

Youth Policy Toolkit

Welcome to the Youth Policy Toolkit, an online resource for improving youth reproductive health (YRH) and HIV/AIDS policy worldwide.

This site contains full-text policies addressing YRH from countries across the world. The Toolkit also contains policy making resources, including case studies, expert interviews, key publications and tools, and helpful links. Use the navigation menu on the right to view tools and resources related to key policy areas.

Are You??	You can use the Youth Policy Toolkit to?
An advocate for YRH	Learn about and evaluate existing policies Generate and share ideas for advocating policy change Network with other advocates worldwide
A young person	See what services should be available to you
A policymaker	Update or establish new YRH policies
A donor	Learn about key issues in YRH policy development
A program manager	Check quickly on YRH policies in your country

Defining Youth

The UN system defines young people as persons in the 10-24-year age group. This grouping includes both adolescents, ages 10-19, and youth, ages 15-24. Rather than adhere to a strict definition of the age range, the Youth Policy Toolkit uses the terms young people, youth, and adolescents interchangeably to refer to the 10-24 age group. This broader use of the terms

underscores the need for policies and programs to focus less on age and more on recognizing the specific developmental needs of people as they transition from childhood to adulthood.

If you wish to suggest a resource for inclusion in the Youth Policy Toolkit or to share your experience working to develop or improve youth policy, please fill out our feedback form.

What are K4Health Toolkits?

K4Health Toolkits are electronic collections of carefully selected information resources on a particular topic for health policy makers, program managers, and service providers. They are based on a continuous publishing principle that allows them to evolve after publication to capture additional resources and to identify and fill remaining information gaps.

Purpose and Audiences of This Toolkit?

This Toolkit contains resources intended to help advocates, young people, policymakers, donors, program managers and other audiences develop and strengthen youth reproductive health (YRH) and related policy worldwide.

Types of Resources in This Toolkit

- Full-text policies addressing YRH from countries across the globe.
- Fact sheets on specific YRH topics
- Guiding principals, definitions, dimensions, and key elements of YRH policy
- Case studies on YRH policymaking experiences from around the world
- Key papers, reports, and articles on YRH and policy
- Links to organizations working on YRH globally
- Advocacy and policymaking tools

How to Use This Toolkit

To browse the content of this Toolkit, use the navigation menu on the right to view resources related to key program topics or particular countries and regions. You can also use the Toolkit search bar.

Resources in this Toolkit can be downloaded and adapted for teaching and training, research, advocacy, policymaking, and program management purposes. Some of the tools are readily available in adaptable format (for example, Microsoft PowerPoint presentations or Word documents). We encourage you to alter and personalize these tools for your own use. (Please remember to credit the source.) If you do use these tools or adapt them, we would love to hear from you via our feedback form.

How can I suggest a resource to include in this Toolkit?

We invite you to contribute to the evolution and enhancement of this Toolkit. If you have developed or use quality resources that you think should be included in the Toolkit, please use the feedback form to suggest them. The Toolkit collaborators will review and consider your suggestions.

How can I make a comment or give feedback about this Toolkit?

If you have comments about the Toolkit, please use the feedback form. Your feedback will help to ensure the Toolkit remains up-to-date and is continually improved. For example, you can share ideas about how you have used the Toolkit in your work so that others can learn from and adapt your experiences.

Publishers of Resources Included in This Toolkit

Resources selected for inclusion in this toolkit were published by a diverse range of organizations working throughout the world to promote evidence-based best practices and improve the delivery of health services. Publishers include national governments, multilateral organizations, nongovernmental organizations, and more.



Advocacy



Advocacy is necessary to ensure that youth reproductive health (YRH)

policy and programs are enacted, funded, implemented, and evaluated well. Advocacy can encompass attempts to influence the political climate, public perceptions, decision-making, and funding allocations in order to improve YRH. A comprehensive advocacy campaign should strive to influence political support for YRH by educating policymakers, which might include national, state or local legislators; county or city council members; school board members; or other

decision makers. Advocacy campaigns might also aim to influence public opinion, since public desires affect political decisions.

This section of the Youth Policy Toolkit contains a selection of advocacy kits, manuals, and other tools, as well as a number of documents that outline the reproductive rights of young people and provide guidance on how to ensure these rights are upheld.

Visit the **Family Planning Advocacy Toolkit** for state-of-the-art information, tools, and evidence for family planning advocacy.

If you wish to suggest an advocacy resource for inclusion in the Youth Policy Toolkit or to share your experience advocating for YRH, please visit our feedback form.

Resources:

- **Advocacy Toolkit: Children and Adolescents Living with and at Risk for HIV**

This tool kit provides statistics, messages, and key actions that first ladies can undertake to advocate for continued uptake of prevention of mother-to-child transmission (PMTCT) of HIV services, increased early infant diagnosis (EID) of HIV, and improved pediatric HIV treatment coverage. It will also help first ladies address the unique issues faced by adolescents both growing up with and at risk for HIV. This tool kit complements the recently launched African Union? Organisation of African First Ladies Against HIV/ AIDS Elimination of Mother-to-Child Transmission of HIV (AU-OAFLA EMTCT) campaign by providing supplemental background information on technical areas and advocacy strategies that can then be tailored for individual use. Finally, the tool kit facilitates the achievement of the goals in OAFLA?s strategic plan of 2014?2018 and beyond.

- **Advocating for Change for Adolescents! A Practical Toolkit for Young People to Advocate for Improved Adolescent Health and Well-being**

Developed by young people, for young people, the toolkit is a practical guide for in-country youth networks to design, implement, and monitor an effective national advocacy action roadmap on adolescent health and wellbeing.

- **RHSC Youth Caucus Key Messages on Young People's RH Supplies Access**

The following key messages can be used to advocate for political and financial support at national and international level for young people to acquire accurate information around sexual and (SRHR) and rights supporting them to access modern contraceptive methods of their choice.

- **Adolescents (Information Series on Sexual and Reproductive Health and Rights)**

The purpose of the information series is to provide detailed guidance for lawmakers, policymakers, judiciaries, health service providers, civil society and other stakeholders, to support the adoption and effective implementation of laws, policies and programmes to respect, protect and fulfil women's sexual and reproductive health and rights (SRHR).

- **Health for the World's Adolescents**

"Health for the world's adolescents" is a dynamic, multimedia, online report. It describes why adolescents need specific attention, distinct from children and adults. It presents a global overview of adolescents' health and health-related behaviours, including the latest data and trends, and discusses the determinants that influence their health and behaviours. It also features adolescents' own perspectives on their health needs.

- **Invest in Adolescents and Young People--It Pays**

The 2013 Women Deliver conference made a strong call for investing in the health and development of adolescents and young people. It highlighted the unique problems faced by adolescent girls and young women—some of the most vulnerable and neglected individuals in the world—and stressed the importance of addressing their needs and rights, not only for their individual benefit, but also to achieve global goals such as reducing maternal mortality and HIV infection. In response to an invitation from the editors of Reproductive Health, the sixteen coauthors of this commentary compiled key themes that reverberated throughout the conference, on the health and development needs of adolescents and young people, and promising solutions to meet them.

- **Young People Today. Time to Act Now. Why adolescents and young people need comprehensive sexuality**

education and sexual and reproductive health services in Eastern and Southern Africa

This report provides a regional assessment of the status of HIV and sexuality education and sexual and reproductive health (SRH) services for adolescents and young people, as well as an evidence base for discussion related to policy change and programming. The report also presents an analysis of the responses under three thematic headings, sexuality education; sexual and reproductive health services; and gender, rights and contextual issues. Ten key recommendations offer guidance on how to move forward, which was the starting point for this campaign.

- ## **Using data to see and select the most vulnerable adolescent girls**

We need to invest in girls to build their key protective assets. But in order to make these investments, we must see these girls. Current youth policies and the data that accompany them block our view of these girls and treat young people as a homogenous group. But the skills and experiences of young people, even in the same community, can vary considerably. By not recognizing how adolescent capacities and opportunities vary by subgroup, these policies have often failed to direct resources to vulnerable and hard-to-reach adolescents. Making adolescent girls visible is essential so that investments can be targeted toward those at the highest risk of the poorest outcomes. This premise underpins this brief, which seeks to find and target vulnerable adolescent girls and shape policy context. It provides guidance on resources and tools that can reveal the internal diversity of adolescents, identify the onset and extensiveness of vulnerability, demonstrate where there are high concentrations of vulnerable girls, assess girls' share of youth resources, and identify communities and vulnerable girls for program participation. The brief concludes with field applications for making dynamic use of data.

- ## **Preventing Early Pregnancy and Poor Reproductive Health Outcomes: A Toolkit**

Nearly 16 million girls between 15 and 19 years old give birth annually, almost all of them in developing countries. After a systematic review of the evidence, WHO developed the guidelines Preventing Early Pregnancy and Poor Reproductive Outcomes among Adolescents in Developing Countries, which focus on key actions that aim to reduce the number of adolescent pregnancies in developing countries. In 2012, in collaboration with WHO and UNFPA, FCI developed this advocacy toolkit, available in English, French, and

Spanish, to promote the dissemination of the guidelines? recommendations to policymakers and program planners globally. Designed for advocates, the toolkit encourages and enables evidence-based action among decision makers, opinion leaders, medical personnel, researchers, and affected communities to prevent early pregnancy and poor reproductive outcomes among adolescent girls.

- **The Time Is Now: Invest in Sexual and Reproductive Health for Young People**

The ENGAGE presentation "The Time is Now: Invest in Sexual and Reproductive Health for Young People," delivers compelling, evidence-based messages about how sexual and reproductive health investments protect the health and well-being of young people and, at the same time, advance social and economic development. Using data and graphics to illustrate how these investments maximize young people's potential for healthy and productive lives and increase returns on investments in education and economic development, the presentation seeks to prioritize sexual and reproductive health for young people on policy agendas in sub-Saharan Africa.

- **Addressing the Risk and Protective Factors in Young People's Lives**

Young people bear significant burdens of poor sexual and reproductive health outcomes, including early marriage and childbearing, unmet need for family planning, maternal disability and death, and higher HIV prevalence. However, investments in young people's sexual and reproductive health can empower them to stay healthy and take advantage of education and employment opportunities throughout their lives. This PRB ENGAGE Snapshot explores the importance of reducing risk and strengthening protective factors in young people's lives to improve their health and well-being.

This short video can be viewed online or downloaded for future use. The video can be embedded into PowerPoint and other presentations, as well as used independently as an educational tool.

- **Want to Change the World? Here's how...Young people as advocates: Your action for change toolkit**

This toolkit is for young activists, volunteers, students and agents of change! It offers a step-by-step guide to help plan, implement or improve advocacy initiatives on young people's sexual and reproductive health and rights. This toolkit complements existing advocacy guides

and provides an IPPF perspective on youth-led advocacy. It can be used by young advocates, programme designers, coordinators and others who work with young people, and will be helpful to build the capacity of young advocates to promote sexual and reproductive health and rights.

- **Advocacy Kit for Adolescent Reproductive and Sexual Health**

This Advocacy Kit contains information on the basic components of an advocacy campaign. Specific sections address working in groups to achieve your goals, promoting your goals to the public, and influencing the legislative process in your favor. It also includes a list of organizations concerned with adolescent reproductive and sexual health, sample press materials, information for addressing criticism and opposition, a sample needs assessment and other materials about specific adolescent health issues.

The Policy Process



Youth reproductive health (YRH) policy consists of expressions or

statements that address the reproductive health needs or problems of young people. The reports and policy briefs in this section of the Toolkit provide key information on the pressing needs of young people in low- and middle-income countries.

Decision makers should ensure their YRH policies adhere to the following guiding principles:

Acknowledge gender differences. Policies should recognize that boys and girls may have different reproductive health needs and thus require different program strategies. At the same time, it is important for policies to recognize that differential treatment for boys and girls can be a barrier to YRH care.

Acknowledge the needs of marginalized sub-populations. Policy should pay particular attention to marginalized groups such as young refugees, street children, and sex workers. Youth in these situations are among the most vulnerable of all young people to risk taking and sexual coercion and abuse.

Be consistent. Laws and policies affecting YRH should be consistent across sectors and from one document to the next. Currently, too many countries have a scattershot approach to YRH policy, with the result that policies lack consistency and often contradict each other. Age of consent is one reflection of this contradiction, with many countries having different age of consent for marriage, consensual sex, HIV counseling and testing, and employment.

Promote access to information and care. Young people, especially those who are sexually active, need access to a variety of reproductive health and HIV services. Researchers have found that youth-friendly services generally share the following traits:

- Providers are trained to communicate with youth in a respectful and nonjudgmental manner.
- The facility has policies of confidentiality and privacy for youth.
- The facility has convenient hours and location for young people, as well as a nonthreatening environment.
- The fees are affordable.
- Youth participate in developing policies and implementing services through an advisory board, as peer educators, and in other roles.

Promote youth involvement. Policy should acknowledge the importance of meaningful involvement of youth at all stages of policy and program design, implementation, and evaluation. Still, the YRH field is grappling with cost-effective approaches to involving youth, and there are legitimate questions about the value of such efforts.

Reinforce the interconnectedness of YRH. Policy should make clear the connection among the various key elements of YRH. Young people's vulnerability to risky sex and other unhealthy behaviors is tied to a host of individual, family, and community factors that influence young people and are closely related to economic and educational opportunities. Reinforce the connection between policies that help to both prevent unwanted pregnancy and prevent HIV/STI infection.

Respect culture. Policy should acknowledge the cultural context for YRH and assign roles to parents, teachers, and other influential adults. YRH programs often face resistance because they challenge deeply held cultural beliefs about sex, parenting, and the roles that men and women play. The success of YRH programs depends largely on recognizing these underlying beliefs, understanding how they manifest themselves as barriers, and employing a range of culturally sensitive strategies to address these obstacles.

Segment the youth population by age and life stage. Policy should recognize that young people differ according to age and life stage. Sexually inexperienced 11-year-olds require a different approach from married 19-year-olds. Similarly, a married young person might have very different needs from an unmarried sexually active young person of the same age.

Treat youth as assets, not problems. Policy should recognize and promote young people as a positive force for economic and social development, not exclusively as a problem group that must be addressed.

Do you have a comment or a resource to suggest for inclusion in the Toolkit? Fill out our feedback form

Resources:

- ### Youth Family Planning Policy Scorecard

The Youth Family Planning Policy Scorecard dashboard allows users to access, interpret, and compare countries' youth family planning policies and programming. Users can assess the extent to which a country's current policy environment enables and supports youth access to and use of family planning.

This assessment uses eight indicators?listed in the dashboard below?that have been shown to be directly linked to increased youth contraceptive use. Countries are classified into one of four color-coded categories to show how well they are performing for each indicator. We invite you to explore the dashboard by clicking on an indicator or country of your choice. The dashboard will also provide you with detailed information about each country's youth family planning policies.

- ### World Population Data 2017: Focus on Youth

The world population will reach 9.8 billion in 2050, up 31 percent from an estimated 7.5 billion now, according to projections included in the *2017 World Population Data Sheet* from the Population Reference Bureau (PRB). This edition of the annual *Data Sheet*, available at www.worldpopdata.org, also shows a worldwide total fertility rate (TFR, or average lifetime births per woman) of 2.5. The three countries with the highest TFRs are Niger (7.3), Chad (6.4), and Somalia (6.4), while there is a five-way tie for the lowest TFR (1.2) among Bosnia-Herzegovina, Romania, Singapore, South Korea, and Taiwan.

- ### Technical Guidance for Prioritizing Adolescent Health

This technical guidance, developed by the UNFPA- and WHO-led Adolescent Working Group of Every Woman Every Child, aims to support countries to both advocate for increased investments in adolescent health and to guide strategic choices and decision-making for such investments to be reflected in national development policies, strategies or plans. It describes a systematic process for identifying the needs, priorities and actions for adolescents to survive, thrive and transform their societies as envisioned through the Global Strategy of Every Woman Every Child. Data sources, resources and tools for conducting a situation

assessment and prioritization exercise are also included.

- **The Sexual and Reproductive Health Needs of Very Young Adolescents Aged 10- 14 in Developing Countries: What Does the Evidence Show?**

This report draws on analyses of national survey data and literature review results to provide an overview of the evidence on key aspects of sexual and reproductive health among very young adolescents aged 10-14 living in developing regions.

- **Global Youth Family Planning Index**

PRB's new Global Youth Family Planning Index, released in October 2016, measures the favorability of national policy and program environments for youth uptake of contraception. It reviews countries' commitments across six indicators that have been proven to affect access to and use of contraception among youth ages 15 to 24. The first edition includes data and analysis for four countries: Democratic Republic of the Congo, Kenya, Nigeria, and Tanzania, with additional countries to be added in future months.

- **WHO Fact Sheets on Adolescent Contraceptive Use**

These facts sheets present information from 58 countries on adolescents' (ages 15-19) contraceptive use by marital status. In addition, key information, such as reasons for non-use of contraception, as well as where adolescents obtain their contraceptive method, is included. The Demographic Health Surveys (DHS) program www.dhsprogram.com conducts nationally representative surveys in low- and middle-income countries. We use the most recently collected data from any country where 1) a survey has been conducted in the past 10 years (2006-2016) and 2) the data are publically available. Analyses of DHS in the fact sheets are weighted according to DHS guidance to be nationally representative.

The data provided is aimed to help policymakers and programme planners reduce inequities in service provision and access by understanding adolescents' current sources of contraception, utilised methods, and reasons why they are not using contraception.

- **Adolescent Women's Need for and Use of Sexual and Reproductive Health Services in Developing Countries**

This report examines a range of sexual and reproductive health indicators for women aged 15-19. The authors then provide recommendations for policy and programmatic strategies that could significantly improve sexual and reproductive health services for adolescents in developing regions: involving youth in planning the programs and policies designed to serve their unique needs, providing them with accurate and effective services and information, and addressing the barriers that young people face when trying to gain access to sexual and reproductive health care.

- **I Know. I Want. I Dream. Girls' Insights for Building a Better World**

More than 500 girls from 14 countries were asked to share their insights and perspectives with global decision-makers. This report synthesizes girls' voices from around the world and argues that girls' insights are crucial to designing effective global development policies.

- **Including Youth in the Post-2015 Development Agenda: A Human Rights-Based Approach**

This policy brief is part of the series *Including Youth in the Post-2015 Development Agenda*. The series illuminates the connections between sexual and reproductive rights and development issues that are central to youth and should be included in the Post-2015 Development Agenda.

- **Making health services adolescent friendly: Developing national quality standards for adolescent-friendly health services**

This guidebook sets out the public health rationale for making it easier for adolescents to obtain the health services that they need, including sexual and reproductive health services, to protect and improve their health and well-being. It defines 'adolescent-friendly health services' from the perspective of quality and provides step-by-step guidance on developing quality standards for health service provision to adolescents.

Interviews

Several years ago, the Health Policy Initiative spoke with people working to craft or implement youth reproductive health policy. Our questions and the insightful answers from these practitioners shed light on the always challenging, often interesting, and sometimes frustrating policy process. The views expressed by the interviewees do not necessarily reflect those of the U.S. Agency for International Development or the U.S. Government. Click the names in the navigation menu on the right side of this page to view interview content.

Dr. John Santelli

Department Chair and Professor of Clinical Population and Family Health at Columbia University's Mailman School of Public Health, New York, NY, September 2009

Dr. John S. Santelli is the Department Chair and a Professor at Columbia University's Mailman School of Public Health. Previously, he was Chief of the Applied Sciences Branch in the Division of Reproductive Health at the U.S. Centers for Disease Control and Prevention (CDC). Dr. Santelli is a pediatrician and adolescent medicine specialist whose past research includes HIV/STD risk behaviors, programs to prevent STD/HIV infections among adolescents and women, school-based health centers, clinical preventive services, and research ethics. He has been a national leader in ensuring that adolescents are appropriately included in health research. He has written numerous articles on adolescents, including "Changing Behavioral Risk for Pregnancy Among High School Students in the United States, 1991-2007."

Youth Policy Toolkit: What interested you in youth RH? Could you please highlight some of the YRH-related projects that you have worked on? What particularly interested you about this/these project(s)?

Dr. Santelli: I became interested in adolescent reproduction in medical school. I did a summer research project in Buffalo on teen pregnancy, and following that, I was doing an adolescent medicine fellowship for pediatrics. My first job out of my training was running school-based health centers in Baltimore. It was a fabulous experience because it was a model for taking clinical care to another level in terms of turning it into a public health intervention. In essence, we took clinical care out of the hospital and into schools where adolescents were. As part of that, I worked for a health department and became involved in all sorts of youth policies, including how schools can be either health promoters or negative influences and compared how those different environments affect sexuality education or health education.

After about five years, I moved to the CDC and worked on HIV/STDs, adolescent school health, and finally reproductive health. At every stage, I received the chance to work with youth issues,

including street youth, so called "high-risk youth," youth coming into STD clinics, and youth in foster care or detention. In all those areas, I think the center of what I have been most interested in is adolescence, reproductive development, and how that [reproductive development] fits into the whole development of healthy individuals and successful adults.

Youth Policy Toolkit: How has some of the work that you have mentioned aided in developing policies for youth?

