What *does not* work in Adolescent Sexual and Reproductive Health: A review of evidence on interventions commonly accepted as best practices

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Why youth?

- One third of the world’s population is aged 10-24
- Pregnancy and HIV: major causes of youth illness and death among youth
  - 16 million women 15–19 years give birth: 11% of all births, 95% in LMIC
  - 10% of girls are mothers by age 16 years (SSA, SEA)
  - 42% of new HIV infections to all people 15 and over are to adolescents 15-24

**HEALTH INVESTMENTS IN TODAY’S ADOLESCENTS HAVE IMMEDIATE AND FUTURE RETURNS**
What we knew then

- Adolescents experienced sexual and reproductive health problems
- Adolescents lacked information, with little or no access to services
- Restrictive enabling environment
- Adolescent sexuality unacknowledged

1994
Human reproductive system. Read the chapter at home...

Don't get pregnant like that girl down the street and bring shame on the family...

Health care providers are non-judgmental, considerate, and easy to relate to.

How could you be so stupid?

Honesty is the best policy.
Knowledge is power.
Always be prepared.
NEVER
What do we know now?

We value:

- Creating an enabling environment
- Providing sexuality education
- Providing SRH services
- Creating demand for services
- Preventing violence
- Promoting youth participation
We have a much better understanding of:

- The needs and concerns of adolescents
- What does and doesn’t work in responding to those needs

**H owever**, there are still gaps in our knowledge **A ND**

- Ineffective interventions and ineffective methodologies are still widely used
- Effective interventions are delivered ineffectively
1. Adolescents are not reached by the interventions intended for them

In peri-urban 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
- 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:
Effective interventions are delivered with inadequate fidelity

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. The process of developing the curriculum
2. The curriculum itself
3. The delivery of the curriculum in educational institutions

Source:
Comprehensive Sexuality Education in Practice

Weak content: inadequate information about contraception, sex, reproduction and sexual health

Weak delivery: Teachers lacked skills and comfort with sensitive topics
Adolescents more likely to use health services where:

- Providers are non-judgmental, considerate and respectful and provide the right services
- Services are welcoming and appealing to adolescents and provide the services adolescents want
- Adolescents are knowledgeable, able and willing to obtain services
- Community members are aware and supportive of health services for adolescents
Inattention to these principles limit adolescent use of services

- A project in Brazil increased the flow of SRH information to secondary school students, and increased their intention to use services.
- No increased use of services was documented.
- The project trained clinic providers, but made little effort to systematically address those factors that make services “youth friendly.”

Interventions are delivered piecemeal

• Poor reproductive health outcomes are determined by a complex web of macro and micro-level factors
  – Individuals make choices to engage in specific behaviors
  – Families, community norms, traditions and socio-economic factors influence choices
  – Policy and regulatory frameworks facilitate or hinder choices

• Action is needed at all levels by different sectors to achieve sustainable change.
  – This includes the importance of engaging adolescents
The experience of the UK

- In 1998, the Government of the UK established a 10 year strategy to reduce teenage pregnancy
- A core theme was coordinated action that included prevention activities for boys and girls and support for young parents
- A midcourse review in 2005 found an overall reduction of 11%, but wide variation.
3 local government areas where under-18 conception rates declined since 1998 were compared with 3 with similar demographics but where conception rates were static or increasing.

Areas with better rates of reduction implemented all aspects of the Strategy to create a ‘whole systems’ approach. In areas with little progress, only some aspects of the Strategy were being implemented.

The Government identified and disseminated nationwide ten ‘must do’ activities,

**Result:** Teenage pregnancy rates began to decline in all 150 local government areas of the country, and this decline continues to this day.
• Dosage: how intensively and for how long an intervention is delivered

• Programs to change behavior must be implemented with intensity over a sustained period of time

• In 2004, a Shanghai project reported a comprehensive community-based sex education and reproductive health service program had had a positive effect on contraceptive use among unmarried youth.

• 5 years later, a follow-up survey found that the intervention appeared to have limited long-term effects on contraceptive use among unmarried youth.
Popular, but ineffective approaches continue to be implemented

- Youth Centers intended to increase youth uptake of SRH services by
  - Providing meeting points
  - Implementing a “one stop shop” approach for health, social recreational and other services
  - Evaluations consistently show this approach does not result in increased uptake of SRH services, are costly and reach a limited number of young people (mostly young men)
Popular, but ineffective approaches continue to be implemented

- High profile meetings to urge the abandonment of harmful practices (early marriage, FGM)
  - Highly visible
  - Quantifiable
  - No effect on practices
  - Can even drive practices underground
Popular, but ineffective approaches continue to be implemented

- Peer Education approaches are hugely popular, and capitalize on the importance of peer relationships in adolescence.
- Peer relationships
  - Help adolescents learn how to interact and negotiate
  - Learn how to deal with problems
  - Give and get support
  - Contribute to both healthy and unhealthy behaviors (peer pressure)
Peer education programs

• Often implemented to enable
  – Information exchange and open discussions among similar groups of adolescents
  – Opportunities for repeat contact
  – Access to hard to reach or marginalized groups

• Effectiveness of peer education to change behavior is limited, and benefits mostly accrue to peer educator

• A more effective approach may be stronger partnership with adult led programs that can provide accurate information complemented by peer-led discussions.
Conclusions

• Implement interventions effectively with fidelity and dosage
• Prevent the implementation of ineffective approaches that waste limited resources, achieve no impact and raise questions about the value of policies and programs that do not demonstrate results
• Consider greater attention to new thinking around prevention science, assets-based approaches, positive youth development and cross-sectoral/systems approaches
A call to action!

