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PIECING IT TOGETHER:

Parliamentarians, People and Policy

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ACRONYMS

AIDS – Acquired Immunodeficiency Syndrome
ARV – Anti-retroviral Drugs
CDC – Centres for Disease Control and Prevention
CSE – Comprehensive Sexuality Education
ESA – East and Southern Africa
DHA – Department of HIV and AIDS
FGM – Female Genital Mutilation
FP – Family Planning
GBV – Gender-Based Violence
HIV – Human Immunodeficiency Virus
ICPD – International Conference on Population Development
IPV – Intimate Partner Violence
LGBTQ – Lesbian, Gay, Bisexual, Transgender, and Queer
MMR – Maternal Mortality Rate
NHI – National Health Insurance
PPH – Post-Partum Hemorrhage
PMTCT – Prevention of Mother-to-Child-Transmission
POA – Programme of Action
PrEP – Pre-exposure Prophylaxis
SADC - Southern African Development Community
SDGs – Sustainable Development Goals
SRH – Sexual and Reproductive Health
SRHR – Sexual and Reproductive Health and Rights
STI – Sexually Transmitted Infection
TOP – Termination of Pregnancy
U = U – Undetectable = Untransmittable
UHC – Universal Health Coverage
UNAIDS – Joint United Nations Programme on HIV/AIDS
UNFPA – United Nations Population Fund
VMMC – Voluntary Medical Male Circumcision

INTRODUCTION

At the landmark 1994 International Conference on Population and Development (ICPD) in Cairo, attendants pledged to align population and development with personal well-being. The ICPD Programme of Action (PoA) articulated a future in which reproductive health and rights, as well as gender equality, were recognised as vital to population and development programmes. On the 25th anniversary of the ICPD, representatives from over 172 countries and territories gathered at the Nairobi Summit in November 2019 to acknowledge the progress achieved and address the challenges that remain through reinvigorated commitments. Between these two watershed events, various milestones marked progress, such as the 1995 Fourth World Conference on Women and the 2012 London Summit on Family Planning. Continent specific achievements include the 1990 African Charter on the Rights and Welfare of the Child, the 2013 ESA Commitment and the 2016 statute of the African CDC and its Framework of Operation. The Nairobi Summit – attended by many heads of state across Africa – provided an opportunity to galvanise political will to ensure that the promise of the ICPD PoA is met. Participating countries issued a range of ambitious but realistic budgetary, programmatic and policy commitments to accelerate progress.

This report **'Piecing it Together:** ***Parliamentarians, People and Policy'*** examines existing policy parameters, analyses the policy environment and consolidates recent axial policy actions which have taken place in Kenya, Malawi, Uganda and Zambia towards advancing their commitments made at the Nairobi Summit. The report maps existing legislative and policy gaps, in both development and implementation, and correspondingly offers ten prioritised recommendations for each country that should be considered in order to better meet the various national commitments, specifically through the lens of attaining the four zeros. While all national ICPD25 commitments are included in each country's individual snapshot, only those relevant to the four zeros are more closely examined. Based on a desk review and interviews with key stakeholders in the four countries, the report ends with ten policy suggestions for regional application across Eastern and Southern Africa.

The Sustainable Development Goals: A Global Compact

Revitalising political and financial momentum through the ICPD25 commitments is an integral part of achieving the 2030 Agenda for Sustainable Development. Established in 2015, the 17 Sustainable Development Goals (SDGs), which buttress the 2030 Agenda, serve as both a rally cry and a blueprint for all United Nations Member States. To achieve the overarching goals, which include ending poverty and hunger as well as tackling climate change, will require bold political will, the strengthening and reshaping of national and global partnerships and the engagement of various communities and multi-sectoral stakeholders. Commitments established at the Nairobi Summit on ICPD25 intersect with specific SDGs. While each participating member state issued a varying number of commitments at the conference, the majority aligned with:

#3: good health and well-being
#4: quality education
#5: gender equality
#8: decent work and economic growth

demonstrating the intrinsic interconnectedness of social determinants and health, and echoing the importance of personal well-being as a cornerstone of national development. The integration of SRH issues into population and development plans is evidenced throughout the commitments.

Commitments in support of goal #3 and #5 were most common among the four countries examined in this report: Kenya, Malawi, Uganda and Zambia, indicating a national willingness to address root causes as well as implement directly impactful policy and programmatic action. Equally important was the dedication to investing in opportunities for young people as part of a holistic approach towards economic growth – especially in settings where a significant proportion of the population is young.

The Four Zeros: Getting to Zero

UNFPA offers a vision of a world in which there is zero unmet need for family planning, zero preventable maternal deaths and zero gender-based violence and harmful practices. The East and Southern Africa regional office introduced an additional goal of zero new HIV infections. Together these four zeros cover the most pressing SRHR issues in Eastern and Southern Africa. Getting to zero across these four linked areas, while challenging, also highlights the importance of an enabling and supportive policy environment to achieving their attainment. Through a combination of proactive policies, the availability and accessibility of integrated and comprehensive services and the removal of structural barriers, progress can be achieved. Actualising the Nairobi Statement and fulfilling the 2030 Agenda are vital to attainment of the four zeros. Key themes which emerged at the Summit as critical areas of focus for attaining the four zeros included universal health care access, increased domestic financing and harnessing demographic diversity. The Summit also highlighted youth leadership, gender equality, political and community leadership, innovation and data, and partnerships as pivotal mechanisms for accelerating progress across all of the key focus areas.

COVID-19: Impact and Implications

The COVID-19 pandemic has had a number of direct impacts on and implications for the substantive policy commitments made at the Nairobi Summit:

(i). Disruption in parliamentary action since the closure of the Summit: Because of the various national lockdowns much of the work on policy, which is usually done through a range of multi-sectoral parliamentary committees, was disrupted for the vast majority of 2020. In addition, much of the focus has been on managing policy issues related to COVID as time and resources (including those for SRH) were redirected. Only in recent months have committees been able to meet more regularly and there are hopeful signs, such as the April 2021 special session of the SADC parliamentary forum on Child Marriage and a report published by the Zambian Committee on Youth, Sport and Child Matters, that the focus of the committees onto SRH issues has been resumed.

(ii). Highlighting the core issues at the heart of the commitments: In addition to widening existing inequalities, the COVID pandemic has elucidated more than ever the importance of strengthening SRHR, health systems infrastructure and prioritising access to services. During the height of the pandemic and notably during lockdown periods, many countries reported a marked increase in GBV and teenage pregnancy. Consequences of unintended teenage pregnancies include termination of education, unsafe abortion, reduced job and career prospects and increased vulnerability to poverty. Lockdown periods also negatively impacted upstream factors, such as educational attainment, job development and access to CSE curricula, which directly influence attainment of the four zeros. The full picture of COVID's epidemiological impact will become clearer in time.

(iii). Increased alignment and contribution of the SRHR response to pandemic preparedness and global health security issues: COVID has demonstrated the importance of increased pandemic preparedness and the SRH community should increasingly find ways to bring some of its expertise and skills in this area to the forefront.

Aspects of policy development have been brought into sharp relief by the COVID-19 pandemic, which has impacted SRH and HIV service uptake and availability, and in many cases potentially reversed trends that were heading in the right direction. All SRH and HIV policy development, implementation and oversight have to more acutely cover issues related to global health security including pandemic preparedness to ensure that services can still be provided during mercurial times, especially for young women and girls.

Youth Centered: Making it Meaningful

Youth related issues are front and center of many of the commitments and the aspiration of ensuring that the benefits of a `young` sub-region are capitalised upon is a recurring theme. Issues proving to be particularly challenging in making the most of the demographic yield include high fertility rates and teenage pregnancy increases. Policy action in relation to these issues focuses mainly on increased budgetary allocation to ensure that adolescent friendly services are available and that comprehensive `age-appropriate` sexuality education is a reality for learners in schools. These persistent challenges on which there are polarised views may require additional policy review and would benefit from a regionally united approach to find innovative avenues of embracing culture and tradition while responding to the realities of the day. The meaningful engagement of young people in the development and implementation of policies which directly impact them is, while more time consuming, more likely to result in effective rollout and uptake as well as foster increased community goodwill.

