

WHO recommendations on adolescent sexual and reproductive health and rights



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Abbreviations

AIDS	acquired immunodeficiency syndrome
ASRHR	adolescent sexual and reproductive health and rights
CSE	comprehensive sexuality education
DMPA/NET-EN	depot medroxyprogesterone acetate/norethisterone enanthate
FGM	female genital mutilation
GREAT Network	Guideline-driven, Research priorities, Evidence synthesis, Application of evidence, and Transfer of knowledge Network
HIV	human immunodeficiency virus
HPV	human papillomavirus
IPV	intimate partner violence
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1 Introduction

1.1 What is the purpose of this document?

This document provides an overview of sexual and reproductive health and rights issues that may be important for the human rights, health and well-being of adolescents (aged 10–19 years) and the relevant World Health Organization (WHO) guidelines on how to address them in an easily accessible, user-friendly format. The document serves as a gateway to the rich body of WHO guidelines, and as a handy resource to inform advocacy, policy and programme/project design and research. It aims to support the implementation of the Global Strategy for Women's, Children's and Adolescents' Health 2016–2030 (1), and is aligned with the WHO Global Accelerated Action for the Health of Adolescents (AA-HA!) as well as the WHO Operational Framework on Sexual Health and Its Linkages to Reproductive Health (2,3).

Full lists of WHO guidelines relevant to adolescent sexual and reproductive health and rights (ASRHR) can be found on the WHO website under the health topics 'Sexual and Reproductive Health' and 'HIV/AIDS'. As new recommendations are issued, it is important to refer to the latest versions of guidelines.

1.2 Who is the intended audience of this document?

This document is intended to be used by policy-makers and decision-makers in ministries of health responsible for ASRHR policies and programmes, international and national nongovernmental organizations carrying out ASRHR projects, and international organizations that provide technical or financial support for ASRHR work. The document is intended to be accessible to people with or without expertise in ASRHR. It is not intended as a technical reference for frontline professionals such as health-care providers, teachers or community development professionals.

1.3 What does this document contain?

In line with the WHO Operational Framework on Sexual Health and Its Linkages to Reproductive Health (3), this document compiles the WHO recommendations on the following issues:

- comprehensive sexuality education (CSE) provision
- contraception counselling and provision
- antenatal, intrapartum and postnatal care

- safe abortion care
- sexually transmitted infections (STIs) prevention and care
- human immunodeficiency virus (HIV) prevention and care
- violence against women and girls prevention, support and care
- harmful traditional practices prevention.

1.4 How is this document organized?

For each issue, this document outlines the following:

- definitions
- rationale for addressing the issue in adolescents
- relevant WHO guidelines
- key concepts to consider
- key complementary documents in addition to the WHO guidelines
- real-life application of the guidelines.

1.5 What are the cross-cutting key messages in this document?

While there are specific considerations in addressing each of the issues included in this document, there are also clear and important cross-cutting messages.

Adolescents are a heterogeneous group with different and evolving needs, depending on their personal development stages and life circumstances. As they transition from childhood, through adolescence, into adulthood, all individuals must be prepared with the knowledge and skills they need to make use of the opportunities and to face the challenges they will encounter in the adult world. These efforts should contribute to building their sense of self-worth and to strengthening their links with the individuals and institutions in their communities. Meanwhile, adolescents need protection from harm on the one hand, and support to make independent decisions and act on them on the other. They need health and counselling services that can contribute to helping them stay well, and to get back to good health when they are ill or injured. The WHO guidelines described in this document call for this package of actions: building knowledge and skills, building individual and social assets, providing a safe and supportive environment, and providing health and counselling services. The guidelines also stress the role of educational and employment opportunities in broadening adolescents' horizons and helping them make a place for themselves in the world. They take into account that in many places, adolescents have limited opportunities to grow and develop to their full potential, and that poverty, insecurity, disempowering social norms and restrictive laws further increase their vulnerability to health and social problems.

Parents (and other family members) have an important role in delivering interventions, such as preparing girls and boys for puberty and building equitable gender norms. They also have a role to play in helping adolescents to access interventions being provided in the community, such as the human papillomavirus (HPV) vaccine and voluntary medical male circumcision. Almost

all parents want their sons and daughters to grow and develop in good health, and contribute to this meaningfully. However, in many places, they feel unprepared and unable to address the sensitive matters around puberty, sexuality and reproduction. For parents to do this, and to do this effectively, they need to be engaged, convinced of its value and supported. An important starting point is their own knowledge, misconceptions, hopes and fears.

Adolescents need different health, education and social services. Further, the right of adolescents below the age of 18 years to these services is enshrined in the Convention on the Rights of the Child. The reality is that in many places, neither the providers of these services nor the systems in which they operate are geared towards meeting the needs and fulfilling the rights of adolescents. To address this widely recognised gap, efforts are increasingly under way to build competence and empathy in teachers, health-care workers, social workers and others. However, these efforts need to be stepped up. Training and supporting service providers and reorienting the systems they are part of are crucial to delivering the many effective promotive, preventive and curative interventions available. Such efforts must go beyond perfunctory, top-down approaches to involving adolescents, community members, service providers and managers to identify the factors contributing to the poor quality and reach of these services and to define and implement evidence-based approaches that are tailored to the local context. It is just as important to build in assessment and accountability systems, with the meaningful involvement of adolescents.

Community norms and traditions have a powerful influence on health. They can – and, in some places, do – promote progressive and pro-social actions. In many places however, especially in relation to adolescent sexual and reproductive health, norms and traditions hinder rather than help. These include widespread unequal gender norms, norms that support harmful traditional practices such as female genital mutilation (FGM), norms that condone violence against women and girls, norms that shun discussion of sexuality and reproduction, and norms that oppose the provision of sexuality education and sexual and reproductive health services. Overcoming such norms and traditions will take the concerted application of approaches based on a sound understanding of the factors that drive them.

Laws and policies authorize the provision of health and social interventions to adolescents and require the relevant authorities to deliver them, provide the basis for the formulation of strategies and budgets, and signal the position of political leadership and government on important issues. Enabling laws and policies, such as those requiring governments to provide CSE, are in place in some countries. But they are the exception rather than the rule. In many places, major barriers include: Absence of enabling laws; the presence of contradictory laws, such as when a law or policy requiring the ministry of health to provide contraceptive information and services to all individuals of reproductive age is undermined by another law that requires mandatory parental consent for the provision of health services to legal minors; the presence of exceptions to laws, such as where age-of-marriage laws can be waived on different grounds; and the presence of restrictive laws, such as restrictions to the provision of safe abortion care. Legal and policy reform take time and effort. But, given their ultimate benefits, they are extremely important.

Although the structure of this document sets out groups of interventions intended to contribute to specific health outcomes, such as preventing and responding to STIs or to harmful traditional practices, both the determinants of problems and the responses to them are closely linked. Laws that require parental consent for legal minors to obtain health services hinder access to contraceptive information and services and, for example, to HIV testing and counselling. Social stigma can hinder care-seeking for intimate partner violence (IPV) and STIs. Health worker bias

can contribute to withholding of safe abortion services and contraceptive information services to unmarried adolescents, even if laws do not require health-care workers to do so. Programmatic responses are also intertwined. Building equitable gender norms through CSE can contribute to preventing gender-based violence and to promoting joint decision-making on contraception in couples. Finally, a caring and competent health-care worker can provide respectful care to a young single woman giving birth and address the distress of a young woman living with the consequences of FGM.

This compilation of the WHO guidelines on ASRHR intends to highlight these linkages and to press us to all to see adolescents' sexual and reproductive health needs and problems, and respond to them in an holistic manner.

2 Comprehensive sexuality education provision

2.1 Definitions

Comprehensive sexuality education (CSE) is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and adolescents with knowledge, skills, attitudes and values that will empower them to realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and understand and ensure the protection of their rights throughout their lives (3,4).

2.2 Rationale

Adolescents have a need for CSE. As they transition from childhood to adulthood, adolescents undergo a number of physical, emotional and social changes (4). Studies demonstrate that they are often unprepared for these changes. For example, substantial numbers of girls in many countries have knowledge gaps and misconceptions about menstruation that cause fear and anxiety and leave them unprepared when they begin menstruating (5). Similarly, critical gaps in knowledge exist among adolescent girls, especially in Africa and Asia, about where to obtain and how to use a range of modern contraceptive methods (6). Additionally, although comprehensive knowledge about HIV has increased, still only around 1 in 3 young men and women aged 15–24 years from 37 countries surveyed between 2011 and 2016 had comprehensive knowledge on how to prevent HIV transmission (7). Adolescents need knowledge and skills to make well-informed choices about their lives, learn how to avoid and deal with problems, and know where to seek help if necessary (4). CSE can help adolescents to develop knowledge and understanding; positive values, including respect for gender equality, diversity and human rights; and attitudes and skills that contribute to safe, healthy and positive relationships (4).

CSE has been shown to be effective. There is strong evidence for the positive effects of CSE on increasing adolescents' knowledge and improving their attitudes related to sexual and reproductive health (4). Research has also shown that curriculum-based CSE programmes can contribute to delayed initiation of sexual intercourse, decreased frequency of sexual intercourse, decreased number of sexual partners, reduced risk-taking, increased use of condoms, and increased use of contraception (4). There is no evidence that CSE increases sexual activity, sexual risk-taking behaviour, or rates of HIV or other STIs (4,8,9). School-based CSE has also been shown to be a cost-effective intervention to contribute to HIV prevention (10–12).

However, access to and provision of good-quality CSE programmes need attention. Most countries have policies or strategies that support CSE, but few have implemented and sustained large-scale CSE programmes (4,13). Many countries that have implemented large-scale CSE programmes struggle with ensuring quality and fidelity (4,13). Furthermore, the ability to access CSE is often based on being in school – but the most marginalized adolescents, who are often most at risk of adverse sexual and reproductive health outcomes, are often the least likely to be in school (14).

States have obligations under human rights law to provide comprehensive information and education to adolescents. CSE is part of the core obligations of states to uphold the right to sexual and reproductive health, which means it is considered one of the basic minimum actions states must take to give meaning to this right (15). According to human rights standards, such education should encompass self-awareness and knowledge about the body (including anatomical, physiological and emotional aspects) and sexual health and well-being (including information about body changes and maturation processes) (16). All children and adolescents, including those who are not in school, should have access to such information and education, which should be free, confidential, adolescent-responsive and non-discriminatory; barriers to such information, such as third-party authorization requirements, should be removed (15–17). In terms of format, human rights standards provide that such information should be available both online and in person, and that it should be age-appropriate, based on scientific evidence, and comprehensive and inclusive in its content (17). Human rights standards also call for CSE curricula to be developed with adolescents and to be part of the mandatory school curriculum (17).

2.3 Relevant WHO guidelines

2.3.1 WHO guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries. Geneva: World Health Organization; 2011

This guideline (18), which is specific to adolescents, provides recommendations for action and research to prevent early pregnancy and poor reproductive outcomes among adolescents. Broadly, it recommends reducing marriage before the age of 18 years, reducing pregnancy before the age of 20 years, increasing use of contraception by adolescents at risk of unintended pregnancy, reducing coerced sex among adolescents, reducing unsafe abortion among adolescents, and increasing use of skilled antenatal, childbirth and postnatal care among adolescents. With regard to CSE, the guideline issues the following adolescent-specific recommendations:

Community:

- Advocate for adolescent pregnancy prevention among all stakeholders through interventions such as information provision, sexuality and health education, life skills building, contraceptive counselling and service provision, and creation of supportive environments.

Individual:

- Implement interventions at scale that provide accurate information and education about contraceptives, in particular curriculum-based sexuality education, to increase contraceptive use among adolescents.

- Offer interventions that combine curriculum-based sexuality education with contraceptive promotion to adolescents, in order to reduce pregnancy rates.

2.3.2 Ensuring human rights in the provision of contraceptive information and services: guidance and recommendations. Geneva: World Health Organization; 2014

This guideline (19), which is relevant for but not specific to adolescents, provides recommendations on high-priority actions to ensure human rights dimensions are systematically and clearly integrated into the provision of contraceptive information and services. Broadly, it recommends ensuring availability, accessibility, acceptability, quality and non-discrimination in the provision of contraceptive information and services, informed decision-making, privacy and confidentiality, participation and accountability. With regard to CSE, this guideline also issues the following adolescent-specific recommendation:

Individual:

- Provide scientifically accurate CSE programmes within and outside of schools that include information on contraceptive use and acquisition.

2.3.3 Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations: 2016 update. Geneva: World Health Organization; 2016

This guideline (20), which is relevant for but not specific to adolescents, consolidates recommendations for HIV prevention, diagnosis, treatment and care for five key populations: men who have sex with men; people who inject drugs; people in prisons and other closed settings; sex workers; and transgender people. Broadly, it introduces a comprehensive package of interventions and describes health sector interventions, critical enablers, service delivery, and the decision-making, planning and monitoring processes. With regard to CSE, this guideline includes the good practice recommendation that sexuality education programmes for adolescents, both in and outside of schools, should be scientifically accurate and comprehensive and include information on contraceptives, including how to use them and where to get them. It also promotes CSE as an approach to addressing social norms and stigma concerning sexuality, gender identities and sexual orientation.

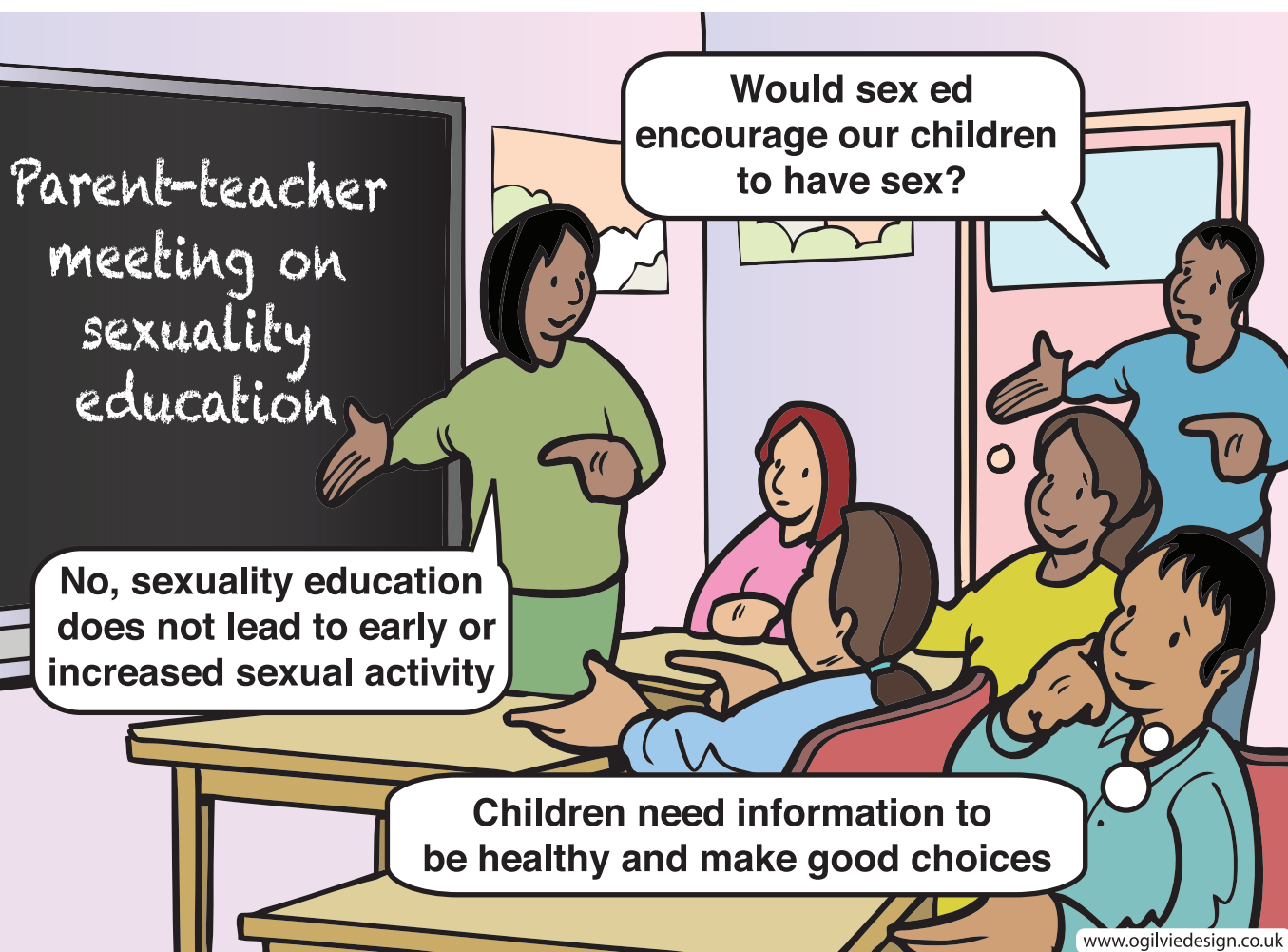
2.4 Key concepts to consider

Around the world, there is deep-seated discomfort about adolescent sexuality, which contributes to legal and social barriers to the provision of CSE. In order to overcome these barriers, CSE needs to be placed on national agendas, and strategies need to be put in place to build community support for CSE and to identify and address factors at regional, national, community and individual levels that could contribute to resistance or backlash or stall implementation progress (4, 18).

There is a widespread misconception that providing CSE will encourage adolescents to engage in early or risky sexual behaviour. As a result, the content of CSE curricula is often watered down or more limited than recommended by international guidance. Studies have shown that CSE does not increase sexual activity, sexual risk-taking behaviour or rates of HIV or other STIs (4, 8, 9). This

information should be communicated to advocate for the provision of comprehensive, accurate and age-appropriate information and education to adolescents (4,18,20).

Teachers often lack good quality training and support on CSE content and on strategies for participatory facilitation and non-judgemental, positive approaches. Concerted efforts must be made to ensure that teachers and schools are supported to deliver CSE effectively, and to engage parents and families in this process (4,18).



