

ASSESSMENT OF POLICY IMPACT ON ADOLESCENTS' SEXUAL AND REPRODUCTIVE RIGHTS IN EAST AND SOUTHERN AFRICA.

CASE OF KENYA, MALAWI AND TANZANIA



WOMEN'S
GLOBAL NETWORK
FOR REPRODUCTIVE RIGHTS
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Abbreviations:

ADHD	Adolescents Health and Development
ASRHR	Adolescents' Sexual and Reproductive Health and Rights
AU	Africa Union
CEDAW	Convention on the Elimination of All forms of Discrimination against Women
CSE	Comprehensive Sexuality Education
COVID	Corona Virus Disease
CSOs	Civil Society Organizations
EA	East Africa
EAC	East Africa Community
ESA	Eastern and Southern Africa
FGDs	Focus Group Discussions
GBV	Gender Based Violence
GoT	Government of Tanzania
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ICPD	International Conference on Population and Development
MPoA	Maputo Plan of Action
NASRH	National Adolescents Sexual and Reproductive Health
NEP	National Education Policy
NGOs	Non-Governmental Organizations
NYDP	National Youth Development Policy
SADC	Southern Africa Development Community
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SRR	Sexual and Reproductive Rights
STIs	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
VAWG	Violence Against Women and Girls
WGNRR	Women's Global Network for Reproductive Rights
YAS	Youth Activist for Sexual and Reproductive Rights
YFHS	Youth Friendly Health Services

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EXECUTIVE SUMMARY

This report is part of a cross-country Adolescents Sexual and Reproductive Health and Rights (ASRHR) project implemented by Women's Global Network for Reproductive Rights Africa (WGNRR Africa) and local partner organizations in Kenya, Malawi and Tanzania to assess the impact of national policies on adolescents sexual and reproductive rights (SRR) and, formulate evidence and rights-based recommendations for policy improvement or their effective implementation that could contribute to the national and regional achievement of SRHR for adolescents and youth.

The report provides an analysis of the impact of the following policies in the three project countries:

- The National Adolescents Sexual Reproductive Health Policy in Kenya (NASRH 2015) on the provision of sexual and reproductive health (SRH) services and information to adolescents in five counties of Kenya, namely Nairobi, Kakamega, Kiambu, Kisumu and Machakos;
- The National Education Policy on the provision of contraceptives to adolescents at school level in Lilongwe and Mzuzu province of Malawi, and
- The National Youth Policy 2007 on adolescent access to SRH services in Tanzania;

The analysis raises concerns over the three countries involved in this analysis for not fulfilling their commitments to adolescents' human rights, particularly their SRHR; and formulates recommendations to governments of the 3 countries to improve the assessed policies or ensure their effective implementation to abide with the countries' ESA commitment. The in-country studies were conducted between March to August 2021 and the selection of the study sites, interview respondents and FGDs/workshop participants were done by WGNRR Africa's local partner organizations in respective countries.

This report compiles the information provided by local partners based on the field research and, the responsibilities of the information in this report lies entirely with the local partners' research team.

Assessment Methodology

This action research used a mixed methodology with a literature review of published academic and grey literature on adolescents' SRHR situation and country policies with potential to address their SRHR issues; stakeholder meetings and workshops with key informants from CSOs, youth serving organizations, government officials, and service providers; qualitative focus group discussions (FGDs) with adolescents aged 15- 24 years; young peer educators, and young potential male and female service users (15-24 years) from the selected areas. The process of data collection and analysis were guided by the questions extracted from the "Policy Impact Assessment Toolkit, a WGNRR Africa's strategic tool & resource guide for NGOs to compare how well the national policies meet human Rights obligations of the states under regional and international human right treaties.

steps process of

The WGNRR Africa' resource guide enable local NGOs to undertake a 6 steps process of

- i) describing the problem and identifying related policy, the affected groups of women and the rights involved;
- ii) finding out which national and international treaties, agreements, policies and laws are relevant to the country and the policy under analysis;
- iii) describing resources availed by the government to implement the policy and which factors limit or expand the implementation capacity;
- iv) describing the effects (short and long term) of the policy on women's health rights;
- v) establishing what the government shall be held accountable for in relation to the impact of your policy; and
- vi) formulating recommendations and strategies to enhance the enjoyment of women's health rights. Each of the six steps consists of a brief explanation of the main human rights issues related to the step concerned, followed by a number of questions to guide the data collection and analysis. The questions are closely related to the texts of the international treaties.

In a nutshell, this process helps to link what actually happens on adolescents' and women's health with what should happen according to the human rights obligations of the country. It analyses the effects of a specific policy on the rights of adolescent and women to health in the targeted countries, examines the local, national and international influences and produces a set of evidence and right based recommendations to improve the impact of the policy on adolescents, develop advocacy strategies as well as an action plan to lobby for adoption of the recommendations at country level. Following key questions were used to guide the research and analysis for this study:

1. What is the problem affecting young people and which policy has the potential to address it; which groups are affected by the policy and which human rights are involved?
2. What are the country commitments toward young people's rights under national laws and policies and which regional and international human rights treaties are relevant to the policy analyzed?
3. What resources the government allocate to implement the policy and the factors that limit or expand the government implementation capacity?
4. What are the effects of the policy on adolescents' health rights
5. What are the gaps in the analyzed policy for achieving the country's commitments to different human rights treaties; and
6. What should be done to improve the policy or its effective implementation to bring change and improve adolescents' health outcomes?

Key Findings:

In Kenya, the National Adolescent Sexual Reproductive Health Policy 2015 (NASRH 2015) is poorly implemented and continues to disrupt the health and lives of young people. While the NASRH 2015 aims to enhance SRH status of adolescents in Kenya and contribute towards realization of their full potential in national development; its implementation is inadequate and in violation of the health right of adolescents and young women. The implementation of the policy is still discriminatory against sexual minorities, teenage mothers and internally displaced and refugees adolescent and young girls as their access to SRH services is most challenging than other groups; only 10% of health facilities countrywide offers youth-friendly health services; there is continuous stock out of commodities like contraceptives and ART, limited information on the available services for young people; and pregnant and non-pregnant adolescents are not meaningfully engaged in the development of programs and interventions intended to reduce teenage pregnancy. All these circumstances force adolescents and young women to drop out of school, or resort to unsafe abortion which have huge implications on their health, social and economic rights.

In Malawi, while the Malawi National SRHR policy and its strategy of 2017-22, the Youth Friendly Health Services Strategy (YFHS, 2015- 2020), HIV/AIDS prevention and management act (2018), and the National Youth policy (2013) promote provision of SRHR services where adolescents congregate, the Malawi National Education Policy (NEP) 2016, inexplicitly bars the provision of these services at school level. The NEP 2016 is in inconsistency with and obstructs the effective implementation of other progressive policies supporting the provision of contraceptives and associated SRHR services to adolescents, specially school going adolescents in Malawi. The analysis raises concerns over Malawi government's ability to fulfill its commitments to SRHR for all people. This policy inconsistency impacts the access of school-going adolescents to SRHR information and services and is in violation of adolescents SRHR. By not mentioning explicitly or implicitly the word contraceptives and SRH of adolescents for school going children, the NEP 2016 discriminates against school going adolescents, limits the provision of comprehensive SRH information and services to adolescents including contraceptives at the same venues although these services are permitted 100 meters away from schools or further (YFHS 2015 2020). The lack of provision of contraceptives and other SRH services at school level leads to the contraction of STIs including HIV/AIDS, early pregnancies and school dropout.

In addition, in school adolescents are not meaningfully consulted and do not participate in the policy development and decision making on SRH.

In Tanzania, despite the good intention of the National Youth Development Policy (NYDP 2007) to promote the establishment of youth friendly health services at all levels and put a mechanism to coordinate the provision of reproductive health education to the youth as stipulated in the Reproductive Health strategy, Education Policy and Family Life Education Programme; the lack of Comprehensive Sexuality Education in the school curriculum, the inadequate youth-friendly SRH services; and the high rate of teenage pregnancy in Tanzania prove that the government of Tanzania has not made significant progress to fulfill its commitment towards adolescents SRHR. The NYDP 2007 has not fully recognized adolescents as a unique demographic segment and do not offer sufficient protection to adolescents, particularly for SRH issues. Also, within the national budget, no financial resources are dedicated to Adolescent Health and Development (ADHD), but rather, ADHD funding is submerged within other potentially insufficiently-funded programmes that are reflected in the budget.

Key Recommendations

Based on the policy gaps identified in each country analysis, the following general evidence and rights-based recommendations were formulated to the governments of the 3 countries, through relevant ministries:

- To urgently review, update and harmonize all contradicting and retrogressive laws and policies hindering access to sexual and reproductive health and rights of adolescents and young people. *“Specifically, we call up the ministries of Health and Education in Malawi to review and harmonize the National Education Policy with the SRHR policy & the youth friendly health services strategy for equitable and accessible sexual and reproductive health services and information for school going adolescents;We call upon the government of the United Republic of Tanzania through the ministry of health to urgently develop a stand-alone adolescents’ sexual and reproductive health policy”....*
- To allocate 15% of the national budgets to health in line with the Abuja Declaration and commit to a target of spending 5% of their GDP translating to 112USD per capita on health as their commitment to realize Universal Health Coverage. In particular, the United Republic of Tanzania should provide more funding for national health priorities, including ADHD, and reduce reliance on development assistance.
- To prioritize adolescents sexual and reproductive health and rights information and services within essential services package in the emergency response plans i.e Covid-19, floods, Ebola e.t.c.
- The United Republic of Tanzania to strengthen the implementation and budget allocation towards National Multi-sectoral Strategic Framework for HIV/AIDS 2017-2023, National Adolescent Health and Development Strategy 2018-2022, National Youth Development Policy 2007 and the Tanzania Health Sector Strategic Plan III.
- To increase access to age appropriate SRH information by effectively implementing Comprehensive Sexuality Education (CSE) and engaging meaningfully the social and educational sectors as well as the civil society organization. The process of accreditation to implement CSE in schools should be well outlined to aid programs implemented by non – state actors.
- Increase number of health care providers skilled on youth friendly health services able to deliver services that address and respond to the specific needs of adolescent and young people of reproductive age in their diversity, living in different socio-economic context, with a particular focus on reducing stigma and discrimination faced by adolescents and young people and improving service providers’ attitudes.
- To enhance meaningful adolescents and youth Engagement in Sexual Reproductive Health Rights policy discussions: plan and provide engagement opportunities for the youth, build their capacity and leadership skills and invest sufficient resources to ensure this becomes a reality.

INTRODUCTION

Sexual and Reproductive Health (SRH) is an intrinsic part of an adolescent's development and a fundamental right for all. Yet, far too often, it is the missing piece of a puzzle in a young person's journey from adolescence to adulthood (Dr. Julitta Onabanjo, Regional Director UNFPA, East and Southern Africa).

The Eastern and Southern Africa (ESA) region is home to more than 165 million young people¹; this figure is expected to climb to 263 million by 2050.² Whilst significant progress has been made in recent years with respect to advancing health and education, the East and Southern Africa (ESA) region's young people still experience challenges in relation to their SRHR. Across the region, millions of adolescents and young people face barriers to exercising their right to SRH information and care. Many are forced into marriages and are vulnerable to unintended pregnancies, risky childbirth, unsafe abortions and sexually transmitted infections (STIs) including HIV. Even those who are equipped with the right information may not access the health services they need to protect themselves.

Whilst there is a noticeable, positive upward trend in HIV knowledge levels, less than 40% of young people in the ESA region have sufficient knowledge about HIV prevention; at the same time, 2.2 million young people aged 15–24 are living with HIV.³ Adolescent fertility rates remain persistently high at 85.9 and 66.9 live births per 1000 girls aged 15–19 in Eastern Africa and Southern Africa respectively, a statistic higher than the world average of 39.9.⁴ The availability of these and other data documenting the impact of HIV, child marriage, early and unintended pregnancy and gender-based violence (GBV) helped to thrust young people's SRHR to the top of governments' political agendas across the ESA region during the first two decades of the twenty-first century. This collective regional momentum culminated in 2013 in the Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health (SRH) services for adolescents and young people in Eastern and Southern African (ESA Commitment).

This study seeks to assess how these regional and other international human rights commitments were translated into national practices to fulfill the SRHR of young people. It aims at highlighting the impact of a number of selected policies on adolescents' sexual and reproductive rights (SRR) at county level and, formulating pieces of evidence and rights-based recommendations for the improvement or effective implementation of these policies in order to contribute to the achievement of national and regional commitment toward SRHR for young people.

This study, is not exhaustive; rather, it provides a "Country case study" analysis from the perspectives of grassroots organizations advancing SRHR of young people in 3 ESA countries, namely Kenya, Malawi and Tanzania.

1. OBJECTIVES AND EXPECTED OUTCOMES OF THE ASSESSMENT

Purpose of the Assessment

To conduct a review of selected existing policies at country level and assess how their implementation is impacting the reproductive health and rights of adolescents and young women in 3 countries of the ESA region. Specific Objectives of the Assessment are to:

- Assess how the selected policies are being applied to improve young people health, especially SRHR, and how these policies contribute positively or negatively to the fulfilment of young people's SRHR at country level.
- Assesses what actually happens and whether the effects of the policy result in a violation of adolescents / youth's health rights.
- Based on the findings above, provides recommendations for improving the assessed policies or their implementation at country level.

Expected outcomes:

- A cross-country report and three national reports with recommendations for improving ASRHR related policies and their implementation at national levels.

Scope of the Assessment

The Assessment highlights what is happening on the ground, including adolescents' and young people's perspectives and realities with regard to ASRH access, learn from what is available, and identify areas for improvement. More specifically, the Assessment is intended to bring out practical recommendations at the policy level to create an enabling legal and policy environment to improve access and uptake of respectful SRH services for adolescents and young people.

Utilisation of Assessment Results

The findings of this Assessment will be used for several purposes including:

- a) provide guidance to national governments, implementing partners and donors on the infringement of adolescents and young people's SRHR due to inadequate implementation of existing policies and;
- b) to inform in-country and cross-country advocacy interventions to influence change in policies and practices toward the improvement of SRHR at both country and regional levels.

