Assessment of policies, laws, and regulations affecting the contraceptive needs of adolescents in the Democratic Republic of the Congo

Dieudonné Mpunga[1,*], Eric Mafuta[1], Fidèle Mbadu[2], Alain Mboko[3], Guy-Octave Lutumba[4], Faustin Chenge[5], Mala Ali Mapatano[1], Gilbert Wembodinga[1]

1. School of Public Health of Kinshasa, University of Kinshasa
   P.O.11850, Kinshasa 1, Democratic Republic of the Congo
2. National Program for Adolescent Health, Ministry of Public Health, Democratic Republic of Congo
3. Direction of Studies and Planning, Ministry of Public Health, Democratic Republic of Congo
4. Faculty of Law, University of Kinshasa, Kinshasa, Democratic Republic of the Congo
5. School of Public Health of Lubumbashi, University of Lubumbashi

* Correspondence to: mpungadieudonn@yahoo.fr

Kinshasa School of Public Health, University of Kinshasa, P.O. Box: 11850,

Kinshasa I, Kinshasa, Democratic Republic of the Congo

Abstract

Background

Poor regulation is a barrier to adolescents accessing family planning (FP) services. The aim of this study was to assess policies, laws, and regulations according to the contraceptive needs of adolescents in the Democratic Republic of the Congo (DRC).

Methods

A mixed method study was conducted in 2018 in 74 structures, including 13 administrative structures identified by convenience sampling and 61 randomly selected health facilities (HFs) offering FP. Data were collected through semi-structured interviews of the structures' managers and document reviews. The main variables were: types of regulatory documents; their availability at delivery points; content; actors; context and the policy formulation process. A health policy analysis framework was used to evaluate the policy formulation process. The content of FP policy documents were analyzed on the basis of WHO recommendations on the sexual and reproductive health rights of adolescents. Thus, the level of integration of these recommendations in national policy documents was determined.

Results

In total 35 policy documents were reviewed, of which 9 (26%) implementing documents; 7 (20%) standards and directives; 7 (20%) laws; 4 (11%) guidelines; 3 (9 %) regulatory acts and 2 (6%) policy documents. Only 7 (20%) of these documents were translated into operational instructions and were available in HFs. The law laying down the fundamental principles relating to the

organization of public health was the main law for the FP. One in 9 recommendations and 5 in 24 WHO sub-recommendations emphasizing on the right of accessing to FP information and services by adolescents were fully integrated into policy documents. The process of formulating FP policies seems to be long and complex, driven mainly by the central services of the health sector, without sufficient involvement of important stakeholders such as adolescents, provincial and peripheral providers. Around 25% of HFs had at least one guideline on adolescent sexual health and in 13% of HFs providers were trained in FP for adolescents.

Conclusions

Regulation of FP services remains problematic in the DRC. The WHO's recommendations on adolescent sexual and reproductive health rights are not yet sufficiently integrated into policy documents. Adolescents do not have a legal basis guaranteeing secure access to and unrestricted use of contraceptive services. The MOH should put in place evidence-based regulations to improve access to contraceptive services by adolescents.

Keywords: policies, family planning, adolescents

Plain English summary

Poor regulation can prevent adolescents from accessing contraceptive services. We aimed to assess current policies, laws, and regulations according to the contraceptive needs of adolescents in the Democratic Republic of the Congo (DRC). A study was conducted in 2018 in 74 structures involved in family planning (FP), including 13 administrative structures and 61 health facilities. Semi-structured interviews with managers and document reviews were performed, focusing on: types of regulatory documents; their availability at delivery points; content; actors and context of the policy formulation process. The process leading to the finalization of regulatory documents and the content of these documents were analyzed based on an analytical framework and on WHO recommendations on the sexual and reproductive health rights of adolescents respectively. In total 35 policy documents were reviewed of which 7 (20%) were translated into operational instructions and were available in HFs. The main law on FP was the law laying down the fundamental principles relating to the organization of public health. One in 9 recommendations and 5 in 24 WHO sub-recommendations emphasizing on the right of accessing to FP information and services by adolescents were fully integrated into policy documents. The process of formulating FP policies is driven by the MOH, without sufficient involvement of adolescents and provincial and peripheral providers. Around 25% of HFs had at least one guideline on adolescent sexual health and in 13% of HFs providers were trained in FP for adolescents. Regulation of contraceptive services remains problematic in the DRC. FP policy documents are not adapted to the WHO recommendations on adolescent sexual and reproductive health rights. Thus, adolescents are not legally secure to use FP services. The MOH needs to put in

place evidence-based regulations to improve access of adolescents to contraceptive services.

Background

Adolescence is a life phase between the ages of 10 and 19 years characterized by physical, biological, and psychological changes and new sexual behavior [1]. At this time, some risk behaviors and specific needs appear [2], including sexual and reproductive health (SRH) needs [3]. The provision of family planning (FP) services, one of the nine components of reproductive health, is an important option for reducing the incidence of teenage pregnancies and induced abortions that are common among adolescents [4, 5]. A number of adolescents around the world experience unmet FP needs [6]. The demand and provision of FP services for adolescents is influenced by contextual, situational, structural, cultural, and environmental factors [7]. Interventions that combine demand-creating activities and the provision of user-friendly services can potentially increase contraceptive use among adolescents [8, 9], especially if policy options are lifted. Health policy is the ability of a group to agree on the priority and objectives to be addressed and the direction to be taken to achieve those goals [10]. A reflective and participative attitude is recommended in the formulation of health policy, as well as involvement of the marginalized and targeted population [11]. Health policy analysis requires a participatory and rational process in order to discuss ways to achieve and evaluate the strategic objectives [7]. Political options in health can be translated into laws, guidelines, decrees, ministerial orders, actions, and regulations. They can be incorporated into government plans, programs, projects, or budgets [12].

In the DRC, the unmet need for FP among adolescents remains high [13]. In order to reduce the high incidence of unwanted pregnancies and induced abortions [4], the government has made a political commitment to expand the country's coverage of FP services [14]. Political leaders recognize the role of FP in improving

community health and economic development [15]. The FP policy is supported by numerous documents, including the national reproductive health policy [16], the law on basic principles for the organization of public health [17], the national health development plan [18], and the national multisectoral FP plan [19]. The political commitment to FP has materialized increasing initiatives, such as the expansion of FP services and methods [15, 20], the improvement of modern contraceptive prevalence, and decreasing the unmet need for contraception [13, 21] and the development of the first national strategic plan for FP [15]. However, the latest available data indicate that access to and use of contraceptive services by adolescent remains low and is consolidating. In 2009, there were only 20 health districts (3.9%) in which adolescent health activities were organized; currently, 180 health districts (34.8%) provide adolescents with health services adapted to their needs [22]. Outside barriers are a lack of knowledge [23, 24], misinformation (rumors) and myths about contraception [25], provider bias against adolescent demand for services [26, 27], and the persistence of financial barriers [28]. A recent study showed that a significant number of health services are not friendly towards adolescents [29].

The organization of FP services for adolescents involves more than one health program [22, 30]. The fragmentation of adolescent health programs can be a determinant of poor progress in adolescent health [31]. Access to and use of contraceptive services by adolescents may be ensured by laws and regulations addressing practical issues. In some high income countries, access to emergency contraception by adolescents is guaranteed through legal documents guaranteeing prescription in secret, free of charge, through school nursing, and eliminating the requirement for a medical prescription [32]. Derogation of the principle of parental

authority has been approved, which allows adolescents to seek treatment without parental consent [33].

