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 International Conference on Population and Development (ICPD) happened in Cairo Egypt in 1994, the global population grew with 163 million more adolescents (in 2019). Through the years, the world has around 16.3% more adolescent boys than 13.7% adolescent girls partly explained by bias selection practices on sex in some areas and excess female mortality. In addition, there has been a decline in fertility rate with variations among and within countries as well as improved life expectancy among adolescents around the world with 72.6 years in 2019 compared to 64.8 years in 1994 (1).

Question 2

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

There are several changes in social context observed globally since the ICPD. More adolescents today live in smaller households as average household size decreased worldwide over the years. As 56% of the current global population live in urban areas, so as the number of adolescents increasingly living in such areas.

There has been a significant global improvement of school enrollment and completion at all levels as well now than 25 years ago. However, despite this increase, sociodemographic inequalities are still present until today. Likewise, as the global population living in poverty decreased, the proportion of young people who are under or unemployed increased compared to adults, with young women still less likely to be employed than their young men counterparts (2).

Furthermore, adolescents now are more likely to be digitally connected now compared to 25 years ago (71% of those aged 15-24 years are online) (3). This link to the digital world or the Internet has brought them access to opportunities for education and employment, and has enabled them to connect to more people regardless of location. However, this also subjected them to new kinds of risks including online harassment and cyberbullying. Adolescents who live in poverty, on the other hand, still experience barriers to access and use of Internet and it becomes harder for girls and persons with disability.

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.

Health Improvement and Gaps in Sexual and Reproductive Health of Adolescents

In general, the changes in demographic, health and social dimensions paved improvements in the sexual and reproductive health state for adolescents since 1994. Adolescents' better access to education and information through digital means and social conditions led to more adolescents that are: likely to engage sexual activities later in life; less likely to get married and/or have children before 18; more likely to use contraception and obtain maternal care; and less likely to experience female genital mutilation than 25 years ago (1).

However, despite social improvements since ICPD, many adolescents (250 million) now live in countries which carry multiple health burdens (2016 data) (1). This means that adolescents in such countries may have problems related to communicable disease, reproductive health, nutrition, injury, violence, and/or noncommunicable disease. Overweight and obesity prevalence in many countries negatively affect many health outcomes including sexual and reproductive health as they become risk factors for issues such as menstrual abnormalities and altered endometrial function. In addition, although global cases for HIV have declined, adolescent deaths caused by HIV show little to no progress (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.

Adolescent Health in the Philippines

Between 1995 and 2018, the life expectancy at birth improved from 68.2 to 71 years old and the average years of schooling increased from 7.1 to 9.4 in the Philippines (4). With globalization and urbanization spreading around the world, adolescents in the Philippines also see increased access to Internet and other digital means which have provided them new platforms for socializing and seeking and sharing information now than 25 years ago (5). In fact, Philippines is one among the four countries of Southeast Asia with highest number of Facebook users (6). Despite these changes, however, the Philippines still has high adolescent birth rates with 47 births per 1000 women per year - higher than the global average of 33 and 33.5 in the ASEAN region (5). This implies that one in nine girls get pregnant before the age of 19. This rate has led the National Economic Development Authority and the Philippine Commission on Population (POPCOM) to declare the still alarmingly high teenage pregnancy rate in the country as a "national social emergency" early in 2020. The COVID crisis, moreover, which hit hard in the Philippines also played a role in the predicted increase of 18,000 more unintended adolescent pregnancies if adolescent sexual and reproductive information and service continue to be disrupted across the year 2020 (7). This calls for duty bearers, relevant stakeholders, and youth to demand and continue implementation of Comprehensive Sexuality Education despite the crisis; maximize the use of media and communications for health promotion; and strengthen interagency coordination and collaboration to mitigate the consequences of the existing national social concern.

Question 5.1

How much was the decline in the rate of adolescent childbearing in Uruguay in between 2014 and 2019?

In the past 25 years, the adolescent fertility in Uruguay significantly decreased from 72 births per 1000 adolescents in 1996 to 2015 to 36 per 1000 in 2016 (8).

Question 5.2

Name two factors that contributed to the decline.

This rapid decline is due to the strong political will of the Uruguay government to put rights-based sexual reproductive health in the center of its multi-sectoral policies and programs. This was also complemented by the strong participation of its civil societies in the implementation of such policies and programs, including sexuality education to prevent adolescent pregnancy, improved access and availability to contraception methods and services and information drive on rights to sexual and reproductive health to its constituents. The government of Uruguay also provided appropriate services to its most vulnerable adolescents.

Question 6.1

What are the levels and trends of HIV infection in 15 - 49 years old's in Zimbabwe?

Since the late 1990s, Zimbabwe has seen a decline of over 25% in HIV prevalence with 13.3% HIV cases among 15 to 49 year olds in 2017 and has had a decrease of 44%in AIDS-related deaths since 2010 in all populations (8).

Question 6.2

Name two factors that helped the scale up of the Zvandiri programme in the country.

To combat HIV, the Zimbabwe government scaled up Zvandiri, a peer-led, multi-component, differentiated service delivery model for children, adolescents and young people with HIV. It has been made possible because of the strong leadership and high-level commitment of its government, ensuring that services are standardized and integrated across the nation. The Zimbabwe government also has enabled adolescents to be involved meaningfully in all levels of its program and used evidence to better inform the Zvandiri service delivery model and costing (8).

