Helpdesk Research Report: Political commitments to improve adolescent sexual and reproductive health

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Query: Please provide examples of the types of political commitments at national/federal state level needed to help improve adolescent girls' sexual and reproductive health outcomes in developing countries (outcomes include: delaying first sexual activity, marriage and first pregnancy; improving access to family planning/dual protection and maternal health care; and reducing the prevalence of STIs (including HIV), FGM/C, and maternal mortality). What factors (domestic and international) have contributed to building this commitment? What (if any) has been the role of donors and other international actors in supporting this?

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1. Overview

The 1994 International Conference on Population and Development (ICPD) in Cairo recognised reproductive rights as fundamental human rights and put universal access to safe, affordable, and effective reproductive health care on the international agenda. Although some progress has been made, adolescents continue to be disproportionately burdened by threats to their sexual and reproductive health (Bearinger et al 2007). Negative outcomes of early pregnancy and sexually transmitted infections (STIs), including HIV/AIDS, threaten the health of people in the second decade of life more than any other age group (Bearinger et al 2007).

In light of this it is critical to understand the factors that contribute to improving adolescent sexual and reproductive health (ASRH) outcomes. These factors include improving access to clinical

services, sex education programmes, youth development, and the promotion of protective factors. Attention must also be paid to the social contexts of interventions, to understand how and why approaches work (Bearinger et al 2007). Reichenbach (2002) further argues that politics heavily influences the priority setting process for reproductive health. Local politics can trump scientific and economic evidence and the priority setting process can have unforeseen equity and social implications. Therefore, political will and corresponding national policies are key (WHO n.d.).

However, the mechanisms for securing political commitment towards sexual and reproductive health are rarely examined in detail. There is little information about the nature of commitments that specifically address ASRH (the focus is more generally on women). Studies that look at political will tend to consider the primary health sector more generally.

This paper provides examples of political commitments that have contributed to some countries making progress in (adolescent) sexual and reproductive health. Political commitments occur at various levels – within the national government and health ministries, at state or federal levels, and, increasingly, at decentralised district and local levels. In many developing countries, traditional leadership is also important. It must be noted, however, that while political commitments have been made in many areas (for instance enacting laws that make child marriage illegal and funding awareness programmes), there is little documented evidence of their effects. Nevertheless there is some evidence of commitments that have resulted in positive outcomes. These include:

- **Scaling up pilot projects**: where governments endorse demonstration projects and roll them out as part of a national policy.
- **Changing legislation**: laws criminalising practices that are considered harmful, such as early marriage and female genital mutilation/circumcision (FGM/C).
- **Commitment to global initiatives**: demonstrating adherence to international strategies through adopting international conventions, participation in international dialogue and implementing appropriate policies. This can include responding to global directives, such as the Millennium Development Goal (MDG) on maternal health.
- **Integrating youth friendly services into public health policy**: a government may show commitment by incorporating ASRH aspects into broader national concerns, such as stopping the spread of HIV/AIDS.

The paper also summarises the factors that have been involved in influencing each type of commitment, both domestically and by the international community, and presents an overview of various efforts currently being undertaken to influence change.

The ability of domestic actors to influence political commitment rests on a number of factors, including:

- the degree of cohesion among advocates and their ability to build consensus
- the presence of respected political champions
- providing evidence of the scale of the problem and its importance relative to competing priorities
- demonstrating clear, affordable policy options

- taking advantage of international partnerships, trends and resources.

Donors and other international actors have played a role in:

- establishing international norms and frameworks
- providing funding both for programmes and for advocacy
- providing technical expertise
- partnering with domestic actors for change.

Additionally, for both groups, it is important to be able to demonstrate clearly not only what works, but also what is affordable, both politically and financially.

2. Scaling up pilot projects

In this context, scaling up is defined as efforts to increase the impact of innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and programme development on a lasting basis (Simmons et al 2007). Simmons et al (2007: vii) note that 'while spontaneous diffusion of service innovations can occur, scaling up typically requires active sponsorship and concerted efforts from multiple stakeholders'. Scaling up from a pilot project into a regional/national programme is therefore a strategic choice that demonstrates political commitment to a particular approach.

Tanzania

Renju et al (2010) research factors that influenced local government uptake and implementation of small-scale adolescent sexual reproductive health programmes in Tanzania. The *MEMA Kwa Vijana* (MkV, 'Good things for young people'), was a multi-component ASRH intervention, comprising teacher-led peer-assisted ASRH education, youth-friendly services and community services. Their evaluation documents how a partnership between an international NGO (AMREF) and local government authorities (LGAs) in four districts in Tanzania influenced the LGA-led scale-up of an NGO programme in the wider context of a new national multi-sectoral AIDS strategy.

Although there was no impact on biomedical outcomes, the intervention (implemented in 62 schools and 18 health facilities in phase 1, 1996-2001) showed substantial and sustained improvement in knowledge, reported attitudes and some reported sexual behaviours in the medium term (3 years), and retained improved knowledge in the long term (8 years). In phase 2 (2004-2008) MkV2 was scaled up to all 649 primary schools and 177 health facilities in the four districts.

