EXEMPLARS IN GLOBAL HEALTH

RESEARCH BRIEF

EXEMPLARS IN ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (ASRHR): LESSONS FROM FIVE COUNTRIES

EXECUTIVE SUMMARY

Investing in women's health and wellbeing is a powerful catalyst for improving health outcomes, driving economic growth, and achieving the Sustainable Development Goals. With the largest generation of adolescents in history, the opportunity to transform communities and economies has never been greater – especially when girls are empowered to make informed decisions about their health, education, and futures.

The Exemplars in Adolescent Sexual and Reproductive Health and Rights project, led by the African Institute for Development Policy (AFIDEP), used a mixed-methods approach in six countries to examine successful strategies to reduce adolescent fertility and advance ASRHR. This brief highlights four key thematic findings and recommendations from the research that can support decision-makers to allocate resources more effectively, craft evidence-based policies, and diagnose areas for further research.

Why is ASRHR important?

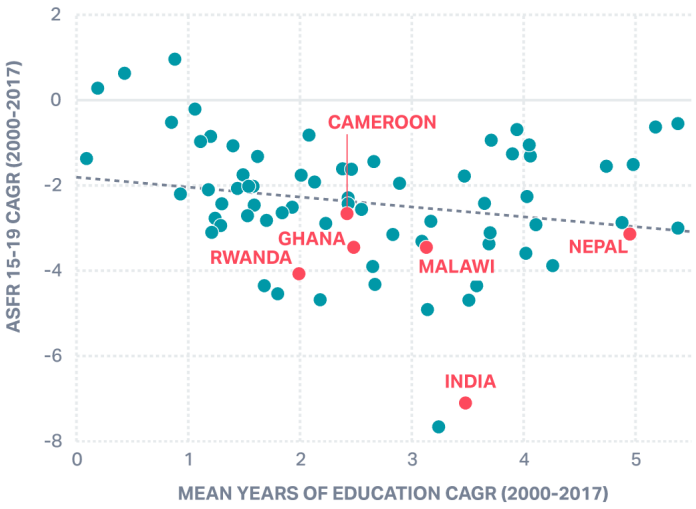
Adolescent sexual and reproductive health and rights (ASRHR) encompasses access to quality comprehensive sexuality education, essential sexual and reproductive health (SRH) services, and the autonomy to make informed decisions about one's body and future. When girls can exercise these rights, their overall wellbeing improves, and they gain access to education and economic opportunities – benefitting families, communities, and economies.

While adolescent fertility has declined globally, pregnancy and childbirth complications remain the leading cause of death among girls ages 15-19. By learning from what has worked, we can accelerate progress toward a future where girls everywhere can exercise their rights, access the care they need, and reach their full potential.

How did we select the ASRHR Exemplar countries?

Positive outlier countries were identified through regression analysis of age-specific fertility rate 15-19 (ASFR 15-19) from 2000-2017, controlling for mean years of education. Additional criteria ensured findings were transferable across diverse contexts. Cameroon, Ghana, India[1], Malawi, Nepal, and Rwanda were selected as Exemplar countries that reduced adolescent fertility beyond expectations.

