Adolescent Sexual and Reproductive Health Initiative

International Federation of Gynecology and Obstetrics (FIGO)

Member Society Survey and Interviews

Professor Hamid Rushwan, Chief Executive FIGO

Supported by: UNFPA
More than 1.5 billion people are between the ages of 10 and 25 and more than half live on less than 2$ a day.

UNFPA uses the following definitions to describe different groups of young people:

- Adolescents: 10-19 year olds
  (early adolescence 10-14; late adolescence 15-19)
- Youth: 15-24 year olds
- Young People: 10-24 year olds

The experience of young people to safely and successfully navigate their transition to adulthood are diversified by age, sex, marital status, schooling levels, residence, living arrangements, migration and socio-economic status amongst other characteristics.
Challenges facing Adolescent Sexual and Reproductive Health

• Child marriage
• Female Genital Cutting/Mutilation
• Harmful Traditional Practices
• Lack of knowledge/experience (sexual education)
• High Risk Pregnancies / Greater risk of Obstetric Fistulae
• HIV Infection
• Risk of sexual abuse/ assault/ exploitation
• Stigma impacting health and knowledge seeking behaviours
• Abduction

• Age
• Sex
• Lack of social status
• Marital Status
• Economic Vulnerability
• Rural/Urban
• Level of Education
• Conflict Setting
• Living Arrangements
• Migration
Introduction: Why this Research?

- Adolescent sexual and reproductive health (ASRH) forms a major component of the global burden of sexual ill-health.

- ASRH has been historically overlooked.

- International agencies are now focusing on improving ASRH and providing programmatic funding.

- FIGO has funding from UNFPA to strengthen the capacity of FIGO member associations to support ASRH interventions at national level.
Methods

Three activities were used to determine how FIGO can effectively contribute to improving ASRH:

• Literature review of adolescents’ (10 – 19 years) attitudes; perceptions of health professionals; and programmes already assessed for effectiveness.

• **Survey of obstetricians’ and gynaecologists’ attitudes, knowledge and perceptions of ASRH (THIS PRESENTATION)**

• Information on existing tools and guidelines for ASRH services.
Methodology cont.

- 69 member associations were randomly selected to FIGO to take part in the survey through phone interview

- 37 member associations participated in the interview

- All regions of FIGO were represented but numbers were not sufficient to allow for regional analysis.

- Overall thematic analysis indicated that the data does provide meaningful insight into broad areas of adolescent sexual and reproductive health
The survey and interviews focused on four key issues:
- Policy
- Service Delivery
- Professional Training and Education
- Social and Cultural Issues

Respondents discussed:
- the situation in their own country
- the role of their national association
- the role of FIGO as an international federation.

73% of respondents were males and 87% regularly treat adolescents as part of their clinical practice. The average number of adolescents attended to each month was 65, ranging from 3 to 700.

Where responses clearly acknowledged regional, cultural or religious impact on attitudes, policy or practice, these are reported.
Policy Issues: National policy

80% reported that national policy addressed **ASRH rights**.
Of these policies:

- 96% supported adolescents’ rights to confidentiality
- 79% supported adolescents’ rights to access contraception
- 71% supported adolescents right to access services without parental/husband’s consent
- 54% supported the right to access abortion services

National policy explicitly restricted adolescents right to access some services:

- Abortion services (46%)
- Right to access services without parental/husband’s consent (25%)
- Rights to access contraception services (21%)

- Western Europe was the only region with entirely supportive national policies.
- 82% of countries gave male & female adolescents equal rights to access services.
- 78% of respondents said married & unmarried adolescents have equal rights to services.
- Middle East & North Africa region reported greatest discrepancies between care given to female and unmarried adolescents.
Policy Issues: Advocacy and Lobbying

- Some national associations are actively engaged in advocacy/lobbying on ASRH. Others find it difficult.
- Mixed levels of success reflect:
  a) willingness of the government to listen
  b) strength and level of influence of national associations
  c) level of significance accorded to adolescents
  d) wider political, religious and social environment

“We try to publish our idea in papers and sometimes we take part in TV discussions and we also are in close cooperation with the parliament group of women”. (Poland)

“They invite us to look usually; but sometimes they invite obstetricians from the society to participate in developing policy”. (Sudan)

“So, we try to do things with them, but it’s like they don’t listen to what we say.” (Venezuela)
Policy Issues: Advocacy and Lobbying

• 93% said obstetricians-gynaecologists should engage in advocacy for improvement of ASRH. 97% said FIGO should actively engage in lobbying.

