

# GLOBAL YOUTH FAMILY PLANNING INDEX

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## **Global Youth Family Planning Index**

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### **INTRODUCTION**

Our world is home to more young people than ever before. Acknowledging their health and human rights and meeting their unique needs is of utmost importance to ensure this generation can realize their full potential. Governments around the world have made great strides in creating a more enabling policy environment that supports young people. Increasingly, countries have acknowledged the rights of adolescents and young people to access health services, including sexual and reproductive health care. The 2015 Global Consensus Statement for Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting Reversible Contraception underscored the urgency for international organizations and governments to ensure all young people have informed choice and full access to contraceptives.

Yet, many barriers remain for young people who want to use contraception. Despite growing commitment, 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 the interventions they should invest in to ensure that their commitments to expanding FP use among young people are realized. Similarly, efforts to monitor the state of policy environments around youth FP are needed to understand how countries are addressing these needs and to identify areas for improvement.

The Population Reference Bureau (PRB) has developed a framework for a Global Youth Family Planning Index to measure and compare countries' youth FP policies and programming. The index categorizes youth as people between the ages of 15 and 24. The index framework is based on existing research and evaluation of what works in youth policies and programming, and defines indicators that can be used to gauge whether a given country's policy environment is favorable to youth FP needs. This report details the purpose of the new index, describes its methodology and indicator selection process, and summarizes results for four countries.

### **PURPOSE**

The goal of the Global Youth Family Planning Index is to measure the favorability of current national policy and program environments for youth uptake of contraception. The leading inquiry guiding the index and selection of its indicators is: Are countries committed to policies and programs that are proven to increase youth access to and use of contraception?

The index is designed to allow users to quickly assess the extent to which a country's policy environment enables and supports youth accessing FP, particularly promotion of evidence-based practices to increase youth access to and use of contraception. The index can be used by governments, donors, and advocates to:

- Evaluate a country's youth FP policy environment.
- Set policy priorities and guide future commitments.
- Compare policy environments across countries.

The index evaluates the status of existing youth FP policies captured in official government documents. Policies are understood to be government-promoted laws, regulations, and actions to achieve a particular objective. Specifically, we assess a country's legal 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.

Policy statements provide only a partial view into young people's ability to fully access and use contraception. The index, in its current form, does not address 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 framework, will be important to assess the actual implementation of policies and their full impact on young people's access to and uptake of FP.

## **METHODS**

The first step in creating the index was 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 sexual and reproductive health 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, 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.<sup>1</sup> 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.<sup>2</sup> 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 shows the policy or program intervention promotes contraceptive use among youth (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 low- and middle-income countries (LMIC).
- The policy or program intervention can be compared across countries.

When selecting indicators, we heavily emphasized the existence of supporting evidence directly linked to increased youth contraceptive use, although it 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.<sup>3</sup>

We translated the policy and program interventions identified in the literature into indicators for the index. Indicators were created to capture the state of the policy environment surrounding an evidence-based policy or program intervention. While program interventions tell us what works to increase uptake of contraception among youth, the index indicators tell us how strong the policy environment is in the promotion of these interventions or approaches. For example, research shows that providing comprehensive sexuality education increases youth use of contraception. To translate these findings into a policy indicator, we considered which programmatic guidelines must be in place for this intervention to



exist at scale, the specificity and comparability of potential indicator parameters, and the potential indicator's usefulness when tracked over time.

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

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

We mapped the potential findings for each of the six indicators into three color-coded categories that allow users of the index to compare how well a country is performing within each indicator. These categories are assigned, for each indicator, based on the extent to which a country provides the most favorable policy environment for youth to access and use of 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.

In cases where multiple findings are available for a single category, a country has been assigned to that category if any one of the findings applies.

In order to categorize countries for each indicator, we reviewed both legal frameworks and programmatic guidelines. Materials most frequently reviewed included national constitutions, reproductive health acts/laws, adolescent reproductive health strategies, FP costed implementation plans, and youth development strategies. A full list of policies reviewed is provided in each country analysis. In addition to policy indicators, the index results table includes selected quantitative indicators to provide additional insight on whether policy environments align with youth FP outcomes.

FP status indicators included in the index are:

- Adolescent birth rate.
- Teenage pregnancy rate (percentage of women ages 15 to 19 who have begun childbearing).
- Modern contraceptive prevalence rate (mCPR) among young married women (ages 15-19, 20-24, and 15-49).
- Modern contraceptive prevalence rate (mCPR) among young unmarried, sexually active women (ages 15-19, 20-24, and 15-49).
- Unmet need among young married women (ages 15-19, 20-24, and 15-49).
- Three most prevalent methods of modern contraception used among young women (ages 15-19 and 20-24).

