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Review article

A Package of Sexual and Reproductive Health and Rights Interventions—What Does It Mean for Adolescents?

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A B S T R A C T

This article analyzes the relevance of the comprehensive definition of sexual and reproductive health and rights (SRHR) to adolescents and identifies adolescent-specific implications for the implementation of an essential package of SRHR interventions. The delivery of a comprehensive approach to SRHR targeting adolescents is underpinned by five principles—equity, quality, accountability, multisectorality, and meaningful engagement. All SRHR interventions included in the package are relevant to adolescents, given the diversity of adolescents' SRHR needs and considering their specific attributes, circumstances, and experiences. Ensuring that this package is available, accessible, and acceptable to adolescents requires an approach that looks at adolescents as being biologically and socially distinct from other age groups and acknowledges that they face some specific barriers when accessing SRHR services. This article provides cross-cutting strategies for the implementation of a comprehensive approach to SRHR for adolescents and specific considerations in delivering each intervention in the package of essential SRHR interventions. To further implement the International Conference on Population and Development Programme of Action, a prerequisite for achieving the Sustainable Development Goals, SRHR interventions must be adolescent responsive, delivered through multiple

IMPLICATIONS AND CONTRIBUTION

This article presents adolescent-specific considerations for implementing a package of essential SRHR interventions. Adolescents' unique attributes and needs, and the barriers they face in accessing care impact the delivery of each intervention of the package. While certain aspects of SRHR are unique to this age group,

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platforms, leveraging multisectoral collaboration, and strengthening accountability and participation.

all SRHR interventions are relevant to adolescents and can be adapted to ensure service delivery is adolescent responsive in practice, and contributing to the progressive realization of UHC.

A breakthrough at the 1994 International Conference on Population and Development (ICPD) was the recognition that sexual and reproductive health (SRH) services are essential for all people, including adolescents and youth (This paper defines adolescents as those aged 10-19 years, youth as 15–24 years, and young people as 10–24 years). The ICPD Programme of Action, was forward-looking in relation to adolescents and young people, it called for "meeting the educational and (health) service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality" [1].

In the decades since, the urgency to address the sexual and reproductive health and rights (SRHR) of adolescents and young people has been repeatedly reaffirmed [2,3]. Buttressed by increased knowledge about adolescence development [3,4], there is now near-universal consensus that promoting and protecting adolescent health will bring health benefits for the adolescent now, in their future lives and for the future generations [3]. Still, ensuring the SRHR of adolescents remains an unfinished agenda in the ICPD Programme of Action [5].

The increased global attention and accumulating evidence related to adolescent SRHR are seldom reflected in robust, scaled-up programmatic responses at the service delivery level [6]. Adolescents risk falling into a policy and service delivery gap, where their specific health needs and barriers to access are overlooked [7].

To respond effectively and adequately to adolescents' health needs, an integrated approach to SRHR (Box 1), implemented through a package of essential SRHR interventions, is needed [8]. Such a package includes promotive, preventive, and curative interventions, taking the social determinants of health into account in its implementation.

Box 1. Guttmacher–Lancet Commission, The Lancet, 2018. Integrated definition of sexual and reproductive health and rights

Sexual and reproductive health is a state of physical, emotional, mental, and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall well-being.

All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realization of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy, and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when, and whom to marry;
- decide whether, when, and by what means to have a child or children, and how many children to have;
- have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.

Contribution of this Article

This article presents adolescent-specific considerations for implementing the package of essential SRHR interventions as identified in the World Health Organization reproductive health framework [9] and the Guttmacher-Lancet Commission's definition of SRHR [8]. It outlines adolescents' unique attributes and needs and the barriers they face and goes on to identify corresponding strategies and approaches to address these. It aims to guide countries seeking to enhance investments in SRHR tailored to adolescents and progressively realize Universal Health Coverage (UHC) by prioritizing, costing, financing, and implementing the package of essential SRHR interventions for adolescents in all their diversity.

Principles underpinning the package of essential SRHR interventions for adolescents

A human rights–based approach to adolescent health is essential to ensure that adolescents can exercise their rights and make informed choices in relation to their sexual and reproductive health. It obliges duty bearers to respect, protect, and fulfill human rights by refraining from denying or limiting access to health care services or withholding information (including parental consent requirements), taking the necessary legislative and other measures to protect adolescents from discrimination, gender-based violence and harmful practices and to adopt/adapt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures to fully realize adolescents' right to health including sexual and reproductive health [10].

