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.

In 1994, when ICPD took place in Cairo, Egypt, there were1.1 billion adolescents globally (1) but twenty-five years later (in 2019), the world has an additional 163 million adolescents with diverse interests, needs, and concerns (1).

The profile and distribution of adolescents across world regions have changed significantly over this period. Indeed, Sub-Saharan Africa has experienced the largest population increase at all ages, and among those aged 10-19 years, the population has nearly doubled, from 127 million in 1994 to 247 million in 2019. Meanwhile, in contrast, Eastern and South-Eastern Asia, Europe, and Northern America each has experienced significant population aging, with declines of approximately 12% in their adolescent populations (1).

These two major democratic changes are accompanied by consequences such as:

Disparities by sex, living in a world of smaller households and better health and longevity, increased proportion of international migration and of displaced persons, etc (1).

Question 2

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

1. New means of communication, knowledge sharing, and social media are transforming the lives of adolescents particularly. Youth are the most likely of all age groups to be connected through social media, with approximately 71% of those aged 15-24 years online, compared with 48% of all persons.
2. Educational attainment and decent work.

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 health issues in which there has been improvement in the sexual and reproductive health of adolescents in the 25 years since the ICPD are:

1. Age at first sex:

The Guttmacher-Lancet Commission on SRHR notes that, as young people are staying in school longer, marrying later, and using contraception, marriage, and sexual activity are increasingly delinked that is, marriage does not always precede sexual activity, and neither sexual activity nor marriage necessarily leads to pregnancy and childbirth. Since 1994, adolescent girls in most countries have delayed sexual initiation; of 35 countries with at least three national surveys conducted since 1994, 29 show a declining trend. The regional exception is Latin America, where the proportion of girls having sex before age 15 years

remained static or increased in five of six countries surveyed. Within Latin America and the Caribbean, the largest increase was in Colombia, where the proportion of girls reporting sex before age 15 years increased from 9% in 1995 to 17% in 2015; the Dominican Republic and Haiti follow reporting levels close to Colombia in 2013 and 2016, respectively. In sub-Saharan Africa (presented as Eastern and Southern Africa and Western and Middle Africa in, 23 of 24 countries saw declines in those reporting sex before the age of15 years, with declines ranging from 8% in Mali between 1995 and 2013 to 47% in Uganda between 1995 and 2016.

2. Age at first marriage:

The proportion of women aged 20-24 years who were married before the age of 18 years decreased in the past 25 years, from one in every four to one in every five. However, because of population growth in highly affected countries since 1994, the absolute number of girls married before age 18 years has increased slightly to an estimated 12 million girls. To end the practice of early marriage by 2030, the annual rate of reduction, at .7% over the past 25 years, will need to increase to 23%. Wide variations in the percentage of girls marrying before age18 years are found both within and across countries. The global burden of child marriage is shifting to sub- Saharan Africa, where rates of progress need to be accelerated significantly to offset the effects of population growth on the number of child brides.

<u>Two health areas in which there has been little progress in the sexual and reproductive health of adolescents in the 25 years since the ICPD are:</u>

1. Female genital mutilation(FGM)

Despite progress, FGM is driven by deeply entrenched norms in many communities, resulting in large variations at the subnational level and uneven progress in eliminating FGM

2. Violence against adolescent girls and young women

Worldwide, many young people experience violence that harms their health and dignity and erodes their well-being. For females, much of that violence is perpetuated by intimate partners. Data from 106 low- and middle-income countries indicates that 18% of ever-partnered women and girls aged 15-49 years experienced physical and/or sexual violence from a current or former intimate partner in the preceding 12 months. Adolescents aged 15-19 years can be particularly vulnerable; based on data from 55 countries.

<u>Two health areas in which there has been no progress in the sexual and reproductive health of adolescents in the 25 years since the ICPD are:</u>

1. Sexually transmitted infections and HIV/AIDS

The global prevalence of all STIs, with the exception of chlamydia, has increased since 1994 among adolescents and of all STIs; no epidemic has led to greater devastation than HIV and AIDS in the past 25 years. In 1994, HIV/AIDS accounted for less than a percentage point (2%) of DALYs among young adolescents, aged 10-14 years. By 2017, it accounted for 7% of DALYs.

2. Reproductive cancers

With growing worldwide attention to cancer, data are increasingly available. Although the prevalence of reproductive cancers is generally low among adolescents, the contribution of ovarian and breast cancers to overall DALYs among adolescent girls aged 15e19 years increased between 1994 and 2017, as has the contribution of testicular cancer to DALYs among adolescent boys in the Americas. Globally, the proportion of DALYs attributable to ovarian cancer increased from .08% in 1994 to .11% in 2017, but it increased from .11% to 25% in the Eastern Mediterranean.

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.

In Chad, faced with galloping population growth, particularly among adolescents and young people, faced with high and worrying morbidity and mortality and has a low rate of contraceptive use and a high fertility rate, faced with multiple inadequacies and challenges in terms of communication and implementation of CSE measures at scale, the Ministry of Public Health, in collaboration with partners, has developed and implemented the following policies, strategies, programs and projects: (i) the National Health Policy of Reproduction as well as the related standards and procedures (ii) the National Road Map for the Acceleration of the Reduction of Maternal, Neonatal and Infant Mortality, (iii) the Strategy to fight against fistula (iv) the Strategy of Securing RH Products (v) the Campaign for the Acceleration of the Reduction of Maternal Mortality in Africa (CARMMA) and (vi) the "Hand in Hand" Campaign for family planning.

