Francophone West Africa Regional technical workshop on adolescent and young people’s sexual and reproductive health

Exploring progress and planning future evidence-based investments for AYSRH

Meeting Report

May 10-11, 2017 - Ouagadougou, Burkina Faso
ACKNOWLEDGEMENTS

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We recognize all country teams, including the 22 youth participants, presenters, and facilitators for their instrumental role in conducting a productive AYSRH workshop for Francophone West Africa countries.

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# ACRONYMS AND ABBREVIATIONS

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<td>Adolescent and young people’s sexual and reproductive health</td>
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<td>Costed Implementation Plan</td>
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<td>CS4FP</td>
<td>Civil Society for Family Planning</td>
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<td>CTMP</td>
<td>Comité Technique Multisectoriel Permanent [Permanent Multisectoral Technical Committee]</td>
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<td>Evidence to Action Project</td>
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<td>Family Planning</td>
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<td>First-time parent</td>
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<td>ICT</td>
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<td>SRH</td>
<td>Sexual and reproductive health</td>
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<td>WAHO</td>
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I. INTRODUCTION

Context and justification for workshop

Since 2011, there has been increasing commitment from the Ouagadougou Partnership (OP) countries and support from donors to address young people’s sexual and reproductive health (SRH) needs. Several important meetings and conferences in the region attest to the governments’ growing interest in including youth as part of their national health and development plans. Such meetings brought together governments, experts in adolescent and young people’s sexual and reproductive health (AYSRH), civil society, young leaders and other stakeholders, to discuss gaps and opportunities, as well as technical strategies and approaches to meet young people’s SRH needs across francophone West Africa. These joint efforts have contributed to building a strong platform for sharing evidence across francophone West Africa on improving access to, and demand for, quality SRH services for adolescents and youth. ¹

Despite these efforts, several gaps persist at the global and regional levels with regards to applying evidence-based practices for developing and implementing national plans for family planning. At the 4th OP Partners’ Annual Meeting (2015), young leaders proposed a set of recommendations aimed to better address the needs of adolescents and youth in national and regional family planning efforts; it was agreed that filling these gaps should be a priority.

Following up from these recommendations, the 5th annual OP Partners’ meeting (2016) focused on the theme: “Promoting contraception guarantees a better future for young people.” On the first day of the annual meeting, a roundtable brought together young ambassadors from the nine OP countries and other stakeholders to develop a roadmap for accelerating action for youth and contraception, with a focus on strengthening the development and implementation of national family planning Costed Implementation Plans (CIPs) in the region. The roadmap includes recommendations related to four main areas: (1) Meaningful participation and inclusion of youth in CIPs; (2) Implementation of evidence-based practices that promote AYSRH; (3) Resource mobilization; and (4) Improved inclusion of vulnerable youth groups in CIPs. In 2016, the OP Coordination Unit established a “Youth Think Tank” to support the implementation of these recommendations. E2A/Pathfinder is a founding member of the Youth Think Tank and one of the co-chairs of the working group on applying evidence-based practices to improve AYSRH.

National and regional efforts supported by Pathfinder and its Evidence to Action (E2A) Project, and other partners reveal that despite the growing consensus about the importance of youth-friendly SRH information and services and the amount of research now published on what works and what does not work in terms of programs and policies for young people, the level of understanding and implementation of effective evidence-based practices to strengthen service delivery remains limited. For example, regional efforts in West Africa have tended to focus on creating demand for services (e.g., through campaigns, peer education, etc.) and/or on youth-led advocacy. It is therefore critical to understand in detail what service delivery strengthening and specifically youth-tailored behavior and social norm change strategies entail, and how best to engage youth in such efforts.

Building upon the momentum in the region as well as global efforts to accelerate change in AYSRH, a workshop on AYSRH in Francophone West Africa was organized jointly by E2A and Pathfinder.

¹ This report uses the World Health Organization’s definitions of adolescents and youth; adolescents are those between 10-19 years of age, while youth are between 15-24 years of age.
International, with input from the OP Youth Think Tank, and support from USAID, the Bill & Melinda Gates Foundation, and Merck/MSD. Held at the Silmandé Hotel in Ouagadougou, Burkina Faso, the workshop explored ways to strengthen investments and actions aimed at developing and/or scaling up evidence-based practices for expanding demand for, access to, and quality of contraceptive services for adolescents and young people. There was a specific focus on supporting countries to implement evidence-based practices as part of their existing or future CIPs.

**Objectives of the workshop**

The workshop’s main objectives were to:

1. Share and reflect on evidence-based practices aiming to improve access to quality contraceptive services and increase contraceptive uptake among adolescents and young people. Practices already been implemented in the OP countries were highlighted;
2. Identify opportunities for strengthening the development or implementation of CIPs and overcoming political and programmatic barriers to advancing AYSRH in OP countries. Specific attention was paid to the implementation of the OP Youth Think Tank Roadmap and the evidence-based practices it presents as priorities for CIPs.
3. Enable young people to take part in efforts to identify opportunities for ensuring CIPs integrate implementation of evidence-based practices, and define mechanisms for young people to be involved in the implementation of the CIPs.

**About the workshop participants**

In total, 111 participants from 11 countries attended the technical workshop (see Annex 1 for the full participant list). Participants included:

- Government representatives (technical-level staff working in the areas of youth’s health and family planning) from the nine OP countries;
- Young leaders from the nine OP countries (including Family Planning Young Ambassadors, members of the International Youth Alliance for Family Planning, and members of AfriYAN and of IPPF’s Youth Action Movement);
- National civil society organizations from the nine OP countries;
- International and regional partners, including: World Health Organization (WHO), West African Health Organization (WAHO);
- International NGOs addressing AYSRH in the region: EngenderHealth and its AgirPF project, IntraHealth, IPPF, Marie Stopes International (MSI), Médecins du Monde, Mercy Corps, Pathfinder International and its Evidence for Action (E2A) project, Palladium;
- The OP Coordination Unit;
- Members of the OP Youth Think Tank, specifically the Thematic Group Co-Chairs such as SOS-JD, Equilibres et Populations, Population Action International (PAI), and IntraHealth’s Civil Society for Family Planning (CS4FP) project;
- Financial partners including: USAID, Merck/MSD, and the Packard Foundation;
- Participants from the Democratic Republic of Congo (DRC) who attended as observers, in preparation for a similar workshop that will take place in their country.
**Methodology and approaches used at the workshop**

- **Youth pre-meeting (May 9, 2017)**

  The day-long youth pre-meeting brought together representatives of youth-led organizations from across francophone West Africa. It was facilitated by the Torchlight Collective. The pre-meeting’s objectives were: (1) to increase young participants’ understanding of national Costed Implementation Plans (CIPs) for Family Planning; (2) build their capacity to analyze their home countries’ CIPs and identify strengths and weaknesses in related to AYSRH; and (3) identify effective ways to ensure young people’s participation in efforts to develop, implement, monitor and evaluate national CIPs.

  Through a participatory process, young people were enabled to autonomously identify opportunities for improving their own SRH, and develop appropriate proposals that can be included in the various countries’ CIP implementation efforts. The pre-meeting was also an opportunity for young participants to prepare their speeches and presentations ahead of the main technical workshop sessions they were taking part in as speakers or facilitators. See the pre-meeting report [here](#).

- **Main technical workshop (May 10-11, 2017)**

  Several methodologies were used to ensure a dynamic and participative workshop ([see Annex 2 for a detailed workshop agenda](#)), including:

  - A panel session featuring representatives of Ministries of Health from the nine OP countries, which included presentations and an interactive discussion;
  - Technical panels featuring oral presentations and questions and answers sessions;
  - Breakout sessions bringing together country delegations of multi-country groups, followed by plenary report-back.

  Such approaches allowed the various stakeholders from OP countries and DRC to examine AYSRH-related activities within their countries’ CIPs, and to articulate specific recommendations, including towards promoting the OP Youth Think Tank Roadmap.²

**Opening ceremony**

Presided by the Minister of Health of Burkina Faso, the opening ceremony featured several speakers including representatives from USAID, E2A/Pathfinder International, the Bill & Melinda Gates Foundation, as well as Burkina Faso’s Minister of Health who officially declared the meeting open.

Overall, all speakers in the official opening ceremony highlighted the inadequacy of strategies for the promotion of young people’s access to SRH services, and specifically family planning services. OP countries and the DRC have therefore experienced extremely limited uptake of family planning services by young people. They noted that these countries need to address the group’s significant unmet needs for family planning.

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² The OP Youth Think Tank was established by the OP Coordination Unit in the aftermath of the Partnership’s 2015 annual meeting. The Youth Think Tank is composed of AYSRH technical experts as well as young leaders affiliated with civil society organisations and international NGOs that work on AYSRH in OP countries. The role of the Youth Think Tank is to support the OP in its efforts to design strategic and technical guidance for OP countries and partners as they implement adolescent and youth-related recommendations from the 2015 and 2016 annual meetings. The Youth Think Tank also serves as an information-sharing and learning mechanism among OP countries, and as a technical group for the promotion of youth participation in decision-making and implementation AYSRH activities.
In that regard, they unanimously acknowledged the need for all OP countries and their partners to commit to develop concrete solutions for improving AYSRH, thus harnessing the demographic dividend in each country and progressing towards sustainable development.

II. SUMMARY OF PROCEEDINGS

1. Overview of existing interventions addressing young people’s family planning needs

1.1. The nine OP countries’ flagship initiatives for increasing access to, and use of, youth-friendly contraceptive services

Representatives from the nine OP countries’ Ministries of Health shared an overview of their current priorities with regards to contraceptives for adolescents and young people, highlighting key measures for implementing activities from their respective CIPs that focus on adolescents and young people.

There were similarities among the initiatives presented by country representatives, which fall into the following categories:

- Promoting meaningful youth participation in the development and evaluation of CIPs (Burkina Faso, Mali, Togo);
- Introducing or institutionalizing age-appropriate and integrated comprehensive sexuality education modules in school and university curricula and for out-of-school youth (Benin, Togo);
- Establishing and sustaining youth-friendly health services as an integral part of existing health training programs;
- Providing free contraceptive methods for young people (Benin, Côte d’Ivoire, Niger);
- Innovative youth-specific strategies: mobile units at youth forums (Niger, Senegal), youth centers in marketplaces (Benin), blues zones (Guinea), zero pregnancy in school campaign (Côte d’Ivoire); provision of family planning methods, including contraceptive injections, at the community level (Guinea);
- Specific strategies for reaching out-of-school youth: through youth groups formed by the Ministry of Youth, through marketplaces, street vendors, youth groups, community groups, etc. (Benin, Côte d’Ivoire, Senegal);
- Strengthening access to AYSRH-related information through social media, counseling centers, and peer education (Benin, Burkina Faso, Guinea, Mali);
- Engaging religious leaders as promoters better communication between parents and children (Mauritania);
- Adopting or developing laws on reproductive health that guarantees access young people’s access to SRH information, education and services (Côte d’Ivoire, Mauritania);
- Developing initiatives aimed at keeping more girls in school (Niger).

1.2. Key challenges to implementing the CIPs’ activities targeting young people

Health Ministry representatives from OP countries and the DRC identified some of the major challenges they have faced in their efforts to implement their CIPs, including:
- Restrictive socio-cultural norms and reluctance from individual health care providers to attend to young people’s needs;
- Lack of family planning activities that specifically target young people;
- Lack of or poor implementation of laws and policies guaranteeing young people’s sexual and reproductive rights (poor implementation of and laws and policies addressing child marriage);
- Limited access to information about young people’s SRH and family planning;
- Few effective strategies targeting out-of-school and vulnerable youth;
- Inadequate girl empowerment strategies.

2. Evidence-based practices for improving young people’s access to, and use of, contraceptive services

The analysis of previous CIPs from OP countries and the DRC revealed a shortage in evidence-based practices and strategies for young people’s access to, and use of, contraceptive services. This session was an opportunity to share effective and promising evidence-based strategies and practices which have yielded results in other contexts. Such strategies and practices will be useful for participating countries in their efforts to improve AYSRH strategies in their current or future CIPs, but also to boost their adolescent and youth family planning indicators.

