



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



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A B S T R A C T

Among the ground-breaking achievements of the International Conference on Population and Development (ICPD) was its call to place adolescent sexual and reproductive health (ASRH) on global health and development agendas. This article reviews progress made in low- and middle-income countries in the 25 years since the ICPD in six areas central to ASRH—adolescent pregnancy, HIV, child marriage, violence against women and girls, female genital mutilation, and menstrual hygiene and health. It also examines the ICPD's contribution to the progress made. The article presents epidemiologic levels and trends; political, research, programmatic and social responses; and factors that helped or hindered progress. To do so, it draws on research evidence and programmatic experience and the expertise and experiences of a wide number of individuals, including youth leaders, in numerous countries and organizations. Overall, looking across the six health topics over a 25-year trajectory, there has been great progress at the global and regional levels in putting adolescent health, and especially adolescent sexual and reproductive health and rights, higher on the agenda, raising investment in this area, building the epidemiologic and evidence-base, and setting norms to guide investment and action. At the national level, too, there has been progress in formulating laws and policies, developing strategies and programs and executing them, and engaging communities and societies in moving the agenda forward. Still, progress has been uneven across issues and geography. Furthermore, it has raced ahead sometimes and has stalled at others. The ICPD's Plan of Action contributed to the progress made in ASRH not just because of its bold call in 1994 but also because it provided a springboard for advocacy, investment, action, and research that remains important to this day.

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IMPLICATIONS AND CONTRIBUTION

This paper reviews the progress that has been made in selected aspects of adolescent sexual and reproductive health and rights in the 25 years since the International Conference on Population and Development, and what helped and hindered this progress. In drawing out these lessons, it provides the basis for well-informed actions to build on the progress made in the next 25 years.

The International Conference on Population and Development (ICPD) is best known for its call to shift the population discourse from control (i.e., a focus on reducing population growth using all possible means) to empowerment grounded in gender equality (i.e., a focus on supporting individuals and couples to make the reproductive choices that best meet their needs and aspirations) [1]. However, the ICPD was also groundbreaking in that it placed adolescent sexuality and adolescent sexual and reproductive health (ASRH) in particular, on the global agenda. The ICPD Programme of Action (POA) called for “meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality” [1].

Twenty-five years have passed since the ICPD POA was adopted. Much has happened, and much has changed since then. These changes and experiences provide useful lessons. That is the focus of this Journal of Adolescent Health supplement. Paper 1 of the

¹ The ICPD Plan of Action did not use the term adolescent sexual and reproductive health and rights (ASRH). However, the focus on rights has grown steadily stronger over the last 25 years. Given this, we have opted to use the term ASRH to frame discussion in the paper because acknowledging and fulfilling adolescents' rights has become central to the agenda in the last 25 years.

supplement examines how the world of adolescents has changed over the last quarter of a century and how their health in general and their sexual and reproductive health (SRH), in particular, have evolved over this period. This paper—the second in this supplement—examines the political, research, programmatic, and social responses to adolescent sexual and reproductive health and rights¹ (ASRHR) over this period and draws out lessons learned. The third and fourth papers address the implications of these experiences for the future. The third paper outlines the needs and problems of different groups of adolescents, the individual and social factors that could contribute to—or prevent them from—achieving their SRHR, the package of evidence-based interventions that could contribute to enabling them to be remain healthy or to return to good health if they are ill, and evidence-based approaches to delivering this intervention package. Finally, the fourth paper discusses opportunities that could help and challenges that could hinder progress in ASRHR and sets out priority actions needed in the next 10 years to achieve the unfinished agenda for ASRHR.

Although the ICPD placed ASRHR on the global agenda and although it was on the Millennium Development Goals (MDGs) agenda, adolescents were largely neglected in the face of other

issues that were seen as more important [2]. This changed completely in the Sustainable Development Goals (SDGs) agenda [3], as is evident in the framing of two key publications from the United Nations (UN). Adolescents were virtually absent in the Global Strategy on Women and Children's Health [4], launched in 2010 by the UN's Secretary General to accelerate progress on MDGs 4 and 5.² In contrast, adolescents are the focus of the updated Global Strategy for Women's, Children's, and Adolescents' Health [5] launched in 2015. As noted by the same Secretary General, "...the updated Global Strategy includes adolescents because they are central to everything we want to achieve, and to the overall success of the 2030 Agenda" [5]. Thus, there is now an opportunity to address adolescent health in general—and ASRHR in particular—that did not exist before. Synthesizing and using the learning from the past 25 years is important to ensure that the world makes full use of this new opportunity.

The two broad questions that this paper seeks to answer are, first, how have epidemiologic trends and political, research, programmatic, and social responses to ASRH evolved in the 25 years since the ICPD; and what helped or hindered this; and second, what contribution did the ICPD make to this evolution.

Methods

To draw together epidemiologic data and information on political processes, research evidence, and programmatic/project experiences and to be as granular as possible, we conducted a retrospective scan of the field with regard to six topics within ASRHR: two that were identified as priorities in the ICPD and were part of the MDGs (adolescent pregnancy and HIV), three that were recognized as important for public health and human rights in the ICPD but were not part of the MDGs (child marriage, violence against women and girls, and female genital mutilation [FGM]), and one topic that was not mentioned—nor seen as important—either in the ICPD or by the MDGs (menstruation).

We addressed each topic as follows:

1. How was the topic named and addressed in the ICPD?
2. How have global and regional levels and trends of the topic changed in the 25 years since the ICPD?
3. How have responses to the topic evolved:
 - a. at global and regional levels, in terms of political priority, funding, research, and norms and standards?
 - b. at national and subnational levels, in terms of laws and policies, programs and projects, and social movements?
4. What lessons can we learn from the last 25 years with regard to factors that helped or hindered progress?
5. What is one country that has made tangible progress on the topic, and how has it done this?

We constituted writing groups of international experts on the six topics from academia, nongovernmental organizations (NGOs), and UN agencies. Seven youth leaders from around the world were engaged to contribute to the writing groups with their perspectives and experiences. The writing groups described the evolution of responses in their respective areas by broadly responding to the questions and providing evidence for each

² MDG 4 was to reduce child mortality. MDG 5 was to improve maternal health. There were indicators related to adolescents in each of the goals.

assertion. To develop the country case studies, they involved government and NGO staff from the countries as well as international organizations operating there. We identified themes that emerged from the analysis of each of the six topics. Using content analysis, we then synthesized these themes into key messages that either cut across all or most of the topics or were noteworthy and specific to one or some of them.

Findings

Adolescent pregnancy and childbearing

Levels and trends. The global adolescent birth rate (ABR) declined from 63 to 44 per 1,000 adolescent girls (aged 15–19 years) between 1994 and 2017. All regions have seen declines with both substantive differences both between regions and within countries in each region, including increases in the rates in some countries [6]. Although childbearing in adolescents aged between 10 to 14 years is generally rare, elevated levels are found in a small number of countries in Asia, Africa, and Latin America [7]. And although rates of ABR are generally declining, the increase in the population of adolescents means that the overall numbers of pregnancies and childbirths are increasing, especially in sub-Saharan Africa [6].

Maternal conditions remain a leading cause of death among adolescent girls aged 15–19 years [8]. The risk is highest for girls aged <15 years. Maternal conditions also give rise to significant maternal morbidity among adolescents [9]. Adolescents aged 15–19 years have higher rates of unintended pregnancies than any other age group [10], which can be explained partly by a range of supply and demand-side barriers to adolescents obtaining and using contraceptives [11]. Unmarried sexually active adolescents and those who are in union often have higher rates of unmet need for contraception than adult women [12]. In some countries, this unmet need is concentrated among unmarried, prechildbearing, adolescents, whereas in others, it is concentrated in married, childbearing adolescents, each group facing different supply and demand-side barriers [11]. For many adolescent girls around the world, first sexual intercourse is a result of sexual coercion or sexual abuse; this is particularly true when first sex occurs at a very young age [13,14]. Of the 49% of pregnancies that are unintended in adolescents in developing regions, about half end in abortions, most of which are unsafe and may result in morbidity and mortality [10,15].

Evolution of the global and regional responses. At the global level, adolescent pregnancy has been a key driver of the increased attention to ASRHR, primarily through an emphasis on pregnancy prevention. In 1994, the ICPD POA highlighted the importance of reducing adolescent pregnancy by addressing its multiple underlying factors as well as its consequences. To this aim, it underlined the need to ensure access to comprehensive sexuality education (CSE); declared that sexually active adolescents require contraceptive information, counseling, and services tailored to their special needs; and called on families and communities to provide contraceptives and support adolescents during pregnancy and after childbirth (paragraphs 7.45–7.48) [1]. The MDGs did not directly address adolescent pregnancy until 7 years after their launch when a subgoal on reproductive health was added that included the ABR as one of its indicators [16]. In contrast, the SDGs included adolescent pregnancy at the outset.

In the last 5 years of the MDGs era and in the first 5 years of the SDGs era, a number of global initiatives and partnerships,

such as Every Woman Every Child,³ Family Planning 2020,⁴ [14] and the Global Financing Facility⁵, have advocated and facilitated increased action on adolescent pregnancy. Evidence about the consequences of early motherhood related to other global health concerns (e.g., neonatal mortality) further contributed to the arguments to prevent pregnancy among adolescents [17]. These efforts have focused on preventing adolescent pregnancy through raising awareness and providing CSE and contraceptive services. Improving access to safe and effective pregnancy care and supporting adolescent girls to return to education or to find employment after a pregnancy have received relatively less attention [18]. At the regional level, the Maputo protocol⁶ and the Montevideo consensus⁷ contextualized and built on the language of the ICPD, reinforcing the importance of addressing adolescent pregnancy [19,20]. Subregional bodies responded with specific policies, strategies, and investments on ASRH [21,22].

The evidence base on preventing adolescent pregnancy and to a certain extent also on ensuring that pregnancy and child-bearing are safe for adolescent mothers and their babies has grown in the last decade. We now know more about the scope of the problem, its complexities and contextual differences, and effective approaches to prevent and respond to adolescent pregnancy [14]. Nevertheless, gaps in knowledge remain, such as how best to prevent and respond to pregnancy in very young adolescents and how to deliver interventions with fidelity, quality, and equity in resource-constrained settings [23]. In response to this, there has been increasing investment in testing approaches to improve the delivery of CSE and to increase the uptake of contraceptive services, with an emphasis on user-centered approaches to respond to the differing needs of different groups of adolescents [24,25]. However, there is far less investment in research on making maternal health and abortion services more responsive to adolescents.

The growing evidence base has fed into the development of norms and standards, including World Health Organization's (WHO) guidelines on preventing early pregnancy and poor reproductive outcomes in adolescents in developing countries, the WHO global standards for quality health care services for adolescents, the United Nations Population Fund (UNFPA) rights-based approach to addressing motherhood in childhood, the original and revised UN international technical guidance on sexuality education, and the consolidated WHO recommendations on ASRHR [26–30]. Adolescent pregnancy is now viewed

not just as health problem but also as an outcome of a Web of factors, including age, education, gender norms, and socioeconomic status, as well as wider issues such as food insecurity and conflict.

