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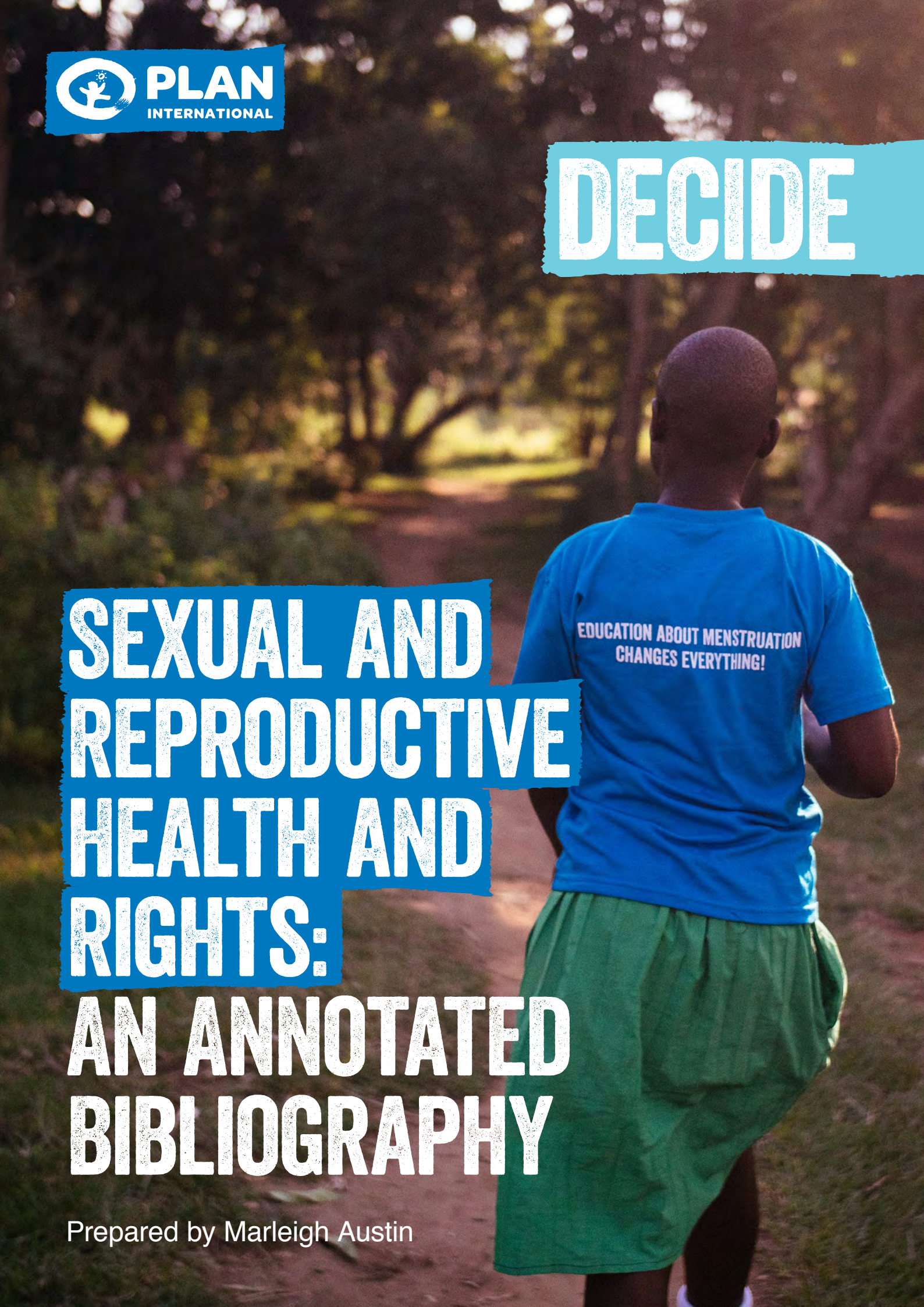

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: AN ANNOTATED BIBLIOGRAPHY

Prepared by Marleigh Austin

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ACRONYMS

ABYM – Adolescent Boys and Young Men

AGYW – Adolescent Girls and Youth Women

AIDS – Acquired Immunodeficiency Syndrome

ASRHR – Adolescent Sexual and Reproductive Health and Rights

CSE – Comprehensive Sexuality Education

FGM – Female Genital Mutilation

GBV – Gender-Based Violence

HIV – Human Immunodeficiency Virus

LGBTQ – Lesbian, Gay, Bisexual, Transgender, Queer

LMICs – Low- and Middle-Income Countries

Mhealth – mobile health

PND – Post-Natal Depression

SRHR – Sexual and Reproductive Health and Rights

STI – Sexually Transmitted Infection

WHO – World Health Organization

EXECUTIVE SUMMARY

This annotated bibliography seeks to explore the evidence from peer-reviewed and grey literature around the sexual and reproductive health and rights (SRHR) of children, adolescents and young people in low- and middle-income countries (LMICs), with particular emphasis given to research published within the last decade. Within this broad topic, it is restricted to identifying what works – and what does not – in SRHR programming alongside key knowledge gaps, as guided by the following research questions:

Improving quality and relevance SRHR service provision:

1. What is known about effective models to improve quality and relevance of existing SRHR service provision for children, in particular teenage mothers?
2. What is known about social accountability models for improving service delivery for children?

Improving the quality and effectiveness of comprehensive sexuality education (CSE):

3. What is known about effective models of CSE design and delivery?

Changing social norms to enable access to SRHR and combat harmful practices:

4. What evidence is there of social norm programmes improving access to and quality of SRHR services for women and girls; and, reducing harmful practices such as child marriage and female genital mutilation (FGM)?
5. What works to prevent sexual and gender-based violence against children?

To identify relevant literature, a preliminary search was conducted of global health databases, including IBSS, PubMed, CABI and Google Scholar. Additional research was identified through a general online search, examining websites of organisations known for their involvement in children's SRHR and, when necessary, following up with relevant staff over email for further documentation. Articles were included if they made a distinct and valuable contribution to answering the research questions listed above. Consequently, this bibliography does not present an exhaustive summary of the evidence compiled on the above-mentioned research topics, but rather, gives priority to presenting the findings from seminal and synthesis pieces. In total, 43 articles were selected for inclusion. They are presented in alphabetical, then reverse chronological order, within their respective topic areas. Of note is that SRHR-related social norms are addressed throughout the annotated bibliography, but also given specific focus when exploring interventions to reduce harmful traditional practices.

Summary of Findings

Improving the Quality and Relevance of SRHR Service Provision for Children, Adolescents and Young People

The literature indicates that service provision stands to benefit from approaches combining service provider trainings with broad information dissemination and adolescent-friendly facility improvements, such as flexible operating hours and affordable – ideally free – access to services. Overall, there is a need to emphasise primary prevention, integrated approaches and decentralised service delivery.

The evidence also speaks to what does not work. Youth centres and high-profile meetings on ASRHR are two popular approaches that have been shown to be ineffective. Going forward, these approaches should be avoided.

Specific to reproductive health, young people need greater contraceptive choice, including access to long-acting reversible contraceptives. What's more, programming often overlooks the fact that many adolescent births are in fact intended, with the gross majority of these births occurring within the context of marriage. Reaching this particularly vulnerable group of young, married females with systematic support to avoid early and frequent childbearing is a critical priority.

The evidence base also makes clear that, both in research and in programming, there are issues and populations that are consistently overlooked. Few resources are directed towards understanding and addressing the unique vulnerabilities of very young adolescents (aged 10-14), adolescents living with HIV, street youth, adolescents with disabilities (physical, cognitive, intellectual, etc.), refugee and internally displaced youth, young people in prisons or other closed settings, LGBTQ youth, married girls, unmarried sexually active girls, adolescent boys and young men, adolescents who are engaged in sex work and young people who inject drugs. Failing to reach these groups will only serve to deepen their social exclusion, further compromising their health and wellbeing.

Researchers are also urged to explore novel and unconventional approaches to allow for anonymous methods of data collection around sensitive SRHR topics, such as sexual activity, pregnancy and abortion. Moreover, given the paucity of evidence available on the topic, there is a need to rigorously evaluate youth-led processes for social accountability in SRHR programming.

Technology has introduced new opportunities – but also challenges. Research on the factors that shape gender attitudes in early adolescence indicate that 'sexting' – the sending of sexually explicit messages or pictures via SMS – is an important strategy for boys and girls to execute the stereotypical sexual scripts of dominance and submission. Online pornography is also emerging as key channel through which young people learn about sex, a fact that is concerning as they often lack the skills to critically examine such content. On the other hand, social media is surfacing as an important platform for young people to explore non-dominant gender identities. There is also promising evidence on the potential of mobile health, or mhealth, strategies to improve service delivery. Going forward, research is needed to elucidate the best strategies for harnessing the positive power of technology while mitigating against its more harmful aspects.

Comprehensive Sexuality Education (CSE)

This bibliography further reveals that there is strong evidence that CSE improves attitudes related to SRHR and contributes to delayed initiation of sexual intercourse, decreased frequency of sexual intercourse, increased use of condoms and contraception, decreased number of sexual partners and reduced risk taking. However, there is still insufficient evidence to draw conclusions as to the impact of CSE on biological outcomes.

Notably, evidence from across the globe suggests that young people rarely receive *comprehensive* sexuality education as key information about reproduction, sexually transmitted infections, abortion, sexual diversity, services and condoms is often excluded from curricula. As well, sexuality education often fails to pay enough attention to empowering young people, building agency and teaching advocacy skills. Going forward, it is critical that young people are reached with evidence-based CSE programmes, delivered with strict fidelity to the original intervention design. For school-based programme, CSE can be delivered as either a stand-alone subject, or integrated throughout other topics. However, to maximise its effectiveness, CSE should be mandatory.

Research also reveals that the benefits of CSE are bolstered when gender and rights are integrated throughout the content, and when CSE is delivered in conjunction with expanded access to youth-friendly SRHR services, including condom distribution. There is also strong support for multi-component interventions that involve parents. For future programming, school-based CSE programmes must strengthen the ability of teachers to foster the critical thinking necessary for students to question prevailing norms of power, privilege and gender. Ideally, peer education models should be avoided as they demonstrate limited ability to promote healthy behaviour or improve health outcomes among young people. However, where this cannot be avoided, programmers must ensure peer educators receive adequate supervision – something that is especially critical when they are dealing with controversial topics or feel threatened by community members.

Interventions to Reduce Child Marriage

With respect to child marriage, the bibliography finds that programming is dominated by five strategies: first, the empowerment of girls with information, skills and support networks; second, the education and mobilisation of parents and community members; third, enhanced accessibility of formal schooling for girls; fourth, the provision of economic support and incentives for girls and their families; fifth, the fostering of an enabling legal and policy environment.

The strongest, most consistent evidence comes from programmes that employ the empowerment approach, nurturing information, skills and networks for girls. Legal and policy reforms are seen as necessary for large-scale change but insufficient in the absence of other efforts, while community engagement is understood as essential for sustaining impact beyond the life of the intervention. The most rigorously evaluated interventions find little support for economic strategies, and indicate that there is ambiguity regarding the effectiveness of community and schooling approaches. However, in reviews with less stringent inclusion criteria and lower standards for measuring effectiveness, there is support for all five strategies for ending child marriage. Evidently, the knowledge base on child marriage remains in its early stages and stands to benefit more high-quality research. Another critical priority for research is to understand how to support child brides, as they are a sub-group that is consistently neglected.

