Review of

Adolescent and Youth Policies, Strategies and Laws

in Selected Countries in West Africa

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CBO	Community-based Organization
CDC	Centres for Disease Control
CI (number-specific)	Confidence Interval
NACC	National AIDS Control Committee
DHS	Demographic and Health Survey
FCUBE	Free Compulsory Universal Basic Education
FP	Family Planning
GEST	Gender Equality Sector Test
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
MAF	Millennium Development Goals Acceleration Framework
MNCH	Maternal, Neonatal and Child Health
MOE	Ministry of Education
MoGCSP	Ministry of Gender, Children and Social Protection
MOH	Ministry of Health
MOJ	Ministry of Justice
MOY	Ministry of Youth
MoYS	Ministry of Youth and Sports
MSA	Ministry of Social Affairs
NGO	Non-governmental Organization
NSYH	National Strategy for Youth Health
STI	Sexually Transmitted Infection
SRH	Sexual and Reproductive Health
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WCA	West and Central Africa

Regional Director Foreword

UNFPA recognizes the critical importance of investing in adolescents and youth to harness the demographic dividend in West and Central Africa. The 2030 Agenda for Sustainable Development highlights the importance of realizing the demographic dividend and it is also recognized in the Africa Common Position on the Post-2015 Agenda as well as the African Union's Agenda 2063 on the Africa We Want. "Harnessing the demographic dividend through investments in the Youth" is also the African Union's theme for 2017 and this will also be the focus of deliberations during the Summits of Heads of State and Government.

However, we will fail to achieve the demographic dividend if we do not take the right actions today to put young people first and invest in their health, education, employment and empowerment. This will require a paradigm shift in the way we do work, and more importantly, the way we work with and empower young people.

Achieving this paradigm shift will only occur if there is an enabling legal and policy environment that empowers and allows young people – especially young girls – to be protected from child marriage, access health services, be educated and have decent employment.

UNFPA West and Central Africa Regional Office (WCARO) commissioned this policy and legal review to shed light on the complex set of policies and legislation that govern adolescents' and youth health, education, protection and well-being in five countries in the region.

Findings from the review show that while there were examples of enabling and supportive policies and laws, most countries had a complex – and often contradictory – set of laws, policies and strategies pertaining to adolescents and youth that may act as significant barriers to adolescents' access and uptake of health services, education and employment, and could increase their vulnerability to child marriage.

The review proposes several recommendations to develop and implement enabling policies and legislation. UNFPA WCARO urges government partners, UN agencies, youth networks and CSOs to take stock of the review findings and recommendations. WCARO is committed to supporting governments and other partners to create this enabling policy and legislative environment and to ensure that the full potential of every young person can be realized in order to harness the demographic dividend.

Executive Summary

Introduction

Adolescent health and development are key foundations for a country's economic development and political stability. The outcomes of adolescent health are closely linked with future adult development, infant and child mortality, maternal morbidity and mortality, and even long-term economic development.

Adolescents and youth in West and Central Africa (WCA) face considerable challenges in terms of their health, education, employment and empowerment. Adolescent girls are particularly vulnerable. This region has some of the highest child marriage rates in the world with two out of five young girls married before the age of 18 years. It is also the region with the largest percentage (28 percent) of women between the ages of 20 and 24 years who reported a birth before the age of 18 years as well as the largest percentage (6 percent) of reported births before the age of 15 years.[1]

One of the key factors determining the life of an adolescent in the region is the policy and legal environment they live in. Policies and laws can act as either a protective factor or a significant barrier to the protection, health, education and employment of young people. This report reviews the legal and policy frameworks impacting adolescents and youth in five countries in West Africa.

Methods

The review was undertaken in the context of the Global Programme to Accelerate Actions to End Child Marriage. In WCA, the programme covers five countries: Burkina Faso, Ghana, Niger, Nigeria and Sierra Leone. The review focuses on the policies and laws in these five countries with the overall aim of shedding light on the complex legal and policy environments that govern adolescents' – particularly adolescent girls' – lives and how these laws and policies can impact their health, education, employment and development opportunities.

The review's objectives were to:

- Identify the main laws, policies and strategies affecting adolescents and youth including those pertaining to child marriage, health, education, employment and youth development.
- Identify the main legal, policy and strategy issues governing adolescents and youth.
- Provide recommendations on next steps.

The methodology employed a desk review of legal frameworks (laws, penal code, child rights acts) as well as ministerial level policies and strategies (national policies or national strategies). The study assessed how the law and policies treat adolescents in terms of defining their protection from early marriage, ensuring their access to SRH services and education and creating job opportunities for them. It also examined legal and policy contradictions in relation to these issues. National policies were also evaluated for the inclusion of specific health and education strategies related to adolescent Sexual and Reproductive Health (SRH) including HIV as well as child marriage. The full set of laws and policies reviewed per country is given in Annex I.

The study is limited because of the desk review nature of the methodology. It is intended to provide an overview and comparison of laws and policies across multiple countries with the aim of identifying both promising examples that create an enabling environment for adolescent and youth development, as well as policy and legal barriers. As it is a desk review, it is not a comprehensive review of policies and laws and their application within target countries. This study can provide a basis for a more thorough review and contextual analysis that assesses how these policy and legal frameworks affect the implementation of child marriage, adolescent and youth health, education and youth employment programmes.

[1] Motherhood in Childhood: Facing the Challenge of Adolescent Pregnancy. State of the World's Population 2013.

Key Findings

This report includes a review of policies and strategies on child marriage, adolescent and sexual health (including adolescent pregnancy strategies that often integrate child marriage issues); other health policies and strategies that have an impact on adolescents and youth (such as reproductive health policies) and education and youth policies with a focus on youth employment. In addition, there is a legal analysis of laws related to age of marriage as well as laws impacting adolescents' access to SRH services, such as age restrictions to contraceptive services and HIV counselling and testing, and sexual consent laws.

The review found that while there were examples of enabling and supportive policies and laws, most countries had a complex – and often contradictory – set of laws, policies and strategies pertaining to adolescents and youth that may act as significant barriers to adolescents' access and uptake of health services, education and employment, and could increase their vulnerability to child marriage. The findings are:

- **Child Marriage:** Child marriage is an issue across all the countries reviewed, though the prevalence varies considerably, with Niger having the highest prevalence rate in the world (76.3 percent) to Ghana with a relatively lower prevalence rate (20.7 percent). Only one of the five countries covered in this review has a national strategy on child marriage – Burkina Faso – while Ghana and Nigeria are in the process of developing national strategies or policies in 2016 on this issue[2]. Both Niger and Sierra Leone address the issue of child marriage, to some extent, in their national policies on adolescent pregnancy. Far less promising is the legal environment related to child marriage across the five countries. According to international and regional conventions related to rights of children and adolescents, the law should set the age of marriage at a minimum of 18 years for both boys and girls. However, only Ghana has unequivocal legislation that sets the age of marriage at 18 years for both boys and girls, with no exceptions. The other countries have the legal age set lower, or have legal loopholes through which marriages are allowed below the age of 18 years, with parental consent. There are several advocacy movements gathering pace in these countries to increase the minimum age of marriage and close the loopholes.

- **Adolescent Sexual and Reproductive Health:** Every country has a policy, strategy or action plan on adolescent health that also covers adolescent SRH. Most of these policies include measures to address adolescent pregnancy. While several policies support adolescent access to SRH services, they often do not provide any specific provisions on the accessibility and quality of these services or healthcare provider training. In many cases, the legal ambiguities surrounding age of access to contraceptives and other SRH services mean that the final decisions may rest in the hands of the healthcare providers, creating a situation of bias in provision of these services. The review included a legal analysis of sexual consent laws. While these laws are primarily protective in nature, in cases where the legal age to sexual consent is very high (18 years and above), it can act as a barrier to adolescents seeking SRH services. For instance, in both Sierra Leone and Nigeria where 18 years is the age of sexual consent (according to federal law; state laws in Nigeria can differ), situations are created where adolescents below the age of 18 years are reluctant to access services, or are denied services by healthcare providers due to this law.

- **Education Policies and Strategies:** All countries in this review have an education policy or strategy stating that basic education is compulsory and free. However, most countries did not cover additional associated costs of schooling such as school uniforms and textbooks that can act as a significant barrier to education access, especially among poorer communities. It is worth noting that Burkina Faso has a specific strategy on accelerating girls' education. The review also examined whether education policies included

[2] Both of these national strategies/policies fall outside the purview of this review

provisions for sexuality education or health education more broadly. All countries' policies included some mention of health education, either with a focus on sexual health, family health or HIV.