1. Youth as partners
2. Stop doing what doesn’t work.
4. Innovate and evaluate!
   - Positive youth development
   - Cross-sectoral programming
Reaching Youth with Sexual and Reproductive Health Messages and Services in Malawi

MARCIE COOK
Global Health Mini University

March 4, 2016
PSI makes it easier for people in the developing world to lead healthier lives and plan the families they desire by marketing affordable products and services.
Development is best when it is nationally rooted and draws from global best practices.

65 national health organizations make up PSI’s global network.
We make markets work for Sara.

We convert need into demand and strengthen delivery systems and build local capacity, by:

- Communicating for Social Change
- Marketing Products and Services
- Franchising for Health
- Market Development
Adolescents and young people are at the center of program design and delivery.
“[We] need to go beyond training health workers on the supply-side, carrying out multicomponent demand-side activities, and integrating demand and supply-side strategies” – Journal of Adolescent Health, 2014
There are many different ways that YFHS can be delivered. The 'rooms' of your YFHS are these different service delivery models.

Quality and service standards make up the 'roof' of the YFHS. They are the standards and values that protect your clients, and protect us as service providers.

Service Delivery Models
- Public Sector
- Private Sector
- Community-based Social Franchise
- Separate Space Integrated Space
- Youth-friendly Pharmacies
- Mobile Peer Providers
- Community Healthy Workers

Provider Attitudes
- Effective
- Acceptable
- Appropriate
- Equitable
- Accessible

A strong and sturdy house is built with support beams that ensure the house will stay standing for a long time. The support beams of your YFHS is an enabling environment. This includes things like supportive policies, gender equitable norms, and a network of family members, peers and community members that support SRH services for young people.

All strong houses are a reflection of the strength of their builders. Critical to an effective YFHS is involving young people in the design, implementation and evaluation of your services.

Service provider attitudes make up the foundation of any YFHS. A respectful, non-judgmental and welcoming attitude must come first; without it, the entire operation will crumble.
In 2013 PSI developed and piloted a comprehensive training program for health providers to strengthen their services to meet the needs of adolescents and young people.
By 2015

- 42 providers are trained
- 33 providers certified and branded as Youth Alert!
- 19,000 voluntary FP services delivered to youth
  - 15,000+ for 20-24 year olds
  - 3,000 for 15-19 year olds
  - Just a few for 10-14 year olds.
- Between June and December 2015:
  - Reached 80,000 youth with Youth Alert! programs
  - Reached 800 youth with FP and HIV services during school and community open day events
What’s Worked?

- Focused training on provider attitudes and behavior (with practice!)
- Supportive supervision and follow-up
- Linking supply and demand.
- Engaging young people in service design, delivery and evaluation.
- Allowing providers to identify the needs of their communities and work to address those.
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What do we know (and what we need to know more) that works (or worked) in First-Time Parents programming?

Regina Benevides
Evidence to Action Project/
Pathfinder International
Who are FTP?

Young women under the age of 25 who are pregnant or already have one child, and their partners.
Why focus on FTPs?

• **Health outcomes**
  – Mothers and babies are healthier if there is at least 24 months between last birth and next pregnancy
  – Maternal health
  – Infant and child health

• **Gender and social norms**
  – Opportunity to form more equitable relationships and shift norms around childrearing
  – Opportunity to promote positive parenting
  – Opportunity to address IPV
### What we know that works

#### Factors that influence closely-spaced pregnancies

**DEMAND-SIDE**
- Young married women’s knowledge and desires
- Desires of their partners and families, peer and community norms
- Power dynamics in their marriage and households
- Broader gender environment in which they live

**SUPPLY-SIDE**
- Provider bias/Power dynamics between clients and providers
- Distance to a health facility
- Community- and facility-based health services that do not offer the full range of contraceptives
- Prohibitive rules and regulations

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**Enabling environment**
What we need to know more

HOW

Context-Specific complex situations
## Situation analysis

- Majority childbirth within context of marriage
- Shorter birth-to-pregnancy intervals
- Married young women socially isolated
- Inequitable gender norms and lower status
- Half of all marriages are polygamous

## Intervention

- House visits+ referrals
- Peer-led small group meetings + community meetings
- YFS integrated in the Health Centers
Target those who influence FTP decision-making ability
(BF: mothers-in-law, husbands, and co-wives;)

MIL in rural areas are different from peri-urban
➢ Strategies had to be different - individual vs group approach

Involving husbands or male partners
Few men were available during home visits
➢ Strategies to meet them at workplace; places of leisure

Age gap between spouses had an impact how to involve husbands:
Strategies:
➢ speak to older husbands and their young wives individually;
➢ involving supportive mothers-in-law and supportive religious leaders facilitated the contact with husbands and engage them in constructive discussions
Engage CO-WIVES
In BF: ‘co-wives’ extend beyond women who share the same husband to include sisters-in-law, cousins, and other older women in the household.

In Peri-urban they were obstacles to the YMW’s participation in the project—they often feared that if a younger co-wife used contraception would become more available to satisfy their husband’s sexual needs.

➤ Strategies:
• Speak to co-wives individually and clearly explain why the project worked with YMW
• Counseling sessions with the older co-wives to show them they were a valued stakeholder in the project.
Thank you!

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