Policy Implementation and Oversight: The Litmus Test

While there are avenues for enhanced multi-sectoral policy alignment and harmonisation in order to more readily meet the ICPD25 commitments, the experience from the four countries (Kenya, Malawi, Uganda, and Zambia) rests on an increased parliamentary policy implementation and oversight role. While policy formulation is not an issue and the policy creation environment is largely enabling, lacking execution and oversight reduces the efficacy of policy impact. This is exacerbated by the common challenging areas on which there are polarized opinions notably with regard to a) the provision of SRH services to teenagers as a key element of reducing teenage pregnancy; b) the expansion of legal abortion services to prevent unsafe abortion; c) a CSE curriculum that responds to the needs of learners in a more proactive and participatory approach; d) the provision of services to key populations (including men who have sex with men, sex workers, transgender people and people who inject drugs); and e) GBV prevention and response. The policy conversations around some of these culturally sensitive topics are often evasive and/or challenging for a range of reasons. Developing a multi-sectoral learning process may assist in delving deeper on certain aspects where there is political will. Harnessing the demographic dividend requires not only commitments to educational expansion and job market opportunities, but also encouraging and requesting young people to be active participants in policy creation. Parliamentary SRH and gender champions – and the nurturing of the next generation of champions – are effective in building a robust understanding of and approach towards the most pertinent policy issues. The commitments made at the Nairobi Summit highlighted the political imperative of specific SRH issues, and the commitment to increasing domestic budget allocation is a clear sign of this intent. Capitalising strategically on this political momentum and will-power is essential to ensuring policy progress – both in the short and long term.

KENYA *Parliamentarians, People and Policy:* Towards Rigorous People-Centered Implementation

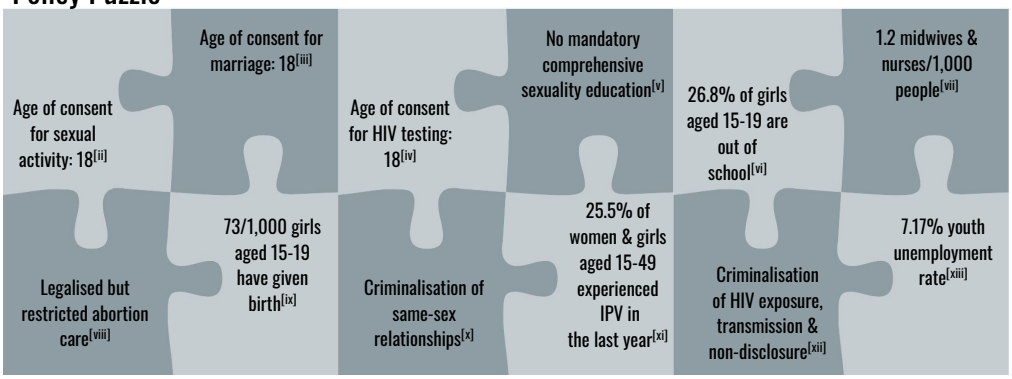
As host country for the Nairobi Summit on ICPD25, Kenya set high expectations, issuing 17 expansive and ambitious commitments. Policy commitments related to attainment of the four zeros[1] included integration of population issues, elimination of female genital mutilation and gender discrimination, as well as promotion of youth participation. Annual targets and actions have been established for ICPD25 commitments to monitor progress, guaranteeing fulfillment of national pledges by 2030. Last year, the Kenyan government reviewed the Demographic Dividend roadmap for alignment with ICPD25 commitments and by June of 2021 a similar review of the Population Policy will be completed. The Parliamentarian Network on Population Development is primarily concerned with implementation of policy through the establishment of an inter-ministerial task force. In addition to the task force, advocates for the ICPD25 agenda are dedicated to expanding support within parliamentary ranks.

ICPD25 Commitments[ii]

At the historic "Nairobi Summit on ICPD25: Accelerating the Promise", Kenya made the following commitments:

1. Employ innovation and technology to ensure adolescents and youth attain the highest possible standard of health. Efforts will be made to eliminate teenage pregnancies, new adolescent and youth HIV infections and harmful practices such as child marriages while at the same time ensuring universal access to friendly quality reproductive health services and information to the youth and adolescents by 2030.
2. Eliminate preventable maternal and newborn mortality, mother to child transmission of HIV and severe morbidity such as obstetric fistula among women by 2030.
3. Progressively increase health sector financing to 15 percent of total budget, as per the Abuja Declaration by 2030.
4. Improve support to older persons, persons with disabilities, orphans, and vulnerable children by increasing the core social protection investment from 0.8 percent of Gross Domestic Product to at least 2 percent over the next 10 years.
5. Enhance integration of population, health and development programmes and projects into Medium Term Plans (MTPs) and the Medium Term Expenditure Framework (MTEF) to ensure budgetary allocations and efficient implementation of programmes and projects by 2030.
6. Enhance the capacity of relevant Government institutions to increase availability and accessibility to high-quality, timely and reliable population and related data at national, county, and sub-county levels, disaggregated by income, gender, age, ethnicity, migratory status, disability and geographic location by 2030.
7. Integrate population issues into the formulation, implementation, monitoring and evaluation of all policies and programmes relating to sustainable development at national, county and sub-county levels by 2030.
8. Harness the demographic dividend through investments in health and citizens wellbeing; education and skills training; employment creation and entrepreneurship; and rights, governance and empowerment of young people by 2022.
9. Eliminate legal, policy and programmatic barriers that impede youth participation in decision making, planning and implementation of development activities at all levels by 2030.
10. Attain universal basic education by ensuring 100 percent transition of pupils, including those with special needs and disabilities, from early learning to secondary education by 2022. Also raise the completion rate for basic education to 100 percent by 2030.
11. Improve the employability and life-skills of youths by enhancing quality and relevance of Technical Vocational Education and Training (TVET) in partnership with industries and private sector by 2030.
12. Fully implement the Competence Based Curriculum (CBC) so that learners are equipped with relevant competencies and skills from an early stage for sustainable development by 2030.
13. End Female Genital Mutilation by strengthening coordination in the area of legislation and policy framework, communication and advocacy, evidence generation and support cross border collaboration on elimination of FGM by 2022.
14. Eliminate, by 2030, all forms of gender-based violence, including child and forced marriages, by addressing social and cultural norms that propagate the practice while providing support to women and girls who have been affected.
15. End gender and other forms of discrimination by 2030 through enforcing the anti-discrimination laws and providing adequate budgetary allocations to institutions mandated to promote gender equality, equity and empowerment of women and girls.
16. Ensure universal access to quality reproductive health services, including prevention and management of GBV, in humanitarian and fragile contexts by 2030.
17. Track and monitor the implementation of the ICPD25 Nairobi Summit commitments through the National Council for Population and Development in the State Department for Planning.

Policy Puzzle



[1] 1) Zero Unmet Need for Family Planning 2) Zero Preventable Maternal Deaths 3) Zero Gender-Based Violence and Harmful Practices 4) Zero New HIV Infections

Zero Unmet Need for Family Planning

23% of Kenyan girls aged 15-19 have an unmet need for family planning (FP) and the Kenyan government affirmed its political will to fulfill this national need through a commitment to employ innovation and technology, which would ensure that adolescents and youth attain the highest possible standard of health.[xiv] Among key FP agenda items, teen pregnancy is one facet which is in need of and would benefit from these advancements. Recent data showed a spike in pregnancy and in particular, teen pregnancy, rates during 2020.[xv] As a result, a new national taskforce has been established to address early motherhood. Additionally, each of Kenya's 47 counties is forming their own teen pregnancy council. Because Kenyans must be 18 years or older to access sexual and reproductive health (SRH) services, and in order to receive prescription contraceptives without a parent or guardian, pregnancy prevention for minors often relies upon condom usage.[xvi] As such, strengthening condom-oriented sexual and reproductive health and rights (SRHR) and HIV dual protection approaches is an avenue that should be explored more fully if this remains one of the primary prevention avenues for sexually active teenagers. Additional policies to improve FP uptake include guidance on male engagement. While this policy implementation has struggled against cultural barriers, it has seen some success in urban areas where sexual partners are more likely to engage in open discussions about FP needs and desires. Increased provision of in and out-of-school comprehensive sexuality education (CSE) for Kenyan youth would offer an opportunity for adolescents to interrogate social and cultural norms surrounding FP usage. While CSE has received both parliamentary and public resistance, efforts are underway to incorporate certain aspects of CSE into curricular development.

Zero Preventable Maternal Deaths

As of 2017, the maternal mortality ratio in Kenya was 342/100,000 and post-partum hemorrhage was the leading cause of preventable death.[xvii] At the Nairobi summit, Kenya committed to eliminating preventable maternal mortality and severe morbidity, such obstetric fistula, by 2030. Disparities in rates of maternal mortality persist between urban and rural areas are due to a multitude of reasons including differing levels of access to health facilities as well as skilled birth attendants. Urban pregnant women are three times more likely to receive a life-saving intervention than rural pregnant women.[xviii] Cultural norms surrounding birth experiences also play a role as 56% of Kenyan women deliver at home.[xix] Service delivery and structural interventions are underway with the provision of increased emergency obstetric training for providers, and expansion of the midwifery workforce. Restrictive abortion legislation also contributes to maternal mortality and morbidity. As outlined by the Reproductive Health Bill of 2019, a pregnancy may be terminated if a trained health professional determines that there is a need for emergency treatment, the life or health of the mother is at risk, or that the fetus will not be viable outside the womb.[xx] Due to the prohibitory legislation, many women and girls rely on unsafe illegal abortion care, on which data and evaluation is sorely lacking. In 2012, an estimated 465,000 induced abortions occurred in Kenya.[xxi] While the current political environment is not conducive to altering termination of pregnancy (TOP) legislation, supportive parliamentarians may find opportunities to foster advocacy through increased community engagement and awareness, and increased investments in the health care workforce.