In alignment with most policy dialogue and advocacy, the index uses the term “family planning” to refer to contraception and related services. However, when considering youth's unique reproductive health needs, it is important to keep in mind that the term “family planning” is less descriptive. Many young people have not yet begun planning a family at this stage of their lives, but do need access to contraception. The index uses the terms FP and contraception interchangeably.

## INDEX INDICATORS

### Parental, Spousal, or Provider Authorization

Law or policy exists that supports youth accessing FP services without authorization from a parent, spouse, or provider.
Law or policy exists that supports youth accessing FP services without authorization from a parent, spouse, or provider at the national level, but policy differs at subnational level.
Law or policy exists that supports youth accessing FP services without authorization by one to two external parties, but not all three (parent, spouse, service provider).
Law or policy exists that requires any authorization from a parent, spouse, or provider for youth accessing FP services.
No law or policy exists on parental, spousal, or provider authorization to access FP services.

Global health and human rights bodies stress the importance of recognizing young people's human right to freely and responsibly make decisions about their own reproductive health and desires. One of the recommendations from the 2012 International Conference on Population and Development Global Youth Forum is 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."<sup>4</sup>

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 outside of medical eligibility criteria (such as determination of maturity, sexual activity, etc.).<sup>5</sup> 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. Instead, these laws serve as barriers that inhibit youth's access to a full range of sexual and reproductive health (SRH) services, including FP. For example, an International Planned Parenthood Federation study on legal barriers for young people in El Salvador when accessing SRH services reported 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."<sup>6</sup>

Laws around consent to FP services are often unclear or contradictory. Many countries may not even have a definitive legal stance on requirements for youth to access FP services. The index intends to recognize countries that take a declarative stance and 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 will be placed in the green category recognizing 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.

If a national-level policy provides for full access to FP services for youth without parental, spousal, or provider authorization but permits differentiation at the subnational level, the country is classified in the yellow category. If the policy document mentions that youth are not subject to authorization by one or two types of third parties—spouse, parent, or service provider—but does not mention all three, the country is classified in the yellow category.

Any country that specifically requires authorization from a spouse, parent, and/or provider for youth to access FP services is placed in the red category, indicating a legal barrier for youth to use contraception. Furthermore, 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**

Law or policy exists that supports youth accessing FP services regardless of age, including the provision of long-acting and reversible contraceptives (LARCs).
Law or policy exists that supports youth accessing FP services regardless of age but does not mention provision of a full range of methods.
Law or policy exists that supports women accessing a full range of FP services regardless of age, but does not specifically address youth access.
Law or policy exists that supports youth accessing FP services regardless of age, including all LARC methods, but policy differs at subnational level.
Law or policy exists that restricts youth from accessing a full range of FP services based on age.

Youth seeking contraception, including long-acting and reversible contraceptives (LARCs), are frequently faced with scrutiny or denial from their provider based on their age.<sup>7</sup> The World Health Organization (WHO) 5th Edition Medical eligibility criteria for contraceptive use, however, explicitly states: "Age alone does not constitute a medical reason for denying any method to adolescents."<sup>8</sup>

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 mention explicitly youth's legal right to access a full range of contraceptive services, including LARCs. Therefore, countries that have an explicit policy allowing youth to access a full range of contraceptive services, regardless of age, will receive a green categorization for promoting the most supportive policy environment around youth access to contraception.

Countries that explicitly protect access to FP regardless of age, including acknowledgement of youth access, but do not explicitly protect youth access to a full range of contraceptive methods, including LARCs, will be categorized as yellow. 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 they explicitly mentioned youth's right to access a full range of contraceptive methods regardless of age. Similarly, countries will be categorized as yellow if they have a policy supporting youth's access to a full spectrum of contraception, regardless of age, but make provisions for this policy to differ at the subnational level.

A country will be placed in the red category if it has a policy in place that restricts access to FP services based on age alone. This creates a direct barrier for youth seeking contraception.

### **Restrictions Based on Marital Status**

Law or policy exists that supports youth accessing FP services regardless of marital status.
Law or policy exists that supports youth accessing FP services regardless of marital status, but permits differentiation at subnational level.