2.1. Overview of the WAHO October 2016 pre-forum recommendations (presented by WAHO)

A panelist from WAHO opened the session by sharing the findings of a 2015 WAHO-led situation analysis on adolescent health. Major challenges were identified, including: the discrepancy between adolescents’ and young people’s knowledge of SRH and their actual practices and behaviors; high prevalence of teenage and unwanted pregnancies in ECOWAS countries; harmful practices that have a negative impact on the health of adolescents and young people; and a need for adolescent and youth health policies and programs to integrate the existing knowledge and evidence. The panelist also shared the key recommendations that emerged from a pre-workshop forum on adolescent health, which took place in Grand-Bassam, Côte d’Ivoire, in October 2016. The recommendations include: promoting the participation of adolescents and young people in all stages of policies, programs, and interventions that pertain to their own health; providing a multi-sectoral and comprehensive response to young people’s diverse yet specific needs; increase domestic investments to address priority issues and needs related to adolescents’ and young people’s health.

2.2. Overview of the evidence about effective and promising practices on AYSRH (presented by E2A and WHO)

The joint presentation by the E2A Project and WHO highlighted the unique and favorable momentum for supporting adolescents and young people. In OP countries, governments are increasingly integrating AYSRH in national policies and programs. In addition, the international community is largely committed to strengthening efforts to improve adolescents’ and young people’s health and wellbeing.3

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3 Signs of such commitment include: the recent addition of adolescence as a key component of what is now the Global strategy on women’s, children’s and adolescent’s health; the ongoing WHO-led preparations for a global framework on adolescent health (AA-HAI); and the choice of adolescence and youth as the main theme for both the OP annual meeting and the July 2017 high-level summit on FAMILY PLANNING.
Yet, the prevalence rates of modern contraceptive methods in OP countries reveal that adolescent and young women’s use of contraception is significantly lower than older women’s, especially those who are married or in union. What, then, should be done, or done differently?

The panelist listed a number of practices proven to increase young people’s access to, and use of, contraceptive services. These included:

- Removing political barriers to young people’s access to SRH services;
- Reaching vulnerable and underserved youth groups;
- Expanding the range of contraceptive methods that are available to adolescents and young people;
- Making integrated adolescent- and youth-friendly SRH services available close to where youth groups are located;
- Putting in place a capacity-building package for service providers;
- Complementing contraceptive services with interventions such as comprehensive sexuality education, support to families and communities, girls’ empowerment and multi-sectoral coordination;
- Effectively promote young people’s leadership in AYSRH programs.

While the above-mentioned practices are critical to increasing young people’s access to, and use of contraceptive services, they will not be effective if used in isolation. Experts have recommended that integrated, multi-sectoral programs be established to promote change at all levels of the socio-ecological model (i.e. individual level, relational level, community level and structural level).

### 2.3. Expanding the offer for contraceptive methods (presented by WHO and Pathfinder International)

In 2015, the WHO reviewed eligibility criteria for clients—including adolescents and young people—to access contraceptive methods. The workshop was an opportunity for participants to learn about the updated, more specific criteria, which they can now include in their action planning and in training programs for family planning practitioners. According to the new eligibility criteria:

- From a medical standpoint, adolescent girls are generally eligible for all effective and reversible contraceptive methods, and for emergency contraception;
- Comprehensive sexuality education needs to be expanded to reach all adolescents and young people;
- All reversible contraceptive methods should be available and accessible to adolescents and young people;
- Service providers should undergo a training on contraceptive technology, but also on the range of youth-friendly contraceptive services;
- It is critical to ensure young people’s access to comprehensive information and quality counseling about all contraceptive options available;
- It is critical to create an environment that enables adolescents and young people to make informed and comprehensive choices regarding contraception, through:
  - Laws, policies and guidelines that guarantee access to the whole range of contraceptive methods;
  - Support to community-level action and promotion of a gender-based approach;
  - Encouraging adolescents and young people’s participation in SRH- and family planning-related initiatives.

Following the WHO’s presentation on eligibility criteria, a panelist from Pathfinder International shared information about “The Global Consensus Statement for Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting and Reversible Contraception”. The statement, which
has garnered support from about 50 organizations and hundreds of individuals around the world, is a powerful tool for addressing the barriers to young people’s access to long-acting and reversible contraceptives (LARCs). It summarizes evidence on the effectiveness, acceptability and safety of LARCs and presents strategies for improving adolescent and young women’s access to these methods.

2.4. Creating demand for, and supply of FAMILY PLANNING services for married young women and first-time parents (presented by Pathfinder International)

A representative from Pathfinder International in Niger presented evidence-based approaches targeting married adolescent girls and first-time parents (FTPs), including:

- Integrating strategies for creating demand for, and supply of, services;
- Implementing interventions that are tailored to the various levels in the socio-ecological model: the individual and social level (through home visits, small-group meetings with married adolescent girls, and referrals to health facilities), the community level (through engaging husbands, co-wives and community leaders), and the structural level (through strengthening the supply of youth-friendly services and improving the legal and policy framework);
- Providing community-based services and access to a wide range of contraceptive methods, including LARCs and Sayana Press;
- Including adolescents and youth in health, education, gender equality and other relevant policies;
- Evaluating and scaling up interventions that specifically target married adolescents and FTPs;
- Involving young married couples and FTPs as early as the interventions’ development stages.

2.5. Young people’s recommendations for strengthening youth participation in AYSRH initiatives (from the pre-meeting)

In addition to taking part in the workshop, youth participants from the OP countries attended a day-long pre-meeting during which they learned more about evidence-based AYSRH practices and identified opportunities for using their newly acquired knowledge to address the needs of fellow young people at home.

During the participative pre-meeting session, young people formulated seven key recommendations for improving AYSRH. The recommendations mostly focus on the need for strengthened capacity and leadership for young people and the importance of involving young people in any intervention, decision, or the development of any strategy that pertain to their well-being.

### Young people’s recommendations, as formulated in the May 9 pre-meeting

1. Formalize the Costed Implementation Plan process to ensure effective contribution and participation from young people.
2. Establish a coalition composed of youth-led groups, which will take part in deliberations and decision-making in each country.
   - Identify and train youth regional focal points in each country (from within influential youth-led groups).
   - Establish monitoring and evaluation groups whose work will focus on evaluating programs/projects and budgets allocated to SRH.

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4 First-time parents include young married women (up to 25 years of age) with a child, and their partners.
3. Hold training and capacity-building sessions for young people, with a focus on budget formulation and management, monitoring and evaluation, and AYSRH-related ICT.
4. Allocate to young people full responsibility for implementing youth-specific activities.
5. Develop a national directory of all youth-led organizations and groups that can convey accurate SRH information.
6. Consider greater transparency over available resources as well as the role of partners in implementing plans.
7. Establish yearly national “youth advocacy days” when young people can share advocacy messages with decision-makers (government officials, donors and technical partners, teachers). Such days will allow young people to interact directly with decision-makers, in order to take stock of progress on decisions that relate to their lives, and to make proposals of their own.

III. METHODOLOGY

3. Analysis of national Costed Implementation Plans (CIPs)

3.1. Methodology and preliminary observations of the study on the inclusion of adolescent and youth in CIPs

Pathfinder International and E2A developed an innovative methodology for analyzing how adolescents and young people and their issues are included in CIPs. The methodology adds to, and complements, recent analysis of AYSRH-related policies and programs such as PAI’s 2015 analysis of CIPs in Burkina Faso, Niger, Senegal and Togo, and PRB’s youth family planning policy scorecard, which was released in 2016/2017.

Pathfinder International and E2A’s methodology aimed to achieve the following:

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 CIPs:
   a. Reinforce activities that specifically target adolescents and young people.
   b. Improve the inclusion of adolescents and young people in non-specific activities.

In the lead-up to the workshop, E2A and Pathfinder conducted a preliminary analysis of CIPs in OP countries and the DRC. The methodology includes three main pillars:

1. Quantitative analysis of the following three elements, illustrated in pie charts (see Annex 3 for preliminary findings for all OP countries):
   a. Proportion of CIP activities that specifically target adolescents and young people\(^5\);
   b. Proportion of the budget that is allocated to activities targeting adolescents and young people\(^6\);

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\(^5\) Activities that explicitly refer to adolescents and young people: activities implemented in schools, etc.
\(^6\) On the basis of the implementation plans’ overall budget.
c. Proportion of activities targeting adolescents and young people, per activity type (e.g., stimulating demand, supplying services, ensuring an enabling environment, and coordination/monitoring and evaluation/research). 

2. Qualitative analysis of how evidence-based practices for improving AYSRH are included in CIP activities that target adolescents and young people. This component of the analysis aims to identify opportunities for strengthening activities targeting adolescents and young people by promoting practices with proven effectiveness. A multicolor evaluation system was used to present the preliminary findings of the analysis.

3. Qualitative analysis of how evidence-based practices for improving AYSRH are included in non-specific CIP activities. This component of the analysis seeks to identify opportunities for

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These are the CIPS’ four main activity areas, as most CIPs already sort activities by area. For countries whose CIPs do not include areas, we referred to the system presented in other countries’ CIPs. It is acknowledged that the most recent CIPs have safeguarded products as an additional area – which is included in the “supply” section of our analysis.
ensuring non-specific CIP activities are youth-friendly. A multicolor evaluation system was used to present the preliminary findings of the analysis.

E2A and Pathfinder International identified eight types of evidence-based practices, based on a review of effective and promising practices for improving access to quality services and increasing young people’s and adolescents’ uptake of these services in low- and middle-income countries (see Annex 5 for an overview of the best practices). The eight types of practices are:

- Provision of adolescent- and youth-friendly SRH services
- Expanding the range of contraceptive methods available to adolescents and young people (including LARCs and DMPA-SC)
- Inclusion of vulnerable and underserved youth groups (including married adolescent girls ad FTPs)
- Youth participation and leadership in AYSRH programs
- Multi-sectoral coordination for AYSRH
- Comprehensive sexuality education
- Support to families and communities for AYSRH
- Girls’ empowerment

The analysis reviewed the following national Costed Implementation Plans (CIPs):

- **Benin**: National CIP for repositioning family planning in Benin for 2014-2018
- **Burkina Faso**:
  - National family planning stimulus plan for 2013-2015
  - Draft national plan for accelerating family planning in Burkina Faso for 2017-2020
- **Côte d’Ivoire**: National family planning CIP for 2015-2020
- **Guinea**: National repositioning family planning action plan in Guinea for 2014-2018
- **Mali**: National family planning action plan for 2014-2018
- **Mauritania**: National action plan for birth spacing for 2014-2018
- **Niger**: Family planning in Niger action plan for 2012-2020
- **Senegal**: National family planning strategic framework for 2016-2020
- **Togo**:
  - National repositioning family planning action plan in Togo for 2013-2017
  - Draft national costed implementation plan for 2017-2020 (not yet validated)
- **DRC**: Family Planning National Multisectoral Strategic Plan for 2014-2020

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8 The draft national plan was still being developed at the time of the workshop.
9 The document was still being developed at the time of the workshop.
**Preliminary observations**

Workshop participants broke into country groups to reflect on the preliminary analysis of the CIPs and make suggestions for improving the analysis.

The analysis highlighted the CIPs’ key weaknesses as follows:

- Only a low proportion of the planned activities target adolescents and young people;
- Only a low proportion of budgets are allocated to activities that promote youth access to family planning (generally under 15%);
- Few youth-friendly services are offered; the CIPs mostly focus on activities that aim at stimulating demand;
- Youth participation in CIP development processes is weak;
- Finding the right balance between coordination and creating an enabling environment remains a challenge.

To improve implementation of existing CIPs or the development of future ones, country groups made suggestions that can be summarized as follows (see Annex 6 for an overview of preliminary country-specific recommendations):

- ✓ Use Information and communication technology (ICT) to reach young people and raise awareness among them;
- ✓ Integrate comprehensive sexuality education in schools;
- ✓ Ensure school-based health facilities (in schools, high schools and universities) provide the full range of services;
- ✓ Involve religious and traditional leaders in all stages of the CIP development and implementation process;
- ✓ Train service providers on the youth-friendly approach;
- ✓ Train stakeholders on using the contraceptive supplies management information systems;
- ✓ Make family planning available to young people free or charge;
- ✓ Empower young people to take part in the implementation of activities, for them with them;
- ✓ Include vulnerable adolescents and young people;
- ✓ Make AYSRH services available to rural in-school youth;
- ✓ Strengthen coordination mechanisms to ensure effective monitoring of the plans’ implementation.

