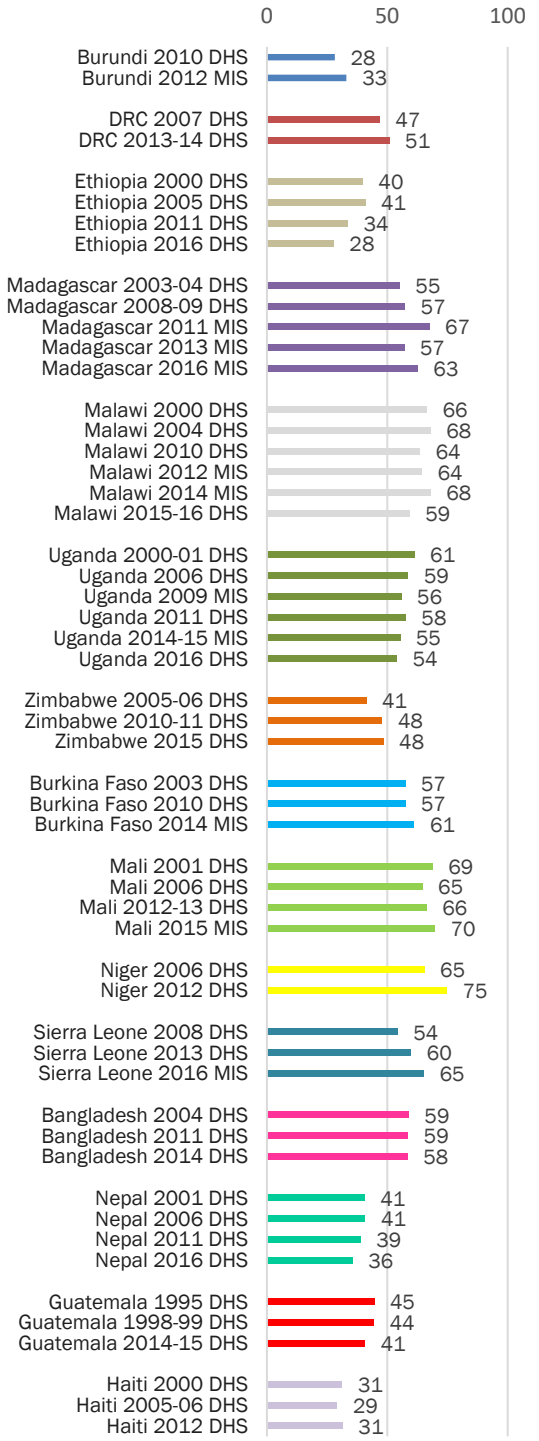
Adolescent Pregnancy and Its Impact on the Prevalence of Stunting: Programmatic Considerations for Food for Peace Programs that Aim to Reduce Stunting

Introduction: What's the issue?

Across the countries where the USAID/Office of Food for Peace (FFP) funds and implements development and emergency food security activities, data show that adolescent pregnancy is widespread. From Haiti to Niger, the percentage of adolescent girls who begin childbearing by the age of 19 ranges from 31 to 75 percent respectively. Ninety percent of births in adolescence globally are to married adolescents (either in formal or informal unions) and estimates suggest that 40 percent of girls are married by age 18 and 12 percent are married by age 15 (UNFPA 2015). Figure 1 shows the trend over time in the percentage of adolescent girls who have begun childbearing by age 19 across the countries where FFP implements development food security activities (DFSAs)—there is no clear downward trend in most countries. Except for Ethiopia and Nepal, progress is stagnant, and, in several countries, there has been an increase in the proportion of adolescent girls beginning childbearing by age 19. Brown et al. analyzed Demographic Health Survey (DHS) data for 57 countries and found that use of and access to modern contraception is significantly lower for girls 18 and under (Brown et al. 2015). In countries such as Bangladesh, where there has been a steady rapid decline in the total fertility rate due to expanded access to family planning services over the past several decades, it could be expected that the number of children born to adolescent girls would also be decreasing. However, the age-specific fertility rate[1] for adolescent girls, even in Bangladesh, has been slow to improve due to lack of family planning and reproductive health services targeted to adolescent girls (Sethuraman et al. 2007).

[1] The age-specific fertility rate measures the annual number of births to women of a specified age or age group per 1,000 women in that age group.

