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Rapid analysis of Adolescent Sexual and Reproductive Health (ASRH) and HIV/AIDS related policies in Zimbabwe, Zambia and Uganda.

Commissioned by the

Commonwealth Regional Health Community Secretariat (CRHCS) for East, Central and Southern Africa (ECSA)

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Acknowledgements

This report provides an overview of the rapid assessment of adolescent sexual reproductive health and HIV/AIDS related policies in the three countries of Zimbabwe, Zambia and Uganda.

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Disclaimer

The views in this report are entirely of the author and not necessarily of the Commonwealth Regional Health Community Secretariat (CRHCS) for East, Central and Southern Africa (ECSA)
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List of acronyms

AIDS  Acquired Immune Deficiency Syndrome
ASRH  Adolescent Sexual Reproductive Health
AYA  African Youth Alliance
BCC  Behaviour Change Communication
CRHCS  Commonwealth Regional Health Community Secretariat
DISH  Delivery of Improved Services for Health
ECSA  East, Central and Southern Africa
FP  Family Planning
HIV  Human Immuno Virus
IEC  Information, Education and Communication
M&E  Monitoring and Evaluation
MVA  Manual Vacuum Aspiration
NAC  National AIDS Council (Zimbabwe)
NGOs  Non Governmental Organizations
PAC  Post Abortion Care
PEARL  Programme for Enhancing Adolescent Reproductive Life
PLWA  People Living with AIDS
RH  Reproductive Health
RHMC  Regional Health Ministers’ Conference
STD  Sexually Transmitted Diseases
TASO  The AIDS Support Organization
TOR  Terms of Reference
UN  United Nations
UNFPA  United Nations Population Fund
UPE  Universal Primary Education
USAID  United States Agency for International Development
VCT  Voluntary Counseling and Testing
WHO  World Health Organization
YFS  Youth Friendly Services
YP  Young People
ZIHP  Zambia Integrated Health Project
Executive summary

Introduction

The Commonwealth Regional Health Community Secretariat (CRHCS) is an intergovernmental organization comprised of 14 member states including Uganda, Zambia and Zimbabwe. The secretariat was established in 1974 to assist the East, Central and southern Africa (ECSA) countries identify and develop capacity to address priority health needs in the region. It is mandated to promote and foster efficiency and relevance in the provision of health related services in the region.

The 30th CRHCS Regional Health Ministers' Conference (RHMC) held in Seychelles in October 1999 and the follow on consultative workshop in Arusha Tanzania from 26th to 30th March 2001, raised concern about the rapid spread of HIV in the region. One of the recommendations from the conference and the workshop was that CRHCS should work with member states in identifying priority issues and strategies to be addressed in mounting an effective response to the pandemic and to consider the development of a regional strategy on HIV/AIDS.

It is with this background that the secretariat commissioned a rapid assessment of policies and guidelines with relevance to young people (10 –24 years) to inform the CRHCS policy and advocacy efforts for ASRH programming in the region as an integral component of the HIV/AIDS pandemic control. This is in view of the disproportionately high new HIV infections in this age group.

Furthermore, current research indicates that effectiveness in stimulating positive health behavior relies on three mutually reinforcing types of interventions for youth namely:

- creating a safe and supportive environment
- providing health education and services, and
- Expanding opportunities.

It is very apparent that policies are needed now than ever before to ensure young peoples rights to access needed integrated ASRH services including voluntary counseling and testing, post abortion care, family planning including condoms, emergency obstetric care and sexually transmitted diseases services.

Scope of the report

This report identifies the current state of existing ASRH and HIV/AIDS policies and to a limited extent, their translation into programs in the three CRHCS member state countries of Zimbabwe, Uganda and Uganda. The report findings are primarily based on qualitative data obtained from interviews with key informants in the three countries, review of a wide array of documents including reports, strategic plans, guidelines, issues reviews and analysis, thematic literature review and internet search.

Current state of ASRH and HIV/AIDS related policies in the three countries.

In all the three countries, there is a positive trend in recognition of young people’s specific related policies and needs as ratified through the existing policies related to young people and their development status, listed below by country.

Zimbabwe

(i) National HIV/AIDS policy, Ministry of Health, Dec 1999 (approved by the cabinet)
(ii) National Youth policy, Ministry of youth development, gender and employment creation, Sept 2000 (approved by the cabinet)
(iii) National population policy, National economic planning commission, Oct 1998 (approved by cabinet)
(iv) Draft Reproductive health policy, ministry of health and child welfare, Jan 2002 (in the development process)

Zambia

(ii) The draft National Population policy, Ministry of Finance and Economic Development, Jan 2000. (The first population policy was promulgated in 1989 in Zambia.)
(iii) **Draft Reproductive health policy**, Ministry of Health, August 2000. The policy is in the final stages of the development process.

**Uganda**

i. **National health policy**, Ministry of health, September 1999. *(Approved by cabinet).*

ii. **National youth policy**, Ministry of gender, labor and social development, June 2001. *(Approved by cabinet).*

iii. **National population policy**, Ministry of finance and economic planning, Jan. 1995. *(Approved by the cabinet)*

iv. **Draft national adolescent health policy**, Ministry of Health, August 2000. *(Adopted and in use by MOH but not approved by the cabinet).*


**Policy development**

The policy development process in all the countries was consultative in general. Unsurprisingly, governments, academia and research institutions, programmers, health workers, bilateral and multilateral donors, UN agencies and non governmental organizations including youth, religious and other groups were involved in the policy development processes for all the policies since they are already involved in ASRH.

There is notable need for:

a) Increased involvement of relevant sectors of society that have an increasingly significant role in ASRH programming like the mass media, lawyers and the judiciary system, law enforcement institutions, trade unions and workers organizations, pharmaceutical industries and the private sector in general, in the policy formulation and implementation.

b) Involvement of young people as a significant stakeholder in the policy formulation and review but more especially in the identification of issues during the concept formulation process.

c) Ensuring the policy formulation processes is not top down biased in the policies issue identification, with more needed intensive consultations at community levels.

**Implementation status of existing ASRH related policies.**

In general, policy development is simultaneously being undertaken along with ASRH programming in all the three countries. In some cases, ASRH programming has superceded the policy formulation. Therefore, it was not easy to access the direct translation of policies into the existing ASRH programs. Furthermore, it was beyond the scope of this assessment to ascertain the effectiveness of policies on ASRH programs.

In all the three countries, ASRH programs are being provided through combined efforts by governments, multi and bilateral donors and civil society including national and international non-government organizations, community based organizations and the private sector. The latter, more in the media and social marketing programs. Youth organized groups are a rarity in ASRH programs in all the three countries and where they are involved, it is on a small scale with minimal funding and expansion opportunities.

The policies and strategic plans in the three countries are developed with the intention to provide ASRH programs in an ‘explosion’ manner but this is not translated into actual programs on the ground. The existing ASRH programs are currently conceptualized and designed with a ‘project like mentality’ both in scale and duration. Consequently, most of the projects are in urban areas and not reaching the most vulnerable and rural young people that need the services most.

There is notable investment and increasing resources allocated to ASRH programs in the recent past, in all the countries. However, national commitments are far from the international agreements of allocation of at least 20% of the official development assistance and 20% of the national budgets respectively, to the social sectors including reproductive health in general. There is general tendency to ‘under invest’ in ASRH programs in all the three countries. The current budget allocations to ASRH were indicated by the key informants as meager, in the respective sectoral ministries in the three countries.

The assessment indicates that in reality, not much evidence-based information is available about ASRH programming in the three countries in relation to health and general development. There was general lack of
national database on who is involved in ASRH programs and clear mapping of ASRH programs by country regions, districts and communities. Consequently, there are hardly any evidence based ASRH policy and advocacy programs. Furthermore, there are no clearly defined national and context specific, defined sets of minimum indicators for monitoring ASRH programs. The existing ASRH initiatives in all the three countries are on project basis and are mainly focused on:

i Improving knowledge, skills, attitudes and self efficiency

ii Improving health seeking safer practices.

There is compelling need for investing in or to undertake preparatory actions to foster an enabling environment through evidence based policy and advocacy activities before introduction of an ASRH intervention in all the three countries. This is in addition to selection of interventions appropriate to community’s needs and readiness to support the activities.

The existing ASRH interventions or projects have been through:
− Planned expansion - expanding the number of sites and the number of young people served through pilot models especially through media, youth centers and peer provided services
− Association – expanding program size and coverage through common efforts and alliances across a network of public, non for profit private sector and civil society organizations as is the case with social marketing of condoms and STI kits
− Grafting – adding youth friendly services initiatives to existing public and other sector health service delivery structure hence making programs directed at adults ‘youth friendly’.

Concluding thoughts
This assessment focused on ASRH related polices and their translation into programs in only three countries. Although the findings from the rapid assessment in the three countries of Zimbabwe, Zambia and Uganda may not necessarily be representative of the situation in all the CRHCS member states, there is demonstrated and compelling urgent need for:

i Policy, advocacy and advocacy relevant research for renewed political will at all levels to support ASRH as part of the national development programs with a focus on:
   − Explicit formulation of HIV/AIDS and young people policies
   − Legalization of existing draft policies
   − Wide dissemination of existing policies.

ii More action and resources to support research and identification of effective strategies to scale up ASRH programs that is adapted to each segment of the youth population and each cultural context.

iii Emphasis on ASRH program innovation and address cost effectiveness and sustainability.

iv Flexibility of donors to provide larger and long-term grants and acceptance of diverse strategies adapted to widely varying social cultural contexts.

In a complex field where there are no biomedical solutions, the high rates of HIV infections and other pressing sexual and reproductive health problems among young people calls for an urgent need to promote health seeking behavior and positive health outcomes among young people in a cost effective way.
1.0 Background

1.1 Introduction

The Commonwealth Regional Health Community Secretariat (CRHCS) is an intergovernmental organization comprised of 14 member states namely Botswana, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. The secretariat was established in 1974 to assist the East, Central and southern Africa (ECSA) countries identify and develop capacity to address priority health needs in the region. It is mandated to promote and foster efficiency and relevance in the provision of health related services in the region.

The 30th CRHCS Regional Health Ministers' Conference (RHMC) held in Seychelles in October 1999, raised concern about the rapid spread of HIV in the region. One of the recommendations from the conference was that CRHCS should work with member states in mounting an effective response to the pandemic and to consider the development of a regional strategy on HIV/AIDS.

The secretariat convened a follow on consultative workshop in Arusha Tanzania from 26th to 30th March 2001 to identify priority issues and strategies to be addressed by the region in order to step up the fight against the epidemic. Creating a supportive and enabling environment for providing multi-sectoral and integrated adolescent sexual reproductive health services was identified as a priority area in the control of the HIV/AIDS pandemic.

It is with this background that the secretariat commissioned a rapid assessment of policies and guidelines with relevance to young people (10 –24 years) to inform the CRHCS policy and advocacy efforts for ASRH programming in the region as an integral component of the HIV/AIDS pandemic control. The following specific objectives guided the assessment.

1.2 Assessment objectives

i. Document existing policies and their key components that focus on adolescents (10 –24 years) in ECSA for sexual and reproductive health, particularly those focusing on HIV/AIDS prevention and care.

ii. Assess existing policies and their key components, including human rights and gender aspects and their translation into programs.

iii. Document results of any evaluations and assessments done on existing policies and their translation into practice.

iv. Document innovative approaches on policy development and translation into programs.

v. Prepare a final report and present it to CRHCS

vi. Work with CRHCS to develop policy briefs and presentations to the DJCC and ministers based on the assessment findings.

The rapid assessment did not include in depth evaluation of the effectiveness of the existing policies but rather focused on ascertaining the availability and status of policies that address ASRH broadly or young people in general. The review was limited to documenting whether key specified components were included in the policy but not the quality, the latter was considered beyond the scope of the assessment.

1.3 Methodology

The assessment was conducted in a 40 days period from May to June 2002 in three countries namely Zimbabwe, Zambia and Uganda. The three countries were pre-selected by CRHCS.

Qualitative information was gathered from key informants in the mentioned countries using an interview guide that was jointly developed by CRHCS, USAID - REDSO Nairobi and the consultants. In each country, efforts were made to have in-depth interviews with the first category of key informants mentioned below:

- Director national AIDS council or the appropriate national coordinating mechanism in the country
- Director of the Ministry of Health HIV/AIDS pogrom
- Ministry focal persons for reproductive health, adolescent health or adolescent reproductive health
- Representative of the ministry of youth affair/social welfare, where they exist.
Views were also got from representatives of:
- The donor community, both Bi and Multilateral donors
- USAID, Chair of the UNAIDS theme group, UNICEF, UNFPA
- People living with AIDS (PLWA) and youth groups,
- NGO’s like Red Cross, family planning associations and health providers

Furthermore, country specific document reviews were done including policy documents, strategic plans, guidelines, assessments and reports. This was complemented with thematic literature review and Internet searches where feasible.

1.4 The importance of the policies and programs focused on young people including their sexual and reproductive rights.

Demography
More than 30% of the world’s total population – over 1.7 billion people – is aged between 10-24 years, making this the largest group ever to enter adulthood. According to the United Nations estimations, by the year 2020, approximately 87% of the world’s young people will be living in the developing countries. Furthermore, while for less developed countries as whole, the increase in numbers of 10-24 year olds by the year 2020 is expected to be 33%, the increase in sub Saharan Africa is projected to be 125%.

Definitions of an adolescent, youth and young people.
World health organization (WHO) in 1989 defined ‘adolescents’ as persons in the 10 – 19 years age group and ‘youth’ as the 15 –24 year age group. ‘Young people’ covers the age range 10 – 24 years, combining the two overlapping groups into one entity. The three terms, depending on the context, are sometimes used interchangeably, as also stated in the terms of reference (TOR) for this assessment.

Although the decade of life from 10-19 years provides us a formal, temporal definition of an adolescent, the social and cultural norms recognition of the concept and values placed on adolescence, as a transition period between childhood and adulthood vary substantially between societies and cultures. In many populations, adolescence is not recognized as such and special rituals commonly - but not universally, mark the relative sudden transition from childhood to adulthood.

Adolescence characterized by an exceptionally rapid rate of growth and development is sometimes divided into early, middle and late periods roughly grouped as 10 -14, 15 –17 & 18-19 years respectively, roughly corresponding with physical, social and psychological development in the transition from childhood to adulthood. (Table 1, summarizes the different development stages in adolescence).

Unfortunately, the relationship between these physical, social and psychological development changes and vulnerability to health problems remains largely unexplored in developing countries. Consequently some countries barely recognize the concept or give scant attention to it programmatically and politically. In contrast, some countries have begun to place more emphasis on this age group logically on education and training, but increasingly on health and well being.
**Table 1: Stages in adolescence**

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>EARLY</th>
<th>MID</th>
<th>LATE (variable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/13 to 14/15</td>
<td>Growth</td>
<td>2nd sexual characteristics appear</td>
<td>2nd sexual characteristics advanced</td>
</tr>
<tr>
<td>14/15 to 17</td>
<td>Growth accelerates and reaches peak velocity</td>
<td>Growth decelerates; approx 95% of adult stature attained</td>
<td></td>
</tr>
<tr>
<td>17 to 21</td>
<td>Cognition</td>
<td>Concrete thinking</td>
<td>Thinking more abstract</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Existential orientation</td>
<td>Capable of long-range thinking</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Long range implications of actions not perceived</td>
<td>Reverts to concrete thinking when stressed</td>
</tr>
<tr>
<td></td>
<td>Psychosocial</td>
<td>Preoccupied with rapid physical change</td>
<td>Re-establishes body image</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Body image disrupted</td>
<td>Preoccupation with fantasy and idealism</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sense of omnipotence</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td>Defining boundaries of Independence/dependence</td>
<td>Conflicts over control</td>
</tr>
<tr>
<td></td>
<td>Peer group</td>
<td>Seeks affiliation to counter instability</td>
<td>Needs identification to affirm image</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Compress self with same Sex/age peers</td>
<td>Peer group define behavioural code</td>
</tr>
<tr>
<td></td>
<td>Sexuality</td>
<td>Self exploration and evaluation</td>
<td>Preoccupation with romantic fantasy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Testing ability to attract opposite sex</td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Ref: WHO

**Importance of ASRH and health related behavior of young people.**

In comparison to the health of children, under fives and even adults, the health of young people in developing countries has largely been ignored. Traditionally, the main “health” indicator used by health planners, policy makers, researchers and programmers has been mortality. Consideration of mortality rates alone has resulted in young people being seen as healthy, and this has lead to their being accorded a low priority for health related interventions, neglecting and denying the young people the basic human right to reproductive health.