Law or policy supports access to FP services for unmarried women, but without specifying youth.
Law or policy exists that restricts youth from accessing FP services based on marital status.
No law or policy exists addressing marital status as a determinant to access FP services.

A 2014 systematic review of research on barriers that adolescents face when attempting to access and use contraception identified laws and policies restricting unmarried youth from accessing contraception as an impediment to youth uptake of contraception.<sup>9</sup> Further, in the absence of a legal stance on marital status, health workers can justify refusal to provide contraception to unmarried youth.<sup>10</sup> Thus, strong laws 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 have explicitly included a provision in their laws or policies for youth to access FP services regardless of marital status. If a country generally 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. Further, if the country supports youth accessing FP regardless of marital status but allows for differentiation at the subnational level, the country will be categorized as yellow. Finally, a country will be placed in the red category if it has a provision that restricts 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**

Mentions all nine UNFPA essential components of comprehensive sexuality education (CSE).
Supports CSE but references fewer than nine UNFPA essential components.
Includes provision for subnational governments to opt out of CSE.
Promotes abstinence-only education or discourages CSE.
No policy exists supporting sexuality education of any kind.

WHO recommends educating adolescents about sexuality and contraception to increase contraceptive use and ultimately prevent early pregnancy and poor reproductive health outcomes.<sup>11</sup> 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.<sup>12</sup>

A growing body of evidence demonstrates a positive impact of CSE on SRH among youth. CSE 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.<sup>13</sup> 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.<sup>14</sup> To be most effective, CSE should be offered as part of a package with SRH services, such as direct provision of contraception or links to youth-friendly FP services.<sup>15</sup>

Many approaches exist to implement CSE in schools. The index relies on the United Nations Population Fund (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 guidelines outline nine essential components of CSE that are concise and easy to measure across

countries' policy documents.<sup>16</sup> Further, these guidelines recognize gender and human rights and build on global standards discussed in the UNESCO International Technical Guidance on Sexuality.

The nine 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 favorable policy environment and is classified in the green category if it not only recognizes the importance of CSE broadly in its policies but also includes each of these nine elements of CSE in an operational policy.

A country is considered to have a promising policy environment if it clearly mandates CSE in a national policy but either does not outline exactly how CSE should be implemented or has guidelines that are not fully aligned with the UNFPA essential components. A country may also be placed in the yellow category if it has fully adopted CSE at the national policy level but allows subnational governments to opt out of CSE.

While the evidence proves that CSE 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 as a preventive health action, and found abstinence-only education was ineffective in preventing negative SRH outcomes.<sup>17</sup> In fact, some reports suggest an abstinence-only approach increases the risk for negative SRH outcomes among youth.<sup>18</sup> Therefore, any country that supports abstinence-only education in any way 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 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 will place a country in the red category.

#### **Youth-Friendly FP Service Provision**

Mentions all seven core elements of adolescent-friendly contraceptive services (FP High Impact Practice (HIP) Enhancement) <u>and</u> explicitly mentions the provision of a full range of contraceptive methods to youth.
References targeting youth in provision of FP services but mentions fewer than seven of the core elements of adolescent-friendly contraceptive services (FP HIP Enhancement).
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.<sup>19</sup> 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.<sup>20</sup>

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.<sup>21</sup> The index uses the seven core elements identified in The Adolescent Friendly Contraceptive Services FP High Impact Practice Enhancement review as the framework for assessing the policy environment surrounding FP service and contraceptive provision.<sup>22</sup> This review identified seven common elements in adolescent-friendly FP service programs that contributed to increased use of contraception. 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.

Explicitly tracking the provision of contraceptive services and whether a full range of methods are offered, including LARCs, is also a critical component of this indicator. 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 the rate of discontinuation was significantly lower than those using short-acting methods. Of the 22 unintended pregnancies that occurred, all were from women using short-acting methods.<sup>23</sup> However, many youth around the world do not know about LARCs and if they do, they may be confused about its use and potential side effects, hesitant to use it due to social norms, or face refusal from providers.

The Global Consensus Statement calls upon all youth SRH and rights programs to ensure 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 is 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.<sup>24</sup>

Many countries have adolescent-friendly health initiatives, but for a country to be placed in the green category, it is essential to also specifically reference providing FP services and contraception to youth in its policies. A country is placed in the green category for this indicator if its policy documents reference all seven adolescent-friendly contraceptive service elements 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 the country has a promising but incomplete policy environment and will be placed in the yellow category.