Zero Gender-Based Violence and Harmful Practices

Kenya aims to end female genital mutilation (FGM), of which 21% of women and girls ages 15-49 have experienced in some form, by 2022 through strengthening the legislation and policy framework, communication and advocacy, evidence generation and cross-border collaboration.[xxii] Due to presidential commitment, the framework for honoring this charge has been accelerated. In all 47 counties, programmatic actions to counter FGM practices have been established and are being implemented. FGM hotspots have been mapped in collaboration with the Ministry of Public Service & Gender and action plans have been enacted in 22/23 hotspots. Those charged with carrying out the ministerial procedures must contend with traditional customs in addition to increased medicalisation and cross-border operations. Throughout the COVID pandemic, collected data did not show an increase in tracked FGM activity, however, reported incidence of intimate partner violence (IPV) and gender-based violence (GBV) increased dramatically. Weekly data collected by the Ministry of Public Service & Gender along with UNFPA showed a marked difference in IPV & GBV incidence during lockdown periods. Officials attribute this increase to COVID related job-loss and economic stress, highlighting the need to address root causes and prevention aspects. In accordance with Kenyan ICPD25 commitments, the 2014 GBV prevention policy has been updated.[xxiii] Additionally, child marriage is of concern as 12% of girls aged 15-19 are married.[xxiv] Moving forward, parliamentarian focus includes a women's empowerment strategy as part of the National Policy on Gender and Development.[xxv] Notably, data on GBV and discrimination against LGBTQ populations was not captured, in part potentially due to the criminalisation of same-sex relationships. Similarly, any violence enacted against sex workers was not recorded.

Zero New HIV Infections

Kenya has experienced and continues to experience one of the largest HIV epidemics across the globe- as of 2019, over 1.5 million people in Kenya are living with HIV and 90% of people know their status.[xxvi],[xxvii] The Kenya AIDS Strategic Framework envisions a Kenya free of new HIV infections, stigma and AIDS-related deaths.[xxviii] It endeavors to reach these linked goals through the provision of comprehensive HIV prevention, treatment and care. County level AIDS plans aim to ensure that HIV services are included in universal health care policies. Other interventions to reduce HIV infection rates include provision of pre-exposure prophylaxis (PrEP) and voluntary medical male circumcision (VMMC). Prevention of mother-to-child transmission (PMTCT) of HIV remains a policy focus, and through concentrating on linkages between HIV testing and treatment with SRH services, in particular, antenatal care, Kenya aims to eliminate vertical transmission by 2030. Policy restrictions, in addition to the gender barriers highlighted in section 3, which could hinder Kenya's ability to significantly reduce the number of new HIV infections, include the age of consent for HIV testing, and stigma and discrimination notably the criminalisation of key populations. Adolescents under the age of majority are unable to consent to HIV testing without a parent or guardian present, increasing the likelihood of unintentional transmission to future sexual partners. Promoting early testing and treatment as a form of prevention is essential. High levels of ARV adherence in Kenya provide the opportunity to fully embrace and expand acceptance of U=U (undetectable = untransmittable) messaging. While many cases of transmission are not prosecuted, the fear of criminal proceedings creates an added barrier to testing, treatment and care.[xxix]

Ten recommendations on the pathway to meeting the commitments:

Based on interviews with key stakeholders and a review of core policy documents related to the achievement of the four zeros, the following ten prioritised actions are recommended to ensure that milestones along the pathway to meeting the ICPD commitments are met. Parliamentarians in Kenya should consider the following 10 policy focused actions:

01. **Fine-tune and track policy implementation indictors and oversight** of a core set of policy imperatives including a) GBV service delivery packages, b) FGM elimination and c) child and forced marriage through enhanced reporting requirements and data generation.

02. Consider a policy **review and assessment of health care consent laws** to better enable Kenyan youth to be involved in and make proactive decisions regarding their health care, notably around accessing SRH services and commodities including prescription FP methods.

03. Build upon and strengthen the 2013 ESA Commitments by promoting the **expansion of CSE implementation**, in and out-of-school, including through participatory learner-oriented curriculum evaluation and review.

04. Dedicate increased domestic funds to **reinforcing and expanding SRH and HIV service infrastructure**, including workforce expansion, training and retention, particularly in rural areas.

05. Assess **the impact of COVID on the four zeros** and policy adaptation as needed including through increased budget allocation; and strengthen resilience and preparedness for other global health and development challenges by ensuring that policy lessons are captured for SRHR and HIV.

06. **Track increased cross-sector percentage budgetary allocations** year on year notably for a) job creation/skills development opportunities for young people, b) gender equality promotion and c) education completion awareness.

07. Review and align Kenya`s policy action in light of the soon to be agreed **2021 Political Declaration on HIV and AIDS** (from the 10 June 2021) which emphasizes that GBV, the unequal socioeconomic status of women, structural barriers to women's economic empowerment and insufficient protection of the SRHR of women and girls compromises their ability to protect themselves from HIV infection and aggravates the impact of the AIDS pandemic and increase domestic resource allocation to HIV.

08. Monitor implementation of a road map to eliminate **vertical transmission of HIV infections and end pediatric AIDS** by 2030 with a focus on core policy imperatives including a) identifying and addressing gaps in the continuum of services for preventing HIV infection among women of reproductive age, especially pregnant and breastfeeding women, b) testing 95% of HIV-exposed children by two months of age and after the cessation of breastfeeding, and ensuring that all children diagnosed with HIV are provided treatment regimens and formulas; c) ensuring that 95% of pregnant women have access to testing for antenatal HIV, syphilis and hepatitis B, 95% of pregnant and breastfeeding women have access to re-testing during late pregnancy and in the post-partum period and d) identifying and treating undiagnosed older children and adolescents.

09. Implement a **participatory national youth survey** to better understand evolving youth perspectives and behaviors, leading to more effective policy guidance on a number of issues including culture and norms related to CSE and teenage pregnancy; and activate diverse and meaningful youth participation and engagement in policy issues through the creation of **shadow youth policy task force** that can serve as a harbinger of youth focused SRHR and HIV trends, notably around some of the issues that are politically more sensitive (such as key and vulnerable populations).

10. Optimise the **use of technology and foster innovation** with the SRHR and HIV response notably on issues of teenage pregnancy – to ensure that learners` experience of and engagement with health and education services in particular are succinctly captured.

Process & Methodology

The legal and policy review was conducted in April and May 2021 through a detailed perusal of various laws and policies which constitute the framework and development of sexual and reproductive health and rights in Kenya. Semi-structured interviews were conducted with representatives from the UNFPA Kenya office as well as other key stakeholders in Kenya to further inform and contextualise the policy review.

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MALAWI *Parliamentarians, People and Policy:* Progressive Oversight and Accountability

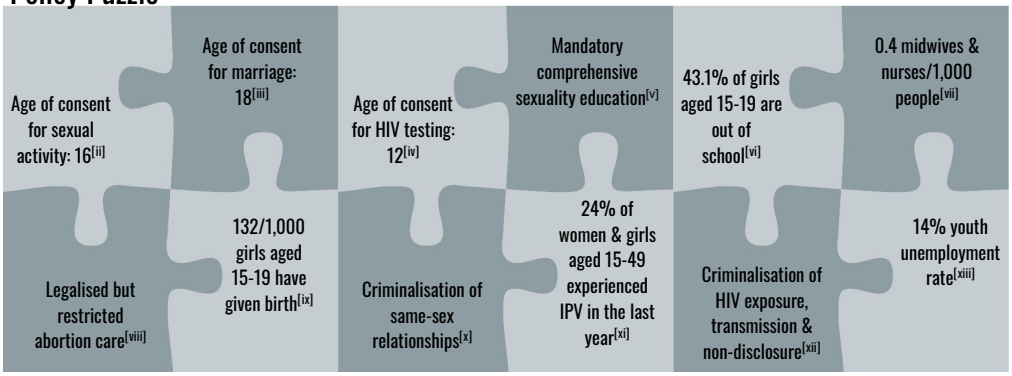
At the Nairobi Summit the government of Malawi issued ten encompassing commitments directed at fulfilling the ICPD25 agenda by 2030. Policy related commitments key to achieving the four zeros[1] included finalizing a legal framework for sexual and reproductive health and rights, engaging youth representation in decision making bodies, as well as expanding comprehensive sexuality education and contraceptive counselling services. Since the Summit, a national steering committee coordinated by the Ministry of Health has been established to oversee progress. The committee is comprised of a diverse group of representatives including government officials, parliamentarians, young people, religious and traditional leaders and the private sector. Aimed to monitor and evaluate based on preset benchmarks, the committee is also able to serve as an advocacy tool for Malawians at large on the ICPD25 Agenda. Unfortunately, COVID has deterred meetings thereby impeding progress, but representatives express an ardent desire to begin the work. In January 2021, the Malawian government, launched Malawi 2063, which offers an ambitious vision of Malawi as "inclusively wealthy and self-reliant." Prominent features of the vision include expanded tracking and accountability measures, which also serve as fundamental cornerstones of ICPD25 commitment implementation. The policy creation environment is largely enabling presenting an opportunity for ICPD champions to foster progress, but lacks robust monitoring.

