

A Regional Experience on Providing Comprehensive Sexual and Reproductive Health for Most-at-Risk Adolescents and Young People

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Abstract

The article aims to evaluate the current state of sexual and reproductive health policy regarding sexual and reproductive health service and reproductive rights for most at risk adolescent/youth. The training of trainers and local trainings present the nature of major challenges in service provision and the quality of services in the light of findings from international trainings conducted in Turkey and Tajikistan. The process of course development and feedback from participants was in focus of attention. The major findings of the study show that the past 10 years have seen unprecedented commitments to global health and development became known as the Millennium Development Goals with their corresponding set of time-bound targets. Greater attention to adolescence Sexual and Reproductive Health and Rights is needed if global health targets are to be met. However, for specific target group as most-at-risk adolescents and young people the access to the quality comprehensive package of reproductive health services is not reality yet. In this article we present the most-at-risk adolescent/young people trends, health service needs and in service trainings on providing comprehensive sexual and reproductive health and rights in the Eastern European and Central Asia countries based on official bodies statements, researchers evidences and acquired experience. The main conclusion is that healthcare providers and services providers, those who work with most-at-risk populations, vulnerable groups of young people, have to be trained to be able to meet the specific needs of most-at-risk adolescents and young people, to respond to their needs and to ensure sexual and reproductive health services and rights. These special trainings are definitely relevant to target populations, especially most at risk adolescents and young people in the Eastern European and Central Asia Region.

Keywords: Sexual and reproductive health and rights services; Most-at-risk adolescents and young people; Training of trainers; HIV

Introduction

Adolescence is the time when puberty takes place, when the majority of people initiate sex, and sexual preference and identity are formed. During the second decade of life, adolescents make important transitions, which often include not only sexual initiation but also leaving school, entering the labor force, forming partnerships, and having children. This is a period of first-time experiences, risk-taking and experimentation with many things, including alcohol and other psychoactive substances [1]. Young people aged 10-24 years make up one-quarter of the world's population, and due to lack of life experience and risky behavior they are among those the most affected by global epidemic human immunodeficiency virus (HIV) [2].

A focus on adolescence is central to the success of many public health agendas. The past 10 years have seen unprecedented commitments to global health and development, beginning in 2000 with the commitments in the United Nations Millennium Declaration that became known as the Millennium Development Goals with their corresponding set of time-bound targets [3]. Goals aim to reduce child and maternal mortality and HIV/AIDS, and the more recent emphases on mental health, injuries, and non-communicable diseases. Greater attention to adolescence is needed within each of these public health domains if global health targets are to be met. Strategies that place the adolescent year's center stage-rather than focusing only on specific

health agendas-provide important opportunities to improve health, both in adolescence and later in life [4].

During last decades with the purpose to achieve Millennium Development Goals Sexual and Reproductive Health and Rights (SRHR) Services were considerably improved in the Eastern Europe and Central Asia region. However, still most-at-risk adolescents and young people (MARA and MARYP) are not in the focus of medical professionals and their access for health care is still discussed. To reach the target group, the large network of non-governmental organizations (NGOs) built, however social workers, psychologists, outreach workers etc. sometimes have limited information about health and health needs, especially in the reproductive health issues. To integrate efforts of medical and non-medical professionals with the goal to improve quality of life for MARA/MARYP by providing comprehensive SRHR services was met challenge which resulted in the necessity of education of people involved in MARA/MARYP care in both directions: about sexual and reproductive health and rights, about what are MARA/MARYP needs and expectation in this context.

Materials and Methods

The purpose of this article is to provide the latest data based on progress of the trainings on comprehensive sexual and reproductive health and rights services for most-at-risk adolescents and young people in the Eastern Europe and Central Asia region was decided to make retrospective and prospective analyses of the components which determine the future project development. The information was

collected from course evaluation forms filed in by participants and verbal feedback during the course. The authors revised the latest epidemiological data on MARA/MARYP, Vulnerability of Adolescents/Young People, The Provision of Health Service for MARA/MARYP in the Region and Issues on Training health providers on the needs of young key populations, based on acquired experience.

WHO, UNFPA, UNAIDS, UNICEF and other official sites were visited. The publications on the topic were searched. In this article the authors present the Most-at-Risk Adolescent/Young People trends, health service needs and on Providing Comprehensive Sexual and Reproductive Health and Rights in the Eastern European and Central Asia countries.

