SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN 2030

IPPF's Future Clients: From evidence into action

Report to IPPF by a
University of Cape Town/
University of Oxford consortium

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LIST OF ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
AGYW	Adolescent girls and young women
ART	Anti-retroviral Therapy
AYP	Adolescent and young people
COVID-19	Coronavirus
CSE	Comprehensive Sexuality Education
EC	Emergency Contraceptives
GBV	Gender-based Violence
Gen Alpha	Generation Alpha
GenZ	Generation Zoomers
HIC	High income countries
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
IPV	Interpersonal Violence
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual +
LMICs	Low-and-middle income countries
MSM	Men who have sex with men
RTI	Reproductive tract infections
SDG	Sustainable Development Goals
SOGIESC	People of diverse sexual orientation, gender identity and expression, and sex characteristics
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infections

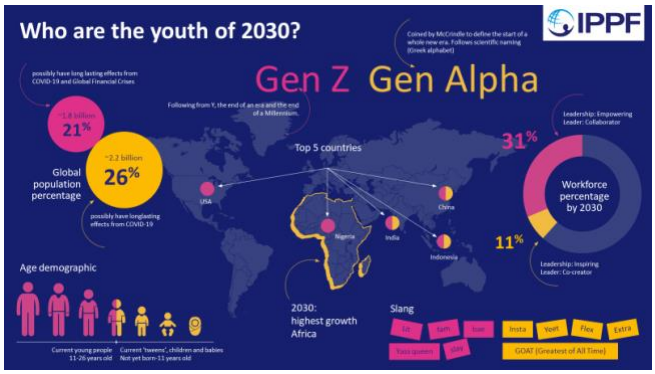
Cover photo: IPPF/Victoria Milko/Nepal

By 2030, the world will be home to over 1.3 billion 10- to 19-year-olds, over 80% of whom will live in sub-Saharan Africa (~45%) and Asia (~40%).[1] As today's children (Generation Alpha) enter their second decade of life and transition to young adulthood, they will face persistent social, economic and legal challenges, which may shape their current life experiences, and influence how they engage as future adults, parents and community members. One in four adolescent girls in sub-Saharan Africa and Asia will become pregnant before age 20, and more than half by age 24.[2] Furthermore, a quarter of adolescent girls will be married before the age of 18. Young women ages 15-24 in sub-Saharan Africa are also among the most vulnerable to HIV and represented 20% of all new infections in the region in 2017.[3] Their parents – today's adolescents and young people, Millennials or Generation Z – will have grown in a fast-paced world characterised by significant leaps in access to technology and large global crises such as climate change, the COVID-19 pandemic, and increases in both access to resources and the visibility of social issues such as interpersonal violence.[4] For both Gen Z and Gen Alpha, IPPF's Future Clients by 2030, **rights**, including sexual and reproductive health and rights (SRHR), are core to their sense of identity with strong and clear links to all life domains.[5]

In May 2021, the IPPF Strategy Research Team started a collaboration with a UCT/ Oxford research team to summarize our knowledge on Gen Z and Alpha by documenting trends in the changing SRHR landscape by exploring the values, aspirations and desires of the IPPF Clients in 2030 and beyond. It aims to address the following questions:

1. Who are IPPF's 2030 Clients? What does current data tell us about their lives and SRHR needs and wishes?
2. How are they engaging (or not) with SRHR products and services?
3. What does the evidence suggest are effective and scalable SRHR solutions?
4. Which interventions/ approaches are shock-adaptable, i.e., possible in response to shocks such as COVID-19, adverse weather events, conflicts, etc.?

Overall approach: Our approach consisted of three main methodologies: (1) rapid rigorous reviews following an existing methodology; (2) emotive evidence through creative workshops, which resulted in the Portraits, and (3) engagement with IPPF youth network via the IPPF youth core team. The report benefited from multiple rounds of feedback and input from IPPF colleagues, which strengthened the messages.



Trends and Issues: Overall Gen Z and Alpha's SRHR needs and wishes will continue to be diverse, not only in terms of gender identity and sexual orientation, but also in terms of family structure and non-health and life priorities. Inequalities, driven by rapid technological change, climate crisis, urbanization and migration, will shape local context driven SRHR needs for future generations, and must inform our services for 2030 and beyond. Two-thirds of IPPF Clients 2030 will live in countries where inequalities have increased, with a growing proportion (25% in 2019-2020) of inequality increase attributed to global warming/ the climate crisis.

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1 United Nations, Department of Economic and Social Affairs, Population Division (2015). Population 2030: Demographic challenges and opportunities for sustainable development planning (ST/ESA/SER.A/389).

2 UNFPA. 2013. Motherhood in Childhood.

3 UNAIDS. 2019. Global AIDS Update.

4 The Atlantic. Oh No, They've Come Up With Another Generation Label. February 21, 2020 https://www.theatlantic.com/family/archive/2020/02/generation-after-gen-z-named-alpha/606862/

5 Ipsos, 2021. LGBT+ Pride 2021Global Survey. [online] Ipsos, p.4. Available at: https://www.ipsos.com/sites/default/files/ct/news/documents/20216/LGBT%20Pride%202021%20Global%20Survey%20Report_3.pdf [Accessed 18 June 2021].

Nearly one in five Gen Z identified as people of diverse sexual orientation, gender identity and expression, and sex characteristics in 2020, the highest ever proportion globally, with four in five young people exploring their sexuality and gender identity. These proportions are expected to grow in some contexts. Despite these trends, key SRHR issues that will affect large numbers (millions) of adolescents and young people in 2030 will include child, early and forced marriage, early and unintended motherhood, unmet contraception needs and HIV infections. These SRH issues will be coupled with growing rates of exposure to violence (self-directed, inter-personal and collective) which will affect children and young people in unstable homes, women in conflict/ humanitarian settings, child/ early/ forced marriage and minorities (ethnic, sexual, political, etc.).

Beyond SRHR: Clients 2030 will be activists with a digital way of life, looking to be co-creators of the products and services that they use. They expect multi-modal learning and services, with education and employment closely linked as goals. Some of these needs, wishes and aspirations are captured in a series titled: Emotive Evidence Portraits, which will be converted into visual tools, in collaboration with Portland Communications:

1. Sesi, 16, Mohale's Hoek, rural Lesotho
2. Nixon, 20, South Kivu, DRC
3. Eden, 18, Cairo, Egypt
4. Alexis, 15, Edmonton, Canada
5. Alina, 20, Kiev, Ukraine
6. Habiba, 17, near Chittagong, Bangladesh
7. Charlie, 23, Shropshire, England
8. Aishwarya, 22, Mazar-e Sharif, Afghanistan
9. Keagan, 17, Cape Town, South Africa
10. Rodrigo, 19, São Paulo, Brazil
11. Nalini, 19, Mumbai, India

The COVID-19 pandemic has exacerbated many of the underlying factors that increase the risk of adolescent pregnancy and parenthood, as well as those that contribute to poor sexual health and HIV outcomes, particularly among young people. While the impact of COVID-19 on population health in low- and middle-income country settings has been inconsistently measured, the long-term economic, social, and political impacts of the global pandemic are likely to be tremendous. One year into the pandemic, UNFPA estimated that at least 12 million women globally had experienced contraceptive interruptions, leading to 1.4 million unintended pregnancies. In addition, the disruption in services, linked to national lockdowns and economic instability, is estimated to increase child marriages by 13 million over the next decade, with associated risks of early pregnancy and violence against girls.[6] The effect of COVID-19 on new HIV infections is also likely to persist: services such as clinic-based HIV testing, counselling, and treatment, and adherence support for individuals living with HIV, have been interrupted or temporarily paused as country-wide lockdowns and health system reallocations have aimed to control the spread of COVID.[7] Adolescents are more likely to bear the brunt of these shifts in care provision, and as a population that is not considered 'at risk' for COVID-19, they may be neglected altogether.

