

CONTRACEPTION FOR ADOLESCENTS AND YOUTH

Being responsive to their sexual and reproductive health needs and rights

ISSUE PAPER

Mandira Paul, Satvika Chalasani, Ben Light and Anneka Knutsson of UNFPA
Adesegun Fatusi of the Guttmacher Institute

© UNFPA November 2019

Contents

Introduction	3
1. Current situation, progress and challenges	5
1.1 Adolescent contraceptive use at a glance	5
1.2 Barriers to using modern contraceptive methods among adolescents and youth	7
2. What will it take to meet the contraceptive needs of adolescents and youth?	9
2.1 Quality of care for adolescents and youth	9
2.2. An integrated approach to services responsive to adolescents and youth	9
2.3 Expanding the method mix for adolescents and youth	10
2.4 A positive approach to providing SRHR services for adolescents and youth	12
2.5 Promoting access to comprehensive sexuality education	13
2.6 Strengthening the evidence base and promoting research	16
3. Emerging issues/neglected areas	18
3.1 Equity: Reaching the adolescents and youth furthest behind	18
3.2 HIV prevalence and contraception	18
3.3 Non-contraceptive benefits and risks of contraception	19
3.4 Post-abortion and postpartum care offers a window of opportunity	20
3.5 AYSRHR in humanitarian settings	21
3.6 Financing for contraceptive services for adolescents and youth	22

About the issue paper

This paper provides a brief review of existing evidence and emerging issues in the area of contraception for adolescents and youth (AY), with a particular focus on integration into sexual and reproductive health and rights services. The paper addresses people working on programming and advocacy for adolescents and youth, as well as family planning (FP) and sexual and reproductive health and rights (SRHR) programming more broadly. The aim is to provide guidance and recommendations for the global SRHR community, including the family planning community and UNFPA. Each section provides a set of proposed actions or recommendations.

This issue paper informed a technical brief prepared for the UNFPA Global Consultation on Ending Unmet Need for Family Planning held June 2019 in Antalya, Turkey.

© UNFPA November 2019

Acronyms and abbreviations

AY	Adolescents and youth
AYSRHR	Adolescent and youth sexual and reproductive health and rights
CSE	Comprehensive sexuality education
DHS	Demographic and Health Survey
DMPA	Depot-medroxyprogesterone acetate (DMPA) for contraception
EC	Emergency contraception
HCD	Human Centred Design
ICPD	International Conference on Population and Development
IUD	Intrauterine device
LARC	Long-acting reversible contraception
MICS	Multiple Indicator Cluster Surveys
PYD	Positive youth development
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infections
UHC	Universal health coverage
UNFPA	United Nations Population Fund
YFS	Youth-friendly services

Introduction

The Programme of Action adopted at the International Conference on Population and Development (ICPD) in Cairo underpins all programming and advocacy that works to ensure sexual and reproductive health and rights for everyone everywhere. These rights are often denied adolescents and youth (AY). Fulfilling these rights and allowing adolescents and youth to make timely, informed choices about their own bodies, their own lives and their situation in the world will result in a lifetime of returns.

Adolescence is a time of change, from physiological, biological and psychological changes to social and contextual changes. It is a time when most people begin exploring their sexuality and begin having intimate relationships.¹ It is a crucial time to lay the foundations for healthy sexual and reproductive lives and to deal with issues that, if unaddressed, are particularly harmful for girls' and women's health, including inequitable gender norms, child marriage, female genital mutilation and gender-based violence.² A number of factors influence the decision-making of adolescents (aged 10–19) and youth (aged 15–24), including the development stage the individual is in as well as the context in which the person lives. Parents and caregivers are important influencers throughout adolescence, particularly for very young adolescents, whereas older adolescents are more receptive to influence from peers, partners and/or the media.³ The choices available to adolescents and youth (aged 10–24) are influenced by the socioeconomic, cultural and religious context of their lives. Decisions and choices are also made based on available information, awareness, agency and the access to, or lack of, services. Importantly, AY are a heterogeneous group with different needs, situations and life goals.

In the past half century, great progress has been made in extending access to sexual and reproductive health information and services to people everywhere. But this progress has been uneven and inequalities persist, both within and between countries, not only for family planning and maternal health, but for information and services that can enable the realization of the full range of SRHR. SRHR inequalities are driven by income inequality, gender inequality, the quality and reach of health systems, laws and policies, social and cultural norms, and people's exposure to sexuality education.⁴ Moreover, SRHR inequalities can perpetuate a cycle of poverty from one generation to the next.⁵ A young person's access to SRHR often intersects multiple factors of inequality, making targeted interventions particularly important in addition to standard provision of services. For example, AY are sensitive to how they are treated, making the issue of acceptability of services particularly important. For AY to even consider seeking services and information, services must meet their needs, meet AY where they live and function, and use a language that resonates with their life situation. In spite of AY being a heterogeneous group with different needs, there are two key aspects of services that AY

¹ High-Impact Practices in Family Planning (HIPs). Adolescents: Improving Sexual and Reproductive Health of Young People: A Strategic Planning Guide. Washington, DC: USAID; 2015 Sep., www.fphighimpactpractices.org/guides/improving-sexual-and-reproductive-health-of-young-people/

² Starrs AM, Ezeh AC, Barker G et al., 2018. Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission, *The Lancet*, [/www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)30293-9/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30293-9/fulltext)

³ Dahl, E.R., et al. 2018. Importance of investing in adolescence from a developmental science perspective. *Nature Res Perspective*.

⁴ UNFPA. 2019. Unfinished Business the pursuit of rights and choices for all. State of the World's Population. www.unfpa.org/sites/default/files/pub-pdf/UNFPA_PUB_2019_EN_State_of_World_Population.pdf.

⁵ Darroch JE et al., 2016. Adding It Up: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents, New York: Guttmacher Institute, www.guttmacher.org/report/adding-it-meeting-contraceptive-needs-of-adolescents

across the world consider crucial: they want to be treated with respect and make sure that their confidentiality is protected.⁶ These are key to information and services provided as part of adolescent and youth sexual and reproductive health and rights (AYSRHR) programming.

Goal 3 of the Sustainable Development Goals on good health and well-being stipulates the importance of strengthening health systems to ensure universal access to health services, including sexual and reproductive health (SRH). The recent report of the Guttmacher-*Lancet* Commission on Sexual and Reproductive Health and Rights suggests an integrated package to include contraception, maternal and newborn health care, safe abortion, prevention and treatment of sexually transmitted infections (STIs) including HIV, reproductive cancers, prevention and treatment of infertility, and gender-based violence prevention and response.

Contraceptive services must be situated within the broader context of SRHR services to ensure sustainable and scalable provision. Doing so allows for the provision of relevant linkages and referrals, and opens opportunities to provide information to adolescents and youth on a range of linked SRHR issues. Such information and service provision takes the whole person and their needs into account, and allows for the application of a lifecycle approach. SRH services, including for adolescents, should themselves be integrated into existing health service provision and guaranteed as an essential component of universal health coverage (UHC). Not only is this critical to upholding the right to health, but particularly in countries with large cohorts of adolescents and youth, it underpins the opportunity to accelerate development by enabling countries to reap a demographic dividend. The integration of sexual and reproductive health and rights within the context of UHC is considered to be an essential element for fulfilling the 2030 Agenda for Sustainable Development given that UHC stands to deliver significant benefits for improved access to health services, including for SRHR.

Demographic dividend

Countries with the greatest demographic opportunity for development are those entering a period in which the working-age population has good health, quality education, decent employment and a lower proportion of young dependents. Smaller numbers of children per household generally lead to larger investments per child, more freedom for women to enter the formal workforce and more household savings for old age. When this happens, the national economic payoff can be substantial. This is a "demographic dividend" (DD).⁷

⁶World Health Organization. 2002. Global Consultation on adolescent-friendly health services. A consensus statement. Geneva, www.who.int/maternal_child_adolescent/documents/pdfs/who_fch_cah_02.18.pdf?ua=1

⁷ UNFPA. 2019. Demographic Dividend, www.unfpa.org/demographic-dividend

1. Current situation, progress and challenges

1.1 Adolescent contraceptive use at a glance

Adolescents have higher rates of unintended pregnancies than any other age group, and the unmet need for contraception is much higher among adolescents compared with all women aged 15–49 (57 per cent versus 24 per cent). Adolescents aged 15–17 also generally have higher unmet need than those aged 18–19.^{8,9} Roughly half of the pregnancies among adolescents aged 15–19 in developing regions are unintended, and about half of these end in abortions, most of which are unsafe.^{10,11,12,13,14,15,16} About half of 19-year-old women in developing regions are sexually active, often but not always within marriage.¹⁷ Thirty-six million (14 per cent) women aged 15–19 in low- and middle-income countries need contraception because they are married, or are unmarried and sexually active, and do not want a child for at least two years. Of these women, 43 per cent are using modern contraceptives, primarily the male condom and oral pill, followed by injectable methods. The remaining 57 per cent or some 20 million adolescent women have an unmet need for contraception where the majority (85 per cent) do not use any method, and the remainder use traditional methods, which are less effective than modern methods. In terms of trends, in many countries, the proportion of adolescent women using contraceptives increased substantially over the last two decades; prevalence among adolescents increased faster than among older women.¹⁸ There is little data on younger adolescents (10–14 years), however, but the available data suggest that most of them have not yet experienced sexual intercourse. With that said, it is an important group to reach with information and services, particularly since the majority of sexual activity among very young adolescents is coerced¹⁹ and adolescents entering puberty may need contraceptive methods for reasons other than sexual

⁸ Guttmacher Institute. Fact Sheet Adding It Up: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents in Developing Regions, 2018, www.guttmacher.org/fact-sheet/adding-it-meeting-contraceptive-needs-of-adolescents

⁹ Darroch JE et al., 2016. Adding It Up: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents, New York: Guttmacher Institute, www.guttmacher.org/report/adding-it-meeting-contraceptive-needs-of-adolescents.

