



PROGRESS IN ADOLESCENT SEXUAL &
REPRODUCTIVE HEALTH & RIGHTS GLOBALLY
BETWEEN 1990 & 2016: WHAT PROGRESS HAS
BEEN MADE, WHAT CONTRIBUTED TO THIS, &
WHAT ARE THE IMPLICATIONS FOR THE FUTURE?

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Progress in adolescent health and wellbeing: tracking 12 headline indicators for 195 countries and territories, 1990–2016

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Summary

Background Rapid demographic, epidemiological, and nutritional transitions have brought a pressing need to track progress in adolescent health. Here, we present country-level estimates of 12 headline indicators from the *Lancet* Commission on adolescent health and wellbeing, from 1990 to 2016.

Methods Indicators included those of health outcomes (disability-adjusted life-years [DALYs] due to communicable, maternal, and nutritional diseases; injuries; and non-communicable diseases); health risks (tobacco smoking, binge drinking, overweight, and anaemia); and social determinants of health (adolescent fertility; completion of secondary education; not in education, employment, or training [NEET]; child marriage; and demand for contraception satisfied with modern methods). We drew data from the Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) 2016, International Labour Organisation, household surveys, and the Barro-Lee education dataset.

Findings From 1990 to 2016, remarkable shifts in adolescent health occurred. A decrease in disease burden in many countries has been offset by population growth in countries with the poorest adolescent health profiles. Compared with 1990, an additional 250 million adolescents were living in multi-burden countries in 2016, where they face a heavy and complex burden of disease. The rapidity of nutritional transition is evident from the 324·1 million (18%) of 1·8 billion adolescents globally who were overweight or obese in 2016, an increase of 176·9 million compared with 1990, and the 430·7 million (24%) who had anaemia in 2016, an increase of 74·2 million compared with 1990. Child marriage remains common, with an estimated 66 million women aged 20–24 years married before age 18 years. Although gender-parity in secondary school completion exists globally, prevalence of NEET remains high for young women in multi-burden countries, suggesting few opportunities to enter the workforce in these settings.

Interpretation Although disease burden has fallen in many settings, demographic shifts have heightened global inequalities. Global disease burden has changed little since 1990 and the prevalence of many adolescent health risks have increased. Health, education, and legal systems have not kept pace with shifting adolescent needs and demographic changes. Gender inequity remains a powerful driver of poor adolescent health in many countries.



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OBJECTIVE (Azzopardi et al., 2019)

- To track selected indicators on adolescent health and wellbeing between 1990-2016.

KEY FINDINGS:

- Decrease in disease burden in many countries has been offset by population growth in countries with the poorest adolescent health profiles.
- Compared with 1990, an additional 250 million adolescents were living in multi-burden countries in 2016, where they face a heavy and complex burden of disease.
- Although disease burden has fallen in many settings, demographic shifts have heightened global inequalities.
- Global disease burden has changed little since 1990 and the prevalence of many adolescent health risks have increased.
- Health, education, and legal systems have not kept pace with shifting adolescent needs and demographic changes.

Objectives

- i. To tease out & direct a spotlight on selected findings in the paper by Azzopardi et al paper, in particular, the levels & trends of the ASRHR indicators used in their analyses, with a focus on multi-burden countries.
- ii. To highlight the progress that has been achieved in these indicators, albeit uneven and often small/slow.
- iii. To link these changes to the investments & efforts made at global and national levels.
- iv. To point to the implications of this for strengthening ASRHR programmes while strategically broadening the adolescent health agenda to include other priority health problems.



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Progress in adolescent sexual and reproductive health and rights globally between 1990 and 2016: what progress has been made, what contributed to this, and what are the implications for the future?

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OBSERVATION 1:

- “...important – albeit uneven – progress has occurred in multi-burden countries, in every one of the ASRHR indicators (maternal health, adolescent live births, child marriage, demand for modern contraception).”
- “... although the rates of secondary school completion have increased between 1990 & 2016, there has been an even larger increase in the denominator: the population of adolescents who currently need secondary school education (and those who will need it in the future). **However, this should not be seen as a failure of adolescent programmes. It means that while goals have been scored during the period, the goal posts have now been shifted. Fortunately, it also means that the adolescent health and development community can build on its successes as it responds to a challenge which has grown in size.**”

OBSERVATION 2:

- “...it is plausible that the significant resources that have supported the implementation of a range of evidence-based interventions over the past several decades, acting at different levels, have had a positive impact on ASRHR outcomes, *even if this is difficult to prove scientifically* because of the complex web of causation underlying ASRHR outcomes...”
- There are many examples of investments and actions in support of ASRHR over the past decades, often with a specific focus on adolescent girls:

OBSERVATION 3:

- “...progress in SRH in the multi-burden countries contrasts sharply with the lack of progress in other areas of health & well-being, of notable concern, increases in the rates of tobacco use, binge drinking & overweight & obesity. In countries in the injury-excess and non-communicable disease categories, while tobacco use has declined, there has been no progress in binge drinking & in overweight & obesity.”
- “England ...succeeded in reducing teenage pregnancy through a textbook example of a well-designed & well-executed public health programme. ...the rate of early childbearing in England declined but the rates of binge drinking, and overweight & obesity increased.”

IMPLICATIONS FOR ACTION

1/5 Recognize that progress has been made in ASRHR.

“Even though the progress has been limited & uneven, we are now able to demonstrate progress among adolescents across a range of ASRH indicators in a number of multi-burden countries.”