Results

Epidemic data shows a critical point for most at risk adolescents and young

HIV continues to be a major global public health issue, having claimed more than 39 million lives so far [5]. Eastern Europe and Central Asia (EECA) continue to see rapid increases in HIV infections among men, women, adolescents and children.

In 2013, there were an estimated 5 million people aged 10-24 years globally living with HIV, and young people aged 15-4 years accounted for an estimated 35% of all new infections worldwide in people over 15 years of age [6]. More than 2 million adolescents aged between 10 and 19 years are living with HIV, and many do not receive the care and support that they need to stay in good health and prevent transmission. During 2005-2012, HIV-related deaths among adolescents increased by 50%, while the global number of HIV-related deaths fell by 30% [7].

The EECA region is the only one in the world where HIV prevalence is rising and HIV is the second largest cause of death among adolescents globally [8]. Russian and Ukraine have the highest number of people living with HIV ratio among general adult population [9]. Approximately over two-thirds of the area's infected people living in both countries, 90 percent of the region's newly reported HIV diagnoses has been excited. HIV prevalence in Russia, Eastern Europe and Central Asia has increased by 250 percent, making the region home to the world's most rapidly expanding epidemic since 2001. Increases up to 700 per cent in HIV infection rates have been found in some parts of the Russian Federation since 2006. Adolescent girls (aged 10-19) who sell sex include an estimated 20 per cent of the female sex-worker population in Ukraine. HIV prevalence among females aged 15-19 who sell sex increased 19 per cent then 1.4 per cent in the general adult population in 2006 [10].

Statistics show rapid increases in HIV incidence in Central Asia especially Caucasus, much of them under estimated. Since 2000, the rapid epidemic of HIV has been increased in Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan. The upward growth of the epidemic reasons due to injection drug use, because of central Asia's geographic position along major drug trafficking routes. HIV incidence has increased more than 11 times in Uzbekistan during 2001-2006 compared with four times in Kyrgyzstan and Tajikistan. HIV epidemic raised among young people: 64% of HIV cases have been among people aged 34 years or younger in Uzbekistan, 57% of cases are in those younger than 30 years in Kyrgyzstan, and 45% were among the 20-29 years age group in Kazakhstan [11].

From 2001 to 2011, there has been a 20 per cent increase in HIV in the 15-24 age groups, with most of these infections occurring among those who inject drugs, sell sex or engage in same-sex relations. Sexual transmission of HIV is increasing across the Region, becoming the most common route of infection. Studies estimates that men who have sex with men are 19 times more likely to have HIV than the general population, and female sex workers are 14 times more likely to have HIV than other women. Available aggregate data show significantly higher HIV prevalence and increasing rates of diagnosed HIV infection among adolescent men who have sex with other men than among their peers in the general population. Moreover, adolescent transgender women with a history of sex work may be more than four times more likely to be living with HIV than their peers without such a history [12].

Unsafe sex is the second largest cause of the loss of disability adjusted life years (DALYs) in the EECA region. According to the results of inject drug's surveys that 15 percent in Belarus and Tajikistan are living with HIV, as are more than 20 percent in Ukraine and more than 50 percent in Estonia. Some vulnerable groups such as the Roma have difficulties to access to health services which compound the inequalities that already exist [13].

The EECA region is home to 20 percent of the world's population. There have been great successes in meeting the goals of the ICPD in the UNECE region. People are living longer, healthier lives and have higher levels of education than past generations. There are some results indicate that the prevention of HIV transmission information has increased in young people. The ratio of young people who have had sex before 15 years has declined; people with multiple sexual partners has risen condom use; and the distribution of young people who have received an HIV test and learned their results has also increased [10]. Early adolescents can be challenging to have sexual intercourse without using any kind of contraceptives the consequence of unintended pregnancies and sexually transmitted diseases [14].

On the other hand the region faces new obstacles; HIV epidemic, early and forced marriage; Maternal Mortality still emerging issue, still observed in Central Asia, Caucasus and Georgia with ratios above 50 and also early and forced marriage adolescent mothers, unsafe abortion and adolescent birth rates [15]. Significant barriers still exist to accessing SRHR services for most at risk adolescents [16].

Are adolescents/young people vulnerable?