Figure 1: ASRHR Exemplars country selection approach



Source: IHME

Overview of research

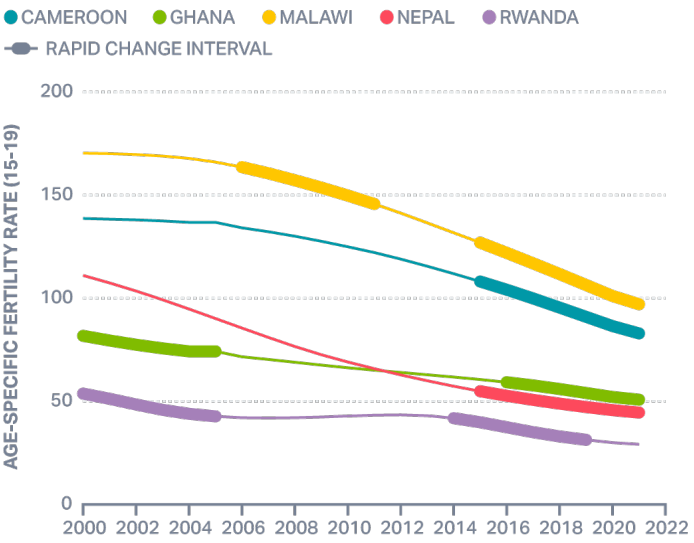
The Exemplars research draws on a robust mixed-methods design, combining quantitative analyses[2] with qualitative insights from key informant interviews and adolescent focus groups to understand the most effective strategies for reducing adolescent fertility and advancing ASRHR. Two youth advisors per country informed research design, validated findings, and supported dissemination efforts alongside country-based research partners.

[1] Research in India is ongoing, with results expected in 2026.

[2] Including Oaxaca-Blinder decomposition, multilevel modeling, and cost-benefit analysis using data and estimates from the Demographic Health Survey (DHS), United Nations Population Division (UNPD), and the Institute for Health Metrics and Evaluation (IHME).

To guide results synthesis, five-year periods of change in ASFR 15-19 were analyzed between 2000-2021, identifying the intervals of most accelerated decline and mapping the key programs and policies associated with those rapid shifts.

Figure 2: Rapid change intervals for adolescent fertility



Source: IHME

Key Findings

1. POLITICAL COMMITMENT TO PRIORITIZE ASRHR AND END CHILD MARRIAGE

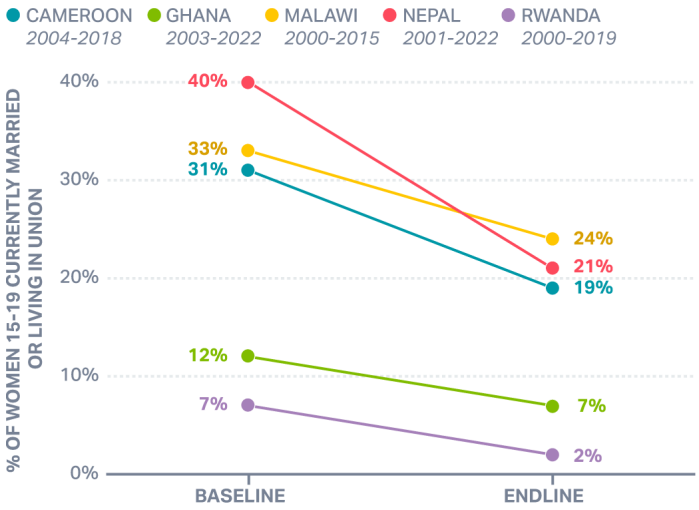
Across Exemplar countries, policies recognizing ASRHR as a national priority helped establish political commitment, mobilize domestic resources, and institutionalize adolescent-responsive service delivery. Governments also implemented coordinated strategies to promote gender equality, with a particular focus on ending child marriage. Raising the legal age of marriage proved instrumental in helping delay sexual debut and early pregnancy, improving maternal and child health outcomes, extending girls' educational attainment, and contributing to poverty reduction. Decomposition analysis identified reductions in child marriage as the primary driver of adolescent fertility decline across all countries.

Country Spotlights

Cameroon and Nepal implemented multifaceted strategies to end child marriage, combining legal reforms with targeted social and behavior change initiatives. Both countries achieved substantial reductions in adolescent marriage during this period, declining by 40% in Cameroon and 46% in Nepal.