2.5 Key complementary documents in addition to the WHO guidelines

- Revised edition: International technical guidance on sexuality education – an evidence-informed approach. Paris: United Nations Educational, Scientific and Cultural Organization; 2018 (4)
- Standards for sexuality education in Europe: a framework for policy makers, educational and health authorities and specialists. Cologne: World Health Organization Regional Office for Europe and Federal Centre for Health Education; 2010 (21)
- Standards for sexuality education in Europe: guidance for implementation. Cologne: Federal Centre for Health Education; 2013 (22)
- Operational guidance for comprehensive sexuality education: a focus on human rights and gender. New York: United Nations Population Fund; 2014 (23)
- The evaluation of comprehensive sexuality education programmes: a focus on the gender and empowerment outcomes. New York: United Nations Population Fund; 2015 (24)

2.6 Real-life application of the guidelines

In 2008, 30 ministers of health and 26 ministers of education, or their personal representatives, from Latin America and the Caribbean made a regional commitment to sexuality education through the Preventing through Education Ministerial Declaration (25). This Declaration, which promised to implement and strengthen “multi-sectoral strategies of comprehensive sexuality education and promotion of sexual health, including HIV/STI prevention”, has stimulated countries to re-examine their sexuality education policies and programmes (13).

Similarly, in 2013 health and education ministers and representatives from 20 countries in eastern and southern Africa made a regional commitment to support adolescents’ access to CSE and sexual and reproductive health services (26). Led by the Joint United Nations Programme on HIV/AIDS (UNAIDS), and with the support of the United Nations Educational, Scientific and Cultural Organization (UNESCO), the United Nations Population Fund (UNFPA), the United Nations Children’s Fund (UNICEF), WHO, bilateral and civil society partners and adolescents’ organizations, the countries agreed on a common agenda to deliver CSE and youth-friendly sexual and reproductive health services to adolescents and youth in order to strengthen national responses to the HIV epidemic, to reduce early and unintended pregnancies, and to reinforce care and support for adolescents, particularly those living with HIV.

3 Contraception counselling and provision

3.1 Definition

Contraception is the intentional prevention of pregnancy by artificial or natural means (3). Contraception allows people to attain their desired number of children and to determine the spacing of pregnancies by delaying or preventing childbearing. Numerous contraceptive options, designated by duration and context of use (long-acting, permanent, short-term, emergency) and by method of operation (hormonal, non-hormonal, barrier, fertility awareness-based), exist (27).

3.2 Rationale

Early pregnancies, both intended and unintended, among adolescents are an important problem.

In 2016, an estimated 21 million girls aged 15–19 years in developing regions became pregnant, approximately 12 million of whom gave birth (28). Estimates suggest that 2.5 million girls aged under 16 years in low-resource countries give birth every year (29). For some adolescents, pregnancy and childbirth are planned and wanted. For others, they are not: Approximately half of pregnancies to girls aged 15–19 years in developing regions are unintended (28). Drivers of adolescent pregnancies are context-specific and can include child marriage, poverty, lack of opportunity, and social or cultural values related to womanhood and motherhood (30).

Early pregnancies among adolescents have major health and social consequences. With regard to health consequences, pregnancy and childbirth complications are the leading cause of death among girls aged 15–19 years globally, with low- and middle-income countries accounting for 99% of global maternal deaths of women aged 15–49 years (31,32). Adolescent mothers aged 10–19 years face higher risks of eclampsia, puerperal endometritis and systemic infections than women aged 20–24 years (33). Additionally, some 3.9 million unsafe abortions among girls aged 15–19 years occur each year, contributing to maternal mortality, morbidity and lasting health problems (28). Early childbearing can increase risks for newborns as well as young mothers. Babies born to mothers under 20 years of age face higher risks of low birth weight, preterm delivery and severe neonatal conditions (33). In some settings, rapid repeat pregnancy is a concern for young mothers, which presents further risks for both the mother and the child (34,35).

With regard to social consequences, unmarried pregnant adolescents may face stigma, rejection or violence by partners, parents and peers (30). Girls who become pregnant before the age of 18 years are more likely to experience violence within a marriage or partnership (36). Adolescent pregnancy may also jeopardize girls' future education and employment opportunities (30,37).

Promotion of contraceptive use to address early pregnancies among adolescents has been shown to be effective. By preventing early and unintended pregnancies, contraception can help to reduce maternal and newborn mortality and morbidity and decrease the need for unsafe abortion (28). Furthermore, male and female condoms provide dual protection against unintended pregnancies and STIs, including HIV (38). If unmet need for contraception among adolescents were to be met, the associated health, social and economic costs of 2.1 million unplanned births, 3.2 million abortions and 5600 maternal deaths could be averted (28).

However, laws and policies and provision of good-quality services need attention. Twenty-three million adolescents aged 15–19 years have an unmet need for modern contraception and are at risk of unintended pregnancy (28). Some girls are not aware of the benefits of contraception (39). Girls who are aware of the benefits and wish to access contraception face numerous barriers, including restrictive laws and policies regarding provision of contraception based on age or marital status, health-care provider bias or lack of willingness to acknowledge adolescents' sexual and reproductive health needs, and adolescents' own inability to access contraceptives because of knowledge, transportation and financial constraints (39). Even when adolescents are able to obtain and use contraceptives, they face barriers that prevent use, or consistent and correct use, including pressure to have children, stigma surrounding non-marital sexual activity or contraceptive use, fear of side-effects, lack of knowledge on correct use, and factors contributing to discontinuation (e.g. hesitation to go back and seek contraceptives because of negative first experiences with health-care providers or health systems; changing reproductive needs; changing reproductive intentions) (39). As a result, unmet contraceptive needs among adolescents are greater than in any other age group (28).

States have obligations under human rights law to provide contraceptive information and services to adolescents. States are obliged to adopt legal and policy measures to ensure access of all individuals, including adolescents, to affordable, safe and effective contraceptives (15). Adolescents should have easy access to short-term, long-acting and permanent contraceptives, and such access must not be hampered by their marital status or providers' conscientious objections (16). Contraceptive information and services, including emergency contraception, as part of sexual and reproductive health services, should be free, confidential, adolescent-responsive and non-discriminatory, and barriers to services such as third-party authorization requirements should be removed (15,17).

3.3 Relevant WHO guidelines

3.3.1 WHO guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries. Geneva: World Health Organization; 2011

This guideline (18), which is specific to adolescents, provides recommendations for action and research to prevent early pregnancy and poor reproductive outcomes among adolescents. Broadly, it recommends reducing marriage before the age of 18 years, reducing pregnancy before the age of 20 years, increasing use of contraception by adolescents at risk of unintended pregnancy, reducing coerced sex among adolescents, reducing unsafe abortion among adolescents, and increasing use of skilled antenatal, childbirth and postnatal care among adolescents. With regard to contraception, the guideline issues the following adolescent-specific recommendations:

Policy:

- Advocate for adolescent pregnancy prevention among all stakeholders through interventions such as information provision, sexuality and health education, life skills building, contraceptive counselling and service provision, and creation of supportive environments.
- Undertake efforts with political leaders and planners to formulate laws and policies to increase adolescent access to contraceptive information and services, including emergency contraceptives.

Community:

- Undertake interventions to influence community members to support access to contraceptives for adolescents.

Health facility:

- Implement interventions to improve health service delivery to adolescents as a means of facilitating their access to and use of contraceptive information and services.
- Implement interventions to reduce the financial cost of contraceptives to adolescents (conditional recommendation).
- Ensure adolescents who have had abortions can obtain post-abortion contraceptive information and services, regardless of whether the abortion was legal.
- Offer and promote postpartum and post-abortion contraception to adolescents through multiple home or clinic visits to reduce the chances of second pregnancies among adolescents.

Individual:

- Implement interventions at scale that provide accurate information and education about contraceptives, in particular curriculum-based sexuality education, in order to increase contraceptive use among adolescents.
- Offer interventions that combine curriculum-based sexuality education with contraceptive promotion to adolescents, in order to reduce pregnancy rates.

3.3.2 Ensuring human rights in the provision of contraceptive information and services: guidance and recommendations. Geneva: World Health Organization; 2014

This guideline (19), which is relevant for but not specific to adolescents, provides recommendations on high-priority actions to ensure human rights dimensions are systematically and clearly integrated into the provision of contraceptive information and services. Broadly, it focuses on ensuring availability, accessibility, acceptability, quality and non-discrimination in the provision of contraceptive information and services, along with promoting informed decision-making, privacy and confidentiality, participation and accountability. With regard to contraception, this guideline also issues the following adolescent-specific recommendations:

Health facility:

- Improve access to comprehensive contraceptive information and services for users and potential users with difficulties in accessing services (e.g. rural residents, urban poor people, adolescents). Safe abortion information and services should also be provided according to existing WHO guidelines.

- Eliminate financial barriers to contraceptive use by marginalized populations, including adolescents and poor people, and make contraceptives affordable to all.
- Provide sexual and reproductive health services, including contraceptive information and services, for adolescents without mandatory parental and guardian authorization or notification, in order to meet the educational and service needs of adolescents.

Individual:

- Provide scientifically accurate CSE programmes within and outside of schools that include information on contraceptive use and acquisition.

3.3.3 Medical eligibility criteria for contraceptive use, 5th edition. Geneva: World Health Organization; 2015

This guideline (40), which is relevant for but not specific to adolescents, provides recommendations on the safety of contraceptive methods for use in the context of specific health conditions and characteristics. Broadly, it assigns a numerical category, ranging from 1 to 4,¹ to designate whether a woman or man is medically eligible to use a contraceptive method. Some recommendations are also assigned as category C (caution),² D (delay) or S (special). Eligibility may vary, depending on whether use of a contraceptive method affects the person's health condition(s), or conversely whether the person's health condition(s) affect(s) the effectiveness or safety of the contraceptive method. In general, adolescents can use any hormonal or non-hormonal contraceptive method (including emergency contraception), regardless of age. This guideline issues the same recommendations on safety profiles for adolescents as for adults, with three exceptions:

- Male and female sterilization (category C): young women and men, like all women and men, should be counselled about the permanency of sterilization and the availability of alternative, long-term, highly effective methods.
- Depot medroxyprogesterone acetate/norethisterone enanthate (DMPA/NET-EN) (category 2): young women (menarche to less than 18 years) can generally use³ DMPA/NET-EN, despite its potential effects on bone mineral density in adolescents. Young women (menarche to less than 18 years) with a body mass index of less than or equal to 30 kg/m² can generally use DMPA/NET-EN.
- Combined hormonal contraception (category 1): women from menarche to less than 40 years of age can use combined hormonal contraception (combined oral contraceptives, combined contraceptive patch, combined contraceptive vaginal ring, combined injectable contraceptives) without restriction, despite potential effects on bone mineral density in adolescents, especially in those choosing very-low-dose formulations.

¹ Category 1: a condition for which there is no restriction for the use of the contraceptive method; category 2: a condition where the advantages of using the method generally outweigh the theoretical or proven risks; category 3: a condition where the theoretical or proven risks usually outweigh the advantages of using the method; category 4: a condition that represents an unacceptable health risk if the contraceptive method is used.

² Caution: the method is normally provided in a routine setting, but with extra preparation and precautions. For fertility-awareness based methods, this usually means that special counselling may be needed to ensure correct use of the method by a woman in this circumstance.

³ WHO uses the language "can generally use" with regard to category 2 conditions. Although, by definition, the advantages of using the method generally outweigh the theoretical or proven risks related to these conditions, in some cases additional follow-up with young women may be appropriate.

3.3.4 Selected practice recommendations for contraceptive use. Geneva: World Health Organization; 2016

This guideline (41), which is relevant for but not specific to adolescents, complements the WHO Medical Eligibility Criteria for Contraceptive Use (40) and provides guidance on how to use contraceptive methods safely and effectively once they are deemed to be medically appropriate. Broadly, it describes safety considerations, including common barriers to safe, correct and consistent use of contraception, and the benefits of preventing unintended pregnancy.

3.3.5 Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. Geneva: World Health Organization; 2017

This guideline (42), which is specific to adolescents and children (aged 0–18 years), provides recommendations on the provision of good-quality trauma-informed care to survivors of sexual abuse. Broadly, it covers recommendations for post-rape care and good practices for taking medical histories, conducting examination, providing psychological support, and documenting findings. Importantly, these guidelines also highlight ethical considerations when health-care providers are mandated to report child and adolescent sexual abuse to designated authorities. Additionally, this guideline emphasizes the importance of promoting safety, offering choices, and respecting the wishes and autonomy of children and adolescents, for example regarding the engagement of caregivers. With regard to contraception, this guideline issues the following adolescent-specific recommendation:

Health facility:

- Offer emergency contraception to girls who have been raped involving penovaginal penetration and who present within 120 hours (5 days) of the incident.

3.3.6 Consolidated guideline on sexual and reproductive health and rights of women living with HIV. Geneva: World Health Organization; 2017

This guideline (43), which is relevant for but not specific to adolescents, consolidates recommendations on the sexual and reproductive health and rights specific to women living with HIV. Broadly, the guideline describes strategies for creating an enabling environment and providing health interventions for the sexual and reproductive health and rights of women living with HIV. It also discusses implementation issues that health and service delivery interventions must address in order to achieve gender equality and support human rights.

3.3.7 Guidance statement: hormonal contraceptive eligibility for women at high risk of HIV. Geneva: World Health Organization; 2017

This guidance statement (44), which is relevant for but not specific to adolescents, provides recommendations on the use of hormonal contraceptive methods by women at high risk of HIV. Broadly, the recommendations for use of progestogen-only injectables among women at high

risk of HIV changed from category 1 to category 2,¹ with an accompanying clarification,⁴ in the *WHO Medical Eligibility Criteria for Contraceptive Use (40)*.

3.3.8 WHO recommendations on health promotion interventions for maternal and newborn health. Geneva: World Health Organization; 2015

This guideline (45), which is relevant for but not specific to adolescents, consolidates recommendations on health promotion interventions for maternal and newborn health. Broadly, it describes recommendations for improving maternal and newborn health; improving the care provided within the household by women and families; increasing community support for maternal and newborn health; and increasing access to, and use of, skilled care.

3.3.9 Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization; 2013

This guideline (46), which is relevant for but not specific to adolescents, provides evidence-based guidance on responding to IPV and sexual violence against women, along with strategies to improve coordination and financing of services. It also discusses strategies to increase attention to responding to sexual violence and IPV in health-care provider training programmes. Broadly, it covers clinical care for IPV and for sexual assault, and policy and programmatic approaches to delivering services. With regard to contraception, the guideline issues recommendations for the provision of emergency contraception for survivors of sexual assault.

3.4 Key concepts to consider

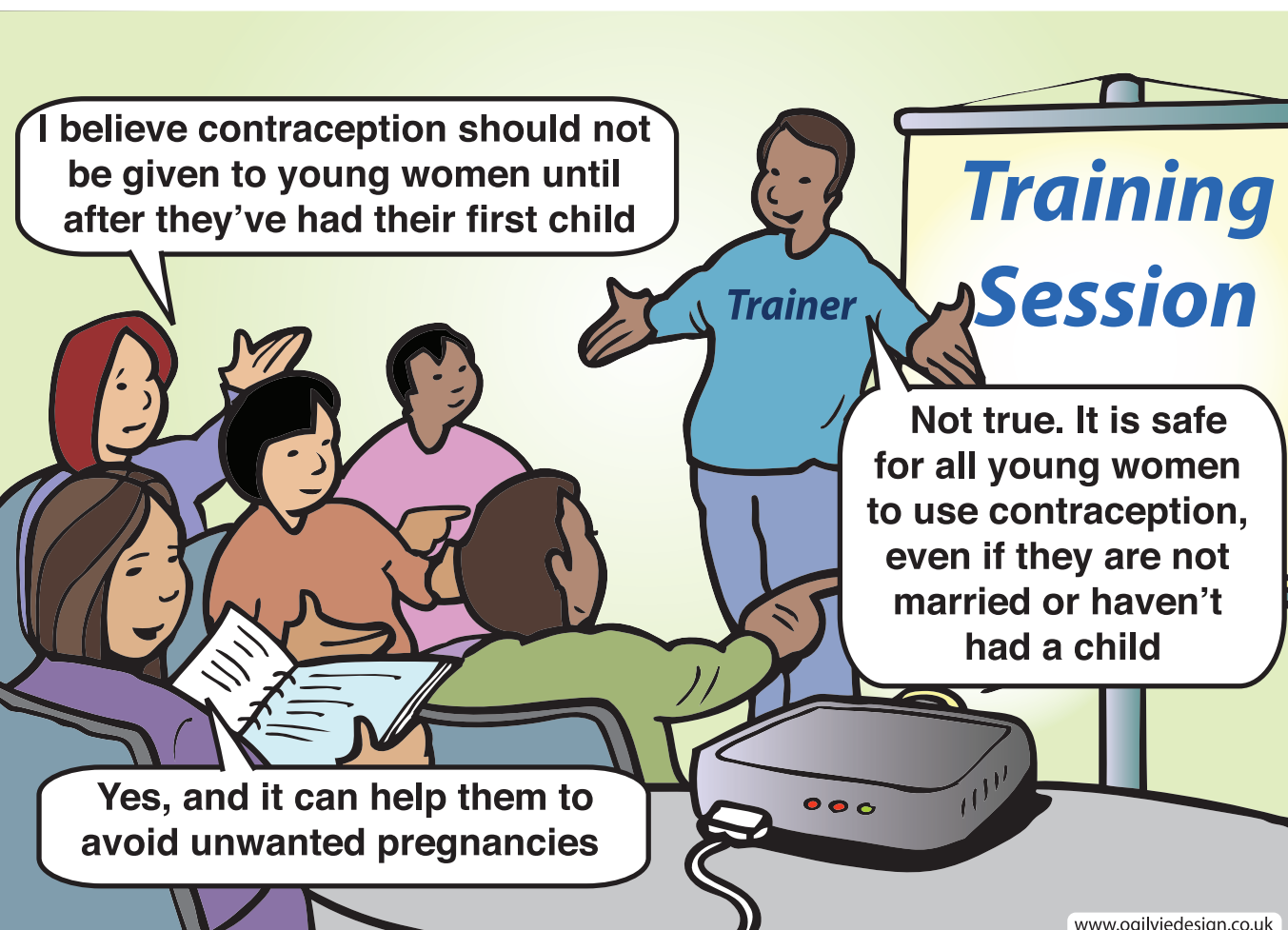
In many places, laws and policies prevent the provision of contraception based on age or marital status (39). Age alone does not constitute a medical reason for denying any method of contraception to adolescents (40). Laws and policies that support adolescents' access to contraception, regardless of age and marital status, and without mandatory parental or spousal authorization or notification, are critical for adolescent-friendly service provision (18,19).

