Adolescent Voices:

Experiences in Implementing Youth Sexual and Reproductive Health and Rights Programmes

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Introduction

Young people – those aged between 10 and 24 – comprise nearly half of the world's population and 90 per cent of them live in developing countries. But they have been virtually ignored in health policies and specific programmes related to their sexual and reproductive health.

Young people are at a critical point in their lives and adolescence particularly is a time of key transitions. As the passage is made from childhood into adulthood, it brings with it developments and responsibilities accompanied by physical, emotional and psychological changes.

Adolescence is also a time when one begins to express one's sexuality. It is imperative to have the right information, knowledge and tools – to avoid unwanted pregnancies (leading to unsafe abortions or other pregnancy-related complications); sexually transmitted infections (STIs), and dropping out of school.

Adolescents: Key statistics

- In 2009 there were 1.2 billion adolescents aged 10-19 in the world, forming 18 per cent of the world population
- 88 per cent of adolescents live in developing countries
- India has the largest national population of adolescents (243 million)
- In 2009, around 50 per cent of the world's adolescents lived in urban areas.
- Adolescents account for more than 1 in every 5 inhabitants of sub-Saharan Africa, South Asia and the least developed countries
- International household data representative of the developing world indicate that around 11 per cent of females and 6 per cent of males aged 15-19 claim to have had sex before the age of 15
- Adolescent males are more likely to engage in risky sexual behaviour than adolescent females

(UNICEF, SOWC, 2011)

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This report was researched by: Sumita Banerjee

We also acknowledge the contribution from: Arabella Moore, Jessie Freeman, Amy Blyth, Elkie Thorndyke, Ragunathapillai Shanthakumar, Emebet Wuhib Mutungi, Mohit Ahuja, Chisomo Ngosi, Margarita Alvarado, Dr. Irfan Ahmed, Nicole Campos and Ahmed Mohammed.

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Unfortunately, for many girls adolescence means getting married, dropping out of school, exposure to violence, getting pregnant, early motherhood and accompanying it the possibilities of maternal mortality, pregnancy related complications and other health problems.

Adolescent Girls: Key facts

- There are 6.1 million unintended pregnancies each year among 15-19 year olds
- Almost half of all maternal deaths from unsafe abortions in Africa are in women under 25
- Young people account for 40 per cent of new HIV infections. In sub-Saharan Africa adolescent girls have higher infection rates than their male counterparts
- In 2008, there were 14 million births to adolescent girls aged 15-19
- Nearly 10 per cent of all adolescent girls in low and middle income countries become mothers under 16
- Young women aged 15-19 are twice as likely to die in pregnancy and childbirth than older women

(Source: Choices for Women: Planned Pregnancies, Safe Births and Healthy Newborns, DFID, Dec 2010)

In 2003 there were 2.5 million unsafe abortions involving adolescents under age 20. Of the unsafe abortions that involve adolescents, most are conducted by untrained practitioners and often take place in hazardous circumstances and unhygienic conditions.

(UNICEF, SOWC, 2011).

To address some of these health challenges facing adolescents, particularly around their sexual and reproductive health, Plan UK and its sister organization Interact Worldwide implement a robust package of sexual and reproductive health and rights (SRHR) programmes with special focus on those who are marginalised and hardest to reach:

- Young Health Programme (page 4) – a partnership between Plan UK, AstraZeneca and Johns Hopkins Bloomberg School of Public Health with the aim of reaching 500,000 young people directly by the end of 2015
- Building Skills for Life for Adolescent Girls: A Programme Partnership Agreement between Plan UK and the UK Government's Department for International Development (page 10) – empowering 40,000 adolescent girls
- Interact Worldwide (page 17) – specialised programmes focused in six countries reaching thousands of young people.

Our programmes look at the broader context in which adolescents live and address the underlying determinants that increase their vulnerability to sexual and reproductive health risks. This is critical to ensure longer term sustainability of programmes.

"Most families don't have food so they force their girl child to get married so that they can lessen the burden and also get labola (dowry). So the girl is usually perceived as a source of income in families while the boy is a source of labour for the family."

Community Representative, Zambia

Young Health Programme: A tripartite partnership between AstraZeneca, Plan UK and Johns Hopkins Bloomberg School of Public Health

The Young Health Programme (YHP) is a global partnership between AstraZeneca, Johns Hopkins Bloomberg School of Public Health (JHSPH) and Plan International. It is designed to help young people in need around the world deal with the health issues they face to improve their chances of living a better life. The Programme works both globally and locally with an integrated approach that supports local community programmes on the ground and provides a global platform of research and advocacy.

Through research led by JHSPH, the Programme will build an understanding of the health needs of the most disadvantaged youth across the world. The key study is WAVE (Wellbeing of Adolescents in Vulnerable Environments) which aims to build a unique understanding of the health needs of adolescents and explore the barriers preventing access to health services and information. The research is being carried out in six cities: Baltimore, USA; Ibadan, Nigeria; Johannesburg, South Africa; New Delhi, India; Rio de Janeiro, Brazil; and Shanghai, China. The site in Ibadan is funded by the Bill and Melinda Gates Foundation – the others by AstraZeneca's Young Health Programme.

