A young woman with long braids, wearing a light green dress and a pink headscarf, is sitting on dark rocks by a body of water. She is looking down at a small object in her hands. The background shows a calm lake and a forested hillside under a clear sky.

MODULE 1  
**ADOLESCENT  
SEXUAL AND  
REPRODUCTIVE  
HEALTH AND  
RIGHTS**

# ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

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# ABBREVIATIONS

<b>ASRHR</b>	adolescent sexual and reproductive health and rights
<b>CRC</b>	Convention on the Rights of the Child
<b>CSE</b>	comprehensive sexuality education
<b>FGM</b>	female genital mutilation
<b>GBV</b>	gender-based violence
<b>HPV</b>	human papilloma virus
<b>ICPD</b>	International Conference on Population Development
<b>ITGSE</b>	<i>International Technical Guidance on Sexuality Education</i>
<b>LGBTQ+</b>	lesbian, gay, bisexual, transgender, and queer/non-cisgender identities (such as gender non-binary/non-conforming and agender)
<b>NGO</b>	non-governmental organization
<b>SDP</b>	service delivery point
<b>SRH</b>	sexual and reproductive health
<b>SRHR</b>	sexual and reproductive health and rights
<b>STI</b>	sexually transmitted infection
<b>UHC</b>	universal health coverage
<b>UNICEF</b>	United Nations Children’s Fund
<b>WHO</b>	World Health Organization

## MY BODY

- 1. ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS
- 2. GENDER-BASED VIOLENCE

## MY LIFE

- 3. COMPREHENSIVE SEXUALITY EDUCATION
- 4. HARMFUL PRACTICES

## MY WORLD

- 5. YOUTH LEADERSHIP AND PARTICIPATION
- 6. YOUTH, PEACE AND SECURITY
- 7. HUMANITARIAN SETTINGS

## CROSS-CUTTING

- 8. HUMAN RIGHTS
- 9. ADVOCACY AND POLICY DIALOGUE



# INTRODUCTION

Sexual and reproductive health (SRH) and the full enjoyment of rights are central to adolescents' transition into adulthood and are vital to their identity, overall health, well-being and personal growth and development. To realize their full potential, young people need the autonomy and ability to deal in a positive and responsible way with their sexuality, and the support, confidence and resources to thrive in secure and healthy relationships.

In order to protect and promote the right of adolescents to the enjoyment of the highest attainable standards of health, the International Conference on Population Development (ICPD) Programme of Action calls for the provision of "appropriate, specific, user-friendly and accessible services to address effectively their reproductive and sexual health needs, including reproductive health education, information, counselling and health promotion strategies." The Programme of Action states that these services "should safeguard the rights of adolescents to privacy, confidentiality, and informed consent, respecting their cultural values and religious beliefs and in conformity with relevant existing international agreements and conventions."

Despite this global commitment, in many countries adolescent sexual and reproductive health and rights (ASRHR) have not traditionally been considered a health priority. Young people face numerous structural, cultural and legal barriers to obtaining information and services on sexual and reproductive health and rights (SRHR). Health services are rarely designed to meet their needs. Health workers only occasionally receive specialist training in issues pertinent to adolescent SRH. In addition, ASRHR programmes remain controversial in almost all countries and at all levels of society, including among health-care providers, because they often challenge beliefs about sex, family and parenting, and gender relations. It is therefore not surprising that health-care seeking behaviour among adolescents is generally low, and that many lack adequate access to the full range of SRHR services and information.





To deliver on the ICPD Programme of Action, the package of essential SRHR interventions must be made responsive to adolescents. Successful implementation of evidence-based interventions requires an enabling legal and policy environment and a service delivery model that considers the determinants of ASRHR and ensures integrated services, free or at very low cost, provided through a variety of platforms and respectful of the rights and evolving capacities of adolescents.

Building on the evidence of what works, this module aims to provide an overview of tested approaches in ASRHR programming. It provides practical guidance to UNFPA country offices on how to promote and protect ASRHR and help countries expand access to the essential package of SRHR interventions for all adolescents. Key concepts that arise in the course of the module – minimum ages of consent, the evolving capacity of children and adolescents, bodily autonomy of adolescent girls and young women, and gender-responsive health services – are discussed in detail at the end of the module.



## WHAT ARE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS?

Sexual and reproductive health is a state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust and communication in the promotion of self-esteem and overall well-being.

All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of SRH relies on the realization of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy and personal autonomy respected
- freely define their own sexuality, including sexual orientation and gender identity and expression
- decide whether and when to be sexually active
- choose their sexual partners
- have safe and pleasurable sexual experiences
- decide whether, when and whom to marry
- decide whether, when and by what means to have a child or children, and how many children to have
- have access over their lifetimes to the information, resources, services and support necessary to achieve all the above, free from discrimination, coercion, exploitation and violence.

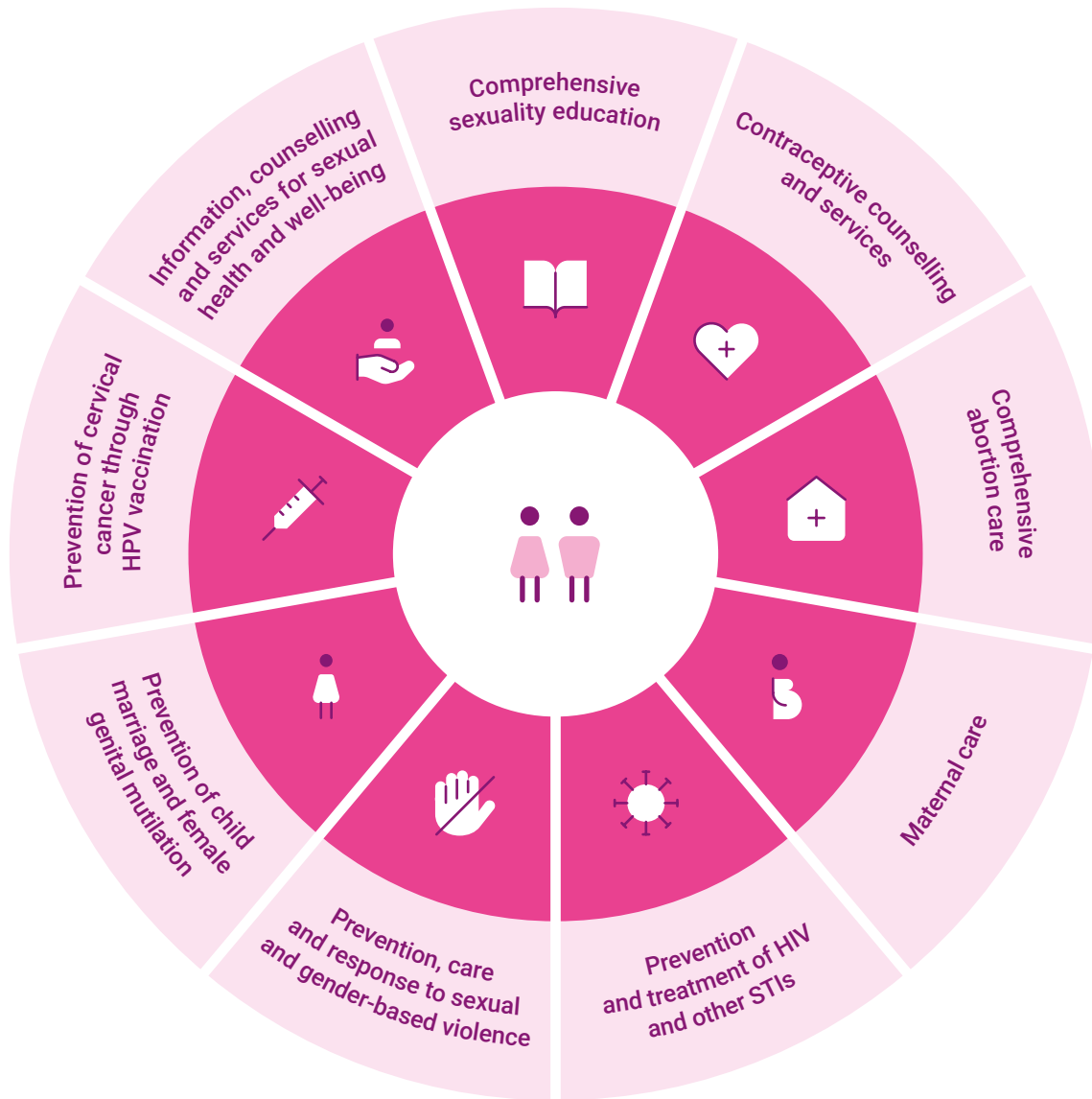


**Source:** Sexual and Reproductive Health and Rights: An Essential Element of Universal Health Coverage. Background document for the Nairobi Summit on ICPD25 - Accelerating the promise (UNFPA, 2019).



The essential package of SRHR interventions has been established by the World Health Organization. The interventions are discussed in more detail beginning on p. 28.

## THE ESSENTIAL PACKAGE OF SEXUAL AND REPRODUCTIVE HEALTH INTERVENTIONS



**Source:** Sexual and Reproductive Health and Rights: An Essential Element of Universal Health Coverage. Background document for the Nairobi Summit on ICPD25 - Accelerating the promise (UNFPA, 2019).

# → WHY DO ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS MATTER TO UNFPA?

In *My Body, My Life, My World*, UNFPA's global strategy for adolescents and youth, the vision of "My Body" is to:



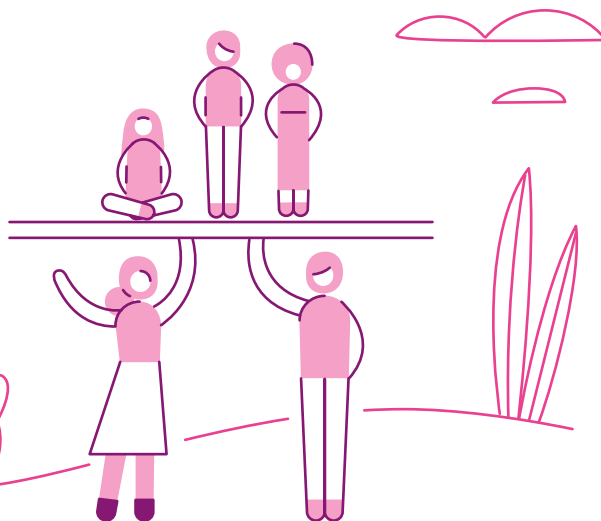
**uphold sexual and reproductive health and rights to ensure that all adolescents and youth can make informed choices about their bodies.**

This depends on SRH services being responsive to the needs of all adolescents and youth and provided in an integrated and accessible manner.

Neglecting ASRHR can result in a lifetime of challenges. For girls, early pregnancy/motherhood can be physically risky and can compromise educational achievement as a young person and earnings as an adult. Adolescents – particularly girls – face increased risk of exposure to HIV and sexually transmitted infections, sexual coercion, exploitation and violence. All of these have significant impacts on an individual's physical and mental health, as well as long-term implications for them, their families and their communities.

On the other hand, adolescence provides a window of opportunity in which early, well-targeted interventions can have lasting positive effects. Fully engaged, educated, healthy, informed and productive adolescents can help break multi-generational poverty and can contribute to the strengthening of their communities and nations.

An investment in ASRHR reduces maternal and child mortality and morbidity and contributes to **a triple dividend** of optimal growth and fulfilled potential of the adolescent today, healthier trajectories across the life course and the healthiest possible start to life for the next generation.



