Training course in adolescent sexual and reproductive health 2020

Lessons learned and experiences gained in improving the SRH of adolescents in the 25 years since the ICPD

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Question 1

Name two changes in the demographic situation of adolescents in the 25 years since the International Conference on Population and Development.

1. **Increase in the population of adolescents**: 163 million adolescents have been added to global population since 1994, though this population change among adolescent differs from country to country.
2. **Sex selective disparities has increased:** Globally, the number of adolescent boys increased by 16.3% in the last 25 years while it increased only 13.7% for adolescent girls, suggesting sex selection.

Question 2

Name two changes in the social context of adolescents in the 25 years since the International Conference on Population and Development.

1. **Connectivity has increased among adolescents:** 71% of those aged 15–24 years have access to internet, compared with 48% of all persons. The rapid increase in internet access has brought opportunities to reach out to adolescents, while it has also shifted norms for SRHR and also increased the digital divide.
2. **Increased access to education**: Globally, the enrollments in education have increased significantly at all education levels. The gross enrollment ratio (GER) in secondary school increased from 56.1% to 76.4% between 1994 and 2016, and the GER in tertiary schools increased from 15.0% to 37% over the same period. Better access to education has delayed the age at marriage and age at first sex among adolescents.

Question 3

Name two health issues in which there has been improvement in the sexual and reproductive health of adolescents in the 25 years since the ICPD, and 2 areas in which there has been little / no progress.

Two improvements in adolescents' SRHR since ICPD are:

1. **Delay in age at first sex and marriage**: Out of 35 countries, 24 countries have shown delayed sexual initiation in their national surveys. Also, marriage before the age of 18 has decreased from 25% to 20% in the last 25 years.
2. **Increase in Adolescent contraceptive use**: Globally, more than 21% of adolescent girls, married or in union, are using a modern contraceptive. This is double the rate of 10 years ago.

Two areas where there have been little to no progress are:

1. **Increase in intimate partner violence**: In the countries with at least two data points over this period, the prevalence of adolescent girls aged 15–19 years who experienced physical and/or sexual violence by a current or former intimate partner in the preceding 12 months has been constant or even increasing for at least half of the countries.
2. **Increase in prevalence of sexually transmitted infections**: The global prevalence of all STIs, with the exception of chlamydia, has increased since 1994 among adolescents. (Eg: 64.8% for HIV, 17.6 for gonorrhea, 27.4% for syphilis)

Question 4

Name one area of change in the demographic situation or social context in your country that is influencing/could influence adolescent health, explain why, and provide a reference to back up your statement.

The rising access of internet and mobile phone among adolescents has been influencing their health in Nepal. According to Hootsuite, around 40 million mobile subscription and 16.19 million internet subscriptions have been recorded in Nepal in 2019, which is 134% and 54% of the country's population respectively.[i] UNFPA estimated in 2014 that more than 22 million Nepali people are mobile phone users, with the majority being young people.[ii] Though nationally representative data do not exist to show the exact number of adolescents using mobile phones in Nepal, pocket researches have shown the trend growing. As stated in the article by Liang M. et al[iii], access to internet has influenced adolescent health in Nepal.

This use of technology by adolescents is influential because:

1. **Untapped potential with rising use of technology**: In 2018, there was a growth of 7.8% in the mobile subscriptions and 0.02% growth in internet subscription. 4 million new users overcame the digital divide in 2018-19.[iv] This means that for Nepal, Internet subscription is has tremendous untapped potential that can be mobilized to reach the farthest and the rural-most young people with latest information and interventions of diverse nature.
2. **Growing recognition of technology in youth SRHR**: The use of internet for reaching out to adolescents is being recognized by the Government and partners now more than ever. Digital Nepal Framework, an initiatives by the Government of Nepal intends to leverage digital technologies (e.g., videoconferencing, e-learning, and mobile health) to address issues relating to access, affordability, and quality of healthcare for the Nepali people.[v] Ministry of Health with collaboration with UNFPA and GIZ Nepal launched an app called khulduli to reach out adolescents with SRHR related information.[vi]

Question 5.1

How much was the decline in the rate of adolescent childbearing in Uruguay in between 2014 and 2019?

The Adolescent Birth Rate (ABR) in Uruguay is half of what is was 23 years ago. The ABR peaked at 72 births per 1,000 adolescents in 1996 that remained stagnant until 2014–2015, and then a rapid decline began in 2016, reaching ABR to 36 per 1,000 in 2019.

Question 5.2

Name two factors that contributed to the decline.

The two factors that contributed to decline in ABR in Uruguay are:

1. **Developing and implementing multispectral policies and programs on SRH**: Since 2005, the country has strengthened policies to recognize SRH as a human right, including especially through landmark laws in 2008 (i.e., Law 18426 on the Right to Sexual and Reproductive Health) and in 2012 (i.e., Law 18987 on the Voluntary Interruption of Pregnancy)
2. **Strong civil society participation:** The government's strong political commitment to ensure rights-based approach to SRH was supported by equally strong civil society participation in monitoring the implementation of laws and programs.