Morbidity statistics reported by health services also tend to show low rates among young people. However, these data are influenced not only by the underlying rates of disease within the population but also by the likelihood that that a person with a disease will attend a health facility. Many of the reproductive health conditions that affect young people disproportionately rarely come to the attention of service providers. Table 2, provides five broad categories of health problems and health-related behaviors in young people with illustrative examples. It becomes immediately apparent from this classification and from the selected examples that the importance of the health and health related behavior of young people will be grossly under estimated if the only criterion used is the current levels of morbidity and mortality.

Gains in child health and survival programs are lost if the young people - at the next stage in the life cycle – are not helped enough in making a healthy transition to adulthood.
Adolescent sexual activity, pregnancy rates, non-marital child bearing, complications of unsafe abortion, STD and HIV rates have increased in many developing countries. A greater concern has developed to address these issues even if it requires overcoming sensitivities and resistance. The HIV pandemic, disproportionately affecting young people, has made this task more urgent. UNAIDS currently estimates over half of the new HIV/AIDS infections each year to be in young people below 25 years. The framework for action to commitments to sexual and RH and rights for all, indicates that more than 15 million girls aged 15 –19 give birth every year. One in twenty adolescents contract an STD, with the highest rates occurring in youth 15 –24 years. In many developing countries, over 60% of all new infections are among the 10 - 24 years of age. 10% percent of abortions or as many as 5 million a year are among women 15 –19 years of age. In addition, girls and young women are especially vulnerable to rape, sexual abuse and sexual exploitation.

Gains in child health and survival are lost if the young people - at the next stage in the life cycle – are not helped enough in making a healthy transition to adulthood. Prevention efforts among the youth are key in preventing the spread of the HIV/AIDS epidemic. Not only are young people the population sector most at risk of contracting HIV/AIDS in most countries but also the most responsive to prevention programs. Adult behavior patterns are formed during this crucial stage in life.

Helping youth make a health transition to adulthood while increasing their opportunities for education and livelihoods is perhaps the most important investment a society can make in its future development and the most important long-term strategy to reduce poverty. Youth are the most important resources for any society and its hope for the future.

Table 2: A classification of the health problems and health related behaviors of young people in developing countries with illustrative examples

<table>
<thead>
<tr>
<th>Diseases particular to young people</th>
<th>Diseases and unhealthy behaviors which affect young people disproportionately</th>
<th>Diseases which manifest themselves in primarily in young people, but originate in childhood</th>
<th>Diseases and unhealthy behaviors of young people, whose major implications are on the young person’s future health</th>
<th>Diseases which affect young people less than children, but more than older adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diseases</td>
<td>Diseases</td>
<td>Diseases</td>
<td>Diseases</td>
<td>Diseases</td>
</tr>
<tr>
<td>Disorders of secondary sexual development</td>
<td>Maternal mortality &amp; morbidity</td>
<td>Chagas disease</td>
<td>Sexually transmitted (including HIV)</td>
<td>Malnutrition</td>
</tr>
<tr>
<td>Difficulties with psycho-social development</td>
<td>Sexually transmitted (including HIV)</td>
<td>Rheumatic heart disease</td>
<td>Leprosy</td>
<td>Malaria</td>
</tr>
<tr>
<td>Sub-optimal adolescent growth spurt</td>
<td>Tuberculosis</td>
<td>Polio</td>
<td>Dental disease</td>
<td>Diarrhoea</td>
</tr>
<tr>
<td></td>
<td>Schistosomiasis</td>
<td></td>
<td></td>
<td>Acute respiratory infections</td>
</tr>
<tr>
<td></td>
<td>Intestinal helminths</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behaviors</td>
<td>Tobacco use</td>
<td></td>
<td>Behaviors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alcohol abuse</td>
<td></td>
<td>Lack of exercise</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other substance abuse</td>
<td></td>
<td>Unsafe sexual practices</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Injuries</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Ref: WHO
1.5 Policy as an important component of ASRH

Definition of a policy
The 4th international edition of the population reference bureau, 2000, describes a policy as a plan or course of action, of a government, party or business, intended to influence and determine decisions, actions and other matters.

Why focus on policy in ASRH?
Commitments to sexual and reproductive health and rights for all: framework for action, 1995, based on the relevant international agreements and conventions including the Beijing, Copenhagen, Cairo and Vienna conferences provides a comprehensive checklist for governmental commitments in this area. It clearly indicates policy as one of the major specific actions necessary for addressing priority issues in sexual and reproductive health and ultimately for ensuring that the core principles and commitments to agreements are honored in relevant national plans. Lessons from HIV/AIDS programs to-date have identified the role of reducing stigma and discrimination as a prerequisite for effective prevention, thus demonstrating how incorporating human rights concern enhances program effectiveness. Furthermore, current research indicates that effectiveness in stimulating positive health behavior relies on three mutually reinforcing types of interventions for youth namely:
- creating a safe and supportive environment
- providing health education and services, and
- Expanding opportunities.
It is very apparent that policies are needed now than ever before to ensure young peoples rights to access needed integrated ASRH services including voluntary counseling and testing, post abortion care, family planning including condoms, emergency obstetric care and sexually transmitted diseases services.

Policy guidelines
The commitments to sexual and reproductive health and rights for all: framework for action further acknowledges that issues of sexuality and reproduction are sensitive and often controversial in every society, more so for ASRH. They lie at the root of private and intimate human relations and decision making; challenge contemporary morality and religious beliefs; and touch on cultural traditions, taboos and socialization patterns.

However, regardless of political, cultural or religious values, the international community has clearly affirmed that human rights are universal and indivisible and must be respected in all countries and ratified through context specific national policies.

Therefore, the framework highlights the following key and overriding commitments and considerations that should be taken into account in developing national policies and programs that place sexual and reproductive health and rights as a central factor of development. This is in addition to implementation and enforcement of the interrelated commitments made in national laws and international agreements to people centered sustainable development and human rights.
- Ensuring an integrated and inter-sectoral approach, cutting across traditional sectoral boundaries
- Recognizing that gender equality and equity is essential for achieving political, social, economic and cultural securities among all peoples, especially young people and requiring attention early on in life.
- In collaboration with non government organizations and other institutions of civil society, develop a comprehensive national strategy for providing universal and equitable access for all to primary health care, including sexual and reproductive health, with special attention to girls and women without any distinction to age, sex, marital, or other status.
- Develop goals and time frame for improving reproductive health and for planning, monitoring and evaluating programs based on gender impact assessments using qualitative and quantitative data disaggregated by age, sex, other demographic criteria and social economic variables.

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1 The term commitment is utilized in reference to the international conventions and conference statements. Conventions (such as the convention on the elimination of all forms of discrimination against women, 1979; convention on the rights of the child, 1989) are human rights treaties that are legally binding and legally oblige state’s parties to enforce them. Conference statements such as those resulting from international conferences (e.g. the International conference on population and development, Cairo 1994; Fourth world conference on women, declaration and platform for action, Beijing 1995) are consensus documents reflecting commitments made by governments. While not legally binding, they are considered part of a growing body of international customary law, which become customary for government to respect and abide by.
• Procure equitable representation of females and males including adolescents, in all sectors and levels of national and international policymaking and implementation.
• Promote male responsibility and equal participation between men and women but more especially for young people, for equal sharing of rights and responsibilities in all areas of public and private life including family life and sexual and reproductive behavior through laws, policy reforms, and changes in social cultural patterns.

Policy making principles

The framework highlights the following fundamental principles in policy making bearing in mind the various historical, cultural, ethnical and religious values.
• Ensuring conformity with all human rights and fundamental freedoms, including the human rights of women and girls, and eliminating barriers to their full enjoyment
• Ensuring transparency, accountability and good governance in all public and private and international institutions, in the budgetary process as well as the in the delivery of services.
• Defining population goals and policies in terms of unmeant need, and not imposing quotas or targets for the recruitment of clients; any form of coercion has no part to play in RH programs, especially in FP.
• Promoting reproductive rights for all people should be the fundamental basis for all government and community supported policies and programs in the area of RH including family planning and sexual health
• Recognizing that discrimination against women especially female girls begins at the earliest stages in life and must therefore be addressed from then onwards
• At the international and national levels, including in public and private institutions and the united nations systems, mainstreaming a gender perspective in all policies and programs to analyze their effects, for both men and women, girls and boys, including on women’s social-economic and health status.

2.0 Assessments Findings

2.1 Existing polices that are focused on young people and their development status

In all the three countries, there is a positive trend in recognition of young people’s specific related policies and needs as ratified through the existing policies related to young people and their development status, listed below by country.

Zimbabwe
i. National HIV/AIDS policy, Ministry of Health, Dec 1999 (approved by the cabinet)
ii. National Youth policy, Ministry of youth development, gender and employment creation, Sept 2000 (approved by the cabinet)
iii. National population policy, National economic planning commission, Oct 1998 (approved by cabinet)
iv. Draft Reproductive health policy, ministry of health and child welfare, Jan 2002 (in the development process)

Zambia
ii. The draft National Population policy, Ministry of Finance and Economic Development, Jan 2000. (The first population policy was promulgated in 1989 in Zambia.)
iii. Draft Reproductive health policy, Ministry of Health, August 2000. The policy is in the final stages of the development process

Uganda
iii. National population policy, Ministry of finance and economic planning, Jan. 1995. (Approved by the cabinet)
iv. Draft national adolescent health policy, Ministry of Health, August 2000. (Adopted and in use by MOH
2.2 Overview of the policy development process

The policy development processes in all the countries have been consultative in general. Unsurprisingly, governments, academia and research institutions, programmers, health workers, bilateral and multilateral donors, UN agencies and non governmental organizations including youth, religious and other groups were involved in the policy development processes for all the policies since they are already involved in ASRH.

The policy development process was mostly through development of a concept by a national level steering committee and/or with technical assistance or by a consultant. The concept identified the issues to constitute the policy background, goals, objectives and strategies. Consultative debates or workshops for inputs at national and lower levels would follow, providing inputs for the final formulation of the policies that would be submitted to the cabinet for approval.

Notable gaps in the policy development process.

a) Relevant sectors of society that have an increasingly significant role in ASRH programming were not or inadequately included in the policy development processes including the mass media, lawyers and the judiciary system, law enforcement institutions, trade unions and workers organizations, pharmaceutical industries and the private sector in general.

b) Involvement of young people as a significant stakeholder in the policies varied from being grouped with adults during consultation to independent focused youth group consultations, the latter for youth policies. Rarely were young people intensively consulted in the identification of issues during the concept formulation process.

c) The policy formulation processes tended to be top down in issue identification rather than bottom up with consultations typically more intense at national levels with diminishing efforts at community levels.

2.3 Overview of the dissemination status of the existing policies

The HIV/AIDS policy in Zimbabwe is the only policy that has been translated into local languages and disseminated up to the district levels. All the other policies have mostly been disseminated at national levels with limited dissemination at lower levels. In Zimbabwe, pamphlets with major highlights from the youth policy have also been disseminated at national level. This may be a “cost saving” way of disseminating policy information in low resource settings.

The major constraint to dissemination of the finalized and cabinet approved policies is availability of adequate financial resources. Many of the policies have been developed with the ‘project like mentality’ without in-built strategies for sustained dissemination and implementation. Additionally, a number of policies have remained as draft policies. Nevertheless, the HIV/AIDS policies are likely to be disseminated and implemented due to the reality of the impact of the HIV/AIDS pandemic and the increasing regional as well as global joint pandemic control efforts.

Given the low literacy levels in some countries and the urgent need to disseminate the policies, it will be inevitable to have translations into the major local languages before dissemination. However, there is need to ensure ‘quality’ translation and also ‘innovative cost effective’ strategies for disseminating these policies.

2.4 Coordination, monitoring and evaluation (M&E) of the policies

All the policies include clear objectives and strategies that constitute the benchmarks for the policy M&E. Nevertheless, only the population policy in Zimbabwe and the draft ASRH policy in Uganda respectively, have policy benchmarks stated as ‘time bound’ objectives for M&E.

Furthermore, all the policies indicate multi-sectoral, inter and intra sectoral coordination, monitoring and evaluation mechanisms for the policies. The frameworks for the intended partnerships with the civil society in the
implementation of the policies are also included. However, this has not been translated into practice for most of the policies.

The National AIDS Council and the Uganda AIDS Commission in Zimbabwe and Uganda respectively have appreciable financial resources and action oriented government support for the implementation of the defined framework for coordination, implementation, monitoring and evaluation of the HIV/AIDS policies. However, it was commonly mentioned by some of the interviewed key informants in these two countries that there is a recognized level of lack of clarity between the roles and responsibilities of the national AIDS coordinating bodies and the sectoral ministries, especially health.

There were no national assessments, studies or reports specifically on M&E evaluation of the existing policies. The scanty available studies were done by projects with support from the interested donors for specific project planning purposes.

Constraints to the operationalization of the defined policy coordination and M&E evaluation mechanisms include absence of a legal framework as reflected by draft policies/ not approved by cabinet compounded by limited financial resources and capacity in the mandated ministries. It is also questionable whether policy M&E is among the national priorities.

There are notable areas that particularly need focus to enhance coordination, implementation and M&E of existing policies including:

- Defining and prioritizing a minimum set of core feasible indicators for each policy M&E
- Preparation of periodic progress assessment reports to monitor the achievements of the goals, objectives and targets agreed in international commitments as ratified in the national policies focused on the defined minimum indicators.
- Establishing and operationalizing multi-sectoral, inter and intra ministry coordination mechanisms for ASRH policies
- Establishing and adequately supporting high level focal points in national planning authorities responsible for policy coordination & M&E
- Establishing and strengthening mechanisms at all levels to ensure the accountability of national programs and policies to the public, in particular to vulnerable groups, marginalized and under served groups such as adolescents and the rural population
- Operationalization and strengthening the national coordination mechanisms for international cooperation, assigning specific responsibilities to all partners including inter-governmental, international and national NGO’s
- Establishment of national follow up mechanisms to involve and support civil society including young people in the design, implementation, monitoring and evaluation of programs and policies at all levels.
- Creation of a supportive environment for the effective participation of civil society in particular young people, in decision making including provision of adequate financial and technical resources, information as well as documentation
- Intensification of cooperation and partnership with the private sector in ASRH policymaking, implementation and M&E.

2.5 Mobilizing technical and financial resources

There is notable investment and increasing resources allocated to ASRH programs in the recent past, in all the countries. However, national commitments are far from the international agreements of allocation of at least 20% of the official development assistance and 20% of the national budgets respectively, to the social sectors including reproductive health in general. There is general tendency to ‘under invest’ in ASRH programs in all the three countries. The current budget allocations to ASRH were indicated by the key informants as meager, in the respective sectoral ministries in the three countries.

There is fundamental need to:
It cannot be repeated often enough that there are few investments that bring greater rewards than investment in young people’s ASRH and HIV/AIDS programs.