Factors that contributed to successful uptake included the integration of the programme into local government mechanisms, and the substantial period of time given for district systems to try out implementation with only minimal NGO support and modest output targets. Other factors included:

- **A good relationship between implementing agencies and government:** AMREF had a longstanding working relationship (over 10 years) with each of the four project districts.

- **Working in [a formalised] partnership:** The intervention was designed in partnership with local and national government agencies specifically to be scaled up through government systems and was implemented with the support of the districts. Furthermore, the memorandum of understanding, signed by all districts, constituted a formal 'political' or 'legal' integration of the intervention.
- **Taking advantage of opportunities:** Policy windows should ideally enhance scale-up by underpinning psychological and operational integration. The content and timing of the first National Multisectoral Framework (the overarching strategy for HIV response at local government level) provided an 'ideal' policy within which to nest the MkV2 scale-up.

This project successfully achieved a ten-fold increase in intervention scale over four years and maintained good standards of implementation through district systems. However, while NGO assistance at local government level was successful in supporting operational scale-up, full integration was hampered by high rates of senior staff turnover, persistent strategic and financial control by the NGO, and limited understanding and acceptance of the overarching policy framework at LGA level. In addition, full financial integration of scale-up activities into LGA plans was not achieved.

The researchers therefore recommend a bottom-up approach to development, which is important to ensure interventions are context specific. Further, when a system is not completely decentralised, as is the case in Tanzania, programmes need to work both from the bottom up and the top down in order to build capacity within the system and bridge the disconnect between policy formulation and its implementation. The researchers also advocate that projects seeking to scale up must go beyond the typical three- to four-year project cycles; NGOs should be flexible enough to adapt to local government planning cycles; and evaluation should be ongoing, to ensure that strategies achieve full intervention integration.

Ghana

In Ghana, when a Navrongo Health Research Centre (NHRC) experiment demonstrated that community-based health services could reduce child mortality and fertility in impoverished communities, the Government of Ghana launched the Community-based Health Planning and Services (CHPS) Initiative to scale up results. Navrongo presented an approach to evidence-based policy development, which aimed to bridge the gap between research and programme implementation (Nyonator et al 2005a). The CHPS Initiative scaled up innovations from NNHRC's experimental study into a programme of national community health care reform that sought to improve the accessibility, efficiency and quality of health and family planning care. Over a two-year period, 104 out of the 110 districts in Ghana started CHPS (Nyonator et al 2005b). Regarded as the primary strategy for reaching the unreached, CHPS became an integral part of the Ghana Health Service Five Year Programme of Work and represented one of the health sector components of the national poverty reduction strategy (Nyonator et al 2005a).

Factors contributing to building commitment

- **Designing programmes with policy needs in mind:** The Navrongo CHFP was designed to correspond with issues central to Ghana's health policy debate in the early 1990s. Among them was the issue of Community Health Nurses (CHNs). Although these

nurses had been hired to improve service accessibility, programme coverage was constrained by logistics problems, supervisory lapses and resource shortages, confining most CHNs to the government's sub-district health centres. The Navrongo experiment tested means of re-engineering the CHN programme by retraining, renaming and recertifying CHNs as Community Health Officers (CHOs) to serve as community resident health care providers. The experiment successfully tested the hypothesis that relocating nurse to communities, and reorienting management systems to support accessible community, would reduce mortality and fertility.

- **Demonstrating clearly what works and sharing findings:** In response to preliminary evidence from Navrongo, the Ministry of Health (MoH) convened a national managers' conference in 1998 to deliberate on the implications of the experiment's model for national action. The project was extended to a second site, Nkwanta District, as a CHPS pilot programme, implemented by the Nkwanta District Health Administration (DHA). Its success was encouraging, and the results were disseminated at a 1999 MoH National Health Forum, which also discussed policies for sustaining CHPS. The various findings generated official interest in replicating the most successful aspects of the pilot in all districts of Ghana.
- **Consensus building** The national health policy conferences were attended by all District Directors of Medical Services. They were designed to foster discussion and debate on the practical implications, and to present evidence from Nkwanta District that replication of Navrongo was possible. Senior political leaders and health officials were involved in these conferences to legitimise CHPS and lead the consensus-building process.
- **Ownership:** The CHPS is a collaborative effort between the Ghana Health Service, the Population Council, EngenderHealth, the American College of Nurse/Midwives (ACNM) and the Centre for Development of People (CEDEP). Often, changes perceived as being brought in from the outside are more problematic to introduce. With CHPS, however, joint research-policymaker ownership of research results was developed from the onset, so that results and change procedures would be a natural outcome of the investigation.
- **Change agents**: Change agents are often experts who are brought to the organisation to facilitate change. However CHPS change agents were internal – the leaders of the Navrongo Project, the former Deputy Minister for Health, the Nkwanta DHA, and various Regional Health Administration teams. External agencies and individuals have nonetheless played a role as change agents, particularly when their technical assistance has been combined with the provision of resources for financing the proposed changes.
- **Credibility and feasibility:** Small-scale operations enable scientists to focus on a manageable operational change agenda, and clarify exactly what is required to undertake change. For the results of the Navrongo project to be credible, the changes suggested by research had to be within reason to the MoH. CHPS demonstrated that it represented a promising improvement over existing operations, and that its costs and operational changes were feasible to achieve.
- **Systemic intervention:** In the CHPS programme all levels of the bureaucracy were involved in the change process. Although initial attention was focused on building high-level support for CHPS and district action, no clear role was developed for the Regional Health Management Teams. This oversight hampered progress until it was corrected by involving regional leadership in key decisions, and building consensus among Regional

