Pre-meeting Workshop on Evidence-Based Progress and Activity Planning for Adolescent and Youth Sexual and Reproductive Health in DRC

Faden House Hotel
Kinshasa, DRC
August 21, 2017
About E2A

The Evidence to Action Project (E2A) is USAID’s global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive health care needs of girls, women, and underserved communities around the world by increasing support, building evidence, and leading the scale-up of best practices that improve family planning services. A Cooperative Agreement awarded in September 2011, E2A will continue until September 2019. E2A is led by Pathfinder International in partnership with ExpandNet, IntraHealth International, Management Sciences for Health, and PATH.

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We thank representatives of Pathfinder International/DRC for serving as rapporteurs during the workshop. We thank Ame Atsu David for writing the original draft in French and for translation of the report into English. Elham Hassen and Regina Benevides of Pathfinder/E2A were key facilitators during the workshop and provided technical review of this report. Laurel Lundstrom and Elizabeth Williams of Pathfinder International/E2A supported the editing and design of the final report.

We recognize the 19 youth participants win the pre-meeting workshops and offered valuable insights about barriers that need to be overcome to improve adolescent and youth sexual and reproductive health in the DRC.
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Acronyms

APA Administrative and Political Authorities
AYSRH Adolescent and Youth Sexual and Reproductive Health
DRC Democratic Republic of the Congo
E2A Evidence to Action Project
LARC Long-Acting Reversible Contraception
NGO Non-Governmental Organization
NPAH National Program for Adolescent Health
NPAAYH National Plan of Action for Adolescents and Youth Health
SRH Sexual and Reproductive Health
Introduction

The Population of Democratic Republic of the Congo (DRC) is young. According to the 2013-2014 Demographic and Health Survey, 61% of the population is younger than 20 years old and 23% are aged between 10 and 19 years. Most adolescents are engaged in early and unprotected sex. Moreover, about 65% of adolescents aged 15-19 years have already experienced intercourse, out of which 22% engaged in sexual activity before they were 15 years of age. On average, 27% of adolescent girls aged 15-19 are pregnant with their first child. More than 37% of young women aged 20-24 years live with a partner or were married before their 18th birthday; this statistic is consistent across most of DRC, with the exceptions being the city of Kinshasa and the province of Northern-Kivu, where less than 20% of young women aged 20-24 years live with a partner or were married as adolescents.

The DRC has made several commitments in favor of family planning and is supported by several donors to meet young people’s sexual and reproductive health (SRH) needs and to fulfill their right to participate in decision-making for program and policy development. Given that the DRC is so vast, the government developed a National Program for Adolescent Health (NPAH) with a strategic plan, which is essential for facilitating exchanges between the various provinces on adolescent and youth sexual and reproductive health (AYSRH). Despite these efforts, there are still several gaps in both applying evidence-based practices in AYSRH and in designing and implementing family planning programs. In addition, the level of youth involvement in planning and implementing these programs is weak.

Pathfinder International and its Evidence to Action (E2A) Project, with support from the US Agency for International Development (USAID) and the Bill & Melinda Foundation, and in collaboration with DRC’s National Program for Reproductive Health, organized a technical workshop on AYSRH in Kinshasa, August 22-23, 2017. The workshop, entitled “Exploring Progress and Planning Evidence-Based Investments in AYSRH,” engaged Congolese youth leaders with representatives of government, civil society, donors, and non-governmental organizations (NGOs) to examine DRC’s national and select provincial operational plans for family planning to see how they can be improved to better address AYSRH. To ensure that young people were able to meaningfully contribute at the workshop, the workshop was preceded by a preparatory phase “pre-meeting workshop,” on August 21, 2017, with the youth leaders.

The pre-meeting workshop and technical workshop on AYSRH adopted a similar methodology used by Pathfinder, E2A, and the Ouagadougou Partnership Coordination Unit, at an AYSRH technical workshop and “pre-meeting workshop” in Ouagadougou, Burkina Faso, in May 2017. The May workshop engaged teams from Francophone West African countries to examine their Costed Implementation Plans for Family Planning to see how they could better address AYSRH. Representatives of DRC’s government and Pathfinder/DRC attended, as observers. At the end of the workshop, the Ministry of Public Health of DRC expressed the desire to organize a similar workshop in his country using Pathfinder/E2A’s methodology to analyze DRC’s National Plan of Action for Adolescents and Youths Health (NPAAYH). The DRC workshop specifically sought to:

1. Identify, share, and examine evidence-based practices for improving access to and the quality of contraceptive services and increasing use of contraceptive methods among adolescents and youth.
2. Identify opportunities to strengthen the development and/or operationalization of a costed national strategic plan for adolescents and youth health and well-being, as well as national and
provincial annual AYSRH operational plans in (four provinces: Kinshasa, Lomami, Lualaba and Kasai Central), with a special focus on the evidence-based practices.

