



**CHALLENGES, BARRIERS AND FACILITATORS
CONTRIBUTING TO PROGRESS TOWARDS
ACHIEVING SDG 3.7: A DOCUMENTARY REVIEW OF
SELECTED SUB-SAHARAN AFRICAN COUNTRIES**

BY

EMAN NOURALDEIN MOHAMMED ALKHIDIR

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INDEPENDENT STUDY

BY

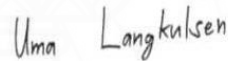
EMAN NOURALDEIN MOHAMMED ALKHIDIR

ENTITLED

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Chair



(Associate Professor Uma Langkulsen, PhD)

Member and Advisor



(Dr. Rodger Doran, MB.BS, DTMH)

Member



(Dr Andrew Lee Corwin, DrPH,)

Dean



(Assistant Professor Soisuda Kesornthong, PhD)

Independent Study Title	CHALLENGES, BARRIERS AND FACILITATORS CONTRIBUTING TO PROGRESS TOWARDS SDG 3.7: A DOCUMENTARY REVIEW OF SELECTED SUB-SAHARAN AFRICAN COUNTRIES
Author	Eman Nouraldein Mohammed Alkhidir
Degree	MPH Global Health
Major Field/Faculty/University	Global Health Faculty of Public Health Thammasat University
Advisor	Dr. Rodger Doran
Academic Year	2023

ABSTRACT

There are disparities in the progress towards SDG 3.7 in sub-Saharan Africa. This documentary review analyzed the challenges, barriers and facilitators that contribute to progress towards achieving SDG 3.7 for adolescent girls in selected sub-Saharan African countries. Six countries were selected for the study based on their averaged performance in six different global development indexes, with the highest and the lowest performing country from three of the four sub-regions of sub-Saharan Africa selected for analysis. One sub region was excluded due to lack of data in English.

This review covered both peer-reviewed and grey literature published in the period 2015 to 2024. It analyzed the data to determine the strengths and weaknesses in adolescent sexual and reproductive health (ASRH) laws, policies, strategies and services in the six study countries.

Facilitators of ASRH services among high-performing countries included conducive policy environments for ASRH and effective multi-sectoral coordination at national level, as well as commitment to family planning in national budgets and offering options for contraceptive choice to adolescent girls. Challenges include weak

(ii)

coordination among stakeholders at subnational level and inconsistencies between national laws and policies, such as conflict between the legal age of consent for contraceptives and age of eligibility to access ASRH services.

Low-performing countries also benefit from conducive policy environment for ASRH, but struggle with weak stakeholder coordination and heavy reliance on external donor funding. The family planning services are provided for free in the three countries, but weak health systems and poor data collection limit these countries' ability to monitor progress towards ASRH targets, including those for SDG 3.7.

Recommendations include urging governments and regional bodies to foster collaboration among countries to share best practices, international development organizations to prioritize data disaggregation for adolescent girls in the reports and studies, and academic institutions to invest in ASRH research to address data gaps that inhibit comparative analysis of national progress towards achieving the 2030 SDG targets.

Keywords: Adolescent girls, sexual and reproductive health, modern contraceptives, Sub-Saharan Africa

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Eman Nouraldein Mohammed Alkhidir

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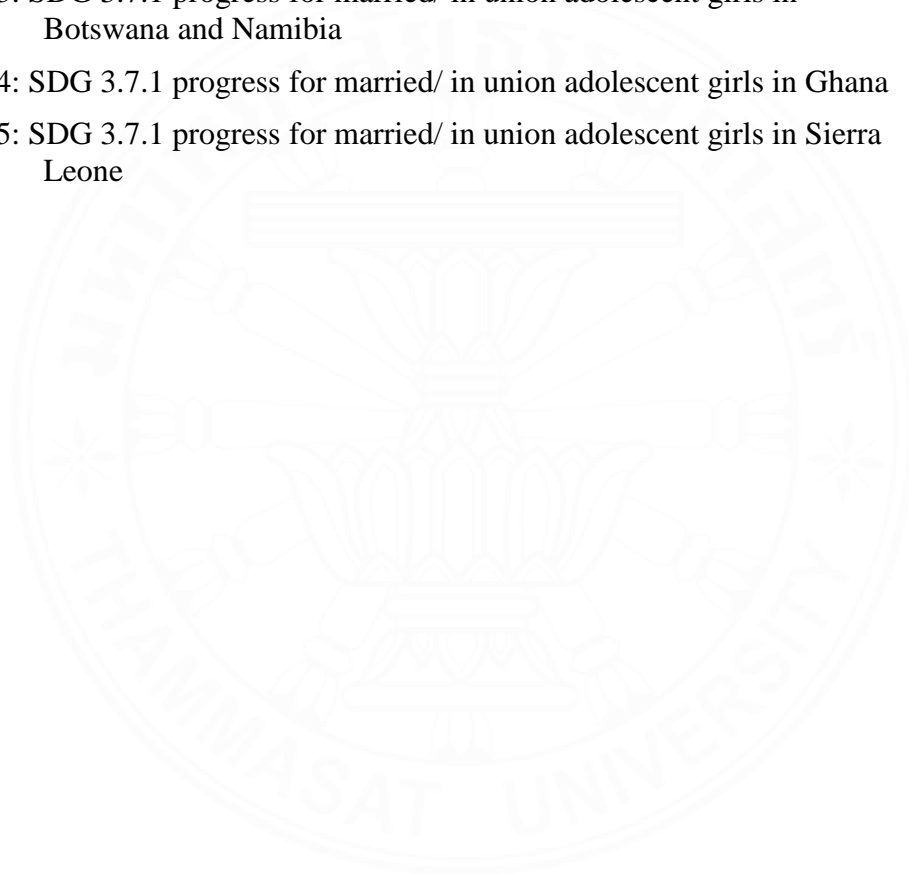
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LIST OF ABBREVIATIONS

Abbreviation	Meaning
AFHS	Adolescent-friendly Health Services
AIDS	Acquired Immune Deficiency Syndrome
APHRC	African Population and Health Research Center
ASRH	Adolescent Sexual and Reproductive Health
AYFHS	Adolescent Youth-friendly Health Services
AYFS	Adolescent Youth-friendly Services
AYPFHS	Adolescent and Young People-friendly Health Services
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organizations
DHS	Demographic and Health Survey
ESA	Eastern and Southern Africa
FP	Family Planning
FY	Fiscal Year
GoK	Government of Kenya
GSS	Ghana Statistical Services
HIV	Human Immunodeficiency Disease
ICPD	International Conference on Population and Development
IUD	Intra-Uterine Device
KNBS	Kenya National Bureau of Statistics
mCPR	Modern Contraceptive Prevalence Rate
MDG	Millennium Development Goals
MHSS	Ministry of Health and Social Services
MICS	Multiple Indicator Cluster Survey
MoE	Ministry of Education
MoH	Ministry of Health
MoHW	Ministry of Health and Wellness
NGO	Non-governmental Organizations
NHIS	National Health Insurance Scheme



NSO	National Statistical Office (Malawi)
SDG	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SSA	Sub-Saharan Africa
SSL	Statistics Sierra Leone
STI	Sexually Transmitted Infections
UN	United Nations
UNDESA	United Nations Department of Economic and Social Affairs
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNFPA ESARO	East and Southern Africa Regional Office
UNFPA WCARO	West and Central Africa Regional Office
UNICEF	United Nations Children's Fund
UNSD	United Nations Statistics Division
WHO	World Health Organization
YFHS	Youth-friendly Health Services
YFS	Youth-friendly Services

CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 Introduction

My research topic is centered around evaluating the progress of sub-Saharan African countries in achieving SDG target 3.7. Since the SDG aims to ensure that no one is left behind, my focus will be on adolescent girls, a group that is often marginalized and faces challenges related to their sexual and reproductive health (SRH), which can impact their health, social and economic opportunities.

Having worked in the field of SRH in Sudan, I have witnessed the difficulties women and girls face in accessing these services. My role as the focal point for family planning allowed me to engage deeply with these issues, and I was part of a team that developed a National Family Planning Strategy aimed at empowering Sudanese women.

My commitment to this field is driven by a personal and professional dedication to improving SRH outcomes. I decided to focus on SDG target 3.7 as it allows me to assess regional progress and understand the various approaches that countries in sub-Saharan Africa are taking to achieve this target. This comparative analysis will not only highlight the advancements made but also reveal gaps and areas needing further attention.

1.2 Background

1.2.1 The 2030 Development Agenda

In 1994, the International Conference on Population and Development (ICPD) affirmed the importance of human rights and dignity in achieving inclusive sustainable development (UNFPA, n.d.). The ICPD Program of Action, which 179 governments adopted, affirmed equality in accessing “reproductive health care, including family planning (FP) and sexual health that would allow all couples and individuals to have the basic right to decide freely and responsibly the number and spacing of their children” (United Nations Department of Economic and Social Affairs [UNDESA], 2022).

In 2000, the United Nations (UN) announced the 8 Millennium Development Goals (MDG), to be achieved by 2015, with MDG 5 aiming at reducing maternal deaths, and has target 5.B “to achieve, by 2015, universal access to reproductive health” (WHO, 2018). In 2015, the UN General Assembly began the negotiation process to reinforce these MDG with the 2030 development agenda. At the heart of this agenda are the 17 Sustainable Development Goals (SDG) (UN, 2016).

Each SDG contains targets and indicators to measure achievements. SDG 3 aims to “ensure healthy lives and promote well-being for all at all ages”. It has nine targets, of which target 3.7 aims “by 2030, to ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs”. The indicators that are used to track the progress towards these goals include:

- 3.7.1 “Proportion of women of reproductive age (aged 15–49 years) who have their need for FP satisfied with modern methods” and;
- 3.7.2 “Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group” (United Nations Statistics Divisions [UNSD], n.d.A).

Globally, there has been some progress in SDG 3.7.1 indicator, increasing from 76.5% in 2015 to 77.6% in 2023, and it is expected to reach 78.2% by 2030 (UN, 2023).

1.2.2 Contraceptive Methods and their Utilization

FP helps individuals decide their pregnancy spacing and the intended number of children, through the use of contraceptive methods. The health benefits of FP include reducing pregnancy-related deaths, especially reducing health risks among young girls that arise from childbearing and among older women who face higher risks of pregnancy (WHO, 2019).

Contraceptive methods can be classified as either traditional methods, including the calendar and withdrawal methods, or modern contraceptives. Modern contraceptives can be divided into short-acting methods (e.g. oral pills, injectables, and condoms), long-acting reversible methods (e.g. intrauterine devices (IUD) and implants), and permanent methods (e.g. female and male sterilization methods) (UNDESA, 2019).

Globally, the use of modern contraceptives is more widespread than traditional ones. For modern methods, it was found that short-acting contraceptives are more prevalent than long-acting methods in five regions including Sub-Saharan Africa (SSA) (as shown in Figure 1.1, below). There are also variations within regions in the type of short-acting method used. For example, in Australia and New Zealand, the pill is the most prevalent method. Injectables are the primary method in the SSA region only (UNDESA, 2022).

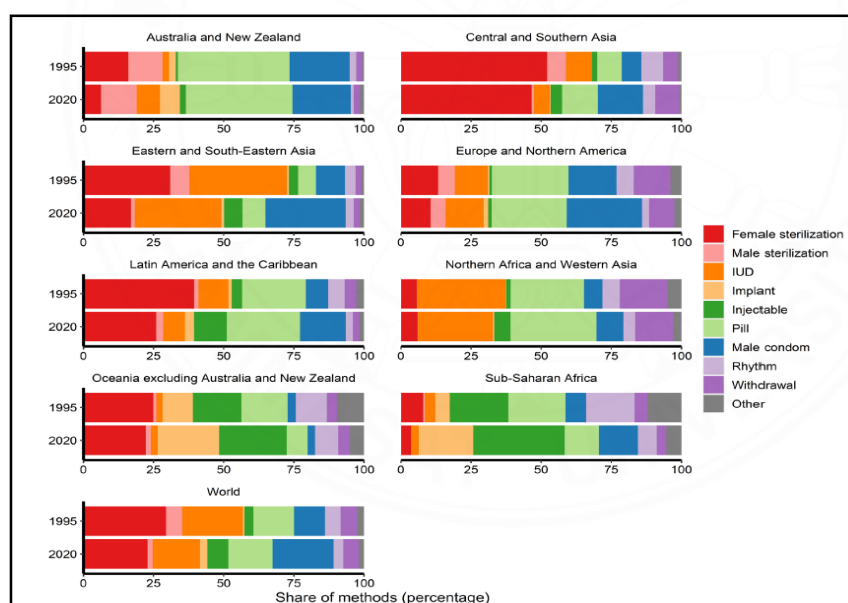


Figure 1.1: Percentage use of contraceptive methods among women of reproductive age (15-49 years) in 1995 and 2020 (UNDESA, 2022).

The highest proportion of women who wish to avoid pregnancy and those who use any contraceptive method is found among women aged 25 to 44 years at global and regional levels. In contrast, women under the age of 25 have the lowest percentage (Figure 1.2) (UNDESA, 2022).

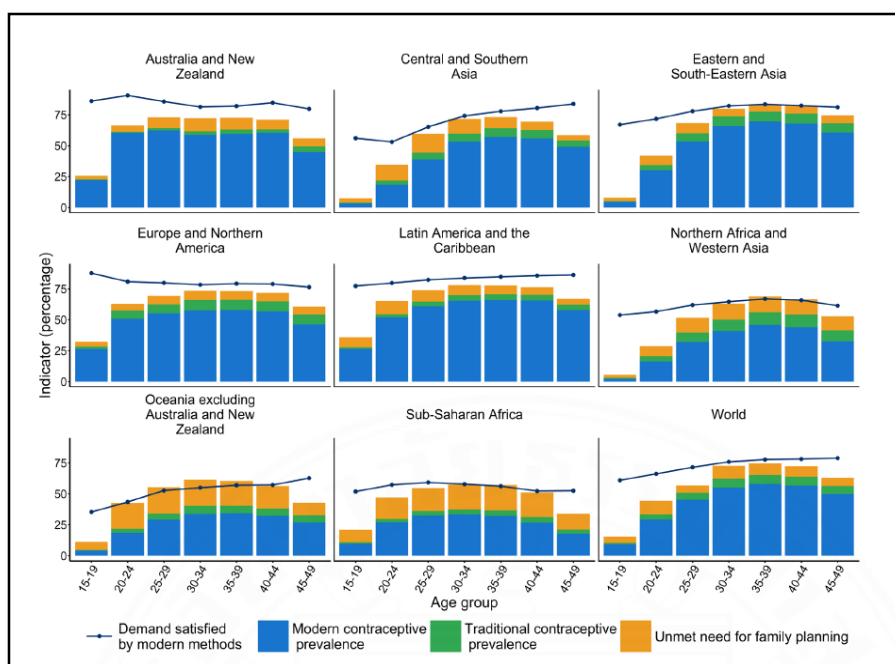


Figure 1.2: SDG 3.7.1 among women of reproductive age (15-49) by age group (2021), world and region (UNDESA, 2022).

1.2.3 Adolescent Girls Sexual and Reproductive Health (ASRH)

UNICEF reports that adolescents account for 16% of the global population, with 1.3 billion adolescents worldwide. According to the UN, adolescents are individuals aged between 10 to 19 years old, undergoing a transitional phase from childhood to adulthood (UNICEF, 2022).

The principle of “Leave No One Behind (LNOB)” is a key aspect of the 2030 Agenda for SDG. It signifies a commitment by all UN Member States to address the vulnerabilities that prevent certain groups of people from progressing and to promote inclusivity and equality for all (UN, n.d.). However, adolescent girls face challenges in sexual and reproductive health (SRH) including high rates of early, unintended pregnancies, lack of health services access, particularly contraceptives, and significant risk of STI including HIV (WHO, 2023). For instance, only one in two adolescent girls and young women (15-19 years) have their FP needs met through modern contraceptives (UNICEF, 2023a).¹

¹ The term “Adolescent girls and young women” is quoted from the UNICEF website, although this age group is defined as adolescents, according to the UN.

Globally, there has been progress in SDG 3.7.1 for adolescent girls, increasing from 45% in 2000 to 61% in 2020. However, this proportion is low compared to other age groups (Figure 1.3) (UNDESA, 2022).

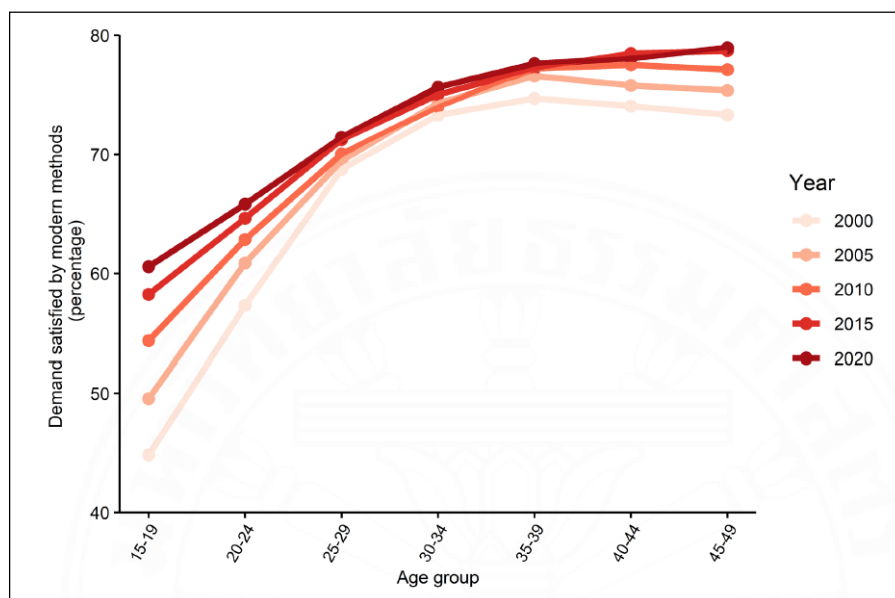


Figure 1.3: SDG 3.7.1 progress among women of reproductive age (15-49 years) by age groups (2000 to 2020), world (UNDESA, 2022).

For SDG 3.7.2 indicator, there has also been global progress. Adolescent birth rate dropped from 51 to 42 births per 1,000 adolescent girls (15-19 years) from 2015 to 2023, respectively. However, SSA remains the region with the highest rate, where one out of ten adolescent girls in that age group gives birth (UNICEF, 2023a).

1.2.4 SDG 3.7 in Sub-Saharan Africa (SSA)

The region of SSA is located below the Sahara and includes the sub-regions of Eastern, Middle, Southern, and Western Africa, consisting of 48 of the 54 African States, according to the UN (UN-Habitat, 2020). SSA has the world's highest population growth rate, and it is expected that this figure will increase to approximately two billion by 2050 (Lange, 2019).

SSA saw the greatest increase in SDG 3.7.1 globally, increasing from 51.6% in 2015 to 57.4% in 2023, and is projected to reach 62.1% in 2030 (UN, 2023). Despite the great increase, the use of modern contraceptives among women

who want to avoid pregnancy is still low in the region, where the unmet need for modern methods is 37% (UNDESA, 2022).

The types of modern contraceptives used varies within SSA countries. For instance, injectables are the primary methods used in Ethiopia, Malawi, Zambia, Madagascar, and Uganda, while implants are prominent in Guinea-Bissau and Rwanda (UNDESA, 2022).

In SSA, the progress in SDG 3.7.1 has been uneven (as shown in Table 1.1 below). In the year 2000, 39 countries had less than 50% of the demand for modern contraceptives satisfied. In 2019, 23 countries still had levels of demand satisfied by modern methods below 50%. Among these, Chad, Somalia, and South Sudan had levels below 25%. However, there has been significant progress in some countries, with the largest increases in the indicator globally between 2000 and 2019 seen in Rwanda, Ethiopia, and others (UN, 2019a).

Table 1.1: SDG 3.7.1 progress among SSA countries (2000-2019) (UN, 2019b).

Country	SDG 3.7.1 in 2000	SDG 3.7.2 in 2019
Rwanda	13%	67%
Ethiopia	16%	63%
Madagascar	26%	62%
Burkina Faso	19%	54%
Malawi	43%	76%
Sierra Leone	21%	53%
Kenya	48%	79%
Senegal	22%	51%
Lesotho	51%	80%
Chad	<25%	<25%
Somalia	<25%	<25%
South Sudan	<25%	<25%

The use of modern contraceptive methods varies greatly across countries in SSA. In 2019, the countries of Eswatini and Namibia had the highest levels of modern contraceptive prevalence in SSA, with both at 52%. South Sudan and Chad had the lowest rates, with only 4% and 6% respectively (UN, 2019b).

1.2.5 ASRH in SSA

The adolescent population in SSA was estimated to be 250 million in 2020, representing 20% of the global adolescent population, which is estimated to reach 24% in 2030 (Population Reference Bureau, 2021). Despite this significant demographic presence, adolescent girls in the region face significant inequalities in SRH challenges compared to their counterparts in other regions, bearing a disproportionate burden of negative SRH outcomes (Chandra-Mouli et al., 2021).

A key factor contributing to these challenges is the limited access to youth-friendly services that provide essential SRH services including FP. This has led to a high rate of adolescent pregnancies among adolescent girls, resulting in elevated rates of maternal mortality and disability (Ninsiima et al., 2021). For instance, the prevalence of unintended pregnancies among adolescent girls and young women in the region stands at 30.01%, with Southern Africa recording the highest rates at 60.01% (Ayalew et al., 2022).

1.3 Problem Statement

In SSA, there has been significant progress in satisfying the need for FP with modern contraceptive methods. However, there still exist significant disparities between different countries. While some countries have experienced the highest increase globally, others have low levels of demand satisfied by modern contraceptive methods. Additionally, the use of modern contraceptive methods among women aged 15-19 years also varies greatly across SSA countries, with a high percentage of unmet needs for FP in the region.

