

Where are we in ASRH&R

(Adolescent Sexual & Reproductive Health & Rights)

20 years since the ICPD

(International Conference on Population & Development) ?

Dr V. Chandra-Mouli (chandramouliv@who.int)



The ICPD was a landmark event in Sexual & Reproductive Health



"...a remarkable consensus among 179 governments that individual human rights & dignity, including the equal rights of women & girls & universal access to sexual & reproductive health & rights, are a necessary precondition for sustainable development..."

Source: Report of the operational review of the implementation of the Programme of Action of the ICPD & its follow up beyond 2014.

The world in which adolescents are growing up today has dramatically changed in many ways
(since the ICPD)

The world has changed dramatically in the last 20 years.



- ❑ Remarkable progress in reducing extreme poverty
- ❑ **Tremendous increase in primary school enrolment**
- ❑ Rapid increase in mobile phone use
- ❑ Steady urbanization

Source: United Nations. Millennium Development Goals Report. 2014.

In some ways the world has not changed since the ICPD.



I'm Here: Adolescent Girls in Emergencies

Approach and tools for improved response



October 2014

- ❑ 2013 was marked by a continuation of multiple refugee crises, resulting in numbers unseen since 1994.
- ❑ Conflicts during the year ... have forced an average 32,000 people per day to abandon their homes and seek protection elsewhere.

Source: United Nations. Millennium Development Goals Report. 2014.

**There has been limited & patchy
progress in the sexual & reproductive
health of adolescents
(since the ICPD)**

Limited & patchy progress – 1/5

Despite gains in selected countries, little progress has been made in preventing child marriage in developing countries

TABLE 1
COUNTRIES SHOWING A DECLINE IN THE RATE OF CHILD MARRIAGE BY REGION

REGION	COUNTRIES WITH SIGNIFICANT* DECLINES IN RATES OF CHILD MARRIAGE
Sub-Saharan Africa	Benin (U), Cameroon (U), Congo (R), Ethiopia, Lesotho, Liberia, Rwanda, Sierra Leone, Togo, Uganda, United Republic of Tanzania, Zimbabwe (R)
Arab States	Jordan (R)
East Asia and the Pacific	Indonesia (R), Philippines (R)
South Asia	Bangladesh (U), Nepal
Eastern Europe and Central Asia	Armenia
Latin America and the Caribbean	Bolivia, Guyana (R)

Source: Results from two consecutive household surveys (MICS and DHS) in 48 countries.
* Measured as changes of 10% or more in the prevalence of child marriage between the two surveys.
(U) Changes observed in the urban areas only.
(R) Changes observed in the rural areas only.

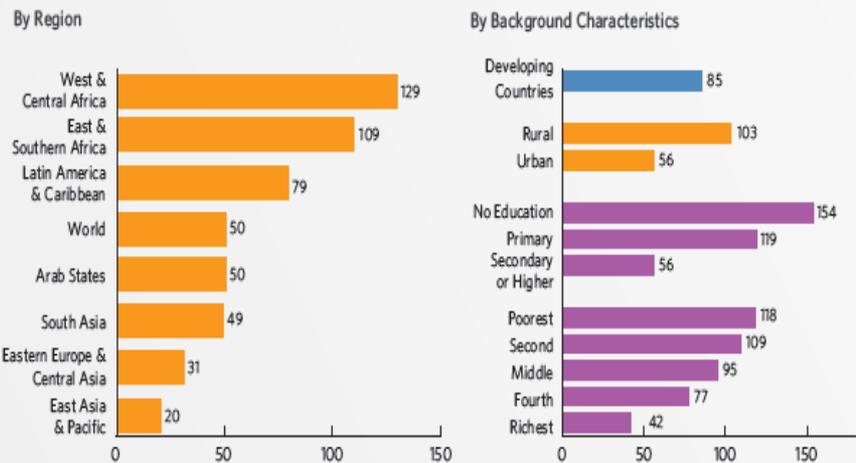
Source: UNFPA *Marrying too Young: End Child Marriage*. 2012.



Limited & patchy progress - 2/5

ADOLESCENT PREGNANCY

ADOLESCENT BIRTH RATES (DATA FROM 79 COUNTRIES)



Source: UNFPA, 2013.

The number of births to girls aged 15-19 years declined globally from 64 in 1990 to 54 in 2011 (per 1000 girls).

Source: United Nations. Millennium Development Goals Report 2014.



Source: UNFPA. Motherhood in childhood. Facing the challenge of adolescent pregnancy. . 2013.