Climate deterioration, socio-legal and political restrictions, coupled with growing inequalities even in stable societies, are all placing additional stress on adolescents as we go into 2030. How do we promote health amidst these competing and growing challenges? In the wake of the social, economic and political shifts due to the COVID-19 pandemic, we need to re-envisage service delivery and access for now and for the future – for Gen Z and Gen Alpha, and their children. We also need to understand how to reach adolescents and young people rapidly, and at scale, to safeguard their health and wellbeing, and promote good health, physical, emotional,

[6] UNFPA. 2020. Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage.
UNFPA. 2021. Impact of COVID-19 on Family Planning: What we know one year into the pandemic.

[7] Waterfield KC, Shah GH, Etheredge GD, Ikhile O. Consequences of COVID-19 crisis for persons with HIV: the impact of social determinants of health. BMC Public Health. 2021;21(1):1–7

cognitive, sexual and reproductive. This means that we need to design service delivery platforms that are entirely COVID-adaptable: able to work flexibly and safely, through movement restrictions and recurring lockdowns. These changes need to be adaptable to COVID but also other shocks, which requires a closer understanding of how to tailor approaches, reach those who are most in need of health information, services, empowering approaches to adolescent and youth SRHR, as well as older generations who will continue to require comprehensive SRHR.

Promising practices and models: Despite the above, experience in providing SRH products, services and rights-based advocacy can inform future planning. Models that are based on promotive peer relationships, self-care interventions and cultural and norms-based transformation will be critical to ensuring that the young people of 2030+ feel seen and served by healthcare systems and the societies they are a part of. These promising models include:

1. self-care approaches and interventions which support access to medical and social services;

2. mHealth/ remote interventions, both as a way to facilitate self-care, and as part of a hybrid package with in-person specialised services;

3. Peer-based interventions that can provide quality, sensitive and responsive knowledge, skills and linkages to products and services; and

4. Integrated services through health system models such as adolescent-responsive clinics but also integrating SRHR into safe spaces.

Shock-responsive approaches: As IPPF develops their 2023-2028 Strategy, one of the most important questions is how to take SRHR beyond facilities and health products/ services/systems with a promotive and transformative lens in mind. Shock-responsive, future-flexible combinations of approaches may be needed, that address SRHR outcomes directly (what we refer to in this report as SRHR boosters) combined with approaches that tackle the structural barriers to SRHR (super-boosters), but may not aim to address SRHR outcomes directly. The combinations of boosters and super-boosters may be critical to accelerating progress towards the SRHR goals and vision for Clients 2030.

Presentations of these findings in September-November 2021 included two briefs to IPPF funders and IPPF's C-SIP, all of which provided rich opportunities to engage with the needs of IPPF Clients 2030.

1. INTRODUCTION

By 2030, the world will be home to over 1.3 billion 10- to 19-year-olds, over 80% of whom will live in sub-Saharan Africa (~45%) and Asia (~40%).[8] As today's children (Generation Alpha) enter their second decade of life and transition to young adulthood, they will face persistent social, economic and legal challenges, which may shape their current life experiences, and influence how they engage as future adults, parents and community members. One in four adolescent girls in sub-Saharan Africa and Asia will become pregnant before age 20, and more than half by age 24.[9] Furthermore, a quarter of adolescent girls will be married before the age of 18. Young women ages 15-24 in sub-Saharan Africa are also among the most vulnerable to HIV and represented 20% of all new infections in the region in 2017.[10] Their parents – today's adolescents and young people, Millennials or Generation Z – will have grown in a fast-paced world characterised by significant leaps in access to technology and large global crises such as climate change, the COVID-19 pandemic, and increases in both access to resources and the visibility of social issues such as interpersonal violence.[11] For both Gen Z and Gen Alpha, IPPF's Future Clients by 2030, **rights**, including sexual and reproductive health and rights (SRHR), are core to their sense of identity with strong and clear links to all life domains.[12]

The COVID-19 pandemic has exacerbated many of the underlying factors that increase the risk of adolescent pregnancy and parenthood, as well as those that contribute to poor sexual health and HIV outcomes, particularly among young people. While the impact of COVID-19 on population health in low- and middle-income country settings has been inconsistently measured, the long-term economic, social, and political impacts of the global pandemic are likely to be tremendous. One year into the pandemic, UNFPA estimated that at least 12 million women globally had experienced contraceptive interruptions, leading to 1.4 million unintended pregnancies. In addition, the disruption in services, linked to national lockdowns and economic instability, is estimated to increase child marriages by 13 million over the next decade, with associated risks of early pregnancy and violence against girls.[13] The effect of COVID-19 on new HIV infections is also likely to persist: access to HIV prevention services and products, including condoms, post- and pre-exposure prophylaxis, clinic-based HIV testing, counselling, and treatment, and adherence support for individuals living with HIV, have been interrupted or temporarily paused as country-wide lockdowns and health system reallocations have aimed to control the spread of COVID.[14] Adolescents are more likely to bear the brunt of these shifts in care provision, and as a population that is not considered 'at risk' for COVID-19, they may be neglected altogether. It may be essential to plan services that can be delivered in the context of not only COVID, but likely future epidemics.

Climate deterioration, socio-legal and political restrictions, coupled with inequalities even in stable societies, are all placing additional stress on adolescents and young people as we go into 2030. How do we promote health - including sexual and reproductive health - amidst these competing and growing challenges? In the wake of the social, economic, and political shifts due to the COVID-19 pandemic, we need to re-envisage service delivery and access for now and for the future – for Gen Z and Gen Alpha, and their children. We also need to understand how to reach adolescents and young people rapidly, and at scale, to safeguard their health and wellbeing, and promote good health, physical, emotional, cognitive, sexual and reproductive. This means that we need to design and roll out service delivery platforms that are COVID-adaptable: able to work flexibly and safely, through movement restrictions and recurring lockdowns, while overcoming the structural drivers and inequalities which limit access to SRH products, services, and rights. These changes need to be adaptable to COVID but also other

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[8] United Nations, Department of Economic and Social Affairs, Population Division (2015). Population 2030: Demographic challenges and opportunities for sustainable development planning (ST/ESA/SER.A/389).

[9] UNFPA. 2013. Motherhood in Childhood.

[10] UNAIDS. 2019. Global AIDS Update.

[11] The Atlantic. Oh No, They've Come Up With Another Generation Label. February 21, 2020 https://www.theatlantic.com/family/archive/2020/02/generation-after-gen-z-named-alpha/606862/

[12] Ipsos, 2021. LGBT+ Pride 2021Global Survey. [online] Ipsos, p.4. Available at: https://www.ipsos.com/sites/default/files/ct/news/documents/20216/LGBT%20Pride%202021%20Global%20Survey%20Report_3.pdf [Accessed 18 June 2021].

[13] UNFPA. 2020. Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage.
UNFPA. 2021. Impact of COVID-19 on Family Planning: What we know one year into the pandemic.

[14] Waterfield KC, Shah GH, Etheredge GD, Ikhile O. Consequences of COVID-19 crisis for persons with HIV: the impact of social determinants of health. BMC Public Health. 2021;21(1):1–7

shocks, which requires a closer understanding of how to tailor approaches, reach those who are most in need of health information, services, empowering approaches to adolescent and youth SRHR, as well as older generations who will continue to require comprehensive SRHR.

