Working to Ensure Accountability on Adolescent Sexual and Reproductive Health: Report prepared for the Independent Accountability Secretariat, Every Woman, Every Child, Every Adolescent

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Introduction
As defined by the Independent Accountability Panel (IAP) of Every Woman, Every Child, accountability is the “independent and transparent review of progress on the implementation of the 2016–30 Global Strategy for Women’s, Children’s and Adolescent’s Health and to identify and advocate the necessary actions to ensure achievement of the Strategy’s goals” [IAP].

Fundamentally, accountability is the promise and foundation upon which all of our global efforts depend. We make sure that accountability exists in international and national documents, and we speak of keeping our collaborators and ourselves accountable, through partnerships, commitments, and initiatives. However, accountability can also be implicit, such as the accountability inherent in becoming a parent, on behalf of the rights of the child. Accountability takes many forms, and exists on every level, and thus, finding ways to measure and ensure accountability should be central to our efforts.

The World Health Organization (WHO) is committed to strengthening accountability for adolescent health and development through the collection and dissemination of rigorous, high-quality data at the global level.

I. Global-Level

Using data to highlight the unmet contraceptive needs of adolescents across countries
WHO has published comprehensive fact sheets on adolescent contraceptive use in 58 low and middle income countries (LMIC), which provides comprehensive data on contraceptive use by marital status, what types of contraception are being used, why contraception is not used, and where adolescents obtain contraception. WHO’s analysis indicates that contraceptive use is alarmingly low in LMIC. For instance, in Tanzania, 60.3% of unmarried 15 to 19 year old adolescent girls are not using contraceptives, while 85.1% of adolescents in union within this age group are not using contraception [WHO Fact Sheet, Tanzania]. Among sexually active, unmarried girls, the majority obtains contraceptives from a shop or friends (see Figure 1).

Figure 1. United Republic of Tanzania: Adolescent contraception [WHO Fact Sheet based on DHS 2010 data]
contraceptive use and nonuse could be used with data to press for accountability at different levels. These data include health outcomes, health behaviours and their determinants, policies and programme performance, and external support. Health outcomes measures include maternal mortality and morbidity; health behaviours and their determinants include contraceptive use (who is using contraceptives and who is not, what are users actually using, where do they get services/commodities, and why are non-users not using). Policy and programme data include how adequately national reproductive health/contraceptive policies, strategies, training materials, and guidelines address the needs and preferences of adolescents, and how adolescent friendly/responsive contraceptive programmes actually are. Lastly, external support means in what way technical and financial support international organizations/initiatives are mandated to support the government, and how much they are in fact providing.

Pressing for accountability through global partnerships/initiatives
WHO fact sheets and data on global adolescent contraceptive use are being use by major global partnerships to press for accountability. One such example is Family Planning 2020 (FP2020), which has committed to the provision of modern contraception to 120 million girls and women in 69 of the world’s poorest countries by the year 2020. Currently, FP2020 has just passed its midpoint and has used this milestone to emphasize the limited and patchy progress made globally to meet the contraceptive needs of adolescents (e.g. in its FP2020 “Momentum at the Midpoint” report). To meet the goals of FP2020, it is critical that we continue to use and gather data, not only on mortality and morbidity associated with the lack of contraceptive provision, but the various social and environmental determinants of health that deeply impact adolescent contraception uptake and usage. Through rigorous, comprehensive data, change at the global level can be achieved. Through FP2020, we are holding international organizations accountable for the commitments made.

Pressing for the use of evidence-based interventions
There is growing evidence on what works, and what does not work, in our responding to the needs and problems of adolescents. However, ineffective interventions and ineffective delivery continue to be widely observed. Interventions that do not work in ASRH have been comprehensively documented, and several common scenarios can be observed: adolescents are not reached by interventions; interventions demonstrated to be effective are delivered ineffectively; interventions are delivered piecemeal, with micro OR macro engagement; interventions are delivered in low “dosages” (short duration or intensity); popular interventions that have been shown to be ineffective for adolescents continue to be implemented [Chandra-Mouli et al., 2015].

