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Review article

Forward, Together: A Collaborative Path to Comprehensive Adolescent Sexual and Reproductive Health and Rights in Our Time

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A B S T R A C T

The 1994 International Conference on Population and Development established a basis for the advancement of adolescent sexual and reproductive health and rights (ASRHR) that endures today. Twenty-five years later, our vision for the future warrants reflection based on a clear understanding of the opportunities and challenges before us. Inclusion of adolescents on global, regional, and national agendas; increased investment in ASRHR policies and programs; renewed commitments to universal health coverage; increased school enrollment; and advances in technology are all critical opportunities we can and must leverage to catalyze progress for adolescents. At the same time, a range of significant challenges remain, have newly emerged, or can be seen on the

IMPLICATIONS AND CONTRIBUTION

To build on the progress made on ASRHR in the 25 years since the ICPD, we must take into account emerging opportunities and challenges,

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horizon, including persistent denial of adolescent sexuality; entrenched gender inequality; resistance to meaningfully engaging adolescents and young people in political and programmatic processes; weak systems, integration, and multisectoral coordination; changes in population dynamics; humanitarian and climate crises; and changes in family and community structures. To achieve as much progress toward our vision for ASRHR as possible, the global ASRHR community must take strategic and specific steps in the next 10 years within five areas for action: (1) mobilize and make full use of political and social support for ASRHR policies and programs; (2) increase and make effective use of external and domestic funding for ASRHR; (3) develop, communicate, apply, and monitor enabling and protective laws and policies for ASRHR; (4) use and improve available ASRHR data and evidence to strengthen advocacy, policies, and programs; and (5) manage the implementation of ASRHR strategies at scale with quality and equity.

progressively build on and scale up what has worked, and diligently monitor quality and coverage. At the same time, we will need to work differently – moving beyond more-of-the-same and business-as-usual – in five key areas of action to achieve those things that we have said are important but have often failed to turn into action.

In 1994, the International Conference on Population and Development (ICPD) set out a bold call-to-action on sexual and reproductive health and rights (SRHR). For adolescents, it was particularly important. It positioned them as central to national population and development programs. It also highlighted the many factors that contribute to safe and supportive environments for adolescents and emphasized their sexual and reproductive health needs in the context of adolescent sexuality and adolescents' rights.

During the last 25 years, we—the global adolescent SRHR (ASRHR) community—have come a long way. We have better data and evidence on ASRHR and therefore have a better understanding of adolescents' SRHR needs and effective (and ineffective) services and interventions [1]. We have confirmed the value of reaching general populations of adolescents with large-scale, multisectoral, multilevel ASRHR programs with meaningful engagement of young people in all steps of the process, while employing innovative and flexible models to meet the needs of the growing number of adolescents living in particularly difficult circumstances [1]. And we are starting to make progress in learning *how* to do so in different contexts and with different resource availability. In turn, we have seen considerable—albeit uneven—progress across many key areas of ASRHR, which promises to have amplified positive influences on adolescents' health and well-being [1–3].

Despite our many achievements, there is still much to be done to fulfill the ICPD Programme of Action for adolescents, as well as to respond to new issues and questions that have emerged. This supplement aims to contribute to this goal. Paper 1 provides an overview of the state of ASRHR in the 25 years since the ICPD, Paper 2 outlines how our political, programmatic, and social responses have evolved over the same time period, and Paper 3 sets out considerations for delivering a package of essential SRH services and interventions to meet the needs and preferences of adolescents [1,2,4]. This fourth paper concludes by reaffirming our vision for ASRHR, charting out emerging opportunities and persistent and new challenges that we must take into account, and proposing five priority actions that will need to be taken in the next 10 years to achieve significant progress toward the unfinished agenda for ASRHR.

What Is Our Vision for ASRHR?

This 25-year anniversary of the ICPD prompts reflection on our vision and aspirations for adolescent health, and ASRHR specifically, taking into account the ways adolescents' lives have remained the same, the ways they have changed, and the ways they are likely to change in the future. Adolescence is a unique and dynamic stage of human development, and our vision is that all adolescents are able to achieve and exercise their full potential. For this to happen, adolescents must:

- be supported to acquire the information, skills, and attitudes to respond to the opportunities and challenges they face;
- be given a safe, supportive, and nurturing environment that provides opportunities to explore and take risks to shape the lives they desire, challenge the norms and environments that constrain and endanger them, and grow into adulthood; and
- be able to obtain and use adolescent-friendly health counseling, products, and services—inclusive of and beyond SRH—that respond to their needs and preferences.

The Sustainable Development Goals (SDGs) consist of a wide range of interrelated issues such as improving the quality of education and health services (including ASRHR), decreasing poverty, safeguarding the environment, and promoting peace and justice. They provide us with a natural foundation for our vision for ASRHR [5].

What Emerging Opportunities Must We Leverage?

There are several timely and emerging opportunities to advance ASRHR that we must act on now.

Inclusion of adolescents on global, regional, and national agendas

For the first time, adolescent health is placed fully on numerous global, regional, and national agendas [1]. In 2016, to fulfill the mission of "leaving no one behind," the special needs of adolescents were recognized in both the SDGs and in the Global Strategy for Women's, Children's, and Adolescents' Health [5,6]. Within this context, ASRHR has been prioritized in numerous global and regional partnerships, initiatives, and commitments (e.g., Family Planning 2020[1], Girls Not Brides[2], the African Coalition for Menstrual Health Management[3], the Eastern and

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

[2] A global partnership of 1000+ civil society organizations committed to ending child marriage and enabling girls to fulfil their potential.