ICPD25 Commitments[ii]

At the historic "Nairobi Summit on ICPD25: Accelerating the Promise", Malawi made the following commitments:

1. Increase the health budget allocated to reproductive maternal neonatal, child and adolescent health from 8% in 2019 to 30% by 2030.
2. Continue to lower the maternal mortality rate from 439 per 100,000 live births in 2016 to a maternal mortality ratio of 110 per 100,000 live births by 2030. The Government will finalize a comprehensive legal framework for sexual and reproductive health and rights, build increased capacity of nurses and midwives, gynecologists and other critical para-medicals, widening access to new long acting reversible contraceptives for adolescents and the development of a universal health insurance framework will increase the sexual and health access of the most vulnerable by 2030.
3. Include 30% of youth in decision making bodies by reviewing the legal framework, national youth policy and guidelines by 2030.
4. Provide 12 years of quality free education for every child ensuring girls and boys enjoy a full primary and secondary education and equal access to vocational, technical and higher education courses.
5. End child marriage and delay first pregnancy among girls (10-19 years) by 2030. It will reduce the number of women that were married before 18 years of age from 47% in 2016 to zero in 2030, effectively reinforcing laws, coordinating policy making, promoting national prevention awareness and advocacy campaigns as part of a wider programme to target all forms of violence against women, girls and boys.
6. Incorporate sexual and reproductive health and rights in 100% of implementation of humanitarian responses, contingency and recovery plans.
7. Achieve 100% of the service points delivering sexual and reproductive health and rights services are youth friendly. Youth friendly sexual and reproductive health services and rights including HIV and AIDS will be scaled up from pilot districts to providing leadership training and comprehensive age appropriate sexuality education and contraceptives counselling.
8. 100% fully digitalized population data collection system supporting the regular production of disaggregated data and high-quality analysis. Schemes to support data literacy in communities assisting improve localized and participatory development decisions will be rolled out across all districts.
9. Reduce the unmet need of married women and unmarried adolescent girls (15-19 age group) for family planning and sexual and reproductive health services from 19% and 22% in 2016 to 11% and 12% respectively by 2030 by scaling up sexual and reproductive health service provision and ensuring 100% availability of affordable family planning services, commodities and life-saving drugs support and advisory services for communities and contraceptives.
10. Increase spending on health by raising the percentage of the national budget allocated for the health sector from 10% in 2019 to 15% by 2030 that will strengthen programme implementation and provide adequate funding to meet key policy indicator targets for scaling up services including sexual and reproductive health and rights services.

Policy Puzzle



[1] 1) Zero Unmet Need for Family Planning 2) Zero Preventable Maternal Deaths 3) Zero Gender-Based Violence and Harmful Practices 4) Zero New HIV Infections

Zero Unmet Need for Family Planning

As of 2016, 19% of married and 22% of unmarried adolescent girls aged 15-19 were lacking both family planning (FP) and sexual and reproductive health (SRH) services.[xiv] At the ICPD25 conference in Nairobi, the Malawian government committed to meeting population level needs for FP through provider capacity building, the expansion of youth friendly SRH services, provision of 'age-appropriate' comprehensive sexuality education (CSE) and ensuring affordability of FP services, commodities and drugs. Through the combined impact of education and service delivery, in particular CSE and youth friendly services, the Malawian government hopes to empower young girls and reduce teenage pregnancy rates. As of 2018, 132 out of 1,000 Malawian girls aged 15-19 had given birth.[xv] Increased domestic funding is encouraged as the 2019-2020 national budget for FP commodities covered only 4.6% of the total projected need.[xvi] The current National Gender Policy indicates the importance of male involvement in FP.[xvii] Innovative programmatic action implemented through a multi-pronged approach, including workplace interventions and adequate budgetary support, are necessary to actualise this policy platform. Gender transformative CSE curricula which address the importance of gender equality in contraceptive use offer the opportunity for Malawian youth to analyse traditional notions of FP as a women-only responsibility. Multi-sectoral engagement and coordination are paramount to achieving zero unmet need for FP. Capitalising on national level commitments to providing CSE linked to youth friendly services and an enabling policy environment offers prospects for progress.

Zero Preventable Maternal Deaths

The Republic of Malawi committed to reducing the national maternal mortality rate by from 439 to 110 per 100,000 by 2030 through the development of a universal health care framework, increasing the capacity of providers to widen access to long-acting reversible contraceptives and finalising legal sexual and reproductive health and rights (SRHR). Post-partum hemorrhage and sepsis are the main causes of maternal mortality in Malawi.[xviii] Both urban and rural health facilities are impacted by structural barriers such as a lack infrastructure, provider availability and basic resources to ensure good health outcomes for patients. Health systems strengthening as well as building advocacy and community engagement are necessary to foster public trust in the health care system and encourage uptake of antenatal services. These issues additionally impact post-abortion care, a contributing factor of maternal morbidity and mortality in Malawi. Unsafe abortions accounted for 6-18% of maternal mortality in 2017.[xix] The current National Sexual and Reproductive Health Policy includes provisions for post-abortion care.[xx] In March 2021, parliamentarians opted out of discussing a bill which would ease termination of pregnancy (TOP) legislation in Malawi. Currently, abortion is solely permissible to save the life of the mother. The recently reintroduced bill (first introduced in 2016) would expand abortion access so that termination is legal in cases of rape, incest, or when the pregnancy endangers the mother's physical or mental health. The mover of the bill plans to continually introduce the bill until it is discussed on the parliamentary floor. Progressive policy champions are critical in attempts to update and align Malawian policy with ICPD commitments.

Zero Gender-Based Violence and Harmful Practices

In Nairobi, the Republic of Malawi committed to ending child marriage by 2030; notably 23.4% of girls aged 15-19 are married.[xxi] According to the 1994 constitution, Malawian citizens must be 18 years of age to consent to marriage, however, youth under the age of 18 may be married with parental or guardian consent. Additionally, a minister or court official may authorise a marriage if there is no living parent or guardian.[xxii] To facilitate harmonisation between policies, and better protect Malawian youth, a 2017 constitutional amendment raised the age of minority from 16 years to 18 years. This progressive synchronicity must be aligned throughout Malawian policy. The 2018-2023 strategy to combat child marriage from the Ministry of Gender includes access to education, transformation of cultural practices and economic empowerment.[xxiii] Further parliamentarian action to combat gender-based violence (GBV) can be found in the National Plan of Action which highlights the existing policy structure as well as priority areas for increased measures against GBV.[xxiv] Among these are addressing root causes and social norms, creating an effective response mechanism for supporting survivors and promoting research, data collection, monitoring and evaluation. Malawi further supports survivors through GBV specific courts which provide female judges and offer mobile court options. While the burden of proof is high, and many women may be reluctant to bring claims, enabling judicial structures increase the likelihood of real accountability, underscoring the importance of integrated GBV prevention and response services across health, police, justice and social services.