Adolescent girls in SSA face challenges to meeting their SRH needs compared to their counterparts in other regions. They face barriers in accessing SRH services, including FP, which leads to high rates of unplanned pregnancies and maternal mortalities.

1.4 Research Gap

Despite the disparities between SSA countries in progress towards achieving SDG target 3.7 and the challenges faced by adolescent girls in the region in

meeting their SRH needs, there is lack of comparative analysis of the facilitators, barriers, and challenges that determine the progress towards achieving SDG 3.7 for adolescent girls in high- and low-performing countries in SSA.

Research on this knowledge gap can help identify the factors contributing to the disparities in adolescent SRH service delivery and utilization among SSA countries. By understanding these factors:

1. future interventions can be tailored to address the specific needs of different countries, based on lessons learned from identifying the strengths/ weaknesses of, and gaps in, SRH and relevant general healthcare service delivery strengthening, as well as SRH-related socio-cultural interventions in the SSA region.
2. shared challenges, barriers and lessons learned can be addressed by promoting new regional approaches by international organizations and donors, and new bilateral collaborations between countries at both government and civil society organization levels.

1.5 Research Question

What are the challenges, barriers and facilitators which determine progress towards achieving SDG target 3.7 by 2030 for adolescent girls in countries whose progress is rated high- and low- performing in sub-Saharan Africa?

1.6 Research Objectives

1. To select the SSA countries to be included in this study.
2. To document adolescent SRH policies, strategies and services that currently exist in each of the study countries.
3. To describe the reported strengths and weaknesses in adolescent SRH service delivery in each country.
4. To determine the challenges, barriers and facilitators which contribute to whether a country is rated high- or low-performing in making progress towards achieving SDG 3.7 for adolescent girls.

1.7 Conceptual Framework

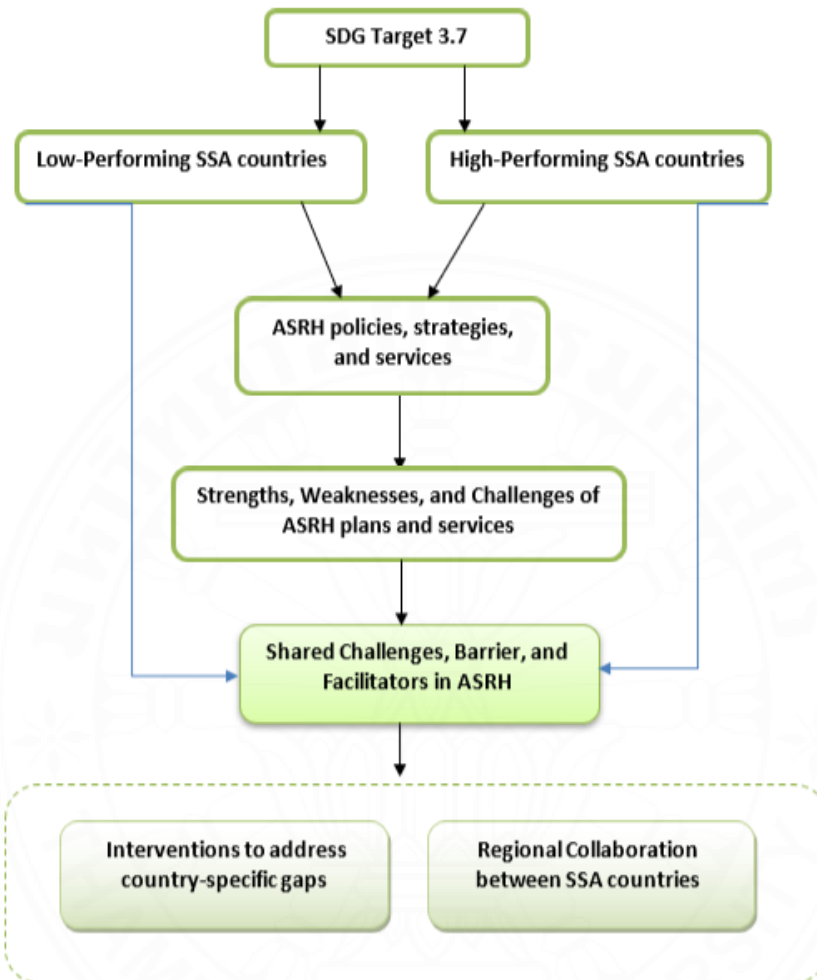


Figure 1.4: Comparison of ASRH services between SSA countries

CHAPTER 2

RESEARCH METHODS

2.1 Data Management Plan

This study is a documentary review. A systematic review of the literature was conducted in PubMed, Google Scholar, JSTOR, and Science Direct. Google, websites of the governments of the study countries, and websites of the UN, UNFPA, WHO and the Guttmacher Institute were also used to identify relevant grey literature. In addition, the reference lists of articles were searched for relevant studies.

After articles were selected, data extraction was done using a matrix for findings of the research objectives. The matrices used for each objective are provided in Appendices A, B, C, and D.

The table below shows the type of documents that were used for each objective, data sources, search strategies, and analysis methods.

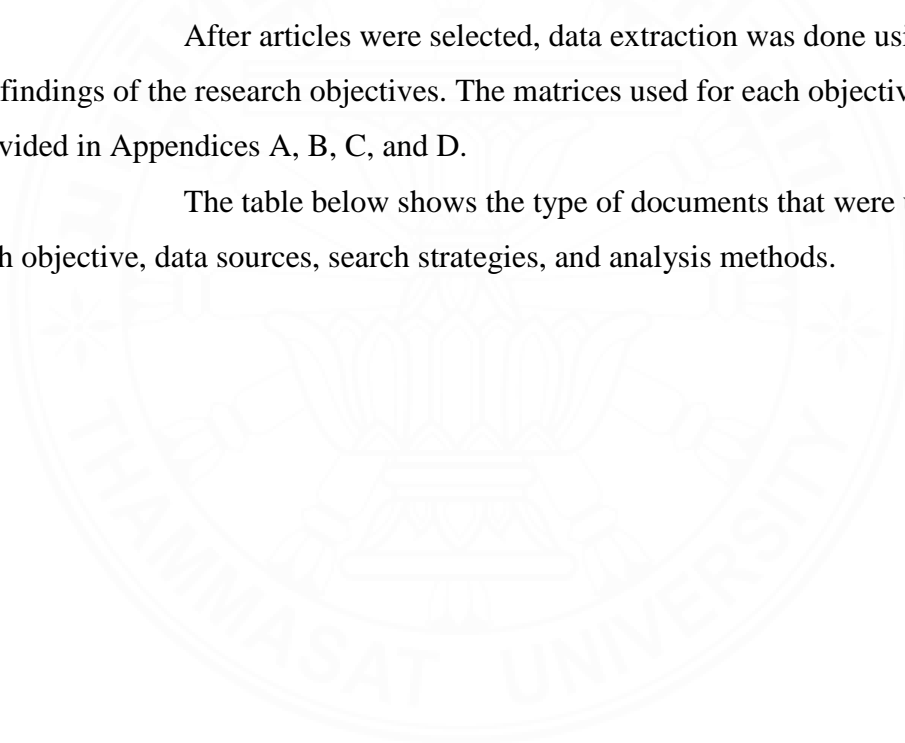


Table 2.1: Matrix for data management plan

Method overview	Data type	Data collection method	Data search strategies	Data processing method	Data analysis method
1. To select the SSA countries to be included in this study.	Quantitative data on index performance for each country	Documentary review	Websites of the World Bank, WHO, and UN	Matrix	Quantitative analysis
2. To document adolescent SRH policies, strategies, and services that currently exist in each of the study countries.	Governments report, Documents on government programs, Academic articles, International organization reports, NGO reports.	Documentary review	Government websites, academic journals, websites of WHO, UN, UNICEF, and UNFPA, Google Scholar, PubMed. Search words: adolescent girls, SRH, ASRH services, policies, strategies, guidelines, study country, SSA.	Matrix	Content analysis
3. To describe the reported strengths and weaknesses in adolescent SRH service delivery in each country.	Documents from NGOs WHO/UNFPA reports Government reports on progress/policy evaluation Research articles on adolescent SRH services	Documentary review	Government websites, academic journals, websites of WHO, UN, UNICEF, UNFPA, Google Scholar, PubMed, ScienceDirect, JSTOR. Search words: Adolescent girls, ASRH, adolescent-friendly services, facilitators, barriers, gaps, implementation, study country, SSA.	Matrix	Thematic analysis
4. To determine the challenges, barriers, and facilitators which contribute to whether a country is rated high- or low- performing in making progress towards achieving SDG 3.7 for adolescent girls.	Government reports on progress/policy evaluation NGO reports WHO/UNFPA reports Research articles on adolescent SRH services	Documentary review	The shared facilitators, barriers and challenges were analyzed based on the reported strengths, weaknesses, and gaps in Research Objective 3 above.	Matrix	Thematic analysis

2.2 Eligibility Criteria

Articles and reports published in English language between 2015 and 2024 were included in the study, since 2015 was the start of the 2030 development agenda and SDG. Papers before 2015 were included if they provide background data on ASRH policies or strategies in the study countries. Papers on adolescent girls aged 10-19 years and SRH in SSA were included. Studies that focus on women of reproductive age (15-49) were excluded if they did not provide disaggregated data specific to adolescent girls. This documentary review included peer-reviewed papers, government publications and websites, organizations reports, and authoritative grey literature.

2.3 Document Selection Process

A PRISMA flow diagram was used to demonstrate the process of article screening, inclusion, and exclusion.

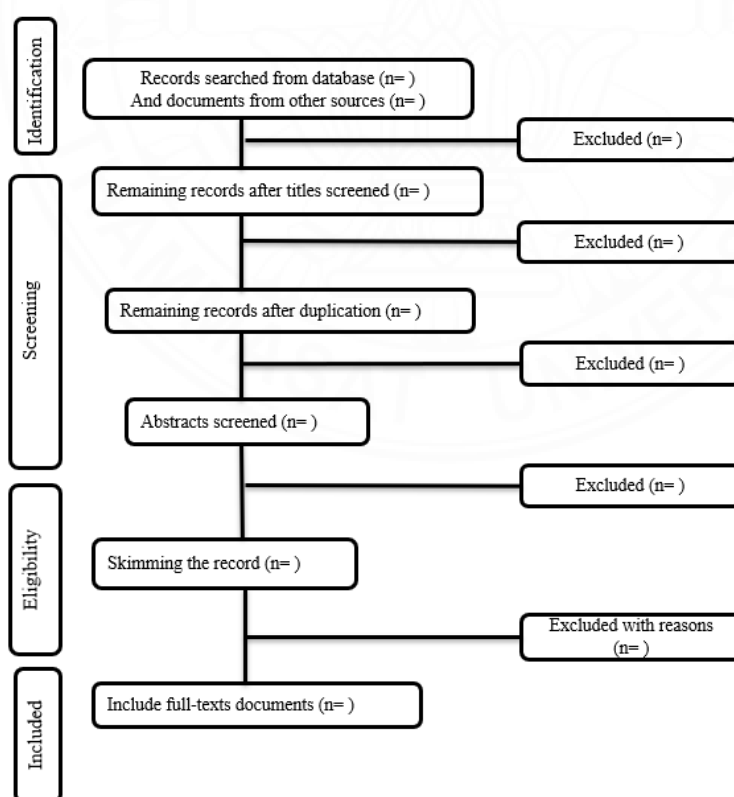


Figure 2.1: PRISMA flowchart

CHAPTER 3

FINDINGS AND DISCUSSION

3.1 Findings

3.1.1 Selection of Study Countries

The number of the countries in the SSA region and its sub regions varies according to different organizations. For example, the UN, WHO, World Bank, and African Union each provide different counts, either 46, 48 or 55 countries. For this study, the UN Geo-scheme for Africa was used for country selection, as the UN is the agency for reporting global SDG progress. The SSA region is divided into four regions: Eastern Africa, Middle Africa, Western Africa, and Southern Africa (UNSD, n.d.B).

The selection of study countries was based on global indexes, including Sustainable Development Index (SDI), Human Development Index (HDI), UHC Service Coverage Index (UHC SCI), Burden of Disease, Poverty rate, and Gender Development Index. Definition and sources for these indexes are detailed in Appendix A, Table A2.

To determine which countries to include, values for each index were documented in a matrix (provided in Appendix A, Table A1) and countries within each sub-region were ranked. Rankings for each index started with 1 for the highest value and ended with the total number of countries in that sub-region. Each country was assigned an average ranking, with lower values indicating higher performance and higher values indicating lower performance. One high-performing and one low-performing country were selected from each sub-region based on these rankings. The SDG index was also used to verify the relevance of selection.

Exclusion criteria for the study included countries experiencing ongoing conflict or political instability, Francophone and other non-English speaking countries, very small countries and countries with less than one million population. Overseas territories of European countries were excluded from the matrix.

Based on these criteria, the study included the following countries: Kenya and Malawi (Eastern Africa), Botswana and Namibia (Southern Africa) and Ghana and Sierra Leone (Western Africa). The high-performing countries in the progress towards SDG 3.7 are Kenya, Namibia, and Ghana, while Malawi, Botswana,

and Sierra Leone are low-performing. All countries in Middle Africa were excluded as they are all non-English speaking.

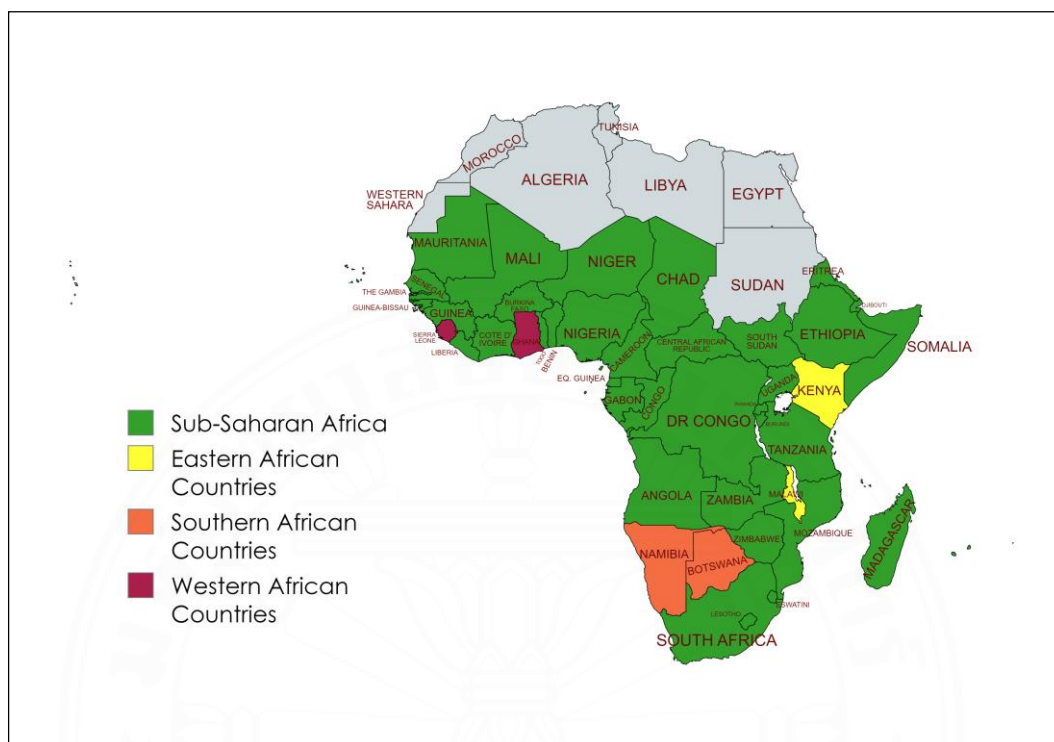


Figure 3.1: Study countries

3.1.2 Document selection

Following the identification of the study countries, the PRISMA method was used to systematically document the selection of studies (see figure 3.2 below). A total of 2,115 studies/ reports were identified through database searches and other searches, from which 1,626 records were removed after title and abstract screening as they did not meet the inclusion criteria, and 268 records were removed due to duplication. A total of 133 full-text articles/ reports were assessed, and 36 records were further removed, leaving a total of 97 articles/ reports for full analysis.

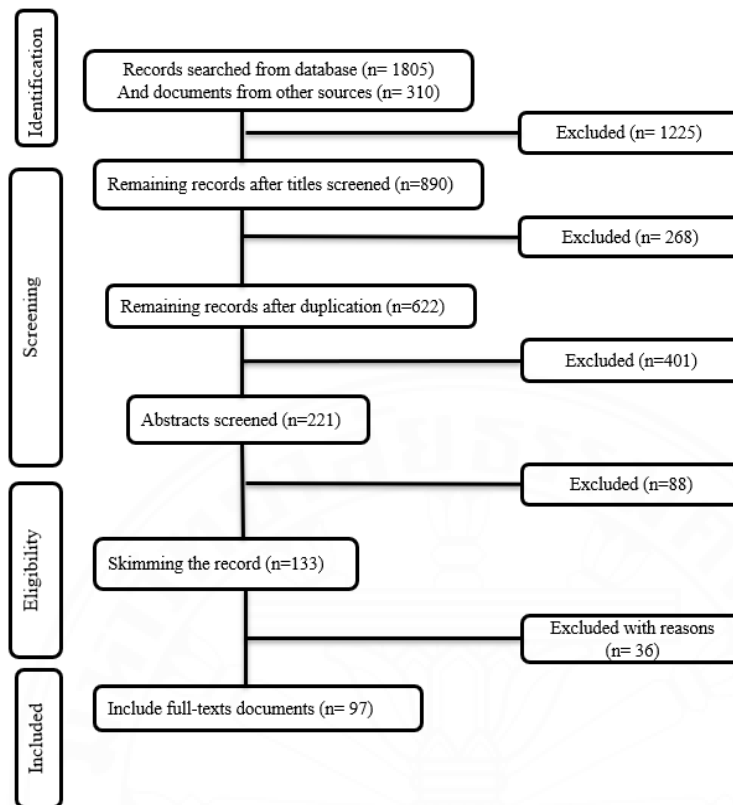


Figure 3.2: PRISMA flowchart diagram of literature search

3.1.2 ASRH Policies, Strategies and Services

3.1.2.1 Eastern Africa Sub-region

3.1.2.1.1 Progress in Achieving SDG 3.7 for Kenya and Malawi

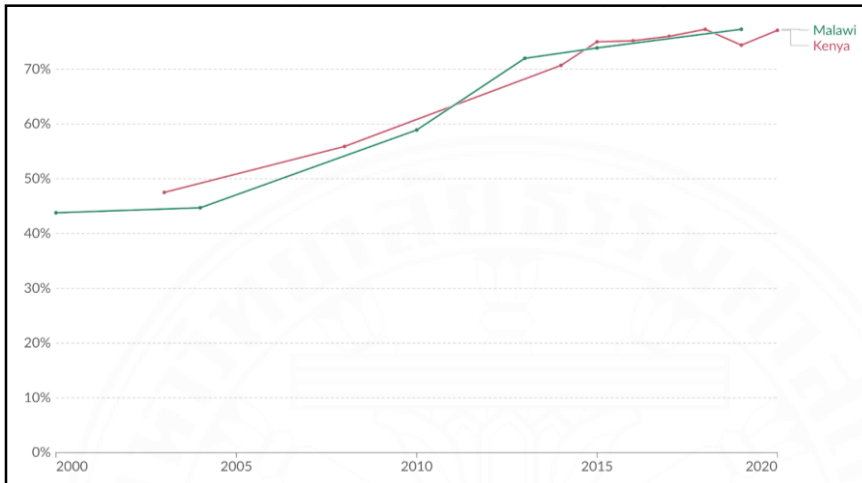


Figure 3.3: SDG 3.7.1 progress in Kenya and Malawi

Source: (Our World in Data, 2023)

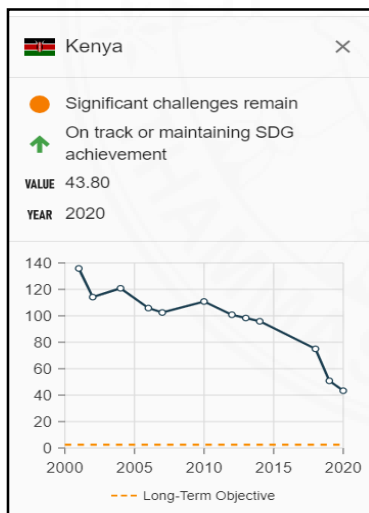


Figure 3.4: SDG 3.7.2 progress in Kenya

Source: (Sustainable Development Report, 2024)

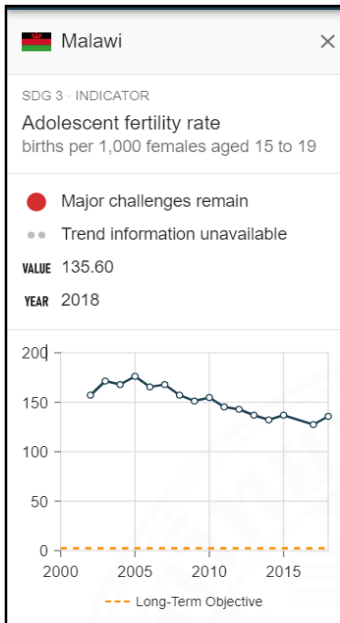


Figure 3.5: SDG 3.7.2 progress in Malawi

Source: (Sustainable Development Report, 2024)

3.1.2.1.2 Kenya

Table 3.1: SDG 3.7.1 progress for married/in union adolescent girls in Kenya

Indicator	2015	2023
CPR	40.2%	40.7%
Unmet need for FP	23%	21.6%
SDG 3.7.1	56.2%	59.4%
Sources: (Kenya National Bureau of Statistics [KNBS], 2015; KNBS & ICF, 2023)		

3.1.2.1.2.1 Political Commitment to ASRH

Kenya is a signatory to the 1994 ICPD Program of Action and the 2013 Eastern and Southern Africa (ESA) commitment to “enhance access to Comprehensive Sexuality Education (CSE) and adolescent and youth-friendly SRH services”. The 2010 Kenyan Constitution guarantees the right of all individuals to access SRH services and education. To implement these commitments, the Government of Kenya (GoK) has established a National ASRH Policy along with an implementation framework (African Institute for Development Policy, 2023).

