Achieving Universal Health Coverage for young people

through realizing their sexual and reproductive rights and scaling up self-care for health

Key findings of country assessments in Kenya, Malawi, Tanzania, Uganda and Zambia

aidsfonds

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Overarching message

Governments must commit to increasing access to self-care interventions for sexual and reproductive health for all young people to be able to realize their sexual and reproductive rights.

1. Self-care for health cannot be seen in isolation of the strengthening of health systems and the removal of barriers to health services.

2. For Universal Health Coverage (UHC) to be achieved, the human rights dimension of sexual and reproductive health and rights (SRHR) and health services must be prioritised in the UHC agenda. This will ensure appropriate service delivery and the promotion and protection of human rights, which go hand in hand.

3. Governments must commit to creating an enabling legal and political environment to achieve the inclusion of comprehensive SRHR interventions and self-care interventions in UHC implementation plans, basic health care packages and resource allocations.

4. Commitments, policies, and guidelines focusing on young people's health services should not only include the term "youth-friendly", but they should also specifically include the term self-care as defined in the World Health Organisation (WHO) Consolidated Guideline on Self-Care Interventions for Health and Well-Being.[1] Governments should, furthermore, adapt this guideline to their country's local context.

5. Access to good quality and affordable sexual and reproductive health (SRH) services and commodities for young people must be improved, by ensuring they have access to youth-friendly services in both urban and rural areas. Additionally, young people must be able to access these without being judged and stigmatized by health workers and in full privacy, ideally in dedicated youth-friendly centers or corners in health facilities.

6. Access to accurate, comprehensive, and reliable SRHR and self-care information must be improved, both as part of school curricula and parental involvement and the development of reliable information websites, apps, and other digital technology.

7. Sustainability of SRHR programmes that support young people must be ensured and youth-led advocacy must be adequately funded.

8. National and local Civil Society Organisation (CSO) networks, and particularly those that are youth-focused and youth-led, must be better resourced to promote movement-building; leverage different expertise and resources; encourage joint funding applications for shared actions; and to seek unrestricted funding for advocacy.

9. Donors must adjust their standards and eligibility criteria for funding youth-led organisations to ensure it is easier for organisations to attract donor funds. Donors should allow for this funding to be used for strengthening organisational systems, structures, and capacity-building.

10. Young people must be meaningfully involved in decision-making processes as equal partners, either through appointing them to government positions; through the creation of young peoples' decision-making bodies or committees which are inclusive of young people in all their diversity; or deliberately including them in existing platforms, committees, and accountability mechanisms.

1 www.who.int/publications/item/9789240052192

1. Introduction

In September 2023 governments will meet in New York during the second United Nations High Level Meeting (HLM) on UHC to agree on new commitments to realize UHC by 2030. UHC means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course.[2]

This policy report presents data and trends from research in five countries (Kenya, Malawi, Tanzania, Uganda and Zambia) and gives policy recommendations to be considered by governments negotiating the outcomes of the 2023 HLM to make significant progress towards realizing UHC for young people.

In 2019, during the first ever HLM on UHC, an ambitious Political Declaration was adopted which aimed at guiding countries in their efforts to reform health systems, increase funding for health, and address barriers that prevent people from accessing the health services they need.

The world has fundamentally changed since 2019, with the COVID-19 pandemic demonstrating the devastating impact of weak health systems, underinvestment, and inappropriate COVID-19-related safety measures that ultimately, negatively impacted vulnerable, marginalized, and stigmatized populations the most.

Getting governments back on track

This new HLM will be critical to get governments back on track and agree on the need to invest in the long term, sustainable responses required to ensure life-saving health services are guaranteed for everyone, even if COVID-19 and future pandemics continue affecting the world. Additionally, achieving UHC requires a continued push for equity and socio-cultural and economic change; an intersectional, human-rights based and gender-inclusive approach to health; inclusive engagement of civil society in the development, and the implementation and monitoring of health policies and funding. Finally, achieving UHC requires empowering and equipping people to meet their own health needs, including through scaling up self-care interventions for SRH.

What is self-care?

Self-care is defined by the WHO as the ability of individuals, families, and communities to actively promote and maintain their own health, prevent disease, and cope with illness and disability with or without the support of a health worker. The practice of self-care does not replace the health care system, but provides additional choices and options for health care, particularly in contexts where there is a lack of good quality health services or poor access to public health facilities. Solutions such as HIV self-testing; self-sampling for sexually transmitted diseases; diagnostic and/or digital tools and information provided fully or partially outside of formal health services, over-the-counter contraceptive products; pregnancy tests, and condoms and lubricants offer options for people who are unable, or unwilling, to access clinic-based services.

Self-care and COVID-19

Self-care has never been more relevant than during the COVID-19 pandemic, when health systems around the world were unable to cope with the increased pressure. Governments and donors increasingly supported self-care and digital health interventions to reduce the burden on the public health system and allow people to access the services they need despite COVID-19 related measures and lockdowns, which resulted in shortages of health workers and an inability to reach clinics. In countries heavily affected by HIV, for example, six months prescriptions of antiretroviral treatment were prescribed to people living with HIV without them having to visit a medical provider in that period, much longer than the usual three months prescriptions.

Self-care for SRH is particularly powerful for adolescent girls and young women (AGYW) aged 15-24 years old and young key populations who are often prevented from accessing services and information in clinical settings due to poverty; gender-based violence; age of consent laws; social, cultural, and religious barriers, and related stigma and criminalization.

Self-care as a critical contribution to realizing UHC for young people

Thus, self-care provides a crucial contribution to realizing UHC as peoples' dependency on the availability of doctors, nurses or the capacity or accessibility of health clinics for all their health needs is decreased. It also increases young people's autonomy, and power in relation to their own health.

For this reason, the partner organizations implementing the You(th) Care, YouthWise and EmpoweRing: Prevention by Choice projects in Kenya, Malawi, Tanzania, Uganda and Zambia are advocating for governments to prioritise access to comprehensive SRH and HIV services and commodities. They are also advocating for self-care for young people to be included in the 2023 Political Declaration and in national UHC plans and budgets. They are asking governments to seriously commit to removing the barriers young people, in all their diversity, face in realising their SRHR and achieving better health outcomes.

To inform this advocacy, Aidsfonds in collaboration with the African Alliance[3] conducted country assessments and stakeholder interviews with partner organisations and young people in the five project countries to better understand the lived realities of young people in these countries, the barriers they face to accessing the SRH and self-care services they need, and the solutions needed to make significant progress towards UHC for young people.

