Training course in adolescent sexual and reproductive health 2020

Approaches to ensuing the continuity of SRH information and services provision to adolescents in the context of the COVID 19 crisis: and using the opportunity of COVID-19 to build back better

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Question 1.1

Name one issue described in the FP2020/IAAH statement that hinders adolescents' access to SRH information and services in your country.

One issue hindering adolescents' access to SRH information and services in Zambia.

The issue that hinders adolescent access to Sexual Reproductive Health information and Services which is reflected in the FP 2020/IAAH statement is the inadequate number of Health personnel with the required skills to attend to Adolescent SRH information and service needs. This aspect alone necessitated the development of a approach to Scale up pre-service and in-service adolescent health training for health workers (Ministry of Health 2017).

Question 1.2

Describe briefly what approach you would use to overcome this issue.

Approach to Overcome Health worker skills deficiencies in adolescent SRH information and service provision.

The lack of requisite skills and behaviours by Healthcare providers to encourage adolescents to access SRH information and services must be approached from two directions.

Health care providers must be given the required skills and made aware of the required dispositions to ensure that adolescent's SRH information and service needs are met.

This must be accompanied by a system which ensures consequences for compliance and non-compliance. The second part can only be achieved if the claim holders, adolescents, are empowered to claim their right to SRH services.

Question 2.1

Which recommendation(s) on CSE does the example from Education as a Vaccine Nigeria illustrate?

Education as a Vaccine Nigeria's response to CSE recommendation(s).

The Education as a Vaccine (EVA) Nigeria case study meets three of the recommendations for delivering Comprehensive Sexuality Education during the COVID19 period.

Radio jingles and WhatsApp campaigns were used to prevent myths and misconceptions taking root.

The need to communicate CSE messages through mass and digital media was met through the use of multiple media platforms which included mobile applications such as Frisky and Diva. This was further augmented through the provision of a Short Message Service (SMS) platform

for young people to access information and counselling services. This increased the number of young people who could access SRH information (Marina Plesons and Chandra-Mouli 2020).

Healthcare providers were informed on the important role they had to play in educating adolescents through the retraining that was provided (Marina Plesons and Chandra-Mouli 2020).

Question 2.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

Feasibility of Nigeria's Education as a Vaccine interventions in Zambia.

The communication of CSE messages through mass and digital media is applicable to the Zambian situation. Zambia has used such platforms to deliver SRH information and services.

The training and retraining of health workers can also be done on condition that the mode of delivering the training is revisited. The current mode of training through workshops is very costly and unsustainable. This is more so as the country faces reducing fiscal space due to a huge domestic and foreign debt. This necessitates the exploring of alternative methods of delivering training content such as through virtual and remote training.

Lastly Zambia has toll free lines for CSE education through Lifeline Child line Zambia and the UReport application. The platforms can be scaled up and advertised to a wider audience to ensure uptake.

Question 3.1

Which recommendation(s) on contraception does the example from RFHA Fiji illustrate?

RFHA Fiji's response to contraception recommendations.

The Reproductive Family Health Association of Fiji (RFHAF) case study illustrated responsiveness to the need to set up hotlines for the provision of SRH information and counselling services by establishing a helpline in partnership with the Ministry of Women (Plesons and Chandra-Mouli 2020).

The recommendation to setup hotlines for adolescents to access information on contraception was met by the provision of telephone and online services (Plesons and Chandra-Mouli 2020).

The recommendations of informing and supporting adolescent to know the SRH services available and how to access them was met by mobilising additional Human resources who provided outreach services in addition to the use of social and mainstream media to share information about the services that were available and how to access them (Plesons and Chandra-Mouli 2020).

The recommendation to consider establishing alternative delivery modalities for contraceptives was met by extending clinic services hours and putting in place infection control measures (Plesons and Chandra-Mouli 2020).

Question 3.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

RFHA Fiji's Contraception programming measures Feasibility for Zambia.

Mobilising retired health workers is already practiced in Zambia through short term contracts. This makes it possible to increase staffing in health facilities in the event of need.

Zambia has a toll free helpline run by helpline ChildLine Zambia. The Ureport platform can be used as an online platform. The service provides free confidential information and counselling services. Its main target are adolescents (https://www.unicef.org/zambia/u-report-zambia).