Many adolescents have misconceptions about contraception (e.g. "contraception causes infertility") or do not know where and how to obtain contraceptive information or services (39). CSE is an effective way to reach and inform adolescents about contraception and other sexual and reproductive health topics (18). The same content should be given to in-school and out-of-school adolescents, with recognition that there are challenges to delivering curriculum-based approaches out of schools (4). CSE should be complemented by other interventions, including those to engage parents, teachers and other gatekeepers (18).

⁴ There continues to be evidence of a possible increased risk of acquiring HIV among women who use progestogen-only injectables. Uncertainty exists about whether this is due to methodological issues with the evidence or a real biological effect. In many settings, unintended pregnancies or pregnancy-related morbidity and mortality are common, and progestogen-only injectables are among the few methods widely available. Women should not be denied the use of progestogen-only injectables because of concerns about the possible increased risk. Women considering using progestogen-only injectables should be advised about these concerns, about the uncertainty over whether there is a causal relationship, and about how to minimize their risk of acquiring HIV.

Contraceptive services and health-care providers are often not adolescent-friendly (39). WHO standards for good-quality health-care services for adolescents include considerations related to adolescents' health literacy, community support, appropriate packages of services, health-care providers' competencies, facility characteristics, equity and non-discrimination, data and quality improvement, and adolescent participation (47). Even when there are no legal or policy restrictions to providing adolescents with contraceptive information and services, there is a need to overcome health-care provider biases and misconceptions regarding contraceptive use by adolescents (18).

The contraceptive needs of adolescents are diverse and evolving (39). Some adolescents may choose not to be sexually active, some may choose to be sexually active, and some may be put in situations where they are expected to be sexually active, regardless of their wishes or choices. As such, complementary strategies must be used to respond to the differing needs of different adolescent populations (18). Additionally, programmes must address the needs of special populations of adolescents, including adolescents with disabilities, adolescents with chronic diseases, migrants and refugees (19).



3.5 Key complementary documents in addition to the WHO guidelines

- Medical eligibility criteria wheel for contraceptive use. Geneva: World Health Organization; 2015 (48)
- Family planning: a global handbook for providers (2018 edition). Geneva: World Health Organization; 2018 (38)
- Compendium of WHO recommendations for postpartum family planning. Geneva: World Health Organization; 2016 (49)
- Training resource package for family planning. Geneva: World Health Organization (<https://www.fptraining.org/>) (50)
- Task shifting to improve access to contraceptive methods. Geneva: World Health Organization; 2013 (51)
- Reducing early and unintended pregnancies among adolescents: evidence brief. Geneva: World Health Organization; 2017 (52)
- Task sharing to improve access to family planning/contraception: summary brief. Geneva: World Health Organization; 2017 (53)
- Adolescents and family planning: what the evidence shows. Washington, DC: International Center for Research on Women; 2014 (54)
- High-impact Practices (HIPs) in family planning: adolescent-friendly contraceptive services – mainstreaming adolescent-friendly elements into existing contraceptive services. Washington, DC: United States Agency for International Development; 2015 (55)
- Youth contraceptive use: effective interventions – a reference guide. Washington, DC: Population Reference Bureau; 2017 (56)
- Global consensus statement for expanding contraceptive choice for adolescents and youth to include long-acting reversible contraception. Washington, DC: Family Planning 2020; 2017 (57)

3.6 Real-life application of the guidelines

In 2017, as part of the Family Planning Umbrella Project, the latest WHO guidelines and recommendations related to contraception were disseminated and shared with policy-makers, programmers, civil society, nongovernmental organizations, academia, and WHO and other United Nations staff in three WHO regions (Africa, Eastern Mediterranean, South East Asia) (58). As a next step, these stakeholders oriented country staff on the recommendations and updated their national guidelines and training materials. Since then, 47 countries (20 completed, 27 ongoing) have updated their national guidelines on family planning and reproductive health policies based on the *Medical Eligibility Criteria for Contraceptive Use* (40). All 47 countries agreed to use one job aid – the *WHO Medical Eligibility Criteria Wheel for Contraceptive Use* (48). Special efforts were made to address the contraceptive needs of adolescents, including updating the recommendations in national policies, guidelines and training materials.

4 Antenatal, intrapartum and postnatal care

4.1 Definitions

Antenatal care is care provided by skilled health-care professionals to pregnant women and adolescent girls in order to ensure the best health conditions for both mother and baby during pregnancy (59).

Intrapartum care is care provided by skilled health-care professionals to women and adolescent girls during childbirth in order to ensure the best health conditions for both mother and baby (60).

Postnatal care is care provided by skilled health-care professionals to women and adolescent girls and their babies up to six weeks following childbirth in order to ensure the best health conditions for both mother and baby (60).

4.2 Rationale

In many contexts, adolescent pregnancy is common. In 2016 an estimated 21 million girls aged 15–19 years in developing regions became pregnant, approximately 12 million of whom gave birth (28). Estimates suggest that 2.5 million girls aged under 16 years in low-resource countries give birth every year (29). For some adolescents, pregnancy and childbirth are planned and wanted. For others, they are not: approximately half of pregnancies to girls aged 15–19 years in developing regions are unintended (28). Drivers of adolescent pregnancies are context-specific and can include child marriage, poverty, lack of opportunity, and social or cultural values related to womanhood and motherhood (30).

Adverse maternal health outcomes among adolescents have major health and social consequences. With regard to health consequences, pregnancy and childbirth complications are the leading cause of death among girls aged 15–19 years globally, with low- and middle-income countries accounting for 99% of maternal deaths of women aged 15–49 years in 2015 (31,32). Globally, maternal mortality is higher for girls aged 10–14 years than for women and girls aged 15–29 years (61). Adolescent mothers (aged 10–19 years) face higher risks of eclampsia, puerperal endometritis and systemic infections than mothers aged 20–24 years (33). Additionally, some 3.9 million unsafe abortions among girls aged 15–19 years occur each year in the developing world, contributing to maternal mortality, morbidity and lasting health problems (28). Early childbearing can increase risks for newborns as well as young mothers: Babies born to mothers under 20 years of age face higher risks of low birth weight, preterm delivery and severe neonatal conditions (33). In some settings, rapid repeat pregnancy is a concern for young mothers, which presents further risks for both the mother and the child (34,35).

With regard to social consequences, unmarried pregnant adolescents may face stigma, rejection or violence by partners, parents and peers (30). Similarly, girls who become pregnant before age 18 years are more likely to experience violence within a marriage or partnership than those who postpone childbearing (36). Adolescent pregnancy may also jeopardize girls' future education and employment opportunities (30,37).

Antenatal, intrapartum and postnatal care are effective. The health benefits of these interventions are clear and well established for adolescent mothers and their children, with no ascertainable harms or burdens (60). Most maternal deaths are preventable by well-known medical interventions (1).

However, access to and provision of good-quality services need attention. Adolescents may face barriers to accessing and using skilled care before, during and after pregnancy (62). Certain subgroups of adolescents, such as very young adolescents, unmarried adolescents, refugees and adolescents in humanitarian crises situations, may face special barriers to accessing care (63).

States have obligations under human rights law to provide antenatal, intrapartum and postnatal care to adolescents. Ensuring reproductive and maternal health is considered comparable to a core obligation under the right to health, which means it is one of the basic minimum actions states must take to give meaning to this right (64). Upholding adolescents' rights in this area is integrally linked to state obligations to ensure universal access to a comprehensive package of sexual and reproductive health interventions before, during and after pregnancy (16). Maternal health care, as part of sexual and reproductive health, should be free, confidential, adolescent-responsive and non-discriminatory, and barriers to services such as third-party authorization requirements should be removed (15,17).

4.3 Relevant WHO guidelines⁵

4.3.1 WHO guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries. Geneva: World Health Organization; 2011

This guideline (18), which is specific to adolescents, provides recommendations for action and research to prevent early pregnancy and poor reproductive outcomes among adolescents. Broadly, it recommends reducing marriage before the age of 18 years, reducing pregnancy before the age of 20 years, increasing use of contraception by adolescents at risk of unintended pregnancy, reducing coerced sex among adolescents, reducing unsafe abortion among adolescents, and increasing use of skilled antenatal, childbirth and postnatal care among adolescents. With regard to antenatal, intrapartum and postnatal care, the guideline issues the following adolescent-specific recommendations:

5 In 2017 WHO consolidated its recommendations on maternal health issued before and during 2017 into the document *WHO Recommendations on Maternal Health* (65). Broadly, this covers health interventions that should be delivered during pregnancy, childbirth and the postnatal period, along with health behaviours that women should practise (or not practise) during these periods to care for themselves and their babies. In 2013 WHO consolidated its recommendations on postnatal care of the mother and newborn issued before and during 2013 into the document *WHO Recommendations on Postnatal Care of the Mother and Newborn* (66). Broadly, this guideline addresses timing, number and place of postnatal contacts, and content of postnatal care for all mothers and babies during the six weeks after birth.

Health facility:

- Promote birth and emergency preparedness in antenatal care strategies for pregnant adolescents in household, community and health facility settings.
- Expand the availability and access to basic emergency obstetric care and comprehensive emergency obstetric care to all populations, including adolescents.

Individual:

- Provide information to all pregnant adolescents and other stakeholders about the importance of using skilled antenatal care.
- Provide information to all pregnant adolescents and other stakeholders about the importance of using skilled childbirth care.

4.3.2 WHO recommendations on antenatal care for a positive pregnancy experience. Geneva: World Health Organization; 2016

This guideline (59), which is relevant for but not specific to adolescents, provides comprehensive recommendations on routine antenatal care for pregnant women and adolescent girls. Broadly, it describes evidence-based practices during antenatal care that improve outcomes and lead to a positive pregnancy experience. It complements existing WHO guidelines on the management of specific pregnancy-related complications.

4.3.3 Use of multiple micronutrient powders for point-of-use fortification of foods consumed by pregnant women. Geneva: World Health Organization; 2016

This guideline (67), which is relevant for but not specific to adolescents, provides guidance on the effects and safety of the use of multiple micronutrient powders for point-of-use fortification of foods consumed by pregnant women. Broadly, it states that routine use of multiple micronutrient powders during pregnancy is not recommended as an alternative to standard iron and folic supplementation during pregnancy for improving maternal and newborn health outcomes.

4.3.4 Optimal serum and red blood cell folate concentrations in women of reproductive age for prevention of neural tube defects. Geneva: World Health Organization; 2015

This guideline (68), which is relevant for but not specific to adolescents, provides guidance on the optimal serum and red blood cell folate concentrations in women of reproductive age for prevention of neural tube defects. Broadly, it includes the genetic, biological and sociodemographic determinants of folate status; blood folate concentrations and risk of neural tube defects; and the response of serum/plasma and red blood cell folate concentrations to nutrition interventions.

4.3.5 Guidelines for the identification and management of substance use and substance use disorders in pregnancy. Geneva: World Health Organization; 2014

This guideline (69), which is relevant for but not specific to adolescents, consolidates recommendations for identifying and managing substance use and substance use disorders in pregnant women. Broadly, it focuses on screening and brief interventions, psychosocial interventions, detoxification, dependence management, infant feeding and management of infant withdrawal.

4.3.6 WHO recommendations for prevention and treatment of pre-eclampsia and eclampsia. Geneva: World Health Organization; 2011

This guideline (70), which is relevant for but not specific to adolescents, provides recommendations to optimize health care for women presenting with pre-eclampsia and eclampsia. Broadly, it covers rest; dietary salt restriction; calcium and vitamin D supplementation; medications; and interventionist versus expectant care for severe pre-eclampsia before term, induction of labour for pre-eclampsia at term, and prevention and treatment of postpartum hypertension.

4.3.7 WHO recommendations for induction of labour. Geneva: World Health Organization; 2011

This guideline (71), which is relevant for but not specific to adolescents, provides recommendations for improving the quality of care and outcomes for pregnant women undergoing induction of labour in under-resourced settings. Broadly, it covers situations when induction of labour may be appropriate, methods for inducing labour, management of adverse events related to induction of labour, and appropriate settings for induction of labour.

4.3.8 WHO recommendations for augmentation of labour. Geneva: World Health Organization; 2014

This guideline (72), which is relevant for but not specific to adolescents, provides recommendations for interventions to reduce the global burden of prolonged labour and its consequences. Broadly, it focuses on diagnosis and prevention of delay in the first stage of labour, treatment of delay in the first stage of labour with augmentation and care during labour augmentation.

4.3.9 WHO recommendations for intrapartum care for a positive childbirth experience. Geneva: World Health Organization; 2018

This guideline (73), which is relevant for but not specific to adolescents, provides comprehensive recommendations on essential intrapartum care practices that all pregnant women and adolescent girls should receive to facilitate a positive childbirth experience. Broadly, it describes evidence-based practices during intrapartum care that improve outcomes and lead to a positive childbirth experience, and it complements existing WHO guidelines on the management of specific-pregnancy related complications.

4.3.10 WHO recommendations for prevention and treatment of maternal peripartum infections. Geneva: World Health Organization; 2015

This guideline (74), which is relevant for but not specific to adolescents, consolidates recommendations on effective interventions to reduce the global burden of maternal infections and their complications around the time of childbirth. Broadly, it describes evidence-based recommendations on interventions for preventing and treating genital tract infections during labour, childbirth or the puerperium, with the aim of improving outcomes for both mothers and newborns.

4.3.11 WHO recommendations for the prevention and treatment of postpartum haemorrhage. Geneva: World Health Organization; 2012

This guideline (75), which is relevant for but not specific to adolescents, provides recommendations for general principles of postpartum haemorrhage care. Broadly, it covers prevention of postpartum haemorrhage (uterotonics, cord management and uterine massage, active management of the third stage of labour), prevention of postpartum haemorrhage in caesarean sections, treatment of postpartum haemorrhage (uterotonics, fluid resuscitation and tranexamic acid, manoeuvres, other procedures) and treatment of retained placenta.

4.3.12 WHO recommendations on tranexamic acid for the treatment of postpartum haemorrhage. Geneva: World Health Organization; 2017

This guideline (76), which is relevant for but not specific to adolescents, provides updated recommendations on the use of tranexamic acid for postpartum haemorrhage treatment in response to important new evidence on this intervention. It supersedes the previous recommendation on tranexamic acid for postpartum haemorrhage treatment, which was issued in the 2012 *WHO Recommendations for the Prevention and Treatment of Postpartum Haemorrhage* (75). Broadly, the guideline states that early use of intravenous tranexamic acid (within three hours of birth) in addition to standard care is recommended for women with clinically diagnosed postpartum haemorrhage following vaginal birth or caesarean section.

4.3.13 Daily iron supplementation in postpartum women: guideline. Geneva: World Health Organization; 2016

This guideline (77), which is relevant for but not specific to adolescents, provides a conditional recommendation for oral iron supplementation for women 6–12 weeks postpartum to improve maternal and infant health outcomes.

4.3.14 Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting. Geneva: World Health Organization; 2012

This guideline (78), which is relevant for but not specific to adolescents, provides recommendations for addressing critical health workforce shortages related to the provision of maternal and newborn health interventions. Broadly, it outlines recommended interventions for lay health workers, auxiliary nurses, auxiliary nurse midwives, nurses, midwives, associate (non-physician) clinicians, advanced-level associate (non-physician) clinicians, and non-specialist doctors.

4.3.15 WHO recommendations on health promotion interventions for maternal and newborn health. Geneva: World Health Organization; 2015

This guideline (45), which is relevant for but not specific to adolescents, consolidates recommendations on health promotion interventions for maternal and newborn health. Broadly, it describes interventions related to birth preparedness and complication readiness, male involvement for maternal and newborn health, partnership with traditional birth attendants, provision of culturally appropriate skilled maternity care, companion of choice at birth, community mobilization through facilitated participatory learning and action cycles, and community participation in quality-improvement processes and programme planning and implementation.

4.3.16 WHO recommendation on community mobilization through facilitated participatory learning and action cycles with women's groups for maternal and newborn health. Geneva: World Health Organization; 2014

This guideline (79), which is relevant for but not specific to adolescents, provides recommendations for community mobilization through facilitated participatory learning and action cycles with women's groups for maternal and newborn health. It also provides recommendations for increasing knowledge of interventions important for improving maternal and newborn health; improving the care provided within the household by women and families; increasing community support for maternal and newborn health; and increasing access to, and use of, skilled care.

4.4 Key concepts to consider

Pregnant adolescents, especially pregnant unmarried adolescents, often face barriers to accessing maternal health services, including antenatal, intrapartum and postnatal care. Barriers to access include lack of information on the importance of using maternal health services, lack of confidentiality, and stigma (18). Efforts should be made to ensure the availability of and access to antenatal, intrapartum and postnatal care, including basic emergency obstetric care and comprehensive emergency obstetric care (18).

Antenatal, intrapartum and postnatal services are often not responsive to the needs of adolescents. It is critical that health-care providers receive appropriate ongoing training and support to ensure they have the knowledge, understanding and skills to provide high-quality adolescent-friendly antenatal, intrapartum and postnatal care, based on the right of all people to health, confidentiality and non-discrimination (18).



