AFIDEP
African Institute for Development Policy

EXEMPLARS IN GLOBAL HEALTH

Policy Brief

September 2024

Advancing Adolescent Sexual and Reproductive Health and Rights in Low-and-Middle Income Countries

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KEY MESSAGES

- Across all the countries, several factors have contributed to progress in ASRHR including:
- **Supportive laws and policies:** Contributed to fostering improvements in ASRHR.
- **Access to education:** Key to delaying sexual activity, marriage, and fertility, improving overall ASRHR outcomes.
- **Multisectoral collaboration:** Helped bring together various stakeholders to advance ASRHR progress.
- **Health system improvements:** Integration of ASRHR services into primary healthcare, youth friendly health services, and enhanced abortion care contributed to successful outcomes.

INTRODUCTION

Many adolescents begin their sexual lives with insufficient knowledge about sexual relationships, their bodies, and reproduction. It is estimated that annually, around 21 million adolescents aged 15 to 19 years in Low- and Middle Income Countries (LMICs) experience a pregnancy, with almost half of these pregnancies being unintended. Wide variations in adolescent sexual and reproductive health and rights (ASRHR) outcomes exist across and within geographical regions. For instance, in 2021, the estimated birth rate for 15-19-year olds in the WHO African Region was 97 per 1000 adolescent girls, compared to 13.1 per 1000 adolescent girls in the European Region. Adolescent mothers, compared to women aged 20 to 24, face higher risks of complications such as puerperal endometritis, eclampsia, and systemic infections, and their babies of adolescent mothers face higher risks of low birth weight, preterm birth and severe neonatal conditions. Over the years, various interventions have been implemented to address ASRHR needs, yielding varying levels of success depending on the context.

The African Institute for Development Policy (AFIDEP), in partnership with Exemplars in Global Health and along with researchers from the University of Southampton (UK) and the University of Portsmouth (UK), implemented the Adolescent Sexual and Reproductive Health and Rights Exemplars (ASHER) project to identify and study low- and middle-income countries (LMICs) that have made exemplary progress in preventing and managing unintended births to adolescents and reducing adolescent fertility rates.

The project focused on six exemplar countries—Cameroon, Ghana, India, Malawi, Nepal, and Rwanda. The study provided evidence of impactful ASRHR interventions and lessons to other LMICs on how they can implement similar interventions in their countries to reduce adolescent fertility rates and improve ASRHR.

Methodology

The research employed a concurrent mixed-methods approach to evaluate ASRHR progress in selected countries. Stakeholder mapping identified and engaged key actors involved in ASRHR, followed by inception workshops to gather insights on policies and programs. A rapid systematic literature review and policy analysis spanning 2000-2020 assessed both published and grey literature, focusing on education, sexual and reproductive health laws, and youth policies. The research team analysed the implementation and impact of these policies, validating their findings with stakeholders. Quantitative data derived from DHS, MICS, and EMIS were used to examine factors lsuch as adolescent pregnancy rates and contraceptive use through multilevel and inferential modelling techniques. This helped understand disparities in ASRHR outcomes. In-depth interviews and focus group discussions yielded thematic insights into stakeholder experiences and adolescent perceptions. Additionally, cost-benefit analyses were conducted to assess the economic feasibility and scalability of ASRHR interventions. Detailed reports were produced for each country, with findings disseminated locally and globally through stakeholder and media briefings, press releases, and academic publications.