Dr. Santelli: I think that public health is intrinsically tied to health policy. I have been involved in a whole set of issues, and the most visible has been abstinence-only education. I was working at the CDC when the [second] Bush Administration began, and I saw this slow then more rapid shift in the emphasis on adolescent health programs in ways that I thought were pretty disturbing because the [policy changes] were not science-based. For four years I put up with it. There came a point, however, when I decided I needed to get out of government and moved to Columbia University. At this university, I felt I could be more public in my critiques, and I've been a major and visible opponent to abstinence-only education for the last five years. I think we've actually been enormously successful in ending this program that was poorly conceived, not science-based, and that violates people's reproductive rights. Every day in public health whether you're doing research or you're a practitioner, you're making decisions based on policy and hoping to advance policy.

Second, I've been involved in ensuring that adolescents are adequately involved in research because oftentimes adolescents are systematically excluded from research. This is because it's been very difficult at various times to ask adolescents questions about their sexual health and also drug use, but if you don't include them in research studies, then we don't know how best to design programs and policies to improve their health. I've been a big advocate through the Society of Adolescent Medicine to try to improve adolescent inclusion in research.

Third, I was trying to improve the CDC's efforts to improve teen pregnancy prevention through policies and also with HIV and STDs. In each of those areas, I've tried to take what I know as a scientist and researcher as well as this sort of "street smarts" I developed in Baltimore to see what you can implement and to see that we have programs and policies that make good sense.

Youth Policy Toolkit: In your opinion, why is it important to develop policies targeted specifically toward youth?

Dr. Santelli: Youth are different than children, and they're different than adults. "Youth" is variously defined, but it begins somewhere in the early teen years and extends into the twenties. The evolving health needs, increased developmental capacity, the ability to make good choices, the transitions from dependency on family to making your own decisions both in health and other realms all emerge during that period of time. I think you need policies that are sensitive to that.

Additionally, adolescent legal status intersects with health status so at age 18 you can make a decision in this country whether you want to be hospitalized or have surgery or see a doctor or not. At age 17, you may be developmentally similar but you lack many of the same rights, and so we have to develop a whole series of laws, including minor consent laws, that allow adolescents to make decisions about those things. Understanding what the difference is between a 12 year old, a 15 year old, and a 22 year old is intrinsic to what adolescent medicine and adolescent

public health thinks about, but not something everybody sees. A question we continually ask ourselves is, "How do you craft policies that work for most if not all adolescents at a particular stage?"

Youth Policy Toolkit: Can you give us an example of a successful policy that you have helped to develop and some real examples of how this policy has affected the lives of youth?

Dr. Santelli: Almost 20 years ago there were guidelines that we at the Society for Adolescent Medicine developed on adolescent health research. [They were] designed to provide some ethical guides to institutional review boards and adolescent researchers. To do this, we had a conference in 1994 where we brought a whole group of adolescent medicine specialists including researchers, IRB members, and chairmen to say, "These are the ambiguities in federal policy. How can we craft a better solution?" We were seeing teens that weren't being included in all sorts of studies. There would be an STD study and everybody would realize adolescents get STDs or STIs, but that they are excluded from the actual study. This conference fundamentally made the climate for doing adolescent research better.

The other area where I've been successful is spearheading the efforts against adolescent medicine and abstinence-only education. I think most people in this society thought it was a crazy idea, but most people couldn't figure out how to deal with it. Knowing what was driving it from inside government in terms of social forces, we put together a team that drafted some very strong statements that have been widely used by advocates as well as policymakers, and I think we've been successful in ending that program. We've seen many states that have rejected funding because their health departments are saying this is not science; this is not good policy. We've seen the Obama Administration zero out the funding in the 2010 budget.

Youth Policy Toolkit: What are some of the RH challenges facing youth at this moment in time? And how do these challenges affect the development of policies that could help in creating a more enabling environment for them?

Dr. Santelli: What we see globally are kids who are not able to reach their full potential because of sexual orientation, abuse, or lack of education. Every human being in their adolescence matures sexually, and it's a challenge for society to have to deal with it. In this country, for example, there are many people who do not accept individuals who have same-sex orientation or who are not traditional in their orientation. We have many people who are not accepting of adolescent sexual behavior outside of marriage. The vast majority of Americans initiate sex before marriage, but we have a vocal minority in the country that believes that that is wrong and that government policy should try to suppress that. Every society has various issues that they have to deal with.

The U.S. is somewhat unique in the sense that it has some of the worst public health indices on adolescent sexual and reproductive health in the world at least vis à vis other developed countries. We have much higher rates of teen pregnancy and STDs. It's pretty clear it reflects not only social mores in this country but also an inadequacy in public health programs to help young people. Everyone needs help in making the successful transition to adult sexuality, but I don't think we're doing such a great job of being supportive. In the last few years, we've seen higher rates of STDs and teen pregnancy. Most of that reflects a failure of public programs including sex education and access to healthcare.

Youth Policy Toolkit: In your most recent paper, "Changing Behavioral Risk for Pregnancy among High School Students in the United States, 1991-2007," you asserted that the increasing rate of teen pregnancy in the U.S. is associated with weaker HIV prevention efforts. What kinds of policies would revitalize HIV prevention efforts? How can these policies target youth?

Dr. Santelli: In the 1980s, we also had some great public policy leadership, particularly in the office of the Surgeon General Koop during the time of the HIV epidemic in the U.S. He told us we had a big issue, had to take it seriously, and this is what we can all do to prevent people, including young people, from being infected with HIV. As a result, we had widespread implementation after 1987 of HIV education and prevention programs of all sorts. Not only did he help create programs but also raised public awareness. Both of those are important. You have to have political leadership saying, "This is important," so people pay attention. I think we were very successful. Rates of condom usage rose dramatically between the 80s and 90s and into the current decade. We saw a reduction in sexual partners, and we saw a delay in sex among young people. We saw all the demographic trends that would reflect the message we were sending out. I still credit Surgeon General Koop and the public health service for accomplishing that. Surgeon General Koop's leadership was essential.

What we've seen in the last 10 years is a shift from HIV prevention to this talk about abstinence. Abstinence can be a very healthy behavior, but abstinence is a "one size fits all" solution for everybody. So to talk about condoms in abstinence-only education, you had to tell people that they didn't work. That's not likely to engender a lot of confidence. The biggest change in contraceptive use we've seen recently since 2003 is a downturn in condom use in this country as well as increases in STD rates and pregnancy. At the same time, there has been very little change in sexual activity. I think we need to talk to young people honestly and straight forwardly about the importance of condom and contraceptive use. I think young people are no longer hearing that message.

Youth Policy Toolkit: What are the greatest gaps in youth RH programming and policies?

Dr. Santelli: Again, I don't think we're taking young people seriously enough. I think we still think of them as children and not as something else. Society has to recognize that adolescents are unique and valuable human beings. We need to recognize adolescents' reproductive rights as well as their human rights. They have rights to privacy and a right to participate in the political process even if they are underage. They show an emerging capacity to make their own decisions. They need to be supported and not suppressed. We need policies like that. That's the broadest change I would like to see. I would also like to see a change in the dialogue around human rights and reproductive rights in this country.

In terms of specific policies, we need to improve access to healthcare for young people, including reproductive healthcare. Care gets worse as you enter the young adult years. Health insurance, access to care, and use of healthcare drops dramatically as you enter the mid-twenties, particularly for young men; and it's because they don't have jobs that have health insurance and we don't have systems of care that are friendly to them. Even younger teens oftentimes don't know where to go to get healthcare. We have great pilot programs, great adolescent health centers, and school-based health centers that serve adolescents, but those only reach a minority of youth. We really need to be serious about providing health insurance and health access for all young people.

Secondly, we need to rejuvenate health and sex education in this country. We need to have health education that provides all the facts they need to improve their health and supports them on healthy goals, such as using contraception and avoiding drinking in certain situations when you know it's highly risky. We need a much stronger and better set of health education policies.

Youth Policy Toolkit: How has the field of adolescent health changed over the years? What new priorities have emerged in policymaking related to youth health?

Dr. Santelli: There have been multiple changes. What's emerged in this country is a strong, vocal well-trained scientifically based group of professionals who take care of adolescents. The number of people in public health who are trained to deal with adolescents has also increased. I don't think we have enough people working in the field, but we clearly have some terrific professional standards we can look to. We've done a great job of professionalizing health education and moving it to a more scientific basis. We've learned a lot about what adolescents are and we've got a good body of research on effective programs such as sex education and contraceptive programs, health promotion programs, and counseling programs.

I still think the biggest priorities to address are these social and cultural barriers; the ability for adults to deal with and accept adolescent sexuality [and] for adults to recognize that adolescents are unique. We are clearly in an upswing, however, and that's really exciting.

Youth Policy Toolkit: Based on your experience, what are the key areas for policy action?

Dr. Santelli: We have to move from ideology back to science in terms of development of public policies. Key areas include women's health and the development of drug policies by the FDA. If we can get policymakers, congressmen, and other types of influential people all supporting an agenda based on health and science, I think we'll be at a much stronger stance to face the future. From that will follow human rights. We need to recognize that healthcare and access to

healthcare is a right. If we continue to treat it as a commodity, I think we will see the failure of healthcare reform. I think we need to utilize both a human rights and science-based perspective.

Youth Policy Toolkit: As you know, a policy is only as good as its implementation strategy. Could you please give us some examples of an YRH policy that has been implemented successfully? And, what do you think are the key components to implementing the policy?

Dr. Santelli: To successfully implement a policy, one needs to have cultural and professional buy-in on basic policies. We have a set of legal rights that young people have to reproductive healthcare. If practitioners are not knowledgeable about those, if they don't support them because of their own religious or cultural beliefs, then we see a failure of those policies. In theory, young people are supposed to access care independently until they're ready to talk to their parents about reproductive issues, and in many places, they can't get that kind of care.

We now have laws in the 50 states that allow a young person to access healthcare independently—in many cases for emergency and mental health and STD diagnosis and treatment. In general, I think it's well-accepted by the professional community and by the public that when they [youth] are engaged in adult behaviors, they should be able to take care of themselves. That's a big success. There are now 2,000 school-based health centers serving a considerable fraction of youth in urban and rural areas, and that's a tremendous accomplishment. We're seeing the recognition of this idea of taking healthcare to people where they are.

Santelli, J.S., M. Orr, L.D. Lindberg, and D.C. Diaz. 2009. **Changing Behavioral Risk for Pregnancy Among High School Students in the United States, 1991-2007.** *Journal of Adolescent Health* 44(7): 25-32.

Dr. Margaret E. Greene

Senior Technical Expert, Reproductive Health, Washington, D.C., August 2009

Dr. Margaret E. Greene has more than 20 years experience working in the fields of family planning, gender, and youth sexual and reproductive health policy. Dr. Greene has worked with many instrumental public health and international development organizations, such as the Population Council, Population Action International, Center for Health and Gender Equity, and the International Center for Research on Women. She is also the director of the Center for Global Health at George Washington University (GWU) and teaches several classes at GWU. Dr. Greene is a member of the Technical Advisory Group to USAID's Interagency Gender Working Group.

We spoke with Dr. Greene about her experiences in the field of youth reproductive health and policy.

Youth Policy Toolkit: What interested you in youth reproductive health?

Dr. Greene: I first became interested in reproductive health when I was in college. There are so many obstacles toward attaining good reproductive healthcare for young people and adults as well. Those obstacles are expressed more intensely for young people, and so if you can really figure out what's going on with young people and solve the problems of accessing information, then you could actually improve things for everybody. There's something really unjust about the conditions young people face and ignorance around the fact that sexual relationships tend to begin at an earlier age, there is a lot of coercion involved, and early marriage is happening, etc.

The women's movement raised awareness of the difficulties women faced in accessing things that were commonly available—jobs and so on in society. That same perspective could shed light on reproductive rights and young people, who I believe are not treated as full human beings on some level—that they have not been treated as full citizens. They are the bearers of rights, but they are not given their rights. Parental rights take precedence. In a way, that [precedence] is damaging; in a way, that [precedence] does not even work for parents. So I think there are some insights from the women's movement, where the dichotomy is male/female, that could be applicable for young people, where the dichotomy is young people and adults. Where you see a whole category of people as lesser somehow, then you are going to have the consequences that we see.

Youth Policy Toolkit: And following up on that, there seems to be a third dichotomy of people in between a child or an adolescent without completely assuming the rights and responsibilities of an adult.

Dr. Greene: This really gets to me—that you can be drafted to the military but you can't have access to full sex education. I find [it] very inconsistent. It's not rational. So, big changes have to happen to benefit young people.

Youth Policy Toolkit: What do you think are the most important changes that we need to work toward? Or what are the key policy areas that need to be targeted?

Dr. Greene: I think it's great that parents and families remain the locus of conversations about values and how the proper conduct of behavior and conduct of relationships is formed, but the society, the education sector, and the health sector in particular have to provide the information so that the young person is able to make a decision about his or her own rights—guided by the ideas that they get from their families. For me, access to information is so profound. It's the most important thing. And I think it's so transformative—when people understand how their bodies work and when they understand some of the challenges they will face in entering relationships or fending off relationships. They have to have people to talk to, and then if they need additional information, they know they can go somewhere. It's really mostly adult information. That, to me, is just fundamental.

And I know that one of the big obstacles is this argument that if you provide this information,

young people will run wild. But they are hurting their own health significantly without that information. And it seems very punitive and controlling for their parents.

Youth Policy Toolkit: Yeah, it kind of handicaps them in becoming full adults, in becoming health adults.

Dr. Greene: Yes, I think that's fundamental. Somebody shared something interesting with me about what they saw as [an] obstacle in the provision of services—particularly [with] information to young people—that had to do with adults' ambivalence with their own sexuality or their sense of loss or misconduct in their own sexual lives, so they resent the beauty and strength of young people. And I see this as a very interesting, psychological explanation. There may be an insight there. I have to think about it in terms of programs and policies.

Youth Policy Toolkit: That's an interesting perspective because I think most people attribute the lack of attention to youth reproductive sexual health being a result of the stigma placed on sex education. You seem to say it's a more convoluted issue than that and we need a deeper look at the adult psyche.

Dr. Greene: Well, there's the joke that sex is so disgusting that you should avoid it at all costs and save it for the one you love the most. I think, in many societies, there is that sort of ambivalence about it.

Youth Policy Toolkit: What kind of policies promote access to information? Have you done any policy-related work to promote access to information?

Dr. Greene: It's very difficult to point your finger at something in particular. I think I can come up with a couple examples. By simply sharing the example of Iran, which has special schools for married girls. So, just to share the example, instead of having pregnant or married girls out of the school system (they're done with education), here's this conservative Muslim society that has found a way of formally structuring girls' ongoing education and access to information. I think it's really important that sex education is a fundamental requirement for obtaining a marriage license. It's so funny, in the U.S., I got married 10 years ago, and all I needed was a syphilis test. It is such a missed opportunity to hand out pamphlets and talk to people and pass out information. The connection that I am making is that in having highlighted this really great example in this review of youth policies I did for Population Action International, so many people have commented on it—expressed interest—because if that conservative society can do it, can we replicate it in other places?

Youth Policy Toolkit: A similar disconnect seems to exist between education-focused programs or public health programs. There seems to be a gap between public health programs that focus on schools and sex education programs that are out of schools. Do you find there to be a gap?

Dr. Greene: Between the services provided and the information provided through schools?

Youth Policy Toolkit: Many IEC [information, education, and communication] campaigns are not channeled through schools.

Dr. Greene: Sex education varies so much from place to place. And it's always charged. In

general, I agree with you. I also think there is a gap. In school sex education, it is a lot about the biology. It's not about the nitty-gritty. It's not about relationship negotiation?not about how you handle yourself. Maybe increasingly that's there?more about the decisionmaking?but the curriculum in schools is very biologically oriented; also there is not the interconnection with services because you might think it is incentivizing sex. But if there is [interconnection], you know when it hits. You're so much more likely to use it. And you're not intimidated. There is a friendly person sitting behind the desk and it makes a difference.

Youth Policy Toolkit: How do you feel the field of adolescent health has changed over the years? How have the priorities changed while you've worked in it?

Dr. Greene: I'm not sure. It's not something that I've thought about. I'll have to think about it as I speak. Well one thing that occurs to me is that [there is a] greater sense and a stronger international mandate for addressing the reproductive and sexual health of young people. So, it's not just about contraception; it's not just about stopping childbearing. Now there is talk about delaying, spacing, managing healthy relationships, STIs. It's partly a function of the Cairo conference?that there is a greater attention to a broader span of RH issues?that makes it much more appropriate to youth.

I think that many global changes have been empty. There is a lot of talk about their [youth] rights, but you don't necessarily see it all that much in practical terms. I just think about the tone people are spoken to?in African clinics, young people are spoken to in very judgmental terms. And it doesn't have to be just there. Ten years ago, I spoke to this doctor in Chennai who basically talked about inserting an IUD [intrauterine device] after doing an abortion without asking the patient and then informing her afterward and telling her that she will have to undergo another procedure to remove the IUD?but without asking her if that was okay. There is a very strong sense of adults knowing what's right for young people. I don't think that broader commitment at the international level has transmitted practically to real change for young people.

Youth Policy Toolkit: And why do you think that is? Do you think it's because there are no representatives for youth or of youth? The people making the decisions for youth are either in international organizations or MOHs [ministries of health]. Do you think that's the reason for the gap?

Dr. Greene: I think it's partly that they are not represented. They have the original problem that the older they get, they lose that experience, and then they're out and then you have new youth. I think that there is more representation over the years. Organizations like IPPF [International Planned Parenthood Federation] have young people on their boards, but I think that young people are not taken as seriously as adults, and that seems to persist. I always feel embarrassed when I go to meetings about youth and people make jokes about how we're all young at heart. I feel like there needs to be more equal conversations between younger people and older adults, and it just doesn't happen all that much. And here we are?exposed to the international agreements and the high-faluting language?and we still struggle with it in Washington, D.C.; but if you go to Mozambique, it'll just be really hard to have serious conversations.

Youth Policy Toolkit: It seems more revolutionary than the women's movement because it's similar in the sense that you are revamping these traditional familial and society structures. How do you begin to engage a child who doesn't speak, doesn't have role?

Dr. Greene: I agree. It just seems really hard to accomplish. It may take a long time and require such a different mindset. And it's ironic that it wasn't that long ago when the creation of childhood [as a sociological concept] happened in Western society in the last 200 years. And it was like it was overdone. Children are different from adults, but now we have those two categories. And this gets back to what you were saying earlier—can we have more of a transition period where you are adapting to the category and status of being an adult?

Youth Policy Toolkit: I think the culture of the U.S. is unique in that children have the ability to explore; they have a safety net to explore being an adult. Whereas in developing countries, children get married and instantly transform into adults and assume all the responsibilities of an adult.

Dr. Greene: Or [children do not gain any responsibilities or rights once they are married]. Or you are completely disempowered when you go to another household. Or you are an adult in that you are supposed to have a child, or you have this new role, or the mother-in-law snaps her fingers and you have to rush around.

Youth Policy Toolkit: It's interesting then? I'm wondering if the best way to advocate for youth needs is in a forum separate from adults or whether we have to integrate it into health programs overall, where we have to bring in youth representatives, or whether the adults who speak louder and are bigger would accommodate for the needs of youth within such settings.

Dr. Greene: Honestly, I think that both are necessary. Before I became more educated, a friend of mine was working with a Norwegian children's organization and the rights of children and children as citizens. And I didn't really take it all that seriously, and I'm someone who should have been especially attentive to that kind of thing. But look at me; it was my resistance. I am a product of my culture. So, I guess that there are some groups and organizations that are doing that. But then young people have to come forward and make statements about the things they need and the things they want and why they need them; and they need to mobilize resources on their own behalf. And organizations like the IPPF and others need to continue to do their thing and integrate young people into their boards and so on. So, I think it needs to happen. And it's ironic, but these are the types of conversations women had—should we do things separately or do we want to integrate ourselves into male systems of power? All of the above.

Youth Policy Toolkit: Looking back as an adult, it's interesting to consider my experience growing up partially in India and partially in the U.S. and how different my upbringing has been from that of children in developing countries.

Dr. Greene: I am writing this report for UNFPA [United Nations Population Fund] that is called "Girls Speak," which is trying to use qualitative data about what girls say about their own life to give some finer messages about health and schooling, etc., and rights and violence. When someone from the West makes a recommendation about what you should do about your girls, it's being colonialist and there's no connection with their lives. But when it's girls themselves

who are saying these things, they have more authority to bring about the change. So, maybe that is just going back to how you do that practically; how do you tell young people? look you are not telling us about sex, but 15 of the 85 girls in our class dropped out because they got pregnant last year. What's wrong with this picture? I look at the TOSTAN model. The model has taken this concept of rights and helping people come to some of these conclusions on their own and helping them find solutions to their own problems through their own routes. It's very owned by the people of the culture.

Youth Policy Toolkit: What kind of policy do you think would enable such types of interventions? Such types of projects?

Dr. Greene: I think that there has to be some national conversation about rights? just as a general conference; it doesn't have to be lecture but rather a general awareness raising about rights and capacity building. So, you have some kind of basic reference. Devolution of power to the local level. This may be positive, but devolution could also mean power in the hands of the local religious leader who may be running the show. If it were accompanied by some types of conversations? I just always come back to these abstract conversations when I talk about young people. It's not about service provision. It's just not. It's so much bigger than that. Service provision is literally a bandaid for the giant problem. It's so limited and it's so driven by the health sector. And I think one of the big challenges is? everyone says [youth programming] needs to be multisectoral, but what does that mean? When you have government sectors and money is spent sector by sector, multisectoral means that no one is ever going to do anything. And so [youth programming] has to belong to somebody. It can't be this nice idea? we're going to create this ministry of youth that has no budget? that is so often the case. We need some fresh ideas about how to drive people toward youth causes. I was really impressed by Zambia. And this is not youth-specific? the ministry has these coordinating bodies at every level (national and district). They visibly replicate these multisectoral advisory groups that reach right down to the local town. And they have conversations like ?this is what our epidemic looks like; what do we need to do to address it.? And I think that people at the most local level don't know what challenges young people are facing as a whole. They don't have the statistics. It's no wonder young people are struggling. They don't have enough information to know how to act in the best way possible.