WHO has made the case in a number of fora that continuing to fund or promote interventions that are not supported by evidence represents a waste of scare human and financial resources, and raises questions about the value of adolescent health policies and programmes. WHO is pressing for greater accountability in the use of resources and is calling funders, technical support agencies, policy makers and programmes managers to challenge the implementation of ineffective interventions

II. Regional-Level

Using disaggregated data to reveal the lack of progress in addressing the needs of the most vulnerable populations, and linking this to specific geographic areas to press for action by policy makers and programme managers

Adolescent Data Disaggregation and Segmentation
Data collected on a global scale have tremendous utility in understanding where the world stands. However, global averages mask individual differences and fail to capture the complexity and context-
specificity that have huge implications on the implementation and effectiveness of contraception programs. Thus, we highly prioritize the disaggregation of adolescent data and segmentation of adolescent data to better understand and respond to their differing needs.

WHO is working to disaggregate data by age group, wealth, urban/rural location, geographic region, religion, ethnicity, and marital status to help identify groups with high rates of adolescent first births or where progress is poor, and enables greater targeting of programs and resources. We have two key examples of our data disaggregation/segmentation work. In 2015, we published a disaggregated paper on adolescent first births in East Africa, where we found that adolescent first births are the most common among the poorest, least educated girls, specifically at the youngest ages. Importantly, there has been very little progress in addressing this specific group of adolescents (Figure 2) [Neal et al., 2015].

**Figure 2.** Percentages of women reporting first birth before aged <16 for lowest and highest wealth quintiles for Uganda, Kenya and Tanzania: urban and rural [Neal et al, 2015].

![Figure 2: Percentages of women reporting first birth before aged <16 for lowest and highest wealth quintiles for Uganda, Kenya and Tanzania: urban and rural](image)

We analyzed this detailed data further in a paper mapping early adolescent births in East Africa. Our paper effectively demonstrated the utility of linking data to geographic areas, which can identify areas of high prevalence and encourage policy makers and countries to act [Neal et al., 2016]. This demonstrated the compelling heterogeneity within geospatial regions, which is necessary to take into consideration when deciding where efforts need to be allocated.

**Figure 3.** Mapping of early adolescent births in East Africa. Weighted proportion of adolescent birth in East Africa among DHS respondents aged 20 to 29, at a) less than 16 years old, b) 16 to 17 years old, and c) 18 to 19 years old [Neal et al., 2016].

![Figure 3: Mapping of early adolescent births in East Africa](image)
WHO seeks to publish disaggregated first birth data for other world regions, and will soon publish findings from the countries within Latin America and the Caribbean (LAC) including Bolivia, Colombia, Dominican Republic, Haiti, and Peru [Neal et al., submitted for publication]. Once again, these data reveal a persistent and prevalent unmet need for contraception among adolescents (Figures 4 and 5).

Figure 4. Trends over time in percentage of women aged 20-24 reporting first birth before age 20 years, disaggregated by age (confidence intervals in parentheses) [Neal et al., submitted for publication].

<table>
<thead>
<tr>
<th>Country</th>
<th>Year of first survey</th>
<th>Year of second survey</th>
<th>Year of third survey</th>
<th>Average % annual rate of change between baseline and final survey year</th>
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<td>2005</td>
<td>2012</td>
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<td>-2.0</td>
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<td>-0.4</td>
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<td>18/19</td>
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<td>15.1 (13.2-17.1)</td>
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<td>-0.8</td>
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<td>30.1 (27.6-32.7)</td>
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<th>Year of second survey</th>
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<td>&lt;16</td>
<td>3.3 (2.8-4.0)</td>
<td>3.5 (3.0-4.1)</td>
<td>3.5 (2.8-4.2)</td>
<td>0.3</td>
</tr>
<tr>
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<td>10.3 (9.4-11.3)</td>
<td>11.1 (9.9-12.4)</td>
<td>1.0</td>
</tr>
<tr>
<td>18/19</td>
<td>14.5 (13.3-15.9)</td>
<td>14.9 (13.8-16.0)</td>
<td>17.1 (15.5-18.8)</td>
<td>0.8</td>
</tr>
<tr>
<td>Total &lt;20</td>
<td>26.9 (25.3-28.6)</td>
<td>28.7 (27.2-30.2)</td>
<td>31.6 (29.7-33.6)</td>
<td>0.8</td>
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</table>