4.5 Key complementary documents in addition to the WHO guidelines

- Pregnancy, childbirth, postpartum and newborn care: a guide for essential practice, 3rd edn. Geneva: World Health Organization; 2015 (60)
- Managing complications in pregnancy and childbirth: a guide for midwives and doctors, 2nd edn. Geneva: World Health Organization; 2017 (80)
- Companion of choice during labour and childbirth for improved quality of care: evidence-to-action brief. Geneva: World Health Organization; 2016 (81)
- Prevention and elimination of disrespect and abuse during childbirth. Geneva: World Health Organization; 2014 (82)
- Strengthening midwifery toolkit. Geneva: World Health Organization; 2011 (83)
- Obstetric fistula: guiding principles for clinical management and programme development. Geneva: World Health Organization; 2006 (84)
- Tibingana-Ahimbisibwe B, Katabira C, Mpalampa L, Harrison RA. The effectiveness of adolescent-specific prenatal interventions on improving attendance and reducing harm during and after birth: a systematic review. *Int J Adolesc Med Health*. 2016;30:(3) (85)

4.6 Real-life application of the guidelines

The GREAT (Guideline-driven, Research priorities, Evidence synthesis, Application of evidence, and Transfer of knowledge) Network was established in 2012 by WHO, St Michael's Hospital, University of Toronto, and international partnerships with low- and middle-income countries to provide guidance and support to health-care system stakeholders on implementation of relevant evidence-based guidelines on maternal and perinatal health (86). The GREAT Network piloted its two-day meeting model with relevant stakeholders, including clinicians (obstetricians, midwives), managers, researchers and policy-makers and WHO in 2012. Focus groups were conducted to identify barriers and facilitators to guideline implementation; then a prioritization meeting was used to establish common priorities using a nominal group process (87) and the Research and Development (RAND) appropriateness method (88). This process led to a set of recommendations to address barriers for implementation of maternal and perinatal health guidelines, along with working groups to support the delivery of the tailored implementation strategy, based on the established priorities (89). The GREAT Network model was later replicated in Ethiopia, Myanmar, Uganda and the United Republic of Tanzania (90).

5 Safe abortion care

5.1 Definitions

Induced abortion refers to the intentional loss of an intrauterine pregnancy due to medical or surgical means (91).

Safe abortion refers to abortion that is done with a method recommended by WHO (medical abortion, vacuum aspiration, dilatation and evacuation), is appropriate to the pregnancy duration, and is provided by a trained health-care provider (92).

Less safe abortion refers to abortion that meets only one of two criteria – either the abortion is done by a trained health-care provider but with an outdated method (e.g. sharp curettage), or a safe method of abortion (e.g. misoprostol) is used but without adequate information or support from a trained individual (92).

Least safe abortion refers to abortion provided by untrained individuals using dangerous methods (e.g. ingestion of caustic substances, insertion of foreign bodies, use of traditional concoctions) (92).

5.2 Rationale

Unsafe abortions among adolescents are an important problem. An estimated 3.9 million girls aged 15–19 years undergo unsafe abortions every year in the developing world (28).

Unsafe abortions among adolescents have major health consequences. Approximately 8% of maternal mortality among all women between 2003 and 2012 was attributable to abortion (93). Compared with older women, adolescents are more likely to seek abortions from untrained providers, to have a self-induced abortion, to terminate their pregnancies after the first trimester when the procedure is more dangerous, and to delay seeking medical care for complications following unsafe abortions; they are less likely to know about their rights concerning abortion and post-abortion care and to report having had an abortion (94).

Safe abortion care carries low health risk. The people, skills and medical standards considered safe in the provision of abortion are different for medical and surgical abortion and also depend on the duration of the pregnancy (95). Safe abortion can have a lower risk than an injection of penicillin or carrying a pregnancy to term (95,96).

However, abortion-related laws and policies and provision of good-quality services need attention.

Access to safe abortion services is highly restricted in many countries, despite evidence that restrictive abortion laws are associated with higher levels of maternal mortality (97,98). Countries often further restrict adolescent access to safe legal abortion through policy interventions related to consent (parental, spousal, health-care provider), age, marital status, and restrictions on information provided to the public (94, 99). Where safe abortion care is available to adolescents, it is often not adolescent-friendly (94, 99). Meanwhile, evidence increasingly shows that, where abortion is legal on broad socioeconomic grounds and on a woman's request, and where safe services are accessible, both unsafe abortion and abortion-related mortality and morbidity are reduced (96,100,101).

States have obligations under human rights law to provide safe abortion care to adolescents. Implementation of measures to prevent unsafe abortion and provide post-abortion care comprises part of the core obligation of states to uphold the right to sexual and reproductive health, which means it is one of the basic minimum actions states must take to give meaning to this right (15). With specific regard to adolescents, states are obliged to ensure universal access to a comprehensive package of sexual and reproductive health interventions, including safe abortion and post-abortion care, irrespective of whether the abortion itself is legal (16). Human rights mechanisms have also called for the decriminalization of abortion with a view to ensuring access to safe abortion and post-abortion care for girls (15,17). Removal of barriers such as third-party consent requirements also forms part of states' obligations in relation to provision of safe abortion, as a component of sexual and reproductive health services (15,17). Denial of abortion and forced continuation of pregnancy have also been identified as forms of gender-based violence, which invokes states' obligations to pursue all appropriate means for the elimination of such violence (102).

5.3 Relevant WHO guidelines

5.3.1 Safe abortion: technical and policy guidance for health systems. Geneva: World Health Organization; 2012

This guideline (95), which is relevant for but not specific to adolescents, consolidates recommendations for the provision of safe abortion care. Broadly, it describes methods for surgical abortion, medical abortion, abortion for pregnancies of gestational age over 12–14 weeks, care preceding induced abortion, and post-abortion care. This guideline issues the following adolescent-specific recommendation:

Policy:

- An enabling environment is needed to ensure that every woman who is legally eligible has ready access to safe abortion care. Gear policies to respect, protect and fulfil the human rights of women, to achieve positive health outcomes for women, to provide good-quality contraceptive information and services, and to meet the particular needs of poor women, adolescents, survivors of rape, and women living with HIV.

5.3.2 WHO guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries. Geneva: World Health Organization; 2011

This guideline (18), which is specific to adolescents, provides recommendations for action and research to prevent early pregnancy and poor reproductive outcomes among adolescents. Broadly, it recommends reducing marriage before the age of 18 years, reducing pregnancy before the age of 20 years, increasing use of contraception by adolescents at risk of unintended pregnancy, reducing coerced sex among adolescents, reducing unsafe abortion among adolescents, and increasing use of skilled antenatal, childbirth and postnatal care among adolescents. With regard to abortion, the guideline issues the following adolescent-specific recommendations:

Policy:

- Ensure laws and policies enable adolescents to obtain safe abortion services.

Community:

- Identify and overcome barriers to the provision of safe abortion services for adolescent girls.

Health facility:

- Ensure adolescents have access to post-abortion care as a life-saving medical intervention, regardless of whether the abortion or attempted abortion was legal.
- Ensure adolescents who have had abortions can obtain post-abortion contraceptive information and services, regardless of whether the abortion was legal.

Individual:

- Enable adolescents to obtain safe abortion services by informing them and other stakeholders about the dangers of unsafe methods of interrupting a pregnancy, the safe abortion services that are legally available, and where and under what circumstances abortion services can be legally obtained.

5.3.3 Health worker roles in providing safe abortion care and post-abortion contraception. Geneva: World Health Organization; 2015

This guideline (103), which is relevant for but not specific to adolescents, consolidates recommendations on the safety, effectiveness, feasibility and acceptability of involving a range of health-care providers in the delivery of recommended and effective interventions for providing safe abortion and post-abortion care, including post-abortion contraception. Broadly, it provides clinical guidelines on provision of information about safe abortion, provision of pre- and post-abortion counselling, management of abortion and post-abortion care in the first trimester and beyond, management of non-life-threatening complications, and provision of post-abortion contraception.

5.3.4 Consolidated guideline on sexual and reproductive health and rights of women living with HIV. Geneva: World Health Organization; 2017

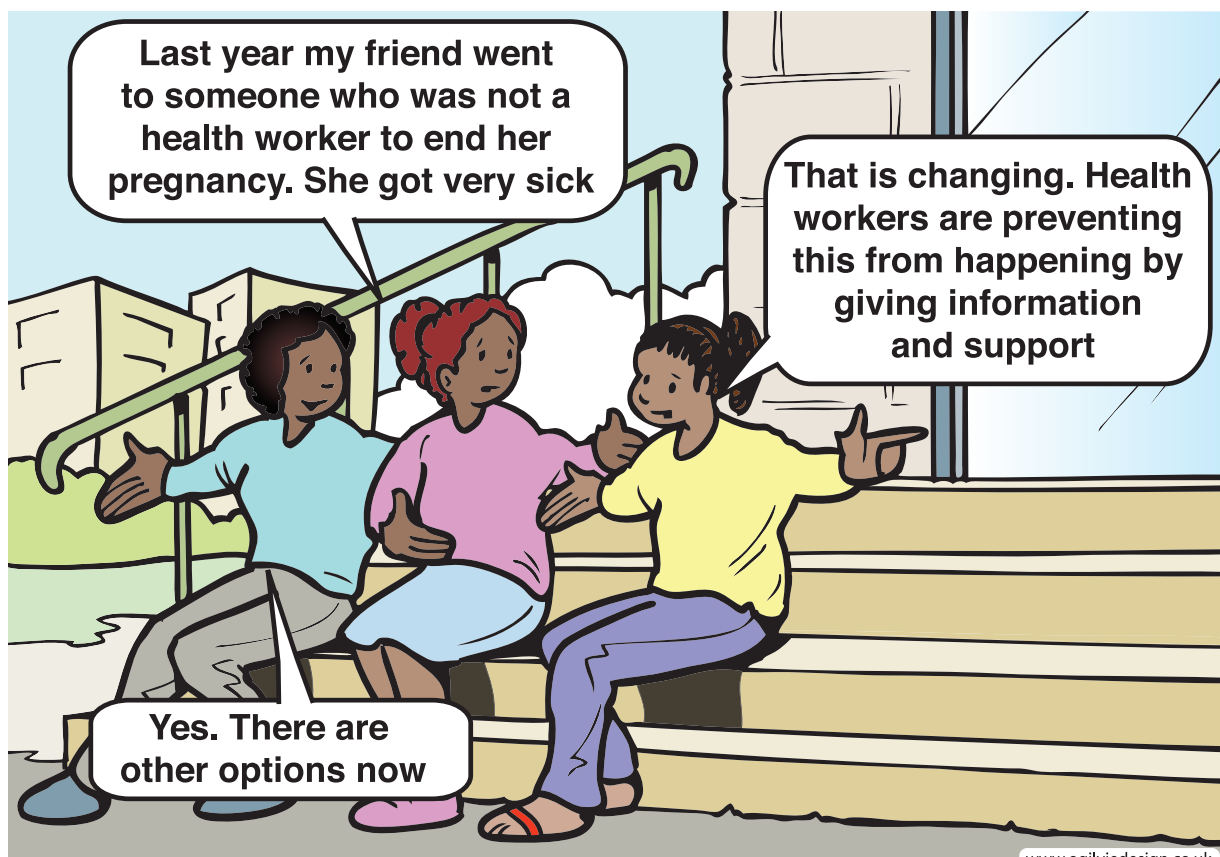
This guideline (43), which is relevant for but not specific to adolescents, consolidates recommendations on the sexual and reproductive health and rights specific to women living with HIV. Broadly, this guideline describes strategies for creating an enabling environment and providing health interventions for the sexual and reproductive health and rights of women living with HIV. It also discusses implementation issues that health and service delivery interventions must address in order to achieve gender equality and support human rights.

5.4 Key concepts to consider

Restrictive laws and policies often force adolescents who need safe abortion care to seek illegal and unsafe abortions (98). Abortion laws and policies should not create situations that lead adolescents to seek unsafe abortions (95). Instead, laws and policies should promote the respect and protection of women and girls; this includes supporting reductions in maternal mortality and morbidity due to unsafe abortion by ensuring that every woman and girl can access safe and timely services. Additionally, laws and policies should prevent and address stigma and discrimination against women and girls who seek abortion services or post-abortion care (18,95).

Adolescents are less likely than adult women to obtain safe abortion services (94). Adolescents and other stakeholders need to be informed about the dangers of unsafe abortions, the safe abortion services that are legally available, and where and under what circumstances abortion services can be legally obtained (18).

Abortion services and health-care providers are often not adolescent-friendly (99). Health-care providers should be trained and supported to inform, counsel and provide services to adolescents according to their evolving capacities, and to be responsive to the specific needs of different groups of adolescents (18). Abortion services should be non-judgemental, be free of coercion, and respect women and girls' informed and voluntary decision-making, autonomy, confidentiality and privacy to terminate an unwanted, mistimed or unplanned pregnancy (18,95,104,105). Services should be available at the primary-care level, with referral systems in place for all required higher-level care (95). As adolescents may be particularly affected by user fees as a barrier to safe abortion services, they should be exempted from charges (18,95). Furthermore, unmarried adolescents may be under pressure to have an abortion, and those who are suspected of being coerced into having an abortion should be referred for counselling and social and legal support (95).



5.5 Key complementary documents in addition to the WHO guidelines

- Clinical practice handbook for safe abortion. Geneva: World Health Organization; 2014 (106)
- Interagency statement: preventing gender-biased sex selection. Geneva: World Health Organization; 2011 (107)
- Renner R-M, de Guzman A, Brahmi D. Abortion care for adolescent and young women. *Int J Gynecol Obstet.* 2014;126(1):1–7 (108)
- Adolescents' need for and use of abortion services in developing countries. New York: Guttmacher Institute; 2016 (94)
- Provision of abortion care for adolescent and young women: a systematic review. Chapel Hill, NC: Ipas; 2013 (109)

5.6 Real-life application of the guidelines

WHO has worked to support countries, including Ghana, Kyrgyzstan, Mongolia, the Republic of Moldova, Romania and Viet Nam, to adapt the WHO guidance on safe abortion care, often using the framework of the WHO Strategic Approach to Strengthening Sexual and Reproductive Health Policies and Programmes (110,111). In the Republic of Moldova, for example, abortion was included among 11 high-priority areas in the 2005–2015 National Strategy for Reproductive Health. WHO, along with other international organizations, collaborated with the nongovernmental organization Reproductive Health Training Centre to develop the National Safe Abortion Standards. These standards, based on the WHO recommendations, were approved by the Moldovan Ministry of Health in 2011 (112). Additionally, the partnership supported a revision of the national training curriculum; development and introduction of the comprehensive abortion care model for outpatient services; upgrading of the health management information system for abortion; and registration of a quality-approved combipack of mifepristone and misoprostol for pregnancy termination (112).

6 Sexually transmitted infections prevention and care

6.1 Definitions

Sexually transmitted infections are infections caused by bacteria, viruses and parasites transmitted through sexual contact, including vaginal, anal and oral sex. Some STIs may also be spread by skin-to-skin sexual contact or through non-sexual means, such as from mother to child during pregnancy and childbirth. There are more than 30 known bacteria, viruses and parasites that cause STIs (113).

6.2 Rationale

Sexually transmitted infections among adolescents are an important problem. There are no published estimates for prevalence or incidence of STIs in adolescents at the global level, and current data sources on STIs among adolescents in most low- and middle-income countries are weak. However, where age-disaggregated surveillance systems exist, a substantial proportion of incidence occurs in adolescents. Among women in sub-Saharan Africa, estimates suggest that the prevalence of all STIs (except for herpes simplex virus 2) is higher among girls aged 15–24 years than among women aged 25–49 years (114). Similarly, in Europe, young women and men aged 15–24 years accounted for 61% of all cases of chlamydia infection in 2015 (115). In the United States of America, half of all STIs in 2008 were reported in young women and men aged 15–24 years (116).

Adolescent girls may have greater biological susceptibility than adult women to some STIs due to the immaturity of the cervical mucosa and increased cervical ectopy (117, 118). Boys, meanwhile, face pressure to have multiple partners from stereotypical masculinity norms that prescribe male dominance and toughness (119). The risk of contracting a STI is often greater for specific groups of adolescents, such as adolescent sex workers and their clients, and boys who have sex with men or boys (120–122).

Sexually transmitted infections among adolescents have major health consequences. Sexually transmitted infections can cause discomfort and pain and can have serious consequences beyond the immediate impact of the infection itself (120). Herpes and ulcerative (syphilis) and inflammatory (chlamydia, gonorrhoea, trichomoniasis) curable STIs are associated with a two- to three-fold increased risk of acquiring HIV (123, 124). All of the curable STIs have been linked with serious pregnancy complications for the newborn, including preterm birth, low birth weight and death (125, 126). For example, syphilis in pregnancy leads to an estimated 215 000 stillbirths and

fetal deaths and 90 000 neonatal deaths each year (127). Furthermore, STIs such as gonorrhoea and chlamydia are major causes of infertility (125). Human papillomavirus was responsible for an estimated 528 000 cases of cervical cancer and 266 000 deaths from cervical cancer in 2012 (128).

Prevention and management services for STIs have been shown to be effective. Behavioural interventions (CSE, brief sexuality-related communication⁶), STI pre- and post-test counselling, safer sex and risk-reduction counselling, condom promotion) and barrier methods of contraception (male and female condoms) have been shown to offer prevention against STIs (120, 129). Accurate diagnostic tests for STIs exist, along with treatments that can cure chlamydia, gonorrhoea, syphilis and trichomoniasis, and treatments that can treat herpes and hepatitis B effectively (120).

However, design and implementation of prevention strategies and access to and provision of good-quality services need attention. Effective STI prevention and management services are an urgent need for adolescent populations, including scale-up of STI case management and provision of HPV vaccination (120). However, many adolescents do not have access to integrated STI prevention and management services (120). Even when STI prevention and management services are available, adolescents often face barriers related to stigma, shame, cost and lack of confidentiality (130).

States have obligations under human rights law to provide STI prevention and care to adolescents. States are obligated to ensure care and treatment of STIs, as part of sexual and reproductive health services, are accessible to adolescents, regardless of marital status, ensuring such services are free, confidential, adolescent-responsive and non-discriminatory (15,17). Removal of barriers such as third-party consent requirements also forms part of states' obligations in relation to provision of services related to STI testing and treatment, as a component of sexual and reproductive health services (15,17).

6.3 Relevant WHO guidelines

6.3.1 WHO guidelines for the treatment of *Treponema pallidum* (syphilis). Geneva: World Health Organization; 2016

This guideline (131), which is relevant for but not specific to adolescents, consolidates recommendations on treatment of syphilis. Broadly, it focuses on treatment recommendations for early syphilis (primary, secondary, early latent syphilis of not more than two years' duration), late syphilis (infection of more than two years' duration without evidence of treponemal infection) and congenital syphilis.