- Youth Policies, including Youth Employment Policies: while none of the countries had a specific policy or strategy on youth employment, all countries had a youth policy, strategy or action plan that covered youth employment in depth, with a focus on job creation, training for youth and inter-sectoral responses to address the issue of youth unemployment.

Recommendations

West and Central Africa's population is predominantly young. More than 64 percent are under the age of 24 years. Young people are a tremendous resource for the region – but only with the right investments in their education, health, skills and empowerment.

The creation of an enabling policy and legal environment that protects and promotes the health, well-being, education and employment of young people, particularly adolescent girls, is an important part of ensuring that their full potential can be realized. Therefore, policies should seek to enable and empower young people and be supported by legislation that upholds their rights. While there are several promising practices that countries can build on, this review found that there is a complex – and often contradictory – set of policies and legislation in place across the five countries covered in this study. The recommendations to address this are:

- Child marriage policies should include a comprehensive set of policy approaches to accelerate actions to end child marriage, and to protect adolescent girls at risk of marriage, as well as cover adolescent girls who are already married.
- Ensure that child marriage laws are aligned with international standards as enshrined in the Convention on the Rights of the Child as well as the African Charter on the Rights and Welfare of the Child. This means that the minimum age of marriage is set at 18 years for both sexes and does not include any exceptions with parental or guardian consent.
- Governments should develop or revise policies and enact legislation that protects young people's rights to the highest attainable standard of health. SRH services should be aligned with the standards for youth- and adolescent-friendly services outlined by the WHO (given in Annex II). Policies and legislation should allow adolescents' access to SRH and HIV services, including contraceptive services and HIV counselling and testing. All countries in the review are signatories to the Convention on the Rights of the Child (CRC). The CRC asks governments to recognize the evolving capacity of adolescents to make independent decisions regarding their health. This calls for a review and overhaul of policies and legislation that do not allow adolescents to access SRH services without the consent of their parents or guardians.
- Laws governing age of consent to sex and age of consent to SRH services should be harmonized. Age of consent to sex should be set at an age that recognizes that many young people commence sexual activity during adolescence.
- Education policies should cover both primary and secondary education, with a special focus on girls' education, and remove barriers to education through removal of school fees, subsidizing of school uniforms and textbooks and, if possible, provision of school meals. They should also include provision for sexuality education programmes in schools.
- Policies and strategies should be costed and funded in order to support their implementation. Laws should be implemented through support through the appropriate judicial systems.

Introduction

Adolescent health and development is one of the key foundations for economic development and political stability in a country. The outcomes of adolescent health are closely linked with future adult development, infant and child mortality, maternal morbidity and mortality, and even long-term economic development.

A major factor that impacts adolescents and youth is the legal and policy environment they live in. Policy and legal frameworks that uphold their rights to health, education, employment and empowerment are often contradictory between and within national laws, and sometimes in contradiction with regional and international conventions signed by the country. These inconsistencies limit adolescent and youth development.

Methodology

The purpose of this study was to evaluate the current legal and policy situation for adolescents in five countries in West and Central Africa, specifically Burkina Faso, Niger, Nigeria, Ghana and Sierra Leone. These countries were the target of the United Nations Population Fund (UNFPA) and the United Nations Children's Emergency Fund (UNICEF) Joint Programme on Child Marriage in the WCA region.

The methodology employed a desk review of:

- Legal frameworks (laws, penal code, child rights acts).
- Ministerial policy-level strategies (national policy or national strategies).

This study assessed how the law and policy treated adolescents, examined legal and policy contradictions and made recommendations to build on good practices and address gaps. National policies were also evaluated for the inclusion of the specific health and education strategies related to child marriage, adolescent SRH including HIV, education, employment and participation.

The findings are limited because of the desk review nature of the methodology. The study is intended to provide an overview and comparison of specific laws and policies across multiple countries but is not a comprehensive review and does not assess the implementation of those policies or laws covered. It can provide a basis for a more thorough review and contextual analysis that assesses how these policy and legal frameworks affect the implementation of child marriage prevention, adolescent and youth health, education and employment programmes.

The results per country are presented within the results section of this report, as are general comparison and data-driven tables.
The specific **national policies and strategies** reviewed were identified as[3]:

- Child marriage policies/strategies.
- Adolescent health policies/strategies, including adolescent SRH.
- Other health policies impacting adolescents and young people.
- Education policies/strategies.
- Youth policies/strategies, including youth employment.

The legal analysis covers the laws below and how their interpretation can act as protective or restrictive barriers for adolescents and youth:

- Age of marriage.
- Age (or other) restrictions to access to contraceptive services.
- Age (or other) restrictions to HIV counselling and testing.
- Age to sexual consent.

[3] It does not include subnational policies/strategies or national policies that were under development at the time of writing.

Based on precedent and on the United Nation's definition of adolescents, this study considered youth, adolescents and young people to be aged between 10 and 24 years. For all policies, strategies and laws related to child marriage, access to services and education, the primary demographic group considered was those aged between 10 and 19 years. For youth employment and development, the broader demographic group of 10 to 24 years was retained.

The desk reviewed over 30 policy and legal documents per country but not every country had specific policies regarding all the subjects detailed above. However, the basic legal framework that governs the approach to adolescents within the government framework was obtainable.

The study covers the following elements in the analysis:

Policy and Strategy: The strategies and policies that existed in each country and the relevant sections that had implications for adolescents and youth. This included policies that have a direct relevance (e.g. child marriage, adolescent health, youth, education policies) and those that have an indirect, but often equally important, impact on adolescents and youth (e.g. reproductive health and other health policies). The review also looked at the years the policy or strategy was valid for, to evaluate if the policy was still currently in affect. Throughout WCA, national strategies, policies and strategic plans are often written in five-year cycles, though some countries have set important development goals in 10-year cycles.

Laws: The review also included a legal analysis specifically related to legal age stipulations related to marriage, sexual consent and access to SRH services. While it is not intended as a comprehensive legal analysis, it does give an indication of the complexity of laws for adolescents and youth. The review provides a legal analysis of national laws against international and regional conventions and commitments where relevant.

- **National laws:** National laws set the precedent for the legal application of adolescent and child rights in a country. In most countries under review, the overall legal structure defines the penal (criminal) code differently from the civil code (a collective group of laws governing private matters, commerce and negligence lawsuits). Contradictions in these codes regarding adolescents create challenges in knowing and understanding how the law is applied. For example, if the civil code defines a child as anyone under the age of 18 but the penal code allows marriage at 15 years, the country has conflicting laws that create a complex and ambiguous environment for health services and programmes to exist. If the legal age of marriage is 15 years, but a child is defined as anyone under 18 years, and HIV testing can only be conducted for children under the age of 18 years with consent from their parent or guardian, this creates a dilemma for a health worker faced with a married woman of 17 years that requests an HIV test during pregnancy.

- **International legal frameworks and conventions:** International treaties and conventions set the standard for the legal approach to a given subject. Signatory countries to international treaties have agreed, in principle, to standardize their national laws and legal application on subjects defined in the international agreement. Issues such as the definition and legal parameters of who is a child and thus deserving of protection from child marriage, and other forms of exploitation of adolescents and the right to health services, have been defined in the Convention on the Rights of the Child (CRC) [UN, 1990], the Maputo Protocol and the African Union Charter on the Rights and Welfare of the Child. All countries in this study have signed and ratified the CRC. However, in all countries, either the penal or civil code, or the national policies contradict one or more of the ratified articles of the CRC or the African Charter. In addition, issues such as child marriage, health and education related specifically to adolescent girls and young women are covered in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).


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Data Overview

The table below provides the epidemiologic and development indicators that give an overview of the sexual health, marital status, education and reproductive health outcomes of adolescents in Burkina Faso, Ghana, Niger, Nigeria and Sierra Leone. Indicators for SRH include age of sexual debut, teenage pregnancy, fertility rates and other data points. Marital status is measured by the median age of individuals at marriage and the percentage of women married by the age of 18 years. Indicators for education include percentage of adolescents attending school. HIV indicators include adolescent prevalence rates and the percentage of females aged 15 to 19 years who have comprehensive knowledge of HIV/AIDS. There are diverse results across the countries and some results are obviously different given the different socio-economic status of each country.