Figure 5. Trends over time of percentage of women aged 15-19 reporting that they wanted their last child (95% confidence intervals in parentheses) [Neal et al., submitted for publication].
Developing and applying accountability frameworks at the regional levels
Within some regions, there are notable accountability and programmatic strategies. Namely, in 2013, Ministers of Education and Health from 20 countries in Eastern and Southern Africa (ESA) endorsed the landmark ESA Ministerial Commitment, which committed to providing comprehensive sexuality education (CSE) and sexual and reproductive health services for adolescents and young people in ESA [Young People Today]. This was an important, historic step that recognized and established adolescent SRH and CSE as global priorities. Of special importance is the development/implementation of the Regional Accountability Framework, an initiative undertaken by UNESCO, UNAIDS, regional economic communities, civil society organizations, and religious and youth leaders with the primary aim of ensuring accountability towards the commitments established by the ESA Ministerial Commitment. The Regional Accountability Framework established a set of 20 indicators that are monitored on a quarterly basis, to monitor the progress of the commitment in five category areas: eliminating new HIV infections among adolescents and young people aged 10-24, promoting gender equality and empowerment, promoting access to services among young people, scaling up CSE, and developing and scaling up adolescent and youth sensitive health services [http://youngpeopletoday.net/resources/].

It is also important to remember the Mexico declaration, which informed the ESA Ministerial Commitment to CSE and SRH, as it effectively placed CSE and SRH on the Ministerial agenda in a world region (LAC). However, there were many lessons to be learned from the Mexico declaration, which lacked structured follow up. Thus, it is promising to see ESA build on the lessons from LAC, through the implementation of a structured set of country progress indicators. It is clear that structured follow-up with the use of objectives should be an essential component of our national and international commitments.

II. National-Level

Gathering and using data to press for accountability at national and subnational levels

<table>
<thead>
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<th>Country</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
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<tr>
<td></td>
<td>Wanted later</td>
<td>Wanted no more</td>
</tr>
<tr>
<td>Colombia</td>
<td>1990</td>
<td>2010</td>
</tr>
<tr>
<td></td>
<td>21.6 (16.6-27.6)</td>
<td>12.6 (8.7-18.0)</td>
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<tr>
<td></td>
<td>51.6 (46.2-57.0)</td>
<td>16.5 (12.8-20.9)</td>
</tr>
<tr>
<td>Dominican Republic</td>
<td>1996</td>
<td>2013</td>
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<tr>
<td></td>
<td>69.6 (59.6-78.0)</td>
<td>34.0 (30.9-37.3)</td>
</tr>
<tr>
<td></td>
<td>28.3 (20.1-38.3)</td>
<td>51.1 (47.7-54.5)</td>
</tr>
<tr>
<td></td>
<td>1.1 (0.7-6.1)</td>
<td>14.9 (12.6-17.5)</td>
</tr>
<tr>
<td>Haiti</td>
<td>1994-95</td>
<td>2012</td>
</tr>
<tr>
<td></td>
<td>32.5 (25.0-40.9)</td>
<td>27.2 (22.1-32.9)</td>
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<td></td>
<td>55.0 (46.5-63.3)</td>
<td>67.5 (61.5-73.0)</td>
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<td></td>
<td>12.5 (7.9-19.2)</td>
<td>5.1 (2.6-9.6)</td>
</tr>
<tr>
<td>Peru</td>
<td>1991-92</td>
<td>2012</td>
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<tr>
<td></td>
<td>43.2 (37.9-48.6)</td>
<td>27.7 (23.3-32.6)</td>
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<td></td>
<td>44.7 (39.4-50.2)</td>
<td>60.7 (55.2-65.9)</td>
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<td></td>
<td>12.1 (8.9-16.2)</td>
<td>11.6 (8.3-16.0)</td>
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</table>
We need national level accountability of programs to make significant gains in the area of adolescent contraception and reducing adolescent pregnancy. A key example of a successful national framework can be seen in the United Kingdom Government’s 10-Year Teenage Pregnancy Strategy for England from 1999 to 2010 [Hadley et al., 2016]. England put in place a national teenage pregnancy strategy in 1999. Five years into the implementation of the strategy, rates were declining in some districts but in others, rates were either stagnant or even increasing. To learn why this was happening, the government decided to do a “deep dive” to examine why progress was uneven. Three 'highly-performing' districts were matched demographically and socioeconomically with three 'poorly-performing' districts. The review pointed to leadership and the implementation of all the elements of the recommended package as a whole. Based on these findings, the government put in place more prescriptive guidance and conducted more active follow-up of less well-performing districts through revolving quarterly monitoring by members of the cabinet. These efforts contributed to the declines extending to all of the districts in the country (Figure 6). This example effectively illustrated how national authorities can use data to demonstrate progress and inform collective action at the local level, providing hand holding and monitoring to ensure change.