The Evidence Base on Reducing Female Genital Mutilation

In terms of FGM, rates remain stubbornly high; of the 29 countries where national data is available, the practice appears to be declining in only 14 with the remaining 15 showing no progress. Notably, there is a dearth of high-quality evidence on what works to end FGM, a factor that likely contributes to the persistent popularity of the practice. Research does confirm, though, that there are strong social motivations underlying FGM. Where it is practiced, most people believe it ensures membership in the community, and critically, opportunities to publicly discuss this and other motivations – be they religious, cultural or social – are rare. Successful interventions, such as intergenerational or community dialogues, have transformed social norms by bringing these issues out of the private sphere and into the public arena.

There is also evidence to support the use of alternative rites of passage for achieving abandonment, wherein a traditional rite is replaced with an alternative practice that maintains the essential components of passage into womanhood but without the cutting. As well, medical personnel, when educated on the practice from a human rights and public health perspective, can be valuable allies in achieving abandonment. Legal and policy measures, when preceded and complemented by community mobilisation, are also critical for creating an enabling environment for achieving abandonment.

In addition to expanding the evidence base on what works, future research must elucidate the decision-making processes involved in FGM, and how social, economic and political factors directly and indirectly affect the risk of FGM.

Preventing Sexual and Gender-Based Violence

For Sexual and Gender-Based Violence, the evidence indicates that effective prevention interventions are founded on five core principles: first, they intervene across the social ecology, (individual, interpersonal, community and societal levels); second, they address the key driver of violence – unequal gender-power relations; third, they are informed by theories of change; fourth, they utilise coordinated, sustained, multi-sectoral investment; and fifth, they employ aspirational programming that offers individuals a vision of a positive, equitable relationship and the benefits of such a relationship for all family members. Of concern, though, is that violence prevention remains under-prioritised; government planning and policy-making in this area is neither commensurate with the burden nor evidence-based. As well, despite the fact that the different forms of violence have common risk factors, few countries adopt an integrated approach for concurrently addressing multiple types of violence, and few seek to address key socio-economic or political drivers.

Overall, the evidence base indicates that important progress is being made in improving the SRHR of young people but, critically, significant gaps remain, both in the knowledge base and in the topics and populations that are addressed. Turning attention to these forgotten topics and populations is vital so that, going forward, children, adolescents and young people – in all their diversity – are able to lead healthy lives and realise their human rights in their entirety.

RECOMMENDATIONS BASED ON THE LITERATURE CONSIDERING SRHR

Programmatic Recommendations

General Recommendations:

- Reach the following populations with information, support and services: very young adolescents (aged 10-14); adolescents living with HIV; street youth, adolescents with disabilities (physical, cognitive, intellectual, etc.); refugee and internally displaced youth; adolescents who engage in sex work; young people who inject drugs; young people in prisons or other closed settings; LGBTQ youth; married girls; unmarried sexually active girls; child brides; and adolescent boys and young men. Henceforth, these populations will be referred to as under-served, vulnerable/or and marginalised young people;
- Avoid investing in interventions proven to be ineffective, including high-profile meetings on ASRHR, youth centres and peer education. Similarly, avoid low-dose interventions that are not sustained across time;
- Implement programmes that are theory-driven, multi-sectoral and that simultaneously work across individual, interpersonal, community and societal levels of influence;
- Leverage the power of mobile and online platforms to improve service delivery and reach young people with SRHR information;
- Remove legal and policy barriers that limit young people's agency around their own health.

Recommendations Related to Addressing Harmful Traditional Practices:

- Mitigate the harmful impacts of early marriage by reaching married girls with systematic support to help them prevent early and frequent childbearing;
- When implementing interventions for the elimination of child marriage, maintain a key focus on girls' empowerment;
- Bring attitudes about FGM out of the private sphere and into the public domain by creating opportunities for critical reflection on harmful practices across generations and cultures;
- Maintain a focus on the key driver of violence – unequal power relations – in violence prevention interventions.

Recommendations Specific to Improving CSE:

- Within school-based CSE programmes, strengthen the ability of teachers to foster the critical thinking necessary for students to question prevailing norms of power, privilege and gender;
- Equip young people with the skills to think critically about the role mobile and online platforms, including pornography, play in shaping their understanding of their bodies, gender norms and sexual scripts;
- Maximise the impact of CSE, both in school and community-based programmes, by emphasising gender and rights throughout the curriculum and expanding access to youth-friendly SRHR services.

Research Recommendations

Compile Evidence on:

- The sexual and reproductive health and socio-economic vulnerabilities of under-served, vulnerable and/or marginalised young people.
- What works to address the SRHR needs of under-served, vulnerable and/or marginalised young people;
- The interplay between social, cultural and economic factors and sexual and reproductive health and rights, especially in relation to adolescent pregnancy, FGM and child marriage. This includes, but is not limited to, interrogating the extent to which these SRHR issues are impacted by structural factors such as urbanisation, migration, labour market fluctuations, food security, climate change and conflict;
- The long-term social and economic costs of child marriage, as well as the health consequences beyond maternal and perinatal considerations;
- The needs of separated, divorced or widowed girls;
- The nature and scale of child brides' access to health and social services. There is also a need for evidence to inform the development of equitable relationships between married girls and their older husbands;
- What young people learn about sexual identify, orientation and same-sex behaviours;
- The social norms that contribute to contraceptive behaviours, as well as adolescents' pregnancy and childbearing intentions. This includes exploring decision-making by women who are not using contraception but who want to avoid pregnancies;
- Youth-led social accountability interventions for improved SRHR;
- The protective factors that impede harmful traditional practices including FGM and child marriage;
- Information to inform the scale-up of SRHR interventions, including cost and cost-effectiveness evidence.

As well:

- Explore novel and unconventional approaches to collecting data on sensitive SRHR topics, including sexual activity, pregnancy and abortion, both safe and unsafe, including audio-computer assisted self-interviews or confidential response sheets for specific questions.

IMPROVING THE QUALITY AND RELEVANCE OF SRHR SERVICE PROVISION FOR CHILDREN, ADOLESCENTS AND YOUNG PEOPLE

Chandra-Mouli, V., Chatterjee, S. and Bose, K. 2015. "Do efforts to standardize, assess and improve the quality of health service provision to adolescents by government-run health services in low and middle income countries, lead to improvements in service-quality and service-utilization by adolescents?" *Reproductive Health*, 13(10).

In this paper, Chandra-Mouli et al explore whether government targets for improving the youth-friendliness of health services – as defined by the World Health Organization (WHO) along the five dimensions of accessibility, acceptability, equity, appropriateness and effectiveness – in 8 LMICs[1] have yielded improvements in the quality of health service provision to adolescents and finally, whether said improvements resulted in increased service uptake by adolescents.

Their findings indicate that governments in the selected countries committed to improving the accessibility, acceptability and effectiveness of health, and, encouragingly these efforts resulted in observable improvements to the quality of health service provision in all eight countries, with seven countries reporting associated increases in service uptake by young people. Notably, the findings did not shed light on whether such efforts had gendered impacts. Of concern, though, is that efforts to address the dimensions of appropriateness and equity were insufficient across the board.

Chandra-Mouli, V., Lane, C. and Wong, S. 2015. "What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices." *Global Health: Science and Practice* 3(3): 333-340.

In this review, Chandra-Mouli, Lane and Wong draw attention to five common failings in adolescent SRHR (ASRHR) programming that significantly constrain the ability of interventions to demonstrate positive results. First, many adolescents, especially the most marginalised or vulnerable, are not being reached. There is very little dedicated outreach for subgroups most at risk, the result being that interventions tend to reach the more advantaged (i.e. older and unmarried adolescents) at greater rates. Second, popular interventions including youth centres, peer education and high-profile meetings on ASRHR continue to be popular, despite evidence of their ineffectiveness. For example, peer education mainly benefits the peer educators – who are the recipients of specialised training and supervision – but demonstrates limited ability to promote healthy behaviour or improve health outcomes. Likewise, once-off, high-profile public meetings to inform communities about harmful SRHR practices have shown little impact. Their use remains widespread, though, as they are highly visible and easy to organise. Third, evidence-based interventions are delivered with inadequate fidelity. For example, CSE should align with UNESCO's technical guidance, which identified 18 characteristics of quality programming. Yet, evidence from across the globe suggests that sexuality education often lacks key information about reproduction, sexually transmitted infections, abortion, services and condoms, and fails to pay enough attention to empowering young people, building agency and teaching advocacy skills. What's more, teachers lack the skills to adequately deliver the content. Fourth, interventions are delivered in piecemeal fashion. For example, laws are reformed in the absence of targeted community engagement – an action that sometimes serves to drive the behaviour, such as child marriage, underground. Fifth, interventions are delivered in low dosage and are not sustained. While guidance is lacking on the exact optimal intensity or duration for interventions, the evidence is clear that those that are not sustained across time do not bring about long-term change at the community level.

1 The countries included in the study are Bangladesh, India, Indonesia, Malawi, Moldova, Mongolia, Tanzania and Ukraine.

Darroch, J., Singh, S., Woog, V. , Bankole, A., and Ashford, L. 2016. *Research Gaps in Adolescent Sexual and Reproductive Health*. New York: Guttmacher Institute.

This review outlines the major data and research gaps in ASRHR. For one, specific sub-populations are consistently excluded from surveys, including street youth, refugees, male adolescents, young adolescents and young people in China. Similarly, unmarried/never-married women in Asia, northern Africa and some francophone countries in Sub-Saharan Africa are either excluded from fertility and health surveys, or included but not asked questions related to their SRHR. Additionally, underreporting remains a significant challenge for stigmatised and illegal behaviours, including early and premarital sex, as well as induced abortion. Research must also shed light on the interplay between social, cultural and economic factors. For example, evidence is needed to disentangle the relative contribution of age and socio-economic status to poor health outcomes faced by young mothers, and the long-term economic impacts of adolescent childbearing. Moreover, in light of the fact that the most interventions to reduce early-pregnancy overlook the fact that many adolescent births are in fact intended, research is needed to understand the social norms that contribute to adolescents' pregnancy and childbearing intentions. As well, ascertaining what young people learn about sexual identity, orientation and same-sex behaviours remains an underexplored area. There is also a dearth of information on the cost-effectiveness of a range of SRHR interventions. Finally, information is also needed to understand the quality of services adolescents actually receive, as distinct from the care guaranteed to them by law.

Foremost among the authors' recommendations for closing these critical research gaps is the need to expand current data collection to new topics and populations. There is also a need to undertake both qualitative and in-depth quantitative research on topics, including, but not limited to, unsafe abortion, decision-making by women who are not using contraception but who want to avoid pregnancies and indirect costs of SRHR services.

Denno, D., Hoopes, A. and Chandra-Mouli, V. 2015. "Effective Strategies to Provide Adolescent Sexual and Reproductive Health Services and to Increase Demand and Community Support." *Journal of Adolescent Health* 56(1): S22-S41.

In this descriptive review, Denno, Hoopes and Chandra-Mouli consider the evidence around initiatives aimed at improving access to and uptake of SRHR services by adolescents in LMICs. They consider four types of interventions: in- and out-of-facility, respectively, those targeting vulnerable or marginalised populations and those aiming to generate demand and/or community acceptance.