¹⁰ Chae S et al., 2017. Characteristics of women obtaining induced abortions in selected low- and middle-income countries, PLOS ONE, 12(3):e0172976, <https://doi.org/10.1371/journal.pone.0172976>

¹¹ Izugbara C et al., 2013. Incidence and Complications of Unsafe Abortion in Kenya: Key Findings of a National Study, Nairobi, Kenya: Ministry of Health, Government of Kenya, www.guttmacher.org/report/incidence-and-complications-unsafe-abortion-kenya

¹² United Nations Department of Economic and Social Affairs, 2016 United Nations Demographic Yearbook, 2017, Table 14, <https://unstats.un.org/unsd/demographic-social/products/dyb/dybsets/2016.pdf>.

¹³ United Nations Department of Economic and Social Affairs, 2015 United Nations Demographic Yearbook, 2016, Table 14, <https://unstats.un.org/unsd/demographic-social/products/dyb/dybsets/2015.pdf>.

¹⁴ Juárez F et al., 2013. Embarazo no planeado y aborto inducido en México: causas y consecuencias, New York: Guttmacher Institute, www.guttmacher.org/es/report/embarazo-no-planeado-y-aborto-inducido-en-mexico-causas-y-consecuencias

¹⁵ Sully E et al., 2018. Playing it safe: legal and clandestine abortion among adolescents in Ethiopia, Journal of Adolescent Health, [www.jahonline.org/article/S1054-139X\(18\)30010-7/fulltext](http://www.jahonline.org/article/S1054-139X(18)30010-7/fulltext)

¹⁶ Sully E et al., 2018. Estimating abortion incidence among adolescents and differences in postabortion care by age: a cross-sectional study of postabortion care patients in Uganda, Contraception, [www.contraceptionjournal.org/article/S0010-7824\(18\)30388-3/fulltext](http://www.contraceptionjournal.org/article/S0010-7824(18)30388-3/fulltext)

¹⁷ Blanc et al. 2009. Patterns and Trends in Adolescents' Contraceptive Use and Discontinuation in Developing Countries and Comparisons With Adult Women, www.guttmacher.org/journals/ipsrh/2009/patterns-and-trends-adolescents-contraceptive-use-and-discontinuation

¹⁸ Blanc et al. 2009. Patterns and Trends in Adolescents' Contraceptive Use and Discontinuation in Developing Countries and Comparisons With Adult Women, www.guttmacher.org/journals/ipsrh/2009/patterns-and-trends-adolescents-contraceptive-use-and-discontinuation

¹⁹ Moore AM, Awusabo-Asare K, Madise N, John-Langba J, Kumi-Kyereme A. 2007. Coerced first sex among adolescent girls in sub-Saharan Africa: prevalence and context. Afr J Reprod Health. 11:62-82, <http://ajrh.info/index.php/ajrh/article/view/1092>

activity. When designing programmes to reach adolescents, it is important to consider their motivations for non-use of contraception despite not wanting a pregnancy. Such reason may include infrequent sex; not being married; concerns about contraceptive side effects; breastfeeding or not having resumed menstruation after a birth; and their own, their partners' or others' opposition to contraception.²⁰

For many adolescents, the first sexual intercourse is a result of coercion or violence. Studies from three sub-Saharan African countries show that the rate is higher among very young adolescent girls before age 12 (28 to 62 per cent), but also significant (21 to 28 per cent) among adolescent girls aged 12–14.²¹ In addition, child marriage disproportionately affect girls and early marriage is associated with early childbearing and motherhood. In 2016, adolescent girls younger than 15 years had an estimated 777,000 births in developing regions, the majority (58 per cent) of them in Africa, 28 per cent in Asia and 14 per cent in Latin America and the Caribbean.²²

Compared with adults, adolescent contraceptive behaviour is characterized by shorter periods of consistent use, higher contraceptive use-failure rates and greater likelihood of stopping for reasons other than the desire to become pregnant.²³ Adolescents' use of contraception is influenced by their parents, peers and sexual partners.^{24,25,26} It is also important to consider adolescents' cognitive development, recognizing that their motivation for consequential thinking and risk analysis is different from that of adults. An adolescent aged 15 and up has almost the same adaptive cognitive capacity as an adult, before that it is evolving. In addition to psychosocial and other developmental factors, the high levels of testosterone (in boys and girls) have been shown to influence motivations, largely being driven by receiving attention, particularly from peers. This influences risk-taking behaviours and undermines existing approaches to family planning and pregnancy prevention. Therefore, services and messages must be designed to address these motivations, focusing on the positive successful outcomes, rather than the negative potential risks.²⁷

Finally, few adolescents and youth identify with planning a family, or having an unmet need for family planning. Contraception is considered a more relevant concept when referring to adolescents and youth. Such insight must be carefully considered when targeting adolescents and youth with services and information.

²⁰ Sedgh G, Ashford LS and Hussain R, 2016. Unmet Need for Contraception in Developing Countries: Examining Women's Reasons for Not Using a Method, New York: Guttmacher Institute, www.guttmacher.org/report/unmet-need-for-contraception-in-developing-countries

²¹ Moore AM, Awusabo-Asare K, Madise N, John-Langba J, Kumi-Kyereme A. 2007. Coerced first sex among adolescent girls in sub-Saharan Africa: prevalence and context. *Afr J Reprod Health*. 11:62-82, <http://ajrh.info/index.php/ajrh/article/view/1092>

²² Guttmacher-Lancet Commission on SRHR. 2018, www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights

²³ Castle S. & Askew I. Contraceptive Discontinuation: Reasons, Challenges, and Solutions. Population Council and FP2020 2015, http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2015/12/FP2020_ContraceptiveDiscontinuation_SinglePage_Final_12.08.15.pdf

²⁴ Commendador KA: Parental influences on adolescent decision making and contraceptive use. *Pediatr Nurs* 2010; 36:147.

²⁵ Amialchuk A, Gerhardinger L; Contraceptive use and pregnancies in adolescents' romantic relationships: role of relationship activities and parental attitudes and communication. *J Dev Behav Pediatr* 2015; 36:86.

²⁶ Widman L, Choukas-Bradley S, Helms SW, et al: Sexual communication between early adolescents and their dating partners, parents and best friends. *J Sex Res* 2014; 51:731.

²⁷ Dahl, E.R., et al. Importance of investing in adolescence from a developmental science perspective. *Nature Res Perspective* (2018).

1.2 Barriers to using modern contraceptive methods among adolescents and youth

The barriers that adolescents and youth face with respect to contraception can be broadly classified into three categories: (a) demand-side barriers related to the contraceptive seeking-behaviour and uptake; (b) supply-side barriers related to the service provision and delivery of contraceptive services; and (c) structural and environmental barriers related to the larger economic factors, social norms and societal attitudes, policies and organizational structures that influence health service access and practices.

Demand-side barriers

Studies show that the main causes cited by women for not using contraceptives are commonly found on the demand side and are related to fear of side effects/health concerns, infrequent or no sex, opposition and breastfeeding/postpartum amenorrhea, with some variations by region.²⁸ For AY in particular, there are a number of known barriers to, or reasons for the limited use of contraception. For example, many adolescents who are sexually active may not yet be married and may have infrequent sex, therefore perceiving that contraception is not meant for them. Some adolescents do not consider themselves to be sexually active.^{29,30} Girls interviewed in Nigeria by the A360 initiative explained that they did not perceive themselves as sexually active because “she did not have sex, the boy had sex with her”. In line with this, the lack of awareness about pregnancy and contraception as well as the misconceptions around whether or not contraception is appropriate for adolescents and youth results in barriers to seeking services. Other barriers include concerns about side effects and health risks such as irregular bleeding, or no bleeding at all, misconceptions around the risk of infertility, or fear of the delay of return of fertility.³¹ Lack of support, and even active objection, from a partner or family inhibit adolescent girls’ usage of contraception particularly in contexts where social norms equate marriage with motherhood, and in contexts requiring spousal or parental consent for minors and/or women. Finally, though the relevant question in the Demographic and Health Survey (DHS) only allows citing of one reason, and cost is rarely cited as the primary reason for non-use among young women, it is likely that the cost of contraception, transportation and the opportunity cost in terms of lost income may influence usage, especially for the poorest AY.³²

Supply-side barriers

A range of studies show the importance of quality contraceptive services provision that includes confidential, respectful and comprehensive counselling, provision and removal of methods, and/or timely and functioning referral mechanisms as required. This is equally important for adolescents;

²⁸ Sedgh G et al., *Unmet Need for Contraception in Developing Countries: Examining Women’s Reasons for Not Using a Method*, New York: Guttmacher Institute, 2016, www.guttmacher.org/report/unmet-need-for-contraception-in-developingcountries.