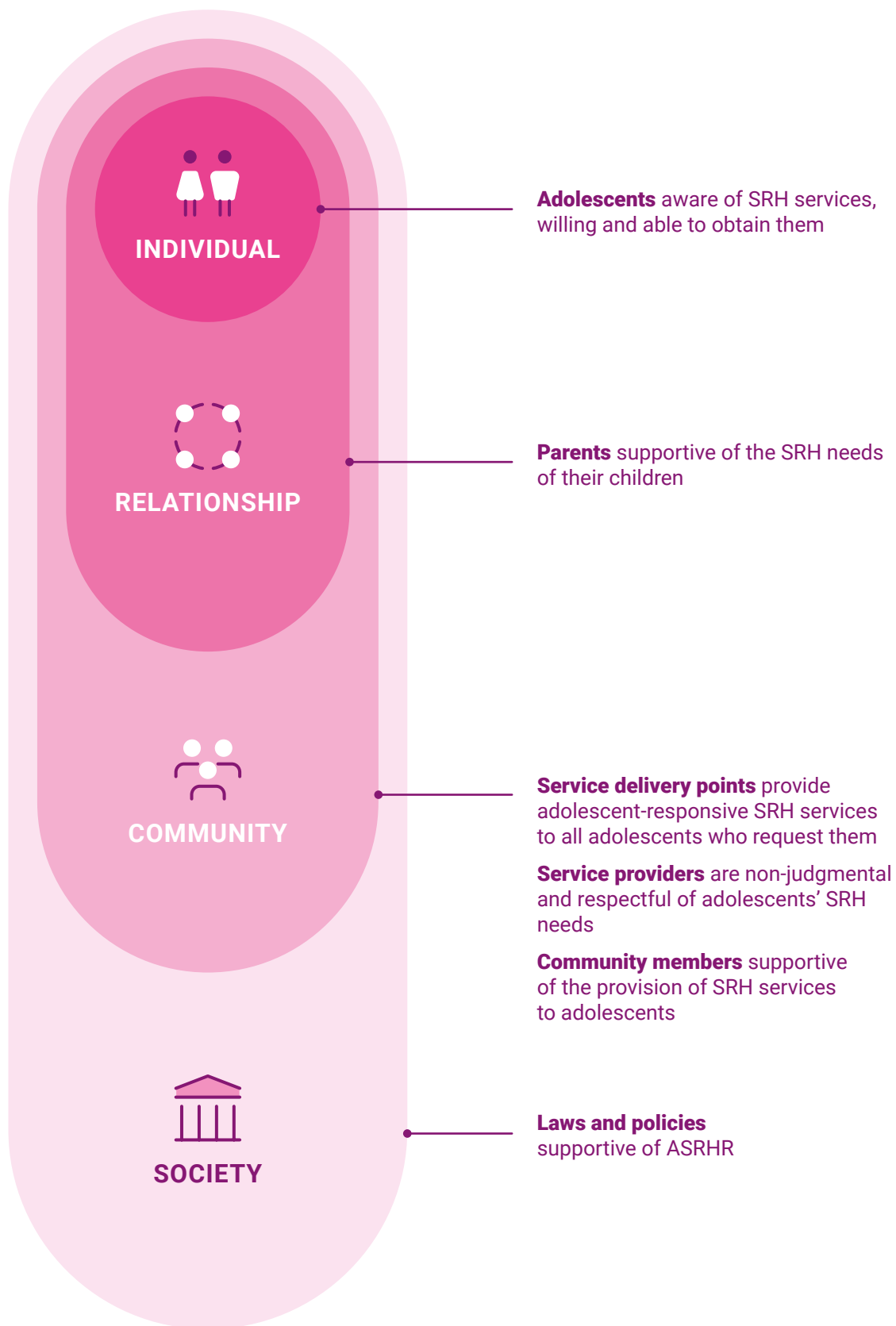


# PROMOTING AND PROVIDING SERVICES FOR ASRHR

## → WHAT MAKES SRH SERVICES ADOLESCENT-RESPONSIVE?

Characteristics of adolescent-responsive SRH services are shown below, together with some of the cultural and institutional barriers that can prevent adolescents from accessing and receiving the SRH information and services they need.

CHARACTERISTIC	WHAT IT MEANS	BARRIERS TO ADOLESCENT-RESPONSIVE SRH SERVICES
<b>AVAILABLE</b>	Adolescents are <b>eligible</b> to receive SRH services that are available to the adult population	<ul style="list-style-type: none"> <li>✎ Restrictive laws and policies</li> <li>✎ Age or marriage restrictions</li> <li>✎ Requirement for third-party consent to services</li> <li>✎ Parental or partner control</li> </ul>
<b>ACCESSIBLE</b>	Adolescents are <b>able</b> to obtain the SRH services that are available	<ul style="list-style-type: none"> <li>✎ Service location and costs</li> <li>✎ Lack of information about service availability</li> <li>✎ Stigma</li> </ul>
<b>ACCEPTABLE</b>	Adolescents are <b>willing</b> to obtain the SRH services that are available	<ul style="list-style-type: none"> <li>✎ Health-provider bias and/or lack of willingness to acknowledge adolescents' sexual health needs</li> <li>✎ Embarrassment and fear of lack of confidentiality</li> <li>✎ Fear of judgmental attitudes and resistance from providers</li> <li>✎ Fear of violence from partner or parents</li> <li>✎ Pressure to have children</li> </ul>
<b>EQUITABLE</b>	<b>All</b> adolescents, not just selected groups, are able to obtain the SRH services that are available (see box on p. 13)	<ul style="list-style-type: none"> <li>✎ Additional barriers faced by married or unmarried adolescents, those living with HIV or disabilities, and those affected by displacement, humanitarian crisis and war</li> </ul>
<b>APPROPRIATE &amp; EFFECTIVE</b>	The <b>right SRH services</b> (i.e. the ones adolescents need) are provided to them <b>in the right way</b> to make a positive contribution to their SRH	<ul style="list-style-type: none"> <li>✎ Lack of health-provider training on adolescent-specific SRH needs</li> <li>✎ Lack of SRH information materials specific to adolescents and provided in adolescent-friendly formats</li> </ul>





## WHO IS MOST LEFT BEHIND WHEN IT COMES TO ASRHR?

Marginalized subgroups of adolescents and young people are especially vulnerable with respect to their SRHR, and they need particular support accessing suitable SRH information and services. These groups include:

- ✎ adolescents living in rural areas
- ✎ adolescents in pastoralist communities
- ✎ adolescents belonging to ethnic-minority groups
- ✎ LGBTQ+ youth
- ✎ adolescents living with disabilities
- ✎ young refugees and internally displaced persons
- ✎ young people living on the streets
- ✎ orphans
- ✎ adolescents living with HIV.

## → KEY CONSIDERATIONS FOR ASRHR PROGRAMMING

1

**Adolescents are sexual beings.** Like adults, adolescents have sexual thoughts, feelings, desires and needs. Adults' discomfort and biases in acknowledging adolescent sexuality may limit young people's access to high-quality information and services. Opposition to accepting the sexual-health needs of adolescents often paralyzes legal frameworks, policies, programmes and service delivery for ASRHR. For more information, see the Key Concepts sections on [minimum ages of consent](#) and the [bodily autonomy of adolescents](#).



### What UNFPA can do:

- ✎ Promote the sexual health of adolescents, including a rights-based, gender-responsive, positive and respectful approach to sexuality and relationships. (See the Key Concepts section on [gender-responsive services](#)).
- ✎ Engage duty bearers in creating an enabling environment for adolescents to realize their SRHR, with access to education, information, services and supplies to prevent pregnancy, sexually transmitted infections (STIs), harmful practices and gender-based violence (GBV).

2

### Adolescents are not all the same, and their needs change.

While all adolescents have needs related to their SRHR, they are as heterogeneous and diverse as the rest of the population. Their needs for services and the barriers they face in accessing them may vary depending on their stage of development and personal circumstances, including their age, sex and marital status. (For example, the needs of a 15-19-year-old single adolescent girl differ dramatically from those of a married girl who

wants to start a family. For more information, see the Key Concepts sections on the evolving capacity of children and adolescents and gender-responsive health services.) Early adolescence (10-14 years) is a poorly served group that requires particular attention.



#### **What UNFPA can do:**

- Ensure that a nuanced, subnational assessment of adolescents' lived realities is available to policymakers and programme managers to inform decision-making processes.
- Support countries to identify subgroups of adolescents who need special attention, in line with the principle of leaving no one behind.

3

#### **ASRHR requires policies, planning and budgeting at a national level.**

Carefully thought-through policy frameworks are the basis of solid and sustainable programmes on the ground and can help counter opposition. Robust, age-disaggregated data on adolescents and youth will identify demographic variables which help target policies, programmes and public financing. Context matters, hence programme priorities on adolescent health should be drawn from a systematic needs assessment anchored in the available data and evidence.



#### **What UNFPA can do:**

- Facilitate a needs assessment and prioritization exercise to support the country in making strategic choices for adolescent health and development, following a step-by step process (see box on p. 15).
- Map the legal frameworks and policies that affect ASRHR and ensure the integration and mainstreaming of ASRHR provisions into relevant national policies and programmes, including in universal health coverage (UHC) and health plans, education and social policies.
- Develop an investment case for adolescent health and well-being to demonstrate the substantial benefits from a programme of interventions to improve adolescent health. Investment cases can help generate political and financial commitments to adolescent health and well-being.
  - If an approved national ASRHR package does not exist, support the country to develop one, within different service-delivery platforms, based on the essential package of SRH interventions.
  - Support governments to identify and address the policy, legal and financial constraints that adolescents experience in accessing care.
  - Support governments to adopt adolescent-responsive and resilient health systems, including promoting adolescent-friendly, integrated SRHR self-care models; expanding the contraceptive method mix beyond short-acting methods; and task-shifting or building the capacity of providers to deliver an expanded range of products.
  - Ensure that supply chains can provide uninterrupted availability of high-quality reproductive health commodities, with distribution channels and platforms best suited to reach adolescents.



## STEPS FOR A SUCCESSFUL SELECTION OF PRIORITIES AND INTERVENTIONS

A needs assessment includes the following steps to identify adolescent health priorities:

- **Step 1** – Conduct a situation analysis on the adolescent health and development situation in a country or subregion.
- **Step 2** – Conduct a landscape analysis to review the current programmes and policies that address the situation. In addition to adolescent- and youth-led organizations, a list of key stakeholders such as families, civil society groups, teachers should be drawn up.
- **Step 3** – Use the results of the analysis conducted in steps 1 and 2 to identify adolescent health priorities based on clear criteria.
- **Step 4** – Define a strategy of interventions and the delivery mechanisms to address the health priorities and gaps identified through the assessment

For a detailed description of these steps, see the EWEC [\*Technical Guidance for Prioritizing Adolescent Health\*](#) (2017).

4

**Adolescents have special challenges in accessing SRHR information and services.** This may be especially true if they are constrained from seeking care by gatekeepers, by financial constraints or by autonomy and mobility restrictions.



### What UNFPA can do:

- Ensure that health services targeting adolescents are inclusive of especially vulnerable, left-behind subpopulations.
- Engage with parents, caregivers, teachers and community members in supporting adolescents to access high-quality SRHR information, services and supplies.
- Promote comprehensive sexuality education (CSE) for in-school and out-of-school adolescents (see Module 3).
- Support new technologies such as mHealth to make SRHR information and services more accessible to adolescents.





## SELF-CARE FOR ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

### What is self-care for SRH?

WHO defines self-care as “the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a health-care provider” (WHO, 2019).

### Why is self-care an important approach in helping adolescents realise their SRHR?

Adolescents have always relied significantly on self-care to support their SRH: for instance, in some countries the majority of adolescents obtain their contraceptive from pharmacies. The anonymity and convenience of this approach may offer the advantage of avoiding some of the age-specific barriers and stigma they face when accessing formal SRH services.

