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«Pas sans nous!» Les jeunes et la santé sexuelle et reproductive dans la coopération internationale

Overcoming the barriers

Where are we today – twenty years since the International Conference on Population and Development (ICPD) ?

De Venkatraman Chandra-Mouli

A total of 179 governments signed up to the International Conference on Population and Development ICPD Programme of Action which set out to provide universal access to family planning and sexual and reproductive health services and reproductive rights, deliver gender equality, empowerment of women and equal access to education for girls, address the individual, social and economic impact of urbanization and migration and support sustainable development and address environmental issues associated with population changes. Where do we stand 20 years after the Cairo Plan of Action, which tied together voluntary family planning, development policy and the strengthening of women's rights?

Young girls attend an informal school outside a mosque in Mian Poshteh (Helmand Province, © Kate Holt/IRIN)

The world that adolescents live in has changed dramatically since the ICPD. Here are three illustrative examples:

1. Substantial increase in access to improved drinking water sources: In 2012 64% of Africans obtained water from an improved drinking water sources, compared on 48% in 1990. However rural residents, the poor and minorities continue to have reduced access. (United Nations. Millennium Development Goals report, pdf)
2. Tremendous increase in primary school enrolment: Net primary school enrolment rose from 52% in 1990 to 78% in 2011. However, children in conflict-affected areas from poor households and children with disabilities are more likely to be out of school. (United Nations. Millennium Development Goals report, pdf)
3. Rapid increase in mobile phone use: By mid-2013, there were already 502 million SIM connections in sub-Saharan Africa are more likely to be out of school. (GSMA. Sub-Saharan Africa – mobile economy 2013, pdf)

Sadly in some ways the world has not changed since the ICPD as is clearly illustrated the following two statements out of the Millennium Development Goals report 2014: “2013 was marked by a continuation of multiple refugee crises, resulting in numbers unseen since 1994.” And: “Conflicts during the year….have forced an average of 32,000 people per day to abandon their homes and seek protection elsewhere.”

Limited and patchy progress in the sexual and reproductive health of adolescents

There has been limited and patchy progress in the sexual and reproductive health of adolescents. Here is information on three specific issues, with a specific focus on sub-Saharan Africa:

- The number of births to adolescent girls aged 15-19 years declined globally from 64 in 1990 to 54 in 2011 (per 1000 girls aged 15-19 years). But rates in sub-Saharan Africa continue to remain extremely high – 129/1000 girls in West and Central Africa, and 109/1000 girls in East and Southern Africa. (UNFPA 2012)
- Across sub-Saharan Africa, there has been only a minor reduction of the overall prevalence of Female Genital Mutilation/Cutting (FGM/C). But in more than half of the 29 countries where FGM/C is concentrated, significantly lower prevalence levels can be found in the youngest age group (15-19) compared to the oldest age group (45-49). (UNICEF. Female Genital Mutilation/Cutting 2013, pdf)
- Globally, new HIV infections in all age groups declined by 33% between 2001 and 2012. New HIV infections among adolescents declined even more sharply - by 43%. An estimated 250,000 new infections occurred in adolescents globally (range 210,000 – 290,000). However progress was uneven across different regions. For example while new infections have decreased substantially in Eastern and Southern Africa, they have remained stable in Asia and the Pacific. (UNAIDS 2014, UNICEF 2014)

The place of Adolescent Sexual and Reproductive Health in the global health agenda is steadily rising. The UN Millennium Development Goals report of 2011 (pdf) stresses the health rationale: "Reaching adolescents is critical to improving maternal health & achieving other Millennium Development Goals." A recent World Bank report stresses the economic rationale: "In Kenya, national income could jump $3.4 billion – almost 10% – if all 1.6 million Kenyan girls completed secondary school and the 220,000 adolescent mothers avoided pregnancy." (Chabaan and Cunningham, 2011, pdf) Temin and Levin point to the human rights rationale: “...by virtue of gender and other social inequalities, many adolescent girls in developing countries are at risk from violence; forced early marriage; HIV/AIDS and other STIs; and especially among the poor, exclusion from schooling, fair employment, and good health care". (Temine and Levin, 2009, pdf)

Adolescent Sexual and Reproductive Health in the global health agenda is steadily rising

The high level of attention being paid to Adolescent Sexual and Reproductive Health at the global level has resulted in limited benefits to adolescent girls and boys in low and middle income countries. One example is sexuality education. UNESCO has led the generation of evidence on the effectiveness of sexuality education, on effective means of delivering the intervention, and on the cost of delivering the intervention. IPPF, UNFPA, UNESCO and WHO have developed tools to plan, implement, monitor and evaluate sexuality education. Another example is adolescent participation which is very visible in international and regional processes e.g. the Global Youth Forum held in Bali, Indonesia in the end of 2012, and has a protected place in the work of some organizations such as the International Planned Parenthood Federation, which requires a certain proportion of its global, regional and national governing body members to be young people. However, its place in national and sub-national processes is uncertain and limited: "Adolescent participation is important but… It is also important to be clear about the ways in which this can really contribute. Too often it is tokenistic and when it is not, it is frequently seen as the goal itself rather than as a method for defining a useful strategy." (Blum 2013)

Health worker explaining birth control in Juba (© Hannah McNeish/IRIN)

Competing pressures, discomfort, weak capacity, lack of accountability and insufficient resources

