Kathmandu, May 2016

What *works* & what *does not* work in Adolescent Sexual & Reproductive Health:

Research evidence & implementation experience

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

1. Can we improve Adolescent Sexual & Reproductive Health through county-level action ?

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The state of country-level work on ASRH&R

"…while many countries have developed sound national policies & strategies & have implemented pilot projects, much more needed to be done to fulfill the promises made to young people in the Programme of Action of the International Conference on Population & Development."

Source: S J Jejeebhoy et al. Meeting the commitments of the ICPD Programme of Action to young people. Reproductive Health Matters. 2013; 21 (41): 18-30.

Why have *so few* countries moved from sound policies and strategies to large scale and sustained programmes on ASRH ?

"In spite of the commitments made by States Parties contained in plans, policies, programmes and declarations…negative social, cultural, economic and legal factors continue to threaten the lives and health of a large number of women and girls… The effective realization of these commitments is, however, dependent on….:

- **Political will**
- **Enhanced capacity**
- **Adequate & sustainable resourcing**
- **Effective monitoring & evaluation**

- **Competing priorities**
- **Discomfort**
- **Weak capacity**
- **Cash shortages**
- **No real accountability**

Special Rapporteur on the Rights of Women in Africa. Intersession Report of the Mechanism of the Special Rapporteur on The Rights of Women in Africa - 52nd Ordinary Session of the African Commission on Human and Peoples' Rights. Yamoussoukro, October 2012.

What enabled *positive deviant* countries to put in place large scale and sustained programmes?

- **Competing priorities** — Strong political leadership and technical consensus
- **Discomfort and weak capacity** — Partnerships with credible and capable change agents (from inside and outside)
- **Cash shortages** — Secure funding
- **No real accountability** — Strong management and effective use of information

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England: Strong country action – 1/2

Journal of Adolescent Health xxx (2016) 1–7

ELSEVIER

JOURNAL OF ADOLESCENT HEALTH

www.jahonline.org

Original article

Implementing the United Kingdom Government's 10-Year Teenage Pregnancy Strategy for England (1999–2010): Applicable Lessons for Other Countries

Alison Hadley, S.R.N., H.V.[a,*], Venkatraman Chandra-Mouli, M.B.B.S., M.Sc.[b], and Roger Ingham, D.Phil.[c]

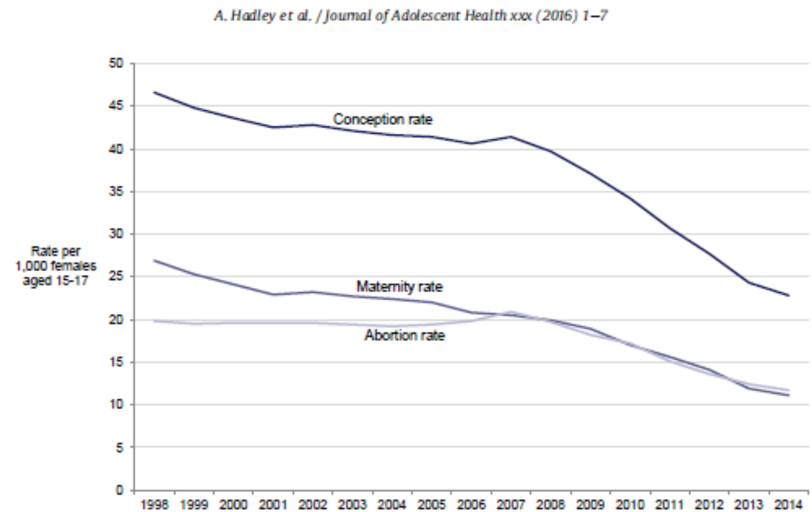

Figure 2. England under-18 conception rate: 1998-2014.

