Assessing Implementation Gaps in Youth-Friendly Services in Five Countries

Elizabeth Leahy Madsen,[a] Burcu Bozkurt,[b] Jill Chanley,[a] Marissa Falk,[a] Ramya Jawahar,[b] Christine Power,[a] and Lena Zague Some[b]

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Introduction

Young people's ability to freely determine their reproductive lives greatly affects their livelihood and that of their future families. Governments around the world have made great strides in creating policies that support the health and human rights of young people. Increasingly, countries have institutionalized the rights of adolescents and young people to access health services, including sexual and reproductive health (SRH), within formal laws and policies. Statements by the United Nations Population Fund (UNFPA), World Health Organization (WHO), and other stakeholders have underscored the urgency for international organizations and governments to ensure that all young people have informed choice and full access to family planning (FP), including contraceptives.[1]

The WHO "Guidelines on Preventing Unintended Pregnancies and Poor Reproductive Outcomes Among Adolescents in Developing Countries" recommend that policymakers make contraceptive services adolescent-friendly to increase contraceptive use among this population.[2] Evaluations show that when SRH services are tailored to meet the specific needs of youth, they are more likely to use these services and access contraception.[3] Seven common elements identified in High-Impact Practices in Family Planning (HIPs) for "Adolescent-Friendly Contraceptive Services" provide one framework for assessing the policy environment surrounding FP service and contraceptive provision.[4] These seven elements in adolescent-friendly FP service provision contribute to increased use of contraception among young people ages 15 to 19:

1. Train and support providers to offer adolescent-friendly contraceptive services.
2. Enforce confidentiality and audio/visual privacy.
3. Offer a wide range of contraception.
4. Provide no-cost or subsidized services.
5. Build an enabling legal and political environment.
6. Link service delivery with activities that build support in communities.
7. Address gender and social norms.

A critical component of youth-friendly contraceptive services (YFS) is the provision of a full range of methods, including long-acting reversible contraceptives (LARCs). Provision of LARCs as part of an expanded method mix is particularly effective. One of the studies identified in the 2016 systematic assessment provided implants as an alternative contraceptive option for young women seeking short-acting contraceptives in a clinic in Kenya. Twenty-four percent of the women opted to use an implant, and their rate of discontinuation was significantly lower than those using short-acting methods. Of the 22 unintended pregnancies that occurred, all were among women using short-acting methods.[5] However,

[a] Population Reference Bureau (PRB)
[b] International Youth Alliance for Family Planning (IYAFP)

many youth around the world do not know about LARCs and if they do, they may be confused about their use and potential side effects, hesitant to use them due to social norms, or face refusal from providers.[6]

Recent analysis by the Population Reference Bureau (PRB) shows that of 16 priority countries, all have a strong policy environment for at least one intervention proven to increase youth access to and use of contraception.[7] But in 26 of 40 Family Planning 2020 (FP2020) focus countries, more than one-fifth of young women ages 15 to 19 have an unmet need for contraception.[8] Many barriers remain for young people who want to use contraception, including provider refusal, limited contraceptive options, stigma, sociocultural pressures to have children early, and cost and physical access barriers.[9] Previous studies have noted that strong policies have faced implementation challenges due to funding and resource shortfalls, especially given that most adolescent SRH programs are carried out at a subnational level.[10] Even as efforts to strengthen governments' policy environments continue, the extent to which these commitments are implemented is the true measure of improvements in young people's health and well-being.

Methods

The Empowering Evidence-Driven Advocacy (EEDA) project is a partnership between PRB and the International Youth Alliance for Family Planning (IYAFP), a youth-led organization. Implemented between 2017-2020 with support from the Bill & Melinda Gates Foundation, the project's goals are to improve implementation of existing FP policies, especially those that support youth access to and use of contraception, and to generate new funding and policy commitments for FP in response to evidence-driven advocacy.