Directors of Health Services that CHPS was a key component of their regional plans of action (Nyonator et al 2005a; 2005b).

The monograph, 'Scaling Up Health Service Delivery: From pilot innovations to policies and programmes' (Simmons, Shiffman and Ghiron 2007) provides further examples of scaling up reproductive health services in different countries, including Brazil, China, Bangladesh and Viet Nam.

3. Changing legislation and policies

Laws on early marriage

Sri Lanka

In Sri Lanka, the average marriage age is now 25 years. This country's success in raising marriage age has been driven by **the introduction of legislative reforms** requiring that all marriages be registered and that the consent of both marriage partners be recorded. Moreover, Sri Lankan courts have ruled that specific cases of non-consensual marriages arranged by parents on behalf of their children are invalid. Underpinning these broad initiatives, which apply to Sri Lankan citizens of any religion, is a legal argument that **Islamic law** recognises the importance of consent to marriage. There are texts in Islamic law that indicate that parental authority in relation to the marriage of a daughter does not permit complete disregard of the child's welfare, and that accept the requirement of obtaining a child's consent to marriage.

Factors contributing to this outcome include **the advocacy of women's groups** in Sri Lanka, who fought a long but successful battle to raise the legal age of marriage to 16 (ESCAP 2007). The positive impact of these legislative changes has been supported by **social policies on health and education** (including free education from primary to university level). The high priority given to education for women as well as men has changed the way men and women perceive their roles and potential, and has led to greater support for the rights of women than is found in many other parts of South Asia. The combination of legislation and social policy has created an environment in which the practice of early marriage is in steep decline (UNICEF 2001). Similar outcomes have been achieved in the Indian state of Kerela

India

One of the most notable initiatives taken by India towards protecting girl children has been the establishment of a National Commission for Protection of Child Rights in 2006 for proper enforcement of the **2006 Prohibition of Child Marriage Act**, and effective implementation of laws and programs relating to children. This Act came into effect in January 2007. The States have been given the freedom to formulate their own rules for this legislation so that they can cater the law to meet the particular needs of girls and women in their constituency (Silva-de-Alwis 2008). The 2006 Law replaced the Child Marriage Restraint Act of 1929

According to Silva-de-Alwis (2008), the catalyst for the introduction of the Bill in December 2006 was a public interest case filed in April 2003, by a human rights NGO, the Forum for Fact finding Documentation and Advocacy (FFDA), which sought strict implementation of the 1929 Child

Marriage Restraint Act. According to the petition, 'more than half of the girls in the State of Chattishgarh are married by the age of 16 which reflect (sic) the gross neglect and callous attitude of government, local administration and officials responsible for abetting child marriage'. The petition cited several international conventions, including the Convention on the Rights of the Child (CRC). The petition stated that that by being a party to this treaty, India had committed herself to protecting and ensuring child rights and has agreed to hold her Government accountable for this commitment before the international community. The FFDA requested that the Court issue a writ directing the respondent states to: require police officials to prevent child marriage from taking place; hold government officials who fail to prevent child marriage liable; ensure that the 1929 Child Marriage Restraint Act is implemented; and to engage NGOs in reporting on the implementation of court directives.

In February 2005, the Court issued an interim order that it would refrain from ruling, noting the pending passage of the Prevention of Child Marriage Bill which by then had been introduced in parliament. In December 2006, the Indian upper house of parliament approved a bill outlawing child marriages and voiding those that have taken place. The Bill provides provision for the establishment of child marriage prevention officers by State Governments and maintenance of the minor girl until her remarriage. In the case of the husband being a minor at the time of marriage, the guardian must be called upon to pay maintenance to the minor; and that every child marriage, whether solemnised before or after the Act came into force, could be declared void at the option of the contracting party.