Zero New HIV Infections

The HIV incidence in Malawi for adults aged 15-49 is 3.71/1,000, and at the Summit, Malawi committed to include HIV and AIDS prevention and treatment services in all youth friendly SRH services, demonstrating the importance of primary prevention and knowing one's status. [xxv] Increased linkages between HIV and SRH services are overseen by the Department of HIV and AIDS (DHA), which is housed within the Ministry of Health. The DHA is also tasked with monitoring sexually transmitted infections (STIs), prevention of mother to child transmission (PMTCT) and voluntary medical male circumcision (VMMC). New infection incidence dropped dramatically between 2005 and 2018, from 66,000 to 38,000 and as of 2018 Malawi was on track to achieve the UNAIDS 90-90-90 targets as 90% of people living with HIV in Malawi were aware of their status, 87% of those who were aware were on treatment and 89% of those on treatment were virally suppressed.[xxvi] Youth in Malawi may consent to HIV testing and counseling from the age of 12.[xxvii] Despite this progressive action, key populations (men who have sex with men, sex workers, transgender people and people who inject drugs) in Malawi are still largely ignored. The continued criminalisation of HIV transmission, exposure and non-disclosure, particularly discriminates against men who have sex with men and sex workers. While sex work itself is legal in Malawi, the current penal code criminalises profiting from sex work and is often implemented against sex workers themselves due to persistent stigmatisation.[xxviii] Increasing data collection and research on key populations is necessary for reducing national HIV prevalence.

Ten recommendations on the pathway to meeting the commitments:

Based on interviews with key stakeholders and a review of core policy documents related to that achievement of the four zeros, the following ten prioritised actions are recommended to ensure that milestones along the pathway to meeting the ICPD commitments are met. Parliamentarians in Malawi should continue to foster and strengthen an enabling policy environment by more deliberately utilising their platform and consider the following policy focused actions:

01. Request **regular updates from the national ICPD25 steering committee** (which is coordinated by the Ministry of Health) on the progress towards and tracking of the commitments.

02. Develop a **stronger oversight role around key indicators of the national CSE initiative** with a specific focus on the following elements: teacher training, curriculum development, implementation, learner-oriented participatory feedback and the use of technology.

03. **Enforce legislation, policies, and practices** that prevent violence and other rights violations against women and girls as well as other key and vulnerable populations.

04. Track both **donor and year on year increased domestic finance allocation** to strengthen cornerstone 1) FP, 2) adolescent friendly services with a focus on increasing the skills and numbers of the health workforce and 3) integration of SHR services within UHC packaging.

05. **Monitor and evaluate** with clients and community representatives the current approach to the **provision of adolescent friendly services** through the creation of innovative incentives around some of the recognised bottlenecks.

06. Increase the **generation and use of real-time data to inform strategic decision-making** notably around: a) disaggregated teenage (13-19 year-old) pregnancy data, b) tracking investments in options for youth who are in education, training and work, c) FGM and d) key and vulnerable populations including sex workers and men who have sex with men.

07. Build on the emerging lessons of the COVID pandemic by **increasing investments in community systems strengthening** for SRHR and HIV.

08. Review, consolidate and align Malawi's policy actions in light of the soon to be agreed **2021 Political Declaration on HIV and AIDS** (from the 10 June 2021) which emphasizes that GBV, the unequal socioeconomic status of women, structural barriers to women's economic empowerment and insufficient protection of the sexual and reproductive health and rights of women and girls compromises their ability to protect themselves from HIV infection.

09. Forge robust **parliamentary partnerships** to support discussion of the Termination of Pregnancy Bill to potentially ease abortion legislation.

10. Become vocal and visible **parliamentary gender champions by pledging to break down gender barriers** and make SRHR issues a working reality in constituencies and spheres of influence within and beyond parliament.

Process & Methodology

The legal and policy review was conducted in April and May 2021 through a detailed perusal of various laws and policies which constitute the framework and development of sexual and reproductive health and rights in Malawi. Semi-structured interviews were conducted with representatives from the UNFPA Malawi office as well as other key stakeholders in Malawi to further inform and contextualise the policy review.

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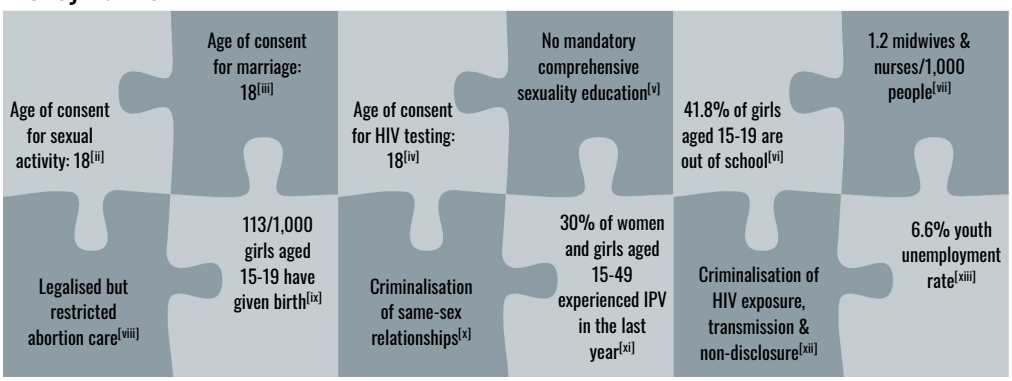
UGANDA *Parliamentarians, People and Policy:* Focusing on the Demographic Dynamics

At the Nairobi Summit, policy affiliated commitments issued by the Republic of Uganda linked to the four zeros[1] involved harnessing the demographic dividend through focusing on human capital development, promoting universal access to all methods of family planning, allocating resources to adolescent friendly health services, using education to improve gender parity and reduce early pregnancy & child marriage and implementing sexuality education policies. While progress has been made since the summit, such as approval of the new Population and National Health Insurance policies, champions within parliament in support of the ICPD25 agenda must contend with dissenting voices. Additionally, new relationships must be forged as some advocates were lost in the transition from the 10th to 11th parliament. Notably, 60% of the new parliament is below 35 years of age, offering a unique opportunity for revised policies which address the desires and realties of Ugandan youth. Capacity building of parliamentarian advocates is necessary for ensuring that policies in support of the four zeros are not only passed, but implemented with oversight.

At the historic "Nairobi Summit on ICPD25: Accelerating the Promise", Uganda made the following commitments:

1. Promote universal access to all methods of family planning and reduce the unmet need for family planning from 28% to 10% by 2022. Re-affirm the commitments that were made at the Family Planning Summit in London (July 2017) to increase financial support towards reproductive health and family planning supplies and commodities to the last mile.
2. Allocate annually at least 10% of maternal and child health resources to adolescent-friendly reproductive health services.
3. Eliminate obstacles that stand in the way of girls' empowerment including teenage pregnancy and child marriage, as well as all forms of gender-based violence. Embark on educational reforms aimed at ensuring that girls enroll and stay in school, as well as scale-up investments in technical and vocational education to create employable skills and competencies relevant to the labour market.
4. Operationalize the National Sexuality Education Policy Framework that was launched in 2018 to provide a formal national direction for sexuality education within Uganda's schools; while upholding the positive cultural and religious values of the country.
5. Ensure that different dimensions of the demographic dynamics and diversity are integrated into planning and budgeting frameworks at all levels.

Policy Puzzle



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Zero Unmet Need for Family Planning

31% of girls aged 15-19 have an unmet need for family planning, correspondingly Ugandan commitments at the Nairobi Summit linked to the national family planning (FP) agenda involved budgetary allocation of maternal and child health funds earmarked for adolescent friendly reproductive health services, educational reforms aimed at keeping girls in school to eliminate teen pregnancy and child marriage, as well as the operationalisation of the National Sexuality Education Policy Framework.[xiv, xv] In March of 2021, the National Health Insurance Bill passed through parliament and is currently waiting on presidential assent. This universal health coverage bill incorporates FP as an essential service. Additionally, the National Family Planning Costed Implementation Plan (2015-2020) articulates the importance of high impact interventions and funding required, which can be utilised to maintain progress and accountability.[xvi] While universal coverage of FP is a step in the right direction, Ugandan minors are still unable to access FP on their own, due to existing health care consent laws and policies, indicating a gap in service delivery.[xvii] Further illustrating the issue is the high rate of teenage pregnancy in Uganda. Officials aim to lower the current rate from 25% to 15% by 2025 through awareness campaigns and by engaging development partners. In April 2021, an important motion on the prevention of teen pregnancy, which urged the government to develop and enforce policies and strategies regarding escalating teen pregnancies, notably impacted by the COVID-19 pandemic, was passed by parliament.[xviii] The impact of lockdown and school closures in particular has led to a reported increase in unintended teenage pregnancies- the consequences of which include termination of education, reduced job and career prospects and increased vulnerability to poverty.[xix, xx] Additional proactive policy creation and oversight is necessary to ensure this goal is met. While the Ugandan government established a National Policy Strategy to address upstream factors of gender inequity and teenage pregnancy through a formal agenda on in-school sexuality education, implementation of this framework has been lacking since its creation in 2018. Parliamentary oversight is needed to ensure the promise issued in Nairobi, and the structural game changers identified in the demographic dividend roadmap, including keeping girls in school, are fulfilled.[xxi]