Figure 1: Percent of adolescent girls who have started childbearing by age 19

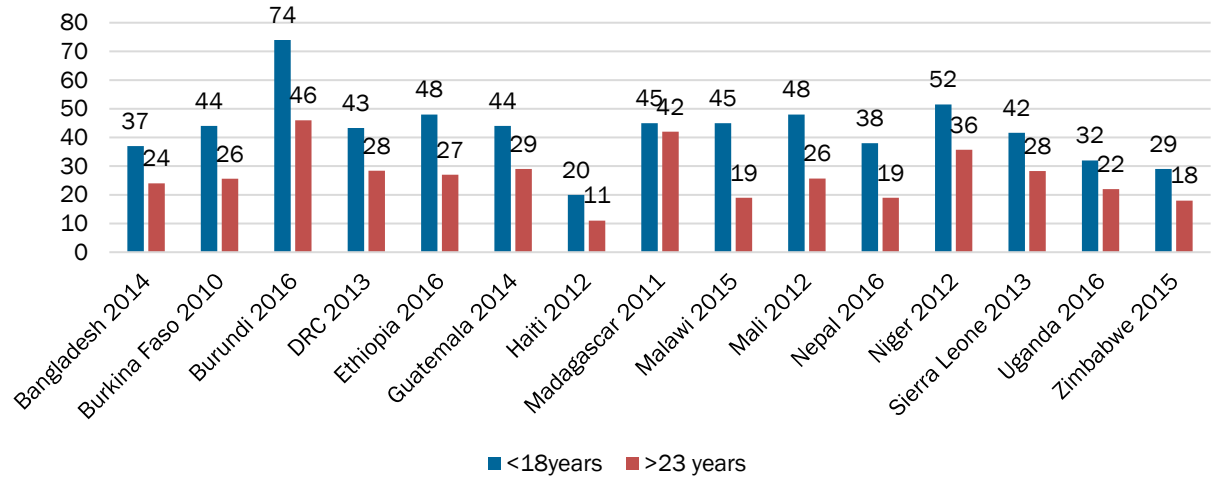


Why does it matter?

The children of adolescent mothers are more likely to be stunted. The evidence shows that the risk of childhood stunting is 38 percent higher globally for first-born children of adolescent girls age less than 18 years (Fink et al. 2014). In sub-Saharan Africa, South Asia, and Latin America, the increased risk of stunting among firstborns of adolescents less than 18 is 33 percent, 36 percent, and 63 percent higher, respectively, compared to older peers (Fink et al. 2014). In this regard, for all the countries where FFP implements development and emergency food security activities, adolescent pregnancy is a determinant of stunting. To get a sense of how significant this is, in Bangladesh, the prevalence of stunting among children under 5 is 36 percent (NIPORT/Bangladesh et al. 2016). If adolescent pregnancy was virtually eliminated, it would reduce the prevalence of stunting in Bangladesh to 33.8 percent.[2] While the contribution adolescent pregnancy makes to the overall prevalence of stunting in any given country varies, it is significant. Figure 2 below shows the prevalence of child stunting by maternal age for countries where FFP implements DFSAs. In *every* country the prevalence of stunting is higher among the children of mothers age 18 years or less compared to the children of mothers age 23 years or more.

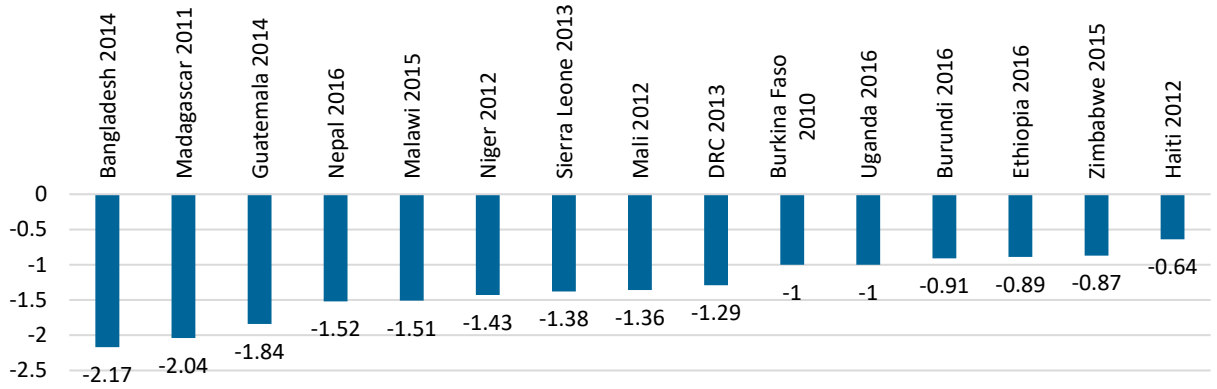
In Bangladesh, if adolescent pregnancy were virtually eliminated, it would reduce the prevalence of stunting from the current 36 percent to 33.8 percent.

Figure 2: Percent of child stunting by maternal age



[2] Calculation based on the relative risk and population attributable fraction provided in Fink et al. 2014.