To enable countries in the formulation and evaluation of FP policies, the World Health Organization (WHO) has developed recommendations to ensure that human rights are respected in the provision of contraceptive information and services [34] and that guidelines are developed for the prevention of early pregnancy and reproductive disorders in adolescents in developing countries [35]. Laws, policies, and guidelines can help improve the use of FP by adolescents if the formulation process is participatory, under the responsibility of health programs [36, 37] and if policies are popularized. In the DRC, few studies have evaluated the regulation and standardization of FP services; no systematic analysis has been carried out on the process and the content of policies, laws and other regulatory documents regarding the FP needs of adolescents. The purpose of this study was to assess policies, laws, and regulations according to the contraceptive needs of adolescents in the DRC.

Context of the study

In the DRC, adolescent FP needs and services are managed by four central departments of the Ministry of Health (MOH), each of which focuses on a specific aspect. The Department of Family and Special Groups' Health (DSFGS) coordinates the finalization of sexual and reproductive services and FP standards and guidelines that involve other public services and partners; the National Reproductive Health Program (PNSR) prepares the strategic and technical documents needed to organize the provision of FP and stimulate the demand for services [30]; the National Adolescent Health Program (PNSA) develops guidelines, standards, and strategies for the promotion and development of adolescent health [22]; and the National School Health Program (PNSS) prepares

strategic and technical documents that organize school medicine and adolescent health education. (Figure 1).

The DSFGS, PNSR, PNSA, and PNSS provide technical support to the Provincial Division of Health (DPS) and provincial coordination of PNSR, PNSA, and PNSS. FP activities are coordinated within the overall health sector coordination framework. At the national level, FP partners are coordinated by the Reproductive, Maternal, Newborn, Child, and Adolescent Health Task Force and the Permanent Multi-sectoral Technical Committee for FP (CTMP/PF). These structures technically validate experiences, normative and technical documents on FP prior to their adoption by the health sector technical coordination committee (CCT-SS). In the provinces, the technical working group (GTT) and the provincial health sector steering committee (CPP-SS) are in charge of contextualizing and validating the operational instructions based on the normative and regulatory documents validated by national organizations. At the local health system level, supervision and monitoring meetings make it possible to coordinate FP activities. However, the finalization of laws and edicts involves administrations at the central or provincial level, government, and Parliament. (Figure 2).

Methods

Study design

A mixed method study was conducted from April to July 2018 in 74 facilities including 13 administrative structures at the central, provincial, and peripheral levels of the MOH identified by convenience sampling, and 61 health facilities (HFs) offering FP selected by simple random sampling.

Selection of surveyed structures

All visited structures were involved in the organization of FP activities. These structures were from the central administration of the MOH, such as the PNSR, PNSA, PNSS, and DSFGS, and provincial services, such as the DPS of Kongo Central and Kinshasa, and the corresponding provincial coordination of the PNSR selected for proximity. At the local level, the coordinating team of four health districts (Matete, Lemba, Kisenso, and Gombe Matadi) and 61 HFs, including 11 hospitals and 50 health centers, were identified in a simple random manner.

Techniques and procedures for data collection

The data were collected through ten semi-structured interviews with the managers of the visited organizations and by document review. Semi-structured interviews helped to collect data on the availability and use of regulatory documents within HFs. They also helped to understand the context and the process that leads to the finalization of laws and policies in the DRC. Among those interviewed were public health and general practitioners, nurses, midwives and managers of HFs. Table 1

Table 1. Socio-demographic characteristics of participants in semi-structured interviews

N°	Functions	Education	Seniority (Nb. years)	Location
1	Expert	Public health practitioner	10	National MOH
2	Expert	Public health practitioner	2	National MOH
3	Expert	General practitioner	7	National MOH
4	Manager	Public health practitioner	6	Provincial Health Division (DPS)
5	Manager	Public health practitioner	8	Provincial Health Division (DPS)

6	Manager	General practitioner	2	Health District
7	supervisor	Nurse	8	Health District
8	Manager	General practitioner	4	Hospital
9	Manager	Midwife	11	Health Centre
10	Manager	Nurse	5	Health Centre

The regulatory and normative documents on FP were reviewed using the archives of the structures and websites of the Official Journal of the DRC (www.leganet.cd), of the MOH (www.minisanterdc.cd) and the Permanent Multi-sectoral Technical Committee/PF (www.planificationfamiliale-rdc.net). The variables of interest were the types of regulatory documents, their availability at delivery points, their content, the stakeholders involved, the context and process of policy formulation. Documents reviewed included legislation, decrees, ministerial orders, strategic plans, standards and guidelines, circulars, operational instructions, fact sheets, and other FP documents deemed important.

Framework for analyzing health policy documents

Several frameworks exist for health policy analysis. However, they differ from each other depending on the content under review; some focus on the health policy formulation process (stakeholder analysis); others focus on the content of the policy or only on the results [7]. To carry out this study, we used the health policy analysis framework developed by Walt and Gilson [38], which takes into account four critical elements: the actors, the contextual factors, the process and the content of the policy. (Figure 3).

In order to assess the process of formulating FP laws and policies, we made a choice to analyze a recent process that led to the adoption of the Law laying down the fundamental principles relating to the organization of public health in the DRC.

Then, qualitative data were collected to evaluate the first, second and third dimension of the policy analysis framework. To analyze the content of regulatory documents, we relied on a grid prepared on the basis of WHO recommendations for guaranteeing respect for human rights in the provision of FP information and services [34]. This document consists of nine recommendations and 24 sub-recommendations on FP that can be applied when policymakers want to take into account the needs of FP for both adults and adolescents. Thus, each policy document was examined in relation to each recommendation. We also took into account the fact that policy documents' content targeted the FP needs for teenagers or adults. The analysis of the integration of WHO recommendations into policy documents resulted in five categories of responses addressing the conformity of the content in relation to these recommendations. The selected categories were: A) *Normative guidelines specific to adolescents* are present and in line with the sub-recommendations of the WHO; B) *Normative guidelines for the general population, but relevant for adolescents*, are present and in line with WHO sub-recommendations; C) *Normative guidance* on WHO sub-recommendations is not present; D) *Normative guidelines specific to adolescents* are present but do not agree with WHO sub-recommendations; E) *Normative guidelines for the general population, but relevant for adolescents*, are present but do not agree with WHO sub-recommendations.

Quality control and data analysis

The data collection was performed by a team of trained investigators. A form prepared following the WHO recommendations helped to extract information contained in policy documents. First, an exhaustive inventory of existing FP documents was carried out. In the second step, each document was read, in order

to identify the recommendation (s) and sub-recommendation (s) to which it was addressed and to ensure its compliance with the directives from the WHO. This procedure made it possible to identify the recommendations and sub-recommendations which were (or were not) incorporated into policy documents. The analysis consisted of calculating proportions, such as the proportion of recommendations and sub-recommendations incorporated into policy documents, the proportion of regulatory documents in the form of operational instruction available at the HFs level, and the availability within HFs of operational instructions whose content was in accordance with WHO guidelines. We also calculated the proportion of HFs having the staff trained in SRH and FP.