Zero Preventable Maternal Deaths

ICPD25 commitments made by the Republic of Uganda did not directly address preventable maternal deaths, however tangentially related policies concentrating on universal health care, reproductive health services and investing in youth will undoubtedly have an impact on the maternal mortality rate (MMR), as 13% of maternal deaths occur in mothers between the ages of 15 and 19 and the overall MMR is 375/100,000[xxii, xxiii] Dedicated parliamentarian action is needed to further reduce preventable maternal deaths as post-partum hemorrhage (PPH) remains the leading cause of MMR. Barriers to reducing this occurrence include a lack of skilled birth attendants, accessibility of services, as well as lack of availability of newer technologies and drugs, especially in rural areas. As of February 2021, a new framework specifically addressing PPH was established, however it neglects additional causes of maternal mortality, including eclampsia and unsafe abortion. Restrictive abortion regulations, in addition to societal stigma, result in many women seeking unsafe abortion services. Complications from unsafe abortion are also a contributing factor to the high maternal mortality rate in Uganda.[xxiv] Post-abortion care is required for many women regardless of the legality of their abortion care. The aforementioned NHI bill would offer coverage for post-abortion care however, lacking accessibility and skilled providers continue to be of concern, particularly among rural populations. Enhanced parliamentarian commitment to the use of data generation and utilisation to inform policy and programmes - including the Maternal Perinatal Death Surveillance and Response report - as well as monitoring and evaluation, and budget allocation are key to progress in this issue.[xxv]

Zero Gender-Based Violence and Harmful Practices

30% of women and girls aged 15-49 have experienced intimate partner violence (IPV) in the last year. At the Nairobi Summit, Uganda affirmed its desire to eliminate all forms of gender-based violence (GBV) through focusing on girls' empowerment. Educational reforms designed to ensure girls enroll and stay in school are intended to decrease rates of child marriage. While the legal age for consent to marriage is 18, between 17% and 58% of Ugandan girls are married before they reach the age of majority, depending on the region.[xxvi] Parliamentarians must confront existing legal structures as well as traditional customs which enable parents to consent to marriage on behalf of their children before they reach adulthood. Early marriage and disengagement from educational opportunities assures that women will be economically dependent upon their husbands, particularly in rural areas. In cases of women experiencing IPV, this economic dependence decreases the likelihood of extrication. The 2019 updated National Policy on Elimination of Gender-Based Violence in Uganda highlights the importance of prevention focused policies as a priority action item. [xxviii] Further tension arises in the implementation of female genital mutilation (FGM) policies. Approximately 1% of women and girls aged 15-49 have experience some form of FGM.[xxvii] The Ugandan government banned FGM in 2010 which was effective in reducing the amount of reported FGM procedures performed annually, however, the practice continues in some communities. Advocates of FGM cite tradition, social, and cultural reasons. Educational reforms put forth by policymakers must include curricular development which inform Ugandan youth about harmful gender-based practices. Additionally, parliamentary focus on increasing engagement of and creating opportunities for girls and young women must concentrate on rural communities where issues are most prescient. Policy creation must acknowledge downstream barriers to implementation and offer local counties and municipalities support in their endeavors to enact and uphold national policies, via financial backing and rollout oversight.

Zero New HIV Infections

HIV incidence among adults aged 15-49 is 2.61/1,000 and Uganda has made significant progress towards the 90-90-90 goal, indicating successful implementation of policy and programmatic action.[xxix] As of 2019, 89% of people in Uganda living with HIV know their status.[xxx] The current National Strategic Plan is focused on engaging men in HIV prevention, accelerating test and treat protocols especially among young people, progressive elimination of mother-to-child-transmission, ensuring financial stability of the national response and bolstering a multi-sectoral institutional response.[xxxi] Additional prevention tools include voluntary medical male circumcision (VMMC) and expanding access to pre-exposure prophylaxis (PrEP). The plan also addresses discriminatory provisions set by The HIV and AIDS Prevention and Control Act of 2014 which authorised mandatory testing for certain populations, forced disclosure and criminalised transmission.[xxxii] This harmful policy disavows the right to privacy as well as the right to bodily autonomy. Furthermore, criminalisation of transmission, exposure and non-disclosure increasingly marginalises key populations whom already experienced legal discrimination through the criminalisation of same-sex relationships and/or sex work. Although the judicial system may not prosecute many cases, the fear of unfair judiciary processes is likely to hinder access to services and thereby fail in its attempts to reduce the number of new HIV infections. Antithetical to this approach, the age of consent to HIV testing in Uganda is 12 years old, enabling a new generation of sexually active youth to be proactive regarding their health including embracing the importance of U = U as part of the evolving prevention paradigm.[xxxiii] Stigma –real or perceived- continues to be a policy impediment and increased attention should be given to address it through strengthened community mobilisation, data and showcasing best practice.

Ten recommendations on the pathway to meeting the commitments:

Based on interviews with key stakeholders and a review of core policy documents related to the achievement of the four zeros, the following ten prioritised actions are recommended to ensure that milestones along the pathway to meeting the ICPD25 commitments are met. With the inauguration of a new parliament and building on the framework of both the Population and National Health Insurance Policies, parliamentarians in Uganda should consider the following 10 policy focused actions:

01. Through focused thematic briefings, external consultations, exchanges and mentoring approaches on a number of key policy issues, utilise the momentum of a new parliament which consists of a record-breaking number of young parliamentarians to ensure that the ICPD policy environment is further enabled by **training and investing in an even stronger and more robust number of ICPD competent policy champions.**

02. **Sharpen the oversight and accountability responsibilities** to address a number of implementation challenges, including through increased investments a) the alignment of ordinances at the district level, b) National Sexuality Education Policy Framework and c) teen pregnancy prevention programmes.

03. Ensure increased **policy alignment** for accessing services including for family planning with the age at which minors can access these services.

04. Accelerate the **integration of SRHR and HIV services into universal health coverage** while strengthening global solidarity around future pandemic response and preparedness through **increased investments in community-oriented systems.**

05. Track both **donor and year on year increased domestic finance allocation** to strengthen 1) FP supplies and commodities, 2) adolescent friendly service provision including a focus on increasing the skills and numbers of the health workforce and c) HIV prevention services.

06. Increase the generation and **use of data to inform strategic policy decision-making** notably around: a) estimates of GBV including among key and vulnerable populations, b) post-abortion care, c) FGM, d) teen pregnancy and e) child marriage.

07. Develop **innovative incentive approaches** to attract and retain a robust and expanded cadre of skilled health personnel especially in rural areas.

08. Expand and nurture a **range of multi-sectoral and inter-disciplinary parliamentary partnerships** –to address SRHR and HIV linkages notably around issues related to education and culture.

09. **Remove core structural barriers**, including parental requirements for SRH services, HIV prevention services, laws that criminalise HIV transmission, exposure and non-disclosure and stigma reduction.

10. Review and strengthen Uganda`s action in light of the soon to be agreed **2021 Political Declaration on HIV and AIDS** (from the 10 June 2021) which emphasizes that sexual and gender-based violence, the unequal socioeconomic status of women, structural barriers to women's economic empowerment and insufficient protection of the SRHR of women and girls compromises their ability to protect themselves from HIV infection.

Process & Methodology

The legal and policy review was conducted in April and May 2021 through a detailed perusal of various laws and policies which constitute the framework and development of sexual and reproductive health and rights in Uganda. Semi-structured interviews were conducted with representatives from the UNFPA Uganda office as well as other stakeholders in Uganda to further inform and contextualise the policy review.

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ZAMBIA *Parliamentarians, People and Policy:* We Need Courageous Parliamentarians

The policy related aspects of the commitments made by the Government of Zambia at the Nairobi Summit in relation to attainment of the four zeros[1] focused primarily on the implementation and enforcement of laws and policies, the alignment and coordination of a policy response to ensure multi-sectoral resonance and synergy and increased investments and public-private partnerships in selected areas that will strengthen the longer-term yield of the demographic dividend. In particular, both the 2020-2030 Population Policy, which was adopted prior to the Summit, and the 2014 National Gender Policy, which is currently undergoing review, provide a nuanced policy frame for a number of aspects related to the commitments especially around maternal health. ICPD25 issues are strategically incorporated into 8th International Development Plan which will take effect in January 2022 and provides an opportunity for enhancing the current monitoring and evaluation framework. To highlight importance of harmonising sexual and reproductive health and rights policies, the parliamentary committee on Youth, Sport and Child Matters anthologized and tabled a comprehensive review of related legal and policy issues in April 2021. The analysis of current gaps and challenges as well as broad-ranging recommendations serve as a beacon for current and future parliamentarians.

