January 2020

Adolescent Sexual & Reproductive Health & Rights

Progress in the 25 years since the International Conference on Population & Development & prospects for the next 25 years

Dr V Chandra-Mouli, @ChandraMouliWHO, chandramouliv@who.int

Ms Marina Plesons, @Mplesons, plesonsm@who.int

Journal of Adolescent Health 65 (2019) S16–S40

ELSEVIER

JOURNAL OF ADOLESCENT HEALTH

www.jahonline.org

Review article

The Political, Research, Programmatic, and Social Responses to Adolescent Sexual and Reproductive Health and Rights in the 25 Years Since the International Conference on Population and Development

Venkatraman Chandra-Mouli, M.B.B.S., M.Sc.[a,*], B. Jane Ferguson, M.S.W., M.S.C.[b], Marina Plesons, M.P.H.[a], Mandira Paul, Ph.D.[c], Satvika Chalasani, Ph.D.[c], Avni Amin, Ph.D.[a], Christina Pallitto, Ph.D.[a], Marni Sommers, Dr.P.H., M.S.N.[d], Ruben Avila[e], Kalisito Va Eceéce Biaukula[f], Scheherazade Husain, M.P.H.[g], Eglé Janušonytė[h], Aditi Mukherji[i], Ali Ihsan Nergiz[j], Gogontlejang Phaladi[k], Chelsey Porter, M.P.H.[l], Josephine Sauvarin, M.B.B.S., M.P.H.[m], Alma Virginia Camacho-Huber, M.D., M.P.H.[n], Sunil Mehra, M.D.[o], Sonja Caffe, Ph.D., M.P.H., M.Sc.[p], Kristien Michielsen, Ph.D., M.Sc.[q], David Anthony Ross, B.M.B.Ch., Ph.D., M.Sc., M.A.[a], Ilya Zhukov, Ph.D.[c], Linda Gail Bekker, M.B.Ch.B., Ph.D.[r], Connie L. Celum, M.D., M.P.H.[s], Robyn Dayton, M.P.H.[t], Annabel Erulkar, Ph.D.[u], Ellen Travers, E.M.A.[v], Joar Svanemyr, Ph.D.[w], Nankali Maksud, L.L.M.[x], Lina Digolo-Nyagah, M.B.Ch.B, M.Med., M.Sc.[y], Nafissatou J. Diop, Ph.D.[c], Pema Lhaki, M.S.[z], Kamal Adhikari, M.A.[aa], Teresa Mahon, M.Sc.[ab], Maja Manzenski Hansen, M.Sc. (Public Health), M.Sc. (Sexual & Reproductive Health)[ac], Meghan Greeley, M.P.H., M.S.N.[ad], Joanna Herat, M.A.[ae], and Danielle Marie Claire Engel, M.A.[c]

https://www.sciencedirect.com/science/article/pii/S1054139X19304690

Two questions:

1. How have epidemiologic trends, & political, research, programmatic & social responses to ASRHR evolved in the 25 years since the ICPD ?

We examined the following 6 areas: adolescent pregnancy & child bearing, HIV in adolescents & young people, child marriage, violence against adolescent girls, female genital mutilation, & menstrual hygiene & health

2. What contribution did the ICPD make to this ?

2

World Health Organization hrp

Adolescent pregnancy

Adolescent pregnancy

Levels & trends:

- The global adolescent birth rate (i.e. births per 1000 girls aged 15-19) declined from 63 in 1994 to 44 in 2017.
- All regions have shown declines, with substantive differences between regions, between countries in each region, & within countries. However, in some countries, the rate has increased.
- Although births in 10-14 year olds are rare, elevated levels can be seen in some countries.
- Although ABR is declining, the large and growing number of adolescent girls in the 15-19 age group, means that absolute numbers of adolescent births are increasing especially in sub-Saharan Africa.
- Adolescents have higher unmet needs for contraception than other groups. They have higher unintended pregnancy rates than other groups. About half of unintended pregnancies in adolescents, end in abortion, most of which are unsafe.

Adolescent pregnancy

Global & regional responses:

- Adolescent pregnancy prevention was on the ICPD agenda. It was missing from the MDG agenda till 2007 when a sub-goal on RH was added to MDG 5, with an indicator on adolescent fertility rate. It is part of the SDGs.
- Since the 2010s, a number of global initiatives have advocated for/supported action on adolescent pregnancy prevention. The recognition that adolescent pregnancy prevention could contribute to neonatal & maternal mortality reduction has also led to increased attention.
- However the focus continues to be on pregnancy prevention; care & support for pregnant adolescent has received less attention.
- The evidence base has grown, while there are gaps. The growing evidence base has contributed to the development of norms & standards.