Using Atlas Ti software, a deductive thematic analysis was carried out on qualitative data. On the basis of the health policy analysis framework proposed by Walt and Gilson, we selected three analysis themes: analysis of main actors involved in the FP; the context analysis, with focus on the FP needs of adolescents; and the policy formulation process. From these themes, we identified open and axial codes. The analytical process involved splitting the data, followed by their analysis for similarities and differences by comparing all semi-structured interviews; similar concepts were labeled with the same name. Each concept was then defined in terms of a set of discrete properties and dimensions to add clarity and understanding of the health policy environment. At the end of the analysis process, important citations that fit in with the purpose of the study were used for illustration purposes.

The research protocol was reviewed and approved by the Ethics Committee of the School of Public Health of Kinshasa (ESPK) under approval number

ESP/CE/027/2018. Before collecting the data, we obtained authorization from national, provincial, and local health authorities.

Results

We collected data across all of the initially identified administrative structures and HFs.

Family planning context and stakeholders' analysis

According to the majority of interviewees, the DRC is characterized by a pronatalist culture pushing adolescents and adult women to progress in the future as wives and mothers. Contraceptive services are mainly used for spacing births rather than stopping births. Most recently, a political commitment to FP was noted on the part of political and health authorities. Since the promulgation of the 2006 Constitution, the health sector has benefited from the enactment of two new laws (of which one focused on FP) out of the ten submitted to the parliament. The health system is undergoing structural reform focused on the decentralization, granting operational decision-making powers to decentralized entities (provincial and health district authorities). Several public and private actors were involved in the formulation of the law laying down the fundamental principles relating to the organization of public health. Some of these actors, such as the faith-based health providers; certain civil society organizations and community leaders, were naturally opposed to the formalization of FP actions in favor of adolescents. Others actors worked for universal access to contraceptive services and methods for both adolescents and adults. Of these stakeholders were found public FP providers, the partners involved in FP and human rights organizations). The MOH partners involved in the FP made the plea and the lobbying so that the aforementioned law

takes into account some important elements for the FP management. However, apart some central structures from de MOH, provincial and local health officials, and local FP providers were less involved in this policy formulation process.

Apart from this law, there are no clear operational instructions/actions addressing specific aspects of the FP, such as the demand and uptake of FP; the financial accessibility of contraceptives; or the use of certain contraceptives among adolescents. An official said this: *"we are facing some false rumors about the side effects of contraceptives in adolescents and this is pushing to improve awareness and education. However, if we do nothing to make FP services affordable, their use cannot improve and the law will not achieved its objectives".* **(CB, 10 years of experience)**

Process leading to the finalization of family planning policy and laws

According to the interviewees, a complex and relatively long process, with certain "atypical" stages, led to the adoption of the first law (in 2018) which deals with the fundamental principles of organizing public health in the DRC. The problem statement concerning the FP needs was clearly identified for this law, especially by clarifying and framing its issue in terms of the effect on adolescent and adult's health. Among different policy options to address the problem of unwanted pregnancies and unsafe abortion in these groups, and based on available data, policymakers opted for the extension of FP to all women aged 15-49. The stakeholders of this law were identified from public to private organizations above mentioned. However, some stakeholders, such as provincial and health district officials, as well as adolescents, who are directly affected by this policy, were not sufficiently involved.

The majority of those interviewed estimated that the strategy for the policy development was not well refined; other stakeholders, such as the members of government and parliamentarians were not involved in the early stages of lawmaking. The result was that it took more than 12 years before the law was passed in parliament. Even, since its enactment in 2018, this law has not yet been applied, as no implementing measure out of the 17 identified, has yet been finalized. As a result, the impact of this law on improving the use of FP services among adolescents aged 15-19 is still marginal. An interviewee said: *"the process conducting to the adoption of new laws is long and complex. Over the years we have been preparing more than one public health bill. However, they have never been discussed in parliament. Therefore, the health sector remained for years without laws. It was in 2018 that officials of the MOH, in collaboration with sectoral partners, resumed pleading with national deputies until the promulgation of the first health sector law''.* **(AD, general practitioner, 7 years of experience)**

To date, there is no effective mechanism for the continuous collection of information on the use of operational instructions which can help to update policies.

Several documents regulate the SRH in general; however, few documents target the organization of FP services in the DRC. These documents are laws, regulatory acts (e.g., decrees and ministerial orders), policies, standards, and guidelines. Most of the normative documents currently in use were developed by 2012; in their majority, they are intended for national and provincial health officials involved in the FP. Some documents deal with the general aspects of the organization of FP services. However, few documents targeted FP providers at the delivery points and were unsuitable. Of all 35 reviewed documents, 9 (26%) were

implementing documents; 7 (20%) standards and directives; 7 (20%) laws; 4 (11%) guidelines; 3 (9 %) regulatory acts and 2 (6%) policy documents. Only 7 (20%) of these documents were translated into operational instructions and available in health facilities. (Table 2).

Table 2. List of laws and other regulatory documents on family planning in the DRC

No.	*Category of document*	*Type of document*	*Publication date*	*Sources*	*Recipients*	*Availability of operational instruction in HFs*
1.	**Laws on adolescents and family planning**					
1.1	Constitution of the DRC 2006 (Articles 13 & 14)	Law	February 2006	President of the DRC	Three levels of the MOH	No
1.2	Congolese Penal Code, Decree of January 30, 1940, as amended and completed to date; Updated November 30, 2004	Ordinance-law	November 2004	President of the DRC	Three levels of the MOH	No
1.3	Ordinance no. 73/089 instituting the National Council for the Promotion of the principle of Desirable Births (CNPND)	Order	February 14, 1973	President of the DRC	Secretary General for Health	Yes
1.4	Law No. 18/035 of December 13, 2018, laying down the fundamental principles relating to the organization of public health	Law	December 2018	Parliament	Three levels of the MOH	No
1.5	Law No. 15/013 of August 1, 2015, on the implementation of the rights of women and parity	Law	August 2015	Parliament	Three levels of the MOH	No
1.6	Law No. 09/001 of January 10, 2009, on the protection of the child	Law	January 2009	Parliament	Three levels of the MOH	No
1.7	Law No. 16/008 of July 15, 2016, amending and supplementing Law No. 87-010 of August 1, 1987, relating to the Family Code	Law	August 1987	Parliament	Three levels of the MOH	No
1.8	The laws on sexual violence (Law no. 06/018 of July 20, 2006, modifying and completing the decree of January 30, 1940, bearing the Congolese Penal Code Law No. 06/019 of July 20, 2006, modifying and completing the decree of August 6, 1959, relating to the code of the Congolese penal procedure	Law	July 2006	Parliament	Three levels of the MOH	No
1.9	Case Book: Reproductive Health Law	Advocacy	June 2015	CTMP	Parliament	
1.10	Ministerial Order No. 015 / ME / MIN.FP / 2017 provisionally approving the framework and organizational structures of the General Secretariat for Health	Ministerial order	2015	Ministry of Public Service	Central and Provincial MOH services	Yes

