

GLOBAL YOUTH FAMILY PLANNING INDEX

FEBRUARY 2017

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Global Youth Family Planning Index

February 2017

Population Reference Bureau

INTRODUCTION

Governments around the world have made great strides in creating policies that support the health and human rights of young people. Increasingly, countries have institutionalized the rights of adolescents and young people to access health services, including sexual and reproductive health (SRH), within formal laws and policies. Statements by the United Nations Population Fund (UNFPA), World Health Organization (WHO), and others have underscored the urgency for international organizations and governments to ensure that all young people have informed choice and full access to contraceptives.¹

Despite growing commitment from decision-makers, many barriers remain for young people who want to use contraception. A limited evidence base has hampered systematic assessment and mapping of the key policies and programs that govern young people's ability to access family planning (FP) information, services, and commodities. Governments and their partners lack clear guidance on supporting interventions that ensure their commitments to expanding FP use among young people are realized. Similarly, civil society needs to establish monitoring efforts to understand how countries address the needs of youth in their laws and policies and to identify areas for improvement.

To address this evidence gap, the Population Reference Bureau (PRB) has developed a "Global Youth Family Planning Index" to measure and compare countries' youth FP policies and programming. The index compiles and analyzes the evidence that identifies the most effective national policies and program interventions to promote uptake of contraception among youth, defined as people between the ages of 15 and 24. This report details the purpose of the new index, describes its methodology and indicator selection process, and summarizes results for nine countries.

In the index the term "family planning" refers to contraception and related services, as is common among advocates. However, the term "family planning" is less useful when considering youth's unique reproductive health needs, since many young people have not yet begun planning a family, although they do need access to contraception. The index uses the terms FP and contraception interchangeably.

PURPOSE

The index is designed to allow quick assessment of the extent to which a country's policy environment enables and supports youth access to and use of FP by promoting evidence-based practices. The index can be used by governments, donors, and advocates to:

- Evaluate the inclusion of evidence-based interventions and policy language shown to reduce barriers and/or increase youth access to contraception in countries' policies.
- Set policy priorities and guide future commitments based on gaps and areas of weakness identified by the index.
- Compare policy environments across countries.

The index evaluates the status of existing youth FP policies reflected in official government documents. Policies are understood to be government-authored laws, regulations, and strategies to set priorities and/or achieve a particular objective. Specifically, the index assesses a country's policy framework (constitutions, laws, reproductive health acts, etc.) and programmatic guidelines (FP costed implementation plans, adolescent health strategies, youth development plans, etc.) that impact youth FP.

From Policy Commitments to Implementation

Policy statements provide only a partial view into youth's ability to fully access and use contraception. The index, in its current form, does not evaluate implementation of country commitments. While commitments are an important first step, the extent to which they are implemented is the true measure of improvements in health and well-being. Further research, building on the knowledge generated by this index, will be important to assess the implementation of policies and their full impact on young people's access to and uptake of FP.

METHODS

To identify policy and program interventions that have been proven to increase youth use of contraception, PRB staff conducted a literature review of 42 studies and systematic reviews (scholarly, gray, and program reports) on youth SRH published between 2000 and 2016. From this evidence base, we identified legal approaches and programmatic interventions that have proven effective in improving access to and use of contraception among youth ages 15 to 24. We did not include adolescents ages 10 to 14 in the review, due to limited data for this age group.

The evidence on what works to address youth FP needs is varied and at times contradictory, due in part to the nature of this population. Youth's thoughts, interests, and behaviors are constantly changing and evolving, and different populations of youth (for example married, out of school, disabled) have targeted needs. Further, the impacts of youth interventions are often not observable for years after a study closes, when youth may initiate or resume sexual behavior.² Variations in outcomes are also related to intervention design and implementation. The 2016 *Lancet* Commission on Adolescent Health and Wellbeing found greater effectiveness when interventions were packaged together rather than implemented individually; however, when interventions are packaged together it can be challenging to tease out the impact of specific interventions.³ Finally, the manner in which interventions are implemented varies by study.

Acknowledging these challenges, we selected policy and program interventions for which three conditions apply:

- Evidence from low- or middle-income countries (LMIC) shows the policy or program intervention removes a barrier to or results in increased contraceptive use among youth (ages 15 to 24).
- It is feasible for the policy or program intervention to exist or be adopted at scale at the national level in most LMIC.
- The policy or program intervention can be compared across countries.

When selecting indicators, we chose those with supporting evidence directly linked to increased youth contraceptive use, although this choice limited the number of policy and program interventions that were ultimately included. Cash transfer programs, for example, have had an impact on decreasing pregnancies

among youth and increasing age of sexual debut, but the evidence has not yet identified a direct link to contraceptive use.⁴

We shared two draft sets of indicators with youth SRH experts, revised the framework based on their feedback, and ultimately selected six indicators that fit the selection criteria:

- Parental consent, spousal consent, or provider discretion.
- Restrictions based on age.
- Restrictions based on marital status.
- Comprehensive sexuality education (CSE).
- Youth-friendly (YF) FP service provision.
- Community support for youth FP services.

We devised three color-coded categories to classify how well a country is performing for each indicator. For each indicator, the color assigned is based on the extent to which a country provides the most favorable policy environment for youth to access and use contraception:

- Green: Strong policy environment.
- Yellow: Promising policy environment but room for improvement.
- Red: Policy environment impedes youth from accessing and using contraception OR a policy addressing the indicator does not exist.
- Gray: Not enough information.

To conduct this analysis, we reviewed all potentially relevant policy documents published by each country's government that could be accessed online. We contacted multiple government and nongovernmental stakeholders in each country to ensure that relevant policies were not inadvertently omitted, and to validate our analysis. A full list of policies reviewed is provided in each country summary.

INDEX INDICATORS OVERVIEW

The following table summarizes the definitions and categorizations of the six index indicators, with details provided below.

| POLICY INDICATOR | Strong policy environment | Promising policy environment but room for improvement | Policy environment impedes youth from accessing and using contraception OR a policy addressing the indicator does not exist |
|---|---|---|---|
| Parental Consent, Spousal Consent, or Provider Discretion | Law or policy exists that supports youth access to FP services free from provider discretion AND consent from a parent or spouse. | Law or policy exists that supports youth access to FP services free from one or two of the following: provider discretion, parental consent, or spousal consent, but not all three. | Law or policy exists that requires provider discretion OR consent from a parent OR spouse for youth access to FP services. |
| | | | No law or policy exists that addresses provider discretion or consent |

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| | | | from a parent or spouse to access FP services. |
| Restrictions Based on Age | Law or policy exists that supports youth access to FP services regardless of age, including the provision of long-acting and reversible contraceptives (LARCs). | Law or policy exists that supports youth access to FP services regardless of age but does not mention provision of a full range of methods. | Law or policy exists that restricts youth from accessing a full range of FP services based on age. |
| | | Law or policy exists that supports general access to a full range of FP services regardless of age, but does not specifically address youth access. | No law or policy exists addressing age in access to FP services. |
| Restrictions Based on Marital Status | Law or policy exists that supports youth access to FP services regardless of marital status. | Law or policy exists that supports access to FP services for unmarried women, but without specifying youth. | Law or policy exists that restricts youth access to FP services based on marital status. |
| | | | No law or policy exists addressing marital status in access to FP services. |
| Comprehensive Sexuality Education | Policy supports the provision of sexuality education and mentions all nine UNFPA essential components of CSE. | Policy supports provision of sexuality education without referencing all nine of the UNFPA essential components of CSE. | Policy promotes abstinence-only education or discourages sexuality education. |
| | | | No policy exists supporting sexuality education of any kind. |
| Youth-Friendly FP Service Provision | Policy mentions all seven core elements of HIPs adolescent-friendly contraceptive services AND explicitly mentions the provision of a full | Policy references targeting youth in provision of FP services but mentions fewer than seven of the core elements of adolescent-friendly contraceptive services. | No policy exists targeting youth in the provision of FP services. |

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| | range of contraceptive methods to youth. | | |
| Community Support for Youth FP Services | Policy outlines a detailed strategy to build community support for youth FP services, including one or more of the following approaches: mass media/multimedia, community engagement, awareness campaigns. | Policy references engaging the community to support youth access to FP, but does not include specific intervention activities. | No policy exists to build community support for youth FP services. |

Parental Consent, Spousal Consent, or Provider Discretion

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|---|
| Law or policy exists that supports youth access to FP services free from provider discretion AND consent from a parent or spouse. |
| Law or policy exists that supports youth access to FP services free from one or two of the following: provider discretion, parental consent, or spousal consent, but not all three. |
| Law or policy exists that requires provider discretion OR consent from a parent OR spouse for youth access to FP services. |
| No law or policy exists on provider discretion or consent from a parent or spouse to access FP services. |

Many countries have taken a protectionist approach to legislating youth's access to FP services, based on a belief that young people need to be protected from harm and that medical providers, parents, or spouses should be able to overrule their reproductive health decisions. Instead, these laws serve as barriers that inhibit youth's access to a full range of SRH services, including FP. For example, an International Planned Parenthood Federation study in El Salvador reports that laws requiring parental consent for minors to access medical treatment create a direct barrier for youth to access FP. The study recommends: "Primary legislation should clearly establish young people's right to access SRH services, independent of parental or other consent; to avoid ambiguity and the risk that informal restrictions will be applied at the discretion of service providers."⁵

Global health and human rights bodies stress the importance of recognizing young people's right to freely and responsibly make decisions about their own reproductive health and desires. The 2012 International Conference on Population and Development Global Youth Forum recommended that "governments must ensure that international and national laws, regulations, and policies remove obstacles and barriers—including requirements for parental and spousal notification and consent; and age of consent for sexual and reproductive services—that infringe on the sexual and reproductive health and rights of adolescents and youth."⁶

National laws should reflect open access to FP services for youth, without being subject to parental consent, spousal consent, or provider discretion. Provider discretion is understood to be any legal provision that allows a provider to determine eligibility for youth to access contraception apart from medical eligibility criteria, such as the provider's personal belief.⁷

Laws around consent to FP services are often unclear or contradictory. The index intends to recognize countries that explicitly affirm youth's freedom to access FP services without parental consent, spousal consent, or provider discretion. Countries that have created such a policy environment have been placed

in the green category, signifying the most favorable policy environment, because their definitive legal stance provides the necessary grounding from which to counteract social norms or religious customs that may restrict young people’s ability to access FP services. Policies that permit providers to authorize access to FP services in adherence with medical eligibility criteria, without permitting other types of provider discretion, are not considered to create a barrier.

If a policy document mentions that youth are not subject to one or two of the following—spousal consent, parental consent, or provider discretion—but does not mention all three, the country is classified in the yellow category.

Any country that specifically requires provider discretion or consent from a parent or spouse for youth to access FP services is placed in the red category, indicating a legal barrier for youth to use contraception. If a country does not have a policy in place that addresses youth access to FP services without consent, it is also placed in a red category. The absence of a policy regarding consent allows for differential interpretation of youth’s rights to freely and independently access FP services and thus serves as a barrier.

Restrictions Based on Age

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| Law or policy exists that supports youth access to FP services regardless of age, including the provision of long-acting and reversible contraceptives (LARCs). |
| Law or policy exists that supports youth access to FP services regardless of age but does not mention provision of a full range of methods. |
| Law or policy exists that supports general access to a full range of FP services regardless of age, but does not specifically address youth access. |
| Law or policy exists that restricts youth from accessing a full range of FP services based on age. |
| No law or policy exists addressing age in access to FP services. |

Youth seeking contraception, including long-acting and reversible contraceptives (LARCs), are frequently faced with scrutiny or denial from their provider based on their age.⁸ The WHO medical eligibility criteria for contraceptive use, however, explicitly states: “Age alone does not constitute a medical reason for denying any method to adolescents.”⁹

To overcome this barrier, countries should have in place a policy statement that legally requires health providers to offer contraceptive services regardless of age. In addition, the policy should leave no ambiguity in the scope of the directive but rather explicitly mention youth’s legal right to access a full range of contraceptive services, including LARCs. Therefore, countries with an explicit policy allowing youth to access a full range of contraceptive services, regardless of age, receive a green categorization for promoting the most supportive policy environment.

Countries that explicitly protect access to FP regardless of age, including acknowledgment of youth access, but do not explicitly protect youth access to a full range of contraceptive methods, including LARCs, are placed in the yellow category. Similarly, countries that support access to a full range of methods for all women but do not explicitly acknowledge the importance of youth access are also classified in the yellow category. These countries are on the right track, but would have a stronger enabling environment if their policies explicitly mentioned youth’s right to access a full range of contraceptive methods regardless of age.

A country is placed in the red category if it has a policy in place that restricts access to FP services based on age alone or lacks any policy addressing age as a determinant to access FP services. These policies create a direct barrier for youth seeking contraception.

Restrictions Based on Marital Status

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| Law or policy exists that supports youth access to FP services regardless of marital status. |
| Law or policy exists that supports access to FP services for unmarried women, but without specifying youth. |
| Law or policy exists that restricts youth access to FP services based on marital status. |
| No law or policy exists addressing marital status in access to FP services. |

A 2014 systematic review identified laws and policies restricting unmarried youth from accessing contraception as an impediment to youth uptake of contraception.¹⁰ In the absence of a legal stance on marital status, health workers can justify refusal to provide contraception to unmarried youth.¹¹ Thus, strong policies providing equal access to FP services for married and unmarried youth are necessary to promote uptake of contraceptive services among all youth.

Countries are determined to have the most supportive policy environment for this indicator if they explicitly include a provision in their laws or policies for youth to access FP services regardless of marital status. If a country recognizes a person's legal right to access FP services regardless of marital status but does not specifically mention youth in this provision, it is considered to have a promising policy environment and classified in the yellow category, because the policy leaves room for interpretation. Finally, a country is placed in the red category if its policies restrict youth from accessing FP services based on marital status or if the country has no policy supporting access to FP services regardless of marital status.