• Publication of position papers, short evidence-informed policy briefs etc., by FIGO gives international credibility and support to national efforts. Documents can also be adapted to national contexts.

• Policy is important to provide rights to adolescents and a framework for service delivery, BUT it does not guarantee access to services. Countries with well developed policies may have major gaps in implementation.

‘Assistance from FIGO would be very helpful. While the government is supportive of ASRH policies and programmes ...support from FIGO would be welcome. It helps to have international links which give greater authority to push for greater change.’ (Morocco - interview notes)

“FIGO should help in creating awareness ... Lobby not only our government, lobby to those governments who are donors, you know, and our government have to listen to them”. (Pakistan)
Service Delivery: Equality of Access

- 27% said adolescents do not have equal access to services.

- 100% from W. Europe, and 71% from Europe & Central Asia reported gender equality in access to services.

- Latin America & Caribbean region: access is easier for girls –services structured to meet their health needs. Elsewhere boys have greater access: social and religious restrictions and health professionals negative attitudes to girls.

- 32% said married and unmarried adolescents do not have equal access. 100% in W. Europe, and L. America & Caribbean said they do have equal access. 100% in Middle East and N. Africa said access is impossible for unmarried girls.

‘Technically they have equal access but the attitudes of society, including parents, teachers and the stigma attached to SRH issues (means) access may be limited particularly to girls.’ (Sri Lanka)

‘The structure of health (service) allow much more access to females than males’. (Chile)

‘If someone sees her to go to that clinic they can think about her ‘why does that girl go there, what is the problem? She has done sexual relations’ they think, and things like that. Social pressures - but, if you look at the laws, there is no restriction.’ (Turkey)
Provision of Services

What works well:

- **Specialized Services** e.g. youth friendly services & adolescent services provided by family planning associations.

- **Specialized Staff** e.g. peer educators, psychiatrists, physicians. Only England and Sweden reported effective multi-disciplinary and collaborative working.

What does not work well:

- Specific aspects of care e.g. abortion services, access to contraception and follow-up care.

- School-based sex education programmes (due to inadequate training of teachers, lack of time, disapproval etc)

- Government run health facilities.
The relatively low priority for improving access to HIV prevention services (including VCT) is due to regional variation. 100% in the most affected regions (Africa, L. America & Caribbean) said skills must be improved.

Age-appropriate information covers information on puberty, body changes and sexual urges, physiology of the reproductive system etc.

97% said FIGO has an essential role to play in developing standards of clinical practice and technical guidance BUT that it is inappropriate/impractical for FIGO to be involved in national service delivery issues.
Professional Training and Education

• ASRH is an explicit part of training for obstetricians & gynaecologists in 37% of countries. Regional breakdown shows low priority in pre- & in-service training.

Table 3: ASRH as an explicit part of the training curriculum for obstetricians & gynaecologists
Professional Training and Education

• 90% want FIGO involved in developing training modules.

• 100% acknowledge need to make training tools fit national legal, religious and cultural contexts.

• FIGO could add value to new or existing tools by investing resources in national associations to do this.

• Development and promotion of tools need to be matched with large-scale, well targeted, skilfully facilitated training workshops – FIGO could help with this.

• Training modules should include social aspects of health; and have a clear focus on male and female adolescents’ needs.