WHO defines social determinants of health as "the conditions in which people are born, grow, live, work and age", conditions or circumstances that are shaped by families and communities, by the distribution of money, power, and resources at global, national, and local levels, affected by policy choices at each of these levels [17]. It also affects young people vulnerability. Biological and socialization processes in adolescence that allow unique opportunities for social determinants to affect health; adoption of behavior (e.g., smoking, drug misuse, and sex) that are risky to health yet might be normal within adolescent social development. Behaviors that put adolescents and young people most at risk of HIV include engaging in multiple unprotected sexual partnerships and injecting drugs with non-sterile equipment. Some situations and circumstances influence risk taking behavior for adolescents such as peer pressure, curiosity, and thrill seeking sometimes lead to experimentation with drugs, alcohol and sexuality. MARA has centered on this cycle [5]. In consequence of discrimination, stigma and violence, combined with the particular vulnerabilities of youth, power imbalances in relationships and,

sometimes, alienation from family and friends made young people vulnerable to HIV. The global response to HIV largely neglects young key populations [6]. Many factors specific to children and adolescents aged 10-17 years contribute to this vulnerability, including severe circumstances of initiation and involvement, such as physical force and lack of control over their situation and finances, inability to negotiate condom use [18].

Adolescents can easily take risks and can be able to influence their peers in both ways. This is the part of the process of developing decision-making skills. At this point adults play a crucial role in this regard and can guide adolescents attain the consequences of their risky behaviors and help them to identify options. Even though adolescents make up a large ration of the population in the developing world, their SRHR needs are largely unmet [19].

The Strategy was developed to guide the expansion of the global HIV response beyond the HIV-specific programs of the past, by strategically positioning HIV within a rapidly changing health and development agenda during the 2011 World Health Assembly. They developed 4 strategic directions on Global Health Sector Strategy on HIV/AIDS and four targets for 2015. In spite of achieving their outcomes, the forth Strategy was highlighted to reduce vulnerability and remove structural barriers to accessing services which is directly target reducing vulnerability [8].

According to latest studies young people has their first experience of sexual intercourse younger than were their parents. But the potential danger of risk does not mean that we should not prevent them all [20]. Therefore, the term of most-at-risk adolescent/young people is accepted to target below situations

Male and female injecting drug users (IDUs) who use non-sterile injecting equipment;

Males who have unprotected anal sex with other males;

Females and males who are involved in sex work, including those who are trafficked for the purpose of sexual exploitation and have unprotected (often exploitative) transactional sex;

Males who have unprotected sex with sex workers [19].

In this article we used “at risk” to express a chance or a probability. Risk factors increase the chance of negative outcomes, while protective factors raise the chance of positive outcomes. It is valuable for programs to understand the levels of risk and protective factors in their program clients, as well as their potential clients. Such understanding can help in developing programs and also in obtaining funding for them [21].

Vulnerability, as a concept, can seem overly broad and abstract. Every adolescent/young people might be vulnerable to some contradictory situations in their life. The most important thing to find the severe prevention method for break the cycle who might be vulnerable, what are they vulnerable to and why. Almost everyone feels vulnerable at some point in life. But some individuals and some groups are more vulnerable than others due to varying exposure to social and economic conditions and at different stages of their life cycles, starting at birth. Young people around the world are especially vulnerable to marginalization on SRHR issues [22].

Health service approach for MARA in the region

Health professional as a change agent therefore we should use influence beyond the health sector; such as in service trainings.

Promote essential interventions for behavior change and positive health practices. The 1994 ICPD Program of Action articulated revised approaches to population issues. The Program of Action highly emphasizes to universal access to an integrated comprehensive package of reproductive health services including HIV/AIDS into the primary health care system. A substantial proportion of the world’s population does not have access to health services. Countries should ensure a comprehensive range of quality health services must them widely available, but also to make them affordable and acceptable to those in need [23]. The Millennium Declaration also again draws attention to improving reproductive/ maternal health, combating the spread of HIV/AIDS and strengthened partnerships. So that the International and national NGO’s should incorporate these goals in their agenda [24].

The major unmet challenges are gender inequalities and gender based violence that continue to contribute to the unequal high incidence of HIV rates for women and girls. HIV services are not easy accessible for all vulnerable populations. Many young people and adolescent cannot access HIV health services for legal restrictions. In many countries also have laws or policies that restrict the provision of certain health services that are particularly important to key populations, such as young people who inject drugs. Surveys demonstrates that more than 40% of national governments in 2013 reported having laws, regulations or policies that can hinder effective HIV services for key populations. In the region a few countries reached the improvements quality of health provision as HIV services are adapted and integrated with other health programs and services. Effective, efficient and comprehensive health and community systems are vital for ensuring accessible, affordable and sustainable HIV services. Strategic direction of the Global Health Sector Strategy on HIV/AIDS 2011–2015 also targets on initiatives and systems to improve the quality, effectiveness and reach of HIV-specific interventions and approaches [25].