3. Enable young people to participate in identifying opportunities for applying evidence-based practices in national and provincial plans, as well as mechanisms for youth engagement in the implementation of these plans.

Nineteen representatives of youth organizations and associations in four provinces of DRC where Pathfinder and E2A are implementing projects (Kinshasa, Lomami, Lualaba, Kasai-Central) attended the pre-meeting workshop and technical workshop. The pre-meeting workshop had the following objectives:

1. Develop a clear understanding of the NPAAYH and how it relates to the National Multi-Sector Strategic Plan for Family Planning, what they are, and why they are important.
2. Analyze the NPAAYH and highlight the strengths and weaknesses of the plan to increase access to AYSRH services.
3. Identify effective ways for youth-led organizations to make an impact and engage in the elaboration and operationalization of the NPAAYH.
4. Enable youth to participate in identifying opportunities for the application of evidence-based practices in existing plans (national and provincial) and identify mechanisms for youth involvement in the implementation of these plans.
5. Identify, share, and review evidence-based practices to improve access to and the quality of contraceptive services and to increase the use of contraceptive methods among adolescents and youth.

E2A staff and DRC government partners facilitated the pre-meeting workshop.

Selection of Youth Participants

With the E2A Project’s support, the NPAH launched a youth selection process for the pre-meeting workshop across the city of Kinshasa, and Lualaba, Central Kasai and Lomami provinces. The selection considered gender parity, age, and work experience with AYSRH. In total, 19 young people representing the four provinces were selected to take part in the meeting (12 young people from the provinces including 2 girls and 2 boys from Lomami, 2 girls and 2 boys from Lualaba, 1 girl and 3 boys from Kasai Central, and 7 young people from Kinshasa including 3 girls and 4 boys).

The selection criteria were as follows:

1. **Age**: Participants had to be younger than 30, with a preference for those under 24.
2. **Commitment**: Participants should be interested and involved in concrete actions aimed at improving access to contraceptive services for adolescents and young people. They had to demonstrate a clear plan to use the learning drawn from the meeting in their work once back in their respective provinces.
3. **Knowledge/experience**: Participants had to demonstrate proven experience or knowledge of AYSRH policy, service delivery, or demand generation.
4. **Representation**: Participants were expected to represent young people in and out of school or who dropped out (young women and boys).
The youth pre-meeting workshop on evidence-based AYSRH Progress and Activity Planning took place on August 21, 2017 at the Faden House Hotel. Below is a summary of presentations, group work, and discussions.

Session 1: Process of Developing the National Plan of Operation and Plan of Action for a Youth Health Program in the DRC

The session was meant to explain to young people an operational plan and a national plan of action for a youth health program. The session explained how these plans are developed, seeking to enable youth to participate in the process of their evaluation, development, and implementation. The session started with a PowerPoint presentation by Didier Lukeme, Training Officer at NAYHP. In his presentation, he emphasized the following:

- The National Health Development Plan defines the health policy. This plan is broken down into the NPAAYH, from which an Operational Plan of Action for a Youth Health Program is derived.
- The NPAAYH is a health program roadmap developed to achieve its medium and long-term vision. This plan helps explore internal and external environments in youth health programs to make projections for the future and to determine strategies for fulfilling its mission and vision. It includes general objectives, actions and strategies that will facilitate the acquisition, utilization and allocation of resources.
- A National/Provincial Plan of Action or “Operational Plan” is the implementation of a strategy or intervention in the field of youth health. It translates objectives and sub-objectives into activities and resources for a youth development program. It is a tool which helps youth health programs monitor actions, costs and timeline. This ensures follow up, takes stock of the intervention, allows necessary adjustments to be made, and is helpful to evaluate outcomes. The development of an Operational Plan should be multi-sectorial with the participation of all stakeholders working in the youth development sector, including young people themselves. The health program operational and action plans are funded by the Congolese State (national and provincial), the Communities (building of information centers for young people), households, and development partners. The methodology for the development of the National Operational Plan for a youth health program includes:
  - Preparatory phase (set up a technical committee, draft Terms of Reference, recruit consultants, resource mobilization);
  - Desk review phase;
  - Writing the document, which includes a situational analysis of AYSRH in the DRC and the definition of the strategic framework;
  - Adoption of the plan by all stakeholders.
At the end of the presentation, the opportunity was given to youth participants to ask questions and discuss how they could use the Operational Plan and the NPAAYH to advance their own AYSRH work.