“...we must acknowledge that there is an enormous unfinished agenda in ASRH.”

IMPLICATIONS FOR ACTION

2/5 Acknowledge that the increasing investment & action in ASRHR has contributed to these tangible results, & that this has the potential to grow.

“...it is plausible that these improvements are due to deliberate action at national & local levels, accompanied by increased investments in ASRHR.”

“While it is true....that adolescent health gets only a small piece of the global development cake, it is also true that there is more funding for specific areas of work on ASRHR than ever before.”

“The challenge...is how to put the resources to the best possible use, and to demonstrate results.”

“This will help grow the investment both for ASRHR & for the wider area of adolescent health...”

IMPLICATIONS FOR ACTION

3/5 Build on the gains in ASRHR through concerted action and a focus on implementation science.

“The Lancet Commission for Adolescent Health and well-being has called for...; prevention priorities to include SRH, under-nutrition, & infectious diseases including HIV; & for policy measures to include injury prevention. There is a sound public health & human rights basis for this prioritization; there is also a practical basis for it.”

“To consolidate & expand progress on ASRHR, the emphasis now needs to shift to questions on *how* to deliver interventions proven to be efficacious in research studies & pilot projects, at scale with quality & equity in “real world” settings with different social, economic, & cultural contexts, & how much this will cost.”

IMPLICATIONS FOR ACTION

4/5 Expand the adolescent health agenda in a progressive and strategic manner.

“ There are good reasons to move ahead in a phased manner beyond the SRH field, taking practical considerations into account in addition to demography & epidemiology. **First**, given the limited human & financial resources available in most places, the agenda could be expanded in a progressive manner. This can build on what is already being done...**Second**, the scale-up that is occurring in the ASRHR field drew upon years of investment in building community understanding and support, in establishing a sound evidence base, & in developing implementation experience.... **Third**, in a context of growing conservatism, decision-makers in countries may be more comfortable pressing ahead with the non-controversial interventions...and set aside the more sensitive interventions...”

The case of Ethiopia & India

- “In the MDG era, both countries had national adolescent reproductive health strategies, aligned to their respective countries’ commitments to reduce maternal & childhood mortality, & to prevent HIV transmission & HIV-related mortality and morbidity.”
- “National government-led efforts, complemented by the efforts of international & indigenous NGOs and aided by economic progress in both countries, contributed to substantive decreases in levels of child marriage & in adolescent childbearing (the latter more in India than in Ethiopia).”
- “Towards the end of the MDG era, both countries launched broader national adolescent health strategies....In both countries there was clearly a sound epidemiologic rationale for this move from ASRH to a broader focus.”
- “However, the rapid increase in scope without effective mechanisms to translate the plans into action has meant that implementation has been patchy. At the subnational level, the focus & clarity of the adolescent reproductive health strategies has been replaced with a dilution of focus & lack of direction on the way forward - ongoing work on SRHR has suffered while work on an expanded set of areas has made limited and uneven progress.”

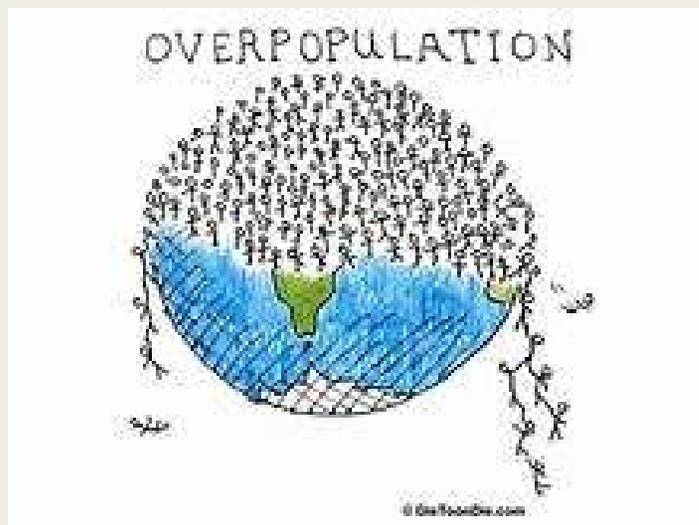
IMPLICATIONS FOR ACTION

5/5 Contribute to wider efforts to address adolescents' rapidly changing contexts, that have an impact on their health and development.

“In addition to demographic changes, the Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights has discussed the influence of displacement & conflict, climate change, & social & economic changes such as urbanization.”

“These changes do not affect adolescent health alone; they have implications across the life-course & in virtually every other field of health and development... Neither can they be addressed by those working on adolescent health or by piecemeal efforts alone.”

How an issue is named & framed has a powerful influence on how it is addressed.



- Before the ICPD, population growth was framed as a problem of overpopulation. This led to actions aimed at persuading people to have fewer children, including coercive approaches in some places. Since the ICPD, it has been framed as one of choice & development. This has led to actions aimed at making contraceptives available & supporting people to make the reproductive & contraceptive choices that suit them best **ALONG WITH** actions to address factors that contribute to high fertility e.g. high childhood mortality & economic insecurity.
- Today, we have the data & the evidence to name & frame ASRHR as follows: firstly, the SRH of adolescents has improved – albeit slowly & unevenly - in the 25 years since Cairo & Beijing; secondly, it is likely that this has occurred because of deliberate action from global to local levels, & thirdly, this improvement provides a springboard for further progress in ASRHR & - progressively & strategically – in other areas of adolescent health.

CONCLUSION