- **The concerted & integrated effort of the ten-year Teenage Pregnancy Strategy for England, delivered within the Labour Government's wider ambitions to narrow inequities, appears to have contributed to a significant reduction in under-18 conception rate.**

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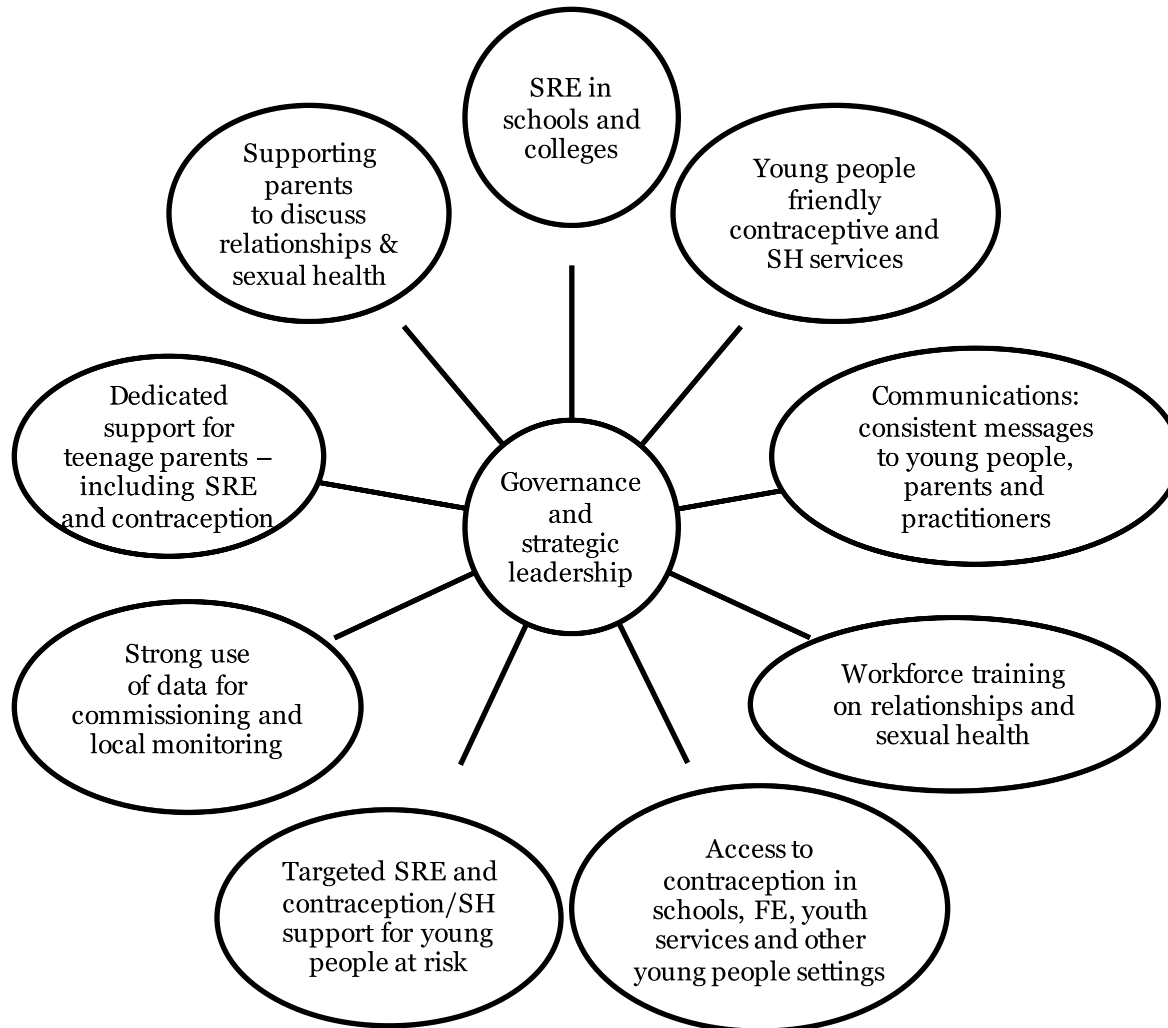
England: Strong country action – 2/2



The drop in teenage pregnancies is the success story of our time. The fall in young women having children is no accident – it's thanks to a programme that should be a model for social policy

