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Good progress in a number of areas of ASRH, but there is much more that needs to be done

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In this commentary, we begin by outlining the progress that has been made globally in improving adolescent sexual and reproductive health (ASRH) in five selected areas: adolescent pregnancy and childbearing, HIV infections and AIDS-related deaths, child marriage, female genital mutilation, and the prevention of cervical cancer. We then outline the progress that yet needs to be made in each of these areas. We conclude with some reflections on the importance of naming and celebrating the progress made, and using this as the springboard for further progress in ASRH and in other areas of adolescent health.

The levels of adolescent pregnancy and childbearing have declined, although progress has been slow and uneven

Globally, adolescent birth rates (ABR) have declined from 52 births per 1,000 girls in 2010 to 42.5 in 2021.¹ South Asia has made the most progress in reducing early childbearing, with the ABR dropping from 49.6 births per 1,000 girls in 2010 to 29 births in 2021.¹ Sub-Saharan Africa (SSA) has also made enormous progress, with the ABR declining from 117.7 births per 1,000 women in 2010 to 101 births per 1,000 girls in 2021. However, because SSA has historically had a high ABR, its levels continue to be high compared to other regions, with huge disparities within the region.¹ Chile is a prime country-level example where there has been a 51 percentage point (pp) reduction in the proportion of births

to mothers aged under 19 years (from 16% in 2000 to 7.8% in 2017).²

A key contributor to the decline in adolescent pregnancy and childbearing is the increase in the uptake of contraception by adolescents

Globally, the proportion of adolescent girls aged 15–19 years whose needs for family planning (FP) were satisfied by modern methods rose from approximately 49% to 60% between 2010 and 2020.³ Although there has been progress globally, both the levels and trends have been uneven across regions. Latin America and the Caribbean (LAC) and Eastern Europe and Central Asia had the highest levels of demand for FP satisfied by modern methods (>70%) in 2020, a relative increase of approximately 8% from 2010 (65).³ There has been an increase in the aggregate level of modern contraceptive use in adolescents aged 15–19 years from 17.8% in 2000–2006 to 27.2% in 2013–2017 and in adult women aged 20–34 years from 30.9% in 2000–2006 to 40.3% in 2013–2017.*⁴

*This study examined 43 countries: Albania, Armenia, Bangladesh, Belize, Benin, Burundi, Cambodia, Cameroon, Chad, Colombia, Congo, Cuba, Côte d'Ivoire, Dominican Republic, Egypt, Ethiopia, Ghana, Guinea, Guinea Bissau, Guyana, Haiti, Indonesia, Kazakhstan, Kenya, Kyrgyzstan, Lesotho, Malawi, Mali, Mongolia, Nepal, Nigeria, Philippines, Rwanda,

Unfinished business

While there has been notable progress in addressing adolescent pregnancy and childbearing, the rate of improvement has been relatively slow, with a decline of approximately 3 pp per decade over the past six decades.⁵ Additionally, progress has been made in increasing the need for FP satisfied by modern methods, but there have been wide variations across regions. Specifically, there is a substantial divergence across regions with regard to the need for FP satisfied by modern methods in adolescents. While South Asia, SSA, and the Middle East and North Africa have witnessed consistent increases in the proportion of adolescent girls having their demand for FP satisfied by modern methods, the figures remain below 50% in these regions. In contrast, in LAC, Europe and Central Asia, 3 in 4 girls have their demand for FP satisfied with modern methods, compared to 88% of girls in North America.⁶

The levels of child marriage have declined. However, progress has been slow and uneven

Globally child marriage has declined over the last decade from approximately 25% in 2010 to 19% in 2020 (a 6pp decrease).^{3,7} Progress has been most marked in South Asia and to a lesser extent in SSA, Middle East and Northern Africa, and Eastern Europe and Central Asia.³ Bangladesh is an example of a country in which there has been a steady decline in the prevalence of child marriage between 2011 and 2019. Nearly 2 in 3 girls were married/in union before the age of 18 years in 2011, whereas in 2019 about 1 in 2 girls were married/in union before the age of 18 years.^{8,9} Further, there has been a decline in females married/in union before the age of 18 across all wealth quintiles and education levels between 2011 and 2019. What this means is that the country has also shown declines in child marriage across richer and poorer segments of society and the gap between educational levels has progressively decreased.³

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While the global reduction in child marriage is to be celebrated, no region is on track to meet the Sustainable Development Goal target of eliminating

Senegal, Serbia, Sierra Leone, Tajikistan, Tanzania, Thailand, Togo, Uganda, Vietnam, Zimbabwe.