Figure 3: Estimated percentage point reduction in stunting among children under 5 years of age attributable to reduced adolescent pregnancy in FFP countries



To generate the estimates shown in this graph, a relative risk (RR) of stunting of 1.20 related to adolescent pregnancy, that is, for children born to mothers younger than 20 years of age, was derived by pooling the adjusted RRs provided by Fink et al. for all births among adolescent girls in two different age strata (<18 and 18–19 years). Since the pooled relative risk is applied uniformly to all countries, however, as shown in Fink et al., it is likely that the relative risk of stunting attributable to adolescent pregnancy varies across regions. Information on the prevalence of stunting among children less than 5 years of age, and the proportion (among all births) of children born to mothers less than 20 years of age were obtained from publicly available DHS findings. The population attributable fraction (PAF) of stunting related to adolescent pregnancies was calculated as a function of the proportion of all births that were to mothers less than 20 years of age and the RR of stunting related to adolescent pregnancy. The PAF is the proportion (or fraction) of the condition (stunting) that is attributable to the risk factor.

Figure 3 shows the estimated percentage point reduction in stunting if adolescent pregnancy were virtually eliminated in FFP countries. This suggests that in addition to existing program activities implemented to reduce the prevalence of stunting in an FFP program area, targeted efforts to prevent adolescent pregnancy and provide adolescents with targeted services in nutrition, family planning, and sexual and reproductive health could further contribute to FFP DFSAs achieving their stated targets for the reduction in stunting.

Beyond the impact on stunting, adolescent pregnancy carries other risks, notably the increased risk of mortality for mother and child and a longer period of lifetime fertility, adding up to one additional child per woman (Onagoruwa and Wodon 2017a). Importantly, adolescent pregnancy also deprives girls of opportunities to complete their education, obtain skills for employment, and contribute to household income (Onagoruwa and Wodon 2017b; Ganchimeg et al. 2013). Teenage mothers also do not have the same capabilities, access to resources, or decision-making authority as older mothers do—significantly limiting their ability to provide the optimal care and nutrition their children need during the first 1,000 days to prevent stunting (Atuyambe et al. 2008). Figures 4 and 5 illustrate examples of the consequences/benefits and impact on child stunting when girls are or are not given opportunities to complete their education or obtain skills for employment. These examples show that if girls stay in school, marriage and childbearing are delayed, which brings a multitude of benefits for girls and for their children in terms of reduced stunting. In contrast, when girls are deprived of these opportunities, they marry early and begin childbearing early, which leads to a series of adverse consequences that increase the risk of stunting in their children. In other words, the risk of stunting among the children of adolescent girls is entirely preventable, and in a context, such as FFP programs, where reducing child stunting is an impact indicator for which targets are set, preventing adolescent pregnancy is a key pathway to reducing the prevalence of stunting. In addition, programs that focus on this aspect can expect a spillover effect on the prevalence of stunting beyond their immediate program area as a result of changing social norms that favor keeping girls in school and delaying pregnancy.

In order to prevent adolescent pregnancy, program interventions can include efforts to keep girls in school, which can contribute to changing social perceptions related to the value of educating girls, and the value of girls for more than their ability to bear children. As communities in FFP program areas are encouraged to envision a different future for girls beyond childbearing, these new social values and norms become attractive to neighboring communities outside an FFP program area. This type of spillover then leads to changing social values and norms in those neighboring communities, which in turn can lead to delaying marriage for girls and preventing adolescent pregnancy, resulting in reduced stunting in their communities in the future as well.