²⁹ Guttmacher. “Adding It Up: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents”, www.guttmacher.org/fact-sheet/adding-it-meeting-contraceptive-needs-of-adolescents

³⁰ Castle S. & Askew I. *Contraceptive Discontinuation: Reasons, Challenges, and Solutions*. Population Council and FP2020. 2015,

http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2015/12/FP2020_ContraceptiveDiscontinuation_SinglePage_Final_12.08.15.pdf

³¹ Paul, M. et al. 2015. *Qual Health Res. Negotiating Collective and Individual Agency: A Qualitative Study of Young Women’s Reproductive Health in Rural India*, <https://journals.sagepub.com/doi/full/10.1177/1049732315613038>

³² Sedgh G, Ashford LS and Hussain R, 2016. *Unmet Need for Contraception in Developing Countries: Examining Women’s Reasons for Not Using a Method*, New York: Guttmacher Institute, www.guttmacher.org/report/unmet-need-for-contraception-in-developing-countries

however, services must also ensure responsiveness to adolescents' particular needs and ensure a welcoming atmosphere, which is often not the case. Instead, adolescents often face additional discrimination or are refused the services they are entitled to. In spite of clear evidence and clinical guidance, contraceptive services continue to be of poor quality in many parts of the world for reasons including lack of skills and supportive supervision, insufficient human resources and time with the patients, and fragmented health services. The availability of a range of different methods is often limited by stock-outs and suboptimal supply chain management.³³ Accessibility also plays an important role and is facilitated through flexible service hours, well-located clinics and where the contraceptive service provision is situated within the health facility. Family planning services are often situated within the maternity ward, demotivating AY from seeking care because it is perceived as a service only for girls and women who are pregnant and/or married.

Stigma and restrictive norms around contraceptive use and around SRH services more generally can affect the quality of services. Health care providers are often not comfortable talking about issues related to sexual and reproductive health.³⁴ Numerous studies have shown that groups such as adolescents, unmarried women and girls, adolescents and youth living with disabilities, and young key populations perceive lack of respect and other barriers to using their method of choice due to the unwillingness to provide a service based on the moral convictions of the health care provider.³⁵

Structural and environmental barriers

Gender inequality and discriminatory social and gender norms restrict adolescent girls' ability to exercise their rights and make informed choices about their lives, particularly in relation to their sexual and reproductive health. Gendered social norms operating in communities as well as in families not only act as a barrier for adolescent girls and boys, and young women and men seeking services but also make it difficult for providers to justify serving adolescents, sometimes even jeopardizing their position in their communities. It is therefore important to promote positive and equitable gender norms to improve contraceptive use and acceptance among adolescents and youth, both in the community as well as among adolescents and youth themselves.

Laws and policies mandating spousal or parental consent for minors, especially girls, to obtain sexual and reproductive health services, including contraceptive methods, pose serious barriers to adolescents' access to and use of such services. The consent laws and minimum ages are often set in an arbitrary manner, informed by social and gender norms instead of evidence on developmental stages and life events of adolescents. Social norms around sexual activity varies across different contexts; however, sex before marriage is often frowned upon, which results in a reluctance to allow unmarried adolescents to use contraceptive methods and subsequently makes it difficult for them to obtain a consent from a guardian. Similarly, in communities where proving fertility is important soon after marriage, contraceptive methods may be frowned upon or discouraged by spouses and/or the extended family. The mere presence of these restrictions deepens stigma, misconceptions and fear around seeking services.

³³ UNFPA background paper on contraceptive supplies prepared for the Global Consultation on Ending Unmet Need for Family Planning in Antalya, Turkey, June 2019.

³⁴ Paul, M. et al. *Glob Health Action*. 2016; 9: 10. Healthcare providers balancing norms and practice: challenges and opportunities in providing contraceptive counselling to adolescents and youth in Uganda – a qualitative study, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4865766/>

³⁵ WHO. 2015. Global standards for quality health-care services for adolescents: a guide to implement a standards-driven approach to improve the quality of health care services for adolescents. Volume 1: Standards and criteria, https://apps.who.int/iris/bitstream/handle/10665/183935/9789241549332_vol1_eng.pdf?sequence=1

2. What will it take to meet the contraceptive needs of adolescents and youth?

2.1 Quality of care for adolescents and youth

Quality underpins the entire approach to adolescent and youth sexual and reproductive health and rights (AYSRHR) service provision. This is because quality care is a right and quality care increases the likelihood that adolescents and youth will use the services they need. A few components are particularly important to keep in mind. AY-responsive contraceptive service provision includes understanding the clients' needs and fertility goals that are, for example, very different for younger populations who may have a higher need to delay pregnancies compared with married and unmarried adolescents and youth. Contraceptive counselling must include comprehensive information about the advantages and disadvantages of different method options, including potential side effects, in order to manage expectations and mitigate discontinuation. It must also clearly communicate the possibility of switching methods, including feasible access to removal services for long-acting reversible contraception (LARC), including intrauterine devices (IUDs).

Health care providers must be supported in acquiring the right skills (both pre-service and in-service) and be supervised in order to be able to provide quality counselling and care to AY. Values clarification and attitude transformation exercises can help providers manage personal and professional values.

2.2. An integrated approach to services responsive to adolescents and youth

The concept of youth-friendly services (YFS) has its origins in observations that adolescents and youth hesitate to seek services in health clinics and hospitals, which were perceived as not being welcoming, not responsive to the needs of adolescents and youth, and disease-centric and curative (rather than positive and preventive). YFS have been and still are often conceived as stand-alone clinics, generally in the shape of a youth centre. However, evidence from 21 studies shows that such mixed-use youth centres are neither well-attended nor effective at improving SRH outcomes, and are often difficult to take to scale.³⁶ For adolescents in low- and middle- income countries, the most effective approaches as measured by uptake of SRH services or commodities, and biological outcomes, are approaches that provide both information and services, using a combination of health worker training; adolescent-friendly facility improvements; and working through the community, schools and mass media.^{37,38} In an adolescent-centred primary care initiative in the United States of America that focused on improved quality of care, health sites identified and trained a multidisciplinary champion team, who together identified areas for improvement and made a plan to address these areas. The most common changes made to health sites included: initiating a method to gather feedback from adolescent patients; adding trainings on confidentiality, cultural humility and using a non-judgmental approach; offering other services such as immunizations; and training

³⁶ Zuurmond MA1, Geary RS, Ross DA.. 2012. The effectiveness of youth centers in increasing use of sexual and reproductive health services: a systematic review, <https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1728-4465.2012.00324.x>

³⁷ Denno DM, Hoopes AJ, Chandra-Mouli V. Effective strategies to provide adolescent sexual and reproductive health services and to increase demand and community support. *J Adol Health*. 2015;56(Suppl 1):S22-S41, [www.jahonline.org/article/S1054-139X\(14\)00424-8/fulltext](http://www.jahonline.org/article/S1054-139X(14)00424-8/fulltext)

³⁸ Hainsworth G, Engel DM, Simon C, Rahimtoola M, Ghiron LJ. Scale-up of adolescent contraceptive services: lessons from a 5-country comparative analysis. *J Acquir Immune Defic Syndr*. 2014;66 Suppl 2:S200-S208, https://journals.lww.com/jaids/fulltext/2014/07011/Scale_up_of_Adolescent_Contraceptive_Services__8.aspx

providers in LARC provision.³⁹ The improvements resulted in significantly improved patient experiences with both their provider and the site overall.

Key elements (with demonstrated effectiveness) from stand-alone youth-friendly services can be integrated into existing service delivery channels in order to provide SRHR, including contraceptive services responsive to the needs of AY. Key elements include ensuring providers are well trained and appropriately skilled; facilities are accessible and welcoming; enforcing confidentiality, privacy and respectful care; offering a wide range of contraceptive methods; and providing free or subsidized services.⁴⁰ Such an approach is both sustainable and scalable and goes hand in hand with the call for universal health coverage. At the same time, dedicated health service delivery points and outreach work in the YFS model may still play a useful role in reaching marginalized and stigmatized groups of adolescents (such as injection drug users), who may be reluctant to use a service delivery point that is open to all.⁴¹

Laws and policies around age of consent to various services that are part of the SRHR package must create a supportive rather than prohibitive environment. Age of consent should be based on the adolescent's sufficient maturity to understand the risks, benefits and consequences of the medical treatment. Laws and policies should explicitly support the access of all adolescents and youth with a need for contraceptive services to be able to access services without any hindrance. Additional provisions in legislation should clearly state that health care providers need to respect the views and opinions of the adolescent or young person accessing a service and their right to confidentiality. The age of consent for HIV testing and pre- and post-counselling has been set at 12 (without parental consent) in several countries.⁴² As for HIV, a similar discussion should be had regarding contraception for adolescents, with clear recommendations to policymakers to guide policy processes.

2.3 Expanding the method mix for adolescents and youth

A rights-based approach to health service delivery refers to the integration of human rights norms and principles in the design, implementation, monitoring and evaluation of health-related policies and programmes. These include human dignity, equity including the needs and rights of vulnerable groups, and an emphasis on ensuring that health services and information are made accessible to all.⁴³ A rights-based approach in the context of contraceptive service provision to AY includes offering method choice, respectful counselling around the full range of options, and tailoring the order of options presented based on the young person's goals and needs regardless of age, gender, marital status and other social categories – while, at the same time, informing them of the effectiveness of each method, possible side effects, including action to take if experienced as well as understanding that different methods work better for different people. This requires that service providers are knowledgeable about all methods and their feasibility for AY, and are trained to provide confidential

³⁹ Riley, M et al., *J of Ped* 2017: 193. The adolescent Champion Model: Primary Care Becomes Adolescent-Centered via Targeted Quality Improvements.