The Programme on the ground involves 11 local countries with 16 partner organisations, bringing together the expertise and innovative thinking needed to make a difference. It will reach 500,000 young people between the ages of 10 and 24 directly and will touch an additional 500,000 lives indirectly by 2015.

As part of the YHP, a three year community programme (2011-2014) is being implemented by Plan UK in partnership with Plan Country Offices and local partner organizations in Brazil (Maranhao state), India (Delhi) and Zambia (Chadiza district in Eastern Province). The Programme is focusing on improving the sexual and reproductive health (SRH) outcomes for young people among other health issues.

In these countries, the Programme is providing information and building capacity of adolescents to protect their own health; advocating for supportive policies on SRHR for adolescents and strengthening the provision, access and quality of SRH services for adolescents.

Some of the strategies adopted by the Programme to address underlying causes that increase adolescents' vulnerability and improve access to SRHR information and services include:

- Evidence-based research to inform and guide the programme design and implementation
- Peer education training on a variety of topics including shaping of gender norms, attitudes and behaviours, sexuality, sexual and reproductive rights, life-skills based education, sexual health, reproductive health and sanitation
- Outreach activities including drama productions, fairs, street plays and campaigns
- Radio programmes
- Capacity-building programmes for parents and other community stakeholders
- Training for service providers
- Creating platforms for young people to discuss and share their issues and concerns with policy makers
- Supporting Health Information Centres (HIC) and Adolescent Friendly Corners
- Creating demand for SRHR services and advocating for supplies and resources
- Strengthening healthcare frameworks and capabilities including the provision of information and commodities
- Policy analysis and advocacy
- Building partnerships and coalitions on adolescent SRHR.

"I was married at the age of 15. However, now after attending the Plan Health Information Centre (HIC), I realize how important it is for my 15 year old daughter to know her health needs and also earn a livelihood for herself as it will empower her. I want my daughter to be educated and work and not to get married early. Both my husband and I are supportive and we encourage our daughter to come and learn from the HIC".

Parent reached by the YHP training, India

YHP in Brazil:

Project Site: Maranhao State (Municipalities of Sao Luis, Sao Jose de Ribamar, Codo, Timbiras, Peritoro)

Key Issues: Gender-based violence, machismo culture (patriarchy), early pregnancy, lack of adolescent friendly information and services

Target beneficiaries: 40,000 adolescents in the five municipalities and indirectly influence a population of over 65,000

Country implementing partners: Plan Brazil in partnership with Promundo

Improving understanding and training peer educators: Tatiana makes a difference through the YHP, Brazil

Photo: Plan

Tatiana lives in Codó, which is the sixth most populated municipality in Maranhão State. She is 12 years old, attending a public school in the municipality. She lives with her grandparents. Her parents are divorced and her mother who is a technical nurse, lives in a very poor area of Codó. Her father is a truck driver and travels a lot. Tatiana says that living with her grandparents was her own choice. She didn't like her mother's neighbourhood, which she considers very unsafe. Moving house also enabled her to be closer to her school.

The rate of teenage pregnancy was high in the neighbourhood because of the lack of public services and information about health among adolescents and youth. Tatiana confessed that prior to the Young Health Programme (YHP) she had not known much about pregnancy and sexuality. She has friends who became pregnant very young and she had been worried that this could happen to her. The YHP helped dispel some myths related to this. She was also worried about drug addiction which was increasing amongst adolescents in Codó.

Tatiana takes pride in being an excellent student. She loves studying and learning about new things, but finds the school environment challenging. Through the Young Health Programme, Tatiana has participated in peer education sessions alongside 106 other adolescents from Codó, Timbiras and Peritoró.

Tatiana attended sessions once a week for six months having heard about the programme at school. Through the programme she learned about issues ranging from human rights and sexual and reproductive rights, to parenthood, alcohol and other drugs dependence, work and community participation. In December 2011 she completed the course and is now involved in the next stage of the programme which is selecting schools, community groups and young people to which the 107 YHP graduates will be delivering the training.

Tatiana is very excited about delivering the peer to peer education. She is determined to give her best, exchange experiences and pass on everything she learnt from the YHP. Her expectations are that other adolescents could change their thinking and behaviour just as she did. She is very clear in her words about this: “I want help to improve the Brazilian society”.

Tatiana has participated in a number of other activities related to the project such as the World AIDS Day campaign and the Children’s Rights Conference in Codó, where young people discussed their rights and problems such as the need for health, education, social assistance and other related topics. She enjoyed the experience and says that she will carry on taking part in these activities – she thinks more political forums and discussions should include young people.

Since her involvement in the programme, Tatiana’s understanding of issues such as teenage health, gender, sexuality, pregnancy, human rights, violence and use of alcohol and drugs has improved a lot. She has challenged a number of myths around these topics and changed some strong opinions based on previous prejudices. Tatiana is now making plans for the future: she is confident that the YHP has helped her to develop the skills to negotiate gender roles with her future husband. For now, all she wants to do is focus on her studies.