Figure 6. England under-18 conception rate (1998-2014) [Hadley et al., 2016].

Assessment of national normative documents (policies, strategies, regulations and guidelines)
Policy sets the framework for action. Of note, WHO has analyzed country-specific contraceptive policies to evaluate whether these policies address the needs of adolescents. In one study analyzing South Africa’s contraceptive policy from a human rights perspective using WHO recommendations, there were several gaps in availability, informed decision-making, and adolescent engagement in program development [Hoopes et al., 2015]. Similar results are soon to be published in a study analyzing national contraception laws, policies, and regulations from Paraguay [Cordova-Pozo et al., 2017 (In Press)]. Although both studies found a substantial emphasis on human rights in the contraception policies of both countries, considerable gaps existed, creating barriers to high-quality
contraceptive access and provision. Analyzing national level policies with WHO recommendations and guidelines is an effective way to hold countries accountable for their provisions around SRH services for adolescents. They also point to what gaps need to be filled and what weaknesses need to be addressed (Figure 7).

**Figure 7**

Potential opportunities to strengthen South Africa’s National Contraception a Fertility Planning Policy and Service Delivery Guidelines and National Contraception Clinical Guidelines

Assessment of national programmes

WHO is working to support assessment of the quality and coverage of programmes directed at young people. Two examples of this are evaluations of an adolescent friendly health services programme in Moldova [Carai et al., 2015] and a state-level multicomponent programme in India [Barua & Chandra-Mouli, 2016].

Although there are various entry points to engage with the issue of adolescent SRH at the national level, ultimately the strongest accountability will arise by learning from and working with countries, motivating country leaders and politicians to prioritize adolescent SRH.

**IV. Community, family and individual levels:**

**Gender Socialization**

Of the numerous, substantial biopsychosocial changes that occur during adolescent development, the formation of attitudes and values is one of the most pronounced. These attitudes and values have tremendous implications upon the lives of adolescents themselves, but also upon the lives of those around them, fundamentally exerting a ripple effect through society.

Children learn at home and in their communities that violence against women is normal. Among 14 LMIC, over 50% of boys and girls aged 15 to 19 in believe that a husband is justified in beating his wife in certain circumstances, including situations such as “if his wife burns the food, argues with him, goes out without telling him, neglects the children or refuses sexual relations” (see Figure 8) [UNICEF, 2012]. Further, across 74 LMIC, adolescent girls are equally as likely as older women to justify wife beating [UNICEF, 2012].

**Figure 8. Left-** 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). Right- Percentage of girls and women 15-49 years old who think that a husband is justified in hitting or beating his wife under certain circumstances, by age group. [UNICEF, 2012].

It is evident that the development of inequitable gender norms begins early. Thus, we must hold communities and families accountable. Our data allow us to understand that social norms and practical economic constraints influence the decisions, and subsequent opportunities or lack thereof, of adolescent girls globally. Research from the Young Lives initiative within the Oxford Department of International Development on child marriage and early childbearing in India revealed the complex, underlying dynamics that drive child marriage and early childbearing. For instance, girls with older sisters and without older brothers are less likely to be married before the age of 18, whereas girls with only older brothers get married earlier [Young Lives, 2016]. This data reveals the complex decision-making process faced by families in LMIC, who are forced to weigh economic factors and meet social norms when making choices over the lives of their daughters.
The Global Early Adolescent Study (GEAS) is an international study that focuses on elucidating the myriad biological, psychological, and social factors that impact adolescent SRH, including gender norms, attitudes, and socialization. A comprehensive systematic review from GEAS, largely based on data from developed countries, demonstrated that stereotypes and norms that propagate gender inequality are pervasive amongst young adolescents. This study found that gender-stereotypical attitudes are shaped by parents and peers, and are deeply entrenched in the larger social environment [Kågesten et al., 2016]. There is a shortage of data on gender socialization and norms in LMIC, and it is critical for us to prioritize efforts to collect data in these countries. In order for our interventions and efforts to be successful, it is essential that communities and parents must be held accountable to the propagation of inequitable gender norms and socialization.