Their results unearth limited evidence for the effectiveness of interventions focused exclusively on delivering youth-friendliness trainings[2] to facility staff. However, there is strong evidence to suggest that, when such trainings are complemented by adolescent-friendly facility improvements (i.e. reducing costs, extending operating hours, modifying the physical layout for improved privacy, etc.) and utilise information-dissemination channels to generate demand and promote community acceptance, they can yield marked improvement in key health and behavioural outcomes. For young females, reductions in pregnancy rates and increases in the likelihood of seeking contraceptive services have been observed, while for young males, self-reported condom use and increased uptake STI-related services have been documented.

In terms of out-of-facility interventions, the results indicate that youth centres are neither good value for money, nor are they effective in improving uptake of SRHR services. They appear to be primarily used as recreation centres, with the youth that do frequent them rarely accessing the associated health services. A paucity of data prevented a comprehensive analysis of the effectiveness of community-based distribution and, in a similar vein, the authors were unable to identify any initiatives meeting their inclusion criteria that reported outcomes for vulnerable or marginalised populations – the latter representing a critical gap in the research.

2 Youth-friendliness trainings, in this context, refer to efforts to improve the knowledge, attitudes and skills of clinic staff so as to more appropriately respond to the needs of adolescents.

Joint United Nations Programme on HIV/AIDS. 2014. The Gap Report. Geneva: Joint United Nations Programme on HIV/AIDS, UNICEF, EFP, UNDP, UNFPA, UNOPS, UN Women, UNESCO, WHO, World Bank.

This report draws on national survey data to present a global picture of the HIV epidemic, charting progress and challenges in ending new infections and preventing AIDS-related deaths. With respect to younger populations, there are reasons for optimism but overall they are being left behind. Considering first the promising findings. For one, progress in eliminating HIV infections in children has been dramatic, with new infections dropping below 200,000 on an annual basis in the 21 priority countries. The rate of mother-to-child transmission fell from 25.8% in 2009 to 16% in 2013 – a critical accomplishment given the rapid mortality associated with paediatric HIV. Of concern, though, is that HIV testing among pregnant women remains low. Despite improvements, only 44% of pregnant women in LMICs received HIV testing and counselling in 2013. For HIV-exposed infants, the WHO recommends that they be tested using a specialised virological test within two months of birth and yet, in 2013, only 42% of eligible infants received this test. In comparison with adults, children living with HIV are also one-third less likely to receive antiretroviral therapy. In fact, in 2012, only 30% were referred for initiation of antiretroviral therapy. To address this, UNAIDS recommends the promotion of decentralised, family-centred care, including the improved integration of maternal and child health services, as well as improved early infant diagnosis.

Adolescent Girls and Young Women (AGYW) also bear a disproportionate burden of the HIV epidemic. They account for 15% of women living with HIV, however only 15% of this population is aware of their status. In Sub-Saharan Africa, which accounts for 80% of AGYW living with HIV, women acquire HIV five to seven years earlier than men – a fact that is attributed, in part, to high rates of intergenerational relationships, which are associated with high rates of risky sexual behaviour and low levels of condom use. This population also experiences elevated rates of sexual and intimate partner violence, both of which are associated with increased likelihood of acquiring HIV. Punitive laws, limited access to CSE and social norms all also limit their agency in matters related to their own health.

As well, risk for HIV begins early for people who inject drugs, transgender women, gay men and other men who have sex with men. For example, the total population of gay men and other men who have sex with men has an HIV prevalence of 3.7%, compared with 4.2% for men who have sex with men aged 25 and below. What's more, in 2009, global HIV prevalence among young people who inject drugs under the age of 25 was 5.2%. As estimates suggest that people who inject drugs account for 30% of new HIV infections outside of sub- Saharan Africa, it is critical that HIV prevention efforts reach this vulnerable group.

Rankin, K., Jarvis-Thiébault, J, Pfeifer, N, Engelbert, M, Perng, J, Yoon, S and Heard, A. 2016. *Adolescent sexual and reproductive health: an evidence gap map.* 3ie Evidence Gap Map Report 5. International Initiative for Impact Evaluation (3ie).

This report uses systematic and comprehensive methods to map out the evidence base on ASRHR programming in LMICs. First, SRHR education – especially from an HIV prevention-perspective – constitutes the bulk of the research, however, most overlooks the impact of this type of programming on 10- to 14-year-olds. There is a geographic bias to the data, with more than half of the evidence coming from seven countries in Sub-Saharan Africa. Outcomes also tend to be narrow in scope, with most studies measuring impact through measures of knowledge, attitudes and self-efficacy.

On the whole, the evidence gap map reveals that, despite lots of impact evaluation evidence, only a few topics, outlined above, receive attention within this field. The evidence is fairly silent on what works for unmarried adolescents, adolescent boys, LGBTQ youth, adolescents in humanitarian settings and 10- to 14-year-olds. There is also a dearth of evidence on the effects of mass media, mobile health interventions (mhealth) and other Information and Communication Technologies on a variety of outcomes, including those addressing health service utilisation, biological outcomes, and social determinants. The evidence base is limited on the use of community health workers and home visits. Moreover, no impact evaluations were identified measuring the effectiveness of health services and counselling in school or the impact of improvements to sanitation infrastructure in educational settings. Very few studies explore how programming can affect menstrual hygiene, abortion, and sexual and intimate partner violence. Likewise, there is a

research gap speaking to what works for preventing and delaying pregnancy for adolescents, including the effectiveness of programming for promoting the uptake of long-acting and reversible contraception. There is also a paucity of research on provider- and supply-side factors such as service quality. Cost-effectiveness information is lacking in all areas of SRHR programming.

Notably, the authors identify opportunities for synthesis around the impact of cash-transfer programmes on ASRHR, family mobilisation and dialogue, and on sex education for adolescents aged 10 to 14.

Improving the Quality and Relevance of Reproductive Health Interventions

Darroch, J., Singh, S., Woog, V. , Bankole, A., and Ashford, L. 2016. *Adding it up: Costs and benefits of meeting the contraceptive needs of adolescents*. New York: Guttmacher Institute.

Using data from over 130 nationally representative surveys, this Guttmacher publication summarises global fertility and contraception trends for adolescents aged 15 to 19, articulating the costs and benefits of investing in modern contraceptive services to fully meet their needs.

In LMICs, sexual debut, marriage and the initiation of childbearing tend to happen within a relatively short time span. Adolescent childbearing is associated with adverse effects for both the mother and child. Additionally, in comparison to older women, adolescents are more likely to obtain unsafe abortions, especially from untrained or traditional providers; to attempt to induce abortions themselves; to terminate their pregnancies after the first trimester when the procedure is riskier; and are more likely to delay seeking medical care for complications following unsafe abortions.

Adolescents and young women across the world cite similar reasons for not using contraceptives despite not wanting a pregnancy. They express concerns over the side effects, state that have sex infrequently or are not married, have not resumed menstruating after a birth, are breastfeeding, or they – or their partners – object to contraception. Notably, limited numbers report that they lack access or are unaware of contraceptive methods. This indicates that women must be reached with better information about contraception, choice in methods and opportunities to switch methods when necessary. As well, only 49 of the 93 countries that report to the World Health Organization have laws or policies allowing for adolescents to access contraceptive services without parental or spousal consent. Removing these legal and policy barriers is a critical step in improving access.

Against this backdrop, the authors argue that reducing unintended pregnancy in 15- to 19-year-olds comes with substantial social, health and economic benefits for women, their families and societies at large. If the 23 million women who currently experience an unmet need for modern contraception were to receive improved contraceptive services, it would result in an estimated decrease of 6 million unintended pregnancies per year – a drop of 59% from current levels. That translates into 2.1 million – or 62% – fewer unplanned births; 3.2 million fewer abortions; 2.4 million fewer unsafe abortions and 5,600 fewer maternal deaths – a decline of 71%. Extending services to address this unmet need would cost an estimated US$770 million a year, or US$548 million above current expenditure. This equates to an average cost of US$21 per user annually. Providing improved services to all women would require improvements in the quality and availability of contraceptive information, strengthened contraceptive counselling and follow-up, an improved method mix and supply-chains; expanded community-based service delivery; and trainings for health workers to ensure they provide youth-friendly services.

Gottschalk, L. and Ortayli, N. 2014. "Interventions to improve adolescents' contraceptive behaviors in low- and middle-income countries: a review of the evidence base." *Contraception* 90(3): 211-225.

In this structured literature review of 15 published and unpublished papers from 12 LMICs, authors Gottschalk and Ortayli explore the evidence base relating to improving adolescents' contraceptive behaviours.

The authors underline the association between duration and effectiveness. Notably, interventions of short duration may be able to change behaviours in the immediate future, such as contraceptive use at first sex, but as of yet, there is no evidence to support their efficacy in addressing outcomes such as consistent condom use and contraceptive use over time. Further research is needed to articulate the amount of reinforcement needed for sustaining behaviour change related to contraceptive use. Another common element of successful programmes is the involvement of targeted populations at key stages of design and implementation. They further highlight the limited method mix available to adolescents, noting that many programmes focus exclusively on condoms while neglecting other methods, especially long-acting reversible contraceptives. Ensuring that women have access to on information on a diverse method mix is important for giving women choice.

The authors call attention to gaps in the evidence base. Notably, refugee and internally displaced adolescents are completely absent from the literature. The research also indicates that very young adolescents are neglected. To build support for extending interventions to this population, the authors recommend collecting longitudinal data linking early-adolescent SRHR interventions with outcomes later in life.

Hindin, M., Kalamar, A., Thompson, T. and Upadhyay, U. 2016. "Interventions to Prevent Unintended and Repeat Pregnancy Among Young People in Low- and Middle-Income Countries: A Systematic Review of the Published and Gray Literature." *Journal of Adolescent Health* 59(3): S8-S15.

This systematic review seeks to identify high-quality interventions for the reduction of unintended and repeat pregnancy among young people in LMICs. On the whole, the authors find very few high-quality articles, indicating that this is an under-researched area. However, their analysis reveals that, of the 21 interventions identified, those with the strongest results were cash transfer programmes, both conditional and unconditional. Five cash transfer programmes reported statistically significant declines in the primary outcome, pregnancy rates, although some did have no impact. Despite this success, the authors raise concerns about the sustainability of these programmes and question whether they can they can lead to long-term change. Direct provision of contraception to young people was found to have significant impact on contraceptive use across three interventions. The authors call attention to the need for informed choice within these interventions. Thirdly, interventions that capitalise on opportunities to engage with young people who are already at health service delivery points, (i.e. for postpartum services, child immunisation, post-abortion care, etc.) showed promise for reducing repeat pregnancy. Life-skills training programmes yielded mixed results. There was limited evidence to support the effectiveness of life-skills programmes, with most interventions yielding mixed or insignificant results. However, such programmes remain important given their impact on improving knowledge and changing gender norms.

Loaiza, E., Liang, M. 2013. *Adolescent Pregnancy: A Review of the Evidence*. New York: UNFPA.