The ICPD Programme of Action highlighted the principles of equity, quality, and accountability as essential for the delivery of SRH services and the realization of individuals' sexual and reproductive rights [1]. Since the ICPD, the importance of multisectorality and meaningful participation of rights holders has been increasingly acknowledged [11]. This article thus outlines

Box 2. Diversity of adolescents and their sexual and reproductive health and rights (SRHR) needs

Ecological level	Examples of adolescents' circumstances and experiences influencing their SRHR needs
Individual	*Adolescents who are:* - Very young (aged 10–14 years) - Unmarried and sexually active - Pregnant - First-time young parents - Suffering obstetric fistula - Lesbian, gay, bisexual, transgender, intersex and other sexuality, sex, and gender-diverse adolescents - Living with HIV and/or other chronic illnesses or disabilities; - In need of mental health and psychosocial support services - Out of school or with low level of educational attainment
Interpersonal	*Adolescents who are:* - Acting as head of households - Married in childhood - Orphans living in host families - Living in households at or below the poverty line - Experiencing or witnessing interpersonal and/or sexual and gender-based violence - victims of trafficking and sexual abuse and exploitation
Community	*Adolescents living in:* - Urban slum communities, rural remote, and/or pastoralist communities - Camps or settlements as a result of crises
Macro	*Adolescents in societies affected by:* - Conflict - Disaster - Climate crises - Forced migration *Adolescents who are:* - Members of ethnic minorities - Refugees - Internally displaced

five key principles that must be considered in the delivery of a package of essential SRHR interventions focusing on how they relate specifically to adolescents.

- Equity in access to SRHR for adolescents means that every adolescent has access to high-quality information and the full range of services to cater to their SRHR needs in a timely manner. It ensures that interventions are inclusive of those marginalized and considers the diversity of adolescents (Box 2). This requires using various delivery platforms to ensure inclusivity, that is, going beyond health facilities and schools, expanding community-based service delivery, including mobile and household-level outreach, as well as reducing or eliminating any financial or physical barriers [12].
- Quality of care has implications across the entire health system [13,14]. Although important for everyone, quality of care has particular implications for service delivery to adolescents. Services must be respectful, nonjudgmental, confidential, and present information that is comprehensible to adolescents to allow for informed decision-making [15]. This requires that providers are trained to provide accurate and nonjudgmental SRHR services and information tailored to adolescents' developmental stage. Variability in quality can be minimized by adopting global standards for quality health care services for adolescents [13] and supporting their achievement by addressing inability to physically access services, out-of-pocket payments, unregulated private health care provision, lack of service demand, and availability of data pertaining to adolescents [6].
- Accountability: A key component of ensuring quality and stigma-free services is to create platforms for feedback, where clients can hold health care providers and decision-makers accountable. Allowing adolescents to engage in accountability mechanisms can be a constructive way to monitor the quality of service provision, identify gaps and traits particularly appreciated by adolescents in different contexts. Such mechanisms can include community scorecard approaches [16], community-facility health management committees, and facility boards that ensure youth representation [3]. Moreover, health management information systems must collect age and gender-disaggregated data on adolescents, including very young adolescents (aged 10–14 years), to allow effective planning, monitoring and evaluation of service delivery. Progress or lack thereof should be documented and transparently shared with communities including adolescents to allow for informed feedback and continuous improvement.
- Multisectorality recognizes that health outcomes are determined by factors both within and outside the health sector and that some interventions critical to the health of adolescents are delivered by other sectors [17]. A multisectoral approach requires programs to build synergies across sectors, such as education, health, labor, transportation, infrastructure, and the social services [11,18–20] and, where relevant, establish coordination mechanisms between line ministries. The Sustainable Development Goals provide an excellent opportunity for tracking multisectoral action, identifying the linkages between the sectors relevant to adolescent SRHR [21].
- Meaningful youth engagement: Adolescents and youth have the right to actively and meaningfully participate in all matters that affect their lives [22]. In addition, greater engagement of adolescents in their health is positively associated with utilization of care and can enhance the effectiveness and sustainability of adolescent SRHR interventions [23–25]. Policy-makers and health service planners need to go beyond the recognition and identification of young people solely as beneficiaries and toward engaging them as equal and valuable partners in decision-making with other stakeholders [26]. This must go hand in hand with positive youth development approaches [27].