ICPD25 Commitments[ii]

At the historic "Nairobi Summit on ICPD25: Accelerating the Promise", Zambia made the following commitments:

1. Provide equitable and comprehensive quality health services, including sexual and reproductive health so as to ensure a Zambia where there are zero new HIV infections, zero maternal and neonatal deaths, and where young people have opportunities to fulfil their potential.

• Invest in primary health care, particularly health promotion, and robust and sustainable healthcare financing mechanisms.
• Reduce preventable maternal deaths from 278 per100,000 live births in 2018 to less than 70 per 100,000 live births and preventable neonatal deaths from 27 per 1000 live births to 5 per 1000 live births by 2030. We shall achieve this through targeted investments in human capital development and establishing sustainable financing mechanisms for improving maternal and newborn health.
• Position Family Planning as a key development agenda for Zambia to Harness the Demographic Dividend. This will be achieved by scaling up advocacy on family planning and population and development, integrating and mainstreaming family planning in National Development Plans and other key national strategic frameworks; and increasing domestic financing for family planning in all sectors by 2030.
• Achieve the 95 95 95 fast-track targets towards ending the AIDS epidemic by 2030 and improving the wellbeing of those infected and affected by HIV and AIDS.
• Create a conducive environment for inclusive health programming for all and meaningful participation of young people for improved health outcomes. This will be done by addressing policy, legal, and socio-cultural barriers, to sexual reproductive health and rights (SRHR), and investing in human capital development by 2030.

2. Attain Vision 2030 making Zambia a prosperous middle-income country where the population enjoys all the facets of a middle-income country by 2030.

· Promote people centered development in all sectors by integrating population dynamics into development planning at the national and sub-national levels
· Invest in inclusive governance mechanisms as well as sustainable International Cooperation and Partnerships. This will be achieved by institutionalizing the participation of various population groups such as women, people with disability, and young people in governance processes.
· Enhance rural industrialization and development by advancing implementation as enshrined in the country's Vision 2030.
· Promote generation and use of data to achieve sustainable development. This will be achieved by implementation of the 2018 National Statistical Act. We commit to make climate change a core part of economic development. This will be achieved by strengthening Zambia's institutional framework for climate resilience and improve the adaptive capacity of vulnerable communities.
· In order to provide financing for the outlined commitments, we commit to create fiscal space. This will be done by broadening the tax base, exploring alternative financing mechanisms, and implementation of the debt sustainability strategy.

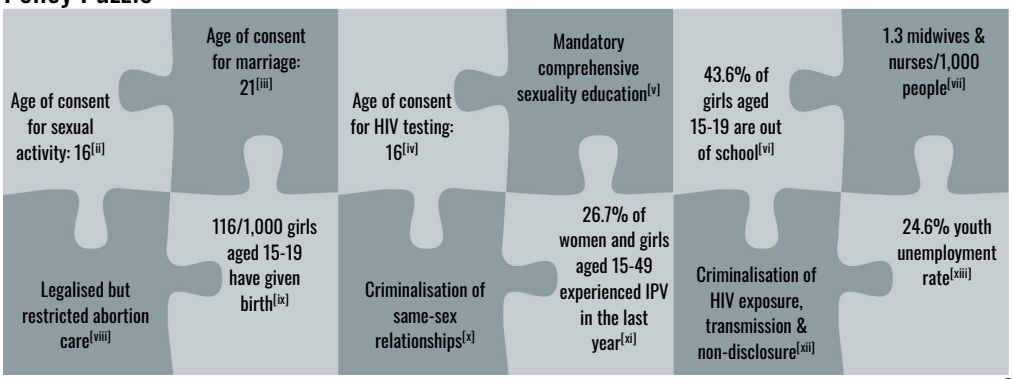
3. Ensuring young people have access to opportunities to develop to their full potential.

· Increase investment in quality and inclusive education, skills development, vocational training, and entrepreneurship to match the demands of the labour market. This will be achieved by strengthening the industrial hubs to be responsive to the need of young people.
· Promote meaningful participation of adolescents and young people in national development by including them in development planning and implementation, monitoring and reporting.
· Invest and empower families and communities to help adolescents and young people to have a positive mind-set on national development issues. this will be achieved through the promotion of national values and principles as enshrined in the national constitution.

4. Protect the enjoyment of basic human rights for every citizen regardless of their heritage or location; where the needs of all population groups are met.

· Eliminate all forms of discrimination.
· Strengthen equitable access to resources to reach the most vulnerable and key populations. This will be achieved by establishing universal social services within five kilometers radius; to create an enabling environment for social services including addressing legal and socio-cultural barriers (and providing targeted social protection for all populations.
· Strengthen humanitarian preparedness and response. This will be achieved by strengthening coordination of humanitarian preparedness and response at all levels; decentralizing of humanitarian actions; integrating humanitarian preparedness and response in key national frameworks.

Policy Puzzle



[1] 1) Zero Unmet Need for Family Planning 2) Zero Preventable Maternal Deaths 3) Zero Gender-Based Violence and Harmful Practices 4) Zero New HIV Infections

Zero Unmet Need for Family Planning

25% of girls aged 15-19 have an unmet need for family planning (FP), and as such, core aspects of the FP agenda within the Nairobi Summit commitments focused on addressing barriers to sexual and reproductive health and rights (SRHR) as well as access to all-encompassing health education for all Zambians.[xiv] The age of consent to sex is 16, and various aspects of comprehensive sexuality education (CSE) are mainstreamed throughout the school curriculum from grades 5 to 12 (approx. 10-18 years old). Unclear policies around parental consent for sexual and reproductive health (SRH) services result in unequal access and unmet need.[xv] Additionally, dissonance among varying marriage consent laws, including statutory and customary, results in a failure to protect girls from child marriage. The policy implementation impediment is primarily around teenage pregnancy, and the critical importance of accessible adolescent friendly services especially in rural areas. As of 2019, 116 for every 1,000 girls aged 15-19 have given birth.[xvi] While teenage mothers are actively encouraged to return to school, a majority do not despite interventions such as the Keeping Girls in School Initiative which offers bursaries to adolescent girls whose families utilise social cash transfers.[xvii] The subsequent lifecourse effects of not empowering girls with education are daunting and generation influencing. The cornerstone of the FP policy and its application to young people in particular is predicated upon the provision of 'age-appropriate' CSE curricula and a rights-based approach to supporting teen mothers as learners. With emotive discourse about the appropriate age at which youth can consent to SRH services, policymakers need to increasingly develop a proactive approach to an issue that has challenged the system for some time.

Zero Preventable Maternal Deaths

At the Nairobi Summit, Zambia committed to reducing preventable maternal mortality from 278 to less than 70 per 100,000 through targeted investments in human capital development and establishing financial mechanisms. Current policy guidance includes a focus on women's empowerment as a critical determinant of access to SRH services.[xviii] Post-partum hemorrhage is one of the largest causes of preventable maternal deaths and the contributing factors that influence this include delays in getting to the facility and the absence of a skilled health care worker, notably in rural areas.[xix] More than 50% of rural Zambian women give birth without a skilled birth attendant present.[xx] Harmful practices are high, including those related to unsafe abortion. While the 1972 Termination of Pregnancy (TOP) Act allows for abortion, it is under strict conditions – permitting abortion in order to save a woman's life and to preserve her physical/mental health, in cases of grave fetal anomaly and under socioeconomic grounds.[xxi] However, due to stigma, unsafe abortion prevalence remains high, resulting in approximately 6% of annual maternal deaths.[xxii] Additionally, the TOP law requires that three physicians, one of whom must be a specialist, sign off on any nonemergency legal abortion.[xxiii] In 2017, the Standards and Guidelines for Comprehensive Abortion Care acknowledged the dearth of advanced providers and extended authorization to mid-level practitioners.[xxiv] The lack of investment in and comprehensive policy on access to post-abortion care is indicative of anti-abortion sentiment which is fueled by stigma and tradition.

Zero Gender-Based Violence and Harmful Practices

26.7% of women and girls aged 15-49 have experienced intimate partner violence (IPV) within the last year.[xxv] Accordingly, policy related commitments surrounding the elimination of gender-based violence (GBV) and harmful practices issues at ICPD25 included stamping out discrimination, enhancing vulnerable populations' access to resources and creating an enabling environment for social services. Increasingly, issues around GBV – in which most of the victims and survivors are female- are taking a more central role in policy fora and discussion. Policy attention is largely focused on the consequences of GBV, including in the Anti GBV Act, which ensures that there are shelters and GBV fast track courts in all provinces, but prevention initiatives should be strengthened in both policy and implementation.[xxvi] This would necessitate a revision of the Anti GBV Act to ensure that it adequately addresses prevention components or the development of an aligned GBV prevention and mitigation policy. Child marriage also remains an active concern as 17% of girls aged 15-19, are currently married or in a union, despite the fact that the legal age of consent to marriage is 21.[xxvii] While ICPD25 commitments which indicate a willingness to develop protections for key populations, the current absence of either laws or policies that specifically safeguard and/or a policy appetite to repeal existing laws which criminalise same sex behavior and sex work reveals the contentiousness and political sensitivity of these issues. The paucity of data around LGBTQ and other vulnerable populations and their experiences of gender and sexual orientation-based violence exacerbates the lack of political will to proactively ensure specific human rights protections including to access services in a non-judgmental manner.