Session 2: Barriers to Access of AYSRH Information and Services

Regina Benevides of E2A facilitated a brainstorming session on what prevents young people from accessing information, products, and services to improve their SRH. For this session, participants were divided into four groups. Each group reflected on examples of barriers to access of contraception in relation to the following four aspects:

1. Demand generation
2. Service delivery
3. Enabling environment (social and political norms)
4. Coordination

Below is a summary of the barriers identified by the youth.

Service delivery

- Lack of confidentiality of providers and poor reception of youth for SRH services;
- Limitation of contraceptive methods for young people by service providers;
- Programs available in cities, but in provinces/rural areas (or the outskirts of major cities);
- AYSRH information and services need to be adapted to the needs of young people.

Demand generation

- Customs and traditions reinforce prejudices about AYSRH;
- Lack of support from the community: caregivers, and APAs are neither informed nor involved;
- Sexuality considered a taboo;
- Inadequate youth-friendly educational material in health centers.

Enabling environment

- Religious leaders and parents should be involved in the development of messages about unwanted pregnancy, STIs, and HIV prevention
- Lack of training of teachers; limited comprehensive sexuality education

Coordination

- Poor involvement of young people in all processes (design, development, implementation, monitoring, evaluation, research);
- Poor involvement in multi-sectoral dynamics;
- Lack of funding for youth associations’ projects;
- Poor dissemination of AYSRH-related policies;  
- Lack of information about the Operational Plan development processes among young people; 
- Operational Plans exist, but implementation/applicability does not necessarily follow; 
- Operational Plans exist, but do not meet young peoples’ needs in their contexts.
After the brainstorming exercise, participants broke into groups by province. Each group was asked to identify the two to three most significant barriers and to analyze the extent to which activities in the Operational Plans address those barriers. Young people could, if necessary, rephrase the activities into solutions to overcome the barriers. Below are the results of group work by province.

**Service Delivery**

<table>
<thead>
<tr>
<th></th>
<th>KASAI CENTRAL</th>
<th>LOMAMI</th>
<th>KINSHASA</th>
<th>LUALABA</th>
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<tbody>
<tr>
<td><strong>Barriers</strong></td>
<td>Poor reception of adolescents and young people by clinical and community service providers</td>
<td>Lack of space for information and communication for adolescents and youth</td>
<td>Inadequate space for adolescents and youth access to information and communication</td>
<td>Lack of information and communication space for adolescents and young people (no experience sharing between adolescents and youth)</td>
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<td></td>
<td>Lack of confidentiality among service providers</td>
<td>Prohibition of adolescents and youth from seeking AYSRH information by parents</td>
<td>Family planning services to adolescent girls and youths are limited</td>
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<tr>
<td><strong>Activities</strong></td>
<td>Training of clinical and community service providers on AYSRH</td>
<td>Set up and equip information and communication spaces for adolescents and young people</td>
<td>Set up/build and equip more information and communication spaces for adolescents and young people</td>
<td>Develop and equip information and communication spaces for adolescents and youth</td>
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<td></td>
<td></td>
<td>Raise awareness among parents and community leaders on AYSRH</td>
<td>Organize support groups for youth who previously or newly adopted the adolescents and youth-friendly and modern contraceptive methods</td>
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### Demand Generation

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<tr>
<td><strong>Barriers</strong></td>
<td>Traditions and customs</td>
<td>Distance from health service facilities</td>
<td>Absence of focal points at all levels</td>
<td>Lack of information among adolescents and young people on AYSRH</td>
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<td></td>
<td>The negative influence of caregivers and administrative/political authorities</td>
<td>Sense of guilt in adolescents and young people</td>
<td>Lack of information among adolescents and young people</td>
<td>Lack of information among adolescents and young people on AYSRH</td>
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<td></td>
<td>Lack of information among adolescents and young people about AYSRH</td>
<td></td>
<td>Lack of information among adolescents and young people</td>
<td>Lack of qualified peer educators</td>
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<tr>
<td><strong>Activities</strong></td>
<td>Refresher training for community leaders, health care providers, and peer educators previously trained on AYSRH</td>
<td>Create secondary health posts</td>
<td>Train 150 clinical and 500 community service providers</td>
<td>Organize AYSRH awareness activities for adolescents and young people</td>
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<td></td>
<td>Advocate with political and administrative authorities, parents, and community leaders for AYSRH</td>
<td>Bring adolescents and young people closer to care facilities</td>
<td>Organize AYSRH awareness for adolescents and young people</td>
<td>Train AYSRH peer educators</td>
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<td></td>
<td>Organize AYSRH awareness activities for adolescents and young people</td>
<td>Train adolescents and young people on responsible behavior</td>
<td>Train AYSRH peer educators</td>
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### Enabling Environment