Through the EEDA project, we conducted a qualitative research study in five countries to assess gaps in implementation of policies that support YFS. The specific aims of the assessment were to:

1. Identify strengths and gaps in the implementation of FP services for youth and the factors contributing to those strengths and gaps.
2. Ensure that the perspectives of youth ages 15 to 24 who access FP services are integrated into analysis of implementation strengths and gaps.
3. Identify programmatic actions that the government and partners can take to improve implementation of existing policies that support youth access to and use of FP.
4. Increase youth advocates' capacity to measure policy implementation.

The countries selected—Burkina Faso, Ethiopia, Kenya, Nigeria, and Uganda—were drawn from the pool of 16 whose policy environments for YFS have been previously assessed through PRB's *Youth Family Planning Policy Scorecard.* The five included in the study were selected based on the relative strength of their policy environments as documented in the Scorecard, the reach of IYAFP's network of youth in each country, and funder preference. It is important to note that the primary purpose of this study was to gather information to inform upcoming programming with youth advocates, and thus its scope and representativeness were more limited than in a larger academic study.

The study was designed with two research phases, conducted in each country in 2017 and 2018. In the first research phase, structured in-depth interviews (IDIs) gathered the views and experiences of key stakeholders such as national and subnational policymakers, program managers, service providers, medical schools or other providers of clinician training, civil society organizations, youth-serving organizations, and community gatekeepers. The second research phase, intended to "ground-truth" the first phase, utilized two methods for collecting youth's experiences: focus group discussions (FGDs) and a web-based survey to "crowdsource" feedback. The aim of this approach was to validate whether the

assertions of decision makers, administrators, and providers who supply services, as recorded in the first research phase, are matched with the actual experiences of youth when they access those services.

Three study geographies were selected in each country: the region containing the national capital and two subnational entities (e.g., counties, districts, states), one demonstrating relatively strong SRH outcomes for youth and the other demonstrating relatively poor outcomes. We examined recent data on indicators including teenage pregnancy rate, median age at first intercourse and first birth, and contraceptive use among youth to select study regions. The aim in choosing two regions on either end of the spectrum of SRH outcomes among youth was to capture divergent and diverse experiences regarding youth access and use of contraceptive services. The region containing the capital city served as a study site because youth living there have a unique viewpoint in accessing services in an area that is likely to be well-served by government programming. Including the capital as a study site also increased access to a variety of stakeholders for the IDIs.

The regions selected in each country were:

- Burkina Faso: Boucle du Mouhoun (high teenage pregnancy), Hauts-Bassins (low teenage pregnancy), Ouagadougou (capital)
- Ethiopia: Addis Ababa (capital), Afar (high teenage pregnancy), Amhara (low teenage pregnancy)
- Kenya: Embu (low teenage pregnancy), Nairobi (capital), Narok (high teenage pregnancy)
- Nigeria: Abuja (capital), Anambra (low teenage pregnancy), Cross River (high teenage pregnancy)
- Uganda: Kabale district, Kigezi sub-region (low teenage pregnancy) Kampala (capital), Mayuge district, Busoga sub-region (young age at first sex and first birth)

Research ethics approval for the study was obtained from an institutional review board (IRB) in Washington, D.C. and from local ethics review committees in each country. Where applicable, research permits were also obtained.

The study team consisted of PRB and IYAFP staff as well as teams of three to four youth research associates (RAs) competitively selected in each country. The RAs were recruited using a call for applications and position description that was circulated through the IYAFP network in each country. Their applications were evaluated based on their experience, interview, references, and a writing assignment. Prior to initiation of the study, the RAs received a three-day training from PRB and IYAFP in qualitative data collection methods, ethical recruitment, and consent practices. They each completed a 3-hour online training in protecting human research participants. Additionally, RAs participated in ongoing research training and capacity-building activities throughout their tenure with the project. The RAs, who were all adults over the age of 18, were compensated with a daily honorarium for their work on the study.

In-Depth Interviews

The study team, aided by a local consultant in each country, prepared a list of potential IDI subjects using knowledge of the field, recommendations from colleagues, and research from publicly available information such as organizations' websites. In most countries, once IRB approval was acquired, the study team obtained a letter of approval from the Ministry of Health that served to introduce the project to potential IDI participants. Stakeholders were contacted by phone and/or email and provided with background information on the study, including an information sheet. IDI participants completed informed consent forms prior to the initiation of each interview. Contemporaneous notes were taken by one member of the study team, and each interview was recorded with the interviewee's permission.