Adolescent pregnancy

Evolution of national & subnational responses:

- Global & regional advocacy/support led to country-based policies & strategies to prevent adolescent pregnancy. Alongside this, policies & strategies were put in place to guarantee rights to education.
- Legal barriers to SRH services have been removed in a growing number of countries – both to contraception and to safe abortion care. However, even where they have been liberalized, stigma hinders care seeking by adolescents.
- As a means of protecting adolescents from sexual abuse, many countries have defined the legal age of consent for sex. While this is positive in some respects, it has negative implications in other respects – firstly, any sex below the legal age of consent – even consensual sex among peers – is considered statutory rape; secondly, because of the legal implications, adolescents are hesitant to seek care, & health workers are reluctant to provide care.
- Youth –led organizations are playing an increasingly important role in this area.
- Many countries have Comprehensive Sexuality Education (CSE) & Adolescent Friendly Health Services (AFHS) programmes in place, but quality & coverage are patchy. While there has been progress, there has also been push back on CSE, safe abortion care & on contraceptive provision to unmarried adolescents.
- While the focus has been on girls & young women, there is growing attention to the roles that boys & young men need to play.
- There is also growing recognition of adolescents' needs & vulnerabilities in humanitarian situations.

‘With solid positioning on global, regional & national agendas, a growing body of evidence feeding into norms/standards/guidelines, & an increasing number of countries stepping up action - the stage is set for continued progress.’

Helping factors:

- The evidence that a combination of feasible & effective approaches implemented together can reduce unintended pregnancy.
- The effect of global advocacy & government-led policies & programmes to prevent adolescent pregnancy have contributed to declines in ABR, global advances in girls’ education & declines in age of marriage have also substantially contributed to this.

Hindering factors:

- Adolescent sexuality is not acknowledged.
- Despite progress, demand & supply side – legal/social/service-delivery/ - barriers continue to restrict adolescents’ access to SRH information & services.
- Health/education, social-welfare & legal systems are weak. There is also weak inter-sectoral coordination.
- Data gaps remain meaning that policies & programmes are based on an incomplete/inaccurate picture.

Challenges:

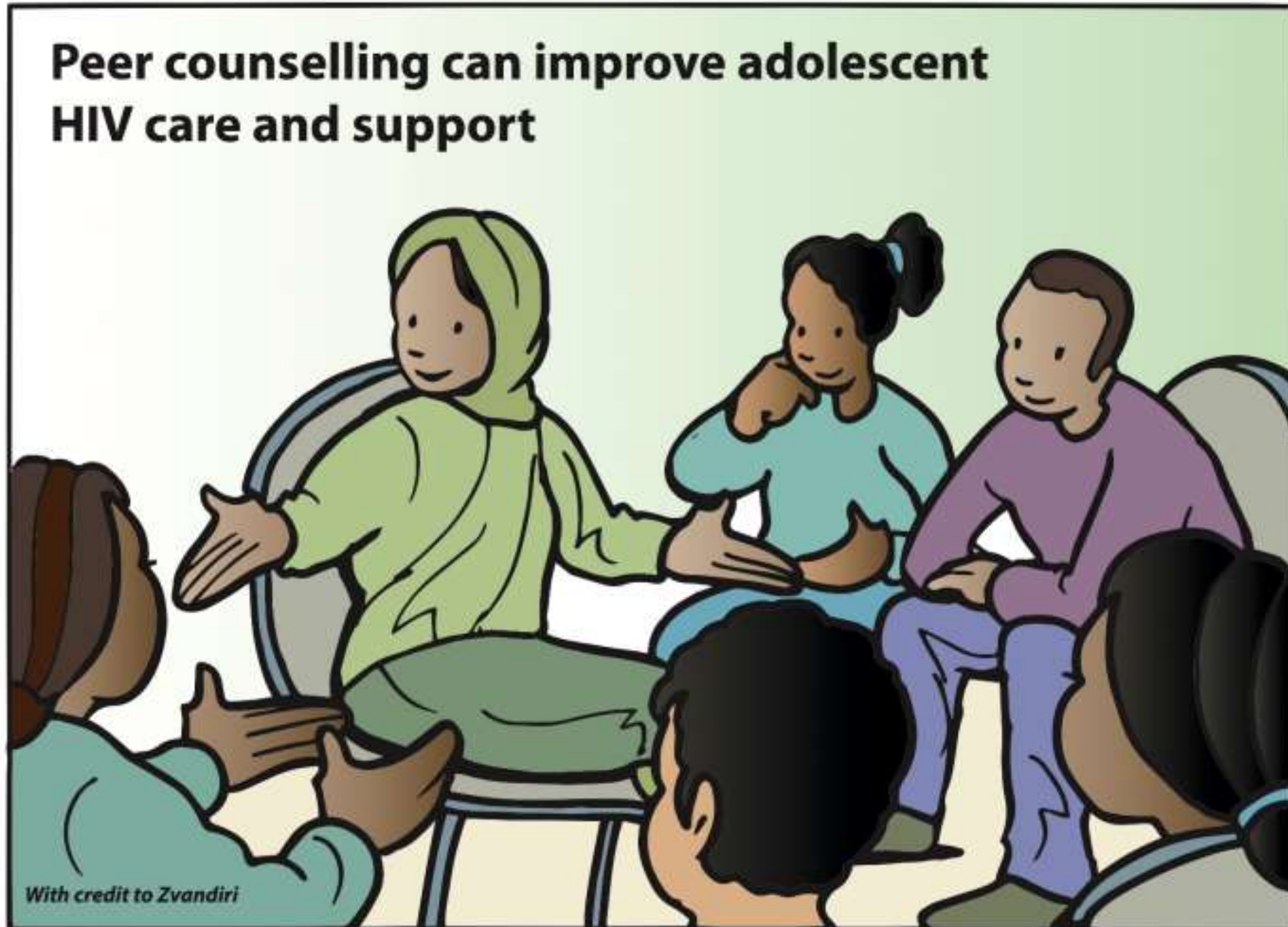
- To focus at the subnational level
- To deliver context specific interventions
- To increase government investments
- To generate evidence on going to scale without compromising quality & equity
- To build private-public partnerships
- To integrate with HIV prevention & care
- To engage men & boys
- To apply a life course perspective
- To use new platforms to extend deliver