2 WHO

3 Africanalliance.org.za

2. Country facts - What does the SRHR landscape look like?

The five countries all have very young populations, however the SRHR landscape is generally not youth friendly. AGYW are disproportionally affected by HIV and gender-based violence and there is low contraceptive prevalence and high levels of maternity mortality and adolescent pregnancies. Other challenges for this group include age of consent, persistence of child and teenage marriages, girls forced to drop out of school due to pregnancy, and limited orientation to sexual and gender minorities in SRHR programmes. Also, there is little evidence of effective integration of SRH and HIV and AIDS interventions.

Country	Age of consent to sex and marriage and HIV testing	Abortion laws	SRHR/comprehensive sexuality education (CSE)	Legal environment
Tanzania	The legal age for sexual consent is 18. For marriage it is 15 for girls and 18 for boys. Age of consent to independently access medical treatment is 18, however in 2019 an amendment to the Tanzanian law lowered the age of consent for HIV testing and counseling to 15. This made HIV self-testing legal, also from the age of 15.[4]	Abortion is legal only under limited circumstances[5] and only on the mainland. Even where abortion is partially decriminalised, women struggle to obtain accurate information about when it is legally available. As a result, they turn to unsafe, clandestine abortions. In addition, the social, religious, and legal stigma around abortion, in a country where the majority identifies as Christian, is significant.	There is an extensive education policy framework which includes the need for SRHR education. In practice, however, there is inadequate responsiveness to adolescents' need for more information and SRH education.[6]	Customary and religious laws often take precedence over statutory policies in the country. Same sex, sexual conduct between men remains a criminal offense, with same sex, sexual conduct between women also criminalised in Zanzibar (but not the mainland). Sex work is fully criminalised.
Kenya	The legal age for sexual consent and for marriage is 18. Age of consent to independently access medical treatment is 18 and is supported by the recently revised National Adolescent Sexual and Reproductive Health Policy (2022) and National Guidelines for Provision of Adolescent and Youth-Friendly Services in Kenya (2016).	Abortion is only legal under limited circumstances, similar to Tanzania, but due to unclear and often confusing abortion laws and information as well as continued stigma, many abortions take place unsafely and illegally.	CSE is supported by the Policy Framework for Education and Training (2004) and the Education Sector Policy on HIV and AIDS (2013), however these have been criticised for a limiting emphasis on HIV prevention education rather than more comprehensive sexuality education.[7]	While notable progress has been made in the recognition of human rights of LGBTQI people in Kenya over the past decade, largely through court victories, in 2019 the High Court upheld a colonial law criminalising same sex, sexual relationships between consenting adults, claiming that the law is not discriminatory and would, if abolished, open the door to same sex marriage, which is unconstitutional in Kenya. While sex work is not criminalised per se, living on the earnings of sex work is illegal, which drives sex workers underground, makes them more vulnerable and hinders their access to health services.[8]

4 UNAIDS (2019)
5 A pregnancy that puts the woman's life at risk or is the result of rape, defilement or incest, or if there are fetal abnormalities.
6 HakiElimu (2021)
7 Sidze E M et.al (2017)
8 AIDS and Rights Alliance for southern Africa (2019)

Country	Age of consent to sex and marriage and HIV testing	Abortion laws	SRHR/comprehensive sexuality education (CSE)	Legal environment
Uganda 	The legal age for sexual consent and for marriage is 18. The age of consent to independently access medical treatment is 18, however independently accessing HIV testing and counseling is permitted from 12 years old onwards.	Abortion is only legal under limited circumstances, similar to Tanzania and Kenya.[9] In Uganda, however, only a doctor can perform an abortion which is a prohibitive issue in a country where medical professionals are in short supply.[10] There are no service delivery points providing care or support for safe abortion in case of rape or incest.[11]	Regarding CSE, 26% - 50% of all primary schools and 51% - 75% of all secondary schools in Uganda are fully implementing the national CSE policy.[12]	Same-sex sexual conduct is criminalised via a colonial era law which prohibits 'carnal knowledge' among people of the same sex.[13] As recently as March 2023, Ugandan lawmakers passed a bill prescribing jail terms of up to 10 years for 'offenses related to same-sex relations.'[14] Transmission, exposure or non-disclosure of HIV is criminalised and sex work is fully criminalised.[15] Trans identities are prosecutable and LGBTQI and sex worker organizations are not able to be legally registered.[16]

9 Alice, F. (2020) p. 16
10 Ministry of Health (2015)
11 WHO (2021) Sexual and Reproductive Health and Rights Infographic Snapshot, p. 6
12 WHO (2021) Sexual and Reproductive Health and Rights Infographic Snapshot, p. 7
13 Human Rights Watch (2022). www.hrw.org/videos-photos/interactive/2020/06/22/human-rights-watch-country-profiles-sexual-orientation-and#uganda
14 apnews.com/article/lgbtq-rights-uganda-africa-gay-rights-3b4631458cb06a5f87c4b0c68a4de434
15 WHO (2021) Sexual and Reproductive Health and Rights Infographic Snapshot
16 Alice, F. (2020) P. 16

Country	Age of consent to sex and marriage and HIV testing	Abortion laws	SRHR/comprehensive sexuality education (CSE)	Legal environment
Zambia 	The legal age for sexual consent is 16. Marriage is regulated by the Marriage Act. To marry, one must be at least 21 years old. A person under 21 needs parental consent to marry. However, the law does not specify the threshold below 21 at which marriage is unacceptable, even with parents' consent. The law also allows a high-court judge to permit a child below the age of 16 to be married. There is no minimum age of consent to marry under Zambian customary law as current practice allows any girl who attains puberty to get married.[17] The position of Zambia on consent to independently access medical treatment for adolescents is unclear. However, adolescents below 16 years old require parental consent to access SRH services.	Zambia's abortion law provides for abortion grounds beyond the life and health of the pregnant woman and includes the physical and mental health of existing children of the pregnant woman. Further, consideration may be made of the risk that continuation of the pregnancy would pose on the woman because of her living circumstances and age.[18] Despite this, however, abortion is highly stigmatised in Zambia, with high numbers of unsafe abortions and death attributable to complications from these.[19]	Reproductive health and sexuality education features as a cross-cutting theme in the Zambian Education Curriculum. Hence, the CSE Framework was developed exploring all aspects of human sexuality in terms of human development, relationships, values, attitudes and skills, culture, society and human rights, sexual behavior, and sexual and reproductive health.[20]	Same sex sexual conduct between men and women remains a criminal offence in Zambia. Sex work is fully criminalised.