Figure 4: Consequences of lack of education and life skills for girls

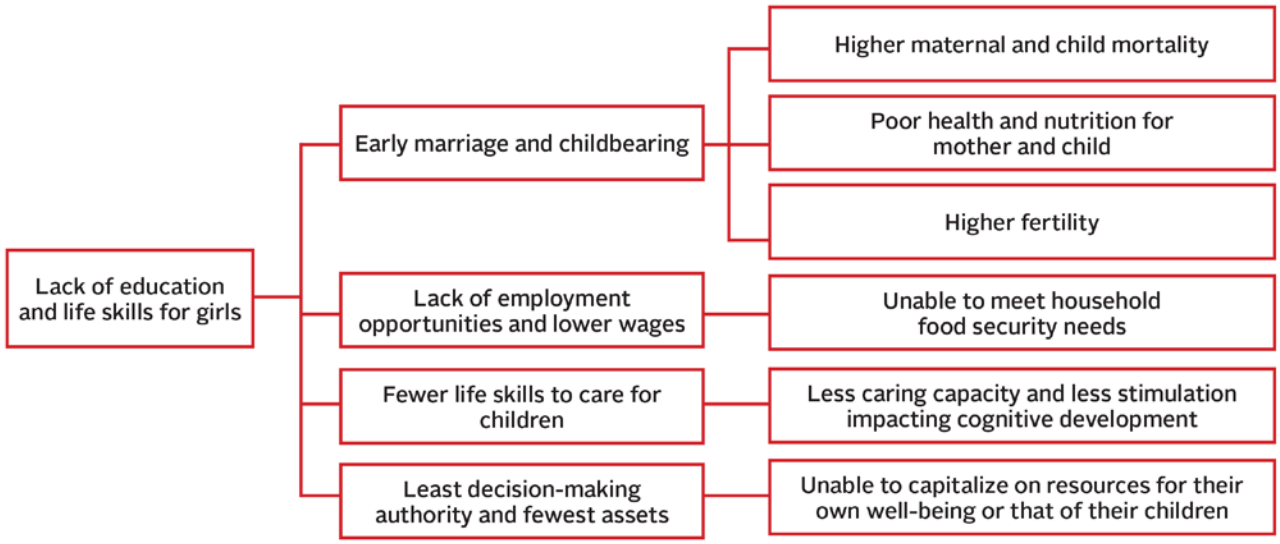
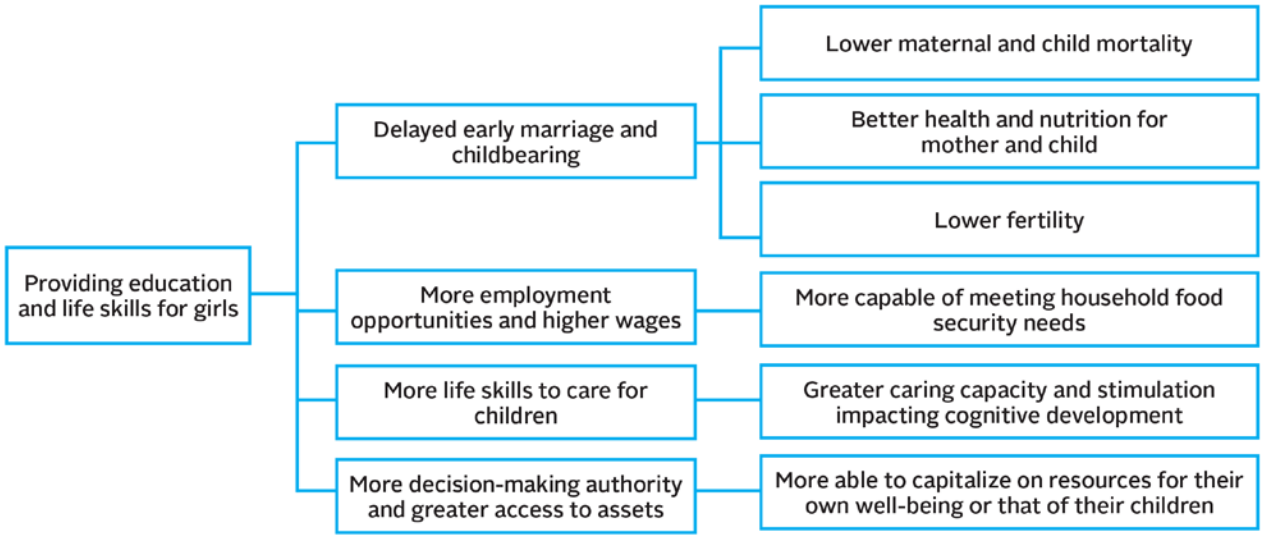


Figure 5: Benefits of improved education and life skills for girls



Why isn't the situation improving?

An adolescent girl is 3 times more likely to die in childbirth than complete primary school in South Sudan

Source: University of Cambridge, 2018.

As Figure 1 shows, in several countries where FFP implements DFSAs where there has been an economic downturn, protracted conflict, complex emergency, or is in a post-conflict state, such as Sierra Leone, Mali, or DRC, there is an increase in the proportion of adolescent girls beginning childbearing by age 19. The point here is that at times of upheaval, economic or otherwise, it is likely and common for girls to be married at an earlier age, exposing them to the adverse risks of sexual and gender-based violence (SGBV) and early childbearing, among other risks (Erulkar et al. 2009, WRC 2016). Families are often desperate for the economic resources a girl brings in the context where a bride price is expected as in parts of sub-Saharan Africa, or they seek to relieve themselves of the economic burden of a dowry in the case of South Asia (Siddiqi 2012). In many contexts, including in conflict and emergencies, families fear for girls' safety, and they especially seek to mitigate the risk and social stigma associated with SGBV or rape outside of marriage, as, in many cultures, both the girl and her family would have no honor (WRC 2016). Over half of the 30 countries with the highest rates of child marriage have been affected by conflict or are considered fragile states. As such, progress on social norms surrounding early marriage and childbearing, while changeable, is not constant or guaranteed without sustained effort. The result is that the prevalence of stunting attributable to teenage pregnancy, while small, may increase if more adolescent girls begin childbearing, and may not be easily overcome unless targeted and tailored interventions are implemented to delay marriage and pregnancy. Box 1 provides evidence of why early marriage is precipitated particularly in emergency contexts.