**Adolescent Accountability**

Adolescent perspectives on SRH services are critical, as they are at the core of our efforts. The country level quality and coverage assessments have sought to learn about the views and experiences of adolescents. There is a growing move to engage and support adolescents to play the role of researchers. WHO has carried out a systematic review of studies and evaluations utilizing adolescent mystery clients to evaluate health worker and facility performance revealed negative experiences with health providers; care was characterized by bias and disrespect [Chandra-Mouli, Lenz, et al., 2017 (Submitted)]. Many of these studies/evaluations revealed that adolescents do not experience negative experiences with health workers and lack of confidentiality and sensitivity with
They also underlined that employing adolescents as mystery clients is both feasible and useful to do.

It is essential that adolescents and young people raise their voices to speak up about the challenges and barriers involved with care. However, youth-led accountability does not simply require ‘voice’, but also “teeth”: (Fox, 2015). WHO’s assessment of national contraceptive policies, strategies and guidelines in Burkina Faso, Democratic Republic of Congo, Ethiopia, Kenya, Madagascar, Nigeria, Rwanda, Tanzania, Uganda and Zambia reveals that clear recommendations on accountability are either missing or very weak. Specifically, Kenya’s normative documents mention the role of national human rights institutions in receiving and investigating human rights violations experienced by adolescents. And Nigeria’s and Zambia’s normative documents mention complaint or feedback mechanisms for adolescents as well as their involvement in monitoring/evaluation. None of the others addressed this. As Fox stresses in his paper on social accountability, citizen involvement is important but it must be accompanied by mechanisms for state responsiveness to ensure real accountability.

**Conclusion**

Accountability takes place at numerous levels. Entities at each of these levels (global, regional, national, and individual) must work collaboratively and hold each other accountable to achieve progress. Each entity either includes, or is part of, another, thus we cannot point the finger and disproportionately place the blame on one entity when failures and setbacks occur. We need to understand that our work results in both upstream and downstream effects, and we must be accountable as much as we hold others to be. We need to recognize and celebrate the exceptional successes that arise when accountability is met. Evidence points to necessity of multicomponent approaches and multilayered accountability in order for us to truly deliver on the promises that have been made to adolescents worldwide.

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Chandra-Mouli, V., Lenz, C., Adebayo, E., Chatterjee, S. A Systematic Review of the Use of Adolescent Mystery Clients in Assessing the Adolescent Friendliness of Health Services in High, Middle, and Low-Income Countries. Submitted to PLOS.

Implementation: A multisectoral approach

Mozambique

Mozambique provides an excellent example of a cleverly and strategically planned programme [Chandra-Mouli V, et al, 2015]. The objectives of the programme – later branded Geracao Biz (Busy Generation) – were: ‘To improve Adolescent Sexual and Reproductive Health, including a reduction in the incidence of early and unintended pregnancy, Sexually Transmitted Infections and Human Immuno-Deficiency Virus infections, through activities that equip young people with the knowledge, skills and services needed for positive behaviour change.’ From the outset, Geracao Biz was a truly multisectoral programme involving three sectors. The Ministries of Health, Education, and Youth and Sport were the key implementers of this initiative. Government staff from each of these sectors worked with community-based organizations, including youth organizations, and young people to deliver three complementary interventions entwined with each other - youth friendly clinical services, school-based education and community-based outreach.

To facilitate collaboration, a strong coordination mechanism was put in place – at the national, provincial and district levels, as shown in Figure 5. Young people were active members of coordination committees at all three levels.

Figure 5. Geracao Biz – Implementation model and coordination mechanism [Chandra-Mouli V, et al, 2015]

The initiative was launched in 1999 in two pilot sites. Over the next ten years, it was scaled up to cover all the provinces of the country. In addition to expanding activities into additional provinces, there was expansion within provinces so as to reach large numbers of adolescents.