In May 2021, the IPPF Strategy Research Team started a collaboration with a University of Cape Town/ Oxford research team to summarize our knowledge on Gen Z and Alpha by documenting trends in the changing SRHR landscape by exploring the values, aspirations and desires of the IPPF Clients in 2030 and beyond. This report starts with an overview of the approach and methodology applied throughout this work's components, summarises the findings of the work to date, and concludes with a summary of the final youth engagement steps in September 2021. Content was adjusted based on feedback obtained during several presentations in October and early November 2021 to IPPF board members, donor groups, and colleagues.

2 APPROACH AND METHODOLOGY

To inform IPPF's 2023-2028 strategy, we combine two methodological components to describe the 2030 SRHR political economy landscape for adolescents and young people and engage adolescents and young people to validate these recommendations. This approach was co-developed with the IPPF Research Strategy Team and colleagues (Casper Erichsen, Fabian Cataldo, Priti Abhijit Prabhughate, Anita Nyanjong and Angela Tatua) and guided by IPPF's Roadmap 2023-2030. It aimed to address the following questions:

1. Who are IPPF's 2030 Clients? What does current data tell us about their lives and SRHR needs and wishes?

2. How are they engaging (or not) with SRHR products and services?

3. What does the evidence suggest are effective and scalable SRHR solutions?

4. Which interventions/ approaches are shock-adaptable, i.e., possible in response to shocks such as COVID-19, adverse weather events, conflicts, etc.?

All ethical and youth engagement elements are guided by IPPF's policies and the UCT/ Oxford research governance protocols, including: meaningful adolescent and youth engagement through different research projects at the Centre for Social Science Research, including the HEY BABY (adolescent mothers-children cohort) and Teen Advisory Groups (TAG) studies' protocols, safeguarding policy and codes of conduct, and Safety and Referrals protocols. The approach co-designed with the IPPF colleagues brought together several research methods and approaches (see Figure 1).

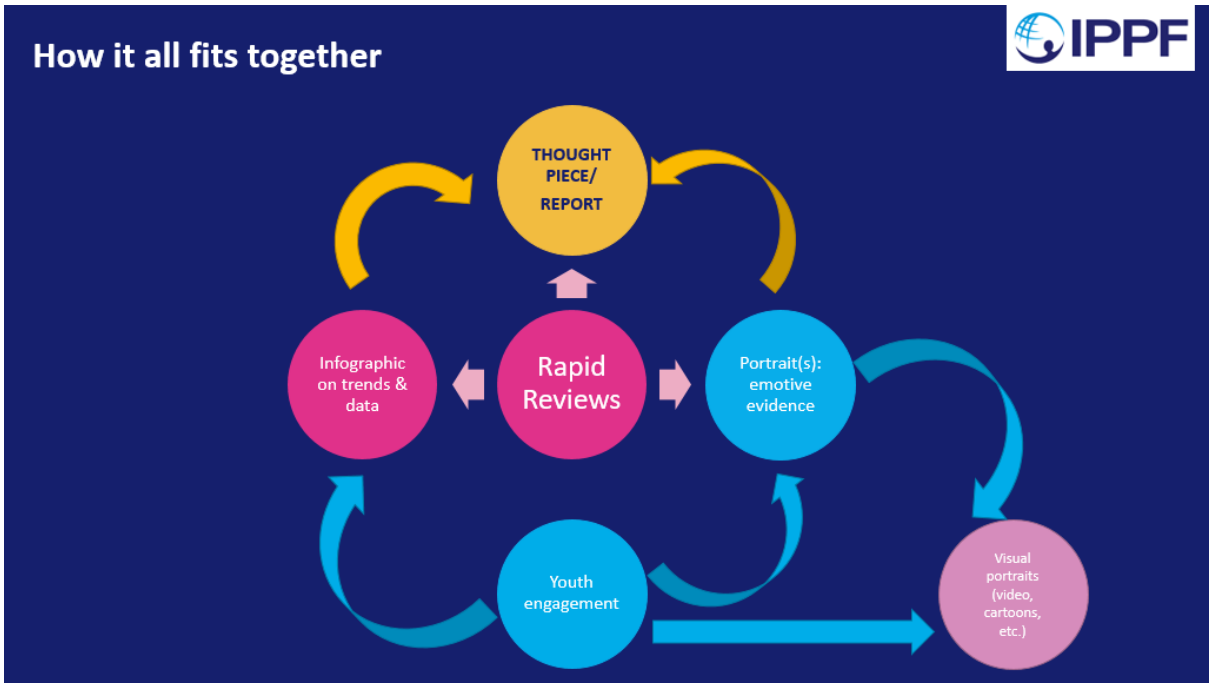


Figure 1. Approaches used to develop this report

The work was centred on a series of rapid evidence reviews conducted using a systematic methodology by Drs Laurenzi and Toska. Ms Genevieve Haupt Ronnie mentored a cohort of early career researchers at UCT to conduct these reviews. The reviews then fed into several parts of this report:

1. Gen Z/ Alpha infographics;

2. Summary of trends/ issues and evidence to inform SRHR 2030; and

3. Draft portraits of young people's visions of SRHR.

These three further steps were integrated with each other as the timeline in Figure 2 shows.

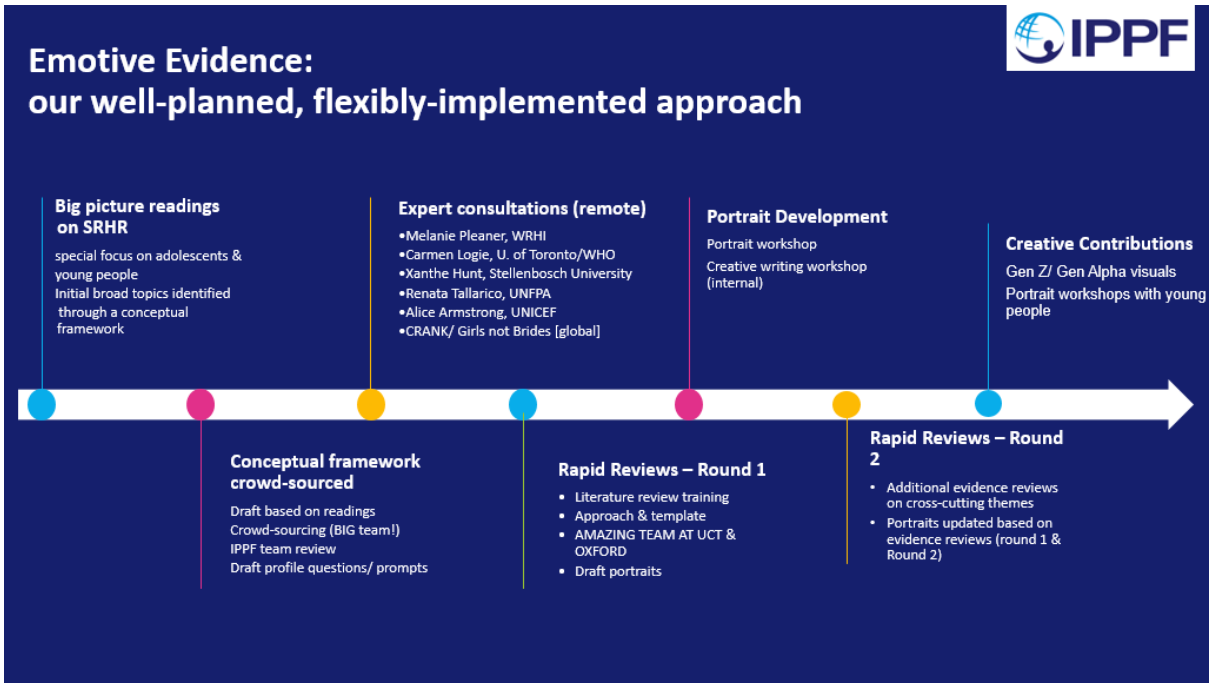


Figure 2. UCT/Oxford team activities in May-September 2021

COMPONENT 1:

Rapid evidence reviews (lead: Dr Elona Toska – UCT; Ms Genevieve Haupt Ronnie – UCT; Dr Christina Laurenzi – UCT/Stellenbosch)

The research team has over a decade of research experience in adolescent SRHR issues, challenges and solutions – and has consistently advocated for their inclusion in programming. This experience was translated into a series of rapid evidence reviews that synthesise the available data on key adolescent SRHR issues, as outlined in this section.