17 zambia.unfpa.org
18 Sexual and Reproductive Health Matters (2020), 28(2)
19 reproductiverights.org/high-court-of-malawi-clarifies-law-on-abortion
20 Republic of Zambia Comprehensive Sexuality Education Framework (2013)

Country	Age of consent to sex and marriage and HIV testing	Abortion laws	SRHR/comprehensive sexuality education (CSE)	Legal environment
Malawi	The legal age for sexual consent is 16 for girls and 14 for boys. Malawi's law does not explicitly address age of consent for medical treatment, leaving it open to interpretation. This often poses indirect barriers for adolescents and young people to accessing SRH services as they are often told to consult their parents first.[21] Policy documents are ambiguous. According to the Malawi Youth-Friendly Health Services Training Manual there is no minimum age for accessing contraceptives. However, the same manual says: "service guidelines allow for youths aged 16 and up to access contraception without parental consent."[22]	While the Malawi Penal Code only allows for abortion if the pregnancy puts the life and health of the woman in danger[23], the Malawi High Court recognized in a 2021 ruling that preservation of life also entails safeguarding the mental and physical health of the pregnant woman.[24] Women and girls seeking abortions in Malawi must first present themselves to a doctor and make a request for abortion services based on existing medical conditions and demonstrate how their pregnancy undermines their health and life in general. The doctor will review the request and decide.[25]	The government commitment to SRH includes a commitment to CSE but despite this, CSE is often not available to adolescents.[26]	Although sex work is legal, sex worker rights are often abused and abuse of power, arrests and harassment happen frequently in the name of the law. Police and health workers are often not aware of the provisions that protect sex workers rights. Malawi's most recent HIV law no longer criminalises HIV transmission.[27] However, consensual, same sex sexual activity is still criminalised and there have been reports of cases of violence against the LGBTQI community. Furthermore, due to stigma, LGBTQI persons do not have effective access to health services.[28]

21 Kanguade et al. (2020) p 8
22 Sexual and Reproductive Health Matters (2020), 28(2)
23 reproductiverights.org/high-court-of-malawi-clarifies-law-on-abortion
24 High Court of Malawi Clarifies Law on Abortion | Center for Reproductive Rights
25 reproductiverights.org/high-court-of-malawi-clarifies-law-on-abortion
26 UNFPA & UNHR Country Assessment Malawi SRMCNH+HR (2016) p. 10 & 46
27 www.beingintheknow/org/understanding-hiv-epidemic/data/glance-hiv-malawi#08401c7e-6e73-4811-ad30-28f2e82b3d49
28 UNFPA & UNHR Country Assessment Malawi SRMCNH+HR (2016) p. 17

3. Barriers to accessing information and youth-friendly services and commodities for young people

Across the countries, young people have limited access to SRHR information, services, and commodities and where services are available, they are often not friendly to young people. Harmful social, cultural, and religious norms and attitudes pose additional barriers.

Lack of reliable information sources on SRHR

In **Tanzania**, young people reported that there is no sufficient and reliable information platforms available to discuss SRHR issues. A young male journalist shared that even official websites run by the government, like the one run by the Ministry of Health, have very little information on SRHR. Most of the information focuses on prevention against Ebola, COVID-19, and HIV/AIDS. He believed this is because the government has not invested in policies that promote educating young people on SRHR. Lack of privacy in clinics also makes young people reluctant to ask for information and counseling on SRHR. Acceptance of adolescent SRHR is slowly improving but cultural beliefs and taboos remain barriers to ensuring young people have adequate access to information and services. Negative perceptions of SRHR within communities was mentioned as a key challenge. Unnecessary secrecy by parents and unwillingness to share SRHR information and their own experience with adolescent children was mentioned as severely limiting young peoples' access to the resources and information they need to make informed decisions about their sexual health.

Young people in **Uganda** highlighted lack of support from parents or care givers as a key issue as well. One young person stated: *"Young people need role models to look up to. However, they are sometimes sidelined by their parents or care givers and end up looking for answers in the wrong places because parents do not want to talk about sexuality education. Every time sexuality education is talked about, there is an assumption that it is about teaching young people about sex which is perceived as immoral in Uganda."*

Furthermore, it was reported that the information that is available in Uganda is not tailored to the needs of young people and is sometimes not age-appropriate: *"Young people then misinterpret the information and draw conclusions based off their first medical encounter or shared experiences from friends."* Certain assumptions stand in the way of young people accessing services as well. For example, where it comes to self-care services and commodities, many young people in Uganda are unaware of these, and those who have some knowledge about the existence of them were scared to share about them because of the assumption that it is illegal to access such services.

In **Zambia** HIV and SRHR information is limited, while the information that is available on HIV, for example, is poorly packaged leading to AGYW focusing more on pregnancy prevention at the expense of protecting themselves against contracting and spreading HIV. Additionally, information targeting adolescents in rural areas is particularly limited. Many young people highlighted their dependence on digital platforms, such as social media, radio stations and television to access correct SRHR information.

In **Kenya**, partners consider the lack of access to correct information and youth-friendly services among the most pressing issues for young people. A young woman shared: *"It is taboo in African culture for parents to discuss sex with their children, therefore those with knowledge are not passing it on. So, then we continue to have myths and misconceptions about SRHR issues."* Lack of accurate information and misinformation on SRHR is seen to be endangering the lives of some young women, with reports of women being lured into taking herbal concoctions for example, only to end up pregnant and experience multiple miscarriages.

Accessing youth-friendly services and judgement by health care providers

In **Tanzania**, young people mentioned the distance to health facilities, especially in rural areas, which are often also under-stocked or under-resourced, as well as the unavailability of affordable commodities as a critical barrier to accessing youth-friendly services. Some self-care interventions (i.e., self-testing for HIV, contraception, including emergency contraception and pre-exposure prophylaxis (PrEP)) are available in Tanzania but may not be easily accessible in certain areas of the country or in some facilities. Additionally, some of the services may require payment, which is a barrier for some young people who cannot afford them. It was also noted that certain products, such as lubrication, are banned in Tanzania.

Also in **Zambia,** limited supply of SRHR services and commodities in health facilities,

including self-care interventions, like self-testing for HIV, contraception, and PrEP, poses a significant barrier for young people. Another key concern is the lack of youth-friendly corners in health facilities. A young woman stated: *"The government should build a lot of youth-friendly corners so that we have somewhere to go where we won't feel judged and where our information will be kept confidential."* Another young woman added: *"They should also teach the health workers to learn to respect our rights and be able to listen to us and our needs with respect for our privacy, whether they know our parents or not."*

Lack of privacy and confidentiality is a critical barrier for young people to access health services in Zambia. Many young people are less likely to access SRH services due to privacy concerns as well as fear of community stigma and negative attitudes of health care providers towards them. A partner organization representative mentioned: *"There are certain social barriers and norms that make people to be so judgmental to the point where it will be hard for young people to access these services."* Young people fear visiting health facilities because of being spotted by people who know them and their parents. Another representative added: *"One of the major barriers for young people when it comes to accessing SRHR services is particularly the values and attitudes of health care providers. There are some sensitive services which young people would like to access but the manner in which they are provided makes it hard... to access them."*

The devolution of the health system to county level in **Kenya** means there is varying consistency in the availability, quality, and affordability of youth-friendly services. Most health facilities in Kenya do not have youth-friendly service corners and the few that have them lack drugs, patient confidentiality, and friendly health care providers, which pushes young people away. Young people reported that many of them, in particular the more vulnerable youth such as people with disabilities or those from the LGBTIQ community, may have to travel further to access appropriate, safe and youth-friendly SRHR services, while many health facilities are often only open during school hours.