### 3.2. Mainstreaming evidence-based practices as part of the implementation of CIP activities targeting adolescents and young people

Reflecting on how to make the most of the CIP development and implementation processes, workshop participants discussed four key areas related to best practices. Their objective was to identify ways to better develop and implement CIPs by including evidence-based practices. Nine cross-country working groups explored the following four themes:

- Providing youth-friendly services
- Expanding contraceptive choice for adolescents and youth
- Reaching married adolescents and first-time parents through demand creation and service provision
- Youth participation and collaboration between young people and adults
Participants discussed the following three questions: (1) What major challenges do you face when implementing evidence-based practices for adolescents and young people? (2) How have you successfully overcome these challenges and barriers? (3) To what extend does your country’s CIP mainstream effective, evidence-based practices in its activities that specifically target adolescents and young people?

Providing youth-friendly services

Adolescent- and youth-friendly SRH services are those that meet the WHO’s five criteria for adapting services for adolescents and youth\(^\text{10}\) and respect international norms for improving the quality of health services for adolescents and youth.\(^\text{11}\)

Challenges
- Socio-cultural barriers are rooted in communities: sexuality is taboo;
- Stigmatization of, and discrimination against adolescents and young people on SRH issues;
- Services are not youth-friendly: opening hours are not practical for young people, service providers are not adequately trained on the youth-friendly approach;
- Adolescents and young people cannot afford SRH services;
- There is inadequacy between demand and supply when it comes to services for young people.

Countries’ efforts to strengthen delivery of youth-friendly services
- Providing AYSRH services to young people under the age of 25 in communities;
- Providing AYSRH services in schools and universities;
- Community-based provision of short-term contraceptive methods (pills, condoms, injectable contraceptives);
- Building the capacity of providers on AYSRH;
- Peer education strategies through youth SRH clubs in youth centers and universities;
- Youth participation and leadership in AYSRH programs;
- Strategies for increasing family and community support to AYSRH;
- Promoting youth centers, which provide free services for young people (e.g., youth-friendly centers, blue zones, counselling centers for adolescents and young people);

Mainstreaming evidence-based practices in CIP activities that target adolescents and young people

Generally speaking, CIP activities that target adolescents and young people include practices such as youth participation and leadership in AYSRH programs, community-based distribution, use of mobile technology, capacity building of providers on AYSRH, school- and university-based health facilities, and youth centers. Comprehensive sexuality education is also featured in CIPs, even though it does not directly contribute to strengthening youth-friendly service supply. However, workshop participants noted that CIPs do not adequately include strategies that aim to increase family and community support to AYSRH and improve acceptance of youth-friendly services. In addition, services provided to adolescents and young people do not fully meet the


WHO-established international norms for improved quality of health services for adolescents.\textsuperscript{12} Lastly, integration of youth-friendly elements in existing contraceptive services was deemed unsatisfactory.\textsuperscript{13}

**Expanding contraceptive choice for adolescents and youth**

Providing a full range of contraceptives, including LARCs, to adolescents and young people helps increase this population’s uptake of contraception.\textsuperscript{14} The provision of a full range of contraceptive methods to adolescents and young people is in line with the WHO’s third norm for improved quality of health services for adolescents.\textsuperscript{15} Any adolescent, regardless of their age, sexual orientation, marital status or state of pregnancy, is eligible for each and every contraceptive method. According to the WHO’s Medical Eligibility Criteria for contraceptive use, age alone does not constitute a contraindication to the use of contraceptive methods, including LARCs.

**Challenges**

- **In relation to demand**: weight of religion and socio-cultural norms (including health providers’ individual belief systems); fear of side effects from LARCs; ill-founded rumors about LARCs; lack of information for young people.
- **In relation to provision of, and access to, quality care**: despite the need for qualified providers, most providers are not competent (and the selection criteria for their positions are unknown); insufficient counseling about LARCs; unavailability of LARCs outside of the main health centers, which frequently run out of stock; and expensive costs of LARCs.
- **In relation to the environment**: Lack of dialogue between parents and their children; lack of knowledge of key legislation regarding SRH; and necessity for young people to obtain consent from parents and/or husbands before accessing certain contraceptive methods.

**Countries’ efforts to strengthen delivery of youth-friendly services**

- Training service providers on issues such as: quality counseling, provision of LARCs, product management and monitoring, and adolescent and youth-friendly approach;
- Ensuring budgets include a specific line item on AYSRH;
- Drafting laws that guarantee young people’s access to contraceptives, free of charge;
- Mobilizing religious leaders and equipping them to convey credible, well-informed messages on the whole range of contraceptive methods;
- Establishing free helplines for young people to obtain information on all contraceptive methods.

**Mainstreaming evidence-based practices in CIP activities that target adolescents and young people**


\textsuperscript{14} Michelle J. Hindin et al., “Interventions to Prevent Unintended and Repeat Pregnancy Among Young People in Low- and Middle-Income Countries: A Systematic Review of the Published and Gray Literature”, *Journal of Adolescent Health* 59, no. 3 (2016): S8-S15.

Workshop participants found that, despite efforts to provide adolescents and young people with a wider choice of contraceptive methods, CIPs’ mainstreaming of evidence-based practices aimed to expanding the range of contraceptives available to youth remains weak. They highlighted the importance for efforts to implement existing CIPs and to develop second-generation CIPs to take into account the broader family planning choices that are available to adolescents and young people, thus ensuring:

- A comprehensive range of methods is available;
- Service providers have the required competences to deliver youth-friendly contraceptive services;
- Adolescents and young people can access information and counseling on the whole range of methods;
- An enabling environment that encourages adolescents and young people to make their own choices related to contraception.

Reaching married adolescents and first-time parents by creating demand and providing services

Adolescents and young people are a complex group whose diverse features result in diverse needs and vulnerabilities. There are blatant inequalities in health and wellbeing within vulnerable and underserved youth groups. In Francophone West Africa, married adolescents and FTPs are among the most vulnerable to being affected by closely spaced pregnancies, and to being underserved by SRH programs and services.

Challenges

- Key community influencers, including mothers-in-law, co-wives, husbands and partners may be opposed to married adolescents’ and FTPs’ use of contraception;
- Certain socio-cultural practices, including polygamy and son preference, limit married adolescents’ and FTPs’ decision-making power;
- Service providers may pass a moral judgement onto young people;
- Married adolescent girls and FTPs themselves lack information about, and do not seek contraception;
- Some religious leaders are opposed to contraception.

Countries’ efforts to strengthen delivery of youth-friendly services

- At the individual level: Creation of safe spaces with youth mentors; home visits and referrals to health facilities by mother-educators; group discussions bringing together young married women and FTPs.
- At the community level: group discussions with key influencers including husbands; mobilizing of marabouts as family planning champions in Niger; sensitization of religious leaders through sermons; and mobilization of co-wives and mothers-in-law in Burkina Faso.
- At the health facility level: addressing target groups separately to address their specific needs; youth-friendly services; postpartum family planning for young mothers in DRC.

Mainstreaming evidence-based practices in CIP activities that target adolescents and young people

It was noted that the above-mentioned evidence-based practices are seldom included in CIPs, and if they are, it is in small-scale, one-off projects.

Youth participation and collaboration between young people and adults
Adolescents and young people are a strength for their own health and that of their families and communities. They are key social change actors—not just beneficiaries of social change programs. The United Nations define youth participation as the active and meaningful participation of young people in all aspects of their own development and that of their communities, including their empowerment towards contributing to decisions that pertain to their personal, family, social, economic, and political development. Meaningful participation of adolescents and young people is essential to the effectiveness of health service and programs, including AYSRH. Adolescent participation is therefore one of WHO’s eight international norms for improved quality of health services for adolescents.

Challenges

- Cultural taboos surrounding adolescents and young people’s sexuality;
- Lack of coordination among youth-led groups that take part in AYSRH-related activities;
- Inadequate official mechanisms for ensuring meaningful youth participation in decision-making;
- Lack of understanding by young people of evidence related to AYSRH, and of national policies and programs.

Countries’ efforts to strengthen delivery of youth-friendly services

- Youth participation in coordination mechanisms that bring together all actors engaged in SRH;
- Involvement of young people in the 90/90/90 initiative that addresses HIV/AIDS;
- Capacity building for young people on SRH, ITC and leadership skills;
- Youth participation in FAMILY PLANNING campaigns.

Mainstreaming evidence-based practices in CIP activities that target adolescents and young people

It was noted that to improve youth participation, mechanisms that aim at strengthening youth participation in the development, implementation, and monitoring and evaluation of CIPs should be formalized in all OP countries and in the DRC.

3.3. Opportunities for mainstreaming adolescents and young people in non-specific CIP activities

Building on the analysis of evidence-based practices, workshop participants came together in country groups to reflect on opportunities for mainstreaming adolescents and young people in the range of non-specific family planning services provided through the CIPs. Countries are faced with the following options for improving adolescents and young people’s access to family planning services (see Annex 7 for country-specific opportunities):

Provision of adolescent- and youth-friendly services

- Building the capacity of service providers to use the youth-friendly approaches, in order to make health facilities more youth friendly;

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- Establishing youth-friendly mobile units and service delivery clinics;
- Making sure contraceptive methods can be accessed free of charge;
- Making youth-friendly services, including the full range of contraceptive methods, available to adolescents and young people through school-based health facilities.

**Expanding family planning choices for adolescents and young people**
- Making the full range of contraceptive supplies available;
- Improving the quality of information provided to young people through better counseling, thus enabling young people to make informed choices about their contraceptive methods;
- Training service providers on the full range of contraceptives, including LARCs;
- Ensuring all service provision units are equipped to deliver all methods;
- Removing the financial barrier (third-party payment policy);
- Establishing a community-level delegation to raise awareness on injectable contraceptives.

**Reaching married adolescents and first-time parents**
- Training previously active service providers on how to use antenatal care contacts to share information with pregnant adolescent girls about the range of family planning methods she can use after giving birth to delay her second pregnancy;
- Using mobile service delivery by building on sensitization campaigns and working with champion religious leaders, soon-to-be married couples, and recently married couples who can be role models;
- Strengthening communications with individuals who can influence recently married adolescent girls’ access to the services provided by the mobile units (mothers-in-law, aunts);
- Unpacking messaging and communication tools and using those that are relevant to the target groups’ specific vulnerability, i.e. for married adolescents and FTPs;
- Scaling up the “husband schools” approach.

**Youth participation**
- Ensuring young people’s participation in activities by sensitizing them before the activities take place;
- Contributing to efforts to mobilize other young people through animations, peer educators, referrals, etc.);
- Mobilizing young people to be part of mobile unit teams (for youth mobilization, advice, etc.);
- Involving young people in the distribution of contraceptive products;
- Ensuring young people are formally involved in reproductive health/family planning coordination mechanisms.

**Multi-sectoral coordination**
- Establishing monitoring and coordination structures that bring together several line ministries as well as civil society organizations;
- Involving various sectors: private sector (clinics), traditional medicine practitioners, local authorities (mayor’s office) and ministries.
IV. RECOMMENDATIONS

The workshop was an opportunity for participants to identify various types of recommendations and priorities, including:

- Overall recommendations for all countries;
- Recommendations by young people from OP countries, addressed to decision-makers;
- Three priorities for each country, aimed at improving the inclusion of adolescents and young people in the implementation of CIPs. The priorities were identified at the end of the workshop, through consensus within each country team after reviewing outcomes of the various sessions and group work. Plans were made to share the priorities with key stakeholders in participants’ respective home countries.

OVERALL RECOMMENDATIONS

1. Increase the proportion of planned activities that target adolescents and young people. Activities should specifically target adolescents and young people, not just affect them indirectly. Burkina Faso and Togo have made good progress in developing their second-generation CIPs, and could become a reference for other countries in the region.

2. Increase the percentage of the budget that is allocated to activities that specifically aim to promote young people’s access to family planning.

3. Highlight activities that aim to increase the provision of family planning services to adolescents and young people, as most countries currently have a disproportionate focus on generating demand.

4. Improve the quality of activities targeting adolescents and young people, as well as their alignment with evidence-based practices. Take into consideration evidence about strategies that do not work—for example, youth centers (which have not led to increased use of contraceptives by young people).

5. Formalize mechanisms that allow for effective and meaningful youth participation in the development and implementation of CIPs and in AYSRH programs.

6. Formalize multi-sectoral coordination that will promote other ministerial sectors’ contribution to efforts to improve adolescents’ and young people’s health.