⁴⁰ HIP Brief: Adolescents friendly contraceptive services: Mainstreaming AF elements into existing contraceptive services (2015), www.fphighimpactpractices.org/briefs/adolescent-friendly-contraceptive-services/

⁴¹ World Health Organization. 2012. Making health services adolescent friendly: developing national quality standards for adolescent friendly health services. https://apps.who.int/iris/bitstream/handle/10665/75217/9789241503594_eng.pdf?sequence=1

⁴² UNFPA. 2017. Harmonizing the Legal Environment for Adolescent Sexual and Reproductive Health and Rights: A review of 23 countries in East and Southern Africa <https://esaro.unfpa.org/en/publications/harmonizing-legal-environment-adolescent-sexual-and-reproductive-health-and-rights-0>.

⁴³ Gloppen et al. 2013. Operationalizing a Rights-Based Approach to Health Service Delivery. Chr. Michelsen Institute, www.cmi.no/projects/1791-operationalizing-a-rights-based-approach-to-health

and respectful counselling. Finally, it means that AY can meaningfully influence relevant programmes and policies to ensure that they address their needs and meet adolescents and youth where they are.

Service provision to adolescents and youth is often influenced by the providers' personal values, social norms and a lack of awareness regarding the safety and appropriateness of different methods for AY. Service providers may prefer counselling AY to abstain from sex or to use condoms and/or oral pills, while being reluctant to introduce long-acting reversible methods such as IUDs or contraceptive implants. Evidence shows that LARCs are safe and feasible for adolescents and youth. Through training and capacity building, changing perceptions and changing gender and social norms, more providers understand the importance of, and feel comfortable with, offering the complete method mix to AY tailored to their needs. In some guidelines, LARCs are recommended as first-line contraceptive methods for adolescents, and service providers are encouraged to counsel about LARCs even before suggesting an oral contraceptive or another less effective method.⁴⁴ Rather than emphasizing one method over the other, however, it is important that counselling should take a rights-based approach and be tailored based on the reproductive intention and reality of the client and allow for informed choices, empowered by the information that all methods are suitable and safe for adolescents.

A common challenge with respect to contraceptive use is addressing discontinuation of use, which tends to be higher among adolescents and youth and in relation to user-controlled methods. The majority of women who discontinue for reasons other than wanting a child or no longer needing protection report that they do so due to "method-related concerns".⁴⁵ This is true of adolescents as well; for example, one of the most common reasons for discontinuation of a LARC method among adolescents is concern over side effects.^{46,47} Discontinuation can be mitigated by providing timely, comprehensive and accurate information at the time of initiation of the method, as well as appropriate information and counselling support throughout the use of the method, ensuring confidentiality, and engaging male partners when in agreement with the wishes of the female client. A study in the United States showed that adolescents were more likely to continue with their LARC if they had access to information about LARCs, and were offered accessible and targeted information in a mobile application.⁴⁸ The availability of non-judgmental and quality removal and counselling services is a critical aspect of rights-based provision of LARCs.

It is important to note that LARCs, with their high effectiveness and ease of use, do not protect against STIs including HIV. Counselling must emphasize the dual protection benefits (preventing unintended pregnancy as well as STIs) of condoms and encourage their use as a compliment, or alternative, to LARCs. Similarly, the advent of pre-exposure prophylaxis for HIV prevention

⁴⁴ K. R. Francis, J., A. Gold, M. JAMA Pediatrics (2017); 171:7. Long-acting reversible contraception for adolescents, a review.

⁴⁵ Castle S. & Askew I. Contraceptive Discontinuation: Reasons, Challenges, and Solutions. Population Council and FP2020. 2015 http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2015/12/FP2020_ContraceptiveDiscontinuation_SinglePage_Final_12.08.15.pdf

⁴⁶ McNicholas C, Peipert JF: Long-acting reversible contraception (LARC) for adolescents. *Curr Opin Obstetr Gynecol* 2012; 24:293, [www.ajog.org/article/S0002-9378\(17\)30171-0/fulltext](http://www.ajog.org/article/S0002-9378(17)30171-0/fulltext)

⁴⁷ Teal SB, Sheeder J: IUD use in adolescent mothers: retention, failure and reasons for discontinuation. *Contraception* 2012; 85:270.

⁴⁸ S.E. Timmons, et al, *J Pediatr Adolesc Gynecol* 31 (2018) 285-290 MyLARC: A theory-based interactive smartphone app to support adolescents' use of LARC.

(PREP/PEP) should not diminish the importance of access to and use of condoms⁴⁹ and modern contraceptive methods.

Emergency contraception (EC) prevents unintended pregnancies and abortion after unprotected or underprotected sex and is safe and effective for AY.⁵⁰ Service providers must be knowledgeable about all EC methods⁵¹ and their feasibility for AY, and are encouraged to provide confidential and respectful counselling about EC during both acute and routine health care visits.⁵²

2.4 A positive approach to providing SRHR services for adolescents and youth

Sexual and reproductive health services often focus on preventing negative consequences associated with sexuality and reproduction. However, a person who is healthy and sexually active, may not identify as a patient in need of care, and would not see the need to go to a health facility for services. The biomedical approach to SRH services fails to acknowledge an individual's sexual rights, their agency, as well as their particular desires, relationships and pleasures. More broadly in the field of youth development, there is recognition that rather than problematizing adolescents and youth, approaches must be intentional and prosocial, engaging them in a manner that is productive and constructive, recognizing and enhancing their strengths, providing opportunities, fostering positive relationships and furnishing the support they need.⁵³ Only then can young people participate fully and contribute to the development of their communities. New positive approaches, underpinned by human rights, in the field of AYSRHR include the positive youth development approach, the pleasure approach, as well as aspirational counselling, which can be useful for many subpopulations of AY.⁵⁴

The positive youth development (PYD) approach⁵⁵ takes a holistic approach to AY programming recognizing the interplay between an enabling environment including access to services and information and an enabling policy environment; agency pertaining to self-efficacy, positive identity and life skills; assets such as training, education and interpersonal skills; and contributions in the form of youth engagement. Positive youth development engages youth along with their families, communities and/or governments so that youth are empowered to reach their full potential. In a systematic review, about half of all programmes using a PYD approach or components of the approach focused on SRHR and HIV. Using this approach has been proven to increase the self-efficacy of adolescents and youth to use condoms and to reduce sexual risk behaviours leading to

⁴⁹ Holt et al. 2018. Community-level changes in condom use and uptake of HIV pre-exposure prophylaxis by gay and bisexual men in Melbourne and Sydney, Australia: results of repeated behavioural surveillance in 2013–17. [https://doi.org/10.1016/S2352-3018\(18\)30072-9](https://doi.org/10.1016/S2352-3018(18)30072-9).

⁵⁰ The Society for Adolescent Health and Medicine. Emergency Contraception for Adolescents and Young Adults: Guidance for Health Care Professionals. *Journal of Adolescent Health* 58 (2016) 245–248, www.adolescenthealth.org/SAHM_Main/media/Advocacy/Positions/Emergency-Contraception-Statement-Paper-SAHM.pdf

⁵¹ The copper IUD is the most effective option for emergency contraceptive; however, there are also a range of different hormonal pills, often referred to as the 'day after pill', that can prevent pregnancy when taken a limited time after unprotected intercourse.

⁵² The Society of Adolescent Health and Medicine have compiled a set of recommendations including in which clinical and service provision settings EC should be provided, means of provision to adolescents and young adults, as well as advocacy messages to ensure an enabling environment.

⁵³ Interagency Working Group on Youth Programs. Positive Youth Development, <https://youth.gov/youth-topics/positive-youth-development>

⁵⁴ Urban poor or rural adolescents, particularly girls, may or may not identify with these approaches. This paper recognizes the diversity in adolescent experiences.

⁵⁵ Youth Power, www.youthpower.org/positive-youth-development

fewer partners, less unprotected sex and fewer incidents of unwilling sex among girls. The PYD approach also has been shown to increase self-efficacy to use contraceptives and has been associated with reduction in adolescent pregnancy, reduction of HIV related stigma and more youth using SRH services.⁵⁶

The pleasure approach refers to using pleasure as an entry point to talking about sexual and reproductive health, particularly safe sex and links sexual health, sexual well-being and sexual rights. It offers a platform for a broader discussion and a positive focus on sexuality and sexual health, guiding people to make informed choices about sexual relationships and to avoid risks.⁵⁷ Research from Malawi suggests that family planning programmes should consider the nuanced ways in which notions of sexual pleasure, partner dynamics and the broader social context influence contraceptive use.⁵⁸ Research also shows that when girls internalize the message that they should not be enjoying sex, they are less likely to negotiate terms of sex, i.e. less likely to insist that their partners use condoms.⁵⁹ The pleasure approach aims to move away from medicalizing an agenda that is positive and personal, while recognizing that pleasure is just one of the many possible motivators for and goals of sex. Moreover, using pleasure as an entry point allows for a non-heteronormative conversation, including masturbation.