Section 1

Overview of Adolescents' Sexual And Reproductive Health And Rights In ESA Region

1. INTRODUCTION

More than one-third of the population in the Eastern and Southern Africa (ESA) region is aged 10 to 24 years. The 182 million population of 10-24 year olds in 2016 is expected to rise to 341 million by 2050. In demographic terms, the region is experiencing a youth bulge, which has major implications for education, health and economic development overall. Young people will drive the development of the region over the next two decades – a demographic dividend in the making. However, they can only transform the world if they survive and thrive. Adolescence is a critical phase in the development of physical, cognitive, emotional, social and economic capacities. Ushering African adolescents them into a healthy and productive adulthood is critical for Africa's development and achievement of the demographic dividend. Since there is no universal definition of 'youth' across the region, comparison of data across countries is difficult. However, throughout this report, adolescents and young people refer to those aged 10-24 years.

2. SRHR OF ADOLESCENTS

The health, especially reproductive health risks for adolescents and young people in ESA region are greater. The full realization of their SRHR is still of concern despite the existence of a very progressive regional policy framework. Adolescents and young people in ESA face many SRH challenges, including early and unintended pregnancy, HIV and sexually transmitted infections (STIs), gender-based violence (GBV) and child marriage – all of which can undermine education opportunities, especially for girls, and affect future health and opportunities. Investing in the education and health of adolescents and young people at the right time ensures that they transition into healthy adults who can contribute to the economy⁶ of their respective countries.

Below are key SRHR issues affecting young people in the region:

2.1. Early Sexual debut

The median age of first sexual experience in the ESA region is 16-18 years for young women and 17-20 years for young men. The percentage of young people who had sex before age 15 years is highest among females in Mozambique and males in Malawi. In addition, more males than girls initiate sex before age 15 years in eight of the countries (i.e., Burundi, Comoros, Malawi, Namibia, Rwanda, Tanzania, Uganda, and Zambia), but few males seem to initiate sex before the age of 15 years in Ethiopia.⁷

2.2. Unintended pregnancy as consequence of contraceptive unmet need

In 2015, there was an estimated 3.3 million of live births among girls aged 15-19 years in ESA region, and this is projected to rise to 5.4 million by 2035. The proportion of unintended pregnancies among girls 15-19 years ranges from 39% in Tanzania to 59% in Kenya.⁸

Adolescent pregnancy increases the risk of the girl dropping out of school, as well as other socio-economic consequences. Many health problems are particularly associated with negative outcomes of pregnancy during adolescence. In East and Southern Africa, there are an estimated 2.4 million sexually active adolescent girls (aged 15-19 years) who have an unmet need for family planning – this is expected to rise to 3.4 million by 2030 if access to family planning methods does not improve⁹. The use of modern contraceptive use among adolescents aged 15-19 years who are already married, remains lower than 30% in many countries with an overall demand satisfied for contraception being 65%.¹⁰ The proportion of women married or in-union aged 15 to 24 years who are currently using, or whose sexual partner is using, at least one method of modern contraception is 50% in Kenya, 38% in Malawi and 24% in Tanzania¹¹.

2.3. Child marriage

Child marriage is most prevalent among girls in rural areas and among under- and un-educated girls and families, with an estimated 37% of women aged 20-24 years being married by the age of 18 years in the ESA region¹². Child brides end up having many children to care for while still young, with nine of ten pregnancies among adolescents taking place within a marriage or union. They are also less likely to receive medical care during pregnancy than women who married as adults.

2.4. Termination of pregnancy

Access to termination of pregnancy is extremely restricted in the ESA region, and it is estimated that 25% of unsafe abortion cases in sub-Saharan Africa occur among adolescent girls. A high proportion of women seeking post-abortion care are aged below 20 years (i.e., 17% in Kenya, 21% in Malawi, between 49% and 58% in Tanzania, 60% in Zambia, and 68% in Uganda)¹³.

2.5. HIV/AIDS

Of the more than 3.9 million (10%) of the world's young people (aged 15-24 years) living with HIV/AIDS, 2.2 million (56%) of them live in ESA region. About 40% of infections (people aged 15+ years) are among young people (15-24 years). The percentage of young people aged 15-24 years who are HIV positive is highest in Swaziland (14.3%) followed by Lesotho (9.3%). The lowest prevalence is in Ethiopia (0.3%), Burundi (0.5%) and the DRC (0.7%). This proportion, however, masks countries with larger population size that have the highest absolute numbers of adolescents and young people living with HIV and higher numbers of new HIV infections. For example, South Africa with 110,000 compared to Swaziland with 3,300 HIV infections among 15-24 year olds per year.¹⁴, ¹⁵

According to UNICEF and UNAIDS in 2015, drivers for HIV among girls and young women include:

- Gender-based inequality - e.g., condom use at last higher-risk sex was as low as 8.5% in the DRC, and other countries also reported less than half adolescent girls using

3. REGIONAL SRHR POLICY FRAMEWORK

Strong international and regional agreements exist to promote SRHR of Adolescents, especially the roll-out of CSE in the Africa region. Within the ESA region, a number of regional agreements have been made post-2013 that commit to advancing adolescents sexual and reproductive health and rights (ASRHR). These include the Extension of the Maputo Plan of Action (MPoA 2016 - 2030), the International Conference for Population and development (ICPD+25), the Southern Africa Development Community (SADC) SRHR strategy (2019 – 2030) and East Africa SRHR Bill 2017. The regional developments in SRHR have bearing on the ESA commitment beyond 2020 (under review).

3.1. The Extended Maputo Plan of Action (MPoA 2016 - 2030)

Adopted in 2006 by the special session of Africa Union health ministers and extended for a 2016 – 2030, MPoA provide a policy framework to accelerate the improvement of SRHR in the African region. The MPoA reinforces the call for universal access to comprehensive SRH services in Africa and lay down the foundation to the Sustainable Development Goals (SDGs), particularly goal 3 and 5, as well as the AU Agenda 2060. It calls states parties to join forces and redouble efforts to implement effectively the continental policy framework on SRHR, Agenda 2063 and SDGs in order to end preventable maternal, newborn, child and adolescent deaths by expanding contraceptive use, reducing levels of unsafe abortion, ending child marriage, eradicating harmful traditional practices, eliminating Violence Against Women and Girls (VAWG) and ensure access of adolescents and youth to SRHR by 2030 in all countries in Africa. If implemented effectively, the plan will bring about improvements in the health status of women, children, adolescents and young people and hence result in greater family savings and stronger economies in Africa.

3.2. The ICPD+25

Gathered in Nairobi Kenya in 2019, states parties to the ICPD+25 have recommitted to accelerate the achievement of “access for all adolescents and youth, especially girls, to comprehensive and age-responsive information, education and adolescent-friendly comprehensive, quality and timely services to be able to make free and informed decisions and choices about their sexuality and reproductive lives, to adequately protect themselves from unintended pregnancies, all forms of sexual and gender-based violence and harmful practices, sexually transmitted infections, including HIV/AIDS, to facilitate a safe transition into adulthood” (ICPD+25 commitment no 4).

Despite this bold commitment in the area of adolescent sexual and reproductive health, inequalities in ASRH services and outcomes still persist between and within regions and countries and the health of adolescents in the ESA region, and particularly their SRH, is still an area of concern.

3.3. The Southern Africa Development Community (SADC) SRHR strategy (2019 – 2030)

The approved SRHR Strategy for the SADC region (2019–2030) and the first ever multi-sectoral score card provides a framework for the Member States to fast-track a healthy sexual and reproductive life for the people in the region, and for all people to be able to exercise their rights. This Strategy is expected to serve as a guide to Member States in

and implementing appropriate SRH and HIV prevention, treatment and care programmes for key populations focusing on the major issues that need to be addressed at policy, legal, institutional and facility levels.

3.4. The East Africa Community Sexual and Reproductive Health Bill, 2021 (EAC SRH Bill)

The bill seeks to provide a framework for the protection and facilitation of the attainment of the life-course sexual and reproductive health and rights of all persons; progressive realization of integrated SRH information and services as part of the universal health coverage; prohibition of harmful practices in the EA community. Specifically, the Bill further seeks states member to strengthen the mechanisms to facilitate attainment universal access to SRH care, including family planning, information and education, and the integration of reproductive health into national strategies and programmes by 2030 as enshrined in the EAC Integrated Reproductive Maternal, Newborn Child and Adolescent Health Policy Guidelines, 2016-2030 and the EAC Sexual and Reproductive Health Rights Strategic Plan.

3.5. The East and Southern Africa Ministerial Commitments on Comprehensive Sexuality Education and Youth-Friendly Services (ESA Commitments, 2013)

In December 2013, Ministries of Education and Health from 20 countries in ESA committed for scaling up Comprehensive Sexuality Education (CSE) and youth-friendly SRH services for children and young people in the region, commonly known as ESA Commitment. Under this commitment ministers committed to improving SRH outcomes and strengthening HIV prevention through access to Comprehensive Sexuality Education (CSE), as well as integrated SRH services for young people in the region. Specifically, ministers pledged to reduce by 2020, new HIV infections among young people by 90%; unplanned pregnancies among young women by 75%, and eliminate child marriage and Gender based Violence. The commitment came with a Regional Accountability Framework linked to the targets, which has been used to track regional and country progress. As the commitment period ended in 2020, consultation for renewal of the commitment are underway and renewal of the ESA commitment is anticipated in December 2021.

4. CONCLUSION

As demonstrated above, the ESA region is home of more than 182 millions of young people between 10 to 24 years old, yet this great population face barriers to exercising their right to SRH information and care. Many are forced into marriages and are vulnerable to unintended pregnancies, risky childbirth, unsafe abortions and sexually transmitted infections (STIs), including HIV. Even those who are equipped with the right information may not access the health services they need to protect themselves. Although the region has a progressive SRHR policy framework for the legal protection of youth and adolescents' rights, still significant gaps in policy development and implementation persist. The adoption and domestication of regional instruments by many member states has been slow, and the effective implementation on the ground is often not systematic or harmonized. All countries in the region report having a policy or strategy to promote SRHR for young people, but there are noticeable gaps in the specific provisions for the protection of the SRHR of vulnerable adolescents and youth, including individuals with disabilities, in the majority of the ESA countries.

Although the 3 countries involved in this study have made significant progress in recent year with respect to advancing health and education of young people, the later still experience challenges in relation to their SRHR due to inadequate policies or their weak implementation. This study brings together learning from the case studies in Kenya, Malawi and Tanzania to clearly demonstrate how governments have failed to fulfil their commitments toward adolescents SRHR; and inform advocacy efforts to influence change of policies and practices in order to achieve SRHR of adolescents and young people's as guaranteed in regional and international human right agreements.

Section 2

Overview Of Country Policy Impact Assessment



KENYA

Assessment of the impact of the National Adolescent Sexual and Reproductive Health policy 2015 on the provision of SRH services and information to adolescents in Nairobi, Kakamega, Kiambu, Kisumu and Machakos Counties, in Kenya

1 EXECUTIVE SUMMARY.

The study here reported was conducted by Zamara Foundation (<https://zamarafoundation.org/>), Youth Changers Kenya (<http://youthchangerskenya.blogspot.com>), Youth Accountability and Strategy Network (https://web.facebook.com/yasnet-work.ke/?_rdc=1&_rdr); three grassroots CSOs operating in Nairobi, Kenya with technical support of WGNRR Africa and funding from HIVOS.

It was conducted in 5 counties of Kenya, namely Nairobi, Kakamega, Kiambu, Kisumu and Machakos, using the WGNRR Africa's Policy Impact Assessment guide which integrate the Health Rights of Women Assessment Instrument (HeRWAI) tool, internet based research, and online youth consultation, group discussions. The analysis study aimed to explicitly highlight the gaps of the National Adolescents Sexual Reproductive Health Policy in Kenya (NASRH2015) to cater for the SRH needs of adolescent and young people with particular attention to adolescent girls; and raises concern over Kenya for not fully fulfilling its commitments to adolescents' human rights, particularly their sexual and reproductive health rights; and provide rights based recommendations and an advocacy action plan for the improvement of the policy.

The study found that despite the good intention of the NASRH 2015 to enhance adolescents' sexual reproductive health status in Kenya by bringing adolescents SRHR issues into the mainstream of health and development, and contribute towards the realization of young people's full potential in national development; it fails to avail services, commodities and information for young people at all facility levels; it's blind SRH needs of sexual minorities, teenage mothers, refugees and internally displaced persons. In the assessed counties, there is continuous stock out of commodities like contraceptives and ART, limited information on the available services for young people, and limited functional youth friendly services. Also, data show that only 10% of health facilities countrywide are offering youth-friendly health services. This reflects the extent to which adolescents and young people in the study counties can access SRH services and information.

The study formulates a number of recommendations to the department of health in the Ministry of Health to improve the policy and fulfill the Kenya government commitments under different regional and international human rights agreements guaranteeing and protecting adolescents' human rights, especially their SRHR.

2 STEP1: PROBLEM STATEMENT AND POLICY IDENTIFICATION

2.1. Problem statement

The gravity of high teenage pregnancy is not new in Kenya. Data from the Demographic and Health Surveys show that almost 2 out of 10 girls between the ages of 15 and 19 are reported to be pregnant or are mothers already with their first child ¹⁶.

This trend has been fairly consistent for more than two decades with little change in prevalence between 1993 and 2014. Teen pregnancies are a major challenge for socio-economic development because they deprive young girls the opportunity to further their education and attain their career goals. It also exposes them and their children to major health risks. Pregnancy and childbirth complications are the leading cause of death among girls aged 15–19 years globally. According to research done by AFIDEP, Nairobi county was leading with 11,795 teenage pregnancies in the period Jan-May 2020; Kakamega county came second with 6,686; and Machakos county, which was the focus of the last public outcry on teen pregnancy, ranks number 14 with 3,966 cases in 2020. From all the counties, the total numbers reported for the period January-May 2020 are 151,433 teenage pregnancies. Teenage pregnancy is not only a social issue but also an economic and health issue. The effects of teenage pregnancy are as follows; school dropouts, an increase in HIV including STIs, unsafe Abortion, deaths due to complications during birth and increased mental health issues like postpartum depression, anxiety and post-traumatic stress disorder.