### An approach for improving access and choice

Current innovations and digital solutions offer possibilities for increasing choice and access to information and services for adolescents. In some contexts, access to self-managed contraception is expanding to include self-administered contraceptive injection (DMPA-SC). Virtual platforms for contraception consultation and prescribing are also available in some countries. Services such as self-testing for HIV and self-collection of STI samples, as well as community-based or online distribution of test kits, are increasingly being offered.

### Conditions for effective self-care for adolescent SRH

Information and education are a crucial part of self-care. Digital platforms are often not fully exploited in environments where adolescents have access to mobile phones and are a promising approach, but need to be supplemented by other methods such as CSE. Self-care must be seen as complementary to the public provision of youth-friendly SRH services, rather than a substitute, with both channels developed together and in partnership to ensure they are integrated.

Legislation and policies must be in place to ensure that pharmacists and other private or community providers, and the commodities they provide, are appropriately regulated. Adolescents should be able to access services, commodities and information without third-party consent and providers should be made aware of adolescents’ rights.

Attention should also be paid to equity: out-of-pocket costs to adolescents accessing commodities through self-care channels may be high if they are not subsidised. Relying heavily on digital tools and platforms for information may exclude the poorest. Vulnerable adolescents may require extra support or information to use self-care interventions safely and effectively, and this should be widely available.

**Adolescents – especially adolescent girls and young people living with disabilities – are particularly vulnerable to sexual abuse, unintended pregnancies, GBV and harmful practices.** These risks are often exacerbated in humanitarian and conflict settings, where social and protective networks are disrupted and there is less access to services.

**What UNFPA can do:**



- Support the establishment of social and protective networks for adolescent girls in all settings.
- Ensure that service providers have capacity to identify and deliver services to adolescent GBV survivors and victims of harmful practices, including child brides.
- Support efforts to ensure access to social justice and social protection systems for adolescents and young people.
- Promote the implementation of UN Security Council Resolutions 2250 and 2535 on youth, peace and security (see Module 6).
- Promote both mainstreamed and targeted ASRHR programming, with an emphasis on scale and sustainability.

**Data and evidence on adolescents' needs and circumstances is lacking.** This is especially true at the subnational and community levels.

**What UNFPA can do:**



- Ensure that high-quality, up-to-date data – disaggregated by age, sex and disability – are available to inform district, regional and national plans and improve service delivery. Advocate for better data disaggregation within Health Management Information Systems (HMIS), national censuses, Demographic and Health Surveys (DHS) and other national and subnational health surveillance systems.
- Promote the use of data in decision-making at national, subnational and district levels.
- Advocate for measuring the modern contraceptive prevalence rate without caveat for marital status; and for lowering the sample age range below 15, or asking retrospective questions for the current age range on experiences before 15 to capture these data.





# WHAT WORKS IN ASRHR PROGRAMMING?

## → WHAT THE EVIDENCE SAYS

Over the last 25 years the SRH field has learned a lot about what girls and boys need – often from their own voices and perspectives. We know considerably more about the kind of programmatic interventions it takes to improve ASRHR. We also know which interventions have lesser or no effects.

Successful ASRHR programmes:

- **establish a multisectoral service delivery model** that considers the determinants of ASRHR and makes available services that are adolescent-responsive, high-quality, integrated, free or low-cost and delivered through a variety of platforms
- **respond to the different needs of subpopulations**, including married/unmarried adolescents, in-school and out-of-school adolescents, and marginalized adolescents
- **engage young people themselves in programme design** to ensure that interventions are respectful of their rights, individual circumstances and evolving capacities
- **engage communities** to address underlying sociocultural barriers to ASRHR
- **create an enabling legal and policy environment**
- **include a measurement framework** (disaggregated by age and sex) to track progress.

In most cases, a combination of approaches is needed for optimal results, since adolescents' SRHR outcomes are determined by a complex web of interrelated factors.







## IMPLEMENTING MULTISECTORAL APPROACHES

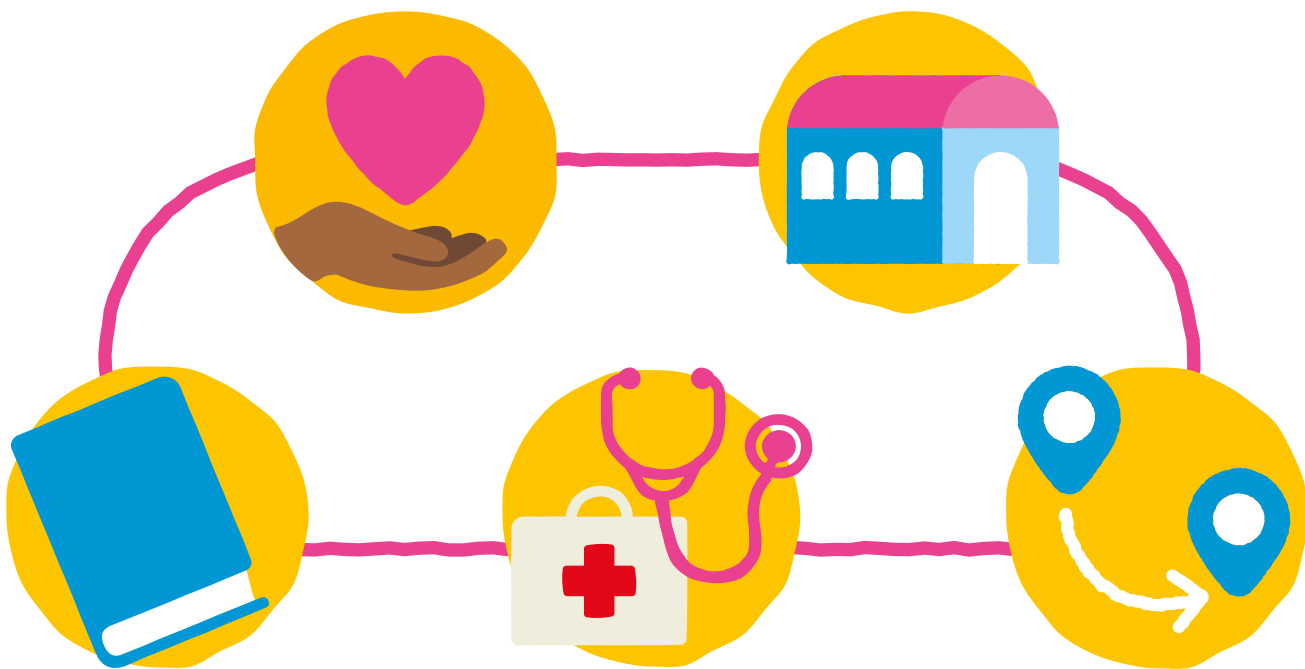
Adolescents' multiple and varying needs mean that they must often navigate a range of health, education and social services. At the programmatic level, this can lead to inefficiencies, duplication of effort, and programmes that undermine or contradict each other. Intersectoral communication and multisectoral coordination are therefore essential, but they are difficult to implement. Many potentially effective interventions fail to have the desired impact precisely because they are unable to deliver multicomponent interventions in an integrated rather than a piecemeal fashion.

A multisectoral approach requires programmes to build synergies across sectors, such as education, health, labour, transport, infrastructure and social services and, where relevant, to establish coordination mechanisms between line ministries. At the service level it entails professional development programmes in ASRHR, involving staff from multiple ministries (e.g. those responsible for health and nutrition, education, youth, labour, information, justice, the police and prisons), parastatals and key non-governmental organizations (NGOs) with major roles related to adolescents.

The Sustainable Development Goals provide an excellent opportunity for tracking multisectoral action and for identifying the linkages between the sectors relevant to adolescent SRHR.

### Driving intersectoral coordination

In Mozambique's Geração Biz programme, the roles and responsibilities of the ministries of health, education and youth/sport were clearly defined (including for separate and joint activities), and based on this, workplans and budgets were prepared for each ministry. Coordination mechanisms involving the three ministries were established at national, provincial and district levels. Funds were disbursed to all three based on a joint report of activities, including on coordination. This meant that the three ministries were accountable to each other as well as to external funders.





# DO'S AND DON'TS



## DO NOT



## DO

### POLICY AND PROGRAMME DESIGN

× Underestimate the challenges of intersectoral coordination on ASRH

- ✓ Put in place mechanisms tailored to the local context to make intersectoral coordination around ASRH happen
- ✓ Ensure that sector managers and workers at national or subnational levels see a gain for their sector's objectives in collaborating

**WHY:** When there is high-level attention and scrutiny, strong intersectoral coordination happens, e.g. with Ebola in Liberia and polio vaccination in India. Without such attention, strong intersectoral coordination and collaboration remains an aspiration that is often unfulfilled. Sector managers and workers at national or subnational levels do not see any gain to their sector's objectives in collaborating, and judge that they have little to lose by not doing so. This results in token collaboration, with sectors doing just enough to have something to report on, in case they are asked to do so.

× Design programmes in a top-down fashion without significant participation of adolescents

- ✓ Involve stakeholders (parents, community leaders and teachers) and adolescents themselves as full partners in the design, implementation, monitoring and evaluation of ASRH programmes

**WHY:** Adolescent participation and engagement – beyond tokenistic participation, and starting from the design phase of the programme – are critical to building adolescent buy-in and increasing the demand for services. Successful ASRH programmes are responsive to the different needs of adolescent subpopulations, and adolescents themselves are often best placed to inform policy and programme managers of their needs and priorities.



## DO NOT

- × Disregard the role of parents/guardians in adolescents' health



## DO

- ✓ Support activities for parents as an important component of programmes for ASRH

**WHY:** Research and programmatic experience have consistently confirmed the important role of parents in promoting adolescent health. Evidence shows that parents' support for the provision of reproductive health information and services increases significantly if they are informed and involved in adolescent health programmes. Helping parents to improve their understanding of adolescent development increases their ability to support their children and help them to be better parents.

### EDUCATIONAL INTERVENTIONS TARGETING BEHAVIOURAL CHANGE

- × Limit SRHR information, including CSE, to older adolescents

- ✓ Begin CSE programmes in childhood/early adolescence, taking care to follow the guidance of the *International Technical Guidance on Sexuality Education* (ITGSE), which provides age- and developmentally appropriate recommendations for each age group. The ITGSE provides guidance for CSE provision to children as young as 5

**WHY:** Children and adolescents are able to understand and learn important concepts at a young age. Attitude and norm formation is incremental, and it is important to begin early. A good example of this is gender attitudes and norms, which form early in life.

- × Focus on school-based CSE or out-of-school CSE alone

- ✓ Focus on both school-based and out-of-school CSE, and build synergies between the two

**WHY:** In many countries, many young people in the lower-secondary and upper-secondary level are not in school. In marginalized communities, the rates of those who are not in school are likely to be higher than the national average. Even those in school could benefit from complementary out-of-school education at home and in community settings, e.g. in the context of youth groups such as sports or Scout groups.





## DO NOT

- × Rely primarily on peer education for increasing access to ASRHR information and services or for changing behaviour or influencing social norms regarding young people’s SRHR

- × Organize stand-alone awareness sessions with young people and focus on short, ad hoc behavioural change interventions

- × Assume digital health and mHealth is a “magic bullet” to reach young people with information and education



## DO

- ✓ Consider using peer educators as one component of a comprehensive strategy, to provide outreach to adolescents and referral to experts and services

**WHY:** While there is evidence from global reviews that peer education programmes are effective at improving knowledge, there is not convincing evidence that they improve SRH outcomes among adolescents.

- ✓ Ensure that awareness sessions are part of a larger demand creation strategy and linked to an improved, increased and high-quality service offer to adolescents
- ✓ Deliver behavioural change interventions regularly, consistently and with intensity over a sustained period

**WHY:** For programmes to improve and change knowledge, understanding, attitudes, beliefs and behaviours over the long term and at the community and individual level, programmes must be delivered regularly, consistently and with intensity, over a sustained period of time.