YHP in India:

Project Site: Delhi in five resettlement colonies of Madanpur Khadar, Badarpur, Mongolpuri, Holambi Kalan and Dwarka

Key Issues: Malnutrition, infectious diseases (tuberculosis, dengue, malaria), early marriage, patriarchy, low knowledge of SRH, lack of SRH information and services

Target beneficiaries: a total population of 190,000 of which 38,000 are adolescents

Country implementing partners: Plan India in partnership with Community Aid and Sponsorship Programme (CASP)

Understanding the links between early marriage and negative sexual and reproductive health outcomes: Rama’s experience with the YHP, India

Photo: Plan

Rama is a young woman who lives in Madanpur Khadar community. The community is made up of 50,000 people who originally migrated to Delhi from other states in search of livelihood opportunities. Rama was married at the age of 15 when she was still in school and too young to understand the meaning of marriage. Rama wished to stay at school and complete her studies and was worried about falling pregnant. She tried to talk to her husband about using contraceptives but he threatened to abandon her and find another wife.

Forced to have sex without a condom left Rama confused and even resulted in her contracting a STI. Because of the taboo associated with visiting the doctor Rama was afraid to go and seek help. Eventually she did go to the Plan Health Information Centre (HIC) and received medicine to cure her STI and more information through video and discussions on menstruation, pregnancy, HIV and AIDS.

Gradually, Rama became one of the regular members at the HIC and with support from the Young Health Programme (YHP) staff her confidence grew. One day she narrated her whole story to the YHP staff and told them of her dilemma. Project staff encouraged Rama to stay in school and undertake the peer educators training in sexual reproductive health and rights. Armed with the right information and knowledge Rama’s confidence grew and she was eventually able to persuade her husband to use contraceptives and avoid an unplanned pregnancy. Rama’s relationship with her husband has transformed. He is now one of her biggest supporters and respects her feelings and rights.

“I was really confused about my future. I was not even able to make a right decision regarding my family life. But now with the help of YHP staff and programme I realised the importance of making a right choice for my career, family life and reproductive health. Now I know how to set goals and lead my friends, family and community towards a better life.”

Rama

Now Rama brings many of her friends to the HIC to discuss the sexual and reproductive health issues and concerns that they don’t feel comfortable talking about with their parents and teachers. Rama is working hard to complete her education and wants to become a teacher.

YHP in Zambia:

Project Site: Chadiza District in Eastern Province

Key Issues: Early sexual debut, early marriage and early pregnancy, harmful cultural practices (puberty initiation rites), low SRH knowledge, high rates of HIV, access to health facilities

Target beneficiaries: 16,200 boys and girls and reach another 33,800 people with health information and messages

Country implementing partners: Plan Zambia in partnership with Planned Parenthood Association of Zambia (PPAZ)

Encouraging girls and their parents to delay marriage and pregnancy: Thandiwe returns to school with support from the YHP, Zambia

Photo: Paolo Black for the Young Health Programme

Thandiwe is a young girl living in Zemba community, Chadiza district, which is situated in the extreme south-eastern corner of Zambia.

Chadiza district is rural and predominantly inhabited by Chewa-speaking people, under the leadership of Paramount Chief Kalonga Gawa Undi. Chadiza borders Mozambique and Malawi and has some trade with its neighbours. According to the District Health Department data, Chadiza district has a total population of 133,121 with approximately an even distribution of males and females. Over half this population is under 15.

Thandiwe is 18 and lives with her family. Her mother takes care of the household and her father works as a security guard. Thandiwe has two brothers and two sisters; she is the middle child and the oldest daughter.

In 2011, when she was 17, Thandiwe became pregnant. She was in Grade 7 at school, the last year of her primary education. Fearing her parents' anger, Thandiwe confided in her grandmother, who in turn informed her parents.

In Zambia, early pregnancy is common, a result of a lack of sufficient information for young people to protect their own sexual and reproductive health and well-being. It is common in rural communities in Zambia for girls to be married early in the event of pregnancy. Early pregnancy is also both a cause and outcome of puberty-related initiation rites that are common among the Chewa-speaking people. This has serious sexual health repercussions for young girls and is an issue that the project is addressing through evidence-based information dissemination and advocacy. Pregnancy can jeopardise the ability of girls to finish school and ultimately their ability to earn an income and fulfil their full potential in life. It also has serious repercussions for girls' health and is a leading cause of death among young girls in Chadiza.

Thandiwe's older brother is a Young Health Programme (YHP) peer educator and he recognised that for Thandiwe, the birth of her son had vital implications for the future. Encouraged by YHP staff, her parents met with the parents of the baby's father, and it was agreed that Thandiwe would not marry and would be encouraged to return to school. Her parents met with the head teacher at her school, who confirmed that she would be allowed to return. This year, when her son was 8 months old, Thandiwe returned to her previous school and took her place alongside her peers in Grade 8.

Thandiwe's parents have been very supportive. Her mother takes care of her baby while she is at school and her parents pay her school fees. Thandiwe believes that if she was married she wouldn't have been able to go back to school when she had her son. "Some of the parents encourage early marriages. They say since you're pregnant it's better to carry on with this kind of life."

She is grateful that her parents and teachers have been encouraging about continuing her education. "I was worried that they wouldn't accept me back at school. Most of my friends do not want to come back to school – they want to wait for someone to come and marry them."

As part of the Young Health Programme, 21 adolescent boys and girls have been trained so far as peer educators in the Chadiza district. Their role is to work in communities like Zemba to help engage and socialise with fellow young people and sensitise them on sexual and reproductive health issues that affect them. Several of Thandiwe's friends are peer educators. This has helped her to access information that would otherwise be unavailable, and has helped inform her decisions about her future and which route to take now that she is a young mother.

