CanWaCH
Canadian Partnership for Women and Children's Health

CanSFE
Partenariat canadien pour la santé des femmes et des enfants

Tracking progress in adolescent sexual and reproductive health
Suivi des progrès dans le secteur négligé de la SDSR des adolescents

University of Manitoba

Countdown to 2030
Women's, Children's & Adolescents' Health

PLAN INTERNATIONAL

APHRC
African Population and Health Research Center

NIMR | National Institute for Medical Research, Tanzania

le 24 juin | June 24, 2020

Canada

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Zoom Features | Caractéristiques Zoom

- **Chat Box - Technical difficulties:** under the ‘more’ section there is a chat function, please use this if you have any technical difficulties and we will be happy to assist you.

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- **Période de questions - Posez vos questions :** vous pouvez envoyer une question de façon anonyme pendant la présentation en utilisant l’icône Q&A dans la barre du bas sur Zoom.

Agenda

- **The Collaborative – UoM + Plan + Countdown 2030 + NIMR Tanzania + APHRC**
- **What we know about ASRHR – Elsabe du Plessis,** University of Manitoba
- **Role of NGO projects – beyond routine monitoring – Rudy Broers,** Plan International Canada
- **Tapping into existing instruments –**
  Dr. Ties Boerma, University of Manitoba, Countdown to 2030, Department of Information, Evidence & Research at WHO

New Methods of Measurement

- **Surveys – Mark Urassa,** National Institute for Medical Research (Mwanza Centre, Tanzania)
- **Peer ethnographic research – Elsabe du Plessis**

Opportunities for growth - project monitoring and measurement – Dr. Ties Boerma

Discussion Period

Collaborative Partnership

Partnership under the umbrella of the CanWaCH Canadian Collaborative for Global Health

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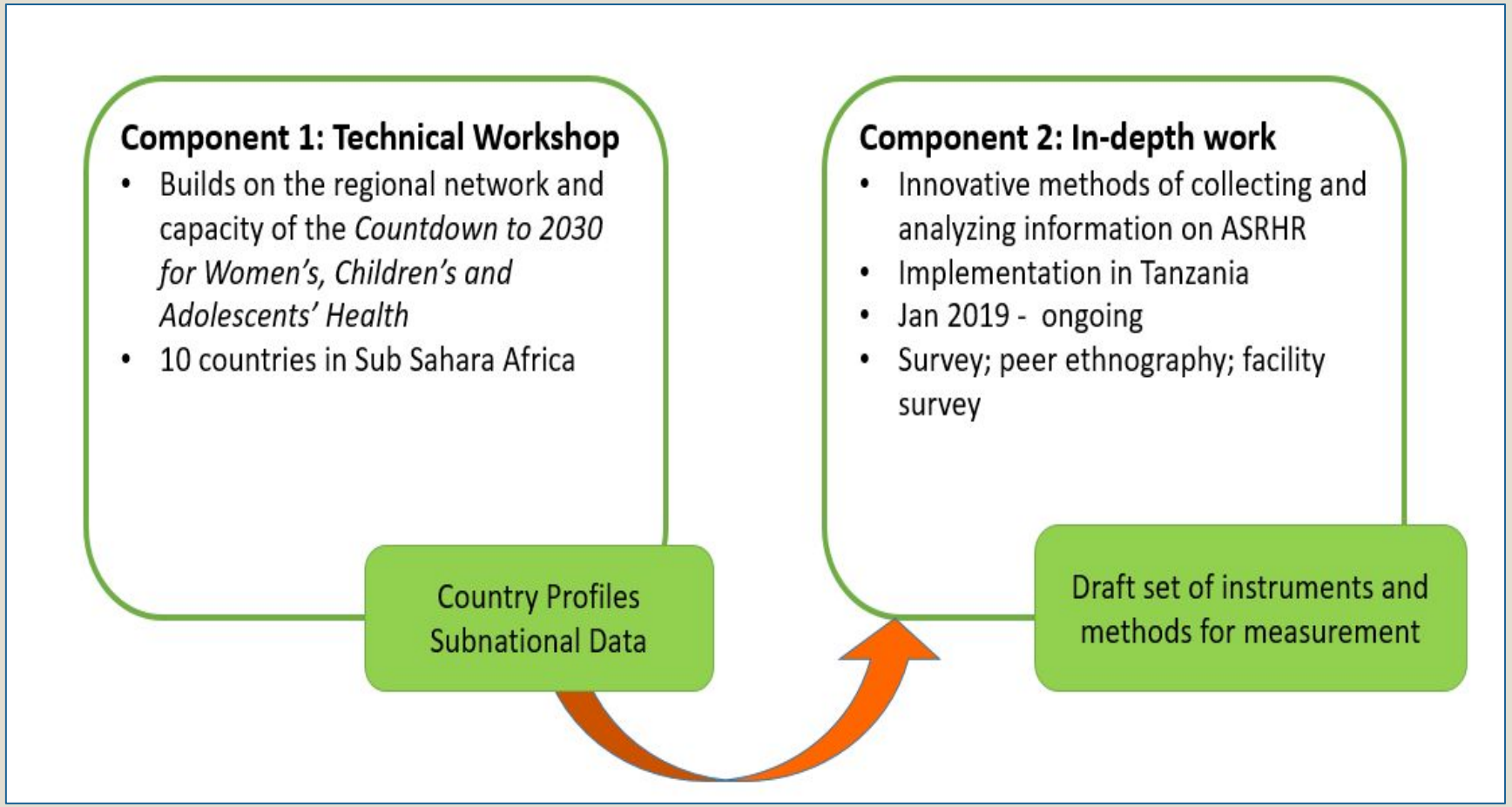
Project Overview