Ghana and Nigeria are considered middle-income countries according to the World Bank Atlas method in 2013, while Niger, Burkina Faso and Sierra Leone are considered low-income countries. Niger has the worst adolescent health results in the world, based on the UNPD Human Development Index of 2014. Niger, Nigeria and Burkina Faso have had political instability over the past five years and, due to growing terrorist activity in the Sahel and within Northern Nigeria, security remains precarious in the countries. Sierra Leone emerged from a shattering civil war just ten years ago, only to be inundated by the devastation of the Ebola outbreak and its aftermath. Ghana is the only country to avoid dramatic political or health devastation over the past ten years and has an emerging strong economic outlook; despite this corruption and disenchantment with political parties still prevails.

Therefore while these health indicators provide an overview of the health and education status of adolescents, they are not entirely indicative of their actual quality of life and simply provide a point of discussion that enables an understanding of the importance of the policies reviewed.

Table 1. DHS and Epidemiologic Survey Data+

	Burkina Faso 2010	Ghana 2015	Niger 2012	Nigeria 2013	Sierra Leone 2013
Sexual and Reproductive Health					
Median age of sexual debut Female	17.7 (25-49 years)**	18.4 (20-49 years)	15.9 (25-49 years)	17.6	16.4
Median age of sexual debut Male	20.7 (25-49 years)	19.9 (20-49 years)	23.6 (25-49 years)	21.1	18.0
Median age of marriage Female	17.8	20.7	15.7	18.1 (ndhs 2013)	18.0
Median age of marriage Male	25.5	26.4	24.6	27.2 (NDHS 2013 Nigerian Men age 30-49 years) (NDHS 2013)	25.0
Sexual activity amongst girls aged 15-19 years*	24.5%	14%	38%	29.1%	33.1%
Adolescent pregnancy aged 15-19 years	24.0%	14.2%	40.0%	23% (mothers or pregnant with first baby) (NDHS 2013)	28% of adolescents 15-19 years have begun child bearing
Total Fertility Rate (TFR) aged 15-49 years	6.0	4.2	7.6	5.5	4.9
Contraception Prevalence Rate	14%	27%	8.0%	16%	16%
Polygamous marriage prevalence Female	42%	—	36%	-1/3 (NDHS 2013)	35% (age 15-49 years)
Percentage of girls age 15-19 currently married	31.5%	6.4%	61%	28.8	18.8%
Percentage of women aged 20-24 years who got married before age 15 years*	10%	4.9%	28%	17.3%	12.5%
Percentage of women aged 20-24 years who got married before age 18 years*	52%	20.7%	76.3%	42.8%	38.9%
Percentage of women aged 20-24 years who gave birth before age 15 years*	2.4%	1.8%	9.9%	5.9%	9.7%
Percentage of women aged 20-24 years who gave birth before age 18 years*	28.2%	16.9%	48.2%	29.1%	36.4%
Modern contraception use among female adolescents aged 15-19 years	6.2%	16.7%	5.9%	1.2%	20.7%

	Burkina Faso 2010	Ghana 2015	Niger 2012	Nigeria 2013	Sierra Leone 2013
HIV					
HIV Prevalence adolescents aged 15 – 19 years	>0.07%ˆ	1.5 female 0.2 male	>0.01%	15-19 years: 2.9% (NARHS 2012)	1.5 female 0.7 male
Percentage of females aged 15-19 years who have comprehensive Knowledge of HIV/AIDS*	29%	28.7%	11.2%	26.5%	28.8%
Education					
Received no formal education: Female*	74%	19%	73%	40.4%	51%
Received no formal education: Male*	59%	9%	60%	29.5%	41%
Percentage of girls aged 15-19 years currently not attending school*	74%	54.5%	84.8%	51%	42.3%
Percentage of boys aged 15-19 years currently not attending school*	66.9%	47.3%	73%	37.4%	31.9%

+ All data obtained from either DHS or UNFPA databases, if data were unavailable it is indicated in the box with a – sign.

** All data based upon reproductive aged 15-49 years unless otherwise noted.

* Data obtained from UNFPA's Adolescents and Youth Dashboard; all other data obtained from most recent Demographic and Health Survey from the country.

ˆ Prevalence listed for individuals aged 15-24 years: DHS Burkina Faso, 2010.

~ Data obtained from SLDHSBS 2009.

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Chapter 1: Child Marriage Policies and Laws

Policies and Strategies on Child Marriage

Among the five countries covered in this study, only **Burkina Faso** has a specific national strategy on child marriage. Its government recently detailed a national strategy for the prevention and elimination of child marriage in the country (2016 – 2025) and an action plan for the implementation of these plans for 2016 to 2018. These efforts are within the government's overall development strategy for 2025, based on the Accelerated Growth Strategy and Sustainable Development (SCADD), the Code of Individuals and the Family (CPF) and National Policy for Social Protection (PNPS). This national strategy takes a multisectoral approach and calls for the development of an action plan including other ministries, civil society and financial and technical partners.

Ghana and **Nigeria** are in the process of developing child marriage strategies or policies in 2016. In **Ghana**, the development process is being facilitated by a consultant with oversight from a National Core Working Group and coordinated by the Child Marriage Unit of the Ministry of Gender, Children and Social Protection (MoGCSP).

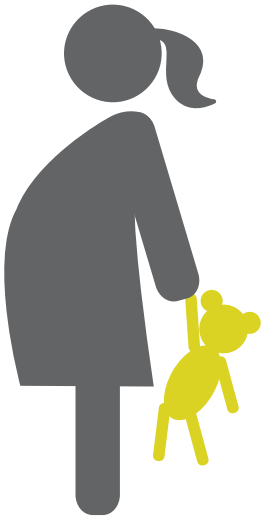
Niger and **Sierra Leone** do not have policies or strategies specifically on child marriage. However, **Niger** has a National Strategy on Prevention of Adolescent Pregnancies that calls for a reduction of child marriages from 76.3% in 2012 to 60% in 2020. In addition, it also seeks to increase the modern contraceptive prevalence rate among adolescents from 5.9% in 2012 to 15% in 2020. The strategy outlines four approaches:

- Advocacy to create a legislative environment and regulatory frameworks that are favourable to the protection of girls.
- Communication to change behaviours and social norms.
- Strengthening family planning services to adolescents.
- Coordination and monitoring and evaluation.

In addition, there are several other policies and strategies in Niger that primarily focus on adolescents but also cover protection against child marriage.

Laws on Age of Marriage

Sierra Leone is currently in the process of developing an adolescent health and development policy as well as updating and reviewing the Reproductive, Maternal, Newborn, Child and Adolescent Health Strategy, and the National Strategy for the Reduction of Teenage Pregnancy. There is an ongoing advocacy process to integrate child marriage in the Teenage Pregnancy Strategy.



Only **Ghana** has unequivocal laws that clearly prohibit marriages below the age of 18 years for both men and women. These laws are enshrined in the 1992 Constitution as well as the Children's Act of 1998. In **Sierra Leone**, while the Child Rights Act sets the age of marriage at 18 years, there is a legal loophole where girls and boys could get married below that age with parental consent, according to the 2009 Customary Marriage and Divorce Act. Section2 (2) of the Registration of Customary Marriage states that any child who is below the age of 18 years can be married with the approval of their parents. The conditions for which a marriage can be seen as legal in the Principal act states: If the personal law of the either of the parties to the proposed marriage is customary law, that the following conditions have been fulfilled-

1. That neither of the parties is a party to the subsisting marriage;

2. if the woman is under 18 years of age, that at least one of her parents or guardians has given his or her consent

Countries that have laws that allow marriages below the age of 18 years for girls, such as Burkina Faso and Niger, have strong ongoing advocacy processes that are pushing for revisions of these laws, in line with international standards.

For example, in **Burkina Faso**, the law on child marriage sets the legal age of marriage at 17 years for girls; this is in direct contradiction to the Inter-Ministerial Strategy on Child Marriage which sets it at 18 years, as well as the international conventions and charters such as the Convention on the Rights of Children and the African Union Charter on the Rights and Welfare of the Child (1990) which state that children are considered those under the age of 18 years.[4] In addition, the law allows marriages for girls between the ages of 15 to 17 years if they and their families make an appeal to the civil courts.[5]

[4] African Union Charter on the Rights and Welfare of the Child 1990; *http://www1.umn.edu/humanrts/africa/afchild.htm*

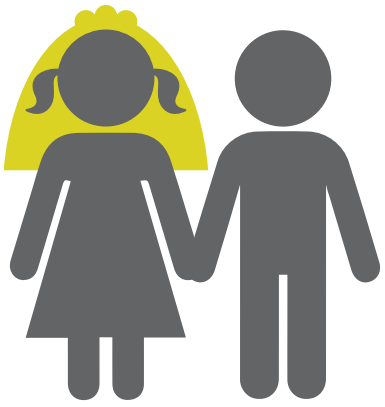
[5] Article 238, Code for Individuals and Family (Civil) 1989; SNPEME 2016.

