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YOUTH FAMILY PLANNING **POLICY SCORECARD**

METHODOLOGY

METHODS

To identify policy and program interventions that have been proven to increase youth use of contraception, PRB staff conducted a literature review of 44 studies and systematic reviews (scholarly, gray, and program reports) on youth sexual and reproductive health (SRH) published between 2000 and 2016. From this evidence base, we identified legal approaches and programmatic interventions that have proven effective in improving access to and use of contraception among youth ages 15 to 24. We did not include adolescents ages 10 to 14 in the review, due to limited data for this age group.

The evidence on what works to address youth FP needs is varied and at times contradictory, due in part to the nature of this population. Youth's thoughts, interests, and behaviors are constantly changing and evolving, and different populations of youth (for example, married, out of school, disabled) have varied needs. Further, the impacts of youth interventions are often not observable for years after a study closes, when youth may initiate or resume sexual behavior.[1]

Variations in outcomes are also related to intervention design and implementation. The 2016 *Lancet* Commission on Adolescent Health and Wellbeing found greater effectiveness when interventions were packaged together rather than implemented individually; however, when interventions are packaged together it can be challenging to tease out the impact of specific interventions.[2] Finally, the manner in which interventions are implemented varies by study.

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

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

When selecting interventions, we chose those with supporting evidence directly linked to increased youth contraceptive use, although this criterion limited the number of policy and program interventions that were ultimately included. Cash transfer programs, for example, have had an impact on decreasing pregnancies among youth and increasing age of sexual debut, but the evidence has not yet identified a direct link to contraceptive use.[3]

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

- Parental and spousal consent.
- Provider authorization.
- Restrictions based on age.
- Restrictions based on marital status.
- Access to a full range of FP methods.
- Comprehensive sexuality education (CSE).
- Youth-friendly FP service provision.
- Enabling social environment.

We devised four color-coded categories to classify how well a country is performing for each indicator. The color assigned for each indicator in a country's results is based on the extent to which that country provides the most favorable policy environment for youth to access and use contraception:

GREEN: Strong policy environment.

YELLOW: Promising policy environment but room for improvement.

RED: Policy environment impedes youth from accessing and using contraception.

GRAY: Policy addressing the indicator does not exist.

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

Countries are categorized based on the language in the most recent version of a given law or strategy. For example, a new reproductive health law in a given country is considered to supersede an old reproductive health law in that country. In cases where there is evidence that an older, more restrictive law is still in effect despite a newer strategy that extends access to youth FP, we consider this as an existing policy restriction. In addition, if there are overt inconsistencies across recent policy documents, we consider this as an existing policy restriction.

REFERENCES

1. Allison Glinski, Magnolia Sexton, and Suzanne Petroni, *Adolescents and Family Planning: What the Evidence Shows* (Washington, DC: International Center for Research on Women, 2016).
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3. Michelle J. Hindin et al., "Interventions to Prevent Unintended and Repeat Pregnancy Among Young People in Low- and Middle-Income Countries: A Systematic Review of the Published and Gray Literature," *Journal of Adolescent Health* 59, no. 3 (2016): S8-S15.

SCORECARD INDICATORS OVERVIEW

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

POLICY INDICATOR	Strong policy environment	Promising policy environment but room for improvement	Policy environment impedes youth from accessing and using contraception	Policy addressing the indicator does not exist
Parental and Spousal Consent	Law or policy exists that supports youth access to FP services without consent from both third parties (parents and spouses).	Law or policy exists that supports youth access to FP services without consent from one but not both third parties.	Law or policy exists that requires parental and/or spousal consent for youth access to FP services.	No law or policy exists that addresses consent from a third party to access FP services.
Provider Authorization	Law or policy exists that requires providers to authorize medically advised youth FP services without personal bias or discrimination.	Law or policy exists that requires providers to authorize medically advised youth FP services but does not address personal bias or discrimination.	Law or policy exists that supports providers' non-medical discretion to authorize youth FP services.	No law or policy exists that addresses provider authorization.
Restrictions Based on Age	Law or policy exists that supports youth access to FP services regardless of age.	N/A	Law or policy exists that restricts youth access to FP services based on age.	No law or policy exists addressing age in access to FP services.
Restrictions Based on Marital Status	Law or policy exists that supports youth access to FP services regardless of marital status.	Law or policy exists that supports access to FP services for unmarried women, but includes language favoring the rights of married couples to FP.	Law or policy exists that restricts youth access to FP services based on marital status.	No law or policy exists addressing marital status in access to FP services.
Access to a Full Range of FP Methods	Law or policy exists that supports youth access to FP methods, including the provision of LARCs.	Law or policy exists that supports youth access to a full range of FP methods without defining full range of methods to include LARC methods.	Law or policy exists that restricts youth from accessing a full range of FP methods based on age, marital status, and/or parity.	No law or policy exists addressing youth access to a full range of methods.
Comprehensive Sexuality Education	Policy supports the provision of sexuality education AND mentions all nine UNFPA essential components of CSE.	Policy supports provision of sexuality education without referencing all nine of the UNFPA essential components of CSE.	Policy promotes abstinence-only education or discourages sexuality education.	No policy exists supporting sexuality education of any kind.