The high numbers of teenage pregnancy in Kenya are majorly contributed by: limited accurate information on sexuality, limited access to quality reproductive health services like to free range of contraception for adolescents and young people, poor implementation of policies that speak on the sexual reproductive health of young people and social-cultural issues like female genital mutilation and child marriages, sexual gender-based violence.

2.2. Policy identification

This analysis focuses on The National Adolescent Sexual Reproductive Health Policy 2015 (NASRH policy) due to its potential to address the issue of teenage pregnancy that affects most Kenyan adolescent girls. Kenya is one of the countries with progressive policies that address the different needs of the Young People. The focus to the NASRH policy 2025 is premised by its intention to enhance adolescents' sexual reproductive health status in Kenya and contributes towards the realization of young people's full potential in national development. The policy intends to bring adolescent sexual and reproductive health and rights issues into the mainstream of health and development. It addresses the prevailing social, economic, cultural and demographic context of SRH of adolescents, including its implications for and consequences to their health and development. As a complement to sector-specific policies and programs, the policy defines structures and key components of ASRH to facilitate their mainstreaming in all sector planning activities. However, teenage pregnancies remain persistent hence drawing attention to analyze how the implementation of this policy has impacted, targeted and effectively addressed teenage pregnancy. The slow progress is holding back adolescent and young people's access, realization of full potential and enjoyment of SRHR interventions and gender equality.

2.3. Groups targeted by the policy

The policy addresses the needs of the following population;

- Adolescents and young People
- Girls and young women
- Marginalised adolescents; married adolescent, adolescents living in informal settlements, adolescents and young people living with HIV, adolescents living in arid areas, living with Disabilities, orphans and survivors of Sexual Gender-Based Violence SGBV

2.4. Main Actors and roles in implementing the policy

- The Ministry of Health: Via the department of health, the Ministry of health is in-charge of implementation and coordination of the policy at national and county levels. It has the key responsibility of developing a comprehensive plan of action for the implementation and mobilize and allocate resources for adolescent sexual and reproductive health programs.
- The Development Partners: Mobilize resources for policy implementation and provide technical support for the implementation of adolescent SRH programs and policies.
- NGO's, CBOS, FBOs - support the provision of adolescent SRH information and services; mobilize the meaningfully involvement of adolescents and young people in policy formulation, program design, implementation and research.
- Media: Advocate and create public awareness on matters related to adolescent SRH.

3. STEP 2: KENYA GOVERNMENT'S COMMITMENTS TO FULFILL THE HUMAN RIGHTS OF ADOLESCENTS

The Kenyan government has committed itself to advance young people and women's rights by ratifying international and regional agreements that uphold human rights including the right to access sexual and reproductive health information and services. Some of these treaties are:

- The Convention on the Rights of the Child (CRC) ratified in 1990,
- The Program of Action of the International Conference on Population and Development (ICPD, 1994),
- The convention on the elimination of all forms of violence against women (CEDAW),
- The SDGs approved by the World Summit on Sustainable Development (SDGs) - in September 2016
- The Ministerial Commitment on Comprehensive Sexuality Education and SRH Services for Adolescents and Young People in Eastern and Southern Africa (ESA commitments, 2013),
- The Maputo protocol and its plan for action

Nationally, the Kenyan government has developed a number of policies, guidelines, frameworks and legislations that are supportive towards access, provision and utilization of the highest attainable standards of health for adolescents and young people in all their diversities. Some of these policies that address sexual reproductive health and rights are:

- The constitution of Kenya 2010,
- The Sexual offences Act 2006,
- The National reproductive health policy 2007,
- The National Youth Policy,
- The Menstrual Hygiene policy,
- The National School health policy 2019,
- The National Gender-Based Violence policy 2014,
- The Children's Act 2001, -the Prohibition of FGM Act 2011,
- The Gender Policy in Education 2007,
- The National Health Policy 2014-2030 and the
- National Adolescents Sexual and Reproductive Health Policy 2015.

The Kenyan government went a step further to develop programs to promote the reproductive health needs of adolescents and young people such as the Linda mama program which offers free Maternal and Neonatal services in order to reduce maternal and newborn mortality, Beyond Zero campaign is a call to action for policy prioritization and formulation, increased resource allocation, improved service delivery for pregnant women and their newborns, Universal Health Coverage which is a commitment by the government to ensure all its citizens have access to quality and affordable health care services by 2022. In 2020 the government set up an Inter-Ministerial Taskforce whose aim is to come up with interventions geared towards reducing teenage pregnancies. However, the rate of teenage pregnancy in Kenya continues to disrupt the health and lives of young people.

Adolescent and young girls unfortunately are forced to drop out of school due to teen pregnancy, resort to unsafe abortion services and, this has had huge implications on the economic, social and health system in Kenya nationally. This shows clearly that the Government of Kenya has failed in its obligations to promote, protect and fulfill young people and women's rights to health and life, and is an obvious violation of several other fundamental human rights under international and regional treaties to which Kenya is a signatory.

4. STEP 3. EXPLORING THE GOVERNMENT CAPACITY FOR IMPLEMENTING THE POLICY

The study has looked at the financial and human resources availed by the Kenya government for the implementing the NASRH policy 2015; the factors that reduce or expand the government's capacity to implement the policy, and the influence of donors and other international partners in implementing the national health policy.

4.1. Financial Resources

In the financial year 2018/19, the proportion of the combined discretionary public budget allocated to health increased from 8.2 % the preceding year to 9.2 %, but fell far below the Abuja declaration target of 15%. The public sector health budget expanded from Kenya shilling (Ksh) 94 billion in pre-devolution FY 2012/13 to Ksh 207 billion in FY 2018/19—more than a two-fold expansion. Over the last three years, Kenya's health budget expanded from Ksh 152 billion to Ksh 207 billion. The national government allocated 5.1% of its budget in FY 2018/19, whereas counties increased their allocation to 27.2 percent, indicating that the latter are primarily responsible for the rapid budget expansion. The government of Kenya also received funding from donors and development partners to implement the policy. However, the allocation of these resources did not prioritize adolescent's sexual and reproductive health. For instance, the government has prioritized curative services and the sexual and reproductive health sector within different counties received less funding for its programs, thus the low prioritization in the implementation of the NASRH 2015.

4.2. Human Resources

Other than financial resources which are important to ensure implementation of the policy, the government also has employed human resources which include health care workers, community health workers, policy experts and the beneficiary of the policy which are adolescents and young people. Through the devolution, the health sector has been devolved to counties and within the county; there are county health management teams and departments that spearhead health programming from the county to the sub-county, community units and facility management teams. This simply means that within the healthcare system, there are different cadres of health care workers who have different roles. However, few health care workers have been trained on Youth Friendly services and majority of them are still facing challenges like lack of privacy and confidentiality, values, attitude among others in providing Youth Friendly Services to the Adolescents and Young people.

4.3. Factors that expand or limit the government capacity to implement the policy

The expansion of the Kenya's health budget from Ksh 152 billion to Ksh 207 over the last three years, the establishment of multi-stakeholders partnership with civil society organizations, development partners and media, the employment of a good number of health care workers cadres at different levels, and the devolution of the health system are the factors that expand the capacity to implement the NASRH policy.

However, the limited budget for the SRH sector, the non-prioritization ASRH in the budget allocation, the limited number of trained health care workers on youth-friendly services and the inadequate engagement of young people in policy development, implementation and evaluation limit the capacity of the government to implement the policy.

5. STEP 4. THE IMPACT OF THE NASRH POLICY 2015 ON ADOLESCENTS', RIGHTS TO HEALTH.

The failure to effectively implement the NASRH policy and related programs results in inadequate provision of youth friendly services and information, affecting thus the right to health right of adolescents in Kenya. Below is a brief analysis of what actually happens and whether the effects of the policy result in a violation of adolescents' health rights. The violation of this right is a threat to other fundamental human rights of young people such as right to education and right to life.

5.1. The right to get timely and appropriate health care and information

Though the NASRH policy expresses high ambitions to enhance adolescents' sexual reproductive health status in Kenya and contributes towards the realization of young people's full potential in national development, its implementation does not address the lack of skilled health care providers on youth friendly services and the social subjugation of young people (specially the poor, non-educated and rural girls and young women) to cultural norms that require them to get parent consent, which hamper timely and proper health care and information, and how that can be addressed.

As in other parts of Sub-Saharan Africa, adolescents and young people in Kenya face severe challenges in accessing timely and appropriate SRH services and information.

The accessibility of young people to information is limited due to the lack of important number of health care providers and facilities that provide youth friendly services and information. Also, both cultural barriers that require adolescents to seek parents' consent prior to receiving SRH services and information and the cultural and religious assumption that adolescents should be subjugated to abstinence only until they get in marriage limit their access to timely and appropriate SRH services and information, especially for adolescents girls and young women. Kenya hasn't trained an important number of health care providers on youth-friendly services and only 10% of health facilities countrywide are offering youth-friendly health services. Also, the Kenya's health system has inadequate capacity to offer comprehensive SRH services to adolescents due to low budgetary allocation towards the particular SRH needs of Adolescents and Young People (AYP) such as contraception and ARVs.

5.2. Discriminatory effects

Although the policy has specific objectives of addressing the SRHR needs of Marginalized and Vulnerable Adolescents, the needs of adolescents' sexual minorities and those with disabilities has not been taken seriously. According to the community led discussions we have had with young people, most public and private facilities do not avail disability inclusive information and services. Adolescent's sexual minorities and those with disabilities are mostly stigmatized and denied services and information they require at the health facilities and in their communities. "...Sign language interpreters and information in braille are always missing in our health facilities, and nobody care, (said one of the respondent). Also, while the policy spell out clearly the marginalized and vulnerable adolescent groups in Kenya, it doesn't have a single mention on sexual minorities. Leaving out and not prioritizing the SRH needs of sexual minorities and adolescent with disabilities discriminate against these group and in violation of the adolescents' right to non- discrimination.

5.3. Non Availability, Accessibility, Acceptability and Quality.

While the policy clearly states that services, commodities need to be available and accessible in all facilities, there are still gaps in the implementation of the policy. The rate at which adolescent and young people are accessing and accepting the services being provided in the counties health facilities is very low.

Yet young people in the assessed counties do not have the laxity of choosing contraceptives methods due to limited options available and the outage of the commodities, i.e continuous stock out of contraceptives and ART, limited information on the available services for young people, limited accessible information on available services for adolescents with disabilities and limited functional youth friendly and disability inclusive services. These gaps demonstrate clearly how the Kenyan government is in violation of adolescents and young people's human right, especially their right to the enjoyment of the highest attainable standard of health.

6. STEP 5: THE GOVERNMENT ACCOUNTABILITY

By ratifying international and regional agreements that uphold human rights including the right to access sexual and reproductive health information and services, Kenya is mandated to respect, protect and fulfill these rights. The NASRH policy 2015 was intended to uphold adolescents human rights including the right to access the highest attainable standard of health, including reproductive health, but its failure to provide timely and appropriate health care and information, its discriminatory aspect and the non-observation of AAAQ principles in the health care provision in the counties are the great violation for which the government of Kenya shall account for.

The Kenyan health sector has not standardized information, education and communication materials at the community level and this has led to poor uptake of SRH information and services. Although a large percentage of adolescents spend most of their time in school, yet the SRH information disseminated at school level is limited, and in some cases no such information is provided despite the fact that the government of Kenya has endorsed the ESA commitments.

The inadequate implementation the NASRH policy as it's demonstrated above is in grave violation of the adolescent's right to health, the right to education and information, the right to privacy and human dignity, and the right to equality and freedom from discrimination.

The Ministry of Health (MoH), through the County Health Management Teams (CHMT), the County Hospital Management Teams, the Sub-County Health Management Teams (SCHMT), the Primary Care Facility Management Teams and the Community Units shall be held accountable for not respecting, protecting and fulfilling the fundamental human rights of adolescents in the five assessed counties.

For which effects the Kenyan government shall be held accountable?

- The failure to provide timely and appropriate health care services and information; and the non-achievement of AAAQ principles by the Kenyan health system in the provision of youth-friendly services to adolescents and young people are grave violation of adolescents and young people's right to access the highest attainable standard of health, including reproductive health.
- Discriminating certain groups of young people based on their sexual orientation, disability status or their geographical location is in violation of the right to non-discrimination and right to equality guaranteed by CEDAW and the Kenyan constitution.
- The lack of accountability framework in the NASRH 2015 contribute to the violation of human right that Kenya is supposed to uphold.

7. STEP 6: RECOMMENDATIONS AND STRATEGIES

7.1. Recommendations

As the NASRH policy has come to an end, there is a great opportunity to improve the policy. Therefore, the study has formulated a number of recommendation as they were highlighted by the adolescents and the young people. These include:

- The Department of Reproductive Health needs to widen a room for a meaningful engagement of young people in their diversity (with specific attention on sexual minorities communities, young people with disabilities, pregnant adolescents and young mothers, internally displaced, victims of FGM) in the review of the NASRH 2015; the formulation of the revised policy and its interventions.
- Prioritize in the revised policy the increase of the number of health care providers skilled on provision of youth-friendly services and number of facilities that can offer such services
- The Department of Reproductive Health should develop an accountability framework for the NASRH policy and enhance multi-sectorial approach when adolescents and young people SRHR issues including SGBV.

7.2. Strategies

To achieve the proposed changes, the organizations that participated in the study (Youth Changers Kenya, Zamara Foundation, and Youth Accountability and Strategy Network) will:

- develop a policy brief based on the gaps identified and disseminate the findings among key stakeholders and work together to review the policy or use this as a lesson to always meaningfully involve adolescents and young people in policy development and decision-making on matters regarding adolescents and young people. The organizations will require financial resources, human resources, and technical help in order to accomplish this goal.
- conduct consultative meetings with officials from the Ministry of health, ministry of education and other key players in the field of ASRH to disseminate the findings of the policy
- conduct consultative meetings with young people and adolescents in rural areas to create awareness on the policy and meaningfully engage them in the policy review process
- Online media campaigns (blogs, OPED, articles) on the NASRH policy
- Plug into the review process for the NASRH policy 2015 and ensure the needs of adolescents and young people are captured in the new policy

MALAWI

Analysis of the impact of National Education Policy (NEP) 2016 on the provision of Contraceptives and associated SRHR services at school level in Malawi.