"I can help myself because I have a lot of information. I discovered that ...you can become pregnant because you do not know [it is important] to use a condom." The peer educators also helped her to understand how important it is to stay in school. "You can't get any employment without a Grade 9 certificate."

"My message [to other young people] would be that it is not good to have early sex and get pregnant early. There is more that peer educators can do – make more outreach programmes in villages, spread the word further. If we go to the villages, that is where we have the problems. After sharing this information with them they start to have a clearer picture."

Thandiwe

Thandiwe is also keen to share her experience with her friends, to help them avoid a similar situation. Following training, Thandiwe can talk to young people about contraception, protection from HIV and other STIs and health problems that early marriage and pregnancy can cause.

Thandiwe explains that she is now focused on completing her education, and would like to finish Grade 12. She enjoys maths and science, and would like to be an accountant in the future.

Building Skills for Life – A programme for adolescent girls

Plan UK secured a three year Programme Partnership Agreement (PPA) from UK's Department for International Development (DFID) for implementing the 'Building Skills for Life for Adolescent Girls' programme. The programme is aimed at empowering 40,000 adolescent girls aged 10-19 years old in Cambodia, El Salvador, Kenya, Malawi, Mali, Pakistan, Rwanda, Sierra Leone and Zimbabwe.

The 'Building Skills for Life' programme takes a life-cycle approach: addressing the multiple and interconnected issues facing girls at adolescence to ensure holistic interventions that enable girls to realise their full potential. The approach puts adolescent girls at the heart of our work and targets interventions on their specific needs and rights, including SRHR.

Plan UK also ensures that country level experience of working on adolescent girls' issues (from both PPA- and non-PPA-funded projects) is used to engage with international policy-makers on issues where international action can help remove barriers to girls' education, and promote their well-being.

At the inception of the programme a rigorous baseline study was carried out, led by the Royal Tropical Institute, Amsterdam (KIT) with extensive involvement of Plan UK and the Plan Country Offices implementing the programme. Key findings from the baseline, which focused on adolescent knowledge about SRHR and attitudes of adolescents and adults to SRHR education, include:

- Adolescents' knowledge regarding sexual and reproductive health and rights was poor
- Girls fared worse than boys on general knowledge of SRHR. Girls were less likely than boys to have knowledge about: protecting themselves from pregnancy through proper condom use; where to get contraceptives; or where to get an HIV test
- The level of support for SRHR education in schools is not high either among adults or adolescents. Many parents are unwilling to have their children taught these subjects in school
- Parental support for adolescents' access to family planning services is also low. The large majority of adolescents report that they could not afford family planning services or contraceptives if needed
- The teachers in some countries acknowledged that they had little interest in teaching sex education and often lacked the skills to do so
- The data suggested that gender norms play a significant role in whether or not adolescent boys and girls can access SRHR knowledge and sexual and reproductive health services.

Malawi:

Project Site: Luvwere Community (Mzimba District)

Key Issues: Early forced marriage, early sexual debut and teenage pregnancy, negative parental and community attitudes towards adolescents' access to SRH services

Target beneficiaries: 500 adolescents (150 boys and 350 girls)

Country implementing partners: Plan Malawi in partnership with Forum for African Women Educationalists

Reaching adolescent girls through 'speak out' clubs: Linda brings about change in Malawi

Photo: Plan

Mzimba, of which Luvwere community is part, ranks poorly on key country social economic indices. The district is home to Ngoni and Tumbuka tribes with pockets of Tonga, 96 per cent of whom are typically patriarchal, resulting in a social system that adversely impacts upon the social position of girls. The dominance of the system feeds cultural norms and attitudes that objectify women as sexual and not human beings.

Poverty is widespread and agriculture is the primary source of livelihood. Girls and women are economically dependent on men and this further affects their sexual and reproductive health choices. Though the law prohibits forced marriage or betrothal as stipulated in the Malawi Child Care, Protection and Justice Act of 2010, the practice of forcing pregnant girls into marriage is widespread – primarily in the name of family honour. According to the 2008 population census, 52 per cent of girls between 15 and 19 years of age in Mzimba district were married.

The interplay of unequal power relations, cultural norms and social systems means girls grow up with low levels of sexual and reproductive health knowledge, making them vulnerable to sexual and physical abuse, forced/arranged marriages and teenage pregnancies. In these communities adults view sex education and reproductive health services as potentially destructive to cultural norms.

In partnership with the Forum for African Women Educationalists in Malawi, Plan Malawi worked to empower 70 girls and 30 boys from Luvwere community – helping them to understand gender and cultural norms and how these shape attitudes and choices, to access SRH information and services and hold local policy makers accountable for provision of services.

Linda fell pregnant at the age of 16. She was forced to marry the father, who was older than her, and leave her studies. Once she had the baby, things changed and she decided to return to her family and see if she could go back to school.

Linda heard about the intervention in the community and got interested. One aspect involved supporting youth clubs where young people could discuss their sexual and reproductive health concerns. Linda became one of the peer educators at the youth club, mainly from the personal motivation to help other girls – especially those not able to return to school after giving birth.

