Training course in adolescent sexual and reproductive health 2020

Lessons learned and experiences gained in improving the SRH of adolescents in the 25 years since the ICPD

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Question 1

Name two changes in the demographic situation of adolescents in the 25 years since the International Conference on Population and Development.

Since the ICPD in Cairo in 1994, there have been important **changes in the demographic situation of adolescents** at the global level. Firstly, there has been as an overall increase of the adolescent population world-wide, especially in African countries – 163 million more in 25 years, with a higher life expectation as well. Secondly, there is a larger population of boys and young men compared to girls and young women, partially due to the gender-biased sex selection which is practiced in some regions, but also due to the excess of female mortality.[1]

Question 2

Name two changes in the social context of adolescents in the 25 years since the International Conference on Population and Development.

Moreover, from a **social perspective**, changes in the situation of adolescents include the fact that nowadays they live in a context of decreased poverty, linked also to other social-related changing factors – as increased access to education, including secondary education, and digitalization. However, the current context is also seeing increasing rates of un- an under-employment in young people, with growing sex disparities.[1]

Question 3

Name two health issues in which there has been improvement in the sexual and reproductive health of adolescents in the 25 years since the ICPD, and 2 areas in which there has been little / no progress.

From a **health perspective,** ASRH has improved as girls are less likely to be subject to harmful practices, such as child marriage and female genital mutilation, therefore are less likely to become pregnant before the age of 18 – even if regional disparities persist. They are also more informed and likely on the use of contraception, which is related to declining rates of HIV globally (but not in terms of HIV-related adolescent mortality). Despite that, non-communicable diseases, such as obesity, anemia and diabetes, are increasing with an impact on ASRH. Moreover, some aspects related to the health and well-being of adolescent have been left behind, such as adolescent MHPSS, due particularly to social norms, values as well as prejudice and biases.[1]

Question 4

Name one area of change in the demographic situation or social context in your country that is influencing/could influence adolescent health, explain why, and provide a reference to back up your statement.

Since 1998, **Tanzania** has criminalized **Female Genital Mutilation (FGM)**[2] and has launched its National Plan of Action to End Violence Against Women and Children (NPA-VAWC, 2015/2016 – 2021/2022),[3] which includes actions to end this practice and its consequences on girls' health and wellbeing. In 20 years, there has been a significant decrease of FGM prevalence, from 18%[4] to 10% among women aged 15-49, with a clear trend towards lower prevalence's among younger women. FGM has huge consequences on the physical and mental wellbeing of a girl, including on her sexual and reproductive health, such as reduced sexual pleasure, difficulty or impossibility of sexual intercourse, increased childbirth complications, and child and maternal mortality.[5] From a social perspective, a girl who has been cut is considered ready to get married, exposing her to school dropout, child marriage and early pregnancy. Therefore, the reduction in FGM has brought to increased girls' chances to conclude their education, delay marriage and childbearing, therefore this has increased their and their families' opportunities for a healthier life and better economic perspectives.[6] The social change in Tanzania is significant, as 95% of women aged 15-49 state to believe that FGM should be stopped.[7]

Question 5

How much was the decline in the rate of adolescent childbearing in Uruguay in between 2014 and 2019? Name two factors that contributed to the decline.

Uruguay sets a good example as a country which has reduced **early pregnancy**. In fact, there has been a decline from 72 births per 1000 adolescents in 2014-15 to 36 per 1000 adolescents in 2019, with the most significant decline happening between 2016 and 2019. This progress, achieved in a relative short period of time, is linked to the strong positioning of the Government on early pregnancy – addressed through multi-sectoral and gender-sensitive laws, policies and long-term programmes on SRH which are very progressive as they recognize SRH as a human right and promote universal and free-of-charge access to quality SRH information, as through both in- and out- of school CSE, and services, including access to modern contraceptive methods, voluntary interruption of pregnancy and maternal care. At the same time, the civil society has played a key role in monitoring the implementation of these laws, policies and programmes. In this enabling environment, adolescent girls in Uruguay are empowered to make informed decisions about their lives, including if, when and how to have a child.[8]

Question 6

What are the levels and trends of HIV infection in 15 - 49 years old's in Zimbabwe? Name two factors that helped the scale up of the Zvandiri programme in the country.

In **Zimbabwe**, the **HIV prevalence** in 15 - 49 years olds has declined from 25% in the late 1990s to 13.3% in 2017, and since 2010 AIDS-related deaths have decreased overall of 44%, with very good prospects to realize the 90-90-90 targets. However, despite these positive trends, HIV is still prevalent among the 15-24 year olds (4.7%) and more prevalent among girls (6.1%) than boys (3.4%); it is mainly sexually transmitted. In this context, the Government of Zimbabwe has launched the Zvandiri Programme in 2014/2015 to address HIV/AIDS among adolescents and young people through standardized model and approaches. At the basis of its

success and especially its scale-up, there is the peer-to-peer counselling approach that the programme has adopted. In this way, the Programme has provided HIV care and support to adolescents through the meaningful engagement of adolescents and young people living with HIV at all levels.[8] At the same time, the Programme has been strongly led by the Government which has collected, analyzed and used data during activities to inform future programming and adaptation and costing of this model.

Question 7

These are the five main conclusions of the paper by Chandra-Mouli et al. Please briefly comment on whether each of these points applies to your country.

1. Yes - Young people make up the largest and fastest growing proportion of the population in Tanzania; half of the population is below the age of 17.[9] ASRHR is currently higher on the health and development agendasof Mainland Tanzania's Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC), which has launched the National Adolescent Health and Development (ADHD) Strategy (2018 – 2022). This has been defined as "a first step of an expanded and holistic focus by the MoHCDGEC on the issues affecting adolescents in the country".[10]
2. Yes - Investment on ASRHR in Tanzania is growing, despite much of the funding is from bilateral donors, such as the Government of Canada, Ireland, Sweden and Finland, and multilateral bodies, such as UNFPA, UNICEF and the WHO. Dependence on external funding may make investment and programmes less sustainable.
3. Yes - The main data on ASRH is taken from the National Census (2012), noting that preparations are ongoing for the next version, and the Demographic and Health Survey (2015/2016), which is conducted every 5 years. These documents have both informed national strategies and action plans, as the NPA-VAWC and the ADHD Strategy above-mentioned, as well as will inform the review process of the Gender and Women Development Strategy and the "One" Health Strategy of the United Republic of Tanzania. UNFPA is among the international agencies that is supporting these processes.
4. Despite an enabling legal and policy environment being in place, implementation of ASRHR policies and programmes in Tanzania remains weak due to, among other factors, social norms and values.
5. Yes – There are some inconsistencies in terms of legal provisions on some topics related to ASRH, as in the case of child marriage[11] in which there is a conflict between legal and customary laws, influenced by social norms and values.

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