6 Brief sexuality-related communication refers to the opportunistic use of counselling by providers (nurses, doctors, health educators), with less certainty about the duration of the encounter or the possibility of follow-up encounters, to address sexuality and related personal or psychological problems and to promote sexual well-being.

6.3.2 WHO guideline on syphilis screening and treatment for pregnant women. Geneva: World Health Organization; 2017

This guideline (132), which is relevant for but not specific to adolescents, provides updated recommendations for syphilis screening and treatment for pregnant women based on the most recent evidence and available serological tests for syphilis. It builds on recommendations relating to the treatment of syphilis for pregnant women and treatment of congenital syphilis from the 2016 *WHO Guidelines for the Treatment of Treponema pallidum (Syphilis)* (131).

6.3.3 WHO guidelines for the treatment of genital herpes simplex virus. Geneva: World Health Organization; 2016

This guideline (133), which is relevant for but not specific to adolescents, consolidates recommendations on treatment of genital herpes simplex virus infection. Broadly, it focuses on treatment recommendations for the first clinical episode of genital herpes simplex virus infection, recurrent clinical episodes of genital herpes simplex virus infection (episodic therapy), frequent recurrent clinical episodes of genital herpes simplex virus infection, and severe or distressing recurrent clinical episodes of genital herpes simplex virus infection (suppressive therapy).

6.3.4 WHO guidelines for the treatment of *Chlamydia trachomatis*. Geneva: World Health Organization; 2016

This guideline (134), which is relevant for but not specific to adolescents, consolidates recommendations on treatment of infection with *Chlamydia trachomatis*. Broadly, it focuses on treatment recommendations for uncomplicated genital chlamydia, anorectal chlamydial infection, genital chlamydial infection in pregnant women, lymphogranuloma venereum and ophthalmia neonatorum.

6.3.5 WHO guidelines for the treatment of *Neisseria gonorrhoeae*. Geneva: World Health Organization; 2016

This guideline (135), which is relevant for but not specific to adolescents, consolidates recommendations on treatment of infection with *Neisseria gonorrhoeae*. Broadly, it focuses on treatment recommendations for genital and anorectal gonococcal infections, oropharyngeal gonococcal infections, retreatment of gonococcal infections after treatment failure and gonococcal ophthalmia neonatorum. The guideline highlights the need for countries to monitor their *N. gonorrhoeae* antimicrobial resistance to inform national *N. gonorrhoeae* treatment recommendations.

6.3.6 Guidelines on hepatitis B and C testing. Geneva: World Health Organization; 2016

This guideline (136), which is relevant for but not specific to adolescents, provides recommendations on testing for chronic hepatitis B and C virus and complements the WHO guidelines on prevention, care and treatment of chronic hepatitis B and C infection (137, 138). Broadly, it discusses who to test for hepatitis B and C virus infection, how to test for hepatitis B and C virus infection, how to confirm viraemic infection and monitor for treatment response, and how to use dried blood spot and other strategies to promote uptake of testing and linkage to care.

6.3.7 Guidelines for the prevention, care and treatment of persons with chronic hepatitis B infection. Geneva: World Health Organization; 2015

This guideline (137), which is relevant for but not specific to adolescents, provides recommendations on prevention, care and treatment of people with chronic hepatitis B virus infection. Broadly, it recommends using simple, non-invasive diagnostic tests to assess the stage of liver disease and eligibility for treatment; prioritizing treatment for people with most advanced liver disease and at greatest risk of mortality; and using nucleos(t)ide analogues with a high barrier to resistance (tenofovir or entecavir in adults and adolescents older than 11 years; entecavir in children aged 2–11 years) for first- and second-line treatment.

6.3.8 Guidelines for the screening, care and treatment of persons with chronic hepatitis C infection: updated version, April 2016. Geneva: World Health Organization; 2016

This guideline (138), which is relevant for but not specific to adolescents, provides recommendations for the screening, care and treatment of people with chronic hepatitis C virus infection. Broadly, it provides guidance on screening for hepatitis C virus infections; care of people living with hepatitis C virus; treatment of people living with hepatitis C virus infection using, where possible, all direct-acting antiviral-only combinations; the preferred regimens based on a person's hepatitis C virus genotype and clinical history; and assessment of the appropriateness of continued use of certain medicines.

6.3.9 Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations: 2016 update. Geneva: World Health Organization; 2016

This guideline (20), which is relevant for but not specific to adolescents, consolidates recommendations for HIV prevention, diagnosis, treatment and care for five key populations: men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers, and transgender people. Broadly, it introduces a comprehensive package of interventions and describes health-sector interventions, critical enablers, service delivery, and the decision-making, planning and monitoring process.

6.3.10 Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach. Geneva: World Health Organization; 2011

This guideline (121), which is relevant for but not specific to adolescents, provides recommendations for the prevention and treatment of HIV and other STIs among men who have sex with men and transgender people. Broadly, it covers prevention of sexual transmission; HIV testing and counselling; behavioural interventions and information, education and communication; substance use and prevention of bloodborne infections; HIV care and treatment; and prevention and care of other STIs.

6.3.11 Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries: recommendations for a public health approach. Geneva: World Health Organization; 2012

This guideline (122), which is relevant for but not specific to adolescents, provides recommendations for the prevention and treatment of HIV and other STIs among sex workers and their clients. Broadly, it covers community empowerment, condom promotion, screening for asymptomatic STIs, periodic presumptive treatment for STIs, needle–syringe programmes, vaccination for hepatitis B virus, voluntary counselling and testing for HIV, and antiretroviral therapy.

6.3.12 Consolidated guideline on sexual and reproductive health and rights of women living with HIV. Geneva: World Health Organization; 2017

This guideline (43), which is relevant for but not specific to adolescents, consolidates recommendations on the sexual and reproductive health and rights specific to women living with HIV. Broadly, this guideline describes strategies for creating an enabling environment and providing health interventions for the sexual and reproductive health and rights of women living with HIV. It also discusses implementation issues that health and service delivery interventions must address in order to achieve gender equality and support human rights. With regard to STIs, this guideline issues the following adolescent-specific recommendation:

Health facility:

- Provide the HPV vaccine for girls aged 9–13 years. Girls receiving a first dose of the vaccine before age 15 years can use a two-dose schedule. The interval between the two doses should be six months. There is no maximum interval between the doses, but an interval of no more than 12–15 months is suggested. If the interval between the doses is less than five months, then a third dose should be given at least six months after the first dose. Immunocompromised individuals, including people living with HIV, and females aged 15 years and older should also receive the vaccine; they need three doses (at 0, 1–2 and 6 months) to be protected fully.

6.3.13 Comprehensive cervical cancer control: a guide to essential practice, 2nd edition. Geneva: World Health Organization; 2014

This guideline (139), which is relevant for but not specific to adolescents, consolidates recommendations for complementary strategies for comprehensive cervical cancer prevention and control, and highlights the need for collaboration across programmes, organizations and partners. Broadly, it focuses on essential elements for cervical cancer prevention and control programmes, including community mobilization, education and counselling; HPV vaccination; screening and treatment of cervical pre-cancer; diagnosis and treatment of invasive cervical cancer; and palliative care. This guideline issues the following adolescent-specific recommendations:

Health facility:

- Consider introducing HPV vaccination when (i) cervical cancer or other human papillomavirus HPV-related diseases constitute a public health priority; (ii) vaccine introduction is programmatically feasible; (iii) sustainable financing can be secured; and (iv) the cost–effectiveness of vaccination strategies in the country or region has been considered.

- Introduce the HPV vaccination as part of a coordinated comprehensive strategy to prevent cervical cancer and other HPV-related diseases. The introduction of HPV vaccination should not undermine or divert funding from the development or maintenance of effective screening programmes for cervical cancer.
- Provide the HPV vaccine for girls aged 9–13 years. Girls receiving a first dose of the vaccine before age 15 years can use a two-dose schedule. The interval between the two doses should be six months. There is no maximum interval between the two doses, but an interval of no more than 12–15 months is suggested. If the interval between doses is less than five months, then a third dose should be given at least six months after the first dose. Immunocompromised individuals, including people living with HIV, and females aged 15 years and older should also receive the vaccine; they need three doses (at 0, 1–2 and 6 months) to be protected fully.
- Screen for cervical pre-cancer and cancer in women and girls who have initiated sexual activity as soon as the woman or girl has tested positive for HIV, regardless of age.

6.3.14 Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. Geneva: World Health Organization; 2017

This guideline (42), which is specific to adolescents and children (aged 0–18 years), provides recommendations for provision of high-quality trauma-informed care to survivors of sexual abuse. Broadly, it covers recommendations for post-rape care and mental health and good practices to provide first-line psychological support in response to disclosure, minimize distress in the process of taking medical history, conduct examination and document findings. Additionally, this guideline emphasizes the importance of promoting safety, offering choices, and respecting the wishes and autonomy of children and adolescents. Importantly, these guidelines highlight ethical considerations when health-care providers are mandated to report child and adolescent sexual abuse to designated authorities. With regard to STIs, this guideline issues the following adolescent-specific recommendations:

Health facility:

- Offer presumptive or prophylactic treatment for gonorrhoea, chlamydia and syphilis for children and adolescents who have been sexually abused involving oral, genital or anal contact with a penis or oral sex, particularly in settings where laboratory testing is not feasible.
- Offer syndromic case management for children and adolescents who have been sexually abused and who present with clinical symptoms (vaginal/urethral discharge – gonorrhoea, chlamydia, trichomoniasis; genital ulcers – herpes simplex virus, syphilis, chancroid), particularly in settings where laboratory testing is not feasible.
- Offer hepatitis B vaccination without hepatitis B immunoglobulin, as per national guidance.
- Offer the HPV vaccine to girls aged 9–14 years, as per national guidance.

6.3.15 Brief sexuality-related communication: recommendations for a public health approach. Geneva: World Health Organization; 2015

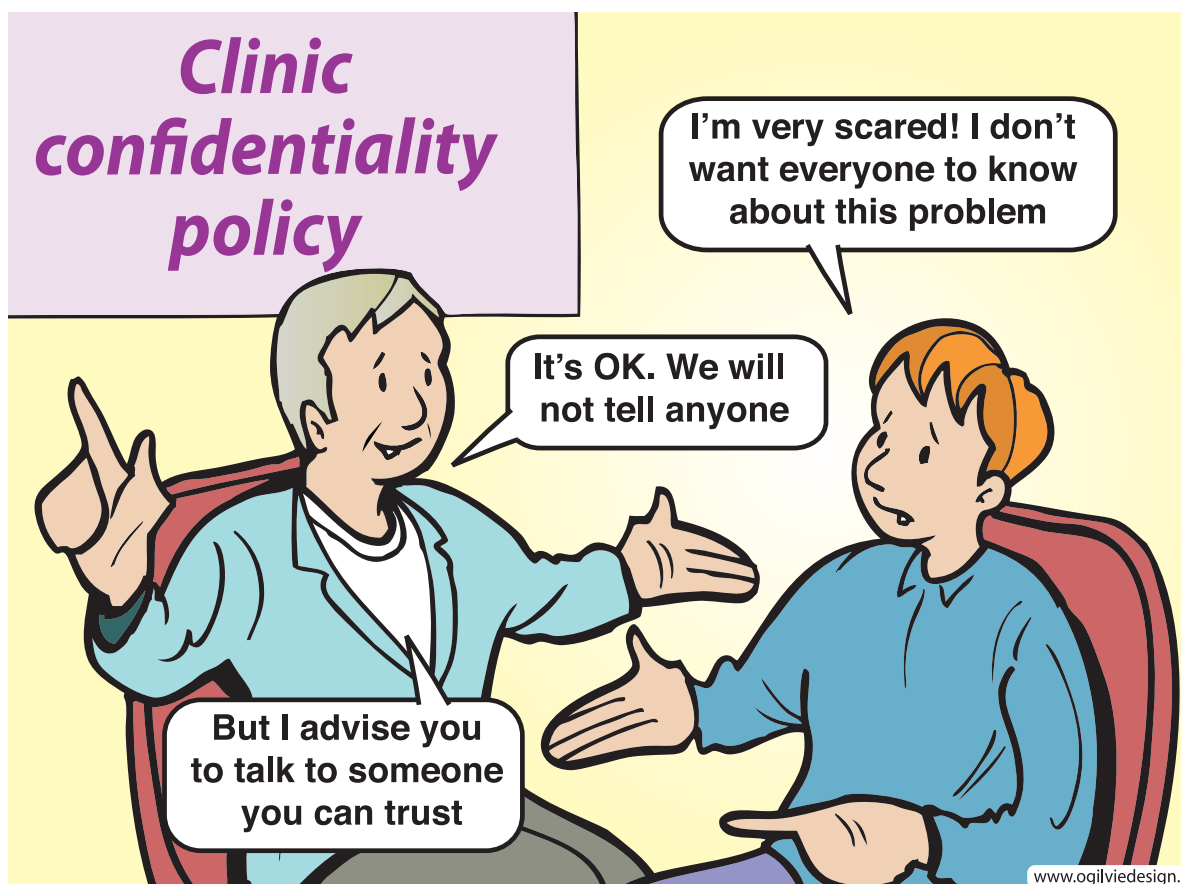
This guideline (140), which is relevant for but not specific to adolescents, consolidates recommendations for health policy-makers and decision-makers in health professional training institutions on the rationale for health-care providers' use of counselling skills to address sexual

health concerns in a primary health care setting. Broadly, it focuses on brief sexuality-related communication to prevent STIs, and preparing health-care providers to deliver it effectively.

6.4 Key concepts to consider

Adolescents lack knowledge and understanding about STIs and STI prevention and management services (130). Adolescents, especially those who would benefit most from vaccination and STI screening, should be informed about STIs when they interact with the health system and through educational outreach (20). Additionally, HPV vaccination strategies offer valuable opportunities for integration with schools and other community-based organizations and institutions (139).

Sexually transmitted infection prevention and management services often do not reach adolescents; if they do, often they are not adolescent-friendly (130). Sexually transmitted infection prevention strategies, including providing information (see Section 2), addressing social drivers of STIs and HIV (see Section 7), promoting condom use, and providing the HPV vaccine, need to be tailored to reach and meet the needs of adolescents (120). Further efforts are needed to ensure that when adolescents know or expect that they have an STI, they seek care (120). Sexually transmitted infection management services must be adolescent-friendly: 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, and STI prevention and management services should be provided for adolescents without mandatory parental and guardian authorization or notification (120). Additionally, girls should not be asked about sexual activity before administration of the HPV vaccine (139).



6.5 Key complementary documents in addition to the WHO guidelines

- Global health sector strategy on sexually transmitted infections 2016–2021. Geneva: World Health Organization; 2016 (120)
- World Health Organization. Human papillomavirus vaccines: WHO position paper, May 2017 – recommendations. *Vaccine*. 2017;35(43):5753–5755 (141)
- Guide to introducing HPV vaccine into national immunization programmes. Geneva: World Health Organization; 2016 (142)
- Scaling-up HPV vaccine introduction. Geneva: World Health Organization; 2016 (143)
- Sexually transmitted diseases: treatment guidelines, 2015. Atlanta, GA: Centers for Disease Control and Prevention; 2015 (144)
- HPV vaccine lessons learnt project overview. Seattle, WA: PATH; 2015 (145)

6.6 Real-life application of the guidelines

Since the release of the STI treatment guidelines for gonorrhoea, chlamydial infection, syphilis and genital herpes in 2016, all WHO regional offices have organized workshops to disseminate the guidelines to country focal points. These workshops brought together 22 countries from the Western Pacific Region, the South-East Asia Region and the Eastern Mediterranean Region in a joint event; 12 countries from the Region of the Americas; and 28 countries from the Africa Region. Sexually transmitted infection guidelines have also been disseminated by linking these guidelines to dissemination workshops of guidelines on HIV and maternal, child and newborn health.

In Cambodia and Myanmar for example, STI technical committees were established to revise national guidelines based on the WHO STI guidelines. In Brazil and Cambodia, national funding has been allocated for implementing gonorrhoea antimicrobial resistance surveillance to inform revision of national gonorrhoea treatment recommendations. Lastly, Kenya and Zimbabwe have revised their STI treatment recommendations according to WHO guidelines and as informed by results of gonorrhoea antimicrobial resistance surveillance.

7 HIV prevention and care

7.1 Definitions

Human immunodeficiency virus (HIV) is a virus that targets the immune system and weakens the body's defence systems against infections and some types of cancer (146). HIV is transmitted via the exchange of body fluids containing the virus, such as blood, breast milk, semen and vaginal secretions (147). The most advanced stage of HIV infection is acquired immunodeficiency syndrome (AIDS) (146). There is currently no cure or vaccine for HIV or AIDS (146).

Antiretroviral medicines are medicines used to treat HIV (147). Antiretroviral medicines can be used for post-exposure prophylaxis (short-term treatment started as soon as possible, and within 72 hours, after high-risk exposure to HIV to reduce the risk of acquiring the virus), and as pre-exposure prophylaxis (HIV prevention for people who have tested negative for HIV but are at high risk of infection) (146).

Antiretroviral therapy refers to the use of a combination of three or more antiretroviral medicines to treat HIV infection (147). Antiretroviral therapy involves lifelong treatment (147). Synonyms are “combination antiretroviral therapy” and “highly active antiretroviral therapy” (147).

7.2 Rationale

HIV among adolescents is an important problem, particularly in sub-Saharan Africa. In 2017 there were approximately 1.8 million adolescents living with HIV worldwide, accounting for 5% of all people living with HIV (148). Additionally, adolescents account for 16% of new adult HIV infections (148). Some adolescents are at much higher risk of HIV than others (149). For example, in eastern and southern Africa, girls accounted for two in every three new HIV infections among young people in 2017, a phenomenon underpinned by gender inequalities and harmful masculinities, violence, poor access to education and employment opportunities, and low levels of economic independence (150).