- ✓ Use digital health as part of a multifaceted intervention aimed at improving SRH outcomes

**WHY:** Digital health is often regarded as the best way to reach young people with information and education. Digital spaces do offer new possibilities – including for marginalized young people – and can fill a gap for adolescents in places where there is ineffective or insufficient school-based sexuality education. However, technological interventions should not be seen as a replacement for interpersonal education, and they are not uniformly accessible to young people. There is still an important place for school-, home- and community-based education by competent and committed educators.



**DO NOT**



**DO**

### CAPACITY-BUILDING

- × Train ASRHR service providers in an inconsistent fashion without providing on-the-job support and supervision
- × Use training as the only performance-improvement approach

- ✓ Prioritize in- and pre-service training on ASRHR combined with in-service formative supervision and support to providers (including precise job descriptions with responsibilities and reference tools)

**WHY:** Training alone is insufficient to lead to sustained improvements in health-worker performance. Comprehensive approaches that combine interactive and participatory training, job aids, supportive supervision and collaborative learning are more effective in building competencies, positive attitudes and motivation and thereby improving performance. This is equally relevant for teachers and facilitators delivering CSE.

### SERVICE DELIVERY

- × Deliver ASRHR services as a stand-alone intervention and/or focus on a single issue or behaviour, such as abstinence, delay of sexual initiation, or contraceptive/condom use only

- ✓ Address ASRHR holistically, considering their determinants and putting adolescents and their evolving needs at the centre of service provision
- ✓ Link ASRHR services to broader health and social services, including school health
- ✓ Link ASRHR programmes to high-quality CSE in and out of school

**WHY:** ASRHR and well-being are determined by the larger environment influencing adolescents' and young people's opportunities, abilities and motivation. Coordinated and complementary interventions that address the risk and protective factors of adolescent health and serve the whole adolescent person will have a better chance of success.

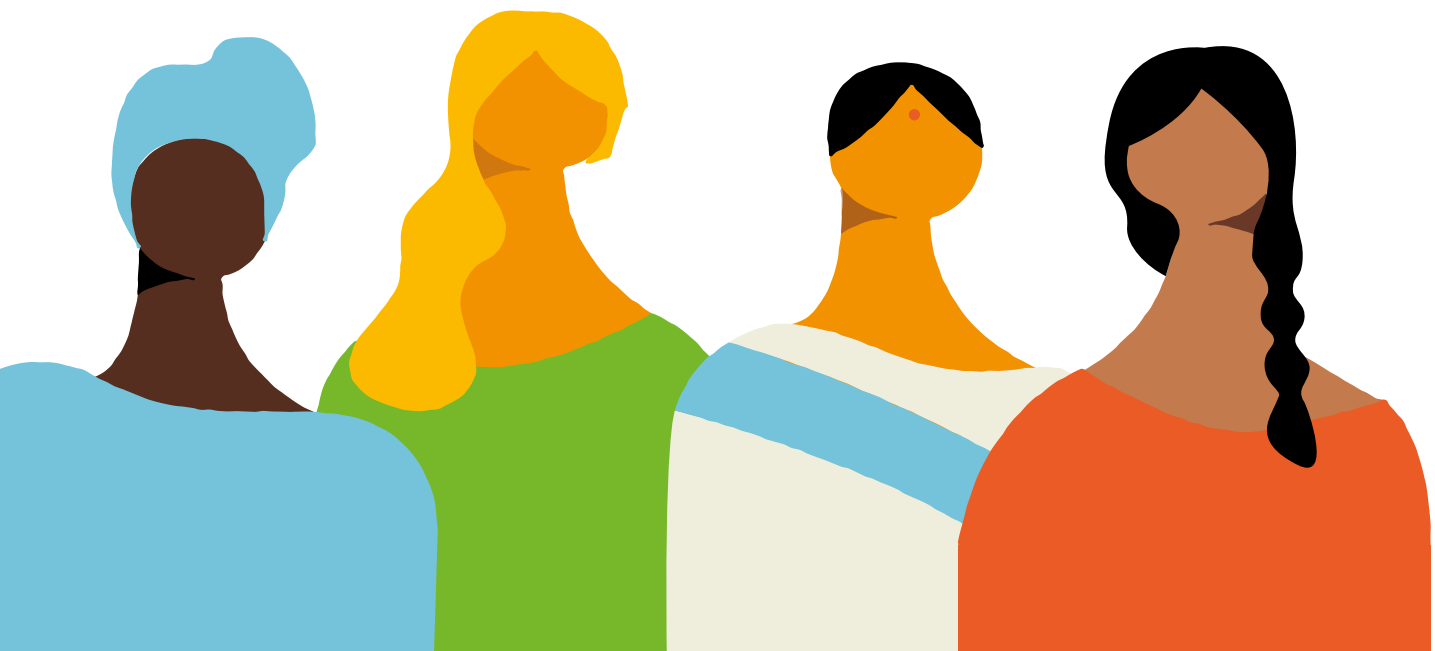
## DO NOT

- × Rely on youth centres to facilitate access to ASRHR services, change young people's behaviours or influence social norms regarding young people's SRHR

## DO

- ✓ Identify lessons learnt from providing ASRHR services in youth centres, and incorporate effective programme components into ASRHR services
- ✓ Where youth centres are well established, examine the clientele they are serving, discuss a plan for phasing out ASRHR services, and/or examine what other function they could provide. Ensure that ASRHR services are available at another accessible service delivery point

**WHY:** Evaluations spanning the last decade have repeatedly shown that youth centres are not a cost-effective way to increase SRH knowledge, services and outcomes among young people. They are overwhelmingly accessed by older male youth (often outside the intended age range) who are repeat visitors and who live nearby. Most youth use the centres for recreational purposes and infrequently access the health services. The cost per beneficiary of youth centres is generally very high.





## PEER EDUCATION

Peer-led interventions (peer education) are a popular way of carrying out sexual health education with adolescents, especially for HIV prevention. Nearly all of UNFPA's adolescent and youth programmes include some form of peer-related interventions. As well as being relatively easy to implement, this approach is based on the common-sense understanding that adolescents may be more open to discussing sensitive issues with friends of the same age than with adults in positions of authority.

In peer-supported programmes, peer educators co-facilitate education with an adult facilitator. Since CSE must be curriculum-based, only a peer-led or peer-supported approach using a structured programme would meet the definition of CSE. Peer education programmes have a positive effect on the peer educators themselves. Evaluations have found that they are the main beneficiaries of the programme, which has a transformational effect on them by increasing their confidence, negotiation, public-speaking and activism skills and changing their attitudes towards vulnerable and marginalized young people. However, despite the popularity of this methodology, using peer educators to deliver health information has not been shown to be more effective with adolescents and young people than other traditional health education strategies. Cost-effectiveness of peer education should also be a consideration when using such an approach.

### **The impact of UNFPA's Y-PEER programme**

Y-PEER began in Eastern Europe and Central Asia in 2000, at a time when HIV prevalence was increasing sharply, fuelled by needle-sharing among people who injected drugs. Qualitative evaluations of the programme found that its impacts were the establishment of youth networks and a structured and standardized system for peer education; increased access to peer education; and increased awareness regarding SRH. However, there were no clear measurements of the outcomes among the young people receiving the education. A qualitative evaluation of Y-PEER in the Eastern Europe and Central Asia region found that adult key informants in Bulgaria and Macedonia believed that peer education had made an important contribution to HIV knowledge, and in Bulgaria to the proportion of registered cases of HIV in youth aged 15-24, and to decreases in having more than one sex partner. However, there was no evidence of the exact contribution of peer education to these changes, or their statistical significance.

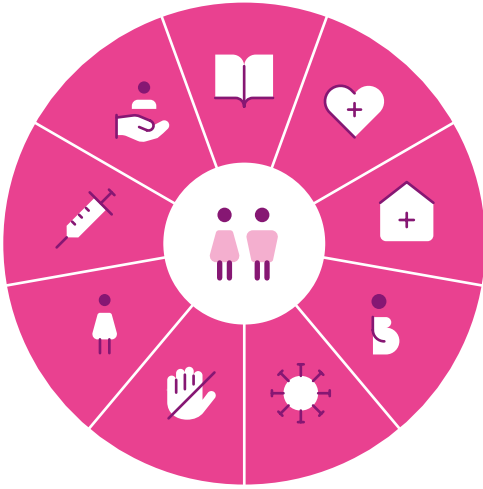








# HOW TO PLAN AND IMPLEMENT THE ESSENTIAL PACKAGE OF SRHR SERVICES FOR ADOLESCENTS



To fulfil UNFPA’s commitments under its Strategic Plan 2022-25 and the adolescent and youth strategy, UNFPA country programmes should support health systems in ensuring that the package of essential SRHR interventions is responsive to the specific needs of young people, especially marginalized groups. This section outlines actions that UNFPA can take to ensure that the essential package of SRHR interventions which is offered to the general population also responds to the particular needs of adolescents, and that service delivery takes into account their specific attributes and the barriers they face.



## COMPREHENSIVE SEXUALITY EDUCATION

*(See Module 3 for detailed information)*



### ADOLESCENT-SPECIFIC ISSUES

Adolescents often receive little or unbalanced information about SRH from their parents and caregivers, and receive contradictory messages from a range of sources.



### IMPLICATIONS FOR SERVICE DELIVERY

Schools have a crucial role to play in CSE. Alongside supporting school-based CSE implementation, programmes should advocate for CSE and support its provision.



### CONSIDERATIONS FOR UNFPA PROGRAMMING

- Create or strengthen policies that put the provision of CSE on the national agenda.
- Seek the cooperation and support of families and communities from the programme outset, and regularly reinforce it.
- Strengthen the abilities of school heads and teachers to explain the rationale and create support for CSE.
- Establish a system to train, retrain and provide ongoing support for teachers to develop their skills to address sexuality and the use of participatory pedagogy.

 **ADOLESCENT-SPECIFIC ISSUES**

Depending on the context, a significant proportion of older children and adolescents may not be in school, or schools may not offer CSE.

 **IMPLICATIONS FOR SERVICE DELIVERY**

CSE should also be provided outside the school setting. Concerted efforts must be made to reach left-behind groups of adolescents and complement and extend what is offered in school-based CSE.

 **CONSIDERATIONS FOR UNFPA PROGRAMMING**

Complement school-based sexuality education programmes in community settings, and link sexuality education with youth-friendly health services, including condom distribution, with providers trained to address the needs of young people respectfully and non-judgmentally.

 **ADOLESCENT-SPECIFIC ISSUES**

Many adolescents become sexually active during adolescence.

 **IMPLICATIONS FOR SERVICE DELIVERY**

CSE should start early (the ITGSE recommends at the age of 5) and increase incrementally with the evolving needs and capacities of adolescents (see p. 54).

 **CONSIDERATIONS FOR UNFPA PROGRAMMING**

Base the content of the CSE curriculum on the age and development of learners, addressing topics when they are most relevant for their health and well-being, with typically more basic information, less-advanced cognitive tasks and less-complex activities for younger learners.

 **ADOLESCENT-SPECIFIC ISSUES**

Adolescence is a time of continued and accelerated gender socialization.

 **IMPLICATIONS FOR SERVICE DELIVERY**

CSE programmes should work to build equitable gender norms among boys and girls.

 **CONSIDERATIONS FOR UNFPA PROGRAMMING**

Include CSE as part of a gender-equality programme grounded in a socioecological context.