7. As part of efforts to develop and implement CIPs, prioritize evidence-based activities that aim to:
   - Increase access to youth-friendly contraceptive services, including by:
     - Integrating youth-friendly service delivery elements in existing SRH services;
     - Expanding community and mobile services that specifically target young people;
     - Making contraceptives available to young people, free of charge.
   - Expand adolescents’ and young people’s contraceptive choices, through:
     - Putting in practice the WHO Medical Eligibility Criteria for contraceptive use and remove legal and political barriers;
     - Provide judgement-free counseling.
     - Ensure access to the full range of methods, including DMPA-SC and LARCs.
   - Review programs to reach underserved and vulnerable youth groups including married adolescent girls, young parents or FTPs, as well as school dropouts and young people who never attended school.
- Scale up evidence-based practices for increasing support from families and communities to adolescents’ and young people’s access to SRH information and services.
- Formally integrate comprehensive sexuality education in school curricula and out-of-school programs.
- Mainstream gender-transformative approaches in activity planning and implementation.
## COUNTRY-SPECIFIC RECOMMENDATIONS

<table>
<thead>
<tr>
<th>Country</th>
<th>Recommendations from young people</th>
<th>Top three priorities for improved mainstreaming of adolescents and young people in CIP implementation</th>
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</table>
| Benin        | • Involve young people early on, in CIP planning, drafting, monitoring of the implementation and through participation in coordination mechanisms.  
• Turn the 2013 commitment to make contraceptives available to young people free of charge into reality.  
• Better include vulnerable youth groups, especially school dropouts and young people who never attended school. | 1. Build the capacity of service providers, on delivering quality health and family planning services for young people and others.  
2. Establish CIP monitoring and coordination mechanisms, including for activities that target young people.  
3. Ensure adolescents and young people are exempted from paying any direct family planning service costs. |
| Burkina Faso | • Put young people first: trust them and give them space to thrive.                                                                                | 1. Make contraceptive services free of charge for adolescents and young people.  
2. Advocate for resource mobilization.  
3. Ensure coordination among partners (technical and financial partners and implementing partners) towards improved inclusion of adolescents and young people in family planning activities. |
| Cote d’Ivoire | • Break the taboos that surround AYSRH.  
• Improve communication and broker dialogue between parents and children.  
• Establish an ongoing youth capacity building process on issues related to reproductive health. | 1. Further promote demand creation (through sensitization campaigns), involving all relevant actors.  
2. Create a great deal of additional services in order to meet the needs of adolescents and young people.  
3. Put in place a coordination mechanism that starts from the central level and trickles down to the local level (préfecture de santé) |
<p>| Guinea       | • Improve the political environment in order to promote youth leadership.                                                                          | 1. Educate and sensitize adolescents and young people through intergenerational communication.                                                                                                  |</p>
<table>
<thead>
<tr>
<th>Country</th>
<th>Key Recommendations</th>
<th>Additional Recommendations</th>
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</table>
| Mali    | • Involve young people early on, in CIP planning, implementation and monitoring and evaluation processes.  
          • Improve youth access to contraceptives by making them free of charge for young people.                                                                 | 2. Establish ‘youth corners’ in health facilities.  
          3. Better involve stakeholders in planning and in coordination meetings.                                                                                           |
| Mali    | • Ensure CIPs include a significant budget line dedicated to AYSRH.                                                                                                                                                     | 1. Conduct advocacy to influence decision-makers and the national youth council.  
          2. Engage religious leaders.  
          3. Effectively mobilize resources.                                                                                                                                                                                     |
| Mauritania | • Inform young people and build their capacity, including through the promotion of ITC.  
              • Include comprehensive sexuality education in schools.  
              • Ensure health facilities in school provide SRH services.                                                                                                                                              | 1. Mainstream family planning in the activity package of 500 health units annually.  
          2. Put in place 1,000 contraceptive community distribution sites across the country every year.  
          3. Include comprehensive sexuality education in schools, and ensure school-based health facilities can provide contraceptive services (secondary school and university-level). |
| Senegal | • Formalize youth participation in AYSRH activities.  
          • Specifically target young people – not just reach them.                                                                                                                                                     | 1. Build young leaders’ capacity (for developing and managing budgets, using ICT for SRH) and develop an app with accurate information about contraception  
          2. Include married adolescent girls and vulnerable adolescents.  
          3. Support efforts to promote family planning among young people during district-level socio-educative activities.                                                                                           |
| Togo    | • Institutionalize comprehensive sexuality education.  
          • Formalize school-based health facilities and make them more systematic.                                                                                                                                         | 1. Institutionalize comprehensive sexuality education.  
          2. Finalize and validate the 2017-2020 CIP, building on AYSRH good practices.                                                                                                                                    |
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<tr>
<th>RDC</th>
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<tr>
<th></th>
<th>Build young people’s capacity to be advocacy agents.</th>
<th>Scale up efforts to integrate SRH services in school- and university-based health facilities.</th>
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</table>

1. Establish an AYSRH sub-group in the CTMPPermanent Multisectoral Technical Committee), both at national and provincial-level.
2. Increase the number of health areas that include AYSRH in at least one reference structure and SES
3. Gradually introduce community-level distribution of contraceptives in at least 5 health areas

\(^{19}\) No youth participants from the DRC attended the workshop.
V. NEXT STEPS

The outcomes from this workshop will feed into the following next steps:

Work with key partners to ensure the workshop’s outcomes are considered in international and regional family planning decision-making mechanisms, including:
- International family planning summit in London, July 2017
- 18th Assembly of the members of the Reproductive Health Supplies Coalition, October 2017
- Annual meeting of the Ouagadougou Partnership, December 2017
- FP2020 Francophone Africa focal point workshop, 2018

Share workshop’s outcomes with members of OP “Youth Think Tank”:
- Ensuring the workshop recommendations are included in the Think Tank’s roadmap (which was developed during the Partnership’s 5th annual meeting, in December 2016)
- Work with Think Tank members to establish a process for monitoring the implementation of the workshop recommendations.

Provide technical assistance to countries towards strengthened youth participation and inclusion of evidence-based AYSRH in CIPs:
- All of the workshop co-organizing partners will continue to support the nine countries to ensure young people are included in AYSRH planning, advocacy and programming, and that the national Costed Implementation Plans include evidence-based practices and can better meet the needs of adolescents and young people from across the region.
- A small team from the DRC also joined the workshop to learn how to adapt the methodology in an upcoming meeting at home. The DRC workshop will take place in August 2017.
- Pathfinder and the E2A Project will provide technical support towards the organization of a youth forum on AYSRH in Niger in 2017.

Provide and share resources and documents about the workshop outcomes
- Produce and share the overall workshop report in French and English.
- E2A will put together a technical document that outlines the CIP analysis technology, to support use of the methodology (and of preliminary results) in other countries.
- Share a blog post by Zeynab Béré, a young participant from Burkina Faso.
- Share FP Voices’ profiles of young participants.

VI. CONCLUSION

The Francophone West Africa Regional technical workshop on AYSRH was an opportunity to collectively explore progress on AYSRH to better plan for future evidence-based investments.

Key issues raised at the workshop mostly focused on the range of adolescent- and youth-friendly services, particularly those targeting married adolescents and FTPs; the expansion of contraceptive method choices for adolescents and young people; youth participation in the formulation of AYSRH plans and strategies; and collaboration between young people and adults. Discussions revealed that despite progress made, several challenges remain. It is critical that CIPs be influenced by youth-led advocacy promoting improved inclusion of young people’s specific AYSRH needs, starting with the need for adolescents and youth to participate at all levels of AYSRH planning and programming. Because, as young people reiterated at the workshop: “what is done for us without us, is done against us.”
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<table>
<thead>
<tr>
<th>Country teams</th>
<th>Name and Title</th>
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<tbody>
<tr>
<td>Benin</td>
<td>Dr. ZANNOU Ahissou Robert Frank</td>
</tr>
<tr>
<td>Benin</td>
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<td>Jérôme CHATIGRE</td>
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<td>Benin</td>
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<td>Burkina Faso</td>
<td>Dr. Robert Kargougou</td>
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<td>Ganda Genevieve Clementine Tarnagda</td>
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<td>Cote d’Ivoire</td>
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<td>Cote d’Ivoire</td>
<td>Akissi Viviane Kouame</td>
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<td>Kotchi Yvan N’gadi</td>
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<td>Guinea</td>
<td>Dr. Feridah MARA</td>
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<tr>
<td>Guinea</td>
<td>Dr Aissatou Diallo</td>
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<tr>
<td>Country</td>
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<tr>
<td>Guinea</td>
<td>Dr. Hadja Bintou Bamba</td>
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<td>Guinea</td>
<td>Cécé Honomou</td>
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<td>Guinea</td>
<td>Hadja Idrissa Bah</td>
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<td>Mali</td>
<td>Mme Fatoumata Maiga</td>
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<td>Dr KEITA Fadima TALL</td>
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<td>Dr Mohamed Lemine Ould Mohamed Khouna</td>
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<td>Dr. HALIMA Moumouni</td>
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<td>HASSANE Atamo</td>
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<td>Kristina Kastler</td>
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<td>Rita Badiani</td>
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<td>Elham Hassen</td>
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ANNEX 2: WORKSHOP PROGRAM

Francophone West Africa Regional technical workshop on adolescent and young people’s sexual and reproductive health

Exploring progress and planning future evidence-based investments for AYSRH

May 10-11, 2017
Ouagadougou, Burkina Faso
Sopatel Silmande Hotel

Workshop objectives
1. Share and reflect on evidence-based practices aiming to improve access to quality contraceptive services and increase contraceptive uptake among adolescents and young people. Practices that are already being implemented in the OP countries will be highlighted;
2. Identify opportunities for strengthening the development or implementation of CIPs and overcoming political and programmatic barriers to advancing AYSRH in OP countries. Specific attention will be paid to the implementation of the OP Youth Think Tank Roadmap and the evidence-based practices it presents as priorities for CIPs.
3. Enable young people to take part in efforts to identify opportunities for ensuring CIPs integrate implementation of evidence-based practices, and define mechanisms for young people to be involved in the implementation of the CIPs.

Expected outcomes
The regional meeting will foster knowledge exchange and technical reflections among country teams, and most importantly, support the implementation and scaling-up of best practices pertaining to youth contraceptive programming.

Each country team will use dedicated working sessions to reflect on their own CIPs and to identify opportunities for advancing AYSRH in line with the evidence-based practices that will be presented at the meeting. Reflections will also aim to identify concrete opportunities for implementing actions outlined in the OP Youth Think Tank’s roadmap. A meeting report with key lessons learned and clear recommendations on the follow-up will be prepared.
**Wednesday May 10, 2017**