Linda and a core team of girls were trained to engage with community members, teachers, health workers, local leaders and members of School Management Committees and Parent Teachers Associations. These adults were given training on how early forced marriage, early sexual debut and negative parental attitude towards sex education affect girls' health and development.

"I think the process of empowering us to speak out and discuss issues among ourselves and in front of local leaders has helped us a lot. Changes have happened like four of my friends have ended their relationships and we have had two girls who got pregnant come back to school."

Linda

Recognising the impact of forced marriage, local leaders have now put in place a by-law stopping early forced marriages. Parents forcing girls to marry will have to pay a 'fine' of up to two cows depending on the age of the girl involved. Involving health personnel and key community members in the discussions has seen an increase in girls visiting local health centres.

Pakistan:

Project Site: Basti kandhi wala UC Hinjrai Tehsil Kot Addu, District Muzafargarh

Key Issues: Early marriage and pregnancy, negative parental and community attitudes towards adolescents' access to SRH information and services

Target beneficiaries: 273

Country implementing partners: Plan Pakistan in partnership with Health and Nutrition Development Society (HANDS) and Children's Global Network Pakistan (CGNP)

Supporting adolescent girls to change attitudes: Shakeela's experience in Pakistan

Photo: Plan

Shakeela is a 13 year old girl. After completing her primary school education, her father decided it was time for her to leave school and get married.

In her community, women and girls' rights are not considered important and are often violated. There is a strong emphasis on practicing local customs and traditions in which girls are seen as upholders of 'family honour' and therefore to need protection. This also forms the basis of widespread gender-based violence against women and girls.

"They celebrate the birth of a baby boy but when a baby girl is born, they think that the mother is responsible for giving birth to a baby girl and leave her alone to bear all the pains after delivery".

Young Girl

Early marriage is common within the community, which has serious sexual and reproductive health repercussions. To respond to some of these challenges, Plan Pakistan is implementing programmes within the 'Building Skills for Life' programme, in partnership with local partners HANDS and CGNP, to address the sexual and reproductive health needs of adolescents in District Muzafargarh. Strategies adopted include interactive sessions highlighting relevant issues and identifying the links between high mortality and morbidity, and early marriage and pregnancy. Village elders, teachers, parents and community leaders have also been involved. The programme has also supported the creation of Adolescent Friendly Centres (AFCs) and Non formal Education (NFE) classes for adolescents to meet, organise learning activities and discuss their health issues.

Shakeela saw her friends participating in AFC sports and other fun learning activities and was keen to join, but her father would not let her.

When Shakeela's friends realised, they approached the AFC staff who reached out to Shakeela's family with community members. They encouraged Shakeela's father to share his concerns. He explained that she should remain at home until she gets married for her own protection.

Having received relevant training, community leaders were able to reassure Shakeela's father and convince him of the importance of education and of SRHR awareness. He was persuaded to allow her to participate.

"Life is beautiful now....I feel confident and like me all girls in Pakistan should be given a chance and we can contribute equally as boys".

Shakeela

Now Shakeela is attending NFE classes and takes part in learning activities in the local AFC. After just a few months, she is no longer shy and has been made the group leader at the AFC. She is a confident, happy young girl with leadership qualities.

El Salvador:

Project Site: 9 Municipalities (Ilobasco, San Ramón, San Cristóbal, Suchitoto, La Reina, El Paisnal, Santo Tomás, Puerto de La Libertad and San pablo Tacachico)

Key Issues: Early pregnancy, early sexual debut, gender-based violence, sexual harassment

Target beneficiaries: 90

Country implementing partners: Plan El Salvador

Using peer educators: Wendy raises awareness in El Salvador

Photo: Plan

El Salvador is the smallest and most densely populated country in Central America. Of its 6.2 million inhabitants, 52 per cent are under 24 years of age and 53 per cent are women. Almost one third of children are born to mothers under 20 years of age (the highest rate of adolescent pregnancy in the region). Giving birth at this age is dangerous, often means girls drop out of school and leads to a perpetuation of intergenerational poverty. A total of 21 per cent of young people aged 15-19 and 43 per cent of youth ages 20 to 24 are neither studying nor working.

Social and gender-based violence are serious problems. Of all reported cases of violence, 60 per cent are the result of gender violence which disproportionally affects girls and women.

Access to a quality education by girls, adolescents and women is limited by discrimination in the school setting, early initiation of sexual activity and subsequent pregnancies, sexual harassment and sexual abuse. There is limited access for children, adolescents and youth to quality information and services regarding sexual and reproductive health. The State does not have integrated, user-friendly programmes on Sexual and Reproductive Health or Gender Equity.

Health indicators reflect a situation that requires urgent attention and concrete actions to meet the needs of adolescents. Many adolescents engage in sexual activity very young, often without protection. This exposes them to the risk of unwanted pregnancies, unsafe abortions and sexually transmitted diseases (STD), including HIV. The average age of initiation of sexual activity is 15 for girls, and 14 for boys. The problem of adolescent pregnancy is of great concern and a reality that has been becoming more and more serious in recent years.