Unpacking the Heterogeneity of Adolescents' and Their SRHR Needs

Adolescent behavior and development are shaped by the immediate and distal environmental contexts in which they live

Table 1
Adolescent specific considerations for the delivery of the package of essential sexual and reproductive health and rights (SRHR) interventions

SRHR intervention	Related adolescent-specific attributes, needs, and barriers	Implication for service delivery
Comprehensive Sexuality Education (in and out of school)	Many adolescents lack basic knowledge of SRHR [30–32].	A sexuality education curriculum that is comprehensive, scientifically accurate, timely and developmentally appropriate, and human rights based should be delivered to all adolescents [33]. The education sector plays a critical role in the provision of CSE, including building the capacity of teachers to deliver effective programs [33].
	In many countries, a significant proportion of adolescents are out of school [34].	CSE programmes should be introduced in nonformal education and community-based settings to reach out-of-school adolescents including those most vulnerable and marginalized, especially in countries where school attendance is low or where adequate CSE is not included as part of the national curriculum [33].
	Adolescents receive no or very little information from their parents and caregivers [35].	Forging a common understanding of CSE, building broad social and political consensus around it, and generating support among stakeholders, including opposition groups, requires an ongoing and adequately funded advocacy strategy targeting teachers, parents, religious and community leaders, and policy makers [36].
	Adolescent girls are often uninformed and unprepared for menarche [37].	CSE can teach adolescents about the stages of the menstrual cycle, including the time around which pregnancy is most able to occur, how to manage menstruation, and that it is a normal and natural part of a girls' physical development and should not be treated with secrecy or stigma [33].
	Most young people around the world become sexually active during adolescence—whether within marriage or before and whether consensual or forced [38].	CSE needs to start at an early age (ideally before the onset of adolescence) and provide content that is responsive to the changing needs and capabilities of children and adolescents as they develop and establish a link to the health services [33]. Specifically, information and education about sexual activity, prevention of STIs and pregnancy, consent and bodily integrity, and promotion of healthy relationships needs to be provided before a person have sex for the first time [39–41].
	Adolescence is a time of continued gender socialization. Evidence links traditional gender norms unequal power in sexual relationships and intimate partner violence with negative SRH outcomes [42,43].	CSE programmes should address gender and power dynamics including how harmful notions of masculinity and femininity affect behaviors, are perpetuated and can be transformed; rights and coercion; gender inequality in society; unequal power in intimate relationships; fostering young women's empowerment; or gender and power dynamics of condom use [43].
Counseling and service provision for a range of modern contraceptives, with a defined minimum number and types of methods	Adolescent contraceptive use compared with adult women is characterized by shorter periods of consistent use, and greater proportions of adolescents discontinue contraceptive methods and experience contraceptive failure [44]. Many adolescents have inadequate knowledge about contraception, and they are particularly sensitive to contraceptive side effects [45,46].	Health care providers should pay attention to and provide support for active management of side effects and continuous access to tailored information throughout the period of method use [47].
	Adolescents are at high risk of rapid repeat pregnancies because of misinformation or lack of awareness of fertility patterns, including return of fertility [48].	Contraceptive counseling and service provision should be included as an integral part of antenatal, postpartum and safe and/or postabortion care for adolescents and with timely and feasible referral mechanisms where needed [49].
	Inadequate knowledge, skills, and judgmental attitudes of health workers (including providers who believe that adolescents should not be sexually active or that contraception may inhibit future fertility) deter service use by adolescents [50].	Adolescents should be able to access respectful and comprehensive counseling, provision of services, and/or timely and functioning referral mechanisms as required [51]. Service providers should be knowledgeable about all methods, including emergency contraception and long-acting reversible contraceptives and their appropriateness for adolescents, including communicating advantages and disadvantages of methods, and the possibility of switching methods [51–53].
	A range of health conditions often manifest for the first time in adolescence (acne, premenstrual syndrome, menstrual cramps, endometriosis symptoms, or polycystic ovarian syndrome) indicating the therapeutic use of hormonal contraceptives [54].	Hormonal contraception should be offered/provided to adolescents for medical reasons other than sexual activity if needed [54].
	Identity formation and future thinking are two key developmental features of adolescence [55]. They include sexuality and relationships building, as well as considering aspirations and plans for the future.	Contraceptive services should relate to adolescents' life goals in addition to reproductive intentions, with a defined minimum number and types of methods made available, including long-acting reversible contraception and emergency contraception [56]. Providers should allow sufficient time with their adolescent patients to address contraceptive needs using a developmentally appropriate, patient-centered approach, such as motivational interviewing [57] or aspirational counseling, meeting adolescents where they are in their life situation, and offering contraception as a means to achieving their life goals [58].

