



Literature Review

Adolescent Sexual and Reproductive Health Initiative

International Federation of Gynecology and Obstetrics (FIGO)

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Supported by:



What do we know about Adolescents?



- Adolescents' health and well-being is intrinsically linked to the social, cultural and economic environment.
- In all regions adolescents are reaching puberty earlier, marrying later so are sexually mature for longer before marriage.
- Adolescents' sexual experience varies across regions BUT within regions key aspects of ASRH are relatively consistent.
- Differences between groups of adolescents (e.g. urban/rural, in-school/out-of-school, girls/boys) influence access to health care and sources of education, information and support.
- Main risk factors affecting adolescents' health outcomes are: early sexual initiation, substance abuse, depression, ignorance about contraception.



Information, Education and Support

- Information must recognize diversity of youth (age, gender, marital & migration status etc.)
- The most effective interventions enhance factors which protect adolescents from harm.
- Protective factors include: education & schooling, families & communities, beliefs & values.
- Societal openness facilitates pragmatism. There is no evidence that it increases adolescent sexual activity.

Teen Pregnancy Rate in US	5 times that of Netherlands 4 times Germany
Teen Birth Rate in US	9 times that of Netherlands 4 times Germany
Teen Abortion Rate in US	Twice that of Germany Nearly twice Netherlands

The single most important barrier to care for adolescents is provider attitude [11]. In many societies adults have difficulty accepting teens' sexual development as a natural and positive part of growth and maturation. Lack of confidentiality, embarrassment, and feeling that they are not taken seriously or respected deters youth from using services but not from having sexual intercourse - exposing them to unnecessary risks.

Information, Education and Support

Adolescents face huge barriers in accessing information and services on SRH, including:

Social or cultural barriers – accepted early marriage and child-bearing, migration, urbanisation, media, peer pressure

Personal barriers – fear of parents or community knowing, fear of violence, concern about side effects

Service related barriers – cost, location, youth-friendliness, judgemental attitudes, concern about confidentiality, lack of supplies.

Successful intervention design includes:

- ✓ Knowing what adolescents are doing and thinking
- ✓ Respecting their diversity
- ✓ Exploring parent & teacher attitudes
- ✓ Encouraging youth leadership and self-confidence
- ✓ Using media effectively
- ✓ Meaningful community involvement
- ✓ Understanding the social environment
- ✓ Building capacity of local stakeholders
- ✓ Effectively synthesising & utilising information
- ✓ A range of interventions for the broader community as well as adolescents

Contraception



- Knowledge about modern contraception is lowest in sub-Saharan Africa.
- Use of contraceptives by teenage girls is low everywhere except Europe & US.
- Contraceptive use by sexually active teenage girls: 2% in Niger, Rwanda, and Senegal, to less than 11% throughout Latin America and the Caribbean, and 34% in Indonesia. It rises to 75% in the US, 88% in France, and 92% in Britain.
- Reported condom use at last higher-risk sex is low in most countries. Fewer female adolescents have used a condom at last higher-risk sex than males.

Contraception

- Primary abstinence (never had sex) is more common in South/Southeast Asia and North Africa/West Asia/Europe than in other regions. It is more likely to be practiced by young women than young men.
- Secondary abstinence (has had sex but has not engaged in intercourse in the past 12 months) is less frequent. It is most common in sub-Saharan Africa.
- Abstinence programmes are not effective at delaying sexual initiation and reducing teen pregnancy. What is effective is providing accurate, balanced sex education, including information about contraception and condoms.



Teen Pregnancy (Intended and Unintended)

- Every year 13 million women aged 15 -19 give birth in less developed countries.
 - Pregnancy- and childbirth-related complications are the primary killers of 15-19 year old girls worldwide - 70,000 deaths every year.
 - Infant mortality is highest where the largest proportions of births are to adolescents.
 - Children born to mothers under 20 are significantly more likely to die than those born to mothers aged 20 to 29.
 - More young adolescents experience premature labour, spontaneous abortion, and stillbirths than older women.
 - Avoiding unwanted adolescent pregnancies and providing adequate care for those who are pregnant could contribute significantly to achieving the MDGs.
- Teenage pregnancy is more common in Sub-Saharan Africa, Latin America and the Caribbean than in South/Southeast Asia
 - It is also more common in rural areas, among girls who are less educated, or have limited exposure to the media
 - Compared to women in their mid-twenties, women under 15 are 25 times more at risk of dying from complications related to pregnancy or childbirth; 15 – 19 year olds are at twice the risk

