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RESEARCH ARTICLE

GUARANTEEING ADOLESCENTS' RIGHT TO PARTICIPATE AND MAKE DECISIONS ABOUT THEIR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

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ABSTRACT

The period of adolescence (10-19, with "youth" defined as up to 24)[i] represents a critical window of opportunity when young people are learning to make independent decisions and forming their own attitudes and beliefs. However, the period of adolescence is also a time of vulnerability and many adolescents experience threats to their sexual reproductive health rights (SRHR).Poor SRHR in adolescence – across both humanitarian and development settings – has both immediate and long-term consequences on health, education, and livelihood outcomes. Globally, the UN Convention on the Rights of the Child (UNCRC) and other international and regional agreements uphold the rights of adolescents, but at national and sub-national levels, laws, policies, and practices often create barriers for adolescents to seek services and information, and supportive policies are rarely implemented in full. The core strategy of adolescent score card tool is to facilitate dialogue between adolescents and service providers in a participatory forum and to strengthen adolescents' voices to exercise their SRH rights. The adolescent score card tool aims to capture three levels of information from adolescents: the *availability* of SRHR services for adolescents, adolescents' *satisfaction* levels regarding the quality of service delivery (among those who have used the services), and suggestions for *improvement* of the quality of services. The adolescent score card intervention resulted in improved supply of the SRHR commodities like IFA supplies improved to 96%, sanitary pads to 82%, contraceptive supplies to 39%. In our study area, majority of the adolescents were not aware of the RTIs/STIs. Post intervention the status of RTI/STI services graded as good improved to 29% from 11% and RTI/STI service status of poor grade decreased to 57% from 79%. Counseling on use of IFA increased by 36%, counselling on use of sanitary napkins increased by 35% and counselling on use of contraceptives was increased by 32%. Enabling adolescents to access sexual and reproductive health services enables them to prevent pregnancy, protect themselves against sexually transmitted infections, and make informed decisions about their sexual and reproductive health. States must guarantee adolescents meaningful participationin the design, implementation, monitoring and evaluation of youth-friendly sexual and reproductive health programs. This will ensure that the youth perspective is incorporated into such programs and enhance transparency and accountability.

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INTRODUCTION

The period of adolescence (10-19, with "youth" defined as up to 24)[ii] represents a critical window of opportunity when young people are learning to make independent decisions and forming their own attitudes and beliefs. However, the period of adolescence is also a time of vulnerability and many adolescents experience threats to their sexual reproductive health rights (SRHR). Early and forced sex; child, early, and forced marriage, other forms of harmful traditional practices, and sexual and gender -based violence are common among adolescents, particularly girls, in low and middle income countries [iii].

In addition, early and unintended pregnancy affects the lives of millions of adolescents. Globally, more than 13 million adolescents give birth each year [iv]. Few sexually active adolescents are using contraception; in fact, 60% of sexually active adolescent girls in developing areas have an unmet need for modern contraception (23 million girls)[v]. In low and middle-income countries, 40% of unsafe abortions are among adolescent's girls and female youth [vi]. Adolescent mothers face a higher risk of maternal mortality and morbidity than older women, and their children face a higher risk of neonatal, infant, and child mortality and morbidity [vii]. India has the largest number of child brides in the world [viii]. Despite the ban since over 85 years, 47.4% of women (20-24 years) are