Dr. Greene: How do you increase communication between youth and adults in an environment where youth feel comfortable? It seems to me that one of the biggest obstacles (based on my field work in Nepal with Save the Children) is that speaking with girls about RH is like pulling teeth. Even young girls in the U.S. don't want to talk about it. I wonder, what is the best strategy to make them talk?

Youth Policy Toolkit: As you know, a policy is only as good as its implementation strategy. What do you think are the key components to implementing the policy?

Dr. Greene: I think another obstacle is that because budgets don't track beneficiaries by age as a general rule, an MOH can say that, yes, we have youth family services? but if they spend \$3 on that [the youth services], you would want to know. You want to see how many young people are coming. Just being able to focus on that [the details] is so fundamental. It requires a lot of record

keeping, but in general, you need to know more, much more. Budgets are behind a real implementation strategy.

Youth Policy Toolkit:What future directions do you see for yourself in youth health? Where would you like to go?

Dr. Greene: Recently, I have done some work on youth but more on the social science side on early marriage, and I'd like to get back to work on youth RSH more centrally. One of the things that came out of working with men and boys is doing awareness raising about gender inequality at a very early age. That's really fundamental. I had this utopian view about men and women, boys and girls?what world would we live in if we had mutual respect and support and cooperation for each other? It would be better for everybody. I can't tell you how many people say, "Well, what do you tell men and boys? What can you say to persuade them? What have they got to gain from it?" They've got everything to gain. It's ridiculous, the thought. And doing the awareness raising early.

Judith Bruce, from the Population Council pounds away about rights?basic human rights education that is well structured. Everything that we are talking about can be placed in a human rights context with a little bit of RSH education. A properly structured curriculum on human rights gives people the basis for understanding their ability to negotiate healthy relationships, how to have equal relationships with future employers, and their ability to respect the other sex. It [this understanding] can be an umbrella?so many fundamental things that end up being important in societies across the world. It is way upstream in many ways, but I think it affects so many facets of our lives?a boy that learns through a human rights-related education about how one should never force anyone to do something they don't want to?it would be so incredible. You would have a generation of people who are thinking twice before engaging in coercive sex. I know that's very abstract, but I think there is something really important there.

Brad Kerner at Save the Children USA has this idea that he has developed a game in Nepal called the gender equality game. Or Ravi Verma at the ICRW [International Center for Research on Women] Asia Regional Office has been working with the Family Violence Prevention Fund on a project called Coaching Boys into Men. That's using cricket?working with a cricket coach to support boys?the gender socialization is often reinforced by sports to get them to be thinking differently or talking differently about sports. The worst insult you can possibly give somebody when they don't kick the ball or do whatever they are supposed to do with the ball is to call them a girl or female genitalia. There is just a really huge opportunity there.

I guess that continues to be very exciting to me. I guess it's still very upstream, but it includes RSH and is so directly connected. I think that's maybe where it's going to overlap with the work that I'm doing with men and boys and youth RSH.

Youth Policy Toolkit:Are there any other ideas that came to your mind as we were speaking?

Dr. Greene: Another obstacle that I see that has to be reconciled before a lot of progress can be made?we perceive conflict between the rights of parents and the rights of children. Two places that come to mind where that really plays a role are in the U.S. and Mexico. Parents are deciding that what's being shared with their children is smut. I don't know how to resolve that, but I think it's one of the great challenges of our time and it totally illustrates the point we discussed earlier

about the rights of children as lesser [being less important]?my right to information is less than your right to deny access to that information. And the whole kind of private control of children that is taking hold in our legal system.

Youth Policy Toolkit: That makes me think of how families are the unit of relations to society?whether it is an extended or nuclear family that has the authority to make decision about the child.

Dr. Greene: I'm trying to think about how they solved the problem in Iran. I think that parents had the right to prevent their children from going to school, but there is an alternative. If you are not going to put your child in school for this program, then you accept a health worker coming to your house to discuss what you need to talk about with your child. There needs to be a back-up plan. I know that it's costly, and it can be relatively costly. But if this information is provided early, then large groups of kids can have this exposure.

Dr. Richard Curtain

Public Policy Consultant, Curtain Consulting, Melbourne, Australia, April 2007



Dr. Richard Curtain is a public policy consultant with Curtain Consulting,

based in Melbourne, Australia. A sociologist and demographer by training, his current work includes assignments for UNICEF's East Asia and Pacific Region on youth livelihoods. For UNFPA, he recently completed a diagnostic tool titled *Putting Young People into National Poverty Reduction Strategies: a Guide to Statistics on Young People in Poverty*. He is the author of many publications on youth, including a recent article in the December 2006 edition of *Current History*, "For Poor Countries? Youth, Dashed Hopes Signal Danger Ahead."

We discussed with Dr. Curtain his experience assisting in the development of a national youth policy in Timor-Leste. At the time of the interview, the national policy was still in the process of getting approval by the Council of Ministers.

Youth Policy Toolkit: What has been your role in formulating the policy and how did you get involved?

Dr. Curtain: I was employed by UNICEF to design and supervise a national survey of young people and to pull together all other relevant data. I was also asked to work with the Secretariat of State for Youth and Sport of the Government of Timor-Leste to prepare a draft of a national youth policy.

I got involved because I wanted to get into the thick of doing some good policy work on the ground. I had written a number of papers for UN agencies on young people in extreme poverty and the case for investing in young people as part of a national poverty reduction strategy. These made me keen to do some "hands-on" work, away from desktop analysis.

My opportunity to work in Timor-Leste arose through a long-term interest in that country, as a supporter of its independence from my time as a graduate student at The Australian National University in the 1970s! I found out that UNICEF was looking for a consultant to work on youth policy and I approached them while I was visiting Dili to help set up a system for disbursing funds for a philanthropic foundation.

Youth Policy Toolkit: Why is it important that Timor-Leste have a national youth policy?

Dr. Curtain: A national youth policy is crucial to Timor-Leste's future because one in three people in the adult population are aged 15 to 24 years. This high share of the adult population points to a classic "youth bulge." In a post-conflict country where the economy is weak and government capacity limited, the youth bulge suggests that the potential for social conflict is high.

This scenario has been borne out in the period after I completed my assignment for UNICEF. From April 2006 and continuing into 2007, life in Timor-Leste, and specifically in the capital, Dili, has been disrupted by gangs of young males, as young as 10 years of age. Despite the presence of foreign peacekeepers and international police since mid-2006, peace still has not returned. News reports of warring gangs and gang violence are commonplace. In particular, clashes between martial arts groups of mostly young men are blamed for the violence, sometimes resulting in deaths and always increasing fears and insecurity of the general population.

Youth Policy Toolkit: In your recent article for *Current History*, "For Poor Countries? Youth, Dashed Hopes Signal Danger Ahead," you write, "the view of young people as critical assets for lifting economies and societies out of poverty offers the most potential for change, yet it has gained the least attention." Why is this so and how did you address this problem in Timor-Leste?

Dr. Curtain: My analysis of the focus on young people in Poverty Reduction Strategy Papers showed that most policymakers viewed young people as vulnerable, for example adolescent girls, or as a threat, for example unemployed youth. However, few Poverty Reduction Strategy Papers proposed policies to build up young people as positive assets. Many UN agencies also have a narrow view of young people, highlighting their vulnerability. The challenge in writing an evidence-based national youth policy was to go beyond narrow and negative stereotypes of young people and to understand the world from their own perspective.

So in Timor-Leste, we started from a much more positive perspective. In the national youth survey, we asked young people about their own capabilities and their access to power resources. The survey was designed to enable young people to rate their access to economic, social,

political, and information-based assets, their perceptions of personal security, the quality of their education, and assessments of their current and future prospects.

This emphasis on the positive carried over into the draft policy, which highlights the value of government supporting young people's collective endeavors. One specific proposal is to encourage young people's sporting and cultural organizations to link into the government's national poverty reduction strategy. This is to be done by funding them to undertake simple but important tasks such as distributing bednets and getting rid of stagnant water as part of a campaign to reduce malaria.

Youth Policy Toolkit: Timor-Leste is a "post-conflict" country. How did this influence the policy development process?

Dr. Curtain: In general, I think that the government and international agencies such as the World Bank failed badly to incorporate an appreciation of the vulnerabilities the population has been experiencing. Little attention was paid to social protection policies, for example, to ensure that people had enough to live on in the poorest country in Asia.

In relation to the national youth policy, we focused on ways to integrate young people into the new structures being set up. On the face of it, young people were the "lost generation" – they were educated under the Indonesians, with many gaining tertiary education. However, the new government specifically excluded them from government service by mandating that all official business be conducted in Portuguese. Finding ways to incorporate young people into the mainstream institutions was the big challenge.

Youth Policy Toolkit: Your Current History article also discusses how governments tend to see young people in need of protection against problems such as early pregnancy and HIV infection. To what extent does the policy in Timor-Leste address these reproductive health issues?

Dr. Curtain: Timor-Leste has one of the highest adolescent fertility rates in the world? 177 per 1,000 women aged 15-19 years in 2004 and it is rising, it was 130 per 1,000 in 2000. However, the draft national youth policy did not address reproductive health issues directly as there was already a new reproductive health policy in place. The draft policy highlighted the need to coordinate policies to reduce poverty among young people. The policy proposes using as key performance measures the youth-oriented indicators of the Millennium Development Goals (youth employment, literacy), and key poverty reduction indicators (improvements in food security, rural incomes). The additional indicator of the adolescent fertility rate is also proposed.

Youth Policy Toolkit: What were some of the successful approaches you used in drafting the policy?

Dr. Curtain: It was important to give young people opportunities to express their views about their situation and about how they wanted to make a positive contribution. The national youth survey, based on a random sample of 1,100 youths, was a powerful way to provide evidence of young people's attitudes to rural livelihoods, and the specific attitudes of young women in relation to their choices.

Also, an important evidence source was the results of focus groups of young people held in all

the major regional centers as well as in the capital city. These discussions highlighted a number of concerns that the survey did not tap. This applied especially to how girls and young unmarried women were viewed and treated by the community and the constraints these views imposed on the options available to them.

Youth Policy Toolkit: What were some of the big challenges you faced in developing the policy?

Dr. Curtain: The biggest challenges came from a lack of strong interest from the government in tackling young people as a cross-cutting issue. The new ministries operated as silos and they saw the Secretariat of State for Youth and Sport as a junior ministry with few resources.

The World Bank, despite an interest in training youth leaders through the Leadership for Economic Development program, had a narrow view of only supporting young people as individual job seekers. The World Bank office in Timor-Leste objected to one of the main proposals of the draft national youth policy?to set up a national fund for youth to provide a guarantee of future funding for youth organizations to engage directly with the government?s national poverty strategy.

Youth Policy Toolkit: If you were doing it all over again, what might you do differently?

Dr. Curtain: The big problem was lack of a youth focus in the government. This has changed now with the ongoing civil unrest, and the key role played by youth gangs in this. But, the response by the government in late 2006/early 2007 has been ad hoc and short-term?providing funding to build youth centers and sporting facilities. These facilities cater mostly to young males. A focus on cementing ties among mainly young males will backfire if it only reinforces an ?us against them? attitude. Policies to link young people into the wider community are still missing?the national youth policy is still in draft form and has not yet been adopted by the government!

The pressures are strong to write up a policy that confirms existing arrangements and makes at best only small changes. Forging a new policy direction requires, in hindsight, much more ground work with the key stakeholders. Providing good evidence is part of this, but this may not be enough. Lobbying key politicians, using another form of evidence in the form of stories and anecdotes, can play a valuable role. Responding to opportunities as they come up to bring home the need for a new policy direction is also part of it. But, this can mean big time lags.

In the end, it is waiting until the time is right?when policymakers can see that the old approach is not working, and one or more of them are willing to take on the role of champions of the proposed new approach and push their colleagues into accepting a new direction.

Do you have a question for Dr. Curtain? If so, please Contact Us and we will synthesize your questions for response from Dr. Curtain. Thank you!

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Mr. Jeff Yussuf Ayami

Executive Secretary, Zambia Interfaith Networking Group on HIV/AIDS (ZINGO), June 2007



Mr. Jeff Yussuf Ayami has worked at the Zambia Interfaith Networking Group on HIV/AIDS (ZINGO) since 2001 and is currently Executive Secretary. His background is in business management and he is also a trained Islamic theologian. His work with ZINGO focuses on mobilizing financial and human resources for communities to respond to the social and economic impact of HIV/AIDS. He is a qualified facilitator and works with many communities to improve the skills of project managers. He advocates a holistic approach to HIV/AIDS, including the need to address human rights and governance issues.

We asked Mr. Ayami to discuss the efforts to produce guidelines to increase young people's access to reproductive health information and services in Zambia.

Youth Policy Toolkit: What prompted you to work with faith leaders and young people?

Mr. Ayami: That is a very good question, but before I answer your question allow me to thank you for according ZINGO an opportunity to interact with you and your audience around the subject of youth reproductive health.

Coming to your question, as you well know, a lot of negative things have been said about the contribution of religion to the AIDS problem in Zambia. Many people have concentrated very much on the negative things, such as their views on condoms or their judgmental attitude towards people living with HIV, etc., and overlooked the many positive contributions the church has made in the fight against HIV and AIDS. The positives include the influence religion and faith leaders have on our communities. Nobody has so much access and influence to people in the communities as the faith leaders. It is this that prompted us to work with faith leaders.

Regarding the reasons for working with youth, we all know that our population in Zambia is heavily populated with the youth. They are the majority and account for about 60 percent of the entire population. If you consider that this number represents our future leaders, then it makes so much sense that our energies should be directed towards protecting this important resource for our country's development.

Youth Policy Toolkit: Tell us a little bit about the Zambia Interfaith Networking Group on HIV/AIDS.

Mr. Ayami: Well, the Zambia Interfaith Networking Group on HIV/AIDS, ZINGO in short, is a network of the major faith bodies in Zambia. These include the different brands of Christianity?Catholic, Protestant, Evangelicals and more recently the independents who are basically a break away from the Evangelicals, the Muslims, Bahá'í, and the Hindu community. The network was established in 1997 but actually was formalized in 2003. The network has its own secretariat that is mandated to coordinate and monitor the faith-based response to HIV and AIDS within its members for and on behalf of the National AIDS Council of Zambia, which is a government creation.

ZINGO works through the faith mother bodies and, therefore, its work is virtually everywhere across the country. Our thrust is mainly HIV and AIDS.

Youth Policy Toolkit: Why did you feel there was a need for policy guidelines specific to young people?

Mr. Ayami: As I have stated earlier on, one of our mandates is to coordinate the FBO response to HIV and AIDS interventions. What we have realized is that whilst many of the FBOs are engaged in very encouraging interventions on HIV and AIDS targeting the youth, many of these interventions are driven by emotion and not by guided and proven strategies. This has resulted in this action being uninformed with realities on the ground. Just to give you an example, while the church talks about abstinence among the youth, the reality is that many youths within and outside the church are freely engaging in sex. Some of these youths might even be holding influential positions within the church structures. The church has not done much with regard to ensuring that the call for abstinence is matched with a suitable environment that promotes abstinence or addresses the sexual developments and needs taking place within the youth as they grow and interact with youths from the wider community.

Another example could be the issue of confidentiality. Our culture dictates that sexual issues are too sensitive to be discussed by one's own parents. Previously, young people would turn to grandparents for counsel. Lately, and with the break up of such arrangements due to ?westernization? of our societies, faith leaders are among the few points of counsel available for our youth. However, faith leaders have not lived up to their responsibility because they have failed to instill confidence in the youth that approach them. As a result, youth are now getting counsel and misinformation from some of their peers who they trust in so much.

All of the things mentioned above prompted us to enlist faith leaders as our entry point to provide accurate reproductive health information and services to youth so as to prevent them from getting early pregnancies, and HIV and other sexually transmitted infections.

Youth Policy Toolkit: What do you expect to come out of your efforts to develop the policy guidelines?

Mr. Ayami: It is our hope that resulting from our efforts, we can get a generation of youth that are very concerned with their sexual well-being and general wellness. Similarly, we do hope we can have capacity within our faith institutions to provide and help young people with information and services that are useful for their own sexual health.

Youth Policy Toolkit: Can you share any successful strategies or approaches you used in developing the policy guidelines?

Mr. Ayami: One of the most successful strategies was using the youth themselves to develop the guidelines. This not only meant that the guidelines were owned by the youth but also that the contents were informed by their own experiences with regard to issues of sex.

Youth Policy Toolkit: What indications do you have that the policy guidelines have been a success?

Mr. Ayami: The overwhelming response their endorsement received by the religious community and the faith leaders. You need to note that initially the Catholics did not want to involve themselves with the project, but because the manner in which the guidelines were developed did not intimate any coercion of any particular group to do what they were not comfortable with, they signed the document, which for us was a major success.

Youth Policy Toolkit: What have been some of the challenges in advocating for endorsement of the guidelines by the various faith groups?

Mr. Ayami: One of the major challenges we faced as mentioned earlier was the suspicion by the Catholic faith that promoting youth reproductive health was more like promoting usage of condoms, abortion, etc. This nearly resulted in them not wanting to be part of the whole project in the first instance. However, their participation in the actual development of the guidelines as well as the strategy to focus the guidelines to deal more with issues of processes and actual guidelines as opposed to services meant that their fears were allayed.

Youth Policy Toolkit: What advice would you give to other practitioners undertaking a similar policy process?

Mr. Ayami: First, consultation is critical. It cannot be overemphasized. Because the subject of reproductive health is sensitive and usually misunderstood, faith organizations involved in the process should be consulted and be part of decision making all the way.

Secondly, it is better that when such an undertaking is considered, the focus should be much on issues such as mobilization and referrals as opposed to actual service delivery. Determining what kind of youth reproductive health services would be provided should be left entirely up to each

particular faith group. Now I don't know if I am clear on that point and perhaps let me use an illustration to articulate myself. We should not go to a faith organization and dictate to them the kind of services they should provide to young people, rather make it known to them the kind of challenges youth face sexually and the need for a faith group to develop a mechanism through which youth sexuality and their reproductive health concerns can be addressed. This could entail them putting in place someone specifically designated to answer frequently asked questions on biological developments in youth or changes in feelings and how to deal with them. This could also entail linking faith groups to resources on reproductive health, including basic facts about HIV and AIDS. However, what we should not do is to ask or coerce a faith group to start providing RH services. This should stem from a need, their need. This should entirely be left up to the particular faith group to decide which services they would provide that fit within the perimeters of their faith.

Do you have a question for Mr. Ayami? If so, please email us at youthwg@fhi.org.

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Mr. Theophilus Ekpon

Team Leader, Center for Sustainable Development and Education in Africa, Nigeria,



September 2009

Mr. Theophilus Ekpon is Team Leader for the Center for Sustainable Development and Education in Africa, based in Nigeria. He is currently a consultant with the United Nations Population Fund (UNFPA) in Nigeria, where he assists with facilitating the ongoing review of the National Youth Policy and development of a national youth profile. He has been the President of

Youth Initiators Nigeria and a Special Youth Fellow with UNFPA in New York, where he carried out research on UNFPA-supported integrated livelihoods interventions among young people and developed a report from a global E-consultation on youth involvement in poverty reduction strategies in collaboration with the World Bank.

We asked Mr. Ekpon to discuss his role in forging a partnership between UNFPA and the Nigerian Ministry of Youth to review the National Youth Policy and ensure that the revised policy adequately addresses youth reproductive health concerns.

Youth Policy Toolkit: Tell us about why there is a need to review the National Youth Policy. Who initiated the review? What was the impetus?

Mr. Ekpon: The need to review the National Youth Policy became obvious due to the fact that the policy was last reviewed in 2001. Again, challenges faced by young people in Nigeria vary with time and need appropriate policies to address them. The idea of the review came as a result of a discussion between the director of the Ministry of Youth and me. The drive to review the policy came as a result of so many development challenges (especially adolescent reproductive health and livelihoods) that were not adequately addressed in the existing policy.

Youth Policy Toolkit: Tell us about the partnership between UNFPA and the Ministry of Youth to review the National Youth Policy. How did it come about? What does it involve?

Mr. Ekpon: UNFPA is giving both technical and financial support to the Ministry of Youth for the review of the National Youth Policy. This partnership started when I reported back to UNFPA on the outcome of my meeting with the director of the Ministry of Youth to review the policy. It was then followed by a proposal from the ministry to UNFPA. This partnership entails the provision of technical guidance and financial support to the Ministry of Youth.

Youth Policy Toolkit: In what ways do you hope to strengthen the current National Youth Policy with respect to reproductive health?

Mr. Ekpon: I hope to strengthen the reproductive health section of the National Youth Policy by involving young people who work in adolescent reproductive health to provide inputs during the proposed consultations in all geopolitical zones of Nigeria. I am also working with the vast network of adolescent reproductive health experts in Nigeria to get their inputs.

Youth Policy Toolkit: What will the review process involve? Who will take part? How long will it take? Who is financing it? What is the expected outcome?