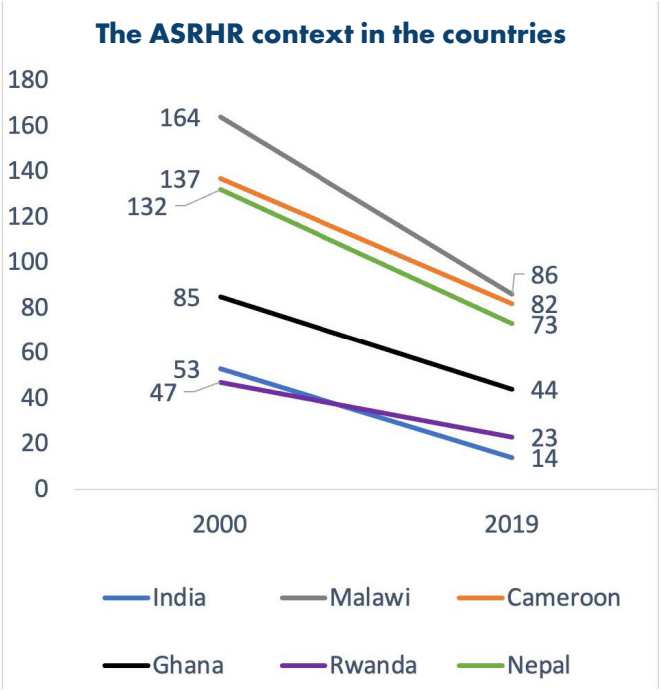

Figure 1: Starting and Ending Age-Specific Fertility Rates (Institute for Health Metrics and Evaluation (IHME))

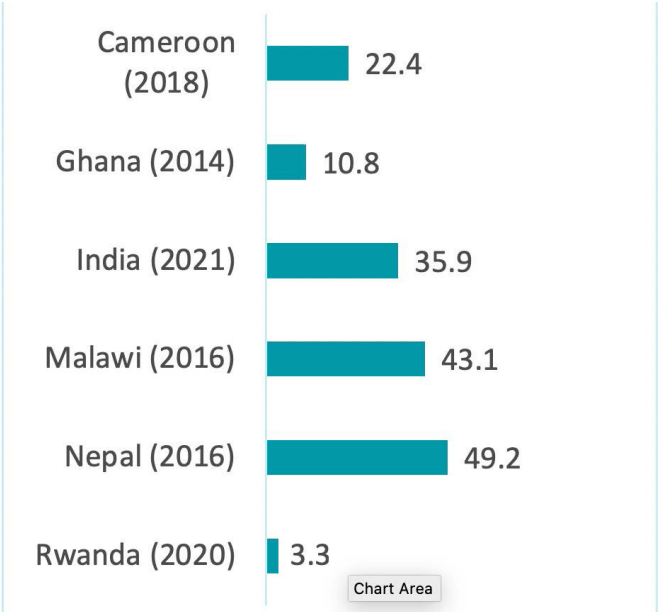

Figure 2: Percentage of adolescents that are married (DHS)

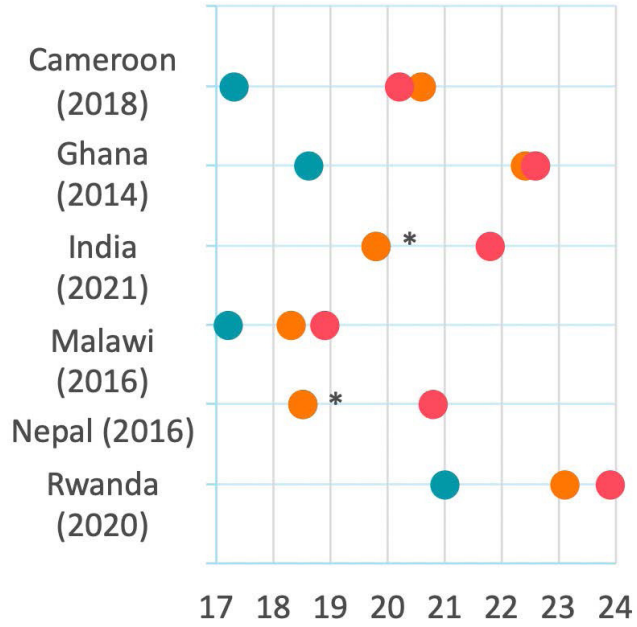

Figure 3: Median ages at first birth, first sex and first marriage (DHS)