Evolution of national and subnational responses. These global and regional responses have catalyzed agenda-setting and action at the country level, which has resulted in the development of evidence-based national policies and strategies [31]. As part of the drive for Education for All⁸ [32] and the likely association between early pregnancy and leaving school, many countries have adopted policies to guarantee girls' rights to education during and after pregnancy⁹ [33]. A number of countries in Africa and Asia (e.g., Ethiopia and India) have removed legal barriers to access to SRH services for unmarried adolescents. In some countries, the legal age of sexual consent has been increased as a child protection measure. This has had unintended consequences, however, such as obliging health workers to report even consensual sex among adolescents before the age of consent as statutory rape, the stigmatization of sexually active adolescents, and adding to the obstacles they face in obtaining SRH services [34]. The global trend of liberalization of abortion laws continues; since the ICPD, 50 countries have enacted laws expanding the grounds upon which abortion is legal [35]. However, barriers such as parental consent for minors remain in many countries. Finally, there has been a rise of youth-led organizations and civil society movements, which complement government efforts and are working with partners to promote the accountability of governments and both national and international organizations.

In terms of programmatic responses, interventions in the last decade have focused on providing CSE¹⁰ and establishing adolescent-friendly health services (AFHS). With regard to CSE, many countries have made the move from small-scale, short-lived projects to large-scale programs. Many of these CSE programs have been poorly implemented, with limited attention to the quality of teaching and learning and weak monitoring [36,37]. However, there is a move in the right direction: CSE is now mandatory in 60 countries, including such diverse countries as Afghanistan, El Salvador, Guatemala, Kenya, India, Lao People's Democratic Republic, and Swaziland [38], and more countries are taking steps to integrate CSE into national curricula and to improve the quality of its delivery [39].

With regard to AFHS, many countries continue to set up either youth centers outside the health system or stand-alone clinics within it, despite evidence that dedicated units are often not well-attended—especially by marginalized adolescents—and are not effective at improving the uptake of SRH services [40]. Furthermore, around the world, health workers receive one-off training without ongoing supportive supervision. This does not prepare them to provide health services effectively and with sensitivity [11]. However, as in the case of CSE, there is a move in the right direction: a growing number of countries are setting national standards to assess and improve the quality of health service delivery to adolescents and developing preservice

³ A global movement that mobilizes and intensifies international and national action by governments, multilaterals, the private sector, and civil society to address the major health challenges facing women, children, and adolescents around the world.

⁴ A global movement that works with governments, civil society, multilateral organizations, donors, the private sector, and the research and development community to enable 120 million more women and girls to use contraceptives by 2020.

⁵ A mechanism that acts as a catalyst for financing for 36 LMICs by using modest GFF Trust Fund grants to significantly increase countries' domestic resources alongside the World Bank's International Development Association and International Bank for Reconstruction and Development financing, aligned external financing, and private sector resources.

⁶ A commitment made by official representatives from 15 countries in the African Union to guarantee comprehensive rights to women, including the right to take part in political process, social and political equality with men, improved autonomy in their reproductive health decisions, and an end to FGM.

⁷ A joint commitment made by official representatives from 38 countries in Latin America and the Caribbean in August 2013 to strengthen the delivery of SRH services, including for adolescents and youth.

⁸ A global movement led by UNESCO that aims to meet the learning needs of all children, youth, and adults by 2015.

⁹ However, evidence suggests that the relationship between early pregnancy and school dropout is not a direct causal one. Instead, education is one of an array of factors that contribute to adolescent pregnancy.

¹⁰ We have used the term CSE here, although the sexuality education generally provided is far from comprehensive.

training programs [41,42]. There is also a large and growing private sector that adolescents with financial resources turn to when government services do not respond to their contraceptive needs [43,44]. However, in many countries, the private sector is largely unregulated, raising concerns about the quality of information and services provided. Finally, although much of the focus in the past has been on girls and young women, there has been increasing recognition of the need to engage men and boys in programming to prevent adolescent pregnancy and to support shared decision-making and sharing of childbearing and child-rearing responsibilities. Initiatives such as Men Care¹¹ and Manhood 2.0¹² engage men in conversations around gender norms and pregnancy prevention, including contraceptive use and violence prevention [45]. However, implementation of such approaches remains small scale.

Finally, there is increasing recognition of adolescents' needs and vulnerabilities in humanitarian settings—including needs related to child marriage, sexual violence, and adverse maternal outcomes. In response to the World Humanitarian Summit's call-to-action in 2016, UNFPA and the International Federation of Red Cross and Red Crescent Societies established a Compact for Young People in Humanitarian Action to bring together key actors to advocate investing in and tailoring humanitarian response mechanisms to the needs of adolescents and youth [46].

Although there has been progress, the past 25 years have witnessed pushback on efforts to address adolescent pregnancy, especially related to CSE, safe abortion care, and contraceptive services. Among parents, teachers, and others, there is still enormous discomfort in providing sexuality education that is truly comprehensive and contraceptive services, especially to unmarried adolescents. Provision of safe abortion also evokes strong opposition.

Lessons learned. The most important lesson learned in the past 25 years is that a combination of feasible and effective approaches, implemented together, can reduce unintended pregnancies and pregnancy-related mortality and morbidity [47]. These approaches include providing SRH information and education in schools, elsewhere in communities, and in the media; improving access to available health services by removing cost-related barriers; training and supporting public and private-sector health workers to provide respectful care and counseling [48–50]; and addressing social determinants that increase adolescents' vulnerability through interventions such as community mobilization and cash transfers [51]. Although global advocacy and the programmatic approaches mentioned previously have clearly made a contribution to the decrease in the ABR, global advances in girls' education and delays in age of marriage have substantially contributed to it [52].

Despite the progress, demand- and supply-side barriers continue to restrict adolescents' access to information and education and to their use of SRH services. These include legal barriers, such as requirements for parental/spousal consent to access SRH services; social barriers, such as stigma around premarital sex and community pressure to prove and protect fertility after marriage;

and service-delivery barriers, such as health workers withholding services from adolescents, especially long-acting contraceptive methods and safe abortion care. Three factors underpin these barriers. First, to make health/education/social welfare/criminal justice systems responsive to adolescents, they must, first, be functional. In many places, because of inadequate investment and poor management, these systems are weak and unable to meet the needs of the population in general, including adolescents. There is also little intersectoral coordination. NGO-run institutions fill the gap in many places, but, with some notable exceptions, they tend to serve only small numbers of people in some parts of a country. Second, even where such systems are operational, a pervasive lack of willingness to acknowledge adolescent sexuality and adolescents' abilities to think, decide, and act for themselves—with education and support—informs laws, policies, practices, and adults' public discourse. Finally, data gaps remain, creating an inaccurate picture of the health status of adolescents and of their need for services [14,53].

Future prospects. With solid positioning on global and regional agendas, a growing body of evidence, norms, and standards to guide country-level action and a steadily increasing number of countries that are stepping up to address adolescent pregnancy, the stage is well set for continued progress. Going forward, it is important to move toward a holistic approach to recognizing and responding to adolescents' wider SRH needs and problems; to shift the focus to the subnational level to plan and deliver interventions contextualized to different communities; to generate evidence on how to take interventions to scale without compromising quality and equity; and to increase governments' investments in ASRHR as a strategic means to improve national development. Other issues that need to be on the agenda include developing and implementing effective approaches to engage men and boys, innovative service-delivery approaches that are adolescent-centered and life-course oriented; new platforms for information and service delivery addressing adolescents; well-integrated contraceptive and HIV/sexually transmitted infection (STI) services; and strengthened public–private partnerships (Box 1: Uruguay).

*Human immunodeficiency virus*¹³

Levels and trends. Globally, over the past 25 years, the estimated number of new HIV infections has decreased by 50% in adolescents aged 10–19 years, whereas the estimated number of adolescents living with HIV has increased by 50%, most of whom were infected through vertical transmission perinatally and have survived to adolescence [60]. The number of adolescent girls living with HIV is still almost one-third greater than the number of adolescent boys. However, the percentage increase in those living with and dying from HIV has been greater among adolescent boys since 1994 [61]. Data on the levels and trends of HIV among young members of key populations (i.e., persons at high risk of HIV because of specific behaviours¹⁴) remain inadequate. However, data from countries such as the Philippines, where new infections among young people—most of whom are

¹¹ A global fatherhood campaign active in more than 50 countries, coordinated by Promundo and Sonke Gender Justice, to promote men's involvement as equitable, nonviolent fathers and caregivers to achieve family well-being, gender equality, and better health for mothers, fathers, and children.

¹² A gender-transformative initiative, coordinated by Promundo, to engage adolescent boys and young men in the U.S. in reflecting on the impacts of harmful gender norms.

¹³ HIV-related activities address young people—aged 10–24 years—rather than adolescents—aged 10–19 years.

¹⁴ Key populations include men who have sex with men, minors who sell sex, transgender people, people who inject drugs, and prisoners and other incarcerated people and their sexual partners.

Box 1. Uruguay: progressive laws and policies, strong government-led multisectoral responses, and active civil society monitoring lead to dramatic declines in adolescent fertility

Uruguay has seen a substantial decline in adolescent fertility in the past 25 years. The ABR peaked at 72 births per 1,000 adolescents in 1996 and remained largely unchanged until 2014–2015. A rapid decline began in 2016, and today, the rate is 36 per 1,000 [54]—half of what it was 23 years ago and nearly half of the average AFR in Latin America of 67 per 1,000 adolescents [55].

This progress has been made possible through significant strides in developing and implementing SRH multisectoral policies and programs. Since 2005, the country has strengthened policies to recognize SRH as a human right, including especially through landmark laws in 2008 (i.e., Law 18426 on the Right to Sexual and Reproductive Health) and in 2012 (i.e., Law 18987 on the Voluntary Interruption of Pregnancy) [56,57]. The former notes that it is the duty of the State to guarantee the conditions for SRHR for all. It requires all SRH policies and programs to ensure universal coverage at the primary level; to guarantee the quality, confidentiality, and privacy of services; to have human resources appropriately trained in both technical and communication skills; to incorporate gender perspectives in all actions and provide conditions for users to make decisions freely; and to promote inter-institutional coordination, emphasizing the contribution that the education section could make to achieving ASRHR.

The government's strong political commitment to ensure that a rights-based approach to SRH was central to the public policy agenda. This was matched by equally strong civil society participation in monitoring the implementation of laws and programs. These measures and actions led to the development and implementation of a national SRH policy and an intersectoral strategy, which includes sexuality education, to prevent unintentional pregnancy among adolescents [58]. One highlight of the strategy is that it gradually introduced contraceptive implants, thereby expanding the contraceptive method mix and promoting the right to free choice [59]. These efforts had a direct impact on access to and uptake of quality free-of-charge or low-cost contraceptive services, as did the dissemination of information reaffirming the right to exercise one's SRHR and to seek assistance for voluntary termination of pregnancy.

Although the priority clearly has been prevention of adolescent pregnancy, the legal framework also assures access to quality maternal health care and emergency obstetric care for all pregnant women, including adolescents. In addition, to avoid social exclusion of adolescent parents, the government put in place an array of social programs to address the needs of the most vulnerable adolescents. These include the following:

- *Uruguay Crece Contigo*, a national early childhood development program that includes special interventions for adolescent mothers and their babies. Centers for adolescent parents and their children have been set up to provide child care and address childhood development issues. Alongside this, they provide adolescent parents with interventions addressing their own development.
- *Espacios de educación y cuidados para hijas e hijos de estudiantes*, day-care programs in the secondary schools to support adolescent parents with the care of their babies and infants during school hours, and evening schools to provide another option for adolescent mothers to complete their schooling.

Accompanying these interventions are activities to prevent repeat pregnancies in rapid succession, including access to SRH services and the provision of CSE outside the school context. Furthermore, social protection policies and schemes are geared toward keeping girls and boys in school to reintegrate out-of-school adolescents into the education system and to facilitate the integration of young people into the job market.

