BELGIUM: BODY & RIGHTS – E-LEARNING ON SRHR FOR DEVELOPMENT STAKEHOLDERS

CONTEXT

Advocating for SRHR in the context of development cooperation requires awareness, knowledge and skills. This is a necessary condition to advance SRHR at the supranational and national level and to realize the SRHR related goals and targets of the 2030 Agenda for Sustainable Development.

PROBLEM

Policy evaluation found lack of awareness and understanding of SHRH amongst the stakeholders of the Belgian development cooperation.

Stakeholders were insufficiently aware of how to promote SRHR in the bilateral relations with other countries, in supranational decision-making bodies or during the development, monitoring and evaluation of programmes.

SOLUTION

The e-tutorial 'Body & Rights' (bodyandrights.be) improves the stakeholders' knowledge of SRHR, their skills to advocate for SRHR and enables them to find accurate and evidence-based information and reference documents. The tool was developed by Sensoa, Be-cause health and other development stakeholders.

APPROACH

Development process:

- Stakeholders survey + pre-testing + expert group
- Freely accessible, user-friendly, intuitive, appealing web application
- 7 modules/17 presentation videos with professional actors
- Themes: family planning, maternal health, abortion, HIV/STI, SGBV, FGM, LGBT rights.
- Mixed media: graphics, audio, video and animation
- Multilingual (ENG, FR, NL), self-paced tool, additional learning support

RESULTS

Successful launch 2nd March at international She Decides conference in Brussels.
In 6 months' time, 520 users registered and 70 certificates awarded.
The majority of the users are under 35 and follow the course in Belgium.

LESSONS LEARNED

E-learning → opportunities for acquiring specific knowledge, cognitive and interpersonal skills on SRHR.

Self-paced → easy and comfortable method to achieve knowledge and skills, especially for geographically dispersed development stakeholders

FUTURE DIRECTIONS

Innovative approaches like e-learning are key for advancing SRHR among development stakeholders and necessary to ensure SRHR remains high on the political agenda. Translating the tool to other languages and an evaluation might be foreseen in the near future.

NEPAL: HEALTH SERVICES ACCESSIBILITY FOR WOMEN WITH DISABILITIES

NEPAL DISABLED WOMEN ASSOCIATION

CONTEXT

- **Population size: 28.98 million**
- **Disability prevalence: 1.94 (45% are women with disabilities)**
- **Newly acquired Disabilities: 8000 due to 2015 earthquake**
- **People with disabilities are among the most marginalized individuals in Nepal.**
- **Massive earthquakes in spring of 2015 left over 8,000 people dead and 22,000 injured**

PROBLEM

SRH services often inaccessible to persons with disabilities:

- physical barriers
- lack of disability-related clinical services
- stigma and discrimination from service providers

SOLUTION

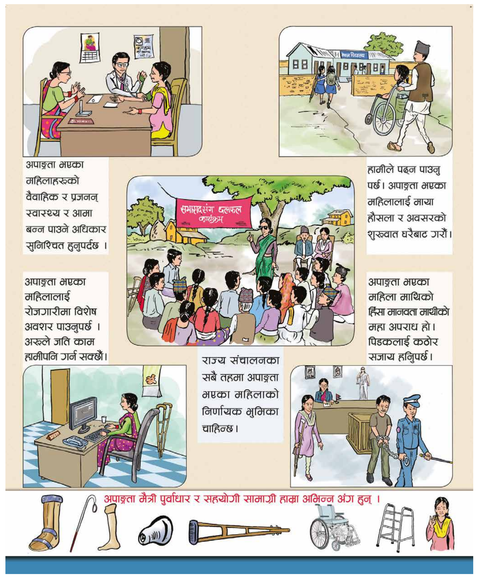
- Advocacy with policy makers
- Orientation for health service providers and young women with disabilities

APPROACH

- Evidence collection and sharing
- Adopting a Rights Based Approach drawing on existing Human Rights instruments (UNCRPD)
- Advocacy, orientation, campaigns

RESULTS

- Verdict implementation (RHR)
- Implementation of 10 years action plan on disability prevention and management
- Service providers offered quality services



LESSONS LEARNED

- Regular advocacy and orientation can change the mind-sets of service providers/ policymakers.