Step 1 – conceptual framework for SRHR evidence reviews

To tackle the complex topic of SRHR needs, wishes, challenges and solutions for Gen Z and Alpha in a systematic way, the team leads reviewed conceptual thinking on the topic of SRHR from leading researchers, including WHO's Dr Chandra-Mouli, the Population Council, the United Nations Population Fund (UNFPA) and Guttmacher Institute.[15] These key documents informed our understanding of SRHR as layered in issues – people –

[15] Liang, M., Simelane, S., Fillo, G. F., Chalasani, S., Weny, K., Canelos, P. S., & Snow, R. (2019). The state of adolescent sexual and reproductive health. *Journal of Adolescent Health*, 65(6), S3-S15.
Engel, D. M. C., Paul, M., Chalasani, S., Gonsalves, L., Ross, D. A., Chandra-Mouli, V., & Ferguson, B. J. (2019). A Package of Sexual and Reproductive Health and Rights Interventions—What Does It Mean for Adolescents? Journal of Adolescent Health, 65(6), S41-S50.
Plesons, M., Cole, C. B., Hainsworth, G., Avila, R., Biaukula, K. V. E., Husain, S., & Chandra-Mouli, V. (2019). Forward, together: a collaborative path to comprehensive adolescent sexual and reproductive health and rights in our time. Journal of Adolescent Health, 65(6), S51-S62.

programmes – lenses as shows in the guiding framework in Figure 3. One of our researchers also searched adolescent and youth blogs for important issues raised by Gen Z themselves around SRHR, including considerations on language, regions, etc. The research team crowd-sourced the contents of the review with a dozen team members contributing to its developed through a mural board.[16] **While this process helped to identify key issues for the rapid evidence reviews, it is not meant to be a conceptual framework for IPPF's work or 2023-2028 strategy.**

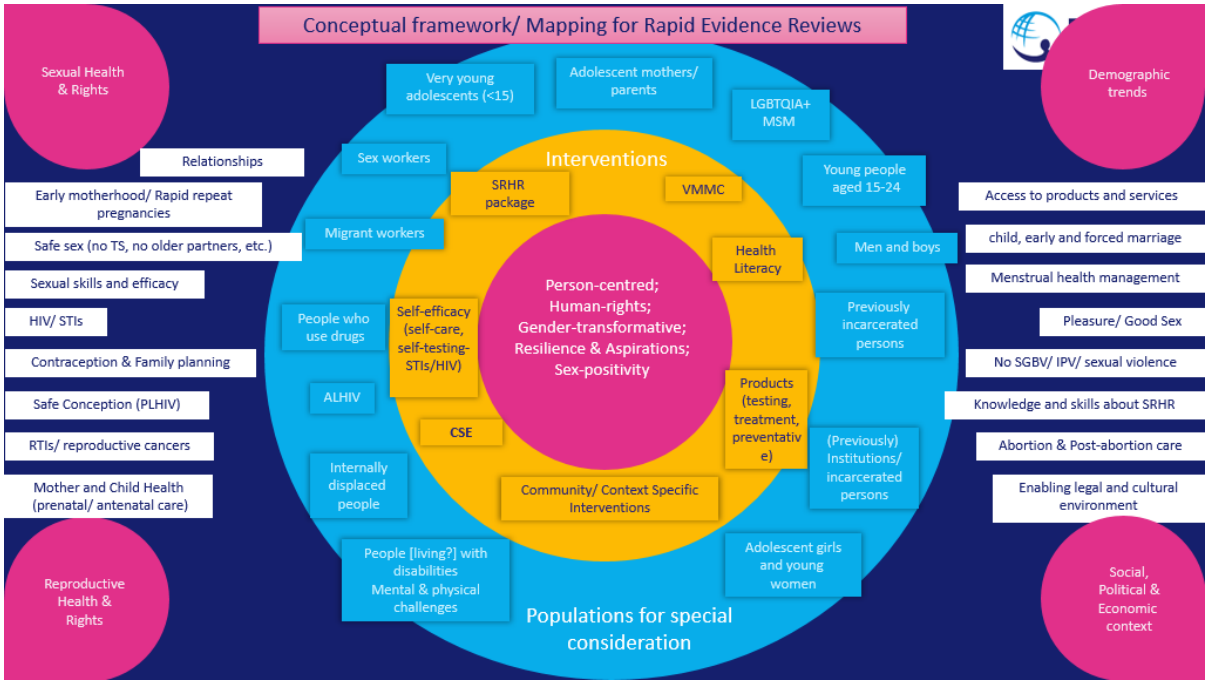


Figure 3. Conceptual framework to guide SRHR Rapid Evidence Reviews

Step 2 – Methodology for rapid evidence reviews

The rapid evidence reviews followed a consistent approach that identifies and summarises different types of evidence (reviews of reviews, systematic reviews, intervention trials, observational data, and/or qualitative data). An adapted approach was developed informed by the team's experience to conducting a range of reviews in the last 5 years, including systematic reviews, scoping reviews, and realist reviews (Laurenzi and Toska). A visual flow of the rapid review methodology is shown in Figure 4.

Employing rapid review methodologies, the team added delimiters to their systematic searches; narrowed studies by year or geography where appropriate; and streamlined review processes to allow for simpler and more nimble screening and data extraction. A template was devised to help organize and synthesize data that would speak to portrait development. Completed templates were workshopped in both individual and team settings to elicit feedback, further structure relevant content, and enhance conceptual clarity.

Chandra-Mouli, V., Ferguson, B. J., Plesons, M., Paul, M., Chalasani, S., Amin, A., & Engel, D. M. C. (2019). The political, research, programmatic, and social responses to adolescent sexual and reproductive health and rights in the 25 years since the International Conference on Population and Development. Journal of Adolescent Health, 65(6), S16-S40.

[16] Platform used: https://www.mural.co/ Specific board completed by the team available here.