[3] A coalition among diverse stakeholders in Africa to launched to strengthen effectiveness and collaboration for better menstrual health management in Africa.

Southern African Commitment[4], the Montevideo Consensus[5], and the Ouagadougou Partnership[6]), which in turn have created strong impetus for learning and action through their advocacy and convening power [7–9]. Countries are also signaling their attention to ASRHR through commitments (e.g., 35 FP2020 countries included adolescents in their commitments at the 2017 Family Planning Summit) and through new and/or updated national laws, policies, and strategies (e.g., nearly all the countries in which female genital mutilation is widely practiced have now banned it, up from only four in 1994) [1,10].

Increasingly, there is also recognition of the potential to harness countries' large, and in some cases growing, adolescent populations to advance social and economic development and achieve the so-called demographic dividend. In 2017, the African Union released its roadmap on "Harnessing the Demographic Dividend through Investments in Youth," which called on countries to invest in the health (especially SRH), education, livelihoods, and political participation of adolescents and youth [11]. Likewise, in 2018, Goalkeepers[7] called for human capital formation to include investments in family planning for adolescents [12]. This human capital framing has the potential to mobilize interest from influential and diverse sectors, including finance. For example, the World Bank's new Africa Human Capital Plan[8], which will provide 15 billion USD in grants and concessional finance for countries from 2021 to 2023, includes efforts to prevent child marriage and adolescent pregnancy within its broader mandate [13]. It is also bringing much needed attention and investment to adolescent girls' educational and employment opportunities and health in countries such as Benin, Burkina Faso, Chad, Côte d'Ivoire, Mali, Mauritania, Niger, and Senegal, in the context of the Sahel Women's Empowerment and Demographic Dividend regional initiative[9] [14,15].

Increased investment in ASRHR

Although certain areas of ASRHR (e.g., violence against women and girls and menstrual hygiene and health) remain underfunded, there is more funding available for ASRHR than ever before, particularly for specific issues (e.g., ending child marriage, preventing and treating HIV, and—increasingly—improving adolescents' access to and use of contraception) [1]. For example, in recent years, more than 90 million USD from a range of funders have been mobilized in support of efforts to end child marriage [16–18]. Similarly, in 2017, the Global Fund to Fight AIDS, Tuberculosis and Malaria's[10] 55 million USD matching fund was used to leverage an additional 140 million USD from 2017 to 2019 country grants in 13 countries to reduce HIV violence, and unintended pregnancies among adolescent girls and young women [19]. The inclusion of adolescents within the broader focus of the Global Financing Facility[11] has also resulted in increased financing for ASRHR, which is intended to complement other bilateral, multilateral, and private foundation investments [20].

Many countries are complementing external funding with their own domestic resources. For example, South Africa now funds about 80% of its own HIV response, which includes prevention, care, and treatment for adolescents [21,22]. Similarly, India now funds almost the entirety of Rashtriya Kishor Swasthya Karyakram, its National Adolescent Health Programme, with domestic resources [23]. In some countries, control over financing is becoming decentralized. If this process is closely managed to mitigate risks of misalignment between national and local goals and commitments, it has the potential to amplify impact by bringing decision-making closer to communities. For example, in the context of the devolution of its health system, Kenya put together a national Reproductive, Maternal, Newborn, Child and Adolescent Health Investment framework to guide counties to set priorities that align with national objectives and that are relevant for their context, mobilize relevant partners for collective effort, and integrate technical assistance and additional resources in their planning and budgeting processes [24].

Renewed commitments to universal health coverage

Cost, poor quality, stigma, and bias are major barriers that prevent adolescents from using health services. As such, reaffirmed global commitments to universal health coverage (UHC) present an important opportunity to improve adolescent health, including ASRHR [25]. The push toward UHC is generating results for the general population: estimates suggest coverage of essential health services increased by 20% between 2000 and 2015 [26]. However, to date, adolescents have received limited attention in such dialog and action. For example, adolescents are not mentioned in "Tracking Universal Health Coverage: 2017 Global Monitoring Report"[12] and adolescents have been largely absent in global health investments beyond HIV and SRH [3,27,28]. Increasingly, youth-led organizations and young leaders are involved in dialog around UHC, a critical step toward increasing attention to adolescents and ASRHR within the UHC agenda [29–31]. As countries work to define packages of essential health (including SRH) services, we have a time-bound opportunity to ensure that they include provisions, adaptations, and resources to accommodate adolescents' specific age and developmental needs and circumstances.

[4] A joint commitment made by ministers of education and health from 20 Eastern and Southern African countries in December 2013 to deliver comprehensive sexuality education and sexual and reproductive health services for young people.

[5] A joint commitment made by official representatives from 38 countries in Latin America and the Caribbean in August 2013 to strengthen the delivery of sexual and reproductive health services, including for adolescents and youth.

[6] A regional partnership among nine Francophone West African countries and their technical partners to accelerate progress to reach at least 2.2 million additional women and girls with contraceptive services by 2020.

[7] An initiative established by the Bill & Melinda Gates Foundation in 2017 to accelerate progress toward the Sustainable Development Goals.