FUTURE DIRECTIONS

- Opportunities: health acts, policies
- Challenges: negative mind-sets of policy makers/health service providers towards WWDs

TURKEY: REACHING YOUNG PEOPLE WITH SRHR EDUCATION AND INFORMATION

Sağlıkta Genç Yaklaşımlar Derneği

Y-PEER Türkiye

CONTEXT

- **Population of Turkey hit 80 million (79.814.871[1]) and over 23% of the population consist of young people between the ages of 10 and 24. Additional 3.3 million Syrian refugees are living in the country and 65% are women and children.**
- **14.695 people is living with HIV and AIDS in Turkey.**
- **One of every four young women said they do not know names of female sexual organs.**
- **Only one in every ten young people has accurate information on HIV/AIDS.**
- **2/3 of young people, among who heard of HIV and AIDS, said they would feel uncomfortable for being the same room with a HIV + person. Peer groups have effects on young people and this applies for both risky and safe behaviors. It's known that young people feel more comfortable speaking to a peer on sexual and reproductive health related issues including HIV/AIDS.**
- **Almost every young person stated his/her need on basic information and health services on sexual and reproductive health.**
- **Rapidly rising refugee population: 75 % are women and children**

PROBLEM

- Persisting gender inequality and discrimination
- Poor knowledge of and negative attitudes towards SRHR among young people
- Legal barriers to accessing preventative and remedial health care services especially for young people

SOLUTION

- Introducing basic knowledge and lifeskills around SHRH
- Integrating a rights-based approach
- Advancing gender equality
- Encouraging young people to take responsibility
- Increasing access to accurate information from reliable sources

APPROACH

- Peer education: ensures internalisation of information on SRHR
- Increase participation and focus by using interactive modules and different educational applications
- Providing accurate information and materials
- Providing information and material support during the week of 1 December World AIDS Day

RESULTS

- Creation of pools of educators to respond to needs of different youth groups
- To reach LGBTI youth, brought together healthcare providers and peer educators
- Reaching refugee youth with peer education and awareness raising, resulting in increased uptake of youth friendly health services
- Established anonymous HIV Testing and Counselling Centre with Çankaya Municipality, Ankara

LESSONS LEARNED

- Being upfront about our aim – for everyone to have access to health services and education – has been instrumental to generate buy-in from participants
- Being flexible with content of training materials necessary to adapt for different target groups

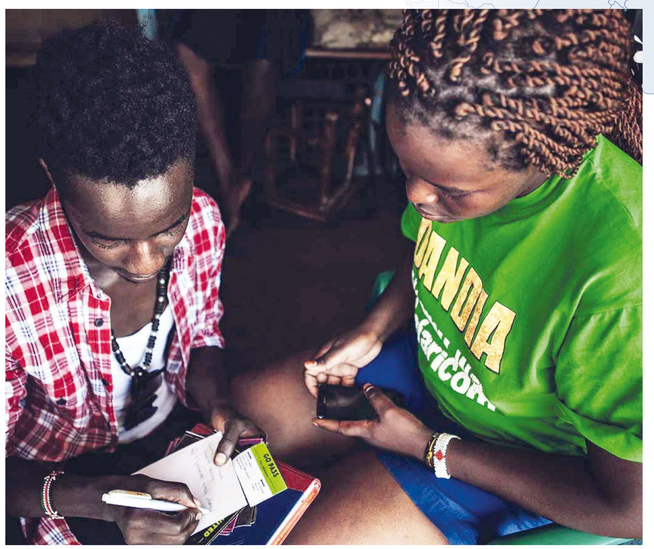
FUTURE DIRECTIONS

- Continue to strengthen the network to reach more young people
- Continue to highlight the importance of SRHR information and services for young people to deicion makers

KENYA: DRIVING UPTAKE OF FAMILY PLANNING SERVICES BY ADOLESCENTS THROUGH SUBSIDISED SERVICES IN THE PRIVATE SECTOR

MARIE STOPES INTERNATIONAL
Children by choice, not chance

CONTEXT



Kenya has a large youth population, with 9.2 million people aged 10-19

- **Modern contraceptive prevalence rate amongst adolescents has increased to 53 % but low level family planning**
- **Almost one-quarter of women have given birth by age 18 and nearly half by age 20**
- **18 % of adolescent women aged 15-19 are already mothers or pregnant with their first child**

APPROACH

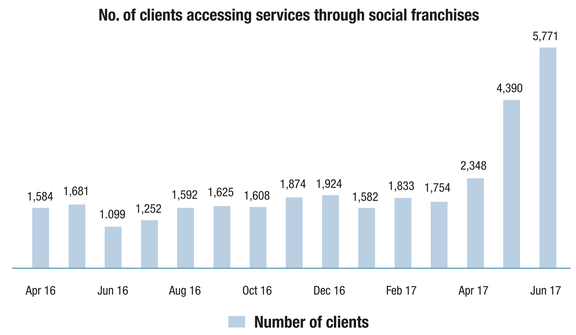
Social franchise voucher programme

- To support better access to family planning services for women under 20, MSI is:
- Offering free/subsidised SRH services through vouchers redeemable in social franchises in 16 counties
- Contracting, training and supporting 131 private health facilities
- Recruiting 262 voucher distributors, mainly community health workers
- Training and supporting voucher distributors, including with mobile technology
- Engaging with county leaders and other community opinion leaders