Unplanned pregnancies persist in Uruguay, especially among adolescents, meaning that there is still a need to strengthen the national response. Persistent challenges include breaches in the implementation of SRH policies/strategies, such as conscientious objection to the voluntary termination of pregnancy by health care professionals and weaknesses and disparities in teacher training, which affect the scale-up of CSE.

from key populations—increased by 170% between 2010 and 2017, reiterate the pressing need to address HIV among these groups [62].

Evolution of global and regional responses. In 1994, the ICPD POA highlighted the importance of addressing HIV among adolescents, with an emphasis on prevention, and explicitly cited the need for sexuality education and adolescent involvement in program design (paragraph 7.47 and paragraph 8.31) [1]. International attention to adolescents' vulnerability to HIV infection was also apparent in the MDGs in 2000 and the commitments resulting from the UN General Assembly Special Sessions on HIV/AIDS, 2001, and Children, 2002 [2,63,64]. These initiatives specified interventions and targets related to adolescents, which, in

turn, provided focus for policies, programs, research, and measurement.

In 1996, UNAIDS was established in recognition of the need for a multisectoral approach to addressing HIV and for greater efficiency and effectiveness in generating political commitment, mobilizing resources, providing country support, and improving measurement. To strengthen programming directed at young people, UNAIDS provided operational mechanisms for country program development and funding and platforms for evidence generation. The first systematic review of what works to prevent HIV among young people was published in 2006 [65]. To accelerate action in countries, in 2008, the UNAIDS Inter-Agency Task Team on HIV and Young People developed a series of seven guidance briefs on HIV prevention, treatment, and care of young

people by sector, population, and setting [66]. Other policy and programmatic guidance publications followed, including those that were specific to adolescents and young people [67] and those that were relevant for them [68]. Research on HIV has been extensive. However, most research has been relevant for but not specific to young people. For example, a recent trial examined the rate of HIV acquisition associated with the use of hormonal contraceptives, and its results highlighted the need to accelerate HIV prevention for the general population but especially among young women [69].

Global monitoring of the availability and expenditure of funds, both external and domestic, to address the HIV epidemic stimulated the creation of specific financing organizations to attract, leverage, and invest additional resources, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), which was set up in 2002. Gradually, specific funding has been targeted to adolescents, primarily adolescent girls and young women [70]. Some governments are now financing HIV treatment scale up, but, overall, external funding for HIV is declining. Similarly, prevention attracts less funding than treatment, thereby endangering countries with high rates of new infections among adolescent girls and young women and key populations [71].

Evolution of the national and sub-national responses. With regard to HIV prevention, until the 2006 International AIDS Conference, which was the first to focus on young people, programmatic responses for this age group focused on improving knowledge and understanding and promoting safer sex. The approach largely ignored the contexts of young people's lives: poverty, gender inequities, sexual violence, restrictive laws and policies, and discrimination and stigma [72]. The bulk of resources was allocated to low-risk young people in school settings until the severity of the epidemic among young members of key populations, especially in Asia, was recognized from about 2010 onward [73].

In all population segments, the best-evaluated successes in HIV prevention are the application of biomedical approaches, including antiretroviral therapy for preventing mother-to-child transmission, voluntary medical male circumcision, pre-exposure prophylaxis, and treatment as prevention. However, the need to also address behavioral and structural factors (i.e., through combination prevention), the importance of addressing inequalities in access to services, and the need to create enabling policy and community environments have increasingly been recognized [74]. Improving the implementation of combination prevention approaches, with quality and at scale for adolescents, and demonstrating their impact in 10 countries are the goals of the Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe initiative (DREAMS) [75]. The DREAMS initiative supports the application of a core package of evidence-based interventions addressing adolescent girls and young women, their sexual partners, their families, and their wider communities to address HIV risk behaviors, socioeconomic vulnerabilities, and gender-based violence (GBV). Impact evaluation activities are ongoing, but important implementation lessons are emerging [76,77].

With regard to treatment and care, the large number of adolescents living with HIV is increasing the pressure to expand intervention coverage and quality, including for the full HIV treatment cascade (i.e., HIV testing, treatment, and retention in care), especially in Africa and for young members of key

populations. Gradually, adolescents' uptake of HIV self-testing is increasing, and treatment support to adolescents by adolescents themselves has shown reduced rates of treatment failure in resource-constrained settings [78–80].

However, both for prevention and for treatment and care, young people's access to services continues to be impeded by significant legal and policy constraints, especially those related to mandatory reporting laws, parental/spousal permission, and age of consent to testing and treatment. However, governments are increasingly reviewing and revising these policies. Additional obstacles relate to the combination of laws that criminalize consensual same-sex/gender activity and stigma toward sexual and gender minorities, aggravated by the age-related stigma against young people that exists in many countries [81].

Alongside efforts to step up HIV prevention and treatment and care efforts, there has been increasing recognition of the need to understand and respond to the different needs of different groups. For example, in recent years, new data have indicated that, among some young members of key populations, behaviors that increase the risk of HIV acquisition may begin in early adolescence [82]. Increasingly, international organizations, governments, and NGOs are addressing these groups with tailored programming, and despite legal constraints in many settings, there are encouraging examples of advocacy and leadership (including by young people themselves), development of national strategies, and rollout of community-based services, such as those in Georgia, Ukraine, and South Africa [82]. Numerous examples of civil society efforts to address the prevention, treatment, and support needs of young members of key populations (e.g., young women who sell sex in Ghana and Myanmar; young people who inject drugs in Mexico, Romania, and Tanzania; and young men who have sex with men in the Philippines) are now being documented and emulated [83].

The involvement of young people in the HIV response has been a hallmark of NGOs and UN agencies from early days [84]. Young people continue to be involved in advocacy, policy and program development, and service delivery (e.g., as peer educators and navigators). Increasingly, their involvement is recommended in normative guidance, assessed through studies, and is a required element in the funding proposals (Box 2: Sexually Transmitted Infections) [85–88].

Lessons learned. Progress on addressing HIV among adolescents has been greatly helped by steady increases in the availability of age- and sex-disaggregated epidemiologic and programmatic data, which has facilitated greater attention to adolescents' needs and revealed crucial data and service gaps, especially among young members of key populations. To continue to build on this progress, bridging these remaining data gaps is urgent [92,93].

Many adults have difficulty acknowledging adolescents as sexual beings, and adolescent sexuality is often viewed as something to be controlled. Such views influenced early HIV-related research and practice concerning young people; confronting the normalcy of adolescent sexuality has been crucial in developing effective responses [94]. However, even as readiness to address HIV among adolescents and young people increased, insufficient attention was given to addressing harmful gender and sexual norms, especially as they relate to the vulnerability of adolescent girls and young women [95]. Beyond these adolescent-specific issues, the road to improved HIV programming for young people has been beset by the tensions affecting

Box 2. Sexually transmitted infections

Unlike in the case of HIV, data on the levels and trends on other sexually transmitted infections (STIs) in adolescents and young people globally are limited and patchy. Data from high-income countries—and limited available data from low- and middle-income countries—point to high levels of incidence and prevalence in this age group of a range of STIs [89]. This is associated with young people's relative lack of knowledge, low perception of risk and lack of access to or improper use of condoms, and a relatively high incidence of new sexual partnerships [89].

Syndromic STI management is the standard of care in most low-income countries because of the cost of sensitive STI diagnostic tests and the logistics challenges of making them available at the primary level. However, given that most STIs in women and girls are asymptomatic, syndromic management has led to under-recognition of the scope of the STI epidemic in adolescents and young people. WHO has called for greater attention to STIs and specifically for reduction in the cost of STI diagnostic tests; for bulk procurement of diagnostic kits and medicines by funders and national programs; and for the prioritization of adolescents and young people in national guidelines for STI testing, including in HIV prevention and care programs [90].

The availability of a highly efficacious human papillomavirus (HPV) vaccine to prevent cervical cancer is an important achievement in this field. High- and middle-income countries have rolled out the HPV vaccine, but progress in low-income countries has been slow. However, thanks to a multiagency initiative, the vaccine is now being offered to 9- to 14-year-old girls (and some boys) in more than 80 countries [91]. HPV vaccination programs are also providing an entry point for other health interventions for young adolescents.

methods for understanding the epidemic among adolescents and a growing move to highlight the need to differentiate and address various populations (e.g., the increasing survival of vertically infected children and adolescents, the need to reach young men, the use of innovations such as pre-exposure prophylaxis to reduce new HIV infections, and to find ways to overcome persistent programmatic challenges [96–99]. This augurs well for the future. Attending to critical enablers (e.g., political commitment, legal reforms, respect for human rights, and community-based services) and synergies with development (e.g., poverty reduction, education, and social protection) is essential, and doing so will demonstrate how addressing HIV can spearhead progress for ASRHR more generally [100–102]. Finally, it is critical that intervention coverage and quality, especially in Africa and for young members of key populations, is greatly expanded. If not, the increasing numbers of adolescents will overwhelm the gains made (Box 3: Zimbabwe) [102,103].

Child marriage

Levels and trends. Each year, 12 million girls are married in childhood. However, in the past 25 years, the proportion of women aged 20–24 years who were married before the age of 18 years decreased from one in every four to one in every five (or 21%, based on data from 106 countries representing 63% of the global population). Five percent of women ages 20–24 are married before the age of 15 years [113].

South Asia (at 30% prevalence), particularly India, and the Middle East and North Africa (at 17% prevalence) have witnessed the largest declines in child marriage worldwide, with a girl's risk of marrying before her 18th birthday approximately halving in the last quarter century. Levels of child marriage remain low in Eastern Europe and Central Asia (11%) and East Asia and the Pacific (7%), although subpopulations of girls in these regions remain at elevated risk. There is no evidence of progress in Latin America and the Caribbean (25%). Finally, because of a combination of the pace of population growth in sub-Saharan Africa and slow declines in child marriage rates, the global burden is shifting to sub-Saharan Africa: one in every three girls recently married before the age of 18 years are now in sub-Saharan Africa, compared with one in every seven girls 25 years ago. However, countries such as Ethiopia, where the prevalence has dropped by one-third in the last 10 years, point to the prospect of progress in the region [114]. Across all regions, poorer girls and rural girls are more likely to be married as children than wealthier girls and urban girls [113]. Now, for the first time, there are also data on the prevalence of child marriage among boys, covering 51% of the global population of men. On average, 4.5% of young men aged 20–24 years were first married or in union before age 18 years, with a range of values among countries from less than 1% to nearly 30% [115].

Evolution of global and regional responses. In 1994, the ICPD POA called on governments to adopt and enforce measures to eliminate child marriage (paragraph 5.5), create a socioeconomic environment conducive to the elimination of child marriage, reinforce countries' educational programs on the social responsibilities that marriage entails, and take action to eliminate discrimination against young pregnant women (paragraph 6.11) [1]. Despite these resolutions 25 years ago, child marriage was not universally recognized as a major violation of the rights of

the broader population, such as balances between prevention and treatment and competition between the HIV and SRH fields. In addition, programming improvements have been further hindered by challenges in achieving and sustaining coordinated actions by multiple sectors [77].

Specific strategies are needed to support adolescents during every step of the HIV prevention and treatment cascades from informing, motivating, and ensuring access and effective use of prevention methods to testing, linkage, and adherence to care.

