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The World Health Organization's work on adolescent sexual and reproductive health

This paper describes the World Health Organization's (WHO) work on adolescent sexual and reproductive health (ASRH). It contains five sections. The first section examines the place of ASRH in the WHO's overall work. The second looks back at selected aspects of the organization's work on ASRH. The third states the principles that guide the organization's work on ASRH. The fourth outlines the rationale for the organization's work on ASRH. The fifth presents both an analysis of where the ASRH field currently stands and what different WHO headquarters departments, regional offices, and country offices are doing—in conjunction with a range of partners within and outside the United Nations system—to respond to the many needs that exist. In some activities, the focus of the WHO's work is exclusively on ASRH, whereas in others, its ASRH work is closely interwoven with its work on adolescent health in general.

ASRH is an integral part of the WHO's work program

The WHO's"Eleventh General Programme of Work" [1] sets out the organization's long-term vision. The WHO's"Medium-Term Strategic Plan for 2008–2013" [2] translates this vision into 13 complementary strategic objectives and provides the basis for detailed operational planning and management [2]. It has guided the development of plans and budgets for the 2008–2009, 2010–2011, and 2012–2013 biennia. It has also provided the basis for results-based management, through the definition of clear and measurable expected results for each level of the organization–country, region, and headquarters–and the organization as a whole.

ASRH is addressed in three of the organization's 13 strategic objectives:

- Strategic objective 2: HIV/AIDS, tuberculosis, and malaria

To combat HIV/AIDS, tuberculosis, and malaria.

- Strategic objective 4: Child, adolescent, maternal health, and aging

To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy aging for all individuals.

- Strategic objective 6: Risk factors for health

To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs, and other psychoactive substances, unhealthy diets, physical inactivity, and unsafe sex.

This ensures that activities relating to ASRH are an integral part of the WHO's work. They are planned, budgeted, implemented, monitored, and reported on.

Many different WHO units and individuals contribute to the organization's work on ASRH. At the headquarters level of the organization, the lion's share of the work on ASRH is done by departments in the Family Women's and Children's Health Cluster: Maternal, Newborn, Child and Adolescent Health; Reproductive Health and Research; and Immunization, Vaccines and Biologicals. Others that contribute to the organization's work on ASRH are the HIV/AIDS department in the HIV/AIDS, TB, Malaria and Neglected Tropical Diseases Cluster (on HIV prevention, care, support and treatment); and the departments of Violence and Injury Prevention and Disability (on preventing violence), Mental Health and Substance Abuse (on preventing alcohol use in the context of pregnancy) and Chronic Diseases and Health Promotion (on school health) in the Non-Communicable Disease and Mental Health Cluster. Each of the six regional offices of the WHO is organized slightly differently, but they all have counterpart units and officers for the departments named above. These officers oversee and support regional activities in their areas of

WHO uses the term "adolescent" to denote individuals between 10 and 19 years and the term "young people" to denote those between 10 and 24 years.

responsibility (e.g., the activity portfolio of the regional adviser for Maternal, Newborn, Child and Adolescent Health would include some activities on ASRH). At the country level, staff members tend to be responsible for several work areas. For example, a National Professional Officer may be responsible for sexual and reproductive health, neonatal and child health, adolescent health and gender. They draw upon the expertise of regional and headquarters colleagues to support country-level work.

This adds up to ensuring that at all three levels of the organization there are work plan items and budgets as well as units and individuals working on ASRH.

The WHO's work on ASRH today builds on over 25 years of experience

The WHO's work on preventing HIV in young people was started by the "Special Programme on AIDS" and its successor the "Global Programme on AIDS" in the second half of the 1980s. The systematic evidence-based approach to advocacy and to providing guidance to national AIDS programs that was used over 20 years ago is captured in this extract from a state-of-the-art review [3]:

"…To address (these) objections to discussing sex in health education programs, the WHO Global Program on AIDS commissioned three reviews of studies on the effects of sex education. Most published studies are from industrialized countries. While they generally report increased levels of knowledge and some attitude change among students who have attended a sex education course, it has been established that this does not necessarily translate into safe sexual practices. Therefore one of the three WHO-sponsored reviews focused on the behavioral impact of sex education programs as measured by rates of teenage pregnancy, abortion, birth, sexually transmitted infections and self-reported sexual activity. The studies in this review showed that:

- Sex education programs did not lead to earlier or increased sexual activity in young people, even when contraceptives were made available.
- Sex education programs may delay initiation of sexual intercourse, decrease sexual activity, and increase the adoption of safer sexual practices in sexually active young people."