These two examples serve to show that the roll out for a hotline or online platform is already a reality in Zambia. What the services need to achieve impact are aggressive education campaigns to inform adolescents of the existence of the services and how to take advantage of them.

The changing of Health facilities working hours is also made possible by the shift based regime that guides health workers.

Question 4.1

Which recommendation(s) on comprehensive abortion care does the example from FRHS India illustrate?

The Foundation for Reproductive Health Services (FRHS) response to comprehensive abortion recommendations.

The Foundation for Reproductive Health Services (FRHS) India addressed the recommendations for ensuring the responsiveness of comprehensive abortion care raised by Plesons and Chandra-Mouli in multiple ways.

The recommendation to inform adolescents on where and how they could access comprehensive abortion care which meets legal requirements was realised through advertisements which were placed in newspapers and other media channels (Plesons and Chandra-Mouli 2020).

The recommendation to ensure that comprehensive abortion care remains available and safe was met by revising service delivery guidelines to ensure safety of clients and service providers from COVID19 (Plesons and Chandra-Mouli 2020).

The recommendation to reduce barriers that delay access to care and therefore increase risks of adolescents reverting to un-safe abortion practices was met by introducing outreach teams whose role was to inform girls about the services available and accompanying them to the health facilities to ensure that they were not affected by mobility restrictions which affected access (Plesons and Chandra-Mouli 2020).

The recommendation to reduce cost barriers was met by reducing the cost of abortion services (Plesons and Chandra-Mouli 2020).

Question 4.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

Feasibility of FRHS Intervention in Zambia.

Advertising abortion services in Zambia would not yield the desired outcomes. There would be a society backlash that would galvanise antiabortion groups. The issue would become political and the state would have to ban such adverts and possibly deregister the organisations associated with promoting the services.

Efforts to inform adolescents of abortion services would have to be done in discrete and creative ways that avoid the public's attention.

Changing aspects of the service to meet COVID19 prevention measures would be possible to implement.

Question 5.1

Which recommendation(s) on maternal care and mental health does the example from the University of Nairobi and the Nairobi City Council in Kenya illustrate?

The University of Nairobi and the Nairobi City Council in Kenya response to maternal care and mental health recommendations.

The University of Nairobi and the Nairobi City Council in Kenya was able to demonstrate responsiveness to some recommendations on changes to maternal care and mental health.

The recommendation to inform adolescents on how and where to access maternal care through mass and digital media was met through the use of the Mental Health Gap Action Programme (mhGAP) Community Toolkit (Plesons and Chandra-Mouli 2020). Through this intervention the service providers were able to create community awareness of factors that impacts mental health, how to identify signs and symptoms, address stigma and how to help people with mental health challenges (World Health Organization 2019)

The recommendation to use telemedicine for counselling and screening services was attended to by establishing a hotline and an online psychotherapy service (Plesons and Chandra-Mouli 2020).

The recommendation to ensure birth and complication readiness are adapted at each contact with pregnant adolescents and for the post delivery period were attended to by training service providers in the Mental Health Gap Action Programme (mhGAP) Intervention Guide (Marina Plesons and Chandra-Mouli, 2020). This intervention equipped service providers to integrate screening of common mental health problems in primary care centres. This increased the points at which mental health issues could be identified and managed in all interactions between service providers and adolescents (World Health Organization 2016)

Question 5.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

Feasible of the University of Nairobi and the Nairobi City Council of Kenya's interventions in Zambia.

Creating community awareness of factors that impacts mental health, how to identify signs and symptoms, address stigma and how to help people with mental health challenges can be replicated in Zambia. It would however suffer slow community attitude change towards mental health issues. This is mainly due to the neglect that mental health education has been subjected to, leading the Ministry of Health to conclude that the legal and policy framework for mental health requires strengthening (Ministry of Health 2017). Mental health issues are still shrouded in mysticism which is not surprising given the low levels of investment in community education.

Establishing a hotline and an online psychotherapy service would be a possible however such a service would require qualified psychotherapists. The low numbers of qualified psychotherapists in the country makes it difficult to roll out a programme that would require this level of skill. Zambia would however make use of counsellors to do most of the counselling work through channels such as the ChildLine Lifeline Zambia.

