

Adolescent sexual and reproductive health and universal health coverage: a comparative policy and legal analysis of Ethiopia, Malawi and Zambia

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Abstract: *Universal Health Coverage (UHC) forces governments to consider not only how services will be provided – but which services – and to whom, when, where, how and at what cost. This paper considers the implications for achieving UHC through the lens of abortion-related care for adolescents. Our comparative study design includes three countries purposively selected to represent varying levels of restriction on access to abortion: Ethiopia (abortion is legal and services implemented); Zambia (legal, complex services with numerous barriers to implementations and provision of information); Malawi (legally highly restricted). Our policy and legal analyses are supplemented by comparative vignettes based on interviews (n = 330) in 2018/2019 with adolescents aged 10–19 who have sought abortion-related care in each country. We focus on an under-considered but critical legal framing for adolescents – the age of consent. We compare legal and political commitments to advancing adolescent sexual and reproductive health and rights, including abortion-related care. Ethiopia appears to approach UHC for safe abortion care, and the legal provision for under 18-year-olds appears to be critical. In Malawi, the most restrictive legal environment for abortion, little progress appears to have been made towards UHC for adolescents. In Zambia, despite longstanding legal provision for safe abortion on a wide range of grounds, the limited services combined with low levels of knowledge of the law mean that the combined rights and technical agendas of UHC have not yet been realised. Our comparative analyses showing how policies and laws are framed have critical implications for equity and justice. DOI: 10.1080/26410397.2020.1832291*

Keywords: abortion, adolescent, Malawi, Ethiopia, Zambia, law, policy, universal health coverage

Introduction

Universal health coverage (UHC) means that everyone receives the health services they need without financial hardship. UHC forces governments to consider not only *how* services will be provided – but *which* services, and to whom, when, where, how and at what cost. Underpinning UHC is an objective of reduced health inequity, reducing disparities that have kept essential high-quality health care out of reach for many. Most recently endorsed at the 2019 UN High Level Meeting, UHC has three key dimensions: full population coverage, a comprehensive package of quality health services, and minimal or no out-of-pocket payments. Universal access

to sexual and reproductive health (SRH) is an integral component of UHC.

Yet, what comprises SRH, and how it reaches those most in need, remains a topic of international debate. The WHO definition of UHC provides very little specificity for policymakers¹ so each state must develop its own pathway to attaining UHC,² making UHC, and what it encompasses, a political choice – with both national and transnational political processes at play.³ If the aim of UHC is for all sub-populations to have access to quality health services, then we need to understand how existing laws and policies frame who does not have equitable access. Analysing laws and policies provides important insights into the

contexts that govern and frame SRH, and ultimately UHC. Policies and laws simultaneously govern and are “experienced, enacted and challenged in everyday interactions, encounters and actions”.⁴

Age and gender are critical social determinants in the debate and movement for equity in health. By focusing on SRH-related policies and laws that are the outcome of political processes, we can illuminate the extent to which progress towards UHC for adolescent SRH is or is not being achieved. Adolescence involves multiple transitions – physical, emotional, social, economic and legal – cutting across age-based legal definitions of minority/majority that are often conflated with child/adult.⁵ Meeting the needs of sexually active adolescents who want to avoid a pregnancy involves economic, social, cultural, legal and health system challenges. Even where comprehensive SRH is available, adolescents are less likely to access these services compared with older people because of: lower levels of knowledge;⁶ fewer financial resources; higher likelihood of delaying care-seeking;⁷ lower ability to navigate health systems;⁶ and higher levels of perceived stigma.⁸ A review of essential packages of healthcare services in LMICs found that only some adolescent SRH services, mainly related to contraception and STI/HIV, were included, and concluded that evidence on adolescent SRH in UHC remain under-researched and evidenced.⁹

Across Africa, SRH laws and policies and the implications for service delivery for adolescents are key health systems issues. To achieve UHC, attention must be paid to intersections of health equity, and to the framing of health by policies and laws. Through the case studies of Ethiopia, Malawi and Zambia, this paper aims to explore how different legal and policy frameworks work to hinder or facilitate UHC of SRH. Using a comparative research design, we ask two research questions. How do age of consent laws influence provision of and access to adolescent contraceptive care? And how do laws and policies relating to adolescent SRH influence adolescent abortion-related care provision and access?

Case study countries: Ethiopia, Malawi and Zambia

All three countries have young population age structures with more than 40% of the population

aged below 15 years and less than half of sexually active unmarried women aged 20–24 currently using modern contraceptives. Malawi is the poorest of the three countries and has the highest poverty ratio (Table 1).