Adolescent Sexual and Reproductive Health

Nearly 1.2 billion adolescents (10-19 year olds) worldwide, many of whom live in developing countries – 250 million in Sub Sahara Africa

2016-2030 UN Secretary General's Global Strategy for Women's, Children's and Adolescents' Health recognizes adolescents as central to the overall success of the 2030 Agenda

Neglected areas in ASRHR have far reaching consequences for adolescents and societies

Adolescents, especially girls, have distinct SRH needs

ASRHR in Sub Sahara Africa

Table 1 Key indicators of adolescent sexual and reproductive health (country medians), 33 countries with most recent DHS since 2010*, sub-Saharan Africa by subregion

	Eastern and Southern Africa		West and Central Africa		Sub-Saharan Africa	
	Girls	Boys	Girls	Boys	Girls	Boys
Median age at first sex (years)	18.1	18.4	16.9	18.9	17.4	18.4
Median age at first marriage (years)†	19.6	24.5	19.3	25.7	19.4	24.9
Median age at first birth (years)	20.2	---	19.8	----	19.9	----
Family planning coverage, married women 15–19 years (%)	55.6	---	20.1	---	29.3	----
Family planning coverage, sexually active single women 15–19 years (%)	50.1	---	33.6	---	43.3	---
HIV prevalence, 15–19 years (%)	3.3	1.5	0.8	0.4	1.2	0.5
Condom use at last sex with non-regular partner, 15–19 years (%)	43.2	58.0	31.8	46.2	37.9	52.1

Source: **Adolescent sexual and reproductive health in sub-Saharan Africa: who is left behind?** Dessalegn Melesse, Martin K. Mutua, Allysha Chaudhury, Yohannes D. Wado, Cheikh M. Faye, Sarah Neal, Ties Boerma. Link here (open access)

Challenges to Understanding ASRHR

Under reporting due to sensitive nature of topics

- Some behaviours highly stigmatized or illegal

Uneven availability of data due to exclusion of certain groups

Data often not analysed adequately or communicated effectively

Sample of M&E Requirements for SRHR Programming sought by NGOs

Ultimate outcomes often go beyond what can be captured from project level data, ie. adolescent birth rate and prevalence of early marriage. However, at Intermediate/Immediate: knowledge, attitude, skill and/or behaviour outcomes are measured in ASRHR programs.