The other important reason why the situation is not improving or is changing only slowly is because most countries do not target or tailor family planning services for adolescent girls. Bangladesh is an example where over the last 50 years the overall total fertility rate has declined substantially—but, as shown in Figure 1, there has been virtually no improvement in the proportion of adolescent girls beginning childbearing by age 19. This is largely due to the lack of a programmatic focus on reducing adolescent pregnancy. In the context of Bangladesh, the health system staff feel there is too much social pressure for adolescent girls who are married early to prove to their husband's families that they are fertile and able to bear children (Sethuraman et al. 2007). In a majority of FFP implementing countries, there are simply no sexual and reproductive (SRH) health services targeted to adolescent girls, and as a result, most adolescent girls only begin interacting with the health system when they are pregnant. Adolescent girls are more isolated than older women once they are married, and they have severe restrictions on their mobility, and so cannot access health care services alone—because they need their husband's permission, must be accompanied to go to a health center, and need money to travel to and from the clinics—all of which is controlled by others. At the same time, health centers that provide maternal and child health and nutrition services view all mothers as one homogenous group. They do not consider the specific needs and capabilities of younger mothers. Youth-friendly services consider the developmental stages of adolescents, the specific barriers adolescents face in accessing health care, and these considerations are addressed in the design of services to promote the acceptability, access, and utilization of services by adolescents (WHO 2012). Adolescents may fear going to a health center because they may be scolded by health care staff; they may meet other community members who may stigmatize them (for example, if adolescents want to access contraceptives before marriage this could be viewed as the adolescents seeking to be more promiscuous); they may have to wait a long time; and others may decide the girls do not need to go to the health center or the distance may be too great. In these cases, providing access through mobile or satellite clinics are some of the ways to reach isolated and vulnerable adolescents.

Box 1. Findings from a study in four refugee camps in emergency contexts related to changing norms around early marriage

A qualitative study across four emergency settings, including two camps in Uganda, one in Ethiopia, and one in Lebanon, shows a consistent pattern as to what precipitates early marriage in emergency contexts more so than in stable development contexts:

- Fear of sexual violence outside of marriage (early marriage is perceived as a way to protect girls' physical safety, chastity, and honor)
- Fear of pregnancy outside of marriage and the stigma associated with it
- Parents not able to track who girls interact with and their movement around the camp
- Poverty and the inability to meet basic needs
- Not being able to safely access school (often, displaced families in conflict settings perceived themselves to be pro-education, but lack of access to schools and the risks of sending girls to school outweighed the benefits)
- The stigma of being unmarried or unable to marry
- Decisions around marriage are rushed or there may be no family involvement

So what?

- Marriages are less formal in the emergency context, undermining girls' traditional rights in marriage that could be protective in terms of providing them with access to the husband's family assets and resources
- Married adolescents are more likely to experience intimate partner violence at the hands of their spouse in these emergency settings
- Married adolescents perceive that they are more isolated than others, leading to depression, which affects infant and young child feeding practices and early childhood development among their children
- Conflict and poverty is exacerbating and increasing the age gap between adolescent girls and their husbands, and is putting adolescent girls more at risk of HIV

Taken together, the implication of these findings for FFP programming on a continuum from emergency to development is that because the risk of early marriage is heightened in emergency and post-conflict situations, it is more likely to lead to early childbearing during adolescence, which likely will drive up the prevalence of stunting and malnutrition in their children. For programs, this means identifying ways to protect girls and boys; providing them access and safe passage to schools, education, and life skills; creating adolescent-friendly services to meet the needs of this vulnerable group; and working with their families to support them in delaying marriage and meeting their basic needs in conflict situations. Chief among these efforts is protection of girls to prevent early marriage and childbearing and its related consequences.

Source: WRC 2016.

What works? Programmatic implications and considerations for FFP Development and Emergency Programs

Although adolescent pregnancy is high in all the countries where FFP implements activities, there is promising evidence of what works in development and emergency contexts that FFP programs can adapt and implement in both their development and emergency programs. Delaying first births beyond adolescence will have a major impact on reducing stunting among children, improving their intellectual and physical capacity in future years, as well as on maternal, neonatal, and infant morbidity and mortality. Targeting adolescents can also be transformative in terms of building the resilience of adolescent girls and boys, and youth more broadly, resulting in sustainable change—all key goals of FFP and its programs. Although it can be challenging to target adolescent girls and their families in both development and emergency contexts, it is urgent that FFP programs begin considering ways to tailor services targeted to adolescents, especially girls, given the impact on stunting prevalence. Boxes 2, 3, 4, 5, and 6 provide examples of programmatic activities that have been successful in both development and emergency contexts that FFP implementing partners can consider, adapt, and tailor to their programmatic context. Key programmatic considerations, based on this review of program experiences in both development and emergency contexts include:

Keeping adolescent boys and girls in school. Research shows that the longer adolescents are in school, the less likely they are to marry early or begin early childbearing. In addition, the rate of return on an additional year of schooling has been consistently estimated to be at least a 10 percent increase in wages, providing adolescents with a greater voice in the household, and positioning them as a more respected member of the family with greater participation in decision making (Patrinos and Montenegro 2014; Mukankusi et al. 2009). Key components of this are making schools affordable, reducing time and distance to school, developing girl-friendly schools, addressing girls' health, providing safe passage to school, and creating non-formal education centers (NFEs) where adolescents can continue to obtain an education in emergency contexts. Also, when maternal education improves, stunting prevalence among their children decreases (Lancet 2013). Policy changes and advocacy and teacher training to influence attitudes and social norms has increased school attendance in some countries, and efforts to provide access to economic and educational opportunities for adolescent mothers unable to attend school have been successful.