- **Cameroon's approach emphasized multi-sectoral gender mainstreaming**. The 2015 National Gender Policy catalyzed multi-sectoral action by mandating the integration of gender perspectives into all government policies, budgets, and programs. It addressed key barriers to women's empowerment – low educational attainment, gender-based violence, high maternal mortality – and revitalized efforts to protect children's rights. In 2016, the legal age of marriage for girls was raised from 15 to 18.
- **Nepal coupled legal reforms with efforts to shift social norms at the community level.** The 2011 Marriage Bill established the legal age of marriage at 18 for girls and 21 for boys, later revised to a uniform age of 20. The 2015 Constitution recognized health and gender equality as fundamental rights and explicitly prohibited child marriage. The 2016 National Strategy to End Child Marriage introduced community engagement efforts – including women-led workshops on violence and safety – that shifted social norms and improved adolescents' access to SRH services.

Figure 3: Prevalence of adolescent marriage



Source: DHS

2. INTRODUCTION AND EXPANSION OF HIGH-QUALITY YOUTH-FRIENDLY HEALTH SERVICES

National ASRHR policies in Exemplar countries were operationalized through the introduction of youth-friendly health services (YFHS), designed to provide safe, accessible, and tailored entry points for adolescents to receive the information and care they need. Countries developed clear guidelines, trained providers in adolescent-responsive care, integrated YFHS into existing health systems, and implemented demand generation efforts to boost awareness and uptake.

Key barriers remain – particularly in expanding coverage, ensuring consistent service quality, and sustaining funding. Gaps in provider training, limited awareness of services, and sociocultural barriers continue to hinder universal access, underscoring the need for strengthened systems and coordination.

Country Spotlights

Malawi and Rwanda have demonstrated sustained commitment to advancing YFHS through progressive policies and innovative delivery models. Both countries tailored their approaches to local contexts – aligning with existing health system structures, addressing entrenched social norms, and responding to geographic barriers. During this period, demand satisfied for family planning among adolescents rose substantially in both countries – from 28% to 62% in Malawi and from 6% to 87% in Rwanda.

- **Malawi's YFHS model integrated facility-based care with designated youth clinics and community-based distribution (CBD).** The 2007 National YFHS Program established service delivery standards and trained over 1,000 CHWs in adolescent-responsive care. The 2015-2020 National YFHS Strategy further enhanced service quality, strengthened multi-sectoral collaboration, and expanded youth and community engagement. By the end of the strategy period, 60% of health facilities offered YFHS. Nonetheless, challenges such as limited sustainable funding, low service utilization, and high rates of child marriage persist.
- **Rwanda ensured adolescent access to SRH services was expanded through the establishment of youth corners in 84% of health centers and a network of dedicated youth centers.** These spaces offered integrated care, including HIV testing, SRH services, and mental health support. The 2018 National Reproductive, Maternal, Newborn, Child, and Adolescent Health Policy provided a national YFHS training manual and deployed digital outreach to improve SRHR awareness. Youth centers also fostered community engagement through cultural and recreational programming, reducing stigma and encouraging service uptake. Persistent barriers include inconsistent service quality, sociocultural resistance, and limited training among CHWs.

3. EMPOWERING ADOLESCENTS THROUGH COMPREHENSIVE SEXUALITY EDUCATION

Most Exemplar countries formalized and expanded comprehensive sexuality education (CSE) programs to promote safer sexual behaviors and equip adolescents with the knowledge and skills to make informed health decisions. Countries typically adopted phased approaches – initially introducing CSE through culturally acceptable topics like family life education or HIV/AIDS prevention, then gradually broadening to cover SRH more comprehensively. Successful approaches included developing harmonized educator guidelines and scaling up peer education and support mechanisms.