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. ASRHR in the health and development agenda

The International Conference on Population and Development in 1994 has been instrumental in emphasizing that adolescent sexual and reproductive health should not be neglected in the health and development agenda in the Philippines, (especially that teen pregnancy is still a national concern for several years). The Nairobi Summit has also been influential for the government of the Philippines to recommit its pledge to ICPD Programme of Action in promoting sexual and reproductive health rights for all Filipinos including the adolescents and youth. However, whether the recommitment translates to health and social outcomes of adolescents is yet to be seen, especially that current health and social system services are preoccupied with COVID-response and resources were reallocated to combat the outbreak.

2. ASRHR in the financing landscape

The ICPD was successful in urging investments for specific areas particularly in HIV and preventing unintended pregnancy globally. In the Philippines, the resources for adolescent sexual and reproductive health and rights has been under the budget for the implementation of Responsible Parenthood and Reproductive Health (RPRH) Law. Although the RPRH budget increased by 10% from 2017 to 2018 (9), data on allocation for ASRHR is not readily accessible and so, there is not much that can be said in terms of public investments in adolescent sexual and reproductive health. Moreover, the programs of different government agencies in the Philippines that include addressing teen pregnancy as its objectives, for instance, provide a current picture of siloed and inadequate investments for ASRHR.

Another concrete example where much of the current funding for ASRH comes from external sources is that the implementation of Comprehensive Sexuality Education (CSE) both in and out-of-school in the Philippines is still being supported by UNFPA Philippines and other development partners. The recent costed implementation plan (CIP) for CSE, although approved by the Department of Education and endorsed to the National Economic Development Authority early this year to lobby for sure line item budget for CSE, unfortunately was not enough to influence CSE allocation for 2021.

3. Data and evidence on ASRH

The National Demographic and Health Survey (NDHS) results and findings from the 2013 Young Adult Fertility and Sexuality Survey (YAFSS) which reveal the state of ASRH status in the Philippines (i.e teen pregnancy rate over the years) has fed into the policy and programming norms in different levels (national and few local). The Philippine adolescent birth rate at 47 live births per 1000 women from NDHS 2017 results along with the studies which indicate health risks and economic consequences (Php 33 billion annual loss due to teen pregnancy study done by UNFPA Philippines) associated with teen pregnancy, for instance, has led the President of the Philippines to order the national health, education, and economic agencies to organize a national summit to understand the social, health, and development dimensions of teen pregnancy and forge a multistakeholder consensus to address the issue in 2019. This initiated an attempt to harmonize the different programs of the government and identify gaps in addressing it.

The global evidence and data as well as local studies related to ASRHR available in the Philippines with the active support of some policymakers and civil society organizations pushed the creation of the bills that would advance the ASRHR in the Philippines (ie. child marriage bill, teen pregnancy bill, raising the age of statutory rape from 12 to 16 or 18 years old, among others). But despite the available evidence in the country, again, much has yet to be done in terms of addressing the ASHR concerns. One of the legal barriers that adolescents face until today is the need for parental consent in order for them to access SRH services. Regular conduct of research to better inform policies and programs with updated and relevant data has also been a gap observed from the inter-agency consultation after the national teen summit (last YAFFS study was done way back in 2013).

4. Enabling legal and policy environments for ASRH

Despite numerous challenges, the Philippines has had its small wins in terms of ASRHR policies and programs. In 2012, the Responsible Parenthood and Reproductive Health Act was passed after several years of lobbying. This law enabled the Department of Education to integrate Comprehensive Sexuality Education in its curriculum to equip learners with rights-based, age- and developmentally appropriate, culture-sensitive, and gender-responsive information and skills for learners to make informed and responsible choices about their health, well-being, and dignity. This is now supported by the Department of Education Order (D.O 31, s. 2008) which serve as a basis to implement CSE in schools where teachers are officially trained on CSE.

The RPRH law also enabled the Department of Health to issue standards and certification of adolescent-friendly health facilities. The adolescent-friendly health facilities standards are followed by its health partners in the local level.

In addition, the Philippine HIV/AIDS Act of 2018 (RA 11166) facilitated better access for young people aged 15 years old and above to know about their HIV status as it enables them to undergo HIV test without parental or guardian consent (10).

5. Ambivalence in other aspects for ASRH

The organized resistance especially from religious groups to sexual and reproductive health, much more on adolescent SRH, is not new and is even expected in the Philippines. The Responsible Parenthood and Reproductive Health took more than 10 years before it passed partly because of the opposition campaigns from religious groups. The most recent case of opposition to ASRH was the suspension of plenary debate of the adolescent pregnancy bill a group of 1,500 religious schools opposed the section of the bill mandating Comprehensive Sexuality Education implementation as a requirement to accredit private schools (religious schools are no exception) (11).

In many aspects of ASRH, the need for adolescents to access SRH as a basic human right will continue to be a driving force for its supporters to advocate, invest, act, and influence the ‘unconverted’ despite many challenges such as opposition and misconceptions.

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