Changing community attitudes toward early marriage. Estimates suggest a 10 percent reduction in child marriage could contribute to a 70 percent reduction in a country `s maternal mortality rate (Raj et al. 2013). Efforts include creating household and community understanding and support to reduce early marriage and pregnancy before age 20.

Supporting transitions to adulthood and providing adolescents and youth with life-skills and livelihoods. Interventions to keep adolescents in school and those that focus on savings-led microfinance and cash-plus models have been shown to improve self-esteem, aspirations, and life skills among adolescents, and an ability to contribute to their families' well-being, positioning them as a more respected member of the family with greater participation in decision making (Mukankusi et al. 2009; Tanzania Cash Plus Evaluation Team 2018).

Providing adolescent girls with tailored support and targeted nutrition and SRH services. Adolescent girls face a significant risk of unintended pregnancy because they have less access to, and are less likely to use, contraception and are at more risk for coerced sex. If the unmet need related to unintended pregnancy among adolescents was met, 2.1 million unplanned births, 3.2 million abortions, and 5,600 maternal deaths could be averted each year (Darroch et al. 2016). A proven intervention in emergency contexts is the creation of safe spaces and youth centers along with mobile clinics to provide adolescents with SRH information, peer-to-peer counseling, and life skills training.

Box 2. What works? Examples of program successes from development programs in Kenya, Zambia, Ethiopia, Tanzania, and Burkina Faso

Keeping Adolescent Boys and Girls in School

In the urban slums of Kenya (Miguel & Kremer 2004), girls from poor households were provided with deworming medication, meals, and sanitation facilities. They found that:

- Deworming had a positive impact on increasing girls' and boys' school attendance in Kenya at a small cost of US$3.50 for each additional year of schooling induced
- Health and school attendance rates increased not only among students who were provided with the drugs but also among students at nearby schools, due to reduced disease transmission

In 2008, in Mukuru kwa Ruben slums in Kenya (HOPE for Teenage Mothers, Center for Education Innovations 2014), advocacy efforts were undertaken, and teachers were trained, to influence attitudes and social norms around pregnant adolescents attending school and provide access to economic and educational opportunities for adolescent mothers unable to attend school. The goals were to reduce stigma and improve attitudes of teachers/school authorities and parents toward pregnant adolescents or those who had already given birth attending school. For adolescent mothers who were unable to attend school, the program offered formal education, vocational training, and skills building. As a result of these efforts:

- Some schools allowed mothers to bring their children to school and were given time to go home or attend to sick babies
- A radio program was developed and aired focused on out-of-school teenage mothers to get people thinking and talking about the issue
- Teen mothers were able to set up small businesses including hairdressing, baking, bead-working, tailoring, knitting, and bag weaving to earn an income to support their family

From 2001 to 2004, in Zambia, the Forum for African Women Educationalists (FAWE 2004), undertook advocacy efforts to reduce stigma and improve attitudes of teachers/school authorities and parents toward pregnant adolescents or those that had already given birth attending school. Efforts included national and regional activities and activities adopted by schools to support and retain girls in school. By 2004, they found that:

- Teacher support for re-admitting pregnant girls increased from 69 to 84 percent and parental support increased from 47 to 75 percent in 3 years.

Changing Community Attitudes Towards Early Marriage

In Ethiopia, Tanzania, and Burkina Faso, (Population Council 2014) four strategies were implemented in each country to delay early marriage including community conversations (informing communities about the dangers of child marriage using community meetings and the engagement of religious leaders); supporting girls' education by providing them with school supplies or uniforms; providing conditional economic incentives to families for keeping girls unmarried, such as chickens or a goat; and combining all these approaches. They found that:

- The combination of all three strategies worked best at delaying marriage
- Each individual strategy was effective at delaying marriage but not as effective as when the three approaches were combined

In Nyanza Province in western Kenya, which has the highest rate of HIV infection in the country, a program (Population Council 2011) combined mass media and community education, working with religious leaders, mentoring, and voluntary counseling and testing to encourage adolescent girls to wait for the right time to marry, to know their own and their partner's sero-status before marriage, and to delay childbearing. The program also focused on couples.