Poly Toynbee, The Guardian, 13 December 2013

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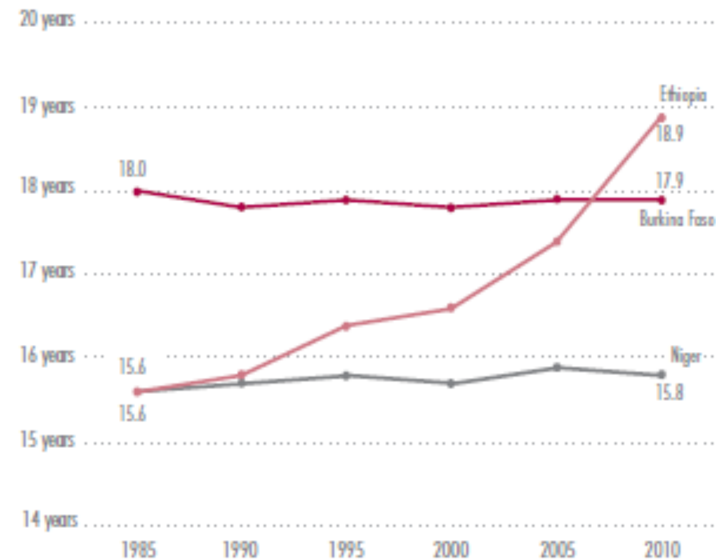
Ethiopia: Strong country action – 1/2

Child Marriage and Female Circumcision (FGM/C): Evidence from Ethiopia

YOUNG LIVES POLICY BRIEF 21 — July 2014 (revised December 2014)

"Remarkable progress has been achieved in reducing both child marriage & Female Genital Mutilation/Cutting in Ethiopia, due to favourable legal frameworks, political will & campaigns with support from donor agencies, international organizations, local civil society & the media, alongside broader forces of modernization".



Source: UNICEF, 2014

Ethiopia: Strong country action – 2/2

PLOS | ONE

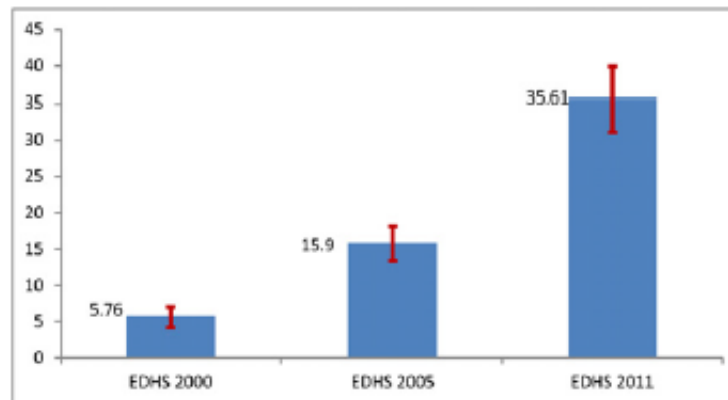
RESEARCH ARTICLE

Trends of Modern Contraceptive Use among Young Married Women Based on the 2000, 2005, and 2011 Ethiopian Demographic and Health Surveys: A Multivariate Decomposition Analysis

Abebaw Gebeyehu Worku[1]*, Gizachew Assefa Tessema[1], Atinkut Alamirrew Zeleke[2]

1 Department of Reproductive Health, Institute of Public Health, University of Gondar, Gondar, Ethiopia, 2 Department of Health Informatics, Institute of Public Health, University of Gondar, Gondar, Ethiopia

* abebawgebeyehu@yahoo.com



Bars Indicate 95% Confidence Interval

Figure 3. Trends in contraceptive use among Ethiopian young married women in the past 10 years, Ethiopia Demographic and Health Surveys 2000–2011.

doi:10.1371/journal.pone.0116525.g003

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Nepal has made impressive progress in women's and children's health in the context of MDGs 4 & 5
Adolescents are central to the SDG agenda

2. What works in Adolescent Sexual & Reproductive Health ?

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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

2014

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Creating an enabling environment for ASRH Evidence from research & experience - 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:

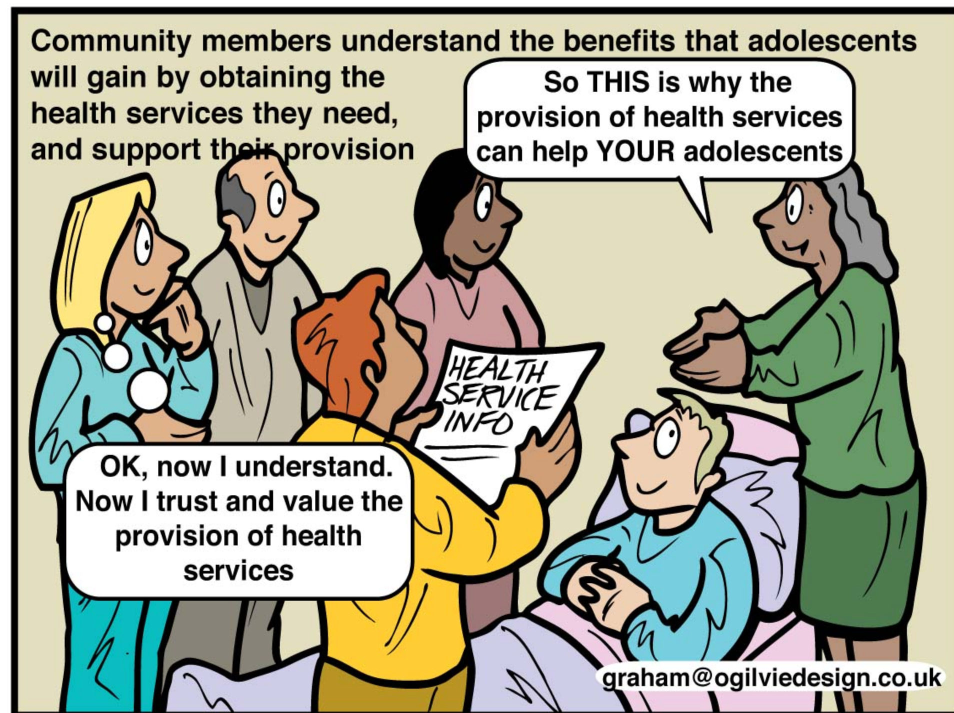
- Most efforts are piece-meal, small scale & time limited.

J Svanemyr, A Amin, O Robles, M Greene. Creating an enabling environment for adolescent sexual and reproductive health and rights: A framework and promising approaches. Journal of Adolescent Health, 2015: 56: S7-14.

Creating an enabling environment for ASRH Evidence from research & experience - 1/2

Implications for action:

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



Sexuality education: Evidence from research & experience – 1/2

Evidence from research:

- ❑ Comprehensive Sexuality Education (CSE) does not foster early or increased sexual activity.
- ❑ Well designed & well conducted sexuality education can:
- ✓ bring about positive changes in sexual behaviour (demonstrated in more studies),
- ✓ reduce negative health outcomes (demonstrated in less studies)

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.

N Haberland, D Rogow. Sexuality Education: Emerging Trends in Evidence and Practice. Journal of Adolescent Health, 2015.

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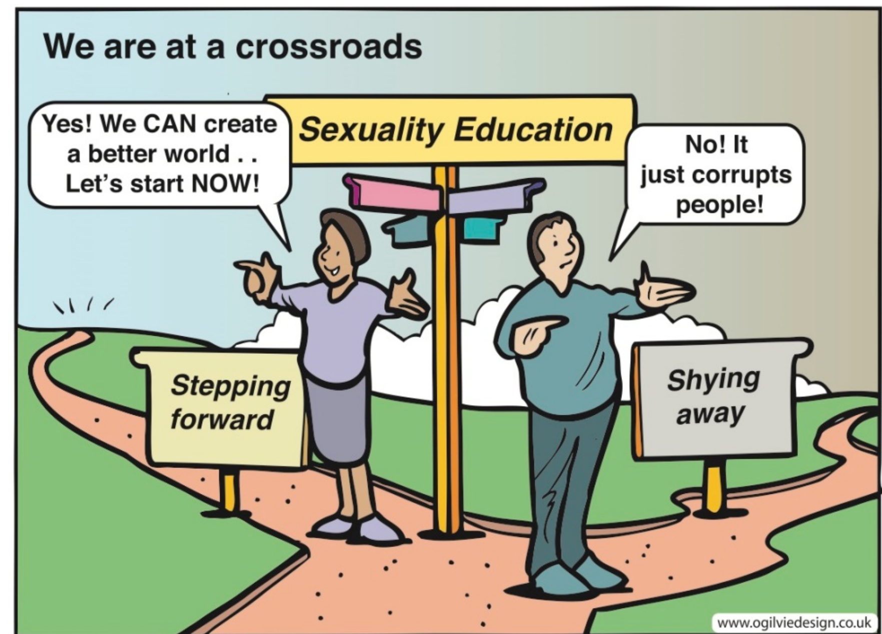
Sexuality education: Evidence from research & experience – 2/2

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).