Mr. Ekpon: The review process involves the development of an initial draft document that will be given to a wide range of stakeholders and the general youth population for inputs. The review is taking into consideration stakeholders in youth development and empowerment, ministries and agencies that work with young people, youth networks, and the underserved youth population. The review process will take close to 12 months and we are expecting it to be completed by February 2008. UNFPA and the Ministry of Youth are the major source of finance. We expect that at the end of the review process, a national policy document with an implementation mechanism that addresses the heterogeneous issues of youth in Nigeria will be developed, launched, and disseminated. The United Nations will assist with the dissemination and

implementation of the revised policy.

Youth Policy Toolkit: Tell us a little about how you personally became involved in the review process.

Mr. Ekpon: I became involved in the review process due to my current position with UNFPA as a consultant on youth development issues and my passion to influence policies that affect young people. I was a Special Youth Fellow with UNFPA, President of Youth Initiators Nigeria, and am now on the Advisory Team of the Center for Sustainable Development and Education in Africa. I was also involved in the development of Nigeria's National Economic Empowerment Development Strategy II (NEEDS II), which is Nigeria's Poverty Reduction Strategy Paper.

Youth Policy Toolkit: What challenges do you expect to confront in the policy review process?

Mr. Ekpon: The most noticeable challenge is the issue of getting inputs from rural youth into the review process. Over 70 percent of young people live in the rural areas and getting them to attend such consultative processes has been a major challenge in the past. The issue of bureaucracy in government is another challenge that we will have to cope with.

Youth Policy Toolkit: How are you planning to meet those challenges?

Mr. Ekpon: We are planning to make the consultative process a grassroots-oriented activity rather than one that occurs only at the state or zonal level. The issue of bureaucracy in government will be a difficult one to overcome, but I do hope that, as the government is taking ownership of the review process, things will be able to move faster.

Youth Policy Toolkit: Can we get back to you for an update when it is all over?

Mr. Ekpon: Yes.

Do you have a question for Mr. Ekpon? If so, please email youthwg@fhi.org.

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Ms. Neema Mgana

Founder, African Regional Youth Initiative, Dar es Salaam, Tanzania, May 2007



Ms. Neema Mgana, a native of Tanzania, is the founder of the African Regional Youth

Initiative(ARYI), a membership organization working with over 400 community and youth organizations on development issues. She also co-founded the Forum for Global Action and the African Women of Empowerment Project. She is currently coordinating projects to improve health delivery and manages partnerships between development agencies and the private sector to fund community-based projects in Africa. She serves on the boards of several organizations (including the MTV Staying Alive Foundation and Kabissa) and global campaigns, and has been featured on radio and in print media, including Teen Newsweek (2005) and Fast Company (2006). Ms. Mgana received a Masters degree in International Health and a B.Sc. in Health Informatics. She was the youngest of 1000 women from around the world jointly nominated for the 2005 Nobel Peace Prize.

We discussed with Ms. Mgana her experience forming the ARYI, and its work on youth reproductive health policy and advocacy.

Youth Policy Toolkit: What prompted you to set up the African Regional Youth Initiative?

Ms. Mgana: The ARYI is a membership organizations set up to address a real gap that existed in 2003, and that gap was the absence of a platform promoting collaboration among youth and community-based organizations in Africa. At the end of that year, I was doing an internship in Tanzania and was involved in running a youth organization that I co-founded. Despite the accomplishments achieved in that organization (including starting ten income-generating projects and building a children's center for education and health services), there were clear signs that more communication, collaboration, and resource sharing needed to take place between youth and community groups. One clear sign was when a Director from a foundation in the U.S. who was in Tanzanian told me about a neighboring community-based organization that was setting up similar activities, and yet I had not heard of them. The fact that it took someone from thousands of miles away to tell me about a project close by with whom we could have worked in setting up our activities was, in my mind, a wake up call that community and youth organizations needed to have a way to learn about each other and form these collaborations.

When ARYI started, we mostly focused on creating a platform for youth and community-based organizations that worked on HIV/AIDS in Tanzania. I remember then getting e-mail messages from different groups in Kenya stating that they were interested to join. These groups not only worked on HIV/AIDS, but also gender, poverty, youth empowerment, and other issues. Soon afterward, a number of e-mails from Ghana and Nigeria requested that ARYI have a presence in West Africa. Since then, ARYI has not stopped growing. We now work with over 400 African organizations addressing development issues as outlined in the United Nations' Millennium Development Goals' namely, poverty and hunger, HIV/AIDS and malaria, primary education, gender equity, child mortality, maternal health, and environmental sustainability. It's not just the issues that set us apart but our structure. ARYI works actively in 20 countries through country teams, country and regional representatives, and program coordinators. The work of ARYI is based on action plans developed by country and regional teams. In addition, ARYI is the only organization that places youth and communities at the forefront of activities that operate cross-regionally through programs such as the African Poverty Monitoring Initiative program planned to take place in 20 countries, an HIV/AIDS project implemented in 16 countries, an African Women of Leadership project active in 17 countries, and a Panel on African Commissions that is

operating in several countries in Africa.

Youth Policy Toolkit: What policy issues does the group focus on and why are these important?

Ms. Mgana: ARYI has recognized that youth in Africa have tremendous unmet family planning and reproductive health needs that require urgent national and international attention. The need for urgent attention is supported by findings from Population Action International, which classified several countries in Africa as "very high risk" in its *Reproductive Risk Index*. This index is a measure composed of 10 key indicators of sexual and reproductive health that documents vast disparities between rich and poor countries and the urgent need to accelerate progress in sexual and reproductive health as narrated in the 1994 International Conference on Population and Development.

Of particular concern are policies (or lack of) addressing sexual and reproductive health that are meant to help young people to exercise their rights, for example, to access youth-friendly health services and gain information on sexual and reproductive health. A number of meetings held by the Interagency Youth Working Group on these issues made me personally aware of the experiences among young people on very specific cases calling for reproductive health policies to protect the rights of young people. Too many countries in Africa are challenged in devising and implementing reproductive health policies, thus increasing the vulnerability of youth to HIV/AIDS, unplanned pregnancies, high morbidity and mortality due to risky pregnancies (usually due to the young age of the woman), female genital mutilation, and abortion.

To address this issue, ARYI started creating Youth Policy Groups to bridge the gap between policy and its implementation, promote and advocate for reproductive health policies, and build a foundation of youth leadership around reproductive health care services, programs, and policies. We are currently focusing on three tools to assist the Youth Policy Groups. One is the use of videoconferencing as a way to bring these groups together (for example, a videoconference planned among Tanzania, Ghana, and Ethiopia). A second is the use of the policy compendium available in the Youth Policy Toolkit. Lastly, we created a forum through the Implementing Best Practices (IBP) Knowledge Gateway that facilitates the communication and action plans between these groups while sharing best practice experiences and information on reproductive health care services, programs, and policies in Africa.

Youth Policy Toolkit: What have some of the big challenges been in setting up and maintaining the ARYI?

Ms. Mgana: A challenge in setting up and maintaining ARYI stems from its creation in the first place. The organization was formed to fill a gap and, as such, there was no "template" to follow in setting it up. However, this challenge has allowed for much uniqueness within the operation of ARYI in that we don't necessarily fit within a mold, and thus have flexibility to adapt according to different situations and also cater more so to on-the-ground needs.

In addition, I had no real experience in starting something of this nature and magnitude. What I did was spend time talking to people and reading books on organizational management, financial management, program planning, how to register an organization, website development, and the like. This helped a great deal to orient myself on the day-by-day operation of the organization.

Every day is a learning experience for me and I am grateful to work with a strong leadership team, composed of mostly young people who are either in school or transitioning between school and work. As such, the organization works around time availabilities of each person, including my own time, since from the start of ARYI, I have been either a full-time student or an employee in another organization. This leaves nights and weekends to work on ARYI. Within the last year, we have been focusing on the decentralization of ARYI to country levels, which has helped tremendously not just in terms of overall coordination but also in the support of local talent and leadership among national ARYI teams.

Funding is always an issue, as we have mostly received financial support for specific projects rather than organizational support.

Youth Policy Toolkit: Of the work the organization has carried out, what are you most proud of?

Ms. Mgana: I am proud of all the work ARYI has carried out, but I am most proud of the over 100 programmatic collaborations that have formed as a result of ARYI. It is common now to read a message posted to the ARYI listserv from an organization in Africa with some need (i.e., looking for partners to implement a project, lacking resources for an activity, etc.) and soon afterward reading a reply from another organization interested to form a partnership and share their resources. I remember the first such message of that nature that was sent to the listserv in 2004 by a group in Kenya that was looking for soccer balls and jerseys for a tournament organized as an HIV/AIDS awareness activity. When I read that message, I had no idea what would happen. Within weeks, soccer balls and jerseys were mailed to them by another group that was interested in the project. ARYI then also contacted equipment stores and others for additional support, as well as facilitated a fundraiser to be done to further their project on using sports as a way to raise awareness on HIV/AIDS.

Another example was in 2005 when we developed a concept for a series of children's forums as part of a global awareness raising and advocacy on the needs and rights of orphaned and vulnerable children in Africa. A call for organizations was made through the listserv and, within weeks, 40 organizations signed on to conduct these forums. All 40 organizations held the forums, but I remember one group in Kenya in particular who wrote a report and sent pictures of the thousands of people that took part in the forum, which was followed by a large march across Nairobi on the rights of children. This was a completely inspiring experience.

Those connections facilitated by ARYI that form into meaningful collaboration and action are what make me feel proud and honored to be part of the overall experience.

Youth Policy Toolkit: What are the group's current activities?

Ms. Mgana: Although we continue our work in HIV/AIDS, there are six main activities that ARYI is spearheading at the moment. One is called the African Women of Empowerment Project (AWOE), co-founded by Amanda Koster, a photojournalist, which highlights through mentorship, the media, and leadership activities, the role of women within development processes in Africa. A heavy focus of the project is nurturing the leadership of young women in Africa and we do this through inter-generational dialogues that are held across the African continent. To date, there are over 180 young men and women AWOD leaders in 17 countries in Africa who are coordinating

the project's activities in their respective countries.

Recently, we increased our work with the Reproductive Health Youth Policy Groups, which were set up to promote and advocate for young women's participation in sexual and reproductive health issues at national and international levels.

Another project we are involved in has been the creation of the African Poverty Monitoring Initiative. The goal of this initiative (which resulted after a detailed research on the poverty reduction strategy paper [PRSP] process) is to increase the participation of civil society groups in Africa to engage within the African Poverty Reduction Strategies. The initiative was launched on March 5, 2007, in Yaoundé, Cameroon, and plans are to conduct civil society consultations similar to the one held in Yaoundé in 20 countries in Africa by 2009.

The setting up of Development Analysts within the last few months has been something I am very proud of. These analysts, who applied for the position and currently number six within the continent, provide regular commentaries on Africa's development. In addition, starting in April 2007, we will hold local gatherings whereby the Development Analysts will have an opportunity to present their commentaries to audiences in order to promote dialogue on key issues that they write about, which have to date included commentaries on elections in Nigeria and human rights issues in South Africa.

The Millennium Community Foundation, which launched in April 2007, aims to facilitate private-public and community linkages in addressing and supporting solutions to community needs.

The Panel on African Commissions (PAC) was launched by ARYI in late 2006 and we recently organized the PAC with ten youth coordinators residing in different parts of Africa. The goals of the PAC are to facilitate public dialogue concerning development processes in Africa, coordinate the work of at least ten national commissions throughout Africa by October 2007, produce clear recommendations to be delivered to government representatives, nongovernmental organizations, donor agencies, and other development actors, and popularize development initiatives (i.e., the African Youth Charter) at community and national levels through publications, research methodologies, conferences, and media work.

Youth Policy Toolkit: What is the single most important thing that makes the ARYI effective?

Ms. Mgana: The people—including Sesan and Bella in Nigeria, Frehiwot in Ethiopia, Jeannie in South Africa, Zachary in Kenya, Cleophas in Rwanda, and Mohamed in Somalia. These are just a few of the people who have been committed to the organization for a long time, are passionate about Africa, and who are clearly tomorrow's African leaders.

Youth Policy Toolkit: What are the criteria for joining the ARYI? How can people or organizations join?

Ms. Mgana: There are two types of members within ARYI, one is as an individual and the other is as an organization. There are no criteria for joining as an individual other than an expression of interest either emailed to us or via the membership form available on the website. Organizations, however, must send us their profile (which includes a mission statement, objectives, a description of their target group, and where they operate) and a contact name and address. We then use

that information to invite them to join their respective country team for in-person meetings and planning sessions. Both types of membership are free to the individual and organization.

Do you have a question for Ms. Mgana? If so, please email youthwg@fhi.org.

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Ms. Sandra Aliaga

Participation Resident Advisor at the Center for Development and Population Activities, La Paz, Bolivia

Sandra Aliaga is a social communicator with 25 years of experience in reproductive health and HIV/AIDS policy analysis, advocacy, formulation, implementation, and evaluation throughout Latin America. She is a gender expert who has researched, taught, and published extensively on mainstreaming gender into HIV/AIDS and reproductive health advocacy strategies and policies. She has more than 20 years of experience working as a reproductive health and gender trainer and women's rights advocate. She has extensive experience in HIV/AIDS, reproductive health, and gender policy analysis and advocacy. She has worked in Bolivia and throughout the LAC region on strengthening advocacy networks and the political participation of civil society groups. She is a working journalist with experience in all mass media and in governmental communications. She has taught university courses on communication; reproductive health information, education, and communication; and gender mainstreaming.

Youth Policy Toolkit: What interested you in youth RH? Could you please highlight some of the YRH-related projects that you have worked on? What particularly interested you about this/these project(s)?

Ms. Aliaga: The possibility of working with youth is very, very big. They [youth] seem to be more willing to assume changes. And working on health issues with youth gives you the possibility of thinking that you are working with people who are not totally consumed with their prejudices or with an old way of thinking about life. And for the Bolivian context, I prefer to talk about sexual

and reproductive health (SRH) because I think that adding sexual health to our work is absolutely meaningful because we assume that SRH refers to the question of having or not having kids, [rather] it should be a question of having or not having a good life, and the possibility of exercising your rights?to be happy, to have pleasure, to develop as a human being. When you work in the field of SRH, you work with issues such as gender, human relations, and human development. So, youth are at a beautiful age, where they can build on other values that do not come from a patriarchal society.

As the co-founder of the Center of Investigation, Education, and Services in Sexual and Reproductive Health (CIES), which is a nongovernmental organization (NGO), one of the YSRH projects we developed was the "Youth Corner Program," which is an SRH educational program geared toward adolescents that enabled youth to participate, explore, and discuss information related to adolescent sexual and reproductive health (ASRH) at clinic sites. At the sites, the youth could engage in reading educational materials, discussions, informative games, and other activities. Other components of the program involve ARSH personnel providing information and education to youth, teachers, and student teachers using the *Para vivir nuestra sexualidad* or the "To Live Our Sexuality" module. Volunteer youth replicated the educational activities with peers in and outside of school, while teachers did the same with their students. The teachers also held meetings with parents to sensitize them to the ASRH issues through face-to-face discussions. The project also implemented the module along with sensitization sessions with government institutes such as the Ministry of Health and the Ministry of Education and health workers. The results of the "Youth Corner Program" along with other activities conducted by CIES showed that youth require special attention when it comes to sexual and reproductive health services?and thereby influenced the Ministry of Health to develop the National SRH Plan with a special component for youth.

Youth Policy Toolkit: Next, I wanted to ask you about your work on the USAID?Health Policy Initiative?s *Avances de Paz* model. That was used in a gender-based violence (GBV) project, correct?

Ms Aliaga: Yes, that is correct. The *Avances de Paz* or the "Advances in Peace" project was conducted from June 2006 to 2008. The project worked in four municipality communities (Quillacas, Machareti, Oruro, and El Alto) to integrate family planning and reproductive health policy with efforts to prevent and reduce incidences of gender-based violence. There were essentially four phases to this project:

(1) Training local people who were considered to be leaders within the four municipalities. We trained the participants continuously for one year on topics such as what is GBV, gender role dynamics, how to participate in the community response to GBV, and how to raise awareness and create a dialogue about GBV with community members. The participants committed to attending 30 or more training sessions in that year.

(2) Community processes analysis and planning, defining the root causes of GBV and opportunities for change, and developing and advocating for GBV action plans at the municipal level. In the community process, the leaders went through auto-diagnostic exercises with community members in order to facilitate a process by which the community members would (a) identify that GBV exists in their communities and (b) identify the root causes related to GBV in

their own family and community structures. Along with the community process, we implemented a parallel process, which was going and visiting leaders from the different sectors (education, justice, police, local powers, health sector, youth organizations) that had the power to intervene in any kind of gender-based violence policy. During these visits, the communities were able to advocate for the implementation of their action plans with the authorities. They said that they ?empowered themselves? and feel that they ?are able to provide their own solutions to their own problems from their own perspective.?

(3) Obtaining political and funding support in order to implement the activities they proposed. All four action plans were funded either by municipal governments or other sources. For example in Machareti, the municipality created a two-year plan for a local network against violence that included the different sectors. In El Altiplano, which is a Quechua and Ayamara indigenous zone, they saw a need for hiring a lawyer to develop a plan to eliminate violence. The lawyer gave continuity to the plan that the community proposed, which was to follow-up on GBV cases that were presented at the health center. They also implemented awareness-raising programs and workshops and created a committee with indigenous authorities from different sectors. In Oruro, they were able to work with a pre-existing network to conduct education and prevention activities with the prefecture, the local government, and the *departemento*, the state government. In El Alto, They advocated for a five-year plan called ?Violence and Art,? where they had a GBV-themed theater contest. Sixteen theater groups participated from El Alto. The entire community of El Alto participated, and there are over a million inhabitants of El Alto, where parents, teachers, and adolescents participated in these plays. The project provided them technical assistance on how to convey these issues through stories and acting. The play that won the contest was hired around five or six times in other places.

(4) Monitoring and evaluation; and you just heard the results from our discussion. Another result that municipality members continuously reported was that the amount of people that attended sexual and reproductive healthcare centers increased. *The project had over 1,000 participants across all four municipalities?of which 40 percent were youth.*

This project was a success because *?we really stressed the fact that it had to start from the facilitators and end in the community. It had to be something that you learned with your stomach and your heart and not with your brain.?*

Youth Policy Toolkit: What are the greatest gaps or challenges in youth SRH programming and policy implementation?

Ms. Aliaga: The challenge is always that you get these beautiful policies sometimes, and do they get implemented? Not always. For example, when we are talking about YSRH policy, you need an office or an institution to articulate with the other national offices, sectors, and stakeholders to guarantee implementation. You need money. You need commitment. You need trained people. You need possibilities of hiring and paying well. Many times, the NGOs [nongovernmental organizations] have more possibilities of implementing policies than the state. For example, CIES, Save the Children, and PCI [Project Concern International] in Bolivia have a lot of success stories in implementing policies. They have advocated for the implementation of particular policies. From our very small perspective as institutions or NGOs that work in this field, we do implement the policy because we have the money, the commitment, the trained people, possibly

the hiring and paying well, and the infrastructure.

Lastly, YSRH planning and policy issues should integrate into the area where youth tend to have issues: work issues, labor issues, educational issues, etc. Health is not an isolated issue, especially when we're talking about SRH. The main goal is that youth should be able to live better, have better human relationships, and contribute in a better way to their own local development.

Policies & Related Resources by Country



Currently, more than half of the world's 7 billion people are younger than 25.

Nearly 2 billion are between the ages of 10 and 24, and, of these, roughly two-thirds live in less developed countries. Ensuring the health and wellbeing of the world's youth will have countless social, economic, environmental, and other benefits. The national youth policies available in this section of the Toolkit outline individual countries' overall commitments to empowering youth and enabling them to succeed in becoming productive members of their local communities and of an increasingly global society. Many of these policies contain strategies that detail the actions that will be taken to ensure young people succeed.

This section of the Youth Policy Toolkit allows you to browse policy and strategy documents organized by region and country. Many of the materials found here are cross-listed in other sections of the Toolkit according to the particular elements of youth policy that they address.

The youthpolicy.org website provides a list of all countries and the current status of their national youth policy. Through this site, individuals can access the available national youth policies and a specific country's factsheet on a number of youth-related issues.

Use the purple navigation menu on the right to access resources from a particular region and from specific countries within each region.

Do you know of a national youth policy that should be included in this Toolkit? Fill out our feedback form to share your suggestions.

Americas & Caribbean



There are roughly 155 million young people ages 10 to 24 living in Latin America and the Caribbean—about one-third of the total population of the region. Many of these young people are sexually experienced, placing them at risk of unintended pregnancy, unsafe abortion, and infection with sexually transmitted infections (STIs), including HIV. Adolescent pregnancy rates are high in Latin America, and the rate of HIV infection among young people in the Caribbean is alarming.

This section of the Youth Policy Toolkit contains national policies, strategy documents, and other materials that support youth reproductive health policy and strive to improve youth reproductive health outcomes in the Americas and the Caribbean.

Resources:

- **Comparative Analysis: Policies Affecting Family Planning Access for Young Women in Guatemala, Malawi, and Nepal**

This comparative analysis examined the family planning needs of young women in Guatemala, Malawi, and Nepal, and how the policy environment shapes their access to services. In all three countries, adolescents make up a significant proportion of the population, and economic and social environments place barriers in the way that these women seek to achieve their sexual and reproductive health goals. Partly as a result, compared to older women, adolescents have the lowest use of family planning and highest unmet need for services. While the policy environment, as measured by the checklist used in this assessment, ranges from very supportive to highly supportive of adolescent access to family planning information and services, what matters most is how well the countries implement these policies.