- The demand for voluntary counseling and testing was far greater than anticipated. Almost 2,000 couples were tested

Box 3. What works? Examples of program successes from development programs in Ghana, Bolivia, India, Nepal, Mexico, Rwanda, Tanzania, and Ethiopia

Supporting Transitions to Adulthood and Providing Adolescents and Youth with Life Skills and Livelihoods

In the 1990s, in Ghana and Bolivia (Freedom from Hunger 1998 and 1999), women were provided with loans and education sessions on child health and nutrition. The types of activities women engaged in included commerce, livestock rearing, agricultural inputs and animal husbandry, and artisanal work. They found that this:

- Increased livestock rearing among women
- Increased income
- Increased knowledge of nutrition practices
- Improved infant and young child feeding knowledge and practices as reported by mothers

In India and Nepal (CEDPA 2001), adolescent girls age 15–26 years were provided with a 9-month life skills training program that focused on training married and unmarried adolescent girls on reproductive health, nutrition, family planning, and HIV prevention:

- Evaluation results showed that in India girls reported increased self-esteem, self-confidence, and ability to obtain health services; better health-seeking behaviors; greater economic empowerment; and improved decision making and reproductive health and child survival practices

In Mexico and India (International Youth Foundation 2006), adolescents age 14–18 were provided with life-skills training that focused on personal competencies, problem-solving, effective work habits, healthy lifestyle, community and environmental awareness, diversity, and service learning. They found that:

- 97 percent of graduates in Mexico and 86 percent of graduates in India were either in school or employed 6 months after the training
- Gave youth purposefulness and aspirations
- Helped youth re-enter school or join the workforce
- Strengthened self-esteem and other life skills
- Gave teens an alternative to getting in trouble

In Rwanda (Mukankusi et al. 2009), Catholic Relief Services provided adolescent orphans and vulnerable children (OVC) affected by HIV a combination of vocational training, youth inclusive financial services, and savings-led microfinance, which resulted in:

- Improved livelihoods through increased income
- Greater youth purposefulness and an ability to contribute to their families
- A greater voice and position as a more respected member of the family with greater participation in decision making

In 2018, in Tanzania (Tanzania Cash Plus Evaluation Team 2018), youth were provided with economic empowerment, HIV and SRH education, and linkages to other existing and new services in combination with the government's cash transfer program. The program was developed based on the recognition that cash alone is rarely sufficient to mitigate all risks and vulnerabilities youth face or to overcome structural barriers to education, delayed marriage and pregnancy, and other safe transitions. They found that adolescents who participated in the program had higher aspirations for their future after the program.

In Ethiopia, the Population Council (Girma et al. 2013) implemented a program with men and youth, and newly married adolescent girls, focused on preventing HIV transmission. The main activities included life-skills training for adolescent boys and married young men. Mentors were trained and then formed groups of about 25–30 men and boys to create a safe space to discuss inequitable gender norms and HIV transmission (reached more than 135,000 boys), and another arm of the project focused on married adolescent girls (reached more than 230,000 girls). They found that:

- Adolescent boys/male youth reported a change in behaviors and attitudes including improved self-esteem, better financial management, and reduced SGBV
- Married adolescent girls were more likely to use family planning, to be able to go for voluntary HIV counseling and testing, and receive more assistance from husbands with domestic chores

Box 4. What works? Examples of program successes from development programs in Burkina Faso, Nepal, Bolivia, and Nigeria

Providing Adolescent Girls with Tailored Support and Targeted Nutrition and SRH Services

In Burkina Faso, the Mères-éducatrices Project (The Population Council/UNFPA, Brady and Saloucou 2007) trained a group of young mothers from the community (known as mères-éducatrices) to visit married adolescent girls in their homes and provide health information on pregnancy and birth. The mères-éducatrices also provided vitamin A and iron supplementation and often escorted girls to health centers for prenatal visits. The role of mères-éducatrices evolved and expanded over time: they served as resource persons for the community, led monthly health discussions, and sensitized health workers to the particular needs and vulnerabilities of young married girls. In these traditional communities, mères-éducatrices were viewed as valuable assets (not as a cultural threat). They disseminated health information, organized community discussions, and screened films on health topics such as sexually transmitted infections, HIV/AIDS, and female genital cutting.

- The project demonstrated that locally recruited young mothers with special training could provide effective outreach to both girls and their families, and could, over time, facilitate girls' increased access to community resources

In Nepal, and previously in Bolivia, Save the Children (2012) developed a "my first baby guide." Initially they created groups of pregnant adolescent girls who met weekly to discuss health and nutrition issues related to pregnancy, childbirth, breastfeeding, safe motherhood, etc. They found:

- Increased knowledge and understanding of reproductive health, maternal and child health and nutrition issues for pregnant adolescent girls
- The guide could be adapted for other settings

In Nigeria, IMC/TOPS piloted (IMC 2015) care groups to include married adolescent girls, and they:

- Found improved knowledge among married adolescent girls, but married adolescents were less able to participate, more isolated, and faced restrictions in participating in care groups
- Recommended working with community and family stakeholders and creating adolescent-only care groups to improve participation and provide more tailored information

Box 5. What works? Examples of program successes from emergency programs in Pakistan, Nepal, Nigeria, and the Philippines

Keeping Adolescent Boys and Girls in School

In the Southern Punjab and interior Sindh areas of Pakistan after the 2010 floods (Plan International 2010), boys schools were re-opened much faster than girls schools after the floods so NFEs allowed adolescent girls to continue receiving a level of education that they otherwise would no longer have had access to. The NFEs provided a safe space and constituted a protection response as well as an education response. The curriculum combined academic studies with life skills and discussions around gender-related issues, allowing girls to discuss violence in a protective space and to come up with solutions to reduce their vulnerability.