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:

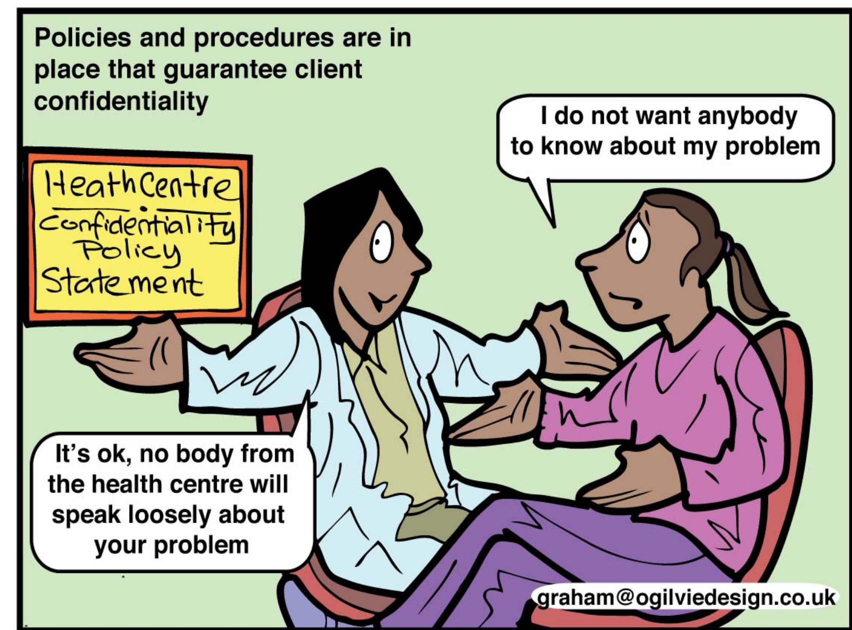
- NGOs have been active in this area for a long time. Increasingly governments are taking the lead in this area.

D M Denno, A J Hoopes, **V Chandra-Mouli**. Effective strategies to provide adolescent sexual and reproductive health services and to increase demand and community support. Journal of Adolescent Health. 2015, 56: S22-S41.

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.**



Ensuring young people's right to participation & the promotion of youth leadership in the development of SRH policies & programmes - 1/2

Evidence from research:

- A number of frameworks have been developed to better define, implement & monitor youth participation.
- There is little evaluation & research on the effectiveness of youth participation & leadership efforts. The one exception is peer education – the available evidence suggests that it is not effective in bringing about behaviour change.

Lessons from implementation experience:

- There is increasing youth participation in global processes.
- There is structured participation in some organizations such as IPPF.
- At the country level, there is more youth participation than before; but it can be token.

Villa- Torres L, Svanemyr J. Ensuring youth' right to participation and the promotion of youth leadership in the development of SRH policies and programs. Journal of Adolescent Health. 2015, 56: S51-57

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Ensuring young people's 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.

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Conclusions: What works in Adolescent Sexual & Reproductive Health ?

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 need research to develop & test interventions & rigorous evaluations of ongoing projects & programmes.

3. What does not work in Adolescent Sexual & Reproductive Health ?

GLOBAL HEALTH: SCIENCE AND PRACTICE

Dedicated to what works in global health programs

OPEN ACCESS

COMMENTARY

What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices

Venkatraman Chandra-Mouli,[a*] Catherine Lane,[b*] Sylvia Wong[c]

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1/5. Adolescents are not reached by the interventions intended for them

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For an intervention to have an effect on adolescents, it must first reach them.

Many adolescents are not actually reached by interventions as intended.