The ASRH Policy (2015) sets goals to improve the SRH of adolescents, targeting a CPR of 60% among adolescent girls. It also aims to ensure that 70% of healthcare facilities provide youth-friendly services (YFS) by 2030. A key focus of the policy is to prevent early and unintended pregnancies by enhancing the availability of various contraceptive methods (Ministry of Health Kenya, 2015).

The National ASRH policy implementation framework (2017-2021) was developed to operationalize the National ASRH Policy (Ministry of Health Kenya, 2017), and the Ministry of Health (MoH) is the responsible entity for managing and coordinating the policy implementation (Ministry of Health Kenya, 2015).

Additionally, the National Action Plan for Addressing Adolescent Health Teenage Pregnancy (2019) aims to integrate adolescent health services and eliminate teenage pregnancy by 2030. The plan was developed by an Inter-Ministerial

Technical Working Group on Adolescent Health (National Council for Population and Development, 2019).

The Family Planning Costed Implementation Plan (2021-2024) focuses on increasing demand for FP services among adolescents and youth, and providing essential information and services to this population (Ministry of Health Kenya, 2021).

3.1.2.1.2.2 ASRH Services

The National Guidelines for the Provision of Adolescent Youth-friendly Services (AYFS) (2016) offer a comprehensive framework for delivering ASRH services. These guidelines state that “all adolescents and youth should be able to receive health services free of charge or are able to afford any charges that might be in place” (Population Reference Bureau [PRB], 2020). The MoH is responsible for overseeing and coordinating the implementation of these guidelines (Ministry of Health Kenya, 2016).

ASRH services in AYFS include SRH counseling, education, pregnancy testing, STI counseling and treatment, and contraceptive counseling and access to a full range of contraceptive methods. These services are delivered through multiple channels (Ministry of Health Kenya, 2016) including:

- Static delivery points: Health facilities, pharmacies, standalone clinics (public or private), clinics in institutions of higher learning, religious institutions, and school clinics.
- Mobile outreach delivery points: Mobile clinics and non-routine outreach events.
- Digital platforms: Helplines and social media.
- Community-based delivery points: Community units and youth clubs.

3.1.2.1.3 Malawi

Table 3.2: SDG 3.7.1 progress for married/ in union adolescent girls in Malawi

Indicator	2017	2021
CPR	38.1%	46.6%
Unmet need for FP	22.2%	21.3%
SDG 3.7.1	62.2%	68.5%
Sources: (National Statistical Office [NSO] Malawi & ICF, 2017; NSO, 2021)		

3.1.2.1.3.1 Political Commitment to ASRH

Malawi is a signatory to the 1994 ICPD Program of Action and the 2013 Ministerial commitment to CSE and SRH services for adolescents in ESA (Ministry of Health Malawi, 2015).

The Malawi National Reproductive Health Service Delivery Guidelines (2014-2019) establish standards for providing youth-friendly health services (YFHS) for adolescents and young people aged 10-24 years and the roles of healthcare providers in providing these services (Ministry of Health Malawi, 2014).

The National Youth Friendly Health Services Strategy (2015–2020) is designed to enhance knowledge, access, and utilization of YFHS for adolescents and young people aged 10-24. This strategy aims to improve the planning, programming, and delivery of YFHS, ensure adherence to national standards, and provide comprehensive, age-appropriate SRH information and services. The MoH leads the implementation and oversight of the strategy (Ministry of Health Malawi, 2015).

The Costed Implementation Plan for Family Planning (2016-2020) seeks to increase the mCPR for all women to 60% by 2020, with a special focus on the 15–24 age group. Priority 2 of this plan aims to enhance youth access to accurate information and FP services, promoting their right to make informed fertility choices (Government of Malawi, 2015).

The National Sexual and Reproductive Health and Rights (SRHR) Policy (2017-2022) emphasizes the importance of young people's SRHR, targeting reductions in HIV/AIDS, STI, and unintended pregnancies. The policy aims to improve the availability and access to YFHS while ensuring privacy and confidentiality. The MoH manages and coordinates the policy implementation (Ministry of Health Malawi, 2017).

The National Strategy for Adolescent Girls and Young Women (2018-2022) includes health objectives designed to improve access to integrated health services such as nutrition, SRH, and HIV services for adolescents and young people aged 10 to 24. The strategy implementation is a multi-sectoral approach, led by four key ministries: The Ministry of Education, Science and Technology, Ministry of Health and Population, Ministry of Gender, Children Disability and Social Welfare, and Ministry of Labour Youth Sports, and Manpower Development (Government of Malawi, 2018).

3.1.2.1.3.2 ASRH services

In Malawi, YFHS include health promotion and counseling on STI/HIV/AIDS, contraceptives, sexual abuse, nutrition, and maternal health. The services are delivered at various levels (Ministry of Health Malawi, 2015):

- Community level: Contraceptive services, HIV testing, and counseling, referral to health facilities
- Health center level: Contraceptive services, prevention and treatment of STI, ante-natal, delivery, and post-natal care services, HIV testing and counseling, and referral to hospitals
- Hospital level: Contraceptive services, post-abortion care, prevention and management of STI, antenatal, delivery and postnatal care services, among other services.
- Outreach programs including Facility-based YFHS separate spaces, Mobile clinics, One-stop centers, and Social marketing.

3.1.2.2 Southern Africa Sub-region

3.1.2.2.1 Progress in Achieving SDG 3.7 for Botswana and Namibia

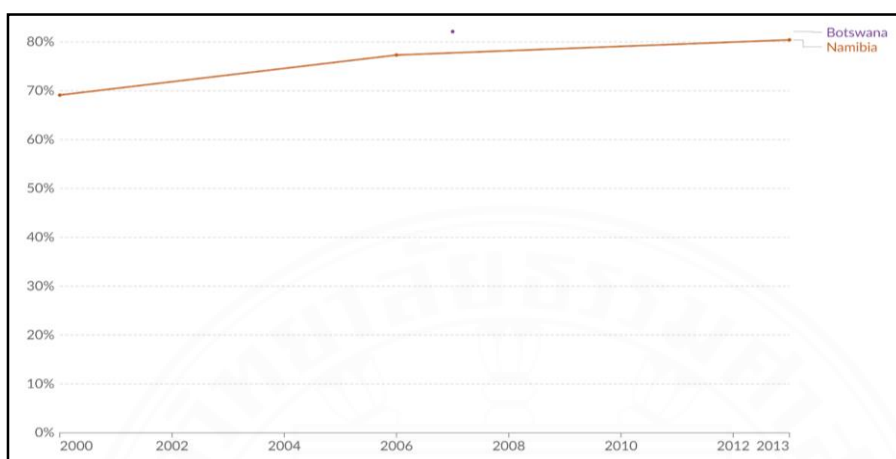


Figure 3.6: SDG 3.7.1 progress in Botswana and Namibia
Source: (Our World in data, 2023)

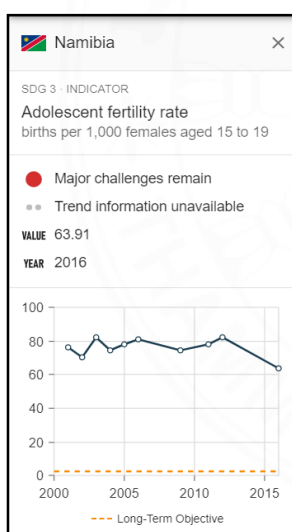


Figure 3.7: SDG 3.7.2 progress in Namibia
Source: (Sustainable Development Report, 2024)

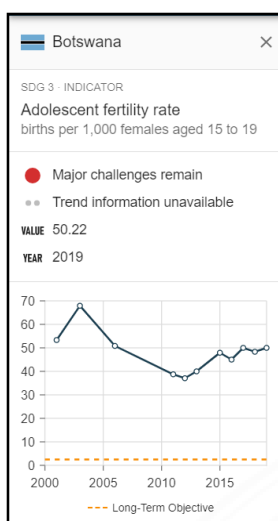


Figure 3.8: SDG 3.7.2 progress in Botswana
Source: (Sustainable Development Report, 2024)

Table 3.3: SDG 3.7 progress for married/ in union adolescent girls in Botswana and Namibia:

Indicator	Namibia (2013)	Botswana
CPR	37.2%	No data
Unmet need	9%	No data
SDG 3.7.1	72.1%	No data

Sources: (The Namibia Ministry of Health and Social Services [MHSS] & ICF International, 2014)

3.1.2.2.2 Namibia

3.1.2.2.2.1 Political Commitment to ASRH

Namibia is a signatory to the Ministerial Commitment to CSE and SRH services for adolescents in ESA (UNESCO, 2023). Vision 2030 aims to ensure that health services are adolescent/ youth-friendly and accessible to all (Government of the Republic of Namibia, 2004).

Namibia's Constitution guarantees individuals, particularly women, the right to access contraceptives and make informed decisions on FP, including choices regarding contraception, the timing of children, and the number of children, regardless of age (Odimegwu et al., 2022).

The Consolidated National Reproductive and Child Health Policy (2008) emphasizes the need for adolescent youth-friendly health services (AYFHS). These services are designed to meet ASRH needs, respecting their privacy and confidentiality. The Ministry of Health and Social Services (MHSS) is responsible for coordinating and implementing these services (Government of the Republic of Namibia, 2008).

The National Health Policy Framework (2010-2020) prioritizes adolescent health by providing strategic guidelines for increasing SRH awareness among young people and offering counseling and AYFHS with well-trained staff. MHSS oversees the coordination and implementation (MHSS, 2010).

The Education Sector Policy for the Prevention and Management of Learner Pregnancy (2010) aims to reduce pregnancies among learners by offering SRH education including for appropriate use of contraceptives. MoE is responsible for implementing and funding the policy (Ministry of Education Namibia, 2010).

3.1.2.2.2.2 ASRH Services

ASRH services in Namibia are delivered through primary health care facilities and are supported by outreach and school-based programs (WHO, 2017). Namibia implemented the AFHS standards (2011) to prevent adolescent pregnancy, and nurses at the primary healthcare level implement these services (Muyenga et al., 2017).

3.1.2.2.3 Botswana

3.1.2.2.3.1 Political Commitment to ASRH

The Government of Botswana is a signatory to the ICPD Program of Action (Ministry of Health Botswana, 2015) and the Ministerial Commitment on CSE and SRH services for adolescents in ESA (UNESCO, 2013).

Botswana's Integrated Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition Strategy (2018–2022) includes specific measures for enhancing FP services and AYPHS. The strategy identifies unintended pregnancy as a significant ASRHR issue and sets a target for monitoring adolescent birth rate (Choonara et al., 2024).

The integrated client-centered health services in Botswana demand that entry points must offer women and adolescent girls with appropriate counseling to choose contraceptive methods and prevent unintended pregnancies. The Ministry of Health and Wellness (MoHW) oversees the implementation of these services (UNFPA East and Southern Africa Regional Office [ESARO], 2022).

3.1.2.2.3.2 ASRH Services

Botswana's policy guidelines and service standards (2015) emphasize the importance of adolescent/youth SRH services. These services are provided in both hospitals and clinics, and include counseling, FP, antenatal care, postnatal care, post-abortion care, and management of STI/HIV/AIDS (Ministry of Health Botswana, 2015). Integrated AYPHS are concentrated in areas with high populations of young people. The services are delivered by basic healthcare providers such as nurses, midwives, healthcare assistants in a single room (UNFPA ESARO, 2022).

3.1.2.3 Western Africa Sub-region

3.1.2.3.1 Progress in Achieving SDG 3.7 for Ghana and Sierra Leone

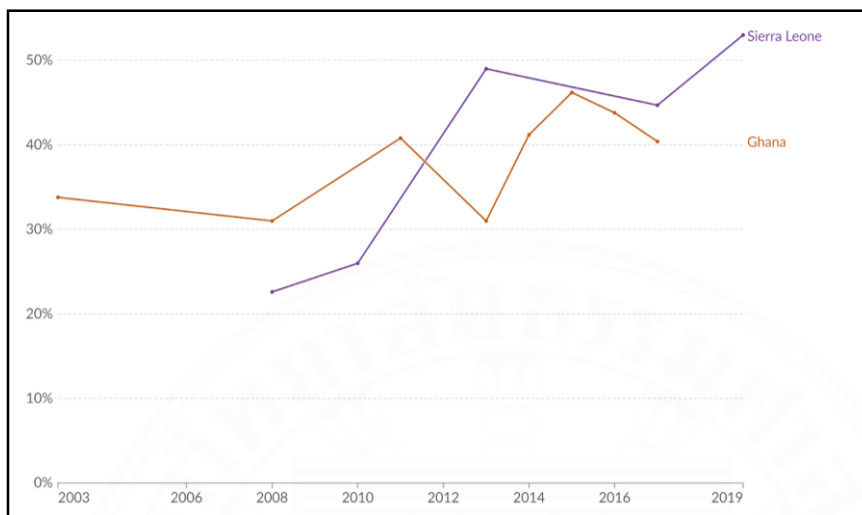


Figure 3.9: SDG 3.7.1 progress in Ghana and Sierra Leone.
Source: (Our World in Data, 2023).

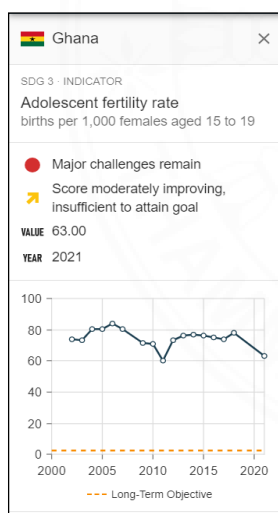


Figure 3.10: SDG 3.7.2 progress in Ghana
Source: (Sustainable Development Report, 2024)

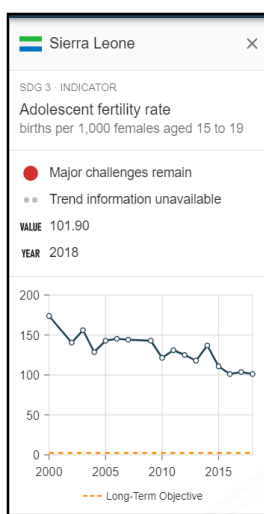


Figure 3.11: SDG 3.7.2 progress in Sierra Leone
Source: (Sustainable Development Report, 2024).

3.1.2.3.2 Ghana

Table 3.4: SDG 3.7.1 progress for married/ in union adolescent girls in Ghana

Indicator	2015	2024
CPR	18.6%	34.3%
Unmet need	50.7%	31%
Demand satisfied	24.1%	41.4%
Sources: (Ghana Statistical Services [GSS] & ICF, 2014), GSS & ICF, 2024)		

3.1.2.3.2.1 Political Commitment to ASRH

Ghana is a signatory to the ICPD Program of Action (Akazili et al., 2020). The Adolescent Health Service Policy and Strategy (2016-2020) is designed to adolescent health. This policy contains nine strategic objectives, including improving access to health information and services, training healthcare providers, and ensuring high-quality health services that are gender-sensitive. Implementation is coordinated by a multi-sectoral National Technical Committee on Adolescent Health (GHS, 2016).

The Ghana Family Planning Costed Implementation Plan (2016-2020) emphasizes the importance of addressing adolescent needs by increasing access

to contraception for adolescents and young people aged 10-24. The MoH oversees the implementation, with adolescent birth rate being a key outcome indicator (Ministry of Health Ghana, 2015).

The Five-Year Strategic Plan to address Adolescent Pregnancy in Ghana (2018 – 2022) aims to prevent early and unplanned pregnancies. Its objectives include promoting community engagement and ensuring access to youth-friendly SRH information and services by the sexually active adolescent girls. The Ministry of Gender, Children, and Social Protection is responsible for implementing the plan (Ministry of Gender, Children and Social Protection Ghana, 2017).

The Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition Strategic Plan (2020–2025) sets specific targets for improving adolescent health. It focuses on enhancing the quality and accessibility of AYFS, disseminating service standards, addressing healthcare provider attitudes towards ASRH, and improving access to a comprehensive package of AYFHS. Key indicators for monitoring include adolescent contraceptive rate and unmet need for FP. The MoH provides overall leadership for implementation (Ministry of Health & GHS, 2020).

3.1.2.3.2.2 ASRH Services

The National Operational Guidelines and Standards for AYFHS in Ghana outline a comprehensive range of ASRH services. These include SRH assessment, development of RH plans, SRH education, FP services, HIV services, care for sexually-abused adolescents, and referrals (GHS, n.d.). AYFHS are delivered through various approaches, including:

- Static: Public and private health facilities.
- Mobile: Targeted hotspots and home visits
- Complementary: Through adolescent clubs, lay counselors, and providers.

The primary service providers of AYFHS include medical officers, physician assistants, and all categories of nurses including midwives (GHS, n.d.).

3.1.2.3.3 Sierra Leone

Table 3.5: SDG 3.7.1 progress for married/ in union adolescent girls in Sierra Leone

Indicator	2014	2020
CPR	7.8%	14.4%
Unmet need	30.7%	27.8%
Demand satisfied	20.2%	34.1%
Sources: (Statistics Sierra Leone [SSL] & ICF, 2013; SSL & ICF, 2020)		

3.1.2.3.3.1 Political Commitment to ASRH

The National Standards for Adolescent and Young People Friendly Health Services (AYPFHS) (2011) establish the framework for providing health services to adolescent and young people (Government of Sierra Leone, 2018).

The Communication Strategy for the Reduction of Teenage Pregnancy (2014-2019) aims to unify various communication approaches and messages to address behavioral factors contributing to adolescent pregnancy. This strategy is designed to support the goals of the National Strategy for the Reduction of Teenage Pregnancy and seeks to foster sustainable behavior change through coordinated communication efforts (Government of Sierra Leone, 2014).

The Sierra Leone National Reproductive, Maternal, Newborn, Child, And Adolescent Health Strategy (2017-2021) emphasizes adolescent health with a focus on preventing teenage pregnancy. One of its main targets is to decrease the adolescent birth rate from 125.1 in 2013 to 74 births per 1,000 women aged 15-19 by 2021. The strategy aims to enhance adolescent health services across all health care facilities and improve school health programs including CSE (Ministry of Health and Sanitation [MoHS] Sierra Leone, 2017).

The National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage (2018-2022) also aims to reduce the adolescent fertility rate to 74 per 1,000. Its strategic objectives include providing a core package of AYPFHS at health, hospitals, schools, and learning centers. It also focuses on improving the

capacities of implementing agencies and ensuring adolescents have access to CSE. Oversight and management of the strategy are the responsibility of the Ministry of Social Welfare, Gender and Children's Affairs, and the MoHS (Government of Sierra Leone, 2018).

The Sierra Leone Basic Package of Essential Health Services (2015-2020) includes school and adolescent health services and prevention of teenage pregnancy (Government of Sierra Leone, 2018).

The School Health Policy (2021) underscores the importance of providing YFS. It recommends that all students have access to these services, either within schools or at nearby health units (UNICEF Sierra Leone, 2024).

3.1.2.3.3.2 ASRH Services

AYFHS in Sierra Leone include management of STI, HIV counseling and testing, FP services, antenatal care, delivery and postnatal care services. The National School and Adolescent Program set the standards for AYPFHS. Providers include community health officers, midwives, and community health nurses (UNFPA Sierra Leone, 2018).

3.1.3 Strengths and Weaknesses in ASRH Services

3.1.3.1 Eastern Africa Sub-region: Kenya

3.1.3.1.1 Strengths of ASRH Policies

Manguro and Temmerman (2022) report that Kenya's ASRH policies are progressive and well-developed to meet adolescents' needs if fully implemented. These policies have successfully attracted funding from governments, donors, and the private sector, and enhanced stakeholder collaboration at different levels of the government. Embleton et al. (2023) suggest that the AYPHS guidelines are applicable to all health system tiers, and the range of service delivery models allow engagement of the diverse adolescent populations across different regions and socioeconomic backgrounds.

The GoK has established the National Adolescent Health Technical Working Group to oversee the implementation of ASRH policy (Rutgers International, 2023a). Onono et al. (2019) note that this multi-sectoral network, including actors from national and local governments and other partners, facilitates the sharing of knowledge and experiences among different stakeholders, helping them to align with both international and national ASRH guidelines.

Kenya has made improvements in public health financing since the Abuja Declaration of 2001 to allocate at least 15% of national budgets to health. A memorandum of understanding (MOU) signed in 2019 between the MoH and key development partners set a plan for MoH to fully finance FP commodities by the Fiscal Year (FY) 2025/26, with decreasing donor support. In FY 2019/20, the government allocated a budget line for FP services, with MoH contributions increasing more than double between FY 2020/21 and FY 2022/23 (Options UK, n.d.).

Choonara et al. (2024) consider Kenya's ASRH policy to be the strongest in ESA region, as it is developed through consultative processes, has specific targets and costs, and is complemented by an implementation framework that specifies intervention areas and targets.

3.1.3.1.2 Positive Outcomes of the Health Sector Devolution

Okoth et al. (2023) argue that the 2013 devolution of Kenya's healthcare delivery function to county governments has empowered counties to create their own implementation strategies, which extends to health facility management. This autonomy has the benefits of adapting policies and training at the county level. In addition, continuous feedback mechanisms have enhanced service delivery and data disaggregation that is used to inform policies.