RESULTS

- 80 % voucher redemption rate
- 60 % redeemed for family planning services

- 124 social franchises recruited
- 248 voucher distributors recruited



PROBLEM

- Lack of access to SRH services and low family planning use by adolescents:
  High unmet need for family planning amongst adolescents: only 10% of women aged 15-19 are using contraception
- Lack of youth-friendly services
- Cost barriers restrict access for adolescents

SOLUTION

- Increased access to SRH services for adolescents through the private sector
- Expand access through private health facilities (social franchises)
- Offer free/subsidised services for youth, including long-acting contraceptive methods
- Improve health service standards and quality in the private sector
- Improve service provider skills to offer youth-friendly SRH services

LESSONS LEARNED

- Voucher distributors need to be well known and must know their communities
- Successful voucher distributors mobilise within schools
- Events are extremely important
- Young people rarely visit the clinics on their own
- The programme involves significant administration

FUTURE DIRECTIONS

- Recruitment of remaining franchises
- Recruitment and training of more voucher distributors
- Sustainability:
  Institutionalisation of ASRH information and service provision at national and county levels
- Financing of ASRH information and service programmes
- Capacity building of national and county institutions to create demand for and provide ASRH information and services

CAMBODIA: INCLUSIVE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

With funding from the
Federal Ministry for Economic Cooperation and Development

CONTEXT

- **Persons with disabilities account for a share of about 10% of Cambodia's population (14 million).**
- **Men and women with disabilities have the same needs for intimate relationships, marriage and parenthood, but face barriers to realise their rights.**
- **Access to sexual and reproductive health information and services is limited.**
- **Persons with disabilities are 2.5 times more likely to be ill than non-disabled people, and spend over 3 times more on health care treatment.**

PROBLEM

Persons with disabilities are exposed to vulnerabilities associated with poverty, gender, disability, living alone, and being childless. Sexual and reproductive lives of persons with disabilities differ in terms of knowledge, practices, and access to services, with implications on their lives: Women with disabilities are less likely to marry, resulting in a lack of social support when their parents are getting older

SOLUTION

Awareness raising and reducing of societal barriers to increase acceptance by communities

Promoting health staff's understanding of inclusion and attitudes towards persons with disabilities

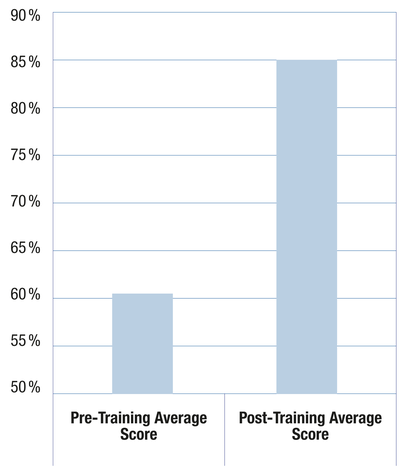
Improvement of accessibility of health facilities for PWDs; i.e. accessible toilets and wheelchair ramps; communication signboards for persons with hearing impairment

APPROACH

- Education, training and awareness raising on SRHR for all, including persons with disabilities:
  - Creative measures such as artistic performances by Epic Arts, a film (Safe Love), and a song related to pregnancy
  - Using radio broadcasting to promote rights of clients, provider rights & duties in the health sector
- Facilitating joint planning between local government authorities, health staff, persons with disabilities, elderly and poor families to integrate their needs for health centers and community planning

RESULTS

Between March and July 2017, the average reproductive health and rights knowledge score of 350 men and women with disabilities increased from 63% to 83%:



Five community sessions and two disability inclusion trainings conducted in 2017 brought together persons with disabilities, health staff and local leaders to discuss how to improve inclusion of persons with disabilities:

A web short film about family planning and rights of persons with disabilities has been viewed more than 80,000 times since 2016

LESSONS LEARNED

Close collaboration of disabled people's organisations, health staff and communities is crucial to remove barriers persons with disabilities face when accessing reproductive health services and information

Distributing key messages on SRHR to self-help groups increases confidence of members