Comprehensive Sexuality Education

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| Policy supports the provision of sexuality education AND mentions all nine UNFPA essential components of CSE. |
| Policy supports provision of sexuality education without referencing all nine of the UNFPA essential components of CSE. |
| Policy promotes abstinence-only education OR discourages sexuality education. |
| No policy exists supporting sexuality education of any kind. |

The WHO recommends educating adolescents about sexuality and contraception to increase contraceptive use and ultimately prevent early pregnancy and poor reproductive health outcomes.¹² Comprehensive sexuality education (CSE) is a specific form of sexuality education that equips young people with age-appropriate, scientifically accurate, and culturally-relevant SRH knowledge, attitudes, and skills regarding their SRH rights, services, and healthy behaviors.¹³

A growing body of evidence demonstrates that informing and educating youth about sexuality and SRH have a positive impact on their reproductive health outcomes. Sexuality education offered in schools helps youth make positive, informed decisions about their sexual behavior and can reduce sexually transmitted infections (STIs) and unintended pregnancies, in part due to increased self-efficacy and use of condoms and other contraception.¹⁴ A study in Brazil that implemented a school-based sexual education program in four municipalities measured a 68 percent increase in participating students' use of modern contraception during their last sexual intercourse.¹⁵ To be most effective, sexuality education should be offered as part of a package with SRH services, such as direct provision of contraception or links to youth-friendly FP services.¹⁶

Many approaches exist to implement sexuality in and out of schools. The index considers CSE as the gold standard and relies on the UNFPA "Operational Guidance for Comprehensive Sexuality Education," which focuses on human rights and gender as a framework to effectively implement a CSE curriculum.

The UNFPA Operational Guidance outlines nine essential components of CSE that are concise and easy to measure across countries' policy documents.¹⁷ Further, these guidelines recognize gender and human rights and build on global standards discussed in the UNESCO “International Technical Guidance on Sexuality Education.”

The nine UNFPA essential components for CSE are:

1. A basis in the core universal values of human rights.
2. An integrated focus on gender.
3. Thorough and scientifically accurate information.
4. A safe and healthy learning environment.
5. Linking to SRH services and other initiatives that address gender, equality, empowerment, and access to education, social, and economic assets for young people.
6. Participatory teaching methods for personalization of information and strengthened skills in communication, decisionmaking, and critical thinking.
7. Strengthening youth advocacy and civic engagement.
8. Cultural relevance in tackling human rights violations and gender inequality.
9. Reaching across formal and informal sectors and across age groups.

A country is determined to have the most supportive policy environment and is classified in the green category if its policies not only recognize the importance of sexuality education broadly but also include each of the nine elements of CSE.

A country is considered to have a promising policy environment if it clearly mandates sexuality education in a national policy but either does not outline exactly how sexuality education should be implemented or has guidelines that are not fully aligned with the UNFPA CSE essential components.

While evidence proves that sexuality education equips youth with the necessary skills, knowledge, and values to make positive SRH decisions, including increased contraceptive use, little evidence exists that abstinence-only education is similarly effective. The 2016 *Lancet* Commission on Adolescent Health and Wellbeing recommends against abstinence-only education as a preventive health action, and found it was ineffective in preventing negative SRH outcomes.¹⁸ In fact, some reports suggest that an abstinence-only approach increases the risk for negative SRH outcomes among youth.¹⁹ Therefore, a country that supports abstinence-only education is seen as limiting youth's access to and use of contraception and as a result, is grouped in the red category. Additionally, the absence of any policy approach to sexuality education altogether suggests the country has not taken a stance on supporting the education of young people on SRH, including contraceptive services. The lack of such a policy places a country in the red category.

Youth-Friendly FP Service Provision

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| Policy mentions all seven core elements of adolescent-friendly contraceptive services AND explicitly mentions the provision of a full range of contraceptive methods to youth. |
| Policy references targeting youth in provision of FP services but mentions fewer than seven of the core elements of adolescent-friendly contraceptive services. |
| No policy exists targeting youth in the provision of FP services. |

The WHO “Guidelines on Preventing Unintended Pregnancies and Poor Reproductive Outcomes Among Adolescents in Developing Countries” recommend that policymakers make contraceptive services adolescent-friendly to increase contraceptive use among this population.²⁰ This recommendation aligns with numerous findings in the literature. A 2016 systematic assessment to identify evidence-based interventions to prevent unintended and repeat pregnancies among young people in LMIC found that

three out of seven interventions that increased contraceptive use involved a component of contraceptive provision.²¹

Additional evaluations show that when SRH services are tailored to meet the specific needs of youth, youth are more likely to use these services and access contraception.²² The index uses the seven core elements identified in High-Impact Practices in Family Planning (HIPs), “Adolescent-Friendly Contraceptive Services” as the framework for assessing the policy environment surrounding FP service and contraceptive provision.²³ This review identified seven common elements in adolescent-friendly FP service provision that contributed to increased use of contraception among this age group. The seven elements are:

1. Train and support providers to offer adolescent-friendly contraceptive services.
2. Enforce confidentiality and audio/visual privacy.
3. Offer a wide range of contraception.
4. Provide no-cost or subsidized services.
5. Build an enabling legal and political environment.
6. Link service delivery with activities that build support in communities.
7. Address gender and social norms.

A critical component of this indicator is explicitly tracking whether a full range of contraceptive methods, including LARCs, is offered. Provision of LARCs as part of an expanded method mix is particularly effective. One of the studies identified in the 2016 systematic assessment provided implants as an alternative contraceptive option for young women seeking short-acting contraceptives in a clinic in Kenya. Twenty-four percent of the women opted to use an implant, and their rate of discontinuation was significantly lower than those using short-acting methods. Of the 22 unintended pregnancies that occurred, all were among women using short-acting methods.²⁴ However, many youth around the world do not know about LARCs and if they do, they may be confused about their use and potential side effects, hesitant to use them due to social norms, or face refusal from providers.

The “Global Consensus Statement for Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting Reversible Contraception” calls upon all youth SRH and rights programs to ensure that youth have access to a full range of contraceptive methods by:

- Providing access to the widest available contraceptive options, including LARCs (specifically, contraceptive implants and intrauterine contraceptive devices) to all sexually active adolescents and youth from menarche to age 24, regardless of marital status and parity.
- Ensuring that LARCs are offered and available among the essential contraceptive options, during contraceptive education, counseling, and services.
- Providing evidence-based information to policymakers, ministry representatives, program managers, service providers, communities, family members, and adolescents and youth on the safety, effectiveness, reversibility, cost-effectiveness, acceptability, continuation rates, and the health and nonhealth benefits of contraceptive options, including LARCs, for sexually active adolescents and youth who want to avoid, delay, or space pregnancy.²⁵

Many countries have adolescent-friendly health initiatives, but for a country to be placed in the green category, its policies must specifically reference providing FP services and contraception to youth. A country is placed in the green category for this indicator if its policy documents reference all seven adolescent-friendly contraceptive service elements as defined above and specifically mention provision of the full range of contraceptive services to youth. Simply referencing the provision of FP services to youth, but not adopting the full elements of adolescent-friendly contraceptive services, indicates a promising but insufficient policy environment, and the country is placed in the yellow category.

Countries that do not have a policy that promotes contraceptive service provision to youth are placed in the red category. In the absence of such policies, youth may have great difficulty accessing the contraception they desire.

Several service provision-related barriers to youth contraceptive use are captured in other indicators in the index: parental consent, spousal consent, and provider discretion; restrictions based on age; and restrictions based on marital status. Since these barriers are already captured in other indicators, they are not included again in this indicator's red category to avoid over-penalizing countries. Additional programmatic barriers to youth accessing contraceptive services exist, such as lack of privacy and confidentiality and cost of services. These and other barriers are addressed in the seven common elements of adolescent-friendly FP service programs outlined above.

Community Support for Youth FP Services

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| Policy outlines a detailed strategy to build community support for youth FP services, including one or more of the following approaches: mass media/multimedia, community engagement, awareness campaigns. |
| Policy references engaging the community to support youth access to FP, but does not include specific intervention activities. |
| No policy exists to build community support for youth FP services. |

The final indicator addresses demand-side factors, specifically efforts to make youth access to and use of a full range of contraceptive methods more acceptable and appropriate within their communities. To support youth's acceptance of contraception and ensure they are comfortable seeking contraceptive services, it is imperative to spread awareness and build support for a wide range of contraceptive methods among the broader communities in which they live. The 2016 *Lancet* Commission on Adolescent Health and Wellbeing identified community-support interventions as a critical component of strong SRH service packages.²⁶

Group engagement activities that mobilize communities through dialogue and action, rather than only targeting individuals, are considered to be a promising practice to change social norms around SRH, including contraceptive use.²⁷ Group engagement can be useful to change the discourse around youth sexuality and address misconceptions about contraception within communities.

This indicator is intentionally broad and can manifest in many different ways within country policies. Since the evidence is still emerging on which community engagement initiatives are most effective in promoting contraceptive use among youth, the index uses a broad approach to categorizing policy commitments. Countries that outline specific interventions to build community support for youth FP are considered to have a strong policy environment and are placed in the green category. Countries that include a reference to building community support for youth FP, without providing any specific plan for doing so, are placed in the yellow category. Countries without any reference to an activity to build support for youth FP among the community are placed in the red category.

LIMITATIONS AND RECOMMENDATIONS

A desk review of electronically-accessible policy documents, supplemented with documents not available online that were provided by local experts, returned over 70 relevant policy documents across the nine countries. However, additional policy documents relevant to the index likely exist. Future iterations of the index might supplement these findings with further collection of primary data, in the form of key informant interviews or questionnaires, from local stakeholders.

Many LMIC are moving towards a decentralized government structure, including several of the countries analyzed here, most notably Pakistan. Inevitably, approaches to health service delivery will vary at the subnational level under these governance structures. However, with the exception of Pakistan, we did not conduct a search of subnational policies. Additionally, the index does not capture the efforts of donors, nongovernmental organizations, and implementing partners to address youth FP needs, and may not fully represent the state of youth FP programming in the country that falls outside of governments' purviews.

While the term "index" generally refers to a scored or ranked classification of indicators, this index does not currently include a composite score for a country's overall performance. The quantitative impact of each indicator on increases in contraceptive use among youth is varied and difficult to generalize. Future iterations of the index will consider how to aggregate the performance of a country's policy environment per indicator into an overall rating.

Finally, the purpose of the index in its current form is to characterize the state of youth FP policy commitments in specific countries. The index does not measure the extent to which a country has implemented youth FP policies. Countries with strong policy environments surrounding youth FP may not sufficiently allocate funding nor implement youth FP programs as outlined in their policies. Thus, an analysis of a country's policy environment is only one component of understanding youth FP programs. To further understand the nuanced policy environment surrounding youth FP needs, policy implementation assessments would deepen the analysis of existing policies and programs.

COUNTRY RESULTS

This edition of the index includes analysis for nine countries: Democratic Republic of the Congo (DRC), Ethiopia, Kenya, Niger, Nigeria, Sindh (Pakistan), Senegal, Tanzania, and Uganda.

The table of results also includes selected quantitative reference data related to youth FP outcomes. These data contextualize the policy indicators to provide initial insight on whether the strength of a country's policy environment aligns with FP outcomes among youth.

INDEX FINDINGS

Table of Results

| | |
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| ■ Strong policy environment | ■ Policy environment impedes youth from accessing and using contraception OR a policy addressing the indicator does not exist |
| ■ Promising policy environment but room for improvement | ■ Not enough information |

| | Policy Indicators | | | | | | Reference Data | | | | | | | | | | | | | | |
|------------------|------------------------|------------------|-----------------------------|-----------------------------------|---|-------------------|-----------------------------------|----------------------------|---|---|--|------------|------------|---|------------|------------|--|------------|--|------------|------------|
| | External Authorization | Age Restrictions | Marital Status Restrictions | Comprehensive Sexuality Education | Youth-Friendly Family Planning Services | Community Support | Adolescent Birth Rate (per 1,000) | Teenage Pregnancy Rate (%) | Percent Women Married/ In Union, Ages 15-19 | Percent Men Married/ In Union, Ages 15-19 | Use of Modern Contraception (mCPR) Among Married Women (%) | | | Use of Modern Contraception (mCPR) Among Unmarried, Sexually Active Women (%) | | | Most Common Modern Contraceptive Methods Used by Married Women | | Unmet Need for Contraception Among Married Women (%) | | |
| | | | | | | | | | | | Ages 15-19 | Ages 20-24 | Ages 15-49 | Ages 15-19 | Ages 20-24 | Ages 15-49 | Ages 15-19 | Ages 20-24 | Ages 15-19 | Ages 20-24 | Ages 15-49 |
| Congo, Dem. Rep. | | | | | | | 138 | 27.2 | 21.3 | 1.4 | 5.4 | 8.2 | 7.8 | 19.5 | 25.2 | 20.9 | C,P,In | C,In,Im | 30.8 | 29.2 | 27.7 |
| Ethiopia | | | | | | | 80 | 12.5 | 19.1 | 2.1 | 31.8 | 38.5 | 35.3 | – | – | 55.0 | In,Im,P | In,Im,P | 20.5 | 18.5 | 22.3 |
| Kenya | | | | | | | 96 | 18.1 | 11.9 | 0.6 | 36.8 | 49.8 | 53.2 | 49.3 | 64.2 | 60.9 | In,Im,C | In,Im,P | 23.0 | 18.9 | 17.5 |
| Niger | | | | | | | 206 | 40.4 | 60.9 | 2.6 | 5.9 | 12.6 | 12.2 | – | – | – | P,LAM,In | P,LAM,In | 13.1 | 18.4 | 16.0 |
| Nigeria | | | | | | | 122 | 22.5 | 28.8 | 1.1 | 1.2 | 6.2 | 9.8 | 49.7 | 63.5 | 54.9 | C,P,In | C,In,P | 13.1 | 16.6 | 16.1 |
| Sindh (Pakistan) | | | | | | | 44 | 7.9 | 13.9 | 2.4 | 6.9 | 14.9 | 26.1 | – | – | – | C,In,IUD | C,LAM,In | 14.9 | 20.6 | 20.1 |
| Senegal | | | | | | | 80 | 16.1 | 22.8 | 0.3 | 5.5 | 17.9 | 21.2 | – | – | 49.2 | Im,In,P | In,Im,P | 24.3 | 25.4 | 25.2 |
| Tanzania | | | | | | | 132 | 26.7 | 23.0 | 1.5 | 13.3 | 29.9 | 32.0 | 34.5 | 47.9 | 44.7 | In,Im,P | In,Im,P | 23.0 | 22.7 | 22.1 |
| Uganda | | | | | | | 134 | 23.8 | 20.0 | 1.9 | 13.1 | 20.4 | 26.0 | 35.3 | 47.9 | 44.3 | In,C,Im | In,P,C | 31.3 | 35.4 | 34.3 |

Notes: Adolescent birth rate is calculated as the age-specific fertility rate per 1,000 women for women age 15 to 19; Teenage pregnancy rate is calculated as the percentage of women ages 15 to 19 who have begun childbearing; Lactational Amenorrhea Method (LAM) is a temporary family planning method based on the natural effect of breastfeeding on fertility. LAM requires that the mother's monthly bleeding has not returned, the baby is fully or nearly fully breastfed, and the baby is less than 6 months old; and C=Condom, P= Pill, In=Injectable, Im=Implant.