In Nairobi County, the government has recognized the importance of ASRH by establishing youth-friendly health services (YFHS) and collaborating with other stakeholders to provide ASRH services. The Ministry of Education (MoE) participates in technical working groups for adolescent health, promoting parental and caregiver engagement in discussing SRH issues with adolescents (Okoth et al., 2023).

In Isiolo, Kilifi, and Makueni counties, FP is included in the County Integrated Development Plan, addressing high pregnancy rates as barriers to development. These counties developed FP cost implementation plans with specific mCPR targets (ThinkWell, 2020).

A study by Mutea et al. (2020) reported improved political support for ASRH programs and enhanced partnerships with implementing agencies in Kisumu and Kakamega counties. Langat et al. (2024) found that ASRH sessions in schools on the Kenya coast have facilitated access to ASRH information for adolescents.

3.1.3.1.3 Weaknesses in ASRH Policy Implementation

Onono et al. (2019) identify several challenges to prioritizing ASRH in Kenya, including the perception that the domestication of ASRH guidelines are donor-driven and do not align with adolescents' actual needs. Other ministries, where ASRH is incorporated, only implement policy recommendations that are in line with their scope and objectives. The multi-sectoral approaches of ASRH policy are considered fragmented due to disagreements in prioritizing different aspects of ASRH.

Rutgers International (2023a) points out that the ASRH policy implementation framework is fragmented at the county level, due to inadequate

resources and uneven distribution of adolescent-friendly facilities. Few providers are equipped to deliver comprehensive care, and stockouts of SRH commodities are frequent.

Additionally, Manguro and Temmerman (2022) highlight that despite the effective coordination between stakeholders at the national level, knowledge of ASRH policies at the subnational level remains limited, which could be attributed to the lack of coordination among implementers and lack of political will at the national level to disseminate these policies.

Manguro and Temmerman (2022) also argue that despite the country being a signatory to the ESA ministerial commitment, ASRH is still a divisive issue due to cultural and religious beliefs. There remain political disagreements over what to be included in CSE curricula, influenced by the Kenyan constitutional designation of those under the age of 18 as children. Okoth et al. (2023) note that the requirement for parental consent for those under 18 is a barrier to ASRH service access, and the limited knowledge among healthcare providers about ASRH policies and lack of resources hinder the establishment of youth-friendly spaces.

3.1.3.1.4 Inadequate Financial Commitment to ASRH

UNFPA ESARO (2018) reports that there is no specific budget allocation for AYFHS at national and county levels, and that only few facilities in the country provide AYFHS.

Embelton et al. (2023) suggest that the devolution of health services to county governments may create disparities in health facility financing and resource distribution to health facilities across counties. Rutgers International (2023a) highlights that there is inequitable distribution of the AYFS facilities between counties, with some counties having more than half of the facilities providing adolescent services, and other counties having none.

Onono et al. (2019) argue that political leaders finance issues that have political and emotional appeal, such as HIV and malaria, which adolescent pregnancy does not have.

3.1.3.1.5 Weaknesses in ASRH Service Delivery and Access

Papers by Mutea et al. (2020), Langat et al. (2024) and Embleton et al. (2023) outline various barriers to accessing ASRH services in Kenya. At the individual level, lack of money, insufficient knowledge of service locations, and negative attitudes of healthcare providers discourage adolescents from seeking care. Relationship-level barriers include being unmarried and inadequate parental ASRH teaching. Health facility-level barriers involve long distances to health facilities, staff shortages, age and gender of healthcare workers, informal fees, and stock-outs. Community-level barriers include poverty, social stigma, and religious beliefs about ASRH. At the policy level, barriers include inadequate awareness among healthcare providers of what information and services adolescents should receive, and limited resource allocation in county budgets.

3.1.3.2 Eastern Africa Sub-region: Malawi

3.1.3.2.1 Strengths of ASRH Policies

According to the African Population and Health Research Center [APHRC] (2020), Malawi's ASRH legal and policy environment is seen as both conducive and progressive. The consultative policy formulation procedures enabled the inclusion of stakeholder perspectives, guiding the implementation of ASRH programs by civil society organizations (CSO) and development partners.

Wigle et al. (2020) observe that the involvement of young people in policymaking has led to significant changes, such as the constitutional amendment to increase the legal age of marriage to 18 years and establishing YFHS. This involvement has also contributed to increased contraceptive use and reduced adolescent pregnancy rates.

FP services in Malawi are provided free of charge, and the government expanded access to a wide range of contraceptive methods available at public facilities and at community level, including injectables which are the most commonly used methods by adolescent girls in Malawi (Ali et al., 2023).

3.1.3.2.2 Weaknesses in ASRH Policy Implementation

The implementation of the YFHS strategy (2015-2020) was inconsistent, varied by district and relied heavily on donor support. In addition, there is weak coordination among stakeholders at the national level (Wigle et al., 2020), and subnational stakeholder engagement is constrained by limited funding (APHRC, 2020).

Additionally, although adolescent health is prioritized, many policies and strategies in Malawi, such as the National Health Policy (2017) and the Health Sector Strategic Plan III (2023-2030), do not explicitly address YFHS (Johnson et al., 2023).

The involvement of young people in policymaking is limited to specific instances, with minimal input in agenda-setting and decision-making. Many are also unaware of key policies due to limited funding and a lack of appreciation of youth involvement at the sub-national level (APHRC, 2020; Wigle et al., 2020).

The national law in Malawi does not specify a clear age of consent for contraceptives, leaving it to interpretation by healthcare providers. Additionally, the MoE 100-meter rule, which prohibits contraceptive distribution within 100 meters of schools, conflicts with MoH goals of making contraceptives accessible to young people (APHRC, 2020).

The implementation of the CSE program faces challenges such as opposition from religious and traditional leaders, lack of teacher training, and inadequate resources (APHRC, 2020). Furthermore, there is no established system between schools and service providers to facilitate access to young people-focused referrals (Johnson et al., 2023).

3.1.3.2.3 Reliance on External Funding

Malawi's health sector budget is constrained. In 2019/20, the national budget allocation to health was only 9.4%, which is far below the recommended 15% in the Abuja Declaration, with minimal focus on SRH within the national budget that is influenced by conflicting political priorities (APHRC, 2020).

Donors are the primary contributors to Malawi's health budget, providing an average of 75% of health sector funding between 2018 and 2019. Due to

this heavy reliance on donor support, NGO increasingly manage donor funds independently, using their own planning, financing, and monitoring systems. This approach contributes to fragmented planning, budgeting and monitoring systems in the health sector (Johnson et al., 2023). The insufficient funding to health contributed to the acute shortage of healthcare workers in Malawi (APHRC, 2020).

3.1.3.2.4 Weaknesses in ASRH Service Delivery and Access

Research by Self et al. (2018); Grace and Rakgadi (2023) and the APHRC (2020) identifies several barriers to accessing ASRH and contraceptive services in Malawi. Individual barriers include being unmarried, stigma, lack of knowledge about YFHS and contraceptives, and misconceptions about contraceptive side effects. Community and cultural barriers involve unsupportive parents, living in rural areas, limited health services, long distances to facilities, and a shortage of skilled healthcare providers. Health system barriers include negative provider attitudes, inadequate training on YFHS, lack of dedicated space to YFHS, lack of confidentiality, insufficient resource allocation, and contraceptive stock-outs.



3.1.3.3 Southern Africa Sub-region: Namibia

3.1.3.3.1 Strengths of ASRH Services

The Namibian government has demonstrated strong commitment to improving adolescent contraceptive use. In 2020, the government endorsed updated guidelines for FP and committed to investing in adolescent and youth-friendly RH services. FP services are provided free of charge in all public facilities (Michael et al., 2024). Additionally, the government expanded the range of contraceptive methods available by introducing implants in all public health facilities (UNFPA Namibia, 2022).

According to Plesons et al. (2019), the 2015 Child Care and Protection Act in Namibia has improved adolescent access to services by lowering the age of consent for SRH services from 16 to 14 years.

3.1.3.3.2 Weaknesses in ASRH Policy Implementation

Muyenga et al. (2017) report that despite the introduction of national standards for AFHS aimed at preventing adolescent pregnancy, challenges persist across Namibia. The effectiveness of these guidelines is hampered by inadequate training and low levels of health education provided to adolescents in schools.

Additionally, there is insufficient coordination among government sectors (such as health, education, and gender) in managing and disseminating high-quality data on ASRH (UN, 2018). Shiningayamwe and Takeuchi (2024) point out challenges in implementing the Education Sector Policy for the Prevention and Management of Learner Pregnancy, including a lack of teacher training and stakeholder involvement, due to inadequate monitoring by MoE. There are also no clear implementation guidelines or budgetary allocations, leading to reliance on donor funding.

3.1.3.3.3 Weaknesses in ASRH Service Delivery

Ashipala and Nuuyoma (2024) identify several barriers to AFHS delivery in Namibia, such as lack of parental support, insufficient resources, limited availability of contraceptive options, inadequate support from MHSS and local

authorities, and poor awareness among adolescents about available services. Additionally, healthcare providers are reported to be unfriendly.

UNFPA Namibia (2022) notes that despite the high access to healthcare facilities, 85% of those not using contraceptives often lack information about FP services.

3.1.3.4 Southern Africa Sub-region: Botswana

3.1.3.4.1 Strengths of ASRH Services

Gender Links (2022) reports progress in Botswana's ASRH services, with most adolescents able to access services without parental involvement. These services are provided for free, and confidentiality is reported to be high by adolescents and young people, with a high percentage of contraceptive access.

In addition, the government has already begun establishing AFHS for the provision of ASRH services in health facilities (Barchi et al., 2021), and expanded the contraceptive methods available for adolescent girls, including the introduction of implants in 2016 (Henry et al., 2021).

3.1.3.4.2 Weaknesses in ASRH Policy Implementation

Despite prioritizing unintended pregnancies in ASRH policies, Botswana's interventions lack cost assessments, which hinders their implementation (Choonara et al., 2024). Furthermore, sustainable financing for SRH is inadequate, failing to meet the demand for FP (UNFPA Botswana, 2017).

Barchi et al. (2021) highlight that although a high-quality CSE curriculum exists, teacher training is limited and resources are insufficient for delivering quality education and establishing AFHS clinics. In addition, cultural norms also hinder the discussion and implementation of sexuality education, coupled with inadequate data systems and a lack of disaggregated data (UNFPA Botswana, 2017).

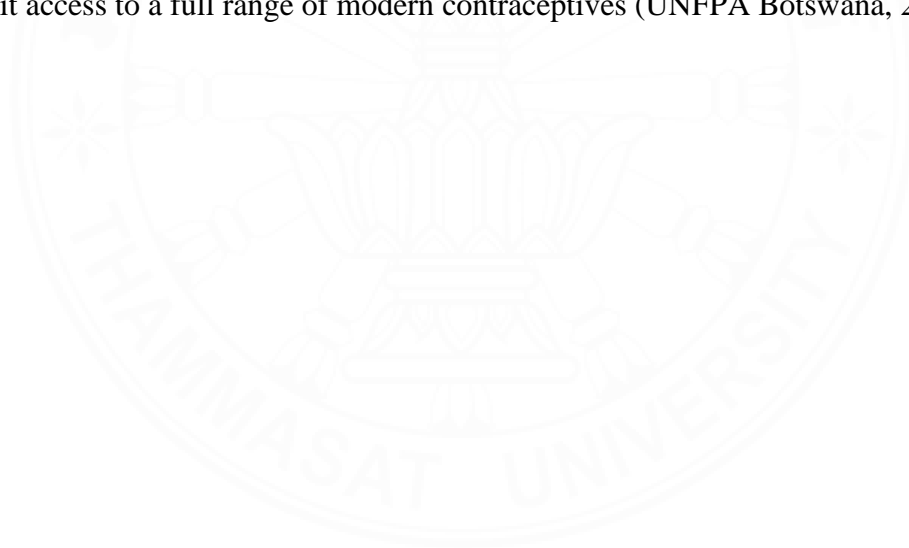
The collaboration between the education and health sectors in implementing CSE and health services is weak (Barchi et al., 2021). Botswana's efforts to provide high-quality FP services are also hindered by gaps in the legal environment that ensures access to ASRH services, data gaps and inadequate capacity

for data analysis at both national and subnational levels (UNFPA Botswana, 2022). The availability of data on the use of long-acting contraceptives among adolescent girls is limited, which limits monitoring ASRH indicators (Henry et al., 2021).

3.1.3.4.3 Weaknesses in ASRH Service Delivery

UNFPA Botswana (2017) notes that despite high accessibility to basic health services, coverage of ASRH services remains low, with only 16 of 335 public health facilities offering AFHS. The quality of these services often falls short of WHO standards for YFS, and healthcare providers are insufficiently trained.

In terms of contraceptive options, short-acting methods are more widely available, while the long-acting methods available for free are only implants and non-hormonal IUDs. Hormonal IUDs are only available in the private sector and are costly (Henry et al., 2021). Stock-outs and weak supply chain management further limit access to a full range of modern contraceptives (UNFPA Botswana, 2022).



3.1.3.5 Western Africa Sub-region: Ghana

3.1.3.5.1 Strengths of ASRH Policies

Agblevor et al. (2023) note that Ghana's political system is an enabler of the implementation of adolescent health policies. According to Ahinkorah et al. (2022), various factors facilitated the implementation of policies that aim to reduce adolescent pregnancies. Community sensitization about ASRH issues has raised awareness and helped strengthen implementation. Informal networks educate parents about adolescent pregnancy, promoting contraceptive use among sexually active adolescents.

Additionally, collaboration between the government, NGO, and communities has improved resource utilization, ensuring sustainability and effectiveness of policies. Joint efforts in monitoring adolescent pregnancy have also helped identify regional adolescent pregnancy prevalence to develop response plans in regions with high rates. Involving adolescents in youth programs through the establishment of youth groups has further supported policy implementation (Ahinkorah et al., 2022).

3.1.3.5.2 Facilitators to ASRH Service Delivery

Kumah et al. (2024) report that in Ghana's Oti, Eastern, and Volta regions, all facilities cover contraceptive and FP services for adolescents under the National Health Insurance Scheme (NHIS). Standard guidelines for ASRH are available, and most adolescents can access these services without parental or spouse consent. Healthcare providers maintain adolescent confidentiality using YFHS corners, and facilities do not refer adolescents to other locations. Ahinkorah et al. (2022) report that adolescents can access free ASRH services, including FP.

Abdulai (2023) reported that Ghana Health Service protocols for adolescent health services are followed by healthcare providers, with outreach interventions like home visits and community meetings helping to attract unmarried adolescents to SRH services. Adolescent health corners help reduce waiting times and avoid community criticism.

3.1.3.5.3 Weaknesses in ASRH Policy Implementation

Agblevor et al. (2023) identify challenges in implementing the Adolescent Health Service Policy and Strategy in Ghana, including inadequate resources and poor coordination of ASRH programs. This has led to incomplete implementation, with only 4 out of the 23 planned strategies fully implemented.

Ahinkorah et al. (2023) highlight poor stakeholder involvement in policy development and poor policy dissemination for implementation. There is also a lack of information on these policies for both adolescents and healthcare providers (Agblevor et al., 2023).

Inconsistencies between policies and legislation, such as the differing ages of consent to sex and age of becoming an adult, affect the implementation of policies and programs aimed at reducing adolescent pregnancies and child marriages (Agblevor et al., 2023).

Despite the government's commitment to allocate 15% of its budget to health under the Abuja declaration, actual allocation was only 7.6% in 2022, which was insufficient to support all the health programs (Agblevor et al., 2023). The government has no dedicated budget for adolescent health (Ahinkorah et al., 2022), leading to significant funding gaps and heavy reliance on external health aids that are often inadequate (Otioku et al., 2023).

Cultural and religious beliefs also hinder ASRH service delivery, particularly affecting the implementation of CSE (Agblevor et al., 2023). This results in limited SRH education, often focusing solely on abstinence and fear-based approaches, according to Rutgers International (2023b).

3.1.3.5.4 Weaknesses in ASRH Services

Despite NHIS exemption from user fees for adolescents, practical implementation is inconsistent due to inadequate funding (Agblevor et al., 2023). Kumah et al. (2024) find that some adolescents are denied access due to lack of active NHIS. Financial constraints are a major barrier to accessing SRH services, especially for adolescents who are from poorer households (Parmar et al., 2024).

Ziblim et al. (2022) and Abuosi and Anaba (2019) highlight multiple barriers at personal, community, cultural, and provider levels. Health facility barriers include inadequate physical space, lack of privacy, insufficient supplies, unaffordability of medicines, limited SRH information, inconvenient clinic hours, and long waiting time. Community and cultural barriers include negative perceptions of ASRH and lack of parental support, while provider-level barriers include discrimination and judgmental attitudes. Personal-level barriers include being unmarried, fear and misconceptions about contraceptives among adolescents, lack of information, and financial challenges.

3.1.3.6 Western Africa Sub-region: Sierra Leone

3.1.3.6.1 Strengths of ASRH Policies

The government of Sierra Leone has significantly increased health sector financing in line with the Abuja Declaration, with health expenditure rising from 7.8% of GDP in 2015 to 11% in 2020 (UNICEF Sierra Leone, 2024). McLean (2022) highlights that the Free Health Care initiative has improved access to quality FP services, resulting in increased availability and use of contraceptives.

Despite the challenges posed by the Ebola Virus Disease (EVD), the strategy for the reduction of teenage pregnancy was reviewed and relaunched in 2018 (November & Sandall, 2018). Additionally, a report by UNFPA Sierra Leone (2018) indicates that facilities are committed to adhering to AYPHS standards, reflecting actions taken since the establishment of these standards in 2011.

3.1.3.6.2 Facilitators for ASRH Service Delivery

According to an assessment conducted by UNFPA Sierra Leone (2018), all healthcare facilities across the country provide privacy and confidentiality

for adolescents. There has been progress in training healthcare workers to provide FP methods, and in making the government clinics adolescent-friendly by assigning trained staff to provide services (November and Sandall, 2018).

The MoHS provides adolescent registers to facilities, which are maintained with up-to-date registers. FP services are provided to adolescents free of charge. Additionally, there is effective coordination between health facilities and school officials to deliver SRH education to students (UNFPA Sierra Leone, 2018).

3.1.3.6.3 Weaknesses in ASRH Policy Implementation

In Sierra Leone, there is ambiguity regarding the age of consent for accessing FP and contraception services, with no clear policy guaranteeing adolescents' full access. The age of sexual consent is 18 years, leading to reluctance among younger adolescents to seek services or denial of services by healthcare providers (UNFPA West and Central Africa Regional Office [WCARO], n.d.).

There is a high level of out-of-pocket spending in Sierra Leone, accounting for 64.6% of health financing in 2018, which creates barriers to accessing healthcare services, particularly for low-income households (UNICEF Sierra Leone, 2024).

The health system struggles with issues such as shortage of skilled healthcare workers, inadequate and fragmented funding, lack of medicines, weak health information system, and limited community participation in planning and implementation of interventions. These challenges impede the provision of high-quality health services, particularly in rural areas where access is limited (UNICEF Sierra Leone, 2024).

3.1.3.6.4 Adverse Impacts of Conflict and EVD

The quality of health services in Sierra Leone has been inadequate due to limited access to SRH information and services, exacerbated by 11 years of civil war and the EVD outbreak in 2014 (APHRC, n.d.). UNFPA WCARO (n.d.) and McLean (2022) report that the epidemic hindered the provision of SRH education and access to contraceptive services, contributing to higher rates of adolescent pregnancy.

In addition, during the EVD outbreak, resources and focus were shifted away from adolescent health programs to epidemic management (UNFPA Sierra Leone, 2018).

3.1.3.6.5 Weaknesses in ASRH Service Delivery and Access

Regional disparities in the availability of contraceptive services and commodities impact service delivery in remote and rural areas (November & Sandall, 2018). Contraceptive availability also varies between facilities, with only 17% of them offering all essential methods. Not all facilities have trained staff to insert implants and IUDs, and facilities are only staffed with 26% of the required staff (UNFPA Sierra Leone, 2018).

Even where services are available, stigma is a major barrier that prevents girls from accessing FP services (November & Sandall, 2018). Nuwabaine et al. (2023) point out that the post-conflict context has led to structural exclusion and discrimination against adolescent girls, affecting their access to FP services.

Girls also face concerns about the visibility of contraceptives like implants and are influenced by the myths and misconceptions about contraceptives (November & Sandall, 2018). Community acceptance of ASRH education varies according to religious beliefs and local traditions, with some adolescents having their implants removed upon returning home (UNFPA Sierra Leone, 2018).

3.1.3.7 Quality and Availability of ASRH Data in SSA

3.1.3.7.1 Data Statistics of SDG 3.7 Indicators according to the UN System

The SDG 3.7.1 indicator is obtained from nationally representative household surveys (e.g. Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS), and other international and national surveys) (UNSD, n.d.B).

To validate SDG 3.7.1 indicators, data are cross-checked by calculating the CPR and unmet need for FP and comparing these figures with those reported in survey results or national SDG reporting platforms. Discrepancies are resolved by consulting with the national agencies that conducted the surveys (UNSD, n.d.B).

Data comparability may be affected by variations in survey designs, implementation methods, and questionnaire formulations. Additionally, differences in how “currently using” a contraception can impact the time frame used to assess contraceptive prevalence (UNSD, n.d.B).