2.	**National Health Policy documents**					
2.1	National Reproductive Health Policy	Policy	July 2008	Secretary General for Health	Central and Provincial MOH services	No
2.2	National Policy on Adolescent and Youth Health	Policy	November 2007	Secretary General for Health	Central and Provincial MOH services	No
2.3	7 billion shares	Advocacy	July 2011	UNFPA-RDC	Three levels of the MOH	
2.4	Ministerial Order No. 1250 / CAB / MIN / S / AJ / KIZ / 009/2001 establishing the National Program for Reproductive Health	Ministerial order	December 2001	Health Minister	Secretary General for Health	Yes
3.	**Strategic documents**					
3.1	Second Generation Growth and Poverty Reduction Strategy Document (DSCRP2)	Implementing document	May 2011	Central Government	Three levels of the MOH	No
3.2	2nd Generation Health System Strengthening Strategy	Implementing document	March 2011	Central Government	Three levels of the MOH	yes
3.3	National Health Development Plan 2019-2022	Implementing document	March 2016	Central Government	Three levels of the MOH	Yes
3.4	Multisectoral National Strategic Plan for Family Planning 2014-2020	Implementing document	January2014	Secretary General for Health	Central and Provincial MOH services	No
3.5	National Strategic Plan for Adolescent and Youth Health and Wellbeing 2016-20	Implementing document	March 2016	Secretary General for Health	Central and Provincial MOH services	No
3.6	Strategic Plan for Reproductive Health Product Safety 2008-2012	Implementing document	2012	Secretary General for Health	Central MOH services	No
3.7	Strategic plan for Reproductive, Maternal, Newborn, Child, and Adolescent Health (SRMNEA)	Implementing document	February 2019	Secretary General for Health	Three levels of the MOH	No
3.8	Mapping supply and distribution systems for drugs and other health products in the DRC	Implementing document	June 2009	National Essential Medicines Supply Program (PNAME)	Central and Provincial MOH services	No
3.9	Review of the Reproductive Health Program	Implementing document	July 2017	National Reproductive Health Program (PNSR)	Central and Provincial MOH services	No
4.	**Normative and regulatory documents on family planning**					
4.1	National Conference for the repositioning of family planning in the DRC: final report	Advocacy	December 2009	CTMP	Central MOH services	No
4.2	Booklet of useful information on health services adapted to the needs of adolescents and young people	Directive	May 2019	National Program for Adolescent Health (PNSA)	Healthcare providers	No
4.3	Adolescent and youth sexual and reproductive health booklet for community health service providers, peer educators, and mentors	Directive	August 2017	National Program for Adolescent Health (PNSA)	Peer educators and mentors	No

4.4	Standards of health interventions adapted to adolescents and young people	Standards	2012	Secretary General for Health	Central and Provincial MOH services; Health districts	No
4.5	Standards of family planning interventions	Standards	2012	Secretary General for Health	Central and Provincial MOH services; Health districts	No
4.6	Health district standards for integrated maternal, newborn, and child health interventions in the DRC	Standards	2012	Secretary General for Health	Central and Provincial MOH services; Health districts	No
4.7	Health district standards and guidelines for integrated maternal, newborn, and child health interventions in the DRC	Guidelines	2012	Secretary General for Health	Central and Provincial MOH services	No
4.8	Standards and guidelines for use of the female condom	Standards	2012	Secretary General for Health	Provincial MOH services; Health districts	No
4.9	Female condom user guide	Guidelines	2012	Secretary General for Health	Provincial MOH services; Health districts	No
4.10	Standards for community-based interventions for maternal, newborn, and child health	Standards	2012	Secretary General for Health	Provincial MOH services; Health districts	No
4.11	Collection of messages on family planning	Guidelines	2012	Secretary General for Health	Provincial MOH services; Health districts	Yes
4.12	Technical sheet for medical care in family planning	Guidelines	2012	National Reproductive Health Program (PNSR)	Healthcare providers	Yes

Although the majority of documents convey a message in favor of FP for the general population, a small number (and not the least) continue to convey the messages against FP. The Decree of January 30, 1940, on the Congolese Criminal Code as amended and completed to date, updated to November 30, 2004, prohibited contraception by stipulating the following: *"...anyone who has exhibited or distributed objects specially designed to prevent pregnancy and has made advertising to promote the sale; any person who, for the purpose of gain, has*

favored the passions of others by exhibiting, selling or distributing printed or unprinted writings which disclose means of preventing pregnancy, and by advocating the use or providing indications of the manner in which to obtain them or to use them; any person who, for the purposes of trade or distribution, has manufactured, imported, transported, delivered to a transport or distribution agent or advertised by any means of publicity the writings referred to in the preceding paragraph, shall punished by a penal servitude from eight days to one year and a fine of twenty-five to one thousand zaïres or one of those penalties only" (Article 178 of the Congolese Penal Code, Book II) [39]. Laws No. 06/018 of July 20, 2006 [40] and No. 15/022 of December 31, 2015 [41], amending and supplementing the above-mentioned Decree, and the Presidential Order No. 73/089 in 1973 which instituted the National Council for the Promotion of the Desirable Births Principle (CNPND) with the mission of popularizing and organizing FP activities [42] did not change the wording of Article 178 of Book II. In 2018, the law No. 18/035 laying down the fundamental principles relating to the organization of public health [17] stated: *"Anyone of childbearing age can benefit, after being informed, from a reversible or irreversible contraceptive method with free consent. In case of irreversible contraception, the consent is written after the opinion of three doctors and the psychiatrist." (Article 81 of the law No. 18/035).* This law repealed all previous dispositions that prohibited the organization of FP (Article 143, *law No. 18/035).* The DRC's Second Generation Growth and Poverty Reduction Strategy Paper (DSCRP2) [14] also reinforces the option for FP in the following terms: *"In the area of population and given its importance to maternal and neonatal health, the revitalization of FP is one of the Government's priorities...The Government's priorities are as follows: (i) increase the coverage rate of FP services; (ii) implement an integrated communication plan on FP; (iii)*

regularly supply FP services with inputs; (iv) advocate for the revision of legal provisions unfavorable to FP; (v) involve the community in the process of revitalizing FP" (DSCRP2, 2015). With regard to the rights of adolescents <18 years old, Child Protection Law No. 09/001 [43] states: *"Every child capable of discernment has the right to express his opinion on any question concerning his views being duly taken into consideration, having regard to his age and degree of maturity."* It also states: *"Every child has the right to enjoy the best possible state of health..."* (Law No. 09/001, Article 7 & 21). At the end of this law, the child under 18 years of age is placed under parental authority with regard to their health; this means that children under the age of 18 cannot decide for themselves to use FP services and methods.

Assessment of the content of family planning policy documents

The achievement of WHO recommendations on rights to access to FP information and services was assessed by analyzing the content of each policy document in Table 2. We present the synthesis from this analysis, with focus on the integration of each recommendation and sub-recommendations in policy documents. (Table 3).