Table 1. State-level socio-demographic indicators^a

	Ethiopia	Malawi	Zambia
GDP capita ppp\$ [2018] ¹⁰	2,018	1,308	4,216
% population urban ¹¹	19.4	16.3	41.9
Poverty headcount ratio [below \$./day] (WB) ¹⁰	30.8 [2015]	70.3 [2016]	57.5 [2015]
Total population median age [2015] [years] ¹²	18.3	17.2	16.7
% population aged below 15 years ¹²	42.2	45.1	46.2
Median age at first sex [females aged 25–49]	16.6	16.8	16.6
% women aged 15–24 married by exact age			
15	14.1	9.0	5.2
20	57.8	66.3	46.5
Median age in years at first marriage [females aged 25–49]	17.1	18.2	19.1
Very young adolescent [10–14] fertility rate	1.0	3.0	3.0
Adolescent [15–19] fertility rate	80	136	135
Total fertility rate [females aged 15–49]	4.6	4.4	4.7
% sexually active unmarried women aged 20–24 using modern contraception	47.0	43.7	47.6

^a Unless otherwise specified, data from most recent DHS: Ethiopia (2016), Malawi (2015–2016), Zambia (2018).

All three countries are normatively conservative with respect to sexual practices of unmarried adolescents, reflected in the reluctance of parents and health providers to support adolescent contraceptive use.^{13,14} In addition to limited services, adolescent use is constrained in all three countries by concerns including confidentiality,¹⁵ provider biases,⁸ and low levels of knowledge.¹⁶

Methodology

These three countries were purposively selected for varying levels of restriction on access to contraception and abortion, particularly for adolescents: in Ethiopia abortion is legal, services are implemented; in Zambia abortion is legal, but there are barriers to information and implementation; in Malawi legal abortion is highly restricted. We analyse two evidence sources: contemporary policies and laws in each country and relevant regional instruments relating to adolescent SRH; and in-depth interviews with adolescents seeking abortion-related care in each country (2018–2019)

Policies and laws: evidence and analyses

We identified current laws and policies relating to adolescent SRH – with a specific focus on contraception and abortion care – in each country. Where they exist in Ethiopia and Zambia, guidelines that operationalise the law on safe abortion (SA) were also included. In addition, we analysed regional – African Union (AU) – instruments relevant to UHC and adolescent SRH. We included AU instruments to situate contemporary state-level laws and policies and to identify contradictions – if any – between regional commitments and state-level laws and policies. We developed a framework to extract information on the content of salient laws and policies in each country; it was informed by documents on rights-based and adolescent-focused SRH.^{17,18}

In-depth interviews with adolescents

Interviews involved facility-based recruitment of girls and adolescents 10–19 years old seeking either SA or post-abortion care (PAC) for the treatment of complications following an abortion initiated elsewhere. In each country, adolescents seeking care at two urban public sector facilities were recruited; a total of 318 interviews were conducted (Ethiopia $N = 99$; Malawi $N = 104$; Zambia $N = 115$). The study design and sample sizes allowed for analysis at three analytic levels: within

country by facility, cross-country and cross-facility; by sub-groups of adolescents who sought facility-based SAs; and by those who presented to facilities with complications of abortions conducted outside of health facilities. All adolescents identified as having sought either SA or PAC by a study-trained senior nurse were invited to participate once ready for discharge. Nurses were not involved in research consent procedures. Trained research assistants completed informed consent with potential participants. For respondents aged below 18 years, informed consent was sought from any accompanying parent or guardian, in addition to assent from the respondent. Respondents aged below 18 years without an accompanying parent or guardian were considered as emancipated minors and their consent sought. For all participants aged 18 years or more, consent was sought. Methodological details, including research instruments, are available;* they include questions on SRH behaviours, care-seeking, decision-making, costs, attitudes and beliefs, satisfaction with services and knowledge. Themes were explored using both quantitative (data presented elsewhere) and qualitative interviewing techniques using an established two interviewer technique.¹⁹ Verbatim translation and transcription of recorded interviews were conducted by trained female research assistants located in two facilities in each country during 2018–2019. Qualitative data were coded and content analysed in Dedoose by a team of five that included two of the authors, using a combination of deductive and inductive themes to explore issues related to barriers and facilitators of adolescent abortion and contraceptive care-seeking and decision-making in each country. To ensure shared understanding of research domains, coding was developed collaboratively, including blind coding by all five team members of 10 cases to check for intercoder variability and understandings. Nearly half (49%) of the interviews were coded by two members of the team blinded to the other coder to check for internal consistency; the remaining interviews were single coded. Ethical review was obtained in Ethiopia (Ethiopian Public Health Institute: 154-2018), Malawi (National Health Sciences Research Committee: 2003), Zambia (ERES- 2017-Nov-005) and the UK (London School of Economics: 000606).

*<https://abortioninafrica.wordpress.com/>

Legal contexts

We first consider regional and national commitments to advancing adolescent SRH. We then focus on an under-considered but critical legal framing – age of consent, followed by policies and guidelines for adolescent abortion-related care. Finally, we present primary evidence from adolescents about the implications of SRH policies in their lives.

Regional legal and political commitments to advancing adolescent SRHR

Ethiopia, Malawi and Zambia are members of both the United Nations (UN) and the African Union (AU). These bodies have developed legal instruments (e.g. UN Convention on the Rights of the Child, African Charter on the Rights and Welfare of the Child) that articulate legal obligations of States to realise human rights including adolescent sexual and reproductive health and rights (SRHR). Agendas such as the 2030 Agenda for Sustainable Development (UN), and Agenda 2063: The Africa We Want (AU), stipulate developmental goals including healthy lives and well-being for all ages. The laws and policies of individual countries are influenced by these commitments.