Sopatel Silmande Hotel

Ouagadougou, Burkina Faso

<table>
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<tr>
<th>Time</th>
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| 08h30 - 09h15 | OFFICIAL OPENING CEREMONY of the Francophone West Africa Regional technical workshop on adolescent and young people’s sexual and reproductive health: Exploring progress and planning future evidence-based investments for AYSRH  
**Facilitator:** Master of ceremony  
**Keynote speakers** (5 min each):  
- Rita BADIANI, Director of the Evidence to Action (E2A) Project/ Pathfinder International  
- Rodrigue NGOUANA, Country Liaison Manager, Ouagadougou Partnership Coordination Unit  
- Bill and Melinda Gates Foundation representative  
- Bijou MUHURA, Health Office Director, USAID Burkina Faso  
**Opening remarks** (10 min)  
- General Secretary, Ministry of Health of Burkina Faso |
| 09h15 – 09h45 | Coffee break / Interviews |
| 09h45 – 10h15 | INTRODUCTORY SESSION  
**Facilitator:** Master of ceremony  
- Introduction of the participants: name, country and organization  
- Logistical information (presented by Pathfinder International and the Sopatel Silmande Hotel)  
- Presentation of the workshop objectives and program |
| 10h15 - 11h30 | PANEL WITH REPRESENTATIVES OF THE MINISTRIES OF HEALTH: OVERVIEW OF EXISTING INTERVENTIONS ADDRESSING YOUNG PEOPLE’S CONTRACEPTION NEEDS  
**Facilitator:** Rodrigue NGOUANA, Ouagadougou Partnership Coordination Unit  
**Expected outcome:** Representatives from the nine OP countries’ Ministries of Health share an overview of their current priorities with regards to contraceptives for adolescents and young people, and participants learn about key measures for implementing CIP activities that target adolescents and young people. |
| 11h30 - 13h00 | PANEL: EVIDENCE-BASED PRACTICES FOR IMPROVING YOUNG PEOPLE’S ACCESS TO, AND USE OF, CONTRACEPTIVE SERVICES  
**Facilitator’ introduction:** Dr Yves MONGBO, West African Health Organization (WAHO)  
**Presentation #1 (10 min):** Overview of the evidence about effective and promising practices on AYSRH – Katie CHAU, Evidence to Action |
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<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>13h00 - 14h00</td>
<td>Lunch break</td>
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<td>Handouts for the breakout session will be distributed.</td>
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<tr>
<td>14h00 - 14h40</td>
<td>Presentation: How Adolescents and Young People are Included in Existing CIPs</td>
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<td>Facilitator: Modibo MAIGA, Regional Director for Project HP+/Palladium</td>
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<tr>
<td>Presentation (20 min): Methodology and preliminary observations of the study on the inclusion of adolescent and youth in the nine CIPs</td>
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<tr>
<td>• Katie CHAU – E2A</td>
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<tr>
<td>• Alison Bodenheimer GATTO – Pathfinder International</td>
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<td>Remarks from PAI (5min): On the links between this CIP study and PAI’s 2015 study on the CIPs of Burkina Faso, Togo, Niger and Senegal.</td>
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<td>Q&amp;A (clarification questions) (15 min) – Session facilitator (Modibo MAIGA)</td>
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<td>Expected session outcome: Participants are familiar with the methodology that was used for the preliminary analysis of CIPs.</td>
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<tr>
<td>14h40 - 15h00</td>
<td>Guidance for the First Breakout Session</td>
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<td>Presented by: Katie CHAU, E2A, and Alison Bodenheimer GATTO, Pathfinder International</td>
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<td>Expected session outcome: Participants understand the objectives and methodology for the first breakout session.</td>
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<tr>
<td>15h00 - 16h00</td>
<td>First Breakout Session</td>
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<tr>
<td>Session objective: To collectively reflect on the analysis of the CIPs and make suggestions for improving it.</td>
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</table>
Expected session outcome: Groups have exchanged thoughts on the CIP study and suggested ways of improving it. Each group has developed detailed feedback on the study that will be shared with the meeting organizers.

16h00 – 16h15 **Coffee break**

16h15 - 17h00 **‘PULSE CHECK’ EXERCISE**

*Facilitated by:* Regina BENEVIDES, E2A

**Expected session outcome:** Preliminary feedback on the CIP study is shared, alongside suggestions of ways to better meet adolescents and young people’s contraception needs.

17h00 **End of the Day**

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### Thursday May 11, 2017

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<tr>
<th>Time</th>
<th>Session</th>
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<tr>
<td>8h30 – 8h45</td>
<td><strong>DAY 1 RECAP</strong> Facilitated by the Master of Ceremony</td>
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<td>8h45 – 9h00</td>
<td><strong>GUIDANCE FOR THE SECOND BREAKOUT SESSION</strong></td>
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<td><em>Presented by:</em> Katie CHAU, E2A, and Alison Bodenheimer GATTO, Pathfinder International</td>
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<td><strong>Expected session outcome:</strong> Participants understand the objectives and methodology for the second breakout session.</td>
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<tr>
<td>9h00 – 10h15</td>
<td><strong>SECOND BREAKOUT SESSION</strong></td>
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<td><strong>Session objective:</strong> To examine ways to strengthen the development or operationalization of CIPs through the implementation of evidence-based practices.</td>
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<td><strong>Expected session outcome:</strong> Ideas for strengthening CIPs’ adolescent- and youth-focused activities are identified. Elements that complement the CIP analysis are identified.</td>
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<td>10h15 – 11h00</td>
<td><strong>SECOND BREAKOUT SESSION REPORT BACK</strong></td>
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<td><em>Facilitator:</em> Master of ceremony</td>
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<td><strong>Expected session outcome:</strong> Main findings of the breakout session are reported in plenary.</td>
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<td>11h00 – 11h30</td>
<td><strong>Coffee Break</strong></td>
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<td>11h30 – 11h45</td>
<td><strong>GUIDANCE FOR THE THIRD BREAKOUT SESSION</strong></td>
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<td><em>Presented by:</em> Katie CHAU, E2A, and Alison Bodenheimer GATTO, Pathfinder International</td>
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<td><strong>Expected session outcome:</strong> Participants understand the objectives and methodology for the third breakout session.</td>
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<tr>
<td>11h45 – 13h00</td>
<td>THIRD BREAKOUT SESSION</td>
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<td><strong>Session objective:</strong> To analyze opportunities for mainstreaming adolescents and young people in non-specific CIP activities.</td>
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<td><strong>Expected session outcome:</strong> Participants develop suggestions for ensuring service supply-related CIP activities are more adolescent- and youth-friendly, taking into consideration the practices discussed during the second breakout session.</td>
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<tr>
<td>13h00 – 14h00</td>
<td>Lunch Break</td>
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<td>14h00 – 15h00</td>
<td>THIRD BREAKOUT SESSION REPORT BACK</td>
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<td><strong>Facilitator:</strong> Master of ceremony</td>
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<td><strong>Expected session outcome:</strong> Main findings of the breakout session are reported in plenary.</td>
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<tr>
<td>15h00 – 15h30</td>
<td>FINALIZING THE ANALYSIS OF CIPs AND PRIORITY INTERVENTIONS FOR IMPLEMENTING THE OP YOUTH THINK TANK ROADMAP</td>
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<td><strong>Facilitator:</strong> Regina BENEDIDES, E2A</td>
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<td><strong>Expected session outcome:</strong> Revisit Day 1 priorities (as captured on post-its) and identify post-workshop actions and next steps.</td>
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<td>15h30 – 16h00</td>
<td>Coffee Break</td>
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<td>16h00 – 17h00</td>
<td>PANEL: RECOMMENDATIONS/PRIORITIES FOR STRENGTHENING CIP IMPLEMENTATION</td>
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<td><strong>Methodology:</strong> Sharing recommendations for country-level action, based on discussions held throughout the workshop.</td>
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<td><strong>Facilitator:</strong> Rodrigue NGOUANA, Ouagadougou Partnership Coordination Unit</td>
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<td><strong>Speakers:</strong></td>
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<td>• Ministries of Health representative</td>
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<td>• Civil society representative</td>
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<td>• Donors representative</td>
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<td>• Youth representative</td>
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<td>• Technical partners representative</td>
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<td>17h00 – 18h00</td>
<td>CLOSING CERIMONY</td>
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<td><strong>Remarks (5 min each) by:</strong></td>
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<td>• Lydia SALOUCOU, Pathfinder International</td>
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<td></td>
<td>• Rodrigue NGOUANA, Ouagadougou Partnership Coordination Unit</td>
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<td></td>
<td>• Teshome WOLDEMEDHIN, Senior Youth and SRH Advisor, USAID</td>
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<td><strong>Closing speech (10 min):</strong></td>
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<td>Ministry of Health of Burkina Faso</td>
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<td>18h00</td>
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ANNEX 3: PRELIMINARY FINDINGS OF THE QUANTITATIVE ANALYSIS OF THE INCLUSION OF ADOLESCENTS AND YOUNG PEOPLE IN THE CIPS (COUNTRY-SPECIFIC)


Proportion of CIP activities targeting adolescents and young people

- Activities targeting young people: 15%
- Activities not targeting young people: 85%

Proportion of the total CIP budget allocated to activities targeting adolescents and young people

- Budget allocated to young people: 12%
- Budget not allocated to young people: 88%

Proportion of activities targeting adolescents and young people, by activity type

- Creating Demand: 33%
- Providing FP Services: 67%
Exploring progress and planning future evidence-based investments for AYSRH


**Proportion of CIP activities targeting adolescents and young people**
- **Activities targeting young people**: 14%
- **Activities not targeting young people**: 86%

**Proportion of the total CIP budget allocated to activities targeting adolescents and young people**
- **Budget allocated to young people**: 5%
- **Budget not allocated to young people**: 95%

**Proportion of activities targeting adolescents and young people, by activity type**
- **Creating demand**: 100%
**Côte d’Ivoire: National family planning costed implementation plan, 2015-2020.**

**Proportion of CIP activities targeting adolescents and young people**

- **Activities targeting young people:** 16%
- **Activities not targeting young people:** 84%

**Proportion of the total CIP budget allocated to activities targeting adolescents and young people**

- **Budget allocated to young people:** 8%
- **Budget not allocated to young people:** 92%

**Proportion of activities targeting adolescents and young people: Creating demand, providing services, fostering an enabling environment, and coordination**

- **Creating demand:** 10%
- **Providing FP services:** 30%
- **Fostering an enabling environment:** 60%

- Proportion of CIP activities targeting adolescents and young people:
  - Activities targeting young people: 12%
  - Activities not targeting young people: 88%

- Proportion of the total CIP budget allocated to activities targeting adolescents and young people:
  - Budget allocated to young people: 91%
  - Budget not allocated to young people: 9%

- Proportion of activities targeting adolescents and young people, by activity type:
  - Creating demand: 57%
  - Providing FP services: 43%
**Mali: National family planning action plan, 2014-2018.**

**Proportion of the total CIP budget allocated to activities targeting adolescents and young people**

- 86% Budget allocated to young people
- 14% Budget not allocated to young people

**Proportion of activities targeting adolescents and young people, by activity type**

- 33% Creating demand
- 59% Providing FP services
- 8% Fostering an enabling environment

**Proportion of CIP activities targeting adolescents and young people**

- 16% Activities targeting young people
- 84% Activities not targeting young people

Proportion of CIP activities targeting adolescents and young people

- Activities targeting young people: 13%
- Activities not targeting young people: 87%

Proportion of the total CIP budget allocated to activities targeting adolescents and young people

- Budget allocated to young people: 11%
- Budget not allocated to young people: 89%

Proportion of activities targeting adolescents and young people, by activity type

- Creating demand: 43%
- Providing FP services: 57%

- **Proportion of CIP activities targeting adolescents and young people**
  - 6% targeting young people
  - 94% not targeting young people

- **Proportion of the total CIP budget allocated to activities targeting adolescents and young people**
  - 9% budget allocated to young people
  - 91% budget not allocated to young people

- **Proportion of activities targeting adolescents and young people, by activity type**
  - 25% creating demand
  - 75% fostering an enabling environment
  - 0% providing FP services
**DRC: Family planning national multi-sectoral strategic plan, 2014-2020.**

**Proportion of CIP activities targeting adolescents and young people**
- Activities targeting young people: 23%
- Activities not targeting young people: 77%

**Proportion of activities targeting adolescents and young people, by activity type**
- Creating demand: 33%
- Providing FP services: 34%
- Fostering an enabling environment: 33%

Pourcentage de l’ensemble des activités du PANB ciblant les adolescents et jeunes

- Activities targeting young people: 2%
- Activities not targeting young people: 98%

Pourcentage du budget total consacré aux activités ciblant les adolescents et jeunes

- Budget allocated to young people: 1%
- Budget not allocated to young people: 99%

Pourcentage des activités ciblant les adolescents et jeunes selon les types d’activités

- Creating demand: 100%
**Exploring progress and planning future evidence-based investments for AYSRH**

**Togo: National repositioning family planning action plan, 2013-2017.**

**Proportion of CIP activities targeting adolescents and young people**

- **Activities targeting young people:** 13%
- **Activities not targeting young people:** 88%

**Proportion of the total CIP budget allocated to activities targeting adolescents and young people**

- **Budget allocated to young people:** 8%
- **Budget not allocated to young people:** 92%

**Proportion of activities targeting adolescents and young people, by activity type**

- **Creating demand:** 43%
- **Providing FP services:** 57%
OVERVIEW OF EVIDENCE-BASED PRACTICES

Francophone West Africa Regional technical workshop on adolescent and young people’s sexual and reproductive health:

Exploring progress and planning future evidence-based investments for AYSRH

May 10-11, 2017

Ouagadougou, Burkina Faso
PROVIDING YOUTH-FRIENDLY SRH SERVICES

What is it about?