Training service providers to integrate screening of common mental health problems in primary care centres would be feasible on condition that the mode of training explores distance and virtual modes of delivery to circumvent the high costs of the traditional way that Zambia's in service training has been delivered. The use of seminars and workshops has proven costly. The reduced fiscal space would not allow such a costly modality. The need for a speedy rollout which the traditional route cannot deliver goes without mention.

Question 6.1

Which recommendation(s) on HIV does the example from the Zvandiri in Zimbabwe illustrate?

Zvandiri's response to HIV recommendation(s).

The Zvadiri case study responds to a number of recommendations relating to Adolescent HIV services.

The case study provides Youth Led development of information on COVID19 as a way to ensure that adolescents are aware of where and how to access services during new restrictions. The existence of the ZVAMODA mobile app gave the adolescents access to information relating to HIV testing and care (Plesons and Chandra-Mouli 2020).

The programme responded to the need to provide home-based HIV and other STI tests, by conducting targeted home visits by mentors. These home visits included ART refills, viral load monitoring and screening for other health risks which include TB and STIs (Plesons and Chandra-Mouli 2020).

Zvandiri also encouraged adolescents by linking them to Virtual support groups in which they could benefit from support and experience sharing thereby strengthening their coping mechanisms (Plesons and Chandra-Mouli 2020).

Question 6.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

Feasibility of the ZVADIRI model in Zambia.

Zambia has experience in developing and running youth led development of information. Trendsetters and the Helping Each Other Act Responsibly Together (HEART) Campaign in the late 1990s proved highly successful in reaching young people. They were supported by external funding. Other platforms which have followed these initiatives are performing sub optimally because of limited support.

The use of applications such as ZVAMODA has equivalents in the form of the Ureport. The Smartcare computer application has proven helpful in providing key information to help treatment supporters follow-up defaulting clients and linking them to other services

Question 7.1

Which recommendation(s) on gender-based violence does the example from Centre for Catalysing Change in India illustrate?

The Centre for Catalysing Change's response to Gender Based Violence Intervention Recommendation(s).

The Centre for Catalysing Change (C3) advocated for the Jharkhand government to embark on community awareness raising on Gender Based Violence (GBV). The centre also provided

adolescent girls and young women with information on GBV through digital platforms and community radio stations. This was in response to the recommendation to inform adolescents on where and how they can access GBV information and services (Plesons and Chandra-Mouli 2020).

C3 also built the capacity of frontline workers in legal procedures and counselling as a way to ensure that the health providers were made aware of adolescent's vulnerabilities in relation to GBV (Plesons and Chandra-Mouli 2020).

Lastly C3 fulfilled the recommendation to establish or enhance help lines for adolescents to seek help by placing mobile phones in each village for use by girls to access helplines. Telephone Counsellors were trained to respond to calls from the girls (Plesons and Chandra-Mouli 2020).

Question 7.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

Applicability of the C3 Case study on GBV interventions to Zambia.

The open democratic space in Zambia would allow for individuals and institutions to lobby and petition the government to provide GBV information and services.

The placement of mobile phones in Villages would be possible but has to ensure the inclusion of electric charging technologies such as solar to ensure that the service is operational. Another key intervention would be to sensitise the girls in the use of the phones and where to access reliable network coverage.

Question 8.1

Which recommendation(s) on HPV does the example from the Ministry of Health of Laos illustrate?

Recommendation(s) on HPV and the Ministry of Health of Laos Case study.

The Laos Ministry of Health responded to the recommendation to inform adolescents and their parents about the importance of achieving full vaccination, changes to the Immunisation schedule and attending to concerns over the efficacy and safety of the HPV vaccine by communicating changes in vaccination service modalities such as dates and places (Plesons and Chandra-Mouli 2020).

The Laos Government also revaluated vaccination points with input from village heads after it became clear that the initial school setting option was no longer viable (Plesons and Chandra-Mouli 2020).

Health workers and others involved in delivering the HPV vaccine were trained via videos and interactive Power Point slides. This was in response to the recommendation to inform all parties involved in the HPV Vaccination of any changes (Plesons and Chandra-Mouli 2020).

