INTRODUCTION

Adolescent sexual and reproductive health for all in sub-Saharan Africa: a spotlight on inequalities

Venkatraman Chandra-Mouli1*, Sarah Neal2 and Ann-Beth Moller1

The focus of this supplement is on inequalities in the levels and trends of progress on sexual and reproductive health among adolescents in sub-Saharan Africa. Whereas adolescents did not get the attention they deserved in the context of the Millennium Development Goals, there is strong commitment to ensuring that they are not left behind in the context of the Sustainable Development Goals [1]. The need to pay particular attention to their sexual and reproductive health needs was reinforced in the list of key actions for the future implementation of the Programme of Action of the International Conference on Population and Development at the Nairobi Summit [2]. Two recent reports highlight the unequal burden of Sexual and Reproductive Health (SRH) problems in adolescents, and their unequal access to the SRH services. Just-published data suggest that the prevalence of violence against women in relation to intimate partner violence starts early in the lives of girls/young women with nearly one in four of every married/partnered 15–19-year-olds already being subjected to physical and/or sexual violence from an intimate partner at least once, and that the levels of violence in the last 12 months (16%) are higher in this age group [3]. Data released by the Guttmacher Institute stressed that as of 2019, adolescents faced vast unmet needs for sexual and reproductive health services (e.g., 41% of adolescent girls aged 15–19 who wanted to avoid a pregnancy had unmet needs for contraception, whereas the comparable rate in 15–49-year-olds was 24%), and projected that this was likely to worsen in the context of the COVID-19 pandemic’s movement restrictions and service disruptions [4].

There is a pressing need to address the sexual and reproductive health (SRH) of adolescents in sub-Saharan Africa (SSA) because there are glaring inequalities in the levels and trends of key SRH challenges between adolescents in this region when compared with that of adolescents in other parts of the world. For example, adolescents in SSA bear the highest burden of adverse SRH outcomes. One example is HIV infection—the vast majority of new HIV infections among adolescent girls are in East and Southern Africa [5]. Additionally, the majority of the countries with the highest rate of child marriage are in West Africa [6]; and the region as a whole has the highest level of unmet need for modern contraception in adolescents, although there has been impressive progress recently [7].

The papers in this supplement point to the huge inequalities in the levels and trends of health outcomes, harmful practices, health behaviours and in the uptake of SRH services between and within SSA countries, and in the access to preventive and curative health interventions.

- Two key messages emanating from the paper by Kanunura Muhuzuma et al. are that progress has been limited and slow across countries, and that there are enormous disparities between countries [8].
• The paper by Melesse et al. extends this point to
within country inequalities, underscoring that dis-
parities in age of sexual debut, early marriage, and
early childbearing are persisting and growing across
a number of countries [9].
• The paper by Wado et al. notes that while all groups
of adolescent girls/young women (and adult women
for that matter) are affected by intimate partner vio-
ence, those who are from poor families, have limited
education and live in rural areas are most affected
[10].
• The paper by Cane et al. highlights the disparities
in the levels and trends of HIV prevalence between
girls/young women and boys/young men, and
between rural and urban residents, while also point-
ing to the considerable progress that has been made
in reducing HIV transmission in all groups [11].
• The paper by Kavao Mutua et al. reiterates that the
least progress in satisfied needs for family planning
over time is among the unmarried and girls/young
women from the poorest communities [12].

This body of work powerfully reinforces the point that
national averages hide huge disparities. To unmask this
by disaggregating data by demographic and socio-econo-
mic characteristics from reports of household sur-
veys can provide very useful insights. Going forward
it is important that disaggregated data are collected (in
future surveys), analyzed, presented and used for deci-
son making.

In moving forward, we see five challenges and
opportunities.

Firstly, SRH survey data are increasingly available in the
public domain and enable the analysis and presentation of
findings disaggregated by age, sex (where appropriate),
wealth status, education status and urban–rural resi-
dence as well as other attributes such as religion, ethnic-
ity and gender norms/attitudes (covered in other studies,
but not in this body of work) [13]. These moves are in the
right direction as are moves such as the inclusion of ado-
lescent fertility indicators for those aged 10–14 years and
marriage for girls aged below 15 years within the Sustain-
able Development Goals targets (which till now rely on
retrospective studies) [14]. But they need to become uni-
versal practice.