Adolescent- and youth-friendly sexual and reproductive health (SRH) services are SRH services that comply the five WHO-established standards as well as international norms for improved quality of health services for adolescents (see table below).20

These elements can be integrated in a range of service provision models (including in health facilities, mobile services, community-based services, etc.). It is critical to note that youth centers (i.e. independent facilities dedicated to entertainment and/or professional training, which include a dedicated room where health care providers offer SRH services) are not an efficient model for increasing SRH service uptake.21

The quality of SRH services can only improve if the key pillars of the healthcare system are all strengthened, including:

- **Governance**, so that policies respect and protect adolescents’ sexual and reproductive rights and are implemented accordingly, and so that national health management information systems are established and provide data that will inform decision-making;
- **Financing**, so that resources are allocated and supplies are provided in a way that meets adolescents SRH needs;
- **Personnel capacity building**, so that healthcare providers have the necessary skills to put the norms and standards into practice;
- **Guaranteeing the availability of the required medicine, supplies and technologies**, so that the healthcare facility can function efficiently.

### Features of adolescent-friendly services (WHO, 2012)

1. **Equitable**: All adolescents, not just selected groups, are able to obtain the health services that are available.
2. **Accessible**: Adolescents are able to obtain the health services that are available.
3. **Acceptable**: Adolescents are willing to obtain the health services that are available.
4. **Appropriate**: The right health services (i.e. the ones adolescents need) are provided to them.
5. **Effective**: The right health services are provided in the right way, and make a positive contribution to adolescents’ health.

### Global standards for improved quality of health-care services for adolescents (WHO, 2015)

1. **Adolescents’ health literacy**: The health facility implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services.
2. **Community support**: The health facility implements systems to ensure that parents, guardians and other community members and community organizations recognize the

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value of providing health services to adolescents and support such provision and the utilization of services by adolescents.

3. **Appropriate package of services**: The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfils the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach.

4. **Providers’ competencies**: Health-care providers demonstrate the technical competence required to provide effective health services to adolescents. Both healthcare providers and support staff respect, protect and fulfil adolescents’ rights to information, privacy, confidentiality, non-discrimination, non-judgmental attitude and respect.

5. **Facility characteristics**: The health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.

6. **Equity and non-discrimination**: The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics.

7. **Data and quality improvement**: The health facility collects, analyses and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff is supported to participate in continuous quality improvement.

8. **Adolescents’ participation**: Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.

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**Reference Documents**


EXPANDING CONTRACEPTIVE CHOICE FOR ADOLESCENTS AND YOUNG PEOPLE

What is it about?

Providing a full range of contraceptives, including LARCs, to adolescents and young people helps increase this population’s uptake of contraception. The provision of a full range of contraceptive methods to adolescents and young people is in line with the WHO’s third norm for improved quality of health services for adolescents (WHO, 2015). Any adolescent, regardless of their age, sexual orientation, marital status or state of pregnancy, is eligible for each and every contraceptive method. According to the WHO’s Medical Eligibility Criteria for contraceptive use, age alone does not constitute a contraindication to the use of contraceptive methods, including LARCs.

A full range of contraceptive methods includes:
- Long-acting and reversible contraception (LARC) methods such as contraceptive implants and IUDs
- Short-term contraceptives such as injections, combined oral contraceptive pills, and progestin-only oral contraceptives
- Barrier methods such as male condoms and female condoms
- The MAMA method (for new mothers)

Unfortunately, adolescent SRH programs often focus on providing barrier and short-term contraceptive methods. Adolescents have less access to long-acting and reversible contraception (LARC) methods than required by the WHO’s Medical Eligibility Criteria, often due to health care providers’ bias or lack of knowledge.

LARCs are among the most effective contraceptive methods. Typically, out of 100 women using a contraceptive implant, less than 1 (0.05%) becomes pregnant within the first year. In the following 3-5 years (depending on the type of implant), up to one pregnancy can happen among 100 women using an implant. The intra-uterine device (IUD) is equally efficient, with less than 1 pregnancy for 100 users (0.08%) within the first year, and up to 10 years. Levonorgestrel IUDs provide similar levels of protection (0.02%) over 5 years.

DMPA-SC contraception (generic name for the DMPA injectable, currently distributed by Pfizer using Sayana Press branding) also provides an opportunity to increase adolescent and young women’s use of contraception. DMPA-SC is an ‘all-in-one’ injectable that could help increase access to family

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planning and expand the range of methods that are available to women, including adolescent and young women, around the world.

The following components are critical to expanding contraceptive choice for adolescents and young people:

- **A comprehensive range of contraceptive methods is available:**
  - Establish an effective system for managing the family planning supply chain, in order to enable adolescents and young people to choose, access and use their preferred contraceptive methods.

- **Service providers have the required competences to deliver youth-friendly contraceptive services:**
  - Training for health care providers on contraceptive technologies, including LARCs, and on the WHO medical eligibility criteria for contraceptive use.
  - Initial and vocational training for health care providers on adolescent- and youth-friendly services available.
  - Facilitative supervision, cue cards and mentorship programs for health care providers.

- **Adolescents and young people can access information and counseling on the whole range of methods:**
  - An informed choice can only be done on the basis of comprehensive information and counselling that focuses on the unique concerns and needs of adolescents and young people.
  - Counselling services must protect young clients’ confidentiality and intimacy.
  - During counselling, the provider should ensure that the adolescent client does not have any medical issues that may prevent him/her from using any given contraceptive methods, as per the WHO Medical Eligibility Criteria.

- **An enabling environment that encourages adolescents and young people to make their own choices related to contraception:**
  - Community support for adolescent demand of, access to, and use of the full range of contraceptive methods.
  - Laws, policies and guidelines that guarantee all adolescents and young people’s human rights to contraceptive information, products and services.
  - Interventions to promote change in the gender norms that hinder adolescent and young women’s use of contraception.

**Reference Documents**

- The Global Consensus Statement for Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting and Reversible Contraception (2016)


  https://www.fphighimpactpractices.org/afcs
• Pathfinder International (2016). *Cue Cards for Counseling Adolescents on Contraception.*

REACHING VULNERABLE AND UNDERSERVED GROUPS, ESPECIALLY MARRIED ADOLESCENTS AND FIRST-TIME PARENTS

What is it about?

Adolescents and young people are a complex group whose diverse features result in diverse needs and vulnerabilities. There are blatant inequalities in health and wellbeing within vulnerable and underserved youth groups. The 2016 *Lancet* Commission on adolescent health and wellbeing highlights that the development and implementation of health interventions for adolescents should consider equity issues, to ensure that the programs’ benefits reach the most underserved groups of adolescent and young people.\(^{24}\) A one-size-fits-all approach to programs or services cannot meet the needs of all the groups within the adolescent and young people population.

In Francophone West Africa, married adolescents and first-time parents\(^ {25} \) are among the most vulnerable to being affected by closely spaced pregnancies, and to being underserved by SRH programs and services. Since the early 2000s, a number of projects have been evaluated, documented and adapted that focus on increasing married adolescents and first-time parents’ access to and use of contraception.

Detailed evaluations of programs implemented in India, West Africa and East Africa have demonstrated the importance of the following elements are critical to reaching married youth and first-time parents, and to increase their contraceptive use:

- Ensuring interventions target all levels of the **socio-ecological model**: reaching individuals, adolescents and young people, their partners, families and communities, and the health systems.
- To reach all the levels of the socio-ecological model, it is essential to **use different channels for strengthening the intervention**. Interventions include: home visits and/or gathering of small groups moderated by young people in order to engage their peers in gender-related participatory activities, decision-making, sexual and reproductive health and rights; engaging husbands and partners through small group activities; using community media and health facilities; sensitizing key influencers such as parents and in-laws on the importance of family planning and the ideal spacing of pregnancies.
- Addressing the discriminatory opinions, behaviors and norms that prevent young women to realize their ambitions and reproduction-related wishes. This should be done through a

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\(^ {25} \) First-time parents include young married women (up to 25 years of age) who are pregnant for the first time, or who have already had a child.
**Gender-synchronized approach** that engages both partners in the intervention. It was demonstrated that such approaches result in an increased adoption of contraceptive methods. In Uganda, a similar intervention led male adolescents – including those married or with a parenting role – experiencing a more significant shift on gender- and SRH-related issues than female adolescents, thus highlighting the importance of engaging boys.

- The timing of the intervention is of critical importance when it comes to reaching married adolescents and first-time parents. Evidence shows that undertaking home visits at different life stages – such as soon after the wedding, before the pregnancy, during the pregnancy, and after the first birth – lead to greater post-partum contraceptive uptake.

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**Reference Documents**

- Documents de formation de Pathfinder International élaborés et testés en Afrique de l’Ouest :
  - Providing Reproductive Health Services to Married Young Women & First-time Parents in West Africa: Training for Facility-based Providers
  - Providing Reproductive Health Services to Young Married Women & First-time Parents in West Africa: Training for Community Health Workers
  - Small Group Facilitation for Young Married Women and First-time Parents in West Africa: Training for Facilitators
- Projet Gender Roles Equality and Transformations (GREAT), activity cards used in social and behavior change activities with married youth and adolescent and young first-time parents.

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**MULTI-SECTORAL COORDINATION FOR AYSRH**

**What is it about?**

Social and environmental determinants of Adolescent and Youth Sexual and Reproductive Health (AYSRH) go largely beyond the health sector. Moreover, many social and structural determinants influence several interconnected aspects of adolescents’ health and wellbeing. Sectors other than the health sector have a critical influence on AYSRH. Evidence shows interventions that include multi- and inter-sectoral components are more effective in realising adolescents’ health and

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26 Evidence-based practices to improve gender norms and increase access to contraception among married adolescents and first-time parents, based on “Theme 1: Findings from Implementation experience” presented by Callie Simon Pathfinder International in Washington DC on 26 April 2017, as part of the Momentum project supported by the Bill and Melinda Gates Foundation. Results are from the PRACHAR project implemented by Pathfinder India; the Gender Roles Equality and Transformation Project (GREAT) led by the Georgetown University’s Institute for Reproductive Health and implemented in partnership with Pathfinder International and Sae the Children; and the DTP project implemented by Pathfinder Burkina Faso.

Healthy adolescents play a key role in the realisation of other sectors’ objectives—such as education or employment.\(^{29}\)

Below are recommendations from WHO, WAHO and the Lancet Commission on adolescent health and wellbeing on how to manage effective multi- and inter-sectoral coordination:

- Ministries of Health should adopt evidence-based multidisciplinary and multi-sectoral approaches.\(^{30}\) Effective engagement of the education, youth, media, finance, justice, interior and social protection sectors is critical to create a package of complementary services that build on one another’s strengths.\(^{31}\)

- **Involving several sectors in the development of national AYSRH policies and strategies.** National strategies are more likely to be effectively implemented if all AYSRH actors have taken part in developing them and negotiating for their adoption. This is why WAHO recommends that, as a first step, the process of developing a national strategy on adolescents and young people’s health should start with identifying, mapping and coordinating with all AYSRH actors in the country.\(^{32}\) To ensure that the multi-sectoral approach is maintained throughout the process, several sectors should be represented in the steering committee and technical committee in charge of developing national AYSRH strategies.

- **Establishing multi-sectoral committees in charge of monitoring the implementation of AYSRH programmes and policies.**

- **Building the capacity of key AYSRH actors to ensure multi- and inter-sectoral interventions are efficient:** complex, inter-sectoral interventions require for each sector to have the capacity to intervene, but also for all sectors to coordinate their investments.\(^{33}\)

- **Establishing transparent and accessible monitoring and evaluation systems as well as clear accountability mechanisms:** Inter- and multi-sectoral coordination for AYSRH requires for all actors from all sectors to access quality data and evidence. Available data and evidence feed into accountability mechanisms and empower all stakeholders, including young people themselves, to monitor progress and hold decision-makers to account. The *Global strategy for women’s children’s and adolescents’ health* highlights the importance of transparent and accessible data to ensure effective inclusion of stakeholders beyond health care providers.\(^{34}\)

**Reference Documents**


- West African Health Organization (2015). *Orientation Guide for Developing National Strategies for Integrated Services for Adolescents and Young People in the ECOWAS Region*

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http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)00579-1/abstract

YOUTH PARTICIPATION AND LEADERSHIP IN AYSRH PROGRAMS

What is it about?

Adolescents and young people are a strength for their own health and that of their families and communities. They are key social change actors—not just beneficiaries of social change programs. Their participation should be promoted and facilitated. The United Nations define youth participation as the active and meaningful participation of young people in all aspects of their own development and that of their communities, including their empowerment towards contributing to decisions that pertain to their personal, family, social, economic, and political development. Meaningful participation of adolescents and young people is essential to the effectiveness of health service and programs, including AYSRH. Adolescent participation is therefore one of WHO’s eight international standards for improved quality of health services for adolescents.