married before the age of 18 years, and 18% before the age of 15 years [ix]. In 2011, of the 0.78 million children born to girls below 15 years of age, 56,000 had already died. Thus, there are thousands of girls who each year get married at a very child age, give birth to children as children themselves and also see their children die. A sizable proportion of adolescents are underweight. Poor nutrition among adolescent girls during pregnancy can contribute a higher risk for negative maternal and newborn outcomes, while early childbearing among adolescent girls can perpetuate the intergenerational cycle of malnutrition. There are over 355 million menstruating women and girls in India, but millions of women across the country still face significant barriers to a comfortable and dignified experience with menstrual hygiene management (MHM). A study found that 71% of girls in India report having no knowledge of menstruation before their first period. At menarche, study of UNICEF from eastern UP, report that 100 % of adolescents had no discussion on the process of menstruation pre-menarche, 86% of girls were not prepared for menarche, more than 60% felt scared during menarche and more than 90 % of adolescent girls missed their school for one or two days during menarche. Girls do not have consistent access to preferred, high-quality menstrual hygiene products. Almost 88% of women and girls in India use homemade alternatives, such as an old cloth, rags, hay, sand, or ash. Qualitative studies and an analysis of the product market indicate that premium commercial products are unaffordable or not consistently accessible for women and girls in low-income communities. 70% of women in India say their family cannot afford to buy sanitary pads. Women and girls lack access to appropriate sanitation facilities. There are 63 million adolescent girls living in homes without toilets. Despite national efforts to improve sanitation, women and girls lack appropriate facilities and community support to manage their menstruation privately and in a safe manner. And in 2012, 40% of all government schools lacked a functioning common toilet, and another 40% lacked a separate toilet for girls.

The poor health outcomes, as mentioned above, among adolescents are driven by a range of factors. Adolescents are particularly vulnerable due to age, gender, and socio-economic status. They lack the power and agency in their relationships, homes, communities, and societies to stand up for their own health and rights, and adolescent girls in particular are rarely the decision-makers about their own bodies and life trajectories. Adolescent sexuality is highly stigmatized, leaving adolescents without support systems to navigate this complex period of life. Menstruation is still a taboo in India and it is common for people across the society to feel uncomfortable about the subject. Adolescents also lack access to comprehensive information about their bodies, health, sexuality, and rights. Health services traditionally focus on young children and mothers, and when adolescents do seek health services they are often treated with disrespect and stigmatized. Poor SRHR in adolescence – across both humanitarian and development settings – has both immediate and long-term consequences on health, education, and livelihood outcomes that can perpetuate the intergenerational cycle of poverty. Globally, the UN Convention on the Rights of the Child (UNCRC) and other international and regional agreements uphold the rights of adolescents, but at national and sub-national levels, laws, policies, and practices often create barriers for adolescents to seek services and information, and supportive policies are rarely implemented in full.

The CRC recognizes that children who are discriminated against "are more vulnerable to abuse, other types of violence and exploitation," and their health and development are put at greater risk [xi].

The intervention: Save the Children has been implementing Marriage No Child's Play (MNCP) project in India supported by Ministry of Foreign Affairs, the Netherlands, across 6 districts of 3 States (Rajasthan, Bihar and Odisha) in India targeting around 35000 adolescents (10-19 years) to reduce incidences of child marriages and improve SRHR services for adolescents. *'Young people are able to decide if and when to marry and pursue their SRHR in a supportive environment'* is the primary objective (goal) of the project. Through MNCP, Save the Children introduced Adolescent Score Card (ASC) a tool guaranteeing adolescents' right to participate and make decisions about their Sexual and Reproductive Health and Rights. The ASC tool guarantee adolescents meaningful participation [xii] in the design, implementation, monitoring and evaluation of youth-friendly sexual and reproductive health programs. This ensures that the youth perspective is incorporated into programs and enhance transparency and accountability. It takes special measures to ensure the meaningful representation of marginalized groups that may face additional barriers in access to sexual and reproductive health services. Giving decision-making power to young people and integrating them into all aspects of program development are vital components of ensuring meaningful participation.

The Adolescent Score Card (ASC) is a two-way and ongoing participatory tool for assessment, planning, monitoring and evaluation of services relevant to adolescents. The Adolescent Score Card brings together the demand side ("service user") and supply side ("service providers ANM, ASHA, AWW") of a particular service or program to analyze issues underlying service delivery and find a common way of addressing them. It is an interesting way to increase participation, accountability and transparency between service users, providers and decision makers. As a tool for participatory monitoring, it effectively facilitates adolescent empowerment. Contrary to what the name suggests, it is not just a scorecard but a process, with an emphasis on feedback and reform. It is flexible and adaptive, and there are many ways to implement this process. ASC serves as mechanism to strengthen the systems ensuring integration of adolescents within programs for decision making and improving the quality of SRHR services. The core strategy of this tool is to facilitate dialogue between adolescents and service providers in a participatory forum and to strengthen adolescents' voices to exercise their SRH rights. The Adolescent Score Card tool aims to capture three levels of information from adolescents: the *availability* of SRHR services for adolescents, adolescents' *satisfaction* levels regarding the quality of service delivery (among those who have used the services), and suggestions for *improvement* of the quality of services.