SCORECARD INDICATORS OVERVIEW (CONTINUED)

POLICY INDICATOR	Strong policy environment	Promising policy environment but room for improvement	Policy environment impedes youth from accessing and using contraception	Policy addressing the indicator does not exist
Youth-Friendly FP Service Provision	Policy details three service-delivery elements of the HIPs recommendations for adolescent-friendly contraceptive services: provider training, confidentiality and privacy, free or reduced cost.	Policy references targeting youth in provision of FP services but mentions fewer than three of the service-delivery elements of the HIPs recommendations for adolescent-friendly contraceptive services.	N/A	No policy exists targeting youth in the provision of FP services.
Enabling Social Environment	Policy details strategy addressing two enabling social-environment elements of the HIPs recommendations for adolescent-friendly contraceptive services: address gender norms; build community support.	Policy references building an enabling social environment but does not include specific intervention activities addressing both HIPs-recommended elements. Policy outlines detailed strategy addressing one of the two enabling social environment elements of the HIPs recommendations for adolescent-friendly contraceptive services.	N/A	No policy exists to build an enabling social environment for youth FP services.

Parental and Spousal Consent

Law or policy exists that supports youth access to FP services without consent from both third parties (parents and spouses).

Law or policy exists that supports youth access to FP services without consent from one but not both third parties.

Law or policy exists that requires parental and/or spousal consent for youth access to FP services.

No law or policy exists that addresses consent from a third party to access FP services.

Many countries have taken a protectionist approach to legislating youth's access to FP services, based on a belief that young people need to be protected from harm and that parents or spouses should be able to overrule their reproductive health (RH) decisions. In practice, these laws serve as barriers that inhibit youth's access to a full range of sexual and reproductive health (SRH) services, including FP. For example, an International Planned Parenthood Federation study in El Salvador reports that laws requiring parental consent for minors to access medical treatment create a direct barrier for youth to access FP. The study recommends: "Primary legislation should clearly establish young people's right to access SRH services, independent of parental or other consent; to avoid ambiguity and the risk that informal restrictions will be applied at the discretion of service providers."[1]

Global health and human rights bodies stress the importance of recognizing young people's right to freely and responsibly make decisions about their own reproductive health and desires. The 2012 International Conference on Population and Development's Global Youth Forum recommended that "governments must ensure that international and national laws, regulations, and policies remove obstacles and barriers—including requirements for parental and spousal notification and consent; and age of consent for sexual and reproductive services—that infringe on the sexual and reproductive health and rights of adolescents and youth."[2]

Laws around consent to FP services are often unclear or contradictory. The Scorecard intends to recognize countries that explicitly affirm youth's freedom to access FP services without parental or spousal consent. Countries that have created such a policy environment have been placed in the green category, signifying the most favorable policy environment, because their definitive legal stance provides the necessary grounding from which to counteract social norms or religious customs that may restrict young people's ability to access FP services. If a policy document mentions that youth are not subject to consent from one of the third parties—spouse or parent—but does not mention the other, the country is classified in the yellow category. Any country that requires consent from a parent and/or spouse is placed in the red category. If a country does not have a policy in place that addresses youth access to FP services without consent, it is placed in a gray category.

Provider Authorization

Law or policy exists that requires providers to authorize medically advised youth FP services without personal bias or discrimination.

Law or policy exists that requires providers to authorize medically advised youth FP services but does not address personal bias or discrimination.

Law or policy exists that supports providers' non-medical discretion to authorize youth FP services.

No law or policy exists that addresses provider authorization.