Table 1
Continued

SRHR intervention	Related adolescent-specific attributes, needs, and barriers	Implication for service delivery
Antenatal, childbirth, and postnatal care, including emergency obstetric and newborn care	Depending on the region, although a large percentage of adolescents use some antenatal care for their first birth, they seek care later, make fewer visits during pregnancy, and receive fewer components of care than adult first-time mothers [59].	The health system should actively target and reach out to pregnant adolescents, mothers, and their families to encourage antenatal care visits and increase awareness around danger signs and when and how to seek care, including giving birth at a facility [60,61]. Health-care providers should have ongoing training and support to ensure they have the knowledge, understanding and skills to provide high-quality adolescent-responsive antenatal, intrapartum and postnatal care [60].
	Adolescent girls are likely to be influenced by social norms and practices around childbirth and may not have the autonomy to seek services according to their needs [62].	All adolescents should have information on the importance of using maternal health services through CSE, and communities need to be engaged through participatory programs [63].
	Pregnant adolescents living with HIV have lower uptake of PMTCT services than older women and their infants have poorer HIV related clinical outcomes [123].	HIV testing of pregnant adolescents during antenatal visits and differentiated services should be ensured to maintain retention [64,65].
	Perinatal depression in parenting adolescents is two to nine times higher than that in the general population, and pregnant and parenting adolescents may face several adversities such as social stigma, lack of emotional support, poor health care access, and stresses around new life adjustments [66].	Adolescent and maternal health policies should recognize mental health needs of adolescents, and health facility and/or community-based sexual and reproductive health services should link to the appropriate mental health and psychosocial support services to address related mental health conditions [67].
	Laws and policies in many places require girls who are pregnant to be expelled/suspended from school or does not allow them to return to school after pregnancy [68].	The legal and policy framework should allow and encourage pregnant adolescents and adolescent mothers to continue their education, and schools must be a safe space for pregnant girls and mothers [68].
Safe abortion services and treatment of complications of unsafe abortion	Compared with older women, adolescents are more likely to seek abortions from untrained providers or to have a self-induced abortion [30].	In countries where abortion is legal, national standards and guidelines should include both surgical and medical methods of abortion, including their application and relevance to adolescents [69].
	Adolescents know less about their rights concerning abortion and postabortion care compared with older women [30], and globally, adolescent girls are more likely than older women to delay seeking an abortion because they tend to recognize and acknowledge their pregnancy later [70].	Adolescents should be informed about their legal rights to abortion and/or post abortion care and the availability of these services at health facilities [30].
	In many countries, stigma against premarital sex and pregnancy outside of marriage is pervasive, which increases adolescents' likelihood of abortion [70].	Providers should be trained to pay specific attention to confidentiality and respect in providing safe abortion care to adolescents, and be knowledgeable of when services are legal, including for adolescents [30,69].
Prevention and treatment of HIV and other sexually transmitted infections	Adolescents have low rates of HIV and STI testing, linkage to prevention and poor treatment and adherence [71].	In generalized HIV epidemics, provider-initiated HIV testing should be offered to adolescents and youth visiting health services [72]. Health service linkages with peer and community-based ARV adherence support groups should be encouraged [73–75]. Health-care providers should be trained and supported to inform, counsel and care for adolescents according to their evolving capacities to understand the treatment and care options being offered [76]. STI prevention and management services should be provided for adolescents without mandatory parental and guardian authorization or notification [60].
	Adolescents living with HIV, acquired perinatally, may not be aware of their status [72].	Adolescents from age 12 years should be made aware of their HIV status, and additional support provided to them in disclosing their HIV status (when, how, and to whom to disclose), and confidentiality maintained [72].
	Young people who inject drugs, men who have sex with men, transgender people, sex workers, prisoners and migrants (young key populations) experience stigma, discrimination even greater than adult key populations and sometimes are subject to criminal proceedings [77].	In low and concentrated epidemics HIV testing should be available particularly in community settings to attract young key populations [72].
Prevention, detection, immediate services, and referrals for cases of sexual and gender-based violence (GBV)	Intimate partner violence (IPV) can start early, with estimates showing nearly one third of 15- to 19-year-old girls experiencing IPV [78]. IPV can increase girls' risk of unintended pregnancies and induced, unsafe abortions. In some settings, IPV also increases girls' and women's risk of acquisition of HIV and STIs.	Relevant clinical treatment for GBV should be offered to adolescent victims including emergency contraception, HIV PEP, STI treatment, and syndromic case management [79].
	Child and adolescent sexual abuse and IPV are linked to increased risk of mental health issues such as depression, posttraumatic stress disorder, and suicidal ideation and attempts [80].	Cognitive behavioral therapy with a trauma focus should be offered to children and adolescents who have been sexually abused and are experiencing adverse mental health outcomes such as symptoms of posttraumatic stress disorder and depression [79].