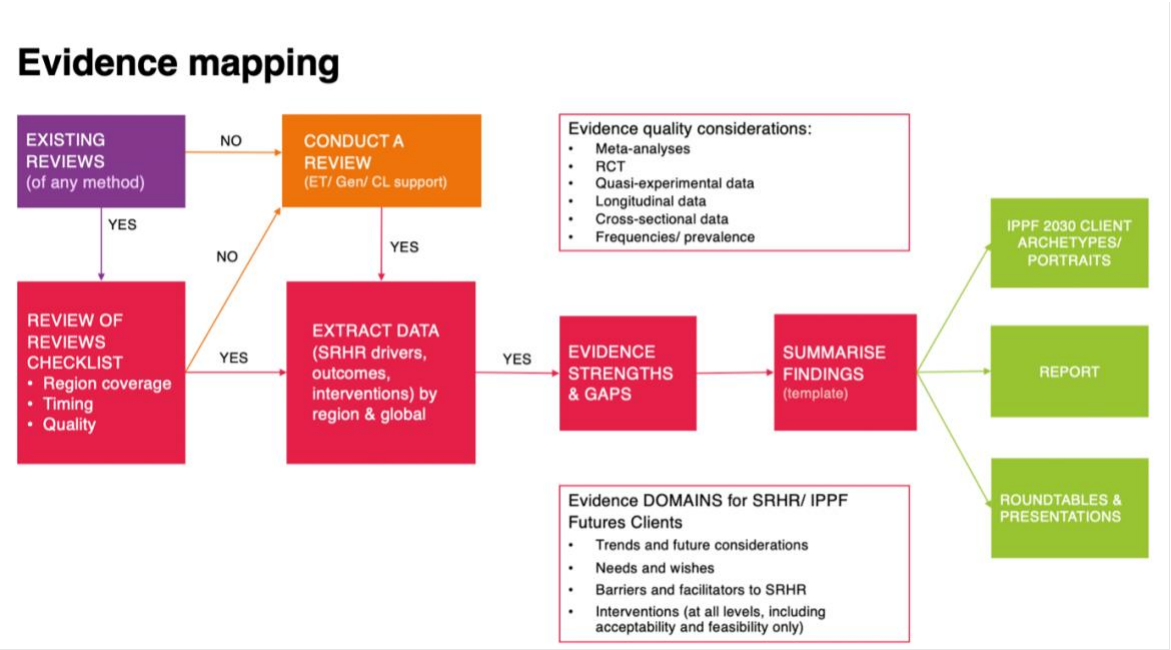


Figure 4. Methodology for SRHR Rapid Evidence Reviews

Step 3 – Workshops on rapid evidence review methodology

Two team-wide sessions focusing on diverse strategies for reviewing literature were held in May 2021. Dr Marisa Casale and Dr Christina Laurenzi co-led these virtual sessions, covering an overview of review typologies; best practices for systematic reviews; adapting systematic review methods for rapid timeframes; and quality appraisal of sources. During sessions, team members engaged with topic-specific questions, and also were able to access supplementary resources through an online shared folder. Workshop slides and materials are available for sharing with the IPPF team.

Step 4 – Expert consultations

To complement the review process, the team contacted lead experts in SRHR globally to consult on emerging evidence, existing reviews, and novel intervention models relevant for Gen Z and Gen Alpha. Initial consultations included (expert name, topic, institution, country):

- Prof Carmen Logie, Self-care interventions, University of Toronto, Canada
- Ms Melanie Pleaner, Adolescent SRHR, Wits Reproductive Health Institute, South Africa
- Dr Xanthe Hunt, SRHR and disability, Stellenbosch University, South Africa
- Dr Maria Barakoudis, Menstrual health management, UNFPA
- Dr Renata Tallarico, Climate Change and Comprehensive Sexuality Education, UNFPA
- Dr Arwin Finnie, GirlsNotBrides, London, United Kingdom
- Prof Robert Blum, Global Early Adolescent Study, Baltimore, United States
- Ms Jane Ferguson, HIV/SRHR integration, Independent consultant, Switzerland

While these consultations were with colleagues selected due to their leadership at a **global** level on the topics listed above. Most importantly, this list of consultation was not meant to replace rapid reviews nor be a representative sample of experts, but to ensure that given the tight timelines we were engaging with cutting edge, and at times unpublished, evidence that could support the visioning of SRHR in 2030 and beyond.

Step 5 – Rapid evidence reviews

The team conducted two dozen rapid reviews topics identified through the conceptual mapping activity, first focusing on major SRHR domains, followed by a second round of reviews which addressed areas of knowledge/ evidence gaps in the original round of reviews, including a mapping of Gen Z and Gen Alpha information. Each review was double-checked for methodology and content by the team leads and cross-review content was highlighted in reports to IPPF Director General and Director and Leadership Team in September 2021.

COMPONENT 2:

The Stories in the Numbers (lead: Dr Elona Toska – UCT; Dr-to-be Angelique Thomas – UCT; Ms Genevieve Haupt Ronnie – UCT; Dr Mona Ibrahim – Oxford University)

Adolescent and youth participation and engagement in co-design is imperative in developing adolescent-responsive and youth-friendly SRHR services. Multiple analyses and reviews have repeatedly found that health care that is accessible, adolescent-sensitive, and age-appropriate is strongly associated with multiple SRHR outcomes, including sexual risk, adolescent pregnancy and onwards HIV transmission.[17] We will build on the body of evidence captured through Component 1 through a two-pronged enrichment approach. Using remote methods co-developed and tested with our Teen Advisory Groups, we collaborated with IPPF colleagues to:

(1) draft portraits of IPPF's Clients based on the evidence reviews, driven by a set of prompts co-developed with IPPF colleagues; and
(2) engage with adolescent and youth volunteer advocacy networks in all global regions through IPPF's network.

Step 1 – From evidence into emotive stories

In July 2021, the team of early career researchers - including Gen Z and parents of Gen Alpha - workshopped a series of portraits based on initial rapid evidence review findings. The final drafts of these portraits are included in Section 4. In collaboration with the IPPF Research Strategy Team, the team conceptualised the broad steps of a process to convert the evidence collected through rapid reviews into **EMOTIVE EVIDENCE**, a series of evidence-informed portraits that included answers to questions listed in the next page. Content for each portrait is based on evidence in the rapid reviews, converted into personalised portraits of IPPF's Future Clients 2030. Some trends indicated specific socio-demographic characteristics or locations which the research team used this build context and storyline for the portraits. **While the content of the evidence-informed portraits was drawn from trends and projections in rapid reviews of SRHR, the portraits are not representative of the largest demographic groups necessarily. Instead, the portraits represent young people from a diverse range of locations, life journeys, sexual orientation, gender identity and expression, and sex characteristics, to ensure that unique experiences of the range of people who make up IPPF Clients 2030 were included. The portraits are not meant to be exhaustive narratives of SRHR needs and wishes for 2030 but aim to bring the evidence to life for those planning and designing SRHR services for the people of 2030.** The research team discussed these draft portraits with the IPPF strategic team on 15 July as well as in mid-September and adapted them in response to feedback from the IPPF team in October 2021. The final content of the portraits will become the

[17] Chandra-Mouli, V., Ferguson, B. J., Plesons, M., Paul, M., Chalasani, S., Amin, A., & Engel, D. M. C. 2019. The political, research, programmatic, and social responses to adolescent sexual and reproductive health and rights in the 25 years since the International Conference on Population and Development. Journal of Adolescent Health, 65(6), S16-S40.
Cluver, L. Rudgard, W.E. Toska, E. Zhou, S. Campeau, L. Shenderovich, Y. Orkin, F.M. Desmond, C. Butchart, A. Taylor, H. Meinck, F. Nxumalo, C. Sherr, L. (in press) Violence prevention accelerators for children and adolescents in Africa. PLoS Medicine. DOI: 10.1371/journal.pmed.1003383
Cluver, L., Pantelic, M., Toska, E., Orkin, M., Casale, M., Bungane, N., Sherr, L. 2018. STACKing the odds for adolescent survival: Health service factors associated with full retention in care and adherence amongst adolescents living with HIV in South Africa. Journal of International AIDS Society, 21(9), e25176. https://doi.org/10.1002/jia2.25176
Toska, E., Cluver L., Boyes, M., Isaacsohn, M., Hodes, R., Sherr, L. 2017. School, supervision and adolescent-sensitive clinic services: combination social protection and reduced unprotected sex among HIV-positive adolescents in South Africa. AIDS and Behavior, 21(9), 2746-2759. https://doi.org/10.1007/s10461-016-1539-y

backbone of visuals that the IPPF will put together in 2022, during which time their content may be adapted further.