In a periurban setting of Addis Ababa Ethiopia over a one year period:

- **Only 1 in 5 boys aged 10-19 & less than 1 in 10 girls of the same age, made a visit to a local youth center over a period of one year.**
- **Just over 1 in 4 boys, & less than 2 in 10 girls were contacted by a peer educator from projects operating in the area.**
- **For boys & girls in the 10-14 years age group, the visit & contact rates were substantially less.**

Source:

Erulkar, A, Mekbib T, Simie N, Guelma T. Differential use of adolescent reproductive health programs in Addis Ababa, Ethiopia. Journal of Adolescent Health. 2008; 38: 253-260.

2/5. Interventions delivered to adolescents have been shown to be effective, but are delivered with inadequate fidelity

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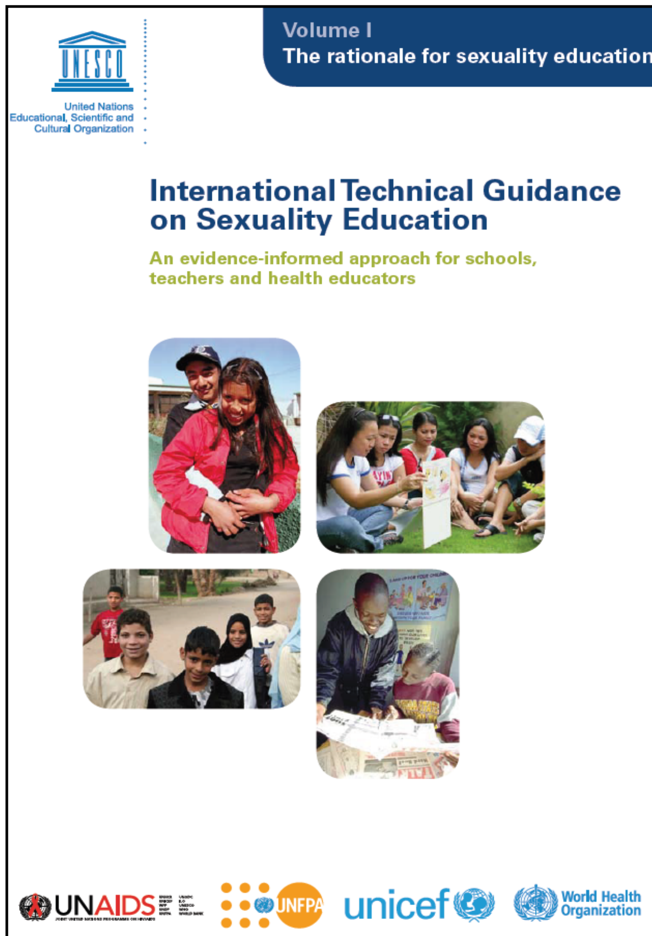
Fidelity of interventions

Fidelity refers to how the intervention corresponds to the original intended design.

Source:

Durlak, J.A., & DuPre, E.P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Psychology*, 41: 327-350.

COMPREHENSIVE SEXUALITY EDUCATION



Characteristics of evaluated sexuality education programmes that have been found to be effective in increasing knowledge, clarifying values and attitudes, increasing skills & impacting behaviour:

1. **Characteristics of the process of developing the curriculum**
2. **Characteristics of the curriculum itself**
3. **Characteristics of delivering the curriculum in educational institutions**

Source:

UNESCO, UNAIDS, UNFPA, UNICEF and WHO. International technical guidance on sexuality education. Volume 1. The rationale for sexuality education. An evidence-informed approach for schools, teachers and health educators. UNESCO. Paris. 2009.

COMPREHENSIVE SEXUALITY EDUCATION

Sources:
1. UNESCO, UNFPA. Sexuality education: A ten-country review of school curricula in East and Southern Africa. UNESCO, Paris. 2012.
2. Pokharel S, Kulczycki A, Shakyac S. School-Based Sex Education in Western Nepal: Uncomfortable for Both Teachers and Students. Reproductive Health Matters. 2006; 14(28):156–161.
3. Shrestha R M, Otsuka K, Poudel K C, Yasuoka J, Lamichhane M, Jimba M. Better learning in schools to improve attitudes towards abstinence and intentions for safer sex among adolescents in urban Nepal. BMC Public Health. 2013, **13**:244 doi:10. 1186/1471-2458-13-244.