Finally, HIV/AIDS education programs took off in the second half of the 1980s in a climate of fear and urgency. They were grounded in a strong shared sense that bold steps needed to be taken in the face of this deadly threat, particularly given that HIV testing was still not available and antiretrovirals were not even on the horizon. These steps included talking about sex openly with all, including young people. In many places, discussion of HIV then legitimized discussion of sexuality. Although this is clearly positive, the prevailing message that sex is dangerous and that children and adolescents should be protected from it/prevented from having it continues posing a barrier to the provision of CSE and other interventions.

Future prospects. Energy and determination to end the HIV epidemic continue. Increasingly, they benefit from improved

Box 3. Zimbabwe: scaling up HIV prevention for adolescent girls and young women and providing treatment and support for adolescents and young people living with HIV

Zimbabwe has a mature, largely sexually transmitted, generalized HIV epidemic. The estimated HIV prevalence was 13.3% in 15- to 49-year-olds in 2017, down from a peak of over 25% in the late 1990s. The most recent data indicate a prevalence among those aged 15–24 years of 4.7%, with prevalence among females (6.1%) almost twice as high as among males (3.4%) [104]. Since 2010, there have been estimated decreases of 44% in AIDS-related deaths in all populations [61].

HIV prevention efforts directed at adolescent girls and boys have been underway for several years. The Government of Zimbabwe adopted Zvandiri, a theory-grounded, multicomponent differentiated service delivery model for children, adolescents, and young people living with HIV in 2004/2005. Through Zvandiri, peer-led community services are integrated into facility-led treatment and care across the HIV cascade in 51 of Zimbabwe's 63 districts, reaching 65,000 children and adolescents living with HIV. Program data and research studies have found that the program has led to improved uptake of HIV testing, retention in care, adherence and viral suppression, and psychosocial well-being. Factors contributing to the success of Zvandiri's scale-up include strong government leadership, standardization and integration of the program into national service delivery, meaningful engagement of adolescents and young people at all levels of the program, and use of program data and research evidence to inform adaptation of the model and costing [105].

In recent years, the implementation of Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe initiative (described earlier) in 10 HIV high-burden districts, with support from the U.S. President's Emergency Plan for AIDS Relief and the Global Fund, has reached almost all 15- to 19-year-olds with at least one DREAMS service and nearly three fourths of the same group with three or more services (Table 1). The program also is on track to achieve high levels of coverage among adolescent girls and young women aged 20–24 years [106]. In addition, the already vibrant voluntary medical male circumcision program implemented by the Ministry of Health and Child Care, which showed 26% increased uptake of vibrant voluntary medical male circumcision among men including adolescents from 2010 to 2017 [107] has provided a gateway for strong linkages with adolescent sexual and reproductive health services, sustained delivery, and transformative masculinity approaches for adolescent boys [108].

As a result, Zimbabwe has made great progress in controlling the HIV epidemic and is well positioned to achieve the 90-90-90 fast-track targets (i.e., global targets to help end the AIDS epidemic) [110]. However, the HIV treatment cascade among young people shows that all achievements are lower than those for adults: currently, 50% of adolescents versus 74% of adults know their HIV status; 84% of adolescents versus 89% of adults living with HIV are on treatment, and 85% of adolescents versus 87% of adults on treatment have a suppressed viral load [111]. Multiple factors contribute to this situation—they include lack of information and understanding; low perception of risk; negative peer influence; and lack of access to and use of services due to costs, distance, disability, stigma, and fears of negative responses from health care workers.

The achievements and progress made in Zimbabwe reflect strong political leadership and commitment to the response to HIV and AIDS in the country from the highest level of the government. The national multisectoral response is managed by the National AIDS Council, which was established by an Act of Parliament in 2000. This commitment is also exemplified by the government's allocation of funding through subventions in the national budget as well as through the National AIDS Trust Fund, which was created by an Act of Parliament 1999 and has been sustained over time. In addition, the government has instituted an AIDS levy of 3% of income tax, which is collected from all employees in formal sectors and corporate bodies, to strengthen prevention and treatment and to mitigate the impact of HIV and AIDS. Adolescents and young people are increasingly involved in their own programs, including in policy and strategy design and development. Zimbabwe is one of the few countries that has developed HIV reporting tools disaggregated by age and sex, which are providing evidence on how the country is performing with regards to young people and HIV.

These successes could falter or even reverse, given that the extremely difficult economic situation that Zimbabwe is currently experiencing will likely affect the functioning of the health system (e.g., disruptions in supplies of antiretrovirals and condoms; exacerbated food insecurity; transport constraints; and, potentially, increases in transactional sex as a means of survival). All this occurs under the continuing shroud of stigma about HIV that exists among health workers, teachers, and young people themselves (some 32% of young men aged 15–19 years show discriminatory attitudes toward those living with HIV. This number decreases to 15% or less among those aged 30–49 years) [112].

girls and women, and specific policy, programmatic, and social attention to it was relatively weak.

International momentum around child marriage was galvanized in 2011 with the creation of Girls Not Brides: The Global Partnership to End Child Marriage¹⁵ and the selection of child marriage as the theme of the first International Day of the Girl Child in 2012. Since then, a number of global and regional efforts have been launched and commitments made, including the UN General Assembly Third Committee and Human Rights Council

resolutions [116], the United Kingdom Girl Summit in 2014 [117], the African Union campaign to end child marriage in 2014, the African Common Position on Ending Child Marriage in 2015 [118], the setting of SDG target 5.3 in 2015 [3], the adoption of the regional action plan on child marriage by the South Asia Initiative to End Violence Against Children in 2015 [119], and recognition of child marriage as a human rights issue by the Organization of American States in 2017 [120].

Thanks to increasing availability and quality of data on child marriage, primarily from the Demographic and Health Surveys and Multiple Indicator Cluster Surveys, we now know more about the nature and scope of the problem. There is also growing

¹⁵ A global partnership of 1,000+ civil society organizations committed to ending child marriage and enabling girls to fulfil their potential.

Table 1

Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe initiative achievements in Zimbabwe [109]

	Annual target	Achievement	Percentage of achievement
Number of caregivers exposed to positive parenting	17,425	18,802	100
Number of AGYW engaged in economic strengthening activities	17,425	18,802	100
Number of AGYW provided with post GBV support	8,808	7,288	91
Number of sexually abused AGYW receiving PEP	1,451	575	40
Number of AGYW receiving family planning	4,270	2,842	66.5

AGYW = adolescent girls and young women; GBV = gender-based violence.

understanding and recognition that child marriage has diverse forms—such as formal and informal unions, those that are arranged by adults and those that are self-initiated, those that are age disparate marriages and those that are not, and those that are preceded by premarital conception—and that approaches need to be tailored accordingly. Finally, the evidence base on interventions—and the associated policy and programmatic guidance—is improving, including evidence on interventions that are more readily scalable, such as education as a social vaccine [26,121,122].

Evolution of national and subnational responses. At the national level, more countries have begun to develop policies and strategies to end child marriage and to strengthen relevant legal frameworks. Since 2011, more than 30 countries have developed national strategies to end child marriages, and since 2015, several countries, such as Chad, Costa Rica, Dominican Republic, Ecuador, El Salvador, Germany, Guatemala, Honduras, Malawi, Mexico, Nepal, Netherlands, Norway, Panama, and Zimbabwe, have banned child marriage outright or tightened legislation by reducing exceptions, for example, with parental permission [123].

As for programmatic responses, the initial efforts to end child marriage in the first half of the 20th century were led by social reform movements in South Asia. These efforts succeeded in stimulating the establishment of laws forbidding child marriage [124] and sporadic efforts to improve girls' access to education [125]. Although larger efforts to end child marriage began to emerge in the 1990s [126], it was not until the 2000s that there was significant growth in the number and coverage of community-based programs—for example, Berhane Hewan in

Ethiopia¹⁶, Ishraq in Egypt¹⁷, the Social Cash Transfer Programme known locally as Mtukula Pakhoma in Malawi¹⁸, and Prachar in India¹⁹ [127–130]. These programs were implemented by NGOs. They provided girls with life skills, health information, and financial literacy, and they provided families with incentives as well as community conversations and mobilization. These programs demonstrably delayed age at marriage and contributed to the evidence base. For example, the Balika program in Bangladesh resulted in a decline of up to one-third in child marriage [131], and early marriage/cohabitation fell by half among adolescent girls in the Empowerment and Livelihood for Adolescents program communities in Uganda [132].

Building on initiatives introduced in the 2000s, the number of programs addressing child marriage—and the associated funding—has grown steadily, with increased action from international NGOs and community-based organizations as well as the launch in 2016 of the UN Global Programme to Accelerate Action to End Child Marriage [133]. The response has evolved from predominantly providing public messaging on the dangers of child marriage to understanding and addressing its structural drivers. Programs are increasingly seeking sustainable service delivery at scale by integrating with delivery platforms such as education, social welfare, and health systems and addressing harmful gender and other social norms that drive the practice [134]. Still, there are few examples of how best to support the health and social needs of currently married girls through, for example, access to contraception and GBV services, facilitation of mentors and support networks, and opportunities for gainful employment. This is particularly important, given that bans on child marriage may have the unintended effect of limiting the recognition of young married girls' needs if their married status is not legally recognized.

Once a taboo topic with little political or public recognition, ending child marriage is now becoming a social movement. Child marriage is widely recognized as a rights violation and has been the subject of global and regional conferences and discussed by parliamentarians, government officials, religious and traditional leaders, and community members, including young people, including, increasingly, young men.

Lessons learned. A number of factors have contributed to the progress made on ending child marriage. Recognition that improvements in girls' education and female labor force participation lead to reductions in child marriage has provided clear avenues for investment and a conviction that child marriage is tractable [135]. Similarly, increased recognition that ending child marriage will advance other health and development goals, such as decreasing adolescent pregnancy, has rallied action by decision-makers, advocates, and communities. Finally, consensus on an indicator of child marriage (i.e., proportion of young women aged 20–24 years who were married before age 18 years) has enabled the measurement of progress (or the lack thereof) and spurred action.

The factors hindering progress relate largely to the persistence of gender inequality and societal (particularly male) control and exploitation of female sexuality, fertility, and labor. Persistent poverty has also limited progress, as child marriage continues to be a way for families to reduce expenditure on food, education, and even weddings (where dowry is practiced) and a source of income (where bride price is practiced). Although awareness of the minimum age of marriage and the harmful consequences of child marriage are increasing, there continues to be widespread social acceptance of the practice and poor

¹⁶ A 2-year pilot project conducted in 2004–2006 by Population Council that aimed to reduce the prevalence of child marriage in rural Ethiopia, through a combination of group formation, support for girls to remain in school and community awareness.

¹⁷ A program launched in 2001 and implemented by Caritas, CEDPA, the Ministry of Youth, the National Council for Childhood and Motherhood, Population Council, and Save the Children that aimed to reduce child marriage by providing literacy, sports, safe spaces, and life-skills training to out-of-school adolescent girls in rural Upper Egypt, in combination with efforts to engage communities and the government.

¹⁸ This an unconditional cash transfer program targeted to ultra-poor, labor-constrained households, which was piloted in Mchinji district, Malawi, and since 2009 was expanded to reach 18 of the country's 28 districts.