A recent study on delaying marriage for girls in India finds that deeply entrenched norms are slowly changing through promising interventions to delay marriage and encourage girls' education in Rajasthan and Bihar, which have some of the highest prevalence rates of early marriage in the country. **Changing social norms**, **positive role models**, **community engagement** and **government-led efforts** have all been mobilised in efforts reduce early marriage (Nanda et al 2011). Although the study does not draw direct causality between legislation and this change – in fact, lack of awareness of the 2006 Prohibition of Child Marriage Act is cited as a factor undermining its potential – it confirms that legislation provides a necessary operational framework.

Laws of Female Genital Cutting/Mutilation (FGM/C)

In 2010, Parliamentarians from all over Africa met in Dakar between the 3rd and 4th of 4 May, 2010 to push for a continent-wide ban on FGM/C and called on the UN to pass a General Assembly resolution appealing for a global FGM ban. Members of parliament from African nations also exchanged lessons learned and actions to take to achieve the ban and resolution. 17 African states have enacted legislation banning FGM/C. Among them are Burkina Faso, Togo, Senegal and Uganda (Karmaker et al).

This international display of political will from African nations is notable in a context where the subject of FGM/C is often taboo and increasingly charged. Policymakers, NGOs, UN agencies, researchers and activists have mounted a sustained campaign through research, public policy work, and work within communities. NGOs, in both developed and developing countries have been instrumental in creating public awareness of the circumstances, effects and future strategies to put an end to FGM/C. Developed country governments are increasingly providing resources to

programmes that aim to stop the practice. International monitoring bodies have been set up, and resolutions passed condemning the practice. National legal frameworks are being revised and efforts are being made to change and adapt social norms in practicing communities, and among practitioners, for instance by providing alternative livelihoods. Rresearch shows that, if practising communities themselves decide to abandon FGM/C, the practice can be eliminated very rapidly (WHO n.d.). Efforts have also been made to link FGM/C with detrimental health outcomes for girls and women. Slowly, these efforts appear to be making a difference.

The proposed UN Resolution was spearheaded by Burkina Faso, which, in June 2011, tabled a draft decision at the African Union 16th Summit of Heads of State, calling on African states to support the UN resolution. Although FGM/C prevalence remains high in Burkina Faso, a 2006 study showed that it had declined to 59 percent (from 77 percent reported in 2003) among women aged 15-49. The prevalence among girls under 10 was 50 percent lower than among older women (Population Council 2008). The study identified political will as a major factor influencing FGM/C decline: the government of Burkina Faso has endorsed the abandonment of FGM/C since the 1983 revolution that brought it to power, and continues to advocate strongly against the practice. Creation of the National Committee Against the Practice of FGM/C (CNLPE) in 1990 and of its permanent, government-funded secretariat in 1997, as well as the adoption of a 1996 law banning the practice, have been key factors driving the decline in the practice. Further, Burkina Faso's First Lady is committed to the campaign to eradicate FGM/C and is the coordinator of the NGO Coalition for the worldwide ban on FGM (Gamcotrap 2011).

Abolishing user fees

Abolishing user fees for health services is often a strong indicator of political commitment. 189 countries pledged to move away from their use at the 2005 World Health Assembly, and in the same year the G8 agreed to assist countries that wanted to stop imposing charges. In 2009 the international community pledged US$5.3 billion in new financing measures for maternal and child health. Six countries – Sierra Leone, Liberia, Nepal, Malawi, Burundi and Ghana – committed to abolish user fees for these groups with support from the international community (HealthPovertyAction 2010). Although it is too early to evaluate the effect of this on improving SRH, evidence from other countries shows that the removal of public health service fees results in increased demand and maternal health outcomes. Important factors that influenced countries' ability to undertake this political commitment include:

- a widespread (international) **change in attitudes** towards user fees (including by the World Bank, which once encouraged countries to introduce fees), based on the **evidence** that they present a barrier to access, are inequitable, and are ineffective in generating income (HealthPovertyAction 2010).
- sustained **advocacy** from international NGOs and the UN at international forums, such G8 meetings (Doctors of the World 2008)
- advocacy at the national level, including **coalition building** among international NGOs, mobilising communities and encouraging debate within the Ministry of Health (Save the Children n.d.)
- international commitment to **funding the resulting financing gap** in meeting health services (for instance, in 2009, then UK Prime Minister Gordon Brown wrote to some of the poorest countries who still impose user fees, offering UK support, both in aid and

technical assistance, to those who wished to abolish the fees) (HealthPoverty Action 2010).

4. Commitment to global initiatives

While ASRH has not yet gained global momentum, efforts to improve outcomes are often nested in two global initiatives: The 1994 ICPD Programme for Action on Reproductive Health, and the MDG on reducing maternal mortality.