‘Whatever the material that somebody develops ... I think there must be provision for some kind of adaptation to that country...that is what is important for it to be useful and to be used ....’
(Sri Lanka)

‘I knew about how to deal with it (ASRH) medically as a gynaecologist, but then I learnt there are more things like counselling. Communicating was another thing; the life skills which are never in our curriculum in my whole of, maybe ten years of medical school. I never knew about this life skills. But that added to my own knowledge of understanding what adolescents really need.’
(India)
Attitudes towards Adolescents:  
*How important is ASRH?*

Nineteen out of twenty two interviewees said ASRH is a critical issue for FIGO due to:

- Global levels of mortality and morbidity among adolescents
- The impact adolescent health/ill-health has on health in later life
- Intrinsic links between ASRH and FIGO’s existing priorities

‘It’s very important ... It’s like, let’s say it’s a starting point, because **how can you care about adult women’s sexual reproductive health if you haven’t taken the problems of young women and young girls?** ... For me it is crucial actually. You can’t like separate them and you can’t work with only adult women’s problems.’ (Estonia)

‘It is very, very urgent and FIGO should concentrate on that problem, not only in the developing countries, but also in developed countries.’ (Poland)

‘In developing countries this (ASRH) is the most important thing because **it will form the future population.** ... This is very important, the most important I think. If this can happen unsafe abortion, safe motherhood will also be affected ... because the individual will be knowledgeable in the future and the other things will be helped automatically.’ (Turkey)
Attitudes to ‘adolescence’:

Differences between physiological and cultural perceptions of adolescence. Where girls marry at a very early age e.g. Lebanon and Ethiopia, they go straight from being perceived as children to being ‘wives’ and ‘mothers’. This may account for some respondents not perceiving adolescents as having specific needs which are different to those of adult men and women.

‘I think that ‘adolescents’ in developing countries is not the same concept we have in, let’s say, developed countries. ... Because maybe a 13, 14 year old young woman who is an adolescent in Italy could be a mother in some other countries.

I think the only thing that makes the difference in terms of policies dedicated to this slice of the population could be awareness and education - very early and very basic.

Just to let the women, and young males, be informed about sexual health, I mean biological family planning, and so on. Very, very early and very simple. Because I think that a girl becomes a woman without even understanding what’s going on.’

(Italy)
Attitudes Towards Adolescents: *Gender*

- Adolescent girls’ powerlessness and vulnerability is a key issue – prejudice exists within government, social & cultural institutions, communities, and individuals.

- This impacts on girls ability to access health care e.g. restrictions on leaving the house, fear about lack of confidentiality, disapproval from health professionals, stigma and possible physical harm if her reputation is damaged.

‘Gender based violence is a huge issue, although it is not called violence - sort of accepted by the society. Then there is this issue of abduction marriage... it is not shunned by society, you see. Illegal of course, but not shunned by the society, so in large areas of the country it is just acceptable.’

(Ethiopia)

‘(Girls) are allowed to go (to health centres), but things regarding family planning, for example, use of contraceptive, use of condoms, this will be top secret and they will do it in other ways, not in the public sector.’

(Sudan)
Attitudes Towards Adolescents: Gender

• As a result many programmes focus on increasing girls access to health services and information. An unintended consequence of this is leaving boys unable to access services specifically designed for adolescents. There is a need to redress the imbalance.

‘The programmes are much more with girls than boys. They seem to be more attuned to girls’ issues because of high rates of pregnancy and complications.’ (Morocco)

‘Because we have gynaecology system we can talk with the girl, advise her, something like that and the boy doesn’t have this kind of specialised service to answer his questions.’ (Romania)
Attitudes Towards Adolescents: 
*Attitudes towards Information*

Health professionals and parents often have negative/judgemental attitudes towards giving adolescents sexual and reproductive health information.

Frequently due to anxiety about the impact of this information on sexual behaviour. **There is no evidence for this** but many believe that lack of knowledge is an effective deterrent.

‘The religious and cultural issues bring out the concerns of the parents: if you talk about this the children will go astray more; you know that kind of fear is brought up.’ (Sri Lanka)

‘I'd say some (professional colleagues) would say they (adolescents) should have the contraceptives. But there are a number of them I think they will also disagree. There are some differences in whether to accept or not accept access to family planning methods for adolescents ... if they use contraception they are likely to have maybe a better life and avoid the unnecessary pregnancies. But then they will say they also allow them to have sex. It means we'll expose them to HIV and AIDS.’ (Tanzania)

‘It’s like they (family practitioners) don’t want to talk about this because it’s like, if they don’t talk about it, the problem doesn’t exist.’ (Venezuela)