The project prioritises the right to education and SRH information and services, the right of girls and adolescents to participate in spaces for decision making, and to be protected against gender violence. The project will enable the participants to counteract the social and cultural pressures faced by girls, adolescents and young women, that increase their vulnerability to negative sexual and reproductive health outcomes.

The project implementation is coordinated closely with the Ministry of Health (MOH), both at central and local levels. Together with the MOH, the project has developed a framework for integrated and user-friendly services for girls, adolescents and young women that addresses their sexual and reproductive health needs.

One of the key aspects of the programme is the training of youth promoters (peer educators) in sexual reproductive health and healthy lifestyles. Wendy is a 16 year old girl who attends Sor Henriquez school in Ilobasco and has undertaken the training, which uses practical games designed to empower and strengthen decision-making in the area of sexuality. Next, the youth promoters will be trained in a specially-designed 'Stepping Stones' methodology, and art and drama sessions. Wendy enjoyed the training and has taken great interest in learning about taking control of her sexual and reproductive health.

"This training has given me the opportunity to meet and get to know new people, I have made many new friends and learned a great many things that will serve me well during the rest of my life...I hope to be able to pass on everything I've learned to many more young people, so that they also learn more about their sexual and reproductive health. I think it is very important for young people to understand how to prevent an unwanted pregnancy and infections such as HIV, for their own lives and for future generations. I think this sort of knowledge is essential for everyone."

Wendy

The youth promoters are replicating the training with their peers, especially for girls, some already pregnant, to empower them regarding their rights. They are provided with information on personal health management, with emphasis on prevention of pregnancy as part of their sexual and reproductive rights, and to prevent further pregnancies.

Interact Worldwide

Interact Worldwide is an international Sexual and Reproductive Health and Rights organization with over 30 years' experience in supporting information, services and advocacy with civil society organizations and the most marginalized communities in Africa and Asia. Interact's work has primarily focused on six countries: India, Pakistan, Kenya, Uganda, Malawi and Ethiopia. Interact works together with local partners to support the empowerment of marginalized people, to overcome discrimination and to improve health and well-being in the world's poorest countries and reaches over half a million beneficiaries through its programmes. Interact merged with Plan UK in 2009.

Interact in partnership with local organizations implements a range of SRHR programmes. Key focus areas of Interact's programme work include:

- Adolescents' sexual and reproductive health and rights
- Sexual rights and human rights
- Gender equality
- Family planning – reproductive choices
- Maternal and newborn health
- Sexual health, HIV and AIDS.

Improving Adolescent Sexual and Reproductive Health Outcomes

India: Through Interact's Community Partnerships Project, young people in Jharkhand and West Bengal in India are challenging their exclusion from SRH services. When the project began in 2007 only 15 per cent knew about sexual and reproductive health issues including HIV and AIDS; now 40 per cent know about these issues. There has been a 60 per cent increase in young people using services for sexually transmitted infections. 109 drop-in-centres provide information and health care, and 3,036 young peer educators are passing on information in engaging ways.

Malawi: Interact's programmes have focused on reducing HIV infection among young people. In 2011, 24,363 young people took part in awareness activities, through youth clubs and through discussion groups covering issues like HIV and early marriage. When the project began, 43 per cent of young people knew about HIV, STIs and contraception; now 58 per cent do. At the start, 87 per cent of rural girls and boys reported experiencing stigma – being excluded from community meetings or feeling judged by health workers. This has now come down to 47 per cent demonstrating the impact the project is having.

Ethiopia:

Project Site: Chefa Robit town, Artuma Fursi district, Amhara region.

Key Issues: Early marriage, early pregnancy, Female Genital Mutilation

Target beneficiaries: 23,323 young people

Country implementing partners: Ethiopian Muslim Relief and Development Agency (EMRDA)

Photo: Plan

Upholding rights: Nuriya achieves justice in Ethiopia

Nuriya Mohammed is a 15 year old girl and a Grade 8 student. She was born into a poor family in a small town in the Amhara region of Ethiopia. She lives with her parents, one brother and three sisters. Her parents make their living through subsistence farming and looking after cattle and have never had any formal or informal education. They cannot read or write. She belongs to a conservative community where practices such as early/forced marriage, female genital mutilation, wife inheritance and rape are quite common. These are the result of deeply entrenched socio-cultural practices, including gender norms. The community does not have adequate knowledge about family planning and almost every household in the community has more than six children on average.

Young people represent one of Ethiopia's largest population groups, comprising about 35 per cent of the total population. Poverty, gender inequality and sexual coercion exacerbate young women's vulnerability to poor sexual and reproductive health (SRH) outcomes, increasing their exposure to early marriage and early childbearing, unintended pregnancies, and sexually transmitted infections (STIs). Early marriage rates are high across Ethiopia, but particularly in the Amhara region. Unconfirmed figures suggest that nearly half Amhara girls are married before they are 15. Lack of access to contraception and voluntary family planning services is an on-going challenge that women face in Ethiopia.

This has contributed to high national maternal mortality rates (including through unsafe abortions), low literacy rates of girls and very high rates of fistula. Further, with 79 births per 1,000 women aged 15-19 (90 births per 1,000 in rural areas compared to 27 in urban areas), Ethiopia's high adolescent birth rate is linked to low use of modern contraceptives.