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Table 1
Continued

SRHR intervention	Related adolescent-specific attributes, needs, and barriers	Implication for service delivery
	Female genital mutilation (FGM) [81] occurs frequently during adolescence in those countries where it is still practiced.	Deinfibulation for preventing and treating urological complications, specifically recurrent urinary tract infections and urinary retention should be offered to girls and women living with type III FGM. Cognitive behavioral therapy for girls and women living with FGM who are experiencing symptoms consistent with anxiety disorders, depression, or posttraumatic stress disorder should be considered [82]. Promoting abandonment of the practice at community-level through a combination of individual empowerment, community mobilization, and law enforcement approaches can support prevention of FGM [83].
	In some countries high numbers of adolescent girls are in formal or informal union [84].	In areas with high prevalence and/or high burden, school- and community-based interventions to inform and empower girls, in combination with interventions to influence family and community norms, in order to delay the age of marriage among girls aged <18 years should be considered [60]. Educational and employment opportunities for girls through formal and nonformal channels, in order to delay marriage until at least 18 years of age should be promoted [60]. Political leaders, planners and community leaders should be encouraged to formulate and enforce laws and policies to prohibit marriage of girls before 18 years of age [60].
Prevention, detection, and management of reproductive cancers, especially cervical cancer	A majority of adult deaths from cervical cancers can be prevented if the HPV vaccine is successfully delivered to all adolescents [85].	Awareness around HPV and the vaccine among adolescent girls, their families, teachers, and other gate keepers should be raised [86]. Legal and policy barriers to HPV vaccine provision to all adolescent girls aged 9–13 years should be removed. Girls should not be asked about their sexual activity before the vaccine is administered [87]. The roll out of the HPV vaccine to all 9- to 13-year-old girls should include mixed models comprising school and health facility –based vaccination including through integration of HPV vaccine into existing adolescent health programs, school health, and other platforms [88,89].
Information, counseling, and services for subfertility and infertility	Adolescence is an important period for developing lifelong healthy lifestyles (eg, nonsmoking, obesity prevention), which can prevent common causes of later subfertility/infertility in adulthood [90]	General sexual and reproductive health promotion (eg, safe sex to prevent STIs) and overall health promotion (eg, healthy nutrition and exercise to prevent obesity, avoiding smoking, etc) including messages around infertility and reasons for infertility [91] should be provided to all adoelscents.
	Adolescent girls who have experienced an unsafe abortion, complicated childbirth or have been exposed to STIs may suffer from subfertility and/or secondary infertility [30]. Some childhood medical treatments and conditions such as oncologic therapy and hormonal therapy used among transgender youth, and other genetic syndromes have been shown to influence fertility. Many adolescent cancer survivors express a desire to have children in the future and have concerns about their fertility [92,93]. Providers serving adolescents who have certain illnesses or chronic conditions that threaten their fertility may not be comfortable or think it appropriate to discuss fertility preservation with them [92,93].	The need for information, counseling, and services for subfertility and infertility to adolescents in service guidelines and training should be recognized especially in contexts of early marriage and childbearing, and high prevalence of STIs and unsafe abortions [91] Providers should be trained to sensitively counsel adolescents undergoing and following treatment for relevant conditions/diseases about possible effects on fertility and options (when applicable) for fertility preservation [91-93].
Information, counseling, and services for sexual health and well-being	Adolescence is a time where a person starts experiencing sexual feelings, exploring sexual behaviors, and may experience anxieties and concerns in relation to body changes, desire, pleasure, masturbation, virginity, romantic love, relationships, and marriage [94]. It is also a time with significant biological changes related to sexual maturity. Girls are less likely to negotiate terms of sex, that is, less likely to insist that their partners use condoms. Harmful masculinities may drive boys to engage in risky sexual behaviors and refuse the use contraceptives including condoms [95].	Much of the strategies to ensure sexual health and well-being are captured under CSE; however, health service delivery strategies should include providing counseling to adolescents about safe, pleasurable, and consensual sex and ensuring linkages with mental health services and counseling, particularly considering adolescent-specific cognitive and behavioral transitions and establishment of identity that may result in anxiety and depression [67].
	Lesbian, gay, bisexual, transgender, intersex (LGBTI) and gender nonconforming adolescents often lack adequate support systems, experience the feeling of being different and not fitting in, and are exposed to higher rates of violence, bullying and harassment, and can consequently experience mental health problems including anger, depression, sadness, stress, or worry [96,97].	Familiarity with the psychological and medical approaches to providing care to LGBTI + and gender nonconforming adolescents including through offering gender-affirming therapies for transgender persons and options for hormonal therapy [98,122].