1. EXECUTIVE SUMMARY

The study here summarized was conducted by 3 local organizations, namely Centre for Youth and Children's Affairs - CEYCA (https://web.facebook.com/ceycamalawi/?_rdc=1&_rdr), Global Hope Mobilization-GLOHOMO(<https://glohomo.org/>), Youth and Society Malawi - YAS (<https://yasmw.org>; https://web.facebook.com/youthandsociety/?_rdc=1&_rdr) operating in Lilongwe capital city and Mzuzu province with technical support of WGNRR Africa and funding from Hivos.

It examines the impact of the National Education Policy (NEP 2016) on the provision of contraceptives and associated SRHR services to school-going adolescents in Malawi versus the aim of several other policies, laws and strategies promoting adolescents' Sexual and Reproductive Health Rights (SRHR) services in Malawi. The focus on this policy is premised on by the fact that although the NEP provides for adolescents' access to HIV/AIDS services including voluntary HIV testing at school level, it limits the provision of comprehensive SRH information and services to adolescents including contraceptives at the same venues, while access to these services is permitted 100 meters away from schools or further (YFHS 2015 2020).

The findings show that although the NEP does not explicitly or implicitly prohibit the provision of contraceptives and associated SRHR, its silence on contraceptives and sexual reproductive health for adolescents or school-going children justify the lack of contraceptives in schools, particularly in primary and secondary schools, and makes adolescents and young people vulnerable to sexually transmitted infections as they indulge in unprotected sex, increasing thus their risks to HIV and STIs, early pregnancies that may eventually lead to complications during birth, unsafe abortions, school dropout, stigma, physical harm and even death. It's also clearly established that by denying adolescents access to contraceptives and associated SRHR in schools is discriminatory against the school-going adolescents while other groups access these services at point of need. Also, in-school adolescents are not meaningfully consulted and do not participate in the policy discussion and decision making on SRH.

The study concludes that the lack of mention and guiding clause in the NEP 2016 limits access to SRHR services for school-going adolescent and is in contradiction with the Malawi National SRHR Policy (2017-22) that requires all SRHR services shall be responsive to the reproductive health needs of the people of Malawi, including the adolescents, youth, adults, the disabled, mentally disturbed and the elderly. This violates the adolescents' fundamental rights to health, education, information and so many other rights to which Malawi has committed. Finally, the study recommends the harmonization of the NEP 2016 and the Malawi National SRHR policy (2017 – 22) and makes them consistent to each other, with reference to the Malawi Constitution.

2. STEP 1: PROBLEM STATEMENT AND POLICY IDENTIFICATION

2.1. Problem statement

Malawi has made progress in increasing its overall modern contraceptive prevalence rate since 2000, resulting in a dramatic reduction in its total fertility rate. However, youth, 15–24 years, have not had the same successes. Teenage pregnancies are on the rise and little progress has been made in reducing unmet need for family planning among youth

Adolescents and youth, aged from 15-24 comprise about 17.6% of the Malawi population (NSRHR Policy, 2017). In general, this age group is clustered around upper primary, secondary and tertiary institutions in the Malawi education system. The World Bank, in its 2016 ASRH policy brief for Malawi, predicts that this already large number of adolescents is expected to more than double in the upcoming decades from 4.1 million to 8.8 million by 2050. With these statistics, reducing unmet need for family planning among youth remains a priority for the government's reproductive health agenda. As it is in other sub-Saharan Africa, the contraceptive use is low among adolescents in Malawi. For adolescent aged from 15-19, contraceptive use ranges from 21-63%, with the unmet need ranging between 34-67 % (Venkatramn et al, 2014). High risk sexual behavior is also more common among this group such that 29% of adolescents age 15-19 have begun children bearing and 15% of adolescent girls and 22% of boys have had sexual intercourse before the age of 15 (MDHS 2015-16). Adolescent fertility rates are high and estimated at 136 per 1000 births and unsafe abortion because of unwanted pregnancy is also common among adolescents which is an indicator of girls' and women's unmet need for contraception. (UNFPA, 2020).

Early childbearing, high fertility rates and inadequate access to maternal health services are the main contributing factors in the high number of maternal deaths among young women in Malawi (UNFPA, 2020). Coupled with HIV, complications during pregnancy and childbirth are the leading cause of death for young women aged 15-19 years. The increase of teenage pregnancies and early marriage was exacerbated by the COVID 19 pandemic. A Malawi government-led COVID-19 rapid assessment on teenage pregnancies and child marriages, indicates that the country has recorded 13,000 cases of child marriages and over 40, 000 cases of teen pregnancies during the COVID-19 period (from March to July 2020), which is an 11 per cent increase in teenage pregnancies compared to the same period in 2019.²⁰ These early pregnancies would be avoided if young people had access to comprehensive sexuality education, including access to modern contraceptives methods.

2.2. Policy identification

Over the years, Malawi has developed several policies, laws and strategies to promote adolescents' SRHR services and curb issues above. These policies include the Malawi National SRHR policy 2017-22, Youth Friendly Health Services strategy (YFHS, 2015- 2020), HIV/AIDS prevention and management Act (2018), National Youth policy and Marriage, Divorce and Family Relations Act (2015) among others. There has been progress made by government and other stakeholders in introducing Youth Friendly Health Service (YFHS) centers, training YFHS coordinators, providers, Health Surveillance Assistants (HSAs) and Youth Community Based Distribution Agents (YCBDAs), but, adolescent fertility rate continues and, school going adolescents still have no or limited access to SRH information and services that would prevent them from getting teenage pregnancies, engaging in child marriages and prevent STI infections including HIV. According to the YFHS evaluation conducted in 2014, only 31.7% of young people have heard of YFHS and 13% have ever used these services. Noticeably, The National Education Policy (NEP, 2016) provides for adolescents' access to HIV/AIDS services including voluntary HIV testing at school level but limits provision of comprehensive SRH information and services to adolescents including contraceptives at the same venues. The school-based initiatives to increase contraceptive use among youth in Malawi is not clear.

The Malawi's most recent National Sexual and Reproductive Health and Rights (SRHR) Policy (2017–2022) commits to repositioning family planning for all, including adolescents, as a crucial development strategy. Specifically, the policy recognizes that family planning impacts individual health, family financial wellbeing, and economic development at a community and national level. Key to achieving this goal, both Malawi's SRHR policy and its National Youth Friendly Health Services Strategy (2015–2020) encourage the harmonization of health, education and youth ministry policies with the aim of improving youth awareness of and access to SRH services. However, the 2019 Malawi Education Sector Analysis indicates that in terms of SRH “there is lack of comprehensive interventions to mitigate HIV and AIDS and non-communicable diseases among students and staff”. While the National SRHR policy and its strategy of 2017-22, the Youth Friendly Health Services Strategy (YFHS, 2015- 2020), the HIV/AIDS prevention and management act (2018) and the National Youth policy (2013) promote the provision of SRHR services where adolescents congregate, the Malawi National Education policy 2016 inexplicitly bars the provision of these services at school level.

There is an apparent conflict or inconsistency between the Ministry of Health advocating for SRH services for youth, and the Ministry of Education, Sciences and Technology (MoEST) prohibiting distribution of commodities such as condoms within certain distance of a school²⁰.

Creating an enabling environment for adolescents to access SRH services at school would ensure that they make their own informed decisions about their sexual health and achieve their right to SRH for improved outcomes in both their health and education and build a better future goals. This analysis focus on analyzing the gaps of the Malawi National Education policy 2016 because, despite the gravity of high fertility rate and teenage pregnancy among school going adolescents, the government of Malawi has failed to harmonise the NEP with the National SRHR policy and implement comprehensive policy and programmatic measures to address fertility rate, low contraceptive use and early pregnancy prevalence among adolescents. The analysis aims to look at how this policy impact the health and well-being of Malawian adolescents, establish the state responsibilities and recommend actions that will ensure that the policy gaps are sealed and adolescents enjoy their right to Comprehensive Sexuality Education (CSE) and access the much needed SRH services at school.

2.3. Groups affected by the NEP 2016

Eighty one percent (81%) of adolescents are in school, they are directly and largely affected group by this policy and its inconsistencies. However, adolescent girls and young women, especially those in rural, resource-limited settings are most at risk of unwanted pregnancies, have higher fertility rates, and marry younger and are therefore most in need of public FP services.

Indirectly affected are guardians, parents, school authorities and their communities at large. It is worth pointing out that these adolescents are basically children at home for the guardians and parents. Each negative impact on the adolescent, directly or indirectly also affects the guardians and parents. For example, an adolescent who drops out of school due to sickness from an STI or pregnancy will become a consumer of the resources at home that would have been spared for his/her education.

School authorities and their surrounding communities are also indirectly affected by losing out on potential or best students to school dropouts, pregnancies early marriages and even deaths.

For example, if an adolescent who is very intelligent in class gets pregnant, married off and drops out of school, it becomes a loss to the community as a whole and the school authority entrusted with the responsibility of developing such adolescents into highly productive and future citizens.

2.4. The Rights affected by the policy.

The interrelationships and overlaps of human rights need to be emphasized. However, the key human rights violated for adolescents by this policy are right to health, education and information.

First, in terms of their Right to Health, and in according to the Universal Declaration of Human Rights, health is a part of the right to an adequate standard of living (article 25). The lack of access to contraceptives by adolescents in schools makes them vulnerable to sexually transmitted infections as they indulge in unprotected sex, which leads to early pregnancies that may eventually lead to complications during birth, unsafe abortions, stigma, physical harm and even death. Secondly, the adolescents Right to Education is violated and affected by the policy. Again, the universal declaration of human rights affirms that education is a fundamental human right for everyone. Failure to access sexual reproductive health services by adolescents is an infringement to the right to education as it affects their education twofold: one is that adolescents need to be educated on how they can protect themselves from STIs and early pregnancies through proper and consistent use of contraception. Secondly, if the adolescents drop out of school due to pregnancies or STIs their right to education is infringed upon as it will lead to illiteracy which further perpetuates the vicious circle of poverty. The third right affected is the right to information. This right encompasses the right to participation, dignity and decision making. The Malawi government just enacted the Right to Information Act of 2017. In compliance to this Act, it follows that if adolescents demand information, that is age appropriate, then the schools are obliged to provide this. Failure of which infringes on the adolescents' right to access the information they need and deserve.

It must be noted however that the Malawi School Education Curriculum has subjects like Life Skills and Social Development studies with the latter being core in adolescents SRH. However, the capacity of teachers to impart knowledge of and deliver content that may be considered to be 'culturally' sensitive or religiously 'offensive', affects the majority of the teachers, especially at primary school level. The teachers fail to open up and teach the adolescents effectively about sexual and reproductive health issues including the use of contraceptives such as condoms. It should be noted, however, that the behavior and attitude of such teachers and tutors is largely due to cultural inhibitions and personal and religious beliefs and values, rather than lack of knowledge on the subject matter. More importantly, and specifically for primary school teachers, they experience challenges with SRH terminologies in vernacular language, since most local languages, including the widely used Chichewa, has limited vocabulary on sex and sexuality concepts, with the few word regarded as 'taboo' if used in the classroom.

3. STEP 2. EXPLORING THE GOVERNMENT COMMITMENTS TO ASRHR.

The Malawi Government is committed to implementing comprehensive and integrated approaches to SRHR despite the financial and institutional challenges it faces. At national level, the Constitution guarantees the various rights of all Malawians including the right to health care and services.

In addition, the Malawi government has the following policies, strategies and acts that cement its commitment to provide access to SRHR services to its citizenry including adolescents: the National Sexual Reproductive Health Rights policy (2017-2022), the Child Care Justice Protection Act (2010), National SRH strategy (2015-2020), National Youth and Health Policies (Including comprehensive maternal and Child Health Policies). The National Education Policy (2016), School Readmission Policy and inclusion of SRH in the primary secondary and university curriculums; The Ending Child Marriage Program, Gender Equality Act (2013), Marriage Divorce and Family Relations Act, HIV Management Act (2018) as core to addressing ASRH issues.

Apart from national instruments, Malawi is signatory to the various regional and international protocols, treaties and conventions that guarantees access to and achievement of ASRHR. Regionally, Malawi is signatory to the various treaties including the SADC SRHR strategy, the SADC Model Child Law, the African Charter on Human and Peoples Rights (ACHPR) and its protocol on the right of women in Africa (Maputo protocol), the African Charter on the Rights of the Child (ACRC), the Abuja declaration, the East and Southern Africa (ESA) Ministerial Commitment on sexuality education and sexual and reproductive health services for adolescents and young people, the African Union (AU) 2063 Agenda and the Africa Gender Protocol among those targeting ASRH services. Internationally, Malawi ratified various instruments including the Universal Declaration of Human Rights, CRC, CEDAW, ICPD and SGDs. More importantly, Malawi ratified the General Comment number 2 of the ACHPR of 2004. Specifically, this protocol on health has three articles that are key to ASRH: article 16 which is about reproductive health; article 10 which is about HIV/AIDS and STDs; and article 17 which is about childhood and adolescent health (MNSRHRP, 2017). To translate this into action, the Malawi government developed the National SRHR strategy which specifically aims to increase accessibility and utilization of reproductive health information and services by all women of child bearing age especially eligible sexually active adolescents.

In a nutshell, by ratifying the international and regional human right agreement enumerated above and domesticating them by creating national laws, policies, programs and strategies, Malawi shall be held accountable for not respecting, protecting and fulfilling the sexual and reproductive rights of women and girls, and implement effective policy and programmatic measures to address SRHR issues of adolescents, especially girls and young women.

4. STEP 3. DESCRIBING THE IMPLEMENTATION CAPACITY OF THE GOVERNMENT

In view of the foregoing discussion on the policy, there is need to look at the capacity of the Malawi government to implement the policies developed to address the issues of ASRHR, while keeping in mind its regional and international obligations as highlighted above.

Four core aspects have been looked at in describing this capacity: human resource, budget and financial allocation, other resources available and political will that can help the government implement these ASRH obligations.