2019 marked the 25th anniversary of the International Conference on Population and Development (ICPD) which remains a seminal document reflecting states' political commitments to implement SRH, including for adolescents (Table 2). Attention to adolescent SRH has increased since ICPD, especially comprehensive and integrated SRH services, comprehensive sexuality education, and the need to consider the evolving capacities of the child in service provision.²⁰

At the 2019 Nairobi Summit, countries renewed their commitments to SRHR. Malawi committed to increasing the percentage of adolescents accessing youth-friendly health services to 100% by 2030.²¹ Zambia committed to eliminating discrimination and strengthening equitable access to resources by establishing universal access to social service, and creating an SRH-enabling environment by addressing legal and social barriers.²² The government of Ethiopia did not register any commitments at the Summit. Despite government commitments to these regional instruments and progressively adopting policies on adolescent SRHR, sociocultural norms, in complicity with restrictive laws, remain critical barriers to SRHR for children and adolescents.²³

Alongside ICPD and its iterations, the *African Charter on Human and Peoples' Rights on the Rights of Women* in Africa (Maputo Protocol)* is one of the most critical commitments on the African continent. Article 14(2)(c) of the Maputo Protocol²⁴ obligates states to take all appropriate measures to:

“protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.”

“Taking appropriate measures” includes not only laws and policies, but also ensuring service availability and accessibility by requiring states to “provide adequate, affordable and accessible health services”.[†] Malawi and Zambia have ratified, and are legally bound by the terms of the Maputo Protocol.²⁵ Though not legally bound to implement the Protocol, by signing the treaty Ethiopia is obligated to refrain from acts that would defeat or undermine the treaty's objective and purpose. International and regional human rights instruments and standards – dependent upon whether signed or ratified – demand that states bring national laws, regulations, policies and practices into alignment. Thus, as a critical component of UHC, the laws that frame SRHR delineate – on paper at least – which services should be made available, to whom, and under which circumstances.

National age of consent laws and policies and their implications for adolescent SRH

Age of consent laws play an important, though not always visible, role in defining and regulating sexual life and access to SRH care. Age of consent laws determine who is considered old enough to engage in sexual intercourse.

In Ethiopia, sex with persons of the opposite sex below the age of 18 is prohibited,[‡] making 18 the age of consent to sex for boys and girls. In Malawi, the law prohibits sexual intercourse with a girl of below the age of 16.^{**} Malawi's law provides for

*Adolescents are not mentioned explicitly, but it is generally understood that “women” is interpreted to include girls in the Maputo Protocol.

[†]Maputo Protocol Article 14(2)(a).

[‡]The Criminal Code of the Federal Democratic Republic of Ethiopia, Proclamation No.414/2004, Article 626.

^{**}Ch 7:01 Laws of Malawi, Penal Code 1930, Section 138.

Table 2. Key African Union legal and policy instruments that could support the advancement of adolescent SRH services under UHC

Nature of instrument	Year of adoption	Focus	Features pertaining to adolescent SRHR	Strengths and limitations
<i>Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa</i>				
Enforceable treaty	2003	Human rights of women	Elimination of discrimination against women; economic and social welfare rights, health and reproductive rights	Recognises the right to health of women including sexual and reproductive rights. Mentions the right to control fertility, the right to decide whether to have children or not. State parties should “protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus”.
<i>Continental Policy Framework on Sexual and Reproductive Health and Rights (CPF)</i>				
Policy	2006	Guidance on implementation of ICPD Plan of Action (PoA) and Millennium Development Goals	Includes: maternal mortality and morbidity; contraceptive use and family planning services; unsafe abortion; adolescent reproductive health	Draws on the ICPD PoA and specifically addresses adolescent SRH and unsafe abortion.
<i>Revised Maputo Plan of Action 2016–2030 (MPoA)</i>				
Policy	2016	MPoA 2016–2030 designed to operationalise the CPF	Actions include: instituting health legislation and policies for improved access to Reproductive, Maternal, Newborn, Child and Adolescent Health services; investing in SRHR needs of adolescents, youth and vulnerable and marginalised populations	Emphasises the need to ensure adolescents have access to SRH services in accordance with ICPD PoA.

age of consent to sexual intercourse for the girl but not for the boy. Zambian law prohibits sexual intercourse with a child, defined as a person below the age of 16,^{††} making 16 years the age of consent to sex for both boys and girls.

One of the challenges with age of consent provisions is that they do not expressly stipulate the

^{††}Chapter 87 of the Laws of Zambia, The Penal Code, Section 138.

exception that adolescents who are under the age of consent would not be criminalised for having sexual intercourse with peers. Without this exception, the law is applied to prosecute adolescents for having consensual sex.^{‡‡} The combination of restrictive social norms and age of consent laws creates a restrictive environment for access to crucial SRH services for sexually active adolescents (Müller et al. 2018²⁶).

