Knowledge Brief

Health, Nutrition and Population Global Practice

ADDRESSING THE SEXUAL AND REPRODUCTIVE HEALTH RIGHTS OF YOUNG PEOPLE: INTRODUCING A HUMAN RIGHTS-BASED APPROACH

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KEY MESSAGES:

- Adolescents and youth encounter many barriers to seeking health services. These include a lack of available confidential adolescent-responsive services, fear of being subjected to discriminatory behavior from health providers, needing permission from parents or guardians to seek services, the cost of health services, and encountering poor quality health services, among others. These barriers, which are often driven or exacerbated by restrictive policies and legislation, as well as conservative social and cultural norms, keep many from seeking health services, leading to low health service coverage rates and ultimately poorer health outcomes.

- Promoting a human rights-based approach (HRBA) to young people’s sexual and reproductive health (SRH) aligns with the 2030 Sustainable Development Agenda.

- Using a HRBA demands that we find more effective ways to move out of thematic silos and focus on intersectoral interventions that address the multiple determinants of health.

Introduction

There are currently 1.8 billion young people (ages 10–24 years), representing 24.5 percent of the world’s population. Today's generation of young people is the largest cohort in history, with their share expected to increase through 2065 (UNDESA, 2015). Now more than ever, young people have access to greater opportunities due to technology, education, globalization, and improved health systems. What’s more is that many countries are currently experiencing – or expected to experience – a demographic dividend in which fertility decline and socioeconomic growth leads to accelerated economic development and poverty reduction.

Yet in order for young people to take advantage of these opportunities, substantial investments in the human capital of adolescents and youth need to be made, through innovative thinking and by ensuring young people’s participation in decisions that impact them. Young people have been – until recently – neglected on the political and public health agenda. In fact, improvements made over the past decade in child health and survival have not translated into healthy development during adolescence and young adulthood. For example, the leading causes of death in this age group at the global level – road injuries, self-harm, violence, and tuberculosis – have declined only slightly between 1990 and 2013. At the same time, adolescent pregnancy, HIV, mental health disorders, and maternal mortality have increased within countries. Indeed, two thirds of young people live in environments in which they are exposed on a daily basis to preventable and treatable health problems, such as HIV/AIDS, early pregnancy, malnutrition, and depression. Meanwhile, lifestyle risk factors like smoking and drinking, unsafe sex, violence, and physical inactivity begin to emerge during this stage of life, influencing not only their risk of disease in later life but also the health and opportunities for future generations (Mokdad et al, 2016).

Young people far too often encounter barriers to seeking health services, whether it be a lack of available confidential adolescent-responsive services; fear of being subjected to discriminatory behavior from health providers; needing permission from parents or guardians to seek such services; the cost of health services; and/or encountering poor quality health services. In comparison to other age groups, young people have the poorest health care coverage, receive limited resources, and are one of the most vulnerable populations (Walker, 2011). These barriers, which are often driven or exacerbated by restrictive policies and legislation, as well as conservative social and cultural norms, keep many from seeking health services, leading to low health service coverage rates and ultimately poorer health outcomes.
services, leading to low health service coverage rates and ultimately poorer health outcomes (WHO, 2014a).

Evidence demonstrates that respecting, protecting, and fulfilling the sexual and reproductive health rights (SRHR) of young people contributes to improved health outcomes, including for the most vulnerable and marginalized. When young people can exercise their rights, they are better able to protect against sexually transmitted infections (STIs) and unplanned pregnancies, and take advantage of educational and employment opportunities, both of which lead to improved productivity, reduced healthcare costs, and greater economic growth (WHO, 2014a). Furthermore, promoting a HRBA to young people’s sexual and reproductive health (SRH) aligns with the 2030 Sustainable Development Agenda and the achievement of universal health coverage (UHC) – key priorities for the World Bank Group (WBG).

The objective of this Brief is to provide an overview of operationalizing a HRBA in WBG adolescent and youth SRH service delivery projects for task team leaders (TTLs). Please refer to the forthcoming Adolescent and Youth Health Guidance Note for further information and details.

Basics of a Human Rights-Based Approach

A HBRA is a conceptual framework shaped by international human rights laws, norms and standards and operationally focused on respecting, protecting and fulfilling human rights (UNICEF, 2012b; Harvard FXB Center, 2013) while addressing common development challenges such as health. There are four essential and interrelated elements to respect, protect and fulfill the right to health, referred to as the 3AQ (CESCR, 2000):

- **Availability.** Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the country.
- **Accessibility.** Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the country.
- **Acceptability.** All health facilities, goods and services must be respectful of medical ethics and culturally appropriate.
- **Quality.** As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality.

The human rights principles of participation, non-discrimination, and accountability are also critical to a HRBA, as well as for good governance of social sector investments.