[8] A regional (22 countries as of April 2019) effort to support African countries as they work to improve their human capital in the areas of survival, health, education, social protection, and fertility.

[9] A regional project led by the United Nations and the World Bank to increase women and adolescent girls' empowerment and their access to quality reproductive, child and maternal health services in the Sahel region.

[10] An international financing and partnership organization that aims to attract, leverage and invest additional resources to end the epidemics of HIV/AIDS, tuberculosis and malaria to support attainment of the Sustainable Development Goals.

[11] A mechanism that acts as a catalyst for financing for 36 low- and middle-income countries using modest Global Financing Facility Trust Fund grants to significantly increase countries' domestic resources alongside the World Bank's International Development Association and International Bank for Reconstruction and Development financing, aligned external financing, and private sector resources.

[12] A biennial report published by the World Health Organization and the World Bank to monitor the world's progress toward universal health coverage.

Increased school enrollment

Today, a greater proportion of adolescents—especially girls—are in school than ever before, and efforts are underway to improve the quality, equity, and relevance of education [32,33]. This trend is expected to continue in the 25 years to come, as compulsory primary education and removal of school fees continue to increase primary school enrollment, and this, in turn, contributes to increased secondary school enrollment. Given that school is protective for many aspects of adolescent health, this bodes well as a step toward addressing some of the social determinants of ASRHR [34]. Similarly, there are tremendous opportunities for education and health sectors to work together to leverage the potential of schools as a platform to reach large numbers of adolescents with comprehensive sexuality education (CSE), as well as school-based and school-linked health and social services [35]. Meanwhile, there is also recognition that many of the most vulnerable adolescents are still not in school, and that they require targeted responses to meet their health, social, and developmental needs.

Advances in technology

One in three Internet users around the world are children and adolescents aged younger than 18 years, and an estimated 71% of youth (15–24 years) are online compared with 48% of the total population [36]. Such technology is profoundly shifting the ways that adolescents interact with their peers, family, and the world at large, including how they learn, communicate, make decisions, form relationships, explore their sexuality, and manage their health [36,37]. Online interventions are enabling adolescents to independently seek ASRHR information on their own terms, as in the case of text lines, online counseling, chatbots, and informational Web sites [36]. Biomedical and technological innovations are increasingly providing new opportunities for adolescents to exercise self-efficacy and autonomy in obtaining health services, as in the case of self-care (e.g., HIV self-testing kits and self-injection of subcutaneous DMPA) [38]. Smartphones, apps, and social media are supporting adolescents to expand their social networks, meet romantic partners, and engage with peer-led social activism, as in the case of numerous youth-led movements now pushing for change around the world [36].

The adolescent health community, and the health community more broadly, has embraced these advances in technology with a flood of digital interventions, albeit with less understanding of how digital interventions can be integrated within health systems and how they are impacting adolescents' health and well-being [39]. In particular, digital health interventions have been lauded as an opportunity to partner with young people to design interventions that are more attractive and relevant to adolescents' needs and preferences. Such innovations hold great promise in improving ASRHR, as long as careful attention is paid to identifying and mitigating risks, such as data privacy, cyberbullying, state surveillance, commercial exploitation, and exposure to unreliable information (e.g., fake news) and non–age-appropriate content—the latter is particularly important in the case of very young adolescents [37]. Similarly, although technological innovations have the potential to improve adolescents' ability to independently access information and services, we must apply them in a way that mitigates rather than exacerbates existing inequities, such as those related to wealth and gender [37].

What Persistent and New Challenges Must We Navigate?

With these opportunities come a number of persistent and new challenges that directly affect the security, agency, opportunities, and aspirations of adolescents.

Denial of adolescent sexuality

Much of the world continues staunchly to refuse to acknowledge and accept adolescent sexuality. Too often, adolescent sexuality is discussed as a risk or problem to be avoided as in the context of disease and pregnancy prevention, and it is promoted as acceptable only in the context of childbearing within marriage. Although girls are seen as the embodiment of sex and sexuality when they reach puberty, and boys are told that they must be dominant and hypersexual to perform their role as "real men," abstinence before marriage is commonly presented as the only allowable option for adolescents [40–42]. Sexual health, including positive and respectful approaches to sexuality and relationships and sexual pleasure, is minimized and ignored [43]. Meanwhile, the sexuality of lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) adolescents is stigmatized, or worse yet, criminalized, and the sexuality of adolescents with disabilities remains largely invisible. Because of this refusal to acknowledge and accept their sexual rights and needs, adolescents in many contexts are more likely to learn about sex from peers and pornography than from the adults in their lives who are responsible for their upbringing at home, at school, and elsewhere in their communities. Similarly, this refusal often manifests as disrespect and judgment from health service providers when adolescents seek services, as well as powerful—often paralyzing—opposition to ASRHR policies, programs, and services [44–46].