The Adolescent Score Card is a participatory mechanism that

- Is conducted at micro/local level with the village as the primary unit of analysis
- Generates information through focus group interactions and enables maximal participation of adolescent girls and

boys in age-segregated groups of 10-14 year olds and 15-19 year olds.

- Provides immediate feedback to service providers and emphasizes immediate response and joint decision-making
- Allows for mutual dialogue between users and providers followed by a joint monitoring process
- Strengthens the voice of adolescents by fostering ownership of relevant services
- Enables peer/ discussion leaders to use the information generated to advocate for quality SRHR services on a continuous basis

Development of tool: Adolescent Score Card Tool was developed by the project team on the services offered by health department for adolescent sexual reproductive health rights. The main services like Body Mass Index (BMI) screening, Hemoglobin test, anemia treatment, menstruation hygiene management, RTI/STI management and counseling, contraceptive services offered by health department formed the basis of framing the indicators for the score card. The draft score card tool was pre-tested in the field and necessary changes were made in finalizing the adolescent score card tool. For uniform understanding of the tool across the intervention group, three color coded criteria namely Good (Green), Average (Yellow) and Poor (Red) were assigned for grading of services.

Table 1. Color coded criteria's for assessment of services

Good		75% and more respondents are satisfied with the indicator progress
Average		50% to 75% of respondents are satisfied with the indicator progress
Poor		Less than 50% of respondents are satisfied with the indicator progress

Training of facilitators: One-day training of project staff and DLs was conducted on developing their understanding on score card and how the data can be filled effectively. Front line Health workers were also sensitized on the tool to assure joint responsibility and accountability.

Time period: August- September 2017 & 2018 (once in a year).

Number of adolescent girls: Total 1733 girls participated in the process (1500 unmarried and 233 married adolescents participated)

RESULTS

Body Mass Index (BMI) screening is one of the anthropometric measurement to assess the growth status of adolescents. In pre intervention seventy one percent of adolescent girls graded BMI screening as poor, fourteen percent graded as good and equally graded as average conducted by health workers. Through the process of ASC gaps were identified and it was realised that the main reason for poor grading was lack of awareness about importance of BMI and poor skills of Health workers in conducting BMI. The ASC process of participatory discussion on the gaps, action with accountability and timeline for overcoming the gaps and continuous follow up, resulted adolescents in grading the BMI screening as good by fifty seven percent improving from 14 percent, the poor grading decreased to twenty one percent.

To detect anaemia among adolescents, status of haemoglobin (Hb) among adolescents is basic parameter. Through adolescent score card process the adolescent girls grading of haemoglobin test by ANMs improved by thirty six percent points, wherein now half of the adolescents are satisfied with haemoglobin test in comparison wherein only one in five were tested in pre intervention phase. The grading of poor decreased to twenty five percent by adolescent girls in comparison to seventy one percent graded as poor in pre intervention. Reproductive Tract Infctions (RTI) is one of the most common problem among adolescent. Aadolescent were sensitized on adolescents sexual reproductive health rights (SRHR) and were made aware about RTI, as a result adolescent acceptance for RTI test had increased 18% from last year, which show a improvement. Health worker were strengthen on various SRHR issues like identification of RTIs/STIs, treatment, management and counseling in RTIs / STIs, which resulted in improvement of services provided by Health worker. Anaemia treatment and management among adolescent girls is a daunting task where in more than half of the adolescent girls are anaemic. Half of the adolescent girls categorised anaemia treatment as poor in their area due to unavailability of regular supplies, poor counselling skills by health workers and un ware on the treatment of anaemia. Post intervention, the poor grading stands at 11 percent and the good grading has been done by three fourth of the adolescent girls. The regular interaction with the health workers and the efforts of health workers in improving quality of services has increased resulting in improvement of anaemia treatment. Menstrual hygiene management among adolescents in the country needs special focus as more than 70 percent of girls have no knowledge on menstruation before their first period. Almost 80 percent of the girls use homemade alternatives and more than 70 percent of women cannot afford to buy in sanitary pads from the market. Even though government have schemes to provide sanitary pads free of cost to the adolescents, in spite of this pre intervention 68 percent of adolescents graded treatment of menstrual related problems as poor and hardly 18 percent graded as good. The main reason cited by the adolescents were non-availability of sanitary pads, unawareness on government schemes of sanitary pads, poor counselling skills of health workers and hesitation of adolescent girls approaching health workers for treatment. Post intervention, working on the gaps identified, the good grade improved to 61 percent and poor grade decreased to 29 percent. Hardly 10 percent of adolescent girls graded pregnancy test services as good in their area due to unavailability of pregnancy kits and unawareness on services of pregnancy test. Post intervention more than half of the girls (54%) graded it as good owing to increased interaction and counselling skills of health workers. To ensure high standard of care for patients, availability of supplies is the major component of health system. Through adolescent score card process it came across that availability of IFA had improved 11%, availability of Sanitary Napkins had also increased 36% within one year.