Using a Human Rights-Based Approach

Using a HRBA to health requires applying the human rights principles and elements identified above throughout the WBG project cycle. This entails an analysis not only of project outcomes and impacts, but also the processes by which they reach those outcomes and impacts, including how they engage relevant stakeholders, conduct situational analyses, articulate project priorities, design project components, identify monitoring and evaluation (M&E) priorities and indicators, and execute projects. Finally, a HRBA requires active stakeholder participation, as well as capacity development activities for all stakeholders, both duty-bearers (those who have obligations to respect, protect and fulfil rights) and rights-holders (those who have the right to exercise rights, formulate claims, and seek redress for rights violations), to ensure that their participation is meaningful. A HRBA views the project cycle in four phases, as explained below (UNFPA, 2010):

1. **Situational Analysis.** Conducting a situational analysis requires identifying relevant rights-holders and duty-bearers, and ensuring their active participation throughout the project cycle. For young people, rights-holders could be those living on the street, substance users, younger adolescents, adolescent mothers, those who are geographically isolated, among others. Duty-bearers include relevant ministries, local governments, NGOs, civic, education and/or faith leaders, parents, or other groups or individuals playing a leadership or service delivery role in the project. A situational analysis also seeks to identify broad civil, cultural, economic, political and social dynamics within a country that in turn help to identify the main development and human rights challenges and the causes of those challenges. This requires collecting and analyzing high quality population data and identifying the immediate, underlying, and root/structural causes of the health problem. Particular attention should be paid to gathering data disaggregated by age, sex, ethnicity, religion, sexual orientation, geographic area, income, and education level, among others. Both quantitative and qualitative data should be identified; the absence of data for particular populations will highlight needs for additional data collection. Key questions that TTLs might ask themselves during this phase include, for example:
   a. What can we learn from the availability, accessibility, acceptability, and quality of current health projects for rural, out-of-school girls designed and implemented by the WBG and others?
   b. Who are the most marginalized girls our project seeks to serve?
   c. How are we going to share results of the situational analysis with the public?

2. **Program Planning and Design.** This phase of the project involves engaging in dialogue and ensuring broad-based engagement. It requires ensuring that project inputs and processes, outputs, outcomes and impacts are rights-based. Developing HRBA indicators includes identifying existing health indicators that can be used or somewhat modified to measure both health and human rights issues. It may require designing new
indic平者，both quantitative and qualitative，that
answer questions that cannot be answered by existing
indicators. Indicators should be identified and
monitored in a participatory manner that allow
stakeholders，including young people，to provide input
and track progress. Indicators are required not only to
measure outcomes and impacts，but also processes
and outputs in every step of the project. In addition，
triangulation across different data sources may
strengthen the power of data and maximize the use of
existing data without overburdening M&E systems with
new indicators (Gruskin and Ferguson，2009). Key
questions that TTLs might ask themselves during this
phase include，though are not limited to:

a. Do our proposed outcomes allow us to
measure changes in rural，out-of-school girls’
ability to exercise their right to health?

b. In the course of our community engagement，
have we clearly communicated our program
goals，roles，and responsibilities to community
members，including young people？

**Box 2. Examples of Key Existing Sexual and Reproductive
Health-related Indicators**

These indicators should be disaggregated by gender and age
group，with other forms of disaggregation applied as appropriate
at the subnational level.

**Inputs**

- Total current expenditure on health
- Total out-of-pocket expenditures on health

**Outputs**

- Service utilization among young people (10-24 years)
- Institutional adolescent (10-14 and 15-19 years) maternal
  mortality ratio
- Antiretroviral Therapy (ART) retention rate among
  adolescents (10-14 and 15-19 years) and youth (20-24
  years)

**Outcomes**

- Demand for family planning satisfied with modern methods
  among female adolescents (15-19 years) and young women
  (20-24 years)
- Antenatal care coverage among female adolescents (15-19
  years) and young women (20-24 years)
- Postnatal care coverage among female adolescents (15-19
  years) and young women (20-24 years)

**Impacts**

- Adolescent (15-19 years) fertility rate
- HIV incidence rate among adolescents (10-14，15-19 years)
  and youth (20-24 years)
- Sexually transmitted infection (STI) incidence rate among
  adolescents (10-14，15-19 years) and youth (20-24 years)

**Source:** World Health Organization. 2015. Global Reference List of 100
Core Health Indicators，Geneva，WHO.

3. Project Implementation. A HRBA requires continuous
capacity building of rights-holders and duty-bearers
while executing activities. Such capacity building
during this phase may include training on human rights，
how to collect and analyze data，public speaking and
advocacy，and developing strategies to build stronger
relationships with communities and policy makers.
Efforts should be made to ensure that such capacity
building is available，accessible，acceptable and of
high quality，and steps should be taken to encourage
high levels of participation among stakeholders，most
especially young people. Similarly，it is important to
identify power inequalities within the implementation
phase that leave some stakeholders with a greater
ability than others to access information，influence
decisions and benefit from programming.