Countries may also have laws regulating access to medical treatment or parental consent laws, most frequently restricting SRH services, such as provision of contraceptives or abortion. A higher age of consent is more restrictive of services for adolescents than a lower age of consent.²⁷

Age of consent to medical treatment in Ethiopia is not stipulated in law, though the law provides 18 years as the age of majority. The law does not provide information or an age of consent to contraceptives, although for HIV services, parental consent is required for persons below 18.²⁸ Yet consent is described in Ethiopia's *National Adolescent and Youth Health Strategy*: "Despite the law that allows access to contraceptives without parental or guardian consent, in Ethiopia...".²⁹ Such an understanding of the position of the law on contraceptives is most likely misleading because there is no such law. It is doubtful the government could be said to have a positive obligation to provide contraceptives to any person of any age. What is most likely the case is that parents assume parental responsibility over persons who have not yet attained the age of majority, and this would include making choices regarding access to medical services and contraception on their behalf.

Neither is the law on consent to medical treatment and contraceptives expressly stipulated in legislation in Malawi. The description of consent requirements in policy documents reveals ambiguities. According to *The Malawi Youth-friendly Health Services (YFHS) Training Manual*, "There is no minimum age for accessing contraceptives. Adolescents and youth can access any contraceptive of their choice at any time" (p.27).³⁰ However, the same manual says that "Service guidelines allow for youths age 16 and up to access

contraception without parental consent" (p.58). Malawi's law does not explicitly address age of consent for medical treatment and contraception, leaving it to interpretation and eventually to service providers.

In Zambia, the position on requirement of consent for medical treatment and contraceptives for adolescents is also unclear. A review revealed that there are no legal age restrictions on access to contraceptives.³¹ However, legal counsel believed that since the age of consent to sexual intercourse is 16, an adolescent below 16 seeking contraceptives would be denied access without parental consent.³¹ The *Zambia Family Planning Guidelines and Protocols* interprets the law differently as approval to "Facilitate access, especially for young girls, to all types of services... without consent of spouse, parents/guardians or relatives as allowed by current legislation".³²

National abortion law contexts

Ethiopian and Zambian abortion laws comply with Article 14(2)(c) of the Maputo Protocol, while Malawi does not (Table 3). Zambia's law is the most progressive of the three because it provides for abortion on broader grounds beyond the life and health of the pregnant woman, and includes the physical and mental health of existing children of the pregnant woman. Further, account may be taken of the pregnant women's environment and age.^{33,34} Abortions can only be provided in registered facilities and three medical doctors, one of whom must be a specialist, must be signatories to the procedure.³⁵ When Ethiopia reformed its abortion law in 2005, debates reflected a clash of values between advocates for a liberal law and those resisting on religious grounds.³⁶ The resulting law was a compromise. The Penal Code maintained abortion as illegal but provided liberal access by allowing generous exceptions to abortion access without requiring legal proof or burdensome documentation, including in cases where the pregnant woman is a minor. Thus, for adolescents, the Ethiopian law is more expansive than that of Zambia. The Ethiopian law is unique on the African continent, explicitly considering the barriers adolescents face and permitting abortion legally on the grounds of being below the age of 18 without requiring proof of age. Malawi's law does not comply with the Maputo Protocol because abortion is restricted to the sole indication of endangerment to the woman's life. The Law Commission (Malawi) reviewed the current law of

^{‡‡}In *Paul v Republic (Criminal Appeal No. 16 / 2017)* the High Court of Malawi heard an appeal where a boy aged 17 had consensual sexual intercourse with a girl of 15 and was convicted of defilement in the magistrate's court. In allowing the appeal, the court considered the boy was young.

Table 3. Abortion laws and services in Ethiopia, Malawi and Zambia

	Zambia	Ethiopia	Malawi
Grounds for abortion	Life, mental and physical health of pregnant woman; physical and mental health of existing children; foetal impairment. In 2005 Penal Code sections 151–3 were amended to include rape and defilement of female children. ^a “The pregnant female child’s word must be taken as a matter of fact ... not subject to the health care provider’s subjective analysis.”	Article 551 of the Penal Code: Life, mental and physical health, of pregnant woman; rape and incest ^b ; mental or physical disability including due to minority status of pregnant woman; foetal impairment. Includes provision to terminate pregnancies legally on the grounds of being below the age of 18 without requiring proof of age.	Life of pregnant woman.
Availability of safe abortion services	Some availability in public sector facilities; limited availability in the private/ NGO sector ^{19,38}	Widely available in the public, private and NGO sectors. ^{39–41}	Very limited availability ^{42,43}
Standards and Guidelines on safe abortion care: adolescent-specific content	2nd Edition (2017) Adolescent Includes standards to ensure availability of services at the community level for both in-school and out of school adolescents. For a person below the age of legal consent to a medical or surgical procedure (less than 18 years of age), to obtain an abortion procedure, the parents or legal guardian approval to terminate the pregnancy must be documented. The best interest of the minor will take precedence over that of the parents or guardian. The guidelines recognise that supportive counselling may be necessary for adolescents.	2nd Edition (2013) No specific mention of adolescents is included in the Ethiopian guidelines. A provider should secure informed consent for a procedure. However, minors are not required to sign a consent form to obtain an abortion procedure.	Standards and guidelines on abortion care not available

^a Section 152[2]: “Any female child being pregnant who, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing or uses any force of any kind commits an offence and is liable to such community service or counselling as the Court may determine, in the best interest of the child.”