The 1980s also saw the beginning of attention being paid to ASRH in the WHO. Under the auspices of the Family Health Division, research studies were carried out and tools to support country-level action were developed: As was noted in a report, to achieve a "multisectoral, interdisciplinary and multiagency approach" to adolescent health, tools were developed for "planning action, setting priorities, behavioural and attitudinal research, training in interpersonal skills, evaluation of work with young people, and advocacy for policy and programmes" [4].

In 1985, the World Health Assembly passed its first resolution on adolescent health—"Maturity before childbearing." This was followed by the World Health Assembly discussions on the Health of Youth in 1989 and the subsequent resolution. ASRH was discussed at the assembly within the context of adolescent/young people's health as a whole: "The importance of sexual and reproductive health aspects was noted, including the need to avoid too early marriage, too early pregnancy, childbearing, and parenthood for both married and unmarried, and the risk of sexually transmitted diseases and HIV infection leading to AIDS" [5]. The discussions at the assembly raised the profile of adolescent health in the global public health community. For example, it contributed to the development of the WHO, UNFPA, UNICEF Joint Statement on the Reproductive Health of Adolescents: A Strategy for Action in 1989, which in turn fed into the preparations for the International Conference on Population and Development. The discussions led to significant developments in the WHO as well. At the WHO headquarters, it led to the establishment of an "Adolescent Health Programme" with far-reaching effects for the organization. And in the WHO's regional offices, it led to the development and implementation of regional strategies on adolescent health.

There are many other milestones in the WHO's long history of work on ASRH; a long history that provides a solid foundation for the work of the organization today.

A conceptual framework guides the WHO's work on ASRH

In 1995, the WHO's Adolescent Health and Development Programme organized a Study Group on Programming for Adolescent Health and Development, with considerable support from UNICEF and UNFPA. One key output of the study group was a Common Agenda for Action on Adolescent Health and Development [6].

The Common Agenda calls for programming to aim for the twin goals of (a) promoting healthy development to meet needs and build competencies, and (b) preventing and responding to health problems. To contribute to healthy development which in turn helps prevent health problems, it calls for the delivery of a package of interventions, tailored to the needs and problems of different groups of adolescents—creating a safe and supportive environment, providing information, building skills, and providing health and counseling services.

The Common Agenda stresses the importance of placing adolescents at the center of policies and programs, but that engaging and supporting the many individuals and institutions around them is crucial. It may be useful to think of these actors in concentric circles of contact and influence. At the center is the adolescent himself or herself. Parents, siblings, and some other family members are in immediate contact with the adolescent and constitute the first circle. The second circle includes people in regular contact with them such as their own friends, family friends, teachers, religious leaders, and others. The third circle includes musicians, film stars, sportsmen and women, and media personalities who have a tremendous influence on them from afar.

The guiding principles underpinning the common agenda are:

- Adolescence—a time of opportunity and risk.
- Not all adolescents are equally vulnerable.
- Adolescent development underlies prevention of health problems.
- Problems have common roots and are interrelated.
- Social environment influences adolescent behavior.
- Gender considerations are fundamental.

The principles and the framework for country programming for adolescent health described here have emerged through the WHO's work with and for adolescents over the years, and shapes the way in which the organization "reads" their needs and responds to them.

The WHO's work on ASRH is based on a sound rationale

There are sound public health, economic, and human rights reasons for investing in the health and development of adolescents.

Investing in the health of adolescents helps prevent the estimated 1.4 million deaths that occur globally every year as a result of road traffic injuries, violence, and pregnancy-related causes, including the consequences of unsafe abortion. It can also improve the health and well-being of many millions of adolescents who experience health problems such as depression, anemia, or HIV infection; and it can promote the adoption of healthy behaviors that could help millions of adolescents avoid health problems that occur later in life, such as lung cancer resulting from tobacco use initiated during adolescence. Finally, investing in adolescent health can prevent problems in the next generation such as prematurity and low birth weight in children born to very young mothers [7].