FUTURE DIRECTIONS

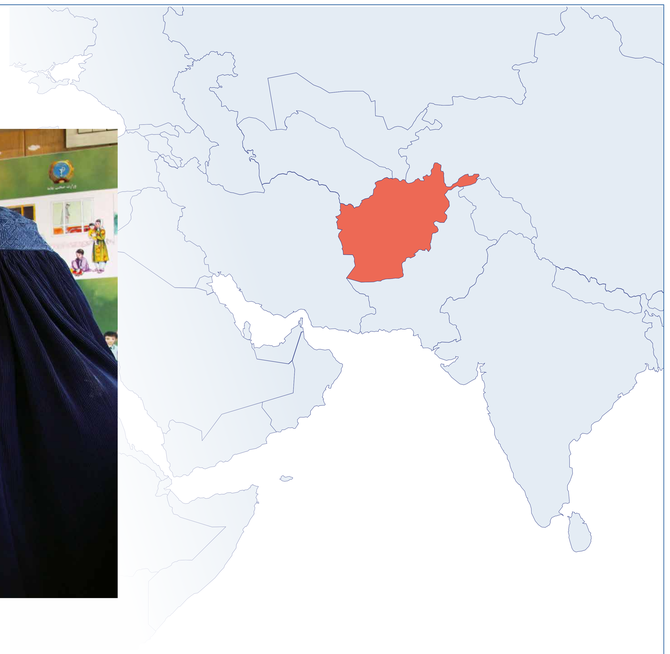
Disabled people's organisations play an important role in addressing SRHR concerns of their members, but need further capacity building support

Promoting inclusive SRHR through social media appears to be a promising way to reach communities

AFGHANISTAN: PROVIDING SRH SERVICES IN FRAGILE SETTINGS

IPPF Humanitarian

CONTEXT



- **87.2% of women have experienced at least one form of physical, sexual or psychological violence, or forced marriage.**
- **MMR: 396 per 100,000 live births (World Bank, 2015)**
- **CPR (all methods): 22.5% of women ages 15-49**

PROBLEM

- Increased number of internally displaced persons and refugees returning from Pakistan to Nangarhar Province in Afghanistan
- Acute SRH needs in resource-poor settings, including addressing GBV
- Lack of skilled service providers in providing SRH services including GBV response

SOLUTION

- Mobile medical van, with separate sections for men and women
- SRH service delivery and dignity kit distribution
- Locally hired community health promoters (safety, security, acceptance of local community, knowledge transfer)

APPROACH

- Mobile team linked with community health promoters
- Coordination with Provincial Emergency Response Units and stakeholders
- Coordination with elders and religious gatekeepers to gain access
- Screening of affected local population for SGBV
- HIV and STI screening and testing
- Maternal and child health services
- Family planning services

RESULTS

- 5,203 clients reached in this localised emergency response

LESSONS LEARNED

- Coordination and preparedness with community and response actors critical
- Tailor approaches to navigate gender norms
- Support to service provider to operate within challenging context

FUTURE DIRECTIONS

- Continue to build capacity of community health promoters, especially as they may be first responders for survivors of SGBV
- Continue to support and empower service providers
- Link with empowerment and livelihood interventions in area for comprehensive approach

YEMEN: ENSURING ACCESS TO MATERNAL CARE IN FRAGILE STATES – THE VOUCHER PROGRAM

With funding from the
Federal Ministry for Economic Cooperation and Development
Yamaan
Together... for a better life

CONTEXT

- **Widespread conflict, food insecurity, cholera**
- **Population of 26.8 m with widespread displacement**
- **MMR of 385/100,000**
- **mCPR 29 % with 9 % LAPM**
- **TFR 4.4 and 5.1 in rural areas**
- **Only 34 % of women in rural areas give birth with the help of a skilled provider**
- **Only 23 % of rural women deliver at a health facility**
- **One quarter of those who did not deliver at a facility cited cost as a barrier and a further 24 % said the facility was too far away**

APPROACH

- Distribution of Safe Motherhood (SM) vouchers which enable access to essential SM services (including family planning) to vulnerable populations at pre-qualified facilities
- Facilities which meet quality standards including CEmONC& BEmONC and midwives can enroll as participating entities. Regular trainings and quality checks are conducted in the KfW supported project
- Accompanied by marketing campaigns and community engagement to support uptake

RESULTS

Vouchers Distributed vs Utilised
April 2013–April 2016

Estimated Impact on service uptake due to vouchers, Lahj 2014

Safe Motherhood services	Increase due to vouchers
ANC1	+ 31%
Up to ANC2 or ANC3 2	+ 24%
Skilled Births Attended	+ 17%
Institutional Delivery	+ 25%
PNC 2	+ 32%