World Health Organization hrp

Uruguay: Progressive laws & policies, strong government-led multisectoral responses & active civil society monitoring has led to dramatic declines in adolescent fertility.

- The Adolescent Birth Rate in Uruguay declined from 72 births per 1000 adolescents in 2014-15 to 36 per 1000 adolescents today, half of what it was 23 years ago.

HIV in young people



HIV

Levels & trends:

- Over the last 25 years, the estimated numbers:

(i) of new HIV infections fell by 50% in 15-19 year olds

(ii) of adolescents living with HIV rose by 50%, mainly because children infected perinatally are surviving into adolescence

- The number of adolescent girls living with HIV is 1/3 more than the number of boys living with HIV.
- Data on levels & trends of young members of key populations are limited; available data suggest that levels are high & increasing.

Global & regional responses:

- HIV in adolescents/young people was in the ICPD, in the UN General Assembly Special Session (2002) & in the MDG agendas. This provided the basis for policies, programmes & for measurement. It is also on the SDG agenda.
- UNAIDS was established in 1996. The first set of inter-agency evidence-based guidance briefs was published by UNAIDS in 1998. This has been followed by many adolescent-specific & adolescent-relevant guidelines.
- Adolescents have been included in research studies directed at adults, but adolescent-specific research has been limited.
- GFATM was established in 2002. In the last few years it has started investing in programmes directed adolescent girls/young women. However, overall funding for HIV has decreased.

HIV

- **National & subnational responses:**
- **In the 1980s and 90s, HIV prevention efforts aimed to improve knowledge & understanding & to promote safer sex among all young people.**
- **In the early 2000s, recognition grew of the need to address environmental drivers of HIV & to address young members of key populations.**
- **While the best evaluated successes are the application of biomedical approaches e.g. anti-retroviral therapy for preventing mother to child transmission, voluntary medical male circumcision, pre/post exposure prophylaxis & treatment as prevention. There is widespread recognition of the need for combination prevention i.e. delivering biomedical approaches & - at the same time - addressing social & structural drivers of behaviour. A good example of the application of this is the DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored & Safe) Initiative.**
- **The large number of adolescents living with HIV is increasing pressure to expand coverage & quality for the full HIV treatment cascade i.e. HIV testing, treatment & retention in care. Gradually adolescent uptake & support by adolescents to adolescents is reducing rates of treatment failure.**
- **Both treatment & prevention have been impeded by legal & policy constraints e.g. mandatory reporting laws, age of consent policies & parental/spousal permission requirements.**
- **Greater attention is being paid to the prevention, treatment & support needs of young members of key populations.**
- **The meaningful involvement of young people is recommended in normative guidance, assessed through studies & evaluations & is a required element in funding proposals.**

World Health Organization hrp

‘Energy & determination to end the HIV epidemic continue. Increasingly, they benefit from improved methods of understanding the epidemic among adolescents.’

Helping factors:

Steady increases in age- & sex- disaggregated epidemiologic & programmatic data.

Clear agreement that specific strategies are needed to support adolescents during every step of HIV prevention & treatment cascades from informing, motivating & ensuring access to & effective use of prevention methods; to testing, linkages & adherence to care.

Hindering factors:

Reluctance to acknowledge that adolescents are sexual beings.

Insufficient attention to the vulnerability of girls & young women

Competition for resources between HIV treatment & prevention; siloes between HIV and SRH; weak inter-sectoral coordination.

Despite some openness, the prevailing message that sex is dangerous & that children/adolescents should not have it/should be protected from it, continues to be a barrier to action.

Future prospects:

Energy & determination to end the HIV epidemic continue.

Increasingly, this benefits from improved methods of understanding the epidemic among different sub-groups of adolescents.