# CONTRACEPTIVE COUNSELLING AND SERVICES



## ADOLESCENT-SPECIFIC ISSUES

In general, adolescents are eligible to use all the same methods of contraception as adults, and they should have access to a variety of contraceptive choices. Age alone does not constitute a medical reason for denying any method to adolescents. Many adolescents access contraceptives through a range of channels outside the formal health system through self-care (e.g. through pharmacies and drug sellers).



## IMPLICATIONS FOR SERVICE DELIVERY

- Adolescents should have easy access to the full range of contraceptives, including short-term and long-acting, and such access should not be hampered by their marital status or providers' conscientious objections.
- Contraceptive information and services, including emergency contraception, as part of SRH services, should be free, confidential, adolescent-responsive and non-discriminatory, and barriers to services such as third-party authorization requirements should be removed. Measures should be put in place to ensure that adolescents can access self-care services safely and effectively.



## CONSIDERATIONS FOR UNFPA PROGRAMMING

Support countries to ensure that the full range of contraceptive methods, including emergency contraception, is available for adolescents.

### ***Age of consent to sex, and age of consent to access SRH services (see also p. 53)***

- Ensure that protocols, training programmes and desk reference tools for adolescent- and youth-responsive services include a discussion on the age of consent to sex and on the age of consent to access SRH services (including contraception), and that these directives and capacity-building are not limited to clinical staff.
- Where there are restrictive laws concerning the age of consent to sex, and/or the age of consent to access SRH services (such as contraception) without parental consent, provide guidance to decision-making bodies on recognizing the evolving capacities of adolescents, and on normative sexual development.
- Review statutes on the rights of minors to consent to health-care services, including access to contraceptives.

### ***Scaling up service delivery points (SDPs) and availability of contraceptives for adolescents***

- Support the country to conduct a situation analysis to identify the most appropriate combination of SDPs for adolescents and ensure that the package of services for adolescents within the different SDP models includes a method mix of contraceptives.
- Develop a georeferenced map of SDPs offering services to adolescents, and support certification for adolescent-responsive services grounded in quality-improvement processes.
- Consider public- and private-sector facilities, community-based distribution, mobile outreach services, peer-to-peer distribution, pharmacies and drug shops, and sports-, school- or workplace-based services.
- Establish a client satisfaction mechanism for adolescents to give feedback on services received and their level of youth-responsiveness.



### ADOLESCENT-SPECIFIC ISSUES

- Health workers' inadequate knowledge and skills, as well as misconceptions (e.g. that contraceptive use is contraindicated in adolescents, or that only short-acting methods should be offered to adolescents), deter contraceptive provision.
- In many places, health workers believe it is wrong for adolescents to be sexually active before marriage. These attitudes translate into judgmental and disrespectful behaviour.



### IMPLICATIONS FOR SERVICE DELIVERY

- Health workers should be knowledgeable about all methods of contraception, including emergency contraception, and about the advantages and disadvantages of each that have particular relevance to the lifestyles and circumstances of adolescents. Health workers should support adolescents' access self-care services safely and effectively.
- Health workers must have the skills to counsel adolescents non-judgmentally. They must be trained, supported and held accountable for providing high-quality, confidential and respectful care.
- The attitudes of other staff (including non-medical staff, such as guards or housekeeping personnel) may influence the decision of adolescents to seek care at the facility. In-charges or administrators who are non-medical personnel may influence how the facility is run and the availability of resources (space, allocation of specific time/staff, educational material) to meet the needs of adolescents.



### CONSIDERATIONS FOR UNFPA PROGRAMMING

#### **Capacity-building of health workers**

- Ensure that all UNFPA-supported capacity-building for health workers includes a focus on the provision of contraceptives to adolescents, including counselling on method mix, associated benefits and potential side-effects.
- When building positive attitudes and capacities among public or private health providers, include exercises to clarify their personal values and attitudes about adolescent sexuality and the provision of ASRHR in the context of their professional roles, responsibilities and ethical obligations.
- Provide technical support to develop and implement contraceptive counselling methods for adolescents who are initiating or continuing contraceptive use, such as motivational interviewing or aspirational counselling.
- Support countries to standardize in-service training and ensure better coordination among stakeholders, including private health-care providers and NGOs, to reduce ASRHR provider training costs, avoid duplication and ensure better geographical coverage.
- Follow up any UNFPA-supported in-service or pre-service training focused on ASRHR with on-the-job support and supervision.



## ADOLESCENT-SPECIFIC ISSUES

- Many adolescents have knowledge gaps and misconceptions on contraception and its effects on fertility or pleasure.
- Because of stigma and social pressure, they are often reluctant to obtain contraceptive information and services.
- Adolescents are more likely than adults to use contraceptives for shorter periods, and to discontinue use. Reasons for this include that they are particularly sensitive to side-effects, and may have more frequent changes in their relationship status.



## IMPLICATIONS FOR SERVICE DELIVERY

- Health workers should meet adolescents where they are in their lives and offer contraception as a means of achieving their life goals.
- Health workers should provide counselling and support to adolescents in their contraceptive choice and facilitate the consistent and continued use of contraceptives for those adolescents for whom it aligns with their sexual and reproductive needs and preferences. They should also actively manage side-effects.
- Contraceptive counselling provides an opportunity for integrated service delivery.
- Community members' support for the provision of contraceptive information and services to adolescents must be built.
- Scaling up adolescents' access to contraception services results in an increased need for contraceptive commodities, including condoms.



## CONSIDERATIONS FOR UNFPA PROGRAMMING

### ***School health and community outreach***

- If school health-service systems exist, ensure contraceptive counselling is included in the services, and include school nurses in capacity-building activities supported by UNFPA.
- Ensure that school health services are included in the contraceptive procurement plans in the areas where they are located. Also, ensure that they offer a mix of methods.
- If school health services do not exist, support the Ministry of Health and Ministry of Education to explore options to facilitate students' access to SRH services, including via specific outreach efforts and formal referral mechanisms.

### ***Procurement***

- Ensure coherence and good communication among different UNFPA teams (Youth, SRHR, Commodity Security etc.) and with the different sections of the Ministry of Health to ensure that the additional needed contraceptives are included in procurement plans and distributed to service delivery points for adolescents' needs.
- Strengthen supply chains and accountability mechanisms (including youth-led accountability mechanisms) to ensure consistent availability of contraceptives at SDPs.



# COMPREHENSIVE ABORTION CARE



## ADOLESCENT-SPECIFIC ISSUES

- Adolescent girls know less about their rights to safe abortion care and post-abortion care than adult women, and about where and how to obtain care. They are more likely than adult women to end up receiving services from an untrained provider or to induce abortions on their own, seek abortions later in pregnancy and delay care when complications arise post-abortion. They are also more likely to suffer complications of abortion.
- In many places, health workers are not fully aware of the circumstances in which abortion care can be provided. They often assume that the laws are more restrictive than they are. Further, many are uncomfortable about providing adolescents with safe abortion care to the full extent of the law and post-abortion care.<sup>1</sup>
- Crises and disease outbreaks increase the likelihood of intimate partner violence, and adolescent pregnancies may also increase, including those that are unintended.



## IMPLICATIONS FOR SERVICE DELIVERY

- Adolescents should be informed about how to prevent unintended pregnancies, as well as their rights regarding safe abortion care to the full extent of the law and post-abortion care. This includes the legal context for care in their country, and where and how to access it.
- National normative documents should specify the eligibility of adolescents to safe abortion care to the full extent of the law and post-abortion care.



## CONSIDERATIONS FOR UNFPA PROGRAMMING

- Gather information on abortion-related service uptake and broader data on mortality and morbidity among adolescents and youth, to inform programming and policy.
- Leverage multiple cadres of health-care providers to provide safe abortion care to the full extent of the law and post-abortion care to adolescents, drawing on the expertise and community roots of midwives and community health workers.
- Inform health workers about the circumstances under which they are permitted to provide safe abortion care, within the context of their country's laws and policies. Engage youth and communities, including traditional leaders, as active members in designing, implementing and evaluating approaches that tackle abortion-related social stigma and limiting social and gender norms, to improve access to safe care.

<sup>1</sup> Rehnström Loi U, Gemzell-Danielsson K, Faxelid E, Klingberg-Allvin M (2015). Health care providers' perceptions of and attitudes towards induced abortions in sub-Saharan Africa and Southeast Asia: a systematic literature review of qualitative and quantitative data. *BMC Public Health.* 15:139.

- Partner with civil society organizations and coalitions to build community understanding and support for SRHR, including safe abortion care to the full extent of the law and, where appropriate, monitor and respond to opposition.
- Ensure coherence and good communication between UNFPA teams (Youth and SRHR) to guarantee that the special needs of adolescent girls in safe abortion care and post-abortion care are not overlooked.
- Advocate with governments for access to safe abortion and post-abortion care in line with international human-rights standards, as this affects health-care providers and women in need of, seeking and having abortions.



### ADOLESCENT-SPECIFIC ISSUES

Health-care providers may be less comfortable providing contraception and abortion services to adolescents and to marginalized populations (e.g. LGBTQ+ adolescents, young people living with disabilities) and may not have a clear understanding of the rights of young people relating to abortion in the context of national laws.



### IMPLICATIONS FOR SERVICE DELIVERY

- Health workers of all cadres should be aware of adolescents' eligibility for abortion services and have the knowledge and skills to provide or refer for surgical or medical abortion to the full extent of the law.
- Health workers must be trained, supported and held accountable for providing high-quality, confidential and respectful abortion care in line with the national legal context (including facilitating self-managed medical abortion, where desired) centred on the choices and rights of adolescents.



### CONSIDERATIONS FOR UNFPA PROGRAMMING

- Ensure that all UNFPA-supported capacity-building efforts targeting health-care workers, both in-service and pre-service, include a focus on safe abortion care to the full extent of the law and post-abortion care for adolescents, including the provision of the full range of contraceptive options, including long-acting reversible contraception.
- Seek to integrate attention to service delivery for marginalized young people in capacity-building efforts for health providers.
- When building the competencies and attitudes of public or private health providers, include exercises for them to clarify their personal values and attitudes about young people and abortion.



### ADOLESCENT-SPECIFIC ISSUES

- Lack of knowledge of where to access safe care, lack of self-efficacy, limited financial means, social stigma and restrictive social norms can inhibit abortion care-seeking among young people.
- Facilities may not be youth-responsive, making access difficult.
- A lack of trained health-care providers, and a lack of availability of high-quality supplies, equipment and commodities, can also make services less accessible.



### IMPLICATIONS FOR SERVICE DELIVERY

- Providers should consider using outreach and non-traditional settings to share SRHR information within communities.
- A physically separate space, or dedicated times and days during the week exclusively for young people, can facilitate confidentiality of services and a more comfortable environment. However, they are not essential for a responsive service.
- Health facilities should ensure the availability of high-quality approved abortion commodities and supplies.



### CONSIDERATIONS FOR UNFPA PROGRAMMING

- Invest in programmes that increase the knowledge, skills and ability of adolescents to prevent unintended pregnancies, detect pregnancy and improve their access to safe abortion care to the full extent of the law and post-abortion care.
- Consider advocating with the Ministry of Education, schools and communities for the integration of abortion-related content into CSE materials as part of the integrated package of SRHR interventions.
- When supporting countries in developing programmes and policies on safe abortion care to the full extent of the law and post-abortion care, ensure that provisions are sensitive to the needs of adolescents by guaranteeing that information and services are accessible, acceptable, affordable, confidential and delivered respectfully.
- Programmes should also provide clients with an opportunity to provide feedback on the abortion services they received.