There is growing recognition of the economic benefits of investing in the healthy development of adolescents and the economic costs of not doing so: Adolescents represent one-fifth of the global population; healthy, competent adolescents who enter the work force can raise the economic productivity of a country. Economists stress the importance of using this "demographic dividend" for national development. On the other hand, not investing in the health and development of adolescents contributes to the vicious cycle of ill health and socioeconomic deprivation. For example, girls from poor communities are more likely than those in more well-to-do communities to get pregnant during their adolescence. This in turn leads to loss of edu-

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Abstract

This paper examines the contribution of the World Health Organization to the field of adolescent sexual and reproductive health (ASRH) from the early 1980s to the present. It is based on published documents and on the experiences of WHO staff members who have been part of much of this journey. It recalls the responses of the organization to the (then) new HIV/AIDS pandemic and to the first calls for a global public health response to early pregnancy. It also highlights selected milestones in the organization's work in the ASRH field over the last 25 years. It concludes with an analysis of where the ASRH field stands today and what the organization is doing to strengthen the epidemiologic and evidence base for action, to build consensus and coordination, and most importantly to support country level action, in cooperation with organizations within and outside the United Nations system. In defining its niche in a rapidly evolving and increasingly crowded field, the WHO's mission on ASRH is to contribute to a world in which the importance of ensuring the sexual and reproductive health of adolescents is understood, accepted, and acted upon by adolescents themselves, by their families and communities, by the workforces of different sectors, by civil society bodies, and by leaders and decision makers.

Keywords

World Health Organization · Sexual health · Reproductive health · Adolescents · Overview

Die Arbeit der Weltgesundheitsorganisation auf dem Gebiet der sexuellen und reproduktiven Gesundheit von Jugendlichen

Zusammenfassung

Der vorliegende Beitrag untersucht die Rolle der Weltgesundheitsorganisation (WHO) zum Thema sexuelle und reproduktive Gesundheit von Jugendlichen („adolescent sexual and reproductive health", ASRH) von den frühen 1980er-Jahren bis heute. Er basiert auf veröffentlichten Dokumenten sowie auf den Erfahrungen von WHO-Mitarbeiter(inne)n, die diese Entwicklung begleitet haben. Er erinnert an die Reaktion der Organisation auf die (damals) neue HIV/Aids-Pandemie und an die ersten Rufe nach einer globalen Antwort der Gesundheitspolitik auf Teenagerschwangerschaften. Zugleich beleuchtet er ausgewählte Meilensteine der Arbeit der WHO zur ASRH in den letzten zweieinhalb Jahrzehnten. Der Artikel schließt mit einer Analyse der aktuellen Situation und zeigt auf, was die WHO heute tut, um die epidemiologische Datenbasis als Handlungsgrundlage zu stärken, um Konsens und Koordination aufzubauen und – am allerwichtigsten – um Aktionspläne der einzelnen Länder in Zusammenarbeit mit Organisationen sowohl innerhalb als auch außerhalb des UN-Systems zu unterstützen. Die WHO definiert ihre Nische in einem sich rasch fortentwickelnden und wachsenden Themenkomplex und sieht ihre Aufgabe darin, zum Aufbau einer Welt beizutragen, in der die Bedeutung der sexuellen und reproduktiven Gesundheit von Jugendlichen nicht nur verstanden und akzeptiert, sondern auch als Anlass zum Handeln begriffen wird. Dies gilt für die Jugendlichen selbst ebenso wie für ihre Familien und ihr gesellschaftliches Umfeld, für die Fachleute der verschiedensten Sektoren, für die Gremien der Zivilgesellschaft sowie für Führungspersönlichkeiten und Entscheidungsträger.

Schlüsselwörter

Weltgesundheitsorganisation · Sexuelle Gesundheit · Reproduktive Gesundheit · Jugendliche · Überblick

cational and employment opportunities, keeping them in poverty [8].

Almost all countries are signatories to the UN Convention on the Rights of the Child, which clearly states that adolescents have the right to obtain the health information and services they need to survive and to grow and develop to their full individual potential, and reiterates the obligations of governments to fulfill their rights in all areas, including sexual and reproductive health.

The WHO's work on ASRH is based on the evolving field of ASRH

The place of ASRH in the global public health agenda

ASRH is higher on the global public health agenda than ever before. Firstly, through the inclusion of adolescent-specific indicators and targets, the Millennium Development Goals gave ASRH a clearly defined place in the global public health agenda. The importance of adolescents in the global effort to achieve the Millennium Development Goals has been further reinforced in recent reports, e.g., an annual progress report published by United Nations in 2011 noted that: "Reaching adolescents is critical to improving maternal health and achieving other Millennium Development Goals" [9]. Secondly, in April 2012 at the 45th session of the Commission on Population and Development, a resolution was adopted on strengthening country-level action to meet the needs and fulfill the rights of adolescents to sexual and reproductive health [10]. Thirdly, in May 2012 at the World Health Assembly, representatives from nearly 30 countries made statements of commitment to preventing early marriage and pregnancies among adolescents [11]. While ASRH is high on the global public health agenda, there is still some lack of willingness to provide adolescents with sexuality education (especially in early and middle adolescence) and to accept that at least some adolescents have sex before marriage and need reproductive health services and commodities, such as contraceptives and condoms.