For real progress, attention to critical enablers i.e. political commitment to HIV prevention & to wider socio-economic development is key.

World Health Organization hrp

Zimbabwe: Scale up of efforts to provide treatment & support to adolescents & young people living with HIV

HIV prevalence has declined from 25% among 15-49 year olds in the 1990s to around 13% in the group in 2017.

HIV prevalence in 15-24 year olds is 4.7% - females 6.1% & males - 3.1%.

Since 2010, AIDS-related deaths in all populations has decreased by 44%.

Zimbabwe is on track to achieve the 90-90-90 fast track global targets (knowing diagnosis, on sustained antiviral treatment & on viral suppression. However, the achievements of the HIV treatment cascades are lower than for adults. This requires attention.

The government of Zimbabwe has adopted & scaled up Zvandiri, a theory-grounded, multicomponent differentiated service-delivery model for children, adolescents & young people living with HIV. Peer-led community services are integrated into facility-led treatment & care across the HIV cascade. The programme has led to improved uptake of HIV testing, retention in care, adherence & viral suppression, & psychological wellbeing. Zvandiri's success is due to:

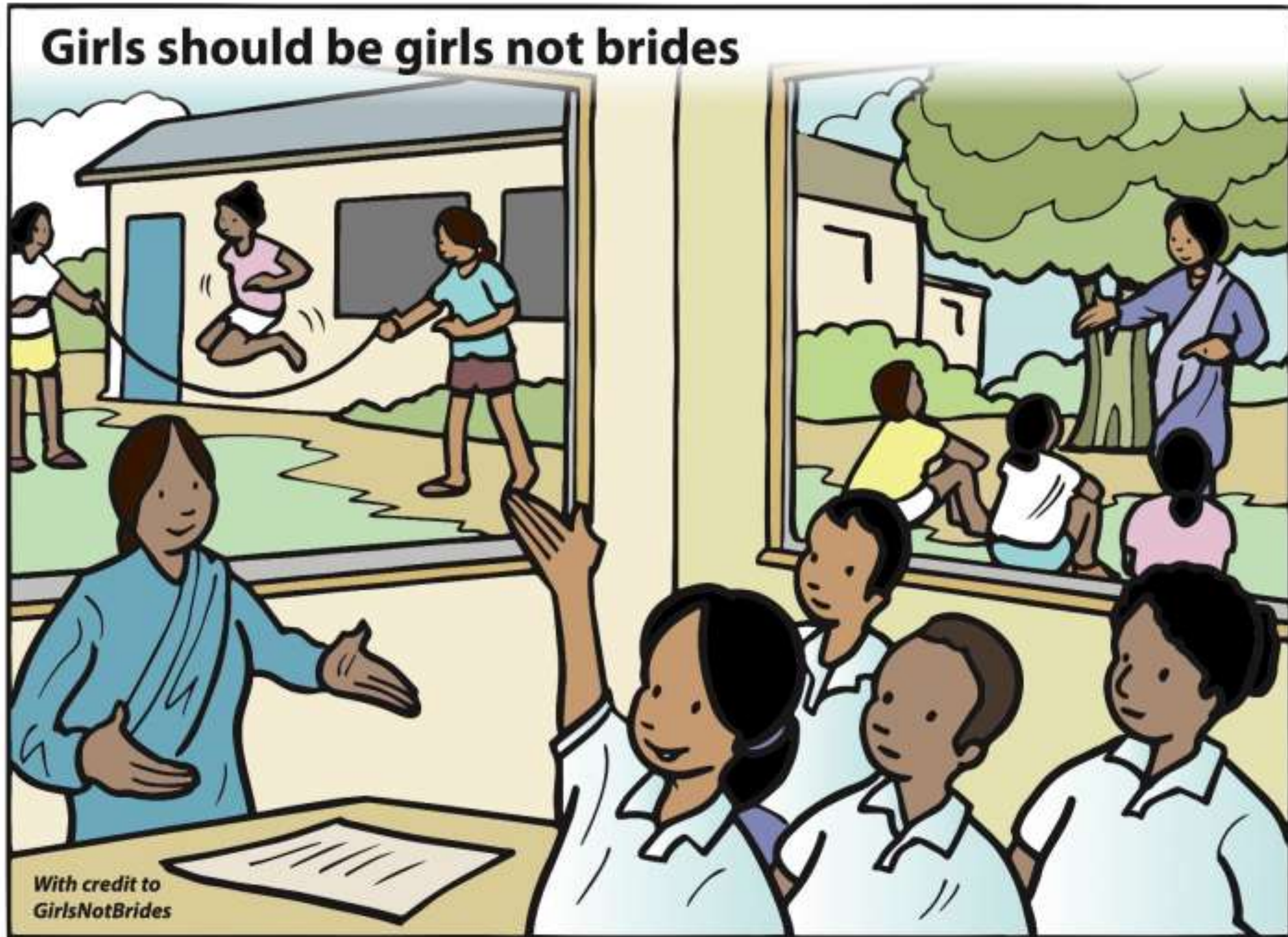
(i) Strong government leadership

(ii) Standardization & integration of the programme into national service delivery

(iii) Meaningful engagement of adolescents and young people at all levels

(iv) Use of programme data & research evidence to inform the adaptation of the model

Child marriage



World Health Organization
hrp

Child marriage

- <u>**Levels & trends:**</u>

In 25 years, the proportion of girls married before 18 has dropped from 1 in 4 to 1 in 5.

