primary focus will be on poverty. The financial constraints of everyday life, trying to fulfill their basic needs. That can create an environment where you don't pay attention to your sexual and reproductive health.*
>
> *Youth Champion, Ethiopia*

everyone benefits equally: 84 per cent of all 15- to 19-year-olds living with HIV are in sub-Saharan Africa.[69] Adolescent girls in this age range are almost six times more likely to become infected than their male peers.[70]

After decades of progress, prevention indicators are now moving in the wrong direction. Surveys show a decline in condom use among 15- to 24-year-olds in several African countries, including Ethiopia, Kenya and Tanzania.[71] In part, this is directly linked to affordability and availability: in 2024 UNAIDS reported that free condom distribution programmes were already being "steadily defunded".[72] With the interruption of USAID the situation is set to worsen.[73] A young interviewee in Kampala told us that accessing condoms is especially challenging for youth in rural Uganda. During a recent mobile outreach programme he participated in, the demand for condoms from young men was overwhelming – the local rural clinics had been out of stock for months.

While there has been overall progress in treatment for people living with HIV, children and young people under the age of 25 are less likely than adults to know their HIV status, receive ART, and achieve viral load suppression.[74, 75] In Uganda, for example, viral load suppression among those aged 0 to 24 rose from 33 per cent in 2016 to 49 per cent in 2020. This is certainly an improvement, yet well below the rate among adults 25 and older: 75 per cent in 2020. Poverty widens these gaps: viral load suppression rates in the poorest households are markedly lower than in the wealthiest. The current funding cuts put HIV prevention and treatment at further risk and could reverse decades of progress.[76] Without renewed and targeted investments in HIV prevention and treatment for children and youth, we risk creating a new generation that will be hit particularly hard by HIV. [77]

Extreme conditions in humanitarian emergencies

At the end of 2024, around 39 million people were internally displaced across sub-Saharan Africa, including over 11 million in Sudan and 3.3 million in Nigeria.[78] Many displaced people lack access to adequate medical care, menstrual products, and sanitation facilities. This puts girls and young women at particular risk. Extreme poverty in the context of displacement forces girls to use used clothing as menstrual pads and routinely go hungry.[79] This precarious situation often leads to relationships of dependency: girls report engaging in sexual relationships in exchange for money or food, and some parents force their adolescent daughters into marriage so they no longer have to financially support them.[80] Young internally displaced people face a particularly high risk of forced marriages, sexual violence, unintended pregnancies, unsafe abortions, and STIs[81, 82] Humanitarian aid programmes must therefore consistently integrate SRHR – from safe obstetric care to protection mechanisms against sexual violence – to safeguard the health and rights of young people.

Investments in health pay off

When comprehensive, free SRH care is not available to all people, this results in costs for patients as well as higher follow-up costs for health systems.[83, 84] For example, the provision of post-abortion care for unsafe abortions is significantly more expensive than the provision of safe abortion care.[85] Moreover, eight out of ten unintended pregnancies in Africa could be averted by fully meeting women's need for modern contraception.[86] Investing in a broad range of contraceptives – for all genders – isn't just good for health outcomes, but also leads to immense cost savings. Each year, there are 4.3 million unintended pregnancies among 15- to 19-year-olds in Africa, of which 1.5 million end in an unsafe abortion. If adolescent girls' contraceptive needs were met, these numbers would fall by more than two-thirds (69 per cent).[87] Health-system savings would follow, since providing modern contraception costs less than pregnancy-related care. The Guttmacher Institute estimates that each additional 1 US dollar invested in contraceptive care reduces the cost of maternal, newborn and abortion care in Africa by 2.77 US dollar.[88]

3.2. Education and SRHR: Prerequisites for a life free from poverty

Education, SRHR and poverty are closely linked: education is first and foremost a human right, but it is also a cornerstone of sustainable development, gender equality, and economic growth in communities and countries. For girls and young women, attending and completing school is a key to self-determination: the longer girls attend school, the later they marry or have their first child – and the better their chances of being able to earn a decent wage as adults.[89] But for young people who are affected by poverty and especially girls, it is difficult both to realise their SRHR and to complete secondary school.