PROBLEM

- Weak health system affected by conflict
- Cost barriers to accessing services
- Distance from facilities and inability to pay for transport
- Inconsistent access to quality contraceptive commodities
- A lack of trained providers

SOLUTION

- Increasing and catalysing uptake of specific health services to reduce maternal mortality amongst vulnerable and underserved populations
- Removal of financial and physical barriers to access including cost of services, transport, food and accommodation (including for a support person)
- Budgetary support for health facilities and the health system. Revenue must be invested in facility upgrade, staff incentives, District and Governorate supervision, support and monitoring

LESSONS LEARNED

- Quality standards are generally low, making site selection challenging
- Revenue generation helps support continuation of other essential (non-SRH) services and improves quality of facilities
- Continued voucher client verification is essential

FUTURE DIRECTIONS

- Expand project to more sites/ Governorates
- Ministry of Public Health and Population has recognized the voucher programme as a key strategy for maternal care in the Reproductive Health Strategy from 2016

KENYA: SRH FOR YOUNG ADOLESCENTS IN KILIFI

DSW Deutsche Stiftung Weltbevölkerung

youth car

CONTEXT

- **Kilifi has a youthful population with people below age 15 making up nearly half (47%) of the total population.**
- **About 1 in 4 (24%) are adolescents aged 10-19.**
- **In Kilifi, 22% of girls aged 15-19 have begun child bearing and 19% have given birth. At national level this is 14.7% and 3.4% respectively.**
- **Adolescent birth rate is 123 births per 1000 girls.**

PROBLEM

- Common held belief that adolescents under the age of 15 are “too young” to be in need of SRH information and services
- Pregnancy is still the major cause of school drop-out rates among girls in Kenya
- Lack of comprehensive under-standing of SRHR among teachers, parents and community
- It‘s a taboo to talk about sexuality to children and youth

SOLUTION

- Empower and educate young adolescents with age appropriate SRHR information
- Integrate projects into local structures
- Empower parents, teachers and community with SRHR information
- Document and share good practices for replication
- Create linkages between schools, health facilities and communities
- Integrate youth friendly teaching methodologies in schools

APPROACH

- Strengthening partnerships and networks at various levels
- Use of mentorship programmes in schools
- Establishing young adolescent health clubs in primary schools
- Capacity building of young adolescents, parents and teachers
- Use of edutainment to mobilise and engage young adolescents
- Development of adolescent friendly IEC materials
- Establish and strengthen community structures
- Support county government to domesticate and realise ASRH policies

RESULTS

- 7 out of 10 young adolescents openly discuss reproductive health topics with their teachers at school
- 9 out of 10 girls of school going age have access to sanitary towels
- Girls’ decision-making power in schools has doubled since the inception of the project in Kenya
- 7 out of 10 teachers now feel confident about discussing reproductive health
- 8 out of 10 of parents now openly discuss life and health choices with their children, including family planning
- 8 out of 10 community leaders are now fully trained on reproductive health topics and are actively involved in awareness creation
- Close to 60% of community health workers now fully engage in school outreach programmes

LESSONS LEARNED

- Mentorship programmes are key
- Community linkages enhances local ownership and sustainability
- Comprehensive and holistic approaches ensure impact
- Provision of SRH commodities reduces vulnerability
- Pooling of strengths through partnerships

FUTURE DIRECTIONS

- Support county governments to domesticate ASRH policies
- Promote strategic scale-ups
- Mainstreame gender into young adolescents’ interventions
- Integrate nutrition into young adolescents’ programmes
- Increase collaboration and partnerships

NEPAL: STRENGTHENING WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR) IN POST-DISASTER RESPONSE

CONTEXT

- **The earthquake that occurred in April 2015 hit Nepal's population severely in different ways**
- **Among the most affected populations were females and adolescents**
- **Women, girls and adolescents are particularly vulnerable and require special attention in regard of humanitarian assistance for the realisation of their sexual and reproductive health and rights (SRHR)**

Population Profile in Earthquake affected Districts (Figures in thousands)

District Category	No of Districts	Adolescent population (10-19 years)		Female population (15-44 years)	
		No	%	No	%
Highly affected	14	1285	20.2	1449	20.3
Moderately affected	17	1077	16.9	1259	17.6
Others	44	4005	62.9	4435	62.1
Total	75	6366	100	7144	100

Source: Government of Nepal, National Planning Commission. (2015). Nepal Earthquake 2015 post disaster need assessment sector report.