Reproductive Health

The Cairo Conference on Population and Development recognised reproductive rights as fundamental human rights and put universal access to safe, affordable, and effective reproductive health care on the international agenda for the two following decades. During the decade after the conference, many countries on several continents – e.g. Bangladesh, Botswana, Brazil, India, Jordan, Malawi, Mexico, Nepal, Nigeria, Senegal, and Uganda – have moved forward with national policies focused on various aspects of adolescents' reproductive health (Bearinger 2007)

Reducing maternal mortality (MDG 5)

Shiffman (2007) conducted case studies on the level of political priority given to maternal mortality reduction in five countries: Guatemala, Honduras, India, Indonesia, and Nigeria. In this context, political priority was defined as: (1) national political leaders publicly and privately express sustained concern for the issue; (2) the government, through an authoritative decision-making process, enacts policies that offer widely embraced strategies to address the problem; and (3) the government allocates and releases public budgets commensurate with the problem's gravity.

The five countries varied considerably in the degree to which the cause of maternal mortality reduction had received political priority. In Honduras, political priority was very high; in Indonesia, high; in India, moderate (with a recent rise); and in Guatemala and Nigeria, low.

In Honduras, safe motherhood became one of the country's foremost health priorities, and between 1990 and 1997, the country experienced a 40 percent decline in its maternal mortality ratio, one of the most significant reductions in such a short time span ever documented in the developing world. In Indonesia, priority for safe motherhood rose from near obscurity to national prominence over the period 1988 to 1997 and received the direct attention of President Suharto, although after his fall from political power it declined. Nominally on the policy agenda in India since independence, maternal mortality reduction took a backseat to other health causes for several decades, but in 2005, it rose to receive meaningful national political attention. Until 2000, the cause received no significant attention in Guatemala and Nigeria, and it remains a neglected issue.

Domestically, Shiffman (2007) found that safe motherhood policy communities formed in each of the countries, consisting of Ministries of Health doctors, parliamentarians, obstetrician-gynaecologists, health-focused nationals employed by donor agencies, and other individuals and groups. All held moral authority by virtue of their commitment to a humanitarian cause: reduction

of maternal death levels. Because the group was largely composed of medical experts, they also held knowledge-based authority, and policymakers deferred to them on technical issues about safe motherhood. The communities differed, however, in degree of coherence. Some coalesced into tight networks, transforming their moral and knowledge-based authority into political influence and pushing their governments to act. Others struggled to come together and therefore had limited agenda-setting influence.

Overall, Shiffman (2007) identified nine factors that shaped the degree to which maternal mortality reduction emerged on the national policy agendas of these five countries. These can be divided into 3 categories:

- Transnational influences
    - efforts by international agencies to establish a **global norm** concerning the unacceptability of maternal death
    - the offer of **financial and technical resources** by international agencies to address maternal mortality
- Domestic advocacy
    - **policy community cohesion:** the degree to which national safe motherhood promoters coalesced as a political force pushing the government to act
    - **political entrepreneurship:** the presence of respected and capable national political champions willing to promote the cause
    - **credible indicators:** the availability and strategic deployment of evidence to demonstrate the presence of a maternal mortality problem
    - **focusing events:** the organisation of forums to generate national attention for the cause
    - **clear policy alternatives:** the availability of clear policy alternatives to demonstrate to political leaders that the problem is surmountable
- the national political environment
    - **political transitions:** political changes, such as democratisation, that positively or adversely affect prospects for safe motherhood promotion
    - **competing health priorities**: priority for other health causes that divert policymaker attention away from maternal mortality reduction.

In Honduras and Indonesia, maternal mortality was a high political priority. Reasons for this in Honduras included an ‘unusually cooperative relationship that developed between international donors and national health officials, resulting in effective transfer of policy and institutionalization of the cause within the domestic political system’ (Shiffman, Stanton and Salazar 2004: 3).

In Indonesia, four factors were important for raising the issue to national-level attention:

- **Prominent focusing events**, including Indonesian representatives’ attendance at the 1987 International Safe Motherhood Conference in Nairobi, followed by a national symposium the following year and subsequent national safe motherhood seminars.
- **Capable political entrepreneurs**, including the Assistant Minister for Women's Roles Abdullah Cholil, a public servant with a long-standing record in political mobilisation for

public health causes, who was directly responsible for giving the issue national visibility and bringing the maternal mortality problem to the attention of President Suharto.

- **The existence of clear indicators:** the high maternal mortality ratio in the country as of the late 1980s provided an initial spur for action. The persistence of a high maternal mortality ratio in the late 1980s and revealed in a 1994 demographic survey sparked additional concern, directly motivating Cholil to act.
- Indonesian bureaucrats developed **feasible policy proposals** to address the problem. This included the village midwife programme (funded by the World Bank), an initiative that senior policymakers could easily grasp and buy into, and which was not excessively costly (Shiffman 2003).

5. Integrating youth friendly services into public health

Because of the stigma attached to adolescent sexuality, there have been pockets of opposition to youth access to SRH information and services due to fear of promoting promiscuity among the age group. For that reason, there have been few efforts by policymakers, government leaders, and SRH service providers to promote provision of youth-friendly SRH services(Pathfinder International 2005). Yet some governments have demonstrated their political commitments by supporting services that integrate youth-friendly services with public and sexual health services.