Access to quality health care is a human right. It includes Most at Risk Adolescent (MARA)/Most at Risk Young People (MARYP); Especially Vulnerable Adolescent (EVA); Especially Vulnerable Young People (EVYP) to appropriate quality health care and counseling without discrimination. Health care providers must serve their clients based on the principle of medical ethics and right to health. To maximize impact, services should be made; accessible, acceptable, affordable and equitable [12]. Effective HIV prevention for MARA/MARYP includes appropriate access to high-quality, youth-friendly sexual and reproductive health and rights services including HIV services by confidentially [25].

It is also important to be clear about the contribution that individual health workers and the health system in general can reasonably be expected to play in delivering information to young people for HIV prevention and care, about the range of health services that are available to help them. Information and counseling as a core element of the health services response for HIV prevention and care among young people. Information needs to be linked to counseling because while there is no direct evidence to demonstrate effectiveness of counseling, there is evidence that information provided in ways that are empowering supporting young people’s development, are more effective at inducing sustained behavior change [26].

In Tajikistan, recent initiates to injecting drug use are twice as likely to be HIV-infected as those with longer injecting histories, implying riskier HIV behavior and potentially less use of harm reduction services than older, more established users. There are numerous

examples of adolescent/youth-friendly health services (YFHS) in the region that have been successful in introducing ‘client-oriented’ approaches and in providing mainstream young people with information, reproductive health services, and prevention information and counseling for HIV and sexually transmitted infections (STIs). Some have also managed to reach and serve effectively the needs of MARA. In health services throughout the region, there are widespread reports of negative attitudes towards people living with HIV, who experience rejection as well as lack of responsiveness towards their needs [10].

All adolescents need access to quality YFHSs provided by clinicians trained to work with this population. Negative outcomes of early pregnancy and sexually transmitted infections (STIs), including HIV/AIDS, threaten the health of people in the second decade of life more than any other age group. At the same time, adolescents are the greatest hope for turning the tide against STIs, AIDS, and early pregnancy [27].

Health care providers must be sensitized and trained to understand their clients and to advocate them to increase the demand for HIV services. Different outreach methods and interventions must be adopted for varied sub groups of vulnerable population [28].

Inadequate access to comprehensive sex education, shown to be effective in delaying sexual debut and increasing condom use among young people who are sexually active, also undermines efforts to protect young people from acquiring HIV. Overcoming structural barriers that hinder access to important health services is crucial for increasing the uptake of affordable, high-quality health services and ensuring that national HIV responses are equitable. When properly enforced, laws and policies that protect and promote human rights can reduce vulnerability and risk of HIV infection, expand access to health services and enhance their reach, quality and effectiveness-especially for populations that are at higher risk of HIV infection [25].

The health service provider training addressing the needs of key populations: some examples

The received information and knowledge are belongs friends, family, teachers, and religious leaders and mostly from the mass media for adolescents. The health service providers must be considered them to reach a coherent package of information for young people about HIV [29].

Health worker training on HIV-related services for adolescents needs urgent attention, especially regarding how to link it with and build on existing training. Other professionals, e.g. social workers, play key roles in the support of MARA/MARYP; their involvement needs to be taken into consideration when planning the strengthening of human resources. Policy and programs should be focused to improve the quality of health services for MARA/MARYP, and to increase adolescents’ demand and use of affordable services [30].

Services are usually provided in contexts that are not designed for young people, by staff that may not have been trained to consider the needs of young people in general, nor the specific needs of young people who sell sex. This has a direct and negative impact on their health. Some HIV service-providers are lack of equipped to serve MARA/MARYP, in the meanwhile health service providers may provide unsusceptible and uninformed to work with especially vulnerable population [31].

Civil society also has important role for capturing inaccessible marginalized population structures [32].