Abortion



- Adolescent birth rates are closely linked to rates of spontaneous and induced abortion.
- Worldwide, mostly as a result of unintended pregnancy, nearly 4.5 million adolescents undergo abortion each year; around 40% of these are under unsafe conditions.
- In countries where abortion is restricted, unsafe abortion causes up to 30% of maternal mortality.
- Unsafe abortions vary substantially across regions: 15-19 year olds account for 25% of all unsafe abortions in Africa. The proportion in Asia, Latin America and the Caribbean is much lower.
- Where abortion is restricted or where adolescents have difficulty in accessing legal abortions, post-abortion care services provide important support and improve the subsequent use of contraceptives.



Access to treatment for sexually transmitted infections (STI)

- Only a minority of adolescents have access to acceptable and affordable STI services.
- Projects for adolescents which address counselling and family planning often fail to include STI care among their service delivery objectives.
- Valid data on STI rates among adolescents is limited but it seems that large proportions of STIs occur in people less than 25 years.
- Adolescent girls have higher rates of STIs than boys - they often have older partners and are biologically more vulnerable.
- At highest risk: adolescent sex workers, their clients and street children.
- Treating STIs is essential - they facilitate the transmission of HIV.
- Provision of services for STI care depends on the country context. It can be provided in schools if incidence is high, or integrated into adult clinics with appropriate adaptations for adolescents.

HIV & AIDS



- A huge threat to adolescents in all regions.
- Sub-Saharan Africa is worst affected region, followed by the Caribbean. Eastern Europe and central Asia have some of the fastest growing HIV prevalence rates.
- 45% of all new infections are in young people.
- Young men are better informed about HIV/STI prevention than young women but are much more likely to have multiple sexual partnerships and higher-risk sex.
- HIV-testing is rare among adolescents despite high levels of knowledge about HIV&AIDS
- Young women comprise 57% of all young people with HIV. In sub-Saharan Africa this rises to 76%.
- It is essential for young people to have the means to protect themselves (e.g. protection from gender based violence, access to condoms, treatment for STIs etc.).

- In parts of **sub-Saharan Africa** almost 50% of girls are pregnant by the age of 19.
- Adolescent girls make up almost half of those having abortions.
- The majority of people newly infected with HIV are aged from 15-24 years.
- Girls are five times more likely than boys of their age to become infected.

Special Circumstances



Early marriage

- Does not necessarily provide security and safety for adolescent girls.
- Problems include: removal from school, isolation, risk of STIs & HIV, potentially negative health outcomes for mother and child from early pregnancy.
- Particularly common in South Asia, and in parts of West Africa, the Middle East and Latin America.

Conflict/post-conflict zones

- Problems affecting adolescents include: fear of violence, including rape; displacement; lack of respect; inability to continue schooling; risk of STIs & HIV; and lack of access to health care.
- Special programmes are required to address their SRH needs and assist them to become reintegrated into society.

Female Genital Cutting (FGC)

- Prevalent across the middle of Africa from Burkina Faso, Mali, and Gambia in the west, to Uganda, Tanzania and Kenya in the east.
- A programme of accelerated abandonment is helping countries take greater action to reduce FGC and its consequences.



Key programmatic issues (1)



Evidence shows key principles and actions for effective interventions:

- There is no ‘fixed menu’ suitable for every country. A **specific package** must be developed for each economic, epidemiological and social context.
- Assessments of local stakeholder and institutional **capacity** are important. As are supporting, implementing and evaluating ASRH programmes; and **involving** young people, families and communities in designing interventions.
- Ensure **age-appropriate** approaches. It is easier to influence behaviour before sexual activity starts
- Abstinence only programmes have not been shown to be effective. More effective is a **life-skills approach** combining abstinence messages with communication on partner reduction, condom use, and dual protection to prevent HIV, STI & pregnancy.