^b Women who request termination of pregnancy after rape and incest are not required to submit evidence of rape and incest and/or identify the offender in order to obtain abortion services.

colonial origin and proposed a revised (2015) Termination of Pregnancy Bill which, if implemented, would expand the grounds for access to SA.³⁷

Ethiopia and Zambia both have national standards and guidelines (S&G) produced by the Ministry of Health for the provision of abortion and PAC;

Malawi has none. S&G represent the operationalisation of laws and policies; standards “are intended to be applied rigidly in almost every case, exceptions being rare and difficult to justify”; guidelines “are recommendations for best practice ... when they are not applied, their justifications

must be rational, logical and documented” (p.15).³⁵ In both Ethiopia and Zambia the S&G also include contraception as part of a continuum of care that includes the prevention of pregnancy, including post-abortion contraception. S&G in both countries are developed by multisectoral technical working groups and framed by regional international agreements.³⁶ In Zambia, this includes explicit mention of ICPD, Beijing PoA (1995) and Maputo PoA (2006) whereas in Ethiopia, mention is made of Millennium Development Goal 5. In Ethiopia, the legal provision for abortion services for legal minors below age 18 years without proof of age makes provision of abortion care universal in a way that is straightforward to communicate and understood by both healthcare workers and the general population. In Zambia, although consent for abortion for minors is framed by “the best interest of the minor”, this nuanced framing is poorly understood by healthcare workers and provides space for individual healthcare workers to restrictively interpret and implement the law. Thus, despite Zambia having a progressive law on paper, it is limited by interpretation.^{34,38}

Legal and policy frameworks in practice: implications for adolescents

All three countries have laws and policies, to varying extents, that are intended to facilitate access to SRH services for adolescents. We identified substantial direct and indirect barriers to access. Direct barriers are where the laws or policies explicitly and deliberately restrict services. Indirect barriers occur if, although laws and policies may not explicitly restrict access to SRH services for adolescents, they function as barriers because of the context in which they operate. For example, social norms about adolescent sexuality can create a stigmatising environment in which health providers behave in ways inconsistent with the law and policies. Silences in laws and policies also create barriers by refusing or omitting to address issues of adolescent SRH. As a result, the basis for providing abortion and post-abortion contraceptive care, especially to adolescents, is neither “universal” nor is it considered “essential health care”. There is substantial opportunity for concerted efforts to promote UHC in adolescent SRH. Adolescents

seeking SRH care are rejected or treated with disrespect and their needs considered inconsequential, making them frequent victims of coercion, extortion or poor quality care. To illustrate the ways in which macro-level factors, such as national laws, regulations and policies, impact adolescent access to universal SRH, we draw on analysis of our in-depth interviews with adolescents. We focus our analyses on barriers in order to illustrate the ways in which laws, policies and/or S&G do not necessarily lead to straightforward access to high-quality abortion-related care for adolescents. Our analyses identified four major themes: parental consent; unauthorised fees; post-abortion contraceptive coercion; and service denial. We use this evidence to situate the micro-level individual SRH care experiences of adolescents within the macro-level legal context in which they live.⁴⁴ In the evidence we present here, we focus on adolescents’ experiences of barriers; not all adolescents that we spoke to experienced such barriers. Our purpose in presenting this evidence is to draw attention to how universality of healthcare has not – yet – been achieved.

Parental consent

In Malawi, requirements for consent function as indirect barriers where adolescents – including those above the age of majority – who tried to seek care alone were often told to consult their parents in order to access lifesaving care for abortion-related complications.

“I just started off from home and came here alone. And when the doctor was about to start treating me, they asked if they should call my mother so that she should be there while they are treating me. And I told them not to because she is at work.” (18 years, Malawi)

Interviewer: *Did they refuse to treat you without her [mother] signing?*

Respondent: Yes.
(19 years, Zambia)

Even in Ethiopia, where abortion law and policies support young women’s autonomous choice of legal abortion at no charge, private health facilities may not adhere to national guidelines, causing fear and delays to appropriate care:

“... I kept it a secret. But after I went to [private clinic], when they asked me for consent, I told her what happened ... They told me the price for the service is 700 birr. I was not worried about the money I

³⁵Ethiopia – Reproductive Health Task Force. Zambia – Safe Abortion Action Group.

would pay. Even though they told me to return back on Monday, I didn't go back because I was not able to get the consent they requested me to bring." (19 years, Ethiopia)

Parental consent or consultation was also required, in some cases, for the provision of post-abortion contraception:

Interviewer: *Have you been offered family planning methods today?*

Respondent: *No, they just explained to me, but they didn't give me any.*

Interviewer: *But you wish you could start?*

Respondent: *It is possible, but they said they should explain to my mother first.*

(XX years, Ethiopia)