Across the five countries, the study team co-facilitated 223 IDIs with national and subnational stakeholders, ranging between 42 and 49 IDIs in each country.

PRB and IYAFP developed an IDI tool aligned with the seven HIPs elements of adolescent-friendly contraceptive services outlined above. The tool also implemented elements of the Policy Implementation Assessment Tool, which considers policy understanding, dissemination, and utilization.[11] Questions were aligned with the policies and guidelines governing YFS and related services published by each country's government. The IDI tool was then reviewed and validated by youth RAs and a group of other youth FP advocates in each country. The final version of each country's IDI tool contained over 30 questions. Given that complete coverage of the questionnaire would not be possible in the 30 to 60 minutes allotted for each IDI, study team members pre-selected priority questions for each interview based on the subject's known expertise.

Focus Group Discussions and Online Surveys

Across the five countries, the youth RAs led 59 FGDs with 266 youth ages 15 to 24.[12] Separate discussions were held for male and female participants and for minors (below age 18) and older youth. On average, five participants joined each FGD, with this group size intended to facilitate meaningful and purposeful dialogue and gain insightful information from the participants.[13] The FGD questionnaire followed the themes and structure of the IDI tool.

Participants were recruited by responding to posters placed by the RAs on community boards and public areas frequented by youth and through a shareable electronic advertisement posted on Facebook. A separate poster advertisement recruiting youth between the ages of 15-17 was placed in places and public areas where parents are likely to congregate and explicitly stated that parental consent is required for participation.

FGDs were conducted in venues with adequate privacy and informed consent was obtained prior to each FGD in accordance with the IRB-approved study protocol. Likewise, participants between the ages of 15-17 provided informed assent and their parents provided informed consent.[14] Each discussion lasted approximately 90 minutes and was recorded. The FGDs were conducted in the language(s) most comfortable for the participants, including: Amharic, Afar, Dioula, Efik, Ejagham, English, French, Igbo, Luganda, Lusoga, Mooré, Rukiga, and Swahili. No study team members other than the youth RAs from the respective country were present during the FGDs. At the end of the discussion, each participant was provided with the local currency equivalent of 10 USD to compensate for their travel expenses to the focus group.

Online surveys were administered in Kenya, Nigeria, and Uganda, with responses obtained from a total of 118 youth. Surveys were initiated in Burkina Faso and Ethiopia but results were not analyzed due to very low response rates. Subjects under the age of 18 were excluded from the survey to account for the inability to obtain their guardian's informed consent. Subjects were asked to check a box confirming that they are age 18 or older before beginning the survey. Participants were also asked to input their age, gender, and town or community of residence.

Results of the IDIs and FGDs were coded and analyzed using MAXQDA software. Recordings from each IDI and FGD were transcribed, utilizing notes to make the transcripts as complete as possible. RAs translated any FGDs and IDIs that were conducted in local languages into English or French, the two languages used for coding.

An initial review of transcripts was used to create a draft codebook, which was refined through test coding by multiple members of the study team including youth researchers; the codebook was also adapted slightly as needed for each country.

Results

The research generated a rich dataset of challenges, successes, and opportunities related to YFS implementation. Research findings for each of the five countries are summarized below.

Burkina Faso

Youth generally do not have access to adequate SRH information. While SRH information is often spread by word of mouth, discussions around sexuality are taboo and infrequent among family members. School curricula do not sufficiently address SRH. If included in school curricula, units are limited in scope, often forcing teachers to provide answers or refer young people to facilities.

Public health facilities and youth centers struggle with finding adequate funding to fully integrate SRH services for young people. While some government entities and non-governmental organizations (NGOs) have successfully trained providers in YFS provision, many providers do not receive such training. Youth cite instances of providers failing to respect their confidentiality and sharing sensitive information with parents and other members of the community. In general, the quality of youth FP services is inconsistent and depends on the client, provider, and facility.