Additionally, judgmental, and negative attitudes of health workers and a lack of availability of commodities, in particular condom shortages, were reported as significant barriers to young people taking care of their health in Kenya. To address these challenges, despite the high cost, some young people opt to get their SRH services from private health facilities as they are of better quality and health workers are more likely to have been sensitized to be more patient and non-judgmental. However, very few young people can afford this option.

In **Malawi**, access to SRH services and availability is a big challenge as well. Already in 2007, the Ministry of Health established the so-called Youth Friendly Health Services centers (YFHS) but a recent evaluation of the programme states that only 31.7% of young people have heard of YFHS in Malawi and only 13% have ever used these services. The main deterrents to sustained utilization of these services include low self-confidence among clients and 'shyness', especially among girls; long distances to health facilities; long waiting times; and the condition that youth receive HIV testing and counseling before accessing other services in some health facilities.[29]

Young people themselves reported in relation to YFHS: *"They sometimes do not have the services or commodities needed by us and then we are referred to the general public sections of the health facility which is oftentimes not a comfortable environment for us".* This is due to health care workers in Malawi having limited knowledge and expertise to provide services to young people and they can be judgmental, especially towards young key populations who continue to face stigma from health care workers.

And finally, in **Uganda**, there is the persistent fear among young people being noticed by people in their communities when they seek services and being judged, for example when collecting antiretroviral treatment. A male youth respondent shared: *"Girls fear to go for antenatal care because they do not want to be seen."* Stigma and discrimination and criminalisation is still a huge issue in Uganda that stands in the way of accessing services especially for people living with HIV and key populations. Other barriers reported include limited access to contraceptives and the difficulty for some women and girls to convince male partners to use condoms; rejection of family planning by male partners as they might want more children or are hoping for a boy-child; and stock outs and long waiting hours in clinics.

29 Ministry of Health, National Youth Friendly Health Services Strategy 2015-2020

4. The policy and funding landscape of SRHR and self-care

All five countries are obligated under international and regional treaties to provide, promote, and protect SRHR, and this is reflected in varying extents in the suite of policies, strategies, and guidelines each country has developed to realize these promises.

However, it is often the rights aspect of SRHR that is lacking, where the focus is on service delivery and uses the language of efficiency, affordability, and quality. It does this without recognizing the need to bring the human rights dimension to SRH services to ensure they are also inclusive, non-discriminatory, prioritize human dignity, and are ethical in their recognition of the rights to consent, confidentiality, choice, and privacy. There are provisions held in the Constitutions of these countries, where, apart from provisions to partially limit protected rights under specific conditions, such as a state of national emergency, every country expressly guaranteed the right to equality under the law and human dignity, either "for all" or "everyone". The right to privacy is also expressly protected. Every country protects the right to non-discrimination, though this is qualified differently in each constitution, with all including, in some form or another, origin, religion, race, color, ethnicity, socio-economic status, tribe and language as grounds for non-discrimination. All countries include 'sex' as grounds for non-discrimination, though sex and gender are narrowly defined as male/man or female/woman based on sex assigned at birth. Of these countries, only Kenya includes explicit constitutional provisions for reproductive choice and access to reproductive health. However, abortion is still criminalised in all countries, except under explicit circumstances.

Malawi

Health is one of the key priority areas of the government of Malawi, and a crucial part of the human capital enabler of the *Malawi Vision 2063*. The health sector is guided by the overarching Malawi National Health Policy (2018-2030) and by a set of additional sector policies and plans. The Government is currently finalising the development of the *Third Health Sector Strategic Plan (HSSP) III* (2022-2030).[30] The health sector budget has reached its highest level (10%) as a share of the total government expenditure since 2017/18 and has increased with 18% in 2022/23 as compared to the allocation of 2020/21. Despite this increase, Malawi is yet to meet the Abuja Declaration target for African countries to allocate 15% of their total budget to the health sector. Out-of-pocket spending on health care remains high, at 16.9% as a share of all health expenditure in 2019.[31] Currently, Malawi has no social health insurance in place. However, introduction of a social health insurance scheme has been a theme of reform by the Malawi Government as an alternative to health financing.[32]

There is still a very high-level of dependency on donor financing for health, particularly for HIV and SRHR services (over 90% of donor funding[33]). Specifically, youth-friendly services and the implementation of the Youth Friendly Health Services Strategy (YFHS) suffer from lack of funding and a clear vision and are also highly dependent on external financing. As a representative of a youth-led organisation stated: "As such, donors choose the district where to go and implement, thereby not speaking to the universality of health coverage", despite Malawi's commitment to UHC through policy documents such as the Health Sector Strategic Plan (HSSP) III and the National Health Financing Strategy (2023-2030).

The term 'self-care' doesn't come up at all in national health policies or SRH policies and strategies and neither in youth-specific policies and strategic plans, but there is an effort to integrate 'youth-friendly' services. In its *Vision 2063* document, the government has committed to "Malawians, especially the youth, to be empowered with the necessary sexual and reproductive health information and services".[34] The *YFHS* (2015-2020) doesn't include the term 'self-care' but the entire strategy is focused on making health services more 'youth-friendly'. Condoms and contraceptives show up among the things listed to be included in the YFHS package, but other services like self-testing and over-the-counter contraceptive and testing options are not mentioned.