Unauthorised fees

In Zambia, many adolescents or their relatives were asked for unauthorised fees:

"Then I heard that there is a doctor near my place, and I went to see him to inquire, ... I asked him if he could find me some medicine to remove a pregnancy ... that is what he told me to come to the [public] clinic because he does not remove from home; I had to come to the clinic, so I went to look for money." (19 years, Zambia)

Similarly in Ethiopia, introducing delays to care:

"When the provider told me to buy from outside of this hospital, I told him that I haven't money at that time. And I went to my home." (18 years, Ethiopia)

Unofficial fees were also requested for PAC in Malawi:

"... the person said if you have k2000, you can be helped fast but I did not have money." (18 years, Malawi)

Coercive post-abortion contraception

Many adolescents were not offered post-abortion contraception. Of those who were, some felt that accepting contraception after abortion care was an obligation, not a choice. Almost all who left with a method seemed confused about what they had received and what they would need to do next to continue protecting themselves from another pregnancy. In Ethiopia, where laws and policies have reduced barriers to all types of SRH care for adolescents, young women felt they had

to accept a postabortion method, even when they did not want one or did not clearly understand their options:

Interviewer: *Were you offered a family planning method today?*

Respondent: *Yes.*

Interviewer: *Which type of method?*

Respondent: *They told me it works for three years.*

Interviewer: *Did they tell you about another option?*

Respondent: *No, they did not tell me.*

Interviewer: *Was it your choice?*

Respondent: *No, it was not my choice. I thought that they would not provide me the service, or the pregnancy would not terminate if I did not use family planning, then I accepted it.*

Interviewer: *Are you happy with this service?*

Respondent: *No.*

(18 years, Ethiopia)

Another Ethiopian adolescent, crying as she spoke to her interviewer, described her interactions about contraception with her provider:

"I don't want it. A nurse told me that I have to use contraception for the first time when I registered at [study site] and told me for the second time when I was in the ward. But I said to her that I don't want it. She couldn't understand me, she considered me as a rude girl and treated me badly." (18 years, Ethiopia)

Whilst such explicit or implicit coercion was not reported in Malawi or Zambia, some adolescents reported little choice in their post-abortion contraception: *"They just told me that I need to be getting an injection"* (Malawi) and *"they said that I should start on the 5-year injection"* (Zambia).

Denial of abortion-related care

Adolescents' lack of experience in the health sector was obvious and commonplace, resulting in delays to appropriate care; fear of negative sanctions surrounding services makes reliable information difficult to obtain:

"The doctor in the delivery ward was not there on the day I went to the health centre. The nurses told me to first consult him about the condition before getting medical card. On the next day, I met with the doctor and he told me the medication for the abortion service was not available on that day, I begged him. Then he told me about one private hospital giving this service. But I forgot the name of the hospital he told me. I was very

emotional that day. So, I went back to the first health centre and got a new medical card for the second time. Again, in this health centre the medication was not available too. I was very terrified. I didn't have enough money to go to a private hospital.” (19 years, Ethiopia)

Another Ethiopian adolescent was turned away when she sought a legal abortion.

“It has been six days since I first find out about the pregnancy. I asked the health professionals in that health centre to terminate the pregnancy. But the nurse there said that I should have protected myself than going there to get an abortion service. I just kept quiet and got out of there.” (18 years, Ethiopia)

In Zambia, adolescents reported being denied abortion care, possibly reflecting healthcare workers' right to practice conscientious objection (although the standards and guidelines require that the individual is referred to someone who will provide the service):

“The doctor refused saying that he cannot give me the medicine, saying that he cannot give me because what I want to do is wrong, that I should just keep my pregnancy ... then he said he cannot give me the medicine because it is more like he is encouraging me to go ahead with what I want to do.” (XX years, Zambia)

Adolescents' responses showed awareness that the care they were able to access was not always delivered empathetically. The message received by some young women was that they should be ashamed of abortion-related care-seeking:

“But when they were training, being trained to be nurses, were they told they would handle a certain age group? So, I think that is really negative ... a girl is a girl. Whether 14, whether 10 ... So that is what really hurt me listening to the comments ... I told my aunt I don't want to receive the medication, better I go die from home and then you come and bring me here, as a dead body.” (18 years, Zambia)

The interviews revealed that while laws and policies fail to ensure universality of SRH care, they are sometimes manipulated by health providers to deny services to adolescents. In spite of it being their right, adolescents themselves have limited power to enforce their right to care and hold healthcare providers accountable.

Discussion

We set out to consider the implications and possibilities for achieving UHC, using a comparative case study of adolescents and SRH. By considering the policies, laws and (where available) guidelines that frame adolescent SRH, we can better understand which services – in theory – are made available, to whom, and under which circumstances. We can also identify where there is greater clarity or ambiguity in interpretation. By combining our macro-level textual analyses with individual-level evidence from adolescents, we can observe the ways in which seemingly distant laws, regulations and policies are interpreted by healthcare workers, and can limit adolescent access to services.