Sources: ICF International, Demographic and Health Surveys: Congo, Dem. Rep. 2013-14; Ethiopia 2016; Kenya 2014; Niger 2012; Nigeria 2013; Pakistan 2012-13; Senegal 2016; Tanzania 2010 & 2015-16; Uganda 2011.

Discussion of Results

The majority of the countries reviewed—DRC, Ethiopia, Kenya, Nigeria, Tanzania, and Uganda—have either a general adolescent and youth health strategy or a tailored adolescent and youth SRH strategy. The age range of adolescence and youth cited in these strategies generally followed the WHO’s definition, ages 10 to 19 and ages 15 to 24, respectively. Ethiopia expanded the definition of youth to ages 15 to 30, aligning with the definition of youth in the national constitution. The policies reviewed did not always specify which FP services would be provided to which cohorts of adolescent and youth.

Tanzania and Kenya recognize the unique needs of very young adolescents (ages 10 to 14) as a vulnerable subpopulation of adolescents and youth. Kenya provides the most comprehensive instruction for service provision to very young adolescents in its “National Guidelines for Provision of Adolescent and Youth Friendly Services,” which outline strategies to reach very young adolescents, including offering a routine health visit for young girls, linking FP services with schools or nearby referral systems, and providing community-based FP services for newly married girls.

Overall, results were most promising for the FP service-provision and community-support indicators. Eight of the nine countries, excluding Niger, have included youth-specific service provision of FP and contraception in their policies. While Ethiopia, Kenya, and Tanzania have the most supportive policy environment around youth access to a full spectrum of FP services. DRC, Nigeria, Senegal, Sindh, and Uganda have room for improvement. Specifically, these countries should consider the inclusion of all seven elements of adolescent-friendly contraceptive services discussed in the HIPs “Adolescent-Friendly Contraceptive Services” in future policies.

Seven of the nine countries, excluding Niger and Sindh, specifically outline steps to build community support for youth FP in their policies. Approaches included in this indicator generally call upon a common social and behavior-change-communication intervention to inform and educate the general community, parents, and youth. As the evidence for engaging communities evolves, the results for this indicator will likely show greater differentiation and prioritization of approaches.

Discussion of CSE in policies was frequently vague and difficult to assess. Generally, countries mention sexuality education in their reproductive health policies but do not provide additional guidance on the components of a sexuality education curriculum nor how to implement it. Nigeria’s family life and HIV education curriculum is the most comprehensive document addressing sexuality education in schools. While quite robust in discussions of human development, social norms, relationships, gender, and life skills, the policy takes a weak stance on SRH. In fact, the curriculum avoids discussion of FP services and promotes abstinence-only education.

Gender norms that promote boys’ sexuality and stigmatize girls’ have been identified in HIPs “Adolescent-Friendly Contraceptive Services” as key barriers to adolescents’ access to FP services.²⁸ Countries frequently identify gender inequalities and gender norms as challenges for youth, particularly young girls who wish to access contraception, and promote various approaches to address gender. Kenya and Uganda include initiatives to mainstream gender responsiveness across youth SRH approaches, while Nigeria specifically includes gender-sensitivity in service-delivery protocols. Ethiopia addresses gender through community engagement actions by engaging men and gatekeepers to improve women’s decisionmaking power. Addressing gender norms as a barrier to youth accessing contraception is a key consideration for CSE and youth-friendly FP service provision.

Analysis of selected FP reference data shows potential connections between evidence-based policy approaches and resulting health outcomes. Further analysis of additional countries is needed to explore the potential associations. Currently, countries with the most-supportive policy environment for service

provision—Ethiopia, Kenya, and Tanzania—also have the highest rate of modern contraceptive use (mCPR) among young married women between ages 15 and 19 and ages 20 to 24 among all countries reviewed. Niger has both the least-supportive overall policy environment for youth, including an antiquated law penalizing the distribution of contraception, and the highest adolescent birth and teenage pregnancy rate. Niger and Nigeria are the only two countries for which the most prevalent methods for young married women do not include a LARC method.

Finally, many policies reviewed were close to the end of their stated timeline or had already expired. This analysis provides recommendations to improve the overall policy environment and can be useful when decisionmakers update strategies and policies surrounding youth FP.

COUNTRY ANALYSES

DEMOCRATIC REPUBLIC OF THE CONGO

Policy documents reviewed:

- Les Codes Larcier de la République Démocratique du Congo, Tome I Droit Civil et Judiciaire, 1987.
- Politique Nationale de Santé de la Reproduction, 2008.
- Normes de la Zone de Santé Relatives aux Interventions Intégrées de Santé de la Mère, du Nouveau-né et de l'Enfant en République Démocratique du Congo, Volume 5, Interventions de Santé Adaptées aux Adolescents et Jeunes, 2012.
- Politique Nationale Santé de l'Adolescent (PNSA), 2013, and Paquet d'Activités PNSA dans la Zone de Santé.
- Standards des Services de Santé Adaptés aux Adolescents et Jeunes, 2014.
- Democratic Republic of Congo Family Planning National Multisectoral Strategic Plan, 2014-2020.
- Plan Stratégique National de la Santé et du Bien-Etre des Adolescents et des Jeunes, 2016-2020.

Parental Consent, Spousal Consent, or Provider Discretion

Law or policy exists that requires provider discretion OR consent from a parent OR spouse for youth access to FP services.

“Les Codes Larcier de la République Démocratique du Congo, Tome I Droit civil et judiciaire” gives husbands full control over the legal rights of married women:

Art. 444. — Le mari est le chef du ménage. Il doit protection à sa femme; la femme doit obéissance à son mari.

Art. 448. — La femme doit obtenir l'autorisation de son mari pour tous les actes juridiques dans lesquels elle s'oblige à une prestation qu'elle doit effectuer en personne.

Art. 450. — Sauf les exceptions ci-après et celles prévues par le régime matrimonial, la femme ne peut ester en justice en matière civile, acquérir, aliéner ou s'obliger sans l'autorisation de son mari. Si le mari refuse d'autoriser sa femme, le tribunal de paix peut donner l'autorisation. L'autorisation du mari peut être générale, mais il conserve toujours le droit de la révoquer.

In addition, the DRC is still governed by a 1933 colonial-era law that prohibits the distribution of contraceptives.

The 2013 “Politique Nationale Santé de l'Adolescent (PNSA)” states that the provision of contraceptives to youth is subject to parental consent, which providers must respect. At the same time, somewhat contradictorily, the policy encourages providers to support the self-determination of youth to use reproductive health services. This language does not define the circumstances when parental consent is warranted:

2. La prestation des méthodes contraceptives chez les jeunes doit être subordonnée le cas échéant par le consentement des parents et l'agent de santé est tenu à se plier à cette obligation dans le respect des principes d'administration et d'éthique de ces méthodes. Par contre, il faut recommander l'achat des préservatifs à la pharmacie et les milieux appropriés et les pilules dans un centre de santé.

3. Les prestataires doivent soutenir l'auto-détermination et le libre choix des adolescents à utiliser les services de santé de la reproduction dans le respect de leur dignité et de leur diversité d'opinion ou de culture. (Page 19)

More recently, however, the “Democratic Republic of Congo Family Planning National Multisectoral Strategic Plan, 2014-2020” included an activity to:

Create a law favorable to family planning, to protect minors and adolescents, and to promote gender.

Advocates have made substantial progress supporting the new reproductive health law, which will overturn restrictive codes for women and give them free and independent access to reproductive health care. In early 2016, the DRC Constitutional Court recognized reproductive health as a fundamental health right, allowing the National Assembly to review the law. The new act, if enacted, will allow for the following:

Article 13:

Tous les individus sont égaux en droit et en dignité en matière de santé de la reproduction sans discrimination aucune.

Article 14:

Les couples et les individus ont le droit de discuter librement et avec discernement des questions ayant trait à la santé de la reproduction dans le respect des lois en vigueur, de l'ordre public et des bonnes mœurs.

Ils ont le droit de décider librement et avec discernement du nombre de leurs enfants, de l'espacement de leurs naissances et de disposer des informations nécessaires pour ce faire. En cas de désaccord, la volonté de la femme prime.

The current laws place the DRC in the red category. However, if the new reproductive health act is enacted, the country has the potential to move into the green category.

Restrictions Based on Age

Law or policy exists that restricts youth from access to a full range of FP services based on age.

The “National Policy on Reproductive Health, 2008” includes a provision for parental consent for minors, defined as any person under the age of 18, to receive reproductive health services. In contrast, the “Plan Stratégique National de la Santé et du Bien-Être des Adolescents et des Jeunes, 2016-2020” seeks to improve the SRH status of adolescents and youth ages 10 to 24. While the newer strategy includes youth as an audience for service provision, the qualifier in the “National Policy on Reproductive Health” for parental consent for youth under age 18 places the country in the red category for restrictions based on age.

When the new reproductive health law is formalized, policymakers should ensure that it includes explicit language allowing youth regardless of age and marital status to access the full spectrum of contraception.

Restrictions Based on Marital Status

Law or policy exists that restricts youth access to FP services based on marital status.

See discussion above under *Parental Consent, Spousal Consent, or Provider Discretion* indicator.

Comprehensive Sexuality Education

Policy supports provision of sexuality education without referencing all nine of the UNFPA essential components of CSE.

The “PNSA, 2013” acknowledges the importance of sexuality education and places emphasis on involving youth, parents, schools, and communities. It does not describe any details or components of what a CSE program should include.

The “Democratic Republic of Congo Family Planning National Multisectoral Strategic Plan, 2014-2020” identified poor integration of CSE in primary and secondary schools as a key FP demand-generation problem. To address this concern, the strategic plan includes CSE activities to increase demand for FP services among youth:

Integrate Family Planning in the curriculum of secondary schools, higher education and universities and train teachers in comprehensive sexual education for youth and adolescents.

The “National Strategic Plan for the Health and Well-Being of Adolescents and Youth” incorporates a priority focus on activities that support behavior change through comprehensive SRH education in and out of schools:

Les interventions de santé en faveur des adolescents et des jeunes reposent sur la communication pour le changement de comportement soutenue par l’offre des services de prévention. Il s’agit de: l’éducation complète sur la santé reproductive et sexuelle en milieu scolaire et parascolaire.

The plan also includes several activities that contribute to CSE, including promoting the core universal value of human rights for adolescents and young people, the provision of safe and healthy learning environments, and strengthening youth civic engagement.

Les objectifs-spécifiques assignés à ce Plan sont les suivants :

Améliorer le niveau de connaissance et les compétences des adolescents et jeunes sur leurs problèmes spécifiques de santé y compris leurs droits.

D’ici 2020 au moins 50% des adolescents et jeunes adoptent des attitudes et compétences favorables au respect de leurs droits dans les 258 zones

D’ici 2020, 890 espaces d’information et communication pour jeunes sont créés dans les 178 zones supplémentaires

Au moins 50% d’adolescents et jeunes participent aux activités récréatives et socio-éducatives dans les 258 zones d’ici 2020

The reference to CSE in these strategic plans indicates that the policy environment is promising towards implementation of CSE. However, additional guidelines, in line with the nine UNFPA essential components, are necessary to inform the delivery of CSE. Thus, the country is placed in the yellow category for this indicator.

Youth-Friendly FP Service Provision

Policy references targeting youth in provision of FP services but mentions fewer than seven of the core elements of adolescent-friendly contraceptive services.

The policy environment in the DRC recognizes the need for youth-friendly FP service provision. The “Democratic Republic of Congo Family Planning National Multisectoral Strategic Plan, 2014-2020” includes the following activity:

Extend integrated youth-friendly services to all health zones.

Further, “The National Strategic Plan for the Health and Well-Being of Adolescents and Youth, 2016-2020” references the provision of youth-friendly services and presents plans for how the country aims to scale up the program. For example, the strategic plan explicitly states the importance of having trained staff capable of offering youth services, setting up “spaces” suitable for young people, and providing contraceptives to this age group.