Contraceptives availability had shown significant improvement from 4% to 39% which depicts that understanding on usage of contraceptives had also increased with one year among married and unmarried adolescents. Acceptance and understanding of pregnancy test amount adolescents had also substantially increased from pre to post intervention. The major reason of lack of availability of SRHR commodities for adolescents was as per service providers SRHR commodities were for adults not for adolescents but after series of interaction with service providers, they were able to understand importance of SRHR commodities for adult as well as adolescents. Training of health service providers on SRHR and supply chain management had played an important role in developing understanding and acceptance of availability of SRHR commodities not only for adults and married couples but also for adolescents. Counselling played vital role to improve health seeking behaviour of community. Through counselling of service providers use of IFA, sanitary napkins and contraceptives had increased after intervention. As compared from pre intervention use of IFA had increased 36%, use of sanitary napkins had increased 35% and use of contraceptives was increased 32% in post intervention. The major challenge was to make girls, adult and even front line health workers feel comfortable to talk on SRHR issues. The training of FHWs helped in breaking the hesitation among the service providers to speak on SRHR issues and able to provide youth friendly counseling service to adolescents. Also trainings and sensitization through different tools helped break the silence of adolescents as well.

DISCUSSION

Adolescents have diverse sexual and reproductive health problems. As per NFHS–3 data, 2.7% boys and 8 % girls reported sexual debut before the age of 15 and most of the sexual activity happens in the context of marriage, this leads to early pregnancy due to social pressure. Even though contraceptive awareness is 94% among girls aged 15–19, only 23% of the married and 18% of the sexually active unmarried girls in this group, used a contraceptive once at least [xiii]. In our study area, pre intervention phase hardly 4% of the adolescent girls were satisfied with the supplies of the contraceptives in the area. Post intervention, increased interaction and planning with frontline health workers, resulted in improved supplies to 39%. Currently, one in four adolescent girls aged 15-19 have an unmet need for contraception [xiv] meaning that they are sexually active or considering becoming sexually active but do not have modern methods of pregnancy prevention. The programmatic inability of empowering adolescents to prevent pregnancy results in over 7 million girls under the age of 18 giving birth each year, and nearly one-fifth of girls in the developing world becoming pregnant before the age of 18.