# MATERNAL CARE



## ADOLESCENT-SPECIFIC ISSUES

For adolescents, pregnancy and childbirth are dangerous since they are not physically mature, which increases the risk of obstructed labour, which may lead to death or produce long-lasting injuries such as obstetric fistula. Many adolescent girls seek antenatal care later and make fewer visits during pregnancy than adult women. This may be especially true for those who are not married/in union, and those who cannot afford to pay for services/reaching services.<sup>2</sup>



## IMPLICATIONS FOR SERVICE DELIVERY

- Pregnant adolescents should be reached out to and encouraged to seek antenatal care, and advised where, when and how to do so.
- Family and community members should be encouraged to support adolescents in obtaining maternal health services.



## CONSIDERATIONS FOR UNFPA PROGRAMMING

- Ensure that UNFPA-supported maternal health programmes identify pregnant adolescents and ensure adequate and differentiated care: this can include scheduled social-work visits during clinical appointments, waiting-room education, clinician inquiries into education and family planning, and regular appointment calls and letters.
- Keep a count of the adolescent pregnancy rates by district, analyse the data and assess trends. Include these tasks in the job descriptions of health workers, and build the competencies and motivation to carry out these tasks.

<sup>2</sup> Li Z, Patton G, Sabet F, Subramanian S V, Lu C (2020). Maternal healthcare coverage for first pregnancies in adolescent girls: a systematic comparison with adult mothers in household surveys across 105 countries, 2000–2019. *BMJ Global Health*. 5(10):e002373.  
Mekonnen T, Dune T, Perz J (2019). Maternal health service utilisation of adolescent women in sub-Saharan Africa: a systematic scoping review. *BMC Pregnancy and Childbirth*. 19:366



**ADOLESCENT-SPECIFIC ISSUES**

In many places, pregnant adolescent girls receive fewer components of care than adult women.



**IMPLICATIONS FOR SERVICE DELIVERY**

Health-care providers should be knowledgeable about maternal health care and have the skills to provide these services. They must be trained, supported and held accountable for providing high-quality and respectful care.



**CONSIDERATIONS FOR UNFPA PROGRAMMING**

Depending on the case load, consider supporting the country in investing in adolescent-specific case workers who follow pregnant adolescents and promote birth and emergency preparedness for pregnant adolescents (in household, community and health-facility settings).



**ADOLESCENT-SPECIFIC ISSUES**

Laws and policies in many places require girls who are pregnant to be suspended or expelled from school and restrict them from returning to school after pregnancy. Even where there are enabling laws, they are often not applied in a way that empowers pregnant adolescents and adolescent mothers.



**IMPLICATIONS FOR SERVICE DELIVERY**

Laws and policies should enable pregnant adolescents and adolescent mothers to continue their education and to return to school.



**CONSIDERATIONS FOR UNFPA PROGRAMMING**

- Conduct advocacy activities with school districts and communities to ensure that pregnant adolescents and adolescent mothers are allowed to continue their education. Develop policy advice to support re-entry policies and the development of other supportive policies.
- Consider developing alternative learning opportunities for pregnant adolescents who choose to pursue those.
- Conduct special outreach efforts to re-enrol students who drop out of school after becoming pregnant or parents.





### ADOLESCENT-SPECIFIC ISSUES

Pregnant adolescents living with HIV have lower uptake of services for prevention of mother-to-child-transmission of HIV (PMTCT) than adult women, and their infants have poorer outcomes.



### IMPLICATIONS FOR SERVICE DELIVERY

Pregnant adolescents with HIV should be actively targeted with PMTCT services.



### CONSIDERATIONS FOR UNFPA PROGRAMMING

- Identify and document challenges faced by pregnant adolescents with HIV in accessing PMTCT services, to inform interventions that help overcome them.
- Support efforts to improve engagement of pregnant adolescents in antenatal care and PMTCT services.
- If appropriate, support PMTCT services in conducting special outreach efforts with adolescents.



### ADOLESCENT-SPECIFIC ISSUES

Perinatal depression occurs at higher levels in adolescent parents than in adults.



### IMPLICATIONS FOR SERVICE DELIVERY

Maternal health services should be linked to mental health services and psychological support. Pregnant adolescents and adolescent mothers should be actively reached out to with these services.



### CONSIDERATIONS FOR UNFPA PROGRAMMING

UNFPA's training on maternal health, including for midwives, should include a module on adolescent pregnancy, with a special focus on mental health needs of pregnant adolescents and adolescent mothers.



# PREVENTION AND TREATMENT OF HIV AND OTHER STIs



## ADOLESCENT-SPECIFIC ISSUES

- Relative to adults, adolescents have low rates of STI care and HIV testing, and low use of and adherence to antiretroviral therapy (ART) and care.
- Ongoing support from caring adults and peer support can enable them to stay on their medication and to feel positive about themselves.<sup>3</sup>



## IMPLICATIONS FOR SERVICE DELIVERY

- STI testing and care should be provided in a way which protects the confidentiality of the adolescent. It is especially important to ensure that anonymous reporting systems are in place.
- In generalized epidemics, provider-initiated HIV testing should be offered to adolescents seeking health services.
- Health workers should be knowledgeable about HIV testing and care and have the skills to provide these services. They must be trained and supported to provide high-quality care with respect, and assuring confidentiality.
- Adolescents living with HIV should be offered ART.
- Health services should be linked with peer- and community-based groups for ART adherence support.



## CONSIDERATIONS FOR UNFPA PROGRAMMING

- Promote self-testing models specifically for adolescents and youth.
- Support the establishment of HIV testing services in schools or referral mechanisms between schools and clinics, including outreach services.
- Advocate for and support the inclusion of HIV testing services during campaigns at community levels such as youth day celebrations, youth dialogues etc.
- Develop resources to help adolescents assess whether they should go for an HIV test, e.g. [this pamphlet](#) from the East and Southern Africa Regional Office.
- Develop recommendations on HIV and STI services for vulnerable adolescents and young people (e.g. young sex workers, young people with disabilities, youth in prisons).

<sup>3</sup> World Health Organization (2019). *Adolescent friendly health services for adolescents living with HIV living with HIV: from theory to practice: Peer-driven adolescent HIV models of care*.  
Mekonnen T, Dune T, Perz J (2019). Maternal health service utilisation of adolescent women in sub-Saharan Africa: a systematic scoping review. *BMC Pregnancy and Childbirth*. 19:366



**ADOLESCENT-SPECIFIC ISSUES**

Young key populations (young people who inject drugs, young men who have sex with men, young transgender persons, young people who sell sex, prisoners and migrants) experience even greater stigma and discrimination than adult key populations.



**IMPLICATIONS FOR SERVICE DELIVERY**

In low and concentrated epidemics, HIV testing should be available widely, and especially in communities, to enable young key populations to access testing and learn their HIV status and other STI statuses easily.



**CONSIDERATIONS FOR UNFPA PROGRAMMING**

*Refer to the considerations listed on p. 39.*



**ADOLESCENT-SPECIFIC ISSUES**

Adolescents living with HIV acquired perinatally may not be aware of their status.



**IMPLICATIONS FOR SERVICE DELIVERY**

Adolescents should be informed of their HIV status and supported in disclosing their status to others if they wish to, while maintaining confidentiality. They should also learn about living positively and preventing onward transmission of HIV.



**CONSIDERATIONS FOR UNFPA PROGRAMMING**

*Refer to the considerations listed on p. 39.*



# PREVENTION, CARE AND RESPONSE TO SEXUAL AND GENDER-BASED VIOLENCE

(See Module 2 for detailed information)



## ADOLESCENT-SPECIFIC ISSUES

- Many adolescent girls experience GBV, which can begin early in their lives.
- GBV can increase girls' risks of unintended pregnancies and unsafe abortions. In some settings, it can also increase their risk of acquiring HIV and other STIs.
- Child and adolescent sexual abuse and GBV are associated with an increased risk of depression, post-traumatic stress disorder, suicidal ideation and attempted suicide.
- This first experience of violence, particularly in the context of an intimate partner, can shape the life course of adolescents, as it forms a basis upon which later relationships are entered.



## IMPLICATIONS FOR SERVICE DELIVERY

- All support and care provided through services must be carefully managed and coordinated through survivor-centred approaches.
- Regardless of the service through which the adolescent survivor first receives care, safe referral to other services must be provided to ensure that she is able and empowered to make informed decisions about her own care. Services are multisectoral and include legal, security, social and health services. Increasingly, in light of escalating technology-facilitated GBV, recourse must also be had to digital companies to respond immediately to support removal or cessation of offending conduct.
- Clinical care for adolescents who have experienced GBV should include emergency contraception, HIV post-exposure prophylaxis, STI testing and treatment, care of wounds and prevention of tetanus, hepatitis B and human papilloma virus (HPV).
- Psychosocial support, including cognitive behavioural therapy with a trauma focus, should be offered to children and adolescents who have experienced GBV, or they should be provided with referral to specialist support services.



## CONSIDERATIONS FOR UNFPA PROGRAMMING

- Support the country in creating comprehensive legislation that criminalizes all forms of GBV, including harmful practices such as child, early and forced marriage and female genital mutilation (FGM).

- Support countries to ensure that specific legal provisions are guaranteed under domestic law, including regarding setting a minimum age for sexual consent, marriage and the possibility of medical treatment without parental consent (see also p. 53).
- Ensure that laws and policies reflect human rights standards on mandatory reporting to relevant national child protection and welfare systems.

### **Resource and build capacity of frontline workers**

Integrate GBV prevention into UNFPA-supported SRH programmes by ensuring that:

- Pre-service and in-service training of health professionals includes the prevention, protection and response to GBV.
- First responders (e.g. ambulance staff, police officers) are trained and provided with ongoing support in responding to GBV, including adolescent-responsive communication techniques and specific issues related to adolescent girls, such as early marriage.
- Frontline providers have training to reflect upon their own attitudes and practices, including those sustained by harmful gendered and social norms, so that services are survivor-centred, respectful and do not cause harm.
- Health workers, particularly adolescent health workers, have access to the range of specialist GBV services to support safe, effective and immediate referral for survivors.
- Information relating to GBV services is available to adolescents as part of CSE programmes, so that adolescents who do not want to disclose violence at school have access to information and relevant services.

### **Coordinate the response**

- Coordinate with organisations working on health, education and protection, and those addressing the needs of groups such as women and disabled persons, and with minority groups, to map safe services for adolescent girls and ensure that referral pathways are disseminated.
- Support youth groups that advocate for changing harmful social norms and fight violence against women and girls.
- Ensure that GBV programme and policy interventions take account of the specialist needs and the different entry points for adolescent girls into GBV services (including schools). Further, GBV prevention programmes must ensure that they target adolescent girls, including through the engagement of Ministries of Education and civil society organizations supporting out-of-school young people.
- Ensure coherence and good communication among UNFPA teams (Youth, SRHR, Gender) to guarantee that the special needs of GBV programmes for adolescent girls are not overlooked.



# PREVENTION OF CHILD MARRIAGE AND FEMALE GENITAL MUTILATION

(See Module 4 for detailed information)



## ADOLESCENT-SPECIFIC ISSUES

Girls are in formal or informal unions in many countries.



## IMPLICATIONS FOR SERVICE DELIVERY

- Laws and policies should prohibit marriage before 18 years.
- Educational and employment opportunities should be expanded for girls and young women.
- School-based and community-based activities should be undertaken to inform girls of laws and policies against sexual abuse and child marriage and empower them to delay marriage.
- These activities should be combined with interventions to influence family and community norms that support child marriage.



## CONSIDERATIONS FOR UNFPA PROGRAMMING

- Support legislative reforms on setting the minimum age at marriage at 18 across legal systems, and lowering ages of consent (to sex and to services, see p. 53).
- Consider which related laws (inheritance, marital rape, divorce, custody, labour and workplace, social protection etc.) can contribute to reductions in child marriage.
- Support girls to enrol and remain in formal and non-formal education, including through the transition from primary to secondary school. Consider the potential benefits of non-formal education models.
- Connect and refer adolescent girls to high-quality information and services that are oriented to their particular needs for health (including SRH), advocacy, and child and social protection.
- Engage families, communities, and religious and traditional leaders in dialogue and consensus-building, and help them become accountable for advancing gender equality and protecting and supporting adolescents.
- Advocate for initiatives that foster economic security of households and strengthen opportunities for girls' economic autonomy. Consider promoting cash transfers to incentivize health-promoting behaviours, care-seeking and school participation.