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<tr>
<td><strong>Barriers</strong></td>
<td>Traditions and customs</td>
<td>Traditions and customs</td>
<td>Law authorizing parents or guardians to accompany adolescents for HIV and AIDS testing</td>
<td>Traditions and customs</td>
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<tr>
<td></td>
<td>Absence of peer educators</td>
<td>Gender inequalities</td>
<td>Lack of peer educators</td>
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<tr>
<th>Activities</th>
<th>Community awareness on AYSRH</th>
<th>Advocate with traditional chiefs and opinion leaders for the inclusion of AYSRH at community level</th>
<th>Advocate with lawmakers for a legal revision</th>
<th>Advocate with traditional chiefs and opinion leaders for inclusion of AYSRH at community level</th>
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<tr>
<td></td>
<td>Train care providers and peer educators on AYSRH</td>
<td>Ensure girls' empowerment and schooling at the community level</td>
<td>Peer educator training in all the 35 health zones in Kinshasa</td>
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#### Coordination

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<th>LUALABA</th>
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<tr>
<td>Barriers</td>
<td>Inadequate post-training supervision</td>
<td>Lack of information among adolescents and young people about Operational Plan development process</td>
<td>Inadequate supervision of AYSRH activities at the national level</td>
<td>Lack of post-training supervision of AYSRH activities</td>
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<td></td>
<td>Lack of interest in and consideration of adolescents and youth for AYSRH</td>
<td>Poor documentation of achievements/evidence-based practices</td>
<td>Poor collaboration among adolescent and youth associations</td>
<td>Lack of knowledge about information channels</td>
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<th>Activities</th>
<th>CENTRAL KASAI</th>
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<tr>
<td>Organize AYSRH post-training supervision in local health zones</td>
<td>Identify and involve adolescent and youth groups in Operational Plan development processes</td>
<td>Organize four visits to supervise and monitor AYSRH activities</td>
<td>Organize post-training supervision for AYSRH activities in health zones</td>
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<td>Organize awareness campaigns on adolescents and young people's health related issues (STIs / HIV)</td>
<td>Document evidence-based practices</td>
<td>Set up provincial task force that joins youth associations to create synergies between their activities</td>
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<td>Develop framework to facilitate information dissemination and the supply chain</td>
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The proposed activities in the Operational Plans were discussed but not reformulated. The objective of the session was simply to stimulate a critical analysis and to share ideas during the main meeting. The youth were very engaged and were thankful for the exercise, which they found productive as it helped them develop an in-depth vision of young people’s needs and realities.

**Session 3: Overview of Evidence in AYSRH Evidence-Based Practices**

The session aimed to strengthen young people’s knowledge of evidence-based practices. This session consisted of a PowerPoint presentation by Regina Benevides of E2A. She explained that at the global level, there is evidence that youth centers are ineffective strategies for increasing use of SRH services by adolescents and young people, including contraception services. She presented the eight categories of evidence-based practices that stem from a literature review on evidence-based and promising practices for improved access to quality contraceptive services and increased use of contraceptive services by adolescents/youth in low and middle income countries.

**Evidence-based practices**

1. **Provision of adolescent- and youth-friendly SRH services**

   Adolescent and youth-friendly SRH services are SRH services that address the five characteristics of adolescent-friendly services defined by the World Health Organization (WHO) and global standards for improving the quality of adolescent health services. These services must be:

   - **Fair**: All adolescents, not only certain groups, can access the health services they need.
   - **Accessible**: Adolescents can access the available services.
   - **Acceptable**: Health services are provided in such ways that they meet adolescent clients’ expectations.
   - **Appropriate**: The health services that adolescents need are provided.
   - **Effective**: Good health services are provided in an appropriate manner and positively contribute to adolescents’ health.

2. **Expanding the range of contraceptive methods available to adolescents and young people (including LARCs and DMPA-SC)**

   The availability of a full range of contraceptives, including long-acting and reversible contraception (LARC), for adolescents and young people contributes to increasing contraceptive use among this population group.