Many African countries have made immense progress in education in the last two decades. Still, in 2023, nearly 20 per cent of African children of primary school age were not in school.[90] While the gender gap in primary school enrolment between girls and boys has generally narrowed, it remains in countries where many children do not attend school, as well as at the secondary level when more girls than boys drop out of school for gender-specific reasons.[91, 92] Girls from households affected by poverty are particularly affected. In Tanzania, one-third of girls from the poorest households do not attend primary school, in lower secondary school the figure rises to more than half, and at the upper secondary level to 90 per cent.[93]

A youth activist from Nairobi told us how this vicious circle can play out in the life of a Kenyan schoolgirl:

> *In Kenya, young women from low-income areas face a high risk of unintended pregnancy. When families live below the poverty line, their limited income goes toward basic survival, leaving no room for essentials like sanitary pads – which have become increasingly expensive. As a result, some girls are forced into risky choices, such as engaging in transactional sex just to afford menstrual products. This often leads to unplanned pregnancies, followed by unsafe abortions or the heavy burden of early motherhood.*

Although laws like the school re-entry and retention policies exist to help school-age mothers continue their education, they are not always practical for families struggling to make ends meet. Many girls are instead pushed into early marriage or have to find work to support their child. For these young mothers, the future becomes drastically different from their more affluent peers, they are often forced to abandon their dreams.

When pregnancy leads to school dropout

Poverty, early pregnancy and motherhood, and school dropout are closely interlinked. The poorer the household, the higher the likelihood that girls aged 15 to 19 become pregnant.

(Unintended) adolescent pregnancies have long-lasting impacts on a girl's education, employment prospects, health and self-determination.[94, 95] Pregnant students are often forced to leave school well before the birth of their child or immediately afterward. For many young mothers, returning to school is impossible without adequate social and financial support.[96] A young woman who can't complete secondary school is likely to face lifelong challenges to achieve economic independence and earn a decent wage in adulthood. As a result, the cycle of poverty and limited opportunities risks persisting across generations.[97]

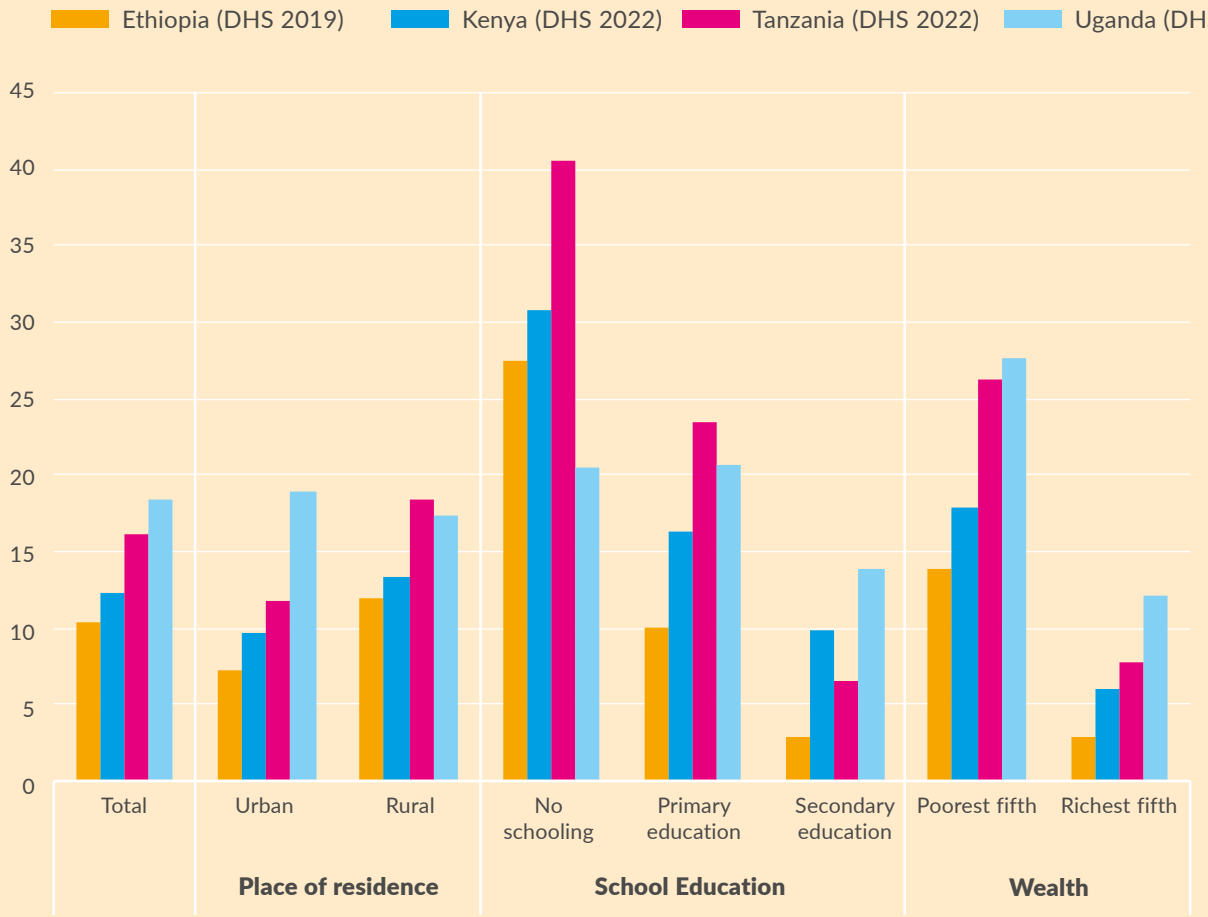
Period poverty: When menstruation and school are incompatible