Table 3. Integration of WHO recommendations to ensure respect for human rights in the provision of contraceptive information and services to adolescents in the DRC's policy documents

	WHO recommendations and sub-recommendations	Categories				
		A	B	C	D	E
1.	**Non-discrimination**	**Totally integrated**				
1.1	Recommend that access to comprehensive contraceptive information and services be provided equally to everyone voluntarily, free of discrimination, coercion, or violence (based on individual choice)	X				
1.2	Recommend that laws and policies support programs to ensure that comprehensive contraceptive information and services are provided to all segments of the population. Special attention should be given to disadvantaged and marginalized populations in their access to these services	X				
2.	**Availability of contraceptive information and services**	**Not integrated**				
2.1	Recommend integration of contraceptive commodities, supplies, and equipment, covering a range of methods, including emergency contraception, within the essential medicine supply chain to increase availability. Invest in strengthening the supply chain where necessary in order to help ensure availability			X		
3.	**Accessibility of contraceptive information and services**	**Partially integrated**				
3.1	Recommend the provision of scientifically accurate and comprehensive sexuality education programs within and outside of schools that include information on contraceptive use and acquisition	X				
3.2	Recommend eliminating financial barriers to contraceptive use by marginalized populations, including adolescents and the poor, and make contraceptives affordable to all		X			
3.3	Recommend interventions to improve access to comprehensive contraceptive information and services for users and potential users with difficulties accessing services (e.g., rural residents, urban poor, adolescents). Safe abortion information and services should be provided according to existing WHO guidelines (Safe abortion: technical and policy guidance for health systems, 2nd edition)				X	
3.4	Recommend special efforts be made to provide comprehensive contraceptive information and services to displaced populations, those in crisis settings, and survivors of sexual violence, who particularly need access to emergency contraception	X				
3.5	Recommend that contraceptive information and services, as a part of sexual and reproductive health services, be offered within HIV testing, treatment, and care provided in the health-care setting			X		
3.6	Recommend that comprehensive contraceptive information and services be provided during antenatal and postpartum care		X			
3.7	Recommend that comprehensive contraceptive information and services be routinely integrated with abortion and post-abortion care			X		
3.8	Recommend that mobile outreach services be used to improve access to contraceptive information and services for populations who face geographical barriers to access			X		

3.9	Recommend elimination of third-party authorization requirements, including spousal authorization for individuals/women accessing contraceptive and related information and services		X			
3.10	Recommend provision of sexual and reproductive health services, including contraceptive information and services, for adolescents without mandatory parental and guardian authorization/ notification, in order to meet the educational and service needs of adolescents			X		
4.	**Acceptability of contraceptive information and services**	**Not integrated**				
4.1	Recommend gender-sensitive counseling and educational interventions on family planning and contraceptives that are based on accurate information, that include skills building (i.e., communications and negotiations), and that are tailored to meet communities' and individuals' specific needs		X			
4.2	Recommend that follow-up services for management of contraceptive side-effects be prioritized as an essential component of all contraceptive service delivery. Recommend that appropriate referrals for methods not available on site be offered and available			X		
5.	**Quality of contraceptive information and services**	**Not integrated**				
5.1	Recommend that quality assurance processes, including medical standards of care and client feedback, be incorporated routinely into contraceptive programs			X		
5.2	Recommend that provision of long-acting reversible contraception (LARC) methods should include insertion and removal services, and counseling on side effects, in the same locality			X		
5.3	Recommend ongoing competency-based training and supervision of health-care personnel on the delivery of contraceptive education, information, and services. Competency-based training should be provided according to existing WHO guidelines			X		
6.	**Informed decision-making**	**Partially integrated**				
6.1	Recommend the offer of evidence-based, comprehensive contraceptive information, education, and counseling to ensure informed choice	X				
6.2	Recommend every individual is ensured an opportunity to make an informed choice for their own use of modern contraception, including a range of emergency, short-acting, long-acting, and permanent methods, without discrimination		X			
7.	**Privacy and confidentiality**	**Not integrated**				
7.1	Recommend that privacy of individuals be respected throughout the provision of contraceptive information and services, including confidentiality of medical and other personal information		X			
8.	**Participation**	**Not integrated**				
8.1	Recommend that communities, particularly people directly affected, have the opportunity to be meaningfully engaged in all aspects of contraceptive program and policy design, implementation, and monitoring			X		
9.	**Accountability**	**Not integrated**				
9.1	Recommend that effective accountability mechanisms be put in place and are accessible in the delivery of contraceptive information and services, including monitoring and evaluation, and remedies and redress, at the individual and system levels			X		
9.2	Recommend evaluation and monitoring of all programs to ensure the highest quality of services, and respect for human rights must occur.			X		

	Recommend that, in settings where performance-based financing (PBF) occurs, a system of checks and balances be in place, including assurance of non-coercion and protection of human rights. If PBF occurs, research should be conducted to evaluate its effectiveness and its impact on clients in terms of increasing contraceptive availability					

Of nine WHO recommendations on the right of access to information and FP services by adolescents, one (11%) was fully integrated into the regulatory documents, two (22%) were partially integrated, and six (67%) were not yet integrated. On the other hand, of the 24 WHO sub-recommendations, 5 (21%) are included in regulatory/policy documents with a particular focus on adolescents, 6 (25%) are integrated but do not specifically target adolescents, and 12 (50%) are not yet integrated. One (4%) sub-recommendation integrated in policy documents is inconsistent with orientations from WHO; this is the sub-recommendation 3.3 targeting safe abortion.

Non-discrimination

This recommendation was fully integrated through national policy documents. The constitution of the DRC states in article 14 that *"The public authorities shall ensure the elimination of all forms of discrimination against women and ensure the protection and promotion of their rights."* Law No. 15/013 of August 1, 2015, on the implementation of the rights of women and parity, article 12, also states this: *"The State shall develop a policy which encourages, by means of incentives, the construction, from public or private funds, of information, training, promotion and defense centers for the rights of women and young girls in each village, group, chiefdom, sector, district, commune and city."* Non-discrimination in the provision of FP information and services secures both men and women as reflected in the Article 82 of the Law No. 18/035 laying down the fundamental principles relating to the organization of public health: *"For legally married persons, the consent of both spouses to the contraceptive method is required. In case of disagreement*

between the spouses on the contraceptive method to be used, the will of the concerned spouse premium"

Accessibility of contraceptive information and services

This recommendation is partially integrated. Two sub-recommendations (3.1 and 3.4) are included respectively in the National Strategic Plan for Adolescent and Youth Health and Wellbeing 2016-20 [45] and the law on sexual violence. Sub-recommendations 3.2, 3.6 and 3.9 are integrated in policy documents only in aspects concerning adult's women.

Informed decision-making

This recommendation is partially integrated; one in its two sub-recommendations (sub recommendation 6.1) is integrated in the law No. 15/013 focused on the implementation of the rights of women and parity, article 12 [46].

Six WHO recommendations on FP are not yet integrated into policy documents targeting adolescents. These are: availability of contraceptive information and services; acceptability of contraceptive information and services; quality of contraceptive information and services; privacy and confidentiality; participation; and accountability.

Other regulatory documents, such as the Family Planning Strategic Plan; the Growth and Poverty Reduction Strategy document; the Reproductive, Maternal, Newborn, Child, and Adolescent Health Strategic Plan; standards for FP interventions; and community-based intervention standards for maternal, newborn, and child health are also intended to improve the delivery of FP services. However, they do not contain actions clearly intended to improve access to and use of FP by adolescents. Of all these documents, the useful information booklet on health services adapted to the needs of adolescents and young people and the norms of health interventions adapted to adolescents and young people are more

informative on FP for both caregivers and adolescents. They describe the criteria required for a health service to be considered "friendly" for adolescents and young people.

Availability of family planning policy documents in health facilities

Within HFs, we mainly looked at the availability of operational instructions on PF which should guide the decision-making process. In addition to the fact that the operational instructions for the majority of policy documents consistent with WHO recommendations were poorly available in HFs, according to Figures 4 and 5, 25% of HFs had at least one guideline for adolescent sexual health. In 15% of HFs, providers were trained in adolescent SRH; in 13% they were trained in FP for adolescents; and in 13% they were trained in both adolescent SRH and FP. (Figure 4).