PROBLEM

- Disaster response teams unaware of women's SRHR specific needs
- SRHR supplies not included in the humanitarian response package; women & girls lack menstrual hygiene management (MHM) skills
- Most women unable to voice their concerns due to language barrier
- Limited safety for women & girls due to lack of privacy, toilets, lights and appropriate protection measures

SOLUTION

- Advocacy for gender sensitive disaster response, including for women's and girls' SRHR needs in crises
- Humanitarian assistance inclusive of kits for sexual and reproductive health
- Psycho social counselling as social component of disaster relief

APPROACH

- Humanitarian response packages containing a "dignity-kit" as a result of advocacy
- Enhancing SRHR education to women and girls
- Providing training on menstrual hygiene management, including practical skills, such as sanitary napkin making
- Women Friendly Space (WFS) operations

RESULTS

The special needs of women and girls in crises were addressed through targeted measures:

- A team for women-friendly disaster management was formed
- Women awakened and voiced through WFS
- Menstrual Hygiene Management skills enhanced
- Indicators on social inclusion and gender equality included in the post-disaster recovery framework

LESSONS LEARNED

- Timely, united and proactive advocacy is key
- Ensuring SRHR in disaster response and recovery is a herculean task
- Educate and train teachers and school management committee in MHM
- Engaging men and boys is essential
- Long-term investments needed

FUTURE DIRECTIONS

- Continue advocacy on SRHR education and services
- Unionise affected women and girls
- Align actions with Sustainable Development Goals
- Address social loafing and free riding tendency to engage communities

Note: This project was funded by Danish Family Planning Association, Global Fund for Women and UN Women in Nepal and BBC's own core fund.

AFRICA REGION: CREATING A POSITIVE POLICY ENVIRONMENT FOR ENHANCING SRHR FOR ADOLESCENT WOMEN AND GIRLS

IPPF International Planned Parenthood Federation
Africa Region

CONTEXT

- **Sub Saharan Africa has 1.033 billion people.**
- **10-19-year-olds account for 23%**
- **SSA has the second highest rate of child, early and forced marriage**
- **Unmet need for family planning among adolescent girls and young women is 60%**
- **HIV prevalence in female youth in 2009 was 3.4%, and FGM is prevalent in Africa, where over 3 million girls under the age of 18 across the continent are at risk of being circumcised**

PROBLEM

- Laws and policies supportive of SRHR are in place in African countries but there is reluctance to fully act on and implement these supportive policies for many reasons
- Increasing opposition to SRHR and CSE across Africa
- Africa's fragile and conflict prone environment exacerbates adolescent girls and young women SRH vulnerability,
- Limited possibility of political engagement in some countries
- SRHR seen as a secondary priority after basic health care
- CSOs working in isolation

SOLUTION

- Mobilize and amplify CSOs voices to dialogue with and hold governments accountable for development and implementation of supportive SRHR policies at global, regional and national levels

APPROACH

- Strengthening and reinvigorating the Reproductive Health Advocacy Network for Africa into a more vibrant CSO League
- Expanding membership base to include women-led and youth-led and focused groups, working on diverse SRHR issues including CSE, LGBTI, abortion
- Building CSO coalitions, identifying and training government allies and champions, using them to influence policy development and prioritization of SRHR issues in international and regional processes, treaties
- Supporting CSO participation in voluntary national reporting on SDGs and ICPD to ensure that SRHR issues are reflected in country report

RESULTS

- African CSOs under auspice of the Reproductive Health Advocacy Network for Africa (RHANA) were instrumental in contributing towards inclusion of SRHR express provision (Goals 3 and 5) in the UN Agenda 2030 and Sustainable Development Goals (SDGs); led the Maputo Plan of Action review 2016; ICPD Beyond 2014, the UN Agenda 2030 on sustainable development goals frameworks among others.
- New legislative changes such as review of the Marriage Act increasing age at marriage in Malawi.
- Increased support towards policy review and funding children and women's rights laws.
- Expanded and strengthened CSO League ready to engage at the UN, AU and RECs levels.