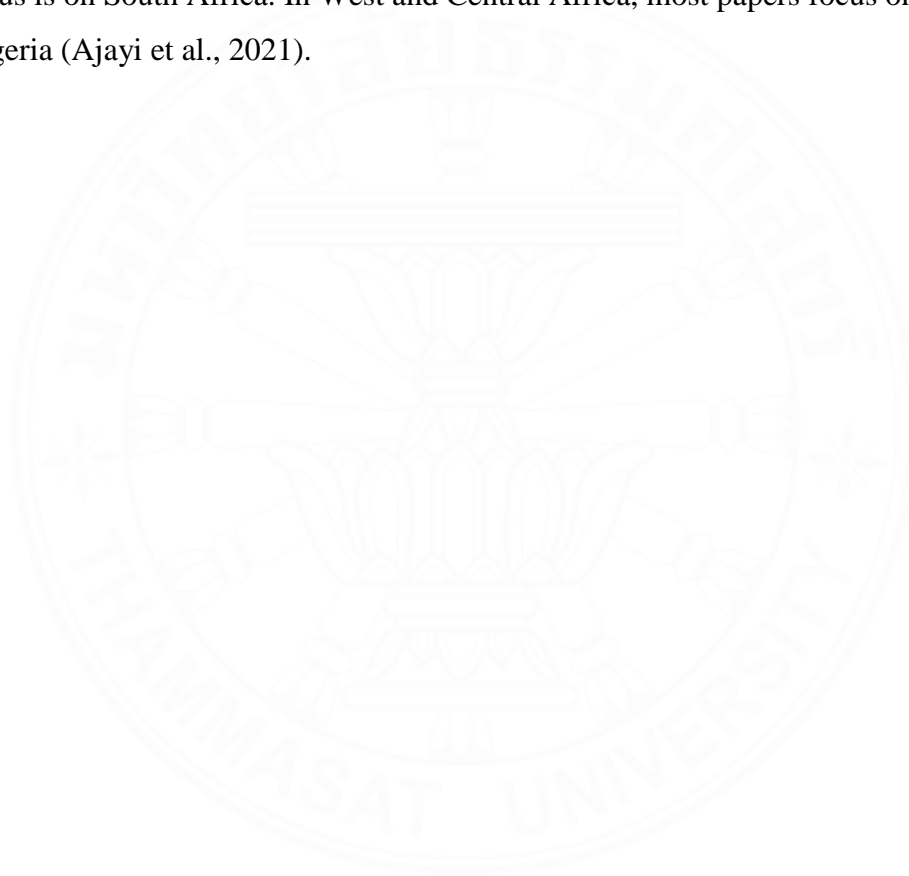
For the SDG 3.7.2 indicator among women aged 15-19 years (also referred to as the age-specific fertility rate for women aged 15-19), civil registration is the preferred source. Censuses and household surveys are used as alternatives when civil registration data is not reliable. The accuracy of the rates from civil registration depends on the completeness of birth registration and the quality of reported information (UNSD, n.d.B).

3.1.3.7.2 ASRH Research in SSA is Limited with Sub-regional Variations

Shinde et al. (2023), found a notable gap in ASRH research in SSA, with only 1,302 articles published between 2010 and 2019. These studies primarily focused on HIV and access to SRH services, with fewer addressing policy evaluations.

ASRH research in SSA peaked in 2015, reflecting increased international and regional focus on ASRH. This rise in research was part of the effort to achieve or assess progress towards the MDG 5 (Ajayi et al., 2021).

A review of the ASRH research in SSA shows that studies are concentrated in a few countries; six countries dominate the research, while ten countries have no publications, and five have only one. Eastern Africa leads with the most ASRH studies, followed by Southern Africa. Research is mainly focused HIV, access to SRH services, Sexual and Gender-Based Violence, followed by adolescent pregnancy and child marriage. Few studies focus on AYPHS. In Eastern Africa, research is concentrated in Kenya, Tanzania, and Uganda, while Southern Africa's focus is on South Africa. In West and Central Africa, most papers focus on Ghana and Nigeria (Ajayi et al., 2021).



3.2 Discussion

This section discusses the facilitators, challenges and barriers among countries in SSA that are rated high- and low-performing in the progress toward SDG 3.7 for adolescent girls, and the lack of data to track the progress toward achieving SDG 3.

3.2.1 High-performing Countries (Kenya, Namibia, and Ghana)

3.2.1.1 Facilitators of ASRH Policy Implementation and Service Delivery

The policy and legal environment on ASRH in Kenya, Namibia, and Ghana is conducive to promoting change, which has enhanced the implementation of ASRH strategies and plans and has contributed to increased CPR among adolescent girls in those countries. For example, Namibia's commitment is evident in the increased CPR among adolescents, facilitated by the Child Protection Act, which lowered the age of SRH access from 16 to 14 years old.

These countries have proved commitment to FP and its provision to adolescent girls, as FP services are provided free of charge. In addition, Kenya has allocated a specific budget line for FP and increased its contribution in recent years, and Ghana's NHIS covers ASRH services for adolescents. Namibia's introduction of contraceptive implants has broadened the options of contraceptive methods available for adolescent girls.

Effective stakeholder coordination, particularly at the national level, has played a key role. The extensive multi-sectoral network for ASRH has enabled knowledge and experience sharing and efficient use of resources in both Kenya and Ghana. The collaboration between the health and education sectors has also enabled community sensitization about ASRH issues, which helped strengthen policy implementation. In addition, the range of ASRH services and service delivery models have enhanced the involvement of adolescents, ensuring effective policy implementation.

Kenya's ASRH policy is considered the strongest in the ESA region regarding early and unintended pregnancy, due to its consultative formulation processes, ability to attract funds from government and other partners, and is supported by an implementation framework that provides specific interventions and

their costs. The health sector devolution in Kenya has enabled counties to create their own policy implementation strategies and improved the political goodwill among implementers. In Ghana, the joint efforts in monitoring adolescent pregnancy has helped identify regional prevalence to develop response plans in regions with high rates.

3.2.1.2 Challenges to ASRH Service Delivery

Despite these facilitators, challenges persist. At the subnational level, coordination among implementers is poor, exacerbated by inadequate dissemination of ASRH policies that are developed at the national level. This results in gaps in dissemination of high-quality data, which further leads to fragmented policy implementation at subnational level.

Funding also poses a challenge. None of these countries have a dedicated budget line for AYPHS, leading to heavy reliance on donor funding.

In addition, there is inconsistency between laws and ASRH policies. In Kenya, the constitutional definition of those younger than 18 years as children affects their access to contraceptives, as SRH healthcare providers require parental consent for those under 18. Ghana faces similar issues, where the legal age of consent is 16 years while legal age of majority is 18. This led to denial of ASRH service access for some adolescents. Frontline healthcare providers are inadequately informed about national ASRH policies, which affects the implementation of those policies.

Despite the implementation of AYPHS guidelines in Kenya and Namibia, most of the health facilities are not adolescent-friendly and do not have space to provide dedicated adolescent-related health services. Additionally, cultural and religious opposition in Ghana and Kenya regarding the CSE has led to a narrow, fear-based CSE curriculum.

3.2.1.3 Barriers to ASRH Service Delivery and Access

Adolescent girls face barriers to access SRH services, including individual, community, health facility, and policy-level barriers. These include lack of knowledge of service availability, negative provider attitudes, limited access to services for unmarried adolescents, lack of parental support, informal application of

service fees, shortage of medicines, long distances to travel to health facilities, social stigma, misconceptions about contraceptives, and lack of sufficient resource allocation to government providers.

3.2.2 Low-performing Countries (Malawi, Botswana, and Sierra Leone)

3.2.2.1 Facilitators of Policy Implementation and ASRH Service Delivery

In Malawi, Botswana, and Sierra Leone, the policy environment for ASRH is also conducive to making change. The involvement of young people in Malawi has led to a constitutional amendment to reset the age of marriage to 18. Sierra Leone's commitment is reflected in the review and relaunch of its national strategy for reducing teenage pregnancy, despite challenges posed by the EVD outbreak.

In all these countries, FP services are provided free of charge, which enhances adolescent access. Both Malawi and Botswana have increased the availability of a wide range of contraceptive methods, such as injectables and implants, respectively. High rates of privacy and confidentiality are reported in both Sierra Leone and Botswana. In Botswana, adolescent girls can receive SRH services without parental consent.

In Sierra Leone, all service provider facilities have a commitment to implement AYPHS standards, with available spaces to establish AYPHS corners and spaces. Community sensitization in Sierra Leone has led to increased awareness on ASRH issues.

3.2.2.2 Challenges to ASRH Service Delivery

There is weak coordination among stakeholders at the national level, with limited collaboration between the health and education sectors in the implementation of ASRH interventions in Malawi and Botswana. For instance, in Malawi, the 100-meter rule of MoE limits the availability of contraceptives for adolescent girls and conflicts with the MoH goals of increasing access and availability of contraceptives. In addition, stakeholder engagement at the subnational level is

inadequate, due to a lack of resources, which impedes the implementation of ASRH interventions at subnational levels.

The Implementation of ASRH interventions is fragmented and there are regional variations in service delivery and availability. Additionally, the health information systems in Botswana and Sierra Leone are weak, leading to a lack of both high-quality and disaggregated data.

There is inadequate government funding for meeting unmet needs for FP and establishing AYPHS in the three countries. All three countries depend mainly on donors to support SRH services, which leads to fragmented implementation and inequitable distribution of services.

The laws and policies regarding ASRH are inconsistent. The national laws in Malawi and Sierra Leone do not clearly state the age of consent for contraceptive access. The age of sexual consent in Malawi is 18 years, leading to healthcare providers denying SRH service provision to those under 18. There are also gaps in the legal and policy environment in Botswana that ensures universal access to ASRH. Furthermore, cultural and religious opposition to the CSE implementation, compounded by the limited resources are reported in Malawi and Botswana.

3.2.2.3 Barriers to ASRH Service Delivery and Access

In all three countries, there is low coverage of ASRH services, including FP, with only a few healthcare facilities providing a broad range of contraceptives, and healthcare providers are not adequately trained to insert long-acting contraceptive methods. In Malawi and Sierra Leone, there is a significant shortage of healthcare providers in healthcare facilities, affecting adolescent access to services.

Adolescent girls face barriers at the individual, community, and health system to accessing ASRH services, including limited access to services for unmarried adolescents, stigma, lack of knowledge of AYPHS availability, misconceptions about contraceptives, negative attitudes of healthcare providers, and community non-acceptance of the use of contraceptives.

3.2.3 Challenges in Collecting Data for Monitoring Progress towards SDG 3

The SDG emphasize equity and “leaving no one behind”, which requires a strong multi-sectoral approach and generating disaggregated data. However, monitoring progress towards SDG 3 faces significant challenges in low- and middle- income countries (LMIC), mainly due to the narrow scope of their health systems. Although the private sector plays a major role in service provision, the majority of these facilities do not routinely submit data to health ministries. For instance, in Kenya, up to 47% of the poorest quintile uses private healthcare, but these providers do not report data to MoH (Nabyonga-Orem, 2017).

Despite the existence of health information systems (HIS) in most countries, they are often inadequate due to poor coordination and leadership. For example, HIS development in Botswana was affected by weak leadership of poor policy frameworks (Nabyonga-Orem, 2017 as cited by Seitio-Kgokgwe, 2015).

Data on SRHR is often inconsistent across countries, hindering comparative analysis and determining best practices. The SRHR infographic snapshot, developed for all 194 WHO Member States using publicly available data, covers policies, health systems, and SRH interventions including contraceptive indicators. However, data availability varies by country income level. LMIC have the highest availability, with an average of 71%, while upper-middle income countries and high-income countries have averages of 60% and 40%, respectively. This discrepancy is due to reporting requirements associated with funding, as LMIC receive foreign assistance for health and are therefore required to report data as a condition for donor funding. Moreover, some SRHR data is only collected through surveys like DHS or MICS which are only conducted in LMIC (Hopkins, et al., 2024). For instance, MICS have never been implemented in Namibia (UNICEF, 2023b), and the most recent DHS was conducted in 2013.

Survey questionnaires are often influenced by donor biases and prejudices, and thus might not reflect the real information and actual data needed. In addition, the irregular frequency of population-based surveys, which provide good equity-related data such as socioeconomic status, rural/urban residence, and education status, poses challenges to regular monitoring of SDG 3 indicators. These surveys are

usually costly, which can be a challenge for LMIC with limited resources to conduct more frequent surveys (Nabyonga-Orem, 2017).



CHAPTER 4

CONCLUSIONS AND RECOMMENDATIONS

4.1 Conclusions

The purpose of this study is to analyze the facilitators, barriers, and challenges impacting progress towards SDG 3.7 for adolescent girls in SSA countries rated as high- and low-performing for SDG 2030 progress. The high-performing countries selected for this study are Kenya, Namibia, and Ghana., while Malawi, Botswana, and Sierra Leone represent the low-performing group. The findings identify strengths, weaknesses and challenges experienced by the selected countries in delivering effective ASRH services. These findings can be used by stakeholders in SSA countries to address specific and shared needs and gaps, based on the lessons learned from different countries.

In countries whose progress towards achieving SDG 3.7 is rated as high-performing, common facilitators include a legal environment conducive to implementing ASRH policies, effective national-level coordination between stakeholders that promotes experience sharing and effective use of resources, and expansion of the range of contraceptive methods available for adolescent girls. However, challenges in these countries include weak coordination among subnational stakeholders, often due to limited awareness of national policies and insufficient resources. The lack of a specific budget allocation for AYFHS affects the establishment of AYFHS dedicated spaces and service delivery for adolescent girls. Barriers to accessing ASRH services at the individual, community, health facility, and policy levels include lack of knowledge, judgmental attitudes of providers, contraceptive stockouts, and stigma, among other factors.

In the low-performing countries, there are also facilitators for ASRH policy implementation, such as conducive policy environments, government commitments to ASRH, and the provision of free FP services. However, these countries face significant challenges, including weak coordination between stakeholders, particularly between the health and education sectors, reliance on donor funding for AYFHS, inconsistencies between laws and policies regarding ASRH, and

weak health information systems which affect the quality of data used to inform policies. Barriers to accessing ASRH services include individual, community, and health system level barriers such as stigma and discrimination, lack of knowledge of ASRH services, misconceptions about contraceptives, negative attitudes of healthcare providers, and community acceptance to contraceptive use.

Monitoring progress towards SDG 3 in LMIC is challenging due to several factors. Health systems in these countries are often weak, which limits comprehensive data collection and analysis. The irregular frequency of population-based surveys affects tracking indicators that are only collected through these surveys. Additionally, ineffective leadership for strengthening HIS exacerbates these challenges, as it leads to gaps in data that hinder progress monitoring.

4.2 Study Limitations

This study has limitations stemming from its exclusion criteria, particularly the exclusion of Francophone countries. This led to the exclusion of all countries in the Middle Africa sub-region. As a result, the findings of this study may not fully represent the broader context of the SSA region. This could lead to an incomplete understanding of the overall situation in SSA due to lack of understanding of Francophone-specific cultural factors on policy and practice and thus impact the study conclusion and recommendations.

4.3 Recommendations

To address some of the barriers and challenges identified by this study, the following recommendations can be made.

At the national level:

- All countries should consider establishing a national stakeholder consultative mechanism to improve coordination between national and subnational stakeholders to ensure that policies are well-communicated and effectively implemented at all levels.

- Botswana and Sierra Leone should consider investing in strengthening their HIS to enhance data collection and analysis, and collaborate with the private sector to ensure regular data is shared to avoid data gaps.
- All countries should improve the capacity of healthcare providers to ensure the provision of adolescent-friendly health services, and healthcare providers should be aware of ASRH policies that are developed.

At the regional level:

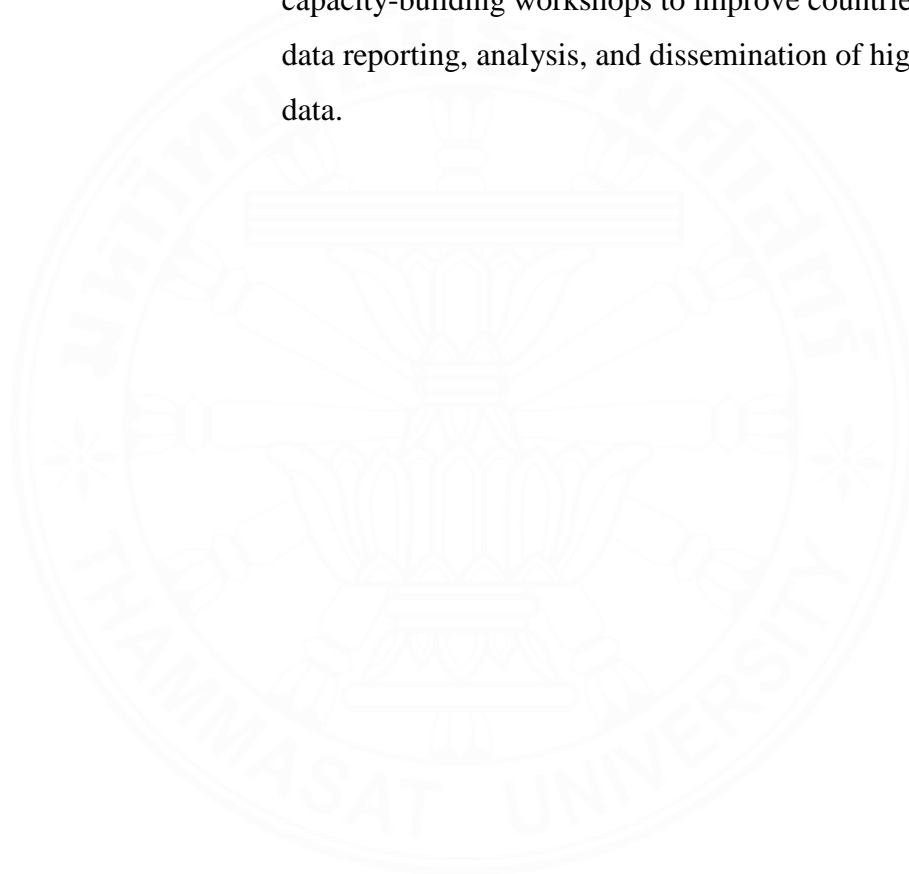
- Regional bodies such as the African Union should consider hosting regular regional forums/ platforms for sharing best practices and lessons learned on ASRH by Member States so that all countries can adopt and adapt successful strategies to their specific contexts.
- All countries should consider establishing partnerships between CSO working on ASRH across countries to enable sharing of knowledge and resources necessary to improve ASRH in the SSA region.

At the international level:

- UN agencies and international NGO should consider supporting the above recommendations with expertise and resources, especially for improving the HIS in countries where there is gap in data collection, monitoring, and reporting, such as Botswana.
- The UN and other international organizations should consider defining a separate category for data collection on adolescents when designing the post SDG strategy to be implemented after 2030. Adolescents are special sub-populations and therefore data about them should be visible in national reporting to the SDG.

For academics:

- Given the limited research on ASRH in SSA, and the focus on only 6 countries, academics should focus on countries such as those in the Southern Africa sub-region (e.g. Botswana and Namibia) to close the gap of missing data.
- In collaboration with government and non-government agencies, academic institutions should conduct training and capacity-building workshops to improve countries ability in data reporting, analysis, and dissemination of high-quality data.