Aspirational counselling refers to meeting adolescents where they are in their life situation and offering contraception as a means to achieving their life goals. It is grounded in adolescents' aspirations and opportunities, and supports AY in navigating life choices, offering contraception as one important way of taking control of their life course as a means of seeking to fulfil their dreams. Tailored messages, making contraception relevant for adolescents, have shown to increase uptake and continuation of modern contraception in Ethiopia and Nigeria. The consortium Adolescents 360 (A360) is "sparking a girl-powered revolution" by fusing AYSRHR with adolescent developmental science, cultural anthropology, social marketing and Human Centred Design (HCD), with the goal of increasing the demand for and voluntary uptake of modern contraceptives among adolescent girls aged 15-19 across Nigeria, Tanzania and Ethiopia. Marie Stopes International recently introduced their approach to aspirational counselling referred to as the Divine Divas, by providing different profiles of girls that clients can relate to. The rationale is that by leading with a vision of who girls want to be, rather than focusing on side effects and clinical outcomes, the Divine Divas help teens imagine a desirable future for themselves, facilitated by deferring motherhood through use of contraception. This allows the use of contraception to be compellingly positioned as a lifestyle choice, which is often unacknowledged.

2.5 Promoting access to comprehensive sexuality education

Contraceptive services must be provided in a context of age-appropriate gender-responsive comprehensive sexuality education (CSE) for AY that gives them the knowledge, skills, attitudes and values to realize their health, well-being and dignity. Comprehensive sexuality education is a

⁵⁶ Youth Power. Systematic Review of Positive Youth Development in Low- and Middle-Income Countries. 2017, www.youthpower.org/systematic-review-pyd-lmics

⁵⁷ Global Advisory Board for Sexual Health and Well-Being. SEXUAL PLEASURE: The forgotten link in sexual and reproductive health and rights. 2019, www.gab-shw.org/resources/training-toolkit/

⁵⁸ Neetu A. John, Stella Babalola and Effie Chipeta. International Perspectives on Sexual and Reproductive Health Sexual Pleasure, Partner Dynamics And Contraceptive Use in Malawi. Vol. 41, No. 2 (June 2015), pp. 99-107, www.guttmacher.org/sites/default/files/article_files/4109915.pdf

⁵⁹ Philpott A, Knerr W, Maher D. Promoting protection and pleasure: amplifying the effectiveness of barriers against sexually transmitted infections and pregnancy. *Lancet*. 2006;368:2028-2031, [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(06\)69810-3/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(06)69810-3/fulltext)

curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It helps AY develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and to understand and ensure the protection of their rights throughout their lives. It provides information on preventing unintended pregnancy and STIs, but also goes beyond reproduction, risk and disease and provide skills necessary to fulfil one's rights and choices.

CSE is a powerful and critical non-health sector complement to contraception. CSE has been shown to contribute to delayed initiation of sexual intercourse, decreased frequency of sexual intercourse, decreased number of sexual partners, reduced risk-taking, increased use of condoms and increased use of contraception. High-quality evidence supports the provision of multi-components interventions, especially linking school-based sexuality education with youth-friendly services that are not based in schools, including condom distribution.⁶⁰

While it is delivered primarily through schools, CSE can also be delivered in non-formal settings, such as community centres, sports clubs, scout clubs, faith-based organizations, vocational facilities, health institutions and online platforms, among others. The link between CSE (in- and out-of-school) and health service provision is important to ensure that the demand side and supply side are aligned, and operate in a complementary manner. For example, CSE provides a platform for health care providers to visit schools to provide information and sometimes services. Another important link is school health, linking the school nurse with provision of CSE, ensuring the availability of information materials as well as an adult to turn to for questions.

Particularly vulnerable categories of AY (definitions vary by contexts) may require a more intensive asset-building approach where information is combined with health, social, economic and other cognitive assets that help them navigate and be resilient in the face of risks, including unsafe and nonconsensual life transitions. This kind of intensive approach requires multi-sectoral convergence, often through community-based platforms, as well as addressing relevant structural factors, encompassing among other things, ensuring access to cash transfers and other forms of social protection, promoting literacy and numeracy, and economic empowerment.

Using digital technology to support AYSRHR

Technology will increasingly support comprehensive sexuality education as well as access to information and services. Mobile phones, tablets, personal digital assistants and wireless infrastructure are used for a wide range of digital health applications in education, diagnosis and treatment support and supply chain management, among other uses.

Mobile Health (mHealth) has grown tremendously over the past decade, yet mHealth for the sexual and reproductive health and rights of adolescents and youth remains in its early stages. Most available examples are limited to smaller-scale pilots and experiments. Currently, most projects use mHealth as a health promotion tool to facilitate knowledge-sharing and behaviour change to improve AYSRHR. A few projects use mHealth as a way to link users to essential SRH services, including family planning counselling and services, medical abortion and post-abortion care, and HIV care and treatment. Almost three-quarters of these projects rely on text messaging. Overall, findings suggest that mHealth interventions are becoming a more common method to connect youth to SRHR information and services in low- and middle-income countries, and evidence is emerging that mobile

⁶⁰ UN. 2018. International technical guidance on sexuality education An evidence-informed approach, www.unfpa.org/sites/default/files/pub-pdf/ITGSE.pdf

phones are an effective way to reach adolescents and youth and to achieve knowledge and behaviour change.⁶¹

Digital technology can improve access to and quality of CSE for in-school and out-of-school AY, with appropriately-designed formal curriculum, in a user-friendly format that may even meet the needs of low-literacy audience.^{62,63} It can provide a critical linkage between CSE and information about the accessibility and availability of adolescent- and youth-friendly services. It can also serve as in-service capability strengthening for teachers and health service providers involved in the delivery of CSE⁶⁴.

Phone applications (apps) for menstrual health have become particularly popular among both adolescents and young adults, offering a period tracking function combined with information about the cycle, symptoms and fertility. Importantly, fertility monitoring applications are garnering increased attention as an alternative to hormonal contraceptive methods. The first phone application combined with temperature measurement was recently approved in both Sweden and the United States as a modern method of contraception.⁶⁵ In Sweden, however, the app has raised serious concerns after a high number of unintended pregnancies were reported by app users.⁶⁶ Similarly, estimates used to market the app in the United States were proven flawed and unreliable, and the app is not as effective as a contraceptive method as it initially set out to be.⁶⁷

Opportunities to use mHealth for accountability regarding the quality of services, mapping of service providers, follow-up care and timely information to AY should be further explored and tested. A study in the United States showed that discontinuation of LARCs decreased significantly after a phone application targeting adolescents using LARCs offered readily available, confidential information.⁶⁸ In addition, more understanding is needed about the challenges of data privacy and phone access, especially among younger adolescents. Overall, more evidence is needed to understand the effectiveness and efficacy of the use of mHealth, including through phone apps for contraceptive information and services for adolescents and youth.

⁶¹ Ippoliti and L'Engle. 2017. Meet us on the phone: mobile phone programs for adolescent sexual and reproductive health in low-to-middle income countries, <https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-016-0276-z>

⁶² Bailey J, Mann S, Wyal S, Hunter R, Free C, Abraham C, Murray E. Sexual health promotion for young people delivered via digital media: a scoping review. Southampton (UK): NIHR Journals Library. 2015, www.ncbi.nlm.nih.gov/books/NBK326984/

⁶³ Oosterhoff P, Müller C, Shephard K. 2017. Introduction: Sex Education in the Digital Era. *IDS Bulletin, S.I.*, 48: 1. Available at: <https://bulletin.ids.ac.uk/idsbo/article/view/2841>

⁶⁴ Vanwesenbeeck I, Westeneng J, de Boer T, Reinders J, van Zorge R. 2016. Lessons learned from a decade implementing Comprehensive Sexuality Education in resource poor settings: The World Starts With Me, *Sex Education*, 16:5, 471-486. Available at: www.tandfonline.com/doi/full/10.1080/14681811.2015.1111203

⁶⁵ U.S. Food and Drug Administration. 2018. FDA allows marketing of first direct-to-consumer app for contraceptive use to prevent pregnancy, www.fda.gov/news-events/press-announcements/fda-allows-marketing-first-direct-consumer-app-contraceptive-use-prevent-pregnancy

⁶⁶ Swedish Medical Products Agency. 2018. The assessment of Natural Cycles is completed, <https://lakemedelsverket.se/english/All-news/NYHETER-2018/The-assessment-of-Natural-Cycles-is-completed/>

⁶⁷ Polis, C.B. Published analysis of contraceptive effectiveness of Daysy and DaysyView app is fatally flawed. *Reprod Health* 15, 113 (2018) doi:10.1186/s12978-018-0560-1 <https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-018-0560-1>.

⁶⁸ S.E. Timmons, et al, *J Pediatr Adolesc Gynecol* 31 (2018) 285-290 MyLARC: A theory-based interactive smartphone app to support adolescents' use of LARC.

2.6 Strengthening the evidence base and promoting research

Large gaps in the understanding of AY contraceptive needs and use, and on AYSRHR more broadly, hinder progress. Below are some of the key gaps, and measures to address these gaps.⁶⁹

Coverage gaps: There are substantial gaps in service coverage data for AY. The gaps are larger for some specific subgroups of AY, including adolescents aged 10–14, unmarried/never-married girls and women, and boys and young men – all of which are groups that the DHS does not cover consistently or at all. Interest in the SRHR of adolescents and youth in vulnerable situations is increasing, including for those living in humanitarian settings, and those who are physically and mentally challenged.