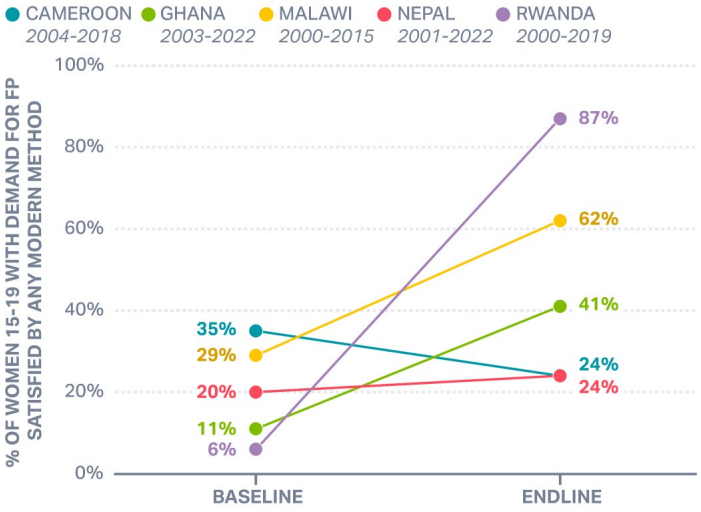
Despite progress, challenges persist. Coverage remains uneven, particularly for out-of-school adolescents; content is often insufficiently tailored to audiences or subject to teachers' personal biases; teacher training remains inconsistent; and CSE programs continue to face resistance from parents and communities.

Country Spotlights

Malawi and Nepal introduced CSE in the early 2000s and have since advanced coordinated national strategies across education and health sectors to expand access and improve quality – underscoring the education sector's vital role in safeguarding adolescents' reproductive health.

- **Malawi's approach relied on coordinated multi-sectoral collaboration.** CSE was introduced into both primary and secondary curricula in 2002, reinforced through broader education reforms and HIV/AIDS prevention efforts. However, it remains elective at the secondary level, limiting consistent delivery of key messages around delaying sexual activity and preventing gender-based violence. Out-of-school adolescents received CSE through community youth volunteers, though delivery remains inconsistent and difficult to monitor.

Figure 4: Demand satisfied among adolescents



Source: DHS

- **Sustained government commitment and systematized delivery were central to Nepal's approach.** CSE was introduced in 2003 as a compulsory lesson for grades 9-10, which expanded in 2013 to grades 4-12 after a decade of advocacy. Adolescent-friendly information corners were established in 193 public schools to reinforce classroom learning, and over 700 teachers and 500 peer educators were trained to strengthen delivery. Out-of-school adolescents were reached through the Flexible School Program, which encourages school enrollment and offers basic health education, although CSE content remains largely focused on HIV/AIDS prevention.

> "Education has been a crucial factor in reducing the fertility rate, primarily through the schooling and awareness raising on SRH issues to school children. Through education, children have come to understand the potential consequences of child marriage, such as deprivation from their future careers and educational opportunities. Schools have been instrumental in imparting knowledge about the legal age of marriage set at 20 years, as well as the legal and health consequences of child marriage."
>
> -Youth Advocate, Nepal

4. ADVANCING ASRHR THROUGH KEEPING GIRLS IN SCHOOL

Education is a proven intervention for advancing ASRHR. While education progress was controlled for in the country selection analysis, education reforms still emerged as a primary contributor to adolescent fertility reductions in the decomposition analysis across Exemplar countries.

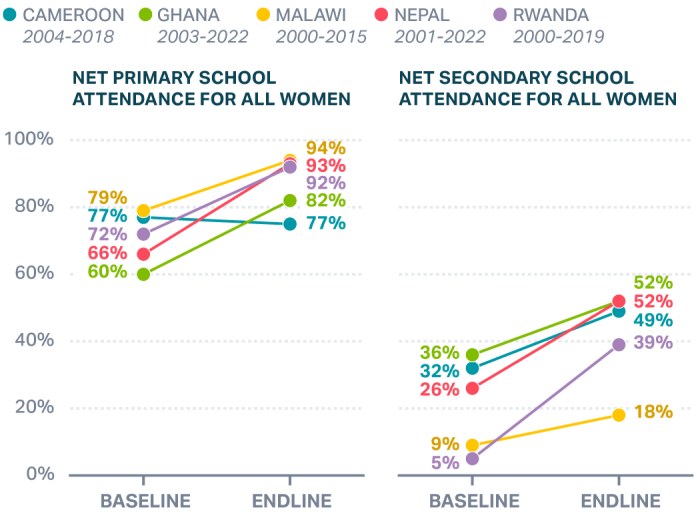
Key initiatives included making school free and compulsory, providing bursaries to marginalized girls, creating pathways for school re-admission after early pregnancy, and addressing the social and economic barriers that limit access to quality education.