### ADOLESCENT-SPECIFIC ISSUES

- Older children and young adolescents form a significant proportion of those subjected to FGM.
- Girls and women living with FGM experience lasting ill effects.



### IMPLICATIONS FOR SERVICE DELIVERY

- The abandonment of FGM should be promoted through a combination of individual empowerment, community mobilization and law enforcement.
- Cognitive behavioural therapy should be offered to girls and women living with FGM who experience anxiety disorders, depression or post-traumatic stress disorder.



### CONSIDERATIONS FOR UNFPA PROGRAMMING

- Engage families, communities, and religious and traditional leaders in dialogue and consensus-building, and help them become accountable for advancing gender equality and protecting and supporting adolescents.
- Provide immediate and long-term treatment and counselling for unmarried girls, married girls and girls in unions who experience GBV, including FGM.



# PREVENTION OF CERVICAL CANCER THROUGH HPV VACCINATION



## ADOLESCENT-SPECIFIC ISSUES

Legal and policy barriers, as well as knowledge gaps and misconceptions, hinder the provision and uptake of the HPV vaccine.



## IMPLICATIONS FOR SERVICE DELIVERY

- Legal and policy barriers to HPV vaccine provision for all adolescent girls should be removed.
- Awareness and understanding about the HPV vaccine should be raised among adolescent girls and boys, their families and communities.
- Girls should not be asked whether they have initiated sexual activity before or during vaccination.



## CONSIDERATIONS FOR UNFPA PROGRAMMING

- If the country is eligible for GAVI support, advocate for and support the country in developing the GAVI HPV vaccine application.
- If applicable, contribute to the post-introduction evaluation of the HPV vaccine, which in most cases is led by WHO.
- Facilitate an adolescent health assessment to help the country determine whether or not to deliver HPV vaccinations along with other adolescent health interventions.
- Support the health system in identifying the size of the target population through accurate data collection.
- Use the HPV vaccine roll-out to scale up a package of adolescent SRH interventions, in particular puberty education and menstrual health.
- Ensure integration between SRH, cervical cancer programmes and EPI programmes (e.g. by advocating for joint HPV vaccination and cervical-cancer screening campaigns).



### ADOLESCENT-SPECIFIC ISSUES

HPV vaccination programmes do not always make use of the full range of available approaches to ensure maximum coverage.



### IMPLICATIONS FOR SERVICE DELIVERY

The roll-out of the HPV vaccine should use a combination of approaches, including school-based, community-based and health-facility-based.



### CONSIDERATIONS FOR UNFPA PROGRAMMING

- Provide technical assistance to the Ministry of Health in selecting the appropriate delivery strategy.
- Provide technical assistance in assessing the feasibility, coverage, acceptability and sustainability of the strategy (e.g. integration with other routine delivery and/or existing school programmes).
- Ensure that the chosen delivery strategy includes strategies to reach girls who have missed vaccination, are out of school, are hard to reach or marginalized, as well as the multi-cohort population (10-13 years).
- Support practice- and community-based interventions to increase HPV vaccine coverage.



# INFORMATION, COUNSELLING AND SERVICES FOR SEXUAL HEALTH AND WELL-BEING



## ADOLESCENT-SPECIFIC ISSUES

Adolescence is a time when biological changes related to sexual and reproductive maturity occur. Sexual activity may also be initiated during this time.



## IMPLICATIONS FOR SERVICE DELIVERY

Health-care workers should provide counselling to adolescents about sexuality, sexual health and well-being, including non-violent and consensual sex.



## CONSIDERATIONS FOR UNFPA PROGRAMMING

Build the capacity and attitudes of health workers to provide adolescent-responsive counselling on sexuality, sexual health and well-being, and give them ongoing support.



## ADOLESCENT-SPECIFIC ISSUES

LGBTQ+ adolescents often have concerns about being different, and face harassment and violence. They can also experience mental health problems.



## IMPLICATIONS FOR SERVICE DELIVERY

- LGBTQ+ adolescents need access to CSE, effective and sensitive medical and psychological care, and linkages to mental health services.
- Gender-affirming therapies for transgender persons opting for hormonal therapy should be available.



## CONSIDERATIONS FOR UNFPA PROGRAMMING

Advocate for legal recognition of LGBTQ+ people, particularly to ensure they are afforded the right to health and to freedom from violence and all forms of discrimination.



### ADOLESCENT-SPECIFIC ISSUES

Many adolescents lack knowledge and information about menstruation, and young people who menstruate do not have access to menstrual supplies and safe sanitation facilities, especially at school.



### IMPLICATIONS FOR SERVICE DELIVERY

- Information on puberty, menstruation and menstrual irregularities needs to be accessible to adolescents, both females and males.
- Young people need to know when menstrual bleeding is abnormal and when to reach out for help.
- Young people who menstruate need direct access to affordable menstrual supplies and safe sanitation facilities.



### CONSIDERATIONS FOR UNFPA PROGRAMMING

- Work with government and civil society actors to galvanize commitment and political leadership for an integrated approach to menstrual health and SRHR, and to support national health systems to promote menstrual health.
- In humanitarian settings, advocate for the inclusion of menstrual health as an essential service, and provide “dignity kits” (containing disposable and reusable menstrual pads along with other menstrual health items).
- Support programmes that improve education and information about menstruation and related human-rights concerns, and integrate information with services.
- Support community-based programmes to create a supportive environment for menstrual health and SRHR which attempt to shift the gender and social norms underpinning adverse menstrual health and SRHR outcomes.
- Build the capacity and attitudes of health workers, including midwives, to provide care for, and information about, menstrual health disorders and integrate menstrual health and SRH with other key health services.
- Procure reproductive-health commodities that can be useful for treating menstruation-related disorders. For instance, hormonal contraceptive methods can be used to treat symptoms of endometriosis and reduce excess menstrual bleeding.
- Gather data and evidence about menstrual health and its connection to global development – a long-overlooked topic of research. For instance, UNFPA can support surveys on girls’ and women’s knowledge about their menstrual cycles, health and access to sanitation facilities.



# FINANCING ASRHR PROGRAMMES AND ENSURING FINANCIAL RISK PROTECTION FOR ADOLESCENTS

As countries pursue UHC reforms, there are important health financing considerations to ensure the inclusion of ASRHR, and adolescent health more broadly. For example, antenatal care services for adolescents are often covered under UHC, but contraception and safe abortion services may not be. Most adolescents are particularly sensitive to costs associated with accessing SRH services. Protection from catastrophic expenditure and removing cost-related barriers can increase service access and use.

For adolescents, three aspects of financing are crucial:

- **maximizing the number of adolescents covered** by an effective prepaid pooling arrangement. This can take the form of an insurance programme or provision of free access to facilities that are financed by prepaid pooled funds
- **reducing or removing out-of-pocket payments** at the point of use
- **expanding the range of services covered** by the prepaid pooling arrangement to include all the services in the country's package for adolescents.



## → KEY AREAS FOR PROGRAMMING

### INCREASING FINANCING FOR ADOLESCENT HEALTH PRIORITIES IN NATIONAL HEALTH PLANS

- Define the required package of health information, counselling, diagnostic, treatment and care services to be provided to all adolescents (see p. 9).
- Estimate resource needs for the implementation of the priority package of interventions and associated programme costs, using tools such as the [OneHealth Tool](#). An adolescent health costing module has been developed for this software tool that allows countries to project costs for adolescent-specific programmes, as well as the cost of delivering adolescent health interventions within other national programmes or national health plans.
- Advocate for public investments and the inclusion of SRHR in key sectoral or multisectoral national schemes to ensure its inclusion as a priority in programmes, policies and budgets.

- Prepare a compelling strategic plan for investment in adolescent health, and negotiate with the Ministry of Finance over resource allocations.
- Build the capacity of national and district project managers to leverage external funds for adolescent health priorities using opportunities provided by the Global Financing Facility and strategic investments by the Global Fund and GAVI the Vaccine Alliance, among others.
- Build the agency and capacity of district and community managers to address adolescent health priorities when making local adjustments to central budgets.

## PROTECTING ADOLESCENTS FROM FINANCIAL RISK

- Ensure that adolescents and youth are covered by mandatory, prepaid and pooled funding to access the services they need. Identify subgroups of adolescents that are not covered by these arrangements, and design mechanisms to maximize their coverage.
- Assess the impact of out-of-pocket payments at the point of use for adolescents accessing key services. Use data to advocate for the reduction or elimination of adolescents' out-of-pocket payments at the point of use.
- Design and implement measures for adolescent financial risk protection (e.g. waivers, vouchers and exemptions or reduced co-payments) so that SRHR services and commodities, including contraceptives, are free or more affordable to adolescents at the point of use.
- Consider cash-transfer schemes to increase adolescents' access to SRHR services.
- Provide incentives that motivate health workers to implement high-quality interventions that are essential for adolescent health and development (e.g. through pay-for-performance mechanisms).





### Vouchers for adolescents significantly increase SRH service uptake in Kenya

In 2017, Marie Stopes Kenya introduced a youth voucher through its AMUA Social Franchise clinics, removing user fees for a comprehensive basket of SRH services for adolescents. Vouchers were distributed by community health volunteers (CHVs), who provided face-to-face counselling and information, involved community leaders in dialogue, and accompanied adolescents upon request to one of 124 AMUA participating youth-responsive centres. As the programme took off, providers overcame their fears of legal issues and parental disapproval and gained skills to counsel adolescents. CHVs were paid monthly per voucher used at the centres, and motivated by voucher income, CHVs and AMUA clinics created youth spaces, expanded opening hours, and organized outreach, including at local schools.

Among the results:

- There was a quadrupling in the proportion of clients aged 10-19 years in voucher clinics, with no displacement of older clients (no increase was seen at non-voucher clinics).
- More than two-thirds of girls chose long-acting and reversible contraceptive methods.
- A high proportion (84 per cent) of voucher users had never previously used contraceptives and most were single (89 per cent) and had no children (75 per cent).

**Source:** *Omari A, Omollo R, Mugwang'a Z, Owino E, Gorter AC (2018). How and why do vouchers increase uptake of Sexual Reproductive Health Services among adolescents in Kenya. Gates Open Research. Cited in: Global Financing Facility (2022). Financing for Results to Improve Adolescent Sexual and Reproductive Health and Wellbeing: Entry Points for Action.*











# KEY CONCEPTS

## → MINIMUM AGES OF CONSENT

Adolescence is a period when children's desire and capacity for autonomy increases. This makes the age of consent an important element in adolescent-responsive programming. The Convention on the Rights of the Child (CRC) is an important reference point for minimum-age legislation. The United Nations Committee on the Rights of the Child General Comment No. 4 on the Convention of the Rights of the Child – Adolescent Health (2003) is grounded in the principle that States parties "need to ensure that specific legal provisions are guaranteed under domestic law, including with regard to setting a minimum age for sexual consent, marriage and the possibility of medical treatment without parental consent".

Minimum ages of consent serve different purposes:



**Marriage:** The minimum age of consent advocated for by UNFPA is 18 years without exceptions, for both women and men, as per international standards.



**Sexual activity:** The age of consent is set to protect adolescents against adults who may prey on them, but laws should also recognize that as their capacity evolves, adolescents should be legally permitted to consent to sexual activity. If the age of consent is set too high, there is a risk that normative and age-appropriate sexual activity between consenting adolescents will be criminalized.