Demand	Supply	Accountability
• Contraceptive, MHM, knowledge and/or use • Knowledge of key GE messages, e.g., attitudes towards early marriage and early pregnancy • Knowledge/ positive attitudes towards contraception, delaying pregnancy, positive sexuality, challenging GBV, romantic partnerships • Parental/partner/community support for SRH decisions and access to SRH services • Equitable decision making power with partner (on seeking health care services and information, delaying pregnancy, etc.)	• Achievement of adolescent-friendly standards at HFs and CSE in schools • HCP and CHW knowledge of adolescent friendly service provision standards • Adolescents' access to and satisfaction with SRH services and those who report needs met	• Adolescent friendly Health Committee/Co-Management Committee action plans • Women and adolescent girls' participation in decision making through health committees/ governance structures • HF regular maintenance of records and sharing of data that is age and sex-disaggregated

M&E for SRHR programming covering both Monitoring and Evaluation

How might NGOs typically measure these knowledge, attitude, skill and behaviour outcomes?

Surveys

- For males and females; married and unmarried; with or without live birth
- At households and/or in the community (i.e. through adolescent groups, etc.)

Focus Group Discussions

- With adolescents in groups segregated by sex, marital status, school attendance
- At community level

Key Informant Interviews

- With CHWs, facility-based HCPs, health committee leaders, community (religious and traditional) leaders and influencers, peer educators/group leaders

Health Facility Assessments

- Service provider KII, observation of available services and supplies
- At a sample of health facilities

Document Review

- Facility, community group, and health committee records (including registers, HMIS, community group membership, meeting minutes, etc.)
- At facility and/or community level tracking adolescent use of services

Challenges in M&E for SRHR Programs

Lack of available secondary data

- Lack of data at the geographical level targeted by the project (i.e. catchment population)
- Need to ensure comparability of baseline and endline (DHS collected outside project cycle)
- Lack of HMIS data on adolescent-friendliness of health service provision
- No age and/or sex disaggregation in HMIS data (both at HF level and above)
- Do not always cover the full spectrum of FIAP gender transformative programming

Resources required to collect large data sets for adolescent girls and boys

- Low conversion factors due to non-response and low rates of facility visits makes it resource-intensive to find a representative sample of adolescents through random sampling strategies;
- Need to explore both random and non-random sampling strategies at community level / outside of HHs, accessing adolescent populations through project interventions (i.e. adolescent groups)

DHS – Demographic and Health Surveys ; HMIS – Health Management Information Systems ; HF – Health Facility; FIAP – Feminist International Assistance Policy; HHs – households

The NGO/CSO community requires effective data collection tools and procedures with unmarried / nulliparous adolescents

Willingness for parents to provide consent can vary

- Both mothers and fathers tend to seek more explanation for daughter
- Fathers of adolescent girls tend to require the most time and explanation before consent is provided
- Parents most often ask about survey logistics such as transport, location of the survey, accompaniment

Data collection teams need to be trained

- Ethical considerations for surveys with adolescents
- Child protection protocols
- Privacy, but not isolation, is required
- Adolescent respondents must give informed assent

Tools need to be adolescent friendly

- Questions and response options must be clear, age appropriate and consider the level of comprehension of respondents
- Sensitive topics need to be approached with care
- Surveys, focus groups and other methods need to be an appropriate length

What's best for projects: Local Survey or Further DHS Analysis

Local Household Surveys

(baseline-midline-endline)

- Results for the district
- Helps targeting
- Document project results
- Assess impact

- Resource-intensive
- Results not very different from DHS
- Large uncertainty, hard to show results / impact

National surveys (DHS)

(once every 5 years)

- High quality results and legitimacy
- Data sets and reports widely available
- Used for trend assessment

- Only to province / region level
- Standard indicators only
- Disaggre-gation for adolescents limited

ASRHR Collaborative: what can national surveys tell us about inequalities in ASRHR?

- Partnership with Countdown to 2030 and African Population & Health Research Centre (APHRC)
- 3 analysis workshops with researchers from public health institutions (Ethiopia, Ghana, Kenya, Malawi, Mozambique, Nigeria, Tanzania, Uganda, Zambia)
- General paper in BMJ Global Health January 2020 on ASRH in Africa: who is left behind?, using national surveys (open access)
- Finalizing a supplement for BMC Reproductive Health, showing what is and what is not possible with survey data to assess ASRH inequalities

Adolescent sexual and reproductive health in sub-Saharan Africa: who is left behind? Dessalegn Melesse, Martin K. Mutua, Allysha Chaudhury, Yohannes D. Wado, Cheikh M. Faye, Sarah Neal, Ties Boerma. Link here (open access)