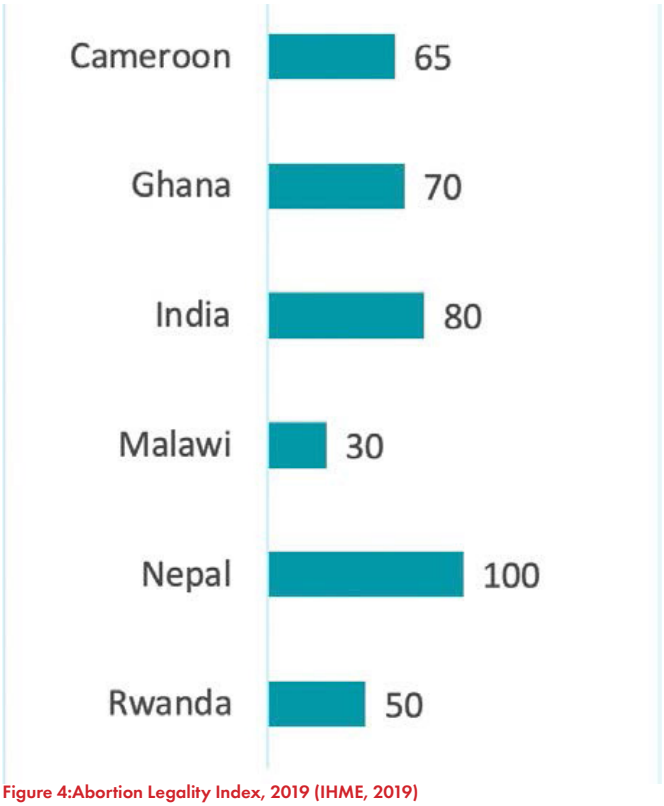

Figure 4:Abortion Legality Index, 2019 (IHME, 2019)

Key Factors Driving ASRHR Progress Across Exemplar Countries

Across all the countries several factors contributed to ASRHR progress. Supportive laws and policies, access to education, multisectoral collaboration and delayed sexual activity, marriage, and fertility were essential in fostering improvements. Additionally, health system elements, specifically the integration of ASRHR services into primary healthcare, youth-friendly health services, and enhanced abortion care, enhanced success. The above strategies, undergirded by targeted social protection and economic empowerment initiatives, helped to reach more adolescents who might otherwise have remained underserved and reduced equity gaps in ASRHR.

Country-specific achievements which enhanced ASRHR success included the following:

- In Cameroon, investments in primary education and girls' literacy helped reduce early marriages and pregnancies.
- In Ghana, adolescents had access to a diverse range of contraceptive methods, including emergency contraception, advanced education opportunities for women, social protection programs, and access to safe abortion.
- In Malawi, key contributions came from investments in primary education, girls' literacy, and youth-focused community health services, as well as increased access to injectable contraception.
- Nepal's progress was enhanced by efforts to delay child marriage, improve education, and expanded access to safe and legal abortions.
- Rwanda's health system investments, particularly in contraception access and HIV programming, helped to prevent and manage adolescent pregnancies.

Key Drivers of ASRHR Progress

1. Youth-Friendly Health Services

Countries have implemented YFHS programs to enhance accessibility and improve the quality of care for adolescents, guided by national ASRH policies. Delivery models differ:

Cameroon, Ghana, and Rwanda have established youth corners in health facilities; Nepal has created adolescent-accredited health facilities; and Malawi utilises its community based distribution network with trained agents and designated youth clinics. Since 2016, Malawi has shown significant commitment to YFHS, with 60% of health facilities providing these services and over 1,000 healthcare workers trained, though challenges such as unsustainable funding, low service utilisation, and high child marriage rates remain. Rwanda's YFHS program focuses on youth centers that offer health services alongside community activities, with youth corners present in 84% of health centers and staffed by trained ASRHR personnel.

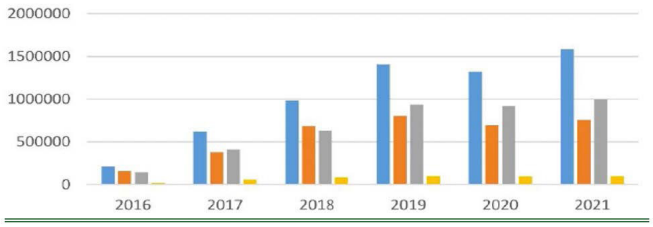

Figure 5: Number of visits for YFHS in Malawi, by service type (2015-2020 Malawi YFHS Strategy Evaluation)

However, barriers such as cultural and religious obstacles regarding abortion and contraception, geographic limitations for rural adolescents, and inadequate training for community health workers hinder access. Additional challenges include low service coverage, poor information accessibility, inconsistent service quality, and insufficient monitoring and evaluation.