Underreporting gaps: Events that are reported less frequently than they actually occur such as sexual activity and induced abortion are considered “underreporting gaps”. This is often due to gender norms, social norms, stigma and discrimination, among other factors.

Substantive gaps: Under-researched issues primarily around the dynamics of contraceptive decision-making, and determinants and impacts of contraceptive behaviour are considered “substantive gaps”. A better understanding is needed regarding the influence of early marriage, sexual violence and low levels of education on contraceptive use and childbearing; the health and long-term economic impacts of adolescent pregnancy and childbearing; adolescents’ childbearing intentions; and the complex interplay of reasons for unmet need for family planning and non-use among adolescents and youth (as opposed to a single reason). Critically, current frameworks do not easily permit the monitoring of the progress of adolescents within the Sustainable Development Goals.

Gaps in operational knowledge include the effectiveness of different interventions across different contexts and subgroups of AY; how to scale and sustain service delivery models for AYSRHR; the cost, content and quality of private and public sector services; monitoring the protection of AY rights in service delivery; and the role of youth participation and leadership in increasing access to contraceptive services among AY.

Implications for addressing data and evidence gaps in AYSRHR

Finer disaggregation of data: The adolescent age category of 10 to 19 years is broad, and although data is sometimes categorized into very young adolescents (aged 10–14) and older adolescents (aged 15–19), the realities of a 10-year-old differ from those of a 14-year-old, for example. Age disaggregation of available data within the adolescent category (down to single ages if possible) would reveal life trajectories that are actionable from a policy or programmatic perspective.

Expanding the ages sampled: To address the data gaps in the very young adolescent category (10–14), the sample age range should be lowered for DHS and other sexual and reproductive health surveys in countries where data already show sizeable proportions of young women beginning sexual activity and even childbearing before age 15. Uganda serves as a good example in this regard as it included adolescents 12 years and older in the latest DHS. To bridge the existing gap in data on very young adolescents, data can be collected retrospectively with respondents older than 15 on their experiences prior to age 15. Such an approach, notwithstanding the potential of recall bias, also overcomes potential ethical or cultural barriers to collecting data from this age group.

Including new questions: National surveys including DHS and Multiple Indicator Cluster Surveys (MICS) should be reviewed and tailored to include questions relevant to AYSRHR, including questions

⁶⁹ Darroch JE et al., *Research Gaps in Adolescent Sexual and Reproductive Health*, New York: Guttmacher Institute, 2016, www.guttmacher.org/report/research-gaps-in-sexual-and-reproductive-health

on multiple reasons for non-use, AY sexual behaviour and abortion. Vital statistics systems also represent an important opportunity to collect data, on marital status for example.

Improving current indicators: Adolescents may not report being sexually active, which would result in an underestimation of unmet need for family planning. Additionally, in many countries, unmet need for family planning is only calculated for women aged 15–49 who are married or in union, excluding unmarried adolescents.

Data collection methodologies: New approaches have been developed to improve reporting on sensitive data through self-guided interviews using tablets, mobile phones and other technology. These methodologies can help improve validity of data for behaviours or outcomes that are usually under-reported. They can also be useful in contexts where there are cultural sensitivities around AYSRHR.

Attention must be given to ethical concerns when collecting data on minors, particularly on very young adolescents and the AY who are furthest behind.⁷⁰ Data collection should follow an adapted and tailored informed consent process, recognizing the power dynamics that are often at play during the data collection encounter, as well as limited literacy and understanding of content.

Specialized studies: Qualitative and in-depth quantitative research, including longitudinal studies, are needed on issues including those mentioned under substantive gaps above (e.g. sexual activity, abortion, contexts, impacts and intentions). Implementation research can be employed to understand delivery mechanisms for SRH services for adolescents and youth.

Some excluded groups cannot be reached by household surveys and require focused attention and targeted sampling and data collection. Ensuring data collection on those furthest left behind requires including data on contraceptive use among migrant AY, internally displaced AY, international refugee AY, nomadic AY, indigenous groups, non-binary and trans AY, among other groups.

Service data and accountability: More and better evaluations of service provision are needed. To collect meaningful data on quality service provision, a set of indicators for monitoring the protection and promotion of human rights in sexual and reproductive health services for adolescents and youth should be developed, validated and integrated into health information systems. Better quality routine data can enhance the understanding of coverage, and can be used in plans for improving health system capacities.

In countries where service provision to minors is restricted, recording or asking for age at the service encounter can be problematic. In such countries broader five-year age categories can be explored, or a tick-box for the adolescent category, indicating that the person is between 10 and 19 years old.

Allowing AY users to provide feedback to service provision through easily available phone applications or SMS services can serve as a means of assessment as well as accountability, holding providers and facilities accountable to their duties as care providers as well as informing other AY where quality services are provided.

⁷⁰ World Health Organization. 2018. Guidance on ethical considerations in planning and reviewing research studies on sexual and reproductive health in adolescents, www.who.int/reproductivehealth/publications/adolescence/ethical-considerations-srh-research-in-adolescents/en/

3. Emerging issues/neglected areas

3.1 Equity: Reaching the adolescents and youth furthest behind

AY constitute a diverse group with different needs, realities and opportunities. Special attention must be given to vulnerable AY, including those with lower educational levels, those living in poverty, married girls, pregnant girls, AY with disabilities, AY who identify as non-binary, as well as AY living at the intersection of multiple issues.

Although programming and service delivery interventions should aim for scale and integration into existing systems, it is important to recognize that some population groups require targeted approaches, and may fall through the cracks of scale platforms designed to reach the “average” young person. This must be reflected in interventions, and is particularly relevant for certain groups of AY that may not present at the health facility to seek AYSRHR services. Guidelines must recognize the specific needs of these groups and, to the extent possible, address them in service provision as well as training of service providers.

3.2 HIV prevalence and contraception

Adolescents and youth (aged 15–19) are the only age group in which new HIV infections are increasing globally. HIV remains among the top 10 leading causes of death among adolescents aged 10–19. In sub-Saharan Africa, adolescent girls and young women aged 15–24 continued to account for one in four HIV infections in 2017, despite constituting only 10 per cent of the population. Moreover, levels of HIV knowledge among adolescents and youth show declining trends, and major demographic changes are under way in the most-affected regions. With the current HIV prevention investments, it is estimated that about 50 million more adolescents will become infected with HIV between 2018 and 2030.⁷¹

Implications for programming and service delivery

Quality comprehensive sexuality education and integrated SRH services for adolescents and youth are key interventions for curbing the HIV epidemic among adolescents. However HIV interventions have traditionally been in silos and therefore not integrated into a holistic approach to AYSRHR. The global community is recognizing the importance of integrating HIV testing, counselling and treatment and making such services responsive to AY. However, efforts and investments in the broader and integrated approach – not only earmarked for HIV – are urgently needed to facilitate this process. Equally important are the guidelines and learning on precisely how services can be better linked. For example, adolescents and youth who seek contraceptive counselling, safe abortion services, HPV vaccination and other SRH services should at the same be offered free voluntary STI testing services and information, including HIV testing in epidemic countries or for key populations.⁷² Addressing the particular needs of young key populations⁷³ is similarly vital given the multiple risks and vulnerabilities they face, including criminalization.

⁷¹ UNAIDS. .2018. “Miles to Go”, www.unaids.org/sites/default/files/media_asset/miles-to-go_en.pdf

⁷² World Health Organization. 2015. Consolidated guidelines on HIV testing services, https://apps.who.int/iris/bitstream/handle/10665/179870/9789241508926_eng.pdf?sequence=1

⁷³ Key populations are defined groups who due to specific higher-risk behaviours are at increased risk of HIV, irrespective of the epidemic type or local context. They often have legal and social issues related to their behaviours that increase their vulnerability to HIV. The five key populations are men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers, and transgender people.

3.3 Non-contraceptive benefits and risks of contraception

A growing body of evidence points to both the benefits and risks associated with hormonal contraceptive methods. Potential negative effects tend to get disproportionate media coverage, and many girls and women worry about side effects. Some factors related to contraceptive use may be particularly important to consider when interfacing with AY:

- AY may worry about weight gain, and the influence of hormones on emotional well-being. There is no proven association between hormonal contraception and weight gain or depression.^{74,75} However, a recent study suggests oral contraception may potentially have some impact on emotional well-being including a potential increase in anxiety and stress.^{76,77}
- Some contraceptive methods can result in persistent bleeding, and others can suppress menstruation.^{78,79} In some contexts, not having a period may be associated with disease or dysfunction⁸⁰ that users, including adolescents and youth, may be sensitive to. In countries where anaemia is common, however, suppressed periods can result in important health benefits, preventing or treating anaemia.
- Many adolescents start their contraceptive use for reasons other than prevention of pregnancy, including to treat acne, premenstrual syndrome, menstrual cramps and endometriosis symptoms. Known positive effects of IUDs and oral pills include decreased risk of cervical and endometrial cancer among women.^{81,82} One of their negative effects may include a slight increase in the risk of breast cancer, as indicated in a recent study.^{83,84}
- A new trial is investigating the potential effects of contraceptive use on HIV infection. Results will be disseminated in 2019 but it already underscores the need for integrating programme

⁷⁴ Institute for Quality and Efficiency in Health Care (IQWiG). 2017. Contraception: Do hormonal contraceptives cause weight gain? www.ncbi.nlm.nih.gov/books/NBK441582/

⁷⁵ The Ohio State University Wexner Medical Center. (2018, February 26). No link between hormonal birth control and depression: Research eases fear around hormonal contraceptive side effects. *ScienceDaily*. www.sciencedaily.com/releases/2018/02/180226085756.htm

⁷⁶ Rike Pahnke, Anett Mau-Moeller, Martin Junge, Julia Wendt, Mathias Weymar, Alfons O. Hamm, Alexander Lischke. Oral Contraceptives Impair Complex Emotion Recognition in Healthy Women. *Frontiers in Neuroscience*, 2019;12 DOI: 10.3389/fnins.2018.01041

⁷⁷ Montoya, E.R., Bos, A.P., How Oral Contraceptives Impact Social-Emotional Behavior and Brain Function. *Trends Cogn Sci*. 2017 Feb;21(2):125-136. doi: 10.1016/j.tics.2016.11.005. Epub 2017 Jan 12, [www.cell.com/trends/cognitive-sciences/fulltext/S1364-6613\(16\)30197-8](http://www.cell.com/trends/cognitive-sciences/fulltext/S1364-6613(16)30197-8)

⁷⁸ Stubblefield. 1994. Menstrual impact of contraception. *Am J Obstet Gynecol*. 1994 May;170(5 Pt 2):1513-22.