One reason why girls are absent from school more often than their male peers is menstruation. This is especially true for those who cannot afford menstrual products such as sanitary pads or whose schools are not equipped with adequate toilet facilities.[98, 99] A study conducted in Kilimanjaro, Tanzania, found that one in three girls has had to miss school during menstruation.[100] Interview partners in Ethiopia, Kenya, Tanzania, and Uganda told us that many teenagers can't afford to buy pads every month. As an alternative, they must resort to improvised materials that are neither hygienic nor adequately absorbent. This increases the risk of infections and undermines well-being. For some girls, reusable, washable pads are preferable to reduce the monthly cost of period products. But interviewees who work in informal settlements in Nairobi, Kenya, emphasised that needs and preferences differ based on living conditions. Where running water is scarce, for example, reusable pads can be impractical.

Periods can therefore take a heavy toll on girls' school attendance and performance. To advance educational equity, programmes seeking to address period poverty must increase access to affordable period products as well as adequate sanitary facilities in schools that are gender-segregated, and have private toilets, running water, and discreet disposal bins for menstrual products.

POVERTY IS ONE OF THE MAIN REASONS FOR EARLY MOTHERHOOD

Percentage of 15- to 19-year-old women who are mothers, by socio-demographic characteristics in selected African countries



Graphic: Deutsche Stiftung Weltbevölkerung (DSW)
Source: ICF [101], Ugandan Bureau of Statistics [102]

Comparing which young women in Ethiopia, Kenya, Tanzania, and Uganda become mothers at an early age reveals similar trends. Young women in rural areas often become mothers earlier than those in urban areas – with the exception of Uganda. The higher a woman's level of education, the less likely she is to become a mother at a young age. Differences in wealth, in particular, appear to have a significant impact on the likelihood of early motherhood: Young women affected by poverty are significantly more likely to have a child than their peers in the wealthiest segment of the population.

Comprehensive sexuality education as the basis for (bodily) autonomy

Comprehensive sexuality education (CSE) is one of the most important building blocks for empowering every person to make free, informed, and responsible decisions about their body, and their sexual and reproductive health. Good quality CSE programmes help adolescents protect themselves from early and unintended pregnancies, HIV infections, and other STIs – and have the potential to reduce gender-based violence (GBV).[103] The young activists we interviewed from Ethiopia, Kenya, Tanzania, and Uganda, unanimously agreed that the lack of CSE is one of the biggest problems facing young people in their communities. Social taboos mean that parents rarely talk to their children about topics such as STIs, contraception, or menstruation – and schools usually offer insufficient information. Most young people are left to fend for themselves, relying on friends or the internet for information, which are not always reliable sources. Nevertheless, access to the internet remains a crucial advantage that previous generations did not have. For young queer people, the internet and social media are often lifesaving resources.[104]

3.3. SRHR enables women's economic and social participation

Good or poor sexual and reproductive health affects not only girls' educational opportunities, but also their participation in society and the economy. For girls and young women, child, early, and forced marriage (CEFM), teenage pregnancy, early motherhood, and GBV are major barriers to participating in public life. These can be further exacerbated by other forms of marginalisation, including extreme poverty, displacement, disability, homelessness, and homophobia. These factors often end girls' education and can make escaping poverty nearly impossible. In contrast, more education increases income and opportunities: in Africa, women with secondary education earn twice as much as women with no education, and those with tertiary education nearly five times as much. Women with more education and a higher income can also better realise their SRHR: they can make self-determined decisions about their health, are more informed about HIV and AIDS, and can afford menstrual products, desired contraceptives, and safe abortion care.