**Sexual and reproductive health services:** Because SRH services are crucial for adolescents, the age at which they may access these services should not be set unreasonably high, particularly for preventive services such as HIV testing, information and/or contraceptives. The Committee on the Rights of the Child states in General Comment No. 4:



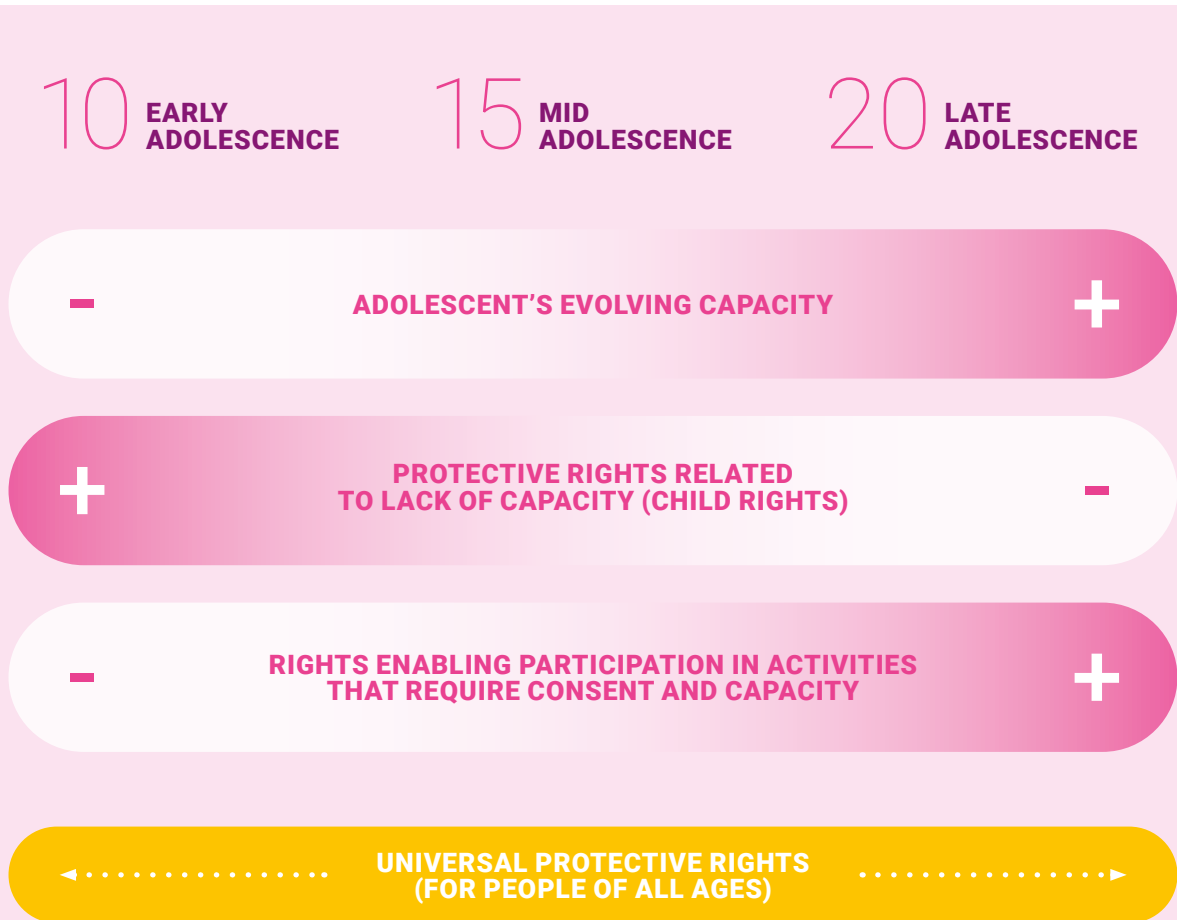
*"States parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs). In addition, States parties should ensure that they have access to appropriate information, regardless of their marital status and whether their parents or guardians consent."*

A strong and progressive legal framework which includes an appropriate age of consent without criminalizing close-in-age, factually consensual and non-exploitative sexual activity can protect younger adolescents without restricting rights. Minimum-age restrictions or the requirement of third-party (usually parental or guardian) consent in order to access SRH services (including contraception and abortion) are major barriers to adolescent bodily autonomy. High-quality, youth-friendly, confidential and comprehensive SRH services without stigma or prejudice should be provided on the basis of objective assessments of the capacity and best interest of the individual.

# → THE EVOLVING CAPACITY OF CHILDREN AND ADOLESCENTS

In fixing minimum ages, balancing the need for protection with the right to autonomy is complicated by the evolving capacities of adolescents. The concept of evolving capacities is introduced in Article 5 of the CRC:

“Direction and guidance, provided by parents or others with responsibility for the child, must take into account the capacities of the child to exercise rights on his or her own behalf. This principle – new in international law – has profound implications for the human rights of the child. It establishes that as children acquire enhanced competencies, there is a reduced need for direction and a greater capacity to take responsibility for decisions affecting their lives. The Convention recognises that children in different environments and cultures who are faced with diverse life experiences will acquire competencies at different ages, and their acquisition of competencies will vary according to circumstances. It also allows for the fact that children’s capacities can differ according to the nature of the rights to be exercised. Children, therefore, require varying degrees of protection, participation and opportunity for autonomous decision-making in different contexts and across different areas of decision-making.”



The evolving capacities of children need to be understood and examined from the following aspects:



**Development:** Children’s development, competence and emerging personal autonomy are promoted when States fulfil children’s rights under the CRC.



**Participation:** States should respect the capacities of children to participate in decision-making about themselves, and transfer rights from adults to the child in accordance with the child’s level of competence.



**Protection:** Because children’s capacities are still evolving, states and parents should protect them from participation in or exposure to activities likely to cause them harm, while recognizing that the levels of protection they require will diminish as their capacities evolve.

CSE is key to promoting healthy behaviours and relationships, and empowering adolescents to make informed decisions about their lives. The evolving capacities of children and adolescents are acknowledged in the ITGSE through the development of a progressive curriculum aimed at four age groups (5-8 years, 9-12 years, 12-15 years and 15-18+ years).

## → BODILY AUTONOMY OF ADOLESCENT GIRLS AND YOUNG WOMEN

### BODILY AUTONOMY AS A UNIVERSAL RIGHT

The right to bodily autonomy gives adolescents the power and autonomy to make choices over their body and future. This includes the right to make decisions on fertility and sexuality free from coercion and violence, but it goes beyond SRH by ensuring that adolescents are empowered to make safe and positive transitions to adulthood, enabling them to reach their full potential.

Ensuring bodily autonomy for adolescent girls essentially requires the same actions and commitments as for older women. They need protection from GBV as well as the right to freedom of sexual expression. They also require access to high-quality SRH services and freedom from harmful practices such as FGM and early, child or forced marriage. They also need to be empowered with the knowledge and confidence to make safe and informed decisions and choices.

## BALANCING BODILY AUTONOMY AND PROTECTION IN THE CONTEXT OF EVOLVING CAPACITIES

During adolescence, a girl's capacity to make informed choices and decisions is still developing. Younger adolescents may not yet have the cognitive or emotional maturity to provide informed consent to sexual activity. Adolescent girls, particularly younger adolescents, may need additional support and protection while they are developing the skills, knowledge and competencies to make healthy, informed choices.



The state, professionals and, most importantly, families all need to provide a supportive framework that protects younger adolescents from harm and ensures they are not exposed to risks or responsibilities which they do not yet have the maturity to manage. This framework should take a rights-based approach that also offers children and younger adolescents the opportunity to develop their knowledge and life skills. As an adolescent's capacities grow, the protective framework can be relaxed to enable them to take full responsibility for decisions affecting their lives. This concept of evolving capacities should underpin sexual health legislation, information and services and how these respond to adolescents at different stages.

## SPECIFIC BARRIERS FACED BY ADOLESCENT GIRLS IN ATTAINING BODILY AUTONOMY

Adolescent girls also face specific barriers to realizing their bodily autonomy as a result of their age and gender. Their growing capacity to make their own choices is often not recognized, and social and cultural norms often challenge their right to sexual expression and independence. Many face barriers in seeking SRH care because of stigma and discrimination as well as laws and policies that restrict access to care for young or unmarried women and girls. Lack of knowledge and autonomy may make it particularly difficult for girls to assert their right to bodily autonomy, placing them at risk of GBV and harmful practices. Changes such as menstruation and breast development can result in negative body image and erosion of self-esteem through shaming, humiliation and exclusion by adults and peers.

## HOW DO WE MEASURE BODILY AUTONOMY IN ADOLESCENTS?

There is currently no readily available individual-level indicator for bodily autonomy that reflects the differing stages and capacities across adolescence. Target 5.6 of the Sustainable Development Indicators has three indicators designed to measure bodily autonomy in SRH, but it is restricted to women and girls who are already sexually active and cohabiting or married, and thus does not cover all adolescent girls.

## AN ENABLING ENVIRONMENT FOR SUPPORTING ADOLESCENT BODILY AUTONOMY IN SRH

Providing access to the rights and protections that adolescent girls need requires a multifaceted approach:

- High-quality, gender-responsive education is a vital channel for girls to become empowered with the information and skills they need to take control of their futures. Removing financial barriers helps keep girls in school, but schools must also be safe places where girls are protected from abuse and can access sanitation facilities that provide privacy and dignity. Education also needs to be complemented by employment and livelihood opportunities that offer economic empowerment and independence and enable them to realize their rights to gender equality.
- Adolescent girls and young women need to be supported by families and communities who promote their rights to bodily autonomy, respect their rights to sexual expression, understand and support their growing capacities to make informed decisions and challenge and reject negative gender norms and harmful traditional practices.

## → GENDER-RESPONSIVE HEALTH SERVICES FOR ADOLESCENTS

Health systems are not neutral: they reproduce structures and processes of oppression and discrimination that exist in families and communities. Gender-responsive services acknowledge and consider women's and men's specific needs and promote targeted interventions to challenge and rectify inequalities and discrimination.

Systems designed for adults, including for women, do not necessarily respond to the needs of adolescent girls. To be age-responsive, services should be attentive to content, modes of delivery and features that matter particularly to adolescent girls. They should also have input and feedback mechanisms and respond to the feedback and solutions proposed by adolescent girls and adolescent boys.





## GENDER-BLIND

- ▶ Adolescent girls are denied access to SRH services and information

## GENDER-AWARE

- ▶ Limited SRH information and services are available
- ▶ Restrictions exist based on marital status, as well as third-party consent requirements
- ▶ Services are available for girls without attention to hours of service, place of provision, having female health providers etc.

## GENDER-RESPONSIVE

- ▶ Adolescent girls have access to basic SRH services and information
- ▶ Both married and unmarried girls have access
- ▶ Services are provided to all adolescent girls through multiple channels – in clinic and mobile services
- ▶ Clinics have separate areas that are adolescent-friendly
- ▶ Service hours are differentiated based on the needs of girls
- ▶ Trained providers provide high-quality, non-judgmental SRHR services and information for adolescent girls
- ▶ Referral services are functioning, including linkages between health services and CSE and life skills education

## GENDER-TRANSFORMATIVE

- ▶ All adolescent girls have access to a full range of high-quality, age-responsive SRH services and information
- ▶ Adolescent girls are able to access these services without spouse, partner or family consent
- ▶ Adolescent girls are able to make decisions about their bodies and their SRHR

**Sources:** Technical Note on Adolescent Girl-responsive Health Systems (UNFPA, 2020) and *Ensuring Gender-responsive Health Systems* (WHO)



**MUSIC**  
HELPS ME ESCAPE  
FROM THE REALITY  
I LIVE IN



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