Training course in adolescent sexual and reproductive health 2020

Approaches to ensuing the continuity of SRH information and services provision to adolescents in the context of the COVID 19 crisis: and using the opportunity of COVID-19 to build back better

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Question 1.1

Name one issue described in the FP2020/IAAH statement that hinders adolescents' access to SRH information and services in your country.

One issue mentioned in FP2020/IAAH statement which is also pertinent to China is that quality sexual and reproductive health (SRH) services for adolescents became less available during the pandemic, because the country targeted limited health resources towards COVID-19, though adolescent responsive SRH services had already been inadequate before the pandemic struck. [1:2] Actually this issue is pertinent to "every country" as mentioned in the statement, yet I haven't found the appropriate references describing how other disruptions (e.g. school closures) affected the adolescent SRH education or services.

Question 1.2

Describe briefly what approach you would use to overcome this issue.

My approaches to overcome this issue are divided into three parts, i.e., the immediate steps, efforts as the pandemic evolves, and the long-term actions.

The immediate steps include: First, Chinese government COVID-19 guidance should commit to adolescent ASR, and be evidence-informed. [1:3] Second, age-disaggregated data should be collected, analyzed, used, and reported to evaluate the impact of the pandemic on the SRH of adolescents. [1:3]

As the pandemic has been effectively controlled in China, the sustained and expansive efforts to promote adolescents' access to SRH information and services include: First, all health services should adopt adolescent responsive approaches to SRH. [1:3] Second, adolescents should have access to full range of contraceptive methods. Third, contraceptive services can be integrated across other essential services that adolescents might seek during the pandemic. [1:4]

Beyond short term needs, health professionals, advocates, and youth leaders can make full use of this opportunity given by COVID-19 to collaborate with the Chinese government to increase investment in adolescent SRH services, and to strengthen health systems to better respond to the SRH care needs of adolescents, so that the persistent cycle of inattention to adolescents' needs for SRH within health systems could be interrupted. [1:2]

Question 2.1

Which recommendation(s) on CSE does the example from Education as a Vaccine Nigeria illustrate?

The recommendation on CSE that the example from Education as a Vaccine Nigeria illustrates is to communicate CSE messages through mass media and digital media which adolescents have access to (e.g. promoting relevant mobile applications, sharing information via Instagram, Twitter and Facebook). [2:7; 3:slide9]

Question 2.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

I think that this example would be feasible in China. According to the latest report, 99.2% of China's adolescents have access to internet, [4] which provides a great potential to share CSE information via digital media. Besides, there have already been a number of mobile applications on SRH (including menstrual health and care, sexual health information and risk assessment) to which adolescents have access.

Question 3.1

Which recommendation(s) on contraception does the example from RFHA Fiji illustrate?

The example from RFHA Fiji illustrates two recommendations on contraception.

One is to inform adolescents where and how to access contraceptive counselling and services, including changes, if any, to service delivery times, location, etc. during the COVID-19 response (e.g. sharing information on social and mainstream media about the available services and how to access them). [2:8; 3:slideds10&15]

The other is to consider setting up hotlines for adolescents providing information and advice on contraception self-use, side effects, method choice and other questions on SRHR (e.g. establishing a helpline, providing telephone services). [2:8; 3:slides10&15]

Question 3.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

I think that this example would be feasible in China. As mentioned before, 99.2% of China's adolescents have access to internet in 2020, [4] the majority of whom (93.9%) use mobile phones, [5] which makes it possible for them to access updated information on contraception via social media, as well as through hotlines.

Question 4.1

Which recommendation(s) on comprehensive abortion care does the example from FRHS India illustrate?

The example from FRHS India illustrates three recommendations on comprehensive abortion care.

The first is to inform adolescents where and how to access comprehensive abortion care, including safe abortion to the full extent of the law and post-abortion care, through appropriate

channels (e.g. information communicated through advertisements in newspapers and other media, as well as from clinical outreach teams and ASHAs). [2:9; 3:slides16&18]

The second is to ensure that in health facilities, comprehensive abortion care remains available for adolescents, is safe and is provided respectfully and confidentially (e.g. available abortion services). [2:9; 3:slides16&18]

The last is to consider reducing barriers that delay access to care and providing services subsidized or free of charge within the relevant legal framework and in-line with international guidelines (e.g. accompanying young women to the health facilities, navigating the mobility restrictions during the lockdown, reducing the cost of abortion services). [2:9; 3:slides16&18]

Question 4.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

I think that this example would be feasible in China. As the pandemic has been effectively controlled and the mobility restrictions mostly lifted in China, adolescents can have easy access to available abortion services, under the revised service delivery guidelines and protocols to ensure the safety of clients and service providers from transmission of COVID-19.

Question 5.1

Which recommendation(s) on maternal care and mental health does the example from the University of Nairobi and the Nairobi City Council in Kenya illustrate?

The example from the University of Nairobi and the Nairobi City Council in Kenya illustrates two recommendations on maternal care and mental health.

One is to consider using telemedicine for counselling and screening, including for risk factors known to be increased in the context of COVID-19 and to which adolescents may be particularly vulnerable and the occurrence of danger signs (e.g. establishing a hotline and an online psychotherapy service). [2:10; 3:slides19-20]

The other is to put in place targeted outreach strategies where coverage and care-seeking among pregnant adolescents have declined (e.g. setting up Zoom and Skype groups to provide self-care, psychological first aid, and to support referrals). [2:10; 3:slides19-20]

Question 5.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

I think that this example would be feasible in China. As National Health Commission, jointly with UNICEF, set up several virtual meetings to train additional health workers on group

psychotherapy for adolescents [6] and ASRHR [7] during the pandemic, I think that the similar strategies could also reach pregnant adolescents in need.