4.1. Human Resources and capacity.

The Malawian government has sufficient human capacity that is a well-trained and capable of giving out SRH services targeting adolescents but they are not fully utilized. Lack of human capacity utilization and uptake of professionally trained personnel greatly contribute to the failure to the delivery of these SRH services. According to the Nurses and Midwives Council in Malawi (NMCM), by 2019, Malawi had close to 13,000 qualified nurses that were not fully employed and utilized by both government and the private sector.

In addition, many well trained health graduates from various universities and colleges, both public and private that are not members of the NMCM are out there and not employed. There are also a good number of Health Surveillance Assistants that are community based and could easily access the schools, on almost daily basis, that are not provided with ample resources to provide ASRH services. Further, there are Community Based Distribution Agents (CBDAs) who work as volunteers for the health sector and are better placed to work with adolescents in informal settings and centers. These could easily distribute contraceptives to adolescents if their capacity were to be developed and enhanced. However, due to lack of or limited motivation and support to drive ahead the ASRH initiatives they sit idle right in the communities where adolescents are.

4.2. Budget Allocation for SRHR

In terms of budget and finance allocation to the Ministry of health, the government of Malawi is a signatory to the Abuja declaration which mandates party states with an obligation to increase their health budget to at least 15%. Over the years, the health budget allocation has increased to about 9.4% as of 2021. However, health being a wide and all-encompassing term, it is still not clear on the specific amount of funds or percentage of the budget that is allocated towards sexual and reproductive health of adolescents, especially the ones in school. There is currently no documentation in the budget lines accessed so far to indicate an amount or percentage of the budget allocated to the Sexual Reproductive Health initiatives in Malawi that specifically target adolescents. Evidently, in Malawi, adolescent SRH services are mostly funded by development partners like United Nations Fund for Population Activities (UNFPA) and other SRHR focused CSOs. The challenge in entrusting this method of implementing adolescent SRHR program is that most of these stakeholders do not cover the whole country. They are mostly confined to implementing in a particular district. Even in those targeted districts, the interventions are often limited to a few Traditional Authorities rendering a bias in terms of progress and universal access to these services by adolescents. Further this makes it difficult to measure the impact of these programs on the entire countries' adolescent population.

Since the last MDHS in 2016, there has not been any recent studies, reviews or research, or at least not to our knowledge, of key national statistics on adolescent SRH to support program and advocacy implementation in improving adolescents SRH. This makes it challenging for CSOs and NGOs as well as other development partners to select target districts for implementation of interventions focused on adolescents SRHR and ensure a national coverage.

In addition, due to unavailability of adequate data at the district level, District Implementation Plans (DIPs) lack proper guidance on prioritization of adolescent SRH services.

4.3. Other resources to help the government implement the policy.

The Malawi's health system is a combination of public and private provision of SRH services. The major provision sites include the 392 public and government owned health facilities representing 63% of the total health facilities in Malawi. Christian Hospitals Association (CHAM) has 161 facilities, making about 26%; 31 facilities (6%) are owned by private individuals and NGOs including Banja La Mtsogolo which is a non-for profit NGO that specializes in the delivery of sexual and reproductive health. Lastly, the Ministry of Local Government owns 5% of the remaining Health facilities. Cumulatively, Malawi has 2 fully fledged medical schools and 18 nursing colleges that produce a good number of qualified health practitioners each year. If these alternative resources were tapped, reaching adolescents with these essential SRH services would be easier than the current status quo.

4.4. Political Will.

As pointed out earlier, Malawi is a signatory to the various regional and international instruments that support member states to finance SRHR programs. Being party to and signatories to these instruments signals a proven element of commitment to respect, protect and fulfill the SRHR for all in Malawi. The SADC SRHR strategy, for instance, clearly states that governments and all partners should ensure that adequate financial resources are provided, and investments made so that adequate human resources with the required skills are available, and all people can access information, education and quality SRHR services. It can also be said, as an indicator for this commitment, the gradual increase in the annual budget to health services now at 9.4% although it is still lower than the Abuja declaration pledge. However, caution need to be exercised as this increase in the Health budget may not only be as a result of the ascribed political will, as it may also be due to other demographic variables like population growth. The national Health Sector Strategic plan 2017-2022 clearly recognizes the need to achieve universal health coverage and investment in Sexual and Reproductive Health care services, but the lack of political will impact the budget allocations. Nonetheless, there has been no clear and declared allocation to SRH services, let alone the amount allocated to SRH services for adolescents considering the prevalent challenges shared herein. Also activities meant to target adolescents have been misplaced and usurped by youth clubs and networks that are used to disseminate information and services to adolescents. Mostly these clubs are patronized by older youths (25 to 35 years olds) leaving behind adolescents. This justifies the need to focus on school based interventions to effectively reach out the 'real' adolescents. The YFHS and the national health sector strategic plan clearly recognizes the need to improve adolescents' health education but there has not been much focus and priority on the school going adolescents among both government and CSOs. Even though the Malawi National Strategy for Adolescent Girls and Young Women (2018 to 2022) calls for joint work in promoting adolescent health between ministries of Education and Health, as shown above, the policies developed to achieve this between these ministries are not in tandem and are inconsistent with the desire to provide CSE, contraceptives and other related SRH services at school level. These inconsistencies, and lack of urgency in addressing them, show a lack of political will. If these gaps were given due priority and effectively addressed, the adolescents will largely be able to access these important services if and when they need them at school level.

5. STEP 4: THE IMPACT OF THE NATIONAL EDUCATION POLICY 2016 ON ADOLESCENTS HEALTH.

The National Education policy 2016 under analysis and its Act have impact on three fundamental rights of adolescents: the right to health, the right to education and the right to non-discrimination.

5.1. Impact of policy on Right to Health:

There are a number of ways the policy under discourse negatively impact the right to health for adolescents. The NEP 2016 and its Act do not cater for the provision of contraceptives and associated SRH services in school in contradiction of other existing policies (i.e. the Malawi National SRHR policy and its strategy of 2017-22, the Youth Friendly Health Services Strategy, 2015- 2020), the HIV/AIDS prevention and management Act 2018), and the National Youth policy 2013) promoting the provision of SRHR services where adolescents congregate.

The lack of access to contraceptives by adolescents in schools makes them vulnerable to sexually transmitted infections as they indulge in unprotected sex, which leads to early pregnancies that may eventually lead to complications during birth, unsafe abortions, stigma, physical harm and even death. This is the infringement of adolescents' right to the highest attainable standard of health"

5.2. The right to education:

The lack of contraceptives, particularly in primary and secondary schools makes the adolescents boys and girls to engage in unprotected sex increasing their risks to contract sexually transmitted diseases, including HIV and getting early pregnancies. Adolescent girls and young women are most vulnerable on this as they are likely to drop out of school and suffering stigma and emotional stress for early pregnancy and STIs/HIV than boys.

Again, the universal declaration of human rights affirms that education is a fundamental human right for everyone, and failure to access sexual reproductive health education and services by adolescents is an infringement to this right. Also dropping out of school and not being given a chance to return to school after giving birth creates education inequalities between boys and girls.

5.3. The right to non-discrimination:

The policy under discussion discriminates against school going adolescents. Adolescence, as a formative developmental stage in life, is where boys and girls experiment with their sexuality, often innocently without due concern of the ensuing consequences. Access to CSE and contraceptive at this stage, therefore, is of optimum use to protect their lives and promote correct decision making processes through informed choices. Denying contraceptive services at school while the national SRHR policy want these services to be provided where adolescents converge and that these services can be accessed by other adolescents at 100 meters from school, is discriminatory against school-going girls who spend most of their time in schools. Particularly, the gaps identified in the policy make girls more vulnerable. Girls who drop out of school due to pregnancy or early marriages are particularly victims of bullying, mocking, and stigmatizing, which make it difficult for them to reintegrate both the school and the society.

6. STEP 5: THE GOVERNMENT ACCOUNTABILITY

Responding to the health needs of adolescents in Malawi requires the concerted efforts of multiple ministries, departments or sectors. Although the ministry of Health assumes the primary responsibility for expanding coverage and improving the quality of health services for adolescents, with a view to improving the health outcomes and attaining the demographic dividend, the MoST has a great responsibility for its implementation as it provides the core avenue where adolescents can be accessed, and has a Comprehensive Sexuality Education department that would ably engage the Ministry of Health to ensure that SRH needs of adolescents are met and their rights fulfilled. The National SRHR policy clearly mandates the ministry of education to “strengthen school clubs to address SRHR issues; empower boys and girls to make informed, decisions about their SRHR and provide age specific sexuality education...”, but the prohibition of distribution of commodities such as condoms within certain distance of a school by the MoEST is a failure by the government of Malawi to respect, protect, and fulfill the sexual and reproductive rights of women and girls.

Secondly, the Ministry of Justice has a legal oversight responsibility to ensure that the laws and policies in Malawi are in tandem with each other and do not, in any way, infringe on the rights of adolescents SRHR. The cacophony between the NEP 2016 and other policies promoting the provision of SRHR services where adolescents congregate, is failure by the Malawi government to implement effective policies and programmatic measures to comprehensively address the SRHR issues of adolescents in the country. The NEP 2016 does not mention anything on how adolescents can access these SRH services nor does it mention Sexual Reproductive Health or contraceptives. This lack of mention and guiding clauses in the NEP limits the SRH services such as contraceptives as proposed and guided by the MNSRHR policy. If these two key policies were harmonized and made consistent with each other, with reference to the Malawi Constitution, such SRHR service could easily and effectively be provided at school level, where adolescents are mostly found and can easily be accessed by service providers.

Finally, denying school-going adolescents a health service intended to be accessed by all just because they are in school is discriminatory against them and in violation of the right to non-discrimination.

The Malawian government's failure to ensure access to necessary reproductive health information and services that are crucial in curbing the fertility rate, preventing unplanned and unwanted pregnancies among vulnerable groups such as school going adolescents is in violation of several rights of adolescents, including the right to health, the right to education and information and the right to non-discrimination, for which the government of Malawi shall be held accountable for.

7. STEP 6: RECOMMENDATIONS, STRATEGIES AND ACTION PLANNING

Malawi's policies and programs show promise for improving opportunities for adolescent Sexual Reproductive Health and CSE. However, substantial improvements need to be undertaken in their implementation to achieve the desired results. In view of this, we need to focus on developing a stronger more ASRH focused policies and laws.

Also the meaningful engagement of adolescents themselves to participate in decisions that affect their SRHR is key milestone in ensuring and deciding what SRHR services the adolescents need and from where they would prefer to access them. Finally, the challenges that have been documented with respect to adolescent participation and duty bearer accountability, show that despite an awareness of their rights and expectations in regard to SRH through the Life Skills curriculum, adolescents lack effective channels for communicating their priorities, exercising their rights or ensuring accountability within the health system. The extent and effectiveness of adolescent participation around SRHR programmes depends in part on the motivation and capability of teachers at school level, who are normally the first point of contact, providing information and services, which the adolescents' parents and guardians may otherwise not be able to provide.

7.1. Recommendations:

Based on the observations highlighted throughout this study, we recommend the following:

- The government of Malawi, through different ministries, especially the MoEST, MoH and Ministry of Justice, to immediately harmonize the existing policies and laws to iron out the conflicting directions between the ministry of Health and the ministry of Education. The existing policies need to speak to each other to promote the wellbeing of the adolescents comprehensively. This measure shall also encompass the inclusion of age appropriate contraceptive education in the Life Skills and Social Development studies in the Malawi School Education Curriculum. This will make the Malawian schools to be an ideal place for adolescents to access contraceptives unlike other avenues of distribution in the country. The opportunity to achieve this harmonization is through the activation and support of the existing (but dormant) joint ministerial committee on SHR to execute its mandate. This committee rarely, if any, meet to deliberate on issues affecting adolescents and it's currently almost deemed non-existent.
- To allocate domestic funds to supplement UNESCO and UNFPA efforts of training teachers on the delivery of CSE. As this intervention has not reached all the districts across the nation, the domestic funds would allow support the adequate training or capacity strengthening of teachers' capacity on CSE and counselling in order to improve the delivery of Life Skills and Development studies curriculum in all districts of Malawi;
- To integrate contraceptives into other health services (i.e HTC, immunization and other health campaigns such as deworming campaigns) currently allowed at school level and used by adolescents. This would enable the country to reduce school dropout rates due to pregnancies and curb early marriages. If this was the case, for many adolescents, contact with these services would be their first opportunity to have a face-to-face discussion about contraception with a competent person and develop their ability to make informed decisions about their sexuality.
- The CSOs to mobilize adolescents in their diversities to meaningfully engage and participate in discussions that make decisions on the issues affecting them, and articulate their SRHR demands.

- The CSOs, the Reproductive Health Directorate of the Ministry of Health, the Parliamentary Committee on Health and SADC parliamentary SRHR governance project to jointly advocate and lobby for the creation of a specific budget line for adolescent SRH services in the Ministry of health budget.
- The government and development partners to commission a national study on how the supply and provision of contraceptives at school level could be done with focus on age appropriateness. This study need to be championed by and target the adolescent themselves, parents, teachers, gate keepers and key officials from the ministry of health and education.