Country Spotlights

Ghana and Nepal implemented wide-ranging education reforms to expand access, improve retention, and strengthen support for adolescents – particularly girls. Both countries prioritized structural and policy changes that not only promoted school attendance but also reduced vulnerabilities to early pregnancy and other SRH risks.

- **Ghana's approach emphasized equitable access through large-scale policy and social support reforms.** The 1996 Free Compulsory Universal Basic Education Program guaranteed free and compulsory primary and junior high school education, with progress accelerated by the 2017 Free Senior High School policy. Complementary reforms supported school retention by protecting girls from gender-based violence, facilitating re-entry of adolescent mothers, expanding vocational education, and scaling the national school feeding program. These efforts contributed not only to educational gains but also to rural development, poverty reduction, and improved access to ASRHR services. Ghana has achieved gender parity in senior high school enrollment, and the transition rate to secondary school increased from 72% to 91% (2014-2024).
- **Nepal prioritized universal education access, with targeted support for marginalized communities.** Reforms such as the Education for All Act (2001-2015) and School Sector Reform Program (2009-2015) guaranteed free and compulsory education up to the secondary level, with targeted initiatives for reaching marginalized students. Other efforts aimed to enhance the quality of education through curriculum reforms, teacher training, and infrastructure development. During this period, Nepal demonstrated the most significant reduction in adolescent female illiteracy among Exemplar countries – from 48% to 11%.

Figure 5: Female school attendance rates



Source: DHS

Conclusion and Recommendations

Policies and programs must evolve to sustain and build on progress in reducing adolescent fertility and promoting ASRHR. Drawing on lessons from Exemplar countries, the following recommendations emerge:

In high-fertility contexts, lay the groundwork for sustained progress by:

- Investing in safe, inclusive, and universal primary and secondary education through free, compulsory policies and incentives such as school feeding, alongside curriculum reform, infrastructure expansion, and teacher training.
- Prohibiting and disincentivizing child marriage through legal age reforms, supported by broader gender equality and child protection policies.
- Engaging communities – including religious leaders and peer networks – to shift harmful social norms that undermine adolescent health and rights.

As social and demographic conditions improve, equip health systems to meet adolescent needs by:

- Expanding access to a full range of contraceptive options, youth-friendly health services, and safe, legal abortion care where permitted.
- Introducing age-appropriate, compulsory CSE for all adolescents – in- and out-of-school – through locally adapted approaches.

At all stages, strengthen the enabling environment by:

- Partnering meaningfully with youth as co-creators – not just beneficiaries – of policies and programs.
- Reinforcing policy and accountability frameworks to ensure sustainable financing.
- Establishing social protection systems to reduce financial barriers, especially for the most vulnerable.
- Investing in robust data systems to monitor reach and impact.

Accelerating ASRHR progress is possible, even in resource-constrained settings. By prioritizing investments in education, adolescent-responsive health services, and rights-based legal reforms, countries can create the conditions necessary for adolescents to thrive– advancing both individual wellbeing and national development for generations to come.

Research partners

AFIDEP African Institute for Development Policy

EVIHDAF

University of Rwanda

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The Exemplars in Global Health (EGH) program is a global coalition of partners including researchers, academics, experts, funders, country stakeholders, and implementers. Our mission is to identify positive global health outliers, analyze what makes countries successful, and disseminate core lessons so they can be adapted in comparable settings. We aim to help country-level decision makers, global partners, and funders make strategic decisions, allocate resources, and craft evidence-based policies. A small, core team supporting EGH is based at Gates Ventures, the private office of Bill Gates, and closely collaborates with the Gates Foundation.