¹⁹ A program implemented from 2001 to 2012 by Pathfinder International, UNFPA, and the government of Bihar, India, that aimed to reduce child marriage through a comprehensive behavior change approach that included interpersonal communication, training programs, home visits, street theater, wall paintings, puppet shows, and information education and communications materials.

enforcement of laws banning it. This is exacerbated by the fact that child marriage often occurs in poor, remote rural areas, where access is limited and efforts to raise awareness or extend programs are hindered. Resourcing and implementing national strategies at the subnational level remain a challenge, and support for community-led efforts is limited and not well-documented. Disasters and conflicts are further exacerbating girls' vulnerability to child marriage [136–138]. Although the underlying drivers of child marriage are similar across contexts, instability and elevated risk of violence potentially increase child marriages in particular settings. Finally, there are limitations in the data on child marriage (e.g., on trends at the subnational level and on the differing nature of child marriage in different parts of the world and how it is changing).

Future prospects. To end child marriage by 2030—the target set out in the SDGs—progress must be significantly accelerated, from an average annual rate of reduction in the prevalence of child marriage of .7% over the past 25 years to 23% [113]. International attention to the issue, the growing epidemiologic and evidence base on what works, committed political and governmental support, and the growing movement of activists mobilizing to end the practice and to create a better future for and with girls augur well for the decades to come (Box 4: Ethiopia).

Violence against adolescent girls

Levels and trends. Adolescent girls experience various forms of violence at staggeringly high rates [143]. Although girls experience some forms of child abuse that boys also experience (e.g., emotional abuse and neglect, corporal punishment, and bullying), they are disproportionately affected by forms of violence that are gendered, which means that violence is directed at them because they are girls as an exercise of male dominance and power over them²⁰. Violence against women and violence against children intersect in adolescence. For historical reasons, gendered forms of violence experienced by adolescent girls have been subsumed as part of the women's agenda and, hence, the data, literature, research, and global development agreements use the terminology of violence against women and girls, which also applies to adolescent girls even where this is not explicitly noted.

According to data for 2014, 120 million girls under the age of 20 years worldwide have experienced forced sex (sexual intercourse or other sexual acts) [144]. Surveys of violence against children have been conducted in the last 5–10 years as part of the Together for Girls initiative with adolescents aged 13–24 years. Data from nine countries that have conducted such surveys show that among girls (aged 0–17 years), the prevalence of sexual abuse ranges from 4% to 38%, with a majority of these countries having a prevalence of more than 25% [145]. As adolescent girls become older, a significant proportion experience forms of violence that are common to adult women. For example, data from violence against women surveys conducted with girls and women 15 years and older show that, globally, 30%

²⁰ The inadequate documentation and attention to violence among adolescent boys and lesbian, gay, bisexual, transgender, queer, intersex, and asexual adolescents is acknowledged but not addressed in this article. The prevalence of sexual abuse among boys is also significant, although not as common as among girls. Sexual abuse against boys is perpetrated as a form of punishment or humiliation in the form of emasculating or feminizing them because what is female or feminine is considered inferior or less valued in most societies.

Box 4. Ethiopia: a multifaceted program to address the multidimensional drivers of child marriage leads to substantial reductions in child marriage

Between 2005 and 2015, the prevalence of child marriage in Ethiopia has declined from about 60% to about 40%, led especially by progress in four regions: Tigray; Amhara; Southern Nations, Nationalities, and Peoples' Region; and Addis Ababa. Ethiopia's progress on this issue is one of the strongest among countries in Eastern and Southern Africa [139].

In 2000, Ethiopia outlawed marriage below age 18 years under the Revised Family Code [140]. Around that time, social mobilization and sensitization campaigns on the issue were already underway. However, policy-makers and public health professionals still perceived child marriage as a rural and relatively rare phenomenon affecting certain ethnic groups. They were unaware of its magnitude and pervasiveness, its economic drivers, and its costs to girls, their families, and communities. Near-universal primary school enrollment and the first girl-centered programs in Ethiopia, complemented by focused outreach to community leaders, families, and also especially influential males, laid the foundations for large-scale declines in child marriage across the country [141].

Although there has been impressive progress overall, it has been uneven, with limited progress in rural areas and among poorer and less-educated populations. For example, the rate of child marriage is three times higher in the northern region of Amhara (75%) than in the capital city of Addis Ababa (26%).

Today, Ethiopia has a national program, which seeks to respond to the multidimensional drivers and consequences of child marriage and to contribute to the national goal of ending child marriage and female genital mutilation (FGM) by 2025. The program builds on the country's constitution and a strong legal framework to promote and protect girls' and women's rights. In 2019, the President of Ethiopia, H.E. Sahle-Work Zewde, launched a 5-year national costed roadmap to end child marriage and FGM under the leadership of the Ministry of Women, Children and Youth and the National Alliance to End FGM and Child Marriage, with contributions from other ministries, civil society, national and international nongovernmental organizations, and UN agencies [142].

of adolescent girls (aged 15–19 years) have experienced physical and/or sexual violence by an intimate partner [146]. Intimate partner violence can be experienced by adolescent girls in the context of early marriage or in the context of dating relationships. Rates of intimate partner violence among adolescent girls range from 16% in high-income countries to 43% in WHO's South-East Asia region (Figure 1) [147]. Data on prevalence and consequences of violence against adolescent girls are only recently available; hence, global trend data are not available.

In 1994, violence against adolescent girls was reflected in principle 4 of the ICPD POA, which stated that “advancing gender equality and equity and the empowerment of women, the elimination of all kinds of violence against women and ensuring women's ability to control their fertility are the cornerstones of population and development-related programmes [1].” Chapter IV also highlighted the needs of girls, including in addressing

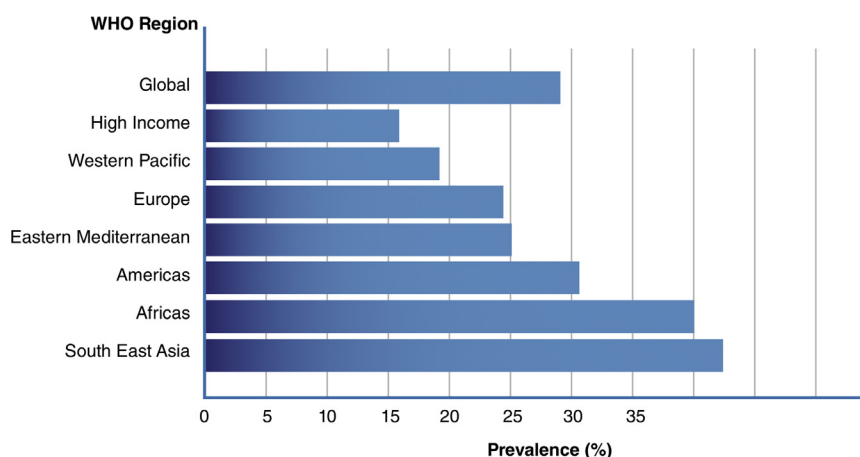


Figure 1. Global and regional prevalence of intimate partner violence among adolescent girls aged 15–19 years, Source: (WHO. Health for the world's adolescents) [147].

discrimination and forms of violence that are specific to them [1]. In 1995, the Beijing Platform for Action included a chapter devoted to addressing violence against women, highlighting gaps in data as a barrier to progress [148]. In the two decades that followed, increased availability of data and continued advocacy resulted in the inclusion of two specific targets related to violence against adolescent girls in the 2015 SDG agenda: target 5.2, which calls for the elimination of all forms of violence against women and girls, and target 16.2, which calls for ending abuse, exploitation, trafficking, and all forms of violence against and torture of children [3].

In the last 25 years, considerable progress has been made in building the epidemiologic database. National data on prevalence of violence against adolescent girls (15–19 years) are now available from 153 countries²¹. Violence against children survey data are also available from 20 countries, providing information about the 0–17 years age group. Both the violence against women and violence against children surveys ask about the age and experience of first sex (e.g., whether or not it was coerced), disaggregate these data by age (i.e., before and after 15 years), and provide additional data about adolescent girls' experience of violence.

We also now know more about what works to prevent violence against women and girls. In the last 5–10 years, investments in research initiatives, such as the UK's Department for International Development–funded “What works to prevent violence against women and girls” and the “Structural drivers of HIV (STRIVE) initiative”²², are collecting evidence of effective strategies [149,150]. Reviews of evidence on effective interventions to prevent violence against women and girls point to the importance of starting early in childhood and adolescence to prevent violence and develop gender-equitable norms through multisectoral strategies [151,152]. From these reviews, promising strategies have emerged, including those that empower

adolescent girls and young women to build skills in self-efficacy, confidence, and assertiveness; address household poverty through cash transfer schemes including those that keep girls in schools; promote women's and girls' rights to inherit and own assets; promote schools that are free of violence; support parents to build nurturing and violence-free relationships with their children; and mobilize communities, including through participatory group education with boys and girls, to develop egalitarian/equitable gender norms and relationships [153].

In the global health agenda, such improvements in data and evidence have enabled the development of norms and standards. In 2013 and 2017, WHO published clinical and policy guidelines and implementation tools for health care providers and managers to respond to intimate partner violence and sexual violence against women and child and adolescent sexual abuse [154–157]. In 2016, the World Health Assembly endorsed a global plan of action to address violence against women and girls and against children that urged governments to speak out against violence, provide quality comprehensive services to survivors, implement prevention approaches, and generate evidence on the issue. In the Global Plan of Action, adolescent girls are covered in the sections on violence against women and girls and on violence against children [158].

Funding for programming on violence against women and girls is rarely included in domestic budgets and relies largely on external donors. Investments to scale up violence against women programming is just beginning in a few countries. One example is the European Union–funded Spotlight initiative [159]. It includes adolescent girls by referring throughout to violence against both women and girls and specifically calling out forms of violence affecting adolescent girls, such as trafficking, sexual abuse, and harmful practices such as child marriage. In addition, the President's Emergency Plan for AIDS Relief DREAMS initiative [75] and the Global Fund's initiative to prevent HIV among adolescent girls and young women [160] are investing small amounts in efforts to prevent violence against adolescent girls in 10 countries of sub-Saharan Africa.

Evolution of national and subnational responses. Many countries have adopted laws addressing different forms of violence, including rape, child sexual abuse, and domestic and/or intimate

²¹ WHO's database for prevalence data on violence against women has been updated as part of the process for updating estimates for 2019. Although the database for this is available on websites of the UN Statistics Division, UN Women, and WHO (not yet publicly available), a consolidated database and country estimates are forthcoming in 2020.

²² An initiative to address violence, particularly against adolescent girls and young women, in sub-Saharan Africa as a key driver of high rates of HIV in this population.

partner violence. Between 1990 and 2015, the number of countries with laws against domestic or intimate partner violence increased from none to 118 and now includes 76% of countries²³. Only 40% of countries have laws that cover sexual harassment in educational institutions, leaving adolescent girls and young women vulnerable to this form of violence [161]. Implementation of these laws is hampered by weak institutional capacities to respond, be it by law enforcement, health, or judiciary systems or social protection units (i.e., child and women protection) and because a majority of those subjected to violence do not seek help because of stigmatizing norms.

With regard to programmatic responses in the health sector, countries have experimented with different models to provide care to women, adolescents, and children who are survivors of gendered forms of violence, including one-stop crisis centers [162]. In the last 5 years, an increasing number of countries are developing or updating national guidelines for health sector responses to violence against women and girls and rolling out trainings for health workers in line with WHO guidelines and tools. Many countries are also developing multisectoral plans to address violence against women and girls that include prevention strategies for adolescent girls. However, although many countries are implementing small-scale prevention interventions, programming at scale is limited and under-resourced [163]. One of the few examples of a large-scale comprehensive and resourced plan comes from the Australian state of Victoria, which in 2017–2018 allocated Australian \$1.9 billion to address violence against women and their children [164]. It is too early to evaluate country-level progress.