Increase budgetary allocations for universal access to primary health care specifically investments in ASRH, giving special attention to the sexual and reproductive health of the hard to reach young people especially girls and protect them from budgetary reductions.

Review all training curriculum and the delegation of responsibilities across the health care levels to avoid unnecessary costly reliance on physicians and secondary and tertiary care facilities.

Improve the financial sustainability of ASRH by integrating services into existing services (such as HIV/AIDS control programs, FP and safe motherhood services) and into other sector programs as well as making use of and increasing budgetary allocations to community based services, social marketing and cost recovery schemes to ensure ‘multi-sectoral and multidiscipline’ ASRH approach.

Review and modify macro economic policies (including the impact of programs related to structural adjustments, external debt and other sectors of the economy on social development) to include social development goals. Furthermore, there is need to provide social safety nets and promote more equitable and gender cognizant distribution of national resources and services to meet the needs of the neglected sectors of the population, specifically young people.

Renew national and international political commitment and investment in young peoples ASRH and HIV/AIDS as an integral component of the overall social development efforts.

2.6 Policy components that focus on adolescents

Legal basis of policies/National and international commitments
The reviewed policies, approved by cabinet or in draft form ratify interrelated commitments made in national laws and international agreements and acknowledge the needs of young people. However, the policies don’t reflect explicit objectives and strategies to ensure conformity with all human rights and fundamental freedoms:

- To address the right to development and the human rights of young people especially girls, and
- Elimination of barriers to their full enjoyment as well as access to needed ASRH and HIV/AIDS services.

Gender
In general all the policies mention gender in the background analysis of policy issues. This is mostly through gender-disaggregated morbidity and mortality indicators. However, the concept of gender equality and equity and women empowerment as being essential for achieving political, social, economic and environmental security among all peoples and are not as an isolated women’s issue, is not reflected in the policies. It would be beneficial to ASRH programming to have national gender specific guidelines reflected in the national strategic plans to address gender issues early on the lives of both male and female adolescents.

Definition of policy goals, objectives and strategies
There are commendable efforts to define policy goals, objectives and strategies in all the three countries. These policy goals, objectives and strategies are defined in terms of pertaining country mortality, morbidity and population and development indicators. Consequently, the policies do not take into account of all the un met needs of young people, often not captured through morbidity and mortality data. Furthermore, non-of the policies are attentive of the need for young people ‘age specific, holistic and life cycle’ programming. Nevertheless, the national youth policy in Zimbabwe; national youth and the draft ASRH policies in Uganda respectively, define the priority policy target youth groups hence categories of young people. Encouragingly, this points to young people ‘category’ specific and ‘targeted’ ASRH and HIV/AIDS programming concept.

ASRH and HIV/AIDS policy issues
Noteworthy, all the policies include sections and strategies to address ASRH and HIV/AIDS in a multi-sectoral and integrated approach. As anticipated, this is more explicit in the HIV/AIDS, health, youth and ASRH policies.

Nevertheless, the policies are not explicit on ASRH emerging issues including:

- Need for multidisciplinary teams in ASRH programming
- Meaningful and responsible youth participation in all ASRH efforts
- Accessibility of minors to VCT services without parental or guardian consent
- Regulation of HIV testing for especially minors and emancipated young people. The circumstances under which young people especially minors can be tested are not clear.
Disclosure of HIV results and other tests like pregnancy and STD results to minors and when should breach of confidentiality happen?

Rights approach to provision of post abortion care and emergency contraception services in general

Protection of the rights to access and provision of ASRH services to young people in schools, workplace, street and institutionalized YP for instance in the army, police, prison etc

Provision of ASRH in general to the 10 - 14 age group.

Access of YP especially to available research based interventions and new technology information advancement in ASRH programming including FP and HIV/AIDS prevention and management.

Family planning programs in all the countries have generally been accepted and to an appreciable degree have implemented guidelines that explicitly indicate that all couples and individuals including married, single young people as well as minors seeking FP services should be accessed the services. The current stage of ASRH field is similar to the initial stages of the family planning field because advocacy – at the community, sectoral or national levels, is a necessary component of most ASRH programs. Adult opposition to or lack of support for sexual and reproductive health promotion among youth creates social and political barriers that child survival and adult health programs simply do not face.

Explicit policies in this area are not only key in providing the enabling and supportive environment and legal framework for ASRH programming but vital for ensuring realization of the rights of young peoples to access supportive ASRH services, more especially in the reality of the HIV/AIDS pandemic.

Policies need specific accompanying implementation guidelines to ensure ASRH programs address the emerging young people ASRH issues at all levels and in all sectors. These guidelines are even more vital for the program implementers and service providers at all levels and in all sectors.

(A detailed analysis of the existing policy components, by country, is provided as annexes 1-3, in this report).

3.0 Translation of policies into ASRH and HIV/AIDS programs

In all the three countries, ASRH programs are being provided through combined efforts by governments, multi and bilateral donors and civil society including national and international non-government organizations, community based organizations and the private sector. The latter more in the media and social marketing programs. Notably in Uganda, faith based and cultural institutions are actively involved in RH including ASRH and HIV/AIDS programming. Youth groups are a rarity in ASRH programs in all the three countries and where they are involved, it is on a small scale with minimal funding and expansion opportunities.

The policies and strategic plans in the three countries are developed with the intention to provide ASRH programs in an ‘explosion’ manner but this is not translated into actual programs on the ground. The existing ASRH programs are currently conceptualized and designed with a ‘project like mentality’ both in scale and duration. According to the key informants, this stems partially from the funding levels, scope, coverage and duration of the funded projects. Most of the projects are in urban areas and not reaching the most vulnerable and rural young people that need the services most. Nation wide ASRH programs are hardly existent. This is inspite of the policy intentions to reach all the young people with ASRH information and services.

The assessment indicates that in reality, not much evidence-based information is available about ASRH programming in the three countries in relation to health and general development. The reason for lack of documented knowledge may be conceptualized as a measurement trap, adopted from WHO (figure 1). In this trap, lack of data leads to a situation in which the importance of a problem is not recognized and therefore inadequate or little attention is given either to the problem or its measurement. The latter is reflected through lack of national database on who is involved in ASRH programs and clear mapping of ASRH programs by country regions, districts and communities. Consequently, there are hardly any evidence based ASRH policy and advocacy programs. Furthermore, there are no clearly defined national and context specific, defined sets of minimum indicators for monitoring ASRH programs.

The existing larger national studies, which have included all age groups, have not identified young people as a specific group in the presentation of results, nor presented results by sufficiently small age groups for the 10 - 24 years to be extracted. This is the case for the three countries demographic and health surveys. The health
management information systems and the HIV/AIDS sentinel surveillance systems in the three countries do not capture data for the entire age group 10 - 24 years. This means that ASRH and HIV/AIDS information can only be extracted for the youth (15 –24 years) but not for adolescents (10 – 19 years) or for young people as a whole (10 – 24 years).

Consequently, separate surveys are conducted on a project like basis. In Zimbabwe, a national survey on YP was recently conducted with support from USAID but the report was not yet available for public use. In Zambia, the national sexual behavior survey conducted in 1998 is the only national young people database. In Uganda, there is no national young people database. The department for international development (DFID) is supporting a separate analysis of ASRH information from the 2000 Uganda demographic health survey (UDHS, 2000). However, this will be limited by lack of data on the 10 - 14 year olds.

**Figure 1: Neglect of young peoples health and inadequate information - the measurement trap.**

In general, policy development is simultaneously being undertaken along with ASRH programming in all the three countries. In some cases, ASRH programming has superceded the policy formulation, as is the case with family planning delivery for young people and provision of post abortion care services. The latter being true in Uganda. Therefore, it is not feasible to assess the direct translation of policies into the existing ASRH programs. It was also beyond the scope of this assessment to ascertain the effectiveness of policies on ASRH programs. Therefore, the ASRH program approaches covered in the assessment focused on three broad objectives (reference table 3):

- Fostering an enabling environment
- Improving knowledge, skills, attitudes and self efficiency
- Improving health seeking and safer sex practices.
### Table 3: ASRH program approaches by objective.

<table>
<thead>
<tr>
<th>Foster an Enabling Environment</th>
<th>Improve Knowledge, Skills, Attitudes</th>
<th>Improve Health-seeking and Safer Sex Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy/Policy Initiatives</td>
<td>Sex/HIV Education</td>
<td>RH Service Provision</td>
</tr>
<tr>
<td>• School-based</td>
<td>• YFS</td>
<td>• Public</td>
</tr>
<tr>
<td>• Community-based</td>
<td>• NGO</td>
<td>• Private Sector</td>
</tr>
<tr>
<td>• NGOs, etc</td>
<td>• Commercial Sector</td>
<td></td>
</tr>
<tr>
<td>• Workplace</td>
<td></td>
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</tbody>
</table>

- **Youth Development Projects**
- **Peer Programs** (education, counseling, distribution)
- **School/Clinic Linkages**
- **Media**
- **Social Marketing**
- **Addressing antecedents/Social Norms**
- **Community Mobilization**
- **VCT**
- **Linkages with livelihood, employment programs**
- **New Information Technologies**

Ref: USAID, 2000

### 3.1 Fostering an enabling environment

**Policy and advocacy**

The child parliament in Zimbabwe, supported by UNICEF is a great initiative promoting youth advocates. The project provides the highest level of political/civic leadership audience for young people to advocate and voice their issues annually. The relatively new four-country African Youth Alliance (AYA) program, also in Uganda, that has policy and advocacy as one of the six program areas, is another innovative initiatives that is essentially promoting youth participation in all the project activities. (UNFPA, Pathfinder International and the Program for Appropriate technology in Health, jointly manage the project).
Addressing antecedents/social norms/community mobilization
The program for enhancement of reproductive life (PEARL) in Uganda is one of the few examples that is addressing antecedents/social norms to address female genital female cutting (FGM) as a policy and advocacy initiative. Other projects in the three countries address social norms and antecedents that effect ASRH in general. All the ASRH initiatives/projects that were mentioned by the key informants, in the three countries included a component of general community mobilization as part of the entry and start up activities.
In Uganda, efforts by projects like AYA and donor support are specifically targeting the cultural and faith based institutions for ASRH policy and advocacy. These institutions are increasingly supporting ASRH through programs and supportive statements and specifically ‘silent consent’ for condom promotion with respect to HIV/AIDS. In all the three countries, the overall national HIV/AIDS programs include mobilization of all the sectors of society though not specifically for ASRH.

There is recognized need for leadership, policy and advocacy skills training for young people in all the three countries as part of the preparatory efforts to foster an enabling ASRH programming environment.

3.2 Improving knowledge, skills, attitudes and self efficiency

Mass media
Media programs are increasingly gaining ground in all the three countries. The media programs, commonly utilized as an enter – educate behavioral change strategy to reach young people, also raises awareness and educates leaders as well as policy makers (civic, political, cultural and faith based). The approach provides Information Education and communication (IEC) for ASRH policy and advocacy. (The mass media cuts across the three objectives in ASRH program approaches – table 3)

The radio and the print media are most commonly utilized in all the three countries with the support of the private sector. However, traditional mass media is also utilized on a smaller scale in the form of music, dance and drama. Straight talk foundation in Uganda and the Youth Media NGO Trendsetters projects in Uganda and Zambia respectively, were commonly mentioned by the young people and the adult key informants as providing both the radio and print ASRH information, with the participation of young people themselves. Straight talk also organizes annual meetings for information sharing among the regional projects involved in ASRH print media. The Zambia Integrated Health Project (ZIHP), Delivery of improved Health Services in Uganda (both of these projects supported by USAID) and the African Youth Alliance Project are some of the other mentioned projects that utilize the mass media for ASRH. These initiatives in all the countries are constrained by inadequate coverage of young people in rural areas in general, but mostly those out of school. There is definite need for increasing complementary efforts to such promising initiatives from the public and civil society sectors as well as private sector to reach all young people, in and out of school in both urban and rural areas.

Sexual/HIV/AIDS/STD education
This is the mostly commonly applied approach to ASRH in all the countries and the one with increasing visible participation of young people through the peer support system. It is provided through schools, work places, community-based structures, mass media and social marketing. It is supported by the public sector, NGO’, private sector and faith based organizations, the latter more in Uganda.

In Zimbabwe, the ministry of education passed the ‘chief education officers circular minute no.16 of 1993’ that makes HIV/AIDS education compulsory in schools through the AIDS action program for schools. According to the key informants interviewed in the ministry of education, almost three-quarters of the schools are implementing the circular provisions and the government is providing support through materials and training of teachers in schools specifically to carry out this ‘specialized’ initiative. Nevertheless, the circular does not provide for provision of supportive services in schools. Isolated efforts, in some schools are made to encourage referral systems.

In Uganda, a recent presidential initiative is in the preliminary stages of nurturing Sexual/HIV/AIDS/STD education in all schools as part of the school curriculum. It has yet to be translated into a national policy or guideline. Furthermore, in Uganda, Family life education has been ongoing in schools on a project basis but has not yet been translated into a national policy or guideline for incorporation into the school curriculum.
In Uganda and Zambia, the respective ministries of education guidelines provide for an adolescent to return to school after delivering. According to the interviewed informants the guideline has not been easily implemented. At the very best, the adolescent will be admitted to a different school to continue education. It is not uncommon for the pregnant adolescents to be discontinued from school. Some of the challenges in implementing the guideline include stigmatization of the pregnant adolescent and fear of ‘encouraging bad behavior’ in the schools.

**Peer Programs (education, counseling, and distribution)**

Almost all the ASRH Sexual/HIV/AIDS/STD education initiatives in all the three countries included a peer provided services component. The Youth Alive, Family life movement, Community Youth Concern, ZIHP, and Trendsetters are some of the projects in Zambia that utilize the peer approach/peer educators. In Uganda, projects like PEARL, AYA, Straight Talk Foundation, DISH also utilize the peer approach. The interviewed key informants mentioned the family planning association of Zimbabwe, as the pioneer of peer approach for ASRH delivery in the country combined with community based distribution strategy. The family planning associations in Uganda and Zambia use the same approach as well.

All the countries have yet to scale up the existing individual project efforts that utilize peer approach to national scale in order to reach mostly the rural and the hard to reach young categories of young people. This has to be done along with evaluation of the effectiveness of the peer educators on the different age groups and categories of especially hard to reach and vulnerable young people. There is need also for quality control and defining explicitly the kind of counseling that can realistically be provided by peer educators that is commensurate with the task at hard and level of maturity of the young person providing the counseling services.

The peer approach would be very beneficial in providing the needed ‘support system’ prevention efforts to young people affected or living with HIV/AIDS, which is still a neglected area in all the three countries. Encouragingly, projects like The AIDS Support Organization (TASO) in Uganda, ZNNP + in Zimbabwe and Kaligana Health center - HIV/AIDS department, in Zambia are some of cited initiatives that are utilizing the peer approach with a focus on HIV/AIDS/STD.

**Mass/folk media**

A recognized and naturally accepted enter-educate approach is unfortunately minimally utilized specifically for ASRH in the three countries. However, a number of national theatre and music, dance and drama groups are increasingly involved in national HIV/AIDS programs in all the three countries, but more marked in Uganda.

**Social marketing**

Social marketing improves knowledge, skills, attitudes and self-efficacy as well as improves safer sex practices of young people. It is provided predominantly by the non-for profit private sector in all the three countries with lead support from USAID. The social marketing programs ‘roll out’ plans have national coverage intentions and currently there is adequate coverage of all urban areas with social marketed products. Nevertheless, there are still challenges in establishing/maintaining delivery systems to maintain regular supplies in remote and hard to reach rural areas, in all the three countries. It was mentioned by key stakeholders that social marketing increases demand for the ministry of health condoms that have no brand name. However, there is need to continuously monitor community perspectives to ensure the MOH condoms, with no brand name, are not viewed as ineffective for HIV/STD protection and family planning methods.