This reports summarises the current situation of pregnancies among adolescents aged 15-19, considers trends over the last ten years, explores variations across different geographies and socio-economic statuses, and identifies promising approaches for minimising pregnancy among this population. The findings indicate that, globally, pregnancies among girls are declining with approximately one in five women aged 20-24 having had a live birth by the time they turned 18. There are important nuances within this finding, though. For one, while pregnancy rates for girls under 15 are declining, pregnancy before 18 remains effectively unchanged. Further research is needed to understand this dynamic.

Significant disparities exist, as well. The adolescent birth rate is highest among adolescents living in rural areas, in the poorest households and with the least education. As well, the data indicates that contraceptive use is lowest among female adolescents as compared to all other age groups. They also have the highest unmet need for contraception at 25%. As for adolescents who are currently married, 55% want a live birth while the remaining 45% need contraception, of which about half have an unmet need. Notably, most of their unmet need is for spacing (18%) rather than limiting (3%) their children.

The correlations between different social and health indicators must also be addressed. It is no coincidence that countries with high rates of child marriage are also those with high adolescent-girl birth and maternal mortality rates. Therefore, a key priority is to mitigate the harmful impacts of early pregnancy on married girls by reaching them with systematic support to avoid early and frequent childbearing. Programmes to help these girls understand their rights to delay or limit childbearing are critical. To delay marriage and early-childbearing, opportunities for girls to benefit from post-primary education should be expanded, especially for rural girls, and, where relevant, laws – both statutory and traditional – should be reformed to reflect 18 as the minimum age for consent to marriage.

USAID. 2015. *Adolescent-friendly contraceptive services: mainstreaming adolescent-friendly elements into existing contraceptive services*. High-Impact Practices in Family Planning (HIPs). Washington: USAID.

This publication is part of a series identifying high impact practices – in other words, interventions that have sufficient evidence to support their scale-up and sustainability – in family planning. Informed by experts in ASRHR, it is designed to inform the next generation of programmers concerned with increasing contraceptive use among adolescents. Overall, it strongly endorses the mainstreaming of adolescent-friendly elements into existing contraceptive services.

Firstly, it recommends that needs assessments be conducted to identify the most effective approaches for reaching adolescents. Such assessments must allow for disaggregation of data, so as to identify the specific needs and preferences of sub-populations. To that end, multiple service modalities and distribution channels should be employed to cater for these diverse and distinct groups. Adolescent-friendly training should be delivered using a whole-clinic approach, and, to ensure that learning outcomes are sustained, the trainings should be reinforced with supportive supervision, job aids and mentorship.

Adolescents must also have choice, which is achieved by ensuring they have access to the full range of contraceptive options. Services should be provided free of charge, or where this is not possible, at subsidised rates

A supportive legal and policy environment is critical for expanding the reach of services. Where required, laws and policies should be reformed to ensure the environment supports the provision of contraceptive services to adolescents. In a similar vein, as community buy-in can significantly enhance the impact of adolescent-focused interventions, complementary interventions can be delivered to parents and other influential community members. Finally, it is important to address gender and social norms to ensure the impacts of adolescent-friendly contraceptive services are maximised. For examples, when adolescent boys feel a sense of responsibility for planning pregnancies, they are more likely to access contraception. Girls, on the other hand, will access contraception where they feel empowered to access services and where socio-cultural norms support their knowing about and accessing SRHR services.

World Health Organization. 2016. *Monitoring Adolescent Sexual and Reproductive Health*. Geneva: WHO.

As two key global health strategies – the 2030 Agenda for Sustainable Development and the UN Global Strategy for Women's, Children's and Adolescents' Health – are put into effect, the author calls on researchers to reflect on the choice of indicators used to track the respective targets, highlighting the need to define what is and what is not measured with each choice. Specifically, the article questions the prevailing logic of tracking progress on reducing unintended pregnancy using the indicator of adolescent birth rate, as was done in the Millennium Development Goals. As the author points out, birth rates can go up and down while pregnancy rates remain unchanged. By extension, a decline in adolescent birth rates may be

the result of a decline in the proportion of sexually active adolescents, an increase in the proportion using contraceptives, or an increase in the proportion of pregnancies ending in induced abortion. Solely tracking adolescent birth rates provides insufficient evidence to properly inform country-specific interventions, policies and resource allocation around ASRHR.

Going forward, innovations are needed to generate data on adolescent pregnancy rates and abortion, both safe and unsafe. Given their sensitive nature, sexual activity, pregnancy and abortion among adolescents is likely to be underreported, especially in face-to-face interviews. Researchers are urged to explore novel and unconventional approaches to data collection, including audio-computer assisted self-interviews or confidential response sheets for specific questions. Better monitoring of these outcomes will allow for improved resource allocation and ultimately better sexual and reproductive health for adolescents.

Teenage Pregnancy – Prevention and Response

Greene, M., Gay, J., Morgan, G., Benevides, R., and Fikree, F. 2014. *Reaching Young First-Time Parents for the Healthy Spacing of Second and Subsequent Pregnancies. Evidence to Action Project*. Washington, D.C.: USAID, E2A.

This report summarises best practices, drawn from both published and grey literature, relevant to reducing the unmet need for contraception among young married or in-union women under the age of 25 and their partners, who are pregnant or already have one child.

The authors provide six programmatic recommendations for reaching first-time parents. On the demand-side, they argue that it is vital to build young mothers' human and social capital. They also stress the importance of fostering support from immediate and extended families by consistently engaging young husbands and by working directly with parents and in-laws as the latter are often instrumental in influencing young mothers' reproductive lives. Finally, they recommend creating enabling environments for young, first-time parents to engage in reproductive planning, especially through community dialogues promoting human rights and equitable gender norms. Addressing norms around son bias is also vital as, where son preference is strong and the first child is a girl, there is increased pressure to rush into another pregnancy.

In terms of supply-side interventions, firstly, there is a need to consider the accessibility, availability and quality of reproductive health services. As many first-time mothers are isolated within their homes and struggle to access facility-based services, they stand to benefit from targeted, community-based outreaches and home visits, especially in the postpartum period. Secondly, the authors recommend improving the quality of care by capitalising on pre-existing opportunities to interface with young mothers. This includes integrating contraceptive and birth spacing counselling into pre- and postnatal care, and child health services such as immunisations. Third, the authors call on countries to establish supportive laws, policies and systems to ensure that first-time mothers and their partners receive the information and services they need for optimal health and well-being.

Leerlooijer, J., Bos, A., Ruiter, R., van Reeuwijk, M., Rijsdijk, L., Nshakira, N. and Kok, G. 2013. "Qualitative evaluation of the Teenage Mothers Project in Uganda: a community-based empowerment intervention for unmarried teenage mothers." *BMC Public Health*, 13(1).

This evaluation presents core findings and lessons learnt from the Teenage Mothers Project – an intervention implemented in Eastern Uganda to help unmarried teenage mothers cope with the repercussions of early pregnancy and motherhood. The intervention aimed to improve the psychological and social wellbeing of these young women through community sensitisations, teenage mother support groups, livelihood activities (i.e. continued education and income generation), counselling and advocacy. Importantly, activities extended to their immediate and wider social networks, targeting parents, religious and community leaders, school administrators, and beyond.

The intervention transformed social norms with regard to the position and future opportunities for unmarried teenage mothers. For example, parents demonstrated increased support for delayed marriage and continued education. However, the intervention demonstrated no effect on norms disapproving of out-of-wedlock sex and pregnancy. The authors indicate that a critical entry-point for changing social norms was the involvement and consultation of influential community leaders at the project's inception. Qualitative data also indicates that parents were influenced by the testimonies of parents of 'successful' unmarried teenage mothers. The support groups were identified as a key strength of the intervention in that they brought these young women out of isolation, providing them with a support network that strengthened their coping skills and psychological wellbeing. Another positive element is that young women were better able to care for their children and a large number (65.4%) returned to school. Parental support, either financial or through the provision of childcare, was identified as a key factor in determining whether young women returned to school. The intervention had little to no impact on rates of transactional sex, which continued to be used as a coping mechanism for those in financial need.

Parsons, C., Young, K., Rochat, T., Kringelbach, M. and Stein, A. 2011. Postnatal depression and its effects on child development: a review of evidence from low- and middle-income countries. *British Medical Bulletin* 101(1): 57-79.

Postnatal depression (PND) is known to have negative consequences on maternal, family and child developmental outcomes and, while the topic is well researched in high-income countries, little is known about PND in LMICs. In an attempt to fill that knowledge gap, this review examines the prevalence rates of PND in LMIC. It then explores the impact of PND on the physical and psychological development of children, concluding with an analysis of the handful of studies conducted in the field. Although this paper does not explicitly focus on young people, its focus on LMICs, where there are high rates of early childbearing, make its findings relevant for improving SRHR service delivery in developing contexts.

The results suggest that rates of PND are marked, with 22 out of 28 countries where studies have been conducted demonstrating average prevalence rates greater than those seen in HICs. The full disease burden is difficult to estimate, though – a fact that is likely attributable to the variations in screening tools and assessment measures used. The authors find that, similar to the findings from HIC, poverty and economic adversity are associated with maternal depression in LMIC. Gender inequality also appears to have moderating effects. For example, research from India, where there is strong son bias, unearthed an association between disappointment with the birth of a female child and the development of PND. In contrast, in African contexts, the sex of the infant was found to be less relevant than the extent of support, and/or marital or family conflict experienced by the mother. A handful of studies have explored associations between PND and child wellbeing, as measured by child growth indicators such as stunting and wasting. Findings have been mixed with strong associations reported in some regions, with robust evidence coming from South Asia, but not others. The varied experiences of motherhood across culture may explain some of this regional variation. Despite the paucity of evidence unearthed, the authors conclude that the available evidence speaks to an urgent need for maternal depression interventions in LMIC.

Sarkar, A., Chandra-Mouli, V., Jain, K., Behera, J., Mishra, S. and Mehra, S. 2015. "Community based reproductive health interventions for young married couples in resource-constrained settings: a systematic review." *BMC Public Health*, 15(1).

- Young married women in LMICs are a neglected population, both from a programmatic and research perspective, despite enormous need. A confluence of factors – from their limited social agency and lack of education, to their inadequate negotiating skills in their marital relationships and economic dependence – contribute to these women experiencing rapid, repeat childbearing, most of which are unintended and/or poorly timed. To inform interventions aimed at improving the reproductive health of young married couples in resource-constrained settings where the female partner is between the ages of 15 and 24, this paper systematically reviews published studies and evaluation reports on community-level interventions aimed at improving their access to contraception, pregnancy care and safe abortion service.

The results demonstrate that the formation of women groups, group-counselling sessions, home visits by frontline functionaries or outreach workers and support in establishing a village health fund for use in emergencies were all effective in reaching young married couples to educate and motivate them around positive healthcare-seeking behaviours. Qualitative findings from interventions targeting family members – namely in-laws who act as important decision-makers and gatekeepers – and community actors indicate that group counselling and opportunistic interactions are effective in improving the reproductive health of young married couples. As well, to ensure that women are receiving the appropriate health care package, the results point to the importance of stratifying young women in line with their specific reproductive stage (i.e. newly married, nulliparous pregnant women, pregnant women with one or more children, etc.)

Increasing Access to SRHR Using Mhealth and Other Technologies

Hewitt, T. 2016. Increasing access to sexual and reproductive health and rights via new innovations and technologies in Africa. Health & Education Advice and Resource Team, DFID.