Ethiopia

The high cost of offering training on YFS is a major challenge, but providers who have been trained are willing to serve youth and withhold bias. Other providers were reported to be discriminatory and judgmental, at times even verbally abusive. Youth use YFS only when they know their privacy is maintained and no one from the community knows they are accessing these services. They prefer not to use youth-friendly corners to avoid being seen by community members and being subject to stigma.

Youth generally did not know, or could not name, any SRH or YFS-related reproductive health policies ratified by the Ethiopian government. Youth end up piecing together the information they need about contraception from a patchwork of sources (e.g., biology textbooks, peers, health workers). Youth reported that the government generally does not actively engage youth as a major stakeholder; consequently, youth feel ignored by the government. Some NGOs and government entities have successfully involved youth in stakeholder dialogues and development of policies and strategies, but there is a lack of platforms to engage youth, especially in rural areas.

Kenya

Most youth participants were not aware of any Kenyan policies related to reproductive health. Most respondents shared that youth are not engaged or consulted in policy decision-making processes in a sustained or systematic way, because political leaders are busy or focused on other priorities. Youth offered recommendations for various ways in which youth engagement could be improved, such as forums where youth may meet to discuss reproductive health issues and meaningful youth engagement in FP-related decision-making, as well as delivery of FP services and information.

Youth indicated that female service providers judge young people more harshly for seeking contraceptives compared to male service providers, and that they judge young women seeking contraceptives more harshly than young men. Also, youth reported that they are often denied services if they do not have an identification card with them or if the provider perceives them to be too young. Youth

reported feeling embarrassed to seek contraceptive services in facilities and cited privacy as an issue. Overall, youth prefer going to chemists for services in lieu of other service providers because chemists are unlikely to ask questions or express judgment.

Youth indicated that abstinence is emphasized in schools, and little to no information is provided about contraception or pregnancy in school settings. Important cultural and religious institutions also encourage abstinence. In the more rural regions of Embu and Narok in particular, chiefs and elders either do not discuss contraception or do not support their own partners' use of contraception; consequently, support for youth access to contraception is limited. Young women often receive contraceptive information from peers, some of whom have been pregnant themselves. Health facility personnel visit communities and markets to talk with youth about contraceptives, and sometimes visit schools.

Nigeria

Levels of contraceptive knowledge among providers differ between the formal and informal sector and by type of facility. Many staff do not have the capacity to provide LARCs and are not knowledgeable about the reversibility of such methods. Health workers' discomfort delivering contraceptive information during counseling impacts young people's contraceptive knowledge. Youth also indicated that family life education, which emphasizes abstinence, further stifles contraceptive knowledge during school years. Successful community sensitization activities around youth contraceptive use include information sharing as well as an accompanying referral component.

Adolescents do not have a place where they can seek services comfortably; they feel they are too old for pediatric clinics and too young for adult clinics. Youth are more likely to seek services where they know their confidentiality will be maintained and/or if there is a separate service delivery point for them. However, youth-friendly health facilities are not always located in areas that are convenient for young people to access. Youth indicate that they are more likely to use contraceptive methods such as condoms and self-injectables that do not require interacting with providers. This practice leads youth to frequent Patent and Proprietary Medicine Dealers and chemists. These facilities are more widely distributed than conventional points of service and are easier for youth access, especially in rural areas, but they do not provide LARCs.

Youth are often questioned about their age when seeking FP services. Policy language around age of consent is vague, and discomfort around age of consent is often more cultural than political. Some providers insist on receiving parental consent before administering contraceptives, as they fear backlash from parents and the community, including a threat of being sued. In turn, youth are deterred from seeking services because they fear being asked for parental consent or being criminalized for seeking contraceptives at their age.

Uganda

Youth learn about contraception from a variety of sources (e.g. peers, the Internet, movies) but indicate that the information is often inadequate and inaccurate. While stakeholders acknowledge the new national framework on sexuality education is a positive step, youth indicate that the focus on abstinence education is a barrier to contraceptive information. Many young people also do not believe FP is relevant to them because of their age. When youth do seek FP, they prefer short-term methods because of misconceptions around LARCs, particularly a fear of infertility and cancer. However, organizations in Kampala and Kabale have been implementing trainings for schoolteachers and have used peer community outreach as a strategy to reach rural and out-of-school youth.