### 3.3 Improved Health seeking and safer practices

There are four general approaches in which ASRH programs can be scaled up, as described in the FOCUS tool series, 2000, namely:

- **Planned expansion** - steady process of expanding the number of sites and the number of people served by a particular program model once it has been pilot tested
- **Association** – expanding program size and coverage through common efforts and alliances across a network of organizations
- **Grafting** – adding a new initiative to an existing program e.g. making programs directed at adults ‘youth friendly’
- **Explosion** – sudden implementation at large scale, usually with its roots in high-level politics.
In all the three countries, the provision of reproductive health services for young people are through the first three mentioned approaches. However, policies and strategic frameworks imply that ASRH services would be provided through an ‘explosion’ approach, all things being equal.

**Youth friendly services (YFS)**

In all the three countries, YFS are provided through complimentary efforts of the public sector, NGO’s, private sector and commercial sector. This is mostly through grafting of youth services on existing health service delivery systems of the public and other sectors.

In Zambia the government, with the support of development partners is implementing ‘youth friendly corners’ in an explosion approach. Public sector health delivery points are supposed to have youth friendly corners that provide young people with specifically HIV/AIDS/STD services. Young people through peer approach are involved in the service delivery. This approach, though currently focused on HIV/AIDS/STD and mostly urban biased, could be utilized as an entry point to introduce and scale up all other YFS including PAC, VCT, safe motherhood, etc.

In Uganda and Zimbabwe, the YFS and centers are provided mostly through ‘project’ initiatives. Youth friendly services are grafted on to existing public sector and NGO services delivery systems to make them youth friendly. The youth centers that are mostly providing recreation services and acting as entry points for health education, guidance and basic counseling are gaining ground in all the three countries. They are still provided on a limited scale and commonly peri or urban based and hardly utilized by marginalized and hard to reach young people like parenting, pregnant, illiterate and married young people.

**Voluntary Counseling and Testing (VCT) as part of YFS**

In all the three countries, VCT services are provided as an integral component of the national HIV/AIDS control programs. There are no separate services specific for young people. According to the interviewed key informants, it appears there is limited access of young people to these services due to a combination of factors including:

- Non-specific policy guidelines with respect to provision of VCT to YP with respect to age of consent in dealing with young people less than 18 years, breach of confidentiality with HIV positive young people etc
- Limited specialized service providers in counseling young people
- Limited coverage of VCT services
- Limited integration of VCT into existing FP and RH services

**Post Abortion Care (PAC) as part of YFS services**

PAC services, especially the now proven effective manual vacuum aspiration (MVA), should be an integral component of emergency obstetric care services in the provision of comprehensive safe motherhood services. Current literature indicates that unsafe abortions contribute over 25% of the maternal mortality. The demographic health surveys in the three countries indicate high teenage pregnancy and only medical legal abortions being constitutionally allowed. Therefore, it reasonable to conclude there is high demand for PAC in the three countries.

In Uganda, manual vacuum aspiration (MVA) PAC services are majorly available at hospital level and health centers where there are medical officers and surgical theatres. Although the nurses approved bill allows nurses to provide life saving skills they have been trained in, provision of these services by nurse midwives has been limited by lack of incorporation of PAC in their training curriculum. (There were indications from key informants that the curriculum is being reviewed to address this issue).

In Zambia, the nurse act provides for nurse midwives to provide life saving skills including PAC. However, MVA PAC services are currently only available at the national teaching hospital.

According to key informants, medical officers in Zimbabwe are the only ones that provide PAC services as well. IPAS, according to their African Division Director, in collaboration with the ministry of health in Zimbabwe is developing a roll out strategy for nationwide MVA services.

PAC services in all the three countries have faced implementation challenges, among other factors, due to the misconceptions about PAC being ‘equated’ to provision of abortion services.
Family planning services as part of YFS

The high teenage pregnancies and total fertility rates imply high demand for FP services for young people. In addition, the national surveillance data for all the three countries indicate that over 50% of new HIV infections are in young people. Encouragingly, condom use among young people shows increasing trends in all the three countries though consistent use is not directly proportionate to the indicated new infection rates. Furthermore, the demographic surveys show that overall modern FP use by young people in all the three countries is disproportionately lower than the high knowledge levels.

Family planning programs in all the three countries, provided through the public sector, NGO’s, social marketing services and private sector have a high percentage coverage reach for young people of all the provided YFS, especially with respect to the condom. The explicit policy of providing services to couples and individuals seeking FP services, irrespective of age and gender, is an example of how enabling policies can be, in the provision of YFS. However, there is apparent need for renewed efforts and commitment to integrate ASRH and the national HIV/AIDS/STD programs, especially the promotion of condoms for dual use with a particular focus on YP. Emergency contraception has been introduced nationwide in Uganda through social marketing services in partnership with ministry of health. It has met with challenges from the religious sector from the initial stages. It is an initiative that is likely to provide valuable lessons on the impact on ASRH.

Livelihood, employment and youth development programs

In all the three countries, information from the interviewed key informants as well as country specific data (annexes) indicates youth unemployment and redundancy as being on the increasing trend. There are a number of existing public and private sector vocational institutions in all the three countries that provide young people with diverse types of livelihood skills. In Zimbabwe, vocational schools seem to be more marketable and meeting an appreciable degree of market employment skill needs for YP.

In Uganda, the ministry of gender, labor and social development is providing seed money for income generating activities to very limited young people per district under the youth employment scheme (YES) pilot project. The coverage reach of young people is currently compared to make meaningful impact on the livelihood needs of the young people but the lessons learned from the project would be helpful in scaling up nationwide income generating activities for YP.

Africa youth alliance project, a relatively new project in Uganda, is one of the few initiates that is trying to institutionalize ASRH in existing livelihood programs. Lessons from such an initiate would be helpful in designing feasible strategies to link and institutionalize ASRH into livelihood programs.

There is need for increased advocacy to reflect linkage between ASRH and livelihood programs in the three countries in all national development programs and poverty eradication plans, more especially as the individual countries define strategies to scale up ASRH programs.

3.4 Programs with a positive bearing on ASRH

AIDS levy Zimbabwe

In Zimbabwe, a small percentage of each paid graduated tax goes to support the national HIV/AIDS/STD prevention and care program and this is called the ‘AIDS levy’. According to the Director of the National AIDS council (NAC), over 80% of the NAC secretariat operational costs were from the AIDS levy support. The implementation of the AIDS levy in Zimbabwe is an example of an initiative with great potential for institutionalization and sustainability of HIV/AIDS/STD prevention and care program. Young people comprise over fifty percent of the new HIV infections hence would benefit from the committed government resources, complimented by support from other development partners, if the funds are effectively utilized to scale up the national HIV/AIDS/STD program.

Victims support unit in Zambia

The victim support unit in Zambia provides general protection of women and Childs rights against marital rape, defilement, incest, willful HIV transmission, child abuse etc. This is through training and deployment of law enforcement police personnel in every police unit as well as in the judiciary system. It was mentioned by key informants in all the three countries including young people themselves that rape, defilement, incest and sexual abuse is not rare and on the increase in many areas.
This program, though not specifically targeted to young people is a step in the right direction in protecting the rights of young people. Lessons learned from such a persuasive program would pave the way for initiating child and youth friendly courts as well as institutionalization of professional training for law enforcement personnel in handling child/young people related sexual offences.

The sexual offences act in Zimbabwe seems to be increasingly providing the needed legal framework to protect the rights of women in general against sexual offences and violation, including young people.

**Universal primary education In Uganda (UPE)**

In an effort to increase literacy rates in Uganda as a recognized need and as an integral component of the national developments, Uganda has been implementing UPE since 1997. Four children are supported per family as an advocacy message for planned families hence support of family planning. Retention of young people especially girls in schools is likely to contribute to the reduction in ASRH problems faced currently by especially young people out of school and also increase their life opportunities.

4.0 **Recommendations**

4.1 **Recommendations to member states**

i. Ensure the rights of all age groups and categories of young people especially the currently under served/marginalized groups, to access ASRH with a specific focus on family planning, HIV/AIDS/STD and safe motherhood services, at minimum through:

- Legalization of draft policies; dissemination of existing policies, sectoral ministry frameworks and guidelines and other relevant laws, acts, bills and guidelines on serving minors.
- Commitment and realization of adequate budgets to ASRH programs
- Training, recruitment and deployment of staff trained in ASRH especially in rural and other under served parts of nations
- Allocation of adequate resources for M&E evaluation of ASRH programs and definition of minimum indicators to monitor ASRH programs.
- Legalization and provision of adequate resources, including financial and qualified human support to defined coordination bodies to monitor ASRH and HIV/AIDS programs.
- Institutionalization and strengthen sexual and reproductive health education in schools
- Institutionalization of re- enrolment of adolescent mothers to the formal education system
- Institutionalization of referral systems and linkages between schools and ASRH services

ii. Ensure that service providers are free from legal liability by providing sexual and reproductive health education and services to adolescents below the age of consent (in view of the HIV/AIDS pandemic, high teenage pregnancy and the need for VCT, PAC, emergency contraception and other ASRH services), by putting into place and disseminating supportive & explicit policies, laws as well as implementation guidelines.

iii. Programs should be conceptualized and designed to move from the current ‘project like mentality’ of scattered, one-time efforts into a more sustainable and comprehensive national programs.

iv. Address ASRH in the broader context of ‘youth and development’ and recognize as well as support youth as assets not problems; actors not victims or beneficiaries; and as a vital part of the solution to the threats they face especially HIV/AIDS.

v. Protect young people especially adolescent girls through enforcement of laws related to sexual exploitation, including incest and rape in addition to providing guidelines and supportive community sensitization about what constitutes forced sex and rape.

4.2 **Recommendations to the commonwealth secretariat**

a) Advocate with member states and catalyze work towards realizing and regularly reporting progress about the commitments made during the international conventions and conferences (now translated into millennium goals) to protect the rights of young people to enjoy and realize their full sexual and reproductive life potential.
b) Work with technical bodies and member states to define cost effective strategies to develop, disseminate, implement and regularly update needed ASRH policies.

c) Advocate with each member state in collaboration with donors and technical bodies to develop and widely disseminate a ‘national young people specific’ HIV/AIDS/STD policy with explicit goals, objectives, coordination mechanisms as well as M&E framework and indicators. This should be accompanied with implementation guidelines at all levels.

d) Advocate and work with member states to harmonize the existing ASRH related policies to ensure integrated and multi-sectoral ASRH program implementation.

e) Work with member states to adopt/define feasible frameworks and minimum packages of indicators to monitor policy and ASRH program implementation to ensure focused and “quality” ASRH programs that are not struggling with unwieldy and overly ambitious objectives and workplans in the absence of adequate resources.

f) Work with member states and other technical bodies to adopt/define cost effective training curriculums, guidelines and professional courses in adolescent counseling.

g) Play a convening role of technical, multi-sectoral and multidisciplinary teams, to work with member states in defining:
- Minimum sets of interventions and program strategies, defined level of intensity, that are most effective in producing positive health outcomes among young people in each country/regional context, and with which segment and age groups of the young people population. The priority health outcomes should include decrease in HIV/AIDS and other STI infections, unwanted or mistimed pregnancies, unsafe abortions, substance abuse, sexual and physical violence as well as overall maternal mortality and morbidity among young people.
- Priority operations research to better understand hence address determinants/antecedents of health and related behaviors among different categories and age groups of young people.
- Strategies for ‘scaling up’ successful and cost effective ASRH programs including the role of partnerships between public, private and civil society sectors.
- Effective strategies for increasing youth and parental participation, especially the former, in ASRH programs.
- Sustainability strategies for large scale and complex ASRH programs.
- Strategies for documenting best practices and lessons learned in ASRH programming and cost effective ‘knowledge sharing’ among member states/within the region.
- Replicable strategies to address gender and rights based ASRH programming.
- Advocacy and advocacy relevant research to increase political will and resources at all levels.

4.3 Recommendations to donors

a) Support more ASRH programs and less of isolated and pilot projects in view of building on and scaling up documented successful interventions and best practices in ASRH programming. The needs of all age groups and categories of young people especially HIV/AIDS cannot wait and need to be addressed now.

b) Be more flexible about semi-rigid sets of indicators, workplans and relative focus on short-term results to allow for long-term evaluations and increasing of organizational capacities as well as participatory design of “innovative context specific” interventions/initiatives.

c) Support more alliances and consortia/partnerships that are a necessary part of scaling up ASRH programs.

d) Increase funding for institutional capacity building, coordination, quality assurance and M&E evaluation as part of the ASRH program funding.

e) Increases funding for livelihood programs and ASRH programs in workplaces and for young people in institutional settings like the army, police, and prison as well as for the internally displaced young people and refugees settings.

f) Support the secretariat to foster regional ‘knowledge sharing’ and exchange of technical expertise and resources as well advocating with member states to prioritize ASRH.

Concluding thoughts

Young people represent a resource for the future whose potential can either be wasted or nurtured in a positive way. We should not forget the enormous potential of young people, their creative drive and capacity for learning.
It is clear that preventable ill health is an enormous drain on the resources of a country, which are embodied in its young people. Their health and development is important for them as individuals, for their children and for society.

This assessment focused on ASRH related policies and their translation into programs in only three countries. Although the findings from the rapid assessment in the three countries of Zimbabwe, Zambia and Uganda may not necessarily be representative of the situation in all the CRHCS member states, there is demonstrated and compelling urgent need for:

- Policy, advocacy and advocacy relevant research for renewed political will at all levels to support ASRH as part of the national development programs.
- More action and resources to support research and identification of effective strategies to scale up ASRH programs that are adapted to each segment of the youth population and each cultural context.
- Emphasis on ASRH program innovation
- Flexibility of donors to provide larger and long-term grants and acceptance of diverse strategies adapted to widely varying social cultural contexts.

In a complex field where there are no biomedical solutions, the high rates of HIV infections and other pressing sexual and reproductive health problems among young people have created an urgent need to promote health seeking behavior and positive health outcomes among young people in a cost effective way. It took the family planning field over 30 years to learn ‘how to do it right’. The current generation of young people in developing countries cannot wait that long in the wake of the HIV/AIDS pandemic. Supporting and strengthening the coordination of disseminating widely, evaluations of current and future ASRH programs can substantially and dramatically shorten the learning process for youth programs.
Annexes

Annex 1: Overview of ASRH related policies, development process, key components and implementation status in Zimbabwe.

Introduction

Zimbabwe is a very youthful nation with approximately 45% of the total national population of 10,412,548 below 15 years of age (National youth policy, Sept 2000). The age group 10 –30 years comprises 43% of the total population, with a total population growth rate of 2.5% (Inter Demographic survey, 1997).

Close to 40% of adolescents are already mothers by the time they are 19 years (National youth policy, Sept 2000). The age specific fertility rate has not shown a significant decline over the years in the age group 15 –19 years, although the general national fertility rate has declined by more than twenty percent from 5.5 in 1988 to 4.0 in 1999 (Zimbabwe Demographic Survey, 1999).

According to the 1992 census projections, the female youth constitute more than 45% of the married female population and more than 94% of the never married population.

Of the total reported HIV/AIDS cases in Zimbabwe, close to 60 % are young adults between the ages of 20 and 39 years. More females are infected at a younger age than males. In the age group 15 –19 years, the infection rates are 6:1 for females to males respectively (Youth Policy, 2000).

Primary education is almost universal in Zimbabwe with the adult literacy rates of 82% in 1997. Statistics from Ministry of education indicate that 46% of the secondary enrollments are females. However, there are marked differentials at secondary level with more girls than boys dropping out of school. The introduction of fee charges and increased costs of schooling in the 1990’s has further created significant barriers to participation among children from poorer families particularly girls.