Only 5 per cent of all women aged 15-19 use a modern contraceptive method, and 32 per cent of sexually experienced women aged 15-24 have an unmet need for contraception. Young people, particularly young women, are also among the most vulnerable to HIV infection, with 1.5 per cent of young women aged 15-24 living with HIV in 2007, compared to a 0.5 per cent of young men the same age. Just 20 per cent of young women and 33 per cent of young men aged 15-24 had comprehensive knowledge of HIV and its transmission and very few actually practice safe sex.

As is quite common in her village Nuriya was only 13 when her father forced her to get married – to a man who she thought was over 35. She had just completed Grade 7. She did not want to get married but her family forced her to accept it otherwise they warned her that she would face social stigma from the rest of the community and even from her relatives.

Even though she was busy doing housework, she continued to attend the sexual and reproductive health club in her youth centre and school that was supported by the 'Young People in Action' project being implemented by Interact Worldwide, with support from the BIG Lottery Fund and in partnership with EMRDA. The project aims to improve the health of the most disadvantaged by implementing community health promotion activities and strengthening services and referrals for vulnerable people, especially young people, orphans and children without protection, people living with HIV and AIDS and their carers. The project has trained and built the capacity of young people in the community on sexual reproductive health and rights including family planning, harmful traditional practices and HIV and AIDS.

The peer educators helped Nuriya to understand sexual reproductive health issues, including her reproductive health rights, like being able to choose who to marry and when to have children. She felt depressed when she saw her friends going to school every morning. After she had spent about five months with her husband, she asked her parents to arrange a divorce, but they refused. She remembered what the peer educators had taught her about the Ethiopian legislation which has 18 as the minimum age of marriage for girls. So, she decided to report the situation to the police and exercise her right to get a divorce.

After the police began its investigation, Nuriya's family and community were angry, but her teachers, her school friends and peer educators supported her to continue the case until she got justice. A discussion was organised with her parents and local religious leaders to convince them to accept what she wanted. Nuriya is continuing her education with her parents'support. She wants to be a lawyer to establish justice and wants all girls to have access to quality education and youth-friendly SRH services.

International Legal Framework and Documents Relevant to SRHR

- **International Covenant on Economic, Social and Cultural Rights (CESR)** recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and obliged states to respect the right to health by refraining, denying or limiting access for all persons, including prisoners and (illegal) migrants to preventative, curative and palliative health services.

- **International Convention on the Rights of the Child (CRC)** states that children and young people have the right to enjoy the highest attainable health, access to health facilities (Article 24), and access to information which will allow them to make decisions about their health (Article 17), including family planning (Article 24). Young people also have the right to be heard, express opinions and be involved in decision making (Article 12). They have the right to education which will help them learn, develop and reach their full potential and prepare them to be understanding and tolerant towards others (Article 29). Additionally, young people have the right not to be discriminated against (Article 2).

- **The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)**, states no discrimination against women of any kind is permitted and obliged state parties to take all appropriate measures to eliminate discrimination against women in the field of healthcare to ensure on the basis of gender equality access to health care services including those related to family planning and gave States in Article 16 1e) the duty to ensure that women and men have: “The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.”

- **Commission on Human Rights Resolution 2003/45 (Para 10)** on Elimination of Violence Against Women, also emphasises that violence against women and girls, including rape, female genital mutilation, incest, early and forced marriage, violence related to commercial sexual exploitation, including trafficking, as well as economic exploitation and other forms of sexual violence, can increase their vulnerability to the human immunodeficiency virus and acquired immunodeficiency syndrome (HIV and AIDS) and aggravate the conditions fostering the spread of HIV and AIDS.

- **Committee on Elimination of Discrimination Against women, General recommendation 19, Para 6** states that the definition of discrimination includes gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. Gender-based violence may breach specific provisions of the Convention, regardless of whether those provisions expressly mention violence.

- **Convention on the Elimination of All Forms of Discrimination of Women Article 16 (2):** The betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, should be taken to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory. In their general recommendations of 1994, the Convention states that the minimum age for marriage should be 18 years.

- **Universal Declaration of Human Rights (UNHR)** emphasises freedom, dignity and equality for all.

- **Declaration of Alma Ata** states the need to protect and promote the highest attainable health for all and the unacceptability of health inequality between developed and developing countries.

- **International Conference on Population and Development (ICPD)** states that all people regardless of age, marital status, ethnicity or sexual orientation are entitled to reproductive health and rights. ICPD defined reproductive rights as ‘the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the means and information to do so and the right to the highest attainable standard of sexual and reproductive rights’.

- **Beijing Declaration and Platform for Action** focuses on gender equality and universal access to quality health services in general and reproductive healthcare in particular and affirmed women’s right ‘to have control over and decide freely and responsibly on matters related to their sexuality including their sexual and reproductive health’.