HIV among adolescents has major health consequences. Undiagnosed and untreated HIV among adolescents results in substantial mortality (151,152). AIDS-related deaths among young adolescents aged 10–14 years have declined since 2010 to approximately 20 000 deaths globally during 2015, due largely to the impact of prevention of mother-to-child transmission (152). However, AIDS-related deaths among adolescents aged 15–19 years have continued to rise, with an estimated 20 800 deaths during 2015, due in part to the unique characteristics,

especially increasing autonomy, of older adolescents and the effects of these characteristics on adherence to treatment and retention in care (152). Compared with children and adults living with HIV, adolescents living with HIV have higher rates of mortality (151). In fact, adolescents comprise the only age group for which AIDS-related mortality did not decline between 2000 and 2015 worldwide; instead, AIDS-related mortality among adolescents more than doubled during this time period (153).

HIV prevention and management services have been shown to be effective. The following package of interventions has been shown to be effective in HIV prevention in adolescents and young adults: provision of CSE, promotion and distribution of condoms, HIV testing and counselling services, voluntary medical male circumcision for risk reduction, harm reduction for people who inject drugs, and targeted prevention programmes for young sex workers and other key populations (154). For adolescents at high risk of HIV acquisition, the package should be extended with the offer of pre-exposure prophylaxis (154). Research evidence and programmatic experience point to the importance of combining the provision of information, counselling, commodities and health services with structural actions such as legal and policy support to access sexual and reproductive health services and community mobilization to address social and gender norms (154). With regard to treatment and care, viral suppression through early initiation of antiretroviral therapy for people living with HIV has been shown to result in reduced rates of sexual transmission of HIV and clinical events (155). Additionally, HIV self-testing and community-based testing and treatment have the potential to increase HIV diagnosis, initiation of antiretroviral therapy, and achievement of viral suppression (156). Lastly, mental health interventions should be included in the package of HIV care services for all people living with HIV, especially adolescents. Integration or linkage to mental health services should be implemented in settings where health-care infrastructure and trained human resources are available (147).

However, prevention strategies and their implementation, and access to and provision of high-quality services, need attention. Only 64 of 107 UNAIDS reporting countries in 2016 had a strategy or plan related to adolescents and HIV (151). Most adolescents lack basic knowledge on prevention of HIV: only 34% of young men and 28% of young women in sub-Saharan Africa between 2012 and 2017 had comprehensive knowledge on how to prevent HIV (150). Further, adolescent girls especially may be unable to negotiate the use of condoms due to low levels of economic independence, interpersonal violence, and power differentials related to age and gender (150). From 2011 to 2016, condom use at last high-risk sex in the previous 12 months was less than 50% for young women aged 15–24 years in 31 countries and for young men aged 15–24 years in 18 countries (154). Therefore, female-controlled options such as pre-exposure prophylaxis provide an additional prevention choice for young women at risk. Adolescents are less likely than adults to be tested for HIV, and in almost 60% of the 107 reporting countries parental consent was required for adolescents to access HIV treatment (151). Innovations such as HIV self-testing, where a test is conducted by an adolescent on their own in private, is another option for expansion of services. However, it is important to provide information for counselling and referral within self-test kits to enable adolescents to have their questions answered and to cope with test results. Adolescents living with HIV are underserved by HIV services and have poorer retention in care and lower rates of viral suppression compared with children and adults living with HIV (152,157,158).

States have obligations under human rights law to provide HIV prevention and care to adolescents. States are obligated to ensure adolescents have access to confidential HIV testing and counselling services and to evidence-based HIV prevention and treatment programmes provided by trained personnel who fully respect the rights of adolescents to privacy and non-discrimination (15,17). Furthermore, states must ensure that the right to health of children, including adolescents, is not undermined as a result of discrimination, including that based on HIV status (16). Removal of barriers such as third-party consent requirements also forms part of states' obligations in relation to HIV prevention, testing and treatment, as a component of sexual and reproductive health services (15,17).

7.3 Relevant WHO guidelines

7.3.1 HIV and adolescents: guidance for HIV testing and counselling and care for adolescents living with HIV – recommendations for a public health approach and considerations for policy-makers and managers. Geneva: World Health Organization; 2013

This guidance document (159), which is specific to adolescents, provides recommendations on prioritizing, planning and providing HIV testing, counselling, treatment and care services for adolescents. Broadly, it describes recommendations for HIV service provision for adolescents and presents operational considerations, including guiding principles for implementation and programmatic experience and lessons learnt, for policy-makers and managers. The guidance document issues the following adolescent-specific recommendations:

Community:

- Consider community-based approaches to improve treatment adherence and retention in care of adolescents living with HIV.

Health facility – HIV testing and counselling:

- Generalized, low and concentrated epidemics: provide HIV testing and counselling services, with linkages to prevention, treatment and care, for adolescents from key populations in all settings.
- Generalized epidemics: provide HIV testing and counselling services, with linkages to prevention, treatment and care, for all adolescents.
- Low and concentrated epidemics: ensure HIV testing and counselling services, with linkages to prevention, treatment and care, are accessible for all adolescents.

Health facility – disclosure:

- Counsel adolescents about the potential benefits and risks of disclosure of their HIV status to others, and empower and support them to determine whether, when, how and to whom to disclose.

Health facility – adherence to treatment and retention in care:

- Train health-care workers to contribute to treatment adherence and improvement in retention in care of adolescents living with HIV.

7.3.2 Guidelines on HIV self-testing and partner notification. Geneva: World Health Organization; 2016

This guideline (160), which is relevant for but not specific to adolescents, is an update to the *WHO Consolidated Guidelines on HIV Testing Services* (161) and issues new recommendations and additional guidance on HIV self-testing and assisted HIV partner notification services. Broadly, it provides recommendations for HIV self-testing⁷ and partner notification.⁸

7.3.3 WHO consolidated guidelines on HIV testing services. Geneva: World Health Organization; 2015

This guideline (161), which is relevant for but not specific to adolescents, consolidates recommendations on HIV testing services. Broadly, it addresses issues and elements for effective delivery of HIV testing services that are common in a variety of settings, contexts and diverse populations. This guideline issues the following adolescent-specific recommendations:

Health facility:

- Generalized, low, and concentrated epidemics: provide HIV testing services, with linkages to prevention, treatment and care, for adolescents from key populations in all settings.
- Generalized epidemics: provide HIV testing and counselling services, with linkages to prevention, treatment and care, for all adolescents.
- Low and concentrated epidemics: ensure HIV testing and counselling services, with linkages to prevention, treatment and care, are accessible to all adolescents.
- Counsel adolescents with HIV about the potential benefits and risks of disclosure of their HIV status, and empower and support them to determine whether, when, how and to whom to disclose.

7.3.4 Updated recommendations on first-line and second-line antiretroviral regimens and post-exposure prophylaxis and recommendations on early infant diagnosis of HIV: interim guidance. Geneva: World Health Organization; 2018

This guideline (162), which is relevant for but not specific to adolescents, provides updated recommendations on antiretroviral regimens for treating and preventing HIV infection and on early infant diagnosis of HIV. Broadly, it provides recommendations on the preferred first-line regimens for adults, adolescents and children initiating antiretroviral therapy, which now include dolutegravir

7 HIV self-testing refers to a process in which a person collects their own specimen (oral fluid or blood), performs an HIV test, and interprets the result, often in a private setting, either alone or with someone they trust. As with all approaches to HIV testing, self-testing should always be voluntary, not coercive and not mandatory.

8 Partner notification, disclosure or contact tracing is defined as a voluntary process whereby a trained provider asks people living with HIV about their sexual partners and drug injecting partners and then, if the person living with HIV agrees, offers these partners HIV testing services. Partner notification is provided using passive or assisted approaches.

and raltegravir. It also recommends that HIV virological testing be used to diagnose HIV infection among infants and children younger than 18 months and that antiretroviral therapy be started without delay while a second specimen is collected to confirm the initial positive virological test result. The guideline emphasizes a woman centered approach with strong linkages between HIV and SRH programs as critical enablers for the provision of quality services to adolescents.

7.3.5 Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015

This guideline (163), which is relevant for but not specific to adolescents, provides guidance on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Broadly, it states that antiretroviral therapy should be initiated in all people living with HIV, regardless of CD4 cell count, and that the use of daily oral pre-exposure prophylaxis is recommended as a prevention choice for people at substantial risk of HIV infection as part of combination prevention approaches. This guideline issues the following adolescent-specific recommendations:

Health facility:

- Antiretroviral therapy should be initiated in all adolescents living with HIV, regardless of CD4 cell count.

7.3.6 Guidelines on post-exposure prophylaxis for HIV and the use of co-trimoxazole prophylaxis for HIV-related infections among adults, adolescents and children. Geneva: World Health Organization; 2014

This guideline (164), which is relevant for but not specific to adolescents, provides new recommendations and updates to previous recommendations outlined in the 2013 WHO *Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection* (147). Broadly, it reflects important advances in the use of antiretroviral medicines to prevent HIV with more simplified approaches to post-exposure prophylaxis and simplifies the indications on the use of co-trimoxazole to prevent opportunistic infections, bacterial infections and malaria. This guideline issues the following adolescent-specific recommendations:

Health facility:

- Co-trimoxazole prophylaxis is recommended for infants, children and adolescents with HIV, irrespective of clinical and immune conditions. Priority should be given to all children under 5 years of age, regardless of CD4 cell count or clinical stage, those with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4), and those with a CD4 count of less than or equal to 350 cells/mm³.
- In settings with a high prevalence of malaria or severe bacterial infections, co-trimoxazole prophylaxis should be continued until adulthood.
- In settings with low prevalence for both malaria and bacterial infections, co-trimoxazole prophylaxis may be discontinued for children aged 5 years and older who are clinically stable or virally suppressed on antiretroviral therapy for at least 6 months and with a CD4 count over 350 cells/mm³.

7.3.7 Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach. Geneva: World Health Organization; 2016

This guideline (147), which is relevant for but not specific to adolescents, consolidates recommendations on the diagnosis of HIV infection, the care of people living with HIV, and the use of antiretroviral medicines for treating and preventing HIV infection. Broadly, it structures recommendations along the continuum of HIV testing, care and treatment. Updated guidance on first-line and second-line antiretroviral regimens and post-exposure prophylaxis and recommendations on early infant diagnosis of HIV was issued in 2018 (see Section 7.3.4). This guideline issues the following adolescent-specific recommendations:

Community:

- Consider community-based approaches to improve treatment adherence and retention in care of adolescents living with HIV.

Health facility – HIV diagnosis:

- Generalized, low and concentrated epidemics: provide HIV testing and counselling, with linkages to prevention, treatment and care, for adolescents from key populations.
- Generalized epidemics: provide HIV testing and counselling, with linkages to prevention, treatment and care, for all adolescents.
- Low-level and concentrated epidemics: ensure HIV testing and counselling, with linkages to prevention, treatment and care, are accessible to all adolescents.

Health facility – antiretroviral therapy:

- Initiate antiretroviral therapy in all adolescents living with HIV, regardless of WHO clinical stage and CD4 cell count.
- Ensure first-line antiretroviral therapy for adolescents consists of two nucleoside reverse-transcriptase inhibitors plus a non-nucleoside reverse-transcriptase inhibitor or an integrase strand transfer inhibitor.
- For older children and adolescents who have more therapeutic options available to them, consider constructing third-line antiretroviral regimens with novel medicines used to treat adults, such as etravirine, darunavir and raltegravir.

Health facility – prevention, screening and management of co-infections:

- Tuberculosis (TB) – provide co-trimoxazole prophylaxis for infants, children and adolescents living with HIV and active TB disease, irrespective of clinical and immune conditions.
- Cryptococcal disease – the use of routine CrAg screening in antiretroviral therapy-naïve adolescents and children with pre-emptive antifungal therapy if positive for CrAg before initiation of antiretroviral therapy is not recommended.

Adolescent-friendly health services:

- Train health-care workers to contribute to treatment adherence and improvement in retention in care of adolescents living with HIV.

- Counsel adolescents about the potential benefits and risks of disclosure of their HIV status, and empower and support them to determine whether, when, how and to whom to disclose (conditional recommendation).

7.3.8 Guidelines for managing advanced HIV disease and rapid initiation of antiretroviral therapy. Geneva: World Health Organization; 2017

This guideline (165), which is relevant for but not specific to adolescents, provides recommendations on a public health approach to care for people presenting with advanced HIV disease, and on the timing of initiation of antiretroviral therapy for all people living with HIV. Broadly, it defines a package of screening, prophylaxis, rapid antiretroviral therapy initiation, and intensified adherence interventions aimed at reducing HIV-associated morbidity and mortality. It also recommends that rapid antiretroviral therapy initiation (within seven days of HIV diagnosis) be offered to people living with HIV following confirmed diagnosis and clinical assessment, and that antiretroviral therapy be initiated on the same day as HIV diagnosis based on the person's willingness and readiness to start antiretroviral therapy immediately, unless there are clinical reasons to delay treatment.

7.3.9 Consolidated guidelines on person-centred HIV patient monitoring and case surveillance. Geneva: World Health Organization; 2017

This guideline (166), which is relevant for but not specific to adolescents, provides consolidated guidance on monitoring systems for people with HIV as part of public health surveillance. Broadly, it recommends the use of unique identifiers to link people with HIV across health services and the use of routine data for care and reporting on programme, national and global indicators, including key global targets for HIV.

7.3.10 Integrating collaborative TB and HIV services within a comprehensive package of care for people who inject drugs: consolidated guidelines. Geneva: World Health Organization; 2016

This guideline (167), which is relevant for but not specific to adolescents, provides consolidated guidance on integrating collaborative TB and HIV services within a comprehensive package of care for people who inject drugs. It provides an update of the WHO 2008 policy guidelines for collaborative TB and HIV services for people who use drugs. Broadly, it consolidates the latest recommendations relating to the management of TB, HIV-associated TB, HIV, viral hepatitis B and hepatitis C, and drug dependence, as well as alcohol dependence, malnutrition, mental illness and psychosocial needs.

7.3.11 Guidelines on the public health response to pretreatment HIV drug resistance. Geneva: World Health Organization; 2017

This guideline (168), which is relevant for but not specific to adolescents, provides guidance on the public health response to pretreatment resistance to non-nucleoside reverse-transcriptase inhibitors in people without prior antiretroviral medicine exposure or in people with prior antiretroviral medicine exposure who are initiating or reinitiating first-line antiretroviral therapy. It is a supplement to the 2016 *Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection* (147).

7.3.12 Consolidated guideline on sexual and reproductive health and rights of women living with HIV. Geneva: World Health Organization; 2017

This guideline (43), which is relevant for but not specific to adolescents, consolidates recommendations on the sexual and reproductive health and rights specific to women living with HIV. Broadly, this guideline describes strategies for creating an enabling environment and providing health interventions for the sexual and reproductive health and rights of women living with HIV. It also discusses implementation issues that health and service delivery interventions must address in order to achieve gender equality and support human rights. This guideline issues the following adolescent-specific recommendations:

Health facility – HIV prevention and care services:

- Counsel adolescents about the potential benefits and risks of disclosure of their HIV status to others, and empower and support them to determine whether, when, how and to whom to disclose.
- Initiate antiretroviral therapy in all adolescents living with HIV, regardless of WHO clinical stage and CD4 cell count (conditional recommendation).

Health facility – adolescent-friendly health services:

- Ensure adolescent-friendly health services are implemented in HIV services to ensure engagement and improved outcomes.

7.3.13 Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations: 2016 update. Geneva: World Health Organization; 2016

This guideline (20), which is relevant for but not specific to adolescents, consolidates recommendations for HIV prevention, diagnosis, treatment and care for five key populations: men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers, and transgender people. Broadly, it introduces a comprehensive package of interventions and describes health-sector interventions, critical enablers, service delivery, and the decision-making, planning and monitoring process.

7.3.14 Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. Geneva: World Health Organization; 2017

This guideline (42), which is specific to adolescents and children (aged 0–18 years), provides recommendations for the provision of high-quality trauma-informed care to survivors of sexual abuse. Broadly, it covers recommendations for post-rape care and good practices for taking medical histories, conducting examinations, providing psychological support, and documenting findings. Importantly, these guidelines also highlight ethical considerations when health-care providers are mandated to report child and adolescent sexual abuse to designated authorities. Additionally, this guideline emphasizes the importance of promoting safety, offering choices and respecting the wishes and autonomy of children and adolescents (regarding the engagement of caregivers). With regard to HIV, this guideline issues the following adolescent-specific recommendations:

Health facility:

- Offer HIV post-exposure prophylaxis, as appropriate, to children and adolescents who have been raped involving oral, vaginal or anal penetration with a penis, and who present within 72 hours of the incident.
- Provide a 28-day prescription of antiretroviral medicines for HIV post-exposure prophylaxis, following initial risk assessment.
- Ideally offer a triple-therapy antiretroviral regimen, but a two-medicine regimen is also effective.
- Incorporate adherence counselling as an important element in the provision of HIV post-exposure prophylaxis to survivors of sexual assault or rape.

7.3.15 Guidance statement: hormonal contraceptive eligibility for women at high risk of HIV. Geneva: World Health Organization; 2017

This guidance statement (44), which is relevant for but not specific to adolescents, provides recommendations for use of hormonal contraceptive methods by women at high risk of HIV.

7.4 Key concepts to consider

Many adolescents do not know how to prevent HIV or where to access HIV prevention services (150). Adolescents at risk of HIV should be provided with the full range of effective HIV prevention methods and interventions. This includes sexual and reproductive health information and education (see Section 2), male and female condoms, behaviour change interventions to reduce the number of sexual partners, use of clean needles and syringes, and opiate substitution therapy (e.g. methadone) (20). It also includes services such as voluntary medical male circumcision in settings with a high HIV burden, antiretroviral medicines for pre-exposure prophylaxis, and treatment of people living with HIV to reduce viral load and prevent onward transmission (20). Complementary efforts including social and gender norm change and economic empowerment must also be made to address the structural drivers of HIV (150).

Many adolescents, especially those in key populations, do not know their HIV status (151). Adolescents need comprehensive information and education on HIV and the HIV testing services available to them (43). HIV testing services, including self-testing, should be made accessible to all adolescents, with linkages to counselling and treatment services and without mandatory age of consent or parental or guardian authorization or notification policies (43,159). Community-based distribution of HIV self-test kits has seen high uptake among adolescents (160). Policies, in particular those regarding age of consent, on access to HIV testing may need to be adapted or developed to enable adolescents to self-test for HIV (160).