Secondly, the papers in this supplement provide impor-
tant new evidence on the inequalities in SRH outcomes
and the determinants of these outcomes including ine-
qualities in access to and uptake of health interventions.
However, even more nuanced and granular analysis are
needed if those adolescents with the most pressing SRH
needs are to be identified. For example, while the SRH
situation in urban settings in most SSA countries is better
than that in rural areas, the situation in illegal and—often
un-serviced—shanty townships that house a large and
growing proportion of the population in urban areas is not always so [15]. Given the heterogeneity within
urban—but not just urban—environments, further disag-
gregation is needed. Geospatial survey methods are prov-
ing to be useful in identifying geographic “pockets” of
poor health outcomes [16]. They will need to be comple-
mented with research studies and administrative data on
health, education and social-welfare systems from these
areas.

Thirdly, while teasing out the effects of individual fac-
tors on health outcomes, harmful practices and health
services uptake is important, it is equally as important
to understand the synergistic effects of these factors and
how they interplay to create and concentrate disadvan-
tage. Intersectionality has rarely been explored in the
context of adolescent sexual and reproductive health, yet
is vital if we are to have a more holistic understanding of
the way in which social systems, power and identity influ-
ence outcomes and behaviours. The conceptual frame-
work for action on the social determinants of health
[17] provides a powerful equity lens to understand how
an intersecting web of factors increases the likelihood of
some groups of adolescents/young people being more
likely to be ‘exposed’ to a SRH outcome or harmful prac-
tice, more likely acquire it, and more likely to suffer nega-
tive consequences as a result of acquiring it. For example,
a 15 year-old girl in Mali is more likely to be ‘exposed
to the risk’ of child marriage than a girl of the same age in
Ghana (one in two girls are married before the age of 18
in Mali, whereas one in five are in Ghana). She is more
likely to be married as a child if she were growing up in
a subsistence farming community in rural Mali than in
an urban middle-class family of the country because of
community norms and very few other life options. She is
also much more likely to suffer health consequences such
as very early childbearing with associated complications
during pregnancy and childbirth, and rapid repeat preg-
nancy because of poor access to free quality health care
and inability to pay for services provided by private sec-
tor providers. She is similarly more likely to be unable to
continue with her schooling during her pregnancy or to
rejoin a school after childbirth because of the dearth of
schools nearby [18, 19].

Fourthly, data on a number of groups of adolescents
who may experience greater risks of SRH problems and
face greater obstacles in accessing and using SRH inter-
ventions, are generally not captured in nationally repre-
sentative surveys; this includes adolescents who live and
work on street, those who are disabled, and those who of
diverse sexual orientations and/or gender identities and
expressions. While boosting sub samples within general
surveys may be appropriate for some groups, others may require specific studies with approaches such as respondent-driven or time-place sampling which are designed to identify and engage hard-to-reach groups [20].

Fifthly, given the nature of the data sources, rapid changes in the demographic and health situation that have occurred because of environmental conditions such as a drought, population movement resulting from insecurity or an epidemic will only become apparent when a new round of the surveys are conducted, which may take years. Stronger Health Information Systems and more regular surveys carried out by Performance Monitoring for Action—and discussed by Kanunura Muhuzuma et al. in this supplement (9)—could play a useful role in filling this gap. Rapid studies could also play a useful complementary role. A case in point is the studies including the Gender and Adolescence—Global Evidence Alliance that have been carried out by a number of organization that point to the effects of the closures, service disruptions and movement restrictions caused by the COVID-19 pandemic [21].

Finally, data is only useful if it is used to inform policies and programmes. In many places, the growing body of abundant epidemiologic information and findings from social and behavioural studies, do not feed into policy formulation, programme design or—as George et al. have shown—in investment case development [22]. This must change. Methods and tools to assess which groups of adolescents are being left behind in programmes and projects and how best to include them are available [23, 24]. The approaches recommended by WHO and Population Council have been tried and tested in projects and are now being applied in large scale programmes particularly in the context of HIV prevention [25]. To meet the needs of the many adolescents who have been—and are being left behind—these approaches must become universal practice.

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Author details
1 Department of Sexual and Reproductive Health and Research/Human Reproduction Programme, World Health Organization, Geneva, Switzerland.
2 Department of Social Statistics and Demography, University of Southampton, Southampton, UK.
3 Department of Sexual and Reproductive Health Programme, World Health Organization, Geneva, Switzerland.
4 Department of Social Statistics and Demography, University of Southampton, Southampton, UK.

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