Providers often refuse to provide contraception to youth, particularly long-acting reversible methods, because of non-medical reasons.[3] Service providers may impose personal beliefs or inaccurate medical criteria when assessing youth FP needs, creating a barrier to youth contraceptive uptake. Three-quarters of Ugandan providers queried on their perspective of providing contraception to youth believed that youth should not be given contraception, and one-fifth of providers said they would prefer to advise abstinence instead of providing injectables to young women.[4] To address this barrier, national laws and policies should reflect open access to medically advised FP services for youth, without their being subject to providers' personal beliefs.[5]

Policies that explicitly underscore the obligation of providers to service youth without discrimination or bias are considered fully supportive of youth access to contraception and receive a green categorization under this indicator. Any country that generally supports the World Health Organization (WHO) medical eligibility criteria for contraceptive use but does not explicitly require providers to service youth despite personal beliefs is placed in the yellow category. Any country that supports providers' non-medical discretion when authorizing FP services for youth is placed in the red category, indicating a legal barrier for youth to use contraception. Countries that lack any policy addressing non-medical provider authorization are placed in the gray category.

Restrictions Based on Age

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

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

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

Youth seeking contraceptives continue to face barriers to accessing services because of their age. For example, a study in Kenya and Zambia found that less than two-thirds of nurse-midwives agreed that girls in school should have access to FP.[6]

In 2010, a WHO expert panel concluded that "the existence of laws and policies that improve adolescents' access to contraceptive information and services, irrespective of marital status and age, can contribute to preventing unwanted pregnancies among this group."[7] As mentioned above, the 2012 International Conference on Population and Development's Global Youth Forum recommended that "governments must ensure that international and national laws, regulations, and policies remove

obstacles and barriers—including… age of consent for sexual and reproductive services—that infringe on the sexual and reproductive health and rights of adolescents and youth."[8]

Countries that explicitly include a provision in their laws or policies that support youth access to FP regardless of age are considered to have a supportive policy environment and are placed in the green category. Countries that restrict youth access to FP by defining an age of consent for sexual and RH services are considered to have a restrictive policy environment and are placed in the red category. Countries that do not have a policy that supports youth access to FP regardless of age are placed in the gray category.

Restrictions Based on Marital Status

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

Law or policy exists that supports access to FP services for unmarried women, but includes language favoring the rights of married couples to FP.

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

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

A 2014 systematic review identified laws and policies restricting unmarried youth from accessing contraception as an impediment to youth uptake of contraception.[9] In the absence of a legal stance on marital status, health workers can justify refusal to provide contraception to unmarried youth.[10] Thus, strong policies providing equal access to FP services for married and unmarried youth are necessary to promote uptake of contraceptive services among all youth.

Countries are determined to have the most supportive policy environment for this indicator if they explicitly include a provision in their laws or policies for youth to access FP services regardless of marital status. If a country recognizes an individual's legal right to access FP services regardless of marital status but includes policy language that places particular emphasis on married couples' right to FP, it is considered to have a promising yet inadequate policy environment and classified in the yellow category because the policy leaves room for interpretation. A country is placed in the red category if its policies restrict youth from accessing FP services based on marital status. Finally, if a country has no policy supporting access to FP services regardless of marital status, it is placed in the gray category.

Access to a Full Range of FP Methods

Law or policy exists that supports youth access to a full range of FP methods, including the provision of LARCs.

Law or policy exists that supports youth access to a full range of FP methods without defining full range of methods to include LARC methods.

Law or policy exists that restricts youth from accessing a full range of FP methods based on age, marital status, and/or parity.

No law or policy exists addressing youth access to a full range of FP methods.

Youth seeking contraception, particularly long-acting reversible contraceptives (LARCs), are frequently faced with scrutiny or denial from their provider based on their age, marital status, or parity.[11] The WHO medical eligibility criteria for contraceptive use, however, explicitly state that age and parity are not contraindications for short-acting or long-acting reversible contraception.[12]

Provision of LARCs as part of an expanded method mix is particularly effective in increasing youth uptake of contraception. One of the studies identified in a 2016 systematic review offered implants as an alternative contraceptive option to young women seeking short-acting contraceptives at a clinic in Kenya. Twenty-four percent of the women opted to use an implant, and their rate of discontinuation was significantly lower than those using short-acting methods. Of the 22 unintended pregnancies that occurred, all were among women using short-acting methods.[13] However, many youth around the world do not know about LARCs, and if they do, they may be confused about their use and potential side effects, hesitant to use them due to social norms, or face refusal from providers.