Adolescents find it difficult to reach and obtain HIV prevention and care services (152,157,158). Services should be provided at times that accommodate school hours, in locations that protect adolescents from stigma and disclosure-related concerns, and without prohibitive user fees (43,159). Linkage to care may be enhanced by peer-based interventions, community-based services and support groups (20). Additionally, access can be affected by policy requirements, such as age of consent for sexual intercourse, HIV testing or antiretroviral therapy provision (20,159). Policy-makers should ensure age of consent policies protect adolescents' right to make choices about their own health and well-being, with consideration for adolescents' different levels

of maturity and development. Service providers should be aware of laws and policies governing age of consent to ensure adolescents have access to the services they require (43, 159).

HIV prevention and care services are often not adolescent-friendly. Adolescents may face specific barriers at each stage of HIV diagnosis, treatment and care, and they may need support to navigate HIV care services (159). Health-care providers and support staff need training and support to provide adolescent-friendly and age-appropriate information and services (159). Additionally, effective planning and support are needed for adolescents to navigate the health system (159).

With regard to diagnosis and post-testing counselling, receiving information about potential HIV exposure may be more emotionally challenging for adolescents than for adults (159). Programmes should make extra efforts to support adolescents to understand their diagnosis; interpret information on their rights (especially related to confidentiality); link them to essential HIV treatment, care and prevention interventions; and build skills to make informed secondary prevention decisions (159). Adolescents should also be given the opportunity to ask questions and discuss issues related to sexuality (159). Programmes should include rapid proactive follow-up and strategies for re-engagement, especially communication technologies, such as mobile phones and text messaging (20).

With regard to treatment, frequent clinic visits, time spent waiting for services and having to miss school discourages adolescents' engagement in care (159). For adolescents who are transitioning from paediatric to adolescent care, or from adolescent to adult care, difficulties in navigating the health-care system, lack of linkages between adult and paediatric services, and health workers who are inadequately skilled in managing transitions pose additional barriers. Effective planning and support for adolescents are needed to ensure these transitions occur as smoothly as possible (159). Where viral load monitoring is widely available, consider more frequent viral load monitoring for adolescents who are at the highest risk for antiretroviral resistance compared with other age groups (159). Additionally, adolescents should be counselled and supported in accessing contraceptive and prevention of mother-to-child transmission services, given that adolescent girls with HIV are more likely than adult women with HIV to have unintended pregnancies, detectable viral loads during pregnancy, and infants living with HIV (20).

With regard to disclosure, the potential loss of social or economic support or loss of a partner may be especially difficult for adolescents, particularly if the partner is older or has more power in the relationship (159). Partner notification for adolescents, whether they are the person living with HIV or the partner being informed of exposure to HIV, requires sensitive and non-judgemental health-care provider engagement, including recognition and minimization of risks of IPV (159). Adolescents should receive individualized planning on how, when and to whom to disclose HIV status (159). Providers should consider appropriate means of contact with adolescents to enable the provision of support services, should they be required (160). Using communication technologies such as mobile phones and text messaging may help with disclosure, adherence and retention, particularly for adolescents and young people (20).



7.5 Key complementary documents in addition to the WHO guidelines

- Adolescent HIV testing, counselling and care: implementation guidance for health providers and planners. Geneva: World Health Organization; 2014 (169)
- HIV prevention among adolescent girls and young women: putting HIV prevention among adolescent girls and young women on the Fast-Track and engaging men and boys. Geneva: Joint United Nations Programme on HIV/AIDS; 2016 (154)
- Key considerations for differentiated antiretroviral therapy delivery for specific populations: children, adolescents, pregnant and breastfeeding women and key populations. Geneva: World Health Organization; 2017 (170)
- The importance of sexual and reproductive health and rights to prevent HIV in adolescent girls and young women in eastern and southern Africa. Geneva: World Health Organization; 2017 (171)
- Clinical manual for male circumcision under local anaesthesia and HIV prevention services for adolescent boys and men. Geneva: World Health Organization; 2018 (172)
- WHO implementation tool for pre-exposure prophylaxis of HIV infection. Geneva: World Health Organization; 2017 (173)

7.6 Real-life application of the guidelines

As adolescents are at increased risk of non-adherence and loss to follow-up while receiving antiretroviral therapy, WHO guidelines recommend that programmes provide community support for adolescents living with HIV to improve retention in HIV care. Using these recommendations, the South African organization Kheth'Impilo implemented an innovative community-based adherence support programme for adolescents living with HIV that used patient advocates (174). Patient advocates are trained community-based health workers who live and work in the same geographical area as their clients. They are primarily responsible for linking antiretroviral therapy sites to the community by providing community-based antiretroviral therapy adherence counselling and support to people living with HIV and TB and their families. In this programme, patient advocates provided regular adherence and psychosocial support for people on antiretroviral therapy and conducted home visits to address factors affecting adherence. People included in the programme were reported to show improved retention and viral suppression.

The Zimbabwean organization Africaid applied WHO guidelines to develop its innovative Zvandiri model, which provides community-based treatment, care, support and prevention services for children and adolescents living with HIV, and has been scaled up nationwide (175). The model uses trained and mentored community adolescent treatment supporters to deliver structured support groups and tailored community-based adherence support, along with counselling for broader psychosocial issues (176). These services are integrated within the clinical care provided by government and private clinics. The Zvandiri model was recognized as a best-practice intervention by WHO, the United States Agency for International Development, and the Southern African Development Community.

8 Violence against women and girls: prevention, support and care

8.1 Definitions

Gender-based violence refers to violence directed against a woman because she is a woman or violence that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion, and other deprivations of liberty (177).

Violence against women refers to any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private life (178).

Intimate partner violence refers to behaviour by a current or former intimate partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours (179).

Sexual violence refers to any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person, regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object (179).

8.2 Rationale

Gender-based violence against adolescents is an important problem. Among ever-partnered girls aged 15–19 years, the lifetime prevalence of IPV is 29% (180). The prevalence of child sexual abuse worldwide is estimated to be approximately 18% for girls and 8% for boys (181). Gender-based violence is rooted in gender inequality. For example, attitudes justifying violence against women and girls are often widely held by women and men, and sexual harassment is widespread, including in institutions assumed to be safe, such as schools (182,183).

Gender-based violence among adolescents has major health and social consequences. Intimate partner violence can increase girls' risk of unintended pregnancies and induced abortions (often in unsafe conditions) (180). In some settings, IPV also increases girls' and women's risk of acquisition of HIV and STIs (180). With regard to adverse mental health outcomes, child and adolescent sexual abuse and IPV are linked to increased risk of depression, post-traumatic stress disorder, and suicidal ideation and attempt (180,184). Child and adolescent sexual abuse is a risk factor for a range of behavioural risks during adolescence and in adulthood, including unsafe sex, alcohol misuse and substance use (185).

Gender-based violence prevention, support and care have been shown to be effective. There is evidence that parenting-support programmes to prevent child maltreatment may help prevent IPV later in life (186). Other promising intervention strategies include school-based dating violence interventions and community-based interventions to form gender-equitable attitudes among boys and girls (186). Programmes that have been shown to be more effective are also those that incorporate multisectoral and multilevel action and intersectoral coordination, that use longer-term investments and repeated exposure to ideas in different settings over time, that place gender and power analyses at the core of content, and that respond to survivors in an empathetic and timely manner (187,188).

However, laws and policies, prevention strategies and their implementation, and access to high-quality support and care services need to be strengthened. Prevention efforts are typically piecemeal and in the context of small-scale projects (187). Women and girls who experience violence face major barriers in disclosing it, including those related to stigma, blame and shame, and very few survivors (10–40%) seek any type of medical or legal help from a formal institution (184,189). Although health-care providers are likely to be the first professional contacts for women and girls who experience IPV or sexual violence, there is limited availability of personnel in the health workforce who have been trained and are being supported to identify and respond to it (47,187). Coverage and quality of services, especially mental health services, needed by survivors are limited, often fragmented and concentrated in cities (187). Furthermore, while most countries have laws in place to hold perpetrators of violence to account, their enforcement is often weak (187). National plans and policies for addressing violence are not adequately resourced, and intersectoral coordination for addressing different forms of violence is lacking, as is coordination within the health system across different programmes and services (187).

States have obligations under human rights law to prevent and address violence against women and girls and provide them with support and care. States are obligated to immediately pursue all appropriate means for the elimination of gender-based violence, which includes addressing violations committed by both state and non-state actors (16,102). State action in this regard should include preventing and responding to gender-based violence in all spheres of life, including within the family, in communities, in schools, and in online and other digital environments (17,102).

8.3 Relevant WHO guidelines

8.3.1 Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. Geneva: World Health Organization; 2017

This guideline (42), which is specific to adolescents and children (aged 0–18 years), provides recommendations for the provision of high-quality trauma-informed care to survivors of sexual abuse. Broadly, it covers recommendations for post-rape care and good practices for taking medical histories, conducting examination, providing psychological support, and documenting findings. Importantly, these guidelines also highlight ethical considerations when health-care providers are mandated to report child and adolescent sexual abuse to designated authorities. Additionally, this guideline emphasizes the importance of promoting safety, offering choices and respecting the wishes and autonomy of children and adolescents (regarding the engagement of caregivers). This guideline issues the following adolescent-specific recommendations:

Health facility – HIV post-exposure prophylaxis treatment and adherence:

- Offer HIV post-exposure prophylaxis, as appropriate, to children and adolescents who have been raped involving oral, vaginal or anal penetration with a penis, and who present within 72 hours of the incident.
- Provide a 28-day prescription of antiretroviral medicines for HIV post-exposure prophylaxis, following initial risk assessment.
- Ideally offer preferentially a triple-therapy regimen, but a two-medicine regimen is also effective.
- Incorporate adherence counselling as an important element in the provision of HIV post-exposure prophylaxis to survivors of sexual assault or rape.

Health facility – pregnancy prevention and management among girls who have been sexually abused:

- Offer emergency contraception to girls who have been raped involving penovaginal penetration and who present within 120 hours (5 days) of the incident.

Health facility – post-exposure prophylaxis for curable and vaccine-preventable STIs:

- Offer presumptive (or prophylactic) treatment for gonorrhoea, chlamydia and syphilis for children and adolescents who have been sexually abused involving oral, genital or anal contact with a penis or oral sex, particularly in settings where laboratory testing is not feasible.
- Offer syndromic case management for children and adolescents who have been sexually abused and who present with clinical symptoms (vaginal/urethral discharge – gonorrhoea, chlamydia, trichomoniasis; genital ulcers – herpes simplex virus, syphilis, chancroid), particularly in settings where laboratory testing is not feasible.
- Offer hepatitis B vaccination without hepatitis B immunoglobulin, as per national guidance.
- Offer HPV vaccine to girls in the age group 9–14 years, as per national guidance.

Health facility – psychological and mental health interventions in the short term and longer term:

- Do not use psychological debriefing in an attempt to reduce the risk of post-traumatic stress, anxiety or depressive symptoms.
- Consider cognitive behavioural therapy with a trauma focus for children and adolescents who have been sexually abused and are experiencing symptoms of post-traumatic stress disorder.
- Consider cognitive behavioural therapy with a trauma focus, when safe and appropriate, to involve at least one non-offending caregiver, for children and adolescents who have been sexually abused and are experiencing symptoms of post-traumatic stress disorder and for their non-offending caregiver(s).
- Offer psychological interventions such as cognitive behavioural therapy to children and adolescents with behavioural disorders, and offer caregiver skills training to their non-offending caregivers.
- Offer psychological interventions such as cognitive behavioural therapy and interpersonal psychotherapy to children and adolescents with emotional disorders, and offer caregiver skills training to their non-offending caregivers.

8.3.2 Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization; 2013

This guideline (46), which is relevant for but not specific to adolescents, provides recommendations for responding to IPV and sexual violence against women and girls in low-resource settings. Broadly, these guidelines cover identification and clinical care for IPV, clinical care for sexual assault, training relating to IPV and sexual assault against women, policy and programmatic approaches to delivering services, and mandatory reporting of IPV.

8.3.3 WHO guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries. Geneva: World Health Organization; 2011

This guideline (18), which is specific to adolescents, provides recommendations for action and research to prevent early pregnancy and poor reproductive outcomes among adolescents. Broadly, it recommends reducing marriage before the age of 18 years, reducing pregnancy before the age of 20 years, increasing use of contraception by adolescents at risk of unintended pregnancy, reducing coerced sex among adolescents, reducing unsafe abortion among adolescents, and increasing use of skilled antenatal, childbirth and postnatal care among adolescents. With regard to violence against women and girls, and specifically with regard to coerced sex, this guideline issues the following adolescent-specific recommendations:

Community:

- Create supportive social norms that do not condone coerced sex.
- Implement interventions to engage men and boys to critically assess gender norms and normative behaviours (e.g. gender-transformative approaches) that relate to sexual coercion and violence. Combine these with wider interventions to influence social norms on these issues.

Individual:

- Implement interventions for adolescent girls to resist coerced sex and obtain support if they experience coerced sex by building their self-esteem, developing their life skills in areas such as communication and negotiation, and improving their links to social networks and their ability to obtain support. These interventions should be combined with interventions to create supportive social norms that do not condone coerced sex.
- Implement programmes aimed at developing life skills in communication and negotiation.

8.3.4 Consolidated guideline on sexual and reproductive health and rights of women living with HIV. Geneva: World Health Organization; 2017

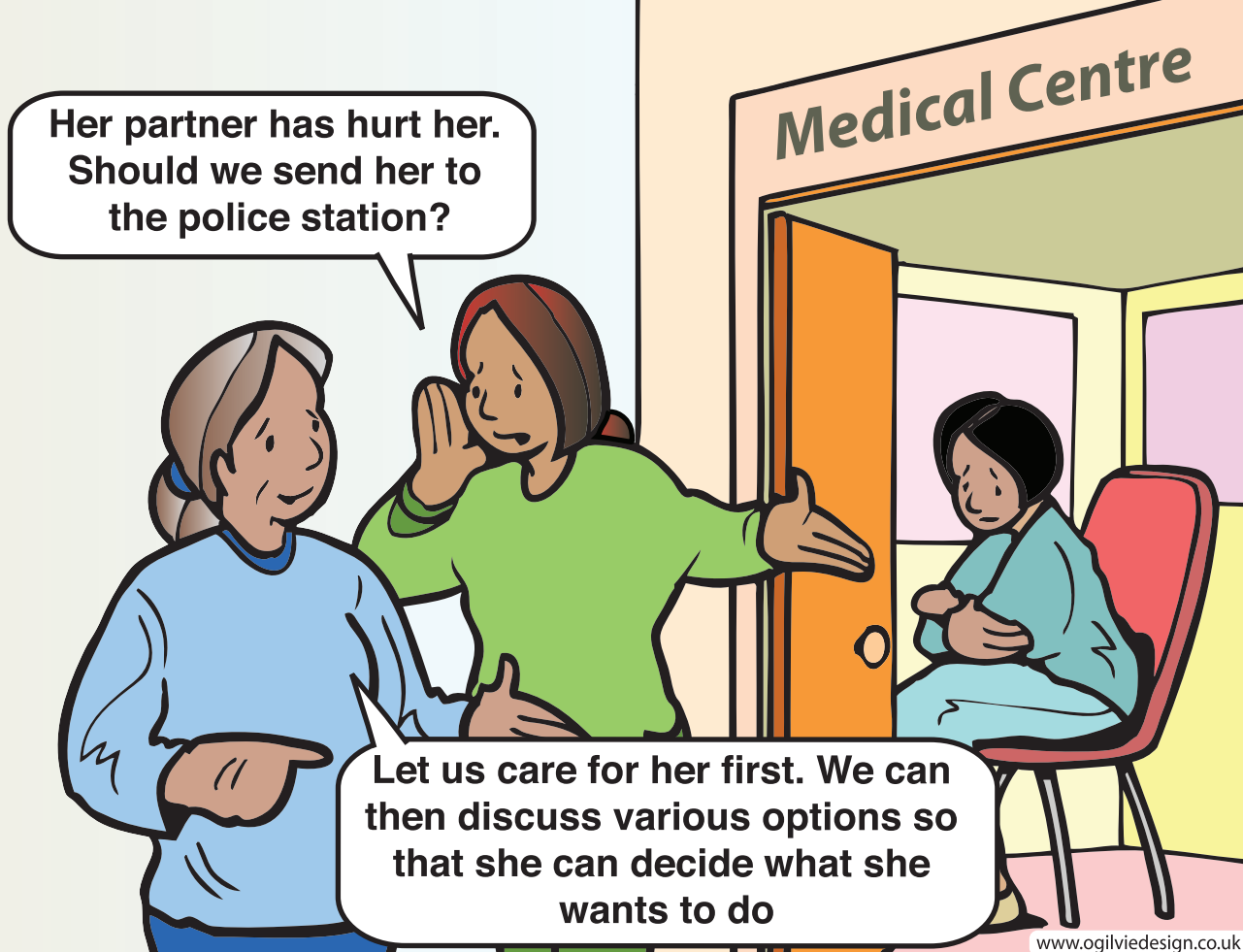
This guideline (43), which is relevant for but not specific to adolescents, consolidates recommendations on the sexual and reproductive health and rights specific to women living with HIV. Broadly, this guideline describes strategies for creating an enabling environment and providing health interventions for the sexual and reproductive health and rights of women living with HIV. It also discusses implementation issues that health and service delivery interventions must address in order to achieve gender equality and support human rights.

8.4 Key concepts to consider

Where gender-based violence prevention and response services exist, they are often implemented on a pilot basis and not scaled up; they are piecemeal and not integrated into existing platforms; and intersectoral collaboration and coordination are weak. To reach the people who need care and to ensure sustainability of efforts, support and care for adolescent girls who experience IPV and sexual violence need to be integrated into sexual and reproductive health, HIV, mental health and adolescent health programmes and services, rather than being standalone interventions (187). Additionally, while the health-sector response is a key element of addressing violence against adolescents, it needs to be complemented with community-based and multisectoral interventions that tackle harmful gender norms and attitudes that justify or condone violence against women and girls (187).