- **U.S. Global Strategy to Empower Adolescent Girls**

In March 2016, Secretary of State John Kerry launched the first-ever U.S. Global Strategy to Empower Adolescent Girls, which brings together four U.S. government agencies to tackle barriers that keep adolescent girls from achieving their full potential. As part of the strategy, each agency—the State Department, USAID, the Peace Corps, and the Millennium Challenge Corporation—has its own implementation plan.

Adolescent girls face a unique set of challenges. Safety, health, and access to education are far from guaranteed for this age group in certain parts of the world. But in almost every country, girls experience stereotypes and bias at home, in their communities, or in the classroom.

By bringing together the expertise and strength of these four agencies, the U.S. government hopes to empower girls to get the education and training they need to succeed. With the help of civil society organizations, the private sector, and governments around the world, the action driven by this strategy will prepare the next generation of women to become the leaders of tomorrow.

- **WHO Fact Sheets on Adolescent Contraceptive Use**

These fact sheets present information from 58 countries on adolescents' (ages 15-19) contraceptive use by marital status. In addition, key information, such as reasons for non-use of contraception, as well as where adolescents obtain their contraceptive method, is included. The Demographic Health Surveys (DHS) program www.dhsprogram.com conducts nationally representative surveys in low- and middle-income countries. We use the most recently collected data from any country where 1) a survey has been conducted in the past 10 years (2006-2016) and 2) the data are publicly available. Analyses of DHS in the fact sheets are weighted according to DHS guidance to be nationally representative.

The data provided is aimed to help policymakers and programme planners reduce inequities in service provision and access by understanding adolescents' current sources of contraception, utilised methods, and reasons why they are not using contraception.

- **Breaking the Silence on Violence Against Indigenous Girls, Adolescents and Young Women: A Call to Action Based on an Overview of Existing Evidence from Africa, Asia Pacific and Latin America**

Violence against women and girls is a pervasive violation of human rights that persists worldwide and cuts across all socio-economic groups. This collaborative study aimed to provide a deeper understanding of the magnitude, nature and context of violence

experienced specifically by indigenous girls, adolescents and young women. Drawing on examples from Africa, Asia-Pacific and Latin America, the study assesses the interface between the historical, political, economic, social and cultural contexts of indigenous peoples, and examines the types of violence they face, their prevalence and the settings in which they take place. The report looks at different interventions underway and offers insights and comprehensive recommendations ? including a set of guiding principles ? to accelerate progress and action to protect and prevent violence against indigenous girls and women in all its forms.

- **USAID Policy on Youth - Youth in Development: Realizing the Demographic Opportunity**

This policy puts forward an overarching goal for youth development along with related objectives and outcomes to be achieved. It outlines a conceptual approach to youth in development and provides guiding principles and operational practices in support of USAID?s efforts to mainstream youth in development, carry out more effective programs, and elevate youth participation. Importantly, this policy will position USAID and its partners to capitalize on favorable global population trends by investing in programs and policies by, with, and for youth that seize opportunity and lead to sustainable growth and human development, including through the realization of what is often referred to as a demographic dividend. (Excerpt)

- **Counter-Trafficking in Persons Policy**

This USAID policy sets forth concrete, measurable principles and objectives for combating trafficking.

- **United States' Strategy to Prevent and Respond to Gender-Based Violence Globally**

USAID?s global mandate in development and humanitarian assistance places the Agency in a strong position to effectively address the complex, multifaceted issue of gender-based violence (GBV).

USAID programs support prevention and response to GBV by:

- **Addressing the root** causes of violence

- **Improving prevention** and protection services
- **Responding to the health** and economic needs of those affected by GBV
- **Supporting legislation** and its enforcement against GBV

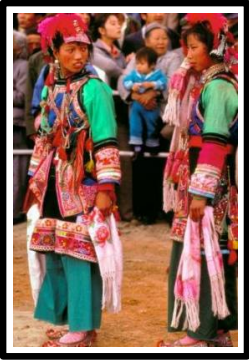
GBV is a human rights and public health issue that limits individual and societal development with high human and economic costs. Eliminating GBV is a long-standing goal of the U.S. Government. The equal participation of women in the political, economic and social spheres is a key ingredient for democratic development.

Unless women fully enjoy their human rights, to which freedom from violence is inextricably bound, progress toward development will continue to fall short. Women who are abused by their partners are less likely to earn a living and less able to care for their children. Children who witness violence are significantly more at risk for health problems, anxiety disorders, poor school performance and violent behavior.

USAID has supported activities around the globe to combat GBV including:

- Educating and encouraging change within communities in Ethiopia regarding the harmful traditional practices of bride abduction, bride price and early marriage;
- Creating safe school environments, in Ghana and Malawi, for girls and boys to promote gender-equitable relationships and reduce school-related GBV;
- Supporting the capacity of local communities to influence changes in attitudes and behavior in order to reduce violence against women and girls in Liberia, Pakistan, Southern Sudan, Uganda, Congolese refugees in Rwanda, and Burmese refugees in Thailand; and
- Promoting community-based efforts to protect women's legal rights in Latin America and the Caribbean.

Asia & Pacific



Currently, one-fifth of the population in South Asia is between the ages of 15 and 24. The large number of sexually active young people and prevalence of early marriage, gender discrimination, and illiteracy in Asia heightens young people's risk of early pregnancy and childbirth, unsafe abortions and unhealthy sexual practices. In the Western Pacific region, young people are major contributors to the labor force and the economy. The ability of young people to contribute to their country's economic prosperity, however, depends on their ability to avoid health risks, particularly those associated with their sexual and reproductive health.

This section of the Youth Policy Toolkit contains national policies, strategy documents, and other materials that support youth reproductive health policy and strive to improve youth reproductive health outcomes in Asia and the Pacific.

Resources:

- **Empowering Indian Millennials: Meeting Youth Sexual and Reproductive Health Needs**

Meeting the needs of India's large youth population is critical. Yet, Indian millennials' desire for sexual and reproductive health information and services is not being met. PRB partnered with Jhpiego India to create this video that uses interviews with youth to highlight youth's lack of sexual and reproductive health (SRH) awareness and barriers they face when trying to access SRH information and services. The accompanying fact sheet summarizes SRH needs of Indian youth, the current state of Indian policy and key steps stakeholders can take to address the needs of young people in India.
- **Comparative Analysis: Policies Affecting Family Planning Access for Young Women in Guatemala, Malawi, and Nepal**

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Guatemala, Malawi, and Nepal, and how the policy environment shapes their access to services. In all three countries, adolescents make up a significant proportion of the population, and economic and social environments place barriers in the way that these women seek to achieve their sexual and reproductive health goals. Partly as a result, compared to older women, adolescents have the lowest use of family planning and highest unmet need for services. While the policy environment, as measured by the checklist used in this assessment, ranges from very supportive to highly supportive of adolescent access to family planning information and services, what matters most is how well the countries implement these policies.

- **Female Genital Mutilation/Cutting Country Profiles**

These statistical profiles present the latest available data on female genital mutilation/cutting (FGM/C) for 30 countries where FGM/C is concentrated. They provide figures on how widespread the practice of FGM/C is, when and how it is performed, and what women and men think about the practice. Trends in prevalence and attitudes are also presented.

- **WHO Fact Sheets on Adolescent Contraceptive Use**

These facts sheets present information from 58 countries on adolescents? (ages 15-19) contraceptive use by marital status. In addition, key information, such as reasons for non-use of contraception, as well as where adolescents obtain their contraceptive method, is included. The Demographic Health Surveys (DHS) program www.dhsprogram.com conducts nationally representative surveys in low- and middle-income countries. We use the most recently collected data from any country where 1) a survey has been conducted in the past 10 years (2006-2016) and 2) the data are publically available. Analyses of DHS in the fact sheets are weighted according to DHS guidance to be nationally representative.

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- **Child Marriage Legislation in the Asia-Pacific Region**

This article focuses on child marriage legislation in 37 countries in the Asia-Pacific region. It discusses how laws and policies can provide for a range of prevention approaches, including measures aimed at empowering girls, improving their health, and building an environment conducive to ending child marriage.

- **Breaking the Silence on Violence Against Indigenous Girls, Adolescents and Young Women: A Call to Action Based on an Overview of Existing Evidence from Africa, Asia Pacific and Latin America**

Violence against women and girls is a pervasive violation of human rights that persists worldwide and cuts across all socio-economic groups. This collaborative study aimed to provide a deeper understanding of the magnitude, nature and context of violence experienced specifically by indigenous girls, adolescents and young women. Drawing on examples from Africa, Asia-Pacific and Latin America, the study assesses the interface between the historical, political, economic, social and cultural contexts of indigenous peoples, and examines the types of violence they face, their prevalence and the settings in which they take place. The report looks at different interventions underway and offers insights and comprehensive recommendations ? including a set of guiding principles ? to accelerate progress and action to protect and prevent violence against indigenous girls and women in all its forms.

- **Child Marriage in Southern Asia: Policy Options for Action**

Child marriage is not only a violation of a girl's rights; it also seriously compromises efforts to reduce gender-based violence, advance education, overcome poverty and improve health indicators for girls and women. In these just released policy and advocacy briefs, the International Center for Research on Women (ICRW) and its partners highlight the life-threatening situations girls in nine Southern Asian countries face on account of child marriage and recommend ways in which policymakers can prevent the practice.

The nine countries included in the briefs are: Afghanistan, Bangladesh, Bhutan, India, Iran, Maldives, Nepal, Pakistan and Sri Lanka.

Europe



Today's generation of young people is larger than ever before. Yet

even in regions like Europe, where youth enjoy relative prosperity, there is a greater need for education, awareness, and supportive laws and policies to promote youth sexual and reproductive health. Young people must be empowered through comprehensive laws and policies that provide them with both awareness about and autonomy over their own sexual and reproductive health. This section of the Youth Policy Toolkit contains national policies, strategy documents, and other materials that support youth reproductive health policy and strive to improve youth reproductive health outcomes in Europe.

Resources:

- **WHO Fact Sheets on Adolescent Contraceptive Use**

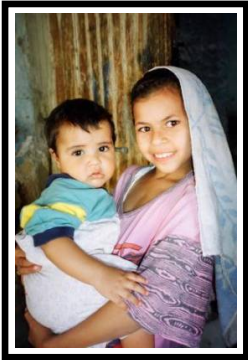
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- **EU Strategy Towards the Eradication of Trafficking in Human Beings 2012-2016**

This strategy expands on issues identified in the Directive on preventing and combating human trafficking and protecting its victims, which include national mechanisms for early identification and assistance of victims. The strategy takes a holistic approach, focusing on prevention, protection, prosecution and partnerships and also looks at ways to increase knowledge on emerging concerns related to trafficking in human beings.

Middle East & North Africa



In the Middle East and North Africa region, one-third of the population is between the ages of 10-24. The ability of these young people to grow into healthy, productive citizens depends on how well governments and nongovernmental organizations invest in youth reproductive health policy and programming.

A Women Deliver fact sheet on young people in the Middle East and North Africa reports that in this region, approximately 4 million young women under the age of 20 are married. In Egypt, female genital cutting is almost universal, with 97% of women of reproductive age having undergone the procedure. In Afghanistan, 40% of girls are married before they reach the age of 18, and in Yemen, one-fourth of girls are married before the age of 15. This trend is particularly worrisome in light of the fact that girls under 15 are five times more likely to die of childbirth-related complications than women in their 20's.

Young people must be empowered through comprehensive laws and policies that provide them with both awareness about and autonomy over their own sexual and reproductive health. This section of the Youth Policy Toolkit contains national policies, strategy documents, and other materials that support youth reproductive health policy and strive to improve youth reproductive health outcomes in the Middle East and North Africa.

Resources:

- **Female Genital Mutilation/Cutting Country Profiles**

These statistical profiles present the latest available data on female genital mutilation/cutting (FGM/C) for 30 countries where FMG/C is concentrated. They provide figures on how widespread the practice of FGM/C is, when and how it is performed, and what women and men think about the practice. Trends in prevalence and attitudes are also presented.

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- ## A Profile of Child Marriage in Africa

This brochure sheds light on historical, current, and predicted future trends in child marriage in Africa.

- ## Ending Child Marriage in the Arab Region

This policy brief presents the latest data on child marriage in the Arab region, which includes members of the League of Arab States (stretching from Morocco to Oman). It explains how ending child marriage would help countries achieve their Millennium Development Goals (MDGs) that aim to combat poverty and improve health and quality of life for all. The brief emphasizes the importance of taking a broad approach to end child marriage, including mandating more years of compulsory education, setting and enforcing the legal minimum age of marriage, raising community awareness about the harm caused by early marriage, and involving families to find ways to prevent child marriage.

Sub-Saharan Africa



Young people constitute a larger proportion of the population of Africa than of any other region of the world. The future of this continent depends on the investments made in African youth today that will allow them to become effective leaders, productive citizens, and good parents tomorrow. Currently, African youth face many challenges as they transition from childhood to adulthood. Poverty, unemployment, violence, sexual coercion, substance abuse, and other harmful situations faced disproportionately by Africa's young people heighten their risk of unintended pregnancy, unsafe abortion, sexually transmitted infections (STIs), and HIV/AIDS.

This section of the Youth Policy Toolkit contains national policies, strategy documents, and other materials that support youth reproductive health policy in Africa.

Resources:

- **Using Data to Target and Scale Up Girls' Support Programs and Child Marriage Prevention in Ethiopia**

This brief is for policy makers and program designers interested in bringing low-cost child marriage prevention interventions to scale. It introduces the Child Census tool, which can be used to identify locations where the greatest numbers of girls are out-of-school and/or married, serve as a rapid baseline survey for project interventions, and monitor the impact of interventions in the areas with the highest rates of child marriage. This rapid tool assesses the status of both girls and boys in communities where it is undertaken, and allows programmers to create a tangible, data-driven justification for programmatic focus on girls. It can also contribute, generally, to evidence-driven programming for children and youth. The Child Census tool was developed as part of the Berhane Hewan program in Ethiopia, a partnership between the Ethiopian government and the Population Council.

- **The Socio-cultural Drivers of Sexual and Reproductive Health for Adolescent Girls in Ethiopia**

This formative research was conducted in order to uncover insights about adolescent girls? (15-19 years old) values, beliefs, and behaviors related to sexual and reproductive health (SRH). It also aimed to understand how the values, beliefs, and behaviors of influencers in girls? lives (e.g. parents, peers, male partners, and community leaders), impact girls? access to SRH information, products and services. This included investigating how cultural norms and expectations related to puberty, sexual debut, marriage, contraceptive use, sexuality, childbearing, maturity and adulthood, influence the contraceptive motivations, emotions, cognitions, and behavior of adolescent girls.

- **Comparative Analysis: Policies Affecting Family Planning Access for Young Women in Guatemala, Malawi, and Nepal**

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- **Kenya National Adolescent Sexual and Reproductive Health Policy**

Kenya's current policy on adolescent sexual and reproductive health

- **A Profile of Child Marriage in Africa**

This brochure sheds light on historical, current, and predicted future trends in child marriage in Africa.

- **Democratic Republic of the Congo Family Planning National Multisectoral Strategic Plan (2014-2020)**

This strategic plan was designed as a reference tool for all family planning interventions in DRC. It aligns with the National Health Development Plan (2011-2015), which seeks to reduce poverty, improve social conditions for the Congolese people through decreasing population growth, and reduce maternal and child mortality, among other things. (excerpt)

- **Let Girls be Girls, Not Mothers! National Strategy for the Reduction of Teenage Pregnancy (2013-2015)**

On the 13th May 2013, the President of Sierra Leone, Ernest Bai Koroma, launched the National Strategy for the Reduction of Teenage Pregnancy. This document was developed by a multi-sectoral committee, set up in 2012, involving key Ministries as well as key stakeholders (UN-Agencies, NGOs, civil society). The strategy's expected outcome is to reduce teenage pregnancy in Sierra Leone by 2015, through integrated and coordinated interventions of all partners.

The multiplicity of actors involved in the Teenage Pregnancy Strategy bears the risk of emitting conflicting messages and overlapping each other's interventions. It is key to ensure that all partners speak with one voice and that communication and training programs be harmonized to develop synergies and widen the impact of interventions. The objective is not to standardize the partners' interventions ? it is crucial that each actor remain in its own area of expertise ? but rather to develop complementarity and collaboration.

The National Secretariat for the Reduction of Teenage Pregnancy is therefore looking to for a partner to design a plan of action for communication in support the National Strategy for the Reduction of Teenage Pregnancy. This communication strategy should be developed by an experienced communication consultant. The following principles should underpin the process:

1. Participatory process: participation to this process should be wide and representation of all key stakeholders is crucial. In addition to the partners of the Strategy, it is important to ensure that young people, service providers, traditional and religious leaders and other key actors be included to guarantee that the selected messages will be adapted to the targeted audience.
2. Holistic approach: the Communication Strategy should not only focus on the classic channels of communication (media, IEC/BCC, etc.) but also include alternative channels such as community mobilization, entertainment events, as well as new communication technologies (social networks, cell-phones, etc.)
3. Government clearance: involvement and participation of key Government officials is also required to ensure that all concerned Ministries will ?own? the results of the strategy and consider the selected messages as ?national messages?.
4. Long-term impact: the Communication strategy should be designed for the total duration of the National Strategy for the Reduction of Teenage Pregnancy. It should aim at a long-term impact taking advantage of the time available.

National Response Efforts to Address Sexual Violence and Exploitation Against Children in Lesotho: A Desktop Study

Scant data exist on the prevalence of violence against children worldwide. However, available information, including the United Nations Secretary-General's Study on Violence against Children, shows that violence against children is a global problem. This desktop study aims to glean from published and grey literature the extent of sexual violence and exploitation against children in Lesotho. The goal of this study is to better understand the government of Lesotho's national response efforts to reduce violence against children.

Breaking the Silence on Violence Against Indigenous Girls, Adolescents and Young Women: A Call to Action

Based on an Overview of Existing Evidence from Africa, Asia Pacific and Latin America

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- ### **Young People Today. Time to Act Now. Why adolescents and young people need comprehensive sexuality education and sexual and reproductive health services in Eastern and Southern Africa**

This report provides a regional assessment of the status of HIV and sexuality education and sexual and reproductive health (SRH) services for adolescents and young people, as well as an evidence base for discussion related to policy change and programming. The report also presents an analysis of the responses under three thematic headings, sexuality education; sexual and reproductive health services; and gender, rights and contextual issues. Ten key recommendations offer guidance on how to move forward, which was the starting point for this campaign.

- ### **Namibian National Gender Policy (2010-2020)**

Namibia developed and adopted its first National Gender Policy (NGP) in 1997. This aimed at closing the gaps created by the socio-economic, political and cultural inequalities that existed previously in Namibian society. To ensure the implementation of the policy, a National Gender Plan of Action was developed in 1998.

In 2010, a review of the 1997 policy was conducted, which showed that some progress had been achieved in the advancement of gender equality and women's empowerment in

Namibia, particularly in economic, political, legal and educational spheres. However, despite this progress, many challenges still remained to be addressed to achieve true equality and thus a new policy was developed to address the gaps.

The Namibia National Gender Policy (2010-2020) seeks to create an enabling environment for sectors to mainstream gender in line with National Development Plans (NDPs). It identifies who will be responsible for the implementation of the policy and who will be accountable for gender equality results.

Compared to the first policy, the new policy has 12 critical areas of concern, with two new areas of peace-building and conflict resolution, and natural disaster management; and gender equality in the family context. Other areas have been made more comprehensive to address emerging issues.

- **Berhane Hewan ("Light for Eve"): Increasing Opportunities to Delay Marriage and Promote Schooling (Policy Brief)**

This policy brief describes girls' experience of early marriage, education, and sexual behavior in rural Amhara Region, Ethiopia. Findings are drawn from a baseline study conducted in 2011, in rural Awi zone of the Amhara Region. Approximately 2,500 girls ages 12 to 17 were interviewed, as well as 500 parents. The brief also discusses efforts in the region to delay marriage and promote girls' schooling. (excerpt)

- **Adolescents and Young People in Sub-Saharan Africa: Opportunities and Challenges**

This interactive map and report present available data for 25 specific indicators, disaggregated by age and sex when possible. The map has been expanded to include trend data for 15 indicators. Graphs have been created for selected indicators for 10 countries. The publication provides an overview of key data findings about population, education, employment, sexual and reproductive health, HIV/AIDS, and gender and social protection issues, and has 45 country profiles.

- **National Strategic Framework for HIV and AIDS Response**

in Namibia 2010/11-2015/16

This framework defines how Namibia will respond to HIV and AIDS through 2016. The country is shifting its focus from service delivery only to understanding how service delivery efforts will lead to changes in the lives of targeted audiences and therefore impact the epidemic itself. Namibia has identified national priorities and articulated national goals to which all stakeholders will contribute. Gender and human rights are mainstreamed into the implementation, monitoring and evaluation strategies.

Policies & Related Resources by Topic



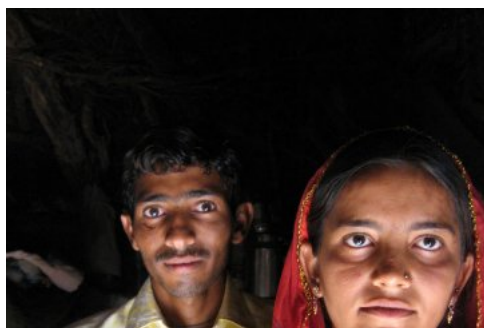
This section of the Youth Policy Toolkit allows you

to browse policy and strategy documents organized by health topic. Many of the materials found here are cross-listed in other sections of the Toolkit according to the particular regions of the world or elements of youth policy that they address.