Niger has a similarly complex and tangled legal environment pertaining to child marriage. Article 144 of the civil code forbids marriage below the age of 18 years for boys and below the age of 15 years for girls. This code was last modified in 1962 and is still in force today. However, there are Islamic and customary laws that are also in place concerning child marriage. There is legal inconsistency about which law supersedes the others. Article 51 of the Law on Judicial organization states that customary law should be followed with regard to marriages; however, Article 81 of the 1999 Constitution says that that the national law, and not customary law, should govern family relations. In any case, both the national law and the customary law on child marriage do not align with international standards.

The **Federal Republic of Nigeria** is made up of 36 states and a Federal Capital Territory (FCT) located in Abuja. The constitution affirms that Nigeria is one indivisible sovereign state, whose constituent units are bound together by a federal arrangement. However, Nigeria operates on a plural legal system that creates contradictions and inconsistencies through the application of statutory, customary and Sharia laws. The existing laws consist of:

- The constitution (which is the supreme law) and its provisions which have binding force on all authorities and persons throughout the Federal Republic of Nigeria.
- Legislation - each of the 36 states and the FCT, Abuja, have their own laws.
- English law.
- Customary law (ethnic, non-Islamic) that applies to the members of the different ethnic groups and is particularly dominant in the area of personal and family relations like marriage, divorce, guardianship and custody of children and succession.
- Islamic or Sharia law, which is considered customary law in the south but exists separately in the north (often codified).

In **Nigeria**, under the 2003 Child Rights Act, children are defined as any individual under the age of 18 years. Children cannot marry nor can they consent to engaging in sexual activities. The Act explicitly states that the betrothal and marriage of children is prohibited. However, as Nigeria operates on a pluralistic legal system, marriage is allowed for children under the age of 18 years for states who do not observe federal law. Some northern states in Nigeria subscribe to Sharia law, or some version of it, which does not prohibit child marriage. This can create a clash of laws and principles but the federal government will rarely intervene. Enforcement of federal law in these states is virtually impossible, given the states' choice on ratification of these laws. In some cases, federal lobbying can provide some influence in policy adoption but this rarely takes place.



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Chapter 2: Adolescent and Youth Health Policies and Laws, including Adolescent Sexual and Reproductive Health

Policies and Strategies on Adolescent and Youth Health

All countries have a policy and/or strategy specifically on adolescent and youth health. In 2015, Burkina Faso implemented the five-year National Strategy for Youth Health (NSYH) that incorporates reproductive health, including maternal and child heath, within its framework. The NSYH also notes that multiple other national strategies, including those fighting malaria, blindness, HIV and oral health, all include adolescents within their frameworks. Within the NSYH, youth are classified as young people aged 15 to 24 years, and adolescents are classified as those in the age bracket of 15 to 19 years. The strategy also covers younger children, from six years onwards.

According to the strategy, the primary SRH issues affecting adolescent and youth include:

- Unwanted pregnancy and clandestine abortions.
- Unprotected and early sexual relations.
- Alcohol and drug consumption.
- HIV and Sexually Transmitted Infections (STIs).
- Violence.

It is noted that limited utilization and promotion of modern contraception in health services targeting youth and adolescents enhance negative reproductive health outcomes.

In the NSYH, it indicates that 10 ministries, including the Ministries of Youth and Employment, Education and Literacy and Secondary Education, are involved in implementing the strategy. One major form of health service delivery for adolescents in Burkina is through the public school system. Public schools have health units (sante scolaire et universitaire) that are run by government public health officials with standards for care determined by the NSYH issues listed above.

In **Ghana**, there is an Adolescent Reproductive Health Policy (2000)[6], currently under review that includes services such as family planning as a key factor in population growth and national development. The new policy is called the Sexual and Reproductive Health Policy for young people and covers 2016 to 2034. The Population Policy review lags behind the ARH policy review but is also progressing. It also looks ahead to 2034. These are outlined in the current Ghana Shared Growth and Development Agenda II: 2014-2017 (NDPC 2014). Guiding documents in the implementation of the National Family Planning Programme include the National Population Policy; the Reproductive Health Service Policy and Standard; the 2000 Adolescent Reproductive Health Policy; the Reproductive Health Commodity Security Strategy (2011-2016); the Draft National Condom and Lubricant Strategy and Market Segmentation Analysis for Family Planning, among others (MoH 2011) (DHS 2014).

As noted in the **Niger** National Strategy for the Prevention of Adolescent Pregnancy, low socio-economic status of women contributes to low levels of education (73% of women in Niger have received no formal education) and limited literacy. This increases the likelihood of increased adolescent pregnancies, early pregnancy or closely spaced pregnancies due to a lack of health education.[7] The National Strategic Plan for the Prevention of Adolescent Pregnancy (NSPAP) recognized the cause of early pregnancy as not specifically a health problem, but a multi-sectoral issue that spans education, traditions, religious practices, and health and gender norms. The NSPAP covers a period of 2015 to 2020 in line with government development objectives and the new Sustainable Development Goals.

In **Sierra Leone**, from 2013 to 2015, the Ministry of Health and Sanitation (MoHS) implemented a National Strategy for the Reduction of Teenage Pregnancy. Among the strategy's outputs are an improved policy and legal environment to protect adolescents and young people's rights; improved access to quality SRH; and comprehensive age appropriate information and education to adolescents. Additionally, the Sierra Leone Reproductive, Newborn and Child Health Strategy (2011 to 2015) identified main barriers to the uptake of adolescent SRH services.

Based on these findings, the first objective in the strategy was *to ensure the provision of comprehensive, adolescent friendly, sexual reproductive health services.*

The strategies under this objective were:

- To ensure the implementation of an adolescent and young people's health and development strategic plan.
- Ensure Adolescent/Youth-Friendly Health Services (AYFHS) are delivered.
- Sensitize the community on adolescent reproductive health issues.
- Strengthen research into adolescents' and young people's issues.

[6] Please note that Ghana is in the process of finalizing a new Adolescent Reproductive Health Policy in 2016 but it fell outside the purview of this review.

[7] National Strategic Plan to Prevention Adolescent Pregnancy, Niger, 2015

In April 2015, the Ministry of Education published a position paper indicating that girls who are visibly pregnant are not allowed in school. The Government of Sierra Leone, however, expressed commitment to the special needs of adolescent girls who have become pregnant during the Ebola crisis and called for an appropriate response. The Ministry of Education officially indicated that the following services needed to be provided to pregnant schoolgirls during the time of their pregnancy:

- Special modalities to continue their education on core subjects, so that they can be reintegrated into formal education after pregnancy.

- Provision of health information and access to maternal and neonatal health services, Gender Based Violence (GBV) and psychosocial support.[8]

While adolescent pregnancy, low rates of contraception, high rates of child marriage and limited education were not new challenges in Sierra Leone, the initiatives that were in place (e.g. National Secretariat for the Reduction of Teenage Pregnancy [NRSTP]), had begun to lapse since 2013 and the Ebola crisis. The Ebola Virus Disease (EVD) adversely impacted service provision on education, Sexual Reproductive Health (SRH) to adolescents in Sierra Leone. Schools were closed nationwide between July 2014 and April 2015. The lack of access to formal schooling and Adolescent Sexual Reproductive Health (ASRH) services amidst persistent sexual and gender-based violence situations contributed to increased teenage pregnancy especially among adolescent girls. More recently, there has been a renewed focus on preventing teenage pregnancies, school dropouts and child marriages.

Nigeria also had an adolescent pregnancy strategy (2013 to 2015) contained in the National Youth Sexual and Reproductive Health strategy with a 2011 to 2015 timeframe. The current status of this strategy is unknown. Embedded within the National Health Policy is a National Adolescent Health Policy published in 1995 thereby opening the health sector to adolescent-specific programming including topics such as sexual behaviour and reproductive health (National Adolescent Health Policy 1995).

While the issue of consent is not addressed, the policy indicates:"[i] In view of the increasing problems associated with adolescent sexuality and teenage pregnancies in Nigeria, it is considered appropriate that sexually active adolescents who seek contraceptive services shall be counselled and served where appropriate." This wording could be construed to mean sexually active adolescents do not need parental consent (National Family Planning/Reproductive Health Policy Guidelines and Standards of Practice). It is left to the providers to consent to provide these services to adolescents and young people – this provider bias can be inhibitory to healthcare access for young people.