Limited & patchy progress - 3/5

NEW HIV INFECTIONS

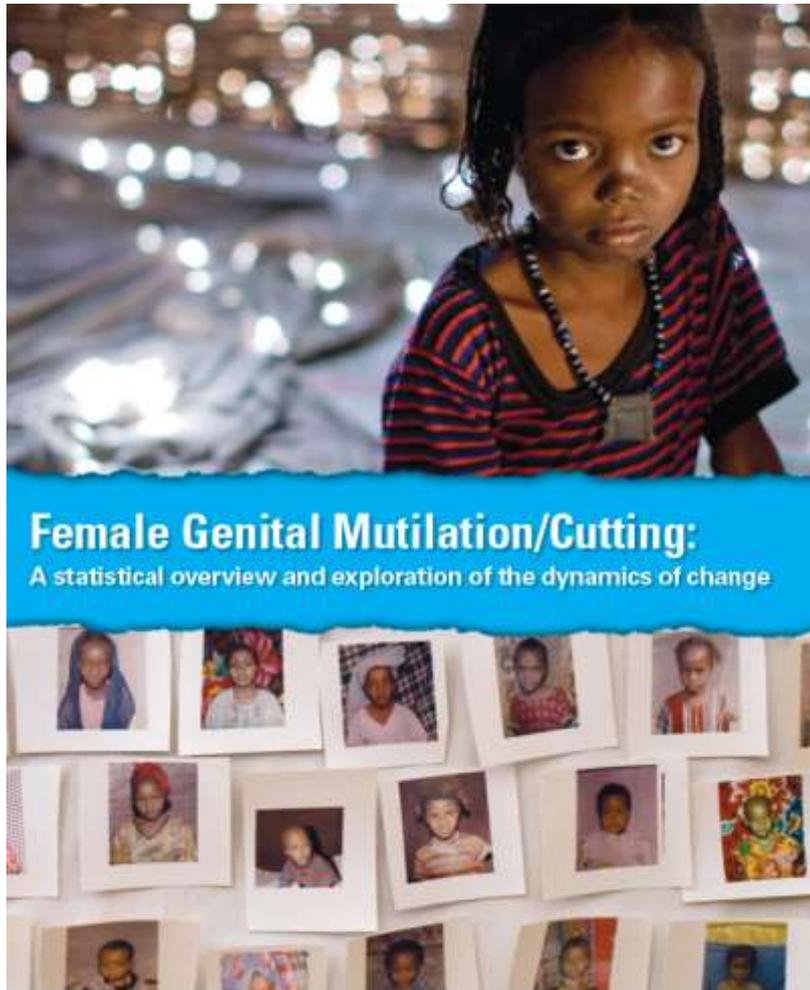
- ❑ Globally, the number of new HIV infections per 100 adults aged 15 to 49 years declined by 44 % between 2001 & 2012. However, there has been no substantive decline in the past decade in new HIV infections among young people between 15-24 years. ⁽¹⁾
- ❑ In 2012, approximately 2/3rd of all new infections were in girls, & mainly in sub-Saharan Africa. ⁽²⁾

Sources:

1. United Nations . Millennium Development Goals Report. 2014.
2. UNICEF. Towards an AIDS-free generation – Children and AIDS. Sixth stocktaking report. 2013.



Limited & patchy progress - 4/5



Female Genital Mutilation/Cutting:

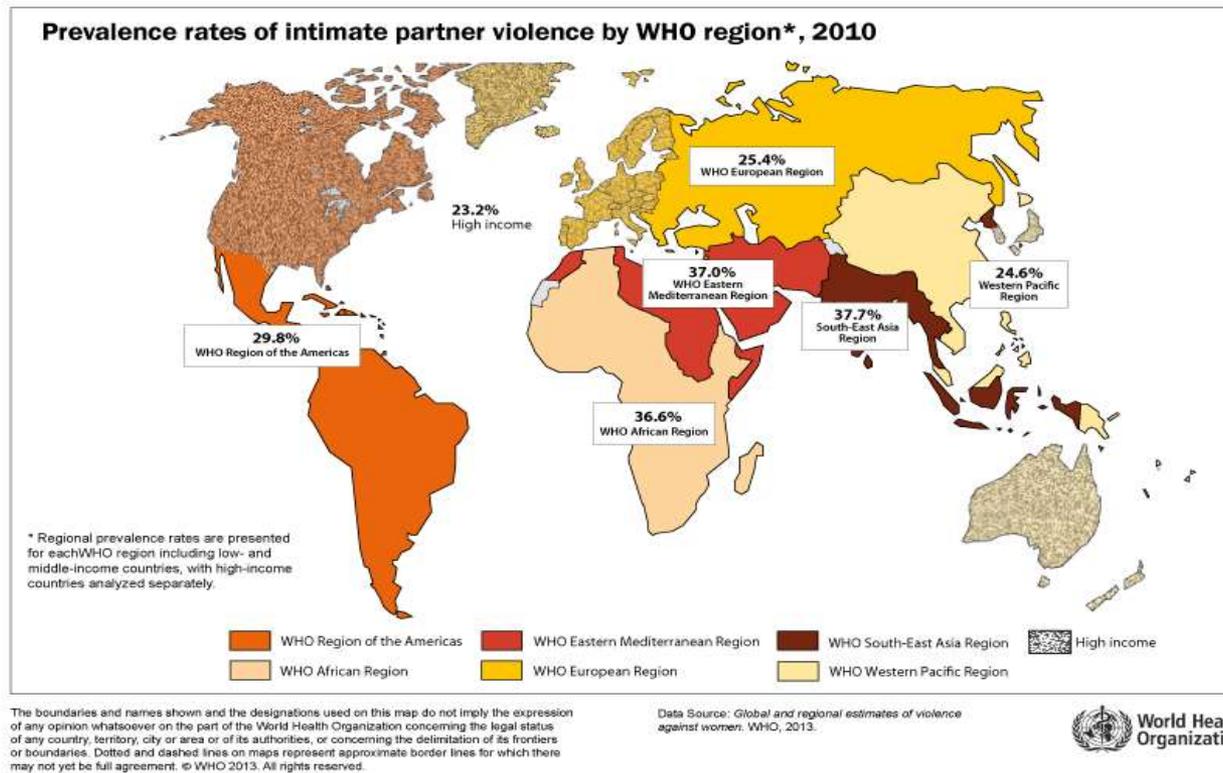
A statistical overview and exploration of the dynamics of change