Entrenched gender inequality

Entrenched gender inequality and harmful gender norms remain major impediments to achieving ASRH—and rights in particular—as well as the SDGs more broadly [42]. As and after they reach puberty, adolescents are expected by the world around them to adhere to specific gender norms. Girls are often considered vulnerable and are taught to be modest and polite, whereas boys are considered brave and independent and are taught to be assertive and self-sufficient [41,42,47]. Those who do not conform to these gender norms, as well as gender norms related to appropriate interests and appearance, face social pressures and sanctions, including violence [42]. These gendered expectations intersect with other inequalities—such as poverty, education, employment, and access to information and services—for an amplified negative impact on adolescents' lives. These consequences particularly manifest in gendered differences in the levels and causes of adolescent mortality and morbidity, including those related to SRH [48]. For example, gender inequalities continue to drive high rates of early pregnancy and gender-based violence worldwide, as well as unacceptably high levels of HIV incidence among adolescent girls in East and Southern Africa. Furthermore, an alarming number of adolescent girls report that their first sexual experience was coerced, forced, or violent [49,50]. Boys, meanwhile, are more likely to experience adverse childhood events and injuries and to use tobacco and alcohol and are less likely to seek promotive and

preventive health services [47,51]. A focus on adolescent boys' risk profiles, in particular, has long been neglected in research, programming, and civil society movements, although there are promising signs that this is beginning to change [52–56].

Resistance to meaningfully engaging adolescents and young people in political and programmatic processes.

Although global rhetoric increasingly acknowledges the value of meaningful adolescent and youth participation, intentional efforts to include adolescents in political and programmatic processes and to ensure they have the real power to hold decision-makers accountable remain limited and underresourced [57,58]. When adolescents and young people are given opportunities to contribute, it is most often older, urban, educated, and well-connected young people that are selected, and their engagement remains largely tokenistic and their responsibilities menial [59,60]. When they are in a position to make substantive contributions, these are rarely measured effectively to demonstrate their value—which will be critical to ensure continued investment in adolescent engagement [59,61]. Furthermore, adolescent and youth contributors are often not appropriately acknowledged nor compensated for their work [59]. As youth-led organizations struggle with funding, access, and succession planning to ensure that they remain truly youth led and nonpoliticized, the continuing need for true commitment to partnership is clear [62]. Given the broader trend of shrinking civic spaces where civil society organizations can act—and where adolescents' and young people's engagement happens almost exclusively—this persistent need is especially urgent and worrying [63].

Weak Systems and Limited Integration and Coordination Across Sectors

Health systems cannot provide services to adolescents—let alone quality, integrated services—when the building blocks of health systems (i.e., leadership and governance; service delivery; financing; health workforce; medicines, vaccines, and technologies; and health information systems) are not in place and functional. In many contexts, however, a number of these building blocks remain weak: health workers are not in place, medicines are in short supply, and accountability is lacking [64–67]. Health system strengthening and systematic scale-up approaches can do more to emphasize and underscore integrated delivery of quality SRH services—with equitable coverage of diverse adolescent populations as a key priority, the importance of which was recently reaffirmed by the Evidence for Contraceptive Options and HIV Outcomes trial[13] results [68]. Similarly, given that human resources for adolescent health have received minimal investment compared with other age groups, more attention must be devoted to ensuring that health workers have the competencies, motivation, and enabling environments they need to serve adolescent populations; this includes integration of adolescent health (including ASRHR) into pre- and in-service training and ongoing support for health workers [34,69]. Finally, there is a need to build on the experience of the pharmaceutical supply chain management field in building human and system capacity at the national and subnational levels by focusing on the "the last mile" to ensure that necessary goods and quality ASRHR services are available in every location where they are needed, even those that are the most difficult to reach [70]. For example, is every CSE session taught using participatory methodologies that not only provide information but also encourage discussion of values and norms? Does every adolescent girl have access to menstrual products/materials that meet her needs and preferences, as well as safe water, sanitation, and disposal services to manage menstruation safely and with dignity? Is every adolescent able to access quality contraceptive services, maternal health care, and safe abortion care no matter their circumstances?

Although some progress had been made toward integration of SRHR services for adolescents within the health system, real gains have been thwarted in part due to siloed funding and vertical efforts to improve some aspects of SRHR over others [71]. In recent years, there has been increased support for integration among key donors, such as the Global Fund and the United States President's Emergency Plan for AIDS Relief [72,73]. However, much more concerted effort is needed to increase health service delivery efficiencies and amplify access to an integrated SRH package across different country contexts.

Similarly, despite acknowledgment for decades of the need for multisectoral programming to address structural determinants and improve ASRHR, there has been limited progress in this area. Parallel and/or stand-alone services for adolescents (e.g., those delivered in the context of youth centers) continue to be popular strategies for meeting adolescents' needs, despite evidence that they are ineffective at improving uptake of ASRHR services [74]. To take full advantage of new opportunities, such as the linkages between ASRHR and human capital development noted previously, a new approach to incentives and accountability for multisectoral coordination is needed to support the whole adolescent to thrive, inclusive of and beyond their SRH.

Changes in population dynamics

The global population of adolescents is currently bigger than ever before. While in high-income countries and in parts of Latin America and South Asia, the total number of adolescents has started to plateau or even to decline, the adolescent population in Sub-Saharan Africa is projected to grow and peak in the middle of the century. As their adolescent populations continue to grow, all countries must respond with sufficient educational and income-generating employment opportunities and health and social services so that adolescents can grow and develop to their full potential. However, some of these countries may not have the capacity to invest sufficiently in young people's education, health, and development to enable them to harness the demographic dividend. There is a huge risk, then, that these countries will not experience a demographic dividend but will rather experience a demographic burden, and that inequalities will become further exacerbated [48,75].