Youth unemployment is one of the formidable problems facing Zimbabwe. Of particular concern is the number of 10 –14 year olds, that should be in school but instead are currently employed. The 1997 Inter Census Demographic Survey (ICDS) estimated 74,722 young people aged 10 –14 years that were employed with 89% being employed in the agricultural sector. This is in-spite of the legal age of employment being 15 years in Zimbabwe, and employed children not supposed to work for more than 6 hours.

The Zimbabwe national youth policy indicates that unemployment is higher among female youth than their male counter parts. The majority of the unemployed will have attained secondary education with ordinary or advanced level education qualifications. The policy further points out that the problem of unemployed school leavers has reached unprecedented levels raising questions whether the academic focus of the education is relevant in meeting the needs of the current economy!

Existing policies

National HIV/AIDS policy, Dec 1999 (approved by the cabinet)
National Youth policy, Sept 2000 (approved by the cabinet)
National population policy, Oct 1998 (approved by cabinet)
Draft Reproductive health policy, Jan 2002 (in the development process)

Other related laws and acts

Labor relations HIV/AIDS regulations: The government of Zimbabwe gazetted the labor relations HIV and AIDS regulations, statutory instrument 202 of 1998. The act creates and promotes a supportive environment in the
work place for a rational response to AIDS which is free from discrimination and stigmatization. (The legislation is included as appendix 1 in the national HIV/AIDS policy)

Legal age of majority: The legal age of majority act of 1982 in Zimbabwe defines persons under the age of 18 years as minors/children.

Public health Act: Sexually transmitted diseases are notifiable under the Zimbabwe public health Act (chapter 15:09), because of the public health benefits regarding contact tracing, treatment and collecting national epidemiological data. However, it should be noted that the surveillance data on HIV is obtained through unlinked anonymous screening.

Termination of pregnancy: The pregnancy termination act of 1974 provides for medico legal abortion. Abortion is illegal if it is based on socio or personal reasons.

Sexual offenses: The sexual offenses act of 2001 offers greater legal protection against sexual abuse, prostitution and trafficking for adolescent girls. However, it does not protect young girls below 16 years from becoming married traditionally.
**Zimbabwe – Key components of the existing ASRH related policies.**

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<td>Policy development process</td>
<td>The foreword and Introduction sections describe the policy development process. The interdisciplinary committee &amp; Intersectoral task force developed the broad areas and key points respectively, which formed the public debate conducted over a three year period through meetings at national, provincial, district and sectoral levels.</td>
<td>The acknowledgement section describes the policy development process. The national steering committee spearheaded the policy development process that was debated as part of the consultative process by youth organizations, donors, NGO’s, private sector, policy makers, public sector, community leaders &amp; individuals.</td>
<td>The preface section describes the policy formulation process that evolved as a result of community participation through consultations at various levels. Sensitization workshops were held in the provinces to capture the aspirations and concerns of the people. The participants included civic society members of parliament, chiefs and traditional leaders as well as government officials. Further research was conducted into areas considered priority in terms of the policy development.</td>
<td>Appendix 1 describes the draft policy formulation process: National documents were reviewed Meetings were held with stakeholders including the local authority, faith based organizations, NGO’s, academia, health professionals. A draft policy concept was then formulated &amp; used for consultative debates during 4 workshops. The draft was amended to include workshop &amp; other expert review inputs.</td>
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<td>Policy definition of young people</td>
<td>Chapter 6: section 6.5, defines young people as persons aged 15 – 24 years.</td>
<td>Although, the policy acknowledges the WHO definition of YP and adolescents Chapter 1: section 2.1, defines youth as persons aged 10 –30 years. The reason for the this definition is that it is after 30 years of age that most youth are expected to have established themselves.</td>
<td>The definition is not included in the policy</td>
<td>Appendix 2: describes adolescents as a person aged 10 -19 years.</td>
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<td>Policy definition of ASRH</td>
<td>In Appendix IV, glossary definitions: RH is defined as the well being of a person, usually female, in matters related to sex, conception and child bearing. ASRH is not defined in the policy.</td>
<td>The policy defines health in accordance with the 1948, WHO definition Chapter 2: section 2.2.3. However, the policy does not include a specific definition on ASRH</td>
<td>The definition is not included in the policy</td>
<td>Introduction and glossary/appendix 2 sections of the policy utilize the 1994 ICPD definition of RH</td>
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<td>Components in the</td>
<td>Chapter 5: section 5.5.2; provides the</td>
<td>Chapter 2: sections 2.2.3.1 - 2, defines</td>
<td>Chapters 4 and 5, sections 4.2.6,</td>
<td>Chapter 3: section 3.2.1 –</td>
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<td>policy that address ASRH including HIV/AIDS</td>
<td>guideline on age of consent requirements for minors with respect to VCT specifically: - Guiding principle 29 states that young below 16 years of age seeking services have the right to appropriate counseling and care services and advice on the means to prevent HIV/STI. - Chapter 5.5.2 indicates that ‘until the legal age of consent (indicated as 18 year in the glossary), a child is considered a minor and consent is obtained from parents or a legal guardian for VCT. Chapter 6: sections 6.5 to 6.5.1, is dedicated to children and YP and HIV/AIDS.</td>
<td>the youth and HIV/AIDS; sexuality and RH issues affecting adolescents and youth in detail</td>
<td>4.3.6, 5.5; is focused on the policy goals, objectives, targets as well as implementation strategies respectively with respect to youth /adolescents ASRH including HIV/AIDS and development.</td>
<td>3.1.4 talks about Adolescent RH and HIV/AIDS. Chapter 3: section 3.7 tackles HIV/AIDS in general for the entire population.</td>
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<td>Policy Responsiveness to young peoples diversity, neglected issues and groups</td>
<td>The policy recognizes that young people as a sector of the population need special attention in the control of the HIV/AIDS pandemic hence the specific chapter 6, on young people and children. The policy lacks specific details on the diversity of YP categories and age groups. Additionally, combining children and young people in one chapter may pause operationalization issues of the defined strategies especially for the programme implementers and service providers.</td>
<td>Chapter 1: section 1.2 notes that lumping together of YP from 10 – 30 years risks masking the particular needs of sub groups within that age range hence necessitating specific strategies and program interventions for the different age groups. Chapter2: sections 2.2.3.1 - 2, analyses HIV/AIDS, sexuality and RH issues affecting adolescents and youth by gender. Chapter 5: explicitly defines the priority target groups for special focus as the disadvantaged group among the overall youth population although the youth policy is directed at the needs</td>
<td>Chapters 4 and 5, sections 4.2.6, 4.3.6, 5.5, of the policy addresses general ASRH/ HIV/AIDS and development issues. However, the policy does not detail the YP age groups and subgroups and all the emerging ASRH issues.</td>
<td>Chapter 3: section 3.2.1 describes priority ASRH risks of YP including HIV/AIDS. It also mentions female adolescents as being more vulnerable to ASRH problems like unwanted pregnancies, unsafe abortion, HIV and other STD’s, sexual abuse, prostitution and trafficking. Adolescent boys are mentioned as needing attention too. However, the policy is not explicit on YP’s age.</td>
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<td>Inclusion in policy of Multi-sectoral development approach to ASRH</td>
<td>Chapters 2 and 9: respectively describe guiding principles and strategies for a multisectoral and multidisciplinary management of the national response to HIV/AIDS/STI and related research.</td>
<td>Chapter 6: sections 6.1 through 6.4, defines the coordination and multisectoral approach to the policy implementation and needed supportive legal framework.</td>
<td>Chapters 4 &amp; 5 detail the policy goals, objectives and strategies from a multisectoral approach in addressing population and sustainable development aspirations of the population and country. Chapter 6: section 6.1, details the multi-sectoral policy implementation framework.</td>
<td>Chapter 5: describes the multi-sectoral strategic framework for the implementation of the policy.</td>
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<td>Legal basis of the Policy through reflection of commitments to international and national laws</td>
<td>Chapter 3: is about general human rights that are included in the constitution and international conventions with respect to observing the human rights and dignity of people with HIV/AIDS; protection against discrimination; and observing the privacy over health human matters as a human right. Chapter 6: provides guidelines on HIV testing and human rights with respect to pregnant women; infants; engaged couples; employment, training and promotion; education; insurance, travel and immigration.</td>
<td>Chapter 1: section 1.3, describes the principles, rights and responsibilities underlying the formulation that should be consistent with the national constitution; major international conventions and agreements which Zimbabwe has subscribed to, in particular the rights and freedoms set forth in the UN universal declaration of human rights.</td>
<td>Chapter 2: section 2.8.1, recognizes the governments ratification of the convention of elimination of all forms of discrimination against women (CEDAW), the UN ICPD and world conference on women of 1994 and 1995 respectively in addressing gender issues. Chapters 4 &amp; 5: sections 4.3.15 &amp; 5.14.2, respectively are about the policy objectives and strategies for legal reform/rationalization of the legal statute to ensure that those laws and regulations that are</td>
<td>Chapter 1: section 1.1 quotes the 1994 Cairo ICPD/plan of action that provides for principles, objectives and interventions in RH. Appendix 3: lists 8 Acts in Zimbabwe with direct impact on RH namely: 1917 customary marriage act 1925 public heath act 1964 marriage act. 1982 legal age of majority</td>
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<td>Inclusion of national benchmarks for the policy M&amp;E</td>
<td>The policy contains 43 guiding principles with accompanying strategies that constitute the benchmarks for the policy. However, they do not indicate the time period in which they are to be achieved.</td>
<td>Chapters 3 and 4: define the policy goals, objectives and key strategic areas that constitute the national benchmarks. However, there is no time period attached to the objectives and strategies.</td>
<td>Chapter 4: section 4.4 provides specific, measurable &amp; time bound main targets for the policy objectives and strategies defined in chapters 4 &amp; 5.</td>
<td>Chapter 3: policy statements, objectives and strategies constitute the benchmarks for M&amp;E. However, the policy statements, objectives and strategies are not time bound.</td>
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<td>Defined minimum ASRH integrated packages in the policy</td>
<td>Chapter 6.5: Guiding principle 27, indicates that children and YP have the right to information and advice on means to protect themselves from early sex, unwanted pregnancy and HIV/STI. This principle is followed by seven strategies for providing a minimum ASRH package to YP within the HIV/AIDS pandemic</td>
<td>Chapter 3: Section 3.2 policy objectives VII, VIII &amp; XIII, are about: Reduction of teenage and unplanned pregnancy; Reduction of STD’s, HIV/AIDS and its impact on the individual and society; Reduction of substance abuse among the youth;</td>
<td>Chapter 4 and 5: sections 4.3.6 &amp; 5.5.1 defines some ASRH objectives and strategies in the context of general population and development. However, there is no specified minimum ASRH package in the</td>
<td>Chapter 3: section 3.2.2 – 3.1.4, describes the policy statement, objectives and strategies for addressing ASRH.</td>
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<td><strong>Policy linkage to the national reproductive health policy – (if the latter exists)</strong></td>
<td>The policy was formulated long before the draft RH policy. However, guiding principal 27 of the strategies indicate the linkage between HIV/AIDS prevention, and within general RH delivery.</td>
<td>Chapter 2: section 2.3.1, refers and indicates the linkage to the national HIV/AIDS and population policies, with respect to YP. The youth policy was formulated before the national RH policy hence the reason there is no specific reference to the latter.</td>
<td>The policy was formulated long before the current draft RH policy. Nevertheless, the policy is cognizant of ASRH, HIV/AIDS/STD’s and general RH as an integral component of population and development as reflected in the: Population profile – chapter 2 Implications on population growth and structure – Chapter 3 Goals, objectives, targets and implementation strategies – Chapters 4 &amp; 5</td>
<td>N/A</td>
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<td><strong>Defined operational responsibility for coordination, implementing and M&amp;E of the policy</strong></td>
<td>Chapter 2: guiding principle 1 mentions the National AIDS Council (NAC) as having the mandate to ensure overall management and coordination of the national HIV/AIDS response as well as promoting effective M&amp;E of all programmes/projects on HIV/AIDS/STD etc.</td>
<td>Chapters 6 and 8: respectively define the coordination, implementation and M&amp;E responsibilities of the various players including the public sector, private sector, youth committees, donors and civil society.</td>
<td>Chapter 6: sections 6.1 and 6.4 define the implementation &amp; coordination framework; and M&amp;E, respectively.</td>
<td>Chapter 5: describes the strategic framework for the implementation of the policy; coordination plans; budget setting and resources allocation; and M&amp;E</td>
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<td><strong>Dissemination status of the policy</strong></td>
<td>The policy has been disseminated up to the district level. The policy has been translated into local languages. The plans after this are to disseminate the policy at community level.</td>
<td>The policy has not been disseminated but is available to stakeholders at national level and lower levels</td>
<td>The policy has been translated into local languages and disseminated widely up to the district level.</td>
<td>The policy is still in draft form. Therefore, it has not been disseminated.</td>
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<td><strong>Implementation status of the policy</strong></td>
<td>Various components of the policy are being implemented through ongoing</td>
<td>Various components of the policy are being implemented through existing</td>
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<td>Constraints/barriers to policy implementation</td>
<td>Inadequate resources</td>
<td>Inadequate financial resources was mentioned as one of the major constraints to the policy dissemination and implementation.</td>
<td>The draft revised status of the policy and inadequate financial resources.</td>
<td>The draft status of the policy</td>
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<td>Specific programs resulting from the policy</td>
<td>There is no specific programme that has resulted from the policy formulation. However, the existence of the policy provides a necessary legal framework for the current national HIV/AIDS prevention, care, and support interventions.</td>
<td>No specific programmes seem to have resulted from the policy formulation. Nevertheless, the policy provides the necessary legal framework for the current ASRH and general youth and development programs</td>
<td>Ongoing Policy and advocacy programmes have resulted from the policy. It should be noted that the population and development programme is comprised of all the sectoral ministry efforts hence the policy provides a legal framework for the programme advocacy, coordination and M&amp;E.</td>
<td>No specific programs seem to have resulted from the policy formulation. Nevertheless, the policy provides the necessary legal framework for the current RH programs</td>
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|Strengths/weakness and gaps of the policy | **Strength** The policy has a separate explicit chapter on children and YP with HIV/AIDS control strategies in the context of general ASRH.  
**Weakness** The policy seems contradictory with respect to age of consent for YP below 16 years of age for HIV/STI prevention and services (guiding principle 29) and consent for VCT services (chapter 5.5.2). HIV/STI prevention and services does not require parental or guardian consent at age 16 years while it is required for VCT. The policy combines children and YP in the same chapter. Therefore, the diverse needs of the different age groups and categories are not explicitly defined and | **Strength** The policy is cognizant of the needs of the different age sub groups and categories of YP that require special focus  
It is linked to the existing polices (HIV/AIDS and population policies  
Policy has legal basis from the international conventions that the country is signatory to and also from the constitutional provisions.  
**Weaknesses** The policy lacks time element to the defined objectives that would be utilized for the M&E of the policy implementation. | **Strength** The policy is cognizant of the need for different age sub group and categories of YP that require special focus  
It is linked to the existing polices (HIV/AIDS and population policy  
Policy has legal basis from the international conventions that the country is signatory to and also the constitutional provisions.  
**Weaknesses** The policy lacks time element to the defined objectives that would be |
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<td>addressed by the policy.</td>
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<td>utilized for the M&amp;E of the implementation</td>
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<td>Benchmarks to-date in terms of:</td>
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<td>Linkage to financial resources</td>
<td>The HIV AIDS levy is a reflection of the government commitment to the HIV/AIDS pandemic control</td>
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<td>Involvement of public, private, and civil society sectors</td>
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<td>Human rights</td>
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Annex 2: Overview of ASRH related policies, development process, key components and implementation status in Zambia.

