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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Geneva Workshop 2016
We knew that:

- Adolescents experienced Sexual & Reproductive Health problems
- They were not getting information & education
- They were unable/unwilling to obtain health services
- Laws & policies were restrictive & social norms did not acknowledge adolescent sexuality

We had little evidence on effective ways of responding to these needs.
A review of research evidence & implementation experience in Adolescent Sexual & Reproductive Health, 20 years since the ICPD:

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
We have:

- a much better picture of the needs and problems of adolescents
- a much better understanding of what works – and what does not -- in responding to their needs and problems

Though there are still many gaps in our knowledge and understanding

Despite this:

- ineffective interventions & ineffective ways of delivering them continue to be widely used
- interventions that have been shown to be effective are often delivered ineffectively
1/5. Adolescents are not reached by the interventions intended for them
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:
2/5. Interventions delivered to adolescents have been shown to be effective, but are delivered with inadequate fidelity
Fidelity of interventions

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

Source:
Sexuality education: Evidence from research

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)

Some additional relevant evidence

Evidence from research:

- CSE programmes that include & effectively address gender equality & power relations are more likely to reduce unwanted pregnancy & Sexually Transmitted Infections.

Note:

- 6 of the 22 studies included were from LMIC.
- 4 of the 6 LMIC studies included gender & power in their work.
- Of these 3 had positive effects on health outcomes.
- Of these 3, 1 was an intensive multi-session intervention & another had a complementary parent-education component.

Some additional relevant evidence

- "Brief Sexuality-related Communication (BSC) takes into account the psychological & social dimensions of sexual health & wellbeing in addition to the biological ones"

- In research studies it has been shown to be effective in:
  - Decreasing episodes of unprotected sex;
  - Increasing condom use;
  - Decreasing number of sexual partners;
  - Overall impact on STI/HIV incidence
  - Increasing contraceptive use.

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:
COMPREHENSIVE SEXUALITY EDUCATION

- **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

**Sources:**
Barriers to implementation & effectiveness

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:
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:
Evidence base: Training health workers is a widely used approach to improve their abilities and attitudes, to respond effectively and with sensitivity to their adolescent patients. *In many places, it is the only approach used.*

A review of the approaches that are employed to improve the performance of health workers in providing effective and empathic care to adolescents, in the 18 initiatives included in the review titled: Effective strategies to provide adolescent sexual and reproductive health services and to increase demand and community support (Denno et al, *Journal of Adolescent Health, 2015*) showed that:

- Training was used in all 18
- Supportive supervision (i.e. assessment and feedback) was used in 10
- Job aids (e.g. desk reference tools and wall charts) were used in 3
- Refresher training was used in 2
- Job descriptions were used in 1

V Chandra-Mouli, S Shilton, D Denno. A descriptive analysis of approaches used in initiatives that are employed to improve the performance of health workers in providing effective and empathic care to adolescents. To be submitted.
Evidence base

5.1 Training health workers alone does not lead to sustained improvements in health worker performance. Training works best when it is combined with supportive supervision and group problem solving.

5.2 Training programmes which involve large groups, are not focussed and use didactic learning methods have poor results. Better results can be achieved with smaller groups, focussed topics, and multi-method training.

- Sending health workers printed or electronic information alone - no effect (0%)
- Training alone improves health worker performance by 6%
- Supervision alone improves health worker performance by 8%
- Training combined with supervision improves health worker performance by 17%
- Group problem solving alone is as effective as training combined with supervision (17%); and training + group problem solving is most effective (25%)


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.
In 1999, the Government of the United Kingdom (UK) established a ten-year Strategy to reduce teenage pregnancy rates.

A key theme of the Strategy was to ensure coordinated action – better prevention activities for boys and girls & improved support for young parents.

A mid-course review in 2005 showed that while the under-18 conception rate had declined by 11%, there was wide variation in results across other areas.

Source:
Deep-dive review: 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.

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

Follow up: The Government identified and disseminated nationwide ten ‘must do’ activities, and established a system for self-assessment and external assessment.

Result: Teenage pregnancy rates began to decline in all 150 local government areas of the country, and this decline continues to this day.
A multicomponent approach is required...

“It is becoming apparent that a multicomponent approach is required that complements school-based sexuality education with youth friendly health services, in an overall enabling (community) environment.”

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

Source:

- 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)
Interventions aiming to challenge & change deeply-ingrained norms, need to be delivered in an adequate 'dosage' to have a sustained effect

Percentage of adolescent boys, age 15-19, who believe that a husband is justified in hitting or beating his wife under certain circumstances. (Subset of countries where prevalence is 50% or higher)

UNICEF. A report card on adolescents. UNICEF. New York. 2012
5/5. Popular interventions that have been shown to be ineffective for adolescents continue to be implemented
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.

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.

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.

Conclusions:

- 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.