The situation of unemployment and insecure employment among older adolescents and young people is particularly concerning, and this has major implications for their aspirations and security [76]. Young people are still three times as likely as older adults to be unemployed [76]. Among young workers in low- and middle-income countries, 16.7% live below the extreme poverty threshold [76]. Although the jobs that are available for young people are increasingly flexible, many require relocation to cities and are considerably more insecure, with fewer opportunities for job-related training [76,77].

[13] A randomized clinical trial on hormonal contraceptives and the risk of HIV acquisition.

Humanitarian and climate crises

Humanitarian crises and emergencies exacerbate the vulnerabilities of adolescents and the readiness of systems to respond to their needs. Adolescents are disproportionately affected by such challenges: more than half of the 1.4 billion people living in countries affected by crises and fragility are under the age of 20 years, and adolescents aged 10–19 years constitute a significant proportion of the population in many conflict and postconflict settings [134]. In such environments, girls face heightened risks of gender-based violence, unwanted pregnancy, maternal death and disability, HIV infection, early and forced marriage, rape, trafficking, and sexual exploitation and abuse [78,79]. Boys—who are the majority of unaccompanied minors worldwide—are more likely to experience violence directly linked to conflict. A growing body of evidence is further revealing that they also face high risks of sexual violence [80,81]. The vulnerabilities of LGBTQIA+ adolescents and adolescents living with disabilities are particularly acute and are commonly overlooked and/or inadequately addressed in humanitarian responses [82,83].

Climate crises—including those that are immediate, cyclical, and every day—are also radically changing the environments in which adolescents live, as sea levels rise, water shortages grow more frequent, desertification increases, and disasters occur more often and are more severe. These stressors are already affecting resource distribution, exacerbating inequality, increasing political tensions, and spurring migration, and both the scale and impact of these crises are predicted to drastically worsen in the future [84]. Climate crises adversely impact health infrastructure and access to health services, especially in low- and middle-income countries whose health systems have limited resilience. Despite this, health projects have received a miniscule 0.5% of the multilateral funds dedicated to climate change adaptation [85]. Adolescents in such contexts are likely to face increased risks to their SRHR, whether they are displaced themselves, or left behind in their home countries or communities by family members who migrate or die [86–88].

Changes in family and community structures

In the past, adolescents typically lived in large, extended family structures. This has become progressively less common, with families having fewer children and more adolescents living in single-unit families or in homes with one or no parents. This trend is because of a confluence of family factors such as deaths, separations, and divorces; urbanization such as the migration of one or more parent—or the adolescents themselves—to cities for education or work; and crises such as those related to conflict or climate change [89–91]. There is convincing evidence that adolescents who grow up without the stability and support of their families are at a much greater risk for numerous health and social problems, including some related to ASRHR [34,88].

What Strategic and Specific Actions Must We Undertake in the Next 10 Years to Accelerate Progress Toward Our Vision for ASRHR?

In the third decade of the 21st century and beyond, we will need to progressively build on and scale up what has worked to improve ASRHR and diligently monitor quality and coverage. At the same time, we will need to work differently—moving beyond more-of-the-same and business-as-usual—to achieve those things that we have said are important but have often failed to turn into action. To do this, we offer five strategic steps that we can take in the next 10 years to make the best possible use of the emerging opportunities for ASRHR and preempt and/or respond to persistent and new challenges to accelerate progress and achieve demonstrable improvements in ASRHR.

First, mobilize and make full use of political and social support for ASRHR policies and programs

At the global level, we must continue to advocate for the place of SRHR, and ASRHR specifically, on global agendas (e.g., in the context of the Global Financing Facility or UHC). At the national level, there is now strong political and social support in many countries to implement national ASRHR policies and programs that did not exist at the time of the ICPD. To take advantage of this support, ongoing attention is needed to strengthen human and system capacity and facilitate efficient technical support to design/strengthen ASRHR programs, ensure their integration and sustainability within the health system, and track progress. As countries demonstrate that success is possible, we must celebrate them as champions to bring others along. For example, Chile, England, and Ethiopia have all demonstrated that important reductions in adolescent pregnancy can be achieved when political and social support is combined with evidence-based interventions, strong leadership and management, and perseverance, and their achievements can be used to motivate and/or pressure others to follow suit [92]. Similarly, political and social support for ASRHR can help to move the broader adolescent health agenda in a progressive and strategic manner [93]. For example, the urgent need to address the unacceptably high rates of HIV and adolescent pregnancy in South Africa created an opportunity to improve the adolescent responsiveness of the health system more generally, notably by expanding recognition of adolescents' evolving capacity to give informed consent for health services and commodities as well as reinforcing specific policies in the education sector [94–96].

In countries where commitment and support for ASRHR policies and programs remain weak, a range of approaches can be considered to make the case for action. Advocates can use politically and socially acceptable entry points where they exist, create new entry points, and/or leverage specific events or moments in time. For example, the tragic rape and murder of a 6-year-old girl in Punjab, Pakistan in 2018 and the subsequent public outcries for government action opened the door for the ongoing integration of a rights-based, life skills–based education program in public primary and secondary school curricula in two of the country's four provinces [97]. Similarly, after years of quieter debate in Ireland, the death of Savita Halappanavar opened a moment of public empathy and understanding about the need for safe abortion care that—alongside well-prepared advocacy—eventually led to the legalization of abortion, including for adolescents [98]. The case for action can also be made by combining epidemiologic data on the scale of the problem and the costs of inaction, compelling stories to personalize the issue, evidence on effective approaches and what they will cost, and examples of how these approaches have worked elsewhere [99–101].