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

- *Providing access to the widest available contraceptive options, including LARCs (specifically, contraceptive implants and intrauterine contraceptive devices) to all sexually active adolescents and youth from menarche to age 24, regardless of marital status and parity.*
- *Ensuring that LARCs are offered and available among the essential contraceptive options during contraceptive education, counseling, and services.*
- *Providing evidence-based information to policymakers, ministry representatives, program managers, service providers, communities, family members, and adolescents and youth on the safety, effectiveness, reversibility, cost effectiveness, acceptability, continuation rates, and the health and nonhealth benefits of contraceptive options, including LARCs, for sexually active adolescents and youth who want to avoid, delay, or space pregnancy.*[14]

This indicator differs from the *Restrictions Based on Age* indicator by focusing on the range of methods offered to youth. Countries should have in place a policy statement that requires health providers to offer short-acting and long-acting reversible contraceptive services regardless of age. In addition, the policy should leave no ambiguity in the scope of the directive but rather explicitly mention youth's legal right to access a full range of contraceptive services, including LARCs. Therefore, countries with an explicit policy allowing youth to access a full range of contraceptive services—regardless of age—receive a green categorization for promoting the most supportive policy environment. Countries with policies that state that youth can access a full range of methods, but do not specify that LARCs

are included in the method choice, are placed in the yellow category. These countries are on the right track but would have a stronger enabling environment if their policies explicitly mentioned youth's right to access LARCs.

A country is placed in the red category if it has a policy in place that restricts access to FP services, including specific methods, based on age, marital status, or parity, or other characteristics that do not align with WHO medical eligibility criteria. Countries that do not have a policy addressing youth access to a full range of contraceptive methods are placed in the gray category.

It is important to note that the Scorecard does not assess policies' inclusion of emergency contraception (EC) in the full range of methods for youth when determining categorization of countries for this indicator. This indicator is focused on whether short-term methods and LARCs are included in the method options that are made available to youth. Therefore, countries that do not list EC in the available methods for youth can still receive a green categorization if they've included access to LARCs. However, due to the growing attention toward EC as an available method for youth, the summary of this indicator in each country section makes note of whether EC was included in the range of methods for youth.

Comprehensive Sexuality Education

Policy supports the provision of sexuality education AND mentions all nine UNFPA essential components of CSE.

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

Policy promotes abstinence-only education or discourages sexuality education.

No policy exists supporting sexuality education of any kind.

The WHO recommends educating adolescents about sexuality and contraception to increase contraceptive use and ultimately prevent early pregnancy and poor RH outcomes.[15] Comprehensive sexuality education (CSE) is a specific form of sexuality education that equips young people with age-appropriate, scientifically accurate, and culturally-relevant SRH knowledge, attitudes, and skills regarding their SRH rights, services, and healthy behaviors.[16]

A growing body of evidence demonstrates that informing and educating youth about sexuality and SRH have a positive impact on their RH outcomes. Sexuality education offered in schools helps youth make positive, informed decisions about their sexual behavior and can reduce sexually transmitted infections (STIs) and unintended pregnancies, in part due to increased self-efficacy and use of condoms and other contraception.[17] A study in Brazil that implemented a school-based sexual education program in four municipalities measured a 68 percent increase in participating students' use of modern contraception during their last sexual intercourse.[18]

To be most effective, sexuality education should be offered as part of a package with SRH services, such as direct provision of contraception or links to youth-friendly FP services.[19]

Many approaches are available to implement sexuality education in and out of schools. The Scorecard considers CSE as the gold standard and relies on the "UNFPA Operational Guidance for Comprehensive Sexuality Education," which focuses on human rights and gender as a framework to effectively implement a CSE curriculum. The UNFPA Operational Guidance outlines nine essential components of CSE that are concise and easy to measure across countries' policy documents.[20] Further, these guidelines recognize gender and human rights and build on global standards discussed in the United Nations Educational, Scientific, and Cultural Organization's "International Technical Guidance on Sexuality Education."

A country is determined to have the most supportive policy environment and is classified in the green

The nine UNFPA essential components for CSE are:

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

category if its policies not only recognize the importance of sexuality education broadly but also include each of the nine elements of CSE.

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

While evidence proves that sexuality education equips youth with the necessary skills, knowledge, and values to make positive SRH decisions, including increased contraceptive use, little evidence exists that abstinence-only education is similarly effective. The 2016 *Lancet* Commission on Adolescent Health and Wellbeing recommends against abstinence-only education as a preventive health action and found it was ineffective in preventing negative SRH outcomes.[21] In fact, some reports suggest that an abstinence-only approach increases the risk for negative SRH outcomes among youth.[22] Therefore, a country that supports abstinence-only education is seen as limiting youth's access to and use of contraception and, as a result, is grouped in the red category. Any country lacking a sexuality education policy is placed in the gray category.

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Youth-Friendly FP Service Provision

Policy details three service-delivery elements of the HIPs recommendations for adolescent-friendly contraceptive services: provider training, confidentiality and privacy, free or reduced cost.

Policy references targeting youth in provision of FP services but mentions fewer than three of the service-delivery elements of the HIPs recommendations for adolescent-friendly contraceptive services.

No policy exists targeting youth in the provision of FP services.