Question 8.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

Replicability of the Laos Case study to the Zambian Situation,

The issuing of new communication messages to ensure accuracy of information in relation an HPV vaccination drive can be done in Zambia. The use of traditional leaders to communicate critical information such as dates, who qualifies and venues to access the service continues to be a key feature of HPV vaccination.

This approach has however included other influential community leaders such the clergy.

Question 9.1

Which recommendation(s) on menstrual health does the example from the Footprints Foundation in South Africa illustrate?

Footprints Foundations response to menstrual health Recommendations.

The footprint foundation demonstrated responsiveness to the recommendation of inclusion of menstrual products in the distribution of other items to girls with limited mobility by securing special permits which extended beyond menstrual products to include food parcels. This permit encompassed deliveries to health centres, shelters, schools, and facilities hosting persons with disabilities (Plesons and Chandra-Mouli 2020).

The recommendation to partner with other community groups in providing affordable menstrual products was achieved by partnering with the Departments of Women, Youth and People with Disabilities, Basic Education, Gauteng Social Development, and with the Seriti Institute (Plesons and Chandra-Mouli 2020).

Question 9.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

Feasibility of the Footprints foundation Menstrual Hygiene Products initiative in Zambia.

The COVID19 pandemic saw a solidarity among different stakeholders in Zambia. Individuals and organisations came together to donate and join hands in making public spaces clean. This

solidarity has however not been sustained. It has also been hamstrung by revelations of resource mismanagement by Public institutions.

The inclusion of menstrual products in the distribution of other COVID items is desirable but would be met by the challenge of incentive replacement. Public agency staff look at distribution mechanisms as a means to make extra money to compliment low public wages. Combining commodities would lead to fewer trips for all concerned and thus to reduced extra income. This pervasive incentive is the main roadblock to the obvious benefits that would accrue from integration. The savings from multiple trips and supply systems can be used to increase the number of beneficiaries and the scope of needs met. It therefore remains a challenge that can be fixed by changing incentive structures to make cooperation in support to vulnerable groups a sought after undertaking.

Question 10

In what ways do you think COVID-19 might, in fact, present an opportunity for accelerating progress on ASRHR?

Opportunities for accelerating progress on ASRHR in the COVID-19 Era.

The COVID19 Pandemic has resulted in disruptions in all aspects of our lives. Looking beyond the negative consequences of the COVID19 outbreak will position Adolescent Sexual Reproductive Health Rights (ASRHR) proponents to identify and utilise unique opportunities.

The COVID19 has had differentiated impacts on populations with different demographic and health profiles. These impacts have revealed underlying vulnerabilities which are grounded in historical challenges in access to health information and services. SRH is not an exception to this reality.

Despite adolescents making up a small proportion of people dying as a direct result of COVID19, they are however disproportionately affected by the resulting impacts manifested in areas such as unemployment, Gender based violence, mental health, Sexually Transmitted Infections, Unplanned pregnancies, gender based violence and reduced access to health services (Sully 2020). This evidence presents an opportunity to demonstrate adolescent vulnerability and advocate for the redress of underlying vulnerabilities.

The restrictions on movements and challenges in delivering services presents an opportunity to explore alternative delivery methods for SRH information and services such as the use of virtual platforms.

Many of the required responses to the constraints that COVID19 poses requires changes in problem solving and systems rethinking that go beyond institutions and sectors. SRH has not been spared from this reality. This situation makes dialogue an imperative that must be embraced. The need for collective change creates an opportunity to look at addressing inter institutional synergy challenges which may have existed for a long time but were not adequately incentivised for action (Plesons et al. 2019).

Creating new realities of working with and for adolescents will require placing the focus and intended beneficiaries at the centre of decision making. Involving Adolescents in designing the new normal will help to address inadequacies in the current systems which have contributed to suboptimal SRH results (Plesons and Chandra-Mouli 2020).

COVID19 has also highlighted areas which can benefit from more information (Plesons et al. 2019). Questions such as how can programmes strike a balance between protecting adolescents from GBV and hold perpetrators to account while ensuring that they do not lose the social capital that family provides need urgent answers. Especially when the perpetrator is a family member. Another question is how to deliver contraceptives to adolescents who are in lockdown with very little space for privacy. The answers to questions such as the ones raised have benefits during and after the COVID19 pandemic.

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