This report seeks to answer whether there is sufficient evidence to endorse the use of new innovations and technology for improving access to SRHR in Africa. It asserts that mobile phones have demonstrated their utility in this regard, both through educating the public directly or providing information to health professionals. Providing examples of effective programmes from across the continent, it demonstrates how confidential, toll-free hotlines have been used to reach vulnerable and marginalised youth; how text-based services can provide support to women having undergone medical abortions; and among other examples, how text messages can be used to deliver appointment reminders. Obstacles to the effectiveness of these mobile health technology, or mhealth, interventions include the fact that, in some areas, only a sub-section of the population owns a mobile, a lack of funds for charging prevents individuals from consistently accessing the relevant services, and certain groups, such as women and socio-economically disadvantaged populations, are less likely to have access to a mobile.

Web-based approaches are also a valuable tool for increasing access to SRHR. Successful interventions have leveraged the power of online health education programmes, informative websites and social media platforms to deliver SRHR information, and are described by young people as authoritative and non-judgmental. They have also been used as a referral tool. Key challenges with web-based approaches include a poor access to computers in some areas and the embarrassment related to accessing SRHR sites in public.

Ippoliti, N. and L'Engle, K. 2017. "Meet us on the phone: mobile phone programs for adolescent sexual and reproductive health in low-to-middle income countries." *Reproductive Health*, 14(1).

In their review, the authors consider how programmes in LMICs are using mhealth to improve ASRHR. After issuing a global call for programmes targeting 10- to 24-year-olds in LMICs with mhealth, they reviewed 25 projects, 17 of which met their inclusion criteria. Their findings indicate that mhealth is being used with success to promote positive, preventive, and post-treatment SRHR care, provide psychosocial support, and encourage use of health screening and treatment services for youth living with HIV. However, the majority of interventions target adolescents 15 and older with health promotion messages, using text messaging as the primary method of information delivery. For example, the creation of mobile 'Question & Answer' platforms has allowed adolescents to access accurate information from qualified health professionals and receive scheduled SRHR content through 'push messaging'. Interventions have also used mobile technology to address barriers to access, namely cost. A notable example is that of MSI Ethiopia, which piloted an electronic voucher system sent directly to mobile phones to increase demand for family planning services and counselling among young people. The intervention led to an increase in contraceptive uptake and choice among young people aged 15 to 29, with the data presented without regard for gendered impacts. This suggests there is strong potential for using mobile technologies to reach young people living in traditional, conservative societies where SRHR remains taboo or relegated to the private sphere.

Importantly, though, the authors highlight programmatic considerations that have, as of yet, been overlooked in the design and delivery of interventions. Firstly, as mobile phones are often shared amongst family members, there are certain privacy concerns that must be thought through. As well, while interventions are poised to have a substantial impact on younger adolescents (10- to 14-year-olds), data indicates that they do not engage with mhealth messaging to the same extent as older adolescents.

Social Accountability Mechanisms for SRHR Service Delivery

Villa-Torres, L. and Svanemyr, J. 2015. "Ensuring Youth's Right to Participation and Promotion of Youth Leadership in the Development of Sexual and Reproductive Health Policies and Programs." *Journal of Adolescent Health*, 56(1): S51-S57.

In this paper, Villa-Torres and Svanemyr summarise key conceptualisations of youth participation, and subsequently critically review the research that has attempted to evaluate its implementation and impact within SRHR interventions. The authors ascribe to the view that youth participation is a civil and political right to share in decisions that affect one's life and that of one's community. They present a number of models for youth participation, all of which are underscored by the recognition that youth participation entails the 'establishment and adoption of processes for shared decision-making power between the holder of the adult role and the young person, through the recognition of young people's contributions, individual and/or collectively.'

There is limited documentation speaking to the impact of youth participation in SRHR programmes. The most evaluated is peer education programmes, with five published meta-analyses collectively reviewing 137 peer education interventions. This model yields small, statistically significant, positive effects. Of concern, though, is that few studies perform a network analysis prior to implementing an intervention, suggesting a one-size-fits-all model that is likely to overlook the lived realities of participating adolescents. What's more, peer education is primarily used as a mechanism to deliver adult-driven messages and agendas, relegating youth to less meaningful levels of participation. Peer educators receive training but are rarely supervised, an element that is critical when youth are dealing with controversial topics or feel threatened by community members. Finally, a key takeaway from this paper is the dearth of evidence on alternative forms of youth participation. There is a need to rigorously evaluate, for example, governance structures that involve youth as the limited evidence that is available indicates that the presence of youth does not guarantee meaningful youth participation.

IMPROVING THE DESIGN AND DELIVERY OF COMPREHENSIVE SEXUALITY EDUCATION (CSE)

Fonner, V., Armstrong, K., Kennedy, C., O'Reilly, K. and Sweat, M. 2014. "School Based Sex Education and HIV Prevention in Low- and Middle-Income Countries: A Systematic Review and Meta-Analysis." *PLoS ONE* 9(3): e89692.

School-based sex education is a core component of HIV prevention across the globe, especially in regions disproportionately affected by HIV. To this end, this systematic review and meta-analysis appraises the existing evidence for school-based sex education interventions in LMICs and their efficacy in changing HIV-related knowledge and risk behaviours. 64 studies met their inclusion criteria, of which nine could be categorised as abstinence-only or abstinence-plus, while a further 55 studies involved the delivery of Comprehensive Sexuality Education (CSE). The results were not disaggregated by sex.

The relative dominance of CSE to the other two abstinence-focused interventions meant that the authors were unable to qualify the comparative effectiveness of the different intervention types. Compounding this is the fact that the majority of abstinence-focused interventions measured outcomes related to knowledge while neglecting behavioural or biological outcomes. Overall, school-based sex education, irrespective of type, was associated with improvements in HIV-related knowledge and decreased sexual risk behaviours, including delayed sexual debut, increased condom use and fewer sexual partners. Notably, a number of commonalities were found across the interventions most effective in driving behaviour change. First, they included community-based components, such as youth-friendliness trainings for health clinic staff, condom distribution, and the involvement of key stakeholders – such as parents, teachers and community members – in the design of the intervention. As well, interventions that adapted curricula previously judged as efficacious continued to yield significant results in terms of behaviour change, even in the new settings.

Haberland, N. and Rogow, D. (2015). Sexuality Education: Emerging Trends in Evidence and Practice. *Journal of Adolescent Health* 56(1): S15-S21.

This article reviews progress that has been made to clarify the definition of CSE, and to implement, evaluate and improve the quality of CSE programmes, both in school-and community-based settings. With respect to defining CSE, the authors turn to UNFPA's 2014 operational guidance, which stipulates that CSE must be culturally appropriate and rooted in the core principles of human rights and gender equality. Delivered using empowering, participatory learning approaches in a safe and healthy learning environment, it must provide scientifically accurate information about human rights, gender, power in relationships, the body, puberty, reproduction, relationships, communication, decision-making and sexual health.

In terms of its effectiveness, there is still no clear consensus. Some reviews and meta-analyses find a paucity of effective programmes, whereas others find the opposite. Where significant positive results are found, the magnitude of the effects is typically quite modest. As well, few programmes assess biological outcomes due to the complex research design and costs involved, opting for self-reported behaviour change indicators, despite their limited utility in evaluating effectiveness and informing conclusions about essential programme elements. Notably, a review of 22 CSE programmes found that those that addressed gender and/or power relations were five times as effective in reducing rates of pregnancy, childbearing and STIs than those that did not.

What's more, scaling up CSE often compromises programme quality, as curricula are modified to secure national consensus and teacher training is pared down. As well, staging content based on age may have obvious logic but it often presents practical and social challenges given that, in LMICs, high rates of repetition mean that grade and age are not always strongly correlated. Likewise, the age of sexual debut can vary across cultures, compromising the value of age-standardised content. More guidance is needed to address this issue.

Strengthening the ability of teachers to deliver CSE is an urgent priority for improving or scaling-up CSE, as evidence suggests they lack the ability to foster the critical thinking necessary for students to question prevailing norms of power, privilege and gender. Finally, though not insignificantly, the most vulnerable out-of-school adolescents continue to be neglected. This includes, but is not limited to, the following populations when out of school: people with disabilities, orphaned and vulnerable children, migrants, young people who work, pregnant and married girls, youth key populations, adolescents living with HIV, and young people who inject drugs. Reaching these populations is a critical priority.

Kivela, J., Ketting, E., and Baltussen, R. 2011. *Cost and Cost-Effectiveness Analysis of School-Based Sexuality Education Programmes in Six Countries*. Paris: UNESCO.

This study provides the economic argument for investing in school-based sexuality education programmes, providing policy-makers with answers relating to the development, implementation and scale-up costs, and also the extent to which these programmes give value for money. Their findings, which analyse programmes in Africa, Asia and Europe[3], indicate that sexuality education programmes can not only be cost-effective but also cost-saving in that, by preventing negative sexual and reproductive health outcomes at the population level, they can save treatment costs on a large scale down the line. This is not a foregone conclusion, though. For the optimal use of resources, the authors advise policy-makers to scale-up good-quality, intra-curricular programmes in schools in conjunction with health service delivery. Extra-curricular programmes are not recommended given their voluntary nature, a feature that reduces their cost-effectiveness. As well, in terms of scale-up, the best approach from an efficiency point of view is to obtain maximum reach within a given region before expanding to another area.

The study provides guidance on how to simultaneously maximise resource efficiency and programme impact. To that end, it recommends that sexuality education programmes be implemented with classes of 20 to 40 students. Where this is not possible, sexuality education should not be rejected. Instead, new techniques should be embraced. Adapting pre-existing, evidence-based curricula to the relevant socio-cultural context is another effective strategy. Furthermore, while shorter programmes can be relatively inexpensive per student reached, international standards recommend at least 12 to 20 lessons, repeated over several years, with each lesson lasting at least one hour. The authors also observe that the extent of socio-cultural opposition has important consequences on programme costs, however, in all countries, advocacy is a necessary expenditure. Where there is strong opposition, engaging NGOs to deliver sexuality education programmes can be an important stepping-stone towards the development of national programmes.

Oosterhoff, P., Gilder, L., and Mueller, C. 2016. *Is porn the new sex education?* Brighton: Institute of Development Studies.

The article presents a high-level analysis of what the Institute of Development Studies identifies as a rapidly emerging and unexpected global issue, exploring its impact on development policy and practice. The authors note that governments across the world restrict access to quality, fact-based sexuality education for young people leaving them to learn about sex from other sources. Into this vacuum, online platforms have emerged as an important channel through which young people acquire knowledge about sex and, while there are many digital sex education platforms that attract millions of users, their reach is dwarfed by that of commercial porn sites. For example, with an average of 1.3 billion visits a month, PornHub was ranked as the 22nd most popular website in the world. That is a reach that is 650 times greater than the most popular sex education site, Scarleteen.com. This situation is not unique to the developed world. Fake phone apps have emerged in Ethiopia and India that allow users to hide what they are looking for and viewing. Porn is also not an exclusively male phenomenon. Research from India found that 92% of young people had watched internet porn, with only moderate differences between men and women. What's more, over 50% of these young people had 'sexted' – one of the ways in which this digital revolution is changing the sex and relationship scripts.