Countries that do not have a policy that allows for 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, spousal, and provider authorization; 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 in adolescent-friendly FP service programs outlined in the HIP Enhancement review. The index positively acknowledges countries who include all or some of the seven elements in the green and yellow category of this indicator, respectively.

### Community Support for Youth FP Services

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.
References engaging the community to support youth accessing 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 to community members. To support young people'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 for strong SRH service packages.<sup>25</sup>

Furthermore, community 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.<sup>26</sup> Community group engagement can be useful to change the discourse around youth sexuality and address misconceptions about contraception.

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, we opted for a broad approach to categorizing policy commitments. Countries that outline a clear approach to building community support for youth FP are understood to have a strong policy environment and are placed in the green category. Countries that have included a reference to building community support for youth FP, without providing any specific plan for doing so, have demonstrated an incomplete commitment to this initiative and are placed in the yellow category. Countries without any reference to an activity to build support among the community are placed in the red category.

## INDEX FINDINGS

Four countries were included in the first round of analysis for the index: Kenya, Tanzania, Nigeria and The Democratic Republic of the Congo (DRC).

**Table of Results**

Country	Policy Indicators						FP Status Indicators												
	External Authorization	Age Restrictions	Marital Status Restrictions	CSE	YF FP Service	Community Support	Adolescent Birth Rate	Teenage Pregnancy Rate (%)	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
Kenya							96	18.1	36.8	49.8	53.2	49.3	64.2	60.9	Injectable Implant Condom	Injectable Implant Pill	23	18.9	17.5
Tanzania							132	26.7	13.3	29.9	32	34.5	47.9	44.7	Injectable Implant Pill	Injectable Implant Pill	23	22.7	22.1
Nigeria							122	22.5	1.2	6.2	9.8	49.7	63.5	54.9	Condom Pill Injectable	Condom Injectable Pill	13.1	16.6	16.1
DRC							138	27.2	5.4	8.2	7.8	19.5	25.2	20.9	Condom Pill Injectable	Condom Injectable Implant	30.8	29.2	27.7

**Source:** Ministry of Health, Community Development, Gender, Elderly, and Children (MoHCDGEC), [Tanzania Mainland], Ministry of Health (MoH) [Zanzibar], National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and ICF International, Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS) 2015-16 (Dar es Salaam, Tanzania, and Rockville, MD: MoHSW, MoH, NBS, OCGS, and ICF International, 2016); National Bureau of Statistics (NBS) [Tanzania] and ICF Macro. Tanzania Demographic and Health Survey 2010. (Dar es Salaam, Tanzania, NBS and ICF Macro, 2011); Kenya National Bureau of Statistics, Ministry of Health [Kenya], National AIDS Control Council [Kenya], Kenya Medical Research Institute, National Council for Population and Development [Kenya], and the DHS Program, ICF International, Kenya Demographic and Health Survey 2014 (KDHS) (Nairobi, Kenya and Rockville, MD, 2015); National Population Commission (NPC) [Nigeria] and ICF International. Nigeria Demographic and Health Survey 2013. (Abuja, Nigeria, and Rockville, Maryland, USA, 2014); Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité (MPSMRM), Ministère de la Santé Publique (MSP) and Measure DHS, ICF International. Democratic Republic of Congo Demographic and Health Survey 2013-2014. (Rockville, Maryland).



## Discussion of Results

The term adolescent was widely used by three of the four countries: Kenya, Nigeria, and Tanzania. These countries cite WHO's definition of adolescents and youth in their adolescent health and development policies. It was not always apparent which FP services would be provided to all ages in this cohort. Tanzania and Kenya recognize the unique needs of very young adolescents (ages 10 to 14) as a vulnerable subpopulation of adolescents and youth in their policies. Kenya provides the most comprehensive instruction for service provision to very young adolescents in the 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 close referral systems, and providing community-based FP services for newly married girls.

Results were most promising for the FP service provision and community support indicators. All four countries have included youth-specific service provision of FP and contraception in their policies. While Tanzania and Kenya have the most supportive policy environment around youth accessing a full spectrum of FP services, Nigeria and DRC have room for improvement, namely the inclusion of all seven elements of adolescent-friendly contraceptive services discussed in The Adolescent Friendly Contraceptive Services FP High Impact Practice Enhancement review in future policies.

Three of the four countries, excluding the DRC, specifically outline steps to build community support for youth FP in their policies. Kenya, Tanzania, and Nigeria have all developed a specific health policy for adolescents. Approaches under 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 evolves around what works to engage communities around youth FP, 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 curricula nor how to implement. 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.