this harmful practice by 2030. As of 2021, child marriage rates remain persistently high in SSA at 34% and South Asia at 28%.³ West and Central Africa face the most substantial challenges and will require significant acceleration in efforts to eliminate child marriage within the next decade. Furthermore, progress in LAC has been limited over the past decade, necessitating a concerted push to overcome this stagnation and steer the region back on course toward achieving the goal of eliminating child marriage. Meanwhile, in East Asia and the Pacific, progress has come to a standstill, highlighting the urgency of revitalising efforts in this region to combat child marriage effectively.³

The levels of HIV infections and AIDS-related deaths have declined, with sex disparities

Globally, there has been a reduction in new HIV infections among young people aged 15–24 years, with a 47% decline observed between 2010 (660,000 cases) and 2022 (350,000 cases). This decline is more pronounced among girls aged 10–19 years, with a 48% decline from 190,000 cases in 2010 to 98,000 cases in 2022, compared to a 42% decline among boys during the same period, reducing from 69,000 cases in 2010 to 40,000 cases in 2022.¹⁰ Notably, in SSA, LAC, and Central and Southern Asia, there has been an overall decrease in sexual encounters with non-marital, non-cohabiting partners among adolescents, coupled with an increase in condom use during sex. Specifically, between 1999/2008 and 2009/2018, the proportion of adolescents using condoms during such encounters rose from 27% to 37% among girls and from 35% to 48% among boys in SSA.¹¹

Additionally, globally, the number of AIDS-related deaths among young people aged 15–24 years has decreased from 61,000 in 2010 to 42,000 in 2022. This decline is consistent among both girls and boys aged 10–19 years, with a 52% decrease among girls (from 27,000 in 2010 to 13,000 in 2022) and a 29% decrease among boys (from 61,000 in 2010 to 42,000 in 2022).¹⁰

A key contributor to the decline in AIDS-related deaths is the increase in HIV testing and anti-retroviral treatment coverage

In 2021, about 59% of adolescents aged 10–19 years living with HIV globally, received anti-

retroviral treatment (ART). Notably, ART coverage stood at 58% for adolescent girls and 60.2% for adolescent boys, showcasing substantial progress since 2010 when only 9.9% of all adolescents were receiving ART – an impressive increase of 49.1 percentage points.¹² In Zimbabwe, the number of new annual HIV infections declined from 9,100 in 2010 to 3,800 in 2019 among adolescents aged 10–19 years. Equally noteworthy is the reduction in AIDS-related deaths among all adolescents, with deaths in the 15–19 years age group decreasing from 3,600 in 2010 to 1,500 in 2019.¹⁰

Unfinished business

Efforts to combat the AIDS pandemic are facing a critical challenge as the curves of HIV infections and AIDS-related deaths are not bending fast enough to stop the AIDS pandemic. Globally, the annual estimated number of adolescents aged 10–19 years contracting new HIV infections stood at 160,000 in 2021, down from 260,000 in 2010. Similarly, the annual estimated number of AIDS-related deaths decreased to 29,000 in 2021 from 54,000 in 2010.¹³ However, further progress against AIDS is hindered by entrenched inequalities that leave the world susceptible to future pandemics. A notable gender-based disparity exists, as males continue to have limited access to HIV testing and treatment. For instance, in 2021, 560,000 girls aged 10–19 years living with HIV received ART, compared to 440,000 boys of the same age. This inequality has grown from 2010 when an estimated 100,000 girls accessed ART and 91,000 boys did so.¹³ Addressing these disparities is essential to accelerate the fight against AIDS and ensure a more equitable response to the pandemic.

The levels of female genital mutilation/cutting (FGM/C) have declined

Based on available data, estimates reveal a decline in the prevalence of FGM/C among girls aged 15–19 in SSA and Northern Africa. Specifically, in SSA, FGM/C prevalence has decreased from 35% in 2003 to 25% in 2018, while in Northern Africa, it has dropped from 92% to 74% during the same period.¹¹ This positive trend is further underscored by a consistent reduction in FGM/C prevalence among girls aged 15–19 years in 18 countries: Djibouti, Egypt, Sierra Leone, Eritrea, Sudan, Burkina Faso, Ethiopia, Mauritania,

Liberia, Cote d'Ivoire, Kenya, Maldives, Central African Republic, Nigeria, Yemen, United Republic of Tanzania, Benin, and Iraq. The prevalence in these countries has decreased from 42% in 2010 to 34% in 2020.⁶ Notably, in Ethiopia, there has been a remarkable shift in attitudes, with 53.4% of adolescent girls supporting the continuation of the practice in 2000, compared to a reduced proportion of 13.6% in 2016.¹¹ Furthermore, in Kenya, girls aged 15–19 are now four times less likely to have undergone FGM/C compared to women aged 45–49, indicating a positive generational change in this harmful practice.¹⁴