UHC has the aim of all people accessing the health services they need, when and where they need them, without financial hardship. To achieve this entails not only service availability but that people seeking and providing those services know and understand the implications of these framing laws and policies. This is important for adolescents because societal norms and values often conflict with the principles of autonomy and evolving capacity included in international and national instruments. Our novel inclusion of age of consent laws and policies demonstrates how criminalising adolescent sexual conduct and the vagueness of laws regarding consent of minors to medical treatment have a restrictive effect on abortion-related care and contraception, whether purposeful or not. Laws and policies incorporating negative norms about adolescent sexuality and agency are inconsistent about minors' consent to SRH services and are poorly understood by healthcare workers and the general population, allowing inequitable practices to flourish.⁴⁵ Our evidence shows that adolescent abortion care-seeking attempts were multiple, confused, and could be met by duplicitous actors. Ambiguity in laws and guidelines makes it easier to obfuscate, deny care or add informal payments. Based on adolescents' reports of their experiences, we show that adolescents' access to SRH information and services is often highly dependent upon the extent to which individual healthcare workers (oftentimes along a complex and disrupted chain of referrals) make decisions about whether to provide or withhold care, making access far from “universal”.

Whilst they are rarely – if ever – considered, age of consent laws are of critical relevance for the attainment of UHC because they have been used

to justify limitation to access to SRH services for adolescents. Age of consent to sex is not always expressly stated in law. Rather, what is described, and usually in criminal law, is the age below which certain sexual acts are prohibited.⁴⁶ Age of consent laws also reflect restrictive social and cultural norms regarding adolescent sexuality.⁴⁷ Where age of consent to care has not been expressly articulated in legislation or is ambiguous, health providers, themselves products of a rapidly changing socio-cultural environment, often assume discretion on who can access services with or without consent, and their actions likely reflect social norms about adolescent sexuality.⁴⁷

Our comparative analyses show how laws and policies shape and frame adolescents' experiences of abortion-related care-seeking, including in terms of what is or is not legally available, and also how some healthcare workers provide disrespectful or coercive care or withhold care. In Ethiopia, the widespread dissemination of S&G leaves much less room for denial of care, but it still happens. Awareness of abortion as an option is widely known to young women, even though navigating the health system remains complex. In Zambia, a confusing abortion law and more limited dissemination of S&G means that healthcare workers either do not know, or are able to obfuscate, how laws and policies pertain to adolescent SRH.

Analysis of policies and laws illustrates tensions within and between international commitments and state-level instruments. Malawi's ratification of the Maputo Protocol is at odds with Malawi's current legal framework for SA; if there is dissonance at the state level, then how are individual healthcare providers able to know which services to provide to whom and on what grounds?

Of the three countries we analysed, only Ethiopia currently appears to consider SA care, regardless of age, as an integral component of UHC. Ethiopia's commitment to SA access for young women, regardless of their age, aligns most closely with the obligations and intentions of regional commitments. Even in Ethiopia, however, UHC for SRH information and services for adolescents is not yet fully realised and adolescents continue to experience: coercive provision of post-abortion contraception; unnecessary demands for parental consent; and requests for illegal fees. Even as progress has been made to make laws and policies more supportive for adolescents in Ethiopia, silence around what this means in practice has impeded important gains.

In Zambia, despite longstanding legal provision for SA on a wide range of grounds, the limited services combined with low levels of knowledge of ambiguous laws and policies mean that the combined rights and technical agendas of UHC have not yet been realised; less than a third of adolescents we interviewed had received safe legal abortion care. The legal and policy provision for abortion is "ambiguous and leaves much room for interpretation",³⁴ manifesting in extortion of unofficial fees by public sector health workers.⁴⁸ In Malawi, reflecting the most restrictive legal environment for abortion in our case studies, little legal progress appears to have been made towards UHC for adolescent SRH. Nearly all Malawian adolescents we interviewed were seeking PAC for abortions procured elsewhere.

Laws and policies only partly determine access to SRH;⁴⁹ they are one component of a complex set of inter-related factors that influence individual adolescent SRH outcomes. However, they can provide opportunities, however infrequent, to further agendas that promote equity in a dynamic and changing socio-cultural and legal environment. Service providers may possess low levels of knowledge⁵⁰ or inaccurate legal knowledge that can prevent otherwise willing practitioners from providing services,⁵¹ while other practitioners may provide services clandestinely despite legal restrictions⁵² and arbiters of law may lack clarity about what is (il)legal.⁵³ By examining in detail how laws and policies (do not) make provision for adolescents we can identify the opportunities and challenges for progress to universal access to SRH as part of UHC.

Our approach has limitations. Our interviews with adolescents are all based in urban areas, and focus on adolescents that sought care from a facility; experiences of rural and/or self-managed care and / or adolescents that were unable to access facility-based care are excluded. We did not interview healthcare workers about their knowledge of laws, policies and regulations, or about their reported practices and behaviours with respect to the provision of ASRH services. Our analyses of adolescents' care-seeking experiences were based on their own perceptions and focused on service quality and barriers to abortion-related care that are framed by laws, policies and guidelines as well as community norms and individual beliefs; some of the adolescents that we interviewed had positive abortion care-seeking experiences, including empathetic and respectful healthcare workers that took account of

adolescents' autonomy and decision-making. By focusing on the barriers experienced by adolescents, we draw attention to the ways in which universality is not – yet – being achieved.