South Asia & the Middle East & North Africa have seen the largest declines.

- <u>**Global & regional response**</u>**:**

Child marriage was in the ICPD agenda.

It was not in the MDG agenda.

It was pushed on the global agenda by a movement led by *GirlsNotBrides*, between 2010-2015.

It is on the SDG agenda. It is also high on global & regional political agendas.

- <u>**National & sub-national responses**</u>**:**

NGO-led efforts began in the 1990s & 2000s.

In the 2010s they moved from public messaging about the dangers of child marriage to understanding & addressing its structural drivers. Today laws banning child marriage & national strategies to end child marriage are in place in a growing number of countries.

The UN Programme on Child Marriage & a number of other players provide funding & implementation support

There is also slowly growing attention to the needs of child brides, including those who are divorced, abandoned & widowed.

‘Once a taboo topic with little political or public recognition, ending child marriage is now becoming a social movement’.

- **Helping factors:**

Clear interventions for investment

Clear recognition that investing in girls is key to achieving other health & social goals

A good indicator in the SDGs

Availability of data

- **Hindering factors:**

Gender inequality & control/exploitation of female sexuality

Persistent poverty

Continued social acceptance of child marriage

Limitations in data, lack of resources & weak programmatic implementation capacity at the subnational level

Humanitarian crises

World Health Organization hrp

Ethiopia: A multi-faceted programme to address the multi-dimensional drivers of child marriage led to substantial reductions in child marriage.

Between 2006 & 2015, the prevalence of child marriage in Ethiopia declined from about 60% to about 40%, led especially by progress in 4 regions.

Ethiopia's progress is one of the strongest among countries in Eastern & Southern Africa.

The following activities in the 2000s laid the foundation for the large scale declines that continue today:

- **Marriage below 18 outlawed: 2000**
- **Near universal primary school education**
- **Girl-centered projects & programmes**
- **Outreach to community leaders & families, especially to influential males**

Today, Ethiopia has a national programme to end child marriage & FGM by 2025, grounded in the country's constitution & a strong legal framework to protect girls' & women's rights.

Violence against adolescent girls

Violence against adolescent girls

- **Levels & trends:**

Boys & girls experience abuse e.g. emotional abuse & neglect, corporal punishment & bullying.

Girls are disproportionately affected by Gender-Based Violence.

Violence against women & violence against children intersect during adolescence.

120 million girls below 20 worldwide have experienced forced sex (2014 data).

The prevalence of sexual abuse in girls aged 0-17 ranges from 9 to 38 % with the majority of the 9 countries surveyed having a prevalence of more than 25%.

Globally 30% of girls aged 15-19 have experienced physical and/or sexual violence by an intimate partner. This can occur in marriage or in dating relationships. Rates range from 16% in high income countries to 43% in South-East Asia. Trend data is not available.

World Health Organization hrp

Violence against adolescent girls

Global & regional responses:

- **Preventing violence against girls & young women was part of the ICPD agenda and the International Conference on Women's agenda. It is an integral part of the SDG agenda.**
- **Considerable progress has been made in building the epidemiologic base for action. Data on the prevalence of violence in girls aged 15-19 is now available for 153 countries.**
- **There is also much more evidence available now both on the drivers of violence, how to prevent it from occurring, & how to respond to it when it occurs.**
- **This has fed into norms, standards & guidelines. It has also fed into a World Health Assembly endorsed plan of action to address violence against women & girls, & against children (2014).**
- **There is limited domestic funding for work in this area. External funding is limited too, although some investments are being made in a limited number of countries.**

Violence against adolescent girls

National & subnational responses:

- **Many countries have adopted laws addressing different forms of violence e.g. rape, child sex abuse, domestic/intimate partner violence.**
- **Implementation of these laws is hampered by weak capacity & because stigma hinders those experiencing violence from coming forward.**
- **Many countries are developing national guidelines and strategies.**
- **Countries have experimented with different models to provide care to those who have experienced GBV. However large scale implementation is limited & under-resourced.**
- **There is heightened public awareness because of high profile cases which have led to public protests in many countries.**
- **On the other hand, data from national surveys suggest that a high proportion of boys and girls condone violence in different situations.**

Dedicated resources, political commitment & coordinated efforts are needed to scale up promising programmes.

Helping factors:

- Grassroots, autonomous feminist movements have been instrumental in driving changes in laws & policies.
- The availability of data has helped to raise visibility.
- Evidence on effective interventions, on their cost effectiveness, & on the cost of not investing in this area has had a strong influence.