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APPENDICES

APPENDIX A: Matrix for Research Objective 1

Table A1: Country index and ranking

SSA Sub-region	Country	SDI	Ranking for SDI	HDI	Ranking for HDI	UHC SCI	Ranking for UHC SCI	DALYs	Ranking for DALYs	Poverty rate national	Ranking for poverty	GDI 2022	Ranking for GDI	Average ranking of all index	SDG Index
Eastern Africa	<u>Burundi</u>	0.467	13	0.42	14	41	12	58181.1	7	64.9	13	0.926	8	11.17	56.1
	<u>Djibouti</u>	0.564	9	0.515	8	44	9	51618.9	3	21.1	3	0.844	13	7.50	51.7
	<u>Eritrea</u>			0.493	10	45	8	60040.7	9	69	14			6.83	
	<u>Ethiopia</u>	0.523	10	0.492	11	35	13	51937.1	4	23.5	4	0.922	10	8.67	55.2
	<u>Kenya</u>	0.647	1	0.601	2	53	4	53177.5	5	36.1	6	0.948	2	3.33	62.2
	<u>Madagascar</u>	0.568	8	0.487	12	35	13	58531	8	70.7	15	0.945	3	9.83	51.2
	<u>Malawi</u>	0.521	11	0.508	9	48	7	69859.1	11	50.7	10	0.926	8	9.33	56.8
	<u>Mauritius</u>	0.609	4	0.796	1	66	1	31638.7	1	10.3	1	0.976	1	1.50	70.4
	<u>Mozambique</u>	0.491	12	0.461	13	44	9	78703.9	13	46.1	9	0.929	7	10.50	54.3
	<u>Rwanda</u>	0.585	6	0.548	6	49	5	50628.8	2	38.2	7	0.921	11	6.17	60.9
	<u>Somalia</u>			0.38	16	27	16	90159.2	16	54.4	11	0.769	14	12.17	45.4
	<u>South Sudan</u>			0.381	15	34	15	82213.8	14	82.3	16			10.00	40.1
	<u>Tanzania</u>	0.569	7	0.532	7	43	11	54679.3	6	26.4	5	0.94	4	6.67	58.2
<u>Uganda</u>	0.586	5	0.55	4	49	5	61279.8	10	20.3	2	0.899	12	6.33	56.1	

SSA Sub-region	Country	SDI	Ranking for SDI	HDI	Ranking for HDI	UHC SCI	Ranking for UHC SCI	DALYs	Ranking for DALYs	Poverty rate national	Ranking for poverty	GDI 2022	Ranking for GDI	Average ranking of all index	SDG Index
	<u>Zambia</u>	0.629	2	0.569	3	56	2	72861.9	12	60	12	0.93	6	6.17	54.4
	<u>Zimbabwe</u>	0.615	3	0.55	4	55	3	86148	15	38.3	8	0.936	5	6.33	57.8
Central Africa	<u>Angola</u>	0.626	2	0.591	4	37	6	62523.2	6	32.3	1	0.905	3	3.67	51.9
	<u>Cameroon</u>	0.607	4	0.587	5	44	3	62046	5	37.5	3	0.9	4	4.00	57.3
	<u>Central African Republic</u>	0.428	6	0.387	8	32	7	97933.1	8	68.8	7			6.00	44.2
	<u>Chad</u>	0.428	6	0.394	7	29	8	70276.6	7	42.3	5	0.776	6	6.50	45.1
	<u>Congo</u>	0.618	3	0.593	3	41	5	60064.7	2	40.9	4	0.909	2	3.17	52.7
	<u>DR Congo</u>	0.517	5	0.481	6	42	4	61019.6	4	63.9	6	0.891	5	5.00	48.7
	<u>Equatorial Guinea</u>			0.65	2	46	2	60681	3	76.8	8			2.50	
	<u>Gabon</u>	0.748	1	0.693	1	49	1	54377.2	1	33.4	2	0.982	1	1.17	64.9
	Southern Africa	<u>Botswana</u>	0.36	5	0.708	2	55	4	66909.9	3	16.1	1	0.998	3	3.00
<u>Eswatini</u>		0.621	3	0.61	3	56	3	99056.3	4	58.9	5	0.987	4	3.67	57.8
<u>Lesotho</u>		0.555	4	0.521	4	53	5	117884.9	5	49.7	3	0.999	1	3.67	55.5
<u>Namibia</u>		0.66	2	0.61	3	63	2	65915.7	2	17.4	2	1.006	2	2.17	66.5
<u>South Africa</u>		0.678	1	0.717	1	71	1	62840	1	55.5	4	0.985	5	2.17	63.4
	<u>Benin</u>	0.587	3	0.504	7	38	12	56512.6	6	38.5	4	0.848	11	7.17	56.8

SSA Sub-region	Country	SDI	Ranking for SDI	HDI	Ranking for HDI	UHC SCI	Ranking for UHC SCI	DALYs	Ranking for DALYs	Poverty rate national	Ranking for poverty	GDI 2022	Ranking for GDI	Average ranking of all index	SDG Index
Western Africa	<u>Burkina Faso</u>	0.487	11	0.438	13	40	9	64495.1	12	43.2	7	0.881	6	9.67	52.9
	<u>Côte d'Ivoire (Ivory Coast)</u>	0.58	5	0.534	5	43	6	56654	7	37.5	3	0.861	9	5.83	62.7
	<u>Gambia, The</u>	0.534	8	0.495	8	46	3	55745.1	5	53.4	14	0.94	1	6.50	57.6
	<u>Ghana</u>	0.659	1	0.602	1	48	2	51315.3	3	23.4	1	0.933	2	1.67	63
	<u>Guinea</u>	0.514	10	0.471	11	40	9	64783.2	13	43.7	8	0.818	15	11.00	56.4
	<u>Guinea-Bissau</u>			0.483	10	37	14	71653.1	15	47.7	12	0.862	8	9.83	51.9
	<u>Liberia</u>	0.517	9	0.487	9	45	4	58621.7	9	50.9	13	0.86	10	9.00	52.5
	<u>Mali</u>	0.467	13	0.41	14	41	7	68253.6	14	44.6	9	0.83	13	11.67	56.8
	<u>Mauritania</u>	0.588	2	0.54	4	40	9	40013.8	1	31.8	2	0.874	7	4.17	58.2
	<u>Niger</u>	0.424	14	0.394	15	35	15	59453.9	10	40.8	6	0.826	14	12.33	49.9
	<u>Nigeria</u>	0.581	4	0.548	2	38	12	57660.9	8	40.1	5	0.886	4	5.83	54.6
	<u>Senegal</u>	0.552	7	0.517	6	50	1	48560.9	2	46.7	11	0.925	3	5.00	63.4
	<u>Sierra Leone</u>	0.486	12	0.458	12	41	7	63192.8	11	56.8	15	0.885	5	10.33	58.2
<u>Togo</u>	0.555	6	0.547	3	44	5	55671.4	4	45.5	10	0.848	11	6.50	58.4	

Table A2: Definitions and sources for indexes:

Index	Definitions	Source
Sustainable Development Index (SDI)	The Sustainable Development Index (SDI) measures the ecological efficiency of human development, recognizing that development must be achieved within planetary boundaries. It was created to update the Human Development Index (HDI) for the ecological realities of the Anthropocene.	https://www.sustainabledevelopmentindex.org/
Human Development Index (HDI)	The Human Development Index, or HDI, is a metric compiled by the United Nations Development Programme and used to quantify a country's "average achievement in three basic dimensions of human development: a long and healthy life, knowledge, and a decent standard of living.	https://ourworldindata.org/human-development-index https://worldpopulationreview.com/country-rankings/hdi-by-country
Universal health coverage (UHC) service coverage index (SCI) SDG 3.8.1	The coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population). The indicator is an index reported on a unitless scale of 0 to 100, which is computed as the geometric mean of 14 tracer indicators of health service coverage. The tracer indicators are as follows, organized by four components of service coverage: 1. Reproductive, maternal, newborn and child health 2. Infectious diseases 3. Noncommunicable diseases 4. Service capacity and access.	https://data.who.int/indicators/i/3805B1E/9A706FD
Burden of disease	Disability-Adjusted Life Years (DALYs) per 100,000 individuals from all causes. DALYs measure the total burden of disease – both from years of life lost due to premature death and years lived with a disability. One DALY equals one lost year of healthy life.	https://ourworldindata.org/burden-of-disease
Poverty rate at national poverty lines (% of population)	The poverty rate at the national poverty line is country-specific. National poverty lines are thus estimating of poverty that are consistent with each country's specific economic and social circumstances. Almost all national poverty lines are anchored to the cost of a food basket—what the poor in that country would customarily eat—that provides adequate nutrition for good health and normal activity, plus an allowance for nonfood spending.	https://pip.worldbank.org/country-profiles/IDN https://data.worldbank.org/indicator/SI.POV.NAHC?skipRedirection=true&view=map
The Gender Development Index (GDI)	GDI measures gender inequalities in achievement in three basic dimensions of human development: health, measured by female and male life expectancy at birth; education, measured by female and male expected years of schooling for children and female and male mean years of schooling for adults ages 25 years and older; and command over economic resources, measured by female and male estimated earned income.	https://ourworldindata.org/human-development-index https://hdr.undp.org/gender-development-index#/indicies/GDI
SDG Index	The SDG Index and Dashboards provides an annual assessment of SDG progress in all 193 UN member states.	https://dashboards.sdgindex.org/

APPENDIX B Matrix for Research Objective 2

Table B1: ASRH policies, plans, and outcomes

Country	Policies / strategies / plans / guidelines	Policies / strategies / plans / guidelines	Policies / strategies / plans / guidelines	Policies / strategies / plans / guidelines	ASRH outcomes
Kenya	(Ministry of Health Kenya, 2015): ASRH policy 2015: Aims to improve SRH of adolescents and prevent early and unintended pregnancy. Targets: 60% CPR and 70% of facilities provide YFS by 2030	(Ministry of Health Kenya, 2017): ASRH policy implementation framework (2017-2021): Was developed to operationalize the ASRH policy	(NCPD, 2019): National Action Plan for Addressing Adolescent Health Teenage Pregnancy (2019): Aims to integrate adolescent health services and eliminate teenage pregnancy by 2030	(Ministry of Health Kenya, 2021): Family Planning Costed Implementation Plan (2021-2024): Aims to increase demand for FP services for adolescents and youths	(KNBS, 2015): Among married adolescents: CPR: 40.2%, unmet need for FP: 23%, SDG 3.7.1: 56.2% (KNBS & ICF, 2023): Among married adolescents: CPR: 40.7%, Unmet need for FP: 21.6%, SDG 3.7.1: 59.4% (Sustainable Development Report, 2024): SDG 3.7.2: 44 births per 1,000 girls
Malawi	(Ministry of Health Malawi, 2015): National Youth Friendly Health Services Strategy (2015-2020): Aims to enhance access and utilization of YFHS	(Government of Malawi, 2015): Costed Implementation Plan for Family Planning (2016-2020): aims to increase mCPR to 60% by 2020, and focusing on 15-24 age groups	(Ministry of Health Malawi, 2017): National Sexual and Reproductive Health and Rights Policy (2017-2022): aims to reduce HIV/STIs and unintended pregnancies and improve access to YFHS	(Government of Malawi, 2018): National Strategy for Adolescent Girls and Young Women (2018-2022): Aims to improve access to integrated health services for young people aged 10-24	(NSO & ICF, 2017): Among married adolescents: CPR: 38.1%, Unmet need for FP: 22.2%, SDG 3.7.1: 62.2% (NSO, 2021): Among married adolescents: CPR: 46.6%, Unmet need for FP: 21.3%, SDG 3.7.1: 68.5% (Sustainable Development Report, 2024): SDG 3.7.2: 135.6 births per 1,000 girls
Namibia	(Government of the Republic of Namibia, 2008): Consolidated National Reproductive and Child Health Policy (2008): emphasizes the need for AFHS	(MHSS, 2010): National Health Policy Framework (2010-2020): Provide strategic guidelines or increasing awareness and offering counselling AYFHS	(Ministry of Education Namibia, 2010): Education Sector Policy for the Prevention and Management of Lerner Pregnancy (2010): aims to reduce pregnancies among learners		(MHSS & ICF International, 2014): CPR: 37.2% Unmet need: SDG 3.7.1: 75% (Sustainable Development Report, 2024): SDG 3.7.2: 63.9%
Botswana	(Choonara et al., 2024): Integrated Sexual, Reproductive, Maternal, Newborn, Child and	(Ministry of Health Botswana, 2021): National Guidelines on Health Services Integration (2021):			(Sustainable Development Report, 2024): SDG 3.7.2: 50.22%

Country	Policies / strategies / plans / guidelines	Policies / strategies / plans / guidelines	Policies / strategies / plans / guidelines	Policies / strategies / plans / guidelines	ASRH outcomes
	Adolescent Health and Nutrition Strategy (2018-2022): includes measures for enhancing FP and AYFHS	emphasizes client-centred approach that enable adolescents to choose preferred contraceptives and prevent unintended pregnancies			
Ghana	(GHS, 2016): Adolescent Health Service Policy and Strategy (2016-2020): aims to enhance adolescent health through nine strategic objectives.	(Ministry of Health Ghana, 2015): Ghana Family Planning Costed Implementation Plan (2016-2020): aims to increase adolescent access to information and contraceptives	(Ministry of Health Ghana & GHS, 2020): Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition Strategic plan (2020-2025): sets targets for improving adolescent health, enhancing access to AYFS	(Ministry of Gender, Children, and Social Protection Ghana, 2017): Five Year Strategic Plan to Address Adolescent Pregnancy in Ghana (2018-2022): aims to prevent early and unintended pregnancy	(GSS & ICF, 2014): Among married adolescents: CPR: 18.6% Unmet need: 50.7% SDG 3.7.1: 24.1% (GSS & ICF, 2024): Among married adolescents: CPR: 34.3% Unmet need: 31% SDG 3.7.1: 41.4% (Sustainable Development Report, 2024): SDG 3.7.2: 63 births per 1,000 girls
Sierra Leone	(Government of Sierra Leone, 2018): National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage (2018-2022): aims to reduce adolescent fertility rate to 74 National Health Sector Strategic Plan (2021-2025): align its goals with above strategy to reduce adolescent birth rate	(Government of Sierra Leone, 2014): Communication Strategy for the Reduction of Teenage Pregnancy (2014-2019): aims to unify various communication approaches to address adolescent pregnancies	(Ministry of Health and Sanitation Sierra Leone, 2017): National Reproductive, Maternal, Newborn, Child, and Adolescent Health Strategy (2017-2021): focuses on preventing adolescent pregnancy and decrease adolescent birth rate to 74 by 2021	(UNICEF Sierra Leone, 2024): School Health Policy (2021): emphasizing adolescent access to YFS	(SSL & ICF, 2013): Among married adolescents: CPR: 7.8%, Unmet need for FP: 30.7%, SDG 3.7.2: 20.2% (SSL & ICF, 2020): Among married adolescents: CPR: 14.4% Unmet need: 27.8% SDG 3.7.1: 34.1% (Sustainable Development Report, 2024): SDG 3.7.2: 101.9 births per 1,000 girls

Table B2: ASRH commitments and services

Country	International/ Regional commitments	National Commitment	Guidelines for ASRH services / AYFHS	ASRH services
Kenya	(African Institute for Development Policy, 2023): ICPD Program of Action. ESA Ministerial Commitment to CSE and SRH services for adolescents and young people in ESA.	(African Institute for Development Policy, 2023): 2010 Constitution guarantees the right of all to access SRH services and education	(PRB, 2020): National Guidelines for the Provision of Adolescent Youth-friendly Services (2016): All adolescents and youth should be able to receive health services	(Ministry of Health Kenya, 2016): SRH counselling, education, pregnancy testing, STI counselling and treatment, contraceptive counselling, and access to a full range of contraceptive methods. These services are delivered through multiple channels: static, mobile outreach, digital platform, community-based
Malawi	(Ministry of Health Malawi, 2014): ICPD Program of Action. ESA Ministerial Commitment to CSE and SRH services for adolescents and young people in ESA.		(Ministry of Health Malawi, 2014): National Reproductive Health Service Delivery Guidelines (2014-2019): establish standards for YFHS	(Ministry of Health Malawi, 2015): YFHS include a wide range of services, including health promotion and counselling on STIs, HIV/AIDS, contraceptives, sexual abuse, nutrition, and maternal health. The services are delivered at various levels: community level, health center level, hospital level, outreach programs
Namibia	(UNESCO, 2023): ESA Ministerial Commitment to CSE and SRH services for adolescents and young people in ESA	(Odimegwu et al., 2022): Namibia's Constitution guarantees individuals, particularly women, the right to access contraceptives and make informed decisions FP, including choices regarding contraception, the timing of children, and the number of children, regardless of age. (Government of the Republic of Namibia, 2004): Vision 2030 aims to ensure health services are adolescent-friendly and accessible to all.	(WHO, 2017): ASRH services are delivered through PHC facilities and outreach and school-based programs. (Muyenga et al., 2017): AFHS standards (2011) to prevent pregnancy, and nurses at PHC level implement these services.	
Botswana	(UNESCO, 2013): ICPD Plan of Action.		(Ministry of Health Botswana, 2015):	(Ministry of Health Botswana, 2015):

Country	International/ Regional commitments	National Commitment	Guidelines for ASRH services / AYFHS	ASRH services
	ESA Ministerial Commitment to CSE and SRH services for adolescents and young people in ESA.		Policy guidelines and service standards (2015): emphasize the importance of adolescent SRH services.	ASRH services include: counselling, FP, antenatal care, postnatal care, post-abortion care, and management of STIs/HIV/AIDS. Services are provided in hospitals and clinics. (Ministry of Health Botswana, 2021): Integrated AYFHS are provided by nurses, midwives, healthcare assistants in a single room.
Ghana	(Akazili et al., 2020): ICPD Program of Action		(GHS, n.d.): National Guidelines and Standards for AYFHS: outline comprehensive range of ASRH services	(GHS, n.d.): ASRH services include SRH assessment, development of RH plans, SRH education, FP services, postpartum FP services for adolescent mothers, emergency contraception, HIV services, care for sexually-abused adolescents, and referrals. They are delivered through static delivery points, mobile, complementary, and providers include physician assistants, nurses, and midwives.
Sierra Leone			(Government of Sierra Leone, 2018): National Standards for Adolescents and Young People Friendly Health Services (2011): Framework for delivering health services to adolescents.	(UNFPA Sierra Leone, 2018): AYFHS include management of STI, HIV counselling and testing, FP services, antenatal care, delivery and postnatal care services. Providers include community health officers, midwives, community health nurses, MCH aides, and child health aides.

APPENDIX C Matrix for Research Objective 3

Country	Paper	Reported strengths	Reported weaknesses
Kenya	Manguro, G., & Temmerman, M. (2022). A critical review of adolescent sexual and reproductive health and rights in Kenya. <i>Med</i> , 3(6), 364–368. https://doi.org/10.1016/j.medj.2022.05.007	Kenya’s adolescent SRH policies are progressive, and, if fully implemented, would go a long way in meeting the information and service needs for adolescents. These policies and commitments have also raised contributions from governments, donors, and the private sector to fund adolescent SRH initiatives, while also increasing collaborations among stakeholders and at different levels of government.	ASRH is still a divisive issue, and some individual, cultural, and religious beliefs operate as barriers. For example, numerous stakeholders are publicly opposing comprehensive sexuality education in schools, in opposition to the ministerial commitment of 2013. Subnational stakeholders have little knowledge of adolescent SRH policies and commitments compared to those at the national level. This could be because of a lack of coordination among implementers, a lack of stakeholder involvement, or a lack of political will to cascade policies to a lower level. As per the Kenyan constitution, everybody under the age of 18 should be considered a child.
	Embleton, L., Braitstein, P., Di Ruggiero, E., Oduor, C., & Wado, Y. D. (2023). Sexual and reproductive health service utilization among adolescent girls in Kenya: A cross-sectional analysis. <i>PLOS global public health</i> , 3(2), e0001508. https://doi.org/10.1371/journal.pgph.0001508	Kenya has a robust National Adolescent SRH Policy and National Guidelines for the Provision of AYFS applicable to all tiers of the health system. The range of AYFS service delivery models aims to support engaging Kenya’s diverse population of adolescents in SRH services who live in different geographic regions of the country with varied health and socioeconomic statuses.	Barriers to ASRH access: Health facility level: concern that there may not be a friendly and respectful provider, there may not be a female provider, there may not be any provider, other adults may see them at the clinic. Community and interpersonal level: being unmarried, individual level: aged less than 18, not engaging in work for money, lack of knowledge about where to obtain family planning. The delivery of health is devolved to county level governments in Kenya, which may differentially influence health facility financing, distribution of the health workforce, and resources across counties, thereby leading to inequities across the healthcare system.
	Rutgers International. (2023a). Kenya. Retrieved on 19 August 2024 from https://rutgers.international/wp-content/uploads/2023/07/Sub-Saharan-Africa-Kenya-Rutgers-ICPD-interactive.pdf	To ensure the implementation of the ASRH policy, the government established the National Adolescent Health Technical Working Group (TWG) as a coordinating mechanism to address adolescents’ concerns.	Adolescent-friendly centers are inadequate and poorly equipped across the country, with few service providers equipped and able to offer a comprehensive package of care for adolescents at community and facility level. Inequitable distribution of these facilities at county level, where some counties have more than half of the existing facilities providing youth-friendly services while other counties have none. A weak and fragmented implementation framework, particularly at the county level; inadequate resourcing, specifically amplified during the COVID-19 pandemic, that skewed the prioritization and allocation of resources towards pandemic response measures; coupled with a rapid decline in donor funding.