3 Countries include Nigeria, Kenya, Indonesia, India, Estonia and the Netherlands.

That is not to say that pornography does not have gendered issues. For example, with revenge and amateur porn sites on the rise, research indicates that women across the world are being pressured by their sexual partners to take pictures or videos of themselves, or are being filmed during sexual acts without their consent. Young people need help in learning how to critically examine the sexual messages they receive from their digital environments. This is true both for the pornography they view and for the riskier, more participatory, digital sexual activities they engage in.

United Nations Educational, Scientific and Cultural Organization. 2018. *Revised Edition: International Technical Guidance on Sexuality Education: An evidence-informed approach*. Paris: UNESCO, UNAIDS, UNFPA, UNICEF, UN Women, WHO.

As part of the technical guidance, this document presents the evidence base around CSE, the core findings of which are presented herein. The authors conclude that there is strong evidence that sexuality education improves attitudes related to SRHR and contributes to delayed initiation of sexual intercourse, decreased frequency of sexual intercourse, increased use of condoms and contraception, decreased number of sexual partners and reduced risk taking. However, there is still insufficient evidence to draw conclusions as to the impact of CSE on biological outcomes.

CSE is likely to have the desired positive effects on young people's SRHR when the curriculum used is comprehensive in scope and delivered as intended. Conversely, a lack of implementation fidelity can reduce intervention effectiveness. As such, modifying evidence-based programmes to reduce the number or length of sessions, remove topics and messages, reduce participant engagement, or make other substantive changes to programmes, is strongly discouraged.

Programmes focusing on gender and rights have been found to be substantially more effective than those that do not. This is attributed to the inclusion of transformative content and teaching methods that support participants to not only interrogate social and cultural norms, but to develop gender equitable attitudes as well. There is also strong support for the provision of multi-component interventions, especially those involving parents and teachers, and linking school-based CSE with non-school-based youth-friendly services and condom distribution.

Going forward, there is a need for more high-quality research, including randomised-controlled evaluations of CSE from LMICs and evaluations interrogating multi-component interventions. There is also a need for research on the demand-creation potential of CSE and the uptake of SRHR services and commodities. Finally, the evidence base stands to benefit from studies exploring the effectiveness of CSE on vulnerable and marginalised groups.

United Nations Educational, Scientific and Cultural Organization. 2015. *Emerging Evidence, Lessons and Practices in Comprehensive Sexuality Education: A Global Review*. Paris: UNESCO.

This review appraises the evidence and lessons learnt around CSE, provides an overview of its implementation across the globe and highlights areas requiring further attention. Firstly, CSE is evidenced to have a positive impact on biological outcomes including reduced rates of STIs, HIV and unintended pregnancy. Effectiveness appears to be bolstered when gender and rights are integrated throughout the content, and when CSE is delivered in conjunction with expanded access to youth-friendly SRHR services. Where young people face legal and policy barriers to accessing such services or where national legal frameworks sanction discrimination, legal and policy reform must be prioritised to ensure young people receive the maximum benefit from CSE.

To maximise its effectiveness, CSE should be mandatory. In terms of CSE's placement within school curricula, it can be delivered as either a stand-alone or integrated programme. In terms of effectiveness, the evidence is inconclusive as to a relative benefit of one over the other. Worth highlighting, though, is that, as a stand-alone programme, CSE is more vulnerable to being sacrificed due to time or budget constraints. Conversely, it is easier to monitor, and there are more opportunities for both specialised teacher training pathways and the promotion of innovative pedagogical approaches, which are increasingly being

recognised as positively impacting learning and education more widely. When CSE is integrated or infused across a number of subjects, it may reduce pressure on an overcrowded curriculum, but monitoring and evaluation are made more difficult.

Effective delivery cannot be guaranteed if CSE is not a compulsory subject in teacher training programs, nor if there are not quotas for CSE teachers in schools. Teachers also require supervision and guidance, especially when it comes to reporting requirements around sexual abuse disclosure and teaching the sensitive topics.

Globally, the majority of curricula fail to foster critical thinking around the roles played by culture, gender norms, and importantly, religion, in shaping attitudes and behaviour. For the most part, programmes exclude diversity issues, failing to address topics such as sexual and gender orientation, SRHR and disability, and living with HIV. In a similar vein, the majority of programmes fail to reach people with disabilities, orphaned and vulnerable children, migrants, working youth, pregnant and married girls, key populations, people living with HIV, people using drugs and LGBTQ/I. Failing to reach these groups will only serve to deepen their social exclusion, further compromising their health and wellbeing.

ADDRESSING SOCIAL NORMS FOR IMPROVED SRHR AMONG YOUNG PEOPLE

Gender Norms in Early Adolescence

Kågesten, A., Gibbs, S., Blum, R., Moreau, C., Chandra-Mouli, V., Herbert, A. and Amin, A. 2016. "Understanding Factors that Shape Gender Attitudes in Early Adolescence Globally: A Mixed-Methods Systematic Review." *PLOS ONE* 11(6): e0157805.

In this first attempt to systematically bring together evidence on what shapes young adolescents' gender attitudes across the globe, Kågesten et al explore the factors associated with gender attitudes in early adolescents and further interrogate how young adolescents learn about and construct gender attitudes in relation to their social environment. The results are organised in line with the social-ecological model. At the individual level, gender attitudes expressed by young adolescents in global settings were predominantly stereotypical or inequitable. Interestingly, both young boys and girls were strongly in favour of gender equality but simultaneously endorsed stereotypical attitudes. Girls were more likely than boys to explicitly critique stereotypical norms and gender inequality, however, there are indications that boys encounter more social barriers to challenging these norms and are given fewer opportunities to do so.

At the interpersonal level, the home emerged as a critical place for transmitting gender role expectations, with mothers appearing to be especially important in shaping gender attitudes. In terms of peer groups, male peer groups were found to reinforce traits of competition, toughness and heterosexual dominance, and to ridicule those who fail to align with local standards of masculinity. Female peer groups, on the other hand, were found to police gender boundaries associated with female sexuality, through actions such as 'slut shaming'.

At the community level, schools were found to either challenge or uphold gender norms. On the whole, though, they disproportionately favoured boys' activities and performance. Where media is concerned, sexting – the sending of sexually explicit messages or pictures via SMS – was identified as an important strategy for boys and girls to execute the stereotypical sexual scripts of dominance and submission but it also emerged as important platform for young people to explore non-dominant gender identities and norms.

Interventions to Reduce Child Marriage

Chae, S., and Ngo, T. 2017. "The Global State of Evidence on Interventions to Prevent Child Marriage." GIRL Center Research Brief No. 1. New York: Population Council.

This review aims to both describe the different types of interventions being implemented to reduce child marriage and to assess their effectiveness. In total, 22 studies met its strict inclusion criteria, which were constructed so as to allow analysis of only the most rigorously evaluated interventions, defined as interventions evaluated as part of a randomised-controlled trial, quasi-experimental study or natural experiment.

The review finds that there are four key approaches used: empowerment, wherein girls are given the information, skills and support to advocate for themselves; community, which aims to influence community attitudes towards child marriage and increase knowledge on its negative effects; schooling, which involves the provision of incentives to keep girls in – or return them to – school; and economic, which involves the provision of economic incentives, either conditional or unconditional, to offset the costs of raising girls. Empowerment approaches are by far the most popular approach, followed by economic, schooling and then community approaches. Empowerment approaches also have the strongest evidence base supporting their effectiveness. Conversely, there was little support for economic interventions, with more information needed to draw conclusions on the effectiveness of community and schooling approaches.

For future research and programming, the authors strongly recommend the incorporation of empowerment strategies in the design and delivery of child marriage interventions. With respect to research, broadly speaking, more rigorous evaluations of child-marriage interventions are required. There is also a need to analyse the impact of individual arms of multi-component interventions to determine the most cost-effective interventions.

Kalamar, A., Lee-Rife, S. and Hindin, M. 2016. "Interventions to Prevent Child Marriage Among Young People in Low- and Middle-Income Countries: A Systematic Review of the Published and Gray Literature." *Journal of Adolescent Health* 59(3): S16-S21.

This systematic review aims to identify high-quality interventions and evaluations to decrease child marriage in LMICs. Using the proportion married and age at marriage as the key outcomes of interest, it identifies eleven studies meeting the inclusion criteria. Of these, four yielded strictly significant effects in the intended direction. Three of these interventions provided some form of economic incentive, either conditional cash transfers or payment of school fees, for girls to remain in school. The fourth intervention involved the delivery of a lifeskills curriculum and found both a decrease in child marriage and an increase in age at marriage.

Notably, studies that found no statistical impact tended to have broad, ill-defined goals beyond reducing child marriage, such as reducing HIV transmission and improving SRHR more generally. However, interventions that yielded significant findings all focused directly on reducing child marriage or highly correlated structural findings, such as education.

Lee-Rife, S., Malhotra, A., Warner, A. and Glinski, A.M. 2012. "What works to prevent child marriage: a review of the evidence." *Studies in family planning* 43(4): 287-303.

This review employed systematic methods to ascertain what works to prevent child marriage. The paper presents findings from 23 distinct programmes, assessing how they are being evaluated and summarising the effective approaches they employ.

Successful programmes employ one or more of the following five approaches: first, the empowerment of girls with information, skills and support networks; second, the education and mobilisation of parents and community members; third, enhanced accessibility of formal schooling for girls; fourth, the provision of economic support and incentives for girls and their families; fifth, the fostering of an enabling legal and policy environment. Additionally, the authors identify patterns in how these approaches are put into practice, asserting that programmes fall into one of three categories: horizontal, vertical and activist programmes. Horizontal programmes employ integrated, multi-pronged approaches that address multiple levers of change concurrently. They are the most successful in sustaining impact beyond the life of the intervention. However, their cost compromises their scalability and programme sustainability. Vertical programmes adopt a narrow focus and tend to be large-scale, school- and incentive-based programmes that target child marriage by keeping girls in school and poverty reduction. They are popular with governments, thus, there is promise of scalability. However, they often fail to incorporate components that research indicate are necessary for sustaining impact beyond the end of the intervention, such as direct community engagement. This approach could be strengthened through greater integration within school, government and community systems and structures. The activist approach, which is less widely implemented, involves a focus on legal and policy reform. This approach, while necessary for large-scale change, will be insufficient in the absence of other efforts.

Malhotra, A., Warner, A., McGonagle, A., Lee-Rife, S. 2011. *Solutions to End Child Marriage: What the Evidence Shows.* Washington, New Delhi, Nairobi: International Center for Research on Women.

In this publication, Malhotra et al present the findings from a systematic review of child marriage prevention programmes and further provide guidance for future programming and research. Their findings reveal that child marriage programmes have expanded in number and scope since the early 2000s, with a number of interventions emerging targeting child marriage as part of broader efforts to improve the health and welfare of young people. The research is heavily biased towards South Asia, although increasingly Ethiopia and Egypt are contributing to the evidence base.

In general, programmes have intervened using five core strategies: empowering girls with information, skills and support networks; educating and mobilising parents and communities; enhancing the accessibility and quality of formal schooling; providing economic support or incentives to girls and/or their families; and finally, fostering an enabling legal and policy environment. The strongest, most consistent evidence comes from programmes that nurture information, skills and networks for girls alongside strong community mobilisation.