FEMALE GENITAL MUTILATION/CUTTING

- ❑ Across sub-Saharan Africa, there has been only a minor reduction of the overall prevalence of FGM/C.
- ❑ But in more than half of the 29 countries where FGM/C is concentrated, significantly lower prevalence levels can be found in the youngest age group (15-19) compared to the oldest age group (45-49).

Source: UNICEF. Female Genital Mutilation/Cutting: A statistical overview and exploration of dynamics of change. 2013.

Limited & patchy progress – 5/5



- Globally, 1 in 3 women will experience physical and/or sexual violence by an intimate partner or sexual violence by someone other than their partner.
- Such violence starts early in the lives of women with estimates showing that nearly 30% of adolescent girls (15–19 years) have experienced intimate partner violence.

Source: World Health Organization, London School of Hygiene and Tropical Medicine, South African Medical Research Council: *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*. Geneva. WHO; 2013.

Taking stock of the progress made on ASRH&R since the ICPD: Looking back & looking ahead

- **The expanding window between the onset of puberty & the age of first marriage may leave a growing number of young persons without access to much-needed SRH services.**

(para 67)

- **Most adolescents & youth do not yet have access to comprehensive sexuality education (CSE), despite repeated intergovernmental agreements to provide it, support from the UN system, & considerable project-level experience in a wide range of countries and research showing its effectiveness.**

(para 68)

Source: Report of the Secretary General, United Nations on 'Assessment of the status of implementation of Programme of Action of the ICPD', Commission on Population and Development, April 2014.

(http://icpdbeyond2014.org/uploads/browser/files/icpd_global_review_report.pdf)

Our complementary review process

- ❑ **Commissioned 5 review papers on research evidence & implementation experience**
- ❑ **Tabled & discussed the papers at an expert group meeting with representatives of national governments, national & international NGOs, researchers, UN agencies & funders**
- ❑ **Fed the conclusions & recommendations of the expert group meeting into regional ICPD review meetings**
- ❑ **Prepared a set of papers for publication in a special supplement of the Journal of Adolescent Health**

Creating an enabling environment for adolescent sexual & reproductive health and rights: A framework & promising approaches - 1/2



Evidence from research:

- ❑ Individual behaviours are shaped by factors that operate at the individual, relational, family, community & societal levels.
- ❑ There are promising approaches to build protective factors & address risk factors at the individual level (*building individual assets*), relational level (*working with parents & peers*), community level (*challenging & changing community norms*) & the societal level (*formulating & applying enabling laws & policies, & increasing investment*).
- ❑ There has been only limited research or rigorous evaluation in this area.

Lessons from implementation experience:

- ❑ *Most efforts are piece-meal, small scale & time limited.*

Creating an enabling environment for adolescent sexual & reproductive health and rights: A framework & promising approaches - 2/2

Implications for action:

- Adapt & apply the promising approaches to the realities of different contexts, using a multi-level approach.

Implications for research:

- Carry out research & more rigorous evaluations.

Sexuality education: Emerging trends in evidence & practice - 1/2



Evidence from research:

- ❑ Comprehensive Sexuality Education (CSE) does not foster early or increased sexual activity.
- ❑ CSE programmes that include & effectively address gender equality & power relations are more likely to reduce unwanted pregnancy & Sexually Transmitted Infections.

Lessons from implementation experience:

- ❑ Only a small number of countries have scaled up CSE.
- ❑ Even in these places, vulnerable adolescents have not been reached.
- ❑ Teachers – in many places - find it very difficult to conduct CSE.