Operational instructions are intended to guide caregivers during the interview with clients requesting FP services. Their low availability appeared to be a major problem among interviewees from provincial and health district levels. A nurse in charge of a health center declared: *"We find it difficult to prescribe some contraceptives to adolescents who come alone; our partner asks us to do it but we have no written instructions on what and how to do it. So we hesitate"* **(MM, Health center manager, Kongo Central)**.

Four types of normative and regulatory documents on FP for adolescents were available from providers, including FP message books, FP circulars and instructions, community-based maternal and child health intervention standards, and the FP strategic plan. Twenty percent of HFs had FP data sheets and 51% had materials for SRH education. (Figure 5).

Discussion

We showed that the process of formulating laws and policies in the DRC remains long and complex. Regarding FP regulation, we identified 35 documents, including laws, policies, standards, guidelines, and strategic documents, that organize FP in the DRC. However, few of these documents regulate the organization of FP for adolescents and were available in HFs. Evaluation of their content, in light of the WHO recommendations on adolescents' rights to FP services, indicated that only 5 of 24 WHO sub-recommendations are taken into account in policy documents currently in effect.

The organization of public health in the DRC is regulated by the framework health law promulgated in 2018, which is one of the constitutional laws for the health sector. As none of the implementation measures provided for in this law are finalized yet, this law is not yet being applied. This observation was also made through the DRC's National Health Development Plan, which links the weak regulation of the health sector to the dysfunctional structures in charge of regulation [18]. Our analyses indicate that current FP regulatory documents in the DRC contain some inconsistencies in the organization of FP, particularly the right of adolescents to access contraceptive methods of their choice. Some provisions in the laws limit unaccompanied adolescents' access to FP services. These include the Child Protection Law No. 09/001 [43] and the Family Code of the DRC [47] which set aside the automatic emancipation of children under 18 years from the marriage or getting job. Until recently, the Congolese Penal Code which prohibits FP remained unchanged [40, 41]. Currently, several laws and other regulatory documents are clearly part of the promotion of FP services [17, 19, 46].

With regard to adolescents, the laws in force are not expressive as to their right to access services and information on SRH in general or FP in particular. The law

providing the fundamental principles relating to the organization of public health describes the right of every person of childbearing age to benefit from a method of contraception of their choice, but it does not clearly define who can be considered a woman of childbearing age [17]. In public health, this encompasses the age group of 15 to 49 years, but the law on the protection of the child sets the age of majority at 18 years [43]. Thus, there is no legal basis to justify and protect the demand for FP services by adolescents or to prescribe contraceptive methods to unaccompanied adolescents. Adolescents who have reached the age of majority enjoy, in terms of access to FP services, benefits provided by laws and other normative and regulatory documents in force [17, 19, 46]. Though the law gives minors the opportunity to express their opinion, it forces them to submit to parental authority for the satisfaction of their health needs [43]. The majority of instructions developed by the MOH aim to regulate and promote modern contraceptive methods as more effective than traditional methods [17, 19]. However, apart from the strategic plan for the health and well-being of adolescents and young people [22], there is little emphasis on traditional methods and the education of adolescents in SRH. Yet, studies indicate that adolescents have unmet needs in both modern and traditional contraceptive methods. The 2013-14 DHS sets the level of unmet need for FP among adolescents in the DRC to 30% and the modern contraceptive prevalence in adolescents to 5%. Some teenage girls use traditional methods; those in school receive sex education, which is rare in the family because sex is considered taboo [24, 25]. Adolescents make up a significant portion of the world's population. In view of the important role they are expected to play, better adolescent health is currently one of the global priorities of the Global Sustainable Development Goals (SDGs) [48]. The WHO recommendations on SRH and rights [3] are part of the SDG implementation.

Based on our findings, one out of nine recommendations and 5 of the 24 WHO sub-recommendations are included in the regulatory documents. In the DRC, there is virtually no regulation of access to FP services by unaccompanied adolescents, such as the subsidization of FP services for teenagers (i.e., free access), confidentiality, and other important aspects. Regulation of FP is still in an early state. The regulator does not have enough regulatory power, as evident in some countries that have specific policies to promote or prohibit the prescription of specific contraceptives to adolescents [49]. Some FP policies in the DRC do not rely on any evidence generated by robust studies. Innovative approaches put in place through funding often stop with the end of the projects that support them. Few efforts include caregivers and adolescents in the formulation of health policies, which are poorly evaluated, unlike other countries around the world [50]. In view of the current expansion of contraceptive services, it is important to improve the regulation of the circulation and prescription of certain contraceptives in the DRC.

Another observation is the multiplicity of structures that target adolescent health and the complexity of their coordination. The DSFGS, PNSR, PNSA, PNSS, technical partners of the MOH, non-governmental organizations such as civil society organizations and churches are structures that work on adolescents. There is also a multiplicity of coordination structures made by the Reproductive, Maternal, Newborn, Child, and Adolescent Health Task Force, the CTMP/PF, the Adolescent Health Task Force, the CCT-SS, and other structures at the provincial level. Therefore, actions in the field of contraception for adolescents appear fragmentary given the mandates, missions and the interests of different structures. These observations are consistent with those found in a study in India that highlighted the problems of coordinating health action around adolescents

[31]. Some recent studies have shown that FP activities are not systematically organized within HFs in the DRC [15, 20]; however, some facilities do not ensure that services meet the needs of adolescents [29]. This situation could be due to the unavailability of instructions, guidelines and organizational norms of the FP within HFs and other service providers. Another reason for this could be the lack of enough trained ASRHR and FP providers as illustrated in figure 4. Apart from the SRH education material for adolescents, less than 20% of facilities have collections of operational messages and instructions on FP for adolescents. The poor quality of supervision, which in turn is explained by the lack of resources at the normative level, could explain these results. Supervision is a known means to improve the quality of services [51].

For a long time, there was no organized worldwide system to regulate and monitor the social needs of adolescents. In 2013, the Committee on the Rights of the Child published guidelines on the rights of children and adolescents. The guidelines for recognizing the specific health and rights of adolescents and young people were finalized and made available to states [2]. In 2014, the WHO published the recommendations to ensure respect for human rights in the provision of contraceptive information and services [34]. However, negative social norms continue to drive gaps in the DRC. A study pointed out that adolescents demand sex education from medical staff, religious leaders, and teachers whom they trust for confidentiality reasons [52]. The DRC has the obligation to put in place policies that meet different guidelines if the country wants to improve the well-being of adolescents.

Strengths and limitations

This study is the first which combines qualitative and quantitative data to analyze regulation process in the field of FP for adolescents. It draws the attention of policy makers to the fact that, as part of ongoing efforts to expand the provision of FP services throughout the country, it remains necessary to remove barriers to accessing FP services due to the poor legal environment for adolescents. We also showed that policymakers need to involve different stakeholders, particularly adolescents, in the formulation of policies. The main limitation of this study could be linked to the methodology: the document review may not have been exhaustive due to the problem of archiving documents. In order to minimize this limit, a meeting to present the results was organized in the presence of the MOH authorities.