- Qualitative case studies suggest that NFEs provided girls with opportunities to gain confidence and play leadership roles within the NFEs as well as the wider community
- Further benefits included parents agreeing to delay marriage until after the completion of studies

Supporting Transitions to Adulthood and Providing Adolescents and Youth with Life Skills and Livelihoods

In earthquake-affected regions of Nepal, in Nigeria's northern region for girls fleeing from Boko Haram-inflicted violence, and in conflict-ridden areas of Pakistan, safe spaces in camps or as mobile units served as an entry point for reproductive health information and services including family planning and psychosocial counseling for SGBV for adolescent girls (UNFPA 2016). Safe spaces included youth volunteers, educators and coordinators who offered youth-friendly access to information and commodities including contraceptives to married and unmarried adolescents, and an opportunity for peer-to-peer knowledge sharing.

- These gathering places built resilience by offering girls opportunities to acquire livelihood skills and engage with others to rebuild community networks
- In some cases, the program's success established the groundwork to continue services in local communities and areas of return for displaced persons

In the Philippines after tropical storm, Washi in 2011, UNFPA engaged adolescents as active partners in, and not passive recipients of, UNFPA's humanitarian response (UNFPA 2016). Youth volunteers were trained to conduct communication sessions to raise awareness of peers in evacuation camps and disaster-affected communities, and to communicate and provide health information to pregnant adolescents. They also distributed hygiene kits, gathered data, and set up Youth-Friendly Spaces—all of which informed the response strategy used in the Philippines today.

Box 6. What works? Examples of program successes from emergency programs in Uganda, Malawi, Myanmar, and Somalia

Providing Adolescent Girls and Youth with Tailored Support and Targeted Family Planning and Sexual and Reproductive Health Services

Starting from 2004, in Uganda's Gulu district, the Straight Talk Foundation implemented "Talk + Services + Livelihoods" (WRC 2012). A youth center was created to provide SRH information and services to adolescents amid the conflict in northern Uganda. In addition to consultations at the youth center, the program organized health dialogues through community outreach to selected sites; visits to schools for health talks; home visits; support groups, such as for young mothers and adolescents living with HIV; Straight Talk clubs (for those in and out of school); radio programs; and "infotainment/edutainment" in the form of films and sports competitions on SRH-related topics. The program issued its own "Young Talk" newspaper targeting youth 10–14 years old and "Straight Talk" newspaper targeting 15–19-year olds. These were made available through the youth center, as well as in schools and other locations where they extended outreach. For services requiring specialized expertise beyond what the youth center was able to provide, referrals were made to the government hospitals/health facilities for HIV care and adherence follow-up. The program has been successful because:

- It has combined a prevention approach with comprehensive health services. The addition of skill-building and livelihoods activities for adolescents has been effective at empowering adolescents and strengthening social cohesion among vulnerable groups and communities. Counseling is also integrated for family planning and HIV, and counselors are trained to be non-judgmental, patient, and friendly with adolescents to build a rapport so they are comfortable sharing their concerns
- The combined "infotainment/edutainment" approach is successful as it appeals to youth and is combined and augmented with facilitated discussions, print messages, SMS text, radio, and interpersonal communication, and the Straight Talk clubs
- There is increased demand for family planning services among youth, and the program has been able to successfully target young adolescents

In Malawi, where severe floods in the southern region forced families into displacement camps (UNFPA 2016), special tents served as 32 youth clubs in an innovative adaptation of existing safe spaces for women and girls. The youth clubs offered recreational opportunities as well as youth-friendly access to SRH information and services.

- Resulted in a high uptake of information and contraceptives among displaced adolescents
- Provided services to more than 18,000 internally displaced adolescents and reduced the incidence of sexually transmitted infections

In Rakhine State, a conflict-torn region of Myanmar, and Somalia (UNFPA 2015), fixed-location clinics along with mobile clinics served the SRH needs of adolescent girls and women. In Somalia, outreach campaigns alerted pastoral populations to the date and place of the next mobile clinic. Training programs prepared a team of health service providers and community health workers to empower girls with culturally sensitive SRH information and services, including family planning. Supplies of contraceptives included a choice of methods: long-acting reversible contraceptives (injectable methods), oral contraceptive pills, and male condoms. Adolescents accounted for a large percent of all clients accessing antenatal care services

- More women (including younger women) have been taking up post-partum family planning services in the UNFPA-supported mobile clinics and static clinic over time

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