Although policies stipulate equal access for adolescents, in reality, cultural barriers exist in easily accessing contraceptives, which leaves the decision of whether to supply contraceptives to sexually active adolescents to the discretion of the provider. Many providers impose parental consent restrictions based on their provider preference.[9] Additionally, the 2007 adolescent health policy includes adolescent-friendly health services, however the availability and accessibility to youth-friendly health services remains critically low.[10]

[8] A Rapid Assessment of Pregnant Adolescent Girls, 2015 (Yet to be Published)

[9] Ezihe Loretta Ahanonu, Attitudes of Healthcare Providers towards Providing Contraceptives for Unmarried Adolescents in Ibadan, Nigeria, Journal of Family & Reproductive Health 8.1 (2014): 33–40.

[10] USAID Deliver Project, Contraceptive Security in Nigeria: Assessing Strengths and Weaknesses, September 2009.

Legal Frameworks for Adolescent and Youth Health

While there are several national laws and legal frameworks governing adolescent and youth access to health services, including SRH services, the overall finding is that every country has a complex and often contradictory legal framework regarding SRH. This can create an environment wherein adolescents are reluctant to access services - or are denied services when they seek them. This section covers two key types of legislation that impacts adolescent and youth SRH:

- Laws governing adolescents' access to SRH services, including HIV services.
- Sexual consent laws.

Laws regarding adolescent access to SRH, including HIV, services

In all countries, with the exception of Ghana, there is no clear legislation that clarifies the age at which an adolescent can access family planning services. None of the countries have specific frameworks that outline which services an adolescent may receive without consent, leaving the decision to provider discretion. In these circumstances, a medical practitioner may institute the necessary care and intervention in the best interest of the adolescent, but individual bias may come into play - or they may err on the side of caution and deny the services requested.

The 2014 National Reproductive Health Policy and Standards in **Ghana** say that adolescents can access family planning services, though no specific age is mentioned. **Burkina Faso** has a Reproductive Health Law (n ° 2005-049/AN) that guarantees the right to reproductive health, including teenagers and children, without discrimination (Article 8). The Government of **Niger** passed a Reproductive Health Law in 2006 that guaranteed the right of every human being access to reproductive and general health care. This act authorized the use of contraceptives in the country (Article 15), with the important caveat that contraceptives could only be provided to 'legally married' couples.

In **Nigeria**, the minimum age of consent for accessing SRH services is unclear. Formal legislature such as the Childs Right Act and Sexual Offenses Act dictates that the national age of consent is 18 years and there are no age- or parity-related restrictions that formally limit access to contraceptives. Similarly, in **Sierra Leone**, the age of consent for accessing family planning and contraception services is unclear and there is no policy that explicitly guarantees adolescents full access to these services.

In terms of HIV-specific legislation, the legal contexts in all countries are complex due to the often-contradictory penal laws and health policy strategies. According to UNAIDS, international standards consider requiring parental consent for HIV counselling and testing as against best practice for adolescent HIV health policy. Even so, countries such as **Burkina Faso**, **Ghana, Nigeria** and **Sierra Leone** have laws that state that adolescents under the age of 18 years cannot access HIV counselling and testing services without parental or guardian consent. Of these countries, three provide legal 'exceptions' to this minimum age.

Ghana has an HIV law (popularly known as the Ghana AIDS Commission Act) that provides a legal framework for the delivery of HIV health services in the country. The policies generated from these laws indicate that while medical consent for a child, a person under the age of 18 years, must be obtained through a legal guardian, parent, partner, or next of kin, there are circumstances where consent is unnecessary because the child is between the ages of 16 and 18 years. These circumstances are described as "impracticable or undesirable to obtain this consent" but they fail to expand upon the specific circumstances, leaving the consent determination to the provider's discretion. This is similar to the case in **Nigeria** that provides exceptions for testing below the age of 18 years in situations where the adolescent shows maturity and understanding of the process and potential results - again leaving the service provision choice to health-provider discretion and possible bias.

In **Sierra Leone**, a pregnant or married adolescent – or an adolescent who is already a parent – can access HIV counselling and testing without parental consent.

Niger passed a law regarding HIV that includes the protection of individuals living with HIV and basic human right of access to HIV testing and treatment in 2007. However, the law states that test results for a minor should be given to a parent or guardian. This is further complicated by the fact that there is no fixed definition of a minor in Niger, as minors are considered under the age of 21 years by penal law and under the age of 18 years by the signed Convention of the Rights of Children (UN and African Union).

Sexual consent laws

Sexual consent laws define the minimum age at which an adolescent can consent to sex. While the aim of the law is primarily protective and is usually outlined in laws relating to rape or sexual assault, it can have a huge impact on adolescents' ability or desire to seek out SRH services. In particular, sexual consent laws that set the age of consent high, such as **Sierra Leone** (18 years) and **Nigeria** (18 years according to federal law), can create situations where adolescents below the age of 18 years are reluctant to access services, or are denied services by healthcare providers due to this law.

Nigeria's federal system creates a complex legal environment on sexual consent. In states that have adopted the Child Rights Act or the Sexual Offenses Act, the age of sexual consent for males and females is 18 years. In Northern Nigeria, the age of sexual consent varies by state and the predominant religion. The age can be either 'puberty', 15 years, 18 years or marriage for females. There is no age of consent for males. In Southern Nigerian states, the age of consent is 16 years for females and 14 years for males. In the FCT of Abuja, the age of sexual consent is 14 years for males and females.[11] The penal code and Child Rights Act make sexual activities with a child under the age of consent a criminal offence; however, ambiguities of the law can create legal loopholes in the justice system. Chapter 21 of the Nigeria Criminal Code states that having sex with a girl under the age of 13 years is a felonious act but having sex with a girl between 13 and 16 years of age is a misdemeanor, regardless of whether the other partner is an adolescent.[12]

In **Burkina Faso**, children under the age of 15 years cannot consent to sexual relations and any sexual act is considered an indecent assault - even if the other child is also under 15 years. In **Ghana**, the sexual age of consent is 16 years according to the Children's Act, 1998.

Of the five countries, the age of sexual consent is the lowest in **Niger** - 13 years of age (Penal Code, Article 278). Despite this, it is extremely difficult to obtain accurate data regarding the sexual lives of adolescents under the age of 15 years, as most research and data collection focuses on SRH among individuals 15 years and older. Therefore, the low age of sexual consent in Niger creates a data vacuum for health and policy professionals to understand the overall sexual health of adolescents, appropriate access to health services and educational needs of sexually-active adolescents in the country. Research among adolescents is also a complex subject and obtaining ethics approval within a country or with international review boards is extremely difficult for children under the age of 18 years without parental consent.

[11] Nigeria Sexual and Reproductive Rights Law

[12] *http://www.nigeria-law.org/Criminal%20Code%20Act-PartIII-IV.htm#Chapter 21*

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Chapter 3:
Other Health Policies that have an impact on Adolescent and Youth Health

There are several other policies and strategies related to health, including SRH and HIV, in each country that cover general populations but also have specific sections or provisions for adolescents and youth.

In **Burkina Faso**, in addition to the policy on Adolescent Health, there are two other key health policies that cover adolescents and youth. These are the National Strategy for Reproductive Health (2010) and the Policy for Family Planning (ended in 2015 and currently under revision).

In **Ghana**, the Ghana Ministry of Health (MOH) advocates and formulates national health policy, and is responsible for monitoring and evaluating progress towards its targeted outcomes. Ghana Health Service (GHS) is an autonomous government agency allied with the MOH as its technical arm and responsible for service delivery (GHS Reproductive Health Strategic Plan). In 2007, the Ghana Health Service and the MoH developed a National Strategic Direction for improving reproductive and neonatal health in Ghana for the timeframe of 2007 to 2011.

Ghana also developed a National Health Policy titled Creating Wealth through Health in 2007. One of the measures in this policy is to develop specific programmes for improving the health and health care delivery in various population subgroups, including adolescents (Creating Wealth through Health, 2007). The Ministry of Youth and Sports (MoYS) is tasked with leading campaigns relevant to their ministry to promote abstinence and safe-sex practices. Currently, the National Youth Authority under the MoYS implements some SRH interventions on a small scale, mainly with support from UNFPA.

