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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

World Health Organization

human reproduction programme hrp
research for impact
UNDP-UNFPA-UNICEF-WHO-THE WORLD BANK

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

World Health Organization hrp

2016

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:

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

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

Fidelity of interventions

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

Source:

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

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)**

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

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.**

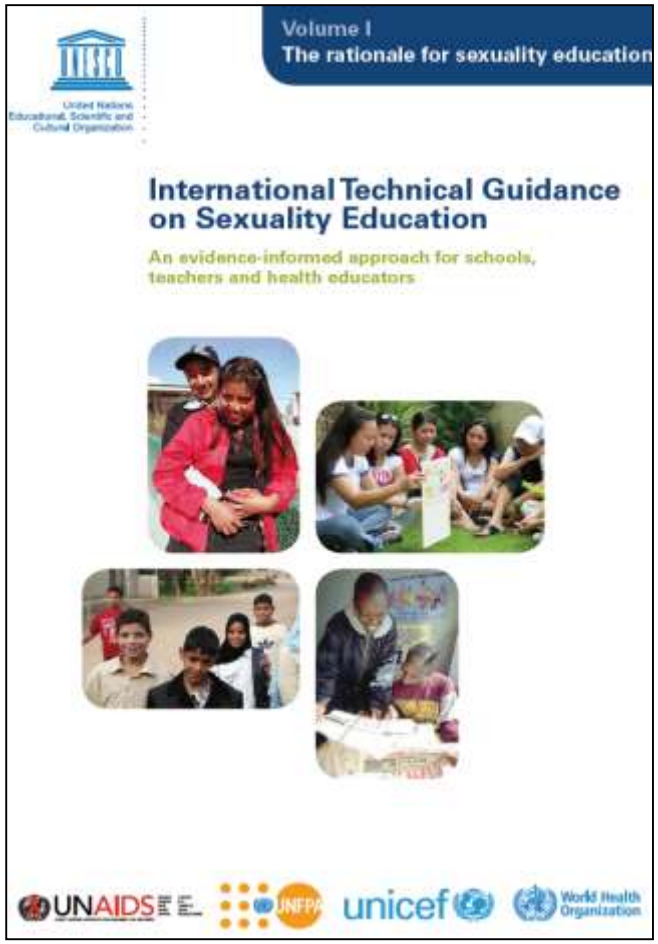
N Haberland. The case for addressing gender & power in sexuality and HIV education: A comprehensive review of evaluation studies. International perspectives in sexual and reproductive health, 2015.

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.***

B Cooper et al. Brief sexuality communication: A behavioural intervention to advance STI/HIV – A systematic review. British Journal of Obstetrics and Gynaecology. 2014.

COMPREHENSIVE SEXUALITY EDUCATION



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

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

Source:

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

COMPREHENSIVE SEXUALITY EDUCATION

- **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:

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

Barriers to implementation & effectiveness

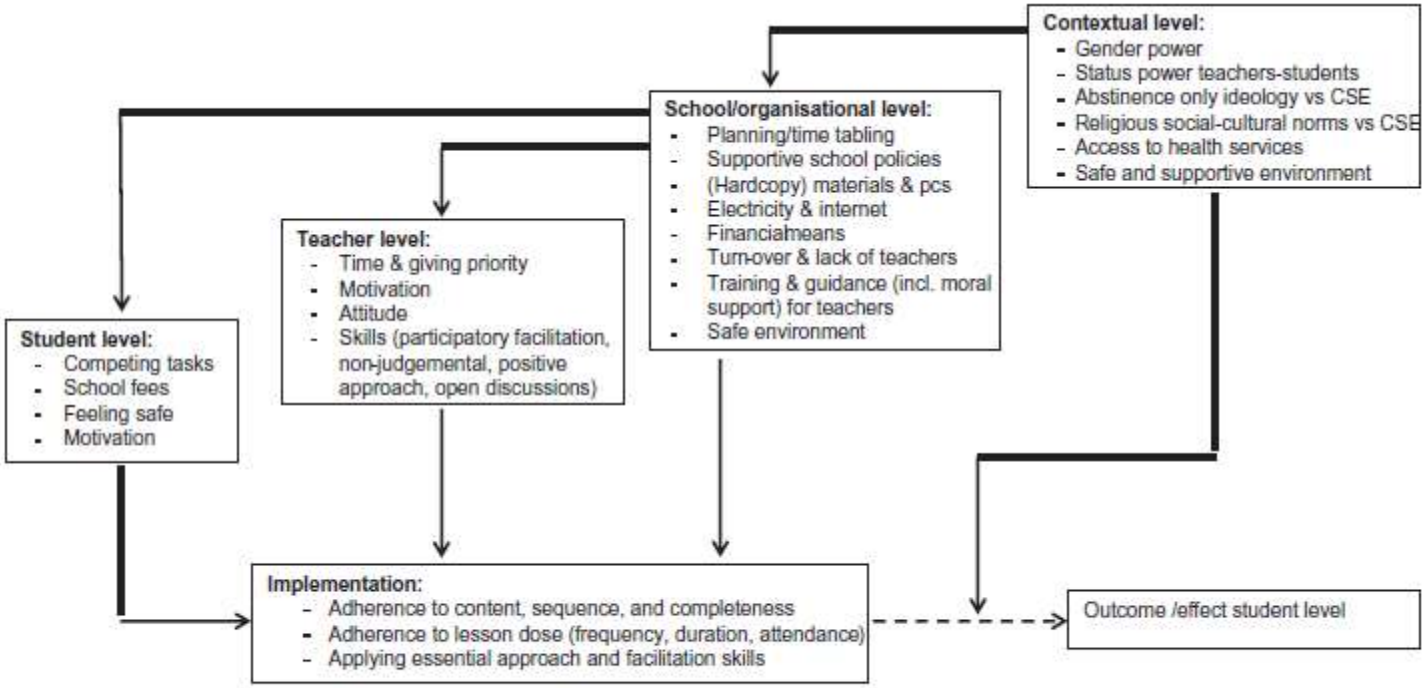


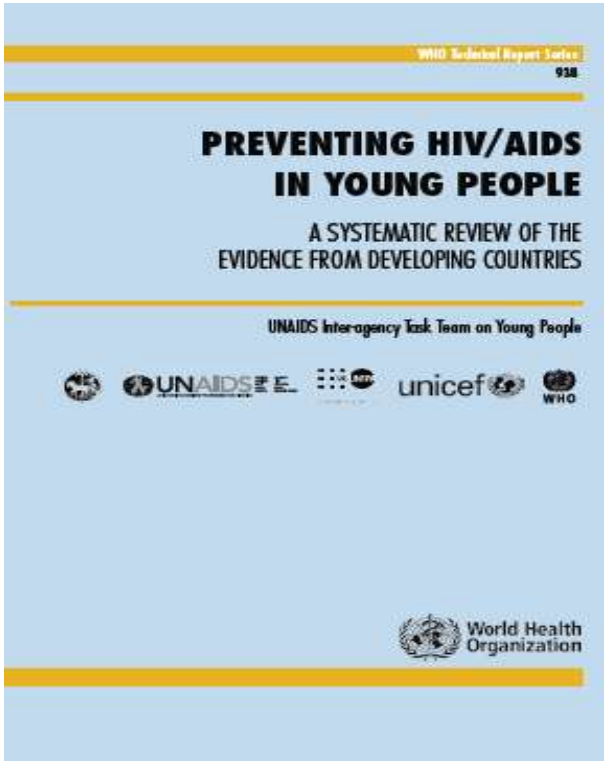
Figure 1. Barriers to CSE implementation and effectiveness.[2]

I Vanwesenbeeck, J Westeneng, T de Boer, J Reinders, R van Zorge. Lessons learned from a decade implementing CSE in resource poor settings: The world starts with me. Sex Education, 2015.