The authors encourage future programmes to leverage technology, including mobile platforms, to expedite the pace of change. As well, they recommend that research interrogate the effects of employing different theories of change. Namely, is it more effective to intervene with the average individual, replicate and scale up or to intervene with pioneers and rely on diffusion in order to reach a tipping point? Finally, they encourage research on finding the right balance between depth, scale and sustainability.

Svanemyr, J., Chandra-Mouli, V., Raj, A., Travers, E. and Sundaram, L. 2015. "Research priorities on ending child marriage and supporting married girls." *Reproductive Health* 12(1).

This article presents the recommendations made at an Expert Group Meeting convened by the World Health Organization to identify research priorities for ending child marriage and supporting married girls. It provides recommendations along five thematic areas: prevalence and trends; causes; consequences; prevention; and, finally, support for married girls.

To address evidence gaps on prevalence and trends, the authors highlight the need for more disaggregated data, especially among 10- to 14-year-olds, and information on marriage trends in relation to other social, economic and health indicators such as employment, food security and violence.

With respect to the causes of child marriage, research must interrogate the impact of structural factors such as urbanisation, migration, labour market fluctuations, climate change and conflict. There is also a need to explore the protective factors that impede child marriage in areas where the practice is prevalent and to collect evidence from Central Asia, North Africa and Latin America – all areas where data is lacking.

The evidence base on the consequences of child marriage stands to benefit from research on its social and economic costs, as well as the health consequences beyond maternal and perinatal considerations. Longitudinal impact studies exploring social development, health and gender issues are also positioned to provide rich and informative evidence.

In terms of prevention, information is required to inform the scale-up of interventions. Guidance is needed on legal matters, including identification of the right mix of sanctions and incentives. Additionally, more information is needed to identify the indicators that predict progress.

For supporting child brides, research is required on the scale and nature of their access to health and social services. What's more, there is a need for evidence to inform the development of equitable relationships between married girls and their older husbands. More information is also required on the needs of separated, divorced or widowed girls.

Walker, J. 2015. "Engaging Islamic Opinion Leaders on Child Marriage: Preliminary Results from Pilot Projects in Nigeria." *The Review of Faith & International Affairs* 13(3): 48-58.

This article presents findings from activities conducted in Northwest Nigeria aimed at mobilising Islamic opinion leaders to address child marriage. Increasingly, there has been a focus on the potentially catalytic role religious leaders can play in public health interventions. With respect to the engagement of Muslim leaders, the model of engagement tends to be premised on the idea that these individuals oppose a given public health intervention because they misinterpret a key precept of their faith. Therefore, it is argued, that by providing these faith leaders with the correct knowledge about the Islamic position on the issue at hand, they will be inclined to change their views and relay their newfound position to strategic audiences. To that end, as part of one of two broader behaviour-change projects on child marriage, Islamic religious scholars were engaged to explore the Islamic perspective on age of marriage.

The findings indicate that, while participants accepted the need to delay marriage on social and health grounds, they were unwilling to recognise 18 as the minimum age of marriage upheld in Islam. To that end, they were unwilling to communicate messages to their respective communities of faith proscribing marriage of girls under a specific age. Notably, though, they did propose alternative messages with implications for delaying marriage, such as recommending that girls complete secondary school before marrying. This experience indicates that new models are needed for the engagement of Muslim leaders for the purposes of driving behaviour change around child marriage.

The Evidence Base on Reducing Female Genital Mutilation

Berg, R. and Denison, E. 2012. "Effectiveness of Interventions Designed to Prevent Female Genital Mutilation/Cutting: A Systematic Review." *Studies in Family Planning* 43(2): 135-146.

This systematic review analyses the available evidence regarding evaluations of interventions to prevent Female Genital Mutilation (FGM). The authors summarise and include the results from eights studies, all of which they qualify as being of low quality due to weak methodological design and non-randomisation. Nonetheless, significant findings were found across 19 of the 49 outcomes evaluated; however the results from four meta-analyses demonstrated considerable heterogeneity.

Critically, this review concluded that there is a dearth of high-quality evidence regarding the effectiveness of interventions to halt FGM. The evaluated interventions demonstrated limited effectiveness, largely, the authors postulate, as a result of low implementation fidelity and imperfect relevance. The former speaks to the fact that interventions are not implemented according to intervention protocol, likely as a result of poor planning. The latter, imperfect relevance, addresses the fact that many interventions do not adequately integrate local considerations into the design and delivery of their programmes.

Johansen REB, Diop NJ, Laverack G, Leye E. 2013. "What Works and What Does Not: A Discussion of Popular Approaches for the Abandonment of Female Genital Mutilation." *Obstetrics and Gynecology International* 2013.

In this paper, the authors present existing evidence from systematic reviews and evaluations of single interventions of FGM abandonment programmes, while also drawing on their professional experiences to provide guidance on eight popular interventions.

The first and most popular strategy is the health risk approach. It entails the provision of information about the health risks of FGM, building on the idea that this knowledge will motivate people to abandon the practice. Such information has been found to influence policy makers to reform harmful laws and policies related to FGM, and similarly, when presented by a health authority, has led religious leaders to take a clear and strong stance against the practice. However, in many communities where FGM is upheld as a social norm, the risk of social sanctions against individuals who do not conform outweighs the health risks associated with the practice, thereby limiting the efficacy of this approach. Third, the conversion of excisors, a popular approach that entails intervening to convince excisors to stop performing FGM, has limited support. However, including excisors in comprehensive abandonment programmes can prevent them obstructing the intervention and protect them against potential backlash from the community. Fourth, training health professionals has been found to increase both their knowledge about FGM and negative attitudes towards the practice. However, as these providers are members of the same communities that support FGM, they may either support the practice or be afraid of involving themselves in the issue. As well, the heavy workload of health practitioners often precludes their ability to deliver the information and/or counselling necessary to promote abandonment. Fifth, alternative rites of passage – wherein coming of age ceremonies involving FGM are modified to exclude the FGM component – have support in communities where FGM is practiced as part of a rite of passage. Sixth, community-led programmes have been identified as essential to tackling the social norm aspects of FGM and creating sustainable change. Seventh, public statements or declarations of abandonment are identified as valuable strategies for mobilising communities. Finally, legal and policy measures, when preceded and complemented by community mobilisation, are also critical for creating an enabling environment for achieving abandonment.

Population Reference Bureau. 2013. *Ending Female Genital Mutilation: Lessons From a Decade of Progress*. Washington: PBR.

Population Reference Bureau draws on the experiences of a range of organisations, countries and researchers to provide guidance on how to end FGM. Synthesising findings from evaluated interventions and programme reports, it identifies approaches from that held promise but, unfortunately, missed the mark. For example, providing alternative income to excisors attempted to curtail of some of the supply-side factors contributing to the practice but ultimately, excisors lacked the social influence to lead abandonments efforts. As well, community motivation – and not economic considerations – appears to have been the key factor motivating them in their work. Likewise, medicalisation, which was seen as a way to lessen the health consequences, served to legitimise the practice by providing a veneer of medical approval. However, when medical personnel are educated on the practice from a human rights and public health perspective, they can be valuable allies in achieving abandonment.

More encouraging approaches include alternative rites of passage, wherein a traditional rite is replaced with an alternative practice that maintains the essential components of passage into womanhood but without the cutting, and positive deviance, which involves building on the experiences of individuals who chose to not be cut.

Finally, PBF highlights three broad categories of promising approaches, labelled as such because of evidence for their effectiveness: transforming social norms by empowering women and girls; working with a wide range of pivotal actors; and embracing multi-sectoral efforts. With respect to transforming social norms, most people believe that FGM ensures membership in the community, especially in intermarrying communities, and critically, opportunities to publicly discuss this and other motivations – be they religious, cultural or social – are rare is rare. Successful interventions to transform social norms, such as intergenerational and community dialogues, have brought these issues out of the private sphere.

Moreover, it is vital that interventions work across sectors and with a wide range of actors, including religious leaders. Despite the fact that FGM is not found in any religious doctrine, communities often cite a religious obligation to justify the practice. Working with religious leaders to address this perception is evidenced to be a powerful approach in changing such attitudes and, furthermore, it can give credibility to abandonment efforts.

Shell-Duncan, B., Naik, R., and Feldman-Jacobs, C. 2016. "A State-of-Art-Synthesis of Female Genital Mutilation/Cutting: What Do We Know Now? October 2016." *Evidence to End FGM/C: Research to Help Women Thrive*. New York: Population Council.

This report reviews nationally representative survey data, academic and grey literature to present a snapshot of what is known about FGM, including the most relevant contextual information. Of the 29 countries where national data is available, 15 show no clear evidence of progress while in the remaining 14, the practice appears to be declining. Girls are increasingly being cut at younger ages, with the majority cut before the age of 5.

Decisions around cutting are rarely made in isolation but dependent on the expectations of families or communities. Notably, men demonstrate low levels of support – a finding that raises questions as to what role men play in decision-making around FGM, and the extent to which they have an influence on the final outcome. Answers to these questions will shed light on the role men can play as allies in abandonment efforts.

With respect to ending FGM, while it is vital that all efforts be informed by the local context, research suggests that improvements to women's socio-economic status and education can lead to a decline in FGM. Indirectly targeting FGM through efforts to increase women's authority in decision-making; improve labour force participation; lessen their economic dependency and change their social roles may all contribute to abandonment. Critically there is a need for further research to elucidate how these social, economic and political factors affect the risk of FGM.

United Nations Children's Fund. 2013. *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change.* New York: UNICEF.

This report by UNICEF draws on data from all 28 countries in Africa and the Middle East where FGM is concentrated to highlight trends, examine differentials in prevalence and highlight promising approaches for the abandonment of the practice. In countries where FGM is not universal, it tends to be concentrated in specific regions of a country and practiced by specific ethnic groups, suggesting that social norms and expectations within communities of like-minded people contribute greatly to its perpetuation. On the whole, little change has been observed in the type of FGM performed across generations, although a trend towards less severe cutting is discernible in some countries. With a few exceptions, FGM tends to be carried out by traditional practitioners.

Of interest is that in most of countries where FGM is practiced, the majority of women and girls think it should end. Notably, the percentage of women in support of the practice is less than the percentage who have been cut. Conversely, men display equal – and in some areas greater – levels of support for abandonment than women. Despite this opposition, the practice continues suggesting that there are other factors preventing people from acting in accordance with their personal preferences. Notably, the most common reason cited for carrying out the practice is a sense of social obligation. What's more, marriageability is often put forward as a motivating factor for FGM, however, with the exception of Eritrea, this appears to no longer be the case.

Going forward, UNICEF recommends that interventions promote full abandonment of FGM as opposed to advocating for milder forms of the practice. Rights and health issues aside, pursuing elimination by progressively reducing the degree of cutting is evidenced to be ineffective. As well, interventions must be cognisant of the differences and similarities in populations groups within and across national borders. This entails developing strategies tailored to the specific features of sub-populations and potentially collaborating across borders, especially if dealing with diaspora populations. Furthermore, interventions must address entire communities, finding ways to magnify voices favouring abandonment. Creating opportunities for individuals to realise the extent of public support for abandonment will help people realise that nonconformity will no longer elicit negative social consequences. Increasing exposure to groups that do not practice FGM is also highly valuable in demonstrating that abandonment does, in fact, allow girls and their families to thrive. As well, increasing engagement by boys and men holds power to shift public perception, especially as men are likely to wield great power within communities.