Objective 4.3.7 of the 1994 National Population Policy seeks to educate the youth on population matters which directly affects them such as sexual relationships, fertility regulation, adolescent health, marriage and childbearing, in order to guide them towards responsible parenthood and small family sizes (Adolescent Reproductive Health Policy, 2000). This policy is currently under review.

Nigeria published a National Reproductive Health Policy and Strategy in 2001 (it is currently under review) with the overall goal to create an enabling environment for appropriate action, and to provide the necessary impetus and guidance to national and local initiatives. The strategy outlined targets from 2001 to 2006. This strategy was to be updated every five years, however, more recent versions were unavailable for this analysis. Nigeria also had a National Sexual and Reproductive Health Policy from 2011 to 2015; it is unclear if this policy still exists.

In **Niger,** the overall policy environment towards ASRH is covered in the Economic and Social Development Plan of the country. This plan clearly shows the government's commitment to:

- Improve the health of all people, particularly vulnerable groups.
- Reduce the disparities in accessing health and social services.
- Protect young people against various health risks.

The Declaration of the General Policy of the Government in 2011 paved the way to universal access to social services particularly for the poor, many of whom are adolescents.

Sierra Leone reviewed its 1993 National Health Policy in 2002 (DHS 2013). In 2010, Sierra Leone published its first National Health Sector Strategic Plan 2010 to 2015 (NHSSP) which was designed to provide the framework to guide the MoHS and its partners in the achievement of the Millennium Development Goals.

Key areas to be strengthened under this plan included[13]:

- Access to health services.
- Quality of health services.
- Equity of health services.
- Efficiency of service delivery.
- Inclusiveness.

In line with the government's Agenda for Change and Health Sector Strategic Plan, the Free Healthcare Initiative (FHI) was introduced in 2010 to provide free health care services for pregnant women, lactating mothers, and children under 5 years. FHI focuses on an essential package of free health care services to ensure a significant improvement in maternal and child health (DHS 2013). FHI makes no mention of minimum ages of consent, nor does it specifically mention adolescents, but it is plausible that this will be a good resource for pregnant adolescents.

The Reproductive, Newborn and Child Health (RNCH) strategy 2011 to 2015 aimed to promote the provision of adolescent and youth- friendly health services (AYFHS); however, adolescent SRH needs are not specifically addressed, and there are currently no specific MoHS health training or activities designed to address the specific health needs of adolescents (RNCH 2011-2015).

[13] DHS 2013

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Chapter 4:
Education Policies and Strategies

All countries have national strategies and policies on education. Most of these promote mandatory basic education and some also include provisions on state subsidies and support for school uniforms, textbooks and other associated schooling costs. This review includes information on whether the policies also cover health education, specifically sexuality education and/or HIV-specific education, as well as whether there is any specific clause of re-integration of pregnant girls or adolescent mothers in schools. Burkina Faso is the only country with a specific strategy on girls' education.

Burkina Faso has a National Strategy for the Acceleration of Girls' Education (2012 to 2021) which was developed by the Ministry of Education and Literacy, supported by UNICEF and other international actors, in 2012. The plan includes specific targets that aim at creating enabling environments within the education sector in order to retain and promote girls in schools.

This is a comprehensive strategy including teacher and administrative training; elimination of barriers for young girls (both married and unmarried) to attend school and community level education interventions for training parents, community and religious leaders. It is not clear if reintegration of pregnant girls is included in this strategy but it is a recommendation for best practices for girls' education and prevention of child marriage programmes. The purpose is to eliminate gender inequalities within the education system and the strategy has funding from the Government of Burkina Faso and other international actors.[14]

In **Ghana**, article 38(2) of the constitution states that the government, through the Ministry of Education (MoE), shall provide Free Compulsory Universal Basic Education (FCUBE). Accordingly, the MoE launched FCUBE in September 1995 with the main policy goal being to provide every school-age child in Ghana the opportunity to receive quality basic education. Additionally, as part of FCUBE, the government supplies all public basic education schools with textbooks and other educational supplies including exercise books, free school uniforms and meals. Senior high schools are also provided with textbook requirements. However, school attendance becomes expensive at senior high level because students must purchase their own uniforms and school supplies.

[14] UNICEF Annual Report, Burkina Faso, 2012

The Policy Goals for Education Strategic Plan 2010 to 2020 policy are:

- Increase access.
- Improve quality.
- Extend and improve Technical and Vocational Education and Training (TVET).
- Promote health/sanitation in institutions.
- Improve planning and management.
- Expand science and technology education.
- Improve academic quality and research.
- Expand preschool education.
- Promote programmes to prevent HIV&AIDS.
- Provide equal opportunities for girls.

The ESP 2010 -2020 provided an overview of national expenditure for the Education Strategic Plan in previous years, and promisingly, national spending for education reached 10 percent of public expenditure as a percentage of GDP in the country. While the total spending may not be enough to cover all the needs in the country, this is an encouraging statistic that shows a growth rate in expenditure over time, as well as an important percentage of the overall GDP of the country reinvested in the education of youth.

Discussions are ongoing in Ghana on harmonizing programmes on sexuality education using recently developed national guidance. The previous ESP (2003-2015) only included a HIV-specific programme while the new one includes education on broader ASRH issues including HIV.

Niger has a National Education Sector Policy guaranteeing free education and requiring compulsory education until the age of 16 years. Niger also has a National HIV/AIDS Education Sector Policy; however, the National HIV/AIDS Education Sector Strategy and Action Plan is part of its National AIDS strategy.

Sexual Health education in formal education is included in the Ministry of Education standard curriculum in Niger. However, sexual health education was not provided till recently, and considering the extremely low rates of education in the country, particularly for girls (roughly 73 percent of girls received no formal education) it is arguable this formal education policy covers a limited proportion of adolescents in Niger.

The National Policy on Education in **Nigeria** was published in 1977; the most recent policy appears to be 2004 which was further revised in 2013. This policy is the guideline for the effective administration and implementation of education at the three governing levels (Federal, State and Local Governments).

The Compulsory Free Basic Education Act was passed in 2004, ruling that children are legally obliged to attend primary and secondary school and that every government in Nigeria shall provide free, compulsory and basic education (Compulsory Free Basic Education Act 2004). The Government of Nigeria established the Universal Basic Education (UBE) Programme - a nine-year compulsory, basic educational programme of six years of primary education and three years of junior secondary education. The programme is free but families must still pay for school uniforms and textbooks. The Child Rights Act, 2003, which protects the right to education, has been adopted in 23 states in Nigeria.

In 2000, Nigeria adopted the National Sexuality Education Curriculum (Family Life Health Education), which mandates the provision of sexuality education, including HIV, in upper primary (4th to 6th grade) and junior secondary (7th to 9th grade) school. However, implementation is based on state adoption making implementation sporadic and inconsistent: some topics are removed while others are watered down and often lose their original meaning. It is reported that in the national curriculum information on condoms and contraception is prohibited and topics are purely disease prevention/HIV focused and abstinence based. It is clear that allowing states to choose whether to adopt the curriculum results in an inconsistent sexual education nationally (UNFPA 2014).

Sierra Leone established the National Commission for Basic Education in 1993 and two years later established a New Education Policy for Sierra Leone. This policy is currently under review. In 1997, Sierra Leone developed the Education Master Plan (World Bank 2007).

Under the 2004 Education Act, basic education in Sierra Leone is legally required for all children for six years at primary level and three years in junior secondary education. This act also mandated compulsory education as free for all children at primary school and at junior secondary school for girls in the northern and eastern areas (Education Act 2004). But again, although the government abolished school fees, education is still unaffordable for many because schools impose a variety of charges on their students such as book fees, uniforms requirements and other administrative fees.

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Chapter 5:
Youth Policies, including Youth Employment

None of the countries in this review have a specific strategy or policy on youth employment. However, all of them have a policy or action plan on adolescents and youth that covers employment, in addition to education and other aspects of adolescent and youth development. This section will cover youth policies in each country with a particular focus on the youth employment element.

In Burkina Faso, a new national youth policy covering the period 2015 to 2024 has been adopted. It covers youth health, employment, civism and capacity development in policy dialogue. It was written under the leadership of the Ministry of Youth through a very long and large participatory process that included several others ministries, national and international NGOs, civil society organizations, youth-led organizations and many other stakeholders.

The National Youth Policy creates a policy framework for youth employment and cultural development and provides the structure in which the Ministry of Youth Empowerment (MYE) engages with youth and works with other ministries, notably the Ministries of Education and Health, to facilitate youth-friendly environments and empower youth within the Burkinabe society. The Ministry of Youth and Employment in Burkina Faso is mandated to create an enabling environment for youth employment, cultural development and youth associations. Youth targeted under this policy are in the age range of 15 to 35 years.