To make sure self-care interventions are part of the basic package of health services in the country, it is important that self-care as a concept is disseminated and adopted. The concept is practiced in Malawi, but the term itself has not been used. This is problematic because the term 'youth-friendly services' is too restrictive and doesn't cover what self-care is really about, namely empowering youth and facilitating self-agency in relation to their SRHR. Young people acknowledged that the term is not well understood, and efforts are needed to educate them, and health care workers and politicians, about this term. A representative of a youth organisation stated: *"We need to start addressing the information around self-care. A lot of people are not aware of the term even though they are already practicing it and the information is there and accessible. However, because the term self-care is not used, it's hard to find the information."*

Another young person added: *"It's important that self-care itself is recognised as one of the health issues. Whenever we are talking about health, SRHR etc., self-care must be included for it to get the same attention as any other health issue."*

Uganda

The health sector is critical in the attainment of Uganda's *Vision 2040*, and health spending has begun to increase since 2021/22, mainly attributable to COVID-19-related spending. Though approved allocation to health for 2022/23 increases the share of total government spending to 7.73%, this is below the Abuja target of spending 15%. The health sector sees high out-of-pocket spending and frequent disruptions in service delivery. Uganda's current health insurance options are employer or community-based schemes and are estimated to cover less than 2% of the population. Health insurers only contribute around 1% to health spending in Uganda. However, in March 2021 the Ugandan Parliament passed the *National Health Insurance Bill* that outlines the general structure for a first-

30 United Nations Children's Fund (UNICEF) Health Budget Brief Malawi 2022/23
31 World Bank
32 Health Sector Strategic Plan II 2017-2022
33 UNICEF Health Budget Brief 2022/23
34 National Planning Commission (2020) p. 38

ever national social health insurance scheme in Uganda, financed by a combination of employee and government contributions. The bill was passed with a pre-set benefits package that includes a range of essential health services including family planning counseling and services. It has not been signed by the President of Uganda yet, though[35]

As about 40% of the total health budget is being funded by development partners in 2021, the health sector is very vulnerable to any changes in the global context.[36] SRH services and commodities are funded by the government mostly for family planning purposes. Furthermore, 97% of the SRH budget is allocated to commodities, 2.5% for service delivery, 0.4% for advocacy and mobilization and 0.1% for 'other things.'[37] The government is now operating a *'one warehouse, one health facility'* method where health facilities can get commodities at no cost for family planning purposes. Other commodities outside of the ones intended for family-planning purposes are supported by donors.

Several national strategies and policies include references to 'adolescent-friendly services', including in the *Health Sector Strategic & Investment Plan III*, the *National Development Policy III*, the *National HIV & AIDS Strategic Plan* and the *National Adolescent Health Strategy.* The term self-care doesn't feature at all in any policy and strategy documents related to health, youth, SRH and HIV. The *National HIV & AIDS Strategic Plan* does mention the importance of self-testing several times and the need for expanding access and availability of condoms including female condoms, but there is no mention of over the counter or easy to access contraceptives.[38]

Similar to Malawi, self-care interventions have been practiced by some groups of people in Uganda, especially during COVID-19 lockdowns, when self-testing became popular and many medical facilities started teaching clients how to self-administer pregnancy test kits, HIV testing kits, and administering ARVs for people living with HIV. This has provided an opportunity to leverage on and scale it up and integrate self-care into SRH services for young people. For this to be successful, there is a clear need to define and popularise the concept of self-care and what it entails for young people in all communities and to get it integrated in the basic health care package covered by Uganda's new national social health insurance. This is critical as most self-care interventions, if at all available, have only been accessible in some private clinics. However, the Uganda Ministry of Health has kickstarted the process of structuring self-care for SRHR by establishing a Self-Care Expert Group to coordinate the development of national SRHR self-care guidelines by adapting the WHO's Guideline to Uganda's needs. The *Uganda National Guidelines on Self-Care Interventions for SRHR* will be finalized and presented for approval in 2023.[39]

Zambia

The 2022 *Budget Speech* and the 2022-24 *Medium Term Budget Plan* provides the policy direction for the health sector in the short to medium term, and the health sector is the fourth largest government expenditure function.

35 John Hopkins University (2021) www.advancefamilyplanning.org/parliament-uganda-passes-national-health-insurance-scheme-bill
36 UNICEF Health Budget Brief Uganda 2022/23
37 Public Health Ambassadors Uganda & Youth Equality Centre (2020). Financing SRHR for Young People in Uganda, p.2
38 Ministry of Health (2021) p. 15, 19, 21, 22
39 www.psi.org/2022/11/adapting-the-who-self-care-guidelines-to-the-local-context-lessons-from-Uganda

However, health expenditure only represented about 8% of the total government budget in 2022, again far below the Abuja target and marginally lower than in 2021 (when it was 8.1%).[40] Despite the official removal of user fees in Zambia and the implementation of a *National Health Insurance Scheme,* people still face significant out of pocket costs (in 2019, this was at 10.23% of current health expenditure)41

External financing for health remains significant, however it reduced from 20% to 15% in 2022 and mostly through loans, accounting for about four fifths of all external financing for health in 2022. The country has been reliant on donors for funding SRHR and family planning services, however the introduction of a new benefits package as part of the new health insurance scheme that includes family planning, key SRH services and legal abortion is a huge win for women and girls in Zambia.[42]

Efforts undertaken by the Government of Zambia to demonstrate commitment to improving access to health services for young people is reflected in the formulation of the Adolescent Health Strategy, mandating the provision of youth-friendly services. Furthermore, the most recent *National HIV and AIDS Strategic Framework 2017-2021* discusses the need for wider distribution of condoms, comprehensive condom programming, water-based lubricants, HIV self-testing and home-based testing.[43] A set of *National Standards and Guidelines for Youth Friendly Health Services* describes the basic 'essential' clinical health services to be provided to young people, including HIV and SRH services, the provision of information and social behavior change communication and

40 UNICEF Health Budget Brief Zambia 2022
41 Index mundi
42 pai.org/resources/zambia-has-family-planning-covered/
43 Ministry of Health (2017)

counseling on family planning issues and services, antenatal care, post-natal care and nutrition, and HIV testing and counseling.[44] Furthermore, the Ministry of Health at the local level is working with civil society partners to adapt the *WHO Consolidated Guidelines on Self-Care Interventions for Health to local settings.*

Despite these efforts, the framing is not explicitly 'selfcare' in these policies and guidelines. Instead, the term 'family planning' is extensively used, which is problematic according to respondents, as it often replaces terms such as sexual and reproductive health, sexual and reproductive rights, and reproductive justice, and assumes the individual is using contraception to plan a family, as opposed to people who want to use contraception solely to exercise their right to choose. It also assumes a very heteronormative version of a nuclear family and procreative path. The term also does not include access to safe and legal abortion and yet family planning is used as a term for all pregnancy prevention.

Tanzania

Tanzania's *Development Vision 2025* mentions health as one of the priority sectors contributing to a higher quality of life for all Tanzanians and the *Health Sector Strategic Plan (HSSP V) 2021-2026* guides health policy in Tanzania Mainland. The main objective of the health policy is to improve health and well-being of all Tanzanians, with a focus on those most at risk. For Zanzibar, the *Zanzibar Development Vision* outlines Zanzibar's health sector strategy, which is to maintain an equitable and sustainable universal healthcare system attainable to all.

44 Ministry of Health (2017)

However, in Tanzania Mainland, the nominal health budget allocation (excluding the National Health Insurance Fund) decreased from 9% to 7.3% of the total government budget between 2017/18 and 2021/22, which is lower than the 15% required by the Abuja target. In Zanzibar though, the nominal health budget allocation rose by 136% in that same period, although health spending as a proportion of the total budget in Zanzibar remained constant at roughly 8% between 2017/18 and 2021/22. But in the new 2021/22 budget this sharply increased to 11.2%, most likely due to expenditure in relation to COVID-19. This is still below the Abuja 15% target.