Social norms and social exclusion

Worldwide, including in many African societies, girls and young women are expected to marry and have children. This is especially common in families affected by poverty, where many girls are married off before they turn 18.[106] In these circumstances, girls usually have no self-determination over contraception or pregnancy, which is why most births among teenage girls occur within CEFM.[107] At the same time, sex among unmarried youth is heavily stigmatised, and young women are particularly at risk of discrimination and social exclusion. In Uganda, for example, young people report that forced marriage is a common punishment for sex outside of marriage.[108]

Restrictive norms foster not only CEFM and stigma but also GBV. Globally, including in Africa, one in three women experiences GBV in the course of her life, usually in the form of intimate partner or sexual violence. The consequences of these human rights violations are severe and range from injuries and STIs to depression, murder, and suicide.[109] In sub-Saharan Africa, one in five girls (aged 15 to 19) who has ever been in a partnership has experienced physical and/or sexual violence at the hands of a current or former partner in the past 12 months.[110] GBV affects women of all economic backgrounds.

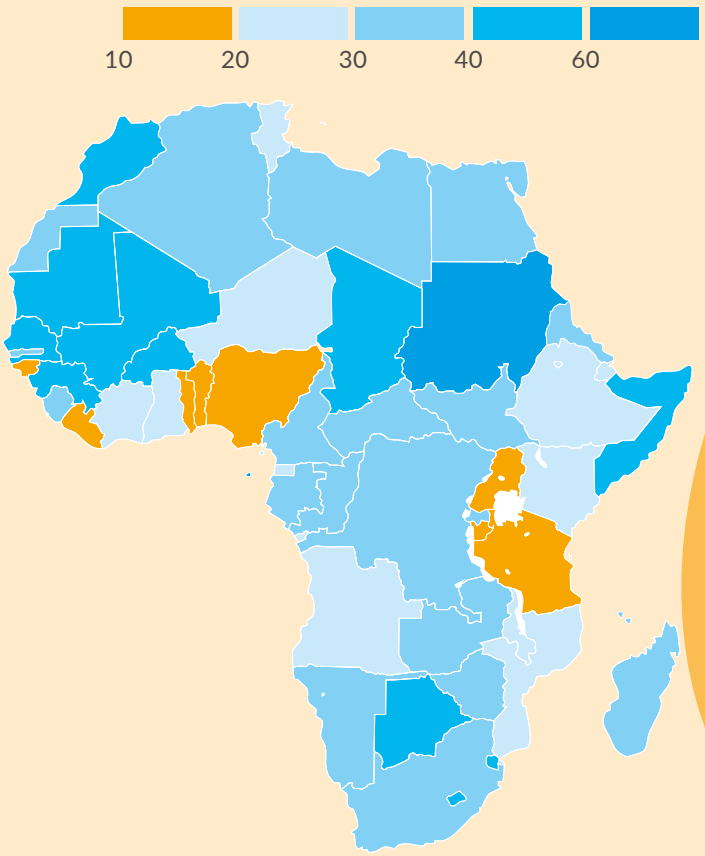
Far-reaching consequences of pregnancy- and birth-related injuries

Pregnancy and childbirth are always associated with health risks, but these can be reduced by adequate antenatal care and professional birth assistance. This care is especially important for pregnant adolescents: complications in the context of pregnancy and birth are the second leading cause of death for 15- to 19-year-olds worldwide. When they don't end in death, such complications account for one of the leading causes of disability-adjusted life years (DALYs) for this age group.[111] In Africa, this is in part directly related to poverty: young pregnant women living in poverty and/or rural areas have less access to antenatal and obstetric care.[112, 113,114] Without adequate care, preventable complications such as obstetric fistula – a severe injury which can lead to lifelong incontinence, depression, and social exclusion if untreated – are more likely.[115] An interviewee in Kenya explained that many young pregnant women don't even know that they can go to a health facility to give birth. Complications that could have been avoided with skilled birth assistance instead result in disabilities or death.

Early pregnancy and birth have lifelong effects on girls' health, as well as their social and economic participation. In sub-Saharan Africa, women spend an average of one-third of their reproductive years (ages 15 to 49) with reproductive health problems, which significantly limits their ability to earn a stable income and participate in public life.[116]

MANY YOUNG WOMEN ARE EXCLUDED FROM EDUCATION AND THE LABOUR MARKET

Proportion of 15- to 24-year-old women not in education, training, or employment (Not in Education, Employment or Training, NEET), in per cent, 2024



Map: Berlin Institute for Population and Development
Source: ILOSTAT [117]
Created with Datawrapper

Girls and women in Africa face diverse forms of exclusion and discrimination in education and employment: from social norms that force them to drop out of school, to various barriers to entry into the labour market, and the gender pay gap. This is reflected in the high NEET rates for young women. While there are significant differences between countries, there is only one country on the continent where fewer than 15 per cent of young women are not in education, training, or employment. In Burundi, the figure is 11.2 per cent.