Hindering factors:

- Conservative political environments, lack of political/governmental will to speak out against violence.
- Limited investment.
- Changes in economic opportunities, use of digital technologies, instability due to migration or crises pose risks of exacerbating violence/new forms of violence.

Kenya: Major strides to tackle gender-based violence including sexual violence.

Enabling legislative & policy frameworks in place.

Gender-based violence services are provided free of charge using an integrated approach in 500 public health facilities & 5 one-stop recovery centers located in tertiary facilities.

Female Genital Mutilation

World Health Organization hrp

Female Genital Mutilation

- **<u>Levels & trends:</u>**

An estimated 200 million women & girls who are alive today have undergone FGM.

The prevalence of FGM has decreased from 49% in 1991 to 31 % in 2019 (projected) in 24 most-affected countries. but progress is uneven across countries.

The absolute numbers of women & girls at risk is greater because of increases in the adolescent segment of the population.

- **<u>Global & regional response</u>:**

FGM was part of the ICPD. It was not part of the MDGs.

Here are some key milestones:

2007: WHO, UNFPA, UNICEF joint statement
2008: Updated statement
2007: UNFPA-UNCEF Joint Programme
2012: UN General Assembly resolution
2016: FGM is part of the Sustainable Development Goals

- **Standardized measures have facilitated consistent & comparable measurement. Topic-specific modules have been introduced into DHS & MICS; they are in use in 30 FGM affected countries.**
- **Research evidence is being synthesized & has contributed to normative guidance on prevention.**
- **WHO has developed guidance & tools to respond to women & girls who have experienced FGM.**

6 FEBRUARY
International Day of
ZERO TOLERANCE
for
FEMALE GENITAL MUTILATION

#EndFGM

World Health Organization
hrp

Female Genital Mutilation

National & subnational responses:

- Nearly all countries in which FGM is widely practiced have laws in place that ban the practice.
- 13 countries have developed human rights-based action plans which are being implemented through coordinated efforts across sectors.
- Initially efforts were limited to awareness raising by civil society bodies. Increasingly, different sectors in governments are working with community organizations in a complementary way. The engagement of the health sector to improve management of health complications & to prevent the practice is a critical component of this multisectoral response.
- There is increasing funding for this work.

World Health Organization hrp

The international consensus for zero tolerance of female genital mutilation must be leveraged more widely for stronger programmes.

Helping factors:

- Single intervention approaches have given way to complementary multicomponent approaches implemented by different sectors to address the drivers of FGM & to respond to survivors.
- The strong global consensus is being leveraged in a growing number of countries to stimulate & strengthen action.

Hindering factors:

- Deep seated social norms embedded in cultural traditions about the status of women & girls & the control of their sexuality are obstacles to progress.
- There is lack of evaluation data on whether & how programmes work to prevent FGM.
- There is limited scale up & replication of promising interventions.
- There is inadequate leadership from women & workers on the front-line.
- There is a lack of accountability of decision makers.

World Health Organization hrp

Burkina Faso: Large scale declines in FGM resulting from community education, pressure to change from influential leaders, accountability encouraged by community commitments & nudged by legal sanction & sensitive care for survivors.

Differing levels in different age groups points to declining trends in FGM: 89% in 45-49 year olds & 58% in 15-19 year olds.

The following activities contributed to this decline:

- National committee & national plan of action developed: 1990
- Law banning FGM passed: 1996.
- Since then the law has been enforced incrementally, progressively & in a community based manner with an innovative centre-piece i.e. A free helpline & mobile court to ensure that judicial hearings take place near communities
- Youth brigades employed to raise community awareness, especially near areas bordering Mali
- FGM prevention included in schools & in non-formal education programmes
- Partnerships forged between government departments, mayoral offices, traditional leaders, religious leaders, journalists, associations of women & young people to implement activities e.g. report instances of the practice & organize community pledges
- Monitoring of villages which have pledged to abandon FGM
- Care & support for those who have experienced FGM

Menstrual hygiene and health

Menstrual hygiene & health

- **<u>Levels & trends:</u>**

There is limited data on levels & trends – within or across almost all Low & middle income countries.

There is growing body of literature on how menstrual stigma & inadequate social & physical environments hinder safe & dignified menstrual management.

- **<u>Global & regional response</u>:**

The ICPD Plan of Action made no mention of menstruation.

Attention to menstruation as public health, social & rights issue began in the mid 2000s.

Norms & standards have been developed by WaterAid, UNESCO and UNICEF.

Alliances to move the agenda forward have been formed e.g. African Coalition for Menstrual Health. Activists, NGOs and academics have been at the forefront of the effort, but governments are beginning to get engaged.

In the 2010s, there has been slowly growing investment in research on menstruation in the school and humanitarian contexts.