Julio Pacca, Senior Advisor at Pathfinder International describes the significance of Geracao Biz, and its fundamental role in empowering and engaging young people in implementation. “The vitality of the youth movement that has been nurtured under Geracao Biz is an integral part of the programme. Young people not only participate in the programme design, implementation, and evaluation, but they also identify new areas that are of importance and advocate for the policy makers to respond to these needs, demonstrating that they can be leaders in solving their own issues. Beginning with the end in mind is fundamental to design a programme that will be scalable. It is also crucial to nurture a new generation.”
England
England’s national Teen Pregnancy Strategy (TPS) is another example of a comprehensive yet tailored multisectoral approach to teen pregnancy. TPS was a 10-year strategy developed by the Social Exclusion Unit newly established by the UK Labour Government. The primary goal was to reduce the under-18 contraception rate by at least 50% from 1998 to 2010; by 2014, the rate had been lowered by 51% [Hadley et al., 2016]. Understanding the structure of a successful programme like TPS has the potential to inform similar approaches in other world regions.

TPS employed a Teenage Pregnancy Unit, which included a team of civil servants and external experts responsible for implementation. The Department of Health was the ministerial lead for TPS, however, there were individual ministers appointed in each department as well as an inter-departmental group that met with TPU. There was also engagement at regional and local levels, with Regional Teenage Pregnancy Coordinators, local Teenage Pregnancy Coordinators, and local Teenage Pregnancy Partnership Boards. In addition, an Independent Advisory Group on Teenage Pregnancy was established to monitor implementation, advise ministers, and submit annual reports to the government. Effectively, this programme included national, regional, and local structures to ensure implementation of TPS, and accountability, at every level.

One of the major strengths of England’s approach to addressing teen pregnancy was its inherent accountability mechanism. All TPS/TPU structures received annual funding from the government; however, this was contingent on accountability. “All areas received dedicated annual funding, conditional on establishing their board and providing an annual report on progress; this helped to maintain focus even if early results were not particular promising. Very accurate conception data were published quarterly and annually by the independent national statistics office and provided a regular and objective measurement of progress. The robustness of the data also allowed comparisons of progress between similar areas... and helped to convince the poorer performing areas that change was indeed possible” [Hadley et al., 2016]. Six key features have been attributed to TPS’ success, a few of which are especially relevant to ensuring accountability. These include developing an evidence-based strategy, regularly reviewing progress, embedding the strategy in wider government programmes, and providing leadership throughout the programme [Hadley et al., 2016]. These central tenants can provide a foundation and useful starting point for the development of evidence-based, multidimensional, and multi-layered approaches to address adolescent SRH.

Thailand
In 2016, Thailand enacted “The Prevention and Solution of the Adolescent Pregnancy Problems Act, B.E. 2559,” a law that focuses on adolescent rights and promotes the use of an integrated approach to prevent and alleviate adolescent pregnancy. The Act outlines the rights of adolescents, establishes formal structures, and clearly defines the roles of each governing body. Specifically, there are five ministries that are responsible for issuing ministerial orders and regulations in order to carry out the provisions of the Act: the Ministries of Public Health, Social Development and Human Security, Education, Labour, and Interior. In addition, “The Prevention and Solution of the Adolescent Pregnancy Problem Committee,” led by the Prime Minister, is responsible for the proposition of policies, strategies, and guidelines for state agencies and private organizations surrounding adolescent pregnancy.
It remains to be seen what results of Thailand’s strategy, however the proposed collaboration of educational institutions, public health facilities, local administrative organizations, workplaces, and social welfare organizations seems to be promising. Given that adolescent birth rates in Thailand have been declining in recent years (Figure 6), it is positive to see Thailand push for increased efforts to continue and accelerate declines.
Mozambique, England, and Thailand show us that the strongest approaches to implementation include players from a variety of sectors. Successful strategies seem to include a diverse range of stakeholders, but are nevertheless cohesive. For multisectoral approaches to be successful, however, it is essential that all key stakeholders have clear, well-defined tasks and responsibilities, to which they are held accountable. It requires a shared understanding and collaborative commitment to quality, equity, and sustainability.
Successful interventions targeting adolescent contraception

There are several outstanding examples of progress in adolescent contraception in several world regions. These examples can teach us valuable lessons about accountability, and help us inform best practices.

European Region

Estonia employed a school sexuality education curriculum in 1996, which resulted in dramatic decreases in abortion and fertility amongst adolescents aged 15 to 19 years (Figure 1) [Haidre & Ketting, 2012]. Increased knowledge about contraception, access to youth-friendly sexual and reproductive health (SRH) services, and a supportive policy environment have all been attributed to Estonia’s success [Federal Centre for Health Education Policy Brief]. The progress in Estonia is indicative of the strength of national, targeted approaches to reduce teenage pregnancy.