LESSONS LEARNED

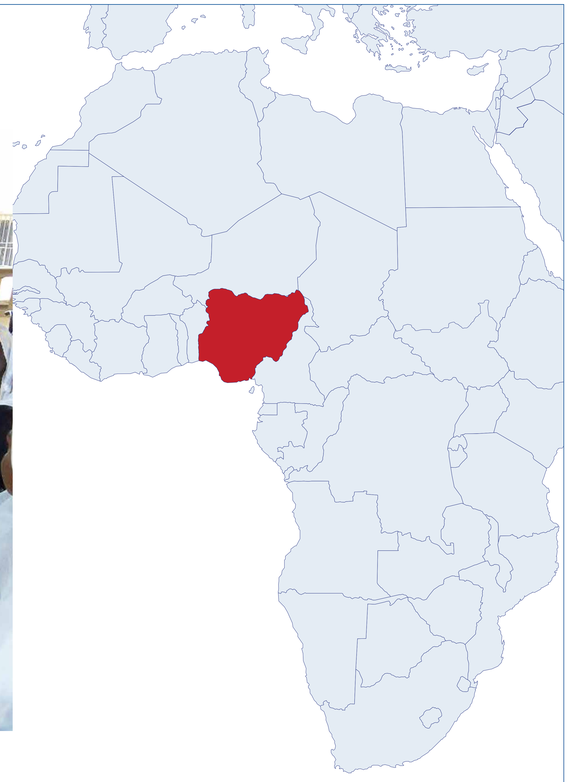
- Networking is proven successful approach in delivering policy, funding and institutional strengthening for SRHR in Africa
- Fragile political situation is a risk factor to adolescent girls and young women SRHR wellbeing, and obstacle to achieving SDGs 3 and 5 in Africa
- Development of an all-encompassing and long-term network strong enough to engage at all levels is a key response to opposition to SRHR

FUTURE DIRECTIONS

- Replicate the CSO League at the national level - create national networks to engage government for policy development and implementation
- Prioritise funding, and focus responses on women's rights and access to SRHR
- Develop and fully implement laws safeguarding adolescents and young women in crises and humanitarian settings address conflicts in Africa
- Formulate, review and adapt laws and policies that accelerate the implementation of SRHR for adolescents and young people
- Lobby governments to align marriage laws with the UNHRC in Benin, Chad, DRC, Mali, Niger, Zimbabwe, Burundi, Cameroon, Togo should align marriage law with the UNCRC

NIGERIA: PRELIMINARY FINDINGS – VIOLENCE AGAINST WOMEN/GIRLS WITH DISABILITIES

CONTEXT



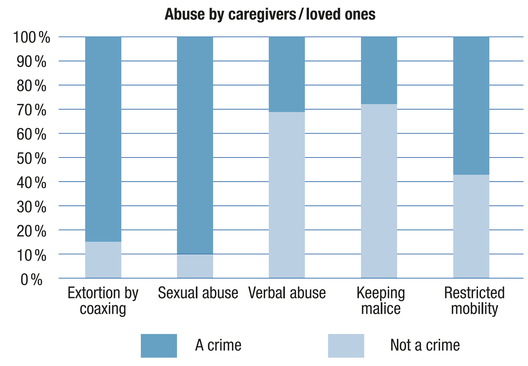
Women and girls with disabilities (WGWD) face discriminations on the basis of gender and disability. In Nigeria, studies indicate that girls with intellectual disability are 5 times more prone to sexual abuse than non-disabled girls. Persons with disabilities (PWD) are less knowledgeable about sexual and reproductive health (SRH), including HIV.

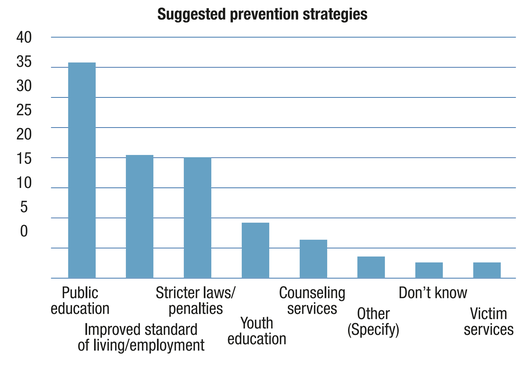
APPROACH

The study utlilised a mixed-method, comprising a knowledge, attitudes and practices (KAP) survey of 350 (186 males; 165 females) participants from the general population, 14 focus group discussions among WGWD and nine expert interviews. Expert interviews targeted those from legal, health, social and advocacy domains. Quantitative data were analysed using SAS 9.0, and descriptive statistics were generated. Qualitative data were content analysed.

RESULTS

Findings indicate that among the general population, 43.0% believe it is not a crime to dismantle a significant other's wheelchair to limit mobility and 11.4% think the police will not take serious cases reported by WGWD. Most of the WGWD will either report violence against them to traditional leaders or commit the perpetrators to God/Allah to address, rather than seek justice.





PROBLEM

Despite their higher vulnerability to violence than non-disabled peers, PWD are often excluded from programmes aimed at improving the quality of life of the general population. They face attitudinal, and environmental barriers in accessing health; social and criminal/justice services. Inclusive SRHR policies are non-existent in Nigeria.