Digging deeper in national survey data to identify adolescents left behind

Inequality dimensions

- Gender, wealth (quintiles), educational status, urban-rural, provincial or regional level

Topics

- Child marriage, early sex, adolescent pregnancy and child bearing
- Modern contraceptive use among adolescent girls
- HIV and sexual behaviour among adolescent girls and boys
- Intrapartner violence against adolescent girls
- Frequent PMA 2020 annual surveys to detect rapid changes

Our impressions

Possible with **national surveys** to obtain detailed and robust information on inequalities even though sampling errors are larger because of triple disaggregation (sex – age – socioeconomic)

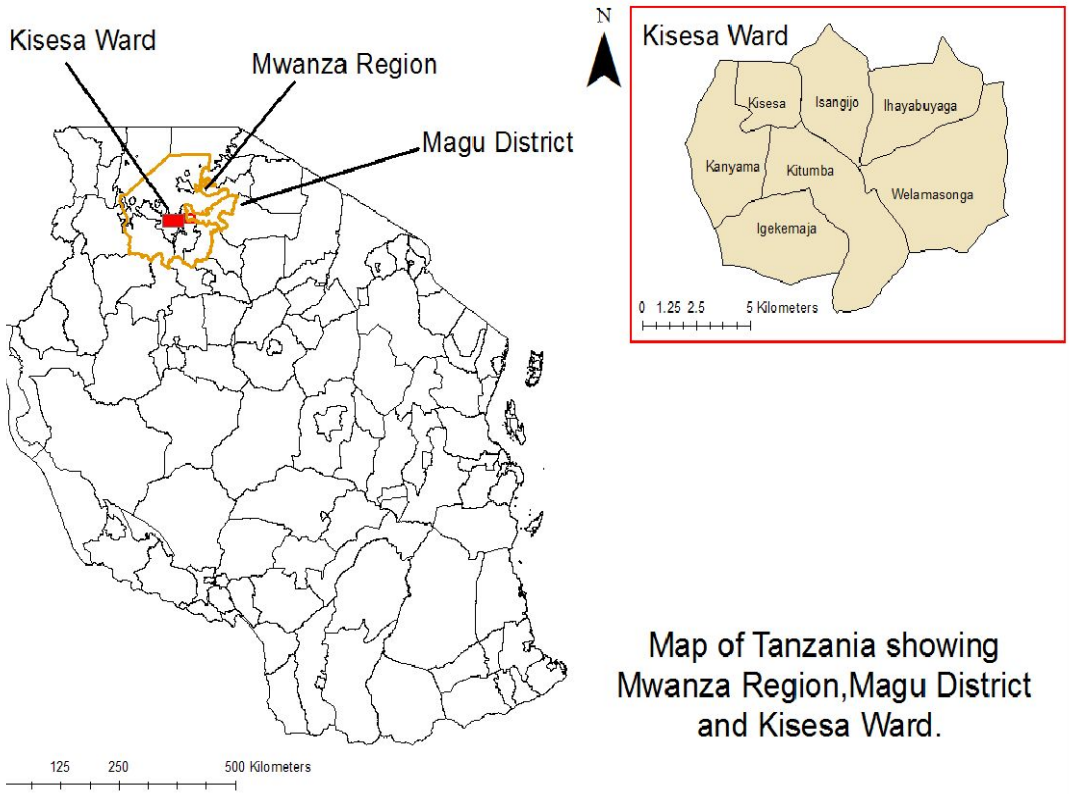
Provincial / regional estimates are possible, but further disaggregation makes the estimates of ASRH indicators unstable

Local district surveys are unlikely to add much information that is different from what can be obtained from national surveys

- Subnational variation in ASRH indicators cannot easily be captured with local district surveys
- Not likely to change local project / program priorities
- Not likely to document impact better than good program monitoring and in-depth qualitative research complemented by national survey data

Exploring new methods of local surveys

- Can local surveys be used to capture different information from national surveys?
- Can we find better ways to capture sensitive information on adolescent attitudes, risk behaviours?
- Partnership of the ASRHR Collaborative with the National Institute for Medical Research in Mwanza, Tanzania



Map of Tanzania showing Mwanza Region,Magu District and Kisesa Ward.