Step 2 – Youth engagement

In order to get youth input on the aforementioned portraits, the UCT/Oxford team designed and conducted two workshops with IPPF's core youth group as well as youth from the IPPF Youth Volunteer Network. To accomplish this, we co-developed a methodology with IPPF's Research Strategy Team and Global Youth Lead to finalise a plan to engage with IPPF's global network of young volunteers. The goal of these engagements was to enrich the portraits and understand views of adolescents and young people across IPPF's vast network. This approach applied remote data collection methodologies developed and tested with our teen advisory groups in South Africa, incorporating emancipation-centred social network interviewing methodologies,[18] where relevant and applicable, through two events. See section 5 for more details on Youth Engagement.

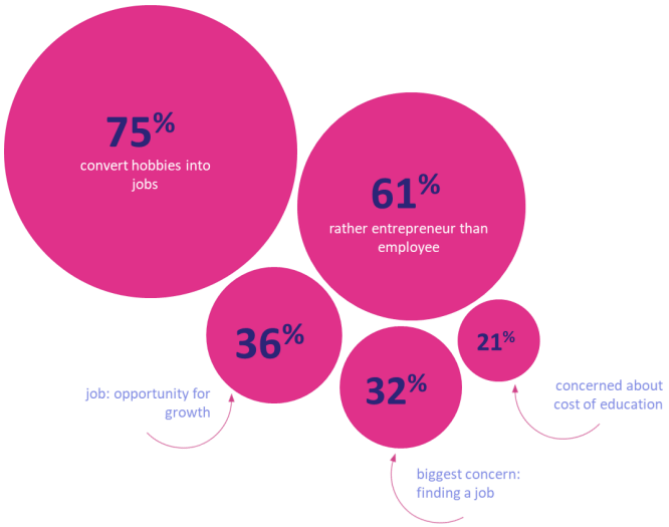
[18] Swartz & Mahali. 2021. Social network interviewing as an emancipatory southern methodological innovation. In Eds. S.Swartz, A.Cooper, M.C.Batan, L.Kropff Causa. *The Oxford handbook of global south youth studies*

Who are IPPF's Clients 2030?

The following section summarises data on trends and projections for IPPF's Clients by 2030. Given the demographic growth trends of Gen Z and Gen Alpha in the next decade, and large-scale changes due to COVID-19 pandemic, technology leaps and persistent inequality, some of these trends may change rapidly. IPPF clients of 2030 are more likely to live in Africa and Asia, with Africa experiencing the highest growth by 2030. Together Gen Z and Gen Alpha will represent 47% of the global population and 42% of the global workforce by 2030[19], with top five countries home to both generations: Nigeria, India, Indonesia, China and the United States.[20] They will be the most diverse generations in terms of ethnicity, race, sexuality and gender identity.[21] A larger proportion will experience migration (forced and voluntary)[22], climate- and war-related displacement, necessitating alternative and additional ways to reach SRHR, especially in areas and times of profound resource scarcity.

Preliminary data and predictions on the youth of 2030 suggest a transition between the "digital native" of Gen Z to a complete digital way of life, but this transition will not be experienced evenly throughout the globe. Inequalities, spurred on by climate change, the uneven reach of technology, urbanisation and migration may deepen some of the inequalities that Gen Z and Gen Alpha will face by 2030.

Nonetheless, education and employment will be important to Clients of 2030, with many of them hoping to have control over jobs and productive activities. Surveys -- primarily from higher-income settings -- suggest that concerns about the cost of education and finding a job will remain paramount to young people with the proportion of people with a university degree between 33% and 50%.



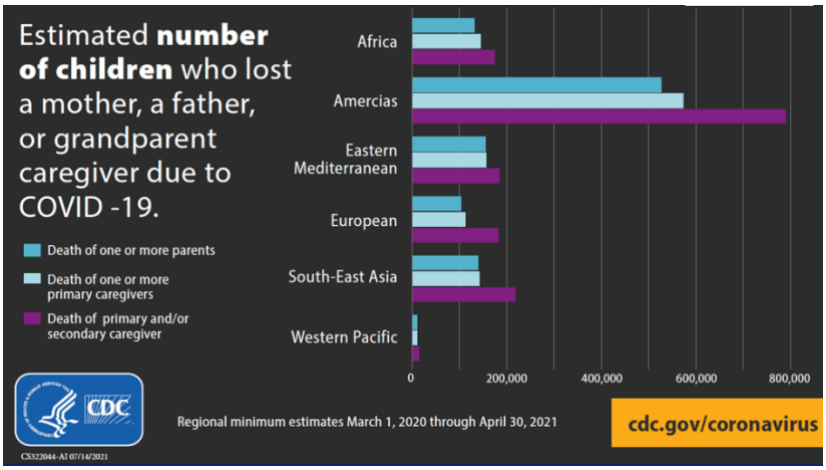
One of the greatest challenges and trends for Clients of 2030 will be experiences of - and awareness of - violence. This will include self-directed violence (self-harm, suicide), inter-personal violence (including identity-based violence as well as emotional, physical and sexual), and collective violence (wars between states, terrorism and ethnic conflicts). Shared

[19] Gen Z and Gen Alpha Infographic Update, 2020. https://mccrindle.com.au/insights/blogarchive/gen-z-and-gen-alpha-infographic-update/
[20] UN DESA, 2018. Revision of World Urbanization Prospects. https://www.un.org/development/desa/publications/2018-revision-of-world-urbanization-prospects.html
[21] McCrindle, Mark & Fell, Ashley. 2020. Understanding generation alpha. McCrindle Research Pty Ltd, Australia. https://generationalpha.com/wp-content/uploads/2020/02/Understanding-Generation-Alpha-McCrindle.pdf
[22] UN Population Dynamics, 2019. *https://population.un.org/wpp/DataQuery/*

risk factors for violence exposure will remain a history of adverse childhood experiences, substance misuse, mental health, unstable communities, behavioural issues, and inequality in access to economic, educational, and health services.

Impact of COVID-19

Research around the COVID-19 pandemic, which started at the end of 2019, has shown rapid and substantial impacts on multiple aspects of the lives of Generation Z and Generation Alpha. These include additional stress on families through lockdowns, mental health distress, school closures and economic instability,[23] with estimated sharp increases in violence against children and adolescents.[24] A fundamental shift during this time has been a lack of access to directly reach children and adolescents with services – whether those are SRHR, social welfare, justice or educational – and so consequent shifts in our reliance on provision of support through families or digital methods. Both of these modalities' present challenges for SRHR services, with navigation of issues of confidentiality, self-determination and access for those on the wrong side of the digital divide.



We also have to consider long-term SRHR impacts, which will be evident in the generations to come, of the rising number of children who will be orphaned by COVID. Within the first 18 months of the pandemic, 2.3 million children lost a parent or primary caregiver to COVID-associated death, rising to an estimated 5 million by 2024,[25] and rising rapidly in surge countries such as India[26]. We know from other epidemics such as HIV that loss of a primary caregiver in childhood and adolescence increases long-term risks of unsafe sex, STIs and HIV infection, and so we need to consider bolstered support for these groups. Importantly, epidemiological predictions suggest that we should be preparing for sequential epidemics, and consequently should be viewing service adaptations as requiring long term flexibility.