Figure 1. Number of legally induced abortions and live births per women aged 15 to 19 years, from 1992-2009, and number of pregnancies and legally induced abortions per women aged 20-24, from 1996-2009, Estonia [Haidre & Ketting, 2012].

Similar to Estonia, Finland introduced school-based sexuality education and SRH services for adolescents in 1990 and enjoyed marked declines in teenage pregnancy rates shortly thereafter (Figure 2, Federal Centre for Health Education Policy Brief). However, the work in Finland also teaches us a valuable lesson on accountability. From 1998-2006, sexuality education and SRH services were cut back because of budget constraints. Reductions in SRH services and education were associated with a 50% increase in adolescent abortions and birth rates among 15 to 19 year olds, as well as increased Chlamydia infections (Apter et al., 2011; Figure 2). However, the collection of valuable data and monitoring allowed the country to respond quickly and effectively, and Finland reintroduced SR health and education programmes in 2006. This example is a powerful demonstration of the value of data to reveal significant patterns, and allow for appropriate and effective ways to troubleshoot.
African Region
Ethiopia is another excellent example of successful adolescent health programming. During the last decade or so, Ethiopia has increasingly focused on achieving universal health coverage through their national Health Extension programme (HEP). Central to HEP are the Health Extension Workers (HEWs), an all-female workforce recruited from communities by the communities themselves. “Health Extension Workers are the key players in [HEP]. They are all female, 10th grade high school graduates, recruited from the community with the active participation of the community. They are trained for one full year and then deployed back into the community to promote health and provide services at the village level. Two HEWs are paired to serve 3,000 to 5,000 people and serve at a health post. Much of their time is devoted to home visits and outreach. Over 35,000 HEWs are recruited, trained, and deployed to the villages” [Workie & Ramana, 2013].

Indeed, this robust healthcare worker programme in Ethiopia reaped tremendous positive results. From 2005-2011, modern family planning utilization among married women more than doubled, increasing from 10.9 % to 23.4% (Figure 3) [Hounton et al., 2015]. According to The World Bank report on HEP in Ethiopia, “this high uptake in family planning is due to the contribution of the HEWs and the availability of contraceptives through the HEP” [Workie & Ramana, 2013]. This is particularly remarkable given that married adolescents in rural areas tend to be disproportionately disempowered and typically exhibit the lowest rates of contraceptive usage. Indeed, during this same time period, contraceptive usage among married adolescents declined in Nigeria (Figure 3) [Hounton et al., 2015]. In fact, while there were huge increases in contraceptive use in Ethiopia, other countries within the same geographic region, such as Burkina Faso and Nigeria, demonstrated stagnation and decline (Figure 4) [Hounton et al., 2015]. Hounton et al. summarize the relationships between the three countries, further underscoring Ethiopia’s advances. “While there was no significant progress in Burkina Faso and Nigeria, the data in Ethiopia point to a significant and systematic reduction of inequalities. The narrowing of the equity gap was most notable for childbearing adolescents with no education or living in rural areas…. ” [Hounton et al., 2015].
Increasing adolescent contraception was not the only achievement of the HEW Programme in Ethiopia. In recent years, the country has also seen declines in child marriage and female genital mutilation/cutting because of commitments made by legislation, government, international organizations, and civil society organizations [Pankhurst, 2014]. It seems that investment in any component of adolescent SRH, whether it is sexuality education, family planning, or reducing harmful cultural practices, exerts an outward ripple effect, enhancing adolescent wellbeing as a whole.

Uganda is another key example with demonstrated progress in education and the SRH of adolescents over the past decade [Santelli et al., 2015; Crossland et al., 2015]. In Rakai, increases in school enrolment corresponded with decreased HIV incidence among adolescent girls [Santelli et al., 2015]. This same relationship was not observed in young men or young adult women. This suggests that there is a critical window of protection afforded to adolescent girls by being in school.

We can learn many valuable lessons from Ethiopia and Uganda. Namely, interventions directed providing contraceptive services to the population at large as well as those directed at keeping kids in school lead to substantial improvements in adolescent SRH. We need to promote accountability amongst national leadership, and simultaneously increase motivation for investment. These
outstanding interventions have generated real, tangible results, backed by hard evidence. It is indisputable that progress is possible.

References