Unintended pregnancy and childbearing can profoundly alter adolescents' lives, undermining their educational attainment, economic opportunities, and ability to participate in public and political life. These affects are worsened for girl children having greater sexual and reproductive health needs due to their reproductive capacities, are open to face greater barriers in accessing sexual and reproductive health services, and struggle with gender roles and stereotypes surrounding childrearing. For many girls, bearing a child signifies the end of their formal education, either due to formal expulsion by the school as a sanction for becoming pregnant [xvi], or as a result of their childrearing obligations or need to work in order to support the child. Empowering adolescent girls on pregnancy delays is a key element of realizing their right to education enabling them to have greater economic opportunities, social empowerment and financial independence [xvii]. Pregnant adolescents are at risk of inadequate access to quality maternal health care. As a result, 70,000 girls die each year as a result of complications during pregnancy or childbirth [xvii], making it the leading cause of death for girls aged 15-19 in developing countries [xix]. Furthermore, 3.2 million minors in developing countries undergo clandestine, unsafe abortions each year [xx], placing their lives and health in jeopardy. In communities and populations with high rates of child marriage, girls – including young girls – who become married have significant pressure to become pregnant immediately resulting in early pregnancies. From the studies done in the past, it is evident that adolescent have no proper knowledge regarding STIs and an educational intervention shows significant improvement in the knowledge level of the participant. In our study area, majority of the adolescents were not aware of the RTIs/STIs. Post intervention the status of RTI/STI services graded as good improved to 29% from 11% and RTI/STI service status of poor grade decreased to 57% from 79%. The main reasons cited from adolescents were that for service providers SRHR supplies were for adults only and they felt that these services are not meant for them, fear of medical procedures and contraceptive methods, concern over lack of privacy and confidentiality, fear of shame and fear from parents and society on their hostile reaction. Where adolescents do not understand their sexual and reproductive health needs, they are unable to take measures to prevent unwanted pregnancy or sexually transmitted infections or disease. Comprehensive sexuality education is critical for informing adolescents about sexual and reproductive health services, their right to access such services and the right to make decisions about their sexuality and reproduction free from violence, pressure or coercion.

The stigma surrounding adolescent sexuality can prevent adolescents from seeking information about their sexual and reproductive health, discussing their sexual and reproductive health needs, and accessing sexual and reproductive health services [xxi]. Many adolescents lack an independent source of income and due to the sensitive nature of sexual and reproductive health services may be unable to ask their parents for financial support. Many of the working adolescents are expected to handover their earnings to their parents. Many of adolescent girls forego sexual and reproductive health services where they feel that their confidentiality will not be maintained [xxii]. Most of the adolescent's decisions get influenced by their perception of the treatment and the care that they receive about accessing sexual and reproductive health services. Where they are mistreated by health care providers, such as when they are chastised or shamed for being sexually active, it may also deter them from seeking health services in the future [xxiii]. Many of the recent studies across regions demonstrate that healthcare providers may limit adolescents access to sexual and reproductive health services or may demand parental authorization even where laws and policies guarantee adolescents the right to independently access sexual and reproductive health services [xxiv]. With so many programme available, the services have not reached the target group adequately because of limited resources, unawareness by target groups on the schemes and programs, adolescents not empowered to seek their SRHR services, societal and cultural norms prevailing in the society. There is no direct access, space for privacy and ideal timing (restrictions in days and

time) for the adolescents. Service providers are not given proper sensitization and training. For the health care providers it is usually an extra burden because no man power has been allotted separately for adolescent health services. Though Adolescent Friendly Health Services (AFHS) based adolescent clinics are said to address all the health needs of adolescents, the delivery of services mainly targets reproductive and sexual health and all other issues are not adequately focused. Even with this great focus on ARSH, NFHS data shows no significant decrease in adolescent pregnancy. In fact there is an increasing trend in first pregnancy in adolescent and the birthrate in the age group 15 to 19 year is still 31.5 per thousand adolescent girls, which is high for the efforts and inputs given by the health system [xxv]. In our study area, the results reveal that only half of the adolescent girls graded the status of pregnancy test as good in comparison to one in ten adolescents in pre-intervention. The main reason cited were unawareness on the pregnancy test services and unavailability of pregnancy kits in their area with the health workers. The anemia treatment status in pre intervention was graded as good only by 39% of adolescent girls which improved to 75% on post intervention. The adolescent score card intervention resulted in improved supply of the SRHR commodities like IFA supplies improved to 96%, sanitary pads to 82%, contraceptive supplies to 39%. This has been possible due to two way and ongoing participatory planning, monitoring of services by adolescents. The demand side (adolescents) and the supply side (service providers ANM, ASHA) were brought together on one platform to analyze the issues underlying service delivery and find a common way of addressing them. It demonstrates an interesting way to increase participation, accountability and transparency between service users, providers and decision makers. The whole process serves as mechanism to strengthen the systems ensuring integration of adolescents within programs for decision making and improving the quality of SRHR services.