Introduction

Zambia’s total population was projected to be 10.2 million people with an annual growth rate of 2.9% in the year 2000 and HIV prevalence of 20% in the general adult population aged 15 to 49 years (National AIDS Council, Feb 2002).

Zambia is one of the most urbanized countries in Sub Saharan Africa with approximately 54% of the total population in the urban areas (Central Statistics) but 80% percent of the population lives below the poverty line (Family Life Education Movement Zambia). About 65% of the unemployed people in Zambia are youths (priority survey 1, 1991)

Approximately 15% of all Zambians are between the ages of 13 and 19 years inclusive while 25% percent of women of reproductive age are 19 years of age and younger (Impact of HEART campaign: Findings from the youth surveys in Zambia, 1999 – 2000)

Approximately one in six urban youth aged 15 –19 years is HIV positive (Zambian sentinel surveillance, 1999). Young women aged 15 –19 years are five times more likely to be infected compared to males in the same age group (National AIDS Council). Girls from poor families are sometimes forced into early marriages, sexual arrangements in exchange for money, or school requisites and thus become more vulnerable to HIV infection. There are, however, hopeful indications from the declining trends in this age group over most of the country for the period 1994 –1998 (NAC)

The majority of youth (84%) are sexually experienced by the age of 19 years. Many have sex by the age of 14 years, with 71% of boys and 34% of girls having had sex by that age (UNICEF). These findings are in agreement with the Zambia sexual behavior survey of 1998) that indicated that by the age of 15 years, 37% of boys and 27% of girls have had sex in Zambia. Furthermore, 17 % of young people in Zambia have had sex by age 10 years in urban compounds of Lusaka (CARE International, 1988). Among 15 –19 year olds, 62% of the boys and 59% of the girls respectively say they had had sex (Zambia sexual behavior survey, 1998). Of those who have had sex, 84% did not use a condom the last time they had sex (Zambia sexual behavior survey, 1998). Only 7% report consistent condom use (HEART campaign survey). 64% of girls and 70% of boys think they are at no risk of contracting HIV (Zambia Demographic Health survey, 1996). Among the sexually active, never married youth, 24 percent of boys and 13 percent of girls reported that they had more than one partner in the past one year (Zambia sexual behavior survey, 1998). However, in the urban compounds of Lusaka, many youth have a higher percentage of multiple sex partners, 55% of males and 40% of females reported more than sexual partner in the previous three months (CARE, 1988). Contraceptive use by young people is very low in Zambia. Only 5% of girls and 12% of boys use a modern contraceptive method (Zambia Integrated Health Project –USAID).

The percentage contribution of teenagers to the total fertility rate has shown an increasing trend since 1969 with more than one quarter of adolescents having had a child according to the Zambia demographic survey of 1996.

In 1993, about 23% of incomplete abortions were in women younger than 20 years while 25% maternal deaths due to induced abortions were in girls younger than 18 years (MOH, draft RH policy, Aug 2000). Inadequate access to safe abortion services is cited as one of the major reasons why so many young women suffer abortion complications leading to death sometimes.

Existing policies


The draft National Population policy, Ministry of Finance and Economic Development, Jan 2000. (The first population policy was promulgated in 1989 in Zambia. However, the impetus for the revision arose from
among other reasons, the 1994 International Conference on Population and Development (ICPD). The revision was intended to include emerging issues as HIV/AIDS, gender, ASRH and new global perspectives on population and development.

Draft Reproductive health policy, Ministry of Health, August 2000. The policy is in the final stages of the development process.

(The reproductive health policy is intended to embrace and incorporate all the existing Ministry of Health/Central Board of Health policies and guidelines on RH so that they are contained in one national policy document)

Zambian Constitution provisions

Age of consent: The statutory legal age of consent in Zambia is 16 years. However, the customary law allows marriage below that age and not protective of the young people from sexual abuse, defilement, violence HIV or other STDs, etc

Termination of pregnancy: The termination of pregnancy act of 1972, of Zambia allows medical legal abortion after certification by there medical doctors. The, implementation of this act is difficult in many areas of Zambia especially the rural areas due to difficulties of accessing three doctors to fulfill the required act provisions. Furthermore, post abortion care services currently seem to be only available in major hospitals around Lusaka city. Manual Vacuum aspiration services are also only available on pilot project basis at the national teaching hospital in Lusaka.

Rights and freedoms of individuals: The Zambian government has guaranteed the rights and freedoms of individuals through the constitution. These rights include the rights to access to health and other social services without discrimination and also apply to work place situations.

Employment act: Section 28 of the Zambian employment act requires that a medical officer shall medically examine every employee before he/she enters into a contract of service of at least six months duration. Though the law does not require that prospective employees be tested for HIV/AIDS, there is no law protecting employees against mandatory HIV testing.

Public health Act: HIV/AIDS, STI’s and tuberculosis are all notifiable diseases under the Zambian Public health act (infectious diseases regulations). Confidentiality is currently upheld for all diseases and clients personal data is kept in confidence. However, there is no specific regulation on sharing ones HIV/AIDS status.

Nurses and midwifery act: The approved nurses and midwifery act of 2000, provides for this cadre of staff to open up private practices and conduct life saving skills. Although the act implicitly indicates they can provide services like Post abortion Care (PAC) and insertion of intra uterine device (IUD), the actual implementation would require additional skills training for this cadre of staff as it is presently not included in the in-service training.

Other existing sectoral ministry policies/guidelines.


Section 2: No 7.1 defines adolescence as a special period in life in which dynamic change takes place, new experiences, challenges, behaviors and relationships are established.’

Section 2: No. 7.1, “strategies and activities for improving RH of adolescents and young adults include: Facilitation of access, especially young girls, to all types of services dealing with RH health concerns, and specifically F/P, without consent of spouses, parents/guardians or relatives as allowed by current
legislation. Spousal/guardian counseling, however is recommended strongly. Special concern has to be given to the counseling of young adolescents under 16 years of age. When after counseling, the young adolescents are unwilling to involve their parents/guardians, special care should be taken to ensure the these adolescents under 16 years have the mental maturity to understand what is involved in their decision along with its possible consequences”.

Implication: It is left to the discretion of the service provider to determine the mental maturity of the under 16 year old. This may operationally become prohibitive to some YP’s access to the needed F/P services.


Glossary: No. 6, recognizes that the Zambian law defines a child as a person under 16 years. For purposes of counseling a child is defined as a person aged 0 – 16 years.

Part 3: sections 3.3.5, numbers 1, 2, 3, 6 respectively, about counseling children indicate that:

Children aged 12 years and below shall always be counseled and encouraged to test for HIV infection through their parent or guardian, while teenage children (13-16) may be counseled and tested individually or through their parent or guardian. The privacy and autonomy of children shall be respected in all situations involving HIV counseling and testing. When the issue of testing children aged 12 years and below arise, both parents or a guardian shall be given the test results together if possible the results are the property of the child tested and shall not be disclosed to third parties.

The differences in the definitions of the state definition of a child and those in the counseling guidelines may pause interpretation issues at service delivery points, at worst discouraging YP less than 16 to seek VCT due to parental consent issues.

National youth policy, late 90’s, (Appears to be guidelines based on the views of the key informants interviewed)

Part 3: defines youth as persons aged 15 –25 year based on the arguments that this definition is ideal in working with the most disadvantaged groups in society like school leavers, many of whom are unemployed. Furthermore, it is stated that the definition is harmonized with the donor definition of youth under whose support a number of youth development projects are implemented.

The policy (read guideline) has no explicit objective or strategy focused on ASRH.
### Zambia – Key components of the existing ASRH related policies.

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<tr>
<td><strong>Policy development process</strong></td>
<td>A central task force developed a concept paper. The concept was utilized as a basis for consultation with all stakeholders at national and lower levels including young people. The central level task force then incorporated the comments into the policy document.</td>
<td>The process was consultative. A core team developed a concept paper that was utilized for consultations and consensus building at national and lower levels from stakeholders including donors, academia, NGO’s, and other civil society sectors of the population.</td>
<td>- A Sub-committee revised the 1989 policy and presented the draft to the Inter agency technical committee on population for approval. - The approved draft was then presented for wider consultation during a national population policy conference after which a final consolidated draft was undertaken pending presentation to the cabinet.</td>
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<tr>
<td><strong>Policy definition of young people</strong></td>
<td>Not indicated in the policy</td>
<td>Defines adolescent according to WHO definition, as a person aged 10 to 19 years old</td>
<td>Defines adolescents as persons aged 10 – 19 years.</td>
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<tr>
<td><strong>Policy definition of ASRH</strong></td>
<td>Not indicated in the policy</td>
<td>Defines RH as it was defined at the 1994 ICPD. There is no definition of ASRH in the policy.</td>
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<td><strong>Components in the policy that address ASRH including HIV/AIDS</strong></td>
<td>Chapter 1: section 1.1.2, highlights the magnitude of HIV prevalence among young people including the gender perpetuating factors to the spread of the infection. Chapter 3: section 3.5.2, is focused on imparting appropriate HIV prevention skills in children and adolescents. Chapter 3: section 3.5 that is dedicated to prevention and control strategies/interventions implicitly includes ASRH. - Section 3.7.3 highlights strategies to address the challenges of orphans n general. -Section 3.9.5 includes strategies to protect the rights of children and young people and availing them access to HIV/AIDS/STI/TB prevention and care services throughout the country.</td>
<td>- Part I: section 1.0, includes adolescent health and development as one of the major areas to be addressed by the policy. - Part II: section 2.6, describes the health situation of YP in general in Zambia with a focus on STI, teenage pregnancy and access to health services. - Part II: section 2.8, describes the abortion related morbidity and mortality faced by young people in general with constraints to abortion and post abortion care (PAC). - Part III: section 3.2.1, mentions as one of the policy objectives: to provide comprehensive integrated health for both men and women and adolescents in order to reduce morbidity &amp; Guiding principle 3, the policy says health facilities and other services should be availed to all regardless of age, gender, marital and social economic status. (This indirectly includes YP) Part II, population strategies 2, 6, 7 &amp; 8 respectively indicate: - Integration and expansion of population and family life education programmes for in school and out of school adolescents and youth. - Enhancement expanding</td>
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<td>- There isn’t a specific chapter on ASRH/HIV/AIDS prevention in young people - Grouping children and young people is very likely to pause policy implementation difficulties due to the recognizable diverse needs and current known programmes for children and young people from age zero to 24 years.</td>
<td>mortality from preventable conditions and diseases. - Part III: section 3.2.5, is dedicated to adolescent health development with two specific policy objectives to: a) Empower adolescents/youth by equipping them with basic life saving information and skills, including self esteem, value clarification and decision making in order to achieve a positive life attitude b) Increase accessibility and availability of affordable youth friendly health services to adolescents/youth at all levels of the health care system. - The entire part III, implicitly touches on adolescents as individuals or couples within the general population with respect to the nine areas addressed by the RH policy including safe motherhood, FP, STI/HIV/AIDS, health service delivery etc</td>
<td>access to guidance and counseling in RH including HIV/AIDS/STD’s for all population groups…etc. - Increasing numbers of facilities providing integrated user friendly RH including FP and sexual health services etc - Sensitization of communities and parents on the value of education especially for girls …etc</td>
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<td>Policy Responsiveness to young peoples diversity, neglected issues and groups</td>
<td>What is mentioned above applies here as well. However, there is a gap in explicitly recognizing and addressing all the young peoples diverse categories, age groups, issues and needs.</td>
<td>- The policy recognizes the need to address STI/HIV/AIDS, high teenage pregnancy, pregnancy related morbidity and mortality including quality PAC &amp; counseling services. - However, the policy does not include a comprehensive analysis of all young people age groups and categories. Therefore, the policy objectives don’t specifically indicate age specific and young people category specific programming as well as attention to emerging ASRH issues including VCT access by YP.</td>
<td>Same as above</td>
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<td>Inclusion in policy of Multi- sectoral development approach</td>
<td>The policy recognizes HIV/AIDS as more than a health sector issue and includes an explicit section 3.3 in chapter 3: on multisectoralism.</td>
<td>- Introductory section on guiding principles of the RH policy, Principle 3: talks of commitment to advocating for a multisectoral approach to RH</td>
<td>Part III: 3.1.5, describes collaboration within the government system whereby</td>
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<td>to ASRH</td>
<td>However, ASRH is only implied</td>
<td>by involvement of stakeholders including users of services, MOH shall advocate for a collaborative, coordinated multi-sectoral approach and political commitment to the provision of integrated RH services. Part III: section 3.2.1, statements 8 &amp; 10 indicate MOH/CBOH is charged with developing, coordinating and implementing a multi-sectoral research agenda for RH, with emphasis on social behavior and health system research; and strengthening the national capacity for multi-sectoral research in RH respectively.</td>
<td>population units would be established or strengthened where they exit in all relevant sectoral ministries in accordance with the cabinet office circular minute of 1996 No. Co 72/2/2… etc. However, there is no specific focus on ASRH.</td>
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<td>Legal basis of the Policy through reflection of commitments to international and national laws</td>
<td>Chapter 1: section 1.8.5, is indicative of the government guarantee of the human rights and freedoms that is in the national constitution and reiterates the national employment act &amp; public health act on notifiable diseases with respect to confidentiality. Chapter 3: section 3.1, talks of the domesticking of international instruments and declarations on HIV/AIDS. Section 3.1.1, says the government will (a) Uphold the international declarations subscribed to on HIV/AIDS and translate them into strategies suitable to the local government (b) Collaborate with international and regional organizations with similar objectives &amp; strategies in addressing the HIV/AIDS/STD/TB. Chapter 3: section 3.9.5, particularly voices the government commitment to ‘ensure children and young people, regardless of their HIV status enjoy rights as enshrined in the African charter, UN convention on the rights of the child and the relevant Zambian laws’</td>
<td>- The introductory guiding principles 1, 2, 5, 6, 7, &amp; 8 of the policy indicate commitment to the ICPD general principles and definition and of RH in the delivery of RH services to individuals, families regardless of age, gender, marital or social economic status. Nevertheless, ASRH is only implied as part of the general RH in all the above.</td>
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<td>Inclusion of national</td>
<td>The Chapter 2, 3, &amp; 4: detail</td>
<td>- Part III of the policy indicates the policy</td>
<td>Part 3, section 3.2, is about</td>
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| benchmarks for the policy M&E                  | Vision, guiding principles and objectives and Implementation framework respectively, Indicate short, medium and long-term benchmarks. *However, the policy objectives lack time element and quantifying measures.* | vision, objectives and statements.  
- *Part 5.2* indicates that the policy will be evaluated over a five year period basis to assess the relevance of the policy objectives and statements  
*However, the policy objectives lack time element and quantifying measures* | M&E of the policy objectives through:  
- End of the year reports  
- Inter agency technical committee on population workshops  
- Policy review workshops for all stakeholders every three years, and  
- Whenever the international community has changed direction on population and development.  
*However, the policy objectives lack time element and quantifying measures* |
| Defined minimum ASRH integrated packages in the policy | *Chapter 3: section 3.5, on prevention and control has defined interventions/strategies for HIV/AIDS prevention, treatment, care and support in which ASRH is implicitly implied* | *Part III: section 3.2.5, statements 1 – 8 define the strategies /interventions/packages for ASRH including family life education and skills; increase of YFS delivery points; strengthening interpersonal communication skills; provide peer provided services; creation awareness about ASRH etc  
Although, PAC, FP, Safe motherhood services, STI/HIV/AIDS prevention and care and support services are mentioned in the policy, they are not included directly in the adolescent RH section, neither are they explicit on accessibility by YP.* | Not included in the policy |
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<th>Policy linkage to the national reproductive health policy – (if the latter exists)</th>
<th><em>There is no specific chapter that makes reference to reproductive health in general or ASRH but Chapter 3: on prevention and care implicitly touches on some aspects of RH.</em></th>
<th>N/A</th>
<th><em>Part II: sections 2.2 and 2.3, RH focused policy objectives and strategies indicate linkage to the overall ICPD RH principles and</em></th>
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<td>Defined operational responsibility for coordination, implementing and M&amp;E of the policy</td>
<td>Nevertheless, it should be noted that both the RH and HIV/AIDS/STI/TB policies are concurrently in the development process.</td>
<td>Part IV, sections 4.0 – 5.2 define the institutional framework for the Coordination, evaluation and monitoring the implementation of the policy at national level, provincial health offices and at the district levels. Involvement of the private sector and NGOs Parliament role Cooperating partners M&amp;E</td>
<td>Part III: sections 3.1 - 3.2 describe the institutional coordination, implementation and monitoring and evaluation framework. Section 3.1.2 indicates that a national population council shall be established as the highest body to advise government on population and related issues etc.</td>
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| Dissemination status of the policy                                        | Draft policy is available to sectoral ministries, donors, & stakeholders as part of the consultation process. 
However, the policy is in draft stage and cannot be disseminated officially. | - The policy is in draft form and not ready for dissemination. 
- However, the draft policy is available to sectoral ministries, donors, & stakeholders as part of the consultation process. |                                                                                                                     |
| Implementation status of the policy                                      | Policy is in draft stage.                                                                                 | Policy is in the finalization process. 
Nevertheless, the policy is a conglomeration of existing MOH/CBOH policies and guidelines that have been operational even before the policy formulation |                                                                                                                     |
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<td>Constraints/barriers to policy implementation</td>
<td>The draft nature of the policy and absence of the legal framework of the NAC seem to be two notable barriers to the policy implementation at the moment.</td>
<td>Draft nature of the policy</td>
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<td>Specific programmes resulting from the policy</td>
<td>Although there is no specific programme that seems to have resulted from the policy formulation, there are programmes in general RH, ASRH and HIV/AIDS/STI/TB that are ongoing in the country, implemented through the public, private and civil society sectors. - It is noteworthy that many of the strategies/interventions included in the policy are at various levels of implementation in the country through the support of the public sector; multi &amp; bi lateral donors; civil society; private sector and communities.</td>
<td>No specific programmes have resulted from the policy formulation. - However, MOH/CBOH has been implementing the mentioned strategies/interventions in the policy alongside the policy development process.</td>
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| Strengths/weakness and gaps of the policy     | Strengths: A draft policy exits formulated with consultation of major stakeholders  
The policy is linked to international conventions and national laws  
Weaknesses  
Although the policy has provisions for programming for children and young people, it does not address the diverse needs and age groups of YP.  
The policy is not explicit on protection of the rights of YP especially on VCT, PMTC, Antiretroviral therapy, HIV/AIDS and work place as well as HIV positive YP.  
The policy lacks time element to the defined implementation and M&E benchmarks. | Strengths in terms of ASRH  
The policy recognizes adolescents as a specific focus group with separate needs  
Weaknesses  
In view of ASRH, the policy lacks comprehensive analysis of the needs of the different YP categories & age groups. Consequently, the policy has no specific policy statements and objectives to address the diverse needs of YP based on different age groups and categories. |                                                        |
| Benchmarks to-date in terms of:  
Linkage to financial resources  
Involvement of public, private, and civil society sectors  
Human rights. | The victim support unit approach that is countrywide is a commendable step in addressing human’s rights and gender violence related issues especially for female YP. |                                                                                                              |                                                        |
Introduction