Ce système devra particulièrement disposer d'un personnel compétent et apte à offrir les soins de santé spécifiques à ce groupe, supprimer le plus possible les barrières à cette cible sans ressources conséquentes, aménager au sein des établissements de soins les espaces d'information et communication pour jeunes, fournir régulièrement les médicaments y compris les contraceptifs et autres intrants (préservatifs féminins et masculins, etc.).

While the strategic plan aims to reach 3,870 facilities in the targeted health areas with contraceptive supplies, including condoms for adolescents and youth, it does not indicate the provision of a full range of contraceptives nor any guidelines around provision of contraceptives to this age group.

The plan also encourages use of a preferential rate for “care of adolescents and young people in the health zones,” but makes no explicit provision for offering contraceptives at no cost or subsidized costs.

The “PNSA 2013” describes several of the seven elements of youth-friendly service provision in the context of adolescent health broadly including: training providers, ensuring confidentiality, linking service delivery with activities that build support in communities, and addressing gender norms. However, the policy does not mention plans to offer youth free or subsidized contraceptive provision. The PNSA 2013 states that contraceptive methods beyond the preferred method of abstinence must be made available to youth, but only references pills and condoms. The related document, “Paquet d’Activités PNSA dans la Zone de Santé,” describes plans for FP activities that include youth-friendly contraceptive methods, rather than explicitly including a full range of methods.

The “Standards des Services de Santé Adaptés aux Adolescents et Jeunes, 2014,” recognize the rights of adolescents to quality and confidential health services. The policy describes the minimum package of youth-friendly services at each level of the health system, including the community level. It includes plans for training providers in youth-friendly services and measuring youth satisfaction with these

services. In the area of reproductive health, the policy emphasizes providing information on reproductive health to youth, rather than contraceptive provision. One exception is the distribution of oral contraception and condoms to youth, which is in the minimum package of services at the community level.

The “Interventions de Santé Adaptées aux Adolescents et Jeunes, 2012,” goes into detail about how providers in health centers should interact with youth when discussing sexual health. Providers should: ensure confidentiality; use friendly, clear, and respectful communication; avoid judgment; recognize stigma experienced by sexually active youth; and ensure autonomy in decision making. The policy encourages condom and contraceptive distribution at the community level, and it says in general terms that youth should be informed about how to prevent unwanted pregnancy in visits to health centers. It does not describe providing youth with a full range of contraceptive methods.

Therefore, the policy environment is understood to be promising but incomplete and the country is placed in the yellow category for FP service provision. In expanding upon youth-friendly service protocols, policymakers should consider including all seven elements identified in the HIPs “Adolescent-Friendly Contraceptive Services” to improve adolescent and youth uptake of contraception.

Community Support for Youth FP Services

Policy references engaging the community to support youth access to FP, but does not include specific intervention activities.

The “Paquet d’Activités” that accompanies the PNSA, 2013 broadly outlines activities for building community support for youth health, such as advocacy aimed at community leaders and community-outreach activities using multimedia/mass media platforms. However, these activities are not specific to building support for youth access to contraception.

Elsewhere, there is general recognition of building community support for FP in the DRC. The “Democratic Republic of Congo Family Planning National Multisectoral Strategic Plan, 2014-2020” includes an activity to mobilize the community surrounding FP. The “National Strategic Plan for Adolescents and Youth, 2016-2020” has as one of its chief priorities the need to promote the health of young people through empowering grassroots communities to find solutions to problems affecting adolescent health:

La promotion de la santé des jeunes doit viser notamment la responsabilisation des communautés de base dans la recherche des solutions sur les problèmes affectant la santé des adolescents.

While there is no explicit reference to community support for youth FP services in general, there is a strategic focus on community mobilization for the promotion of adolescent and youth health, which includes: voluntary counseling and testing on HIV, comprehensive education on reproductive and sexual health, promotion and availability of condoms, promoting postexposure prophylaxis in cases of rape, preventing violence, and strengthening the community system in synergy with national sectors and the capacity of civil society to provide services.

Axe stratégique 1 : Communication stratégique et mobilisation communautaire pour la promotion de la santé des adolescents et des jeunes

Les interventions de santé en faveur des adolescents et des jeunes reposent... Il s’agit de : (i) services de conseil et dépistage volontaire sur le VIH, (ii) l’éducation complète sur la santé reproductive et sexuelle, (iii) la promotion et la disponibilité des

préservatifs, (iv) la promotion de la prophylaxie post exposition (en cas de viols), (v) la prévention des violences, ainsi que (vi) le renforcement du système communautaire en synergies avec les secteurs nationaux clés et de la société civile à fournir des services.

Since the strategy includes specific activities to build community support for youth RH in general (including the promotion of condoms), but does not specifically reference building community support for a broad range of contraceptive methods or for seeking FP services, the country is placed in the yellow category for this indicator.

ETHIOPIA

Policy documents reviewed:

- National Reproductive Health Strategy, 2006-2015.
- National Adolescent and Youth Reproductive Health Strategy, 2007-2015.
- Education Sector Policy and Strategy on HIV & AIDS, Responding to the Challenges of HIV & AIDS in Ethiopia, Federal Ministry of Education, Addis Ababa, Ethiopia, July 2009.
- National Guidelines for Family Planning Services in Ethiopia, 2011.
- Health Sector Transformation Plan, 2015/16-2019/20.
- Costed Implementation Plan for Family Planning in Ethiopia, 2015/16-2020.
- National Health Promotion and Communication Strategy, 2016-2020.
- National Adolescent and Youth Health Strategy, 2016-2020.

Parental Consent, Spousal Consent, or Provider Discretion

Law or policy exists that supports youth access to FP services free from one or two of the following: provider discretion, parental consent or spousal consent, but not all three.

While Ethiopia has a strong and inclusive policy environment supporting young clients' access to FP services, the policies reviewed have limited recognition of youth's right to contraceptive services without spousal or parental consent. Language in the policy documents acknowledges the rights of youth to receive these services, and the "Adolescent and Youth Reproductive Health Strategy, 2007-2015" explicitly instructs providers to offer FP services to youth without bias:

Providers should be non-judgmental, respect privacy, and know how to communicate with youth.

However, the policies do not explicitly outline youth's right to access FP services without parental or spousal consent. In the absence of this language, youth may face barriers when attempting to receive care.

Ethiopia is placed in a yellow category for this indicator because the policy environment includes provisions discouraging provider discretion, but does not address consent by parents or spouses. To strengthen the policy environment, the country should consider including direct language allowing youth to access FP services without parental or spousal consent.

Restrictions Based on Age

Law or policy exists that supports youth access to FP services regardless of age, including the provision of long-acting and reversible contraceptives (LARCs).

Policies reviewed thoroughly address youth's right to access a full range of contraceptive options, regardless of age. The "Adolescent and Youth Reproductive Health Strategy, 2007-2015" defines adolescents and youth as ages 10 to 24:

To enhance reproductive health and well-being among young people in Ethiopia ages 10-24 so that they may be productive and empowered to fully access and utilize quality reproductive health information and services, to make voluntary informed choices over their RH lives, and to participate fully in the development of the country.

In addition, the "National Guidelines for Family Planning Services in Ethiopia" underscore the right of all people to access FP care without discrimination based on age or other nonmedical criteria:

Access to services: Clients have a right to services that are affordable, are available at convenient times and places, are fully accessible with no physical barriers, and have no inappropriate eligibility requirements or social barriers, including discrimination based on sex, age, marital status, fertility, nationality or ethnicity, social class, religion, or sexual orientation.

Further, the "National Adolescent and Youth Reproductive Health Strategy, 2007-2015" emphasizes the medical eligibility for youth to receive all contraception methods, except sterilization:

No medical reasons currently exist for denying any contraceptive method based on young age alone.

Based on these policy inclusions, Ethiopia is placed in the green category for this indicator. Policy documents directly recognize the rights of young people to receive FP services, including a full range of contraception, regardless of age.

Restrictions Based on Marital Status

Law or policy exists that supports youth access to FP services regardless of marital status.

As with policies surrounding potential age restrictions, Ethiopia has a strong policy environment supporting youth's right to access FP services regardless of marital status. The right to access services in the "National Guidelines for Family Planning Services in Ethiopia," excerpted above, includes the right to access FP services regardless of marital status. Additional language in the same policy document further emphasizes this right:

Any reproductive age person, male or female regardless marital status is eligible for Family Planning services including information, education and counseling.

The "National Guidelines for Family Planning Services in Ethiopia" also recognize the unique context of both married and unmarried adolescents, further addressing the need to provide tailored services to this population:

Married adolescents require FP services to delay and space childbirth;

Unmarried adolescents may have more than one sexual partner that predisposes them to STIs more than older people. Hence, dual use of FP method should be included in counseling sessions.

Ethiopia is placed in the green category for this indicator because relevant policies directly support married and unmarried youth receiving FP services.

Comprehensive Sexuality Education

Policy supports provision of sexuality education without referencing all nine of the UNFPA essential components of CSE.

Sexuality education is presented as “Family Life and Sexuality Education” in Ethiopia's “National Adolescent and Youth Reproductive Health Strategy.” The document acknowledges that few reproductive health issues are incorporated into the Family Life Education curriculum but notes that this is a policy issue under the purview of the Ministry of Education (MoE). The strategy does build in segmented activities related to Family Life Education for married and unmarried boys and girls ages 10 to 14, both in-school and out-of-school:

Create safe spaces in kebele, churches, mosque (other suitable places); assign mentors; and provide family life and sex education.

Provide age appropriate family life education in schools.

The “Education Sector Policy and Strategy on HIV & AIDS” provides further guidance on the provision of sexuality education. The policy includes some elements of CSE essential components, but is limited in the breadth of instruction regarding sexuality, sexual behavior, and reproductive health. The policy does include an integrated focus on gender:

As HIV and AIDS impacts differently on men and women due to the biological, economic and socio-cultural factors, all aspects of this policy will be applied in a way that is responsive to the different vulnerabilities and susceptibilities of men, women, boys and girls.

Additionally, the “Education Sector Policy and Strategy on HIV&AIDS” includes an emphasis on a safe and healthy learning environment:

*Provide a safe and sanitary environment in schools and other learning institutions.
To create a supportive and protective learning environment in schools and other learning institutions.*

Other policies suggest additional emphasis will be placed on educating Ethiopian youth regarding FP. The “Costed Implementation Plan for Family Planning in Ethiopia, 2015/16-2020” incorporates an activity that seeks to work through the MoE to strengthen sexuality education:

MC1.4 Advocate with the MOE to assess the capacity of schools to integrate SRH and family planning into the curriculum, including sexual education in the school health programme.

Ethiopia is placed in the yellow category for the CSE indicator. Policies directly support providing some form of sexuality education, and indicate that the development of a more robust curriculum is in the conception phase.

Youth-Friendly FP Service Provision

Policy mentions all seven core elements of adolescent-friendly contraceptive services AND explicitly mentions the provision of a full range of contraceptive methods to youth.

The policy environment in Ethiopia strongly supports the provision of youth-friendly FP services. Multiple policies reviewed incorporate youth-friendly FP services.

The “National Reproductive Health Strategy, 2006-2015” is the earliest policy reviewed that discusses the pressing need for services to be tailored to meet the needs of youth. This strategy includes an initiative to develop a “National Adolescent and Youth Reproductive Health Strategy” and regional implementation plans.

The “National Adolescent and Youth Reproductive Health Strategy,” launched the following year, includes clear action steps to deliver youth-friendly FP services. The first objective of the “National Youth and Adolescent Reproductive Health Strategy” is:

Objective 1.1: To improve access to quality reproductive health and STI/HIV services.

The strategy further references all seven core elements of adolescent-friendly contraceptive services. For example, to address gender and social norms, the strategy includes an activity to increase young women’s limited agency:

Enlist participation of boys/men, gatekeepers such as mothers-in-law or other family members:

All programs need to include men and gatekeepers as women have very limited decision making power. Young adolescent boys can be sensitized early on about gender inequities, HTP [harmful traditional practices], and sexual violence.

Programs engaging young married men will increase the chances of young women’s agency to decide on their reproductive lives.

To comprehensively address the range of health issues faced by youth in Ethiopia, the Ministry of Health broadened the scope of the “National Adolescent and Youth Reproductive Health Strategy, 2007-2015” when preparing the most recent adolescent health policy, the “National Adolescent and Youth Health Strategy, 2016-2020.” SRH remains a key feature in this policy. The policy seeks to increase contraceptive prevalence among youth, reduce unmet need for modern contraception, and reduce unintended adolescent pregnancy. To achieve these outcomes, the “National Adolescent and Youth Health Strategy, 2016-2020” reinforces initiatives from the previous policy iteration, addressing core elements of adolescent-friendly contraceptive services:

Promote male involvement in prevention of early and unintended pregnancy.

Ensure availability and accessibility of all types of modern contraceptives including LARC for Adolescents and youth who are sexually active.

Facilitate revision, where appropriate, of age and sex related restrictions that prevent adolescents from accessing full HIV and SRH services.

Address social pressure and concerns related to child marriage, conception and contraception.

The “National Guidelines for Family Planning Services in Ethiopia” include additional recommendations that address enforcement of confidentiality and privacy, training and supporting providers to offer adolescent-friendly contraceptive services, and linking service delivery with activities that build support in communities:

Offer privacy and maintain confidentiality, conveniently located with convenient working hours.

Providers should be competent, with good communication skills, motivated and supportive, informative and responding to questions and concerns.

Have comprehensive service package and ways of increasing access with outreach and peer-to-peer services.