   **The full range of contraceptive methods:**

   - LARC like implants and IUD;
   - Short-acting contraceptive methods like injectable, combined oral contraceptives, progestin-only pills
   - Barrier methods like emergency contraception
   - The lactational amenorrhea method (for new mothers)
3. **Inclusion of vulnerable and underserved youth groups (including married adolescent girls and first-time parents)**

Adolescents and youth are complex and heterogeneous with different characteristics that influence their needs and vulnerabilities. Married adolescents and first-time parents are among the most vulnerable groups due to the risk of close pregnancies. Moreover, they are often not covered in SRH programs and services. A single approach to programs and services cannot meet the needs of all the adolescents and youth.

In terms of strategies, it is important to take into consideration the following to address the needs of all:

- Target all levels of the socio-ecological model: adolescents and youth, their partners, families, communities, and health system;
- Use different means to strengthen the intervention;
- Use an integrated gender-based approach;
- Focus in the different stages of sexual life.

4. **Adolescent and youth participation and leadership in AYSRH programs**

The active and meaningful participation of young people in all aspects of their development is a key element to ensure effective health services and programs, including AYSRH. Young people are actors of social change and not mere beneficiaries of social programs. To engage in the most effective way, youth need resources such as financial resources, training, ongoing mentorship, and knowledge of political and management processes.

5. **Multi-sectoral coordination for AYSRH**

The social and environmental determinants of AYSRH are mainly external to the health sector. The most effective interventions for adolescents’ health and well-being include multi- and intersectoral

6. **Comprehensive sexuality education**

Provide young people with age-appropriate, scientifically accurate, and culturally relevant information on human development, sexuality, gender, healthy relationships, SRH and human rights.

7. **Support from families and communities in AYSRH**

Family and community support is important to create an environment that empowers adolescents and youth to access contraceptive information and services.

8. **Girls’ empowerment**

Implementing SRH and contraceptive interventions at the same time as interventions that support girls’ empowerment can sensibly increase the return on investment in both types of interventions.
Session 4: The Methodology for Operational Plan Analysis

This session was facilitated Elham Hassen of E2A. She explained to youth that in most cases, action plans are developed on an annual basis and the same activities are repeated each year without really taking time to assess changes. Reflection is important to see what has worked and what should be improved in order to increase efforts to achieve even better results. This has been particularly observed in the field of AYSRH in most of the countries where Pathfinder/E2A works.

Learning from this observation, Pathfinder/E2A has developed the methodology for analyzing Operational/Budgeted Plans to see how activities relate to the eight global evidence-based practices. Pathfinder/E2A used this methodology for the first time in May 2017 to analyze the plans of the nine member countries of the Ouagadougou Partnership. For the first time, this type of analysis was conducted in the DRC. Pathfinder/E2A worked with NAYHP as a partner in this process. While at the Ouagadougou meeting, a representative of the NAYPH learned and welcomed this methodology and expressed the desire to replicate it in the DRC. The group work objectives were not only to familiarize young people with the method, but to also collect suggestions for improving the strategy.

Description of the methodology and findings

The first part of the analysis consisted of examining how the Operational Plan activities were distributed among the four activity categories: service delivery, demand generation, enabling environment, and coordination. These four categories are important to ensure integrated service delivery is in line with people's health needs. But in each context, the composition of these dimensions varies. Our expectation was to analyze the distribution of activities per domain. The finding from this analysis is that a large part of the plan is devoted to coordination activities.

Activities by Type, National Operational Plan, 2017

![Activities by Type, National Operational Plan, 2017](image)

The second part of the analysis sought to show an overview of the distribution of the NAYHP budget by the four activity categories. The objective of this second phase was to see if this distribution reflected the priorities identified by each level. For example, it has been found out that the service delivery includes...
many more activities compared to other categories. This gives an indication in the analysis and helps us to ask more questions about priorities when allocating budgets. It is important to note that the two pie charts should not necessarily be aligned. For example, some activities that come from a category such as service delivery may cost more than coordination activities. Therefore, the first pie chart may show activities with more coordination while the second pie chart shows a budget mostly allocated to activities under service delivery.

Operational Plan Budget Dedicated to Activity Types

The third and last part of the analysis aims to examine to what extent the Operational Plan activities take into account the eight global evidence-based practices. This part is done using color coding:

- **GREEN**: Activities closely aligned with the evidence-based practices
- **YELLOW**: Activities somewhat aligned with the evidence-based practices
- **GREY**: Activities not aligned and/or not applicable to the evidence-based practices
This methodology helps to:

1. Review evidence-based practices that seek to improve adolescent and young people’s access to, and use of, quality contraceptive services;
2. Identify opportunities for strengthening the development or implementation of Operational Plans:
   a. Reinforce activities that specifically target adolescents and young people.
   b. Improve the inclusion of adolescents and young people in non-specific activities.