With regard to social responses to violence against adolescent girls, on the one hand, it seems there is heightened public awareness globally of violence against adolescent girls and young women because of several high-profile cases of sexual violence in such countries as India, Mexico, Brazil, and South Africa. These incidents resulted in mass protests that were covered by national and international media and amplified in campaigns such as #MeToo and the annual 16 days of activism against gender violence. On the other hand, data from Demographic and Health Surveys in 10 countries find that a high percentage (from 50% to 83%) of both boys and girls (aged 15–19 years) justify violence toward women under certain circumstances. These statistics highlight the urgent need to change norms that condone violence and women's and girls' subordinate status [165].

Lessons learned. Several factors have contributed to the progress in addressing this issue. First, grassroots, autonomous feminist movements have been instrumental in driving legislative and policy changes [166]. Second, the availability of data has increased visibility and political attention to this issue. Third, there has been increased research on what works to address violence against women and girls. Investments in research to develop innovative interventions, evaluations showing impacts on a broad set of health and development outcomes, and evidence on the cost of not addressing violence and on the cost-effectiveness of interventions are contributing to a growing knowledge base to support action.

Progress is endangered by conservative political environments that contribute to backlash against progressive agendas and feminist movements. Political will to address violence against women and girls is lacking in many countries, and governments are not investing adequate resources to tackle the issue. They are also failing to exercise leadership in speaking out publicly about the unacceptability of such violence. In many societies, changes in economic opportunities for young people, the increasing use of digital technologies, and the instability related to migration and humanitarian crises pose risks of exacerbating existing violence and increasing new forms of violence against women and girls.

Future prospects. Going forward, to make an impact, dedicated resources, political commitment, and coordinated efforts to scale up promising programs are required. The SDGs and the renewing of commitments made at ICPD 25 years ago present an opportunity to learn how progress was made and to build on the evidence to end violence against women and girls in the rest of the SDG generation (Box 5: Kenya).

Female genital mutilation

Levels and trends. It is estimated that 200 million women and girls who are alive today have undergone FGM. However, there are signs of progress; across the 30 countries where FGM is practiced and data are available, the prevalence of FGM among young girls has decreased in 24 countries, from 49% in 1994 to 31% projected for 2019 (Figure 2) [172]. But the rapid decline in FGM in countries such as Burkina Faso, Ghana, and Kenya is not evident in other countries, such as Chad, the Gambia, Guinea, or Nigeria. In addition, the absolute numbers of girls and women affected by FGM are expected to increase as a result of population growth unless the practice is curtailed [173].

In 1994, the ICPD POA included reference to FGM in the sections related to girls, adolescents, reproductive health and rights, human sexuality, and gender relations, thus establishing the issue as a critical component of SRHR and a violation of a number of human rights principles that predated the ICPD [1].

Since 1994, there has been greater recognition of the scale and impact of harmful traditional practices, including FGM. In 1997 UN partners released a joint statement describing the public health and human rights implications of FGM and calling for its abandonment. A series of actions and landmark resolutions followed [174]. These resolutions included a 2007 Joint Statement by WHO, UNFPA, and UNICEF, which was reiterated and updated in an Interagency Statement in 2008 [175]. In addition, in 2007, the UNFPA-UNICEF Joint Programme was established, thereby creating a UN mechanism with the mandate to support UN Member States to systematically take action to abandon FGM, and with dedicated funding to do so. In 2012, the UN General Assembly passed a resolution on FGM [176], and in 2016, the issue was included as a target in the SDGs as target 5.3.2, which measures the proportion of girls and women who have undergone FGM, by age [3]. Such international statements, commitments, and goals are both a marker of progress and a call to action to spur additional efforts.

With regard to data on FGM, the development of standardized measures has enabled consistent and comparable measurement of the scale of the issue and how prevalence has changed over time. Topic-specific modules on FGM have been developed and included in the Demographic and Health Surveys and the

²³ A repository of multisectoral plans of actions on violence against women and girls is available in the Global database on violence against women available at: <http://evaw-global-database.unwomen.org/en/search?typeofmeasure=48885833498943ba8626019c8004177>.

Box 5. Kenya: civil society fosters government clinical services for women and girls who experience sexual violence

Kenya recognizes gender-based violence (GBV), including sexual violence against women and girls, as a violation of human rights. The 2014 Kenya Demographic and Health Survey estimated that almost half (45%) of women aged 15–49 years have experienced either physical or sexual violence [167]. Kenya's 2010 violence against children survey showed that 32% of girls reported experiencing sexual violence before age 18 years, and 30% of these girls reported becoming pregnant [168].

Kenya has made major strides to tackle the issue by developing enabling legislative and policy frameworks and programmatic guidance (e.g., the Children Act 2001, Sexual Offenses Act 2006, guidelines on the management of sexual violence 2014, Protection Against Domestic Violence Act 2015, and standard operating procedure for managing child survivors of violence 2018) [169–171].

This progress is a result of many years of advocacy and awareness creation by feminist activist groups, other civil society organizations (CSOs), and collaborations between CSOs and the government. Kenya offers services for GBV free of charge through an integrated model in over 500 public health facilities and five one-stop recovery centers located in tertiary facilities. The rapid scale-up of these services can be attributed to increased funding from government and donors; increased availability of local data and research evidence to inform programming, training of health care providers, and strengthening of health systems, and increased efforts to build community awareness.

Despite this progress, several challenges continue to hinder efforts to address GBV in Kenya. There is a lack of coordination among efforts by the government and CSOs. Specifically, the cross-sectoral linkages (i.e., among education, health, justice, security, and social welfare) are poor, inhibiting the quality of care offered to survivors. Finally, an overreliance on external donor funding is a major hindrance to the long-term sustainability of the country's program.

Multiple Indicator Cluster Surveys, which are carried out periodically in 30 FGM-affected countries. These population-based surveys have been the primary data sources for tracking trends in prevalence and attitudes surrounding FGM.

Reports of research studies on preventing FGM and reports of documentation/evaluation of implementation efforts are being synthesized [177]. This learning has fed into normative guidance to inform prevention of FGM [178]. To address care and support for those who have experienced FGM, WHO has developed clinical guidelines and a clinical handbook on FGM [179].

Evolution of national and subnational responses. International human rights laws have created the normative framework and obligation for countries to ensure the protection and fulfillment of girls' and women's rights. Major achievements have been made in the last 25 years with regard to national laws and policies on FGM. Before, 1994 only four countries had banned the practice, whereas today, nearly all countries in which FGM is

widely practiced have done so. Thirteen countries have also developed human rights-based action plans on FGM and are implementing them through coordinated efforts across sectors, including the health, education, and social service sectors as well as community organizations [180].

With regard to programmatic responses, efforts to end FGM initially fell to civil society bodies to raise awareness of the issue and challenge harmful norms. Increasingly however, countries have implemented multisectoral responses (including those based on the previously mentioned plans) involving multiple government sectors (e.g., health, education, and social services) as well as community organizations, each reinforcing the others. The engagement of the health sector to improve management of health complications of FGM and to prevent the practice has also been a critical component of a multisectoral approach, bolstered by international norms and standards. These efforts have led to a marked increase in funding from bilateral agencies and private foundations to bring about tangible results at the global, national, and community levels [181].

Lessons learned. Learning from experience, single intervention approaches to preventing FGM have given way to multicomponent ones that address the social norms driving FGM and engage different community stakeholders to reinforce their efforts to abandon the practice and to provide support for those committed to abandoning it [182]. Having said that deep-seated social norms—embedded in cultural traditions—about the status of women and girls and about the need to control their sexuality will require sustained effort to change.

Despite marked progress, there are critical challenges that perpetuate gaps in implementation. For example, there is a lack of evaluation data on whether and how programs work to prevent the FGM. In addition, scale-up and replication of promising community-based programs across countries have been limited. Furthermore, there is a need to foster more leadership among women and frontline health workers at the community level. They can be powerful opinion leaders if they are supported. Finally, decision-makers should be held accountable for ensuring that sufficient resources are allocated and encouraged to promote the sustained prioritization of the health and rights of girls and women.

Future prospects. Efforts to abandon FGM began well before the ICPD and continue today. In particular, global mechanisms, including the ICPD and SDGs, have endorsed the international consensus for zero tolerance of FGM, calling on State and non-State actors at the national level to develop and implement policies and programs. This support must be leveraged because, without concerted action, 68 million girls will be subjected to FGM by 2030, with substantial health and social costs [173]. Sustained efforts and scale-up of promising interventions are needed to spare girls from this harmful practice and its painful and debilitating consequences and to prevent its associated economic costs (Box 6: Burkina Faso).

Menstrual hygiene and health

Levels and trends. There does not yet exist much comparable trend data on menstruation, aside from a WHO multicenter study surveying the average age of menarche in countries [184]. This study did not stimulate country interest in menarche, and most countries still lack data on the average age of menarche

Percentage of girls aged 15 to 19 who have undergone female genital mutilation

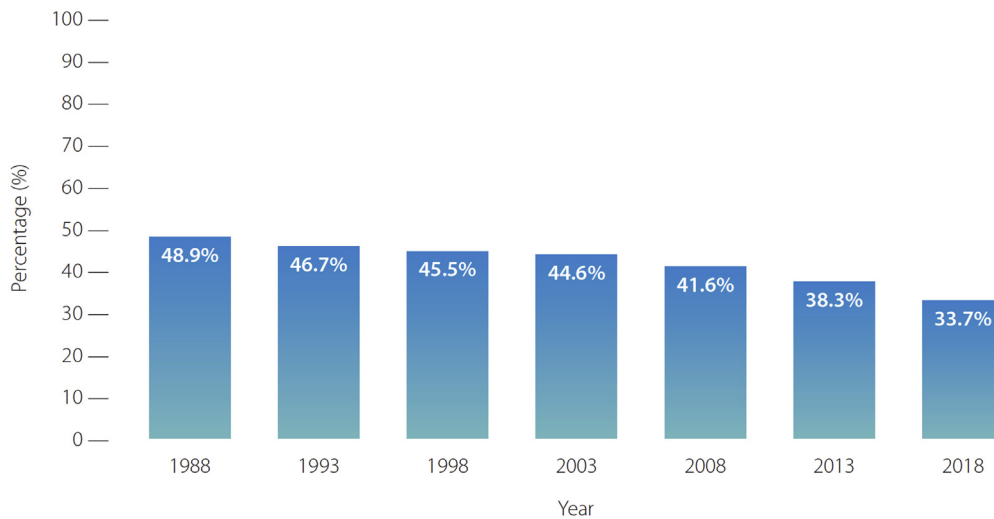


Figure 2. Percentage of girls aged 15–19 years who have undergone FGM [172]. Source: UNICEF. Female genital mutilation/cutting: A global concern. New York: UNICEF, 2016 [172].

[185]. However, a growing body of literature has documented the menstruation-related needs of girls and women in low-resource contexts, capturing the many ways in which menstrual stigma and inadequate social and physical environments create barriers to safe and dignified menstrual management [186]. An effort was made recently to compare menstruation-related data in the South Asia region. Although this exercise provided useful insights, such as the large percentage of girls in various countries who knew nothing about menstruation before their first period, the ability to compare data on menstrual hygiene and health across countries remains limited in the absence of international consensus on measures [187].