Finally, the “Costed Implementation Plan for Family Planning in Ethiopia, 2015/16-2020” includes an initiative to increase youth-friendly service provision beyond youth centers and highlights the availability of a wide range of contraceptive methods:

SDA6. Increase the number of FP service access points for youth: To improve access to FP services for youth and adolescents, FP and SRH trainings will be organised for youth centre staff across the country so they can effectively engage youth in conversation about family planning, impart knowledge regarding the full spectrum of FP options available to them, and refer them to youth-friendly service providers should they choose to receive an FP service. In conjunction, additional health facilities will be made more youth friendly by establishing youth corners and training service providers on youth-friendly services. To address the FP needs of university students, advocacy meetings will be organised to ensure high-quality FP service delivery by university and college clinics.

All seven core elements of adolescent-friendly contraceptive service provision are recognized in the policies reviewed. Thus, Ethiopia is placed in the green category for this indicator.

Community Support for Youth FP Services

Policy outlines a detailed strategy to build community support for youth FP services, including one or more of the following approaches: mass media/multimedia, community engagement, awareness campaigns.

The importance of building community support for youth FP services features prominently in Ethiopia’s “Adolescent and Youth Reproductive Health Strategy, 2007-2015.” Goal 2 outlines specific action steps to inform youth and members of the community:

Goal 2: To increase awareness and knowledge about reproductive health issues, which lead to healthy attitudes and practices in support of young people’s reproductive health.

Strategies under this initiative include engaging community members in community dialogue and sensitization, supporting parents and family members to speak about adolescent SRH with their children, and establishing communication channels between children and adults.

Ethiopia is placed in the green category for this initiative as policy documents reviewed thoroughly address building community support for youth FP services and include specific actions to do so.

KENYA

Policy documents reviewed:

- National Reproductive Health Policy, 2007.
- Reproductive Health and Rights Act, 2008.
- National Family Planning Guidelines for Service Providers: Updated to Reflect the 2009 Medical Eligibility Criteria of the World Health Organization, 2010.
- Republic of Kenya, Ministry of Health, National Family Planning Costed Implementation Plan, 2012-2016.
- Ministry of Medical Services, Ministry of Public Health and Sanitation, Kenya Health Policy, 2012-2030.
- Republic of Kenya, Ministry of Education, Science, and Technology Education Sector Policy on HIV and AIDS, Second Edition, 2013.
- Republic of Kenya, Ministry of Health, National Adolescent Sexual and Reproductive Health Policy, 2015.
- Republic of Kenya, Ministry of Health, National Guidelines for Provision of Adolescent and Youth Friendly Services in Kenya, 2016.

Parental Consent, Spousal Consent, or Provider Discretion

Law or policy exists that supports youth access to FP services free from one or two of the following: provider discretion, parental consent or spousal consent, but not all three.

Within Kenya's strong policy environment supporting SRH services for adolescents and youth, the legal stance on parental and spousal consent for youth accessing FP services is noticeably weak. The "National Guidelines for Provision of Adolescent and Youth Friendly Services in Kenya" outline a clear strategy to improve adolescents' access to and use of SRH services. While this document identifies laws and policies requiring parental and partner approval as a structural barrier to youth accessing SRH services, it does not make any definitive statement on the right of adolescents to access services without parental and spousal consent.

Efforts are underway in Kenya to enact the "Reproductive Health and Rights Act," which would explicitly allow for youth in Kenya to freely access SRH services without parental consent. The draft of this act states:

§21: (i) The Minister for health shall in conjunction with the Board, Regulatory authorities and other relevant institutions and bodies facilitate the provision of adolescent friendly reproductive health service; (ii) In the provision of reproductive health services to adolescents, parental consent shall not be mandatory.

The "Reproductive Health and Rights Act," if enacted, would likely heighten the impact and reach of the "National Adolescent Sexual and Reproductive Health Policy" by providing the necessary legal justification for youth in Kenya to access the contraceptive services outlined in the national policy's program strategies. In the absence of this legal recognition of youth's rights, youth will continue to face barriers at facilities when attempting to access the contraceptive services they desire.

Although the law is not clear regarding parental or spousal consent for youth to access FP services, strong policies exist directing providers to offer nondiscriminatory, unbiased care to adolescents based on medical eligibility criteria. The “National Guidelines for Provision of Adolescent and Youth Friendly Services in Kenya” promote five characteristics of adolescent service provision that follow the “WHO Quality of Care Framework” for adolescent service provision: accessible, acceptable, appropriate, equitable, and effective. The guidelines specifically address the role of the provider to offer adolescent-friendly health services, including the provision of contraception, in a manner that respects the five quality of care characteristics:

The service providers should be non-judgmental and considerate in their dealings with adolescents and youth and deliver the services in the right way.

The guidelines further recognize and address the challenges providers face when balancing personal beliefs with the provision of SRH care to youth:

Health service providers report being torn between personal feelings, cultural and religious values and beliefs and their wish to respect young people’s rights to accessing and obtaining SRH services. Training of service providers should address service provider attitudes and beliefs, and improve provider knowledge of normal adolescent development and special characteristics of adolescent clients and skills—both clinical and counselling.

Kenya is placed in the yellow category for parental consent, spousal consent, or provider discretion. The country could move into the green category if policymakers enact the “Reproductive Health Rights Act” and include a provision that recognizes youth’s right to access FP services without parental or spousal consent.

Restrictions Based on Age

Law or policy exists that supports youth access to FP services regardless of age but does not mention provision of a full range of methods

The 2010 Constitution of Kenya recognizes the right of all people to access reproductive health care:

Article 43: (1) Every person has the right—(a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care.”

This strong declaration in favor of all people accessing health care sets the stage for equal access to health care services. However, the absence of language referencing the right to reproductive health regardless of age leaves ambiguity in the interpretation of the intended beneficiaries.

The “National Guidelines for Provision of Adolescent and Youth Friendly Services in Kenya” recognize adolescents’ right to access services independent of their age or marital status, including access to FP services and contraception. FP and contraceptive services are included as a subset of services under the “Minimum Initial Service Package (MISP) for Reproductive Health.” Under the MISP operational guidelines, health providers are directed as follows:

Health staff should be aware that adolescents requesting contraceptives have a right to receive these services, regardless of age or marital status.

This explicit recognition of adolescents' right to contraception regardless of age is a critical step towards addressing the barriers many youth face when accessing these services. However, the document does not mention the provision of LARCs to youth specifically.

Restrictions Based on Marital Status

Law or policy exists that supports youth access to FP services regardless of marital status.

Kenya is placed in the green category for this indicator because the “National Guidelines for Provision of Adolescent and Youth Friendly Services” make a clear provision for youth to access FP services regardless of marital status. See additional discussion above under *Restrictions Based on Age*.

Comprehensive Sexuality Education

Policy supports provision of sexuality education without referencing all nine of the UNFPA essential components of CSE.

CSE is defined and promoted in the “National Adolescent Sexual and Reproductive Health Policy, 2015”:

Age-Appropriate Comprehensive Sexuality Education is an age-appropriate, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic and non-judgmental information. Sexuality education provides opportunities to explore one's own values and attitudes as well as build decision-making communication and risk reduction skills about many aspects of sexuality.

The guidelines in the “National Adolescent Sexual and Reproductive Health Policy” lay out a vision for sexuality education in the country, including elements such as reaching in-school and out-of-school youth, using medically accurate information and training health care providers to provide SRH information. However, the guidelines do not cover all nine essential components of CSE.

It appears that the Ministry of Education is updating the curriculum on life skills and sexuality education. The updated protocol should take into consideration the nine essential components of CSE, particularly integration of gender, participatory teaching methods, strengthening youth advocacy, and cultural relevancy. In the absence of such a protocol, the policy environment surrounding CSE in Kenya is considered promising but incomplete and the country has been placed in the yellow category.

Youth-Friendly FP Service Provision

Policy mentions all seven core elements of adolescent-friendly contraceptive services AND explicitly mentions the provision of a full range of contraceptive methods to youth.

Kenya has an inclusive and supportive policy environment for the provision of SRH services, including the full range of contraception, to both youth and adolescents. The “National Guidelines for Provision of Adolescent and Youth Friendly Services in Kenya, 2016” recognize the health and human rights of young people. All seven common elements of adolescent-friendly contraceptive services discussed in the HIPs “Adolescent Friendly Contraceptive Services” review are included in Kenya's policy environment. The guidelines explicitly address the high cost of services as a barrier to youth seeking FP services:

All adolescents and youth should be able to receive health services free of charge or are able to afford any charges that might be in place.

Adolescents and youth in Kenya can access a full range of contraception under existing policies. The “National Guidelines for Provision of Adolescent and Youth Friendly Services in Kenya” include contraception as a component in the essential package of service offerings for adolescents:

Contraception counselling and provision of full range of contraceptive methods, including long-acting reversible methods.

Community Support for Youth FP Services

Policy outlines a detailed strategy to build community support for youth FP services, including one or more of the following approaches: mass media/multimedia, community engagement, awareness campaigns.

Kenya’s “National Costed Implementation Plan, 2012-2016” outlines steps to engage the community to support youth’s reproductive health needs under Intervention 3.2:

Strengthen the community component of youth reproductive health programme.

This intervention includes activities to train community health workers to distribute contraception, as well as advocate for FP in the community. Two additional demand-generation interventions, Intervention 4.6 and 4.7, have specific activities targeting outreach and advocacy for youth:

Intervention 4.6 Enhance the organizational capacity of communities to effectively participate in FP activities.

Intervention 4.7. Increased demand for FP by improving advocacy.

The implementation plan lays out a detailed strategy to build community support for youth FP services and, accordingly, Kenya is placed in the green category.

NIGER

Policy documents reviewed:

- Loi Sur la Santé de la Reproduction au Niger, 2006.
- Plan de Developpement Sanitaire, 2011-2015.
- Planification Familiale au Niger: Plan d’action, 2012-2020.

Parental Consent, Spousal Consent, or Provider Discretion

Law or policy exists that requires provider discretion OR consent from a parent OR spouse for youth access to FP services.

None of the policy documents reviewed for Niger include language addressing parental consent, spousal consent, or provider discretion for FP services. The lack of policy language supporting youth access to FP services without these authorizations creates a potential barrier for youth in Niger interested in accessing contraception. To improve the policy environment, policymakers should consider including specific provisions for youth to access FP services without consent from a parent or spouse or provider discretion.

Restrictions Based on Age

Law or policy exists that restricts youth from accessing a full range of FP services based on age.

Nigerien law recognizes the rights of all people to receive SRH care broadly. Article 2 of the 2006 “Law on Reproductive Health” acknowledges that reproductive health is a universal human right free from discrimination, including discrimination based on age or marital status:

Article 2 - Caractère universel du droit à la santé de la reproduction. Tous les individus sont égaux en droit et en dignité en matière de santé de la reproduction. Le droit à la santé de la reproduction est un droit universel fondamental garanti à tout être humain, tout au long de sa vie, en toute situation et en tout lieu. Aucun individu ne peut être privé de ce droit dont il bénéficie sans discrimination aucune fondée sur l'âge, le sexe, la fortune, la religion, l'ethnie, la situation matrimoniale ou sur toute autre situation. (Lui du Sur la santé de la reproduction au Niger 2006)

While this law makes a declarative statement supporting the rights of all people, regardless of age or marital status, to receive reproductive health care, the following article restricts contraceptive use to legally married couples:

Article 3 – Autodétermination

Les couples et les individus ont le droit de décider librement et avec discernement des questions ayant trait à la santé de la reproduction dans le respect des lois en vigueur, de l'ordre public et des bonnes mœurs. Les couples légalement mariés peuvent décider librement et avec discernement de l'espacement de leurs naissances et de disposer des informations nécessaires pour ce faire, et du droit d'accéder à la meilleure santé en matière de reproduction.

This qualifier restricts contraceptive use to married youth, which further restricts users based on age. In Niger, the legal minimum age of marriage is 15 for girls and 18 for boys. While there is general recognition of SRH services for people, regardless of age, the marriage qualifier for contraception creates a barrier for youth. Thus, Niger is placed in the red category for this indicator.

Restrictions Based on Marital Status

Law or policy exists that restricts youth from access to FP services based on marital status.

Only married couples are recognized as legal entities to access reproductive health care in the 2006 “Law on Reproductive Health.” Article 3, excerpted above, makes a clear declaration in favor of people accessing reproductive health care, if they are legally married. By implication, this language indicates that unmarried youth do not have access to contraceptive information or the right to access reproductive health. To address this population’s barriers to receiving FP services due to marital status, the government should include policy language supporting married and unmarried couples, including youth, access to FP services.

Comprehensive Sexuality Education

Policy supports provision of sexuality education without referencing all nine of the UNFPA essential components of CSE.

Activity 1.1.19 of the “Planification Familiale au Niger: Plan d’action, 2012-2020” briefly references strengthening FP education for high school students through the home economics curriculum.

Renforcer l'enseignement de la PF au cours d'économie Familiale dans les CES

Recognizing the need for FP education demonstrates a level of policy commitment on this issue. However, the policy fails to include specific guidelines on the content of the material and how the lessons should be instructed, nor coverage for young people outside of a specific course. Given this limited detail and potential lack of coverage, the country is placed in the yellow category for this indicator.

Youth-Friendly FP Service Provision

Not enough information.

The “Planification Familiale au Niger: Plan d’action, 2012-2020” does not identify youth as a priority population. A few demand-generation activities in the action plan specifically target youth; however, the plan does not provide much guidance on FP service provision to youth. Activity 3.2.4. includes formative research on youth-friendly centers, which suggests there may be future actions to tailor FP services to youth:

Réaliser une recherche action sur la contribution des “Centres amis des jeunes” à l’offre de la PF chez les adolescents

Given limited evidence of effectiveness in changing reproductive health behaviors, youth centers are not included in the recommended components of the HIPs “Adolescent-Friendly Contraceptive Services”. Since there is no further information on the outcome of the formative research, Niger has been placed in the gray category. To promote the most effective policy environment for youth-friendly FP service provision, the country should incorporate all seven elements of adolescent-friendly service provision in its FP action plan and make a clear provision supporting youth accessing a full range of contraception.