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While there is evidence of declining rates of FGM/C and reduced support for the practice among younger generations in many settings, the risks associated with FGM/C continue to persist at concerning levels. For instance, in Djibouti, FGM/C prevalence was as high as 98% in 1990, and although there has been some progress, it still stands at 88% in 2020. Similarly, in Egypt, the prevalence was 97% in 1990 and has reduced to 70% in 2020. Several other countries, including Somalia, Guinea, Mali, and Gambia, continue to grapple with FGM/C prevalence exceeding 70%.⁶ Despite the progress made in combatting FGM/C, the practice is driven by deeply entrenched norms in many communities, resulting in large variations at the subnational level and uneven progress in its elimination. For instance, in Ethiopia, the North East region has witnessed a slower reduction in FGM/C compared to other parts of the country, leading to substantial subnational disparities.¹¹ In order to achieve the ambitious goal of eradicating FGM/C by 2030, there is an urgent need to accelerate and sustain progress. Achieving this goal requires well-coordinated multisectoral interventions that address the underlying norms and factors driving the practice, thereby fostering a comprehensive and effective approach to combat FGM/C and protect the rights and well-being of girls and women.

The levels of HPV vaccine coverage have increased over time

Globally, there has been a notable increase in HPV vaccine coverage for girls aged 9–14 years, both for the first dose and the last dose, over the period from 2010 to 2022. Specifically, the coverage for

the first dose has risen by 4%, climbing from 4% in 2010 to 21% in 2022, while the last dose coverage has similarly increased by 4%, going from 3% in 2010 to 15% in 2022.¹⁵ This progress is further highlighted by the fact that as of 2022, at least 129 countries have introduced HPV vaccines, with 17 countries having done so between 2006 and 2019.¹⁵

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The progress in HPV vaccine coverage for girls has been uneven across different regions. Some regions have made enormous strides, such as the Region of the Americas (AMR), while others have made moderate progress, as observed in the African region (AFR) and the European region (EUR). However, certain regions, including the Eastern Mediterranean Region (EMR), South-East Asia region (SEAR), and Western Pacific Region (WPR), have made limited progress in HPV vaccine coverage.¹⁶ Despite the introduction of the HPV vaccine in 116 countries by 2021, it's noteworthy that these efforts only cover 41% of the global population burdened by cervical cancer.¹⁶ Low coverage rates and the failure of many individuals to complete the full vaccination schedule in numerous countries contribute to a situation where a significant number of girls remain inadequately protected against cervical cancer, despite the availability of the HPV vaccine.¹⁶ Furthermore, since 2019, several regions and countries have witnessed a decline in the number of girls receiving the HPV vaccine. However, in 2021, the European region (EUR) bucked this trend, reporting a slight increase in HPV vaccine coverage among boys, even in the face of disruptions caused by the COVID-19 pandemic.¹⁶

Discussion

Undoubtedly, there have been discernible improvements in various aspects of ASRH outcomes on a global scale. It is important to acknowledge that although progress may be relatively slower in certain regions and exhibits disparities, it is undeniably under way. However, this progress is often not adequately recognised within the published literature pertaining to ASRH. Instead, the literature tends to employ three distinct approaches that inadvertently obscure the strides being made in this domain.

First, there are strong assertions of the levels of undesired health outcomes, harmful practices, or health behaviours with limited accompanying data on trends over time.¹⁷ Second, data on areas of adolescent health where there has been progress, principally in ASRH, are combined with data from other areas of adolescent health in which there has been little or no progress (e.g. mental health), concluding that on an average, there has been little or no progress in adolescent health.¹⁸ Third, any progress that has been made in reducing the rates of negative health outcomes are not celebrated, citing the increase in absolute numbers of adolescents affected by the problem. For example, in relation to the levels of child marriage globally, the reductions in the rates of child marriage are seen to have little value because of the increase in the overall numbers of child marriages that are occurring.¹⁹

There may sometimes be valid reasons for stating the levels (not the trends) of health outcomes, harmful practices, and health behaviours, for providing an average “score” of progress on all adolescent health issues (including those that have been on the global agenda for 25 years and those that have been recently placed on the agenda), and to point to the expanding numbers of adolescents affected by a health problem or harmful practice, without also pointing to the changing rates on these issues. But doing this routinely amounts to communicating half the story, which can be misleading.

There are sound reasons for sharing data on trends in progress. First, it communicates to all those working in and supporting ASRH programmes that progress has been made with investment and effort, and that further progress can be made. Second, it points to which geographic areas and population groups of adolescents have benefited from this progress and which ones have been left behind and why. This can then inform further action. Third, it points to the expertise and learning that has built up over 25 years which can be put to good use: for example, expertise in contraceptive counselling could be used to provide mental health diagnosis and care.¹⁸

It must be noted that while we have pointed to areas in which progress has been made, we have not discussed the factors that have helped and hindered progress. That is an important discussion which we have dealt with elsewhere.¹⁸ Nor have

we discussed why there are gaps in the data in a number of areas that need to be filled. That too is an important discussion which we have addressed elsewhere.²⁰

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