[23] Cluver, L., Lachman, L. M., Sherr, L., Wessels, I.; Krug, E. Rakotomalala, S., Blight, S. Hillis, G. Bachman, G, Green, O. Butchart, A., Tomlinson, M., Ward, C.L., Doubt, J. & K. McDonald, K. 2020. "Parenting in a time of COVID-19." Lancet 395(10231): e64.
[24] UNICEF (2020) Protecting Children from Violence in the Time of COVID-19: Disruptions in prevention and response services. https://www.unicef.org/reports/protecting-children-from-violence-covid-19-disruptions-in-prevention-and-response-services-2020
[25] Hillis, S. D., H. J. T. Unwin, Y. Chen, L. Cluver, L. Sherr, P. S. Goldman, O. Ratmann, C. A. Donnelly, S. Bhatt, A. Villaveces, A. Butchart, G. Bachman, L. Rawlings, P. Green, C. A. Nelson, 3rd and S. Flaxman. 2021. "Global minimum estimates of children affected by COVID-19-associated orphanhood and deaths of caregivers: a modelling study." Lancet.
[26] For most recent estimates, visit: https://imperialcollegelondon.github.io/orphanhood_calculator/#/country/India

KEY ISSUES FOR CONSIDERATION

This section summarises some emerging themes and issues from the rapid evidence reviews around overall health and well-being of IPPF's Clients in 2030 and beyond. First, the importance of **mental health challenges as a growing issue**, and their ramifications with regards to sexual and reproductive health and rights, but also access to general and specialised health services. One of the ways to support **greater access to health products and services** is through mHealth interventions, which will be in high demand for the **tech savvy digital native (Gen Z) and fully digital lifestyles of Gen Alpha**. Compared to older generations, Gen Z and future generations are expected to prefer limited face-to-face interaction with physicians and primary care, in part due to their dissatisfaction with current services. However, the increase in digitalization of social engagements, healthcare and service access also comes with the possibility of risks for younger people, especially fatigue from social media, cyber-bullying, and poor social support through limited social interactions. The reviews are included in the Appendices. The following paragraphs summarise key issues emerging from the rapid reviews.

Family planning and contraception

There has been an overall decline in adolescent birth rate globally since 1990s, but this varies by region, with the adolescent rate of 104 per 1000 girls in sub-Saharan Africa, which is five times that of adolescents in North America, four times that of adolescents in South Asia and nearly double that of adolescents in Latin America[27,28]. The decline has largely been due to the increased knowledge and awareness of contraceptives by adolescents and young people and supportive policies to improve access to SRHR products and services for younger people. Despite the afore-mentioned successes, repeat pregnancies remain high, about two-thirds of young mothers (13-19 years of age) do not want or intend to have another birth within two years after their first birth, largely due to unmet needs in rural versus urban regions with regard to family planning, contraception and safe abortion/ termination of pregnancy. The ECHO trial - whose main goal was to test the impact of different types of hormonal contraception on HIV risk among women - ultimately showed that access to a contraceptive mix, delivered through women-centred services and structures is central to integrating services and improving access to family planning, reducing HIV risk and delaying unsupported early motherhood, and the related morbidities and mortality.

Safe abortion and post-abortion care

Women around the world are prevented from accessing safe abortion care due to, restrictive laws and other regulatory barriers, poor availability of services, high cost, stigma, objections of health-care providers, and unnecessary requirements designed to delay and restrict access to care [29] (such as mandatory waiting periods or third-party authorisation) and these barriers are often exacerbated for young women. As a result, women turn to unsafe and illegal forms of abortion. The proportion of unintended pregnancies ending in abortion was estimated at 61% between 2015–2019.[30] Furthermore, WHO[29] and the Guttmacher Institute,[30] between 2010-2014, 14% of all abortions were carried out in the least safe or dangerous conditions. An additional 31% were classified as "less safe", which include those done using outdated methods like sharp curettage even if the provider is trained or if women using tablets do not have access to proper information. In highly restrictive contexts, clandestine abortions are now safer because fewer occur by dangerous and invasive methods, with women increasingly self-managing abortion using medical abortion methods. Of the estimated 5.6 million

[27] Chandra-Mouli, V., & Akwara, E. 2020. Improving access to and use of contraception by adolescents: What progress has been made, what lessons have been learned, and what are the implications for action? Best Practice & Research Clinical Obstetrics & Gynaecology.

[28] Kassa, G., Arowojolu, A., Odukogbe, A., & Yalew, A. 2018. Prevalence and determinants of adolescent pregnancy in Africa: a systematic review and Meta-analysis. *Reproductive Health, 15*(1). doi: 10.1186/s12978-018-0640-2.

[29] WHO. 2020. Recommendations on self-care interventions Self-management of medical abortion WHO-SRH-20.11-eng.pdf

[30] Guttmacher Institute. 2020. Unintended Pregnancy and Abortion Worldwide. https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide

abortions that occur each year among adolescent girls aged 15–19 years, 3.9 million are unsafe, contributing to maternal mortality, morbidity and lasting health problems.[31]
There is an interplay between gender, environment, education status and marital status with adolescent access to information and services. In addition, young people face compounded stigma, both for being sexually active and for seeking an abortion, which can lead them to keep their abortion a secret, deterring them from seeking information or support from the formal health system. According to a systematic review of 21 studies of LMICs, some young women in rural areas, but not limited to these, were most likely to consult traditional healers, while their urban counterparts went to the health facilities (accessing still mostly illegal procedures), or they would consult a pharmacist or tried to induce the abortion themselves based on advice from their mothers, relatives or peers[32]

Access to safe abortion services and post-abortion care is required to prevent further sexual and reproductive challenges to guarantee women's right to abortion care and to prevent mortality and morbidity due to unsafe abortion. Additional barriers to seeking safe abortions and post-abortion care, include the lack of sexual autonomy experienced by young girls and women, their lack of agency when negotiating sexual encounters as well as accessing information and services related to their all of their SRH needs. This highlights the need for interventions at all levels and the engagement of a wide range of stakeholders including advocacy with policy makers for legislative and policy reform to support women's agency and bodily autonomy, the creation of movements of abortion champions comprised of healthcare workers, young activists, feminist networks and other stakeholders for the provision of accurate and accessible information, and the expansion of access to a full spectrum of services and support from facilitated self-care to telehealth and client-centred in-clinic care. A diverse range of services and options will be necessary to support access to safe abortion despite potential restrictive norms and practices within existing systems, especially during pandemics and in humanitarian settings.

Reproductive Health, cancers and other RTIs

Breast cancer and testicular cancer are two of the most common cancer types among young men and women, while cervical cancer is the second most prevalent cancer among women in low-and-middle-income countries (LMICs).[33] Moreover, women in Africa experience the highest burden of cervical cancer globally.[34] The human papillomavirus (HPV) is a sexually transmitted infection which increases the risk of cancer of the cervix, vulva, vagina, penis, anus, mouth, tonsils, or throat.[35] Moreover, the majority of cervical cancer is due to HPV, where two specific strains of this virus.[36] In 2018, approximately 88% of the new cases of cervical cancer occurred in LMICs and upper middle-income countries[37]. In high income countries (HICs) 85% of woman have received the vaccination for the Human papillomavirus (HPV) vaccination, versus less than 30% of LMICs (PATH, 2019). Only approximately 20% of women in LMICs have been screened for cervical cancer compared to over 60% of women in HICs. Thus, large global disparities remain. High prevalence of HPV infection among women in many African countries may be linked to early sexual debut, number of sexual partners of women and their partners, and concurrency with other STIs, especially HIV. WHO estimates that reaching a 90% vaccination rate by 2030 could reduce cervical cancer incidence by 42% by 2045.[38] Cancer treatment broadly and, reproductive cancers in