Most health-care providers are not prepared to deal with gender-based violence, including as it relates to reporting of sexual abuse. Health-care providers need training and ongoing support to provide care that is child- and adolescent-centred, is age-appropriate, is responsive to the needs of adolescents, and considers the evolving capacities of adolescents in determining when and how best to engage parents, legal guardians and other relevant caregivers (42, 187). Reporting of sexual abuse, where mandated by law, needs to take into account situations where protection systems are not functioning optimally and where adolescents under the legal age of sexual consent may be having consensual sex with peers (46).

Adolescents often do not seek gender-based violence prevention, support and care services. Uptake of services needs to be facilitated. Health-care providers, including those working in communities, can support this by raising public awareness of the signs, symptoms and health consequences of IPV and sexual abuse, and the need to reduce stigma and to seek timely care (189).



8.5 Key complementary documents in addition to the WHO guidelines

- Global plan of action: health systems address violence against women and girls. Geneva: World Health Organization; 2016 (187)
- INSPIRE: seven strategies for ending violence against children. Geneva: World Health Organization; 2016 (190)
- Global guidance on addressing school-related gender-based violence. Paris: United Nations Educational, Scientific and Cultural Organization; 2016 (191)
- 16 ideas for addressing violence against women in the context of the HIV epidemic: a programming tool. Geneva: World Health Organization; 2013 (192)
- What works to prevent partner violence? An evidence overview. London: London School of Hygiene and Tropical Medicine; 2011 (193)
- Lundgren R, Amin A. Addressing intimate partner violence and sexual violence among adolescents: emerging evidence of effectiveness. J Adolesc Health. 56(1):S42–S50 (186)

8.6 Real-life application of the guidelines

The WHO guidelines *Responding to Intimate Partner Violence and Sexual Violence against Women* (46) and *Responding to Children and Adolescents who Have Been Sexually Abused* (42) are currently being implemented in Pakistan. A clinical handbook on health care for survivors of

intimate partner or sexual violence was developed as an implementation tool for the guidelines. The tool offers practical “how to” guidance with job aids and instructions for provision of clinical care. In 2016, the Pakistani Ministry of Health, with support from WHO, adapted and approved an updated clinical handbook with a chapter on child and adolescent sexual abuse response. In 2018, two training of trainers sessions with doctors and female health visitors were held in Punjab and Khyber Pakhtunkhwa provinces using the adapted clinical handbook. Plans are currently in development for cascade training up to the district level. Additionally, Punjab province is developing a monitoring and evaluation component to assess improvements in knowledge, attitudes and skills of providers, and Khyber Pakhtunkhwa province will conduct a facility readiness evaluation to assess what changes are needed at the service delivery level. Uptake of guidelines will be evaluated by assessing changes in provider knowledge, attitudes and skills in responding to violence.

9 Harmful traditional practices prevention

9.1 Definitions

Traditional cultural practices reflect values and beliefs held by members of a community for periods often spanning generations (194). Every social grouping in the world has specific cultural beliefs and practices, some of which are beneficial, some with no benefits or harms, and some that can be harmful to a specific group, in particular women (194). These harmful traditional practices include FGM, child marriage, female infanticide, menstrual stigma and nutritional practices (194).

Female genital mutilation (FGM) refers to any procedure that involves the partial or total removal of external genitalia or other injury to the female genital organs (such as stitching of the labia majora or pricking of the clitoris) for non-medical reasons (195). WHO classifies FGM into four types (196).⁹

Child marriage refers to a formal marriage or informal union before the age of 18 years (197).

9.2 Rationale

Harmful traditional practices among adolescents are an important problem. Over 200 million girls and women are estimated to be living with the effects of FGM, which is predominantly performed on girls under the age of 18 years (198). FGM is a global problem, most prevalent in 30 countries in Africa and in a few countries in Asia and the Middle East (198, 199). In some countries, such as Djibouti, Guinea, Mali, Somalia and Sudan, the prevalence of FGM is over 75% among women and girls aged 15–49 years (200). However, estimates indicate that although FGM remains common in a number of settings, an adolescent girl today is about a third less likely to undergo FGM compared with 30 years ago (201).

Each year about 12 million girls are married before the age of 18 years (202). Worldwide, girls are approximately five times as likely as boys to be married before the age of 15 years (203). In 25 high-prevalence countries, approximately 36% of women aged 18–22 years were married before the age of 18 years (204). Globally, the proportion of women who were married as children has decreased by 15% in the past decade (202). However, progress has been uneven across

⁹ Type I: partial or total removal of the clitoral glans (clitoridectomy) or the prepuce; type II: partial or total removal of the clitoral glans and the labia minora, with or without excision of the labia majora (excision); type III: narrowing of the vaginal opening with the creation of a covering seal by cutting and appositioning the labia minora or labia majora, with or without excision of the clitoral prepuce and glans (infibulation); type IV: all other harmful procedures to the female genitalia for non-medical purposes, such as pricking, piercing, incising, scraping and cauterization.

regions: while north Africa and the Middle East have decreased the percentage of girls married by age 18 years by about half, and south Asia has reduced a girl's risk of marrying before age 18 years by more than a third, less change has been observed in Latin America and sub-Saharan Africa (202,205). Meanwhile, country-level studies point to immense subnational variability in child marriage prevalence (206,207).

Harmful traditional practices among adolescents can have serious health and social consequences.

FGM has no known health benefits. On the contrary, it can cause immediate health consequences, such as haemorrhage, shock, infections and death (195). It can also cause long-term health and social consequences, such as post-traumatic stress disorder, menstrual problems, and pain and discomfort during intercourse (195). Women with type III FGM, in particular, are more likely to experience difficult labour and obstetric haemorrhage compared with women without FGM (208). Additionally, the children of mothers who have undergone FGM are at increased risk of stillbirth and other neonatal complications (209).

Ninety percent of births to adolescents aged 15–19 years globally occur within marriage, and child marriage is likely to be the cause of early childbirth for 75% of the girls who have their first child before the age of 18 years in 25 high-prevalence countries (210). Adolescent pregnancies are associated with a range of negative health outcomes, especially among girls aged 10–14 years (see Sections 3 and 4) (33,211). Additionally, women who are married before the age of 18 years may have a higher risk of experiencing IPV (see Section 8) (210). Child marriage also has a negative effect on educational attainment and secondary school enrolment and completion for girls, and on the educational attainment of the children of women who are married before age 18 years (210).

Prevention of harmful traditional practice interventions has been shown to be effective.

Multicomponent interventions, especially those that include community mobilization and female empowerment strategies, have the potential to improve a range of adolescent sexual and reproductive health outcomes and could reduce FGM (212). Additionally, other promising intervention strategies include legislation against FGM, prevention counselling in health settings, education about health risks associated with FGM, training of health workers, training and conversion of circumcisers, promotion of alternative rites (in certain contexts), use of positive deviance, and comprehensive social development including outreach and advocacy (212).

To prevent child marriage, interventions must be multisectoral to address the numerous drivers of the issue by establishing and implementing laws and policies; mobilizing families and communities; providing health, social and legal services; and empowering girls (18). Life skills curriculum and empowerment approaches are promising intervention strategies (213,214). In some contexts, economic interventions such as cash transfers or programmes to decrease school-associated costs have contributed to reductions in the rate of child marriage or increases in age at marriage; however, they are more likely to be effective when combined with efforts to build individual confidence and links to social networks (213,214). Programmes to prevent child marriage are more likely to have a positive impact if they focus directly on child marriage or on closely related structural factors such as schooling rather than on broader topics such as HIV, sexual and reproductive health, or empowerment (213).

Laws and policies and prevention strategies and their implementation need attention. A total of 27 of the 30 countries where FGM is prevalent have laws or decrees banning FGM, and yet the practice continues (215). Additionally, there is emerging evidence indicating that health-care providers are increasingly carrying out FGM in different settings (216). As such, enforcement of laws and policies is a major gap in progress to address FGM. Further, the evidence base about which components and sequences of programmatic interventions have the most impact on individual behaviour and social norm change related to FGM is lacking. Similarly, implementation of promising strategies needs to be accelerated, and their effectiveness further evaluated (217).

Globally, 99 countries have laws that allow a girl to be married before age 18 years if her parents provide consent (218). Additionally, girls in 30 countries with laws prohibiting child marriage may not be legally protected when exceptions under customary and religious law are considered (218). Regional model laws, such as the Southern African Development Community Parliamentary Forum Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage, must be adopted and countries must be supported to implement and enforce laws consistent with these models (219). Given that evidence clearly shows that laws alone are not sufficient to prevent child marriage, legislative changes need to be complemented with programmatic efforts, such as those described above, to empower adolescents, build equitable gender norms, and promote girls' educational attainment (18).

States have obligations under human rights law to prevent and address harmful traditional practices. Human rights standards call for an holistic approach to the prevention and elimination of harmful practices. States must adopt legislative measures to expressly prohibit these practices, which are a form of gender-based violence, including providing for adequate sanctions, combined with other legal and policy measures, including social measures (102, 220). These measures must include attention to the root causes of harmful practices, capacity-building at all levels, and protective measures for women and children who have been victims of harmful practices (220).

9.3 Relevant WHO guidelines

9.3.1 WHO guidelines on the management of health complications from female genital mutilation. Geneva: World Health Organization; 2016

This guideline (195), which is relevant for but not specific to adolescents, provides recommendations for management of health complications from FGM. Broadly, it covers prevention and management of obstetric, gynaecological or urological complications; promotion of mental health and female sexual health; and provision of information and education. This guideline issues the following adolescent-specific recommendations:

Health facility – deinfibulation:

- Offer deinfibulation for preventing and treating urological complications, specifically recurrent urinary tract infections and urinary retention, in girls and women living with type III FGM.

Health facility – mental health:

- Consider cognitive behavioural therapy for girls and women living with FGM who are experiencing symptoms consistent with anxiety disorders, depression or post-traumatic stress disorder.

9.3.2 WHO guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries. Geneva: World Health Organization; 2011

This guideline (18), which is specific to adolescents, provides recommendations for action and research to prevent early pregnancy and poor reproductive outcomes among adolescents. Broadly, it recommends reducing marriage before the age of 18 years, reducing pregnancy before the age of 20 years, increasing use of contraception by adolescents at risk of unintended pregnancy, reducing coerced sex among adolescents, reducing unsafe abortion among adolescents, and increasing use of skilled antenatal, childbirth and postnatal care among adolescents. With regard to harmful traditional practices, and specifically child marriage, the guidelines issue the following adolescent-specific recommendations:

Policy:

- Encourage political leaders, planners and community leaders to formulate and enforce laws and policies to prohibit marriage of girls before 18 years of age.

Community:

- Undertake interventions to delay marriage of girls until 18 years of age by influencing family and community norms. These interventions should be undertaken in conjunction with interventions directed at political leaders and planners.
- Increase educational opportunities for girls through formal and non-formal channels, in order to delay marriage until 18 years of age.

Individual:

- Implement 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 under 18 years of age.

9.4 Key concepts to consider

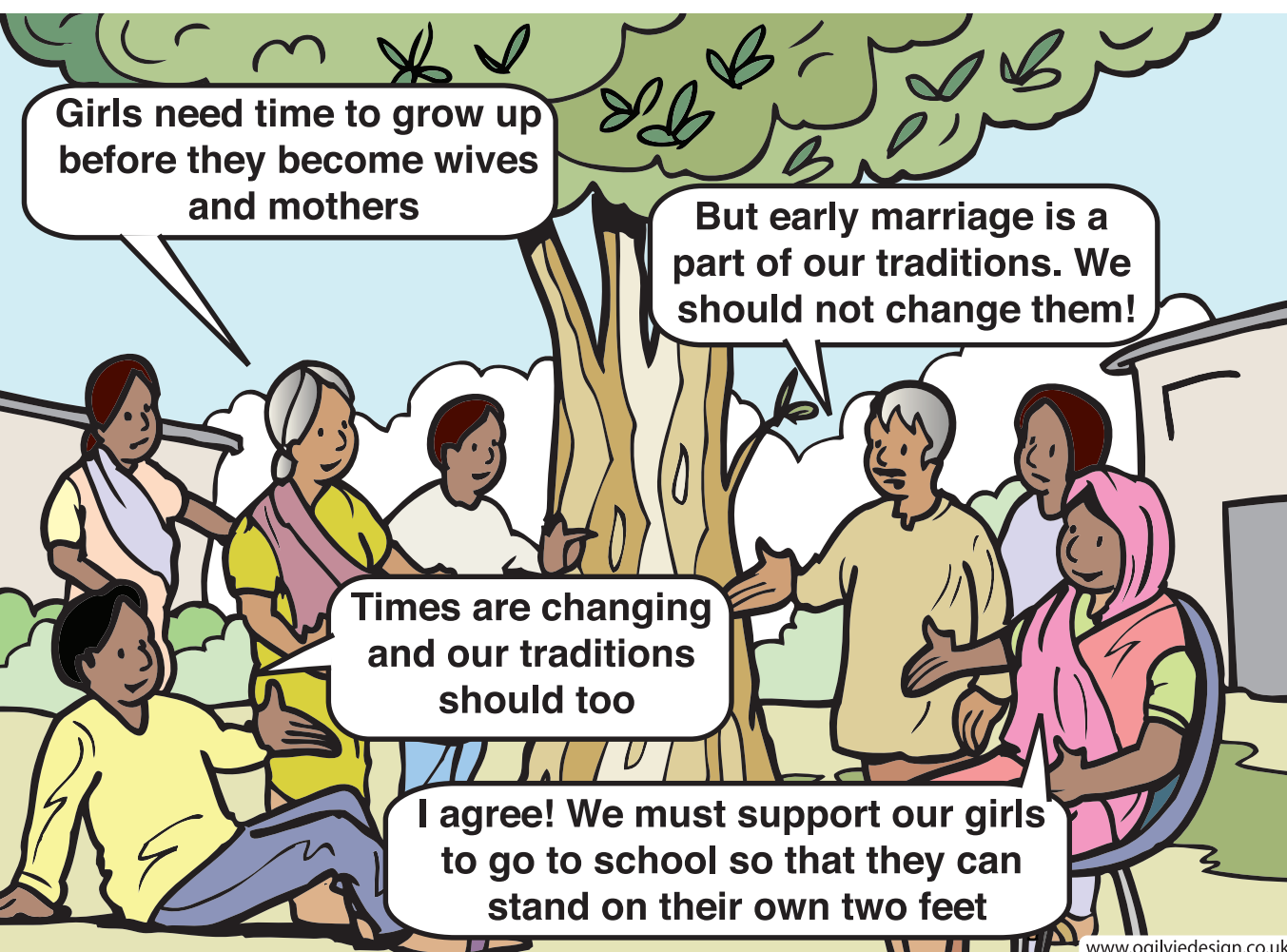
FGM and child marriage are longstanding, deep-rooted traditional practices that cannot be reversed by briefly-implemented single-component interventions. Efforts to prevent FGM and child marriage require long-term and multilevel interventions (18,195). Necessary interventions include securing political will and funding to address the harmful traditional practices, improving legislative frameworks and accompanying enforcement mechanisms, strengthening civil registration systems that provide proof of age for children for reporting of child marriage and implementing community interventions to address customary or religious laws and social norms that condone the practices (18,212). These efforts should be complemented with efforts to increase education and employment opportunities for adolescent girls.

Leaders, including health-care providers, may themselves support FGM or child marriage (215).

All stakeholders, at the community, national, regional and international levels, should play a role in prevention of FGM and child marriage (195). With regard to FGM, health-care providers should receive information regarding different types of FGM and the associated immediate and long-term health risks so that they can contribute to preventing FGM (195). Medicalization of FGM (performance of FGM by health-care providers) is never acceptable because this violates medical ethics: FGM is a harmful practice, medicalization perpetuates FGM, and the risks of the procedure outweigh any perceived benefit (195).

Many adolescents who have undergone FGM or have been married before age 18 years do not have access to care and support.

In addition, girls and women may delay seeking care because they are embarrassed or ashamed (195). Adolescents and other stakeholders need to be informed about the consequences of FGM and child marriage, as well as the health, social and legal services available to them. Married girls and girls who have experienced FGM need access to and support to utilize physical and psychosocial care and support for immediate and long-term health and social consequences (18,195).



9.5 Key complementary documents in addition to the WHO guidelines

- Care of girls and women living with female genital mutilation: a clinical handbook. Geneva: World Health Organization; 2018 (196)
- Female genital mutilation: integrating the prevention and the management of the health complications into the curricula of nursing and midwifery – a teacher's guide. Geneva: World Health Organization; 2001 (221)
- Interagency statement on eliminating female genital mutilation. Geneva: World Health Organization; 2008 (222)
- Global strategy to stop health care providers from performing female genital mutilation. Geneva: World Health Organization; 2010 (223)
- Salam RA, Faqqah A, Sajjad N, Lassi ZS, Das JK, Kaufman M, et al. Improving adolescent sexual and reproductive health: a systematic review of potential interventions. *J Adolesc Health*. 2016;59(4 Suppl.):S11–S28 (212)
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- Ending child marriage: progress and prospects. New York: United Nations Children's Fund; 2014 (205)
- Wodon QT, Male C, Nayihouba KA, Onagoruwa AO, Savadogo A, Yedan A, et al. Economic impacts of child marriage: global synthesis report. Washington, DC: World Bank Group; 2017 (210)

9.6 Real-life application of the guidelines

In April 2016, Zambia's Minister of Gender finalized and launched the National End Child Marriage Strategy. In December 2017, a costed, multisectoral national plan of action was developed to guide the comprehensive and integrated response to child marriage. The development of both documents was technically supported by the United Nations Global Programme to Accelerate Action to End Child Marriage and both documents are aligned with the *WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes among Adolescents in Developing Countries* (18). Two pilot districts were selected for initial implementation of the multisectoral action plan. Additionally, the National Assembly of Zambia and the Inter-Parliamentary Union organized a parliamentary seminar on child, early and forced marriage, and identified a list of actions that parliamentarians could take to play a more active role in the national implementation process, including approving and supporting legislation, oversight, budget allocation and representation (224).

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Even if it makes us uncomfortable,
we must acknowledge the sexual and
reproductive health needs of adolescents

And we have a responsibility
to respond to them



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