Precarious employment and limited options

Harmful social norms and lack of SRHR cause many girls to drop out of school, later reducing their chances of securing safe, decent work. In 2024, 30 per cent of young women (aged 15 to 24) in Africa were not in education, employment, or training (NEET), compared to 17 per cent of young men.[118] However, this regional average obscures large differences between countries: in Chad, Mauritania, Morocco and Somalia, around 50 per cent of young women are NEET in contrast to 17 per cent in Uganda, and Tanzania.[119]

Many women are disadvantaged in the labour market due to unpaid care work responsibilities for their children and families.[120] Most women who work outside the home do so in the informal sector, which is typically poorly paid and offers no social protection. Across Africa, an average of 87 per cent of employed women are in precarious jobs.[121] One in four women in sub-Saharan Africa works in her family's business and therefore has no income of her own.[122] Young people told us how hard it is for youth affected by poverty to make ends meet with no access to cash. Some therefore seek informal work, where they might earn at most 1 US dollar a day, or they may not even receive a monetary wage and work only for a plate of food.

Girls and young women who have no education or only completed elementary school have extremely limited options to earn an income. As a last option, some resort to selling sex to survive. This increases their risk of HIV and other STIs, GBV and unintended pregnancy. This reinforces the cycle of poverty: those struggling to survive on a daily basis cannot invest in education or afford contraceptives or health care.

> *Sexual and reproductive Health cannot really go alone without including GBV but also the component of economic empowerment. They all go together.*
>
> *Employee, DSW Tanzania*

4 Calls to action for the German Federal Government and Parliament

African countries face vast, cross-cutting challenges that demand integrated, cross-sector investment to secure sustainable development, social justice and gender equality. Ensuring SRHR for all is a foundational requirement for achieving these goals. Young people across the continent are increasingly asserting their rights in this regard: sexual and reproductive autonomy, and also greater social, political and economic participation. Promoting SRHR for youth – in conjunction with the eradication of poverty – must therefore be a priority in development cooperation. On this basis, the study sets out recommendations for German development cooperation to meet young people's needs and support African economies.

- The Federal Government should increase the budget of the **Federal Ministry for Economic Cooperation and Development (BMZ) by at least 2 billion euro.** DSW also calls for additional investments of 50 million euro for UNFPA, 2.5 million euro for the UNFPA Supplies Partnership, 20 million euro for the International Planned Parenthood Federation (IPPF), 50 million euro for the Global Financing Facility (GFF), at least 100 million euro per year for bilateral SRHR measures, as well as contributions of 1.4 billion euro to the Global Fund to Fight AIDS, Tuberculosis and Malaria and 15 million euro to Gavi, the Vaccine Alliance, to support the integration of SRHR and HIV/AIDS.

- The Federal Government and BMZ should, in bilateral cooperation with like-minded partner countries, work towards **stable financing of health systems** in line with Universal Health Coverage (UHC).

- **In connection with investments in SRHR, the Federal government should invest in poverty reduction across all sectors,** including in food security, education, employment promotion and climate adaptation. This is necessary to give all children a healthy and fair start in life.

- BMZ should, in bilateral cooperation, **address the intersections of SRHR, girls' education, vocational training and employment promotion for young women.** Removing SRHR-related barriers that make it difficult for girls to stay in school and complete training must be accelerated to advance gender equality and poverty reduction. The Federal Government should also support partner countries in expanding social protection systems that are gender-responsive, intersectional, and climate-resilient.

- BMZ must **strengthen the participation of marginalised young people in SRHR programmes,** particularly by supporting relevant youth organisations.

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DSW youth car
Deutsche Stiftung Weltbevölkerung

ABOUT DSW

Deutsche Stiftung Weltbevölkerung (DSW) is an international development organisation, which focuses on the needs and potential of the largest youth generation in history. Our objective is to empower young people, especially young women and girls, by creating demand for and access to youth-friendly health information and services including modern contraceptives, and by securing their right to bodily autonomy. With offices in Europe and East Africa, we achieve this through a combination of youth-oriented programmes and gender transformative advocacy that also champions for investments in research and innovation to fight poverty-related diseases and to foster women's health.

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