- **Weak content:**

Inadequate information about contraception

Key aspects of sex, reproduction & sexual health were missing

- **Weak delivery:**

Some teachers lacked the needed skills

Most did not want to deal with sensitive matters

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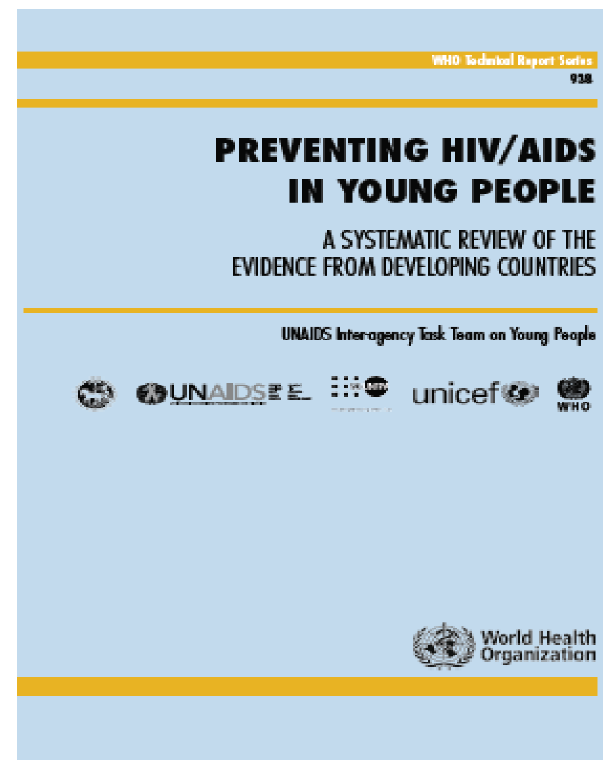
ADOLESCENT FRIENDLY HEALTH SERVICES

Health services have been shown to increase utilization of health services by adolescents only if they have all 4 of these characteristics:

- **Service providers non judgemental & considerate in their dealings with adolescents; & deliver the required services in the right way.**
- **Health service delivery points welcoming & appealing to adolescents; & provide the health services that adolescents need.**
- **Adolescents knowledgeable, able & willing to obtain the health services they need**
- **Community members aware of the health service needs of different groups of adolescents, & support their provision.**



Source:

1. Dick B, Ferguson BJ, Chandra-Mouli V, et al. Review of the evidence for interventions to increase young people's use of health services in developing countries. In: Dick B, Ferguson J, Ross DA, eds. Preventing HIV/AIDS in young people: A systematic review of the evidence from developing countries. Geneva: World Health Organization, 2006:151-199
2. Napierala Mavedzenge SM, Doyle AM, Ross DA. HIV prevention in young people in sub-Saharan Africa: a systematic review. *Journal of Adolescent Health* 2011 49(6):568-586.
3. Denno D M, Hoopes A J, Chandra-Mouli V. Providing adolescents sexual and reproductive health services and increasing adolescent demand and community support for their provision: What works? In press.

ADOLESCENT FRIENDLY HEALTH SERVICES

Abstract:

"The project was successful in increasing the flow of SRH information to secondary school students, & had an impact on intention to use public health clinics. No effect on the use of sexual or contraceptive-use behaviors or on use of public clinics were observed."

Discussion:

"...although the project trained clinic staff to provide RH services appropriate to adolescents, few of the features of clinics believed to make health services 'youth friendly' were incorporated into the project.

Source:

Magnani R et al. Impact of an integrated adolescent health program in Brazil. Studies in Family Planning. 2001 32 (3) 230-343.

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3/5. Interventions have limited effects because they are delivered piecemeal

Early pregnancy and poor reproductive outcomes among adolescents are determined by a web of micro- and macro-level factors:

- Individuals make choices to engage in specific behaviours
- Family and community norms, traditions, and economic circumstances influence these choices
- Policy and regulatory frameworks facilitate or hinder choices

Actions are needed at each of these levels by different sectors.

Adolescents too have key roles to play.

Laws – on their own – do not prevent child marriage

- There is *little correlation* between the existence of laws preventing child marriage & level/trends in child marriage.
- There are very few indications that laws – on their own - have contributed to discouraging and eradicating child marriage.