7.2. Proposed strategies and work plan

OBJECTIVE	ACTIVITY	PROPOSED DATE	RESPONSIBILITY	UNCOSTED RESOURCES	REMARKS
Facilitate the review the 2016 NEP to provide support for provision of CSE, and comprehensive HIV services including voluntary HIV testing for the learners at school level	• Conduct a national meeting to disseminate findings	March 2022 (Soon before National Budget Formulation consultation)	YAS, CEYCA & GLOHOMO	• Conference facility. • Participants and media DSAs, fuel and communication.	
	• Mobilize CSOs into a coalition for advocacy for review of NEP.	On Going (to August 2022)	YAS, CEYCA & GLOHOMO	• Conference facility. • Participants and media DSAs, fuel and communication.	
	• Conduct national awareness and lobby meetings on the need for NEP review	Ongoing to July 2022	YAS, CEYCA & GLOHOMO	• Conference facility. • Participants and media DSAs, fuel and communication.	
	• Convene a policy review meeting with key stakeholders to draw recommendations.	July 2022	YAS, CEYCA & GLOHOMO	• Conference facility. • Participants and media DSAs, fuel and communication.	To include inter-ministerial committee on SRH, Parliamentary Committee on Health and key ministry officials
	• Conduct a capacity building workshop for the inter-ministerial committee on SRH	June 2022	YAS, CEYCA & GLOHOMO	• Conference facility. • Participants and media DSAs, fuel and communication.	
Enhance teacher training on delivery of CSE at districts level strengthening of teachers in order to improve the delivery of programs like Life Skills and CSE.	• Build capacity of teacher trainers of LSE in public and private teacher training colleges in CSE.	On Going to Dec 2022	YAS, CEYCA & GLOHOMO	• Conference facility. • Participants and media DSAs, fuel and communication.	
	• Lobby for review and enhanced LSE training curriculum to include CSE.	May 2022	YAS, CEYCA & GLOHOMO	• Conference facility. • Participants and media DSAs, fuel and communication.	
Advocate with the Health Directorate of the Ministry of Health, the Parliamentary Committee on Health and SADC	• Analyse the National health budget to identify ASRH budget lines and gaps. .	May 2022	YAS, CEYCA & GLOHOMO	• Consultant fees • Conference facilities for validation and findings dissemination workshop.	

OBJECTIVE	ACTIVITY	PROPOSED DATE	RESPONSIBILITY	UNCOSTED RESOURCES	REMARKS
Advocate with the Health Directorate of the Ministry of Health, the Parliamentary Committee on Health and SADC parliamentary SRHR governance the creation of a specific budget line for adolescent SRH services in Malawi.	• Analyse the National health budget to identify ASRH budget lines and gaps. .	May 2022	YAS, CEYCA & GLOHOMO	• Consultant fees • Conference facilities for validation and findings dissemination workshop.	
	• Support Capacity Building initiatives for Ministry of Health Sexual Reproductive Health Unit and budget focal persons for ASRHR budgeting.	April 2021	YAS, CEYCA & GLOHOMO	• Consultant fees • Conference facilities for validation and findings dissemination workshop	
	• Support the Ministry of Health and National Parliamentary Committee on Health to ensure the develop of an ASRH budget line	April 2022	YAS, CEYCA & GLOHOMO	• Conference facility. • Participants and media DSAs, fuel and communication.	
Revive and support the inter-ministerial committee on SRHR to regularly meet and charge it with the mandate to explore the operationalization of access to contraception at school level by adolescents.	• Support the quarterly meeting of the national inter-ministerial committee on health for the 2022-23 financial year	March, June, September and December 2022.	YAS, CEYCA & GLOHOMO	• Conference facility. • Participants and media DSAs, fuel and communication.	Preferably rotate the meeting venues across the country and include field or school visits as art of the meeting to interact with students and learners on their needs.
Commission a study on best practices on how the supply and provision of contraceptives at school level could be operationalized	• Identify a competent consultant to undertake the study	March 2022	YAS, CEYCA & GLOHOMO	• Consultant fees • Conference facilities for validation and findings dissemination workshop	An alternative would be to support a teacher training institution to undertake the study with the project financial support.
	• Conduct a meeting to disseminate the study findings.	March 2022	YAS, CEYCA & GLOHOMO	• Conference facility. • Participants and media DSAs, fuel and communication.	

	<ul style="list-style-type: none">• Lobby for implementation of study recommendations.	May 2022	YAS, CEYCA & GLOHOMO	<ul style="list-style-type: none">• Conference facility.• Participants and media DSAs, fuel and communication.	

TANZANIA**Analysis of the impact of the National Youth Development Policy 2007 on adolescents and young people health in Tanzania.****1. INTRODUCTION**

This case study presents an overview of the findings of an assessment of the impact of the national youth development policy 2007 on adolescents and young people health in Tanzania conducted by two grassroots organizations, namely HakiZetu Tanzania organization (<https://hakizetu.org/>) and Wadada Solutions on Gender Based Violence (<https://wadadat.org/>) based in Mwanza, in the lake region of Tanzania. The assessment was conducted between March to August 2021, under the technical support of WGNRR Africa with funding from Hivos – Southern hub.

2 PROBLEM STATEMENT AND POLICY IDENTIFICATION**2.1. Problem statement**

Tanzania has the second youngest population in East Africa, with a median age of the population being 18 years. Sexual and reproductive health right status of adolescents in Tanzania remains an area of concern for the country. They face a multitude of SRH risks that, if not managed, will have consequences that follow them into adulthood (Nguyen et al., 2019).

Low levels of knowledge on SRHR and STI/HIV, high prevalence of child marriage, correspondingly high levels of adolescent fertility and limited access to quality and age appropriate youth friendly information and services are challenges which perpetuate poor SRH outcomes. Given that 57% of young women and 48% of young men report having had sex by age 18, it is important for adolescents to have access to comprehensive sexual education.

• Lack of Youth-friendly Services and stigma about Adolescents' Sexuality

Although young people face a multitude of SRH risks, our analysis focused on the lack of youth friendly services and its impact on young people health and life. The government of Tanzania recognizes that when it comes to SRH services, it is crucial to offer youth-friendly services that 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.”²³ Despite this, youth-friendly services, particularly in rural areas, continue to remain very limited.²⁴ Since the existing health facilities serve the larger communities and not exclusively adolescents, many youths fear running into their parents and other people they know at these facilities.²⁵ The wait time required to receive services and the working hours of the facilities — which are usually the same as school hours further discourage adolescents from seeking their service²⁶ because they would need to miss school and provide evidence justifying their absence. The lack of health care professionals trained in providing youth-friendly services, which results in a personal bias against adolescents accessing reproductive health services, including contraceptives, is an additional challenge. As a government Youth Department Officer in Mwanza explained: “*The decision to give [contraceptive] services is at the discretion of the provider*”.

Sometimes health care providers discriminate against adolescents who want to access [contraceptives], because of their values and/or traditions. They do not have enough education and training on how to provide youth-friendly reproductive health services”²⁷. Further, while the National Family Planning Guideline and Standards provides that all young people (ages 10 to 24) are eligible for contraceptive information, education, and services “irrespective of their parity and marital status” and without parental consent,²⁸ some providers continue to impose age-based restrictions. One study, for instance, found that between 79% and 81% of contraceptive service providers in rural Tanzania impose age restrictions for accessing a contraceptive pill.²⁹ A head nurse working in a public facility confirmed: “We talk to adolescents first and ask them if their parents are aware of them taking that service, and we also ask for their parents' contacts so as to have conversations with them for further directions. ... If the parents are unaware, then we do not provide them with contraceptives.”³⁰

As a result, young people have limited access to quality and age appropriate information and services which perpetuate poor sexual and reproductive health outcomes³¹. The adolescent fertility rate has increased from 116 to 132 between the 2010 and 2015 (TDHS 2015/16). Among adolescents aged 15 to 19 years, 27% of them have begun child bearing (21% have given birth and 6% are pregnant with their first child)³². Teenage pregnancy has also increased by 4 per cent in Tanzania since 2010 and by 2016 one in four adolescents aged 15-19 had begun childbearing. Thirty-two percent of adolescents living in rural areas have had a live birth or are pregnant, compared with 19% of those living in urban areas³³ and; only 37% in adolescent girls and 35% in adolescent boys between the ages of 15-19 use condoms outside marriage and youths in rural areas use condoms at a lower rate compared to their urban counterparts³⁴.

2.2. Policy identification

This analysis focus on exploring the impact of the National Youth Development policy 2007 (NYDP 2007) on adolescents and youth health in Tanzania. The choice of this policy is premised by its focus on youth development issues including adolescent reproductive health and family life; its recognition of inadequate health services for youth and its good intention to promote the establishment of youth friendly health services. In its statement section 3.27 on “Inadequate Health Services for the Youth” the policy recognizes that most young people do not have access to youth friendly health services and that the situation is worse in the rural areas, especially for young women because they are given less priority and most programs focus on the mother and child disregarding young women. The policy states that “the government in collaboration with other development partners shall promote the establishment of youth friendly health services at all levels” and; “the government in collaboration with other stakeholder shall put a mechanism to coordinate the provision of reproductive health education to the youth as stipulated in the reproductive health strategy, education policy and family life education programme.

Though the statements above, the policy attempts to build a case for youth on the basis of a given fact that a “nation will have a healthy youth if its programmes on early child development have created an opportunity for the growth of a healthy society” (United Republic of Tanzania 2007a: 5). The policy goes on to conclude that “the real situation shows that youth encounter the following health problems that are related to physical, mental, maternal and reproductive health: - escalation of sexually transmitted infectious diseases including HIV/AIDS; malnutrition which causes amongst other things blood deficiencies (anaemia) and low birth weight; female genital mutilation to girls, young women and children; early marriages and pregnancies; and inadequate youth friendly health services and information.

Based on what precedes, the policy is intended to address the demands for the provision of youth friendly health services and information to ensure that Tanzania have a healthy youth and have created an opportunity for the growth of a healthy society.

2.3. Groups affected by the National Youth Development policy

Although the government recognizes the contradictions on the legal definition of youth in Tanzania in existing policies and the need to harmonize the definition of youth in Tanzania so that different programs for youth empowerment can be developed systematically to meet the needs of youth, the national health policy 2007 states, however, that youth in Tanzania shall be defined as young men and women from the age group of 15 to 35. Without explicitly stating which groups to be targeted, the policy implicitly is likely to affects any young men and women between 15 - 35 year old living under difficult conditions (namely orphans, youth with disabilities).

The policy doesn't have a specific mention on adolescents below 15 years and those who don't identify themselves as men nor women. This deliberated omission is likely to increase the vulnerability of these other groups of young people who need specific attention of the government.

3. STEP 1. EXPLORING THE GOVERNMENT COMMITMENTS TO ASRHR.

Tanzania as many African countries has embarked on efforts to advance human rights and foster young people's welfare. It has committed to several national, regional and international conventions that could improve the operating environment for Adolescents' Health and Development (ADHD). Over the past few decades, the Government of Tanzania (GoT) subscribed to several pro-ADHD conventions, committing itself to abide by their tenets. A few of these conventions include: i) the UN political declaration on HIV / AIDS, ii) the Eastern and Southern African (ESA) commitments on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people, iii) the convention on the rights of the Child, iv) the SADC protocol on child and adolescent health, v) the Ouagadougou declaration on primary health care, and vi) The UN Convention on the Elimination of all forms of Discrimination against Women (CEDAW). Collectively, these conventions commit to ensure the full health of all people in the member countries; pledge to strengthen social services, legal, health and educational systems to ensure the holistic development of all people; emphasize the need for gender equality and forbid any distinction, exclusion or restriction made on the basis of sex; protect the needs of women, children and other vulnerable groups; and elevate primary health care as a fulcrum for universal health coverage. It is important that the GoT reflects on and maintains these commitments in the spirit of improving ADHD.

3.1. International human rights instruments

Tanzania has ratified all the six key international treaties as commitment to their monitoring committees to fully implement necessary legislative and administrative measures to create an enabling environment for young people's access to SRH services and information. The six relevant treaties related to Adolescents and young people's SRHR include but not limited to:

- International Covenant on Civil and Political Rights (ICCPR) ratified on June 11, 1976;
- Convention on the Rights of the Child (Children's Rights Convention)
- The International covenant on Economic, social and cultural rights [ICESCR] ratified and accessed on 11 July 1976 , Art 5 on persons with disability, and 19 on social security;
- The convention on the Elimination of all forms of discrimination against women [CEDAW] signed on 17 July 1985, ratified on 20 August 1985, Article 12 and general recommendation no.24 on health, general recommendation no 19 on violence against women, Art 5(b), 10,11 on (family) education and employment and 1,2 and 3 on discrimination in general;
- International Convention on the Elimination of All Forms of Racial Discrimination (Convention against Racial Discrimination)
- Convention against Torture and Other Cruel, Inhuman or Committee against Torture (CAT) and Degrading Treatment (Convention against Torture)
- Convention on Rights of People with Disability (CRPD) signed on 30 March 2007, ratified on 10 November 2009;

3.2. Relevant regional treaties include:

- The African Charter on the Rights and Welfare of the Child (African Charter on Children),
- The African Charter on Human and People's Rights ratified on 18/02/1984, and its protocol on women rights (Maputo protocol), Art 14 on health and reproductive rights

3.3. Consensus documents supported by Tanzania

Tanzania supports without reservation the following consensus documents:

- The International Convention on Population and Development (ICPD)
- The Sustainable Development goals (SDGs.....),
- Beijing Platform for Action, (paragraph 89 -105, strategic C1-C5);
- Maputo Plan of Action 2016 - 2030
- The Abuja declaration
- The Southern African Community's Strategy for sexual and reproductive health and rights, 2019-2030
- The Ministerial Commitment on CSE & SRH services for adolescents and young people in Eastern and Southern Africa (ESA commitment)

3.4. Bilateral and multilateral binding agreements

Other bilateral agreements influencing the implementation of the policy are those concluded between the government of Tanzania and the Development Partners groups for Health (DPG Health), a collection of 17 bi-lateral and multi-lateral agencies including the African Development Bank, the Canadian International Development Agency, the Clinton Foundation Tanzania, DFID, UNICEF, UNAIDS, UNFPA, the World Bank and WHO.

3.5. National policy framework on adolescents and young people SRHR

Tanzania has important progress in protecting the rights of all its citizens, including adolescents and young people. The key laws and policies guaranteeing SRHR of young people include, but not limited to:

- The Constitution of Tanzania (1977), article 14 states: "every person has the right to life and ... the protection of his life by the society in accordance with law". The constitution provides the basis for quality health services to reduce the burden of disease and death in people. It further guarantees the right to privacy and personal security, including the "respect and protection of . . . private communications," in its article 16.
- The Sexual Offences Special Provisions Act (1998) - SOSPA - is a milestone in the legal framework for promoting adolescents SRH. SOSPA makes it an offence of rape for a male person to have sexual intercourse with a girl who is below 18 years with or without her consent.
- The Law of child Act 2009
- The Tanzania Development vision 2025 – promotes access to quality primary health care for All and

- access to quality reproductive health services for all individuals of appropriate age
- The National Health policy 2017 – 2022 – with a mission to facilitate the provision of basic health services that are of good quality, equitable, accessible, affordable, sustainable and gender sensitive. It aims at improving reproductive, maternal, newborn, child and adolescents health services; and enhance gender based equity and equal opportunities to access health services.
- The National Youth Development Policy (2007) - recognize the inadequate health services for youth; promotes the establishment of youth friendly health services at all levels” and; the establishment of a mechanism to coordinate the provision of reproductive health education to the youth as stipulated in the reproductive health strategy, education policy and family life education programme.
- The National Adolescent Health and Development (ADHD) Strategies (2004 – 08, 2011 – 15 & 2019 -22)
- is the first government step of an expanded and holistic focus on issues affecting adolescents and extends the reach of adolescent friendly health services.
- The Health Sector Strategic Plan (HSSP) 2015 – 2020, and the One Plan II which both recognize adolescents and call out the need to address adolescent health.