Country	Paper	Reported strengths	Reported weaknesses
			<p>Inadequate service providers, who hold poor attitudes towards young people's SRHR</p> <p>While the Ministry of Health has launched a National Reproductive Health Policy (2022-2032), it does not comprehensively address the real SRH needs of adolescents and young people, risking the gains made so far.</p>
	<p>Onono, M. A., Brindis, C. D., White, J. S., Goosby, E., Okoro, D. O., Bukusi, E. A., & Rutherford, G. W. (2019). Challenges to generating political prioritization for adolescent sexual and reproductive health in Kenya: A qualitative study. <i>PLoS one</i>, 14(12), e0226426. https://doi.org/10.1371/journal.pone.0226426</p>	<p>Within Kenya, there is an extensive multi-sectoral network of actors ranging from local and national levels of government, non-governmental and civil society groups, as well as journalists, researchers and policy analysts. These actors are organized into several technical working groups and often chaired by Ministry of Health program managers. Within these technical working groups, the actors leverage their knowledge, experiences, beliefs, and power to adapt the international and regional norms and guidelines regarding adolescent SRH to Kenya.</p>	<p>Even though adolescent SRH had been incorporated into nearly all line ministries, some ministries lacked the know-how to implement or enforce some of the recommendations unless they were clearly aligned with the primary scope of the particular minister's office. Adolescent SRH policy community members in Kenya hold conflicting views concerning what age range comprises adolescents, which had hamstrung the effectiveness of the policy community. Political leaders primarily focused and financed other health issues, such as HIV, malaria, and maternal and child mortality, which have political and emotional appeal that adolescent pregnancy does not have. Perception that the domestication of international norms and guidelines for adolescent SRH was a donor-driven issue and did not reflect the actual priority of adolescent SRH. Despite agreement on adolescent SRH being a priority topic within the different technical working groups, different partners dictated what specific aspects of adolescent SRH were fundable. This tension resulted in fragmented, often conflicting, multi-sectoral approaches that paralyzed the execution of the very policies they championed. Adolescents, who are below the age of 18 are seen as dependents and their issues are marginalized. Despite numerous guidelines and published road maps, there was no political commitment or reliable mechanism to earmark funds for adolescent SRH and to account for it.</p>
	<p>Okoth, L., Steege, R., Ngunjiri, A., Theobald, S., & Otiso, L. (2023). Policy and practices shaping the delivery of health services to pregnant adolescents in informal urban settlements in Kenya. <i>Health policy and planning</i>, 38(Supplement_2), ii25–ii35. https://doi.org/10.1093/heapol/czad070</p>	<p>The County government promotes the establishment of youth-friendly spaces as a strategy to improve access to SRH services for young people. As part of joint governance, policy makers at the Ministry of Education reported being involved in technical working groups that encourage joint efforts in adolescent health service provision.</p>	<p>Little knowledge about adolescent policies among healthcare providers, thus limiting implementation. Certain cultures and religions promote practices that inhibit adolescent access to SRH. A lack of resources has affected the establishment of the youth-friendly spaces defined in the policy.</p>

Country	Paper	Reported strengths	Reported weaknesses
		<p>Devolution of the health sector in 2013 allowed counties to develop their own policies and implementation strategies. The education sector participants recognized the importance of encouraging parents and caregivers to discuss sexual and reproductive health with their adolescents</p> <p>This highlights the benefit of having autonomy to adapt policies and training at the County level, which is a result of devolution. This autonomy has also been extended to health facility management. Managers at the facility reported how continuous feedback mechanisms are used to improve services and that age and sex disaggregated data is used to support policy development for adolescents</p>	<p>Many care providers requested parental consent to receive services for those under the age of 18 years in line with the 2010 Kenyan Constitution and the Sexual Offences Act.</p>
	<p>Options UK. (n.d.). Increasing domestic financing for family planning commodities in Kenya. Tracking the progress made as a result of matched funding commitments. Retrieved on 19 August 2024 from https://options.co.uk/wp-content/uploads/2023/08/Increasing-domestic-financing-for-family-planning-commodities-in-Kenya.pdf</p>	<p>Kenya is gradually moving toward the 2001 Abuja Declaration. In FY 2019/20 the government committed to increasing the portion of the national health budget for FP services. Adoption of MOU between government and development partners to increase Kenya's financing of FP, while decreasing partners' funding. Engagements with partners have led to the reintroduction of the FP budget line and allocation of KES 785 million, which marked a major milestone achieved to date. Kenya has ramped up domestic funding for family planning commodities, especially in the past two fiscal years. From FY 2020/21 to FY 2022/23 the Ministry of Health's contributions more than doubled. The increases have been dramatic, by about 55% from FY 2020/21 to FY 2021/22 and about 38% from FY 2021/22 to FY 2022/23.</p>	
	<p>Choonara, S., Hwati, R., Tayebwa, M., & Govender, K. (2024). Early and unintended pregnancy in Eastern and Southern Africa: Analysis of adolescent sexual and reproductive health and rights policies. <i>BMJ Global Health</i>, 9(4), e013929. https://doi.org/10.1136/bmjgh-2023-013929</p>	<p>Kenya is considered to have the strongest policy in terms of EUP, for example, specific targets, intervention(s) and costing. The policy and strategic areas are informed through consultative processes with national- level and county- level stakeholders. Kenya is the only country in the ESA region that supplements its ASRHR policy with a detailed implementation framework. The framework details specific intervention areas and targets.</p>	

Country	Paper	Reported strengths	Reported weaknesses
	<p>ThinkWell. (2020). Kenya brief 4. County perspectives on Kenya's family planning program. Retrieved on 19 August 2024 from https://thinkwell.global/wp-content/uploads/2020/08/Family-planning-brief_31-July-2020.pdf</p>	<p>FP is included in County Integrated Development Plans (CIDP) to harness the demographic dividend. As part of this, county governments have identified issues such as teenage pregnancy and high fertility as impediments to human development. Makueni and Kilifi counties have also developed FP costed implementation plans (CIP). These county CIP and CIDP documents include mCPR targets.</p>	
	<p>Mutea, L., Ontiri, S., Kadiri, F., Michielesen, K., & Gichangi, P. (2020). Access to information and use of adolescent sexual reproductive health services: Qualitative exploration of barriers and facilitators in Kisumu and Kakamega, Kenya. <i>PloS one</i>, 15(11), e0241985. https://doi.org/10.1371/journal.pone.0241985</p>	<p>Policy-level facilitators: Key informants noted that political goodwill had improved, which enabled implementation of ASRH programs and creation of partnerships with other implementing organizations.</p>	<p>Barriers to use of ASRH information and services: Individual-level: lack of money to access services, consultation and medicine fees, negative attitude of HCWs. Relationship-level: Absence of parental teachings on ASRH. Organization-level: Long distance to SRH services, shortage of staff and long queues, health facility costs, and supply stock-outs Community-level: Social stigma, Religious beliefs about adolescent SRH. - Policy level: lack of knowledge of ASRH policy. Health service providers and teachers were not fully aware of what information and services adolescents were entitled to, lack of resource allocation in county budgets for ASRH.</p>
	<p>UNFPA ESARO. (2018). Regional Report Assessment of adolescent and youth-friendly health service delivery. East and Southern Africa Region. Retrieved on 20 August from https://esaro.unfpa.org/sites/default/files/pub-pdf/Assessment%20of%20Adolescents%20and%20Youth-Friendly%20Health%20Service%20Delivery%20in%20ESA.pdf</p>		<p>A lack of budgetary allocation towards AYFHS both at the national and county levels of government. Most of the health facilities in the country do not offer AYFHS, despite the government having guidelines on provision of a comprehensive package of health services to all young people.</p>
	<p>Langat, E.C., Mohiddin, A., Kidere, F. et al. Challenges and opportunities for improving access to adolescent and youth sexual and reproductive health services and information in the coastal counties of Kenya: a qualitative study. <i>BMC Public Health</i> 24,</p>		<p>Barriers to access of ASRH services: Individual factors: personal and social stigma connected with SRH concerns. Parental factors: parents perceive AY to be unprepared for SRH information and services, Health worker and health institution factors: age and gender of health care workers (elderly, men),</p>

Country	Paper	Reported strengths	Reported weaknesses
	484 (2024). https://doi.org/10.1186/s12889-024-17999-9		<p>Despite free services in public hospitals, they have to pay informal fees during a hospital visit. Some services were only available during specific hours of the day, which was inconvenient for AY. Health facilities were located far from users.</p> <p>Teacher factor: teachers provide limited SRH information.</p> <p>Contextual factors: literacy challenges in the community, cultural and religious barriers, and poverty.</p>

<p>Malawi</p>	<p>APHRC. (2020). Increasing adolescents' access to sexual and reproductive health information and services in Malawi: A problem driven political economy analysis. retrieved on 28 August 2024 from https://aphrc.org/wp-content/uploads/2023/06/Malawi-PEA-report-print-version.pdf</p>	<p>Malawi's legal and policy environment for adolescent SRH is considered reasonably conducive and progressive. Adolescent SRH policies are aligned with previous and existing legal documents, with policy formulation procedures being consultative in nature. Almost always, policies and strategies developed over the past five years have included the participation of the National Youth Council (NYC) and Youth Net and Counselling (YONECO). NYC is a parastatal umbrella body of youth-focused and youth-led organizations, while YONECO is an NGO focused on implementing various adolescent and youth programs. The consultations allowed the government to obtain the views and contributions of relevant stakeholders regarding proposed policies. Policies offered a broad framework and direction for CSOs and development partners, which created a conducive environment enabling CSOs and development partners to implement SRH service delivery programs for adolescents within communities. Malawi has sought to encourage the implementation of out-of-school CSE programs.</p>	<p>Barriers ASRH services:</p> <p>Individual level: stigma, lack of knowledge of contraceptives, misconceptions about modern contraceptives.</p> <p>Community, cultural and household level: unsupportive parents to contraceptive use, living in rural areas, limited availability of services, long distances to healthcare facilities, shortage of skilled health workers</p> <p>Health system: Religion and cultural beliefs of providers, coupled with a lack of training in the provision of youth-friendly services, are reasons for providers' judgmental attitudes, inadequate resources for provision of YFS is limited, Contraceptive stock outs.</p> <p>Legal and policy level: Despite the willingness to sign up international and regional frameworks, there is failure to domesticate them fully. The law and policies are unclear concerning the age of consent for contraceptives. No minimum age for accessing contraceptives was specified in the YFHS Training Manual.</p> <p>The Ministry of Education's 100-meter rule, which states that there is no contraceptive distribution or availability within 100 meters of schools, is at odds with the Ministry of Health's goal of making contraceptives accessible to young people.</p> <p>Malawi's resource ceiling for health has been limited, allocating only 9.4% of its FY 2019/20 budget to health. Donor financing accounts for the bulk of Malawi's health sector budget. Insufficient funding creates additional challenges, with the WHO identifying Malawi as one of the countries with an acute shortage of health workers.</p> <p>Inadequate in-service training and poor staff retention are key factors contributing to the poor delivery of SRH services. Quality of health care is also compromised by drug stockouts, weak supply chains, as well as inadequate basic equipment and infrastructure.</p> <p>Malawi's law does not explicitly address the minimum age of consent for contraception, leaving it to interpretation by service providers. Although the government is supportive of CSE, implementation has been hindered by several challenges such as opposition from some religious and traditional authorities.</p> <p>Evaluation of Malawi's YFHS 2015–2020 strategy found that implementation in Malawi varied by district, was implemented sporadically and relied heavily on donor support.</p>
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Country	Paper	Reported strengths	Reported weaknesses
	<p>Wigle, J., Paul, S., Birn, A., Gladstone, B., & Braitstein, P. (2020). Youth participation in sexual and reproductive health: policy, practice, and progress in Malawi. <i>International Journal of Public Health</i>, 65(4), 379–389. https://doi.org/10.1007/s00038-020-01357-8</p>	<p>Young people’s engagement had led to certain tangible changes in policy and community-level translation. Examples identified included recent advocacy for legislation and constitutional amendments to increase the legal age of marriage to 18 years, and the introduction of youth-friendly health services nationally. At the community-level these efforts were related to perceived increases in contraceptive use, decreased rates of child marriages, adolescent pregnancy, and school dropouts among pregnant girls.</p>	<p>At the national level, young people represent a focus across multiple sectors (e.g., youth, gender, health, education, and HIV/AIDS), but coordination and collaboration among these stakeholders remain weak. Youth-friendly health services are funded primarily by donors, leading to inequitable distribution of services and fragmented implementation. Most Malawian youth reported that their involvement was restricted to specific instances of policy formulation, with many considering their roles in agenda-setting, ongoing decision-making, and monitoring and evaluation to be minuscule or nonexistent. Several youths were not aware of key policies, such as the National Youth Policy, and this impeded the realization of their participatory rights.</p>
	<p>Ali, G., Erlank, C. P., Birhanu, F., Stanley, M., Chirwa, J., Kachale, F., & Gunda, A. (2023b). Perspectives on DMPA-SC for self-injection among adolescents with unmet need for contraception in Malawi. <i>Frontiers in Global Womens Health</i>, 4. https://doi.org/10.3389/fqwh.2023.1059408</p>	<p>The Ministry of Health in Malawi provides free of charge, voluntary FP services and a broad range of contraception methods in all public facilities and at community level through Health Surveillance Assistants and Community-Based Distribution Agents. Increased CPR and decreased unmet need in the country was achieved through expanding access to reliable modern contraceptive methods, including injectable contraceptives, which were estimated to be the most commonly used method among adolescents aged 15–19 in Malawi</p>	
	<p>Johnson, T., Alice, F., Luba, M., Matendawafa, A., & Mohamed, B. (2023). Achieving universal health coverage for young people in Malawi. Retrieved on 29 August 2024 from https://africanalliance.org.za/wp-content/uploads/2024/03/UHC-Malawi-31.pdf</p>		<p>There is no system between schools and SRH service providers for learners to easily access youth-focused referrals. Youth-friendly health centres sometimes do not have the services needed by young people, so they are referred to general population sections to access the service, which is not comfortable for young people. Healthcare worker attitudes hinder AYP from accessing SHR services. This also impacts the quality of SRHR services being provided. There is limited to no mention of youth in policies such as the National Health Policy (2017), The Health Sector Strategic Plan III (2023-2030), The National Community Health Strategy (2017-2022) Malawi’s law does not explicitly address the age of consent for contraception, leaving it to interpretation by providers. Donors contributed an average of 75% to the funding of the health sector between 2018 and 2019.</p>

Country	Paper	Reported strengths	Reported weaknesses
			There are several factors undermining the efficiency of health sector spending, largely linked to weak public finance management systems. This has led to an increase in agencies and NGOs managing financial resources on behalf of donors. These agencies mostly use their own planning, financing, procurement, and monitoring and evaluation (M&E) systems bypassing Government systems, contributing to fragmentation of the planning and budgeting, delivery, and M&E systems in the health sector.
	Self, A., Chipokosa, S., Misomali, A., Aung, T., Harvey, S. A., Chimchere, M., Chilembwe, J., Park, L., Chalimba, C., Monjeza, E., Kachale, F., Ndawala, J., & Marx, M. A. (2018). Youth accessing reproductive health services in Malawi: drivers, barriers, and suggestions from the perspectives of youth and parents. <i>Reproductive Health</i> , 15(1). https://doi.org/10.1186/s12978-018-0549-9		Barriers to ASRH service access: misconceptions of the use of contraceptives, costs as some NGO providers regularly charge for certain services, transport costs and long distances, negative attitudes about youth using FP, parents negative opinions of youth using FP, health providers were known to report youth to their parents.
	Grace, C. S., & Rakgadi, G. M. (2023). What's holding back youth-friendly health services in Blantyre, Malawi? A qualitative exploration. <i>African journal of reproductive health</i> , 27(9), 57–64. https://doi.org/10.29063/airh2023/v27i9.6		Barriers to access: Frequent stockouts of contraceptives, Lack of dedicated space for conducting YFHS, Lack of knowledge about YFHS, Distance to the Health Facility, Misconceptions about SRH issues and YFHS, Misconceptions from parents and community.
Namibia	Michael, T. O., Ojo, T. F., Ijabadeniyi, O. A., Ibikunle, M. A., Oni, J. O., & Agboola, A. A. (2024). Prevalence and factors associated with contraceptive use among sexually active adolescent girls in 25 sub-Saharan African countries. <i>PLoS ONE</i> , 19(2), e0297411. https://doi.org/10.1371/journal.pone.0297411	Government commitment played a critical role in encouraging contraceptive usage among adolescents. For example, in 2020, the Namibian government released revised National Guidelines for Family Planning. They pledged to invest in adolescents' youth-friendly reproductive health, and thus provided free family planning services at all public health facilities.	
	Plesons, M., Cole, C. B., Hainsworth, G., Avila, R., Biaukula, K. V. E., Husain, S.,	Namibia's 2015 Child Care and Protection Act, which lowered the age of consent for HIV testing and other SRH services from	

Country	Paper	Reported strengths	Reported weaknesses
	<p>Janušonytė, E., Mukherji, A., Nergiz, A. I., Phaladi, G., Ferguson, B. J., Philipose, A., Dick, B., Lane, C., Herat, J., Engel, D. M. C., Beadle, S., Hayes, B., & Chandra-Mouli, V. (2019). Forward, Together: a collaborative path to comprehensive adolescent sexual and reproductive health and rights in our time. <i>Journal of Adolescent Health</i>, 65(6), S51–S62. https://doi.org/10.1016/j.jadohealth.2019.09.009</p>	<p>16 to 14 years, has improved adolescents' access to numerous services</p>	
	<p>UNFPA Namibia. (2022). Evaluation of the United Nations Population Fund (UNFPA) Namibia 6th country programme (2019 – 2023). Retrieved on 20 August 2024 from https://namibia.unfpa.org/sites/default/files/pub-pdf/namibia_6th_cpe_final_report.pdf</p>	<p>There is expansion of contraceptive method mix through the introduction of implants in public facilities.</p>	<p>Even though a substantial number of Namibians access a health facility, it was noted that Eighty-five percent of non-users who had contact with a health facility were not informed about family planning. The main challenges in SRH: insufficient knowledge of youth about sexual reproductive health and related risks including low use of modern contraceptives.</p>
	<p>Muyenga, M., Amakali, K., & Wilkinson, W. (2017). Deliverance of the adolescent friendly health service standards by nurses in Otjozondjupa region of Namibia. <i>Global Journal of Health Science</i>, 9(9), 51. https://doi.org/10.5539/gjhs.v9n10p51</p>		<p>Health facilities were not adolescent friendly as the majority of them had no room or space designated for adolescent related health services, coupled with limited information on adolescent health. Despite the implementation of the national standards for AFHS towards the prevention of teenage pregnancy the problem continues to rise across the regions of Namibia. The average rate of teenage pregnancy in Otjozondjupa region before and after the implementation of the AFHS standards showed no significant difference. The study revealed that although the guidelines for the implementation of AFHS are available at the health care facilities, there is lack of relevant training among a significant number of nurses as providers, and low provision of health education to adolescents at schools.</p>
	<p>United Nations. (2018). Country programme document for Namibia. Retrieved on 22 August 2022 from https://namibia.unfpa.org/sites/default/files</p>		<p>Limited availability of an adequate method mix, including long-acting reversible contraceptives; a poor supply chain infrastructure; the lack of robust social structures to educate adolescents on sexuality; reluctant health service providers; and negative perceptions of contraceptive use,</p>

Country	Paper	Reported strengths	Reported weaknesses
	<p>/pub-pdf/4_NAM - CPD - 2018SRS - FINAL - 5July18 0.pdf</p>		<p>combined with deep-rooted social norms, means that the use of contraception among adolescents remains low. Coordination of information management systems across sectors such as health, education and gender to ensure the production, management, dissemination and use of high-quality and timely disaggregated data on adolescent sexual and reproductive health and rights remains a challenge.</p>
	<p>Shiningayamwe, D. N. E., & Takeuchi, S. (2024b). Exploring actors' collaborations and involvement in the Namibian learner pregnancy policy. <i>Frontiers in Education</i>, 9. https://doi.org/10.3389/educ.2024.1337441</p>		<p>Challenges in recruiting life skills teachers, who are the key implementers of the ESPMLP in a school setting, and they were not trained before being appointed. Schoolteacher claimed being intimidated when executing tasks. Absence of monitoring and follow-up of activities by the Ministry of Education also affects stakeholder involvement. Dependency of NGOs on donor-funded priorities and interests deters collaborations. According to the representative. Absence of implementation guidelines for the ESPMLP to guide actors on detailed activities.</p>
	<p>Ashipala, D. O., & Nuuyoma, T. (2024). Exploring challenges and improvement strategies of adolescent-friendly health services in the northwest region of Namibia: A qualitative descriptive study. <i>African journal of reproductive health</i>, 28(2), 73–82. https://doi.org/10.29063/ajrh2024/v28i2.7</p>		<p>Challenges affecting the delivery of AFHS: Lack of parental support in the provision of AFHS, lack of the resources needed to provide AFHS, lack of availability of family planning options, limited support from the MoHSS and the local authorities for the provision of adolescent-friendly programs, adolescents lacked knowledge about the availability of programmes for adolescents, nurses are said to be unfriendly</p>
Botswana	<p>Gender Links. (2022). Botswana rapid assessment of adolescent sexual and reproductive health (ASRHR). Retrieved on 20 August 2024 from https://genderlinks.org.za/wp-content/uploads/2022/01/Botswana-ASRHR-RA2022-A3-A4fin.pdf</p>	<p>Botswana is making progress in delivering Adolescent Sexual and Reproductive Health Services (ASRHR) services to its youth. Over two thirds (71%) of young people said they received services without their parent's present. The government provides these services free. Youth rate confidentiality and quality of service in Botswana high. What is encouraging is that in Botswana (94% compared to 87% in the region) the youth who sought contraceptives received them.</p>	

Country	Paper	Reported strengths	Reported weaknesses
	<p>Choonara, S., Hwati, R., Tayebwa, M., & Govender, K. (2024). Early and unintended pregnancy in Eastern and Southern Africa: Analysis of adolescent sexual and reproductive health and rights policies. <i>BMJ Global Health</i>, 9(4), e013929. https://doi.org/10.1136/bmjgh-2023-013929</p>		<p>The policy of Botswana recognises unintended pregnancy as an ASRHR problem and sets out an indicator (teenage pregnancy rate) and other related interventions, like family planning and strengthening AYFHS; however, interventions are not costed.</p>
	<p>UNFPA Botswana. (2022). Government of Botswana/UNFPA 7th country programme 2022 - 2026. Retrieved on 22 August 2024 from https://botswana.unfpa.org/sites/default/files/pub-pdf/unfpa_a5_booklet_wednesday_edit.pdf</p>		<p>While access to basic health services is high (97%), coverage for adolescents and youth is low. Only 16 out of 335 public health facilities provide youth-friendly services. Quality of the service does not meet the WHO global standards for YFHS. The facilities do not offer a comprehensive package of services; health care providers are not adequately trained; the opening hours of facilities are inconvenient for young people; and confidentiality is not always guaranteed. Comprehensive sexuality education (CSE) is not integrated in primary and secondary school curricula, and cultural norms hinder open and honest discussion on sexuality issues. The implementation, monitoring and evaluation of these policies are inadequate due to unavailability of timely disaggregated data, inadequate data systems and lacking capacity for analysis and dissemination on SRH and rights. Secondary analysis of data at national and district levels is limited, impeding effective monitoring of the implementation of the International Conference on Population and Development (ICPD) Programme of Action.</p>
	<p>UNFPA Botswana. (2017). Government of Botswana/UNFPA 6th country programme 2017 - 2021. Retrieved on 22 August 2024 from https://genderlinks.org.za/wp-content/uploads/2022/02/ASRHR_Botswana-Country-Programme-UNFPA2017-2021.pdf</p>		<p>Gaps in access to information and services, weaknesses in adolescent responsive health services and limited access to comprehensive sexuality education remain barriers to adolescent sexual and reproductive health. Gaps in the legal and policy environment for promoting universal access to high-quality sexual and reproductive health and reproductive rights (SRHR), gaps in data and evidence to monitor key sexual and reproductive health indicators, limited access to method mix of modern contraceptives arising from persistent stock-outs associated with a weak supply-chain management system, and disruptions in the distribution of</p>