Implementation roles and responsibilities should be
clearly articulated to all parties and，together with
records of how decisions are made，should be made
accessible to the public to increase accountability and
transparency. Finally，3AQ should be the lens through
which all implementation activities are executed. Key
questions that TTLs might ask themselves during this
phase include，though are not limited to:

a. Are project activities readily available to rural，
out-of-school girls identified for the project，
regardless of age，culture，gender identity，and
residence？

b. Are capacity building activities well attended
by a diverse set of rights-holders and duty-
bearers？

c. How will 3AQ of the project be objectively
measured？

d. How will rights-holders’ perceptions of the 3AQ
be measured？

4. Monitoring and Evaluation. In a HRBA，M&E teams
should involve a diverse set of stakeholders，including
both rights-holders and duty-bearers，who have the
capacity（knowledge，skills，time and support）to
participate in a meaningful way. Critical questions to
answer in the M&E phase include，though are not
limited to:

a. How will project contributions to rights-holders’
and duty-bearers’ increased capacity to
improve health be assessed？

b. How will 3AQ of the project be objectively
measured？

c. How will rights-holders’ and duty-bearers’
perceptions of the 3AQ of the project be
measured？

d. How will rights-holders’ perceptions of being
heard and engaged be assessed？

**APPLYING A HUMAN RIGHTS-BASED APPROACH:
JUSTIFICATIONS AND LIMITATIONS**

There are several reasons why TTLs should apply a
HRBA to young people’s SRH service delivery:

- A HRBA is based on international law and legal
obligations，and draws attention to national law and
policy as critical enablers of，or barriers to，the right to
health.

- A HRBA draws attention to the importance of an
intersectoral approach to address health challenges，
especially for vulnerable populations.

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• The HRBA principle of participation changes passive beneficiaries into rights-holders.
• A HRBA develops clear accountability mechanisms improving social sector governance.
• A HRBA focuses attention on the most vulnerable and marginalized, and those most likely to face discrimination.
• A HRBA may produce more sustainable outcomes.
• A HRBA may impact economic outcomes.
• A HRBA has meaningful synergies with universal health coverage (UHC) goals and the Sustainable Development Goals (SDGs).

While many countries now integrate human rights language and obligations into their laws and policies, and while the value of a HRBA is increasingly understood by States, donors and others, challenges of implementing and evaluating the results of a HRBA remain. These include: cultural concerns; state concerns; definitional challenges; lack of adequate economic data explicitly supporting a HRBA; and UHC and HRBA may not fully align.

GOOD PRACTICES

While there are many examples of using a HRBA to shape laws and policies, the literature on applying a HRBA specifically to SRH service delivery for young people is limited (Bustreo et al, 2013; OECD, 2013; WHO, 2014b; Gruskin et al, 2007). Below are a few examples of good practices that involve respecting, protecting, and fulfilling the SRHR of reproductive-aged women and young people:

• ‘Stronger Voices for Reproductive Health’ was a project in Geita District of United Republic of Tanzania that aimed to build capacity of women to be informed and empowered users of SRH services. The project implemented a series of seven capacity-building workshops for women on SRHR. During the project period of about five years, the proportion of service providers who were aware of clients’ rights to privacy increased from 22 per cent to 80 per cent. The proportion of women engaging in discussions with health-care providers to improve quality of care increased from 3 per cent to 20 percent during the project period (WHO, 2014b).

• Since 2008, with the support of UNFPA, the Colombia Ministry of Education has been implementing a program aimed at delivering quality education to support sustainable development and foster citizenship capacities of young people. Colombia’s comprehensive sexuality education program to promote rights, gender, citizenship and critical thinking has expanded from 71 to 94 education departments and is now transversal, continuous, and taking place both inside and outside the formal educational system. Through Law 1620 (2013), a National System of School Coexistence was created to ensure inclusion in the education system of training in human rights, sexuality education, and the prevention and mitigation of school based violence. (UNFPA, 2010)

• Link Up (2013-2016) has improved the SRHR of almost 940,000 10-24 year olds most affected by HIV in Bangladesh, Burundi, Ethiopia, Myanmar and Uganda. The project has enabled young people to make healthier choices regarding their sexuality, and to advocate for their sexual and reproductive health and rights. This has contributed to a reduction of unintended pregnancies, HIV transmission and HIV-related maternal mortality amongst young people affected by HIV (Ross and Santelli, 2017).

Conclusions

A HRBA to health should be used throughout the program cycle, from inception through final evaluation and reporting; it focuses not only on outcomes and impacts but the processes by which those outcomes and impacts are achieved (UNICEF, 2012b). A HRBA to health also focuses on identifying and then developing the capacity of, duty-bearers, to help remove barriers and help them meet their obligations to respect, protect, and fulfil rights. Similarly, it focuses on identifying and then developing the capacity of, rights-holders, to help them claim their rights. Capacities include skills, abilities, resources, responsibilities, authority, and motivation. The use of a HRBA will demand that we find more effective ways to move out of thematic silos and focus on intersectoral interventions that address the multiple determinants of health (WHO, 2014a). With all that we know, it is clear that achieving true improvements in SRH service delivery for young people is going to require longer-term efforts, smarter efforts and more intersectoral efforts, focused on, and meaningfully engaging, those most in need.