**Session 5: Youth Recommendations and Action Plans to Improve the Implementation of Operational Plans**

The last session allowed the youth to discuss in groups how they could support the improvement and implementation of Operational Plans. They were specifically requested to:

- Create a list of five ways for the government to engage young people in the development/review/implementation/monitoring and evaluation of action plans.
- Reflect on the actions they can take back in their provinces to advance the recommendations they will make at the main technical meeting.

They highlighted the following recommendations to be presented at the main meeting.

1. **To the Multi-Sectoral Technical Committee:**
   o Carry out an evaluation on the family life education subject in schools and scale it up.

2. **To Government (general):**
   o Engage, support, and facilitate youth advocacy work for the adoption of the AYSRH Act.
   o Organize the use of social networks for AYSRH programs.

3. **To the Ministry of Health:**
   o Bring reforms to the health facilities by integrating psychosocial support service for adolescents and youth.
   o Set up and equip adolescents and youth support centers in the provinces and outskirts.
Facilitate the creation of a national youth network for exchange of experience and capacity building in AYSRH.

Involve adolescents and youth at all levels of the Operational Plans as well as strategic and action plan development processes.

4. Technical and financial support partners:

- Provide free AYSRH services to adolescents and youth.
- Expand the intervention areas for funding.
- Develop a national consultation framework for adolescents and youth as well as mechanisms to follow up on these meetings recommendations.
- Facilitate national and international trips for experience sharing.
- Involve adolescents and youth at all levels of decision-making on matters concerning them.
- Anticipate an adequate budget line in the NAYHP to fund all national Operational Plans to avoid the constraints of funding shortages in all five renewable years.

The pre-meeting workshop ended with the appointment of youth representatives for panel discussions and group work.

Conclusion

This preparatory phase provided young people with the skills necessary to participate actively in an environment where they often feel marginalized because the presence of youth participants is perceived as tokenistic. This pre-meeting was held in the context of an ongoing conversation among provinces, advocates, donors, and implementing partners in the country about the crucial need to address young people’s needs as part of national initiatives for family planning and access to contraception. Young people from these various provinces of the DRC were trained as spokespersons to demand more attention to their needs and rights. They must be meaningfully involved and supported to continue to lead these conversations as full partners and to build on that momentum.

This was an excellent exercise worth replicating in other countries as it provides young people with tools that help them to be more than mere spokespersons who raise the challenges faced by their peers, and to use evidence to develop the best possible strategies and activities to address these challenges.
## Annex A: Workshop Program Outline

<table>
<thead>
<tr>
<th>Times</th>
<th>Activity</th>
<th>facilitator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4PM-5:30PM</td>
<td>Registration of participants</td>
<td>Rianne</td>
<td></td>
</tr>
<tr>
<td>4PM-5:30PM</td>
<td>Welcome address</td>
<td>Aben</td>
<td></td>
</tr>
<tr>
<td>4PM-5:30PM</td>
<td>Participants Presentation: Names, Province, Project and Organizations</td>
<td>Rianne</td>
<td></td>
</tr>
<tr>
<td>4PM-5:30PM</td>
<td>Presentation of the workshop objectives and chronogram</td>
<td>Elham</td>
<td></td>
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</tbody>
</table>

**COFFEE BREAK** *(10h05 - 10h20)*

| 4PM-5:30PM    | Development process of national plan of operation and plan of action for a youth health program in the DRC | Didier Lukeme | Presentation  
|               |                                                                                                        |              | Why a Budgeted Operational Plan?  
|               |                                                                                                        |              | ● What does an Operational Plan include for young people in particular?  
|               |                                                                                                        |              | ● How are Operational Plans used?  
|               |                                                                                                        |              | ● Who funds the costs of an Operational Plan?  

| 4PM-5:30PM    | Brainstorming Session                                                     | Regina      | **Group work**  
|               |                                                                                                        |              | What prevents young people from accessing information, products and services to improve their sexual and reproductive health?  
|               |                                                                                                        |              | What are the obstacles?  