Question 6.1

What are the levels and trends of HIV infection in 15 - 49 years old's in Zimbabwe?

Zimbabwe has general epidemic of HIV that are mostly transmitted sexually. The current prevalence among 15-49 years in Zimbabwe is 4.7%. The estimated HIV prevalence was 13.3% in 2017, down from a peak of over 25% in the late 1990s. Since 2010, there have been estimated decreases of 44% in AIDS-related deaths in all populations.

Question 6.2

Name two factors that helped the scale up of the Zvandiri programme in the country.

Two factors that contributed to the success of Zvandiri's scale-up are:

1. Standardization and integration of the program into national service delivery
2. meaningful engagement of adolescents and young people at all levels of the program

Question 7

These are the five main conclusions of the paper by Chandra-Mouli et al. Please briefly comment on whether each of these points applies to your country.

All the 5 concluding points devised in the paper by Chandra-Mouli et. al. applies to Nepal. However, some are more relevant than others in Nepal's context, which has been discussed below:

1. **Some aspects of ASRHR are higher on health and development agendas than ever before.**

   ASRHR is increasingly recognized as an important aspect of health and development. The emphasis on increasing access to family planning, reducing maternal mortality and adolescent birth rate etc. were programmatic strategies taken since 1950s. Since ICPD, rights based perspectives heightened Adolescent Friendly Health Centers' concept, which is currently implemented in all 77 districts of Nepal. The restructuring of the country from unitary to federal structure, provided ample opportunity to formulate or revise new laws and policies. However, the need for better implementation of policies, and to engage young people meaningfully still needs to be strengthened as per the vision of ICPD.

2. **There is a steadily growing financial investment in ASRHR, although much of the funding is from external sources and remains inadequate & fragmented.**

   In Nepal, more than 80% of the FP services are financed and delivered through private sector, around 16% from government and around 4% out of pocket depicting that investment of SRHR is mostly donor driven. However, the budget size on health is growing steadily each year. Health budget has increased to NRs. 90.69 billion (US$748.1 million) in the fiscal year 2020/21 from NRs. 68.78 billion (US$610.8 million) in the previous fiscal year budget (2019/20). The share of budget for ASRHR is very low, as highlighted in Chandra-Mouli et. al. for Nepal too, but Nepal has strongly spoken about investing in youth for their SRHR in international forums and commitments such as ICPD+25 Nairobi summit in 2019.

3. **While there are still many gaps to be filled, there is a growing body of data and evidence on ASRH. This has fed into norms and standards to guide policies and programmes.**

   Department of Health Services of Nepal develops its annual report by referring more than 10 different types if national information system. 71% of the indicators for Goal 3 under SDG i.e.

health and wellbeing, has publicly available national data to track the commitments and progress on SDG, making it the goal with most data available. More than 10 national health surveys are conducted in Nepal. Besides that, the capacity and resources to generate evidence have been growing both from civil society organization and private sector alike. This shows that the data and evidence have been growing. However, this does not mean that gaps do not exist. For eg: several indicators in SDG do not have a baseline, making tracking still difficult. This highlights the need for segregated data for evidence based decision making in the health sector. Also, the interventions and standards designs are not yet able to translate the existing evidence to guide policies and programs.

4. **Although implementation of ASRHR policies and programmes in many countries remains weak, a small but growing number of countries have created and implemented enabling legal and policy environments, and strong government-led programmes.**

   The restructuring of the country from unitary to federal structure, provided ample opportunity to formulate or revise new laws and policies. Safe Motherhood and reproductive Health and Rights Act 2017, National health Policy 2018, Karnali Provincial health policy 2019, National Adolescent Development and Health Strategy 2018, Nepal Health Sector Strategy Implementation Plan (2016-2021) are examples of policies at the national and provincial level that have recognized adolescents and youth's SRHR as imperative agents. Criminalization of discrimination during menstruation, recent update of Comprehensive Sexuality Education (CSE) including issues of LGBTIQA+, recent ordinance regarding acid attack all reflect enabling policy environment for Nepal regarding adolescent SRHR. However, gaps such as lack of directives and regulations on certain laws have made implementation challenging besides other challenges posed by social, cultural, political and economic contexts.

5. **Although there is growing support for addressing some aspects of ASRH, there is ambivalence about other aspects, and there is increasingly well-financed & organized resistance.**

   Nepal's adolescent SRHR issues do not have much ambivalence in papers, as Nepal has taken progressive stand in most of the issues legally. For eg: formally introducing CSE in schools, formulation of safe abortion policy, recognition of health and other rights of LGBTI+ in the constitution (named as sexual and gender minorities in the constitution of Nepal) itself was pioneer steps in the Asian region. However, the progressive stands on the legal documents are not reflected in practice. The opposition on safe abortion is not very strong yet but is getting strengthened silently. CSE was removed as compulsory subject for high school recently showing that it is less important than other subjects.

References

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