Finally, our ability to achieve progress is contingent on our ability to prevent and quickly overcome backlash, if and when it occurs. This will require making the case for action in ways that resonate with different stakeholders (e.g., preventing adolescent pregnancy as essential to human capital formation when engaging with ministries of finance), integrating ASRHR

interventions within trusted systems/structures, and fostering ongoing partnerships between governments; civil society, faith-based and youth-led organizations; and communities. When resistance arises, we must map influential stakeholders and decision-makers, understand their priorities and concerns, proactively engage with media and civil society, and directly counter misinformation with compelling data, evidence, and stories. By using such strategies, programs have shown that it is possible to navigate sensitivities to CSE, for example, in countries as diverse as Mexico, Nigeria, Pakistan, and the U.S. [45,46,102,103].

Second, increase external and domestic funding for ASRHR while making effective use of the available resources to demonstrate impact

With regard to external funding, we must make full use of the tremendous increase in available resources for ASRHR to demonstrate tangible results. For this, we must build both human and system capacity to scale up integrated packages of evidence-based services and interventions and to improve monitoring and evaluation with a "last mile" lens to ensure the quality and equity of these services and interventions [4,70]. We must also use these resources to improve how we address intersecting ASRHR areas (e.g., prevention of sexual violence against girls and young women in the context of HIV prevention) and areas of importance to ASRHR (e.g., mental health and substance use), which are not as well-funded. Finally, to sustain and grow this support, we must show the results of our work and how this links to the wider public health agenda (e.g., how reducing adolescent pregnancy and preventing rapid repeat pregnancy among adolescent mothers can help to reduce neonatal and infant mortality and morbidity).

With regard to domestic financing, we must ensure that countries that have allocated domestic resources for health, and for adolescent health and ASRHR in particular, have the support they need to demonstrate that such investment is worthwhile and to sustain these investments. First, we must ensure that adolescent health strategies are translated into costed implementation plans and that there are dedicated line items in health budgets to support ASRHR services and interventions. Second, we must ensure that domestic financing is also allocated to non–health sector services and interventions that are critical for improving adolescent health. Third, as countries plan and roll out UHC, we must ensure that health financing incorporates specific provisions for adolescents and SRHR [104,105]. For example, countries must include adolescents under prepaid pooling arrangements (e.g., insurance programs or direct funding to facilities) that ensure access to an expanded range of essential age-appropriate services without out-of-pocket expenses at points of use [105,106]. In practical terms, this might mean including adolescents in risk pools, using vouchers or other demand-side financing schemes to target subsidies to adolescents, ensuring that adolescent-responsive service outlets are included as service providers in UHC schemes, and/or incorporating novel information and service delivery platforms (e.g., mHealth solutions, telemedicine providers) and private-sector channels including pharmacies and drug shops in strategic purchasing schemes.

Third, develop, communicate, apply, and monitor enabling and protective laws and policies for ASRHR

Many countries have taken enormous strides in the last 25 years to create more enabling legal and policy environments for ASRHR [107,108]. In these countries, we must work to ensure that those who are responsible for law and policy implementation are aware of them and of their obligation to apply them. For example, where there are no legal restrictions to the provision of contraception, safe abortion, or HIV testing related to age or marital status, health workers must be aware of this and of their obligation to respect these laws in their work. Alongside this, we must create wider awareness of these legal provisions to ensure that adolescents and their families know their rights and entitlements and are equipped to hold governments accountable. Beyond awareness raising, we must dramatically step up efforts to ensure that these laws and policies are adequately resourced, implemented, and enforced in a progressive manner [1]. In practical terms, this requires improving legislative frameworks and accompanying enforcement and redressal mechanisms, such as has been done with civil registration systems that provide proof of age for children for reporting of child marriage in Ethiopia and with mobile courts with public hearings for responding to female genital mutilation in Burkina Faso [1,109]. At the same time, we must ensure that the most marginalized and vulnerable persons and communities are not scapegoated along the way.

However, many countries still have legal and policy environments that act as barriers to effective action on ASRHR. Such environments may include restrictive laws and policies, contradictions between laws and policies, and/or loopholes. For example, many countries still have policies that restrict access to health services based on age or marital status. Others have policies that allow for the provision of SRH services regardless of age or marital status but have penal codes that criminalize sex before the age of 18 years [110]. Still others have laws that forbid child marriage, on the one hand, but provide exceptions to the rule on a number of grounds. As legal and policy shifts and implementation take time and effort, we must identify those that are most crucial (e.g., those related to age of consent given their implications for access to services and insurance schemes under UHC) and work to change them. For example, Namibia's 2015 Child Care and Protection Act, which lowered the age of consent for HIV testing and other SRH services from 16 to 14 years, has improved adolescents' access to numerous services in the context of the country's National Strategic Framework for HIV and AIDS Response for 2017–2018 to 2021–2022 [111,112].

Fourth, use and improve available ASRHR data and evidence to strengthen advocacy, policies, and programs

There is a growing amount of publicly available data on ASRHR; however, these data are not always used to inform national and subnational-level work. We must make sure that real-time age- and sex-disaggregated data from administrative data systems (e.g., health information systems), as well as surveys (e.g., Performance, Monitoring, and Accountability, or PMA2020[14]), are synthesized in formats that are accessible and useful for decision-makers. In collaboration with health system strengthening initiatives, we must then ensure that decision-makers have the adaptive management capacity to use such data to shape (and reshape) their programs. This is especially true at the subnational level, given that there is growing diversity

[14] A project that uses innovative mobile technology in 11 countries to support low-cost, rapid-turnaround surveys to monitor key indicators for health and development.

within countries, and that responsibilities for developing work plans and budgets (including in the context of UHC reforms) are increasingly being decentralized [113,114].