⁷⁹ Hillard, 2014. Menstrual suppression: current perspectives, www.dovepress.com/menstrual-suppression-current-perspectives-peer-reviewed-article-IJWH

⁸⁰ As a recently married young woman in parts of India, menstruation may allow a visit to their maternal home, a rest from household chores, or provide a pocket of not having to negotiate sexual intercourse with their husbands. Contraception completely limiting or removing monthly bleeding may therefore not be attractive, <https://journals.sagepub.com/doi/full/10.1177/1049732315613038>

⁸¹ In a systematic review of IUD use and cervical cancer, invasive cervical cancer was one third less frequent in women who have used an IUD.

⁸² Cortessis, V. K., et al., Intrauterine Device Use and Cervical Cancer Risk A Systematic Review and Meta-analysis. *Obstetrics & Gynecology*: December 2017 - Volume 130 - Issue 6 - p 1226-1236.

⁸³ A recent study suggested that the risk of breast cancer was higher among women who currently or recently used hormonal contraception compared to women who had never used hormonal contraception.

⁸⁴ Mørch, S.L., et al. Contemporary Hormonal Contraception and the Risk of Breast Cancer. *N Engl J Med* 2017; 377:2228-2239, www.nejm.org/doi/full/10.1056/nejmoa1700732

efforts and seeing AY as whole persons, in need of a range of different services and information.⁸⁵

Implications for programming and service delivery

Counselling based on scientifically accurate and up-to-date information allows girls and women to make decisions about their preferred method, if any (some will choose not to use contraception). It should include sufficient information about benefits as well as potential side effects that girls and women may experience, based also on individual differences in tolerance of various methods. More research is needed on the positive and negative effects of hormonal contraception, with a specific focus on adolescents given their unique stage of development. New findings should be taken into account and inform clinical guidelines. Moreover, to avoid discontinuation because of side effects, and to mitigate situations such as the “pill scare” in the United Kingdom and beyond in 1995⁸⁶ it is important to be transparent about both the positive and negative effects of contraception in conversations as well as in more targeted contraceptive counselling.

3.4 Post-abortion and postpartum care offers a window of opportunity

Post-abortion and postpartum care are important opportunities for contraceptive counselling. In spite of contraception being part of comprehensive abortion care, it is often provided in a haste or not at all. Women seeking abortion have a clear unmet need for contraception, and offering them a method at the time of or after their abortion can motivate uptake and decrease the risk of repeated unintended pregnancies.⁸⁷ Postpartum contraception immediately or soon after childbirth is often not prioritized or perceived to be necessary, by women or service providers, particularly if the mother is breastfeeding. However, rapid repeat pregnancy is common, especially among adolescent mothers, and is associated with increased risks of adverse maternal and perinatal outcomes. Postpartum contraception can decrease adverse maternal and perinatal outcomes⁸⁸, making first-time young parents an important group for targeted interventions.

In addition to fragmented services separating post-abortion care and postpartum care from family planning services, providers' lack of relevant awareness and skills and social and cultural barriers play important roles. Such barriers include the lack of respectful counselling, particularly for adolescents and young women, cultural norms around frequent births and misconceptions around the use of contraceptives.

Implications for programming and service provision

Both the antenatal and postpartum periods provide excellent opportunities to discuss contraceptive options, some of which can be initiated immediately after childbirth (e.g. copper IUD, LNG-IUD and

⁸⁵ Evidence for Contraceptive Options and HIV Outcomes (ECHO) Trial Consortium. HIV incidence among women using intramuscular depot medroxyprogesterone acetate, a copper intrauterine device, or a levonorgestrel implant for contraception: a randomised, multicentre, open-label trial. [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(19\)31288-7/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)31288-7/fulltext).

⁸⁶ Furedi, A. Social consequences. The public health implications of the 1995 'pill scare'. *Human Reproduction Update*, Volume 5, Issue 6, November 1999, Pages 621-626, <https://academic.oup.com/humupd/article/5/6/621/745751>

⁸⁷ Curtis C, Huber D, Moss-Knight T. Postabortion family planning: addressing the cycle of repeat unintended pregnancy and abortion. *Int Perspect Sex Reprod Health*. 2010;36:44-8, www.guttmacher.org/journals/ipsrh/2010/03/postabortion-family-planning-addressing-cycle-repeat-unintended-pregnancy-and

⁸⁸ Frarey A, Gurney EP, Sober S, Whittaker PG, Schreiber CA: *Postpartum contraceptive counseling for first-time adolescent mothers: a randomized controlled trial*. *Arch Gynecol Obstet* 299(2):361-369, Feb 2019.

hormonal implant) and others at six weeks after childbirth (e.g. combined oral pill and injectable DMPA).^{89,90}

Most contraceptive methods can be provided immediately after an abortion. The IUD can only be provided after a medical abortion is completed; however, all other contraceptive methods can be initiated on day one of a medical abortion, ensuring uptake also among women who choose to conduct the medical abortion at home.⁹¹

Health facilities must be set up to allow contraception as an integral part of care, including delivery, abortion and post-abortion care. Health care providers must be trained in the safety and efficacy of providing contraception immediately after, or during (in the case of medical abortion), an abortion⁹² as well as childbirth. It is particularly crucial that adolescent girls and young women are met with respectful and non-judgmental care when they seek abortion or post-abortion care. Ensuring a safe and respectful environment will motivate AY to initiate a contraceptive method post-abortion.^{93,94}

In countries where early pregnancy is common, programmes should specifically target first-time young parents as a window of opportunity to establish a trusted relationship with adolescent girls and young women and their partners. This increases the likelihood of contraceptive uptake after the pregnancy and that the parents return for other services. It can avoid unintended pregnancies, unsafe abortions and/or unsafe deliveries, and generate momentum among other adolescents and youth in the community to increase their trust in the health system regardless of pregnancy status.

3.5 AYSRHR in humanitarian settings

A staggering 136 million people needed humanitarian aid in 2018, an estimated 34 million of whom were women of reproductive age; 5 million of those women were pregnant.⁹⁵ An unprecedented 70.8 million people around the world have been forced from home. Among them are nearly 25.9 million refugees, over half of whom are under the age of 18.⁹⁶

Adolescents are vulnerable to the loss of support systems, routine and a sense of safety. Such circumstances may result in increased risky behaviours such as having multiple sexual partners, and unsafe sex. All these factors contribute to unintended pregnancy and STIs. Adolescent girls are particularly vulnerable in these contexts for a number of reasons including the increased risk of sexual

⁸⁹ Cooper, M, Cameron, S. Postpartum contraception. Successful implementation of immediate postpartum intrauterine contraception services in Edinburgh and framework for wider dissemination. *The Obstetrician & Gynaecologist*. 2018; 20: 159-166. <https://obgyn.onlinelibrary.wiley.com/doi/full/10.1002/ijgo.12606>

⁹⁰ World Health Organization. Medical eligibility criteria for contraceptive use. 2015. https://apps.who.int/iris/bitstream/handle/10665/181468/9789241549158_eng.pdf?sequence=1

⁹¹ World Health Organization. Safe abortion: technical and policy guidance for health systems. 2nd ed. Geneva, Switzerland: World Health Organization; 2012. https://apps.who.int/iris/bitstream/handle/10665/173586/WHO_RHR_15.04_eng.pdf?sequence=1

⁹² Paul, M., et al Does mode of follow-up influence contraceptive use after medical abortion in a low-resource setting? Secondary outcome analysis of a non-inferiority randomized controlled trial. *BMC Public Health* 2016;16:1087. <https://bmcpublihealth.biomedcentral.com/articles/10.1186/s12889-016-3726-1>

⁹³ Sedgh G, Hussain R. Reasons for contraceptive nonuse among women having unmet need for contraception in developing countries. *Stud Fam Plann*. 2014;45:151-69, www.guttmacher.org/sites/default/files/pdfs/pubs/journals/j.1728-4465.2014.00382.x.pdf

⁹⁴ Kalyanwala S, Acharya R, Francis Xavier AJ. Adoption and continuation of contraception following medical or surgical abortion in Bihar and Jharkhand, India. *Int J Gynaecol Obstet*. 2012;118 Suppl:S47-51, <https://obgyn.onlinelibrary.wiley.com/doi/full/10.1016/j.ijgo.2012.05.010>

⁹⁵ UNFPA Humanitarian Action Overview 2019, www.unfpa.org/humanitarian-action-2019-overview

⁹⁶ UNHCR. 2019. Figures at a glance, www.unhcr.org/en-us/figures-at-a-glance.html

violence, forced marriage and human trafficking. In addition to being serious human rights violations, they also contribute to unintended pregnancies, unsafe abortions and subsequently maternal mortality. Despite the right to access to sexual and reproductive health information and services in these settings according to international human rights law, women and girls face a range of barriers in obtaining such services.^{97,98} Moreover, adolescents and youth on the move require particular attention, both in camps and in host communities.