2. Preventation of Child Marriage

Ghana, Malawi, and Rwanda have significantly increased the proportions of adolescents aged 15-19, with their demand for family planning satisfied by modern methods of contraception. Rwanda leads with an 80 percentage point increase. Malawi and Ghana also made notable progress, while Cameroon saw a 10-percentage point decline, and Nepal's progress plateaued.

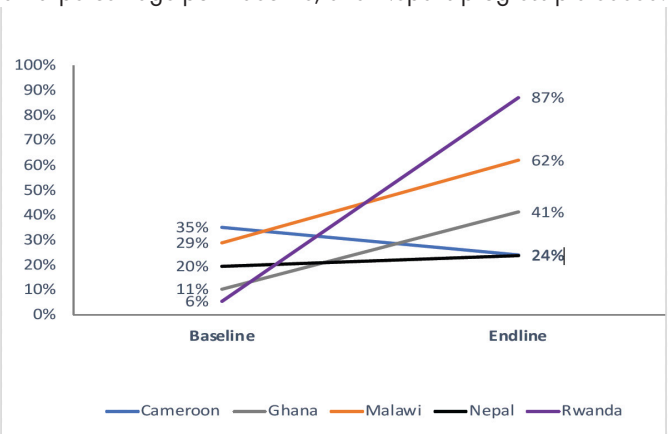

Figure 6: Percentage of women 15-19 with demand for FP satisfied by modern methods of contraception (DHS)

Note: Baseline and endline years: Cameroon – 2004-2018; Ghana – 2003-2022; Malawi – 2000-2015; Nepal – 2001-2022; Rwanda – 2000-2019

Family Planning Method Mix

Ghana has the most diverse mix of methods used by adolescents, including condoms, injections, implants, and emergency contraception. In Cameroon, male condoms are the most common method (used by about 80%), while In Malawi and Nepal, injections are the preferred method, followed by condoms. In Rwanda, implants are the most prevalent contraceptive method used (around 70%), followed by male condoms and injections.

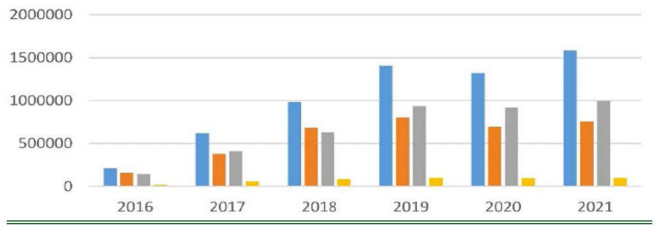

Figure 7: Contraceptive method mix among women 15-19 (DHS)

3. Access to Safe Abortion

Ghana and Nepal have made significant advancements in access to safe abortion care through targeted legal reforms and comprehensive implementation efforts. Both countries established guidelines for healthcare providers, conducted extensive training for medical professionals, and ensured adequate supplies of medical equipment. Community engagement has been crucial, utilising educational activities and peer educators to combat cultural and social barriers, stigma, and misinformation surrounding abortion. Access to information on SRHR, including safe abortion care, has been enhanced through YFHS and Comprehensive Sexuality Education (CSE). In Nepal, legal reforms since the legalization of abortion in 2002, which allows for abortion up to 12 weeks and 18 weeks in cases of rape or incest, have been pivotal. The government integrated safe abortion services into the healthcare system, trained providers, established protocols, and made safe abortion care free at public facilities by 2017. However, adolescent girls in Nepal still encounter challenges, including stigma, lack of awareness, accessibility, affordability, and parental consent requirements. Ongoing advocacy by NGOs and women's health advocates aims to improve access to safe abortion care, further develop policies, and expand services in underserved areas.

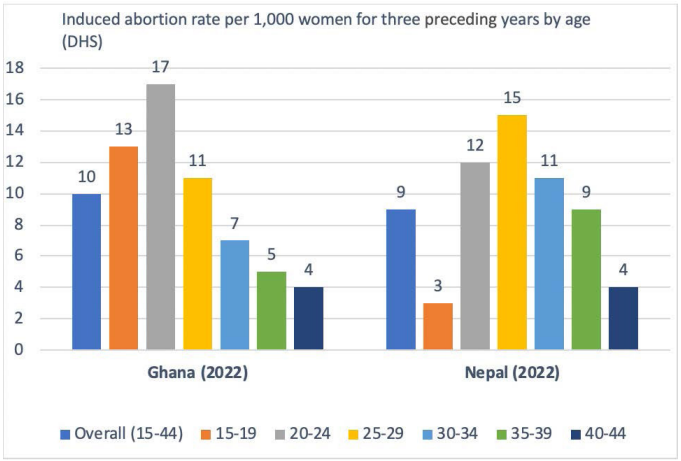

Figure 8: Induced abortion rates in Nepal and Ghana (DHS)