Key programmatic issues (2)

- Sex education programmes should offer **accurate, comprehensive information** & build skills for negotiating sexual behaviours
- **Peer education and outreach** can be combined with non-peer education methods
- **Essential programme components:** information & counselling, STI/HIV treatment & care, contraception, maternal health services

Thailand - Friend Corners

Ministry of Public Health has developed 350 Health Promoting Hospitals committed to health promotion and making health services more user-friendly.

In 2001 the DoH introduced Friend Corners outside school/college hours in shopping malls and community housing areas. First point of contact is with adolescent peer counsellors. Health staff provide counselling or basic primary care, or refer adolescents to specialised services.

The Friend Corner web site combines music, fashion and health information. It has been praised for making information accessible in an attractive way.

Key programmatic issues (3)

- **Effective** youth-friendly services (YFS): easy to reach but not obvious; free/very affordable; warm, informal atmosphere; confidentiality; services and supplies to meet multiple needs
- Situation analyses/needs assessments show **health care providers** often unable and unwilling to adopt an effective and sensitive manner with adolescents.
- Adolescents need access to quality YFS & technically competent, non-judgemental health care providers trained **how to work with adolescents**

Costa Rica

Strong programme for adolescents based on a solid political, legislative and social structure.

Key success factors & results include:

- ✓ A comprehensive service covering the whole country
- ✓ Broad political commitment to the needs of adolescents
- ✓ National training programme is being implemented for health workers
- ✓ Young people receive training to provide leadership on health
- ✓ Supporting efforts to build adolescent programmes in other countries

Key programmatic issues (4)



- **Monitoring and evaluation** should be included from the start; ideally a comparative methodology to measure effectiveness and outcomes
- **Girls and boys need equal access** to youth development programmes - connecting with supportive adults and educational & economic opportunities
- ASRH programmes can be complemented with **additional supportive measures** in the community e.g. with the media, and local institutions.
- **Scaling up** should be planned from the start, including costing, documentation, committed partners, and support from government

South Africa – National Adolescent Friendly Clinic Initiative (NAFCI)

Certification and assessment used to improve the quality of health services to youth at public clinics. Planned as a national program from the outset. After an 18-month pilot period, 350 clinics were participating, with 171 associated clinics by end 2005. Part of the LoveLife Programme which addresses adolescents' sexual health through multiple approaches, implemented through the DoH (to ensure sustainability). Positive youth health policies helped to facilitate the launch. The majority of externally assessed clinics complied with 80% to 90% of NAFCI standards. Success due to strong leadership, political support, collaboration with stakeholders, youth & community involvement, & technical support.

Key policy issues (1)



Policy issues needing to be promoted at country level include:

- Advocate for laws protecting adolescents from **sexual exploitation**, particularly highly vulnerable groups e.g. street children, young sex workers, migrants, refugees, victims of violence
- Work with government to enforce laws on **age of marriage**. If early marriage is prevalent, work with health care providers, parents and communities to encourage delay of first pregnancy
- Where **abortion** is legal, promote greater accessibility for adolescents combined with post-abortion counseling and access to contraception. Where abortion is illegal or restricted, facilitate provision of family planning programmes and post-abortion care
- Support enforcement of laws against **female genital mutilation/cutting** where the practice is prevalent





Key policy issues (2)

- Explicitly address **gender and other inequities** and advocate against the restriction of ASRH programmes to any section of the youth population
- Ensure **very young adolescents** (10-14 years) are also targeted in ASRH programmes so they can access appropriate information before becoming sexually active
- Advocate for keeping adolescents **in school** as long as possible, including following pregnancy for girls
- Support the development of **youth leadership**
- Design programmes that encourage **active participation** of parents, community leaders and youth
- Campaign for comprehensive, life skills-based **SRH education** in schools and communities



Key policy issues (3)



- Design **multi-sectoral, integrated programmes** addressing multiple youth needs
- Increase accessibility to **SRH services and supplies** by strengthening health systems
- Encourage **private sector** involvement for social franchising schemes, voucher systems & social marketing
- **Scale up** successful interventions with government support. Keep expansion in mind when designing new programmes
- Ensure **vulnerable groups** are included in ASRH policies (refugees, street children, married adolescents, victims of violence, orphans, drug users, young sex workers)
- Recognize that health care workers cannot meet all the needs of adolescents alone. **Join or create networks** that act together and maximize resources