CSE = comprehensive sexuality education; STI = sexually transmitted infection; PMTCT = prevention of mother-to-child transmission; ARV = antiretroviral; PEP = post-exposure prophylaxis.

[28]. Access to health services is influenced by social factors at personal, family, community, and national levels [18]. To this end, adolescent SRHR interventions must recognize the risk and protective factors across these ecological levels and how they influence adolescent health outcomes [19]. Box 2 illustrates the diversity of adolescents' circumstances and experiences that influences their SRHR needs as well as their ability to access services and information. This article argues that all the interventions included in the package of essential SRHR interventions [8] should be made available to adolescents, given the diversity of adolescents' SRHR needs.

A Package of Essential SRHR Interventions for Adolescents

Ensuring that the package of essential SRHR interventions is available, accessible, and acceptable to adolescents [29] requires an approach that looks at adolescents as being biologically and socially distinct from other age groups and acknowledges that they face some specific barriers when trying to access SRHR services.

Certain aspects of SRHR are unique to adolescents (Table 1), such as menarche, initiation of sexual activity, the recommended age of HPV vaccination, and the opportunity to provide comprehensive sexuality education in school [8]. For other aspects of SRHR, the risk of adverse outcomes can be exacerbated during adolescence. This is reflected in the higher proportion of adolescent girls with an unmet need for contraception (than women aged 20–49 years married or in union), compared with older women, adolescents have a greater tendency to seek abortions from untrained providers or to self-induce; a smaller proportion of pregnant adolescent girls attending all four ANC visits compared with other women of reproductive age; adolescents being the only age group in which HIV-related deaths are not decreasing; and the greater burden of recent intimate partner violence among adolescent girls relative to their adult counterparts in several settings, including the high risk of forced sexual debut [29,30,70,78,80,99–102].

Factors increasing the risk of adverse SRHR outcomes include restrictive laws and policies, expensive or fragmented services [103], biased providers [60], and social and gender norms that do not admit adolescents' rights to autonomy over their bodies and to explore consensual, safe, and pleasurable sexual experiences [5,52,60,104,105]. Addressing these factors is critical for the success of every intervention included in the package of essential SRHR interventions. At the legal and policy level, this may require removing barriers to service provision such as compulsory parental or spousal consent for services including contraception, safe abortion and postabortion care, and HIV and STI testing and care [30,60,104,105]. At the service delivery level, critical strategies include removing or reducing costs of services for adolescents, introducing flexible opening hours adaptive to adolescents' schedules, and training and supporting providers on delivering SRHR services to adolescents in a respectful, confidential, and relevant manner [29,52,53,99,100,103,104,106,107]. At the community level, engaging parents, local leadership, and influential community members such as teachers through participatory learning and reflection, and supporting adolescent participation and leadership can generate support and increase demand for adolescent health care seeking behavior [52,60,69,104,108].