Out-of-pocket spending on health remains high across Tanzania and only 32% of people were covered by health insurance as of 2019. However, a UHC Bill is currently being discussed in Parliament which proposes enactment of a Universal Health Insurance law to establish a management and control system for the provision of health insurance services. It would guarantee all citizens and residents access to health services without financial constraints.[45]

Currently, international donors contribute up to 40% of the total health budget. SRH and HIV interventions remain especially heavily reliant on foreign funding.[46]

Adolescent specific health services are lagging, despite the significant number of policies and strategies adopted by the Tanzanian Government guiding adolescent and young people's SRH services. According to a partner: *"We have documents which are very good on paper, but where is the Government's accountability when it comes to implementing the policies and strategies we have?"* Some young people reported having access to health insurance (mainly those in universities and from well-to-do families). However, they also indicated that the available packages didn't cover everything they needed and limited their access to health services. As reported by a young male university graduate: *"What I have seen is that only very few hospitals accept the use of health insurance cards and you might find people require urgent care and believe that since they have the insurance, they can access the service, but once they get to the hospital, they are informed that their package doesn't cover that specific service".*

45 www.clydeco.com/en/insights/2023/03/universal-health-coverage-bill-2022-tanzania
46 www.trade.gov/country-commercial-guides/tanzania-healthcare

Regarding self-care, the term in and of itself is not used. In the *Health Sector HIV & AIDS Strategic Plan 2017-2022* and the *Health Sector Strategic Plan V* (2021-2026), an attempt is made to integrate interventions that could be considered part of a self-care package of services, for example self-testing for HIV[47] and ensuring availability and accessibility to condoms in public and private outlets to reach all populations including key vulnerable populations.[48] The HSSP V mentions the use of private sector platforms such as Accredited Drug Distribution Outlets which are located close to the homes and schools of young people and offer opportunities for reaching adolescents more effectively with services such as contraceptives.[49] However, there is no mention of self-care services like sexually transmitted infection (STI) self-sampling, pregnancy tests and over-the-counter provision of any kinds of contraceptives.

47 Ministry of Health, Health Sector HIV&AIDS Strategic Plan 2017-2022, p. 53
48 Ministry of Health, Health Sector HIV&AIDS Strategic Plan 2017-2022, p. 7, 12, 20-21
49 Ministry of Health, Health Sector Strategic Plan V (2021-2026), p. 31

The concept of self-care is relatively new in Tanzania even among partner organizations, as they use specific terms such as self-testing rather than self-care as a general term. Partners felt that more information is needed on self-care interventions especially as there are concerns about the use of unregulated or substandard products, incorrect or unclear health information, or lack of guidance on, or management of, potential side effects or complications. More needs to be done to also 'popularise' the concept and ensure that more service providers can provide a wider range of self-care interventions to young people. As stated by a representative of a Tanzanian SRHR organisation: *"Self-care is becoming more prevalent in the market, and it is important for governments and other stakeholders to improve the infrastructure and legal environment needed to support it."*

Kenya

There is a strong focus on UHC in Kenya. Kenya has a Presidential/Cabinet political commitment to UHC, and the *Kenya Community Health Policy (2020-2030)* has as its primary goal the *'attainment of Universal Health Coverage and access to essential health services that positively contribute to improved health.'*[50] However, the government acknowledges that government spending on health is lagging. In 2020, general government health expenditure (from tax revenue only) was at 2% of GDP whereas the intended target was 5%. And as a share of the total government budget, the portion translates to 7-9%, so the country is not meeting the 15% Abuja Declaration target.[51]

50 Ministry of Health 2020)
51 Ministry of Health (2020)

Furthermore, as of 2021, Kenya's National health Insurance Fund covered only 18% of Kenyans and the 32 private health insurers covered just 1%.[52] Out-of-pocket spending on health remains very high in Kenya, especially for the poor, and so does the level of external funding for health, with a significant share of such funding being 'off-budget.'

While Kenya has a solid policy framework on both SRH and HIV, a key issue is implementation, particularly for SRH. Policy-making institutions in the country are becoming more conservative in exercising their mandates and regression and conservatism is seen in policymaking. The recently adopted *National Reproductive Health Policy* (2022-2032), for example, is viewed as problematic by partners because it looks at reproductive health from a very narrow perspective and excludes the critical elements of reproductive health, in particular reproductive rights. The term 'family planning' is used extensively in this policy and others, again, like in the other countries, solely taking the assumption that contraception is used to plan a family in the heteronormative sense of the word. It was reported that the religious community is pushing an anti-SRHR narrative including that abortion is murder and perpetuating stigma around sex before marriage. The new National Administration is also working to portray Kenya as a 'Christian' country, despite the Constitution stipulating that Kenya is a secular State.

In Kenya's policies, specifically guiding the SRH services for AYP, the term self-care in and of itself is rarely used. Instead, language such as youth-friendly and adolescent-friendly services is prevalent. However, in January 2023, Kenya became one of the first African countries to domesticate the WHO's *Guideline of Self-Care Interventions for Health and Wellbeing* (together with Nigeria, Senegal and Uganda), when the Ministry of Health approved the National Guideline for Self-Care in Reproductive Health.[53] It contains recommendations on a range of reproductive health-care issues, including contraception, antenatal care, STIs, menstrual care and post-abortion care. This is a significant step towards improving access to reproductive health care in the country, but it might also help to increase the understanding of the concept of self-care among people. Young people expressed that they felt that many organisations and individuals still have a simplistic or narrow perspective on self-care, considering it merely from a mental health perspective. They discussed the need for more sensitisation on self-care and increase awareness on the concept beyond family planning before seeking to integrate it into basic health care packages in Kenya.

52 allafrica.com/stories/202110060524.html

53 Kenyan Government Approves Self-Care Guidance for Reproductive Health - Safe Abortion Action Fund (saafund.org)

5. Youth leadership and advocacy: an investment in the future

Participation and engagement of young people at all levels of decision-making processes are key. Young people themselves are best positioned to voice their demands for SRHR information, services, and supplies. The best health outcomes for young people will be achieved when young people feel empowered and capacitated to raise their voices and claim their rights. In all stakeholder interviews across the five countries young people expressed that they want the knowledge and information to be empowered to take care of their health; they want to be included in decision-making processes on what services should be provided to them; they want to see young people themselves in positions of influence and working on their issues; they want to ensure that parents are actively engaged and supporting them, and they want to be funded to do much needed advocacy.