- **<u>National & sub-national responses</u>:**

The water/sanitation, education & health sectors in a small but growing number of countries have developed policies & strategies on menstrual hygiene and health e.g. Kenya, South Africa, Philippines, India and Nepal.

Activities include free product distribution & education. But the focus is largely on the former.

There is growing menstrual equity movement – which is fighting to overcome restrictions on the entry of menstruating girls/women to temples, to overcome taxes on sanitary products & to address period poverty.

Menstrual Hygiene Day activities in countries, have become increasing visible.

‘The menstrual hygiene movement still struggles to gain traction within larger ASRHR efforts…’

- **Helping factors:**

Reports of girls & women’s experiences of shame & embarrassment, & of the barriers they face in managing their periods have helped draw attention to this issue.

The growing attention to girls’ needs & rights have helped raise this issue on the agenda.

- **Hindering factors:**

The limited evidence on how to meet girls’ needs & how to measure them – has hampered investment & action.

There is still widespread lack of understanding & acknowledgement of the place of menstruation in issues such as early menarche being a trigger to child marriage, & the effect of amenorrhoea on contraceptive discontinuation.

Nepal: Putting menstrual hygiene & health on the national health, development & human rights agenda

2005: Chhaupdi (a harmful traditional practice in which in which girls & women are required to stay in an outhouse during their periods) was outlawed

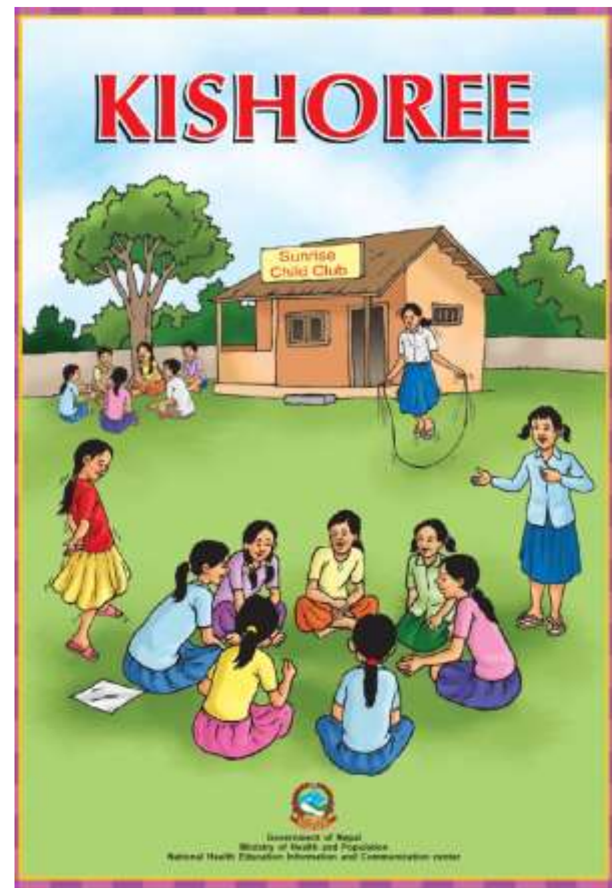
2008: Chhaupdi Eradication Guidelines published by the Ministry of Women, Children & Social Welfare

2017: Law criminalizing Chhaupadi passed

Education & social change movements complement these efforts

Menstrual hygiene is part of a number of policies: Health, Education, Water & Sanitation, but there are gaps e.g. in Disability.

These policies have stimulated activities within these sectors but coordination is weak.



World Health Organization hrp

Conclusions - 1/5

2

- ❑ *Advocacy by a growing body of stakeholders, including young people themselves.*
- ❑ *High profile international consultative processes*
- ❑ *International conferences*

… have drawn attention to the demographic, public health, economic & human rights rationale for investing in adolescent health.

- ❑ **Some aspects of ASRHR are higher on health & development agendas than ever before.**

World Health Organization hrp

Conclusions – 2/5

2

Funding for some areas has grown substantially:

- ***Preventing & treating HIV***
- ***Preventing child marriage***
- ***Increasing access to and uptake of contraception to prevent unintended/unwanted adolescent pregnancy.***

- **There is steadily growing financial investment in ASRHR, although much of the funding is from external sources & remains inadequate & fragmented.**

2

Conclusions – 3/5

A growing body of data & evidence:

- *Nature & scale of problems*
- *Causes of problems*
- *Consequences of problems*
- *What works & what does not to prevent & respond to them*

But there are still important gaps e.g.

- *Costing*
- *Delivering interventions at scale with quality & equity*

Norms & standards have been developed on many issues, but:

- *Some areas are not covered e.g. contraceptive provision to unmarried adolescents*
- *Guidelines produced by different international organizations sometimes contradict each other*
- *Guidelines not do not always reach & influence decision makers*

- **While there are still many gaps to be filled, there is a growing body of data & evidence on ASRH. This has fed into norms & standards to guide policies and programmes.**

Conclusions – 4.1/5

2

In some areas e.g. child marriage prevention:

- *Laws to end this practice have been passed*
- *Efforts are underway to communicate & apply these laws (in some – not all – places)*

In other areas e.g. provision of CSE, safe abortion care & contraception to unmarried adolescents:

- *Legal & policy restrictions remain*

In many places, laws defining the age of sexual consent & classifying sex before that age as statutory rape requiring reporting.