Kisesa Health and Demographic Surveillance System (HDSS)

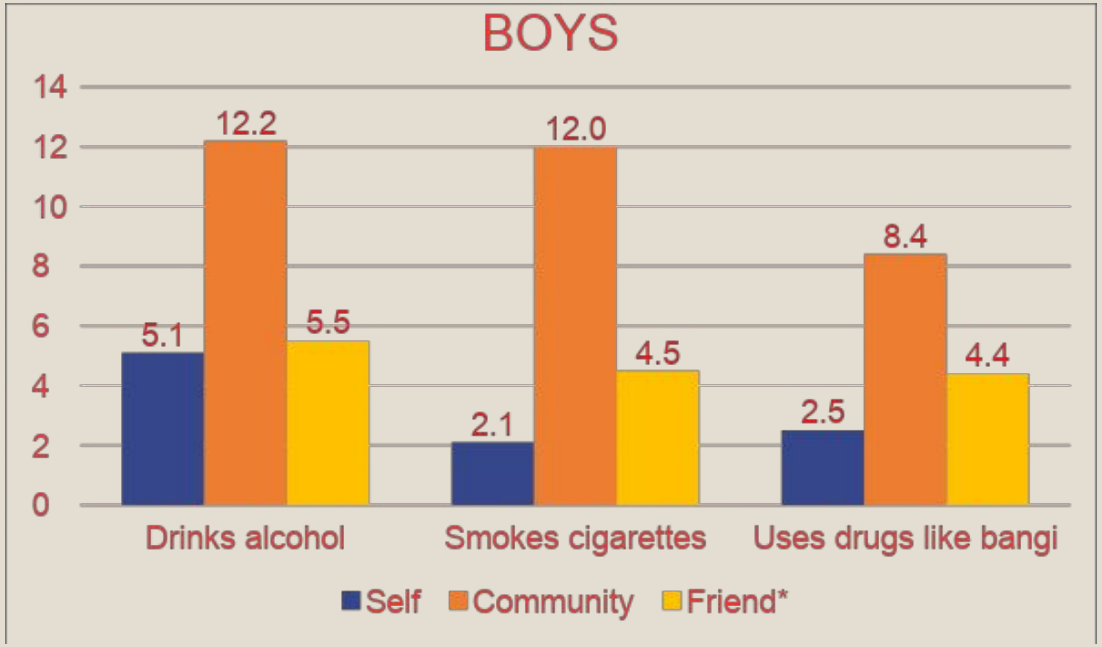
- **Start:** Since 1994 and ongoing
- **Cohort size:** 7 villages with a population of 19,000 (1994) to 42,028 (2019)
- **Population monitoring** through a Health and Demographic Surveillance System (HDSS; 35 rounds completed to date) and indepth HIV monitoring through epidemiological sero-surveys (8 rounds)
- **Other activities**: antenatal surveillance and behavioral studies, as well as health services related research (e.g. VCT services, ART services