PREVENTING SEXUAL AND GENDER-BASED VIOLENCE

Ashburn, K., Kerner, B., Ojamuge, D. and Lundgren, R. 2016. "Evaluation of the Responsible, Engaged, and Loving (REAL) Fathers Initiative on Physical Child Punishment and Intimate Partner Violence in Northern Uganda." *Prevention Science* 18(7): 854-864.

This article describes the evaluation results of the Responsible, Engaged and Loving Fathers Initiative, a low-resource intervention implemented with over 500 married or cohabitating 16- to 25-year-old fathers of toddlers in northern Uganda. The intervention aimed to improve positive parenting, couple communication and reduce men's perpetration of intimate partner violence and childhood maltreatment. Grounded in social learning theory, it provided participants with the opportunity to learn through observation, expanding their knowledge and skills by modelling desirable behaviours. The programme was structured such that mentors guided up to four mentees over a six-month period, in one-on-one and group sessions. Additionally, a series of posters were prominently displayed in key hotspots around town, reinforcing the messages addressed each month in the mentoring sessions. The final activity was a community celebration – an activity that supported norm change at the community level by providing fathers with a public forum to commit to continue practicing new skills, and for the community members to declare support for the men's adoption of positive change.

The intervention had significant positive effects on adoption of positive parenting practices, confidence in using nonviolent discipline, rejection of both child maltreatment and IPV, and reduced odds of both physically punishing a child and perpetrating physical and psychological intimate partner violence. Furthermore, in comparison to the control group, men who participated in the intervention demonstrated improved communication with their partners, a promising finding as other research suggests couple communication may be critical for challenging the rigidity of gender roles within the household. However, this intervention had limited effects on changing gender roles despite efforts to do so. Authors postulate that the modest effects in this arena might be attributable to the short duration of the intervention.

Foshee, V, Bauman, K, Ennett, S, Suchindran, C, Benefield, T & Linder, G. 2005. "Assessing the Effects of the Dating Violence Prevention Program "Safe Dates" Using Random Coefficient Regression Modeling." *Prevention Science* 6(3): 245-258.

The Safe Dates Project is a randomised trial for evaluating Safe Dates, a school-based dating violence prevention program for young adolescents in the United States. Four separate randomised control trials supports its effectiveness in reducing perpetration rates of psychological, moderate physical and sexual dating violence, as well as physical dating violence victimisation at all four follow-up periods – the equivalent of four years post-intervention.[4]

The programme targets behavioural outcomes through activities designed to transform gender and dating norms, and equip participants with conflict management skills. It consists of a student-led theatre production; a ten-session curriculum, which is delivered by a teacher; and a poster contest. Authors attribute its long-term effectiveness to the timing of its delivery as it is administered at a critical period in the life course—right as youth are first forming their dating-related attitudes and practices.

4 See Foshee, V, Bauman, K, Arriaga, X, Helms, R, Koch, G & Linder, G. (1998). An evaluation of Safe Dates, an adolescent dating violence prevention program. *American Journal of Public Health*, vol. 88, pp. 45-50.; Foshee, V, Bauman, K, Ennett, S, Linder, G, Benefield, T & Suchindran, C. (2004). Assessing the Long-Term Effects of the Safe Dates Program and a Booster in Preventing and Reducing Adolescent Dating Violence Victimization and Perpetration. *American Journal of Public Health*, vol. 94, no. 4, pp. 619-24.; Foshee, V, Bauman, K, Ennett, S, Suchindran, C, Benefield, T & Linder, G. (2005). Assessing the Effects of the Dating Violence Prevention Program "Safe Dates" Using Random Coefficient Regression Modeling. *Prevention Science*, vol. 6, no. 245; Foshee, V, Bauman, K, Greene, W, Koch, G, Linder, G & MacDougall, J. (2000). The Safe Dates program: 1-year follow-up results. *American Journal of Public Health*, vol. 90, no. 1619-1622.

Jewkes, R, Nduna, M, Levin, J, Jama, N, Dunkle, K, Puren, A & Duvvury, N. 2008. "Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behavior in rural South Africa: a cluster randomised controlled trial." *British Medical Journal*, 337: 1-11.

In this article, Jewkes and colleagues present the findings from a cluster randomised controlled trial of the Stepping Stones HIV prevention programme – an intervention that took place with 1360 men and 1416 women aged 15-26 years in 70 villages in South Africa. Notably, Stepping Stones is a 50-hour program designed to improve sexual health by "building stronger, more gender-equitable relationships with better communication between partners"[5] (Jewkes et al 2007, p. 1). It employs participatory methods to promote communication skills, educate participants on sexual health and facilitate self-reflection on relationship and sexual behaviour. For the purposes of the study, villages were randomised to receive either the Stepping Stones programme or a three-hour intervention on HIV and safer sex.

With respect to the results, male participants reported perpetrating both physical and sexual intimate partner violence significantly less than controls across two years of follow-up. Men also reported reduced levels of problem drinking and lower rates of transactional sex[6] at the 12-month follow-up, although the latter finding disappeared at the 24-month follow-up. Additionally, Stepping Stones led to a 33% reduction in the incidence of herpes simplex type 2, although no impact was observed on lowering the incidence of HIV. In women, the intervention was found to have no effect on the primary outcomes of interest. However, increased rates of transactional sex were observed at the 12-month follow-up. This finding disappeared by the 24-month follow-up. The authors speculate that this finding might be a consequence of the way transactional sex was discussed within the sessions. The group discussions may have inadvertently encouraged the practice, by presenting it as a common and effective method of acquiring desired goods. This is likely as a result of efforts by the facilitators to avoid being moralistic, which may have served to underemphasise the negative consequences of transactional sex. The authors urge that extra care be taken when addressing this topic in future interventions.

Michau, L., Horn, J., Bank, A., Dutt, M. and Zimmerman, C. 2015. "Prevention of violence against women and girls: lessons from practice." *The Lancet* 385(9978): 1672-1684.

This series paper describes effective programming for the prevention of violence against women and girls in LMICs. The authors argue that effective interventions are founded on five core principles: first, they intervene across the social ecology, (individual, interpersonal, community and societal levels); second, they address the key driver of violence – unequal gender-power relations; third, they are informed by theories of change; fourth, they employ coordinated, sustained, multi-sectoral investment; and fifth, they employ aspirational programming that offers individuals a vision of a positive, equitable relationship and the benefits of such a relationship for all family members.

Drawing on lessons from practice, the paper also puts forward recommendations for policy makers, programmers and funders in order to make the world safer for women and girls. The foremost recommendation is commitment to the five principles of effective prevention of violence. The authors also stress the centrality of the health sector and women's movements to the design and delivery of violence prevention efforts, and call for greater investment in innovative, theory-informed interventions. More resources should also be made available to support social norm change at the community and societal levels, as well as collaborative practitioner-researcher impact evaluations.

5 Jewkes, R, Nduna, M, Levin, J, Jama, N, Dunkle, K, Wood, K, Koss, M, Puren, A & Duvvury, N. (2007). Evaluation of Stepping Stones: A Gender Transformative HIV Prevention Intervention, *Medical Research Council of South Africa Policy Brief*, pp. 1-4.

6 For men, transactional sex was interpreted as men providing goods in exchange for sex, whereas for women, it was understood as the receipt of goods in exchange for sex.

Ricardo, C., Eads, M., and Barker, G. 2011. *Engaging Boys and Young Men in the Prevention of Sexual Violence: A systematic and global review of evaluated interventions.* Pretoria, South Africa: Sexual Violence Research Initiative and Promundo.

This systematic review considers the effectiveness of interventions for the primary prevention of sexual violence perpetration among ABYM in global settings. It considers interventions aimed at changing both attitudes that are directly and indirectly related to an increased risk of sexual violence perpetration, and also behaviours. 65 studies met the inclusion criteria, of which nine were conducted in LMICs. The authors find that the majority of the research on this issue is of poor quality; only 9 studies employed strong or moderate research designs and only one of these, Safe Dates, demonstrated a significant impact on behaviour.

The authors interrogate elements of programme design and delivery, subsequently highlighting their implications for practice. Firstly, engaging professionals with experience in sexual violence beyond the scope of the intervention themselves (i.e. lawyers, doctors, police officers, etc.) conferred no added benefit in terms of yielding significant findings. Also, despite more research being needed, the authors contend that single-sex interventions are beneficial, at least in the initial stages, when working with high-risk populations or when there are marked differences in the knowledge levels between men and women. Also, since a big part of male 'role learning' takes places in male groups, single-sex interventions can be an appropriate space for challenging rigid norms and practicing new roles. However, mixed-sex interventions, while generally preferred by participants, offer opportunities for men to come to understand women's experiences and for women to show public support for men willing to challenge hegemonic masculinity and reject norms of violence. Finally, while targeted interventions dominate the field, system-wide interventions have yielded promising results; of the four included in the review, three system-wide interventions showed significant changes in outcomes, including, but not limited to reductions in violence against women. Overall, there is a need for further high-quality research measuring behavioural outcomes at longer follow-up periods as well as research exploring protective factors for perpetration.

World Health Organization. 2014. *Global Status Report on Violence Prevention 2014*. Luxembourg: World Health Organization, United Nations Office on Drugs and Crime, United Nations Development Programme.

This report captures the progress made by 133 countries in implementing the recommendations of the World Health Organization's seminal publication, *The World Report on Violence*, which employed a public health framework to addressing the issue of violence.

The data indicates that the non-fatal consequences of violence are by far the greatest part of the social and health burden arising from violence, with women, children and elderly people disproportionately victimised. Of significance, though, is that key data on violence is often lacking, critically undermining violence prevention efforts. The majority of violence experienced by women and children does not come to the attention of authorities or service provider, making population-based surveys a critical source of information for capturing the nature and magnitude of these problems. Importantly, the superior sensitivity of population-based surveys when it comes to capturing data on violence underscores the fact that a reliance on police and health statistics is inadequate for the design and monitoring of comprehensive violence prevention efforts.

The report also unearths the fact that, while countries are starting to invest in violence prevention, planning and policy-making is neither commensurate with the burden nor evidence-based. For example, national actions plans, while present in many countries, exist in the absence of national survey data. As well, despite the fact that the different forms of violence have common risk factors, only half of countries have adopted an integrated approach for concurrently addressing multiple types of violence and few seek to address the key socio-economic or political drivers. However, it is essential that strategies seek to mitigate or buffer against these risks, through, for example, the provision of incentives for youth at risk of violence to complete secondary school, efforts to tackle the harmful use of alcohol and the development of national-level housing policies to reduce the concentration of poverty in urban areas.

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We strive to advance children's rights and equality for girls all over the world. We recognise the power and potential of every single child. But this is often suppressed by poverty, violence, exclusion and discrimination. And it's girls who are most affected. As an independent development and humanitarian organisation, we work alongside children, young people, our supporters and partners to tackle the root causes of the challenges facing girls and all vulnerable children. We support children's rights from birth until they reach adulthood, and enable children to prepare for and respond to crises and adversity. We drive changes in practice and policy at local, national and global levels using our reach, experience and knowledge. For over 80 years we have been building powerful partnerships for children, and we are active in over 75 countries.

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