SOLUTION

Disability Rights Advocacy Center, with support from CBM, conducted a baseline study on violence against WGWD in Nigeria. Findings will guide programmes for improved access to sexual and reproductive health and rights. These will also be used as advocacy tools for inclusive policies and services to address violence against WGWD.

LESSONS LEARNED

WGWD are less aware of what constitutes abuse and afraid of seeking justice. Interventions should target public education on disability rights/inclusion; stricter laws/penalties for committing acts of violence against WGWD and networking/ partnership.

FUTURE DIRECTIONS

- Strengthen capacities of disability actors and community gatekeepers
- Advocacy and engagement for SRHR policy reviews and implementation
- Improve public awareness on the insidious nature of violence against WGWD
- Raise awareness on rights of WGWD

ESTONIA: IMPLEMENTATION OF SEXUALITY EDUCATION AND YOUTH-FRIENDLY COUNSELLING SERVICES

EESTI SEKSUAALTERVISE LIIT

CONTEXT

The starting point in 1991

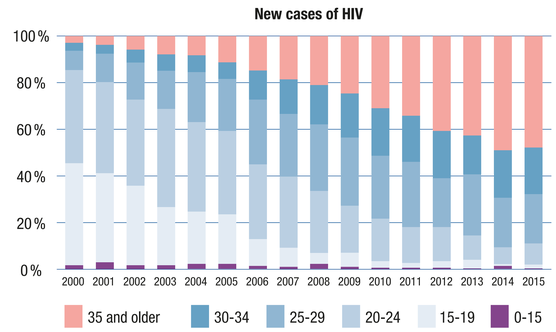
- **A new country struggling with poverty, high crime rate and political instability**
- **Very high (>50.0) teenage pregnancy and abortion rate**
- **High syphilis, gonorrhoea and chlamydia rate**
- **No sexuality education in schools (previously, 'personal hygiene' and 'family studies')**
- **No SRHR services for young people**
- **Sexuality – a taboo and a medicalized issue**
- **Prejudice towards hormonal contraception**

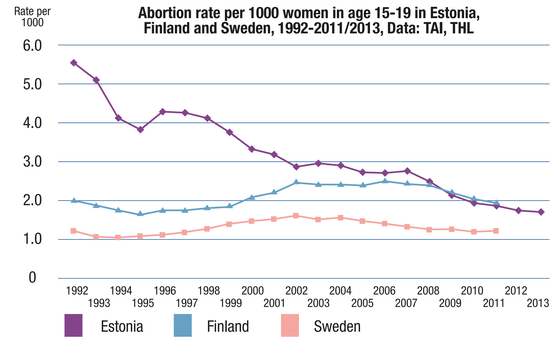
APPROACH

- Creating a network of youth-friendly clinics with shared values and quality standards and ongoing training of staff
- Estonian Sexual Health Association provided the clinics with supplies, training and supervision
- In 2017 a total of 16 clinics
- Services free of charge regardless of health insurance status
- 1996 – mandatory subject "Human Studies" introduced to the school curricula
- Sexuality education in youth counselling centres strengthens school-based sexuality education and promotes youth-friendly services
- Internet-based counselling www.amor.ee started in 1998, currently 4000 letters answered every year

RESULTS

- Free youth-friendly services
- 16 clinics across the country
- Mandatory school-based sexuality education
- Abortion rates plummet
- STD rates drop





PROBLEM

- Concerns about high teenage pregnancy rates and rising STD incidence
- Access to sexuality education was lacking
- Judgemental attitudes towards young people's sexuality among professionals and society
- Long abortion traditions
- Prejudice towards hormonal contraception
- Contraceptives available, but not affordable

SOLUTION

- Change in attitudes
- Reliable data about teenage pregnancies, STDs, HIV epidemic
- School curriculum has to fill the void
- School-based SE is important
  ↓
- Political will and decisions
  ↓
- 1 + 1 = 3
- Youth-friendly counselling centers for young people of both sexes up to the age of 25
  - Free of charge
  - 'Youth-friendly' principles +
  - Sexuality education

LESSONS LEARNED

- School-based sexuality education in combination with youth-friendly services bring maximum improvement in youth SRH
- Minority groups and high-risk regions need to be covered for best results
- Funding has to be sustainable, yet diverse

FUTURE DIRECTIONS

- Pay it forward – developmental aid
- Continuing & improving services when "everything seems great"
- Responding to the changing needs of the target group
- Steady funding remains a challenge
- Changing political climate as a lurking threat to SRHR