In addition to the cross-cutting strategies discussed previously, there are specific considerations in delivering each intervention included in the essential package to adolescents. Although every intervention needs to meet the global standards for medical ethics, public health, and human rights—applicable to adolescents and adults alike—Table 1 provides a nonexhaustive list of adolescent-specific considerations for each of the interventions drawn from WHO guidelines and from published studies and evaluations in emerging areas [8].

Reaching Adolescents With a Package of Essential SRHR Interventions

Adolescents rarely seek services from a health facility, particularly not for preventive care [53,109]. To reach them with a package of essential SRHR interventions, the way the services are delivered matters therefore nearly as much as the services themselves. The Lancet Commission on Adolescent Health and Wellbeing [3] lists six main platforms, which provide opportunities to deliver health action to adolescents: health services, schools, laws and policies, communities, mHealth, and media and social marketing.

Programs that integrate SRHR across different platforms and sectors have shown promise to increase the coverage of SRHR services for adolescents [110]. Examples of integration of adolescent responsive services, coupled with adolescent-specific outreach and awareness raising interventions to address adolescent pregnancy, include countries such as Chile, the United Kingdom, Ethiopia [111], and Uruguay [112]. In these countries, programs were grounded in supportive national policies, scaled up across the health system and included different means of service delivery to cater to adolescent needs in respective contexts.

Adolescent immunization programs, such as the HPV vaccine roll out—administered in late childhood or early adolescence—also provide an opportunity to link to an integrated package of SRHR care for adolescents [87,113–115]. For example, in Togo, providers immunized girls against HPV while working hand in hand with teachers to inform girls and boys about puberty, menstrual health, and handwashing practices [116]. Although these programs focused on pregnancy prevention or vaccination rather than delivering a comprehensive approach to SRHR, the success of the delivery model points to the scaling up a package of essential SRHR interventions for adolescents in a similar manner.

Across sectors, synergies between health and education can yield particular high returns on coinvestment [117]. The growing number of adolescents enrolled in and attending school and a closing gender gap in education provides a strong case for intensifying collaboration between the health and education sector in particular. The school system is a cost-effective and equitable platform to deliver components of the package of essential SRHR interventions to adolescents [40,118]. With that said, cross-sectoral collaboration faces barriers, including differing priorities, funding streams, and timelines across sectors; and overcoming these barriers will require a shift in financial and political incentives [119].

Finally, as countries pursue UHC reforms, there are important health financing considerations for ensuring inclusion of adolescents' SRHR and adolescent health more broadly. For example, antenatal care services for adolescents are often covered, whereas contraception and safe abortion services may not be [120]. Most adolescents are particularly sensitive to costs associated with accessing SRH services [120]. Protection from

catastrophic expenditure [120] and removing cost-related barriers can increase access and utilization [121]. In practical terms, this means including adolescents in risk pools, using vouchers or other demand-side financing schemes to target subsidies to adolescents, and ensuring that adolescent-responsive service outlets are included as service providers in UHC schemes. This may involve adopting novel information and service delivery platforms such as mHealth solutions, telemedicine providers, and private sector channels, including pharmacies in strategic purchasing schemes.

Conclusion

All SRHR interventions are relevant to adolescents, and to deliver on the ICPD Programme of Action, the package of essential SRHR interventions must be made responsive to adolescents. As the health sector moves toward UHC, it must include SRHR, and it must cater to all adolescents including marginalized subgroups, such as unmarried adolescents, adolescents living with disabilities, and lesbian, gay, bisexual, transgender, intersex and other sex, and gender-diverse adolescents. This requires that the package of essential SRHR interventions is made available to all adolescents, leveraging multisectoral collaboration, strengthening accountability, and ensuring that adolescents are meaningfully engaged in the process. Successful implementation will rely on an enabling legal and policy environment and on a service delivery model that considers the determinants of adolescent SRHR, ensures integrated services, free or at very low cost, provided through a variety of platforms, respectful of the rights, and evolving capacities of adolescents.

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