Evolution of global and regional responses. The ICPD POA made no explicit mention of menstruation. At that time, menstruation as a priority within ASRHR, and more broadly within public health, was almost nonexistent. Inclusion of menstruation as an issue relevant for intervention existed primarily in the clinical literature, with attention to menstrual abnormalities as an aspect of family planning and with attention to the psychological implications of menarche in high-income countries [188–190]. A separate body of evidence existed in the social sciences, with anthropologists studying menstrual exclusion, stigma, and the onset of menstruation within puberty rituals. Attention to menstruation as we know it today—that of a growing global public health, rights, and social movement—was largely initiated in the global south and did not emerge until the mid-2000s [191].

To date, this movement still struggles to gain traction within larger ASRHR efforts, largely because of limited evidence on menstruation generally and on how to effectively address girls' needs, as well as inadequate means to measure progress. There are efforts underway to address this. For example, a meeting was convened in early 2019, with the intention of improving the alignment of measures for global, national, and local comparisons in key areas of menstrual hygiene and health [192]. In the water, sanitation, and hygiene (WASH) and education sectors,

there is evidence suggesting the value of addressing menstruation, given the barriers that it presents to girls in school, in particular. Overall, however, there is still limited evidence of effective interventions—a limitation that continues to hinder investment and action.

In response to the growing interest in this area, a number of norms and standards to guide country-level action have been developed, such as Menstrual Hygiene Matters published by WaterAid, guidance on puberty education and menstrual hygiene management (MHM) from UNESCO, and the UNICEF guidance materials on menstrual health and hygiene [193,194]. There are also growing regional efforts to address this issue, as exemplified by the formation in 2018 of the African Coalition for Menstrual Health Management, supported by UNFPA's East and Southern Africa Regional Office [195]. Although activists, NGOs, and researchers have led the growing global menstrual movement, governments are increasingly paying attention to the issue, with the global north following the learning from the global south.

In recent years, there has been growing interest from funding agencies to support research and action on menstruation, such as Canada's support for formative research on MHM in schools in 14 countries and for social entrepreneurs addressing menstrual products, and the UK's support for building the evidence and developing an MHM in Emergencies Toolkit and for randomized trials exploring MHM interventions in schools [196,197]. Nevertheless, there is still far too little investment being made to understand the intersection of menstruation with other aspects of ASRHR and beyond, especially in terms of building the evidence base of effective and efficient interventions and comparative measures.

Evolution of national and subnational responses. In recent years, shifts have occurred in the political and social realm in relation to menstruation, including increasing attention to the issue within ASRHR. Initially pushed by those working in water, sanitation, and education, a small but growing number of countries have

Box 6. Burkina Faso: large declines in reported female genital mutilation resulting from community education, pressure to change from influential leaders, accountability encouraged by community commitments and nudged by legal sanction and sensitive care provided for survivors [183]

Burkina Faso serves as a model of effective programming for female genital mutilation (FGM), as it has decreased the prevalence of the practice from 89% of 45- to 49-year-old women to 58% of 15- to 19-year-olds.

The country has employed a multipronged approach with wide-ranging actions, which has proven key to its success. It developed a national committee and National Action Plan to address FGM in 1990, which catalyzed action at national and local levels. In 1996, Burkina Faso was the first African country to introduce national legislation on the issue. Since then, it has enforced the law in an incremental, progressive, community-based, and effective manner. An innovative centerpiece of the process has been the establishment of a free helpline and mobile courts. Rather than bringing defendants to hearings in the cities, judicial hearings take place near the communities in which the cases arise. Recognizing that laws can be effective only with adequate community engagement, youth brigades have been employed to raise awareness of the consequences of the practice. This has been particularly effective in targeting communities where parents attempt to cross the border into Mali to practice FGM. In addition, FGM prevention has been introduced in primary and secondary schools and in nonformal education programs.

At the national and local levels, partnerships have evolved with different government departments, mayoral offices, networks of traditional and religious leaders, associations for human rights, journalists, and networks of young people and women to provide technical and financial support to implement additional activities to end FGM. These activities include reporting instances of the practice to security agents using the helpline, caring for those who have experienced FGM, and organizing public pledges in the community to abandon FGM. Monitoring units have been established to follow the villages that have declared their commitment to abandon the practice.

Key to the success of Burkina Faso has been the collaboration between nongovernmental organizations, international organizations, and the national and local governments. Through this collaboration, communities have been swayed by influential leaders, individuals have been educated through schools and service providers, messages have been disseminated and reinforced by radio shows and popular music, accountability has been encouraged by community commitments and nudged by laws and sanctions, and survivors have been offered sensitive care when needed. All these interventions are at work simultaneously in Burkina Faso, where political will, external support, and a readiness to accept change are all converging and resulting in significant shifts in attitudes and behavior.

Although the progress is encouraging, more than half of 15- to 19-year-old women report having had FGM. There is a long way to go to fully overcome this deeply entrenched practice.

developed menstrual hygiene policies. Some, such as Kenya and the Philippines, have focused on school environments; others, such as India and Nepal, have a broader focus, including workplaces and ASRHR [198]. In addition, some countries, such as Kenya and South Africa, are providing free sanitary products in schools, and others have developed girls' puberty books with the aim of reducing the fear, confusion, and shame that many girls experience when they begin menstruating, building their knowledge about the changes happening in their bodies, and breaking the silence between girls, teachers, and parents/caregivers on the topic [199].

However, there continues to be an overemphasis on the importance of providing menstrual products in lieu of addressing menstruation and its impact more holistically, such as through gender transformative approaches to address stigma and discrimination around menstruation; the almost universal gap in girls' preparation for menarche; the inadequate support they receive when they have their monthly periods; the need for safe, clean, and accessible toilets with water and disposal; and the lack of training that health workers receive in dealing with menstrual problems. Of critical importance, as well, are implications for the environment as product distribution expands to new contexts and as innovation and investment in waste disposal and waste management systems continue to be neglected.

With regard to social responses, there is a burgeoning global menstrual equity movement focused on addressing stigma and discrimination associated with periods and advocating normalization of this natural experience. In India, for example, this has included campaigns to enable access to temples during menstruation; in the United Kingdom and South Africa, this has included campaigns to remove taxes on sanitary products. Globally, Menstrual Hygiene Day has sparked media attention, advocacy, and action on the issue.

Lessons learned. Progress in bringing the menstruation-related needs of girls to light has been helped by reports of girls' and women's experiences of shame and embarrassment and of the ongoing barriers they face in managing their periods [200]. In addition, larger efforts around girls' issues, such as reducing the gender gap in education, ending child marriage, and preventing adolescent pregnancy, have helped to bring attention to the unique needs and vulnerabilities of girls, making the transition into young adulthood around the world.

However, progress has been hindered by the continued lack of acknowledgment of the importance of menstruation for ASRHR: the need for girls to be educated about menstruation before menarche, the onset of menstruation as a trigger for child marriage and pressure or coercion to engage in sexual relationships; the vulnerability of menstruating girls and women to iron-deficiency anemia; transactional sex for acquisition of sanitary products in some settings; irregular bleeding patterns among adolescent girls; and the influence of menstruation or amenorrhea on contraceptive discontinuation. Improved articulation of these issues and advocacy will convince the ASRHR community and others of the importance of menstrual hygiene and health (Box 7: Nepal) [201–204].

Discussion

This article set out to answer two questions—first, how the ASRHR field has evolved in the 25 years since the ICPD and what helped and hindered progress and, second, what contribution the

Box 7. Nepal: putting menstrual hygiene and health on the national health, development, and human rights agenda

Nepal has taken meaningful action to address menstruation as a fundamental aspect of public health and SRHR. It has enacted laws to address ongoing menstrual stigma and restrictions that adversely impact girls' and women's health. In 2005, the Supreme Court of Nepal outlawed Chhaupadi, the practice of seclusion outside the home during menstruation, which is predominantly practiced in the Western regions of Nepal. The ban was backed up in 2008 by the Chhaupadi Eradication Guidelines promulgated by the Ministry of Women, Children and Social Welfare and in 2017 by a law criminalizing Chhaupadi enacted by the Legislature-Parliament. Despite these initiatives, the tradition continues. However, although bans may not change deeply rooted cultural and gendered practices, they do indicate political commitment to addressing key health issues. To supplement these bans, initiatives are being implemented to provide menstruation information and address menstrual stigma and taboos, with the aim of empowering communities to address the harmful gender norms and cultural beliefs that underpin restrictive menstrual practices.

Nepal's 2014 health policy guarantees the rights of all, promoting a more enabling social environment for all women and girls with periods [205–209]. Local and international nongovernmental organizations are working in partnership with the government to promote attention to menstruation in the health, education, water, and sanitation sectors [210]. The National ASRH Programme launched in 2010 specifically addresses menstruation within the context of counseling and tracks the number of cases of menstrual problems as a required monthly reporting indicator [211]. Menstrual hygiene has also been covered to some extent under the Ministry of Water Supply and Sanitation's WASH plans and strategic documents related to education and health. For example, the Total Sanitation Guideline [212] promotes extensive public awareness raising and advocacy on the management of menstruation, including on the use and disposal of sanitary products in schools and communities. The National School WASH Procedure also includes indicators for menstrual hygiene in schools [213].

There remains a number of policy gaps. For example, the National Policy and Plan of Action on Disability [214], the second draft of the disability-related 10-Year National Policy and Plan of Action [215], and the recently endorsed Disability Rights Act [216] all remain silent on menstruation-related challenges faced by women and girls with disabilities. Beyond laws and policies, persistent challenges include assuring collaboration across the many sectors and actors working on the issue of menstruation. In addition, the intense media focus on Chhaupadi, while important for raising awareness about the issue, serves at times to occlude the more wide-ranging menstrual restrictions that girls and women face, which create social and health vulnerabilities and perpetuate gendered discrimination.

ICPD made to this. In response to the first question, our thesis, based on the findings of this review, is that over the last quarter of a century the field has evolved in the following five broad areas.

First, some aspects of ASRHR are higher on health and development agendas than ever before

As discussed earlier, in 1994, the ICPD called for attention to and investment in ASRHR. Six years later, selected aspects of adolescent health were an integral part of the MDGs. However, although adolescents were specifically mentioned in relation to the goals on maternal mortality reduction and HIV prevention, they were largely neglected in the face of other pressing health and development issues [216]. It was clear as the MDG era was ending and the SDGs were being formulated that adolescents should not be left behind. Health issues such as preventing adolescent pregnancy, pregnancy-related mortality and morbidity, HIV infection, and HIV-related mortality and morbidity, which were already on the agenda in the MDG era, are even higher on the SDG agenda. Furthermore, issues such as child marriage, FGM, and violence against adolescent girls, which were not on the MDG agenda, are integral parts of the SDG agenda.

A small group of NGOs (e.g., International Planned Parenthood Federation, the World Assembly of Youth, and the World Organization of the Scout Movement) were working to respond to the SRH needs and problems of adolescents and to champion their cause even before the ICPD. Over the years, this group of champions has expanded to include bilateral and multilateral health and development agencies, private foundations, political bodies such as the Inter-Parliamentary Union, and partnerships such as Girls Not Brides and Family Planning 2020. Adolescents and young people too have become increasingly better organized and more effective in championing their cause (e.g., the International Youth Alliance for Family Planning and the International Federation of Medical Students' Associations). The concerted advocacy of all these groups on the demographic, public health, economic, and human rights rationale for investment in adolescent health has contributed enormously to placing ASRHR on global and regional agendas [217]. So have high profile international consultative processes such as the UN Commission on Population and Development, deliberations and resolutions passed by the UN General Assembly, the UN Human Rights Council, and the WHO, as well as regularly convened international conferences on HIV, family planning, and girls' rights. These global processes and calls-to-action have been echoed by regional ones on various aspects of ASRHR, such as access to CSE and AFHS with the Eastern and Southern African Commitment and the Montevideo Consensus.