Employment promotion and job creation in **Ghana** is an important objective in its Shared Growth and Development Agenda (GSGDA II) 2014 to 2017 which talks of "leverage[ing] Ghana's natural resource endowments, agriculture potentials and human resource base for accelerated economic growth and job creation through value addition, especially manufacturing" (National Employment Policy 2014).

The Ministry of Youth and Sports (MoYS) released a National Youth Policy in 2010 with the theme Towards an Empowered Youth, Impacting Positively on National Development. Priority areas included, but were not limited to, education and skills training, employment, gender mainstreaming and health and HIV/AIDS. Ghana's 2014 National Employment Policy (NEP) targets youth aged 15 to 35 years. The NEP adopts an intersectoral and integrated approach toward promoting employment and creating jobs, thereby creating a favourable environment not only for target audiences but also for Ghanaians at large.

Research informing the policy identified high percentages of youth unemployment and underemployment. It aimed at providing a framework for improved economic status including promoting a national system of apprenticeship. This primarily focused on further preparing youth and those who leave school early to acquire proficiency in numerous areas of skills, industry, and craftsmanship (NEP 2014).

The Ministry of Youth in **Niger** developed a National Policy for Youth in 2015 that requires a programme to create an enabling environment for youth employment; continued learning and skills development; economic opportunities and integration of youth perspectives in public discourse. In this policy, the ministry considers youth to be aged between 15 and 34 years. The policy creates an enabling environment with some key best practices such as educational resources; continuing education and skill-based education; budgets for income generating activities and protection activity for youth. Protection activities include increasing access to health services, reinforcing the health system for service delivery of adolescent SRH and other health-related access and education subjects.

In Niger, the National Youth Policy outlines strategies to ensure that young people are more integrated into society, have economic opportunities, are politically engaged and can participate fully in the development of the country.

The key goals are:

- Young girls and boys have access, without discrimination, to learning and development opportunities to acquire specific skills.
- To strengthen the commitment and participation of young people in the promotion of citizenship, citizenship and the democratic exercise of social and political leadership at all levels.
- Better integration of young people into the economy.
- Improved protection of young people to enable them to lead healthy lives.
- Young people are integrated into the design, implementation and monitoring of global and sectoral development strategies and are instruments of development planning at the regional and municipal levels.
- Strengthened sectoral coordination capabilities and steering the implementation of the NPC.

There is also a Plan of Action for Adolescents that covers the period 2015 to 2018. This plan is based on several interlinked strategies:

- Promotion of behaviours and social norms that enable the full development of an adolescent.
- Increased access by adolescents to services in order to reduce their vulnerability.
- Improvement of social services so that they effectively meet the needs of young people.
- Creation of a favourable policy and legislative environment to protect and strengthen adolescent rights.
- Improvement in the production and use of data on adolescents.

In Nigeria, the National Youth Policy is currently in its second edition. It is the guiding policy for youth health and development issues and identifies the priorities, directions and practical support that the government should be providing for the development of its young men and women (age 18 to 35 years) although it also has references to the pre-youth age group. It identifies 14 categorical cohorts of youth as target beneficiaries:

- Students in secondary and tertiary institutions.
- Out of school youth.
- Unemployed and underemployed youth.
- Youth with disabilities.
- Youth engaged in crime and delinquency.
- Female youth.
- Gifted youth.
- Rural youth.
- Young people living in the street.
- Young men and women living with HIV/AIDS.
- Youth engaged in and affected by armed conflict situations.
- Illiterate youth.
- Sex workers.
- Youth in Diaspora.

It has an accompanying action plan. Challenges of the current policy include poor dissemination of its contents to the subnational levels and poor operationalization of the policy to actionable activities.

There are plans to review the policy and make it more in tune with current youth realities (including specific targeting of youth in humanitarian settings) and to make the document more user-friendly. At the time of writing, this review was scheduled to take place in September 2016.

Sierra Leone established a National Employment Policy in 2014 and a National Youth Programme 2014-2018. Prior to this, the government largely depended upon outdated policies from the 1960s. In 2003, GoSL launched a revised National Youth Policy (NYP) and established a Youth Commission to promote opportunities for youth advancement. It was revised again in 2014. The NYP has the potential to significantly improve the youth sector by strengthening collaboration between youth organisations and youth servicing agencies, both international and local NGOs, and all line ministries that have youth-related activities. The policy defines youth as any Sierra Leonean (female and male) within the 15 to 35 years age bracket (NYP 2003).

The 2016 National Youth Service Act was also enacted to create job opportunities for young people. Largely due to the war, many young people do not have formal education or skills with only 20 percent of 15 to 35-year-olds having finished primary school.

Unemployment among urban youth is extremely high, with a 2012 UNDP report indicating that 60 percent of youth (15 to 35 years) in Sierra Leone were unemployed[15] which places Sierra Leone's youth unemployment rate at the highest in West Africa. There are fewer opportunities in formal employment for youths in the country, and young women are further disadvantaged based on gender disparities and have less access to paid employment and formal employment.[16]

[15] *http://www.sl.undp.org/content/dam/sierraleone/docs/projectdocuments/povreduction/sl_status_ofthe_youth_report2012FINAL.pdf*

[16] *http://dhsprogram.com/pubs/pdf/sr171/sr171.pdf* (DHS, 2008)

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Key Findings and Recommendations

West and Central Africa's (WCA) population is predominantly young. More than 64 percent are under the age of 24 years. Young people are a tremendous resource for the region – but only with the right investments in their education, health, skills and empowerment.

64%
under the age of 24 years

The creation of an enabling policy and legal environment that protects and promotes the health, well-being, education and employment of young people, particularly adolescent girls, is an important part of ensuring that the full potential of young people can be realized. Policies should seek to enable and empower young people and be supported by legislation that upholds their rights.

Key Findings

The review covers policy and legal frameworks for child marriage and adolescent SRH; broader health policies and strategies that have provisions or sections pertaining to adolescents and youth; education policies and youth and youth employment policies. The legal analysis reviewed laws pertaining to child marriage (age of marriage including parental consent exceptions); adolescents' access to SRH services including contraceptives and HIV counselling and testing and sexual consent laws.

The review found that while there were examples of enabling and supportive policies and laws, most countries had a complex – and often contradictory – set of laws, policies and strategies pertaining to adolescents and youth. These often acted as significant barriers to their access and uptake of health services, education and employment and could increase their vulnerability to child marriage. The findings are:

- **Child Marriage:** Child marriage is an issue across all the countries reviewed, though the prevalence varies considerably with Niger having the highest prevalence rate in the world (76.3%) and Ghana having a relatively lower prevalence rate (20.7%). Only one of the five countries covered in this review has a national strategy to end child marriage – Burkina Faso – while Ghana and Nigeria are in the process of developing national strategies/policies on this issue. Both Niger and Sierra Leone address the issue of child marriage, to some extent, in their national policies on adolescent pregnancy. Far less promising is the legal environment related to child marriage across the five countries. Only Ghana has unequivocal legislation that sets the age of marriage at 18 years for both boys and girls, with no exceptions. The other countries have the legal age set lower, or have legal loopholes through which marriages are allowed below the age of 18 years with parental consent. There are several advocacy movements gathering pace in these countries to increase the minimum age of marriage and close the loopholes.

- **Adolescent Sexual and Reproductive Health:** Every country has a policy, strategy or action plan on adolescent health that also covers adolescent SRH. Most of these policies include measures to address the high levels of adolescent pregnancy. While several policies support adolescent access to SRH services, they often do not provide any specific provisions on the accessibility and quality of these services or training of health care providers. In many cases, the legal ambiguities surrounding age of access to contraceptives and other SRH services mean that the final decisions may rest in the hands of the healthcare providers creating a situation of healthcare provider bias in provision of these services. The review included a legal analysis of sexual consent laws. While these laws are primarily protective in nature, in cases where the legal age to sexual consent is very high (18 years and above), it can act as a barrier to adolescents seeking SRH services. Both Sierra Leone and Nigeria (where 18 years is the age of sexual consent) have situations where adolescents below the age of 18 years are reluctant to access services, or are denied services by healthcare providers due to this law.