Alongside this, we must work to fill data gaps [115]. At the global level, we must make full use of new initiatives, such as the Global Action for Measurement of Adolescent Health Advisory Group[15], to harmonize and apply a core set of indicators on adolescent health. These indicators must go beyond health outcomes and include measures of quality, coverage, and cost, include attention to the determinants of adolescent health, and have relevance across country contexts [116]. At global and national levels, we must improve population-based surveys (e.g., the Demographic and Health Surveys[16]) so that they collect relevant and appropriate data (e.g., by extending to 10- to 14 year-olds and including boys and young men) while tapping into a wider range of data sources (e.g., metadata from search engines or social media) to attain data that are not collected through large surveys [115,117]. For example, analyses of data from Love Matters[17] through Google Analytics have allowed researchers to better understand young people's interest in and engagement with information about sexual pleasure in Egypt, Kenya, India, Mexico, and Nigeria [118].

In addition to data, there is also a growing evidence base on effective ASRHR services and interventions that can be used to inform policies and programs. We need to improve the availability and dissemination of such evidence and support country-level stakeholders' capacity to develop evidence-based plans, strategies, and investment cases to ensure that common challenges (e.g., delivery of interventions in a piecemeal manner or with inadequate dosage) are addressed and that interventions which have been shown to be ineffective (e.g., high-profile public meetings to inform communities about harmful practices) are no longer implemented [74]. We also must address key evidence gaps, such as on cost and cost-effectiveness of various ASRHR services and interventions, or effective approaches to reach and meet the needs of different groups of adolescents (e.g., those with disabilities and those who are LGBTQIA+). Finally, we must support implementation research on what it takes to adapt services and interventions that have proven to be effective in research studies and/or small-scale projects and deliver them at scale in different contexts.

Fifth, manage the implementation of ASRHR strategies at scale with quality and equity

Since 1994, many countries have developed multisectoral ASRHR strategies with technical consensus based on sound epidemiology and up-to-date evidence. These strategies provide the basis for developing scale-up plans to systematically extend the coverage of interventions across a country. However, in many places, the interventions included within strategies are poorly designed and delivered, with little if any coordination. This is especially true as programs move—often rapidly—to scale.

To support the implementation of multisectoral ASRHR strategies, we must first ensure that there is agreement regarding how, where, and by whom the different services and interventions within them are to be delivered. This will require ministries of health (the institutions that typically "own" ASRHR) to bring together government, civil society, and private-sector partners within and beyond the health sector, with concerted attention to the involvement of youth-led organizations and grassroots movements. Given emerging opportunities related to human capital development and technological advancements, this will also require linking with new and different partners for stronger and more synergistic action. To do so—and to do so better than we have in the last 25 years—such multisectoral coordination will require intentional and persistent efforts to build a shared understanding of the issue and how to address it, lay out clear roles and responsibilities, establish referral, coordination, and accountability structures with real power to incentivize participation, and create bridges to allow for joint—or at least coordinated—budgeting and monitoring [119]. This coordination will be critical to bring services and interventions closer to adolescents—wherever they are—through innovative and complementary means (e.g., through engagement with pharmacies, outreach with technological innovations, or task shifting for expanded community-based care, including that delivered by peers) [6,120–123].

Second, as countries proceed to scale up their strategies, we must support them to ensure relevant delivery platforms have the system and human capacity to deliver the services and interventions with quality and fidelity. System capacity is a major barrier to achieving ASRHR in many countries, but it is not a problem that the ASRHR community can tackle alone. Instead, we must actively work to communicate and align with health, education, and protection system strengthening efforts to ensure that adolescents are considered within broader reforms [124]. For example, as systems improve their ability to use adaptive management[18] techniques, we must leverage this opportunity to ensure health policies and programs remain responsive to adolescents' needs and preferences. At the service provider level, we desperately need to move beyond one-off, off-site trainings to improve human capacity and comfort in acknowledging and addressing sexuality among adolescents. Frontline workers, such as health workers and teachers, must receive preservice training that includes ASRHR and CSE content and delivery methods, as well as facilitated opportunities to examine their attitudes and values related to adolescents. This must be complemented with efforts to provide ongoing in-service capacity building (e.g., through refresher trainings and pocket/desk reference tools), ensure workers are able and empowered to perform their duties (e.g., by ensuring supplies and equipment are available and functional, workloads are manageable, and salaries are paid on a timely basis), foster motivation (e.g., through peer-sharing and collaborative learning), and promote accountability (e.g., through quality standards and supportive supervision) [43,125,126].

Third, we must use improved data (e.g., from health information systems) proactively and differently. We must conduct ongoing monitoring and periodic reviews, use strategic real-time information to assess quality, equity, and effectiveness on a routine basis, and promote good governance [127]. We must seize the potential of approaches such as continuous quality improvement, problem-driven iterative adaptation, and

[15] An advisory group established by World Health Organization and the United Nations to harmonize and prioritize adolescent health indicators and to converge data collection and reporting efforts.