Community Support for Youth FP Services

Not enough information.

Similar to the *Youth-Friendly FP Service Provision* indicator, Niger is classified in the gray category for this indicator. The “Planification Familiale au Niger: Plan d’action, 2012-2020” does include an FP communications intervention, activity 2.1.2, that targets multiple stakeholder groups, including youth:

Renforcer la communication à travers le marketing social et le partenariat avec les leaders religieux et traditionnels, les élus locaux, les ONG et associations, les groupements féminins et les jeunes chaque année dans les huit régions du pays.

However, no further details exist regarding the purpose of the communication materials or actual activities within the intervention. It is unclear if the activity will target youth as an audience or merely support youth access to FP in general communication materials. In the absence of this information, the country is placed in the gray category, subject to updating if further policy documents provide additional information regarding the content of this intervention.

NIGERIA

Policy documents reviewed:

- National Family Life and HIV Education Curriculum for Junior Secondary School in Nigeria, 2003.

- National Family Planning/Reproductive Health Policy Guidelines and Standards of Practice, 2005.
- Federal Government of Nigeria, Federal Ministry of Health, National Policy on Health and Development of Adolescents and Young People in Nigeria, 2007.
- Federal Government of Nigeria, Federal Ministry of Health, National Strategic Framework on the Health and Development of Adolescents and Young People in Nigeria, 2007-2011.
- Action Plan for Advancing Young People's Health and Development in Nigeria, 2010-2012.
- National Family Planning/Reproductive Health Service Protocols, Revised Edition, 2010.
- Federal Ministry of Health, Clinical Protocol for the Health and Development of Adolescent and Young People in Nigeria, 2011.
- Federal Ministry of Health, Increasing Access to Long-Acting Reversible Contraceptives in Nigeria: National Strategy and Implementation Plan, 2013-2015.
- National Guidelines for the Integration of Adolescent and Youth Friendly Services Into Primary Health Care Facilities in Nigeria, 2013.
- National Guidelines on Promoting Access of Young People to Adolescent and Youth-Friendly Services in Primary Health Care Facilities in Nigeria, 2013.
- National Standards and Minimum Service Package for Adolescent and Youth-Friendly Health Services, 2013.
- Federal Republic of Nigeria, National Health Bill, 2014.
- Federal Government of Nigeria, Federal Ministry of Health, Nigeria Family Planning Blueprint (Scale-Up Plan), October 2014.

Parental Consent, Spousal Consent, or Provider Discretion

No law or policy exists on provider discretion or consent from a parent or spouse to access FP services.

There is no mention of parental consent, spousal consent, or provider discretion in available FP and youth guidelines and strategies. The absence of these guidelines in policies reviewed suggests that either the guidelines exist in policies not available to reviewers or that Nigeria has not taken an official stance on these issues. The ambivalence of the legal framework on youth's right to freely and independently access FP services creates a barrier for youth accessing such services. Providers can opt to use their own discretion when offering services to young people if they do not have a legal obligation to do so.

Restrictions Based on Age

Law or policy exists that supports general access to a full range of FP services regardless of age, but does not specifically address youth access.

The "National Family Planning/Reproductive Health Service Protocols, Revised Edition, 2010" acknowledge clients' rights, including the right to access services. Service providers are directed to inform every client of his or her right to:

Access—obtain services regardless of age, sex, creed, colour, marital status, or location.

This recognition of the rights of all people to access FP services is critical to address the barriers women of all ages frequently face when attempting to access contraception. However, the FP protocols do not link this right to the specific needs of youth. Nigeria is placed in the yellow category for this indicator.

Restrictions Based on Marital Status

Law or policy supports access to FP services for unmarried women, but without specifying youth.

See discussion above under *Restrictions Based on Age* indicator.

Comprehensive Sexuality Education

Policy promotes abstinence-only education or discourages sexuality education.

Nigeria's policy environment surrounding sexuality education is weak. The leading guidance on provision of sexuality education in the country is the "National Family Life and HIV Education (FLHE) Curriculum for Junior Secondary School in Nigeria, 2003." This document provides a substantial overview of the FLHE curriculum for junior secondary schools, primarily focused on human development and life skills. The component of the curriculum most relevant to contraceptive provision is HIV education. While the curriculum presents comprehensive information on STI/HIV definitions, modes of transmission, and signs and symptoms, it falls short of informing youth on how to prevent these infections through safe sexual behavior and condom and contraceptive use. Further, there is no discussion of where or how to access SRH services. Rather, the guidance for preventing STI/HIV is:

- Abstain from sexual behavior.
- Avoid sharing sharp objects (such as needles, razor, clippers).
- Insist on screened blood.

Nigeria is placed in the red category for CSE since the country's current guidance on sexuality education refers only to abstinence. However, the "National Guidelines on Promoting Access of Young People to Adolescent and Youth-Friendly Services in Primary Health Care Facilities in Nigeria" does reference peer education as a strategy to supplement in-school SRH instruction to reach in-school and out-of-school youth, as well as parents and guardians.

Further, the "Nigeria Family Planning Blueprint (Scale-Up Plan), October 2014" includes an activity to improve the FLHE curriculum:

DBC3. Fully Integrate family planning into school health programs: The Family Life and HIV Education (FLHE) curriculum will be updated to support the goal of increasing appropriate FP messaging to adolescents and youth.

To improve the policy environment surrounding sexuality education, policymakers in Nigeria should consider addressing the nine UNFPA essential components of CSE when updating the FLHE curriculum.

Youth-Friendly FP Service Provision

Policy references targeting youth in provision of FP services but mentions fewer than seven of the core elements of adolescent-friendly contraceptive services.

The "National Policy on Health and Development of Adolescents and Young People in Nigeria" briefly addresses the SRH needs of young people. The "National Guidelines for the Integration of Adolescent and Youth Friendly Services into Primary Health Care Facilities in Nigeria" include specific directives to provide contraceptive counseling and services as a part of all clinical preventive services targeting adolescents and youth in primary health care facilities. The list of essential drugs, however, limits contraceptive offerings to barrier methods, oral contraceptives, and emergency contraception. While an intrauterine device (IUD) kit is listed in the medical equipment addendum, this contraceptive offering is absent in the essential drug list.

The “Nigeria Family Planning Blueprint (Scale-Up Plan), October 2014” includes a specific service delivery activity addressing provision of youth-friendly FP services:

SD16. Make PHCs [primary health care centers] youth-friendly. FP providers will be given adequate orientation to enable them to provide youth-friendly FP services. Part of making FP youth-friendly requires providing places where youths can have adequate privacy to receive FP services. When possible, private, youth-friendly service points will be established in existing PHCs. These rooms will be closed off so that the identity of the person inside cannot be viewed from the rest of the facility. The rooms will be furnished with FP materials and necessary supplies. Peer educators trained to dispense pills and condoms will staff the service points.

This activity covers two out of the seven elements identified in the HIPs “Adolescent-Friendly Contraceptive Services” review to improve adolescent and youth uptake of contraception. To improve upon this initiative, policymakers should consider including the remaining adolescent-friendly elements in the provision of FP services:

3. Offer a wide range of contraception.
4. Provide no-cost or subsidized services.
5. Build an enabling legal and political environment.
6. Link service delivery with activities that build support in communities.
7. Address gender and social norms.

Policies in Nigeria support youth accessing short-term methods of contraception and IUDs. The “National Standards and Minimum Service Package for Adolescent and Youth-Friendly Health Services in Nigeria” includes counseling and provision of contraception as a component of the minimum service package:

Youth-friendly clinics are to provide services for Oral Contraceptive Pills (OCPs), condoms and IUD insertion as per the national guidelines. Service providers are to be encouraged to offer a package of contraceptives, so that young people can choose a particular method as per their need/s.

The “National Family Planning/Reproductive Health Service Protocols, Revised Edition, 2010” include youth under medical eligibility for contraception. The guidelines allow for the provision of injectables generally for persons under age 18, oral contraceptives generally for women between menarche and less than 18 years, implants at any age, and IUDs with follow up for women between menarche and 18 years old. Alarming, the protocol’s text on abstinence exclusively references youth: “In regards to abstinence adolescents/youths are encouraged to adopt this method.”

The “Clinical Protocol for the Health and Development of Adolescents and Young People in Nigeria” provides guidance to providers on how to counsel youth regarding contraception, emphasizing youth’s choice:

Discuss all temporary forms of contraceptives available in the clinic with the client. Show all the methods to the client. Discuss the advantages and disadvantages of each method. Allow the client to make a choice. Discuss the method chosen by the client with him/her.

While supportive of contraceptive provision to youth, this protocol also emphasizes youth abstinence. Under the counseling guidelines for abstinence, providers are instructed to:

Provide information on the need to continue with abstinence for as long as possible.

Avoid situations that can provoke sexual stimulations.

Furthermore, a national strategy to increase access to LARCs, “Increasing Access to Long-Acting Reversible Contraceptives in Nigeria: National Strategy and Implementation Plan, 2013-2015,” does not include a targeted strategy to increase uptake of LARCs among youth.

The inconsistency in the service and LARC protocols creates an opportunity for providers to differentially interpret the directives. Adding a provision that explicitly supports youth access to all medically eligible contraceptive methods would strengthen this policy in respect to youth FP and support full implementation of the “Nigeria Family Planning Blueprint (Scale-Up Plan),” which promotes the provision of LARCs to youth.

Nigeria is placed in the yellow category for youth-friendly FP service provision. The country has the potential to move to a green categorization if all seven elements of adolescent-friendly service provision are incorporated in its FP service provision guidelines and a clear provision introduced supporting youth access to a full range of contraception.

Community Support for Youth FP Services

Policy outlines a detailed strategy to build community support for youth FP services, including one or more of the following approaches: mass media/multimedia, community engagement, awareness campaigns.

The “National Strategic Framework on the Health and Development of Adolescents and Young People in Nigeria, 2007-2011” includes two relevant objectives:

Promote awareness of reproductive health issues of young people amongst all stakeholders.

Strengthen the capacity of parents, guardians and significant others to respond positively to the needs of young people through effective IEC [information, education, and communication] approaches.

Specific activities are outlined under these objectives to engage the community through advocacy and community mobilization, and promotion of health reproductive behaviors through information, education, and communication. Since the strategy includes specific activities to build community support for youth FP services, the country is placed in the green category for this indicator.

SINDH (PAKISTAN)

Pakistan’s decentralized government structure necessitates evaluation of policies at the subnational level. In 2010, the Government of Pakistan passed the 18th Constitutional Amendment, which devolved planning, administrative, financial, implementation, and regulatory powers of the National Health Department and Population Welfare Department to provincial governments. Issues related to FP are now featured in provincial health sector strategies and population and development plans, rather than national-level policies.

Instead of reviewing outdated national-level policies, the index analyzes the policy environment for youth FP in the province of Sindh, which is currently the focus of increased attention for FP advocacy and

policy. Some national documents that influence province-level policies and programs are included. Overall categorizations, however, are specific to Sindh’s policy environment.

Policy documents reviewed:²⁹

- Pakistan National Population Policy, 2002.
- Manual of National Standards for Family Planning, 2009.
- National Program for Family Planning and Primary Health Care, “The Lady Health Workers Programme,” January 2010-June 2015.
- Sindh Health Sector Strategy, 2012-2020.
- Reproductive and Healthcare Rights Act, 2013 (national policy).
- Costed Implementation Plan on Family Planning for Sindh, 2015.

Parental Consent, Spousal Consent, or Provider Discretion

No law or policy exists on provider discretion or consent from a parent or spouse to access FP services.

The “Reproductive and Healthcare Rights Act, 2013,” a law applicable across Pakistan, signals increased political acknowledgment of the reproductive rights of women, in an effort to curtail maternal mortality and morbidity. While the act provides increased legal protection for women overall, it ignores the particular reproductive health rights of young women.

The act does not include any provision for youth. Further, under Line B, Article 4, the right of parents to educate their children is prioritized as a means of promoting reproductive health care information. The acknowledgment of parental responsibility without subsequent recognition of youth’s rights to FP services creates an opportunity for interpretation that favors parental rights in regards to their children’s reproductive health decisions.

Article 4: Promotion of reproductive healthcare rights:

(1). The right to reproductive healthcare information can be promoted,

(b) through the exercise of parental responsibility which assures the right of parents as educators.

Sindh policies reviewed do not provide further guidance on youth’s right to access family planning services without parental consent, spousal consent or provider discretion. The absence of these declarations can create barriers for youth attempting to access contraception. The province is placed in the red category for this indicator.

Restrictions Based on Age

Law or policy exists that supports general access to a full range of FP services regardless of age, but does not specifically address youth access.

The “Costed Implementation Plan on Family Planning for Sindh, 2015” includes the “Family Planning 2020: Rights and Empowerment Principles of Family Planning” as an annex to the document. This list addresses age and marital status as a determinant to access FP services:

Quality, accessibility, and availability of information and services should not vary by non-medically indicated characteristics i.e. age, location, language, ethnicity, disability, HIV status, sexual orientation, wealth, marital or other status

While this declaration references the right of all people to access services regardless of age and marital status, it lacks specific reference to youth access. Thus, Sindh is placed in the yellow category for this indicator. To further strengthen the policy environment in Sindh, future policies should directly reference the right of youth, regardless of age or marital status, to receive FP services.

Restrictions Based on Marital Status

Law or policy supports access to FP services for unmarried women, but without specifying youth.

See discussion above under *Restrictions Based on Age* indicator.

Comprehensive Sexuality Education

Policy supports provision of sexuality education without referencing all nine of the UNFPA essential components of CSE.