Second, although much of the funding is from external sources and remains inadequate and fragmented, there is steadily growing financial investment in ASRHR

Although it is true that adolescent health gets only a small piece of the global development cake, it is also true that the funding for specific areas of work within ASRHR has grown steadily and in some areas (e.g., preventing and treating HIV, preventing child marriage, and preventing unintended/unwanted pregnancy) substantially. Here are three notable examples. First, the Global Fund is investing US dollars 200 million to support multiyear initiatives to reduce HIV transmission in adolescent girls and young women in 13 Eastern and Southern African countries [70]. Second, the Global Program to Accelerate Action to End to Child Marriage spent nearly US dollars 25 million to support efforts in 12 countries in 2017 [218]. Third,

the Global Financing Facility is stepping up its investment in adolescent health in the 36 countries with the highest need [133].

Still, the available financing continues to be inadequate and fragmented, hindering progress with regard to specific areas of ASRHR and to geographic coverage. For example, although funding for preventing child marriage has grown substantially, gaps remain in funding for providing girls with CSE and contraceptive information and services and in preventing and responding to GBV. Similarly, much of the available funding is limited to supporting programming in small regions of select countries. Finally, substantial domestic resources are only now being put on the table to complement external funding [219].

Third, although there are still many gaps to be filled, there is a growing body of data and evidence on ASRH; this has fed into norms and standards to guide policies and programs

As a result of investment over the years, there is much more data and evidence related to ASRHR today than even 10 years ago. First, there is stronger evidence on the nature and scale of problems (e.g., HIV-related mortality in adolescents) [220]. Second, there is a better understanding of the causes of these problems and how they differ depending on the context (e.g., the differing causes of adolescent pregnancy among different groups of girls even in the same geographic area) [221]. Third, there has been impressive progress in defining the consequences of the problem to individuals, families, and communities in some areas (e.g., the World Bank-ICRW study on the economic costs of child marriage) [222]. Fourth, based on intervention-effectiveness research and evaluations, there is growing evidence and consensus on what works and what does not work (e.g., in responding to violence in girls and young women). Without a doubt, this growing body of evidence has contributed to increasing investment and directing it in the right areas.

Although there are much more data and evidence related to ASRHR to inform advocacy and guide planning and action, there are still gaps. Analyses of investment returns in adolescent health interventions, including ASRHR, have been prepared [223,224], but the application of recently developed costing models (e.g., the OneHealthTool²⁴) [225] to programs in low- and middle-income countries is rare. This has critical implications for scale-up and sustainability. Furthermore, although there is evidence of effectiveness of interventions in the project context, there is little evidence on how to deliver these effective interventions at scale with quality and equity [226].

The development, publication, and dissemination of norms and standards, such as those that have been produced for pregnancy, HIV, violence against women and girls, and FGM have helped decision-makers see that these issues can be successfully addressed and invested in and have given programs and projects strategic direction [30].

Still, there is work to be done. First, there are topics for which normative guidance is still missing (e.g., how to respond to the contraceptive needs of sexually active and unmarried adolescents). Second, normative guidance published by different organizations does not always make the same recommendations (e.g., on the value of economic incentives for child marriage). Third, the wealth of evidence-based guidance does not always

reach or influence decision-makers and investment in their careful application in countries is rare.

Fourth, although implementation of ASRHR policies and programs in many countries remains weak, a small but growing number of countries have created and implemented enabling legal and policy environments and strong government-led programs

As discussed earlier, many countries have passed laws to end harmful traditional practices, such as child marriage and FGM, which are violations of adolescents' human rights. Alongside efforts to strengthen these laws (e.g., to avoid exceptions on different grounds), efforts are under way to promote the application of these laws to create promotive and protective legal environments. In other areas, such as providing CSE, providing contraception to adolescents below a particular age and to those who are unmarried, and providing safe abortion services, significant legal and policy restrictions remain in numerous countries [227]. In addition, with the aim of protecting and safeguarding children and adolescents, many countries have instituted laws and policies defining the age of sexual consent and classifying sex before this age as statutory rape—a criminal offense. These restrictions have had the unintended consequence of impeding access to information and services and now represent a significant barrier to progress on ASRHR [228]. The intersection of the frequently cited laws related to age of consent, the necessity of parental/spousal consent to access services, and the rampant stigma and discrimination and legal challenges faced by LGBTQIA+ young people hinders attention to adolescents' needs in many countries [92,93]. There remains much to be done.

As mentioned earlier, NGOs were among the first to respond to the needs and problems of adolescents in their communities, and they continue to play the roles of innovators, watchdogs, and implementers. Over the years, in response to the ICPD's call-to-action and those that followed, and based on their growing recognition of the need, national governments have formulated policies and strategies and established programs—including those that are integrated within National HIV/AIDS and Reproductive Health programs and those that are specific to adolescents and young people (e.g., National Adolescent Reproductive Health Programmes or as a component of National Adolescent Health and Development Programmes) [229]. Twenty-five years since the ICPD, national government-led programs that address SRH are in place in most countries, in some form.

There is growing evidence from research studies and evaluations about interventions that are effective and those that are not and about what it takes to deliver interventions effectively. Some of this learning is from the work of frontline NGOs. Despite that, and as noted previously, both government and NGO-led initiatives in many places use interventions that have been proven to be ineffective and, even as importantly, deliver them poorly and in a piecemeal manner. As a result, health, education, and social systems are still largely not geared toward meeting the needs and fulfilling the rights of adolescents.

A small but slowly growing number of countries have demonstrated that tangible results can be achieved through the application of good science, leadership and management, and persistence. Consistently, these achievements have only been possible because governments have placed scale-up on the national agenda, planned for scale-up from the start, managed scale-up effectively and efficiently, built support while

²⁴ A software tool developed by WHO to support national strategic health planning in low- and middle-income countries.

anticipating and addressing opposition, and safeguarded sustainability [47].

Fifth, although there is growing support for attention to some aspects of ASRHR there is ambivalence about other aspects, and there is increasingly well-financed and organized resistance

In a growing number of countries, although there is broad consensus in some areas of ASRH (e.g., ending child marriage and violence against girls), there are areas for which there is still substantial resistance (e.g., promoting safe abortion). Furthermore, although there is support for the goal of preventing early pregnancy in adolescents, there is still discomfort and reticence in providing adolescents with information and education on contraception and in providing contraceptives to unmarried adolescents. In many places, efforts to promote ASRHR face resistance and opposition, which has become increasingly well-financed and organized and has led to stalled programs and—in some cases—reversals of the progress made. A small number of initiatives point to the importance of strategically working to build community support on the one hand and to skillfully plan and respond to backlash on the other [230–232].

Within this overall social response, robust grassroots movements, including some led by young people themselves, have become increasingly active and have had an influence on the discourse (e.g., they have been instrumental in carrying forward the agendas related to HIV, child marriage and menstruation and in demanding an equal place and voice at the table: “nothing about us, without us”!) [233].

In summary, looking across the six health topics over a 25-year trajectory, there has been great progress at the global and regional levels in putting adolescent health, and especially ASRHR, higher on the agenda, raising investments, building the epidemiologic and evidence-base, and setting out norms to guide investment and action. At the national level, too, there has been progress in formulating laws and policies, in developing strategies and programs and executing them, and in engaging with communities and societies to move the agenda forward. However, progress has been uneven across issues and geography. It has raced ahead sometimes and has stalled or even moved backward—many—other times [217,234]. In response to the paper’s second question (i.e., what contribution did the ICPD make to this), in some cases, there is a direct documented link between the participation of national decision-makers in the ICPD and their establishment of national bodies and ambitious national initiatives to address ASRHR; Mozambique’s Geracao Biz²⁵ is a case in point [235]. In most other cases, such a direct link would be difficult to demonstrate. However, as our analysis has shown, the ICPD POA’s call for attention to ASRHR provided a springboard for advocacy, investment, action, and research that remains important to this day.

It is important to note that the ICPD POA was a living document in that it provided a benchmark for reviews and reaffirmations over the last 25 years. For example, one could draw a direct line between the reaffirmation and the call-to-action made at the 2012 Committee for Population and Development; the then UN Secretary General’s frustration at the lack of progress in

a stocktaking report published in 2014, 20 years after the ICPD; and his call to place adolescents at the center of the agenda in the renewed Global Strategy for Women’s Children’s and Adolescents’ Health in 2015 [5].

Extract from commission for population and development, 2012 resolution

‘Para 4.2: Also reaffirms its strong commitment to the full implementation of the Programme of Action and the key actions for its further implementation agreed at the five-year review of the Programme of Action, and the Copenhagen Declaration on Social Development and its Programme of Action;

Para 26: Calls upon Governments, with the full involvement of young people and with the support of the international community, to give full attention to meeting the reproductive health-service, information and education needs of young people, with full respect for their privacy and confidentiality, free of discrimination, and to provide them with evidence-based comprehensive education on human sexuality, sexual and reproductive health, human rights and gender equality to enable them to deal in a positive and responsible way with their sexuality.’

Extract from review of progress in the implementation of the ICPD, POA, 2014

‘Para 68: Most adolescents and youth do not yet have access to CSE, despite repeated intergovernmental agreements to provide it, support from the UN system, and considerable project-level experience in a wide range of countries and research showing its effectiveness’ [236,237].

In summary, it would be fair to say that the ICPD has contributed to the progress made in ASRHR, and that this was both because of its bold call in 1994 and because it stimulated efforts at the global, regional, national, and local levels that continue to this day.

Twenty-five years have passed since the ICPD POA was adopted. As discussed previously, the UN has carried out periodic reviews of the progress made in relation to the ICPD POA. Similar stocktaking reviews were published on the progress made in relation to the MDGs [238] Both these broader reviews included adolescent components. Other reviews have tracked progress in a health issue over several decades; the move from a child survival to a broader child health and development approach is a case in point ([239,240]). Other publications have reviewed the epidemiological situation and the research evidence and proposed a way forward [241]. Our review complements these publications by charting how responses to six very different topics affecting ASRHR have evolved over a 25-year period and drawing out the lessons learned from these experiences for the future. It also builds on a review we published in 2015, which took stock of the evidence and programmatic experience in relation to a range of interventions to improve ASRHR [242]. The strengths of our review are that it brought together writing groups with representation, including youth leaders, from academia, normative organizations, implementing organizations, and civil society on each topic. Each group was tasked to generate insights using the same analytic framework based on their specialist knowledge and based on country case studies

²⁵ A multisectoral program implemented by the Government of Mozambique with financial support from UNFPA and technical support from Pathfinder International to improve ASRHR through youth-friendly health services, school-based interventions, and community-based outreach.

that were prepared to inform the review. A key limitation of our review is that it is based on insights, and although it draws on research evidence and programmatic experience, it is not based on a series of systematic reviews. Another limitation is that, although the discussion on each topic has sought to highlight regional specificities, this has been done only in broad terms.

As we prepare to step into the third decade of the 21st century, we must build on the lessons learned in ASRHR, make full use of the opportunities available, and effectively address the challenges facing us. In doing so, we would expand on the gains in ASRHR and contribute to improving adolescent health more widely.

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