Question 6.1

Which recommendation(s) on HIV does the example from the Zvandiri in Zimbabwe illustrate?

The example from Zvandiri in Zimbabwe illustrates three recommendations on HIV.

The first is to inform adolescents where and how to access HIV and other STI testing and care, where access is possible, through mass media and digital media (e.g. virtual support groups, and scaled-up mobile app ZVAMODA). [2:11; 3:slides21-2]

The second is to use digital platforms and mobile health strategies (to minimize clinic visits) to provide adolescents with test results, treatment and prevention messaging, while ensuring privacy and confidentiality (e.g. virtual case management). [2:11; 3:slides21-2]

The last is to modify services to promote out-of-clinic delivery of elements of the advanced disease package of care (e.g. targeted home visits by mentors). [2:11; 3:slides21-2]

Question 6.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

I think that this example would be feasible in China. As mentioned before, 99.2% of China's adolescents have access to internet in 2020, [4] the majority of whom (93.9%) use mobile phones, [5] which makes it possible for them to access updated information on HIV and other STI services via social media or digital media.

Question 7.1

Which recommendation(s) on gender-based violence does the example from Centre for Catalysing Change in India illustrate?

The example from Centre for Catalysing Change in India illustrates three recommendations on gender-based violence.

The first is to inform adolescents where and how to get care, where access is possible, through mass media and digital media (e.g. providing information through digital platforms like YouTube, WhatsApp, and community radio). [2:12; 3:slides23-4]

The second is to sensitize and alert health-care providers, community workers and support networks to the potential for increases in sexual and gender-based violence and ensure they are

aware of adolescents' specific vulnerabilities (e.g. advocating awareness raising with communities). [2:12; 3:slides23-4]

The last is to establish help lines or enhance existing help lines for adolescents to seek help if needed (e.g. providing telephonic counselling services). [2:12; 3:slides23-4]

Question 7.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

I think that this example would be feasible in China. As mentioned before, 99.2% of China's adolescents have access to internet in 2020, [4] the majority of whom (93.9%) use mobile phones, [5] which makes it possible to provide information and support to adolescent girls and young women via social media or digital media, as well as through help lines.

Question 8.1

Which recommendation(s) on HPV does the example from the Ministry of Health of Laos illustrate?

The example from the Ministry of Health of Laos illustrates three recommendations on HPV.

The first is that if school-based HPV vaccination initiatives continue—or when they resume—infection prevention and control measures need to be implemented to avoid increased risk of transmission of the COVID-19 virus among students, school personnel and health care providers (e.g. providing an update on plans for school-based programs). [2:13; 3:slides25-6]

The second is to inform health workers and others involved in different aspects of HPV vaccine delivery about altered HPV schedules and updated age restrictions, and communicate the importance of HPV vaccination and the efficacy and safety of the new schedule or longer interval between vaccine doses (e.g. issuing new communication messages). [2:14; 3:slides25-6]

The last is to inform adolescents and their parents about the importance of a full series of HPV vaccination and any altered HPV schedule, reassuring them about the efficacy and safety of HPV vaccination and the alternative interval (e.g. issuing new communication messages). [2:14; 3:slides25-6]

Question 8.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

I think that this example would not be feasible in China. In China, the recommended age to receive 2vHPV vaccine is 9-45 years, 4vHPV 20-45 years, and 9vHPV 16-26 years. [8] Apart from the age restrictions, weak public awareness and non-coverage by medical insurance make it

difficult to carry out or scale up HPV vaccination among adolescents in school-based programs in China.

Question 9.1

Which recommendation(s) on menstrual health does the example from the Footprints Foundation in South Africa illustrate?

The example from the Footprints Foundation in South Africa illustrates two recommendations on menstrual health.

One is to advocate for the inclusion of menstrual products in the distribution of food or non-food items to girls with limited movement or those in camps and institutions (e.g. delivering dignity packs and food parcels). [2:15; 3:slides27-8]

The other is to engage community groups to extend the availability of affordable menstrual products (e.g. delivering parcels to schools, shelters, youth health centers, etc.). [2:15; 3:slides27-8]

Question 9.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

I think that this example would be feasible in China. According to National Plan for Child Development in Poor Areas (2014-2020), there estimated to be 4 million girls aged 12-16 years suffering period poverty in addition to general poverty. [9] The sustainable provision of menstrual products and puberty education needs partnership across various groups, as NGOs which advocate and commit to the delivery of menstrual packs to girls in desperate need indicate that the biggest problem is fundraising and need external financial support, [9] especially during the pandemic.

Question 10

In what ways do you think COVID-19 might, in fact, present an opportunity for accelerating progress on ASRHR?

I think that the new and innovative approaches developed during the pandemic (e.g. sharing ASRHR information via social media or digital media, and providing telephone services) could expand access to SRH information and services for adolescents, if sustained beyond COVID-19.

COVID-19 might also provide an opportunity to think and solve problems differently, which could help interrupt a persistent cycle of inattention to ASRHR. First, health professionals, advocates, and youth leaders might wish to consider how this crisis could enable the more rapid introduction of supportive measures and actions on ASRHR, such as systematically institutionalizing adolescent responsive programs and SRH service delivery approaches, which could also be sustained beyond COVID-19. Second, advocate of the collection of age-

disaggregated data can not only better track the effect of the pandemic on young people, but shine a spotlight on adolescent ASRHR needs beyond COVID-19. Third, emerging new frontline health providers have unique interactions with and insights into adolescents and can bring those experience to policy makers as COVID-19 evolves. [10]

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