Sindh addressed FP education for youth at the university level, under Activity 5.4.1. of the “Costed Implementation Plan) on Family Planning for Sindh, 2015”:

Consultations held with Department of Education, Health Education Commission, professional colleges to include life skills into the curriculum

Although the Costed Implementation Plan recognizes the provision of sexuality education, the scope is limited to college-age students and does not incorporate the nine UNFPA essential components. Therefore, Sindh is placed in the yellow category for this indicator.

Youth-Friendly FP Service Provision

Policy references targeting youth in provision of FP services but mentions fewer than seven of the core elements of adolescent-friendly contraceptive services.

The provision of contraception to youth is highlighted as a special area of focus in the “Sindh Health Sector Strategy, 2012-2020”:

Strategy 3.4: Re-defining links with DoPW (Department of Population Welfare) with shift of contraceptive services through district and urban PHC [primary health care] systems and aimed at birth spacing in younger couples

Under this strategy, contraceptives should be provided at no cost to encourage birth spacing. Further information on contraceptive options is absent from the document, however.

The “Costed Implementation Plan on Family Planning for Sindh, 2015” further identifies youth as a vulnerable segment of the population and includes activities to train health providers in youth-friendly service provision:

During the training of providers and community-based workers on FP, youth-friendly services and engagement will be added as a compulsory element of training (in-service and pre-service). Such an orientation of providers to the principles of youth-friendly services will allow existing facilities and community-based workers to incorporate ownership of providing services to meet the needs of young people.

Sindh is placed in the yellow category for this indicator, given that its policy environment for youth-friendly FP service provision is promising, but not yet fully comprehensive.

Community Support for FP Services

Policy references engaging the community to support youth access to FP, but does not include specific intervention activities.

The “Costed Implementation Plan on Family Planning for Sindh, 2015” highlights reaching youth as a key concern and priority area. As a part of the discussion for reaching youth, the plan recognizes the importance of engaging the community to support youth access to FP:

Engagement with key gatekeepers and community leaders to foster an enabling environment for service uptake.

However, additional guidance on how this activity will be implemented is missing, placing the province in the yellow category for this indicator.

SENEGAL

Policy documents reviewed:

- Loi n° 2005-18 du 5 Août 2005 Relative à la Santé de la Reproduction.
- Stratégie Nationale en Santé des Adolescentes/Jeunes au Sénégal, 2005.
- Protocoles de Services de Santé de la Reproduction au Sénégal.
- Loi n° 2010-03 du 9 Avril 2010 Relative au VIH/SIDA (HIV/AIDS).
- Plan d'Action National de Planification Familiale, 2012-2015.
- Plan Strategique de Santé Sexuelle et de la Reproduction des Adolescent(e)s/Jeunes au Sénégal, 2014-2018.

Parental Consent, Spousal Consent, or Provider Discretion

No law or policy exists on provider discretion or consent from a parent or spouse to access FP services.

The policy documents reviewed for Senegal include no references to parental consent, spousal consent, or provider discretion to FP services.

Restrictions Based on Age

Law or policy exists that supports youth access to FP services regardless of age, including the provision of long-acting and reversible contraceptives (LARCs).

The right of youth to receive SRH care is written into Senegalese law. The 2005 “Reproductive Health Law” includes a clear declaration allowing all people to access reproductive health services without discrimination, including discrimination based on marital status or age. Under Articles 3 and 10, the right to reproductive health is acknowledged as a fundamental health and human right for all people. The law further promotes access to reproductive health for adolescents under Article 4.

Article 3: Le droit à la Santé de la Reproduction est un droit fondamental et universel garanti à tout être humain sans discrimination fondée sur l'âge, le sexe, la fortune, la religion, la race, l'éthnie, la situation matrimoniale ou sur toute autre situation.

Article 4: la promotion de la santé de la reproduction des adolescents;

Article 10. - Toute personne est en droit de recevoir tous les soins de santé de la reproduction sans discrimination fondée sur l'âge, le sexe, le statut matrimonial, l'appartenance à un groupe ethnique ou religieux.

The right to a full range of contraceptive options is explicitly outlined in the “Protocoles de Services de Santé de la Reproduction au Sénégal.” The service protocols recognize the unique SRH needs and interests of youth and instruct providers to offer medically-appropriate contraception to adolescents, regardless of age or marital status:

En ce qui concerne la planification familiale, les adolescents peuvent utiliser n'importe quelle méthode de contraception et doivent avoir accès à un choix étendu. L'âge ne constitue pas à lui seul une raison médicale permettant de refuser une méthode à une adolescente. Si certaines inquiétudes ont été exprimées concernant l'utilisation de certaines méthodes contraceptives chez l'adolescente (par ex. l'emploi des progestatifs injectables seuls pour les moins de 18 ans), elles doivent être pesées en regard des avantages présentés par le fait d'éviter une grossesse.

Senegal is placed in the green category for this indicator since national laws and policy guidelines support adolescents' access to a full offering of contraception.

Restrictions Based on Marital Status

Law or policy exists that supports youth access to FP services regardless of marital status.

See discussion above under *Restrictions Based on Age* indicator.

Comprehensive Sexuality Education

Policy supports provision of sexuality education without referencing all nine of the UNFPA essential components of CSE.

The 2010 “Law on HIV/AIDS” includes a specific mandate for education on the prevention and treatment of HIV and STIs. This law provides a foundation to incorporate sexuality education into education curricula.

Article 8. - De l'éducation en matière de VIH et de SIDA dans les établissements d'enseignement formels et non formels. Tous les départements ministériels ayant en charge les structures d'éducation et de formation doivent intégrer dans les programmes d'enseignement et de formation, des modules sur les modes de transmission et les moyens de prévention du VIH et du SIDA et des infections sexuellement transmissibles. Avant d'être autorisés à dispenser des enseignements sur le VIH et le SIDA, les enseignants, instructeurs tous autres intervenants, dans les cours et modules d'enseignement reçoivent une formation appropriée.

In the early 1990s, two family life education programs were piloted in Senegal. In 1990, the Ministry of Education (MoE) piloted a population education curriculum in primary schools. In 1994, the MoE appointed le Groupe pour l'Étude et l'Enseignement de la Population (GEEP), a Senegalese nongovernmental organization, to pilot a family life education (FLE) program in secondary schools. Both

programs incorporated cross-curricula instructional material related to population and family life in select regions in the country. In 2010, the MoE incorporated aspects of the FLE pilot programs into the national basic education curriculum; however, critical elements of CSE were omitted, including “rights, gender, personal values, interpersonal relationships, gender-based violence, skills-building related to SRH (for example, negotiating condom use), and critical thinking skills to assess social norms.”³⁰ The MoE has facilitated efforts to refresh the national curriculum. In doing so, the policy revision should consider the nine UNFPA essential components of CSE.³¹

The “Plan Strategique de Santé Sexuelle et de la Reproduction des Adolescent(e)s/Jeunes au Senegal, 2014-2018” describes the aims of a proposed sexual health education program, including some of the essential components of CSE programs. It describes strengthening skills in critical thinking, personalization of information, and reaching across formal and informal sectors and across age groups. For example:

L'éducation à la santé sexuelle consiste à informer sur la sexualité en transmettant un certain nombre de valeurs et de recommandations aux adolescent(e)s/jeunes. En effet elle vise à... développer l'exercice de l'esprit critique, notamment par l'analyse des modèles et des rôles sociaux véhiculés par les médias.

Elsewhere, the plan describes educating youth on human rights and gender inequalities:

Dans le cadre de l'éducation de ces derniers, les questions de genre et les conséquences néfastes de la violence basée sur le genre seront abordées afin que toute forme de violence soit prévenue. Les jeunes seront informés et sensibilisés sur les Droits Humains (le genre faisant partie intégrante des questions de droit de l'homme).

However, this component is not included as an aim of the previously described sexual health education program. Additional components are also acknowledged in some form, often in the context of service delivery, but not in the context of CSE, such as providing accurate information, linking SRH services and other initiatives for young people, providing youth-friendly spaces, and strengthening youth input into SRH programming. While this policy acknowledges CSE broadly, the plan falls short of including all nine essential components together in a clear operational policy for CSE. Senegal has a promising policy environment for CSE, but until these policies are revised, the country will remain in the yellow category.

Youth-Friendly FP Service Provision

Policy mentions all seven core elements of adolescent-friendly contraceptive services and explicitly mentions the provision of a full range of contraceptive methods to youth.

The “Plan Strategique de Santé Sexuelle et de la Reproduction des Adolescent(e)s/Jeunes au Sénégal, 2014-2018” includes plans to train providers to offer youth-friendly contraceptive services, with particular emphasis on good communication skills:

Pour le professionnel de santé, le dialogue et la relation de confiance noués avec l'adolescent(e)/jeune sont des déterminants fondamentaux de la qualité de la prise en charge, qu'il s'agisse de diagnostiquer, de dépister et d'informer. En effet, il doit avoir des compétences nécessaires pour communiquer avec les adolescent(e)s/jeunes, détecter leurs problèmes de santé de façon précoce et fournir des conseils et des traitements. Il doit placer les besoins, les problèmes, les pensées, les sentiments, les

*points de vue et les perspectives des adolescent(e)s/jeunes, au coeur de ses activités...
L'accent sera mis sur l'apprentissage et la formation continue.*

The “Plan d’Action National de Planification Familiale, 2012-2015” further references the provision of FP services to youth and identifies the need for discretion, confidentiality, and tailored service provision:

L’accent sera mis sur la qualité du service et du counseling tout en assurant la disponibilité du matériel et des consommables. Un focus particulier sera mis sur l’amélioration de l’accès aux services de Planification Familiale pour les jeunes en leur assurant la discrétion, la confidentialité et un service adapté.

Similarly, the “Protocoles de Services de Santé de la Reproduction au Senegal” include a direct reference to the provision of FP services for youth and recognize the rights of youth to receive services, including their right to information, access, privacy, and dignity.

Les protocoles définis doivent être respectés pour les différents services. Cependant du fait de la spécificité et de la vulnérabilité de cette cible, une attention particulière doit être apportée aux droits à l’information, à l’accès, à l’intimité et à la dignité de ces adolescent(e)s et jeunes.

Also, the “Plan Strategique de Santé Sexuelle et de la Reproduction des Adolescent(e)s/Jeunes au Sénégal, 2014-2018” outlines the necessary criteria for youth-friendly services in line with the WHO “Quality of Care Framework” for adolescent service provision, including that services must be accessible (and affordable), acceptable, equitable, effective, appropriate, efficient, and comprehensive:

Ces services doivent être:

- *accessibles: ils sont disponibles au bon endroit, au bon moment, à un bon prix (gratuit si nécessaire).*
- *acceptables: ils répondent à leurs attentes et garantissent la confidentialité.*
- *équitable: ils sont offerts à tous sans distinction de sexe, d’âge, de religion d’appartenance ethnique, de handicap, de statut social ou de toute autre nature.*
- *efficaces: ils sont assurés par des prestataires disponibles, compétents, accueillants qui savent communiquer avec les jeunes sans porter de jugement de valeur.*
- *appropriés: les soins essentiels sont fournis d’une manière idéale et acceptable dans un environnement sécurisé.*
- *efficaces: les soins de qualité sont dispensés au coût le plus faible possible.*
- *complets: la prestation de soins couvre tous les aspects de la prise en charge et la référence est assurée en cas de besoin.*

Across these policies, all seven elements of adolescent-friendly contraceptive service provision are addressed. Further, a policy is in place to offer youth a full range of contraceptive options (see discussion above under *Restrictions Based on Age* indicator). Therefore, Senegal is placed in the green category for this indicator.

Community Support for Youth FP Services

Policy outlines a detailed strategy to build community support for youth FP services, including one or more of the following approaches: mass media/multimedia, community engagement, awareness campaigns.

The “Plan d’Action National de Planification Familiale, 2012-2015” highlights the need to inform youth and their communities regarding FP. One of the strategic actions under the communication plan is to roll out a mass media campaign aimed at young people. This strategic action has three main activities:

Batir une campagne participative pour les jeunes.

Renforcer les centres d'écoute pour les jeunes et centres d'information.s

*Utilisation des reseaux sociaux et nve lles tech pr informer les jeunes sur la PF
(facebook, sms, blogs.)*

The “Plan Strategique de Santé Sexuelle et de la Reproduction des Adolescent(e)s/Jeunes au Senegal, 2014-2018” includes plans to use information and communications technology and media to reach youth and the broader community.

Une campagne nationale médiatique de sensibilisation sur la SRAJ sera également menée. De même il serait judicieux d'utiliser des radios communautaires qui représentent un moyen de mobilisation important, pour garantir la participation de la communauté.

Since these plans includes detailed steps to build support among youth and communities for FP services, the country is placed in the green category for this indicator.

TANZANIA

Policy documents reviewed:

- United Government of Tanzania, Ministry of Education and Culture, Guidelines for Implementing HIV/AIDS/STDs and Life Skills Education in Schools and Teachers’ Colleges, Version 2, 2002.
- United Government of Tanzania, Ministry of Health, National Health Policy, 2003.
- United Government of Tanzania, Ministry of Health, Standards for Adolescent Friendly Reproductive Health Services, December 2004.
- United Government of Tanzania, Ministry of Health and Social Welfare, National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn, and Child Deaths in Tanzania, 2008-2015 (One Plan).
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Parental Consent, Spousal Consent, or Provider Discretion

Law or policy exists that supports youth access to FP services free from provider discretion AND consent from a parent or spouse.

The right of young people and adolescents to freely access FP services is situated prominently in the Tanzania “National Family Planning Guidelines and Standards, 2013”:

Decisions about contraceptive use should only be made by the individual client. No parental or spousal consent is needed for an individual to be given family planning information and services, regardless of age or marital status.