While progress on ASRH is limited and patchy in many countries, a small number of countries have put in place large scale and sustained programmes. At he Commission on Population and Development in 2012, Shireen Jejeebhoy lamented in her key note address that: "…while many countries have developed sound national policies and strategies and have implemented pilot projects, much more needed to be done to fulfil the promises made to young people in the

Programme of Action of the International Conference on Population and Development." (Jejeebhoy, Zavier, Santhya 2013)

Competing pressures, discomfort, weak capacity, lack of accountability and insufficient resources – often in combination – lie at the heart of the policy/strategy-implementation gap in ASRH in many low and middle income countries. (Special Rapporteur on Rights of Women 2012)

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

However, a small number of countries have overcome these barriers and put in place large scale and sustained programmes. Here are two examples:

The first youth clinic was set up in Estonia in 1991, soon after independence. Over the next nine years, a national network of 18 youth clinics was established under the auspices of the Estonia Sexual Health Association. Alongside this, a national sexuality education programme was implemented. This twin-initiative coincided with a steady decline in annual rates of abortion and sexually transmitted infections including HIV.

Estonia and Mozambique as positive exemples

Six factors contributed to the successful scaling up of the Youth Clinic Network, and for it to be sustained:

1. Acknowledgement of the high levels of pregnancy and STI levels in adolescents and young people among senior government officials in the health and education departments, and of the need for a concerted response to the problem.
2. Support for the implementation of an adapted version of Sweden's youth clinic model, which was well known and well regarded.
3. The presence of a committed and capable national professional association (i.e. the Estonia Sexual Health Association) outside of - but closely linked to - the government, which led the implementation.
4. Ongoing support from organizations with expertise from abroad, including Swedish youth and reproductive health organizations and United Nations agencies.
5. Use of data on programme performance to shape efforts and to advocate for continued support for the initiative.
6. The availability of unbroken and reasonable levels of funding from 1991 to 2001, and guaranteed funding from 2002 following the establishment of the Estonia Health Insurance

Fund. (Kempers, Ketting, Chandra-Mouli, Raudsepp)

Programa Geracao Biz (PGB), the Busy Generation Project in Mozambique, is a multisectoral initiative involving the health, education, and youth and sports sectors put in place by the Government of Mozambique with a range of partners to improve adolescent sexual and reproductive health with a focus on preventing early and unintended pregnancy, STIs and HIV. It was launched in two pilot sites in 1999. Over the next ten years, it was scaled up to cover all the provinces of the country. In addition to expanding activities into additional provinces, the project expanded within provinces to reach larger numbers of adolescents. PGB reached considerable numbers of young people across the country over a sustained period and contributed to positive effects on adolescents' knowledge, attitudes, care seeking practices, and some sexual behaviours. Its effect on adolescent health outcomes is questionable.

Six factors contributed to the successful scaling up of PGB and for it to be sustained:

1. There was strong and support for the project from the highest levels of the Health, Education, and Youth and Sports government departments.
2. These government departments received strong and ongoing technical support from Pathfinder International and UNFPA.
3. PGB was carefully designed. Its objectives, the three-pronged strategy to achieve them, and responsibility for carrying out the activities within the three prongs of the strategy, and mechanisms for coordination were clearly thought through.
4. PGB was designed for sustainability by being grounded within existing government structures e.g. clinics and schools, and by institutionalizing activities such as training and monitoring into existing systems.
5. A number of governmental development agencies – Denmark, Norway, Sweden and Belgium – provided substantial financial support for the project over several years.
6. Serious attention was paid to implementation through ongoing support on both managerial and technical issues. There was ongoing monitoring and periodic evaluation and the data generated was used to address weaknesses and reshape the project. (Chandra-Mouli, Gibbs, Badiani, Quinhas, Svanemyr)

What enabled these positive deviant countries to put in place large scale & sustained programmes ? They addressed the barrier of competing commitments with advocacy from external and internal champions. They overcame discomfort and weak capacity by building partnerships with committed organizations with a credible track record and expertise in this area. They addressed financial constraints, by raising resources of from within and outside the country. Their improved accountability with good management included the effective use of data. These attributes are in line with those identified by Shiffman, Kuruvilla and Levine in other areas of public health. (Centre for Global Development 2007; Shiffman 2007, Shyama Kuruvilla et al. 2014).

Windows of opportunity

Windows of opportunity provide us with opportunities to scale up ASRH programmes. The experiences described above show that even in conservative and resource constrained contexts, scaling up of ASRH programmes is doable.

A number of 'windows of opportunity' are becoming available for us to use to do. Two examples from sub-Saharan Africa are the African Union Campaign to end child marriage in Africa and the Eastern and Southern African Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people. The renewed Global Strategy on Women's, Children's and Adolescents' Health is another great opportunity. In 2010, the United Nations Secretary General launched the Global Strategy for Women's and Children's Health to step up efforts to achieve the Millennium Development Goals 4 and 5. He stressed in his introduction: "Every year, millions of women and children die from preventable causes. They are not mere statistics. They are people with names and faces. Their suffering is unacceptable in the 21st century". The Global Strategy contributed enormously to drawing attention to childhood and maternal mortality reduction, and to strengthening global, regional and country level action. As we move from the Millennium Development Goals to the new Sustainable Development Goals, the Global Strategy is being renewed with a stronger focus on adolescents: Global Strategy on Women's, Children's and Adolescents' Health. Its focus is on survival (i.e. ending preventable mortality), on thriving (i.e. enabling children, adolescents and adults to achieve the highest standard of health) and on transformation (i.e. achieving transformative and sustained change).

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