Use the purple navigation menu on the right to access resources on a particular topic related to youth reproductive health.

Do you have a comment or a resource to suggest for inclusion in the Toolkit? Fill out our feedback form.

Early Marriage



union between two people in which one or both parties are younger than 18 years of age. The Universal Declaration of Human Rights recognizes the right to "free and full" consent to a marriage, acknowledging that consent cannot be "free and full" when one of the individuals involved is not sufficiently mature to make an informed decision about a life partner. Nonetheless, in many low- and middle-income countries, particularly in poorer rural areas, girls are often committed to an arranged marriage without their knowledge or consent. Such an arrangement can occur as early as infancy. Parents see marriage as a cultural rite that protects their daughter from sexual assault and offers the care of a male guardian. Parents often feel that a young girl is an economic burden and therefore wish to marry off their young daughters before they become an economic liability.

Early Marriage Threatens Youth Reproductive Health

- *Spousal age difference can make women more vulnerable to health risks and social isolation by creating power dynamics.* These power dynamics can increase girls' vulnerability to emotional, physical, and sexual abuse. In addition, young married girls are more likely to be illiterate and of low social status. They tend to have no access to financial resources and restricted mobility; they are therefore less likely to leave home to socialize with others, limiting their ability to obtain information on reproductive health, contraception, HIV, and other sexually transmitted infections (STIs). This power differential can also limit girls' ability to negotiate contraceptive or condom use, putting them at high risk for contracting STIs and HIV.
- *Early childbearing poses serious health risks for mother and child.* Marriage often signals the beginning of frequent and unprotected sexual activity. Many girls under the age of 18 (and particularly girls under the age of 15) are not physically mature and therefore unprepared for sexual intercourse or childbirth. Sexual intercourse at a young age is associated with physical pain and pregnancy-related complications, such as obstetric fistula. Pregnancy-related health problems can have emotional and social consequences and pose a financial burden to the household.

Key Areas for Policy Action

- *Enforce existing laws and policies.* Although laws against child marriage exist in many countries, the implementation and enforcement of such laws is often weak. Technical assistance is needed to increase the number of in-country professionals who can appropriately monitor and evaluate programs to better implement, review, and update laws and policies intended to prevent child marriage. A committed multisectoral approach that integrates action plans from the health, education, legal, economic, and labor sectors can help reduce the incidence of early marriage and pregnancy.
- *Provide economic incentives for delayed marriage.* In certain settings and cultures, addressing the economic factors associated with early marriage, such as dowry practices, is essential to developing successful programs that delay the age of marriage among girls.
- *Implement community-based mobilization programs.* Advocating for changes in social

attitudes and norms through multisectoral and integrated community-based programs?such as through religious institutions and associations, health institutions, other local civic organizations, and schools?are the best channels for raising awareness of the negative consequences of early marriage and the many economic, social, and health benefits of delaying marriage.

- *Create safe spaces for girls.* Social networks and civil society organizations play a critical role in developing sustainable safe spaces for girls to meet to share information and ideas and obtain support and guidance. Using public facilities, such as schools after hours or places of worship during non-worship hours can offer catch-up education, financial literacy instruction, savings clubs, and health services either directly or on referral.
- *Support education beyond primary school.* Investments must be made to support girls? education. Evidence suggests that educated girls are less likely to agree to marry at a young age. Development programs need to be creative in implementing programs that support a girl through the critical drop-out period, along with secondary and vocational opportunities that are acceptable to the girls? families.
- *Provide safe and nonexploitative means of livelihood outside the home.* Education and professional training that build the capacity of girls and young women to generate income can enable them to postpone marriage. When education is not a feasible option, income-generation programs can empower women and girls with the skills and tools to reduce their dependency on family members and gain some autonomy.

The State of Policymaking

In countries in South Asia, sub-Saharan Africa, and the Middle East, policy makers recommend enforcing existing laws about age at marriage and implementing programs to delay marriage. Gaining the commitment of law enforcement agencies in countries with a high prevalence of early marriage is important. Greater involvement of teachers and school administrators, health officials, and other authorities is critical in helping girls resist parental and social pressures to marry early.

In the wake of the **Universal Declaration of Human Rights** in 1948, several international treaties and agreements have followed to eradicate early marriage to protect the human rights of children. The 1962 **Convention on Consent to Marriage, Minimum Age for Marriage, and Registration of Marriages** establishes minimum marital ages and requires the registration of marriages. Building on that treaty, the 1979 **Convention on the Elimination of All Forms of Discrimination against Women** (CEDAW) states that ?the betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory.? CEDAW also states that the marriage of a girl is not an official marriage, because the girl is not an adult who can freely and fully consent to the union. This declaration was re-emphasized by the **Convention of the Rights of the Child** in 1989.

Resources:

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Using Data to Target and Scale Up Girls' Support Programs and Child Marriage Prevention in Ethiopia

This brief is for policy makers and program designers interested in bringing low-cost child marriage prevention interventions to scale. It introduces the Child Census tool, which can be used to identify locations where the greatest numbers of girls are out-of-school and/or married, serve as a rapid baseline survey for project interventions, and monitor the impact of interventions in the areas with the highest rates of child marriage. This rapid tool assesses the status of both girls and boys in communities where it is undertaken, and allows programmers to create a tangible, data-driven justification for programmatic focus on girls. It can also contribute, generally, to evidence-driven programming for children and youth. The Child Census tool was developed as part of the Berhane Hewan program in Ethiopia, a partnership between the Ethiopian government and the Population Council.

- ## Lessons Learned from National Initiatives to End Child Marriage

Our 2016 report, *Lessons learned from national initiatives to end child marriage*, explores what lessons can be drawn from the increasing number of national strategies, action plans, and country-wide initiatives to address child marriage around the world, particularly in relation to their implementation across sectors.

This report considers the experiences in 11 countries: Bangladesh, Burkina Faso, Chad, Egypt, Ethiopia, Ghana, Mozambique, Nepal, Uganda, Zambia and Zimbabwe. It will be of particular interest to *Girls Not Brides* members in countries where (i) a national initiatives is still in development, (ii) is about to be rolled out, or (iii) is currently being implemented.

- ## Child Marriage Legislation in the Asia-Pacific Region

This article focuses on child marriage legislation in 37 countries in the Asia-Pacific region. It discusses how laws and policies can provide for a range of prevention approaches, including measures aimed at empowering girls, improving their health, and building an environment conducive to ending child marriage.

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A Profile of Child Marriage in Africa

This brochure sheds light on historical, current, and predicted future trends in child marriage in Africa.

- ### **Ending Child Marriage and Empowering Child Brides**

This policy brief offers suggestions for how to end child marriage, including policy recommendations.

- ### **Harmful Practices, Especially Forced Marriage and Female Genital Mutilation (Information Series on Sexual and Reproductive Health and Rights)**

The purpose of the information series is to provide detailed guidance for lawmakers, policymakers, judiciaries, health service providers, civil society and other stakeholders, to support the adoption and effective implementation of laws, policies and programmes to respect, protect and fulfil women's sexual and reproductive health and rights (SRHR).

- ### **Ending Child Marriage: Prospects and Progress**

Ending child marriage will help break the intergenerational cycle of poverty by allowing girls and women to participate more fully in society. Empowered and educated girls are better able to nourish and care for their children, leading to healthier, smaller families. When girls are allowed to be girls, everybody wins. This brochure explores the data and statistics behind those stories: the current situation of child marriage, lifelong ? sometimes intergenerational ? consequences, progress to date and prospects.

- ### **No Time to Lose: Child Marriage (video)**

This short video examines trends in child marriage in countries around the world and makes predictions and recommendations for the future.

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Solutions to End Child Marriage: Summary of the Evidence

This policy brief highlights five evidence-based strategies identified by ICRW to delay or prevent child marriage: 1) Empower girls with information, skills and support networks; 2) Provide economic support and incentives to girls and their families; 3) Educate and rally parents and community members; 4) Enhance girls' access to a high-quality education; and 5) Encourage supportive laws and policies. In order for the next generation of development programs to make ending child marriage a priority, policymakers must pay attention to these strategies while continuing to test innovative approaches and evaluation techniques.

- ### **Ending Child Marriage in the Arab Region**

This policy brief presents the latest data on child marriage in the Arab region, which includes members of the League of Arab States (stretching from Morocco to Oman). It explains how ending child marriage would help countries achieve their Millennium Development Goals (MDGs) that aim to combat poverty and improve health and quality of life for all. The brief emphasizes the importance of taking a broad approach to end child marriage, including mandating more years of compulsory education, setting and enforcing the legal minimum age of marriage, raising community awareness about the harm caused by early marriage, and involving families to find ways to prevent child marriage.

- ### **Untying the Knot: Exploring Early Marriage in Fragile States**

In this report, World Vision found that of the 25 nations with the highest rates of child marriage, the majority were countries affected by conflict or natural disasters. The report also cites poverty, weak legislative frameworks and enforcement, harmful traditional practices, gender discrimination and lack of alternative opportunities for girls (especially education) as other driving factors of child marriages.

- ### **Child Marriage in Southern Asia: Policy Options for Action**

Child marriage is not only a violation of a girl's rights; it also seriously compromises efforts to reduce gender-based violence, advance education, overcome poverty and improve health

indicators for girls and women. In these just released policy and advocacy briefs, the International Center for Research on Women (ICRW) and its partners highlight the life-threatening situations girls in nine Southern Asian countries face on account of child marriage and recommend ways in which policymakers can prevent the practice.

The nine countries included in the briefs are: Afghanistan, Bangladesh, Bhutan, India, Iran, Maldives, Nepal, Pakistan and Sri Lanka.

- **Berhane Hewan ("Light for Eve"): Increasing Opportunities to Delay Marriage and Promote Schooling (Policy Brief)**

This policy brief describes girls' experience of early marriage, education, and sexual behavior in rural Amhara Region, Ethiopia. Findings are drawn from a baseline study conducted in 2011, in rural Awi zone of the Amhara Region. Approximately 2,500 girls ages 12 to 17 were interviewed, as well as 500 parents. The brief also discusses efforts in the region to delay marriage and promote girls' schooling. (excerpt)

- **Early Marriage Has Consequences for Development**

Fifty-eight million girls in developing countries were child brides in the last decade. This PRB ENGAGE Snapshot highlights the consequences that early marriage can have for girls, such as poor health outcomes and lost opportunities for education and empowerment. But effective strategies to address early marriage do exist and can help millions of girls fulfill their potential and contribute to the development of their families and communities.

This short video can be viewed online as well as downloaded for future use. The video can be embedded into PowerPoint and other presentations, as well as used independently as an educational tool.

- **Convention on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages**

This treaty was agreed upon in the United Nations in order to reaffirm the consensual nature of marriages, to require the establishment of a minimum age of marriage by law, and to

ensure the registration of marriages.

Sexual & Reproductive Health



Young people face a greater risk of unplanned

pregnancy now than ever. Girls are beginning to menstruate younger, and young people are waiting longer to marry; as a result, there is a growing window of time during which premarital sex and pregnancy can occur. On average, one-third of women in developing countries give birth before age 20; a large proportion of these pregnancies are unplanned. Each year, between two million and four million adolescents undergo clandestine or unsterile abortion. Moreover, teen mothers are twice as likely as older women to die of pregnancy-related causes, and their own children are at higher risk of illness and death.

All contraceptive methods are safe for young people, although permanent methods such as vasectomy and female sterilization are not recommended. Yet many people lack access to contraception and related information; in fact, young people have the highest levels of unmet need for family planning of any population.

Access to Contraception is Important to Youth Reproductive Health

- Early and unwanted pregnancy is detrimental to the health and socioeconomic status of young people and their children.
- About 11 percent of all births in low- and middle-income countries are to young women between ages 15 and 19. Many of these 13 million young women are giving birth before their bodies have fully matured.
- Young mothers are at increased risk of complications such as vaginal tears, obstructed labor, fistulae, excessive bleeding, and infection during and after childbirth. Young mothers are also at higher risk of preterm birth and of having low birth weight babies.
- For both physiological and social reasons, women between the ages of 15 and 19 are twice as likely to die in childbirth as those in their twenties. Girls younger than 15 are five times as

likely to die as those in their twenties.

- Infants born to young mothers are more likely to die and suffer from disease than those born to older women.
- Helping young people prevent unwanted pregnancy is the best way to prevent unsafe abortions.

Key Areas for Policy Action

Many of the same policy actions that would help to make contraception available to women and men more generally also apply to contraceptive access for young people. Countries should undertake the following key policy actions that are especially important in improving access for young people:

- *Promote abstinence while recognizing the contraceptive needs of sexually active youth.* Abstinence is a primary means of preventing unwanted pregnancy. However, policy should acknowledge that sexually active youth need increased contraceptive access and options.
- *Promote laws and policies that reduce pregnancy-related death and illness.* These include laws that promote young women's access to reproductive health care and information and that protect young women's health such as prohibition against early marriage.
- *Ensure that youth have access to a wide range of contraception.* Nearly all contraceptive methods are appropriate for adolescents. Law, policy, and clinical guidelines should reflect international consensus on the safety and appropriateness of contraceptive methods, so that health workers have clear guidance to advise and prescribe appropriately to young people based on sound medical criteria.
- *Eliminate restrictions based on social status (for example, denying contraceptives to unmarried adolescents) or based on unfounded medical criteria.*
- *Allow minors to consent to use of contraception without adult approval or notification.* Policies requiring adult consent unnecessarily restrict access to contraception.
- *Ensure that young people have access to comprehensive, youth-focused information about contraceptive options, through schools and other channels.*
- *Promote dual protection against unintended pregnancy and STIs.*
- *Address the role of emergency contraception as a backup to failure of condoms and other contraceptives.*
- *Support youth-friendly services that train health workers to address the special concerns of young people, that maintain confidentiality and privacy, and that are accessible and affordable to young people.*

- *Emphasize open discussion and promotion of condoms and allow schools to provide condoms and other contraceptives, as appropriate.*

The State of Policy Making

A growing number of policies promote access to contraception for young people. Still, in several countries, formal and informal policy barriers limit such access. Often such policy language regarding young people can be found within national population policies, Ministry of Health policies, and guidelines and the policies and guidelines of nongovernmental organizations.

Resources:

- **Empowering Indian Millennials: Meeting Youth Sexual and Reproductive Health Needs**

Meeting the needs of India's large youth population is critical. Yet, Indian millennials' desire for sexual and reproductive health information and services is not being met. PRB partnered with Jhpiego India to create this video that uses interviews with youth to highlight youth's lack of sexual and reproductive health (SRH) awareness and barriers they face when trying to access SRH information and services. The accompanying fact sheet summarizes SRH needs of Indian youth, the current state of Indian policy and key steps stakeholders can take to address the needs of young people in India.
- **WHO Recommendations on Adolescent Sexual and Reproductive Health and Rights**

This document provides an overview of sexual and reproductive health and rights issues that may be important for the human rights, health and well-being of adolescents (aged 10-19 years) and the relevant World Health Organization (WHO) guidelines on how to address them in an easily accessible, user-friendly format. The document serves as a gateway to the rich body of WHO guidelines, and as a handy resource to inform advocacy, policy and programme/project design and research. It aims to support the implementation of the Global Strategy for Women's, Children's and Adolescents' Health 2016-2030, and is aligned with the WHO Global Accelerated Action for the Health of Adolescents (AA-HA!) as well as the WHO Operational Framework on Sexual Health and Its Linkages to Reproductive Health.
- **Comparative Analysis: Policies Affecting Family Planning Access for Young Women in Guatemala, Malawi, and**

Nepal

This comparative analysis examined the family planning needs of young women in Guatemala, Malawi, and Nepal, and how the policy environment shapes their access to services. In all three countries, adolescents make up a significant proportion of the population, and economic and social environments place barriers in the way that these women seek to achieve their sexual and reproductive health goals. Partly as a result, compared to older women, adolescents have the lowest use of family planning and highest unmet need for services. While the policy environment, as measured by the checklist used in this assessment, ranges from very supportive to highly supportive of adolescent access to family planning information and services, what matters most is how well the countries implement these policies.

- ### **Facing the Facts: Adolescent Girls and Contraception**

This detailed brochure paints a picture of adolescent access to contraception and related services around the world.

- ### **Global Youth Family Planning Index**

PRB's new Global Youth Family Planning Index, released in October 2016, measures the favorability of national policy and program environments for youth uptake of contraception. It reviews countries' commitments across six indicators that have been proven to affect access to and use of contraception among youth ages 15 to 24. The first edition includes data and analysis for four countries: Democratic Republic of the Congo, Kenya, Nigeria, and Tanzania, with additional countries to be added in future months.

- ### **Girlhood, Not Motherhood**

When a girl becomes pregnant, her present and future change radically, and rarely for the better. Pregnancy before a girl is physically, developmentally and socially ready jeopardizes her right to a safe, successful transition into adulthood.

This publication presents strategic thinking and reviews the best available evidence on effective strategies and interventions to empower girls and reduce their vulnerability to adolescent pregnancy. Drawing from the evaluated evidence, it provides guidance on how to implement effective programmes that operate at multiple levels and with multiple stakeholders, including and most importantly, with the adolescent girl.

- **Adolescents (Information Series on Sexual and Reproductive Health and Rights)**

The purpose of the information series is to provide detailed guidance for lawmakers, policymakers, judiciaries, health service providers, civil society and other stakeholders, to support the adoption and effective implementation of laws, policies and programmes to respect, protect and fulfil women's sexual and reproductive health and rights (SRHR).

- **Adolescent Women's Need for and Use of Sexual and Reproductive Health Services in Developing Countries**

This report examines a range of sexual and reproductive health indicators for women aged 15-19. The authors then provide recommendations for policy and programmatic strategies that could significantly improve sexual and reproductive health services for adolescents in developing regions: involving youth in planning the programs and policies designed to serve their unique needs, providing them with accurate and effective services and information, and addressing the barriers that young people face when trying to gain access to sexual and reproductive health care.

- **Kenya National Adolescent Sexual and Reproductive Health Policy**

Kenya's current policy on adolescent sexual and reproductive health

- **Educating Girls: Creating a foundation for positive sexual and reproductive health behaviors**

Investments that promote keeping girls in school, particularly in secondary school, have far-reaching and long-term health and development benefits for individuals, families, and communities. The purpose of this brief is to describe the relationship of girls' education on family planning and reproductive health and behaviors; highlight evidence-based practices that increase girls' enrollment, retention, and participation in school; and provide recommendations for how the **health sector** can support keeping girls in school.

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Now Is the Time to Address the Sexual and Reproductive Health Needs of Youth

This policy brief explains what barriers young people face in accessing reproductive health care, and how we can help them break through.

• **Let Girls be Girls, Not Mothers! National Strategy for the Reduction of Teenage Pregnancy (2013-2015)**

On the 13th May 2013, the President of Sierra Leone, Ernest Bai Koroma, launched the National Strategy for the Reduction of Teenage Pregnancy. This document was developed by a multi-sectoral committee, set up in 2012, involving key Ministries as well as key stakeholders (UN-Agencies, NGOs, civil society). The strategy's expected outcome is to reduce teenage pregnancy in Sierra Leone by 2015, through integrated and coordinated interventions of all partners.

The multiplicity of actors involved in the Teenage Pregnancy Strategy bears the risk of emitting conflicting messages and overlapping each other's interventions. It is key to ensure that all partners speak with one voice and that communication and training programs be harmonized to develop synergies and widen the impact of interventions. The objective is not to standardize the partners' interventions ? it is crucial that each actor remain in its own area of expertise ? but rather to develop complementarity and collaboration.

The National Secretariat for the Reduction of Teenage Pregnancy is therefore looking to for a partner to design a plan of action for communication in support the National Strategy for the Reduction of Teenage Pregnancy. This communication strategy should be developed by an experienced communication consultant. The following principles should underpin the process:

1. Participatory process: participation to this process should be wide and representation of all key stakeholders is crucial. In addition to the partners of the Strategy, it is important to ensure that young people, service providers, traditional and religious leaders and other key actors be included to guarantee that the selected messages will be adapted to the targeted audience.
2. Holistic approach: the Communication Strategy should not only focus on the classic channels of communication (media, IEC/BCC, etc.) but also include alternative channels such as community mobilization, entertainment events, as well as new communication technologies (social networks, cell-phones, etc.)
3. Government clearance: involvement and participation of key Government officials is also required to ensure that all concerned Ministries will own? the results of the strategy and consider the selected messages as ?national messages?.
4. Long-term impact: the Communication strategy should be designed for the total duration

of the National Strategy for the Reduction of Teenage Pregnancy. It should aim at a long-term impact taking advantage of the time available.

- **Adolescent Pregnancy: A Review of the Evidence**

This report presents an update on the current situation of pregnancies among girls less than 18 years of age and adolescents 15-19 years of age. The report also covers trends during the last 10 years and variations across geographic, cultural and economic settings, as well as interventions available to minimize pregnancy among adolescents. The report lists evidence for these programmatic approaches, and challenges that nations will have to deal with in the next 20 years given current population momentum.