It was noted by young people in **Tanzania** that involving them in decision-making processes is key, either through the creation of a specific young people's decision-making body or by including them in existing platforms. In fact, the lack of an independent decision body for young people was highlighted as a big gap. A young female activist remarked: *"Although Zanzibar has a youth council, Tanzania mainland doesn't have one. We are advocating for this platform, but not many people are moved by this agenda. If we get this platform, we as young people can take part in decision-making as we will be represented. We are tired of other people who are not youths making decisions on our behalf."*

However, youth-led organisations in Tanzania have limited funds and fundraising skills to sustain their interventions. They lack proper governance structures and courage to approach donors for funding. It was also noted that lack of evidence and studies demonstrating the experiences of young people contribute to the misconceptions and misinformation in the interventions aimed at addressing youth SRHR. By conducting more studies and creating young people's platforms young people's voices will be amplified.

Also, SRHR organisations in Tanzania are continuously confronted with social and cultural barriers, including backlash from government and must navigate the political dynamics in Tanzania, such as the previous regime's ban on the mention of family planning and discouragement of the use of contraceptives. Representatives from these organisations acknowledged that politicians may understand the importance of addressing SRHR-related issues, but fear losing their positions if they speak out about them.

Certain strategies employed by organisations supporting youth-led advocacy in **Uganda** were mentioned as critical for scaling up youth engagement. This includes bringing youth in to the process of developing proposals, collecting information, analyzing data, presenting findings, and interpreting and defining the key issues. It also means including young people as major stakeholders in project planning, implementation, and monitoring processes to improve levels of acceptance among young people.

Many youth-led organisations in **Malawi** are dependent on donor support to sustain their activities, thus if donors decide to pull out, most of them would be unable to continue. Some young people shared that, as a result, advocacy is often catered to donor needs as opposed to the specific needs of young people. Donor funding standards were found to be non-accommodating and their support focusing on activities rather than on systems and structures strengthening and building capacity which would allow these organisations to grow. As remarked by a young person from a youth-led organisation: *"The biggest challenge we face is requirements by donors for youth-led organisations be eligible for a grant, where donors set standards that we cannot meet."*

Government bureaucracy is another challenge in Malawi where only established organisations can partner with and are recognised by the government. Furthermore, poor collaboration among youth-led organisations was seen to have a negative effect on ensuring an amplified and unified voice to achieve more impact.

Partners in **Zambia** expressed that a shift is needed from administering adolescents and young people's SRHR being with a top-down approach to something that, with adequate support and resourcing, could be more youth-led and determined, based on young people's lived realities. For example, most youth-led advocacy is supported by national organisations that are not specifically youth-led and there is a lack of meaningful youth representation in key government decision-making spaces, such as the Adolescent Health Technical Working Group meetings.

Among the challenges mentioned in **Uganda** is the reality that some young people are unable to speak for themselves due to shyness, stigma and discrimination and criminalisation, amongst other reasons. Furthermore, it might not be safe for them to speak up or they lack confidence and self-esteem due to judgement and cultural and societal attitudes. In addition, a lack of facts or evidence to back up advocacy activities was mentioned and the need for more investment in research to obtain community-based evidence to inform advocacy.

Young people in **Kenya** shared that most young people do not trust their political leaders. They are therefore seeking opportunities to be engaged as equal partners to secure their own SRHR and want to be supported to hold decision-making positions both in civil society as in political office. As one male young person stated: *"I know if it was a young person in the Governor's seat, our SRHR needs would be met."* And a young female person added: *"The older office bearers have different experiences from us. Also, their time is up."* Another young person shared: *"I am afraid of the people we have elected as a country."*

A need for caution around power dynamics among organisations working in the country was also mentioned. National organisations are seen to dominate conversations in the space they share with grassroots organisations because of the differences in resources and scope. They *"may abuse their financial muscle to influence decisions on strategies to align with their own priorities or use young people solely for reporting purposes and attracting more funding rather than considering them as valuable and equal partners."*

Internal opposition within the Kenyan SRHR movement itself poses a significant obstacle to progress as well due to the lack of a unified position on key issues affecting adolescents and young people's SRHR. For example, many organisations working on HIV and/or SRHR may also hold the position where they are against safe abortions because of their personal beliefs or will not provide access to contraception or will not support CSE in schools.

And finally, the concern was expressed that youth-led advocacy work is not evidence driven and there is a lack of documenting interventions to ensure continuity, accountability, and growth. It is also inadequately funded, which is partly due to a lack of understanding among many CSO advocates on how to influence budget-making processes and get more access to national public resources rather than foreign aid. This is especially important when 'rigid' donor agencies are not confident in granting awards to youth-led organisations.

6. Key messages and recommendations

UHC can never be achieved without realizing the SRHR of all young people. They are the future and their health and wellbeing, and empowerment is critical for the shaping of that future in all countries.

This policy brief described the main challenges young people face in accessing the comprehensive SRHR and HIV services they need and in being seen and supported as critical partners and leaders in realizing UHC for young people.

The key messages highlighted by young people in the stakeholder interviews conducted with them in the five countries outlined at the start of this document are consistent and clear and should be used by all governments to guide the new commitments they will be making at the 2023 HLM on UHC.

Annex

Methodology

In August 2022, following reflections from You(th) Care consortium partners at an internal monitoring, evaluation and learning (MEL) meeting about gaps in knowledge of the policy landscape for SRHR and HIV in each programme country, Aidsfonds commissioned the African Alliance ('the Alliance') to undertake an initial country-specific (Kenya, Tanzania and Zambia) policy analysis. The aim was to provide the consortium with insights into each country's policy environment to support partners to better promote and realise AYP's SRHR and HIV self-care needs, including AYP access to self-care services and commodities.

This first phase of work focused on mapping policies, strategies and guidelines related to AYP aged 10–25, identifying key stakeholders, and the specific barriers or enablers to progress in improving SRHR and the practice of self-care. To that end, the Alliance engaged stakeholders from the You(th) Care consortium cohort (partners and young people) alongside a small sample of thought leaders working regionally, continentally, and globally on SRHR and self-care to better understand the policy landscape and what opportunities may exist for You(th) Care to inform its adaptation and future implementation. The policy analysis process sought to understand the state of the national adolescent and young people's SRHR and HIV response in each country and the possibilities to practice self-care; key policies and guidelines that influence adolescent and young people's SRHR and HIV vulnerability and access to self-care; barriers and opportunities for improving adolescent and young people's SRHR, the practice of self-care; the main stakeholders; recommendations to impact on adolescent and young people's SRHR, the practice of self-care and HIV/AIDS in the country.