3.6. Participation of adolescents and young people in policy development

Though the policy making processes are not open enough to youth CSOs engagement and that the policymakers do not accept CSOs evidence as credible, there are some official ways by which young people and their CSOs influence policy-making and legislation in Tanzania. These include public opinion polls, technical working groups, NGOs platforms, oral and written reports; focus groups discussions, etc. However, these ways are mostly practiced in cities and urban areas rather than in rural areas. They are also selective leaving behind other groups of young people.

In conclusion, Tanzania has committed itself to advance young people’s human rights by ratifying the main international human rights instruments and regional agreements that guarantees those rights, and by developing a progressive national policy framework, but the political will to effectively implement the existing laws and policies remain very limited. Also the institutional checks and balance are too weak to change things.

4. STEP 2: THE GOVERNMENT CAPACITY FOR IMPLEMENTING THE NYDP 2007.

This chapter looks at the financial and human resources which are available for the implementation of the national Youth development policy in relation to the establishment of youth friendly health services and the coordination of the provision of reproductive health education to the youth. It will therefore analyse the factors that expand or reduce the capacity of the government to implement the policy statement on youth health instead of focusing on broad youth development issues. It will also look at the influence of donors and other international relations in implementing the policy.

4.1. Financial resources available

According to Unicef, over the last three years, the share of public spending on health in relation to total public spending and the GDP has been declining. The sector budget therefore remains significantly below the Abuja Declaration target that all member governments allocate at least 15% of their national budgets to health. The health sector was allocated TSh 2.21 trillion in FY 2019/20, which amounts to a 0.4 per cent decline in nominal terms, when compared to TSh 2.22 trillion allocated in FY 2017/18. The allocation accounts for 6.7 per cent of the total national budget and 1.5 per cent of Gross Domestic Product (GDP), down from 7 per cent, and 1.8 per cent respectively over the same period. Budget execution rates are much lower for health than for the education sector, as well as the national budget. The overall health sector budget execution rate varied between 54.5 per cent and 71.6 per cent in FY 2017/18 and 2018/19 respectively. Overall spending for health stood at 7% of the total budget for FY 2017/18, but has since declined to 6.7% per cent in FY 2019/20. The relative share of the health sector has declined from 10% to 9.3% in the total budget excluding Consolidated Fund Services (CFS) during the same period.

International health targets suggest that total health spending should be 15% of total government expenditure as defined by the Abuja Declaration. The government of Tanzania currently falls short of the target by a wide margin. The health budget as a share of GDP has declined from 1.8% to 1.5% between FY 2017/18 and 2019/20.³⁶ In comparison to neighboring countries, Tanzania's health expenditure per capita is low, standing at US\$ 36.8 compared with US\$ 88.4 in Kenya and US\$ 58.3 in Rwanda. Tanzania's health expenditure as a share of GDP was lower than that of Kenya, Rwanda and Uganda.

Looking at the budget by economic classifications, the Unicef budget brief states that for FY 2017/18 the recurrent budget stood at 57.8 per cent and the development budget at 42.2 per cent, compared to 59.2 and 40.8 per cent respectively for FY 2019/20. The trend in health budget decrease from 2013 to 2020 might be interpreted as weak capacity for implementing the policy, but the recent reform that made Tanzania to rely on its own in financing its health budget show its capacity to cater of the health sector budget. However, looking at the health budget by programs, the largest share of the MoHCDGEC budget goes to salaries at 33.5%, which is followed by institutional capacity building at 31.8%. Curative services were allocated 7.1% of the budget, while prevention and control of communicable diseases was allocated 3.7 per cent for FY 2019/20. Also, although the RMNCAH is clearly earmarked in the health budget structure, the SRHR of adolescents is not given due attention as it is in many other sectors. Most of the program spending goes to maternal health.

4.2. Functioning of public health and health-care facilities, goods, services and programmes

Studies indicate that between 2015 and 2019 there has been improvement in physical status of primary health facilities as a result constructions, upgrading and equipping the facilities to offer youth friendly sexual and reproductive health services and related diagnostic services. Despite the achievements, still there is a high demand for good physical statuses and functioning of primary health facilities with capacity to offer essential and respectful SRH services to young people in the country also as an important strategy towards achieving UHC.

4.3 Human resources available

Tanzania, like many other countries, is struggling with the retention of the skilled health workforce in its primary health care facilities, especially in rural areas³⁶. Estimates show that by 2015, Tanzania had less than half the required health workforce with a rural-urban divide favoring urban areas³⁷. The shortage of health workers in rural areas jeopardizes accessibility of health care services to rural communities thus contributing to poor health indicators in the country³⁸. One of the major efforts in addressing health workforce retention challenges is the 1990s health sector reforms. The health sector reforms aimed at, among other things, increasing health workforce availability through training, absorption and retention.^{39 - 40}. It's only in August 2020, that the Nursing and Midwifery Services Department (NMSD) of MoHC-DEC approved the inclusion of adolescent and youth sexual and reproductive health (AYSRH) content in the midwifery curriculum for all diploma programs by 2022. At the same time, the pace of training youth-friendly service providers in Tanzania has been slow. Only 57% of the 2,400 providers that were scheduled to receive the current youth-friendly services training in 2019 received training.

While there have been significant achievements for training, absorption and retention have remained low due to budget limitations⁴¹. In 2019, an estimated 63% of health facilities were providing youth-friendly services⁴²; however, only 30% of health service delivery points met national standards for AYSRH.⁴³ This shortage doesn't spare the adolescents SRH sector as well. The WHO regional office's assessment of barriers to accessing health services for disadvantaged adolescents found low availability of skilled human resources to be an overarching barrier to adolescent health services. The findings revealed that health workers are not adequately equipped to deliver quality services to adolescents and face heavy workloads and competing priorities. It was also found that commodities for adolescent SRH services are not always available at health facilities, including free contraceptives and antiretroviral (ARV) drugs. As a result, adolescents are sometimes required to purchase family planning products from private pharmacies and may find they cannot afford them. Long distances to health facilities are also a barrier to services, especially among those in rural areas who report incurring transport costs to reach facilities. Furthermore, when adolescents reach the health facilities they often face long queues before they are attended.

4.4. Cultural, religious, social, environmental and other factors that limit or expand the implementation of the policy.

Any discussion related to the implementation of youth sexual and reproductive rights or comprehensive sexuality education in the country quickly turns into a controversy over cultural (traditional) and religious values. Cultural values related to young people sexuality continue to be a stumbling block to practices that encourage contraception for young people, sexual rights and termination of pregnancy. Unfortunately, more traditionalist policy and decision makers express their concerns on CSE program and access to safe abortion for young people on the ground that they are against African morals, values and practices. In a country that claims to have a secular government but whose leaders individually abide to a great extent to their denominations, religious values and morals are the greatest block to the effective implementation of some of the youth SRHR related policies. Most eminent religious leaders support abstinence only as an approach to curb unwanted pregnancy, HIV and STIs, and they stand against safe abortion. This sparks in Tanzania a narrative around SRH that uses a narrowed lens of maternal health and family planning, which indirectly exclude adolescents and

young people who are not mothers and have not planned yet to have a family.

In Conclusion, The Government of Tanzania has made a clear and decisive commitment to improving the health status of young people, as it can be derived from the various policies and programs. Important issues that affect the wellbeing of young people in Tanzania are recognized and addressed in the health sector-specific programs. Although it was not clear about how does the youth-related SRH components benefits from general health budget, it's at least clear that these young people health sector programs benefits from a strong support of several bilateral and international partners in terms of technical support and funding. However, there are more serious problems than the budget dependency on external funding. On the one hand, budget allocation in the health sector is below the Abuja declaration to which Tanzania is signatory. Besides, the largest share of the MoHCDGEC budget (65%) goes to expenditures that may not directly benefit young people (salaries and infrastructures). There is an alarming shortage of health care and educational personnel who can provide comprehensive youth friendly SRH services and information respectively, and the country suffers from great disparities among the regions, urban areas being much better than rural areas. But most importantly, even where legal frameworks are supportive for youth empowerment, discrimination still exists in the values and attitudes of adults against young people especially young women, girls and youth in special circumstances. Young people are viewed as a problem and unable to take care of themselves rather than an active population capable to participate in the shaping of their lives and communities.

5. STEP 3. THE IMPACT OF THE NYDP 2007 ON ADOLESCENTS' HEALTH.

The lack of access to sexuality and reproductive health information services has a grave impact on the lives of adolescents. Due to their age and associated physical development, adolescents have a higher risk of pregnancy-related mortality and morbidity.

Despite the good intention of the NYDP 2007 of promoting youth friendly health services and coordinating the provision of reproductive health education to the youth, the deliberate omission of adolescents (youth below 15 years old) and the lack of specific measures to ensures that youth friendly health services and reproductive health education are accessed by young people affect both the right to health and the right education of young people in Tanzania. This section provides a brief analysis of what actually happens and whether the effects of the policy result in violation of young people's health right and other fundamental human rights.

5.1. Effects of policy on timely and appropriate health care and information

Although the national youth development policy aimed at promoting youth friendly health services and coordinate efforts around the provision of reproductive health education, a number of barriers faced by adolescents and young people affect the timely and appropriate health care in Tanzania. The limited number of health care providers skilled on youth friendly health services determine the limited number of health facilities that can provide timely and appropriate youth-friendly health care to adolescents and young people.

Younger adolescents (aged below 15 years) are disadvantaged as health providers often become prescriptive of the type of services that young people need. Evidence suggests younger adolescents who are sexually active are denied family planning services. Most health care workers have negative attitudes towards female students in uniform, especially when they seek family planning services. In addition, parents do not provide adequate support to younger girls who may want or need reproductive health services. In-school adolescents also face challenges in accessing reproductive health clinics, which only provide services on weekdays and so conflict with school hours. Adolescent boys are under-served due to a relative lack of tailored SRH services in comparison to girls, who are more able to access such services through reproductive and child health clinics.

5.2. Effects of the social determinants of health on the policy

Factors such as lack of SRH information, absence of skills for YFS, lack of equipment for provision of YFS, unfavorable cultural practices, gender disparities, poor enforcement of by-laws create barriers to access to SRH services for adolescents and youth in Tanzania. Also cultural and traditional norms and attitudes of parents and providers toward SRH of adolescents negatively influence their access to SRH services and information.

Furthermore, adolescents in rural settings and living in poverty are of particular concern, where limited social, educational, and health services contribute to make them victims of unwanted pregnancies, unsafe abortion, and sexually transmitted infections including HIV.

5.3. Participation of young people in policy formation

Participation is a key issue that has recently been brought up in the policy arena of Tanzania by political opposition parties and civil society organizations in the wake of human rights activism and advocacy. These movements have been at the basis of popular demands for review of several policies including the national Constitution, and more specifically laws and policies related to gender such as the Law of Marriage Act of 1971, the HIV and AIDS Act of 2007, etc.

However, people's participation in policy formation in Tanzania has been generally weak over the past years five years, worse than how it was previously. With the political shift observed under the Magufuli administration narrowing civic spaces, the formal process of policy development has remained closed to public debate, leaving it to the privilege of only a few elects (parliamentarians, selected academicians and NGO experts) and ministerial elites. Young people are viewed as a problem and unable to take care of themselves rather than an active population capable to participate in the shaping of their lives and communities. There is a need to promote their rights as human beings and eliminate all forms of bias.

5.4. Effects of the policy on Availability, Accessibility, Acceptability and Quality (AAAQ) of relevant services goods and facilities

Availability

There is a number of issues that limit the availability of relevant AYSRH services and information. These include, but not limited to:

- Inadequate number of skilled health care workers
- Stock out of commodities and supplies
- Unavailability of adolescent friendly services and life-skills education programmes
- Lack of adolescent/youth SRH clubs

Accessibility

Key factors that obstruct the accessibility of young people to SRH in Tanzania include, but not limited to:

- Cost of services or products
- Long distance to a health facility
- Need for consent/permission from parents
- Lack of information on where to get family planning services
- Health service operational hours which conflict with school days/hours

Acceptability

The key issues affecting the acceptability of AYSRH in Tanzania include:

- Stigma around use of condoms, family planning and abortion
- Stigma and discrimination from parents and elders/community
- Lack of privacy and confidentiality
- Unwillingness of distributors to provide condoms to adolescents
- Some adolescents disapprove of condom promotion and distribution
- Gender disparity
- Cultural and religious barriers
- Community perceptions that family planning is inappropriate for girls aged 10–18 years
- Myths and misconceptions around condoms and family planning
- Lack of support by the community, including parents and caregivers
- Inability to negotiate condom use with partners

Quality

Negative attitudes of health care providers, the limited number of healthcare providers skilled on youth friendly services, the discriminatory nature of the policy and the requirement of parent consent do not favor the availability, accessibility, acceptability of SRH services and information for adolescents and young people in Tanzania. Such a context, it's obvious that the quality of AYSRH services is also poor. Adolescents and young people are able to obtain SRH information and advice relevant to their needs, circumstances and stage of development. The existing services are poorly preventive, promotional, rehabilitative and curative and not appropriate to adolescents and youth needs. The right to sexual and reproductive health information and services are denied by most service providers and teachers. There is inadequate knowledge, skills and positive attitudes to provide sexual and reproductive health services to adolescents effectively and in a friendly manner; and the mechanism to enhance community and parental support are oriented on abstinence only approach.