The lack of YFS training is a major challenge, but some providers who have been trained are willing to serve youth and withhold bias. Many other providers were reported to be discriminatory and judgmental,

often withholding contraception due to societal expectations around sexual activity and personal beliefs in contraceptive myths. Funding is a major barrier to expanding provider training in YFS, especially as YFS is rarely offered as a stand-alone training. However, model facilities also train administrative staff to ensure that the entire facility is responsive to young clients. Facilities struggle with provider retention as trained providers often move on to opportunities in urban districts or private facilities, leaving a gap in rural and public facilities.

Youth indicated that lines and facility spaces shared with elders and other members of the community compromise health-seeking behaviors, but that facilities with youth activities, such as TV and games, do not always have trained providers. Young people indicate a preference for public facilities where they can access subsidized or free services. However, the instability of supply chains and public sector stockouts were stated as major barriers to access. In Kampala, injectables were cited as being increasingly available and popular among youth.

Utilizing the Research Findings

The findings were presented to and analyzed by a competitively selected group of 10-15 youth advocates in each country during a five-day workshop focused on data synthesis and policy communication. After reviewing research results and participating in a guided strategy exercise, the team of youth advocates in each country identified specific advocacy objectives:

Burkina Faso: 1) Accelerate the insertion of comprehensive sexuality education (CSE) into school curricula and create a CSE implementation plan by the 2019/2020 school year; 2) Create budget lines to fund YFS in Bobo-Dioulasso and Dédougou.

Ethiopia: 1) Create mechanisms for policymakers to report to youth on implementation progress of the National Adolescent and Youth Health Strategy in at least two regions; 2) Disseminate SRH information via a media broadcasting company in Addis Ababa using domestic funding.

Kenya: 1) Increase funding for YFS in the Nairobi county budget; 2) Formalize youth engagement in Narok county government structures through the creation of a Youth Technical Working Group.

Nigeria: 1) Institute at least one day each month for the dedicated provision of youth SRH services at public health facilities in Cross River State, including designating a health care provider at each facility who is trained in YFS.

Uganda: 1) Increase youth access to contraception in Kawempe neighborhood of Kampala by creating and updating in real time a Google Map promoting available products and services at public and private health facilities; 2) Secure commitment of district councilmembers in Mayuge and Kabale to prioritize funding for provider training on YFS in each district's 2020/21 health budget.

Following completion of the research, we trained youth advocates in each country on policy communication skills to integrate evidence generated by the research results into their advocacy. In close partnership with youth advocates, we also created tailored communications materials that make the case for each specific advocacy objective tied to the findings of the implementation assessment.

Currently, youth advocates are launching advocacy strategies aimed at key stakeholders with ongoing guidance and technical support from IYAFP and PRB. They have already achieved several promising successes, especially in Kenya (the first country where advocacy was launched), including a commitment from the Nairobi county government to increase funding for YFS and a Memorandum of Understanding

with the Narok county government to create a Youth Technical Working Group for collaborative policy implementation.

Discussion

The data collected in this study have practical implications for ongoing policy development, implementation, and programmatic design. Across five countries, this study identifies the key challenges and barriers faced as young people try to access contraceptive services, even in settings where policies are supportive. Moreover, these findings are derived from the assessments of expert professional stakeholders in the field, as well as from the lived experiences of youth themselves.

The findings have yielded a robust body of evidence about implementation of youth-friendly FP services, underscoring the value of elevating youth voices in analyzing and acting on the social context for policy commitment and implementation. Young people are not only beneficiaries—they increasingly shape their countries' policy and program landscapes. As they become policy and advocacy influencers, they will play a key role in determining achievement of national and global development goals. While many countries host robust advocacy communities that actively support increased FP access for youth, this study offered young people the opportunity to lead substantive policy research and drive accountability for commitments that affect youth themselves.

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