The process was phased, consisting of an initial briefing with You(th) Care colleagues from Aidsfonds, a desk review, and country-based semi-structured discussions with consortium partners and the young people (aged 18-25) they work with. A second phase was commissioned in September 2022 to add an analysis of Malawi and Uganda and build on the initial process with an adjusted focus to consider what commitments or policies on UHC each country has in place and how they are being implemented.

In Kenya, the following stakeholders were engaged in this process:

Network for Adolescent and Youth in Africa (NAYA, staff and young people)

Ambassador for Youth and Adolescent Reproductive Health Program (AYARHEP, staff and young people)

Reproductive Health Network Kenya (RHNK, staff and young people)

Centre for the Study of Adolescence (staff)

Kenya Ethical and Legal Issues Network (KELIN, staff)

Sitiri Dada Kenya (staff)

Woman First Digital (staff)

Xhale Africa (staff)

Network for Youth Empowerment Kenya (staff)

Zamara Foundation (staff)

Limitations

- Any instance of participants not feeling comfortable using English was largely mitigated by conducting face-to-face conversations in local languages (Kiswahili or Shen with young people). The recordings were transcribed and translated into English and used to generate synthesis reports of the conversations.

- The sample of young people (aged 18-24) who participated in the conversations was limited due to i) insufficient time to organise discussions with adolescents (age 10-17) due to the lead-in time required to coordinate informed consent processes with their parents and guardians; and ii) the time of year the second phase conversations took place (November-December) where stakeholders had competing deadlines before the end of year break; iii) consultations were held in urban centres (Nairobi in Kenya) which meant that only those young people who could reasonably travel to the meeting locations (i.e. those living in proximal urban or peri-urban areas) participated.

In Malawi, the following stakeholders were engaged in this process:

Youth Act Alliance (young people)

Lilongwe Youth Organisation (young people)

Youth Wave Malawi (young people)

SRHR Africa Trust (young people)

SRHR Africa Trust Youth Hub (young people)

Limitations

- Any instance of participants not feeling comfortable using English was largely mitigated by conducting face-to-face conversations in local languages. The recordings were transcribed and translated into English and used to generate synthesis reports of the conversations.

- The sample of young people (aged 18-24) who participated in the conversations was limited due to i) insufficient time to organise discussions with adolescents (age 10-17) due to the lead-in time required to coordinate informed consent processes with their parents and guardians; and ii) the time of year the second phase conversations took place (November-December) where stakeholders had competing deadlines before the end of year break; iii) consultations were held in urban centres (Lilongwe in Malawi) which meant that only those young people who could reasonably travel to the meeting locations (i.e. those living in proximal urban or peri-urban areas) participated.

In Tanzania, the following stakeholders were engaged in this process:

Children's Dignity Forum (CDF, staff and young people)

Network of Young People Living with HIV and AIDS in Tanzania (NYP+, staff and young people)

Eastern Africa National Networks of AIDS and Health Service Organisations (EANNASO, staff)

Tanzania Youth Alliance (TAYOA, staff)

Young and Alive Initiative (YAI, young people)

African Youth and Adolescents Network (AFRIYAN, young people)

Chama cha Uzazi na Malezi Bora Tanzania (UMATI, young people who form part of the Youth Action Movement (YAM) in Dar es Salaam).

Limitations

- Any instance of participants not feeling comfortable using English was largely mitigated by conducting face-to-face conversations in local languages (Kiswahili in Tanzania with young people). The recordings were transcribed and translated into English and used to generate synthesis reports of the conversations.

- The sample of young people (aged 18-24) who participated in the conversations was limited due to i) insufficient time to organise discussions with adolescents (age 10-17) due to the lead-in time required to coordinate informed consent processes with their parents and guardians; and ii) the time of year the second phase conversations took place (November-December) where stakeholders had competing deadlines before the end of year break; iii) consultations were held in urban centres (Dar es Salaam in Tanzania) which meant that only those young people who could reasonably travel to the meeting locations (i.e. those living in proximal urban or peri-urban areas) participated.

In Uganda, the following stakeholders were engaged in this process:

Youth Livelihood Development Company (staff and young people)

International Community of Women Living with HIV Eastern Africa (ICWEA)

Community Health Alliance Uganda (CHAU, staff)

Reproductive Health Uganda (staff)

National Youth Advocacy Platform (NYAP) (staff)

Ngabo Youth Friendly Service Centre (staff)

Men Engage Alliance (staff)

Uganda Youth and Adolescent Health Forum (UYAHF, staff)

Limitations

- Any instance of participants not feeling comfortable using English was largely mitigated by conducting face-to-face conversations in local languages (Luganda in Uganda with young people). The recordings were transcribed and translated into English and used to generate synthesis reports of the conversations.

- The sample of young people (aged 18-24) who participated in the conversations was limited due to i) insufficient time to organise discussions with adolescents (age 10-17) due to the lead-in time required to coordinate informed consent processes with their parents and guardians; and ii) the time of year the second phase conversations took place (November-December) where stakeholders had competing deadlines before the end of year break; iii) consultations were held in urban centres (Kampala in Uganda) which meant that only those young people who could reasonably travel to the meeting locations (i.e. those living in proximal urban or peri-urban areas) participated.

In Zambia, the following stakeholders were engaged in this process:

Copper Rose Zambia (staff and young people)

Zambia Network for Young People Living with HIV (staff and young people)

Nyali Zambia (staff and young people)

Foundation for Adolescent Girls and Young Women in Zambia (staff)

Limitations

- Any instance of participants not feeling comfortable using English was largely mitigated by conducting face-to-face conversations in local languages (Nyanja and Bemba in Zambia with young people). The recordings were transcribed and translated into English and used to generate synthesis reports of the conversations.

- The sample of young people (aged 18-24) who participated in the conversations was limited due to i) insufficient time to organise discussions with adolescents (age 10-17) due to the lead-in time required to coordinate informed consent processes with their parents and guardians; and ii) the time of year the second phase conversations took place (November-December) where stakeholders had competing deadlines before the end of year break; iii) consultations were held in urban centres (Lusaka in Zambia) which meant that only those young people who could reasonably travel to the meeting locations (i.e. those living in proximal urban or peri-urban areas) participated.

List of Abbreviations

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
HIV	Human Immunodeficiency Virus
HLM	High Level Meeting
HSSP	Health Sector Strategic Plan
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer and Intersex
PrEP	Pre-exposure prophylaxis
UHC	Universal Health Coverage
UNAIDS	United Nations Programme on HIV/AIDS
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually transmitted infection
YFHS	Youth Friendly Health Services
WHO	World Health Organisation

UHC can never be achieved without realizing the SRHR of all young people. They are the future and their health and wellbeing, and empowerment is critical for the shaping of that future in all countries.

This policy brief describes the main challenges young people face in accessing the comprehensive SRHR and HIV services they need, and in being seen and supported as critical partners and leaders in realizing UHC for young people.

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