Achieving the objectives of these plans requires broad awareness-raising among all stakeholders, and adequate support and support for these plans by donors, national decision-makers and opinion leaders (2).

Question 5.1

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

In Uruguay, the ABR peaked at 72 births per 1,000 adolescents in 2014 and has rapidly declined to 36 per 1,000 at 2019 (10), half of what it was 23 years ago and nearly half of the average AFR in Latin America of 67 per 1,000 adolescents (1).

Question 5.2

Name two factors that contributed to the decline.

1. Progressive laws and policies (recognizing SRH as a human right, including especially through landmark laws in 2008 such as Law 18426 on the Right to Sexual and Reproductive Health) and in 2012 such as Law 18987 on the Voluntary Interruption of Pregnancy) and strong government-led multisectoral responses and significant strides in developing and implementing SRH multisectoral policies and programs;

2. Active civil society monitoring lead to dramatic declines in adolescent fertility.

Question 6.1

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

Zimbabwe has a mature, largely sexually transmitted, generalized HIV epidemic. The estimated HIV prevalence was 13.3% in 15-49 years olds in 2017, down from a peak of over 25% in the late 1990s. The most recent data indicate prevalence among those aged 15-24 years of 4.7%, with prevalence among females (6.1%) almost twice as high as among males (3.4%). Since 2010, there have been estimated decreases of 44% in AIDS-related deaths in all populations (3).

As a result, Zimbabwe has made great progress in controlling the HIV epidemic and is well positioned to achieve the 90-90-90 fast-track targets (i.e., global targets to help end the AIDS epidemic). However, the HIV treatment cascade among young people shows that all achievements are lower than those for adults: currently, 50% of adolescents versus 74% of adults know their HIV status; 84% of adolescents versus 89% of adults living with HIV are on treatment, and 85% of adolescents versus 87% of adults on treatment have a suppressed viral load.

Question 6.2

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

Factors contributing to the success of Zvandiri's scale-up include:

1. Strong government leadership, standardization and integration of the program into national service delivery with meaningful engagement of adolescents and young people at all levels of the program,
2. Use of program data and research evidence to inform adaptation of the model and costing.

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.

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

   In Chad (as in most other countries), young people and adolescents constitute a positive force in society, which deserves special attention in policies, advocacies, programmes, laws and guidances. The gender aspects, equity and rights of adolescent girls, the fight against sexual and gender-based violence, the fight against female genital mutilation and early marriage of children and adolescents, as well as the empowerment of women, girls and adolescents are becoming increasingly important in reproductive health and in link with development agendas than ever before.

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

Sexual and Reproductive Health, specifically for Adolescents in Chad, is a health field that involves a large number of stakeholders, including government structures through the involvement of various ministries, partners of the United Nations System, including UNFPA, WHO, UNICEF, UN WOMEN, UNAIDS, etc. The health sector is also a major concern for the health of adolescents. National and international NGOs and civil society associations including the Global Fund, Expertise France, Care International, various international foundations and bilateral and multilateral international cooperation, national NGOs such as ASTBEF, CELIAF, AFJT, REFEMPT, ATEP, AMASOT, not to mention various networks including the network of parliamentarians for population and development, REJPOP, CONA-CIAF, etc.. These structures develop different communication activities in Reproductive Health. However, these numerous interventions are disparate, poorly structured and coordinated in order to optimize actions and measure their impact. More and more important financing is being ejected.

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.

   In Chad, the Division of Health Information Systems (DSIS) of the Ministry of Public Health, with the support of WHO and international NGOs, has updated and harmonized its database integrating key activities related to adolescent sexual and reproductive health and rights, as well as indicators of community activities in the field. The DHIS2 is increasingly being used for health data management, and Multiple Indicator Demographic and Health Surveys (EDMICS) make extensive use of it.

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.

   In Chad, the sexual and reproductive subcomponent for adolescents and young people (SRAJ) has enabled social reforms and the development of policies and strategies through advocacy actions which have produced remarkable progress namely: promulgation by the President of the Republic of Chad of law 006/PR/2006 prohibiting child marriage, promulgation of the law on reproductive health, adoption of the National strategy to fight against fistulas and promulgation of the HIV/AIDS law, and the adoption of the action plan of the National Roadmap for the Reduction of Maternal, Neonatal and Child Mortality (2009-2015) and the adoption and implementation by Chad and other countries of the Campaign to Accelerate the Reduction of Maternal Mortality in Africa (CARMMA) and the creation of the “Maison de la Femme” are related key policies and laws on the sexual and reproductive health of youth and adolescents.

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.

   The Chadian government's decision to create and adopt the family code, which is a religious and legal instrument giving more freedom and power to women and especially to adolescents and youth, was largely blocked by religious associations and initiatives, especially Muslim and sometimes Christian women who oppose contraception and remain ingrained in the customs and traditions that a man has the right to four women (Islam in Chad) and that the place of the adolescent and young girl is in the home and that

having many children is a blessing and a source of wealth. Thus, in their multiple interventions or projects, they do not carry out activities in favor of CSE.

References:

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