Our analysis of selected FP outcome indicators shows potential connections between specific policy approaches and resulting health outcomes. More analysis of additional countries is needed to further explore the potential associations. At the moment, it appears countries with the strongest policy environment surrounding service provision, Kenya and Tanzania, also have the highest mCPR among young married women between the ages of 15 and 19, 37 and 13 percent, respectively, and among married women between the ages of 20 and 24, 50 and 30 percent, respectively. Nigeria is the only country for which no LARCs method is among the most prevalent for young married women.

## 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.
- 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, Spousal, or Provider Authorization

Law or policy exists that supports youth accessing FP services without authorization by one to two external parties, but not all three (parent, spouse, service provider).

Within Kenya's strong policy environment supporting SRH services for adolescents and youth, the legal stance on parental and spousal authorization for youth accessing FP services is noticeably weak. The nation outlined a clear strategy to improve adolescents' access to and use of SRH services in the National Guidelines for Provision of Adolescent and Youth Friendly Services in Kenya. 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.

There are efforts 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, there are strong policies 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 promotes 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, spousal, and provider authorization. There is potential for the country to 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 accessing FP services regardless of age but does not mention provision of a full range of methods

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 methods to youth specifically.

#### **Restrictions Based on Marital Status**

Law or policy exists that supports youth accessing 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. Additional discussion above under *restrictions based on age* indicator.

#### **Comprehensive Sexuality Education**

Supports CSE but references fewer than nine UNFPA essential components.

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 CSE in the country, including elements such as reaching in- 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 has been placed in the yellow category.

#### **Youth-Friendly FP Service Provision**

Mentions all seven core elements of adolescent-friendly contraceptive services (FP High Impact Practice (HIP) Enhancement) 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. National Guidelines for Provision of Adolescent and Youth Friendly Services in Kenya, 2016 recognize the health and human rights of young people and emphasize the five elements of the WHO quality of care framework—adolescent and youth-friendly health services are accessible, acceptable, equitable, appropriate, and effective.

All seven common elements of adolescent-friendly contraceptive services discussed in The Adolescent Friendly Contraceptive Services FP High Impact Practice Enhancement review are included in Kenya's policy environment. Worth noting, 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 includes 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**

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 Enhance the organizational capacity of communities to effectively participate in family planning activities* and *Intervention 4.7. Increased demand for FP by improving advocacy*, have specific activities targeting outreach and advocacy for youth.

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.

## 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, The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008-2015 (One Plan).
- United Government of Tanzania Ministry of Health and Social Welfare, National Family Planning Guidelines and Standards, 2013.
- United Government of Tanzania Ministry of Health and Social Welfare, National Family Planning Costed Implementation Program, 2010-2015.
- United Government of Tanzania Ministry of Health and Social Welfare, National Adolescent Reproductive Health Strategy, 2011-2015.
- United Government of Tanzania Ministry of Health and Social Welfare, The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2016-2020 (One Plan II).

The Tanzania National Family Planning Guidelines and Standards, 2013, define adolescents and youth according to the WHO definition of 10 to 24 years. Generally, the policy environment in Tanzania recognizes the unique FP needs of adolescents and youth and targets this age group specifically in service provision protocols.

### Parental, Spousal, or Provider Authorization

Law or policy exists that supports youth accessing FP services without authorization from a parent, spouse, or provider.

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, spousal, or provider authorization 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, spousal, or provider authorization, restrictions based on age, and restrictions based on marital status.

### **Restrictions Based on Age**

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

See discussion above under *parental, spousal, or provider authorization* indicator.

### **Restrictions Based on Marital Status**

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

See discussion above under *parental, spousal, or provider authorization* indicator.

### **Comprehensive Sexuality Education**

Supports CSE but references fewer than nine UNFPA essential components.

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 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 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**

Mentions all seven core elements of adolescent-friendly contraceptive services (FP High Impact Practice (HIP) Enhancement) 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 recognized 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% 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, The National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child & 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 Adolescent Friendly Contraceptive Services FP High Impact Practice Enhancement 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**

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.

## NIGERIA

Policy documents reviewed:

- The National Family Life and HIV Education Curriculum for Junior Secondary School in Nigeria, 2003.
- The 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.
- The National Family Planning/Reproductive Health Service Protocols, Revised Edition, 2010.
- Federal Ministry of Health, Increasing Access to Long-Acting Reversible Contraceptives in Nigeria: National Strategy and Implementation Plan (2013-2015).
- The 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, Spousal, or Provider Authorization

No law or policy exists on parental, spousal, or provider authorization to access FP services.