Conclusion

Unclear or ambiguous legal and policy positions constitute additional barriers to access to services for adolescents. SRH laws, policies and services shift in response to religious, societal and political change. Facing extraordinary barriers to seek SRH care, it is important that international, regional and national commitments clearly tackle these barriers and decisively promote a model of greater reproductive autonomy for adolescents. UHC provides another opportunity to gather evidence related to adolescent care-seeking and to refine and simplify the way adolescents learn about and obtain care. For UHC to achieve both its technical and human rights agendas, it is insufficient to focus only on the provision of services. The equity

and justice implications of how policies and laws are framed, operationalised and understood are equally critical. The UHC movement provides an opportunity to address existing inequities and ambiguities to reach the most under-served groups, including adolescents. With such a large mandate, however, it is important that the opportunities to improve comprehensive SRH are examined carefully and not squandered.

Funding

This work was supported by MRC/DFID [grant number MR/P011454/1].

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Résumé

La couverture santé universelle (CSU) oblige les gouvernements à se demander non seulement comment les services seront assurés, mais aussi quels services seront proposés, à qui, quand, où et à quel coût. Cet article s'intéresse aux conséquences de la réalisation de la CSU dans la perspective des soins relatifs à l'avortement pour les adolescentes. Notre étude comparative inclut trois pays sélectionnés précisément pour représenter divers niveaux de restriction de l'accès à l'avortement: l'Éthiopie (l'avortement y est légal et les services sont mis en œuvre); la Zambie (avortement légal, services complexes avec de nombreux obstacles à la pratique de l'avortement et la fourniture d'informations); le Malawi (accès extrêmement restreint du point de vue juridique). Nos analyses politiques et juridiques sont complétées par des anecdotes comparatives obtenues au cours d'entretiens ($n = 330$) réalisés en 2018/2019 avec des adolescentes âgées de 10 à 19 ans qui avaient demandé des soins liés à l'avortement dans chaque pays. Nous nous concentrons sur un cadre juridique insuffisamment pris en compte mais pourtant essentiel pour les adolescentes: l'âge du consentement. Nous comparons les engagements juridiques et politiques en faveur des progrès de la santé et des droits sexuels et reproductifs des adolescentes, notamment les soins liés à l'avortement. L'Éthiopie paraît s'approcher de la CSU pour les soins sûrs liés à l'avortement, et les dispositions juridiques pour les filles de moins de 18 ans semblent essentielles. Au Malawi, l'environnement juridique le plus restrictif pour l'avortement, peu de progrès semblent avoir

Resumen

La cobertura universal de salud (CUS) obliga a los gobiernos a considerar no solo cómo proporcionar los servicios, sino qué servicios y a quién, cuándo, dónde, cómo y a qué precio. Este artículo considera las implicaciones para lograr CUS desde la perspectiva de los servicios relacionados con el aborto para adolescentes. Nuestro diseño de estudio comparativo abarca tres países seleccionados intencionalmente para representar diversos niveles de restricción al acceso a los servicios de aborto: Etiopía (donde el aborto es legal y los servicios son implementados); Zambia (donde hay servicios legales complejos con numerosas barreras a su implementación y al suministro de información); Malawi (donde el aborto es muy restringido por la legislación). Nuestra política y análisis jurídicos son suplementados por viñetas comparativas basadas en entrevistas ($n = 330$) realizadas en 2018/19 con adolescentes de 10 a 19 años que buscaron servicios de aborto en cada país. Nos enfocamos en un marco jurídico poco considerado pero esencial para las adolescentes: la edad para dar consentimiento. Comparamos los compromisos jurídicos y políticos con promover la salud y los derechos sexuales y reproductivos de las adolescentes, que incluyen los servicios relacionados con el aborto. Etiopía parece acercarse a la CUS para los servicios de aborto seguro, y la prestación de servicios legales para adolescentes menores de 18 años parece ser fundamental. En Malawi, el entorno jurídico más restrictivo con relación al aborto, se ha logrado poco progreso hacia la CUS para adolescentes. En Zambia, a pesar de que desde hace muchos años se proporcionan servicios de aborto

été accomplis vers la CSU pour les adolescentes. En Zambie, malgré des dispositions juridiques autorisant de longue date l'avortement sans risque pour plusieurs motifs, les services limités, s'ajoutant à de faibles niveaux de connaissance de la loi, font que les droits et les programmes techniques de la CSU n'ont pas encore été mis en œuvre. Nos analyses comparatives montrent que la manière dont les politiques et les lois sont encadrées a des conséquences capitales sur l'équité et la justice.

seguro y legal por una gran variedad de causales, los servicios limitados combinados con bajos niveles de conocimiento de la ley significan que aún no se han realizado los derechos combinados y las agendas técnicas de CUS. Nuestros análisis comparativos que muestran cómo se formulan las políticas y leyes tienen importantes implicaciones para la equidad y justicia.