Incorporating youth friendly services and public health in Tanzania and Uganda

The African Youth Alliance (AYA) was an initiative implemented in Botswana, Ghana, Tanzania and Uganda, which aimed to integrate youth-friendly services (YFS) into public health facilities, and countered the view that such services could only be provided by NGOs rather than through the public health delivery system (Pathfinder International 2005). The five year project (2000-2005) was supported by the Bill and Melinda Gates Foundation and executed by the United Nations Population Fund (UNFPA), Pathfinder International, and the Program for Appropriate Technology in Health (PATH). The government of Tanzania was an AYA key collaborator and host, especially the President's Office - Planning and Privatisation, and the Ministries of Health, Mainland and Zanzibar, and participated in operationalising and coordinating project activities. The main aim of AYA was to improve overall sexual and reproductive health of youth aged 10-24 years and reduce the incidence of HIV/AIDS and other sexually transmitted infections, through YFS; institutional capacity building; policy and advocacy; coordination and dissemination; behaviour change communication; and life and livelihood skills.

Before the start of the programme, the government system did not have an adolescent health and development strategy, and, due to fear of community opposition, had been happy to leave the provision of providing SRH information and services to young people to NGOs. However, such programmes tended to be urban based and donor-dependent. Given that the government has a very extensive network of public health facilities throughout the country with qualified service providers, and given that those health facilities are covered within government budgets, AYA decided to work within the government health system in an attempt to establish sustainable quality, youth-friendly SRH services that would be available to a larger percentage of the youth population.

Factors that promoted joint working included: the involvement of the government in writing the AYA proposal; an MOU from the AYA partners that clarified roles and responsibilities; stakeholder meetings; joined goal and agenda setting. Evaluation of the project pointed to many achievements, including a rapid increase in youth visits to facilities and the provision of services (in Zanzibar) where policy formerly prohibited the provision of SRH needs to unmarried youth.

The AYA programme in Uganda provides an example of how a programme can help build political commitment at community level and among traditional leadership. In Uganda, several macro-factors supported communities' capacity to engage in ASRH-focused efforts, including the recent adoption of a national ASRH strategy, the active involvement of Ugandans in a variety of religious institutions as well as Kingdoms[1], and social-cultural institutions.

Community involvement was fundamental to the success and sustainability of the AYA program. Through a range of integrated interventions, communities participated during all stages of programming. Key stakeholder groups in government, NGOs, and community-based organisations - including youth, parents, religious leaders, the media and policymakers – were involved in participatory learning and action activities to identify ASRH issues locally, plan interventions, and implement a wide range of activities. AYA-Uganda served as a catalyst to involve communities and build their capacity to analyse and act upon ASRH issues. For example, AYA resources helped to build institutional capacity of selected NGOs and government health services, to foster leadership on ASRH issues among influential people, and to support ASRH activities planned and implemented by community groups.

Outcomes occurred at a range of levels – at the individual level of youth, adults, and community leaders; at the social level in intergenerational relations and normative community institutions having more favourable, supportive youth environments; and at the structural level in leadership, new organisational networks, and new policies and bylaws. Specifically, AYA's partnerships with four Kingdoms, covering 50 percent of the Ugandans, were designed to further HIV/AIDS prevention among young people. Uganda Kingdoms influence policy and norms. As a result of the partnership, ASRH and HIV/AIDS prevention initiatives were deemed critical concerns within the Kingdoms' development agendas, for which Toro and Busoga Kingdoms subsequently secured funding. The Busoga Kingdom set up a by-law prescribing 18 as the earliest age of marriage; this has now been taken on by all the other Kingdoms, leading to harmonisation with national age of consent in Uganda.

AYA's partnership with Christian and Muslim denominations in Uganda resulted in policy change related to the age of marriage, contraceptive use and school continuation: sensitisation of religious leaders led to ASRH issues being incorporated into religious pronouncements and sermons. The Anglican Church signed a declaration supporting ASRH and revised prenuptial counselling guidelines to include VCT. His Eminence Mufti of Uganda announced that Muslim couples should use condoms in marriage to prevent HIV/AIDS and other STIs. Educational institutions have added ASRH into seminary school curriculums (IAWG 2007).

[1] Kingdoms are cultural institutions in Uganda that have significant influence over traditions and social norms, and on the formulation and implementation of laws and policies.

The IAWG's framework's analysis of the factors influencing change in this context centred on the importance of community involvement, and operationalising the following framework:

1. Examine **community capacity** around ASRH issues, including its level of ASRH awareness (i.e. establish a baseline).
2. **A catalytic event:** awareness may be catalysed by a specific event (e.g., the death of an adolescent due to an unsafe abortion) or by an accumulation of ASRH-related observations, such as a rise in school dropouts due to pregnancy. External catalysts such as ASRH programs can often build awareness of ASRH issues, facilitate community dialogue and collective action, and build the capacity of local organisations and individuals to play catalytic and support roles, but can lead to controversy as some may perceive them as negative or foreign to community norms and values.
3. **Community involvement:** individuals begin addressing the issue as a *community* concern, rather than as an *individual* or *family* problem. This public dialogue then leads to collective action to address the identified issue of concern.
4. **Social change:** collective (and individual) actions lead to a wide spectrum of change, which will occur at the individual, structural and/or social level
5. **Broader base of community support:** these activities and changes lead to the creation of an *enabling environment* of community support for positive changes in ASRH knowledge, agency and behaviours.