Conclusions

Regulation and standardization of FP services remains problematic in the DRC. Adolescents do not have a legal basis guaranteeing secure access and the unhindered use of contraceptive services. The integration of WHO recommendations on adolescent SRH rights is still insufficient. In addition, there is weak coordination of the various actors in the field of FP and poor support of providers by the MOH. To improve access to and use of contraceptive services and methods by adolescents, the DRC MOH should work towards establishing, monitoring, and evaluating evidence-based regulation.

Prospect

In perspective, there is a need to discuss with adolescents about important aspects of SRH including FP that they would like to see included in policy documents; we also need to work on the formulation of SRH policy incorporating the WHO recommendations.

Abbreviations

FP: family planning; DRC: Democratic Republic of the Congo; HF: health facility; WHO: World Health Organization; SRH: sexual and reproductive health; MOH: Ministry of Health; DSFGS: Department of Family and Special Groups' Health; PNSR: National Reproductive Health Program; PNSA: National Adolescent Health Program; PNSS: National School Health Program; DPS: Provincial Division of Health; CTMP/PF: Permanent Multi-sectoral Technical Committee for Family Planning: CCT-SS: Health Sector Technical Coordination Committee; GTT: Technical Working Group; CPP-SS: Provincial Health Sector Steering Committee; CNPND: National Council for the Promotion of the Principle of Desirable Births; PNAME: National Essential Medicines Supply Program; DSCRP2: Second Generation Growth and Poverty Reduction Strategy Document; ASRH: adolescent sexual and reproductive health; MNCH: maternal, newborn, and child health

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Authors' contributions

DM and GW designed the project. DM conducted the data collection, performed the analysis, and drafted the manuscript. DM, EM, FB, AM, GL, FC, MM, and GW contributed to the interpretation of the data and edited the manuscript. All authors read and approved the final manuscript.

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The datasets used for this study are policy documents that are available online. These documents are also available from the corresponding author upon reasonable request.

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Competing interests

The authors declare that they have no competing interests.

Author details

[1]Kinshasa School of Public Health, University of Kinshasa, P.O. Box: 11850, Kinshasa I, Kinshasa, Democratic Republic of the Congo; [2]National Program for Adolescent Health, Ministry of Public Health, Democratic Republic of Congo; [3]Direction of Studies and Planning, Ministry of Public Health, Democratic Republic of Congo; [4]Faculty of Law, University of Kinshasa, Kinshasa, Democratic Republic of the Congo; [5]Lubumbashi School of Public Health, University of Lubumbashi, Democratic Republic of the Congo.

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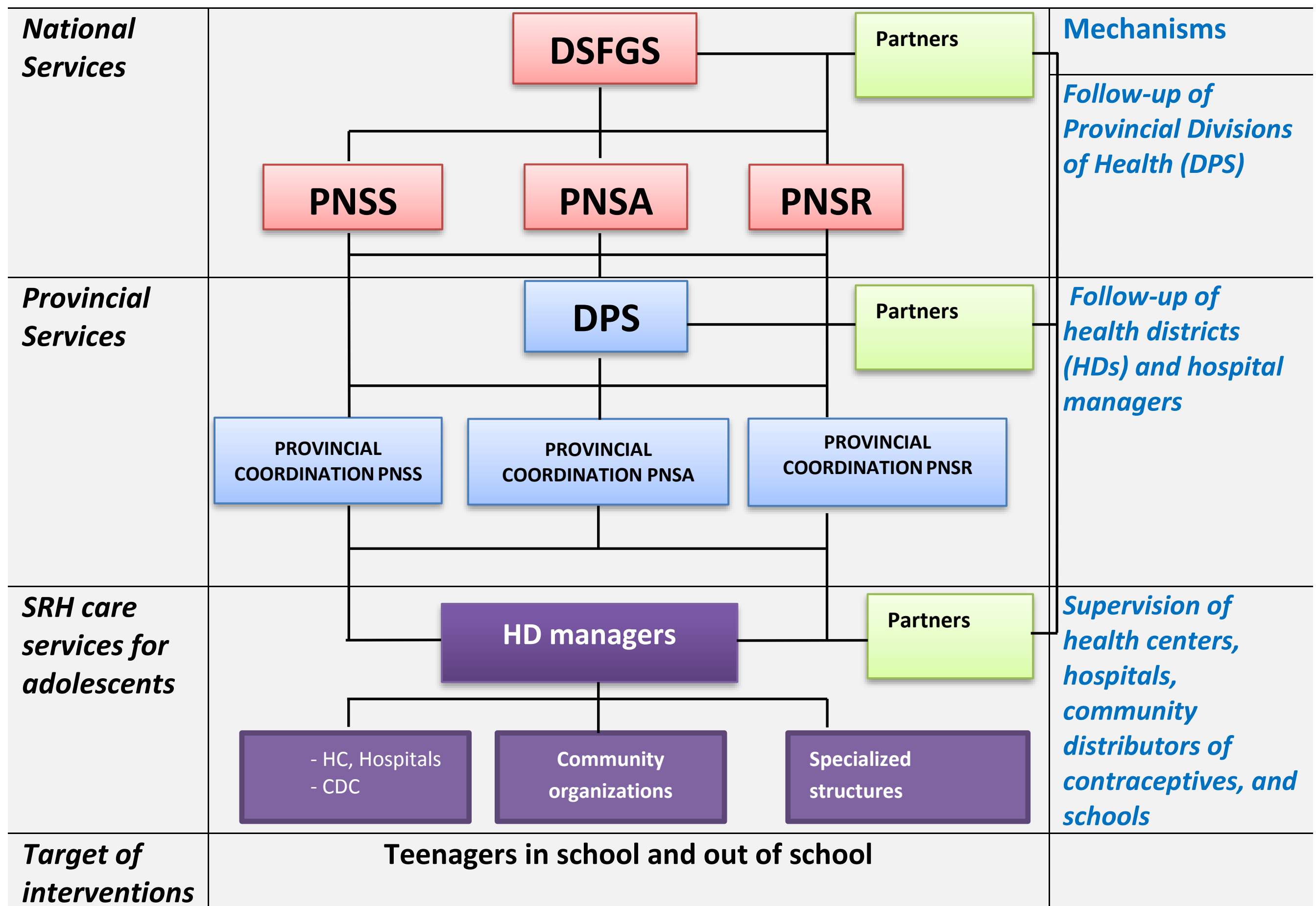
Figure 1. Organization of the health system around the family planning