UNFPA EECA Regional Office and International Children’s Center (ICC) guided and support for increasing demand SRHR services for MARA/MARYP in the region. It is very critical role to developing the core competencies of health service provider. Focusing on the technical skills on MARA required delivering quality health service provision. Management skills of service providers were strengthened to ensure efficiency, effectiveness and the ability of their Organizations, institutions to adapt to a changing and updating knowledge on HIV/AIDS. The recruitment and training of adequate numbers of health workers remains the mainstay of an effective health system. Services for HIV and for sexual and reproductive health services, including for family planning and sexually transmitted infections, are increasingly being linked or integrated. A comprehensive HIV program needs to deliver a broad range of interventions that cover the continuum of HIV prevention, diagnosis, care and treatment that reach diverse populations in many different settings. Several authors have suggested that training is most extensive and important in any organization or establishment [33,34].

One of UNFPA’s particular focus areas is supporting provision of improved, comprehensive and user-friendly SRHR services especially to vulnerable populations. The UNFPA EECA Regional Office and the International Children’s Centre have been collaborating on a long-term training strategy in the adolescent/youth field. The long-term training strategy on Sexual and Reproductive Health and Rights services for MARA/ MARYP focus on the following:

Building the capacity of national partners in comprehensive SRHR and addressing SRH needs of most-at-risk adolescents and youth;

Establishing a systematic approach in training on comprehensive SRHR services for most-at-risk adolescents and youth;

Setting up quality standards for the EECA region on SRHR services for most-at-risk adolescents and youth;

Establishing competency standards for trainers;

Assessment and certification of trainers; and

Monitoring and evaluation of training results, learning outcomes and impacts.

As part of SRHR systems strengthening, UNFPA EECARO supported development of a Trainers Training (ToT) course on provision of comprehensive SRH services for MARYP/MARA. The aim of this course was to build the capacity of SRHR service providers, to increase MARYP/MARA access to “youth friendly” SRHR services, including HIV and STIs. For this purpose, a ToT Manual on MARYP/MARA’s SRHR was developed in 2011 by ICC in collaboration with EECARO. The ultimate objective of the ToT in this respect is to ensure that all health facilities acquire skills for MARA/MARYP through a common policy and service delivery standards in the region. The first draft of Manual was developed by a group of international experts in SRHR according to proposed strategy.

Some of the materials in this curriculum were adapted from materials developed by the Melbourne Consortium for Adolescent Youth Health and Development: The Nossal Institute for Global Health (School of Population Health, University of Melbourne); The Youth Research Centre (Graduate School of Education, University of Melbourne) in collaboration with The Burnet Institute, The Bilkent University, Turkey.

Two different training curricula were developed and updated after each of international trainings. The first starting point was creation of ToT for MARA in the region. The first training module was for health professionals working with MARA, and aims to raise awareness on Comprehensive SRSR for MARA. The training topics intend to stimulate providers to reconsider their attitudes and approaches to young people. An overall theme of this training was to create greater trust and understanding between youth and health care providers. Towards this end, the trainings also share experiences of sides, best practices and lessons learned by international trainees.

The ToT Manual was tested in a two regional pilot courses (one in English and one in Russian), in Ankara in 2011 in English and 2012 in Russian. These one-week courses were attended by 36 participants from eight countries: Albania, Bulgaria, Georgia, Macedonia, Moldova, Turkey, Azerbaijan, Kyrgyzstan, Kazakhstan, Uzbekistan, Tajikistan, Turkmenistan, and Belarus (Figure 1). Valuable feedback was received on the ways how to improve the manual.

We will skip in this article quantitative answer on course evaluation form and will point out common opinion. The results revealed that the participants have positive feelings about training, since the training afforded them the opportunity to acquire additional knowledge in basic issues concerning HIV/AIDS and its counseling and testing, to build data collection skills to be able to be comported to service for MARA/MARYP as well as to manage a research study of this magnitude. It also afforded them the opportunity to learn about international standards and regulations. It is clear from the training results that recent trainees feel very well prepared (well trained and competent) in many areas, particularly in HIV management.

For participants, the training afforded them the opportunity to acquire new knowledge and build skills to be able to conduct national trainings as well as developed trainers' skills to work with most-at-risk adolescents/youth and expand the access to Sexual Reproductive Health Services for MARA of this magnitude. It also afforded them the opportunity to understand the specific needs of the MARA/MARYP; to learn about quality standards of SRHR services for them. Despite the relatively small number of participants, these two trainings provide the only current and detailed assessment of training of MARA in EECA Region across a wide spectrum of learning and content areas. The ToT course was effective in developing sustainable quality on comprehensive SRHR services for MARA/MARYP in Eastern Europe and Central Asia as demonstrated by the fact that there is increase in knowledge base of the participants. In addition, the central training helped to build a cadre of trainers who will be able to do an effective step down training throughout their countries as seen in the result. The participants learned they must take time to hear and understand the experiences of young key populations, and they appreciated the opportunity to address any feelings of discomfort about working with them.