Guaranteeing the right to autonomously make decisions about sexual and reproductive health to all adolescents is a critical step towards realizing the right to life, survival and development. Convention of the Right Of Child Treaty monitoring bodies have expressed concern about adolescents' lack of access to sexual and reproductive health services and the impact that this has on their lives and development, including by requesting states to ensure adequate access to sexual and reproductive health services in order to reduce adolescent pregnancy and maternal mortality [xxvi]. Enabling adolescents to access sexual and reproductive health services enables them to prevent pregnancy, protect themselves against sexually transmitted infections, and make informed decisions about their sexual and reproductive health [xxvii]. Adolescents who are unable to autonomously access sexual and reproductive health services, may be forced to unsafe methods to try to prevent pregnancy or to terminate an unwanted pregnancy, posing serious threats to their lives [xxviii]. Enabling all adolescents the right to make autonomous decisions about their sexual and reproductive health and rights is a critical component of the right to equality and nondiscrimination, due to the disproportionate impact this has on girls. In decisions about sexual and reproductive health, the right to be heard is of paramount importance. In relation to the decisions about abortion, the CRC has gone further than just calling for an adolescent's right to voice her opinion, indicating that pregnant adolescents' views should always be respected [xxix]. Healthcare workers often play a critical role in enabling adolescents to access sexual and reproductive health services, but proper training is essential to ensure they fulfill – and do not undermine – adolescents' rights. States to ensure that health workers do not discriminate against adolescents, including on the basis of age, sex, or social status, among others; are respectful of adolescents, meaning that they be nonjudgmental, friendly and considerate of their needs, and do not criticize them; administer adolescent-friendly sexual and reproductive health services, including on client privacy, confidentiality and respecting minors' needs; provide scientifically-accurate and comprehensive information on adolescents' sexual and reproductive health and rights, including on the full range of reproductive health options; and communicate effectively with adolescents to ensure they understand their sexual and reproductive health needs.

Even though having increased attention to this issue over the past decade or so, significant gaps remain in adolescents' knowledge about their sexual and reproductive health and rights and ability to access essential sexual and reproductive health services. Notably, the Committee on the Rights of the Child and the Special Rapporteur on the Right to Health have strongly affirmed the importance of adolescents' sexual and reproductive rights, urging states to take a host of specific measures to ensure the full exercise of these rights. Adolescents have a fundamental human right to participate in matters that affect their lives. Governments at the United Nations have made a series of commitments {ICPD-1994, ICPD+5 – 1999, Beijing+5 - 2000, CPD – 2012, CRC General Comment No. 4 (2003) para 13, CESCR General Comment No. 14 (2000) para 23} to realize young people's right to participation and decision making including in sexual and reproductive health policies and programs [xxx]. Enabling adolescents to access sexual and reproductive health services enables them to prevent pregnancy, protect themselves against sexually transmitted infections, and make informed decisions about their sexual and reproductive health [xxxi].

In accordance with international human rights norms, sexual and reproductive health services for adolescents should be youth-friendly meaning that they are designed to meet the unique needs of adolescents and resolve the barriers they face in accessing health services. Youth-friendly services should also guarantee adolescents confidentiality throughout the full spectrum of their health care, from when the adolescents arrives at the clinic through follow-up care, such as by having designated times and spaces specifically for adolescents, in order to reduce the likelihood of running into a known adult; providing privacy when adolescents explain why they are seeking care; guaranteeing confidentiality during their actual visit with the provider; storing health records in a secure, safe place; and ensuring patients that their medical information and history will not be improperly disclosed.

Conclusion

States must guarantee adolescents meaningful participation in the design, implementation, monitoring and evaluation of youth-friendly sexual and reproductive health programs to ensure that the youth perspective is incorporated into such programs and enhance transparency and accountability. States should take special measures to ensure the meaningful representation of marginalized groups that may face additional barriers in access to sexual and reproductive health services. Adolescents must further have knowledge about their rights

and available mechanisms of redress to access remedies for human rights violations and how to go about doing so. Information about adolescents' rights, including their right to an effective remedy, must be "conveyed in language children are able to understand and which is gender- and culture-sensitive, and supported by child-sensitive materials and information services [xxxiii]."

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