- **Education Policies and Strategies:** All countries in this review have an education policy or strategy that stated that basic education is compulsory and free. But most countries did not cover additional associated costs of schooling such as school uniforms, textbooks etc. that can act as a significant barrier to education access, especially among poorer communities – and this can often disproportionately impact girls. It is worth noting that Burkina Faso has a specific strategy on accelerating girls' education. The review also examined whether education policies included provisions for sexuality education or health education more broadly. All countries included some mention of health education, either with a focus on sexual health, family health or HIV.

- **Youth Policies, including Youth Employment Policies:** While none of the countries had a specific policy or strategy on youth employment, all countries had a youth policy, strategy or action plan that covered youth employment in depth, with a focus on job creation, training for youth, and intersectoral responses to address the issue.

Recommendations

While there are several promising practices that countries can build on, this review found that there is a complex – and often contradictory – set of policies and legislation in place across the five countries covered in this study. The recommendations to address this are:

- Child marriage policies should include a comprehensive set of policy approaches to accelerate actions to end child marriage and to protect adolescent girls at risk of marriage, as well as cover adolescent girls who are already married.

- Ensure that child marriage laws are aligned with international standards as enshrined in the Convention on the Rights of the Child as well as the African Charter on the Rights and Welfare of the Child. This means that the minimum age of marriage is set at 18 years for both sexes and does not include any exceptions with parental or guardian consent.

- Governments should develop or revise policies and enact legislation that protects young people's rights to the highest attainable standard of health. SRH services should be aligned with the standards for youth- and adolescent-friendly services outlined by the WHO (given in Annex II). Policies and legislation should allow adolescents' access to SRH and HIV services, including contraceptive services and HIV counselling and testing. All countries in the review are signatories to the Convention on the Rights of the Child (CRC). The CRC asks governments to recognize the evolving capacity of adolescents to make independent decisions regarding their health. This calls for a review and overhaul of policies and legislation that do not allow adolescents to access SRH services without the consent of their parents or guardians.

- Laws governing age of consent to sex and age of consent to SRH services should be harmonized. Age of consent to sex should be set at an age that recognizes that many young people commence sexual activity during adolescence.

- Education policies should cover both primary and secondary education, with a special focus on girls' education, and remove barriers to education through removal of school fees, subsidizing of school uniforms and textbooks and provision of school meals if possible. They should also include provisions for the inclusion of sexuality education programmes in schools.

- Countries should develop policies pertaining to youth employment that includes clear guidance and concrete measures on how to equip young people with education, skills and training for the marketplace; reduce youth unemployment and underemployment and improve quality of jobs for youth.

- Policies and strategies should be costed and funded in order to support their implementation. Laws should be implemented through support through the appropriate judicial systems.


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Annex I:
Table of Policies Reviewed per Country

BURKINA FASO		
Policies, Strategies and Documents Reviewed		**Date**
Background documents	Demographic Health Survey	2010
	2011 UNICEF Humanitarian Action for Children; Building Resilience	2011
	UNICEF Annual Report 2012 for Burkina Faso, WCARO	2012
	Situational Analysis of Poverty and Vulnerability of Children and Women in Burkina Faso	December 2010
Legal	Penal Code	1996
	Code for Individuals and the Family	1989
	African Union Charter on the Rights and Welfare of the Child	1990
	Convention on the Rights of the Child (UN)	1990
	HIV Law	2008
Health	National Policy for Health	
	National Policy and Norms for Reproductive Health	May 2010
	National Strategy for Youth Health	2015 – 2020
	National Strategy for the Prevention and Elimination of Child Marriage	2016 – 2025
	Action Plan for the Three Year Strategy for the National Prevention and Elimination of Child Marriage in Burkina Faso	2016 – 2019
	National Policy HIV	2008
	National Plan for Relaunching Family Planning	2013 – 2015
Youth and Youth Employment	National Policy for Youth	September 2008
	National Policy for Youth – includes employment and education topics	2015
Education	National Strategy for the Acceleration of Girls' Education	2012 – 2021

GHANA		
Policies, Strategies and Documents Reviewed		**Date**
Background documents	Demographic Health Survey	2014
Legal	Penal Code	1960
	Constitution of the Republic of Ghana	1992
	Juvenile Justice Act	2003
	African Union Charter on the Rights and Welfare of the Child	1990
	Convention on the Rights of the Child UN	1990
	Children's Act	1998
Health	National Health Policy: Creating Wealth through Health	2007 (Currently under review)
	Adolescent Reproductive Health Policy	2000 (Currently under review)
	National HIV/AIDS and STI Policy	2013 (In final stages of review)
	Reproductive Health Strategic Plan DRAFT	2012
	Ghana Health Service Reproductive Health Strategic Plan	2007 – 2011 (Replaced by MAF)
	Millennium Development Goals Acceleration Framework (MAF)	2011 – 2015 (Soon to be reviewed)
Youth	National Youth Policy	2010
Education	Education Strategic Plan	2010 – 2020
Employment	National Employment Policy	2014
Gender	Domestic Violence Act	2007
Gender	National Strategic Framework on ending Child Marriage	Under development

NIGER		
Policies, Strategies and Documents Reviewed		**Date**
Background documents	Demographic Health Survey	2013
	2011 UNICEF Humanitarian Action for Children; building resilience	2011
	Framework for Protection of Children	2010
	Juvenile Protection Policy	No defined dates
	National Civil Registration Policy	No defined dates
	National Policy of Social Protection	2013-2015
	3N Initiative for agricultural sustainability	2012
Legal	Penal Code	1961 updated 2004
	African Union Charter on the Rights and Welfare of the Child	1990
	Convention on the Rights of Children (UN)	1990
Health	National Policy for the Prevention of Adolescent Pregnancy	2015 – 2020
	National Policy on Gender	2008
Youth and Youth Employment	National Policy for Youth	2015

NIGERIA		
Policies, Strategies and Documents Reviewed		**Date**
Background documents	Demographic Health Survey	2013
Legal	Penal Code	1960
	2003 Child Rights Act Factsheet	2007
	Universal Basic Education Act	2004
	Criminal Code Act	1990
Health	National Policy on HIV/AIDS	2009
	National HIV Strategy for Adolescents and Young People	2016 – 2020
	National Reproductive Health Policy and Strategy	2001
	Revised National Health Policy	2004
	National Adolescent Health Policy	1995
	National Policy on the Health and Development of Adolescents and Young People in Nigeria	2007
	National Reproductive Health Strategic Framework	2002 – 2006
	National Strategic Framework on the Health & Development of Adolescents & Young People in Nigeria	2007 – 2011
	National Youth Sexual and Reproductive Health Strategy	2011 – 2015
	National Family Planning / Reproductive Health Policy Guidelines and Standards of Practice	2005
	National RH/FP Clinical Service Protocol	Revised 2015
Employment	National Employment Policy	Unknown

SIERRA LEONE		
Policies, Strategies and Documents Reviewed		**Date**
Background documents	Demographic Health Survey	2013
Legal	Penal Code	1965
	Child Rights Act	2007
	Education Act	2004
	The National HIV and AIDS Commission Act	2011
Health	Reproductive, Newborn and Child Health Strategy (currently being revised to be the Reproductive, Maternal, Newborn, Child and Adolescent Health Strategy)	2011 – 2015
	The National Strategic Plan on HIV/AIDS	2016 – 2020
	National Strategy for the Reduction of Teen Pregnancy (currently under review)	2013 – 2015
	National Health Sector Strategic Plan	2010 – 2015
Youth	National Youth Policy	2003

Annex II:
WHO –UNAIDS Global Standards for Quality Health Care Services for Adolescents

Standard 1. Adolescents' health literacy	The health facility implements systems to ensure that adolescents are knowledgeable about their own health and they know where and when to obtain health services.
Standard 2. Community Support	The health facility implements systems to ensure that parents, guardians and other community members and community organizations recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents.
Standard 3. Appropriate package of services	The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfills the needs of all adolescents. Services are provided i n the facility and through referral linkages and outreach.
Standard 4. Providers' competencies	Healthcare providers demonstrate the technical competence required to provide effective health services to adolescents. Both healthcare providers and support staff respect, protect and fulfill adolescents' rights to information, privacy, confidentiality, nondiscrimination, nonjudgmental attitude and respect.
Standard 5. Facility characteristics	The health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.
Standard 6. Equity and nondiscrimination	The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics.
Standard 7. Data and quality improvement	The health facility collects, analyses and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff are supported to participate in continuous quality improvement.
Standard 8. Adolescents' participation	Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.

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Delivering a world where every pregnancy is wanted every childbirth is safe and every young person's potential is fulfilled

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