Sexuality education: Emerging trends in evidence & practice – 2/2

Implications for action:

- ❑ Scale up school-based programmes with serious investments to strengthening teachers' capacity to deliver CSE that is participatory, & generates critical reflection & dialogue about gender, power, sexuality & rights.
- ❑ Prioritize the most vulnerable adolescents, as well as students in upper primary grades (because in many places many girls do not make the transition to secondary school).

Implications for research:

- ❑ Carry out implementation research to identify & overcome barriers to the delivery of CSE programmes in different contexts.
- ❑ Evaluate health & social outcomes of CSE programmes, not just self-reported sexual behaviours.

Effective strategies to provide ASRH services & to increase demand & community support - 1/2



Evidence from research:

- ❑ Training & supporting health workers, making health services friendly, & outreach education – together – contribute to increased service utilization by adolescents.
- ❑ **Complementary efforts to generate adolescent demand for services & build community support for their provision, increase service utilization.**
- ❑ There is limited evidence of the effectiveness of delivering health services outside health facilities. (Multi-purpose youth centres are not effective in increasing service utilization).
- ❑ **There are no evaluations of programmes directed at vulnerable & marginalized adolescents.**

Lessons from implementation experience:

- ❑ NGOs have been active in this area for a long time. Increasingly governments are taking up work in this area.
- ❑ **Often there is one-off training for health workers and there is little complementary demand creation work.**

Effective strategies to provide ASRH services & to increase demand & community support - 2/2

Implications for action:

- ❑ Formulate & apply laws & policies to enable the provision & promotion of SRH services for adolescents.
- ❑ Implement a package of actions that include: **health worker training & support; improvements to make facilities adolescent-friendly; informing adolescents about available services & building community support for their provision.**

Implications for research:

- ❑ Identify effective strategies to reach vulnerable & marginalized groups of adolescents.
- ❑ **Identify effective types of demand generation/community acceptance interventions.**
- ❑ Carry out cost-effectiveness analyses to identify the most efficient way to expand coverage without compromising quality.

Addressing intimate partner & sexual violence among adolescents: Emerging evidence of effectiveness - 1/2



Evidence from research:

- ❑ Parental support interventions prevent child maltreatment.
- ❑ Psychological support interventions aimed at children & adolescents exposed to violence reduces violence perpetration.
- ❑ School-based dating violence prevention interventions reduce violence perpetration.
- ❑ Community-based participatory group education improves gender-equitable attitudes but has not been shown to change behaviour.

Lessons from implementation experience:

- ❑ Most efforts in low and middle income countries are small-scale and time-limited projects.

Addressing intimate partner & sexual violence among adolescents: Emerging evidence of effectiveness - 2/2

Implications for action:

- ❑ Formulate & apply laws that promote gender equality.
- ❑ **Implement interventions that challenge social norms that condone gender-based violence.**
- ❑ Adapt & test interventions that have been successfully applied in high income countries.

Implications for research:

- ❑ Carry out longitudinal research to identify pathways to violence.
- ❑ **Conduct longer term follow up on perpetration/experience of violence, to assess the sustainability of behaviour change.**
- ❑ Carry out research to find out what works to prevention violence against special groups e.g. migrants, domestic workers.

Ensuring youth' right to participation & the promotion of youth leadership in the development of SRH policies & programmes - 2/2

Implications for action & research:

- Combine efforts to pursue meaningful youth participation with efforts to assess whether they contribute to the success of programmes and projects.

Participation is a right and therefore, should not be evaluated only in terms of whether or not it improves health programmes & health outcomes.

What do we need to do to achieve the ICPD objectives in ASRH&R ?

1. We must reach adolescents earlier in their lives than we have. And we must do a much better job of reaching vulnerable & marginalized adolescents.
2. **We must address ASRH&R programmes - not with isolated interventions, but with a package of “joined up” interventions, implemented synergistically at different levels.**
3. We must address gender inequalities in terms of beliefs, attitudes & norms, & promote more egalitarian power relationships, as an integral part of all ASRH&R programmes.
4. **We must move beyond small & short-lived projects to large scale & sustained programmes. This will require both greater investment & attention to the special factors that are critical to scaling up programmes in this sensitive & contentious area.**
5. We have a rich but still insufficient mix of effective approaches for improving ASRH&R. We need research to develop & test interventions & rigorous evaluations of ongoing projects & programmes.



Where are we with Adolescent Sexual and Reproductive Health & Rights, twenty years after the International Conference on Population & Development ?



A review of research evidence & implementation experience in five inter-related areas:

1. creating an enabling environment
2. providing sexuality education
3. providing sexual & reproductive health services, & creating demand & support for their use
4. preventing intimate partner violence & sexual violence
5. promoting youth participation & leadership