ADOLESCENT FRIENDLY HEALTH SERVICES

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

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



Source:

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

ADOLESCENT FRIENDLY HEALTH SERVICES

Abstract:

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

Discussion:

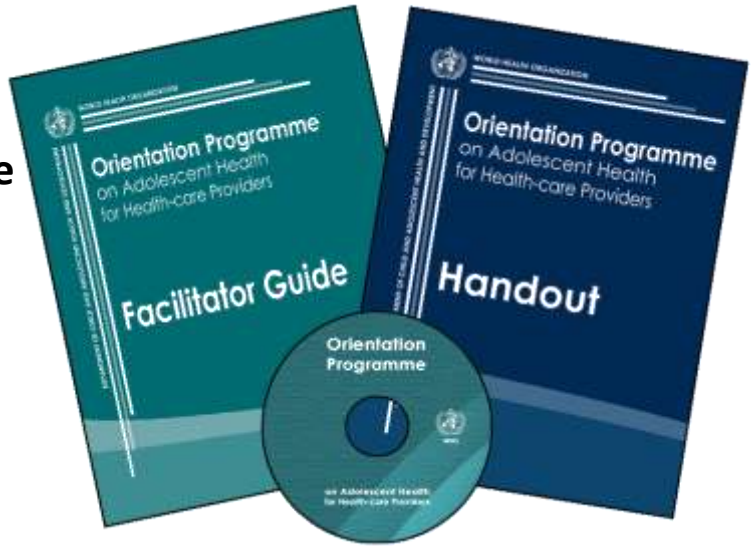
"…although the project trained clinic staff to provide RH services appropriate to adolescents, few of the features of clinics believed to make health services 'youth friendly' were incorporated into the project.

Source:

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

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.

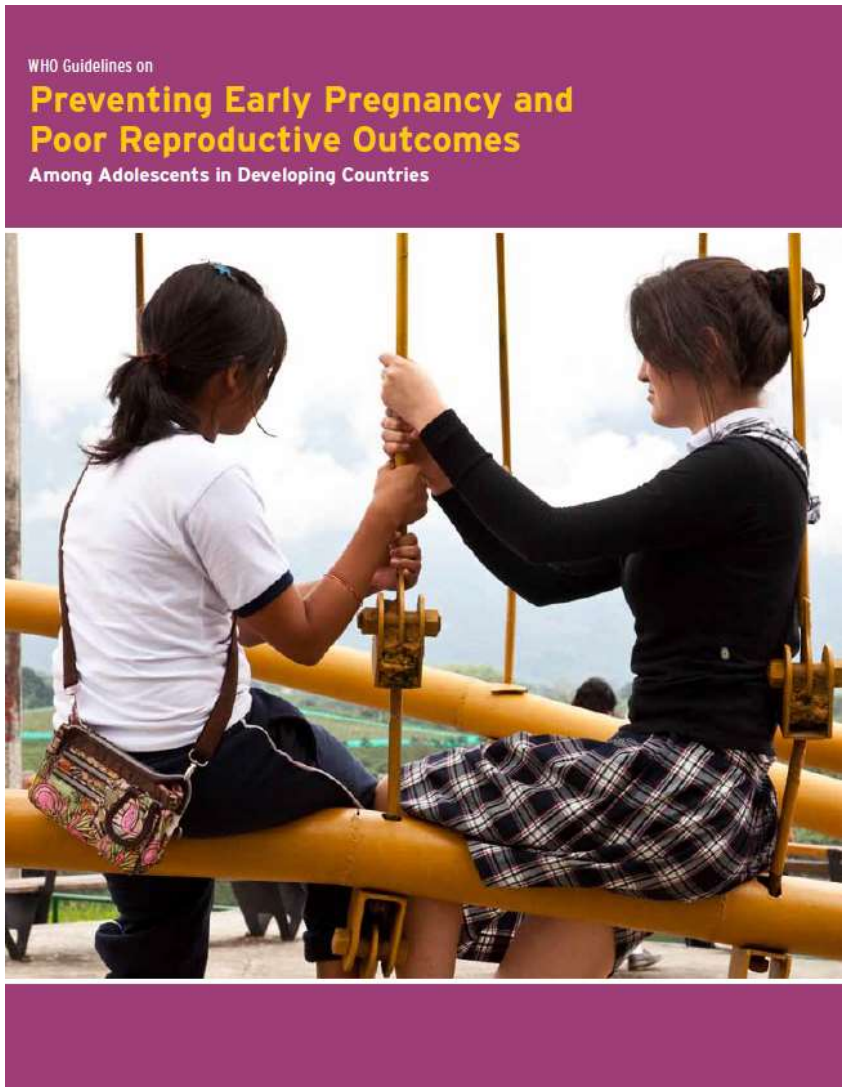
5.2 Training programmes which involve large groups, are not focussed and use didactic learning methods have poor results. Better results can be achieved with smaller groups, focussed topics, and multi-method training.