Implications for programming and service delivery

In humanitarian contexts, international humanitarian law and international human rights law provide a framework for providing SRHR services and information to all who need it, including adolescent girls and boys. It enables provision of comprehensive sexual and reproductive health services, including contraception and safe abortion care. Ensuring the provision of sexual and reproductive health information and services is central to an effective humanitarian response and to fulfilling fundamental human rights and humanitarian law obligations.⁹⁹ Access to antenatal, obstetric and postpartum care for pregnant women; access to contraceptive information and services, including emergency contraception; and access to safe abortion and post-abortion care to the full extent permitted by the applicable law, especially for survivors of sexual and gender-based violence, are among the critical services needed by girls and women affected by conflict.

3.6 Financing for contraceptive services for adolescents and youth

For both policy and programming, it is important to understand the financial requirements to meet the AY contraceptive need now and in the immediate future. The costs as well as the benefits must be considered, in order to gain a holistic perspective of the need for the investment in contraceptive services for adolescents and youth. Studies have shown that such investment results in significant health gains through reductions in unintended pregnancy, unsafe abortion, maternal morbidity and mortality and infant mortality. The investment also yields substantial gains in other realms: it promotes gender equality, increases household productivity and contributes to economic growth, and acts as a catalyst for a sustainable future for countries. An expert review of the 169 targets of the Sustainable Development Goals by the Copenhagen Consensus Centre ranked the universal provision of contraceptives as one of the overall 19 best global investments.¹⁰⁰ Each dollar spent on family planning programmes is estimated to yield \$120 in return in benefits.^{101,102,103} As such, financial input

⁹⁷ Center for Reproductive Rights. Ensuring SRHR of women and girls affected by conflict, www.reproductiverights.org/sites/crr.civicaactions.net/files/documents/ga_bp_conflictnrcrisis_2017_07_25.pdf

⁹⁸ For example, more than 200 women and girls rescued by the Nigerian Army from Boko Haram in 2015 were reported to have been pregnant as a result of serial rape or forced marriage; none were offered access to safe abortion, leading some of them to seek out illegal, unsafe abortions (See, e.g., Laura Bassett, Instruments of Oppression, Huffington Post (2015), available at <http://highline.huffingtonpost.com/articles/en/kenya-abortion/>).

⁹⁹ Center for Reproductive Rights. Ensuring SRHR of women and girls affected by conflict, www.reproductiverights.org/sites/crr.civicaactions.net/files/documents/ga_bp_conflictnrcrisis_2017_07_25.pdf

¹⁰⁰ Copenhagen Consensus Centre. Nobel Laureates Guide to Smarter Global Targets to 2030 <https://www.copenhagenconsensus.com/post-2015-consensus/nobel-laureates-guide-smarter-global-targets-2030>

¹⁰¹ Lomborg B. 2014. Why we need to invest in family planning, www.weforum.org/agenda/2014/11/why-we-need-to-invest-in-family-planning

¹⁰² Post-2015 Consensus. Smarter Goals for 2030. (2015), www.copenhagenconsensus.com/post-2015-consensus/economist Accessed November 10, 2019.

¹⁰³ Women Deliver. 2016. Meet the Demand for Contraception and Reproductive Health (undated), <https://womensdeliver.org/wp-content/uploads/2016/05/Deliver-for-Good-Card-2.pdf>. Last accessed November 10, 2019.

into contraceptive services is, in the proper sense of it, not an expenditure but an investment – an investment with huge health and development benefits for the present and for the future.

The Adding It Up study estimated the total annual cost of providing contraceptive services to the 16 million female adolescents using modern contraceptives in the developing regions of the world (Africa, Asia, Latin America and the Caribbean) to be \$276 million in 2017; this estimate covered both the direct (commodities, supplies, and personnel) and indirect costs (programme and systems costs).¹⁰⁴ Meeting the contraceptive needs of the 10 million adolescents with unmet needs will increase the cost to an estimated \$889 million each year. The benefit of such scale up of services will be significant: unintended pregnancies will reduce by 63 per cent (6 million unintended pregnancies prevented) with the additional benefits of reducing unplanned births by 2.4 million and abortions by 2.9 million, and averting 6,000 maternal deaths.

Going forward, it is projected that the number of adolescents using modern contraceptives will increase to at least 17 million by 2020, 18.3 million by 2025 and 19.8 million by 2030.¹⁰⁵ Concomitantly, the estimated total annual cost of adolescent contraceptives will increase from \$276 million in 2017 to \$280 million in 2020 and \$310 million in 2030. An expected change in the contraceptive mix with a doubling of the proportion using long-acting reversible contraceptives (from 10 to 20 per cent) will reduce the overall annual cost in 2030 from \$310 million to \$275 million. The average cost for each contraceptive user will also reduce from \$15.71 to \$13.90. The projected increase in modern contraceptive users to 9.8 million in 2020 will result in the prevention of 7.1 million unintended pregnancies, while an increase in the proportion using LARC to 20 per cent will avert additional 300,000 unintended pregnancies.

As the Guttmacher-*Lancet* Commission on Sexual and Reproductive Health and Rights noted, the investments in SRHR are quite modest and constitutes only a small fraction of the national health expenditure, but the yield is very high. The Commission also noted that all countries are in the financial position to meet women's contraceptive needs as well as the related cost for maternal and newborn services. Furthermore, other analyses have indicated that virtually all countries can meet the cost of achieving the Sustainable Development Goals for health by 2030 from their domestic resources¹⁰⁶, with the exception of the world's poorest countries who may require development assistance to cover the funding gap they may experience. Thus, what is called for is the political will to allocate adequate funds to adolescent contraceptive services, and the systems and frameworks for the efficient use of allocated funds. In addition, international development assistance will be required in the case of the poorest countries. So far, evidence suggests that adolescent health¹⁰⁷ in general, and adolescent contraceptive services specifically¹⁰⁸, has not been considered a priority in global

¹⁰⁴ Guttmacher Institute. 2018. Adding It Up: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents in Developing Regions, www.guttmacher.org/sites/default/files/factsheet/aiu-adolescents.pdf

¹⁰⁵ Biddlecom A, Riley T, Darroch JE, Sully E, Kantorová V, Wheldon M. 2018. Future Scenarios of Adolescent Contraceptive Use, Cost and Impact in Developing Regions, www.guttmacher.org/report/adolescent-contraceptive-use-in-developing-regions.

¹⁰⁶ Stenberg K, Hanssen O, Edejer TT-T, et al. Financing transformative health systems towards achievement of the health Sustainable Development Goals: a model for projected resource needs in 67 low-income and middle-income countries. *Lancet Glob Health* 2017; 5: e875–87, [www.thelancet.com/journals/langlo/article/PIIS2214-109X\(17\)30263-2/fulltext](http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30263-2/fulltext)

¹⁰⁷ Dieleman JL, Schneider MT, Haakenstad A, Singh L, Sadat N, Birger M, Reynolds A, Templin T, Hamavid H, Chapin A, Murray CJ. Development assistance for health: past trends, associations, and the future of international financial flows for health. *Lancet*. 2016 Jun 18;387(10037):2536–44, [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(16\)30168-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30168-4/fulltext)

¹⁰⁸ Li Z, Li M, Patton GC, Lu C. Global Development Assistance for Adolescent Health From 2003 to 2015. *JAMA Netw Open*. 2018 Aug; 1(4): e181072. Published online 2018 Aug 10, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2696504>

development assistance. The time has come for that scenario to change. Clearly, meeting the contraceptive needs of adolescents is crucial to the 2030 Agenda¹⁰⁹ and funding adolescent contraceptive services as an essential service¹¹⁰ is integral to universal health coverage.

Overall, both domestic resources and international development assistance must prioritize the funding of adolescent contraceptive services to address the current high level of unmet need. Furthermore, countries must put in effective and efficient frameworks that ensure the access of every adolescent and young adult – male and female – to quality contraceptive and related services. In meeting the contraceptive needs of adolescents, individual countries and the global community stand to make great gains in terms of health, gender equality and economic growth, and will be better positioned for a sustainable future.

¹⁰⁹ Starbird E, Norton M, Marcus R. Investing in Family Planning: Key to Achieving the Sustainable Development Goals. *Glob Health Sci Pract*. 2016 Jun 27;4(2):191-210, www.ghspjournal.org/content/4/2/191

¹¹⁰ Waddington C, Sambo C. Financing health care for adolescents: a necessary part of universal health coverage. *Bull World Health Organ*. 2015 Jan 1;93(1):57-9. doi: 10.2471/BLT.14.139741. Epub 2014 Oct 27, www.ncbi.nlm.nih.gov/pmc/articles/PMC4271683/