Evidence on ways to ensure meaningful youth participation to efforts to improve AYSRH is increasingly available. When it comes to youth participation, adolescents’ and young adults’ ability to work in partnership with adult people is a key success factor. This requires both efforts to promote meaningful youth participation (e.g. through supporting young people to become champions or leaders) and to promote appropriate responses from adults (e.g. through training adults to listen). Resources (including financial resources), training, sustained mentorship, and capacity to understand political and management processes are also key to youth participation.

1. **Youth participation to AYSRH advocacy, development, monitoring and accountability mechanisms.** To ensure AYSRH policies meet their needs, young people need to make sure that their voices are heard and that they take part in policy development processes. The past two decades have seen increased youth engagement in health-related advocacy at the global, national and community levels. In West Africa, the Young Ambassadors for Family Planning are a good example of that trend.

2. **Youth participation in the planning, monitoring and evaluation of AYSRH services and interventions, and in planning for scaling up.** Young people have a fundamental role to play in the development, monitoring and evaluation of AYSRH services and interventions. Involving young people and empowering them to become leaders adds value to programs and interventions and contributes to making these sustainable (e.g. University Leadership for Change in Sexual and Reproductive Health in Niger project). Establishing a human-based development of AYSRH programmes is a way of engaging young people. The WHO also

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3. **Youth participation in service provision and project implementation.** Young people can participate meaningfully in service provision and project implementation, including through peer education, peer counselling, training, defence, quality control, etc. Peer education in SRH and HIV programmes is the most frequently used and best evaluated approach. While peer education programmes have yielded positive results for the peer educators themselves, evidence shows that they have had average results in terms of improving the health of the larger youth population the programmes were targeting. Peer education is more effective when combined with other evidence-based practices and focuses on the peer educators’ value for sensitizing young people and referring them to health services.

4. **Youth participation to AYSRH research.** Researching youth-led participative action is an increasingly popular way to promote youth engagement and empowerment. Such youth-led research fosters social change and improves the conditions for the health development of the community.

5. **Youth participation in decision-making about their own SRH care.** All adolescents should make their own decisions on all matters pertaining to their SRH, unless an adolescent is unable to make decisions, or his/her decision-making has been delegated, by law, to a third party. Health care facilities and other actors in the health sector should develop and implement policies and processes that empower adolescents to make informed choices. This can be done through providing accurate, clear and appropriate information on the nature, benefits, risks and alternatives to SRH services – including the comprehensive range of contraceptive methods.

Reference Documents


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COMPREHENSIVE SEXUALITY EDUCATION

What is it about?

Comprehensive sexuality education provides young people with information that is age-appropriate, scientifically accurate, and culturally relevant, about human development, sexuality, gender, healthy relationships, SRH and rights.44 There is convincing evidence that comprehensive sexuality education is effective for increasing knowledge and promote healthy behaviors among young people.45

The most effective comprehensive sexuality education programs are those which provide accurate and specific information, are age-appropriate, and highlight values and opinions that promote the development of competencies in daily life, while enabling learners to manage the emotions and experiences that are associated with sexual development.46 In addition, UNFPA has identified nine elements as critical for comprehensive sexuality education programmes’ effectiveness:47

1. **Based on human rights as universal and fundamental values, and on gender equality.** Programmes, classroom culture, as well as policies and practices within schools and community groups should voluntarily promote a non-discriminatory environment, and encourage norms and opinions that are respectful of human rights and diversity (including sexual diversity).

2. **Integrated approach to gender equality.** Programmes should highlight gender equality, by treating it as a standalone curricula item, but also by mainstreaming gender equality across the curriculum themes.

3. **Detailed, scientifically accurate information.**

4. **A learning environment that is safe and healthy.** Schools and community groups that work with children should adopt policies of zero tolerance to discrimination, bullying, sexual harassment, and to any sexual activity between learners and adult teaching and non-teaching personnel. Policies that guarantee learners’ confidentiality and enable them to report abuses should be put in place.

5. **Closely linked with sexual and reproductive health services** and other initiatives that focus on gender equality, equality in general, as well as youth empowerment, young people’s access to education and social and economic advantages.

6. **Participatory teaching methods** that help personalize the information provided and strengthen communication, decision-making and critical thinking skills.

7. **Strengthening youth-led advocacy and young people’s civic engagement** through strategies such as: enabling young people to take active part in curricula development to ensure the initiatives are relevant and meet the learners’ needs; including teaching modules focused on practical skills for civic engagement and advocacy.

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8. **Cultural relevance** in the way the human rights violation and gender inequalities are addressed. Promoting local ownership and involving a wide range of stakeholders – including gender equality activists and human rights defenders – in the comprehensive sexuality education curricula development phase is critical to ensuring curricula are relevant and culturally-sensitive.

9. **Engaging both the formal and informal sectors, and reaching all age groups.**

**Reference Documents**


**FOSTERING FAMILY AND COMMUNITY SUPPORT TO AYSRH**

**What is it about?**

Family and community support is critical to creating an environment that promotes adolescent and young people’s access to contraceptive information and services. While there is little documented evidence on community-based strategies that effectively result in increased support for AYSRH, studies suggest that the following practices are promising:

- **Participation of parents and parent-child communication.** In Africa, there is often limited communication between adolescents and their parents about issues related to sexual intercourse, teenage pregnancy, HIV/AIDS and contraception.48 The findings from several studies suggest that if parents are supported to develop better parental receptiveness qualities and enabled to communicate with their children about sexuality, they will do so. It is possible to improve the contents of the conversations, to raise awareness of, and challenge the social and cultural norms that hamper communication on sexuality-related issues.49

- **Engage men and boys to promote norms that foster gender equity.** During adolescence, girls and boys socialize more within their gender groups, and gender norms become strongly rooted. An increasing number of SRH programs address inequalities and the dangers associated with negative gender norms and behaviors by engaging men and boys through a range of approaches, including group participatory education, media campaigns and activities to mobilize the community at large. Findings from such programs suggest that integrated interventions, which combine group education including men and boys, media-focused activities and community

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sensitization efforts, yield promising results for improving results in SRH, HIV/AIDS, maternal and child health, gender-based violence, and norms and behaviors related to gender equality.  

- **Mobilizing community leaders, including religious leaders.** Evidence shows that involving key community leaders, including religious leaders, can help generate stronger community support. However, there have been few evaluations of the impact of community sensitization programs, particularly their impact on SRH service uptake or changes in the opinions of community members.  

- **Working with community groups** rather than only targeting individuals. Community group participation is a promising, high-impact FP practice when it comes to influencing individual behaviors and social norms on SRH. The High-Practice document entitled *Community Group Engagement: Changing Norms to Improve Sexual and Reproductive Health*, recommends for education and community dialogue on SRH issues to be led by individual from within the community as well as community groups that work with young people, especially out-of-school youth. For enhanced impact, engaging community groups should be combined with other social and behavioral change strategies (e.g. engaging the media, interpersonal communication, or counselling) and/or investments in improving service provision.  

- **Promoting laws and policies and their implementation.** Laws and policies provide a framework for AYSRH programming, by defining responsibilities in the event there is an appeal or a need for compensations. Yet many countries’ legal and policy frameworks hinder adolescents and young people’s access to contraception services. Advocacy is therefore critical to take down these legal and policy barriers. Even when good laws are in place, they must be implemented through political will, adequate resource allocation, capacity building and the establishment of accountability mechanisms.  

- **Media campaigns and mass communication programs** (e.g. entertainment-education programs) can contribute to increasing sensitization and encouraging conversations about AYSRH issues. However, there have been very few evaluations of these programs’ impact beyond knowledge-building and awareness raising. Separately, media campaigns could not be enough for increasing community support for AYSRH. They should be implemented as a component of a wider, multi-pronged strategy that also includes other social and norm change interventions.  

**Reference Documents**


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EMPOWERING GIRLS

What is it about?

Many AYSRH social and environmental determinants are rooted in gender inequalities, which disproportionately affect girls. AYSRH programming will only be effective if gender-related obstacles are addressed. Combining SRH and contraception interventions with girls’ empowerment interventions can greatly improve the return on investment for both intervention types. Evidence-based strategies for girls’ empowerment include:

- **Improve school access and retention for adolescent girls and provide literacy support.** Investments that enable girls to stay in school, especially secondary school, have wide, long-term benefits on the health and development of individuals, families and communities. Evidence shows strong, positive linkages between higher levels of formal education among girls and healthier sexual and reproductive behaviors, including condom use. Strategies that are critical to improving school access and retention for girls include: mobilizing communities to challenge the social norms that undermine girls and their education; improving the quality of the school environment; provide economic incentives for sending girls to school and keeping them there, such as cash incentives; and linking health programs with schools.

- **Ban early marriage and influence the cultural norms that promote early marriage.** In several countries, marrying before age 18 is allowed by the law. Even in countries where the law bans early marriage, implementation is lacking. Political leaders should adopt and implement laws that ban marriage before age 18. In some areas, girls are expected to marry and have children during their adolescence, i.e. before they are physically or mentally ready to do so. Parents feel compelled to marry off their daughters at an early age due to dominant norms and traditions as well as economic constraints. Community leaders should engage with all stakeholders to challenge and change norms that promote early marriage.

- **Positive Youth Development (PYD) programs.** Positive Youth Development engages young people together with their families, communities and/or government towards supporting young people in the realization of their full potential. PYD approaches build the capacities, assets and competencies, strengthen the environment and transform systems. PYD programs seek to create an atmosphere that supports and empowers young people, communicates expectations related to positive behaviors, provides opportunities for creating value, and is stable and relatively long-term – thus giving young people enough time to build the relationships and reaping the program’s benefits. Emerging evidence on PYD programs in low- and middle-income countries reveal that PYD programs can lead to positive health behaviors.

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gender norm changes (e.g. improved economic and social empowerment for young women and reduced gender-based violence), and to improved SRH knowledge, opinions and behaviors (e.g. increased use of health services and contraceptive methods). Elements from DYP programs that are showing results include enabling young people to acquire transferrable competencies and knowledge that will support positive result they have in other sectors (e.g. social skills, problem-solving skills, self-determination, leadership and positive behaviors that empower young people) and implementing innovative, youth-centered and youth-led activities.

Reference Documents


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ANNEX 5: SUMMARY OF PRELIMINARY RECOMMENDATIONS FOR STRENGTHENED INCLUSION OF ADOLESCENTS AND YOUNG PEOPLE (OUTCOMES OF THE WORKSHOP’S FIRST BREAKOUT SESSION)

The first breakout session enabled participants to share reflections on the analysis of the CIPs and to make suggestions for improving it. With the assistance of a facilitator, each country delegation was able to study the preliminary findings of the CIP analysis, and share their observations. The following table summarizes their conclusions per country:

- **Table 1: Summary of Group Work, Session 1**

<table>
<thead>
<tr>
<th>Country</th>
<th>Preliminary recommendations for strengthened inclusion of adolescents and young people</th>
</tr>
</thead>
</table>
| Benin         | • Using ITC technology to sensitize young people  
                • Strengthening peer education methods  
                • Training actors to use contraceptive products information and management systems |
| Burkina Faso  | • Integrating sexuality education in school  
                • Advocating for decision-makers to implement the CIP  
                • Engaging religious and traditional leaders throughout the CIP development and implementation process  
                • Training providers on the youth-friendly approach  
                • Focus on girls’ education  
                • Ensuring SRH services are free for all  
                • Ensuring vulnerable groups can access FP services free of charge  
                • Strengthening coordination of activities  
                • Providing post-partum and post-abortion FP services  
                • Increasing young people’s participation in AYSRH decision-making bodies |
| Cote d’Ivoire | • Giving young people greater responsibilities for putting in place activities that affect their lives  
                • Using ITC technology to build young people’s FP capacity  
                • Aligning technical and financial partners as per the Paris Declaration  
                • Organizing regular caravan journeys, with several schools in several communities  
                • Mobilizing human, material and financial resources towards actual implementation of the CIP  
                • Working in partnership with all actors in the implementation of concrete activities  
                • Fostering wide consensus on high-impact interventions in the next new-generation plan  
                • Advocating for adolescents’ and young people’s reproductive health to be effectively financed  
                • Integrating service provision in high school, university and business school infirmaries |
<table>
<thead>
<tr>
<th>Country</th>
<th>Actions</th>
</tr>
</thead>
</table>
| Guinea | • Strengthening efforts to create demand  
• Engaging all actors: religious leaders, CSOs, parliamentarians, media outlets, adolescents and young people  
• Undertaking a study to determine the country’s contraception prevalence, as soon as possible |
| Mali | • Revitalizing the coordination mechanism to ensure effective monitoring of the CIP’s implementation  
• Engaging a consultant to help with CIP finalization and validation  
• Holding a workshop to provide information to adolescents and young people  
• Presenting the CIP to key ministries to generate strong government support  
• Holding a one- or two-day workshop with Young Ambassadors to build their capacity |
| Mauritania | • Focusing on young people  
• Building the capacity of health personnel |
| Niger | • Empowering young people and ensure activities planned for them are implemented with them  
• Using ITC to strengthen young people’s knowledge of FP  
• Aligning technical and financial partners as per the Paris Declaration  
• Organizing regular caravan journeys, with several schools in several communities  
• Mobilizing human, material and financial resources towards actual implementation of the CIP  
• Working in partnership with all actors in the implementation of concrete activities  
• Fostering wide consensus on high-impact interventions in the next new-generation plan  
• Advocating for adolescents’ and young people’s reproductive health to be effectively financed  
• Integrating service provision in high school, university and business school infirmaries  
• Introducing comprehensive sexual education in schools |
| Senegal | • Strengthening young people’s capacity to develop and manage budgets  
• Developing an app that includes all information pertaining to the CIP  
• Ensuring inclusion of vulnerable adolescents and young people  
• Supporting efforts to raise young people’s awareness of FP during socio-educative and district-level activities  
• Initiating youth advocacy days that involve technical and financial partners, parents and children |
| Togo | • Finalizing and launching the new CIP (2017-2022)  
• Setting specific objectives, with specific figures (impact, consequences, products), to facilitate evaluation of the CIP  
• Making AYSRH services available to young people attending schools in rural communities |
<p>| | |</p>
<table>
<thead>
<tr>
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<th></th>
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<tbody>
<tr>
<td><strong>Ensuring that policies and standards integrate the innovations presented in the CIP</strong></td>
<td><strong>Extending integrated services targeting adolescents and youth to all health zones</strong></td>
</tr>
<tr>
<td><strong>DRC</strong></td>
<td><strong>Integrating FP in training curricula</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Adopting law that promotes family planning, protection of minors and adolescents, and gender equality</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Ensuring that the national health system integrates the package of adolescent- and youth-friendly interventions/services, through: training of health care providers and non-medical staff; making inputs available; establishing adolescent- and youth-friendly information centers</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Adopting the law on FP, which covers young people</strong></td>
</tr>
</tbody>
</table>
ANNEX 6: SUMMARY OF THE THIRD BREAKOUT SESSION’S OUTCOMES- ANALYZING HOW ADOLESCENTS AND YOUNG PEOPLE ARE INCLUDED IN NON-SPECIFIC, SERVICE SUPPLY CIP ACTIVITIES

The objective of breakout session 3 was to analyse opportunities for including adolescents and young people in non-specific, service-supply CIP activities, basing on evidence-based practices. Participants broke into 11 groups (one group per PO country – apart from participants from Burkina Faso who broke into 2 groups – and a group for participants from the DRC).

The following tables summarize their conclusions per country:

- Tables: Opportunities for strengthening inclusion of adolescents and young people in non-specific, FP service-supply CIP activities

<table>
<thead>
<tr>
<th>BENIN</th>
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**Focus activity to be strengthened:** Retraining providers on contraceptive technology and counselling, in order to integrate FP in reproductive health services (postpartum care, postabortion care, nutrition, etc.)

<table>
<thead>
<tr>
<th>How to strengthen implementation of this activity, taking into account evidence-based practices pertaining to:</th>
<th>Adolescent- and youth-friendly service provision?</th>
<th>Expanding contraceptive choice for adolescents and youth?</th>
<th>Reaching married adolescents and first-time parents?</th>
<th>Youth participation?</th>
<th>Multi-sector collaboration?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building capacity to use the youth-friendly approach. The retraining efforts will allow existing centers to become youth-friendly spaces.</td>
<td>Providing the full range of contraceptive products. Providing young people with better information through improved counselling, thus enabling young people to make an informed choice about their contraceptive method.</td>
<td>Retraining providers and enabling them to reach pregnant adolescent girls through antenatal care, and share information about FP methods girls can adopt after they give birth to delay their second pregnancy. This is also an opportunity to build awareness among husbands.</td>
<td>Retraining providers will enable them to encourage young people to visit the now youth-friendly health facilities. They will also acquire useful arguments to engage with parents and promote parent-child dialogue.</td>
<td>Establishing monitoring and coordination organs that bring together several ministries and civil society organizations.</td>
<td></td>
</tr>
</tbody>
</table>
**BURKINA FASO**

Focus activity to be strengthened: Organizing FP mobile strategies supply and mobile clinic service provision, in collaboration with NGOs.

<table>
<thead>
<tr>
<th>How to strengthen implementation of this activity, taking into account evidence-based practices pertaining to:</th>
<th>Multi-sectoral collaboration?</th>
</tr>
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<tbody>
<tr>
<td>Adolescent- and youth-friendly service provision?</td>
<td>Including schools, professional training centers (e.g. hairstyling, welding, ENEP, etc.) and suburban areas (through train stations, street restaurants, hair salons). Training mobile health unit providers on AYSRH. Integrating mobile unit teams in existing structures (in schools that already have a health facility). Establishing a mobile unit that offers services beyond contraceptive method provision.</td>
</tr>
<tr>
<td>Expanding contraceptive choice for adolescents and youth?</td>
<td>Providing the full range of contraceptive methods, including long-acting contraception. Providing emergency contraceptive methods.</td>
</tr>
<tr>
<td>Reaching married adolescents and first-time parents?</td>
<td>Providing mobile strategies and services by building on sensitization activities, working with religious leaders, husbands- and wives-to-be, ‘model’ recently married couples, etc.</td>
</tr>
<tr>
<td>Youth participation?</td>
<td>Pre-event sensitization of young people to ensure active youth participation to activities. Making participation to events voluntary. Enabling youth to contribute to mobilizing other young people through moderation, peer-education, referrals, etc. Promoting young people’s use of the services.</td>
</tr>
</tbody>
</table>
**COTE D’IVOIRE**

**Focus activity to be strengthened:** Establishing FP/HIV/AIDS service provision booths within other reproductive health services of public health facilities that already provide FP services (antenatal care, postabortion care, nutrition, HIV, etc.)

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<td><strong>Adolescent- and youth-friendly service provision?</strong></td>
<td><strong>Youth participation?</strong></td>
</tr>
<tr>
<td>Youth-friendly service provision spaces. Training providers on youth-friendly health services. Sensitizing non-party for progress and socialism (non-PPS) providing personnel.</td>
<td>Having young people moderate youth-friendly spaces. Ensuring young people become members of the mobile unit teams (for mobilizing and counselling other young people, etc.)</td>
</tr>
<tr>
<td>Training providers on all reversible contraceptive methods. Making all methods available at all facilities. Remove financial barriers (third party payer)</td>
<td>Multi-sectoral engagement: Private sector (clinics), traditional medicine practitioners, local government (town halls), Ministry of youth, family, education. Ensuring the above-listed actors join the CIP implementation coordination group. Supporting actors from other sectors.</td>
</tr>
<tr>
<td>Encourage married adolescents and first-time parents. Engage communities to actively take part in sensitization efforts. Strengthen communication with people who can influence recently married girls to use mobile units’ services (mothers-in-law, aunts, etc.)</td>
<td></td>
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</tbody>
</table>
**GUINEA**

**Focus activity to be strengthened: Including the SBC approach in suburban areas**

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<td></td>
<td>Training community-based service providers (youth). Keeping clients informed. Making the range of products available. Ensuring services are available free of charge. Providing services 24/7. Comply with AYSRH policies and standards.</td>
<td>Making injectables available at community level.</td>
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</table>

**MALI**

**Focus activity to be strengthened: Expanding mobile strategies and progresses to all regions in Mali, including mining areas**

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<tr>
<td></td>
<td>Advocating for resources to be mobilized and for sustained activity. Reorganizing services to ensure better programming.</td>
<td>Ensuring the full range of contraceptive products and advanced strategies are available for mobile teams.</td>
<td>Strengthening engagement of religious and community leaders in communication and sensitization campaigns. Expanding the school of husbands approach.</td>
<td>Expanding the youth ambassador strategy (which is already effective in the 5th region) to all regions in Mali.</td>
<td>Strengthening inter-ministerial coordination and coordination among various actors. Promoting public-private partnership.</td>
</tr>
</tbody>
</table>
### MAURITANIA

Focus activity to be strengthened: Expanding the community-based distribution approach

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<tr>
<td>Expanding the DBC approach</td>
<td>Sustained advocacy for sanaya press to be added to DBC products.</td>
<td>Engaging in dialogue and advocacy activities with oulemas. Sensitizing men and recently married men. Advocacy targeting providers.</td>
<td>Engaging young people in the provision of information and contraceptive products.</td>
</tr>
</tbody>
</table>
**NIGER**

**Focus activity to be strengthened: Integrating FP in 500 health huts’ activity packages every year**

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<td>Strengthening community mobilization and referrals of adolescents and young people to health huts.</td>
<td>Expanding contraceptive choice for adolescents and young people, through: adding implants to the range of contraceptive methods available in health huts; building the capacity of health care providers on the youth-friendly approach and on service delivery. Including implants in the health huts’ minimum package of activities (delegation of tasks).</td>
<td>Strengthening efforts to sensitize the public to the existence and availability of FP services in health huts, through messaging that is relevant to each level in the gender-synchronized socio-ecological model. Make health huts services adolescent- and youth-friendly.</td>
<td>Ensuring youth participation in the development and monitoring of health huts’ micro-plans. Including young people as members of health huts’ management committees and health committees.</td>
<td>Establishing a coordination framework that brings together adolescents, young people, teachers, religious leaders, and community-based women’s groups. Ensuring that the coordination framework is extended to the local level through local government authorities and community-based partners.</td>
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</table>
**SENEGAL**

Focus activity to be strengthened: *The Senegal country team did not focus on any specific activity.*

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<td><strong>Expanding contraceptive choice for adolescents and youth?</strong></td>
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<tr>
<td>Strengthening IEC and access to information. Improving the welcoming services. Identifying an appropriate network of young people. Ensuring providers are familiar with the youth-friendly approach. Developing sexual health training curricula for providers.</td>
<td>Ensuring all contraceptive methods are available to young people.</td>
</tr>
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**TOGO**

*Focus activity to be strengthened: Overall strengthening of FP services supply*

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<td><strong>Expanding contraceptive choice for adolescents and youth?</strong></td>
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<tr>
<td>Continue strengthening school infirmaries to include provision of youth-friendly SRH services, including contraceptive methods.</td>
<td>Promoting provision of modern contraceptive methods as part of advanced strategies.</td>
</tr>
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</table>
DRC
Focus activity to be strengthened: 2.2. Progressively increase the amount of health zones that are equipped with one referral facility and at least five health centers

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<tr>
<td>Including adolescent- and youth-focused activities: Building AYSRH capacity for medical and non-medical staff Building inputs stocks Counselling Reduced cost for adolescents Monitoring and evaluation, with data broken down (contraception, STI-HIV) Post-training monitoring Training supervision that includes adolescents and young people Establishing youth-friendly spaces in health facilities, with youth-friendly opening hours</td>
<td>Ensuring availability of contraceptive methods. Building personnel capacity to provide counselling on all contraceptive methods including long-acting methods. Organising sensitization activities targeting adolescents and young people, to take place in the health facilities. Raise awareness of the policies in favour of access adolescents and young people’s access to all contraceptive methods.</td>
<td>Initiating FP immediate post-partum services.</td>
<td>Ensuring adolescents and young people’s participation in health facilities’ decision-making organs. Engaging adolescents and young people towards taking part in the development of Plans d’Actions Operationelles (PAOs). Engaging adolescents and young people as part of monitoring and evaluations efforts (individual interviews, focus groups). Youth community-based distribution for young people and referrals. Combining peer education and mentorship. Engaging adolescents and young people as part of baseline development and need assessments.</td>
<td>Establishing an AYSRH sub-group within the Comité Technique Multisectoriel Permanent/Standing Multisectoral Technical Committee (CTMP), with inclusion of the ministries in charge of youth, education, women, family and children, social affairs, planning, finance, interior, justice. Involving all of these ministries in the AYSRH policy development process.</td>
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