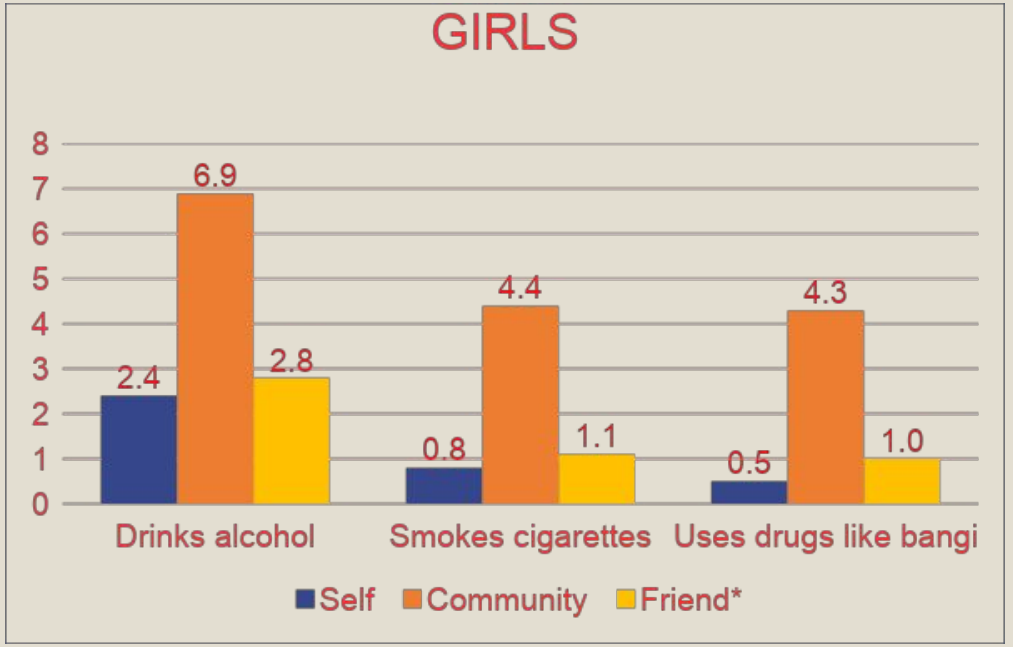
Features of the Kisesa ASRHR survey

- Adolescent survey: to document impact of use of ACASI using tablets and headsets in "safe" spaces for interview on results by comparing with other data sources (Kisesa surveys, DHS)
- Explore new way of collecting data:
- (1) on risk behaviours through proxy reporting (perception about community, best friends) in comparison to self-report;
- (2) vignettes to capture information on gender and social norms
- (3) comparison of survey results with qualitative methods (rapid peer ethnographic research)

Sample selected from the HDSS population database: 2000 invited and 1,611 interviews conducted adolescents 15-19 years (81% participation rate

Example: % reporting specific risk behaviour: self-reports, community estimate from respondents and best friend reports: Kisesa adolescent survey 2019-2020, preliminary results





Indirect questions

Best friend and community reports

- Good correspondence between self report and best friend report for risk behaviours and sexual behavior
- Community reports tend to overestimate across all questions
- Gender and age differences

Vignettes

- Great insight into adolescent understandings of gender in relationships with opposite sex
- Expected behaviours in relationships with opposite sex: boys is more assertive and direct in communicating
- Pregnancy is predominantly seen as girls' responsibility

Impressions

- ACASI worked well;
- Taking adolescents away from household and school setting for the interview is good – possible to get high participation rates (with small incentive)
- Indirect methods present opportunities for understanding ASRH and other risk behaviours but may be more beneficial for girls or older age groups

Exploring rapid qualitative methods

Current methods of key informant interviews and focus group discussions may be vulnerable to social desirability bias when collecting information from adolescents

Participatory and ethnographic methods are often too lengthy to be practical for program information

Approach based on peer ethnography but included interview component

Conducted in 2 distinct geographies: Kisesa and Sumbawanga

“Peer ethnography”

Recruited and trained 12 peer ethnographers between ages 15-19

Purposive sampling: gender, age, residence and school attendance

Training: 2-day training on ASRHR and how to conduct research

During training identified key ASRHR topics for their areas

Peer researchers each identified 3 friends. Engaged in discussions over the course of 3 weeks which they documented in field notes

At the end of each week, peer researchers summarized and presented their thoughts on the discussions in interviews with research assistants

Preliminary findings

Very limited knowledge of sexual and reproductive health, and even less so for sexual and reproductive health rights

* Adolescents acknowledged that they knew little, but felt that they still knew more than their parents or elders

Associated with women's health, for instance pregnancy and childbirth

Adolescents' perceptions of sexual and reproductive health services is situated within broader context

Poverty one of main barriers to ASRHR mentioned in Kisesa

Impressions

Analyses still time consuming, adapted this in second round

Insight into adolescents' lives

Detailed discussion of risk behaviours

WHAT DOES THIS MEAN FOR PROJECT MONITORING AND EVALUATION ?

Supplementary resources

- Collaborative project summary and updates – Link
- Global Strategy for Women's Children's and Adolescents' Health (2016-2030) – Link
- Countdown to 2030 Country Profiles – Link
- Article – ASRH in sub-Saharan Africa: Who is left behind? – Link
- Audio-Computer Assisted Interviews – Link
- PMA Surveys – Link

Questions and Reflections

Questions et Refléxions

Connect with us!

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Thank you for joining us!
Merci de vous être joint(e) à nous!

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