Uganda has a projected total population of 22.2 million people with an annual growth rate of 2.9% annually (1991 census projections). About 87% of Ugandans live in rural areas (UDHS 2000).

Young people aged 10 –24 years of age constitute over 30% of the total population while adolescents aged 10 -19 years olds make up a quarter of the total Uganda population.

At age 15 –19 years, 69% of are still in school but more than half of the women in the same age group are no longer attending school. In the same category, more than half of the women are currently employed; where as only 27% of young men are working (UDHS 2000).

Overall, 43% of women 15 – 24 years and 77% of young men in the same category have never been married. The median age at first sexual intercourse has increased from 16 years in 1995 to 16.6 years in the 2000 UDHS for young women aged 15 –24 years. Men show similar trends and the corresponding ages are 17.6 years and 18.8 years respectively. Eleven percent of women who had sex before age 25 reported that the first sexual partner was at least 10 years older. By age 15 and 18 years, 23% and 67% have had sex respectively (UDHS 2000)

The total fertility rate in Uganda was 7.3 in 1987 and has remained at 6.9 births since then. The contribution of young women to the overall fertility rate has not changed much. The ideal number of children among women aged 15 –19 years declined from 5.9 children in 1988 - 1989 to 4.1 children in 2000 –2001. Because of this desire, there is a large demand for family planning services in this age group (UDHS 2000).

Although young adults have heard of contraception, few actually use any method of birth control. Young women are less likely to than older women to use contraception, largely because of their lower level of sexual activity. The current FP use in age group 15 – 19 years is 9% compared to the national average of 16.5% (UDHS 2000)

Unsafe abortion is a major public health problem in Uganda contributing to about 22% of maternal death (MOH).

Although the knowledge of HIV/AIDS is almost universal in Uganda, this knowledge is not matched with knowledge of ways to avoid disease, knowledge of source of condoms and ability to obtain condoms. Among 15 –19 year old males, 86% know of two or more ways to avoid HIV and 76% know a source for condoms, but only 66% said that they could get condoms themselves (UDHS 2000). Young people form nearly 50% of those infected by HIV (MOH/ACP). The male to female ratio for HIV in Uganda is 1:4 for the teenagers compared to 1:1 for adults. The diagnostic and treatment services for both STI and HIV/AIDS are still limited in Uganda and where available are often inaccessible to the young people.

There are many traditional practices, which impact on adolescent health and development including early marriages, female genital mutilation, food taboos and wife sharing /inheritance. There is increasing substance abuse especially tobacco and alcohol among young people.

Overall, 17% of women and 6% of men reported having sexually transmitted infections or their symptoms. A small percentage of and men have been tested for HIV/AIDS including young people (8% of women 15 –49 and 12% of men 15 –54) (UDHS 2000)
Existing policies

National health policy, Ministry of health, September 1999. Approved by cabinet.
Draft national adolescent health policy, Ministry of Health, August 2000. *Adopted and in use by MOH but not approved by the cabinet.*

Policies in the pipeline

Draft HIV/AIDS policy for Uganda, Uganda AIDS commission, March 2001. *First draft consultancy. The document is a report of the consultancy findings from consultations and discussions with various stakeholders at national level. It will act the concept paper for further debates and consultations for the policy development process.*

Uganda Constitution provisions

Age of consent: The statutory legal age of consent in Uganda is 18 years. *However, the customary law allows marriage below that age and not protective of the young people from forced/coerced marriages, sexual abuse, marital defilement, violence HIV or other STDs, etc*

Defilement: Sexual act with a female minor below the age of 18 years is defilement and punishable under Uganda laws by a death sentence. *This is aimed at protecting the girl child and female young people from sexual abuse and violence. However, the implementation of the law has been difficult due to the community reactions about the death sentence. Furthermore, a male minor can be punished for defilement of a female minor under the same law.*

Termination of pregnancy: Article 22 of the 1995 Uganda constitution about the protection of the right to life states that no person has the right to terminate life of an unborn child except as may be authorized by the law, which provides for only *medical legal abortions* that require certification by three medical doctors.

The, implementation of medical legal abortions is difficult in many areas of Uganda especially the rural areas due to difficulties of accessing three doctors to fulfill the required certification provisions. Furthermore, the constitution is rather silent with respect to abortions based on psychosocial medical reasons including rape, incest, HIV/AIDS etc.

*Post Abortion Care (PAC):* Post abortion care services including manual vacuum aspiration (MVA) are available in almost all major hospitals and health center 4 in Uganda. In health facilities where MVA services are available, midwives are trained to carry out the procedure and the ministry of health guidelines allows the nurses to conduct MVA. However, the draft nature of the existing ASRH policy means the nurses are not protected by the Uganda law with respect to conducting MVA.

Rights and freedoms of individuals: Article 21 of the constitution on equality and freedom from discrimination states that all persons are equal before and under the law… in every aspect and shall enjoy equal protection of the law. It further states that a person shall not be discriminated against on the grounds of sex, race, color, ethnic origin, tribe, and age.

*Article 34 of the constitution* states that no person shall be deprived by any person of medical treatment, education or any other social or economic benefit by reasons of religious or other beliefs.

However, this is not explicit with respect to HIV, VCT, FP and PAC services for YP.

Family Planning: The MOH guidelines indicate that all person seeking FP services irrespective of age and marital status should be availed the services.
However, the implementation of this policy is still inadequate with respect to accessibility of FP services by young people especially below 18 years and the single young people.

Voluntary counseling and testing services (VCT): The policy is that informed consent with counseling and confidentiality be observed in voluntary HIV testing. HIV testing shall not be included as part of a routine medical examination without knowledge and consent of the patient. HIV testing shall not be mandatory for travel.

However, the policy is not explicit on accessibility of VCT services by YP below 18 years of age. There is no legal framework to protect HIV testing at work places, for insurance and education scholarships as well as of orphans.
## Uganda – Key components of the existing ASRH related policies.

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<td>Policy development process</td>
<td>A national ASRH committee with the facilitation of a consultant during a national level workshop developed the first draft. This was utilized for consultations from the public sector representatives from the national and district levels including young people, donors, technical bodies, and academia. The final draft incorporated the consultative effort inputs.</td>
<td>A draft was formulated with the technical assistance of a consultant and utilized to solicit input from stakeholders at national level with representation from the district. The inputs were utilized to finalize the policy document.</td>
<td>Preface and introduction section 1.1 of the policy describes the policy formulation process that is indicated to have been consultative, participatory and inclusive of the involvement of key stakeholders and was lead by a national youth policy committee.</td>
<td>The preface describes the development process that was coordinated by the population secretariat. Intensive consultations and discussions were done with the public sector &amp; society at national, district and lower levels.</td>
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<td>Policy definition of young people</td>
<td>Part 1: section 1.1 preamble recognizes the ICDP &amp; WHO definitions of adolescents, youth and YP. However the policy defines youth as YP, female and male from the ages of 10 –24 years. The policy acknowledges that the term’s adolescent, youth and YP are used interchangeably.</td>
<td>Definition not included in the policy</td>
<td>Part 3.0: youth are defined as all young person’s females and males aged 12 – 30 years. The policy clarifies that the definition of youth takes into account programmatic issues and is in harmony with the UN definition of youth as a person 15 –24 years and the commonwealth youth program definition of 15 –29 years!</td>
<td>Part 5.0: section 5.3.11, defines youth as persons under 30 years of age.</td>
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<tr>
<td>Policy definition of ASRH</td>
<td>The definition is not included in the policy.</td>
<td>Definition not included.</td>
<td>Not included in the policy.</td>
<td>Definition not included.</td>
</tr>
<tr>
<td>Components in the policy that address ASRH including HIV/AIDS</td>
<td>Part 5: section 5.4.1 is focused on RH of YP. However, the entire chapter is about the goal, objectives, beneficiaries and targets to address the general well being of YP.</td>
<td>Topic 4.2.3: section c), defines adolescent RH, as a component of the health care minimum package, focused on: Promotion of sexual RH &amp; rights of adolescents Sex education in and out of school Life skills against STI; unwanted pregnancy and unhealthy life styles.</td>
<td>Part 8: section 8.4 only describes general strategies for health programs for YP.</td>
<td>Part 9.0: section 9.11, only describes strategies for addressing youth rights, general development issues. <em>ASRH is not addressed</em></td>
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CRHCS consultancy report, May 2002
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<td>Policy Responsiveness to young peoples diversity, neglected issues and groups</td>
<td>Part 4.0: sections 4.1 – 4.13, describe the components and implications of adolescent health. Part 5: sections 5.3, in attempt to set priorities for programmatic purposes considers YP by background circumstances, for the various categories of YP. However, the policy is not explicit on different age sub-groups of YP.</td>
<td>Not included in the policy</td>
<td>Part 9.0: lists the categories of YP that comprise the priority target groups in the policy implementation, although the policy aspiration is to improve the quality of life of all Ugandan youth. The policy does not focus on the different YP age group needs and diversity.</td>
<td>Part 5.0: sections 5.3.11, acknowledges common needs for children and youth The diversity of young people age groups and categories as well as emerging issues affecting YP are not indicated.</td>
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<td>Inclusion in policy of Multi-sectoral development approach to ASRH</td>
<td>Part1: sections 1.2.1 &amp; 1.2.2 on principles recognize that the policy is an integral part of the national development process as well complementing all the sectoral policies and programs. Topic 2.3: guiding principle h), recognizes that health is an integral component of overall development. Therefore, inter-sectoral cooperation and coordination between the different health related ministries, development agencies, and other relevant institutions needs to be strengthened for stronger solidarity in health development. Topic14: sections 14.1 – 2, describe the policy objectives and implementation strategies for stronger donor coordination and sector wide approach.</td>
<td>Part 5.0: principles underlying the policy states that the national youth policy is intended not to substitute sectoral plans, but to prioritize public actions through comprehensive and multi-sectoral responses for the objective of integrating the youth and working with them in national development.</td>
<td>Preamble 1.0: acknowledges the need to address identified population issues in a comprehensive and multi-sectoral manner Annexes 1 &amp; 2: describe respectively: -The roles of various ministries and institutions in the policy implementation - The institutional inter-linkages for population policy and program implementation</td>
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<td>Legal basis of the Policy through reflection of commitments to international and national laws</td>
<td>Part 1: section 1.3.2, indicates that the policy is guided by the: Constitution of Uganda, Relevant existing sectoral ministry policies, Universal declarations of human rights, and Young people related forums and programs as well as other relevant statements of commitment to the health of YP.</td>
<td>Topic 2.0: states that the policy was formulated in the context of the provisions of the constitution and the local government decentralization act of 1997. It also derives guidance from the national health sector reform program; national poverty eradication program; and the Alma-Ata declaration of Health for all.</td>
<td>Part 4.0: about national commitment and rationale for the policy indicates it was formulated based on the: - national objectives and principles of the state policy enshrined in the constitution, 1993 youth council statute; vision 2025; It commits the government to fulfill its obligation agreed at ICPD and international conventions relevant to YP.</td>
<td>Part 2.0: indicates that the policy: - is an integral part of the national development policy and not a substitute -Respects fundamental human rights &amp; freedoms.</td>
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<td>Inclusion of national benchmarks for the policy M&amp;E</td>
<td>Part 5: section 5.4 provides both qualitative and quantitative targets for the policy and program planning over a five-year period.</td>
<td>Topics 2 through to 14, defines the implementation of the set policy objectives and these could be utilized as the benchmarks for the policy M&amp;E. <strong>However, they lack time element in which they are to be achieved.</strong></td>
<td>Parts 7.3 &amp; 8.0: describe the policy objectives and strategies respectively that are the benchmarks for M&amp;E. <strong>However, they lack time period for being achieved.</strong></td>
<td>Part 8.0: sections 8.1 –8.3, defines measurable targets to guide the population policy and programming planning up to the year 2000 categorized into: Demographic targets Health service targets Social services targets</td>
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<tr>
<td>Defined minimum ASRH integrated packages in the policy</td>
<td>Part 6: section 6.1 – 6.7, provides strategies to achieve the policy goals, objectives and targets categorized broadly in the following levels: Advocacy IEC Training Services Resource mobilization Research Coordination</td>
<td>As indicated earlier, Topic 4.2.3: that describes the minimum health care package, defines in section C), the following for addressing adolescent health: Promotion of sexual RH &amp; rights of adolescents Sex education in and out of school Life skills against STI; unwanted pregnancy and unhealthy life styles.</td>
<td>Part 8.4: defines the health programs including: -Advocacy for scale up of services like information, guidance, counseling and making them youth friendly by removal of legal, regulatory, structural, medical and attitudinal barriers to access of the services -Life skills building for YP, mobilization of stakeholders for supportive and enabling environment for YP -Protection of YP from all forms of violence, &amp; promoting psychosocial economic reintegration of the victim</td>
<td>N/A Although the RH does not exist, Part 2.0: about the policy principles acknowledges other sectoral policies and programs.</td>
</tr>
<tr>
<td>Policy linkage to the national reproductive health policy – (if the latter exists)</td>
<td>The national RH health policy does not exist. However, the policy is cognizant of existing sectoral ministry policies in Part 1:section 1.3.2.</td>
<td>The national health policy does not exist.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Defined operational responsibility for coordination, implementing and M&amp;E of the policy</td>
<td>Part 7: sections 7.1 – 7.4.8, describes the institutional framework for the policy implementation, coordination and roles of the various sectoral ministries, NGO’s, inter governmental bodies, private sector, research bodies, national and district level adolescent technical committees. Part 8: sections 8.1 – 8.4, describes the plans for the monitoring and evaluation plans of the policy</td>
<td>Topic 14.2: sections c) &amp; d), say that: A common framework would be promoted to be used by all stakeholders in the health sector for planning, program management and M&amp;E Capacity will be strengthened at national and district levels for effective coordination of all development partners in health.</td>
<td>Parts 10.0 &amp;11.0: describe the implementation framework and M&amp;E and review of the policy respectively.</td>
<td>Part 10.0: describes the institutional framework for the policy implementation.</td>
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<tr>
<td>Dissemination status of the policy</td>
<td>The policy has been disseminated at national level.</td>
<td>The policy has been disseminated at national and district levels</td>
<td>The policy has only been disseminated at national level to stakeholders directly involved in the implementation of the ASRH program including development partners and NGO’s with ASRH programs due to inadequate resources to disseminate it beyond this group. However, the policy is available for public consumption. <em>The policy needs to be disseminated to members of parliament and the judiciary at national level as well, later on the community and district levels.</em></td>
<td>The policy has been disseminated at national and district levels. <em>It requires translation into local languages for further dissemination at community levels.</em></td>
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<tr>
<td>Implementation status of the policy</td>
<td>Some of the components of the policy are already being implemented through the existing general RH and ASRH programs.</td>
<td>The sector wide approach has been effected as well as the decentralization policy. The current health programs are addressing the national prioritized health issues, defined in the policy health minimum package.</td>
<td>Some components of the policy are being implemented through existing programs that address the policy aspects of: -Education, training &amp; capacity building; -Employment and enterprise development -Youth involvement, participation and leadership -Health -Recreation, sports and leisure</td>
<td>Components of the policy are being implemented through various existing sectoral ministries programs. -It is noteworthy that the population and development program is comprised of the various sectoral ministries programs.</td>
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<tr>
<td>Constraints/barriers to policy implementation</td>
<td>Financial resources for the policy dissemination at district levels and to the current members of parliament. The draft nature of the policy does not provide a legal framework for the policy implementation, although it is adopted and in use by the ministry of health.</td>
<td>Resource constraints Inadequate sectoral coordination mechanisms</td>
<td>Inadequate resources The policy is not widely disseminated.</td>
<td>-Limited available resources -The policy is not widely disseminated -The National population council that was to legally be established, as the supreme advisory body to government has not been formed.</td>
</tr>
<tr>
<td>Specific programs resulting from the policy</td>
<td>No specific program has resulted from the policy formulation. Nevertheless, the ASRH program design and implementation were concurrent with the policy formulation.</td>
<td>An income generating and enterprise development scheme targeting YP called ‘Entadikwa’ which is in its early stages of implementation, is a result of both the policy formulation and the overall national poverty eradication efforts.</td>
<td>The Policy and advocacy program implemented by the population secretariat resulted from the policy formulation</td>
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<tr>
<td>Strengths/weakness and gaps of the policy</td>
<td>Strength -The policy embraces the Uganda constitution and international conventions. -Recognizes categories of YP -Recognizes existing policies and multisectoral approach -Has defined ASRH strategies &amp; measurable objectives Weaknesses - Does not explicitly analyze the different ASRH issues with respect to different age sub groups</td>
<td>Weaknesses The policy does not address the: YP age categories and age sub groups needs Emerging ASRH issues</td>
<td>Strength -Embraces the national constitution, international conventions and declarations, national development goals. -Defines target priority categories of YP Weaknesses Does not address the age specific and emerging ASRH issues</td>
<td>Strength Defined measurable and time bound policy targets. Weaknesses YP are addressed with children. The different diversity needs of YP age groups and categories are not addressed.</td>
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<tr>
<td>Benchmarks to-date in terms of: Linkage to financial resources Involvement of public, private, and civil society sectors Human rights.</td>
<td>The public, private and civil society sectors are embraced in general health development programs</td>
<td>There is a state minister of youth and children, youth parliamentarians that reflects the government commitment to improvement of YP health including ASRH.</td>
<td>The public, private sectors and civil society including the religious and cultural institutions, are all involved in the implementation of the population program.</td>
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</tbody>
</table>
Annex 4: General lessons learned from other ASRH programmes