- **Young People Today. Time to Act Now. Why adolescents and young people need comprehensive sexuality education and sexual and reproductive health services in Eastern and Southern Africa**

This report provides a regional assessment of the status of HIV and sexuality education and sexual and reproductive health (SRH) services for adolescents and young people, as well as an evidence base for discussion related to policy change and programming. The report also presents an analysis of the responses under three thematic headings, sexuality education; sexual and reproductive health services; and gender, rights and contextual issues. Ten key recommendations offer guidance on how to move forward, which was the starting point for this campaign.

- **Preventing Early Pregnancy and Poor Reproductive Health Outcomes: A Toolkit**

Nearly 16 million girls between 15 and 19 years old give birth annually, almost all of them in developing countries. After a systematic review of the evidence, WHO developed the guidelines Preventing Early Pregnancy and Poor Reproductive Outcomes among Adolescents in Developing Countries, which focus on key actions that aim to reduce the number of adolescent pregnancies in developing countries. In 2012, in collaboration with WHO and UNFPA, FCI developed this advocacy toolkit, available in English, French, and Spanish, to promote the dissemination of the guidelines' recommendations to policymakers and program planners globally. Designed for advocates, the toolkit encourages and enables evidence-based action among decision makers, opinion leaders, medical personnel, researchers, and affected communities to prevent early pregnancy and poor reproductive

outcomes among adolescent girls.

Female Genital Cutting



An estimated 200 million women and girls who are

alive today have undergone female genital cutting (FGC), and 3 million girls are at risk each year. FGC, a traditional practice that involves excision of part or all of the external genitalia - often with unclean sharp instruments such as razor blades or pieces of glass - can have a devastating effect on girls' physical and psychological health.

Female Genital Cutting Threatens Youth Reproductive Health

- A significant proportion of girls undergo FGC during early adolescence. In Egypt, for example, 43 percent of women circumcised had the procedure between ages 10 and 14.
- Even if they have been cut as a young child, girls continue to suffer the physical and emotional consequences of the cutting into adolescence and beyond. In particular, the negative health effects of FGC manifest themselves as girls become sexually active and begin to bear children.
- Young girls are more than just victims of FGC. Young women--and young men--are the next generation of decision makers within the family and community. Thus, they are a prime target for the educational campaigns that aim to eventually eradicate the practice.
- In addition to being the targets of educational campaigns, young women and men also can be effective as advocates for eliminating the practice.

Key Areas for Policy Action

FGC in general is an active area for policy making, with much of the attention focused on outlawing the practice through legislation. Although banning FGC would certainly have an impact

on youth, there are several other key policy actions that specifically focus on young people. These include the following:

- *Recognize the youth dimension of the practice.* For example, national action plans for abandonment of FGC should include specific references to young people.
- *Integrate FGC into existing Maternal and Child Health and Adolescent Health and Development policies.* Countries need to ensure that existing policies that focus on youth also appropriately address FGC as a reproductive health issue.
- *Encourage a rights-based approach.* A focus on the rights of children and young women not to undergo FGC may be more effective than an approach that focuses on the health consequences of the practice.
- *Modify and clarify operational guidelines for health workers.* Such guidelines should recognize the medical problems FGC-affected adolescent girls may face when starting their sexual and reproductive lives.
- *Acknowledge the need for youth-focused educational campaigns.* For instance, education sector policies should include appropriate policy language on FGC. This might encompass inclusion of FGC as a topic within comprehensive sexuality or life-skills education in the schools.
- *Recognize the youth role as advocates.* Policy language should recognize the importance of involving young people in advocacy efforts to eliminate FGC.

The State of Policy-Making

A growing number of countries have taken action to outlaw FGC. However, very few youth-specific FGC policies exist. Experts recognize this as an important gap that countries need to address. Anti-FGC laws are important because without them, it is difficult to upscale interventions to the national level. Such laws and policies provide a positive environment for abandoning the practice. Experience has shown, however, that laws are not a panacea. FGC is deeply rooted in traditions of many communities. Merely outlawing it is unlikely to affect the practice.

Resources:

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Manual on Social Norms and Change

This manual is meant for training programme managers to promote the abandonment of female genital mutilation/cutting (FGM/C). It has been designed under a joint programme of the United Nations Population Fund and the United Nations Children's Fund. The Joint Programme applies an innovative approach to FGM/C abandonment, using a social norms perspective to guide the selection of an appropriate mix of strategies and activities most conducive to self-sustained social change.

- **Female Genital Mutilation/Cutting Country Profiles**

These statistical profiles present the latest available data on female genital mutilation/cutting (FGM/C) for 30 countries where FGM/C is concentrated. They provide figures on how widespread the practice of FGM/C is, when and how it is performed, and what women and men think about the practice. Trends in prevalence and attitudes are also presented.

- **Harmful Practices, Especially Forced Marriage and Female Genital Mutilation (Information Series on Sexual and Reproductive Health and Rights)**

The purpose of the information series is to provide detailed guidance for lawmakers, policymakers, judiciaries, health service providers, civil society and other stakeholders, to support the adoption and effective implementation of laws, policies and programmes to respect, protect and fulfil women's sexual and reproductive health and rights (SRHR).

- **Female Genital Mutilation/Cutting: A Global Concern**

This two-page brochure provides key facts and statistics about female genital cutting around the world.

- **Female Genital Mutilation/Cutting: Data and Trends Update 2014 - Infographic**

This infographic highlights key data and trends from PRB's datasheet, *Female Genital Mutilation/Cutting: Data and Trends Update 2014*. The infographic explains what female genital mutilation/cutting (FGM/C) is; who is affected by the practice; where the practice is still

present; progress toward ending FGM/C; and lessons learned from 20 years of interventions.

- **Female Genital Mutilation/Cutting: Data and Trends - Update 2014**

An estimated 100 million to 140 million girls and women worldwide have undergone female genital mutilation/cutting (FGM/C) and more than 3 million girls are at risk for cutting each year on the African continent alone. The PRB data sheet, *Female Genital Mutilation/Cutting: Data and Trends Update 2014*, contains the latest information available on the practice. This update of PRB's 2010 wallchart shows the practice is still present in at least 29 developing countries, although there is some evidence that younger generations in some countries may face a slightly smaller risk.

- **Implementation of the International and Regional Human Rights Framework for the Elimination of Female Genital Mutilation**

A human rights approach to FGM places the practice within a broader social justice agenda ? one that emphasizes the responsibilities of governments to ensure realization of the full spectrum of women?s and girls? rights. In order to place FGM within a human rights framework, it is critical to know more about human rights law. The aim of this paper is to contribute to the dearth of literature focusing on the gross violation of human rights through the practice of FGM. It also addresses the corresponding duties of governments under international human rights law.

- **No Time to Lose: Female Genital Mutilation/Cutting (video)**

This three-minute video explores how trends in female genital mutilation are changing and makes predictions and recommendations for the future.

- **Female genital mutilation (Fact sheet)**

This WHO fact sheet provides key facts on female genital mutilation, describes the procedures and the harm they can cause, and explores the cultural, religious, and social causes of this harmful practice. The fact sheet also summarizes the current international

response to female genital cutting.

Gender-Based Violence



Gender-based violence (GBV) is violence involving men and women in

which the female is usually the victim. GBV often stems from unequal power relationships and includes physical, sexual, and psychological harm. Various forms of GBV include intimate partner violence (including marital rape, sexual violence, and dowry-related violence), female infanticide, femicide, sexual abuse of female children in the household, early marriage, forced marriage, female genital cutting (FGC) and other harmful traditional practices, sexual harassment in schools and workplaces, commercial sexual exploitation, trafficking of girls and women, and violence against domestic workers. GBV also encompasses violence which is perpetuated or condoned by the state.

Although the global community has focused greater attention on GBV in recent years, levels of violence against women remain high. Eliminating GBV is a political challenge because it necessitates challenging the social, political, and economic inequalities between men and women.

Gender-Based Violence Threatens Youth Reproductive Health

GBV results in reproductive health problems-- often with lasting physical, social, emotional, psychological, and economic consequences. Research has uncovered numerous links between exposure to GBV and subsequent health outcomes among youth.

- **Fatal outcomes** include femicide, suicide, AIDS-related mortality, and maternal mortality.
- **Non-fatal outcomes** encompass the following:
 - Physical: fractures, chronic pain syndromes, fibromyalgia, permanent disability, gastrointestinal disorders
 - Sexual and reproductive: STIs including HIV, unintended pregnancy, pregnancy complications, traumatic gynecologic fistula, abortion complications
 - Psychological and behavioral: depression and anxiety, eating and sleep disorders, drug and alcohol abuse, poor self-esteem, post-traumatic stress disorder, self-harm

Key Areas for Policy Action

Effective action involves addressing both the complex root causes of GBV, as well as its immediate and long-term effects on victims. Aside from the health sector, the education sector

can play an important role in preventing and addressing GBV, particularly through health programs and policies in schools. The judicial sector and police can also play important roles by enforcing laws and policies aimed at GBV prevention and treatment. A comprehensive approach to addressing GBV as a youth reproductive health issue should include the following integrated and multi-sectoral policy actions:

- *Enact policies to empower women and girls.* To reduce gender imbalances at the root of GBV, key legal and policy actions should advocate for delayed marriage, promote equitable divorce and property laws that allow women the chance to leave abusive relationships, and establish constitutional frameworks that guarantee equality for women.
- *Pass laws against sexual coercion and domestic violence.* It is just as important to have a legal and justice system that enforces these laws effectively.
- *Demonstrate clear political commitment to ending GBV.* High-level government officials should consistently and publicly denounce GBV and support necessary changes in community norms that influence GBV-related behaviors of boys and young men.
- *Establish operational policies and guidelines to support program efforts.* Public and private health facilities should institute policies and procedures to help providers recognize the signs of GBV and respond appropriately to meet the needs of GBV victims.
- *Ensure that national reproductive health, HIV, adolescent health, and maternal health policies and legislation specifically address the negative reproductive health consequences of GBV.* Such policies should give clear guidance to health workers on their obligations in reporting and treating GBV. Policies should also address the provision of emergency contraception and post-exposure antiretroviral prophylaxis to rape victims to protect against pregnancy and HIV infection.
- *Ensure that school policies and guidelines directly address GBV.* Schools may be a particularly unsafe place for young women. Policies should strengthen the ability of teachers and administrators to address GBV and also require them to report sexual violence against students.

The State of Policymaking

Although many governments have adopted policies related to GBV, few of them specifically relate to young people. Furthermore, many supportive laws and policies are not enforced. Several international agreements and policies address GBV and can be useful for formulating national laws and policies and conducting advocacy:

Convention on the Elimination of All Forms of Discrimination against Women (1979)

Vienna Declaration and Programme of Action (1993)

The UN Declaration on the Elimination of Violence against Women (1993)

International Conference on Population and Development Programme of Action (1994)

Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (1994)

Beijing Declaration and Platform for Action (1995)

For more on international policies, see Prevent GBV Africa and UN Division for the Advancement of Women.

From Rhetoric to Reality: Policy Implementation Tips

Watch out for well-intentioned GBV-related policies that could negatively affect provision of reproductive health services. Laws requiring health workers to report GBV cases can run counter to principles of confidentiality. Without clear guidelines and careful training of health workers, such policies may inadvertently diminish the willingness of both victims and health workers to discuss violence. Health workers must be trained to recognize the symptoms of GBV and assist victims of GBV in a knowledgeable manner. Victims should feel secure that health workers will not blame them or divulge confidential information to relatives, thus putting the victims at additional risk of violence. Furthermore, HIV prevention services, sexual and reproductive health services, antenatal care, maternal and child health services, and voluntary counseling and testing services need to address GBV in an integrated manner.

Resources:

- **Essential Services Package for Women and Girls Subject to Violence**

The United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence (the Joint Global Programme) was officially launched by UNFPA and UN Women in December 2013, with support and funding from the Government of Spain and the Australian Government. The participating UN agencies include: UNFPA, UN WOMEN, WHO, UNDP and UNODC.

The Joint Global Programme aims to improve the quality of and access to essential services for women and girls who have experienced violence and seeks to encourage implementation of the Agreed Conclusions from the 57th Commission on the Status of Women by bridging the gap between international commitments and what is actually implemented at country level. The programme strives to: 1) reach global consensus on standards and guidelines for delivering quality essential services in the areas of health, police and justice, social services and coordination and governance; 2) provide technical advice to guide implementation; and, 3) build the capacity of service providers to deliver the essential services.

The standards and guidelines for all four sectors ? health, police and justice, social services and coordination and governance ? were finalized in December 2015 and the global launch of the UN Essential Services Package took place on 10 December 2015 at the Global Conference on Ending Violence against Women in Istanbul (this conference was co-organized by UNFPA, UNW and the Government of Turkey).

- **Essential Services for Women and Girls Who Experience Violence (video)**

The United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence and the rationale for why women and girl victims and survivors of violence need to access quality essential services as a matter of right.

- **Minimum Standards for Prevention and Response to Gender-based Violence in Emergencies**

Gender based violence is a life-threatening, global health and human rights issue that violates international human rights law and principles of gender equality. In emergencies, such as conflict or natural disasters, the risk of violence, exploitation and abuse is heightened, particularly for women and girls. UNFPA's ?Minimum Standards for Prevention and Response to GBV in Emergencies (GBViE)? promote the safety and well being of women and girls in emergencies and provide practical guidance on how to mitigate and prevent gender-based violence in emergencies and facilitate access to multi-sector services for survivors.

- **Global status report on violence prevention 2014**

The *Global status report on violence prevention 2014*, which reflects data from 133 countries, is the first report of its kind to assess national efforts to address interpersonal violence, namely child maltreatment, youth violence, intimate partner and sexual violence, and elder abuse.

Jointly published by WHO, the United Nations Development Programme, and the United Nations Office on Drugs and Crime, the report reviews the current status of violence prevention efforts in countries, and calls for a scaling up of violence prevention programmes; stronger legislation and enforcement of laws relevant for violence prevention; and enhanced services for victims of violence.

- **The Making of Sexual Violence: How Does a Boy Grow Up to Commit Rape?**

This report presents an overview of five study sites of the International Men and Gender Equality Survey (IMAGES), presents findings related to men's self-reported perpetration of sexual violence, investigates seven domains of possible influences on men's sexual violence perpetration and provides actionable lessons and recommendations.

- **A Statistical Snapshot of Violence Against Adolescent Girls**

While all adolescents may experience violence, being a girl presents some unique vulnerabilities - some with consequences that can last a lifetime.

- **National Response Efforts to Address Sexual Violence and Exploitation Against Children in Lesotho: A Desktop Study**

Scant data exist on the prevalence of violence against children worldwide. However, available information, including the United Nations Secretary-General's Study on Violence against Children, shows that violence against children is a global problem. This desktop study aims to glean from published and grey literature the extent of sexual violence and exploitation against children in Lesotho. The goal of this study is to better understand the government of Lesotho's national response efforts to reduce violence against children.

- **Breaking the Silence on Violence Against Indigenous Girls, Adolescents and Young Women: A Call to Action Based on an Overview of Existing Evidence from Africa,**

Asia Pacific and Latin America

Violence against women and girls is a pervasive violation of human rights that persists worldwide and cuts across all socio-economic groups. This collaborative study aimed to provide a deeper understanding of the magnitude, nature and context of violence experienced specifically by indigenous girls, adolescents and young women. Drawing on examples from Africa, Asia-Pacific and Latin America, the study assesses the interface between the historical, political, economic, social and cultural contexts of indigenous peoples, and examines the types of violence they face, their prevalence and the settings in which they take place. The report looks at different interventions underway and offers insights and comprehensive recommendations ? including a set of guiding principles ? to accelerate progress and action to protect and prevent violence against indigenous girls and women in all its forms.

United States' Strategy to Prevent and Respond to Gender-Based Violence Globally

USAID's global mandate in development and humanitarian assistance places the Agency in a strong position to effectively address the complex, multifaceted issue of gender-based violence (GBV).

USAID programs support prevention and response to GBV by:

- **Addressing the root** causes of violence
- **Improving prevention** and protection services
- **Responding to the health** and economic needs of those affected by GBV
- **Supporting legislation** and its enforcement against GBV

GBV is a human rights and public health issue that limits individual and societal development with high human and economic costs. Eliminating GBV is a long-standing goal of the U.S. Government. The equal participation of women in the political, economic and social spheres is a key ingredient for democratic development.

Unless women fully enjoy their human rights, to which freedom from violence is inextricably bound, progress toward development will continue to fall short. Women who are abused by their partners are less likely to earn a living and less able to care for their children. Children who witness violence are significantly more at risk for health problems, anxiety disorders, poor school performance and violent behavior.

USAID has supported activities around the globe to combat GBV including:

- Educating and encouraging change within communities in Ethiopia regarding the harmful traditional practices of bride abduction, bride price and early marriage;
- Creating safe school environments, in Ghana and Malawi, for girls and boys to promote gender-equitable relationships and reduce school-related GBV;
- Supporting the capacity of local communities to influence changes in attitudes and behavior in order to reduce violence against women and girls in Liberia, Pakistan, Southern Sudan, Uganda, Congolese refugees in Rwanda, and Burmese refugees in Thailand; and
- Promoting community-based efforts to protect women's legal rights in Latin America and the Caribbean.

HIV and other STIs



Preventing sexually transmitted infections (STIs), including HIV, is a central goal of youth reproductive health policy. Approximately 2 million young people ages 10 to 19 are living with HIV, and young females are disproportionately affected. Eighty-two percent, or 1.6 million, of the 2 million adolescents living with HIV live in sub-Saharan Africa, where 7 in 10 of new HIV infections among young people ages 15 to 19 occur in girls. The concentration of new infections among youth has created immense health problems and threatens the economic and social underpinnings of the countries hit hardest by the epidemic.

In addition, more than 100 million young people each year contract curable STIs. An untreated STI can cause infertility, chronic pain, stillbirth, and ectopic pregnancy and heighten the risk of HIV infection. Yet rates of reinfection are substantially higher among young people than adults, partly because they are less likely to use a condom and to seek effective treatment. Young people are generally less informed about STIs, less likely to recognize symptoms, and more averse to seeking treatment due to stigma and societal pressures. Training health providers on how to provide youth-friendly services can help ensure young people are properly diagnosed and treated for STIs.

HIV and STI prevention efforts aimed at young people focus on the following goals:

- Access to condoms, education, and information on safer sex and HIV/AIDS
- Care and support for people living with HIV (YPLHIV)
- Reaching orphans and vulnerable children (OVC)
- Prevention of mother-to-child transmission of HIV (PMTCT)
- Prevention and treatment of STIs
- Prevention of stigma and discrimination
- Access to youth-friendly HIV testing and counseling

Key Areas for Policy Action

Because of the importance of voluntary counseling and testing (VCT) in combating HIV and AIDS, health ministries in many countries now support VCT through national policies. To address the special needs of youth, a number of key policy actions are warranted. These include the following:

- *Allow minors to consent to VCT without requiring the consent of a parent or other adult.* In addition, policy should direct counselors to encourage all minors to consult parents or other trusted adults about their decision to test, where such consultation would be conducive to testing.
- *Protect the confidentiality of HIV test results for minors consistent with the obligation to protect their right to privacy.* Policy should prohibit the disclosure of information on the HIV status of minors to third parties including parents without the consent of the minor. At the same time, policy should direct counselors to encourage minors to discuss test results with their parents or guardians, in the case of those minors who have supportive relationships with parents or guardians.
- *Reassure counselors and other health care workers that they can provide VCT to adolescent minors who request it, without fear of retribution.*
- *Modify operational guidelines.* VCT policy should support adjustments to training, communications, referral, and other systems to make services more attractive to adolescents and to improve their quality and effectiveness.
- *Encourage a youth-friendly approach in all VCT centers.* Young people seek VCT services regardless of where the services are provided. Thus, policies should ensure that all VCT services provide appropriate care to young clients.
- *Support the development of VCT services for especially-vulnerable youth.* Policies should make it a priority to serve vulnerable groups such as young people who sell sex, young people who inject drugs, orphans, and street children.
- *Encourage the involvement of young people as VCT peer educators.*
- *Forge links between VCT and other aspects of young people's lives.* VCT services are an opportunity to connect young people with other health care and to services that help meet job and education needs.
- *Develop stand-alone youth and VCT policy.* Particularly in high HIV prevalence countries, it is important to have a stand-alone policy that addresses youth and HIV issues, as opposed to

addressing youth within a larger HIV policy.

- *Include VCT within national YRH policies.*
- *NGO policies are important too.* In some countries, NGOs are the main provider of VCT care. Such NGOs should develop their own policies-ideally based on a national standard-for serving youth with VCT services.

The urgency of addressing HIV/AIDS has somewhat overshadowed policy and program action on other STIs. Policies should reflect the importance of STI treatment and diagnosis for young people. Some key policy actions include:

- *Position STI diagnosis and treatment as a health problem that shares priority with and complements HIV/AIDS prevention efforts.*
- *Allow minors to consent to STI examinations and treatment without requiring consent of parent or other adult.* Parents are an important source of emotional support and clinic-based counselors should encourage all minors to consult with parents or other trusted adults. Consent and disclosure requirements for mature minors should be similar to those recommended for voluntary counseling and testing programs.
- *Promote comprehensive sexuality education programs in schools to enable youth to recognize STI symptoms and choose to seek treatment.*
- *Encourage youth friendly reproductive health care through stand-alone clinics or "youth corners."* Sexually active, unmarried youth tend not to utilize existing reproductive health services for fear of being judged.
- *Promote affordability of STI treatment.* Young people often have limited financial resources and would be reluctant to borrow money from friends or relatives.
- *Encourage comprehensive reproductive health services that provide STI care, family planning, and voluntary counseling and testing for youth.*

The State of Policy Making

Recent advances in HIV and AIDS policies present an opportunity for the inclusion of STI considerations. Many HIV policy documents also address STI diagnosis and treatment, but few explicitly address the needs of young people.