4.Sexuality Education

CSE is recognised as a key strategy for advancing ASRHR in exemplar countries, although significant implementation challenges persist. Effective sexuality education programs typically integrate sexuality education into existing education systems, are delivered by trained teachers and peer educators, and may be compulsory for certain age groups. While most countries have initiatives aimed at reaching out-of-school adolescents, issues such as low geographic coverage, limited program availability, and a lack of tailored content for vulnerable groups (e.g., those living with HIV or disabilities) hinder progress. Inconsistent teacher training and resistance from parents and communities regarding topics like sexuality and contraception further complicate implementation. Additionally, in some contexts, sexuality education remains elective, resulting in unequal access to essential curriculum components.

5. Reducing Equity Gaps

Reducing adolescent fertility rates for vulnerable populations remains a critical challenge, even with the progress in exemplar countries. Equity gaps are most pronounced in Cameroon and Malawi, especially concerning education and wealth quintiles, while Rwanda shows the smallest disparities across all metrics. Ghana and Nepal have moderate equity gaps, with Nepal facing more challenges related to educational attainment. Differences between urban and rural adolescents are generally minor across these countries.

Difference in ASFR 15-19 between the highest and lowest performing group

	Education level	Wealth quintile	Residence
Cameroon (2018)	216	128	78
Ghana (2022)	90	90	45
Malawi (2016)	138	124	86
Nepal (2022)	150	95	40
Rwanda (2019)	32	40	12

<50 | 50 - <100 | 100 - <150 | 150 - <200 | 200+

Progress in addressing these equity gaps has been uneven; Cameroon continues to struggle with significant disparities despite some improvement by wealth quintile, while Ghana has made notable strides in wealth and geographic equity but has regressed in educational equity. Malawi and Rwanda have also faced difficulties reaching lower wealth quintiles and rural adolescents. Ghana's substantial investments in social protection initiatives, like the National Health Insurance and various empowerment programs, have likely supported poorer adolescents. Rwanda's reduced equity gap among women with no formal education is likely a factor of efforts such as youth corners and improved access to contraceptive choices potentially contributing, although it remains unclear whether targeted efforts were made for this demographic.

Recommendations

We propose the following recommendations to address the ASRHR challenges within the five study countries and in similar settings:

- Investing in universal primary education and providing equal opportunities for secondary education for women and men.
- Partnering with community and religious leaders to shift harmful social norms, including prohibiting and disincentivising child marriages.
- Equipping health systems to reach adolescents with the information and services they need, including;
  - A full range of contraceptive options, including implants, injectables, pills, condoms, and emergency contraception.
  - Safe and legal abortion services
- Improving the quality and accessibility of health education and services, including providing age-appropriate, compulsory comprehensive sexuality education in and out of school.
- Expanding social protection to ensure access to health services with a focus on reaching vulnerable adolescents.
- Supportive policy and accountability mechanisms to ensure sustainable financing of ASRHR.
- Designing and implementing robust data systems to understand the reach and effectiveness of policies and programs and,
- Partnership with youth leaders to design, implement, and evaluate ASRHR interventions.

This research highlighted the synergistic effect of political, legal, social and economic factors to prevent and manage unintended adolescent pregnancies and improve adolescents' sexual and reproductive health and rights. The findings underscore the need for efforts to advance ASRHR to take a multi-pronged approach, with different sectors collaborating and actors at the national, community, and individual levels playing their parts. The ASHER project was part of the broader Exemplars in Global Health programme, which seeks to identify and analyse positive outliers in global health issues such as women's health, maternal and child health, nutrition, epidemic preparedness, and health systems. This global coalition of researchers, academics, experts, funders, and stakeholders aims to disseminate core lessons learned to help make strategic decisions, allocate resources, and craft evidence-based policies.

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