Zero New HIV Infections

As of 2019, the HIV prevalence rate for Zambians aged 15-49 was down to 11% from 15% in 2016, indicating policies to prevent the spread of HIV have been successfully implemented.[xxviii],[xxix] In Nairobi, the Government of Zambia committed to achieving the fast-track targets of 95-95-95 in aims of ending the AIDS epidemic. The 2015-2020 AIDS Response Fast Track Strategy outlines challenges and opportunities for the elimination of new HIV infections in Zambia, while acknowledging that this roadmap should exist as a living document, continually updated as new data are collected.[xxx] Many of the programmatic initiatives place emphasis on voluntary medical male circumcision (VMMC) and prevention of mother-to-child-transmission (PMTCT). However, rates of condom usage and STI prevalence remain a concern which is indicative of other systemic implementation issues. Less than 50% of Zambian adults used a condom at last high-risk sex.[xxxi] The policy environment around biomedical HIV prevention is largely enabling, but there are gaps – in substance and value – that require policy attention. The key policy related structural prevention barriers pertain to the empowerment of young women and girls, and those facing key populations (notably men who have sex with men, sex workers and transgender people) and their access to HIV prevention. Policy impediments include the criminalisation of HIV transmission, exposure and non-disclosure as enforced through various policies, including Penal Code Act, which do not adequately reflect the evolution of the science of HIV prevention.[xxxii]

Ten recommendations on the pathway to meeting the commitments:

Based on interviews with key stakeholders and a review of core policy documents related to the achievement of the four zeros, the following ten prioritised actions are recommended to ensure that milestones along the pathway to meeting the ICPD25 commitments are met. Parliamentarians in Zambia should continue to foster and strengthen an enabling policy environment by more deliberately utilising their platform and consider the following policy focused actions:

01. Forge an enhanced oversight role on core aspects of **training, curriculum development and implementation** in relation to a number of aspects that would ensure that directives to meet FP, teenage pregnancy and early marriage issues are adequately addressed, including a) increased investment in health workforce training notably around FP and the provision of a diverse range of adolescent friendly services, b) reviewing the pre and in-service health care worker curriculum to ensure that it covers a comprehensive approach that is broader than only medical issues related to FP and teenage pregnancies and c) strengthen teacher training and support to efficiently put CSE (including life skills) into effective practice.

02. Increase the **generation and use of current data to inform strategic policy decision-making** notably around: a) disaggregated teenage (13-19-year-old) pregnancy data, b) size estimates of GBV including among key and vulnerable populations and c) tracking investments in options for youth who are in education, training and work.

03. **Enforce and harmonise legislation, policies and practices** that prevent violence and rights violations against women and girls and other key and vulnerable populations including **clarifying core structural barriers**, such as consent requirements for SRH services, HIV prevention and testing services, as well as aligning legal, statutory and customary marriage laws, and removing laws that criminalise HIV transmission, exposure and non-disclosure.

04. Strengthen investments in and oversight of **multi-sectoral leadership** to inform and address a number of areas related to responsive norms and culture in a) the prevention of and response to GBV, b) community engagement and c) adolescent friendly services.

05. Commission with partners a **national survey** that focuses on understanding a range of abortion related issues that also tracks and generates data around post-abortion care.

06. **Monitor and evaluate** with learners and community representatives the shape and strength of the **current approach to CSE**, which forms the backbone of many initiatives, to discover aspects for renewal and innovation.

07. Review and strengthen Zambia's action in light of the soon to be agreed **2021 Political Declaration on HIV and AIDS** (from the 10 June 2021) which emphasises that GBV, the unequal socioeconomic status of women, structural barriers to women's economic empowerment and insufficient protection of the SRHR of women and girls compromises their ability to protect themselves from HIV infection and aggravates the impact of the AIDS pandemic and increase domestic resource allocation to HIV.

08. Increasingly act on the **policy linkages between SRHR and HIV** by strengthening coordination and policy synchronisation notably around prevention by a) catalysing dual protection policies within all subpopulations, age groups and geographic settings, b) informing revised policy components with the recent scientific evidence showing that virally suppressed individuals have zero transmission risk to their sexual partners, known as U=U and c) identifying and addressing gaps in the continuum of services for preventing HIV infection among women of reproductive age, diagnosing and treating pregnant and breastfeeding women living with HIV and preventing vertical transmission of HIV to children.

09. **Continue to foster parliamentarian champions** through multi-pronged approaches including a) informational workshops introducing key SRHR issues, b) multi-sectoral rapport building across committees and c) increased meaningful participation from community advocates.

10. While the National Youth Policy and Youth Action Plan showcase the importance of addressing issues related to young people, the **engagement of young people in policy** should be strengthened to ensure that there is greater alignment with the demographic dividend by: a) enhanced policy cohesion to ensure that school and university graduates have increased access to the job market and job creation schemes and opportunities and b) creation increased skills development and catalytic on-the-job training and incentivised work experience exposure mechanism especially in rural industrialisation.

Process & Methodology

The legal and policy review was conducted in April and May 2021 through a detailed perusal of various laws and policies which constitute the framework and development of sexual and reproductive health and rights in Zambia. Semi-structured interviews were conducted with representatives from the UNFPA Zambia office as well as other stakeholders in Zambia to further inform and contextualise the policy review.

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Considerations For Regional Application:

Based on the review of the various ICPD25 policy commitments in Kenya, Malawi, Uganda and Zambia – primarily those related to the four zeros – a number of common opportunities and challenges have emerged which could also shape and strengthen the policy pathway for other countries across Eastern and Southern Africa.

1. **Revitalise policy implementation** by either creating or dramatically sharpening the oversight role in a number of key policy areas within and across a range of parliamentary committees. Policy creation and generation needs to be matched with an equally robust implementation and learning approach to ensure that policies are proactive and responsive - especially for issues such as family planning and teenage pregnancy.

2. Increase domestic and other investments in **fine-tuning the core health and community systems strengthening aspects of a comprehensive SRHR and HIV** response to support resilient pandemic preparedness. Many of the commitments aimed to increase domestic resource allocation to ICPD25 issues, but this increase should also specifically strengthen community-oriented responses – especially in many rural areas – as an avenue of increased global health security.

3. **Harmonise and align multi-sectoral policies and practices** in a number of areas including age of consent and criminalisation of certain sexual behaviors to better align with rights-based practices and honour the evolving capacities of youth. Additionally, coordinate HIV/AIDS policy plans with the framework established by the upcoming (June) **2021 Political Declaration on HIV and AIDS**.

4. Purposefully accelerate and support through **innovative policy application various components of differentiated service delivery models** notably for family planning, the prevention of teenage pregnancy and HIV care and treatment. Increase digital, mobile and community-based services by removing policy impediments.

5. With the rise in the number of young parliamentarians across the sub-region, nurture a strong and robust **ICPD parliamentarian champions network,** which is grounded in science and evidence, and based on human rights principles. Develop spokespersons on key issues notably a) U=U, b) stigma and culture and c) preventable maternal deaths.

6. Increase the **generation and utilisation of data to inform region-wide strategic policy decision-making** notably around: a) disaggregated teenage pregnancy data b) size estimates of GBV including among key and vulnerable populations and c) tracking investments in options for youth who are in education, training, and work.

7. Ensure that the **'endemic of GBV across the region' becomes and remains a political priority** by a) consistently raising it as an agenda item for the Africa Union, b) closely monitoring policy implementation and c) developing reports on policy creation.

8. Invest in the demographic dividend through the **meaningful engagement of young people in policy fora**. Create opportunities which concretely utilise young people in the process of policy formulation and idea generation, including through the support of shadow reports on selected issues, thereby optimising policy efficacy and generational buy-in.

9. Endorse and welcome enhanced **participatory approaches**, such as learner-oriented curriculum review, to ensure that **CSE** – which is a fundamental building block in achieving many of the commitments to address attainment of the four zeros – is medically-accurate, evidence-based, culturally competent, non-discriminatory and linked to adolescent friendly SRH services.

10. Expand **tracking and evaluation of abortion care (safe and unsafe), as well as post-abortion care,** to address structural contributors to preventable maternal deaths, coupled with provider bias training and community awareness campaigns to address sociocultural barriers to care.

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