Linking SRH and HIV/AIDS prevention in Haiti

In Haiti, the Ministry of Health is partnering with GHESKIO and UNFPA to establish nationwide sexual health services based on GHESKIO's model of linking sexual and reproductive health with HIV/AIDS prevention and treatment. Part of GHESKIO's remit is to address the needs of people who may not have access to sexual and reproductive health services, partly due to stigma: this includes people living with HIV, **unmarried adolescents**, sex workers and men who have sex with men. Through supporting integrated services, the government supports a service that addresses adolescent SRH issues (WHO 2008).

GHESKIO was started by a group of doctors in 1982 as a research institute with support from the MoH. In 1985 it began providing voluntary HIV counselling and testing but by 2000 it was also providing diagnosis and treatment of STIs, family planning, antiretroviral therapy, maternal health programmes, and care for survivors of sexual violence and youth programme.

GHESKIO's decision to offer sexual and reproductive health services integrated with its existing HIV/AIDS programme, all under one roof, was motivated partly by the following factors: the great majority of HIV infections in Haiti are contracted sexually; without intervention, about a third of infants born to women living with HIV become HIV-positive themselves; although improving, stigma and lack of necessary professional skills result in many PLHIV being denied access to sexual and reproductive health care in other health facilities; and people do not have the time or money to go from one place to another to meet their different health needs.

6. Tools and programmes aimed at developing political commitment

Reichenbach (2002) argues that for reproductive health, existing priority setting tools, such as providing evidence and technical data, do not consider the influence of politics on the priority setting process, or account for the interpretation of evidence in priority setting. In her view, although the importance of politics in priority-setting decisions and health planning has been described, there are few analyses of how micro-level politics influences health policymaking in developing countries and it has not been operationalised within the context of priority setting. Social construction (the idea that broad societal concerns influence how particular issues or problems are portrayed and, as a result, how those issues are perceived) and agenda setting (the process by which an issue is placed on a policy or political agenda) better explain which issues end up becoming priorities. This section summarises efforts that aim to influence and promote political commitment to improved SRH outcomes, as well as some successes.

Every Woman Every Child, 2012, '2011 Commitments to advance the Global Strategy for Women's & Children's Health', Every Woman Every Child
http://everywomaneverychild.org/images/content/files/Every_Woman_Every_Child_2011_Commitments_9_28_11.pdf
The UN Secretary General's 2010 Global Strategy for Women's and Children's Health (http://www.un.org/sg/globalstrategy) sets out a plan to achieve better health for women and children, including saving the lives of millions of women and children and preventing 33 million unwanted pregnancies. It calls for a bold, coordinated effort, building on what has been achieved so far – locally, nationally, regionally and globally. Every Woman Every Child is a collective effort by global leaders to put the Global Strategy into action. This 2011 document outlines over 100 commitments made by governments, philanthropic institutions, UN and other multilateral organisations, civil society, NGOs, the business community, healthcare workers, and academic and research institutions. In addition to financial investment (US$40billion has already committed over the next five years), other commitments, such as policy change, advocacy and investment in specialist knowledge have also been committed.

Cottingham, et al, 2010, 'Using human rights for sexual and reproductive health: improving legal and regulatory frameworks', WHO Bulletin vol. 88, no. 7
http://www.who.int/bulletin/volumes/88/7/09-063412.pdf

Strong leadership from the ministry of health, with support from the World Health Organisation or other international partners, and the serious engagement of all involved in this process can strengthen the links between human rights and sexual and reproductive health, and contribute to national achievement of the highest attainable standard of health. Field tests of this Human Rights tool demonstrate that the tool can specifically contribute to improving health by focusing on five critical areas relevant to sexual and reproductive health policy and planning:

- **Understanding States' obligations:** The tool's methodology is based on internationally-accepted human rights standards so it helps stakeholders to find out their countries' obligations in relation to sexual and reproductive health.
- **Vulnerable groups:** The discrepancies in health status among different population groups within and between countries have long been recognised. Initiatives make clear the case for investing in policies and interventions geared towards redressing inequities in the distribution of power, money and resources such that everyone can access and

utilise the same range of good quality services according to needs and preferences, regardless of gender, income level, social status or residency.