5.5. Discriminatory effects of the policy.

The national youth development policy focus only on youth aged 15 to 35 years old, leaving behind those below 15 years old. This fuel the perception that adolescents do not SRH services and information, and shall be kicked off whenever they attempt to access them. The current policy is also discriminatory as it favors urban, more educated and economically empowered women to take advantage of existing loopholes in the policy to seek and obtain SRH services and information. The most discriminated and affected are rural, illiterate, disabled and sexual minorities groups.

Although the Medical Association of Tanzania has issued guiding principles on medical ethics and human rights which prohibit discrimination towards patients, the provision of medical care to disadvantaged groups, such as adolescents whenever it is appropriate is still challenging in the country. The implementation of the youth development policy and other relevant programs related to AYSRHR affect negatively adolescents, especially girls and young women in multiple ways. Although the impact of the national development policy can affect all young people, the marginalized groups such as young people with disabilities, sexual minorities, young people living with HIV/AIDS and rural and poor young people are more discriminated in accessing SRH services and information.

6. STEP 4: THE GOVERNMENT ACCOUNTABILITY

By ratifying international and regional agreements that uphold human rights including the right to access SRH services and information; and by developing different national laws and policies, Tanzania has committed to respect, protect and fulfill the rights of ALL Tanzanians, including adolescents and young people to access standards health care, including sexual and reproductive health. It's in such a logic that Tanzania has developed the Youth Development policy in 2007. However, although promoting the establishment of youth friendly health services at all levels of health care system and coordinating reproductive health education in Tanzania was one of the objectives of the national youth development, its implementation and accountability framework is far from fulfilling youth SRHR. The National Youth Development policy 2007 is outdated and doesn't respond to the current challenges faced by adolescents and young people in Tanzania.

The lack of the interpretation and implementation framework sustain bias among health services providers which leads to discrimination of adolescents and young people denying them the fundamental health services and information they are entitled to. The same bias leads to the violation of adolescents' right to privacy and confidentiality, and push them away from seeking sexual and reproductive health care. As a reproductive health advocate explained: "Sometimes health care providers tell adolescents that they are too young and ask what they are doing here. 'Go to school, after school you can come back.'... Sometimes the right to privacy of the youth is disrespected, because they may get services at the health facility but then the provider discusses the issue with the parents, without their consent, causing the youth not go to facilities anymore." In addition to being a violation of their right to privacy and confidentiality, requiring adolescents to obtain parental consent for accessing contraceptives is a great impediment, given the stigma attached to adolescents' sexuality. As several participants interviewed for this research clearly pointed out, "... due to cultural beliefs and traditions, sexuality is a taboo subject and parents do not discuss these issues with their children openly". The stigma associated with adolescents' sexuality goes beyond parents and providers and is also widespread in the government and communities. The statement of a high-ranking government official involved in developing and implementing policies, including that of health policies for youth, is a clear illustration of this: When asked whether adolescents can go to public facilities to obtain contraceptives, the official responded: "Yes, from 18 years onwards. For us, it is post high school [that young people should engage in sex]. That is traditional to us, under 18 they are not supposed to engage in intercourse."

An outdated policy and its lack of implementation and accountability frameworks; the denial of youth friendly services, and the discrimination against adolescents and some groups of marginalized young people are all in violation of the right to access the highest attainable standard of health, including reproductive health, the right to live free from discrimination, the right to information and education, and the right to equality and human dignity.

These are the violation of fundamental human rights for which the GoT, through the MoHCDGE, the Ministry of Regional Administration and Local Government, and the Ministry of Labor, Youth, Employment and Disabled, shall account for.

7. STEP 5: RECOMMENDATIONS AND STRATEGIES

The importance of youth has been acknowledged in the NYD policy 2007, yet the health of this population group, especially adolescents has not been given the special attention that it deserves. While the government of Tanzania recognizes that when it comes to sexual and reproductive health services, it is crucial to offer youth-friendly services that 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." Despite this, youth-friendly services, particularly in rural areas, continue to remain very limited.

Since adolescents are particularly vulnerable to negative reproductive health outcomes, the government has failed to provide comprehensive sexuality education in order to facilitate informed decision and access to youth-centered reproductive health services. The lack of health care professionals trained in providing youth-friendly services, which results in a personal bias against adolescents accessing reproductive health services, including contraceptives, is an additional challenge.

Although the major ADHD barriers have been addressed in the NYD policy 2007 and in other policy and legislative frameworks, very little information exists on how well these policies and legislations are being implemented, and any impact from ongoing execution.

7.1. Recommendations

Based on what precedes, we recommend the government of Tanzania, through the MoHCDGE, the Ministry of Regional Administration and Local Government, and the Ministry of Labor, Youth, Employment and Disabled to:

- Update the NYD policy document to fully recognize adolescents as a unique demographic segment, and to have a comprehensive implementation and accountability framework to fulfill youth SRHR. Given the unique needs of adolescents, their size (about a third of Tanzania's total population) and their importance to the future of Tanzania, it is important that they are called out as a distinct demographic segment in policy and legislative programming, and not bundled into a broader category of youths or children. Particularly, the landmark policy and other legislative pieces like the National Health Plan, Public Health Act, and the Law of the Child Act should elevate adolescents and factor their SRH needs into the design of these documents to produce output that better caters to ADHD.
- Increase budgetary allocation to the health sector, including dedicated resources for ADHD. Double budgetary allocation from present-day average of 7% to the Abuja declaration target of 15% to provide more funding for national health priorities, including ADHD, and reduce reliance on development assistance. Consider other innovative financing approaches and include a line item in the local and national budgets to dedicate some financial resources to ADHD implementation
- Strengthen the implementation and budget allocation towards National Multi-sectoral Strategic Framework for HIV/AIDS 2017-2023, National Adolescent Health and Development Strategy 2018-2022, NYDP 2007 and the Tanzania Health Sector Strategic Plan III.
- Increase the number of health care providers skilled on youth friendly and disability inclusive services
Train an important number of health care providers on youth friendly and disability inclusive services to curb the shortage in human resources at different levels of the national health care system.
- Disseminate of existing guidelines, strategies and curriculum on adolescents SRHR
Take deliberate decision to widely disseminate existing youth and adolescents related guidelines, strategies such as the National Adolescent Health and Development 2018 -2022, the National Accelerated Action and Investment Agenda for Adolescent Health and Wellbeing (NAIA-AHW), ... to ensure they are well by implementers and right holders.

- Promote the meaningful participation of youth and adolescents in the creation of policies related to them. Youth community mobilization and participation in development of policies related to them will help to tailor the policy implementation strategies to the needs of adolescents rather than making the policies for them.

7.2. Key strategies to influence changes

To achieve the proposed changes, following strategies are suggested:

- Develop and disseminate the policy brief/factsheet on the findings of the policy analysis in simple language among key stakeholders
- Conduct consultations and advocacy meetings with key Ministries (MoHCDGEC, MoLYED, PO-RALG) at both local and national levels to influence the development of Adolescents SRHR policy, the meaningful engagement of adolescents in policy development and decision making
- Conduct advocacy meetings with key ministries to influence the increase of budget in their ministries and have specific allocation of youth and adolescents' health
- Collaborate with government to train health care providers on youth friendly services and information.
- Engage media to deliver key messages to create public awareness on the gaps in the NYD policy 2007 and the necessity of developing a standalone Adolescents SRHR policy
- Development of an adaptable change tracking tool in a simple format and language to monitor change of attitudes among adolescents, parents, healthcare providers....
- Raise public awareness on AYSRHR and promote adolescents leadership on SRHR.



DISCUSSION AND RECOMMENDATIONS

1. Discussion

While the regional policy framework is progressive and that countries involved in this assessment has taken some bold steps in advancing SRHR of adolescents and young people by developing policies, the implementation of the late still need specific attention.

This Assessment shows examples of how weak implementation of a few policies intended to advance SRHR of adolescents and young people in the 3 countries of the ESA region results in the violation of the rights to health and many other fundamental human rights of adolescents and young people at country level. In Kenya for example, the inadequate implementation the NASRH policy 2015 is in grave violation of the adolescent's right to health, the right to education and information, the right to privacy and human dignity, and the right to equality and freedom from discrimination. In Malawi, the deliberate silence of the National Education policy 2016 on the provision of contraception and associated SRHR services limits school-going adolescents' access to SRH services such as contraceptives as proposed and guided by the MNSRHR policy is discriminatory against them and in violation of the right to non-discrimination and many other rights of adolescents, including the right to health, the right to education and information, for which the government of Malawi shall be held accountable for.

In Tanzania, the outdated National Youth Development policy 2007 lacking also an implementation and accountability framework is one of the many other causes behind the denial of youth friendly services and the discrimination against adolescents and some groups of marginalized young people. This is in violation of the right to access the highest attainable standard of health, including reproductive health, the right to live free from discrimination, the right to information and education, and the right to equality and human dignity for adolescents and young people.

2. Recommendations

From what precede, the 3 countries involved in this assessment have a pressing need to revise, review and harmonize their policies, especially in light of SDGs and the ICPD+25 commitments; while considering to renew their engagement in the ESA recommitment process. Based on the policy gaps identified in each country policy impact analysis, the following general evidence and rights-based recommendations were formulated to the governments of the 3 countries, through their relevant ministries:

- To urgently review, update and harmonize all contradicting and retrogressive laws and policies hindering access to sexual and reproductive health and rights of adolescents and young people. "Specifically, we call up the ministries of Health and Education in Malawi to review and harmonize the National Education Policy with the SRHR policy & the youth friendly health services strategy for

equitable and accessible sexual and reproductive health services and information for school going adolescents;We call upon the government of the United Republic of Tanzania through the ministry - of health to urgently develop a stand-alone adolescents' sexual and reproductive health policy"....

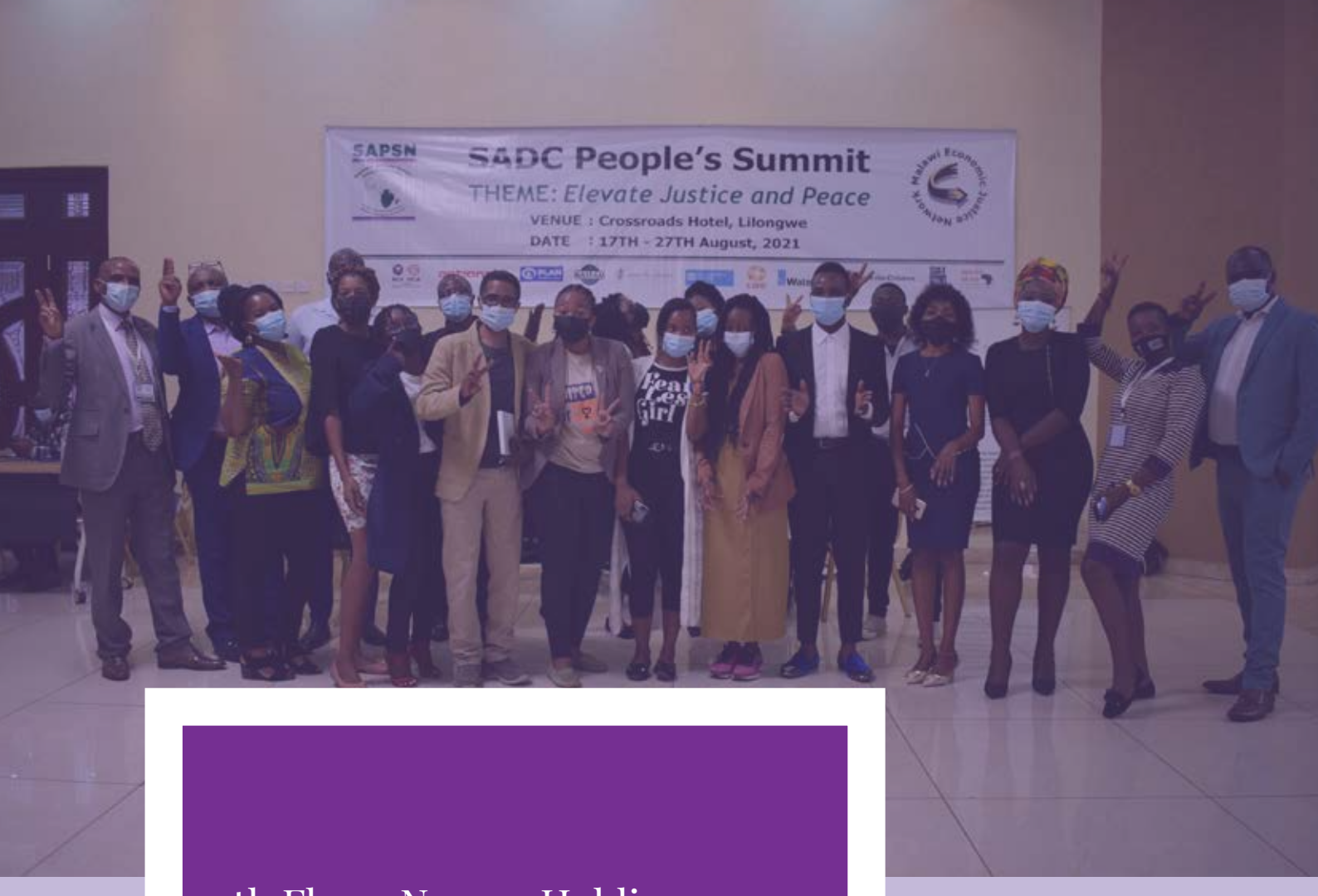
- To allocate 15% of the national budgets to health in line with the Abuja Declaration and commit to a target of spending 5% of their GDP translating to 112USD per capita on health as their commitment to realize Universal Health Coverage. In particular, the United Republic of Tanzania should provide more funding for national health priorities, including ADHD, and reduce reliance on development assistance.
- To prioritize adolescents sexual and reproductive health and rights information and services within essential services package in the emergency response plans i.e Covid-19, floods, Ebola e.t.c.
- The United Republic of Tanzania to strengthen the implementation and budget allocation towards National Multi-sectoral Strategic Framework for HIV/AIDS 2017-2023, National Adolescent Health and Development Strategy 2018-2022, National Youth Development Policy 2007 and the Tanzania Health

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