Through its advocacy and technical work in conjunction with partners within and outside the United Nations system, the WHO has contributed to raising the profile of ASRH. The WHO works with these partners to maintain the place of ASRH in the global agenda by engaging actively in the International Conference on Population and Development +20 and Millennium Declaration +15 review processes. This is to ensure that when the new agendas are set, they are fully informed by the realities on the ground—both on the needs of adolescents and on the response.

The state of adolescent epidemiology and program monitoring

There are more epidemiologic data on ASRH in the public arena than there were even 5 years ago. For example, just in the last 4 years, the WHO has collaborated in or led the publication of global estimates of pregnancy-related mortality in adolescents aged 15–19 years, global estimates of births to adolescents aged 12–15, and global estimates of unsafe abortion that include adolescents [12, 13, 14]. The WHO's Chronic Diseases and Health Promotion Cluster has also supported countries in collecting data on the health-related behaviors (including sexual behaviors) of 13- to 15-year-old school goers in a number of countries. Fact sheets on 70 countries are posted on the WHO's website: http://www.who.int/chp/gshs/factsheets/en/index.html.

These data provide a firmer ground for advocacy and action. But there are still major gaps in our collective knowledge. At the global level, for example, estimates of sexually transmitted infections in adolescents are based on limited and outdated data. And at the country level, for example, patchy epidemiologic data hinder the development of targeted and well-designed programs to prevent poor reproductive health outcomes in adolescents. The WHO is working to identify and fill the knowledge gaps that exist. This includes actions at two levels—firstly, gathering, analyzing, and using the data that are already available; and secondly, stimulating and supporting age and sex disaggregated data collection in future research studies and programmatic monitoring through health information and other systems.

Moving to programmatic monitoring, the health-related Millennium Development Goals contain some adolescent-specific indicators (on adolescent birth rates for goal 5 and on HIV prevalence and comprehensive knowledge for goal 6). These indicators are in line with the indicators identified in the United Nations Special Session on HIV. In addition, important areas of ASRH are addressed by indicators that are not specific to adolescents and young people but are relevant to them (e.g., contraceptive prevalence, goal 5; and condom use and high-risk sex, goal 6). Data on these indicators are not always gathered disaggregated by age and sex. The WHO works with partners to ensure that that this is done and that key indicators that are relevant to adolescent health programs are included in important monitoring mechanisms such as Countdown to 2015. The WHO's Maternal Newborn Child and Adolescent Health Department has also worked to gather more detailed data from nearly 70 countries on the state of national policies and health systems and is feeding these data to Ministries of Health [15].

The strength of the evidence base for policies and programs

In some areas, e.g., sexuality education programs, there is strong evidence of effective interventions. In some other areas, e.g., the most effective ways of improving the access of adolescents to safe abortion services where they are legal, evidence from intervention studies are not available. Between these poles there are many areas in which the evidence base of both effective interventions and of delivering them is weak.

The WHO's Reproductive Health and Research Department has contributed to improving our knowledge and understanding of the sexual and reproductive health of adolescents through social and behavioral studies [16, 17]. The WHO has also contributed to strengthening the evidence base for action by putting together whatever evidence exists and formulating recommendations for action, us-

ing a transparent and consultative process. The systematic reviews on preventing HIV among young people in developing countries (Department of Child and Adolescent Health and Development), the recently completed guidelines on adolescent pregnancy (Department of Maternal Newborn Child and Adolescent Health), and on preventing intimate partner violence and sexual violence (Department of Reproductive Health and Research) are examples of this [18, 19, 20]. Alongside this, the WHO has led a process through which the global research community has identified priorities in research to improve adolescent sexual and reproductive health outcomes [21].