List of Key Risk and Protective Factors for Adolescent Sexual and Reproductive Health (ASRH) outcomes, 1990–2010

An extensive literature review of 235 studies – source: Johns Hopkins Bloomberg School of Public Health

Outcome of Interest	Key Risk Factors	Key Protective Factors
Sexual coercion◆ (Number of studies:9)	• Alcohol use before sex by at least 1 partner* (2/3)❖ • Ever experienced RTI symptoms* (2/2) • Beaten by partner* (2/2) • Ever worked (2/2) • Had friend of opposite sex (2/2) • Had friend of opposite sex (2/2)	
Condom use (Number of studies:55)	• Married (3/3) • Forced first sex (2/3) • Do not perceive social support for condoms from parents (2/3) • Use alcohol (2/3)	• More years/level of educational attainment (11/14) • Knowledge on condoms (2/2) • Self-efficacy • Discussed HIV with current partner (2/2) • Perceived ability to discuss condoms with partner (2/2) • Live with both parents (3/4)
HIV and STIs (Number of studies:39)	• Older age (7/12) • Forced first sex (2/2) • Younger age at first sex (2/3) • History of STI (4/6) • Exchanged sex for money and gifts (2/2) • Higher number of sexual partners (5/5)	• Sex: male (2/3) • Currently use condoms (2/3)
Contraception (Number of studies:25)	• Older age (7/12) • Forced first sex (2/2) • Younger age at first sex (2/3) • History of STI (4/6) • Exchanged sex for money and gifts (2/2) • Higher number of sexual partners (5/5)	• Older age (5/9) • Higher education level* (11/16) • Spousal communication* (7/7) • Visited by FP worker* (3/3) • Attended FLE class (2/2) • Knowledge about contraception (4/5) • Desire fewer children* (3/4) • Positive attitude about family planning* (2/2) • Frequent sex (2/2) • Partner has professional job* (2/2) • Partner approves of FP (2/3)
Number of sexual partners (Number of studies:19)	• Earlier age of sexual debut (2/3) • Alcohol use (3/4) • Peers/friends have had sex (3/4) • Discusses RH issues with friends (2/2) • Drinks alcohol with friends (2/2)	• Sex: female (3/4)
Sexual experience (premarital or otherwise) (Number of studies:64)	• Sex: male (15/17) • Older age (39/48) • School drop out (2/2) • Use drugs (4/4) • Use alcohol (9/10) • Perceive that friends have sex (10/10) • More liberal attitude towards sex (8/8) • Viewed X-rated materials⊙ (3/4) • Carries a weapon⊙ (3/3) • Residentially mobile (2/2) • Lived away from home (3/3) • Perceive parents have unstable marital union (2/2) • Older sibling became pregnant as an adolescent (2/2) • Higher level or perceived risk for HIV infection (2/2) • Weak intention to remain a virgin/remain a virgin until married (2/3) • Lower parental monitoring (5/5) • Substance use (4/6)	• Lives with both parents (9/16) • Father present in household (2/2) • Ever had a boyfriend/ girlfriend (5/6) • Marital status: unmarried* (3/5) • High grade point average (GPA) (2/2) • In school (5/5) • High educational aspirations (2/2)
Pregnancy/Early childbearing (Number of studies:24)	• Early sexual debut* (2/2) • Younger age at first sex (2/3) • Forced first sex* (2/2) • Ever experienced sexual violence/abuse (4/6) • Use drugs (2/2) • Did not use contraception at first sex (2/3) • Higher frequency of sex (2/2) • Lived away from home (2/2)	• Live with both parents (2/2) • Father present in household (3/3)

Source:
⊙ ASRH outcomes that were not included in 1990-2003/4 literature review
✶ Effect observed especially among females
❖ Effect observed especially among males
◆ Numbers in parenthesis refer to the number of studies which found that particular factor significant out of the total number of studies that examined the factor in relation to the outcome.

Key Recommendations

Recommendations that have emerged from our Adolescent Sexual and Reproductive Health and Rights (ASRHR) programmes include:

- ASRHR programmes must be evidence based and address the broader context in which adolescents live
- ASRHR programmes must be holistic and include a comprehensive package of SRH information and services
- ASRH programmes must be rights based and adolescents should be integral to the design, delivery, monitoring and evaluation
- Peer education programmes and creative strategies like dramas, radio programmes targeting young people, street plays, fairs are critical Information, Education and Communication (IEC) strategies
- ASRHR programmes must include other key stakeholders: community leaders, parents, teachers, religious leaders, policy makers and health service providers among others
- Power relations that impact upon adolescents access and uptake of services must be addressed in all ASRHR programmes
- ASRHR must address underlying determinants increasing adolescents' vulnerability to negative health outcomes for longer term sustainable change
- Gender should be a key component in the design and delivery of any SRHR programme to bring about attitudinal and behavioural changes and reduce both men and women's vulnerability to sexual and reproductive ill health
- Local partnerships and ownership is critical to address harmful cultural norms and traditions and also to ensure sustainability
- ASRHR programmes are strengthened by in-built advocacy mechanisms that engage with policy makers to create an environment enabling increased access to and uptake of SRH information and services.

Plan UK
Finsgate
5-7 Cranwood Street
London
EC1V 9LH

www.plan-uk.org

Tel: 0300 777 9777
Fax: 0300 777 9778

Tel (non-UK): +44 (0)20 7608 1311
Fax (non-UK) +44 (0)20 7253 9989

Interact Worldwide
Finsgate
5-7 Cranwood Street
London
EC1V 9LH

www.interactworldwide.org

Tel: 0300 777 8500
Fax: 0300 777 9778

Tel (non-UK): +44 (0)20 3217 0202
Fax (non-UK) +44 (0)20 7253 9989