ICRW. 2013. Solutions to end child marriage: summary of the evidence.

Sources:

S Lee-Rife, A Malhotra, A Warner, A McGonagle Glinski. What works to prevent child marriage: A review of the evidence. Studies in Family Planning. 2012. 43, 4, 287-303.

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4/5. Interventions have limited/transient effects because they are delivered in a low ‘dosage’

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Dosage of interventions

Dosage (or strength) refers to *how intensively* and *for how long* a single intervention or a package of interventions has been delivered.

Source:

Durlak, J.A., & DuPre, E.P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Psychology*, 41: 327-350.

- **Interventions to reduce HIV, STI and pregnancy in adolescents that are delivered with greater intensity or for a longer duration are more effective**
- **Programmes to improve and change knowledge, understanding, attitudes, beliefs & behaviours need to be delivered with intensity, over a sustained period of time.**

- **In 2004, a Project in Shanghai project reported that their comprehensive community-based sex education and reproductive health service program had had a positive effect on contraceptive use among unmarried youth. (1)**
- **5 years later, a follow-up survey found that the intervention appeared to have limited long-term effects on contraceptive use among unmarried youth. (2)**

Source:

1. Lou C, Wang B, Sheny Y et al. Effects of a community-based sex education and reproductive health service program on contraceptive use of unmarried youths in Shanghai. Journal of Adolescent Health, 2004; 34(5):433–440.
2. Tu X, Lou C, Gao E, Shah I H. Long-Term Effects of a Community-Based Program on Contraceptive Use Among Sexually Active Unmarried Youth in Shanghai, China. Journal of Adolescent Health. 2008; 42, 249–258.

5/5. Popular interventions that have been shown to be ineffective for adolescents continue to be implemented

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Youth Centers to increase the uptake of contraception & other health services

Youth Centers are conceptualized as meeting points & "one-stop shops" to offer a friendly, safe & non-clinical environment where SRH information & services can be provided along with other social services, such as recreational activities or internet cafes.

Evaluations have shown that this approach does not result in increased use of SRH services.

V Chandra-Mouli, C Lane, S Wong. What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices. Global Health: Science and Practice. 2015. 3, 2, 333-340.

High-profile public meetings to urge communities to abandon early marriage & female genital mutilation

- **Bringing community members together to inform them about the risks of early marriage and female genital mutilation and urging them to abandon these practices – often in well-publicized one-off public sessions – has been shown to have little effect in changing these practices.**

V Chandra-Mouli, C Lane, S Wong. What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices. Global Health: Science and Practice. 2015. 3, 2, 333-340.

1. Peer relationships are one of the defining features of adolescence. They are very important to adolescents.

2. Peer relationships shape adolescents. They help them to:

- Learn how to interact with others
- Observe how others deal with their challenges and problems
- Give & get support

3. Peer relationships contribute to healthy & pro-social behaviours, & to unhealthy & anti-social ones.

4. All of us – children, adolescents & adults – face peer pressure. The closer an adolescent is a peer group, the stronger is its influence on him/her.

5. Adults should help adolescents understand & deal with peer pressure.

Peer education to encourage safe sexual behaviour

Peer education is a popular alternative or complement to adult-led health education approaches. It enables:

- Information exchange and open discussion between adolescents of similar age & social status
- Opportunities for repeated contact in a friendly context
- Access to those who are hard to reach through traditional adult-led health-education approaches

The effectiveness of peer-education in increasing safe behaviours/reducing risky behaviours *is limited*.

Adult-led education programmes can provide accurate information, answer questions & clarify misconceptions. Peer-led education programmes could complement this through discussion & interpretations in the context of adolescents' lives.

V Chandra-Mouli, C Lane, S Wong. What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices. Global Health: Science and Practice. 2015. 3, 2, 333-340.

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Conclusions: What does not work in Adolescent Sexual & Reproductive Health ?

- **Ensure the implementation of interventions that have shown to be effective, with fidelity & adequate dosage.**
- **Prevent the implementation of ineffective interventions that waste human & financial resources, & raise questions about the value of policies & programmes that do not demonstrate results.**