**BREAKFAST** *(11:50 am - 12:50 pm)*

| 4PM-5:30PM    | Working groups by province                                                | Elham, Rianne, Regina, Charles, | **Group work**  
|               |                                                                                                        |              | Participants to be divided into small groups (by province) and to review how the 2017 AY
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4PM-5:30PM</td>
<td>Evidence-based practices for improving access to services</td>
<td>Regina</td>
<td>Overview of evidence in AYSRH evidence-based practices</td>
</tr>
<tr>
<td>BREAK</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4PM-5:30PM</td>
<td>Methodology of Operational Plan analysis</td>
<td>Elham</td>
<td>Present the analysis methodology</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Group work</strong></td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Group discussion on how young people can support Operational Plan improvement and implementation.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>List five ways in which the government can engage young people in the development / revision / implementation / monitoring and evaluation of Operational Plans.</td>
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<tr>
<td></td>
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<td></td>
<td>Think about what you can do back in your provinces to advance recommendations you plan to make at the main technical meeting.</td>
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<tr>
<td></td>
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<td></td>
<td><strong>Restitution (40 min):</strong> Each group presents the highlights</td>
</tr>
</tbody>
</table>

1 H
1 H

Conclusion, Q & A
Rianne
### Annex B: Barriers Listed by Youth

<table>
<thead>
<tr>
<th>Service delivery</th>
<th>Demand generation</th>
<th>Enabling environment</th>
<th>Coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of information and communication spaces for adolescents and young people</td>
<td>Lack of information</td>
<td>Legal: absence of law on SRH</td>
<td>Young people’s lack of information about Operational Plan development process</td>
</tr>
<tr>
<td>Lack of confidentiality from care providers</td>
<td>Negative influence and pressure from peers</td>
<td>Cultural: traditions and custom</td>
<td>Lack of collaboration and consideration between the various sectors involved</td>
</tr>
<tr>
<td>Poor reception by health care providers</td>
<td>The law on minors’ HIV testing in the presence of their parents or guardians</td>
<td>Economic: poverty</td>
<td>Poor documentation of achievements compared to good practices observed</td>
</tr>
<tr>
<td>Lack of information about the existence of health services for adolescents and young people</td>
<td>Traditions and customs (cultural barriers)</td>
<td>Overcrowded households/communities</td>
<td>Lack of formative supervision</td>
</tr>
<tr>
<td>Health services for adolescents and young people are limited</td>
<td>The distance between health facilities</td>
<td>Low level of education</td>
<td>Guilt (fear of)</td>
</tr>
<tr>
<td>Gender discrimination</td>
<td>Stigma (fear of)</td>
<td>Lack of advocacy initiatives</td>
<td></td>
</tr>
<tr>
<td>Limited contraceptive methods for adolescents and young people</td>
<td>Guilt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certain products are out of stock</td>
<td>Negative influence of APAs and guardians on adolescents and young people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service providers not trained</td>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prohibition of some contraceptive methods adapted to adolescents and young people by parents and religious leaders</td>
<td>Lack of peer educators</td>
<td></td>
<td></td>
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<tr>
<td>Side effects of modern contraceptive methods</td>
<td>Influence of rumor/gossip</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigma from healthcare providers</td>
<td>Absence of AYSRH focal points at provincial level</td>
<td></td>
<td></td>
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<tr>
<td>The exorbitant cost of care services</td>
<td></td>
<td></td>
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<tr>
<td>The absence of community-based distribution for youth, which offer a full range of modern contraceptive methods</td>
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<td></td>
<td></td>
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<tr>
<td>Long distance between health facilities</td>
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</table>
Annex C: Worksheet

Worksheet: Mastering and Owning your Costed National Operational Plan

• Which strategies or activities are defined in the DRC’s National Strategic Plan for Adolescents and Youths Health and Well-Being (2016-2020) (NSPAYH) to improve the demand for FP services for adolescents and young people?

• Is the integration of comprehensive sexuality education mentioned in your NSPAYH? What are the key components?

• What are the interventions and activities best suited for adolescents and young people’s needs and questions in the DRC’s NSPAYH?

• What are the DRC government's commitments and actions to improve access to family planning services specific to adolescents and young people?

• What are the activities of the NSPAYH of the DRC specific to adolescents and young people already implemented? What are their levels of implementation? Which have not yet started?