[16] A program that has collected representative data on population, health, HIV, and nutrition through more than 400 surveys in over 90 countries.

[17] A program that uses a pleasure-positive approach and nonjudgmental discussions on mobile-friendly platforms to provide information on relationships, sex, and love in five countries.

[18] A structured and iterative process of decision-making and implementation that uses active learning methods to collect information and make changes as needed on an ongoing basis.

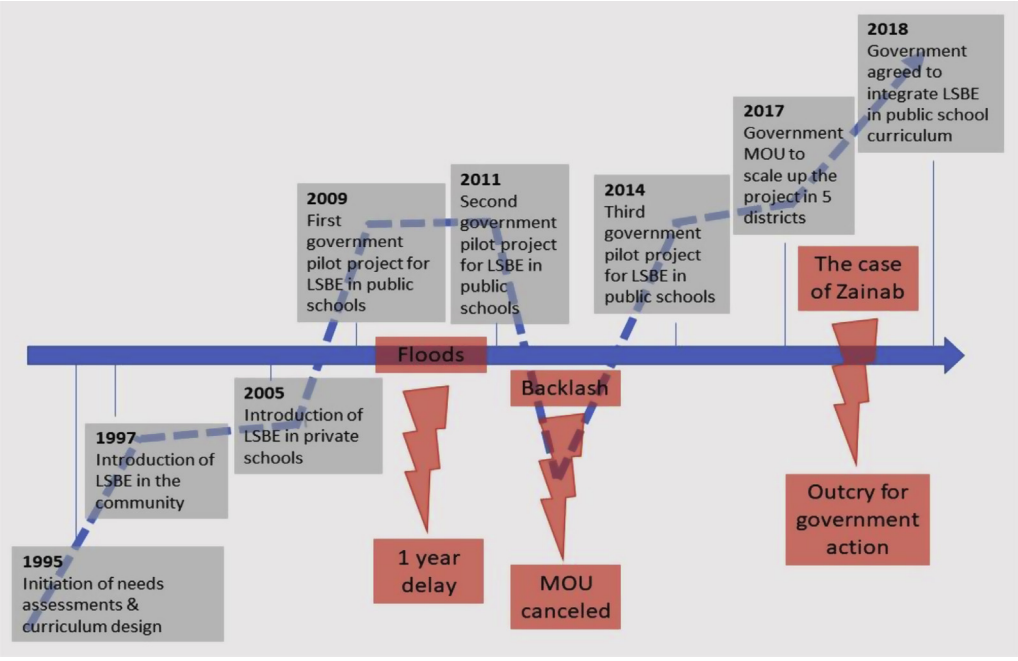

Figure 1. Aahung's 20-year journey to scale up life skills–based education (LSBE) in Sindh, Pakistan [45].

"collaborating, learning, and adapting" to "fail fast" and make adjustments in response to dynamic change [128,129]. In doing so, we must account for the fact that such approaches are hugely dependent on the organizational context in which they are meant to occur and require a fundamental behavior shift in management and decision-making dynamics [130]. Finally, we must couple such approaches with participatory assessments (e.g., mystery client methods and client feedback mechanisms) that collect data from the perspectives of adolescents themselves to ensure their voices inform decision-making and promote real accountability to the beneficiaries we seek to serve [131].

Throughout these efforts, we must recognize that perfect cannot be the enemy of the good, and that the path to scale-up will be messy and nonlinear. For example, Aahung, an indigenous nongovernmental organization, persevered diligently through changes in government, backlash, and even floods to achieve scale-up of its life skills–based education program in Pakistan, referred to earlier (Figure 1) [45]. Many of the countries that have demonstrated success on ASRHR have shown that it can be useful to start strategically (and sometimes, opportunistically) versus comprehensively; then, once a program is up and running, add additional components or content. For example, Botswana's progress in addressing HIV shows how a country can start with a limited program (i.e., its first national program to address HIV in 1998), build on it incrementally to improve its comprehensiveness and quality (i.e., through scale-up of ART provision in 2002 and routine HIV testing with opt-out option in 2004), encounter setbacks (i.e., introduction of mandatory HIV testing in 2013), and continue to grapple with persistent challenges (i.e., cessation of external funding, laws against same-sex relations, and gender inequality) [132,133].

What Do We Need to Consider in Carrying Forward the ASRHR Agenda in the Next 25 Years and Beyond?

On the 25th anniversary of the ICPD, we continue to strive to ensure that the world is a better place for all adolescents. Now and in the future, we will persevere toward our vision, which is firmly rooted in the SDGs. There will be changes that we can predict and that have been outlined in this article. However, there may very well be changes that we cannot yet imagine that could completely change the way people live. In light of this, we must assure our resilience by building our capacity, including that of adolescents and young leaders, to respond to the ever evolving global, regional, national, and subnational landscapes. Our policy and programmatic environments must be flexible and responsive to future circumstances, where it is likely that dynamic change will be a norm for many adolescents. Similarly, our programmatic responses must be rapid, iterative, and adaptive, adhering to the key principles included in our vision for ASRHR.

The ICPD Programme of Action was revolutionary in its forward-looking vision that reimagined the way the world thought about—and worked for—SRHR, including for adolescents. As we celebrate our achievements in ASRHR in the last 25 years, we also look ahead to what it will take to consolidate our gains, overcome challenges, and progress toward our renewed vision for ASRHR.

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