The WHO "Guidelines on Preventing Unintended Pregnancies and Poor Reproductive Outcomes Among Adolescents in Developing Countries" recommend that policymakers make contraceptive services adolescent-friendly to increase contraceptive use among this population.[23] This recommendation aligns with numerous findings in the literature. A 2016 systematic assessment to identify evidence-based interventions to prevent unintended and repeat pregnancies among young people in LMIC found that three out of seven interventions that increased contraceptive use involved a component of contraceptive provision.[24]

Additional evaluations show that when SRH services are tailored to meet the specific needs of youth, they are more likely to use these services and access contraception.[25] The Scorecard draws upon the four service-delivery core elements identified in the United States Agency for International Development's HIPs brief, "Adolescent-Friendly Contraceptive Services," as the framework for assessing the policy environment surrounding FP service provision.[26] One of the four elements is addressed in a separate indicator, *Access to a Full Range of FP Methods,* which evaluates the extent to which a country's policy environment supports youth access to a wide range of contraception. The remaining three service-delivery elements are addressed in this indicator, *Youth-Friendly FP Service Provision.*

Many countries have adolescent-friendly health initiatives that include a wide range of health services, but for a country to be placed in the green category, its policies should specifically reference providing FP services to youth as part of the package of services. A country is placed in the green category for this indicator if its policy documents reference the three adolescent-friendly contraceptive service-delivery elements as defined above. Simply referencing the provision of FP services to youth, but not adopting the three service-delivery elements of adolescent-friendly contraceptive services, indicates a promising but insufficient policy environment, and the country is placed in the yellow category. Countries that reference provider training in youth FP services but do not acknowledge judgment as a barrier or do not specify that the training is to combat provider discrimination will result in a yellow categorization. A country is similarly placed in the yellow category if policies reference making youth services affordable or confidential but do not specify FP services or products specifically.

The three service-delivery elements are:

1. Train and support providers to offer non-judgemental services to adolescents.
2. Enforce confidentiality and audio/visual privacy.
3. Provide no-cost or subsidized services.

Countries that do not have a policy that promotes FP service provision to youth are placed in the gray category.

The HIPs brief recommends three additional enabling-environment elements of adolescent-friendly FP service provision. Two of these elements are evaluated in the separate Scorecard indicator, *Enabling Social Environment.*

Enabling Social Environment

Policy details strategy addressing two enabling social-environment elements of the HIPs recommendations for adolescent-friendly contraceptive services: address gender norms; build community support.

Policy references building an enabling social environment to support youth access to FP but does not include specific intervention activities addressing both HIPs-recommended elements.

Policy outlines detailed strategy addressing one of the two enabling social environment elements of the HIPs recommendations for adolescent-friendly contraceptive services.

No policy exists to build an enabling social environment for youth FP services.

The final indicator addresses demand-side factors, specifically efforts to make youth access to and use of a full range of contraceptive methods more acceptable and appropriate within their communities. To support youth's acceptance of contraception and ensure they are comfortable seeking contraceptive services, it is imperative to spread awareness and build support for a wide range of contraceptive methods among the broader communities in which they live. The 2016 *Lancet* Commission on Adolescent Health and Wellbeing identified community-support interventions as a critical component of strong SRH service packages.[27]

Group engagement activities that mobilize communities through dialogue and action, rather than by only targeting individuals, are considered a promising practice to change social norms around SRH, including contraceptive use.[28] Group engagement can be useful to change the discourse around youth sexuality and address misconceptions about contraception within communities.

This indicator assesses the extent to which a country addresses enabling-environment elements as outlined in the adolescent-friendly contraceptive service provision HIPs brief:

- Link service delivery with activities that build support in communities.
- Address gender and social norms.

Countries that outline specific interventions to build support within the larger community for youth FP and address gender and social norms are considered to have a strong policy environment and are placed in the green category. Countries that include a reference to building an enabling social environment for youth FP, without providing any specific plan for doing so, are placed in the yellow category. Additionally, countries that discuss one, but not both, of the enabling social environment elements in detail are placed in the yellow category. Countries without any reference to activities to build an enabling social environment for youth FP are placed in the gray category.

The HIPs brief recommends a third enabling-environment element: "Ensuring legal rights, policies, and guidelines that respect, protect, and fulfill adolescents' human rights to contraceptive information, products, and services regardless of age, sex, marital status, or parity." This element overlaps with the first four indicators of the Scorecard and is not assessed separately under this indicator. The extent to which a country addresses all seven elements of adolescent-friendly contraceptive services provision, as outlined in the HIPs, can be found in the *Discussion of Results* section.

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