Source: According to Ministry of Health documents

Figure 2. Framework for regulating family planning services in the DRC

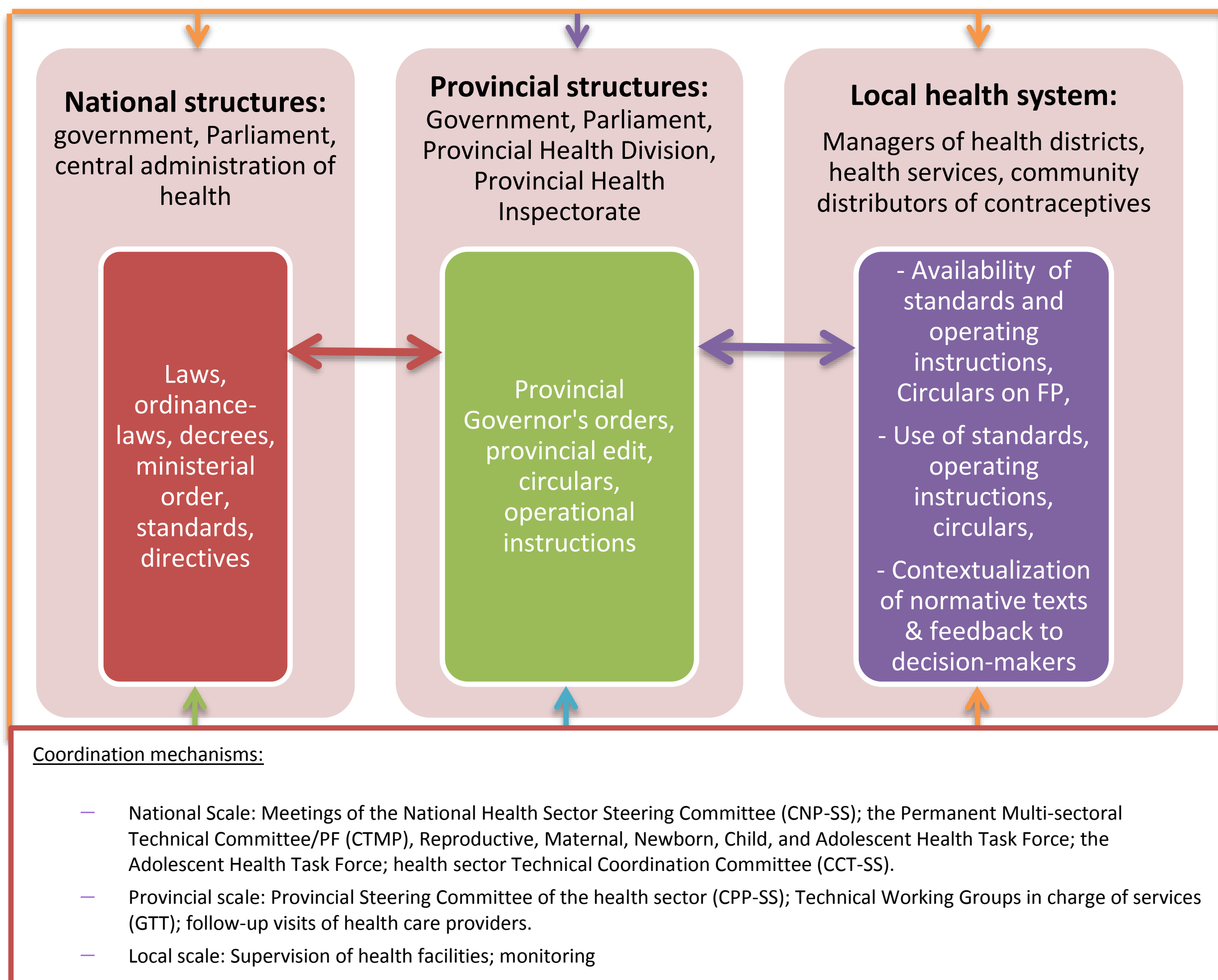
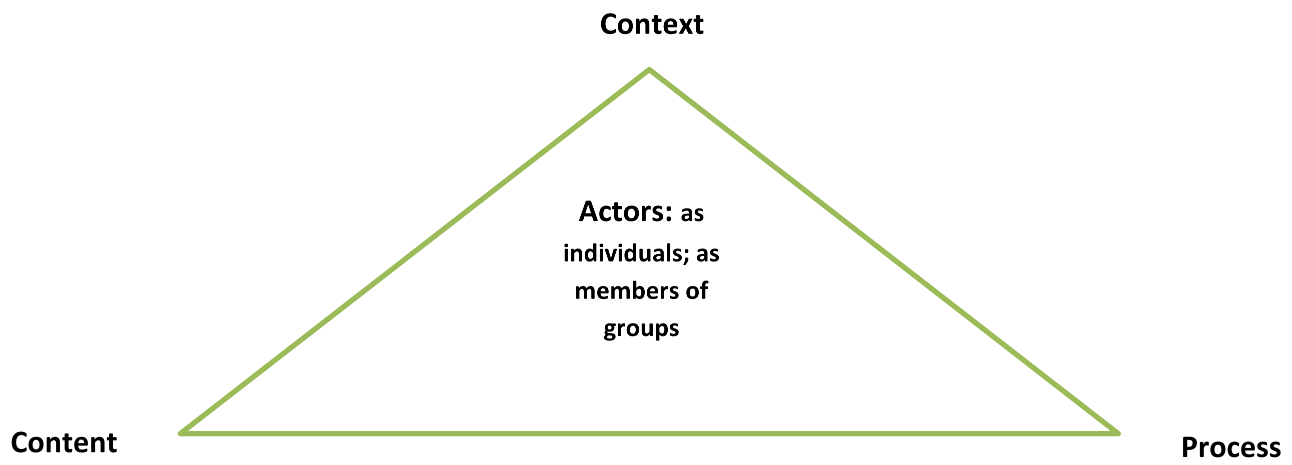
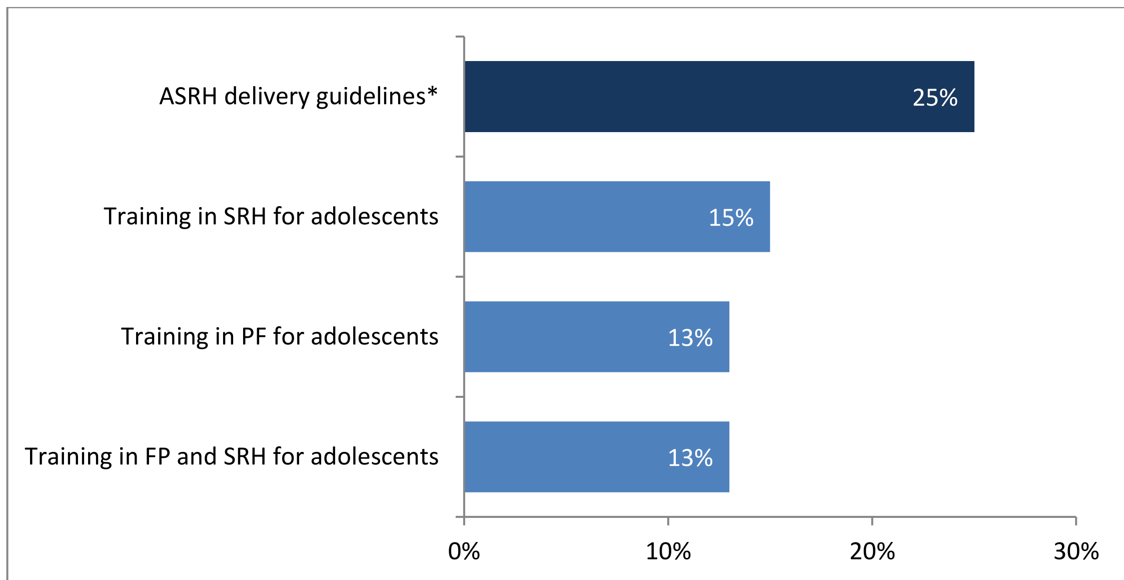


Figure 3. A model of Health Policy Analysis



Legend: according to Walt and Gilson

Figure 4. Availability of guidelines and trained providers in Adolescent Sexual and Reproductive Health (N = 61)



* Adolescents Sexual Reproductive Health (ASRH) guidelines.

Figure 5. Types of family planning regulatory documents available within health facilities (N = 61)