There is no mention of parental, spousal, or provider discretion in available FP and youth guidelines and strategies. The absence of these guidelines in policies reviewed suggests that either these guidelines exist in policies not available to reviewers or that the country 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 women accessing 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 the clients' rights, including the right to access services. Service providers are directed to inform every client of their 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. As such, 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 *age* indicator.

### Comprehensive Sexuality Education

Promotes abstinence-only education or discourages CSE.

Nigeria's policy environment surrounding CSE 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 Nigeria Family Planning Blueprint (Scale-Up Plan), October 2014 does include 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 CSE, policymakers in Nigeria should consider addressing the UNFPA nine essential components of CSE when updating the FLHE curriculum.

### Youth-Friendly FP Service Provision

References targeting youth in provision of FP services but mentions fewer than seven of the core elements of adolescent-friendly contraceptive services (FP HIP Enhancement).

The National Policy on Health and Development of Adolescents and Young People in Nigeria lightly addresses the SRH needs of young people. While the policy includes SRH as a key intervention area, it does not provide any guidance on how to provide these services nor directives for the provision of contraception.

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 Adolescent Friendly Contraceptive Services FP High Impact Practice Enhancement 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 intrauterine devices (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, pills 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.

However, the protocols take an incomplete stance on how to counsel adolescents on contraceptive use. Unlike the directives for male involvement in reproductive health, which explicitly direct providers to counsel men on using contraceptive methods, there is no directive on how to counsel youth on using contraceptive methods. The counseling guidelines suggest discussing the risks of sexual behavior but do not mention discussing actual methods of FP. More alarming, the protocol's text on abstinence exclusively references youth: "In regards to abstinence adolescents/youths are encouraged to adopt this method."

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 create an opportunity for providers to differentially interpret the directives. Adding a provision that explicitly supports youth accessing 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.

Thus, 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 it incorporates all seven elements of adolescent-friendly service provision in its FP service provision guidelines and makes a clear provision supporting youth accessing a full range of contraception.

### Community Support for Youth FP Services

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 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.

### 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.
- Democratic Republic of Congo Family Planning National Multisectoral Strategic Plan (2014-2020).

### Parental, Spousal, or Provider Authorization

Law or policy exists that requires any authorization from a parent, spouse, or provider for youth accessing 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.

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 women 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 accessing 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. The country is placed in the red category for restrictions based on age because the minimum age is 18 to receive reproductive health services without parental consent.

When the new reproductive health law is formalized, policymakers should ensure 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 from accessing FP services based on marital status.

See discussion above under *parental, spousal, or provider authorization* indicator.

### **Comprehensive Sexuality Education**

Supports CSE but references fewer than nine UNFPA essential components.

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 reference to CSE in the strategic plan 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 CSE.

### **Youth-Friendly FP Service Provision**

References targeting youth in provision of FP services but mentions fewer than seven of the core elements of adolescent-friendly contraceptive services (FP HIP Enhancement).

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.*

While the strategy references the provision of youth-friendly services, it does not outline specifically how the country plans to achieve this activity nor any guidelines around provision of contraceptives to this age group. 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 developing youth-friendly service protocols, policymakers should consider including the seven elements identified in The Adolescent Friendly Contraceptive Services FP High Impact Practice Enhancement review to improve adolescent and youth uptake of contraception.

### **Community Support for Youth FP Services**

Not enough information

There is general recognition of building community support for family planning 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. However, there is no specific reference to youth in the description of this activity. Therefore, there is insufficient information to categorize the country under this indicator.

## LIMITATIONS AND RECOMMENDATIONS

We conducted a desk review of electronically-accessible policy documents to populate the index. The search returned over 20 relevant policy documents across the four countries. Additional policy documents related to the index likely exist that are not available online. 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. Three of the four countries included in the index (Kenya, Tanzania, and Nigeria) have already devolved all or part of their health governance structures, and the DRC is in the process of decentralizing core government structures. Inevitably, approaches to health service delivery will vary at the subnational level under these governance structures. However, in this initial iteration, we did not conduct a search of subnational policies. Additionally, the index does not capture the efforts of donors, NGOs, 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.

Finally, the purpose of the index is to capture the state of youth FP policies. The index does not, however, 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, we suggest undertaking policy implementation assessments of a few priority countries to deepen the analysis of existing policies and programs.



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