• In your opinion, which specific actions or activities could be added to the NSPAYH to improve adolescents and youths’ access to specific family planning services?
Annex D: List of Participants

<table>
<thead>
<tr>
<th>Nº</th>
<th>NAME</th>
<th>SEXE</th>
<th>Age</th>
<th>Address</th>
<th>Health Zone</th>
<th>Health Area</th>
<th>Occupation</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>MBOMBO PAMWE Aimerance</td>
<td>F</td>
<td>24</td>
<td>DIBAYA</td>
<td>Tshimayi</td>
<td></td>
<td>Primary school teacher /Peer educator</td>
<td>099 069 54 56</td>
</tr>
<tr>
<td>2</td>
<td>TSHIMINYI MAMBA Thoms</td>
<td>M</td>
<td>24</td>
<td>DIBAYA</td>
<td>Tshimayi</td>
<td></td>
<td>Humanities teacher /Peer educator</td>
<td>097 850 61 48</td>
</tr>
<tr>
<td>3</td>
<td>MISENGA MALU Fidèle</td>
<td>F</td>
<td>19</td>
<td>NDEKESHA</td>
<td>KAFUBA</td>
<td></td>
<td>Student / Peer educator</td>
<td>097 588 83 88</td>
</tr>
<tr>
<td>4</td>
<td>SOMBAMANYA MULUNDA Germain</td>
<td>F</td>
<td>32</td>
<td>TSHIKAJI</td>
<td>Kalemba Mulumba</td>
<td></td>
<td>Nurse / Youth supervisor in Kalemba MULUMBA youth center</td>
<td>099 160 82 24</td>
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</tbody>
</table>

**LUALABA**

<table>
<thead>
<tr>
<th>Nº</th>
<th>NAME</th>
<th>SEXE</th>
<th>Age</th>
<th>Address</th>
<th>Health Zone</th>
<th>Health Area</th>
<th>Occupation</th>
<th>Contact</th>
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<tbody>
<tr>
<td>1</td>
<td>Zaina KABWITA</td>
<td>F</td>
<td>24</td>
<td>BUNKEYA</td>
<td></td>
<td></td>
<td>Janitor / Peer educator</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Sandra KAYAKEZ</td>
<td>F</td>
<td>20</td>
<td>MUTSHATSHA</td>
<td></td>
<td></td>
<td>Student / Peer educator</td>
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</tr>
<tr>
<td>3</td>
<td>BULUNGO MUMBA</td>
<td>M</td>
<td>23</td>
<td>LUALABA</td>
<td></td>
<td></td>
<td>Teacher / Peer educator</td>
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<tr>
<td></td>
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<td>Location</td>
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<tr>
<td>1</td>
<td>TSHIKEZA NGOYI Freddy</td>
<td>M</td>
<td>29</td>
<td>KALENDA</td>
<td>TSHILOMBA</td>
<td>Teacher at Tshianga de Tshiomba High school/ PE, et young married men</td>
<td></td>
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</tr>
<tr>
<td>2</td>
<td>KONGA KALENDA Monique</td>
<td>F</td>
<td>20</td>
<td>LUPUTA</td>
<td>TRIANGLE</td>
<td>High school teacher</td>
<td></td>
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<tr>
<td>3</td>
<td>MUSUAMBA TSHITOMPA Donatien</td>
<td>M</td>
<td>29</td>
<td>KAMIJI</td>
<td>KAMIJI</td>
<td>Religious Intern</td>
<td></td>
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<tr>
<td>4</td>
<td>Nadine MASHIND IRUNG</td>
<td>F</td>
<td>22</td>
<td>WIKONG</td>
<td>KAYIND</td>
<td>Seller</td>
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**LOMAMI**

**KINSHASA**

<table>
<thead>
<tr>
<th></th>
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<th>Gender</th>
<th>Age</th>
<th>Location</th>
<th>Occupation</th>
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<tr>
<td>1</td>
<td>MUSIFU Marie</td>
<td>F</td>
<td></td>
<td></td>
<td>Kinshasa/MAJ</td>
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<tr>
<td>2</td>
<td>BETESHI Elioth</td>
<td>F</td>
<td></td>
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<td>Kinshasa/Si jeunesse savais</td>
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<tr>
<td>3</td>
<td>VESE Carlin</td>
<td>M</td>
<td></td>
<td></td>
<td>Kinshasa/PECS</td>
</tr>
<tr>
<td>4</td>
<td>SEMOPA Annosee</td>
<td>F</td>
<td></td>
<td></td>
<td>Kinshasa/RACOJ</td>
</tr>
<tr>
<td>5</td>
<td>LANDU Teddy</td>
<td>M</td>
<td></td>
<td></td>
<td>Kinshasa/COJET</td>
</tr>
<tr>
<td>6</td>
<td>DIANTISA Gracia</td>
<td>F</td>
<td></td>
<td></td>
<td>Kinshasa/RAJECOPOD</td>
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