Further, guidance directs providers to offer FP services in accordance with the WHO medical eligibility criteria:

Contraceptives should be provided to clients in accordance with nationally approved method-specific guidelines, as defined by the World Health Organization (WHO) Medical Eligibility Criteria (MEC).

Taken together, the inclusion of these statements supporting youth’s full access to a range of contraception regardless of age or marital status and without parental consent, spousal consent, or provider discretion in national FP guidelines indicates a supportive and favorable policy environment towards youth having the freedom to independently make decisions about contraceptive use. Therefore, the country is placed in the green category for the indicators assessing parental consent, spousal consent, or provider discretion, restrictions based on age, and restrictions based on marital status.

Restrictions Based on Age

Law or policy exists that supports youth access to FP services regardless of age, including the provision of LARCs.

See discussion above under *Parental Consent, Spousal Consent, or Provider Discretion* indicator.

Restrictions Based on Marital Status

Law or policy exists that supports youth access to FP services regardless of marital status.

See discussion above under *Parental Consent, Spousal Consent, or Provider Discretion* indicator.

Comprehensive Sexuality Education

Policy supports provision of sexuality education without referencing all nine of the UNFPA essential components of CSE.

The Ministry of Education and Culture (MoEC) in Tanzania has taken a broad stance on the form of sexuality education to offer to youth. The MoEC developed the “Guidelines for Implementing HIV/AIDS/STDs and Life Skills Education in Schools and Teachers’ Colleges, 2002” as a response to increased transmission of HIV among youth. As a result, the directives focus primarily on the prevention of HIV and STDs. CSE, specifically, is not referenced and accordingly not defined.

The “Guidelines for Implementing HIV/AIDS/STDs and Life Skill Education in Schools and Teachers’ Colleges, 2002” describes the national approach to sexual education as:

The content of HIV/AIDS/STIs control education shall aim at developing and promoting knowledge, skills positive and responsible attitudes such as assertiveness, effective communication, negotiation, informed decision making and provide motivational support as a means to responsible sexual behaviour.

These guidelines were developed in 2002, prior to the publication of international guidance on CSE, and are largely framed around the prevention of HIV/AIDS/STDs. This framing is not comprehensive and limits the provision of information on sexuality, safe sexual behaviors, SRH care, and gender. To improve upon these guidelines, the MoEC should consider publishing additional directives based on the nine essential components for CSE.

Youth-Friendly FP Service Provision

Policy mentions all seven core elements of adolescent-friendly contraceptive services AND explicitly mentions the provision of a full range of contraceptive methods to youth.

The “National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn, and Child Deaths in Tanzania, 2008-2015” recognizes the urgent need to target adolescents in delivery of FP services. The strategic plan set an operational target of “Increased number of health facilities providing adolescent friendly reproductive health services to 80 percent by 2015.” The target was not met by 2015; however, recognition of adolescent and youth-friendly FP services remains a priority. The second iteration of the “One Plan, National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child, and Adolescent Health in Tanzania, 2016-2020” has set the same target to increase the proportion of adolescent and youth-friendly health services from 30 percent to 80 percent by 2020.

The Tanzania “National Family Planning Guidelines and Standards, 2013” recognizes the unique FP needs of young people as a group deserving special consideration:

All family planning service-delivery points—whether in a facility, community, or outreach setting—should incorporate youth-friendly services, as further described in Section II: Standards. Services are youth-friendly if they have policies and attributes that attract youth to the services, provide a comfortable and appropriate setting for serving youth, meet the needs of young people, and are able to retain their young clients for follow-up and repeat visits.

This document further details specific directives for the provision of youth-friendly services (Standard 5.1.-5.6.). These standards address each of the seven elements identified in the HIPs “Adolescent Friendly Contraceptive Services” review to improve adolescent and youth uptake of contraception. Further, the considerations for young people state that young people have the right to a full range of contraception:

Like persons of other age groups, young people have the rights to decide if and when they want to have children, be informed and obtain information about family planning services, and access a full range of contraceptives methods.

Therefore, Tanzania is considered to have a supportive and favorable policy environment surrounding service provision.

Community Support for Youth FP Services

Policy outlines a detailed strategy to build community support for youth FP services, including one or more of the following approaches: mass media/multimedia, community engagement, awareness campaigns.

The “National Adolescent Reproductive Health Strategy, 2010-2015” includes an initiative to generate demand and community support for adolescent SRH services. Strategic Objective 3 in this strategy is:

Positive attitudes and behaviour change promoted among adolescents, parents and the community on adolescent friendly reproductive health services.

The strategy intends to achieve this initiative through conducting a knowledge, action, beliefs, and practices survey in communities, disseminating behavior change communication materials, conducting community-sensitization activities, and forming parent support groups.

The country is placed in the green category for this indicator since the strategy not only acknowledges the importance of engaging the community in the provision of FP services to youth but also lays out a detailed strategy to build community support for youth-friendly FP services.

Engagement with key gatekeepers and community leaders to foster an enabling environment for service uptake.

UGANDA

Policy Documents Reviewed:

- National Policy Guidelines and Service Standards for Reproductive Health Services, 2001.
- Health Sector Strategic Plan III, 2010/11-2014/15.
- National Adolescent Health-Strategy, 2011-2015.
- National Condom Programming Strategy, 2013-2015.
- National Strategy for Girls’ Education in Uganda, 2015-2019.
- Uganda Family Planning Costed Implementation Plan, 2015-2020.

Parental Consent, Spousal Consent, or Provider Discretion

Law or policy exists that supports youth access to FP services free from one or two of the following: provider discretion, parental consent, or spousal consent, but not all three.

Uganda’s policy environment supports youth access to FP services without authorization by two of the three external parties. The “National Policy Guidelines and Service Standards for Reproductive Health Services” explicitly dictate the rights of all people, including youth, to access FP services without parental or spousal consent:

No verbal or written consent is required from parent, guardian or spouse before a client can be given family planning services.

This document further implies that youth are able to access all FP services, including short- and long-term contraceptive methods, as age is not included as a contraindication for the provision of any short-term or long-acting reversible method. However, the policy does not include a protection for youth to access contraception without provider discretion. Uganda is placed in the yellow category for this indicator. To improve the policy environment, the country should consider including a direct statement discouraging provider discretion.

Restrictions Based on Age

Law or policy exists that supports youth access to FP services regardless of age but does not mention provision of a full range of methods.

The “National Policy Guidelines and Service Standards for Reproductive Health” include a broad eligibility statement for FP services:

All sexually active males and females in need of contraception are eligible for family planning services provided that: they have been educated and counseled on all available family planning methods and choices; attention has been paid to their current medical, obstetric contra-indications and personal preferences.

This statement, while inclusive of all people, does not explicitly recognize age nor marital status as criteria for provision or refusal of FP services. Providers and clients may differentially interpret this statement, potentially creating a barrier for youth desiring access to contraception. To strengthen the eligibility criteria, the guidelines eligibility statement should specifically recognize segmented parts of the population, such as married and unmarried youth.

A later chapter in this document does, however, instruct providers on how to manage adolescent reproductive health. Adolescents, defined as ages 10 to 24, are explicitly included in eligibility criteria for general health services:

All adolescents are eligible for the health services. The services will be provided in a friendly environment and manner that meet their needs.

The objectives in this section further tailor adolescent service provision recommendations to SRH services:

Provide adolescents with appropriate, acceptable and affordable quality information and sexual reproductive health services; increase availability and accessibility of accurate information to adolescents.

While this section acknowledges adolescents’ right to receive SRH services, it does not mention provision of a full range of contraception. Uganda, therefore, is placed in a yellow category for this indicator. To strengthen the policy environment, guidelines should include detailed language supporting youth access to contraception, including LARCs.

Restrictions based on Marital Status

No law or policy exists addressing marital status in access to FP services.

See earlier discussion of *Restrictions Based on Age*.

Comprehensive Sexuality Education

Policy promotes abstinence-only education or discourages sexuality education.

The “Presidential Initiative on AIDS Strategy for Communicating to Young People (PIASCY),” launched in 2003, sought to provide HIV prevention information to primary and secondary youth through in-school assemblies and classroom discussion. A 2006 evaluation of PIASCY suggests that the curriculum

promoted sexual abstinence outside of marriage and restricted SRH information to students. The final manuals distributed to schools lacked critical SRH text, in part due to religious opposition:

The new manuals omitted information from the initial text, including diagrams on how to correctly clean the penis and foreskin, how the body changes at puberty for boys, and how semen is ejaculated during sexual intercourse. A chapter on “ethics, morals and cultural values” was added as well as two assembly messages on the risks of pre-marital sex and on “acceptable moral practices.” The assembly message on condom use was altered, and a diagram illustrating a condom offering protection from HIV was removed. The withdrawal of important and potentially life-saving material from primary school texts raises serious concerns about children’s right to complete and accurate HIV/AIDS information.³²

The exclusion of critical sexuality education material and promotion of abstinence-only practice suggests that the policy environment creates a barrier to youth accessing care. Thus, Uganda has been placed in the red category for this indicator.

Youth-Friendly FP Service Provision

Policy references targeting youth in provision of FP services but mentions fewer than seven of the core elements of adolescent-friendly contraceptive services.

Youth-friendly FP service provision features prominently across Uganda’s policy documents. While none of the policies detail clear action steps aligned with all seven elements of adolescent-friendly contraceptive services, each recognizes the need to tailor services to youth.

The “National Policy Guidelines and Service Standards for Reproductive Health Services” identifies youth as a priority audience for consideration of tailored FP service delivery:

Top priority will be given to preparing providers to handle adolescents and men.

All service delivery points (SDPs) providing RH will be, rehabilitated and, remodeled to enhance patient flow and ensure privacy to patients and clients. An important consideration will be to make them friendly to the adolescents, youth and men.

Further, the “Health Strategic Plan III, 2010/11-2014/15” specifically targets adolescent and youth in the SRH services strategy. The strategy proposes the following activities to strengthen adolescent SRH services and the policy environment surrounding SRH:

Strengthen adolescent sexual and reproductive health services:

-Integrate and implement adolescent sexual and reproductive health in school health programmes; and

-Increase the number of facilities providing adolescent friendly sexual and reproductive health services.

Strengthen the legal and policy environment to promote delivery of SRH services.

-Review SRH and related policies and address institutional barriers to quality SRH services.

-Review SRH policies, standards, guidelines and strategies as need arises.

Finally, the Uganda “Family Planning Costed Implementation Plan, 2015-2020” includes an FP service delivery activity targeting youth:

SD9. Youth-friendly services are provided in clinics. To increase the availability of youth-friendly services, youth-friendly corners will be established, and health workers will be trained on youth-friendly services. In addition, FP service delivery hours will be increased to include outside school hours to accommodate youth.

Combined, the strategies address four out of the seven core elements of adolescent-friendly contraceptive services: train and support providers to offer adolescent-friendly contraceptive services, enforce confidentiality and audio/visual privacy, build an enabling legal and political environment, and link service delivery with activities that build support in communities (discussed under *Community Support for Youth FP Services*). The inclusion of these elements signals a promising policy environment in favor of youth-friendly FP service provision, placing Uganda in a yellow category for this indicator. To bolster the policy environment supporting youth-friendly FP service provision, future guidelines should consider all seven recommended core elements of adolescent-friendly contraceptive provision.

Community Support for Youth FP Services

Policy outlines a detailed strategy to build community support for youth FP services, including one or more of the following approaches: mass media/multimedia, community engagement, awareness campaigns.

The “Uganda Family Planning Costed Implementation Plan, 2015-2020” includes comprehensive actions to create demand for FP services among youth, including elements of building community support:

DC3. Young people, 10-24 years old, are knowledgeable about family planning and are empowered to use FP services: To increase the knowledge and empowerment of young people, peer educators will be engaged and supported; media (print and online) targeting youth will be disseminated; and “edutainment” community events will provide the opportunity for knowledge exchange amongst young people and empower adults to help youth avoid teenage pregnancy.

The action steps proposed not only target youth in awareness and mass media campaigns, but also seek to engage gatekeepers in additional community engagement activities:

Empower parents, caregivers, and teachers to help their children to avoid teen pregnancy, including improving parent-child communication on sexual issues.

The inclusion of a detailed strategic initiative to build community support among youth and adults for youth FP services indicates a strong policy environment, placing Uganda in the green category for this indicator.

ACKNOWLEDGMENTS

This report was written by Sara Harris, Elizabeth Leahy Madsen and Meredith Pierce of Population Reference Bureau (PRB) with significant contributions from Kate Gilles. Support for the development of the index was provided by the Bill & Melinda Gates Foundation, in particular Caitlin Feurey, Gwyn Hainsworth, and Ryan Cherlin. Several experts kindly reviewed and provided input in the selection of the index indicators, including: Katelyn Bryant-Comstock, Heather Boonstra, Vicky Boydell, Jason Bremner,

Venkatraman Chandra-Mouli, Megan Donovan, Alanna Galati, Jillian Gedeon, Karen Hardee, Kiki Kalkstein, Catherine Lane, Tom Merrick, Jeremy Schiffman, and Sylvia Wong. At PRB, Kristin Bietsch, Stephanie Kimou, Nicole LaGrone, Shelley Megquier, and Rhonda Smith provided useful conceptual and research assistance. Colette Ajwan'g (Kenya), Chibuike Alagboso (Nigeria), Margaret Bolaji (Nigeria), Sada Danmusa (Nigeria), Katie Chau (Senegal), Iram Kamran (Pakistan), Catherine Lane (Global), Alem Mekonnen (Ethiopia), Mbadu Muanda (DRC), and Emily Sullivan (Global), improved the coverage of country analyses by providing additional policy documents unavailable online and clarifying interpretations of policy language. The report was edited by Heidi Worley of PRB, with design assistance from Jessica Woodin of PRB, and Prographics.

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