The level of consensus on the package of interventions to be delivered

In some areas of ASRH, global consensus on the package of interventions to be delivered has been forged. One important example is the development and dissemination of guidelines on HIV prevention in young people by the United Nations Task Team on HIV and young people [22]. Another example—going beyond health—is the interagency consensus on objectives and related action that the United Nations Adolescent Girls Task Force is promoting: to educate adolescent girls, improve their health, keep them free from violence, promote girl leaders, and count girls in data efforts [23]. In many other areas, such consensus has not yet been reached, e.g., on preventing forced sex.

The WHO has contributed to, and continues to work actively on, consensus building. This is to ensure that the resources available are used to deliver proven interventions.

The state of coordination and collaboration on ASRH

Many international organizations are active in the field of ASRH including intergovernmental bodies such as the United Nations and the European Union, and international nongovernmental organizations such as Family Health International, Population Council, and International Planned Parenthood Association. They in turn are supported by numerous governmental development agencies and private foundations.

Mechanisms for coordination and collaboration exist at the global level. The two United Nations-supported collaborative mechanisms mentioned before play a useful role, as do others such as the United States Agency for International Development-supported Interagency Working Group on Youth Reproductive Health http://www.iywg.org/.

Despite these mechanisms, some things are duplicated and others fall through the cracks. Mechanisms are needed that provide more incentives to collaborate effectively and to hold organizations accountable if they do not. The Global Strategy on Women's and Children's Health is seeking to do just this [24].

The state of ASRH work at the country level

Many countries have developed national policies and strategies on ASRH and on HIV—either as part of population-wide documents or as stand-alone ones focusing on adolescents. In a small number of countries, these policies and strategies have been translated into work plans containing activities to address adolescents and budgets with funding for these activities. In most others, they have not.

Large-scale and sustained programs are in place in some countries—e.g., sexuality education programs in Nigeria and Uruguay [25, 26] and health service provision programs in Estonia and Mozambique [27, 28]. In most countries, however, implementation is patchy and monitoring and evaluation are infrequently done. Where there is no concerted and sustained government-led effort, the empty space is filled by nongovernment organization-led initiatives, which usually are piece-meal, small-scale, and time-limited [29].

Barriers to stepping up country-level action are many. Firstly, policy makers and program managers in many places seem less committed to ASRH than to issues such as child and maternal mortality reduction. Secondly, the paucity of sound national data on ASRH mortality and morbidity hinders the identification of clear priorities. Thirdly, lack of know-how on effective interventions, how to measure them, and how to cost them translates into weak plans. Fourthly, lukewarm political commitment and poorly defined and defended priorities feed into weak plans that are often unable to attract resources. And finally, limited capacity in managing, implementing, and monitoring ASRH activities and discomfort in dealing with the sensitivities around ASRH mean that little good work is done even when other prerequisites are in place.

In 2010, the WHO's Department of Child and Adolescent Health and Development developed a framework to strengthen the health sector's response to adolescent health, and within the context of the framework to systematize and scale up health service provision to adolescents [30] Using HIV and maternal mortality as programmatic entry points, the WHO has worked with UN partners (notably UNFPA and UNICEF) and others to support ministries of health in many countries to apply this framework to improve the coverage of quality health service provision and its use by adolescents [31, 32].

Conclusion

ASRH is an integral part of the WHO's overall work on adolescent health, which in turn is grounded in a life-course approach to health and well-being. The WHO's work in ASRH has a long history. It is based on a sound rationale and employs a well-informed and thorough framework that has been developed in conjunction with a range of partners. This evidence-based and consensual approach has enabled the WHO to place ASRH firmly in the global public health agenda. On the basis of careful analyses of the ASRH situation globally, regionally, and nationally, units responsible for different technical areas at all three levels of the WHO are working to contribute to a world in which the importance of ensuring the sexual and reproductive health of adolescents is understood, accepted, and acted upon by adolescents themselves, by their families and communities, by the workforces of different sectors, by civil society bodies, and by leaders and decision makers.

In 2011, the 64th World Health Assembly passed a resolution on youth and health risk which (a) acknowledged that addressing young people is key to attaining the three health-related Millennium Development Goals (4, 5, and 6) and to preventing noncommunicable diseases; (b) reaffirmed the WHO's strategies that address the major health risks facing youth; and (c) urged WHO member states to accelerate action as appropriate, and to develop policies and plans to address the main determinants of health affecting young people, including health-related behaviors and their impact on health at later stages of life [33] The WHO committed itself then, to supporting its member states take the steps they needed. We reaffirm this commitment.

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Conflict of interest. On behalf of all authors, the corresponding author states the following: All three authors are staff members of the WHO and are strong believers in the vision and mission of the WHO.

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