Such laws combined with stigma & discrimination impede access to SRH information & services.

- **Although implementation of ASRHR policies & programmes in many countries remains weak, a small but growing number of countries have created & implemented enabling legal & policy environments, & strong government-led programmes.**

World Health Organization hrp

Conclusions – 4.2/5

2

NGOs were the first to respond to ASRHR. They continue to play the role of service providers, innovators, advocates & watch-dogs.

Over the years, national governments have developed policies & strategies, & developed programmes. Today, most countries have national ASRH programmes of some form.

In many places, both NGOs and governments employ ineffective interventions, & deliver interventions poorly & in a piece meal manner.

In a small – but growing number of - countries, this is beginning to change.

- **Although implementation of ASRHR policies & programmes in many countries remains weak, a small but growing number of countries have created & implemented enabling legal & policy environments, & strong government-led programmes.**

Conclusions – 5/5

2

There is support for:

- *Preventing child marriage*
- *Ending violence against girls & young women*

There is substantial resistance to:

- *Promoting safe abortion*
- *Providing contraceptive information & services to unmarried adolescents*

In many places:

- *Increasingly stronger resistance has led to stalled programmes & reversal of progress made*

On the other hand, in some places:

- *initiatives have learned to build support & overcome resistance*

Robust grassroots level movements, including those led by young people have become active & influential in moving the agenda forward

- **Although there is growing support for addressing some aspects of ASRH, there is ambivalence about other aspects, & there is increasingly well-financed & organized resistance.**

Journal of Adolescent Health 65 (2019) 316–340

ELSEVIER

JOURNAL OF
ADOLESCENT
HEALTH

www.jahonline.org

2

Review article

The Political, Research, Programmatic, and Social Responses to Adolescent Sexual and Reproductive Health and Rights in the 25 Years Since the International Conference on Population and Development

Venkatraman Chandra-Mouli, M.B.B.S., M.Sc.[a,*], B. Jane Ferguson, M.S.W., M.S.C.[b], Marina Plesons, M.P.H.[a], Mandira Paul, Ph.D.[c], Satvika Chalasani, Ph.D.[c], Avni Amin, Ph.D.[a], Christina Pallitto, Ph.D.[a], Marni Sommers, Dr.P.H., M.S.N.[d], Ruben Avila[e], Kalisito Va Eceéce Biaukula[f], Scheherazade Husain, M.P.H.[g], Eglé Janušonytė[h], Aditi Mukherji[i], Ali Ihsan Nergiz[j], Gogontlejang Phaladi[k], Chelsey Porter, M.P.H.[l], Josephine Sauvarin, M.B.B.S., M.P.H.[m], Alma Virginia Camacho-Huber, M.D., M.P.H.[n], Sunil Mehra, M.D.[o], Sonja Caffe, Ph.D., M.P.H., M.Sc.[p], Kristien Michielsen, Ph.D., M.Sc.[q], David Anthony Ross, B.M.B.Ch., Ph.D., M.Sc., M.A.[a], Ilya Zhukov, Ph.D.[c], Linda Gail Bekker, M.B.Ch.B., Ph.D.[r], Connie L. Celum, M.D., M.P.H.[s], Robyn Dayton, M.P.H.[t], Annabel Erulkar, Ph.D.[u], Ellen Travers, E.M.A.[v], Joar Svanemyr, Ph.D.[w], Nankali Maksud, L.L.M.[x], Lina Digolo-Nyagah, M.B.Ch.B, M.Med., M.Sc.[y], Nafissatou J. Diop, Ph.D.[c], Pema Lhaki, M.S.[z], Kamal Adhikari, M.A.[aa], Teresa Mahon, M.Sc.[ab], Maja Manzenski Hansen, M.Sc. (Public Health), M.Sc. (Sexual & Reproductive Health)[ac], Meghan Greeley, M.P.H., M.S.N.[ad], Joanna Herat, M.A.[ae], and Danielle Marie Claire Engel, M.A.[c]

1. How have epidemiologic trends, & political, research, programmatic & social responses to ASRHR evolved in the 25 years since the ICPD ?

Progress has been made in each of the following areas, but the nature of the response and its trajectory has been different in each case: adolescent pregnancy & child bearing, HIV in adolescents & young people, child marriage, violence against adolescent girls, female genital mutilation, & menstrual hygiene & health

2. What contribution did the ICPD make to this ?

The ICPD has contributed to the progress made on ASRHR both because of its bold call to action in 1994, & because it stimulated efforts at the global, regional & national levels, that continue to this day.

World Health Organization hrp