The major international policy documents on VCT, while applying equally to young people, generally lack youth-specific provisions. One of the international agreements with most relevance to VCT and youth is the Convention on the Rights of the Child. The Convention defines a "child" as a person below the age of 18, unless the relevant laws recognize an earlier age of majority. Article 24 of the Convention affirms that children have the right to attain the highest standards of health and to health care, including family planning education and services (a right also recognized in earlier conventions and conferences).

The Convention on the Rights of the Child also acknowledges that children's ability to make important decisions, including decisions about their health, increases with age and experience. Article 5 calls on governments to respect the rights and duties of parents, legal guardians and extended families or communities (if empowered by local custom) to guide and direct children in the exercise of their rights "in a manner consistent with the evolving capacities of the child". The

ICPD similarly noted the need to balance the responsibilities and rights of parents or guardians with the "evolving capacities" of "adolescents" (a term not in the Convention but used throughout the ICPD Programme of Action). (adapted from State of World Population, UNFPA, 2003)

Resources:

- **Advocacy Toolkit: Children and Adolescents Living with and at Risk for HIV**

This tool kit provides statistics, messages, and key actions that first ladies can undertake to advocate for continued uptake of prevention of mother-to-child transmission (PMTCT) of HIV services, increased early infant diagnosis (EID) of HIV, and improved pediatric HIV treatment coverage. It will also help first ladies address the unique issues faced by adolescents both growing up with and at risk for HIV. This tool kit complements the recently launched African Union? Organisation of African First Ladies Against HIV/ AIDS Elimination of Mother-to-Child Transmission of HIV (AU-OAFLA EMTCT) campaign by providing supplemental background information on technical areas and advocacy strategies that can then be tailored for individual use. Finally, the tool kit facilitates the achievement of the goals in OAFLA?s strategic plan of 2014?2018 and beyond.

- **Guidance Document: Strengthening the Adolescent Component of National HIV Programmes Through Country Assessments**

This guidance document and its accompanying tool, the Adolescent Assessment and Decision-Makers Tool (AADM), were devised to facilitate country assessments aimed at strengthening the adolescent component of national HIV programmes. The purpose of the country assessments is to: (1) support country teams in the identification of equity and performance gaps affecting adolescent HIV programming; and (2) define priority actions to improve the effectiveness of the national adolescent HIV response.

- **HIV and Young Transgender People**

Key populations at higher risk of HIV include people who sell sex, men who have sex with men (MSM), transgender people and people who inject drugs. Young people who belong to one or more of these key populations ? or who engage in activities associated with these populations ? are made especially vulnerable to HIV by factors including widespread

discrimination, stigma and violence, combined with the particular vulnerabilities of youth, power imbalances in relationships and, sometimes, alienation from family and friends. These factors increase the risk that they may engage ? willingly or not ? in behaviours that put them at risk of HIV, such as frequent unprotected sex and the sharing of needles and syringes to inject drugs.

This brief aims to inform discussions about how best to provide health services, programmes and support for young transgender people. It offers a concise account of current knowledge concerning the HIV risk and vulnerability of young transgender people; the barriers and constraints they face to appropriate services; examples of programmes that may work well in addressing their needs and rights; and approaches and considerations for providing services that both draw upon and build the strengths, competencies and capacities of these young people.

- ## **HIV and Young People Who Inject Drugs**

Key populations at higher risk of HIV include people who sell sex, men who have sex with men (MSM), transgender people and people who inject drugs. Young people who belong to one or more of these key populations ? or who engage in activities associated with these populations ? are made especially vulnerable to HIV by factors including widespread discrimination, stigma and violence, combined with the particular vulnerabilities of youth, power imbalances in relationships and, sometimes, alienation from family and friends. These factors increase the risk that they may engage ? willingly or not ? in behaviours that put them at risk of HIV, such as frequent unprotected sex and the sharing of needles and syringes to inject drugs.

This brief aims to inform discussions about how best to provide health services, programmes and support for young people who inject drugs. It offers a concise account of current knowledge concerning the HIV risk and vulnerability of young people who inject drugs; the barriers and constraints they face to appropriate services; examples of programmes that may work well in addressing their needs and rights; and approaches and considerations for providing services that both draw upon and build the strengths, competencies and capacities of young people who inject drugs.

- ## **HIV and Young Men Who Have Sex with Men**

Key populations at higher risk of HIV include people who sell sex, men who have sex with men (MSM), transgender people and people who inject drugs. Young people who belong to one or more of these key populations ? or who engage in activities associated with these populations ? are made especially vulnerable to HIV by factors including widespread discrimination, stigma and violence, combined with the particular vulnerabilities of youth, power imbalances in relationships and, sometimes, alienation from family and friends. These

factors increase the risk that they may engage ? willingly or not ? in behaviours that put them at risk of HIV, such as frequent unprotected sex and the sharing of needles and syringes to inject drugs.

This technical brief is one in a series addressing four young key populations. It is intended for policy-makers, donors, service-planners, service-providers and community-led organizations. This brief aims to inform discussions about how best to provide health services, programmes and support for young MSM. It offers a concise account of current knowledge concerning the HIV risk and vulnerability of young MSM; the barriers and constraints they face to appropriate services; examples of programmes that may work well in addressing their needs and rights; and approaches and considerations for providing services that both draw upon and build to the strengths, competencies and capacities of young MSM.

- **HIV and Young People Who Sell Sex**

Key populations at higher risk of HIV include people who sell sex, men who have sex with men (MSM), transgender people and people who inject drugs. Young people who belong to one or more of these key populations ? or who engage in activities associated with these populations ? are made especially vulnerable to HIV by factors including widespread discrimination, stigma and violence, combined with the particular vulnerabilities of youth, power imbalances in relationships and, sometimes, alienation from family and friends. These factors increase the risk that they may engage ? willingly or not ? in behaviours that put them at risk of HIV, such as frequent unprotected sex and the sharing of needles and syringes to inject drugs.

This technical brief is one in a series addressing four young key populations. It is intended for policy-makers, donors, service-planners, service-providers and community-led organizations. This brief aims to inform discussions about how best to provide services, programmes and support for young people who sell sex. It offers a concise account of current knowledge concerning the HIV risk and vulnerability of young people who sell sex; the barriers and constraints they face to appropriate services; examples of programmes that may work well in addressing their needs and rights; and approaches and considerations for providing services that both draw upon and build the strengths, competencies and capacities of young people.

- **Children & AIDS: 2015 Statistical Update**

At the turn of the century, and the beginning of the Millennium Development Goals, an HIV diagnosis was equivalent to a death sentence for most children and their families in low-income countries. But now, an early diagnosis paired with treatment and care can ensure long healthy lives, regardless of location, and can help prevent transmission of HIV to others. Since 2000, thirty million new infections were prevented, nearly eight million deaths averted, and fifteen million people living with HIV are now receiving treatment.

- **A new health sector agenda for HIV/AIDS (Advocacy brochure on the Global Health Sector Strategy on HIV/AIDS, 2011-2015)**

WHO has developed a new Global Health Sector Strategy on HIV/AIDS that proposes a fundamental shift in health-sector programmes in countries over the next five years. The strategy builds on recent advances in prevention and treatment and on new knowledge that is broadening our understanding of what is needed to confront not only HIV/AIDS but also other major health challenges. It is designed to respond to the demands of a rapidly evolving epidemic.

- **National Strategic Framework for HIV and AIDS Response in Namibia 2010/11-2015/16**

This framework defines how Namibia will respond to HIV and AIDS through 2016. The country is shifting its focus from service delivery only to understanding how service delivery efforts will lead to changes in the lives of targeted audiences and therefore impact the epidemic itself. Namibia has identified national priorities and articulated national goals to which all stakeholders will contribute. Gender and human rights are mainstreamed into the implementation, monitoring and evaluation strategies.

Poverty Reduction



Youth reproductive health (YRH) is compromised by poverty. Studies

have found that girls living in poor households are more likely to be exposed to sexual coercion and to engage in high-risk behaviors, such as transactional sex, nonconsensual sex, and sex with multiple partners than girls who are financially better off. Youth advocates cite a growing body of evidence that economic disparities fuel the HIV epidemic and contribute to other negative health outcomes among young people.

Investing in the human and social capital of these young people is crucial to ending the cycle of poverty. Comprehensive policies should acknowledge the relationship between investments in the reproductive health of young people and broader positive impacts on society, including the economic stimulus, poverty reduction, and slowed population growth. Such investments are particularly important in light of the unprecedented numbers of young people now entering their reproductive years.

Poverty Threatens Youth Reproductive Health

- Youth ages 15 to 24 years old constitute 25 percent of the global working-age population, but account for 44 percent of the unemployed.
- Studies of female sex workers show that a large majority of them are under the age of 25. Poor household conditions often force young women to engage in sex work, which increases their risk of HIV infection.
- Poverty and inadequate health care systems compound the vulnerability of young women to maternal morbidity and mortality. Every minute, a woman somewhere dies in pregnancy or childbirth. This adds up to 1,400 women a day?529,000 a year?dying from pregnancy-related complications. Young mothers are at higher risk of serious complications during pregnancy and childbirth because their bodies often have not yet fully matured.
- Poverty and reproductive health are intricately related. Poverty is associated with high-risk behaviors, such as transactional and coerced sex. These behaviors put young women at risk of unintended pregnancy, HIV, and sexually transmitted infections (STIs).
- Globally, HIV is spreading most rapidly among young people between the ages of 15 and 24. Half of new infections worldwide occur in this age group. In sub-Saharan Africa, 75 percent of all new HIV infections occur among young women and girls ages 15 to 24.
- Great disparities exist between adolescents from high- and low-income families for indicators including age at marriage, skilled attendance at birth, nutrition, contraceptive use, and knowledge of HIV.

Sustainable Livelihoods

Attention is now being focused on how sustainable livelihoods can help young people achieve improved health outcomes and lead empowered and productive lives. Sustainable livelihood programs seek to create long-lasting solutions to poverty by empowering their target population with knowledge, skills, and a means of generating income. The programs are varied in their focus, approach, and target audience, although many do the following:

- Provide youth with opportunities to earn income.
- Offer financial services and related on-the-job training.

- Develop institutions, alliances, and networks for youth to advance their economic interests.
- Promote policy and social changes that improve young people's livelihood prospects.

Youth livelihood programs can improve YRH by preventing exploitation of young people, linking young people with RH and HIV information and services, and reducing risky behavior. Most programs are small-scale, community-based interventions that reflect the specific context and needs of their target population.

Key Areas for Policy Action

By highlighting inequities in health access and outcomes, advocates and policymakers can enrich the understanding of the links between poverty and poor reproductive health. Such analyses can also influence decisions on how countries can set priorities for spending in ways that reduce poverty, while also achieving national health goals, including reductions in maternal and child deaths. To encourage action, countries should develop policies that do the following:

- *Take youth into account as a special population when diagnosing and assessing poverty.* Accurately assessing poverty in a given community requires attention to vulnerable or at-risk groups, such as youth, who are much more likely than older people to lack access to health care.
- *Promote approaches to providing young women with technical skills and advocate for greater income-generating opportunities in their communities.* Labor force participation and employment issues are among the most pressing in most countries worldwide.
- *Ensure that youth have access to reproductive health services and supplies.* This is crucial in achieving the Millennium Development Goals and improving health in low-and middle-income countries.
- *Stress the multisectoral impact of YRH interventions.* Linking reproductive health with actions in other sectors, particularly education and employment, strengthens the case for investment in youth. Programs that support girls' education and literacy have ancillary benefits, such as increasing women's employment opportunities, discouraging early childbearing, decreasing school dropout rates, and reducing malnutrition.
- *Stress the interrelatedness of HIV/AIDS, poverty and reproductive health needs when adapting and implementing policy.* Due to unequal power relationships between women and men in many countries, women are often unable to take actions to prevent pregnancy or HIV. As a result, an estimated 630,000 newborns are infected with HIV during pregnancy each year.
- *Involve men in sexual and reproductive health as clients, partners, and agents of social change.* Male involvement is crucial to promoting women's health and alleviating poverty and malnutrition.

Youth participation in the policy making process, as well as in program planning, design, and implementation, is critical to the ability of sustainable livelihoods policy and programming to improve the reproductive health outcomes and socioeconomic status of young people.

The State of Policymaking

In recent years, international development agencies including the United Nations and World Bank have increased their attention to the link between poverty reduction and YRH. In addition, some countries' national policies include language reflecting the importance of this linkage. Several national poverty reduction strategies include specific youth reproductive actions for poverty reduction within their overall frameworks. For example, Nicaragua's 2005 National Development Plan identifies adolescents as a priority group for reproductive health services, and its policy matrix and action plan specifies a line item for a campaign to reduce teen pregnancy. However, despite the progress in addressing the link between reproductive health and poverty reduction, recent reviews have concluded that countries need to do much more to tie these poverty reduction strategies to specific monitoring objectives and budget outlays.

Resources:

- **U.S. Global Strategy to Empower Adolescent Girls**

In March 2016, Secretary of State John Kerry launched the first-ever U.S. Global Strategy to Empower Adolescent Girls, which brings together four U.S. government agencies to tackle barriers that keep adolescent girls from achieving their full potential. As part of the strategy, each agency—the State Department, USAID, the Peace Corps, and the Millennium Challenge Corporation—has its own implementation plan.

Adolescent girls face a unique set of challenges. Safety, health, and access to education are far from guaranteed for this age group in certain parts of the world. But in almost every country, girls experience stereotypes and bias at home, in their communities, or in the classroom.

By bringing together the expertise and strength of these four agencies, the U.S. government hopes to empower girls to get the education and training they need to succeed. With the help of civil society organizations, the private sector, and governments around the world, the action driven by this strategy will prepare the next generation of women to become the leaders of tomorrow.

- **Economic Empowerment Strategies for Adolescent Girls**

This strategy document on adolescent girls and finance is based upon programmes of the Adolescent Girls' Advocacy and Leadership Initiative (AGALI) in Guatemala, Honduras, Liberia, Malawi, and Ethiopia. From the Executive Summary: "This research investigates economic empowerment strategies for adolescent girls, analyzing data from a wide array of

initiatives. This report identifies key findings from the field and develops recommendations to inform future program development for civil society organizations and funders working in the field of adolescent girls' economic empowerment.

- **Including Youth in the Post-2015 Agenda: Youth Sexual and Reproductive Rights & Poverty**

This policy brief is part of the series *Including Youth in the Post-2015 Development Agenda*. The series illuminates the connections between sexual and reproductive rights and development issues that are central to youth and should be included in the Post-2015 Development Agenda.

- **Children and Economic Strengthening Programs: Maximizing Benefits and Minimizing Harm**

It is a common belief that programs designed to increase household income will automatically have positive effects on children. In fact, the evidence shows that this assumption cannot be taken for granted. In some cases, the interventions that increase household economic activities actually lead to greater problems for children and youth, such as more child labor and less school attendance, particularly in the short term.

Trafficking & Coercion



Reducing human trafficking and sexual abuse and coercion is a key element of youth reproductive health policy. Most trafficked children are recruited by someone they know, including men, women, family members, neighbors, friends, or boyfriends. A majority of the victims trafficked are manipulated by false promises of opportunities and a higher quality of life.

Human trafficking is a crime that deprives people of their rights and freedoms, increases global health risks, fuels growing networks of organized crime, and can sustain levels of poverty and

impede development in certain areas. Not only do trafficked persons suffer devastating consequences, including physical and emotional abuse, rape, threats against self and family, and death, but trafficking also undermines the health, safety, and security of all nations it touches.

Trafficking Threatens Youth Reproductive Health

- More than 12 million adults and children are in forced labor, bonded labor, and commercial sexual servitude at any given time; more than half of all forced labor victims are women and girls under the age of 25.
- Trafficking of children and young women is often, but not always, associated with prostitution, sexual coercion, and sexual violence. This can lead to severe psychological and physical trauma, putting women and children at greater risk for unintended pregnancy and HIV and other sexually transmitted infections (STIs).
- Youth who have been trafficked for sex often have difficulty seeking reliable health care and suffer stigma and discrimination, especially if they become infected with HIV or other STIs.

Key Areas for Policy Action

To be effective, anti-trafficking programs should address the four phases experienced by a trafficked person: (1) pre-movement, (2) movement, (3) post-movement/exploitation, and (4) post-exploitation. The trafficking of minors requires a policy response that recognizes their distinct experiences. To address trafficking among women and youth, policies should do the following:

- *Outlaw trafficking* and prescribe stringent penalties to deter the crime, but ensure that laws and regulations do not infringe on legitimate migration.
- *Enforce laws against trafficking*, including support to develop local law enforcement capacity to adequately investigate and prosecute traffickers, while protecting the rights of trafficked persons and maintaining their confidentiality. It is especially important that trafficked minors not be treated as criminals.
- *Support educational efforts* that combine specific anti-trafficking messages with primary and secondary education. This will inform young people and influential adults (e.g., parents, teachers, and coaches) about the dangers of trafficking. Such efforts can occur within existing programs to improve youth reproductive health or increase economic opportunities.
- *Address the social context*, including the vulnerability of women and other underlying causes of trafficking. Adolescent reproductive health programs can easily incorporate messages about the risks of trafficking and the promotion of safe labor migration.
- *Encourage links* between HIV prevention programs and anti-trafficking groups. This is particularly important during both the exploitation and post-exploitation stages of trafficking, when trafficked persons are most vulnerable.

- *Support rehabilitation for trafficked youth, including school and job opportunities.* Compared with trafficked adults, care and support services for youth are more demanding, and reintegrating youth into the community is more challenging.
- *Support participation of youth* by allowing them to influence national policy development through public forums with local authorities and participation-based organizations.

It is important to distinguish between trafficking of adults and trafficking of children. Children need special programs to protect their rights and ensure their needs are met by their parents and the government. Trafficking in children deserves particular attention and specific responses because of children's vulnerability to being trafficked and the distinct psychological, physical, and social impacts of trafficking on children and their prospects for reintegration.

The State of Policy Making

The U.S. Department of State drafted the U.S. Trafficking Victims Protection Act (TVPA) of 2000, which guides efforts to combat human trafficking and outlines minimum standards for its elimination. Many countries have anti-trafficking policies that address the various stages of trafficking, but often these policies are not comprehensive. Some countries are currently working toward recognizing human trafficking as an international problem by holding conferences addressing human trafficking or developing national action plans. However, there are others that have not attempted to comply with the minimum standards set forth in the TVPA. Policies addressing trafficked youth are included in policies on child protection and mental health. Few reproductive health and HIV/AIDS policies specifically address trafficking.

Key Web Sites

Global Alliance Against Traffic in Women (GAATW). GAATW is a network that advocates for a human rights-based approach to trafficking.

International Organization for Migration (IOM). The IOM's website describes its counter-trafficking activities, which include aid to governments to improve legal systems to combat trafficking.

Legislationline.org. This online legislative database from the Office for Democratic Institutions and Human Rights of the Organization for Security and Co-operation in Europe provides assistance to those who prepare and draft laws; it includes a special section on trafficking.

Office to Monitor and Combat Trafficking in Persons. The Department of State's Office to Monitor and Combat Trafficking in Persons leads the United States' global engagement against human trafficking, an umbrella term used to describe the activities involved when someone obtains or holds a person in compelled service.

Polaris Project. A leading organization in the global fight against human trafficking and modern-day slavery. By successfully pushing for stronger federal and state laws, operating the National Human Trafficking Resource Center hotline (1-888-373-7888), conducting trainings, and providing vital services to victims of trafficking, Polaris Project creates long-term solutions that

move our society closer to a world without slavery.

Resources:

- **2016 Trafficking in Persons Report**

"If there is a single theme to this year's *Trafficking in Persons (TIP) Report*, it is the conviction that there is nothing inevitable about trafficking in human beings. That conviction is where the process of change really begins—with the realization that just because a certain abuse has taken place in the past doesn't mean that we have to tolerate that abuse in the future or that we can afford to avert our eyes. Instead, we should be asking ourselves—what if that victim of trafficking was my daughter, son, sister, or brother?

"This year's *TIP Report* asks such questions, because ending modern slavery isn't just a fight we should attempt—it is a fight we can and must win." ? *John F. Kerry, Secretary of State*

- **Human Trafficking Protection Checklist**

This checklist represents a non-exhaustive collection of effective victim protection practices compiled by the State Department's Office to Monitor and Combat Trafficking in Persons from a variety of sources, including NGOs and foreign governments. The suggestions listed may not be feasible or appropriate in all situations, but represent practices that governments may consider in developing victim protection strategies.

- **Counter-Trafficking in Persons Policy**

This USAID policy sets forth concrete, measurable principles and objectives for combating trafficking.

- **EU Strategy Towards the Eradication of Trafficking in Human Beings 2012-2016**

This strategy expands on issues identified in the Directive on preventing and combating human trafficking and protecting its victims, which include national mechanisms for early identification and assistance of victims. The strategy takes a holistic approach, focusing on prevention, protection, prosecution and partnerships and also looks at ways to increase knowledge on emerging concerns related to trafficking in human beings.

Source URL: <https://www.k4health.org/toolkits/youthpolicy>