- Sending health workers printed or electronic information alone - no effect **(0%)**
- Training alone improves health worker performance by **6%**
- Supervision alone improves heath 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%)**

A K Rowe, D de Savigny, C Lanata. C G Victora. How can we achieve & maintain high-quality performance of health workers in low-resource settings ? www.theLancet.com August 9, 2005 DOI: 1016/SO 140-6736(05) 67028-6.

A K Rowe, A systematic review of the effectiveness of strategies to improve health care provider performance. In press. Fourth Annual National Institutes of Health Conference on the Science of Dissemination & Implementation: Policy and Practice. March 2011.

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.

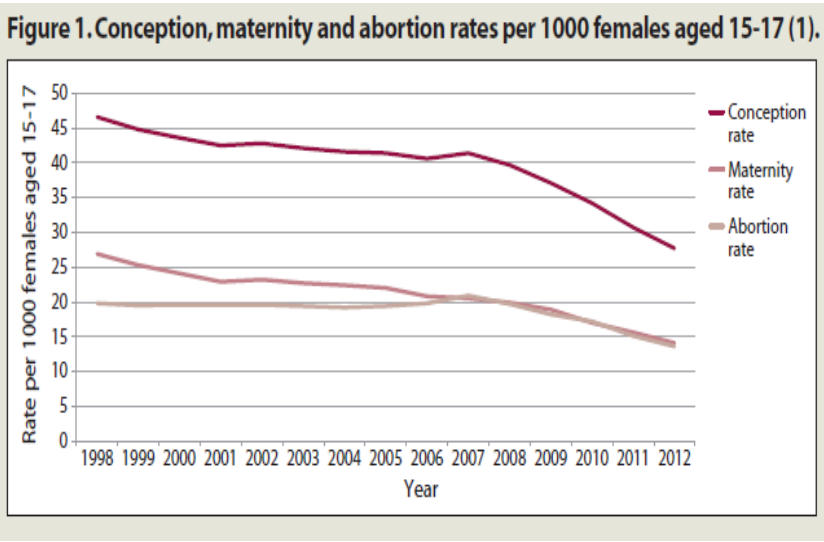
Adolescents too have key roles to play.

- **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:

Hadley A. The teenage pregnancy strategy for England: Concerted effort can make a difference. Entre Nous. Entre Nous. 80, 2014 Pages 28-29.

THE TEENAGE PREGNANCY STRATEGY FOR ENGLAND: CONCERTED EFFORT CAN MAKE A DIFFERENCE!



Source:

Hadley A. The teenage pregnancy strategy for England: Concerted effort can make a difference. Entre Nous. Entre Nous. 80, 2014 Pages 28-29.

- **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.”

I Vanwesenbeeck, J Westeneng, T de Boer, J Reinders, R van Zorge. Lessons learned from a decade implementing CSE in resource poor settings: The world starts with me. Sex Education, 2015.

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:

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

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

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

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

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
UNICEF: Boys and girds in the life cycle. 2011.

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.

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

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

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

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

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

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

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

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

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

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

Peer education to encourage safe sexual behaviour

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

- Information exchange and open discussion between adolescents of similar age & social status

- Opportunities for repeated contact in a friendly context

- Access to those who are hard to reach through traditional adult-led health-education approaches

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

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

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

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.**