- **Involving other sectors:** In most of the field test countries, the ministry of health had not previously collaborated with other sectors. The field tests showed, however, that engagement with different sectors of government was not only desirable but completely feasible.
- **Civil society participation:** An often-repeated but rarely realised goal is ensuring the participation of civil society. All country teams stressed the value of the tool for bringing together government ministries with nongovernmental organisations such as the family planning associations and human rights commissions as well as the more activist civil society organisations.

The tool – both the instrument and the process – provides a methodology for mapping a country's legal and regulatory environment and its connection to sexual and reproductive health, by using human rights analysis. It also provides a useful point of reference for national policy-makers and actors to reflect on their policies, programmes, guidelines and other actions by highlighting them in one consolidated document. Use of the tool contributes to understanding States' human rights obligations and creates a method for systematically examining the status of vulnerable groups. It involves non-health sectors, fosters a genuine process of civil society participation and develops recommendations.

Policy Project: improving reproductive health through policy change
http://www.policyproject.com/index.cfm
http://www.policyproject.com/byTopic.cfm/ARH

The POLICY Project, funded by the US Agency for International Development (USAID), led a major effort to improve the policy environment for family planning/reproductive health (FP/RH), HIV, and maternal health in developing countries, and included a strong adolescent health component. Implemented in two phases (1995-2000 and 2000-2006), the project combined several USAID technical assistance areas – awareness raising, policy dialogue, and policy formulation – into a single programme. POLICY's mandate was to improve policies for an expanded range of reproductive health issues, including HIV and maternal health and to strengthen these policies by promoting multi-sectoral involvement in policy development processes.

Under POLICY II the project:

- fostered the adoption of more than 140 policies and plans to guide FP/RH, HIV, and maternal health services
- helped to form or build the capacity of more than 100 civil society networks, including reproductive health advocacy networks and networks of people living with HIV
- brought groups such as faith-based organisations and businesses into the health policymaking process
- awarded more than 250 small grants to support grassroots policy dialogue and advocacy efforts
- conducted policy analyses to raise awareness of issues such as contraceptive security, resource needs, women's inheritance rights, and HIV-related stigma

- assisted countries and partners to allocate, mobilise, and/or leverage more than US$200 million in additional funding for FP/RH, HIV, and maternal health.

For the POLICY Project, how it achieved its objective was as important as what it accomplished. The project's innovative model for implementing the work was both a facilitator and indicator of its overall success. Recognising that sustainable policy processes must inevitably come from within a country, POLICY set out to establish a project model that put its principles – country focus, multisectoral engagement, capacity development, decentralisation – into practice. POLICY transferred authority to local country directors and staff and equipped them with the necessary training, technical assistance from U.S.-based staff, and operational systems to effectively carry out their work. The project employed more than 600 field staff and worked closely with hundreds of local consultants and partners, thereby fostering 'policy communities' in each country that would sustain policy work long after the project ended.

Pakistan Initiative for Mothers and Newborns (PAIMAN)
http://jhuccp.org/whatwedo/projects/pakistan-initiative-mothers-and-newborns-paiman

Pakistan Initiative for Mothers and Newborns (PAIMAN) was a six-year project funded by USAID designed to reduce Pakistan's maternal and neonatal mortality and improve child health. The initiative aimed to ensure women have access to skilled birth attendants during childbirth and throughout the postpartum period, to improve maternal, newborn and child health at the household level and to increase the quality of care delivered in the public and health sectors. As the lead strategic communication partner, Center for Communications Programs developed the Communication Advocacy and Mobilization (CAM) strategy for the project, and advocacy led to the adoption of this strategy, which was adopted by all partners during project implementation, and in 2009 was adopted by Pakistan's Ministry of Health. Additionally, advocacy efforts led to the signing of a Karachi declaration in October 2009 scaling up best practices; a public commitment by the Ministry of Information and Broadcasting, dedicating TV and radio airtime to address maternal, newborn and child health (MNCH) issues; and the inclusion of MNCH issues on the national Ulama (religious scholars) agenda in 2010.

A related programme, Improving Women's Lives and Reproductive Health through Strategic Advocacy, (http://www.jhuccp.org/whatwedo/projects/improving-women%E2%80%99s-lives-and-reproductive-health-through-strategic-advocacy) also achieved a number of significant results, including reaching over 200 policy makers, journalists and media professionals through three national and regional roundtables on improving women's health; and airing fourteen hours of entertainment-education addressing family planning, women's health, and the value of women and girls on ATV and TV One, two leading channels in Pakistan, under the TV drama series Angoori.

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8. Further information

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http://www.ippf.org/en/What-we-do/Adolescents/Girls+Decide.htm

Plan International Adolescent Sexual Health Publications
http://plan-international.org/where-we-work/africa/publications/adolescent-sexual-health-in-west-africa-rights-realities-responses

UNFPA
http://unfpa.org/public/home

WHO Sexual and reproductive health: adolescents
http://www.who.int/reproductivehealth/topics/adolescence/en/index.html
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Experts consulted

Judith Bruce, Population Council
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Peter Fajans, WHO
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Zoe Matthews, Southampton University
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