In between training initiative working group of experts was reviewing course materials by organizing workshops and e-meetings. It was decided as second step of the ToT Manual development to adjust from main materials a training package to be utilized during national roll out of training course. The training manual was developed in Russian and the first national roll-out was tested in Tajikistan in 2013. It was designed to build the capacity of national institutions including NGOs, state institutions and professionals (general practitioners, midwives, health providers and social workers working with most-at-risk adolescents and youth). Feedback received

during this pilot-testing was used by organizers for further improvements.



Learnt lessons

Based on experience accumulated during run trainings the following practical advices come up:

Make educational programs and services integrated, linked and multidisciplinary in order to ensure the most comprehensive range of services possible and address the overlapping vulnerabilities and intersecting behaviors of different key populations.

Invite competent in SRHR field trainers, who experienced working with EVA/EVYP and/or MARA/MARYP, offer the opportunity to study course materials in advance.

Pre-select training participants and give them lead in SRHR promotion in their countries, and share their experience and attitude towards MARA/MARYP with other health professionals. Train services providers, both those who work with most-at-risk populations and those who work with vulnerable groups of young people, so that they are better able to meet the specific needs of most-at-risk young people.

Train health-care providers and other staff to ensure that services are non-coercive, respectful and non-stigmatizing, that young people who sell sex and other MARA/MARYP are aware of their rights to confidentiality and that the limits of confidentiality are made clear.

Train health-care providers on the sexual and reproductive health needs of young people and especially those who sell sex, as well as relevant overlapping vulnerabilities such as drug use.

During trainings provide developmentally appropriate information and education for young people who sell sex, focusing on skills-based risk reduction, including condom use and education on the links between use of drugs and unsafe sexual behavior.

Advocate to implement a comprehensive health package for young people who sell sex as recommended in the WHO Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations: make programs and services accessible, acceptable and affordable, involve well educated staff.

The main challenge for future training progress is to keep educated trainers to provide trainings in their own countries, and to involve critical mass of caregivers in the providing services for target groups of population as MARA/MARYP.

Conclusion

The training-of-trainer model has the potential to rapidly increase capacity for much needed health services such as HIV counseling and testing by preparing service providers to train other providers in clinical skills. One of the key benefits of this model is that as more trainers are trained, more trainings can be conducted, thus allowing more providers to be trained. This capacity is critical in both achieving rapid roll-out of services and ensuring a continual supply of providers trained to deliver needed services. There will always be some attrition and hence the ongoing need for training of new staff.

Although a global meta-analysis of studies determined that 'behavioral interventions reduce sexual risk behavior and avert sexually transmitted infections and HIV', many countries lack a comprehensive strategy for rolling out these programmatic approaches [35].

Social-behavioral programs are often implemented in isolation, uncoordinated, insufficiently tailored to address the needs of the intended population and lacking in rigorous evaluation at a scale necessary for widespread roll-out. It is clear that only when a comprehensive set of HIV prevention initiatives is rolled out at a national scale, with sufficient access to, and frequent use of, quality services, will countries realize the optimal prevention returns [25].

It is important to underline that MARA/MARYP needs in the sexual and reproductive field are not only precisely connected to HIV transmission. As persons they wish to have sexual satisfaction in their life, to get married, to have children and happy family life. That's why it is important to provide comprehensive SRH services including family planning and contraception, sexual education and counseling in order to ensure their sexual and reproductive rights.

It is also very important for the health service providers to participate in up-to-date in- training. In this study evaluations of trainees have emphasized the crucial importance of in-service training. In-service training is of key importance in providing quality service and sustaining motivation among service providers. It should never be forgotten that not only health professionals but all health care professionals should have training on MARA in order to ensure effectiveness and sustainability of services offered. It is crucial to allocate resources and budget in order to overcome the challenges and to reach out to more adolescents/youth. New strategies have emerged to reduce young people's vulnerability to HIV, including social cash transfers that create incentives for safer behavior.

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