Country	Paper	Reported strengths	Reported weaknesses
			<p>commodities to the 'last mile', impede the country's efforts to ensure access to high-quality and sustainable family-planning services. Sustainable financing for SRHR is insufficient to accelerate progress towards ending the unmet need for family planning. The availability of timely high-quality disaggregated data remains a challenge, with limited statistical analysis capacity at national and subnational levels</p>
	<p>Barchi, F., Apps, H., Ntshebe, O., & Ramaphane, P. (2021). Social and Behavioral Correlates of Adolescent Sexual Experience and Intention to Use Condoms in Northwestern Botswana. <i>International journal of environmental research and public health</i>, 18(11), 5583. https://doi.org/10.3390/ijerph18115583</p>	<p>The government has also begun to establish adolescent-friendly sexual and reproductive health (SRH) services in clinics and health centers.</p>	<p>Resource constraints have limited progress in both of these areas.</p>
	<p>Barchi, F., Ntshebe, O., Apps, H., & Ramaphane, P. (2021). Contraceptive literacy among school-going adolescents in Botswana. <i>International Nursing Review</i>, 69(1), 86–95. https://doi.org/10.1111/inr.12713</p>		<p>Despite the availability of a high-quality comprehensive sexuality education curriculum across all grades, pre- and in-service training for teachers continues to be limited. Although Botswana is a signatory to the 2013 Ministerial Commitments, there has been limited collaboration between the education and health sectors in the delivery of comprehensive sexuality education and health services. Despite a national mandate to improve adolescent SRH education and services, implementation has been slow due to inadequate human and physical resources.</p>
	<p>Henry, D., Wood, S., Moshashane, N., Ramontshonyana, K., Amutah, C., Maleki, P., Howlett, C., Brooks, M. J., Mussa, A., Joel, D., Steenhoff, A. P., Akers, A. Y., & Morroni, C. (2021). Facilitators and barriers to implementation of long-acting reversible contraceptive services for adolescent girls and young women in Gaborone, Botswana. <i>Journal of Pediatric and Adolescent</i></p>		<p>Short-acting methods are more commonly used than LARCs globally. Implants and non-hormonal IUDs are the only types of free LARCs available in Botswana. Hormonal IUDs are available in limited supply in the private sector, but are costly and accessible only to individuals who can afford them. Contraceptive implants were introduced in Botswana in 2016 and IUDs have been available for several years, yet very little data exists estimating LARC use by AGYW.</p>

Country	Paper	Reported strengths	Reported weaknesses
	<p><i>Gynecology</i>, 34(4), 504–513. https://doi.org/10.1016/j.jpap.2021.03.005</p>		
Ghana	<p>Agblevor, E. A., Darko, N. A., Acquah, P. A., Addom, S., Mirzoev, T., & Agyepong, I. A. (2023). "We have nice policies but...": implementation gaps in the Ghana adolescent health service policy and strategy (2016-2020). <i>Frontiers in public health</i>, 11, 1198150. https://doi.org/10.3389/fpubh.2023.1198150</p>	<p>Current political systems and priorities could be described as enablers rather than constraints to adolescent health policy implementation.</p>	<p>The highly religious nature of the country did not always facilitate the delivery of adolescent RH services. There was strong opposition to the implementation of a Comprehensive Sexuality Education (CSE) Programme from religious groups. Ultimately, the policy had to be halted. ASRH policies in Ghana face significant implementation challenges. Financial resources are inadequate and overly reliant on external funding, and there is poor coordination of ASRH with other parts of the health system. Of the 23 planned strategies and programs for implementation, only four (17%) were fully implemented. Even though adolescents under 18 years are to be exempted from user fees, under the NHIS, this was not always the case in practice because of inadequate funding. Inconsistencies and fragmentation in policies and legislation: For example, the age of consent to sex in the Criminal Offences Act 1960 (Act 29) is 16 years. The legal age at which one becomes an adult in the Children's Act 1998 (Act 560) is 18 years. At the primary care level, some health providers were not aware of the various policy and implementation strategy documents for adolescents. Despite the government's commitment to the Abuja Declaration in 2001, the Government's budget allocation for health in 2022 was only 7.6% of the total budget. This was inadequate to the amounts needed to support health programs, including adolescent health.</p>
	<p>Ahinkorah, B. O., Perry, L., Brooks, F., & Kang, M. (2022). Barriers and facilitators regarding the implementation of policies and programmes aimed at reducing adolescent pregnancy in Ghana: an exploratory qualitative study. <i>BMJ Open</i>, 12(7), e060576. https://doi.org/10.1136/bmjopen-2021-060576</p>	<p>The community has become aware of some of these issues through community sensitization and information sharing sessions. Informal parental support networks educate adolescents about teenage pregnancy. The establishment of girls' clubs and youth groups is effective means of enhancing the participation of adolescents in the implementation of policies. These also led to the implementation of youth- focused policies and programs. Government and non- governmental organisations worked with each other and with communities to implement policies and programmes. Such collaboration enhanced judicious use of</p>	<p>Community barriers: Gender inequality is expressed by gender-based violence and male spousal dominance in ASRH decision-making which impacts programme implementation. Family poverty is a major determinant of risky sexual behaviour mediated by lack of financial support for adolescent girls. Gatekeeping adolescents' access to SRH information and services through stigma. Community leaders and parents have inadequate knowledge about SRH issues and resist and/or withhold SRH information and services.</p>

Country	Paper	Reported strengths	Reported weaknesses
		resources and ensured the sustainability and effectiveness of policies. They conduct interviews and literature searches to obtain information to guide policies and programs, which served as benchmarks for identifying regional prevalence of adolescent pregnancy. This helped program implementers in delivering policies and programmes where adolescent pregnancy is more prevalent. Adolescents were able to access and use SRH services, including family planning, and most of the services are accessible, free and provided with high levels of confidentiality.	Inadequate data systems impede the development of innovative programmes and SRH service delivery. Lack of collaboration between stakeholders and poor community engagements results in duplication of programmes and lack of community support for programmes. The government doesn't have budget lines for adolescent health and that can affect organisational capacity.
	Kumah, A., Aidoo, L. A., Amesawu, V. E., Issah, A., & Nutakor, H. S. (2024). Assessment of structural and process factors in delivering quality adolescent sexual and reproductive health services in Ghana. <i>Global Journal on Quality and Safety in Healthcare</i> , 7(1), 1–8. https://doi.org/10.36401/jqsh-23-20	In Oti, Eastern, and Volta regions, all facilities cover contraceptive and FP services for adolescents under the National Health Insurance Scheme (NHIS). Standard guidelines for ASRH are available, and most adolescents can access these services without parental or spouse consent	
	Abdulai, A. (2023). Assessing the availability and utilisation of adolescent reproductive health services in northern region of Ghana. <i>Texila International Journal of Public Health</i> , 11(3), 86–106. https://doi.org/10.21522/tijph.2013.11.03.art008	GHS protocol for adolescents' health service are used in facilities. Measures and strategies adopted by healthcare workers to attract the youth and unmarried adolescents for SRH services include home visits, community durbars to identify youth and adolescent groups for SRH service provision. The adolescents' health corners to attract unmarried adolescents for SRH services as well as ensuring that services are provided on time to avoid long waiting periods or overstaying of adolescents at the clinic to be seen by a closed relation who may criticize them.	
	Ahinkorah, B. O., Kang, M., Perry, L., & Brooks, F. (2023). Knowledge and awareness of policies and programmes to reduce adolescent pregnancy in Ghana: a qualitative study among key stakeholders. <i>Reproductive Health</i> , 20(1).		Several factors might account for the reported low policy awareness and knowledge. First, in most instances, policy development and implementation have been considered distinct and separate stages within policy cycles in Ghana. Not all key stakeholders for the implementation of policies are involved in policy formulation. There is often inadequate policy dissemination among the key stakeholders for policy implementation.

Country	Paper	Reported strengths	Reported weaknesses
	https://doi.org/10.1186/s12978-023-01672-2		
	<p>Otieku, E., Fenny, A., Achala, D., Ataguba, J., & Obse, A. (2023). Understanding the implication cost of priority adolescent sexual and reproductive health interventions in Ghana. Evidence Brief. https://doi.org/10.13140/RG.2.2.19616.15368</p>		<p>Annual expenditures on ASRH interventions indicate that funding to mitigate ASRH problems remains inconsistent, indicating a significant funding gap for ASRH interventions. Funding for most interventions comes from health aid and grants, and external funding sources are equally inadequate and unreliable</p>
	<p>Parmar, D., Berhe, S., Bradley, S., Fenny, A., Aziato, L., & Ceesay, H. (2024). Access to adolescent sexual and reproductive health services in Accra, Ghana: An exploratory qualitative study. <i>Global Public Health</i>, 19(1). https://doi.org/10.1080/17441692.2024.2341420</p>		<p>Although adolescents in schools indicated they had come across SRH in the CSE syllabus, they criticised it for centring abstinence and failing to provide a more holistic education on SRH topics.</p>
	<p>Ziblim, S., Suara, S. B., & Adam, M. (2022). Sexual behaviour and contraceptive uptake among female adolescents (15-19 years): A cross-sectional study in Sagnarigu Municipality, Ghana. <i>Ghana Journal of Geography</i>, 14(1). https://doi.org/10.4314/gjg.v14i1.8</p>		<p>Barriers to contraceptives use: Religious reasons, long distance to acquisition sites of contraceptives, the poor attitude of the contraceptive providers, fear of side effects, lack of knowledge, cultural and traditional beliefs.</p>
	<p>Abuosi, A. A., & Anaba, E. A. (2019). Barriers on access to and use of adolescent health services in Ghana. <i>Journal of Health Research</i>, 33(3), 197–207. https://doi.org/10.1108/jhr-10-2018-0119</p>		<p>Facility-level barrier: inadequate physical space and privacy, insufficient resources like medicines, Inconvenient operating hours, long patient waiting time. Community level barrier: Lack of parental support, Negative perceptions on adolescents who accessed health care from the ACs. Provider-level barriers: Disrespect for adolescents, Discrimination, judgemental attitudes from healthcare providers. Personal-level barriers: Fear, Lack of information, financial challenges</p>

Country	Paper	Reported strengths	Reported weaknesses
Sierra Leone	UNICEF Sierra Leone. (2024). Situation analysis of children and adolescents in Sierra Leone. Retrieved on 01 September 2024 from https://www.unicef.org/sierraleone/media/2351/file/UNICEF%20Sierra%20Leone%20SitAn%20Main%20Report.pdf.pdf	The government has increased its investment in the health sector, with health expenditure increasing from 7.8% of GDP in 2015 to 11% in 2020.	high level of out-of-pocket spending by households, which accounts for 64.6 per cent of health financing, followed by donor partners (30.6 per cent), the government (4 per cent) and corporations (0.8 per cent). This creates significant financial barriers to accessing health care, particularly for low-income households with children and adolescents. Sierra Leone's health system is still facing significant challenges, including a shortage of skilled health workers, inadequate and vertical funding, shortage of medicines, limited community engagement (from planning to implementation) and weak health information systems. These challenges make it difficult to provide high-quality health services to the population, particularly in rural areas. One of the biggest obstacles to Sierra Leone faces significant challenges in terms of human resources.
	McLean, K. E. (2022). Contemplating abortion: A qualitative study of men and women's reactions to unplanned pregnancy in Sierra Leone. <i>Culture Health & Sexuality</i> , 25(4), 444–458. https://doi.org/10.1080/13691058.2022.2052186	In 2010, as part of its post-conflict development agenda, the Government of Sierra Leone implemented the Free Health Care Initiative (FHCI) for pregnant women, lactating mothers and children under five years of age. Part of the FHCI emphasised access to quality family planning services, and as a result of this, the availability and use of contraceptives increased.	
	November, L., & Sandall, J. (2018). 'Just because she's young, it doesn't mean she has to die': exploring the contributing factors to high maternal mortality in adolescents in Eastern Freetown; a qualitative study. <i>Reproductive Health</i> , 15(1). https://doi.org/10.1186/s12978-018-0475-x	There is work in progress to train health workers in family planning methods, including implants, and to make government clinics adolescent-friendly by allocating trained staff to treat teenagers, with, in some clinics, a separate room to accommodate them. In the aftermath of the EVD epidemic, the national strategy was revised and updated.	In Freetown and the provinces, are well stocked with contraceptives, but this is not always the case in the more remote rural areas. Despite availability, ongoing stigma is the major reason why girls do not access family planning. Though implants have increased in popularity, with younger girls there is a concern about being 'found out' due to the visibility of the implant. There was also evidence of myths around contraceptive use. Progress in addressing the issue of teenage conception was stalled by the EVD outbreak, and during this time a combination of closed schools and increased poverty is thought to have led to a significant increase in the numbers of teenage pregnancies.
	UNFPA Sierra Leone. (2018). Report on the assessment of adolescent and young people friendly health services Sierra Leone. Retrieved on 01 September 2024 from	All facilities had counselling rooms, either general and/or family planning, that provided privacy and confidentiality. The in-charge officers expressed commitment to implementing the AYFHS standards..	Community acceptance regarding SRH education to adolescents and young people varied. Religious beliefs and local traditions had a direct impact on the likelihood of SRH education being accepted within the community. Several clinics reported that contraceptive implants were

Country	Paper	Reported strengths	Reported weaknesses
	<p>https://sierraleone.unfpa.org/sites/default/files/pub-pdf/AYFHS_Final_%20sept%2024.pdf</p>	<p>Most facilities had family planning posters. Each facility had a general register of data regarding service uptake by all clients including young people. The registers in were up-to-date. The data is being submitted to the DHMT.</p> <p>In almost all health facilities, family planning was the most common of the services provided to 10-24-year old.</p> <p>Approximately half the communities had active health forums, in which discussions of the SRH needs of adolescents and young people took place. These groups participated in sensitizing the community regarding the need for SRH education.</p> <p>The majority of facilities had arrangements with school officials to provide SRH and education. All facilities provided free services to adolescents and young people, including family planning.</p>	<p>being removed when young people returned home, and at times the girls were abused as a result.</p> <p>Due to the Ebola outbreak, attention was and resources were diverted from the adolescent health programme to the management of the epidemic.</p> <p>For family planning, five facilities had the full range of methods available.</p>
	<p>APHRC. (n.d.). Policy brief : Sierra Leone. A case for a Safe Motherhood & Reproductive Health (SMRH) Law in Sierra Leone. Retrieved on 01 September 2024 from https://aphrc.org/wp-content/uploads/2023/02/Policy-Brief-Sierra-Leone-final-.pdf</p>		<p>The quality of healthcare services in Sierra Leone has been a significant problem over the last decade. In addition, there is limited access to sexual and reproductive health information and services, partly due to the 11 years of civil war followed by the Ebola outbreak in 2014. Further, there is an acute shortage of trained medical personnel to provide the needed healthcare services.</p>
	<p>UNFPA WCARO. (n.d.). Review of adolescent and youth policies, strategies, and laws in selected countries in West Africa. Retrieved on 01 September 2024 from https://wcaro.unfpa.org/sites/default/files/pub-pdf/UNFPA_WAfrica_Youth_ENG_20170726%20%281%29_0.pdf</p>		<p>The Ebola Virus Disease (EVD) adversely impacted service provision on education, Sexual Reproductive Health (SRH) to adolescents in Sierra Leone. Schools were closed nationwide between July 2014 and April 2015. The lack of access to formal schooling and Adolescent Sexual Reproductive Health (ASRH) services amidst persistent sexual and gender-based violence situations contributed to increased teenage pregnancy especially among adolescent girls.</p> <p>In Sierra Leone, the age of consent for accessing family planning and contraception services is unclear and there is no policy that explicitly guarantees adolescents full access to these services.</p> <p>Sierra Leone (where 18 years is the age of sexual consent) has situations where adolescents below the age of 18 years are reluctant to access services, or are denied services by healthcare providers due to this law.</p>

Country	Paper	Reported strengths	Reported weaknesses
	Nuwabaine, L., Sserwanja, Q., Kamara, K., & Musaba, M. W. (2023). Prevalence and factors associated with teenage pregnancy in Sierra Leone: evidence from a nationally representative Demographic and Health Survey of 2019. BMC Public Health, 23(1). https://doi.org/10.1186/s12889-023-15436-x		The trends to the country's post-conflict context, in which teenage girls face profound structural exclusion, discrimination and poverty, as well as traditional norms related to gender (as cited from

Table C2: Quality and availability of ASRH data in SSA region

Data Quality in SSA	(United Nations Statistics Division, n.d.)	(Shinde et al., 2023)	(Ajayi et al., 2021)
	For SDG 3.7.1 indicator, data comparability may be affected by variations in survey designs, implementation methods, and questionnaire. Additionally, differences in how "currently using" a contraception can impact the time frame used to assess contraceptive prevalence. For SDG 3.7.2 indicator, the accuracy of the rates from civil registration depends on the completeness of birth registration and the quality of reported information.	There is a significant gap in ASRH research in SSA, with only 1,302 articles published between 2010 and 2019. These studies primarily focused on HIV and access to SRH services, with fewer addressing policy evaluations.	ASRH studies in SSA are concentrated in a few countries; six countries dominate the research, while ten countries have no publications, and five have only one. Eastern Africa leads, followed by Southern Africa, with research mainly addressing HIV, sexual behaviors, access to SRH services, Sexual and Gender-Based Violence, followed by adolescent pregnancy and child marriage. Few studies focus on AYFHS. In Eastern Africa, research is concentrated in Kenya, Tanzania, and Uganda, while Southern Africa's focus is on South Africa. In West and Central Africa, most papers focus on Ghana and Nigeria. ASRH research in SSA peaked in 2015, reflecting increased international and regional focus on ASRH. This rise in research was part of the effort to achieve or assess progress towards the Millennium Development Goal 5.

APPENDIX D Matrix for Research Objective 4

	Facilitators		Challenges	Barriers
Countries	Shared	Unique	Shared	
Kenya, Namibia, and Ghana	<p>1. Conducive policy and legal environment enhanced the implementation of the ASRH policies.</p> <p>2. Commitment to FP, reflected in free FP services, specific FP budget line in Kenya, expansion of methods in Namibia, NHIS coverage in Ghana.</p> <p>3. Effective stakeholder coordination, particularly at the national level, has played a key role in experience and knowledge sharing.</p> <p>4. The range of ASRH service delivery points in Kenya and Ghana have enhanced the involvement of adolescents and young people, ensuring effective policy implementation.</p>	<p>1. In Ghana, sensitizing the community about ASRH issues which helped strengthen policy implementation.</p> <p>2. Kenya's ASRH policy is considered the strongest in the ESA due to its consultative formulation processes, and having an implementation</p> <p>3. The health sector devolution in Kenya allowed counties to develop their own policy implementation strategies.</p>	<p>1. At the subnational level, coordination among implementers is poor, exacerbated by inadequate policy dissemination of ASRH policies that are developed at the national level.</p> <p>2. None of the countries have a dedicated budget line for AYFHS, leading to heavy reliance on donor funding.</p> <p>3. Inconsistency between laws and ASRH policies regarding age of consent and age to be adult.</p> <p>4. Most of the health facilities are not adolescent-friendly and do not have space to provide adolescent-related health services.</p> <p>5. cultural and religious opposition in Ghana and Kenya regarding the CSE.</p>	<p>Barriers at individual, community, health facility, and policy levels. Examples include lack of knowledge of service availability, provider attitudes, being unmarried, lack of parental support, informal fees, shortage of medicine, long distances to health facilities, social stigma, misconceptions about contraceptives, and lack of resource allocation.</p>
Malawi, Botswana, and Sierra Leone	<p>1. Conducive policy environment for ASRH.</p> <p>2. FP services are provided free of charge.</p> <p>3. Expansion in contraceptive options available for adolescents, such as the introduction of injectables in Malawi and implants Botswana</p> <p>4. High rates of privacy and confidentiality in Sierra Leone and Botswana.</p>	<p>1. In Botswana, adolescent girls receive services without parental consent.</p> <p>2. In Sierra Leone, all the facilities are committed to implement AYFHS standards.</p> <p>3. Community sensitization in Sierra Leone led to increased awareness on ASRH issues.</p> <p>4. Good coordination between health and education sectors in Sierra Leone.</p>	<p>1. Limited collaboration between health and education sectors in ASRH implementation of in Malawi and Botswana.</p> <p>2. Stakeholder involvement is only at national level, due to lack of resources.</p> <p>3. Inadequate funding for meeting unmet needs for FP and establishing AYFHS.</p> <p>4. Heavy reliance on donor funding.</p> <p>5. Inconsistency between laws and policies regarding ASRH.</p> <p>6. Cultural and religious opposition to CSE implementation in Botswana and Malawi.</p> <p>7. Weak health information systems in Botswana and Sierra Leone.</p>	<p>1. Low coverage of ASRH services, including FP, and few healthcare facilities providing a broad range of contraceptives.</p> <p>2. Healthcare providers are not adequately trained to insert long-acting contraceptive methods.</p> <p>3. In Malawi and Sierra Leone, there is a significant shortage of healthcare providers in facilities, affecting adolescent access to services.</p> <p>4. Barriers to accessing ASRH services include being unmarried, stigma, lack of knowledge of AYFHS availability, misconceptions about contraceptives, negative attitudes of healthcare</p>

				providers, and community acceptance to contraceptives.
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BIOGRAPHY

Name	Eman Nouraldein Mohammed Alkhidir
Educational Attainment	Bachelor in Pharmacy (Honors) Postgraduate Diploma in Health Economics
Work Position	SRH Coordinator – Federal Ministry of Health, Sudan
Scholarship (If any)	Thammasat International Student Recruitment (TISR) SRH Coordinator - Federal Ministry of Health, Sudan.
Work Experiences	Focal Point for Family Planning - Federal Ministry of Health, Sudan. Reproductive Health Supply Chain Officer - Federal Ministry of Health.