Policy and advocacy

- Program planners should undertake preparatory actions to foster an enabling environment before introducing an ASRH intervention and select designs appropriate to the communities’ needs and readiness to support these activities.
- Data collection needs identification and supporting rationale for interventions are important for effective advocacy.
- Communications at the personal and community level are essential in order to introduce issues and surface topics for public discussion.
- Participatory research and community mobilization for advocacy, including the involvement of young people are useful to identify the most urgent issues and develop a shared vision for ASRH programs.
- Leaders representing a broad spectrum of youth concerns, including traditional/cultural and religious leaders should be engaged as advocates.
- Policy development should be multi-sectoral and multi-disciplinary with coordination occurring at national and local levels.

Behavioral Change Communication

- Mass media, formal and informal communications can be selectively used at all levels of program readiness and development, and can help programs achieve a supportive environment, enhanced and skills building activities and improved health services.
- RH education and youth development courses should help youth develop skills and abilities to be sexually responsible.
- Mass media is useful to break taboos on sensitive topics and promote the sustainability of ASRH initiatives.
- Use of mass media can assist in changing social norms.
- Mass media can reach large numbers at a modest cost and disseminate practical information to both illiterate and literate YP.
- An array of topics can be included in entertainment formats to appeal to a diversity of ages and situations.
- Carefully constructed communications’ components can publicize activities, improve interpersonal communication, and inform policy makers and donors of project achievements.
- New information technologies can increasingly be used to reach policymakers and youth service providers.

Youth Friendly Services

- YP should have access to a variety of commercial, private, NGO and public health services, where they can receive respectful and confidential treatment for their ASRH needs.
- More youth oriented programs should be available through non clinic service providers, including private practitioners, community based agents, peers, traditional health workers, commercial outlets and social marketing.
- Pregnancy and STD/HIV prevention education and FP method promotion should be integrated.
- Existing clinics and health centers should be made youth friendly.
- All service providers who come in contact with youth should be trained in ASRH.
- There should be careful balancing of recreational activities and ASRH in youth centers in order to produce ASRH impact.
- Services must be in place if peer education and mass media programs generate demand.
- Condoms should be the social norm for sexually active adolescents and should be promoted for dual use.
- Emergency contraception should be publicized and made more available to adolescents.
Annex 5: References

Zimbabwe


Zambia


Youth Media. *What Young People decide to do today, will shape the world tomorrow* (Information Kit). Zambia.


Uganda


General references


Janet Smith, Charlotte Colvin. 2000. Getting to scale in Young Adult Reproductive Health Programs. Focus tool Series – Futures Group International USA.


Annex 6: List of key informants by country

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Mrs Mwaza Katemwangwe – site supervisor/ peer educator
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Dr. Dyness Kasiungami - Reproductive health specialist
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Mathew Mwanza – peer educator
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INTERVIEW GUIDE
Adolescent Reproductive Health & HIV/AIDS Policies

Demographic Data

Title/Position:
Number of Years:
Highest Qualification:
Age:
Gender:
Name of ministry
Name of Country:
E-mail:

Policy Information

Indicate, by a tick, the developmental status of each Policy mentioned below:

<table>
<thead>
<tr>
<th>Policy/Status</th>
<th>Approved by government/ Parliament</th>
<th>Drafted/In process</th>
<th>Don’t have</th>
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</thead>
<tbody>
<tr>
<td>National HIV/AIDS Policy</td>
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<tr>
<td>Youth Health Policy</td>
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<td>Adolescent HIV/AIDS Policy</td>
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<td>Youth Policy</td>
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<tr>
<td>Adolescent Sexual and Reproductive Health Policy</td>
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</table>

What are the components in each policy that address adolescent reproductive health and/or HIV/AIDS prevention and care?

LIST:

National HIV/AIDS Policy?
National Youth Health Policy?
Adolescent Sexual and Reproductive Health Policy?
National Strategy for Adolescent Health?
Other Policies (name)
Is the Focus Area mentioned is addressed in the Policy indicated (The term Adolescent Sexual and Reproductive Health is used here to include HIV/AIDS):

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<tr>
<td>Definition: Recognizing ASRH as more than absence of RH problems but part of holistic concept of well-being &amp; quality of life</td>
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<td>Evidence based: Analysis of priority needs and realities of young people, ASRH problems, etc. in the country</td>
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<td>Responsive to young peoples diversity, neglected issues and groups (different age groups, vulnerable groups in camps refugees, streets, younger adolescents, married adolescents, young people in institutions like the military, gender specific issues, etc)</td>
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<tr>
<td>Multi-sectoral development approach to ASRH: Building on relationship between ASRH and other social and economic development aspects as well as linkages and inputs from other relevant sectors health, education, youth, sports, women’s equality, labor etc.</td>
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<td>Legal basis of policy: Response under national and international laws and policy commitments (including constitutional articles; laws on age at marriage, educational access, poverty reduction and youth development plans, UN convention agreements and conventions (ICPD and Beijing ‘plus fives’, UNGASS, CEDAW and Convention on Rights of the Child, etc)</td>
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<tr>
<td>Developed national benchmarks (medium and long term): to measure policy implementation and progress in relation to international benchmarks and existing national goals under relevant plans; M+E plan</td>
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<td>Defined minimum ASRH integrated packages Indicates strategies, settings and supportive logistics for delivering the ASRH services (through private, public structures etc)</td>
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<td>Linked to national reproductive health policy</td>
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<td>Identified operational responsibility for implementing this policy</td>
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<td>Benchmarks</td>
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<td>Linkage to financial resources</td>
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<td>Involvement of public and private sectors</td>
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<td>Gender</td>
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<td>Human Rights</td>
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Policy Application:

What is the evidence that the key components of this policy are being implemented? List key components of each policy

<table>
<thead>
<tr>
<th>Policy/Status</th>
<th>National AIDS Policy</th>
<th>Youth Policy</th>
<th>Youth Health Policy</th>
<th>Adolescent AIDS Policy</th>
<th>Adolescent Reproductive Health Policy</th>
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<td>National HIV/AIDS Policy</td>
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<td>Youth Policy</td>
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<td>Reproductive Health Policy</td>
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<td>Adolescent Sexual and Reproductive</td>
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<td>Other Policy</td>
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Have any components of the policy been unable to be implemented?

Barriers and constraints

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<thead>
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<th>Barriers and Constraints</th>
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<td>Youth Policy</td>
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<td>Adolescent Sexual and Reproductive</td>
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<td>Other Policy</td>
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</table>

What was process in developing this policy?

Indicate by a tick, who was involved in the development process for existing policies:

<table>
<thead>
<tr>
<th>Policy/Status</th>
<th>National AIDS Policy</th>
<th>Youth Policy</th>
<th>Youth Health Policy</th>
<th>Adolescent AIDS Policy</th>
<th>Adolescent Reproductive Health Policy</th>
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<tr>
<td>Donor(s)</td>
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<td>Government: Sector-Ministry</td>
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<td>NGOs</td>
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<td>Other (specify below)</td>
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For each policy, indicate the level up to which the policy has been disseminated:

<table>
<thead>
<tr>
<th>Policy</th>
<th>National Political</th>
<th>Senior Management</th>
<th>Program Development</th>
<th>Program Implementation</th>
<th>Service Delivery Sites</th>
<th>Local Communities</th>
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<tr>
<td>National HIV/AIDS Policy</td>
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<tr>
<td>Youth Health Policy</td>
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<tr>
<td>Adolescent AIDS Policy</td>
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<tr>
<td>Reproductive Health Policy</td>
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<tr>
<td>Adolescent Sexual and Reproductive Health Policy</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

Programme Information

Have the policies led to specific programmes to provide ASRH services for adolescents?
Yes  No  Don't know

List types, focus and coverage of programmes:

<table>
<thead>
<tr>
<th>Programmes</th>
<th>Type</th>
<th>Focus</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Please give examples of youth involvement in design, implementation and monitoring and evaluation of programmes targeting adolescents:

<table>
<thead>
<tr>
<th>Programme</th>
<th>Design</th>
<th>Implementati on</th>
<th>Mgt.</th>
<th>M &amp; E</th>
<th>Describe how</th>
</tr>
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</table>

Are there any programmes outside your sector targeting adolescents that include an ASRH and HIV/AIDS component?

<table>
<thead>
<tr>
<th>Enterprise education/vocational training</th>
<th>Yes  No  Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recreation/outdoor education</td>
<td>Yes  No  Don't know</td>
</tr>
<tr>
<td>Youth leadership</td>
<td>Yes  No  Don't know</td>
</tr>
<tr>
<td>Other:_________________________</td>
<td>Yes  No  Don't know</td>
</tr>
</tbody>
</table>
Policy Monitoring and Evaluation (M & E)

Are these policies monitored and evaluated? Yes  No  Don’t know
Who does monitoring and evaluation?
When?
How?
How are evaluation findings utilized? (Give examples)

Strengths and Weaknesses of Existing Policies and Programs in Your Countries

Identify 2 in each question

What do you perceive as "strengths" of ASRH Policies?
What do you perceive as "weaknesses" of ASRH Policies?
What possible solution(s) /recommendations do you suggest to strengthen ASRH Policies?

What do you perceive as "strengths" of Adolescent HIV/AIDS Policies?
What do you perceive as "weaknesses" of Adolescent HIV/AIDS Policies?
What possible solution(s) /recommendations do you suggest to strengthen Adolescent HIV/AIDS Policies?

What do you perceive as "strengths" of ASRH programmes?
What do you perceive as "weaknesses" of ASRH programmes?
What possible solution(s) /recommendations do you suggest to strengthen ASRH programmes?

What do you perceive as "strengths" of HIV prevention programmes for adolescents?
What do you perceive as "weaknesses" of HIV prevention programmes for adolescents?
What possible solution(s) /recommendations do you suggest to strengthen HIV prevention programmes for adolescents?

What do you perceive as "strengths" of HIV care programmes for adolescents?
What do you perceive as "weaknesses" of HIV care programmes for adolescents?
What possible solution(s)/recommendations do you suggest to strengthen HIV care programmes for adolescents?

Indicate any lessons learned and best practices from the development, implementation, monitoring & evaluation of the policies and programmes?

Lessons learned

Best practices
Any Other Comments/Suggestions:

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FOR DONORS and other key informants:

What are the critical policies that could improve ASRH and adolescent HIV/AIDS?

What are strengths and weaknesses of existing policies?

Are effective are the coordination of donors, government, etc?

What are the special needs of this country to address the issues of ASRH and HIV/AIDS?

Can you give examples of model programs and policies?