[31] Darroch J, Woog V, Bankole A, Ashford LS. 2016. Adding it up: Costs and benefits of meeting the contraceptive needs of adolescents. New York: Guttmacher Institute; as cited in Adolescent pregnancy (who.int)
[32] Munakampe, M.N., Zulu, J.M. & Michelo, C. 2018. Contraception and abortion knowledge, attitudes and practices among adolescents from low and middle-income countries: a systematic review. BMC Health Serv Res 18, 909. https://doi.org/10.1186/s12913-018-3722-5
[33] Bray F, Ferlay J, Soerjomataram I, Siegel RL, Torre LA, Jemal A. 2018. Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. CA Cancer J Clin. 2018 Nov;68(6):394-424. doi: 10.3322/caac.21492. Epub 2018 Sep 12. Erratum in: CA Cancer J Clin. 2020 Jul;70(4):313. PMID: 30207593. https://pubmed.ncbi.nlm.nih.gov/30207593/
[34] Finocchario-Kessler, S., Wexler, C., Maloba, M., Mabachi, N., Ndikum-Moffor, F., & Bukusi, E. (2016). Cervical cancer prevention and treatment research in Africa: a systematic review from a public health perspective. *BMC women's health*, 16(1), 1-25.
[35] WHO. HPV and cervical cancer factsheet. https://www.who.int/en/news-room/fact-sheets/detail/human-papillomavirus-(hpv)-and-cervical-cancer
[36] CDC. 2021. The Link Between HPV and Cancer. https://www.cdc.gov/hpv/parents/cancer.html
[37] Bray F, Ferlay J, Soerjomataram I, Siegel RL, Torre LA, Jemal A. 2018. Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. CA Cancer J Clin. 2018 Nov;68(6):394-424. doi: 10.3322/caac.21492. Epub 2018 Sep 12. Erratum in: CA Cancer J Clin. 2020 Jul;70(4):313. PMID: 30207593. https://pubmed.ncbi.nlm.nih.gov/30207593/
[38] WHO. 2021.Immunization coverage. https://www.who.int/news-room/fact-sheets/detail/immunization-coverage.

particular, have a myriad of direct and indirect ways of impacting short- and long-term sexual and reproductive health including body image, sexual dysfunction, psychosexual dysfunction, and ability to reproduce long-term.

Most adolescent cancer patients report desiring children one day. However, little information about overall about reproductive cancers for adolescent girls and, none to date documented from a global perspective for girls or boys. Moreover, while there is more of a focus in HICs on the impact of fertility issues linked to cancer on boys' short- and long-term needs, there is far less on girls in these settings. This is partly documented and reported as a result of the difficulty in maintaining fertility for girls (e.g., more invasive procedures that take longer to complete). Further, the existing information on cancers and psychosocial risks and needs are on cancer more broadly, rather than rep cancers specifically.

In addition, reproductive tract infections or RTIs provides another serious threat to women living in LMICs. RTIs include sexually transmitted diseases (STDs) such as chlamydia, gonorrhoea, chancroid, and human immunodeficiency virus (HIV), as well as endogenous infections, which are caused by overgrowth of organisms normally present in the genital tract of healthy women, such as bacterial vaginosis or vulvovaginal candidiasis.[39] If left untreated RTIs may lead to adverse health outcomes, including infertility, ectopic pregnancy and lowered immunity with an increased susceptibility to contracting HIV.[40]

Provider training on all aspects of sexuality and reproductive care – from conversing with parents and adolescents, to knowing referrals, supporting in needed procedures, and best guidelines on FP/sexuality for cancer patients. In terms of what can be done related to the prevention of reproductive cancers, the focus must therefore be on vaccination and screening in LMICs. With HICs pushing towards 100% HPV vaccination coverage, the reduction on global cervical cancer cases prevented would be negligible, as the cases in HICs only contribute a small fraction to the global incidence rates. In addition, low cost, accurate point-of-care tests for HPV screening is what is needed in terms of preventative measures. For those are unable to attend regular screening for cervical and other reproductive cancers, self-testing needs to be made available.

Child, Early and Forced Marriage

Child, early and/or forced marriage brings with it a myriad of interrelated SRHR challenges, including, high rates of early pregnancies, maternal and child mortality or morbidity, and intimate partner violence. Some of the associated SRH are high rates of early pregnancies, and child mortality or morbidity, and intimate partner violence during adolescence stemming from intergenerational poverty, poor health, in turn leads to poorer lifelong outcomes for younger mothers and their children.[41]

There are often conflicting contradictions between civil, criminal, and customary laws about child marriage; these laws can greatly affect the ways in which adolescent girls are made visible and granted protections. In Tanzania, over 30% of girls are married by age 18, and 21% of girls ages 15-19 have given birth.[42] Tanzania's Constitutional Court recently upheld its 2016 ban on marriage under 18, which had been challenged by the government; however, unspecified circumstances still allow girls as young as 14 to be married.[43] This clash between protection by laws and their enforcement is also apparent in Zimbabwe, where the legal age of sexual

[39] Nava-Memije, K., Hernández-Cortez, C., Ruiz-González, V., Saldaña-Juárez, C.A., Medina-Islas, Y., Dueñas-Domínguez, R.A., and Guadalupe Aguilera-Arreola, M.A., 2021. Frontiers in Reproductive Health. Research Topic: Infections of the Female Reproductive System and their Implications on Women's Health. https://www.frontiersin.org/research-topics/16059/infections-of-the-female-reproductive-system-and-their-implications-on-womens-health

[40] Rabiu, K. A., Adewunmi, A. A., Akinlusi, F. M., & Akinola, O. I. 2010. Female reproductive tract infections: understandings and care seeking behaviour among women of reproductive age in Lagos, Nigeria. *BMC women's health*, *10*, 8. https://doi.org/10.1186/1472-6874-10-8.

[41] Anju Malhotra, A.,& Elnakib, S. 2020. 20 Years of the Evidence Base on What Works to Prevent Child Marriage: A Systematic Review. *Journal of Adolescent Health*, 68, 847e862.

[42] Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) [Tanzania Mainland], Ministry of Health (MoH) [Zanzibar], National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS) and I. *Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) 2015-2016*. Dar es Salaam, Tanzania, and Rockville, Maryland, USA; 2016.

[43] Odhiambo A. 2019. Victory Against Child Marriage in Tanzania: Court of Appeal Upholds 2016 Ruling Barring Marriage Before 18. *Human Rights Watch: Dispatches*. https://www.hrw.org/news/2019/10/25/victory-against-child-marriage-tanzania.

consent is 16 as defined in the Criminal Law Act [Chapter 9:23], and sex with an adolescent younger than 16 is regarded as statutory rape, but special exemptions may be made. Lack of rights and human centred designed and enforced laws and policies around consent to access SRHR services with a focus on HIV, return-to-school policies, and prevention and protection against child marriage can multiply the adversities faced by adolescent mothers, and are underpinned by inequitable gender norms. These inconsistencies further highlight the need to prioritize comprehensive, multi-level, and multi-sectoral responses to issues of health and well-being, child and social protection and access to education in relation to HIV and early and unintended pregnancy.

Early motherhood[44]

There is a growing need to understand and act on the needs of adolescent parents (10-19 years), especially mothers, in high HIV prevalence and early marriage prevalence countries and regions. In many countries – for example Lao PDR in South East Asia - adolescent pregnancy is closely interlinked with early marriage, and despite active work to prevent early marriage this is likely to remain a longstanding issue for Gen Z and Gen Alpha's girls and young women. Adolescent pregnancy and HIV are also closely interlinked, particularly in sub-Saharan Africa, where rates of adolescent births and HIV prevalence are the highest globally, and where girls represent 80% of newly HIV-infected 15–19-year-olds.[45] As a result of a growing adolescent demographic in the region more adolescent girls than ever are living with HIV and if not, navigating the double risk of acquiring it and experiencing early and unintended pregnancies. Adolescent pregnancy and HIV can be framed as a syndemic: health issues that interact with structural, social, and environmental factors to deepen and further entrench adolescent girls' vulnerabilities. Both HIV and child marriage (defined as marriage before the age of 18) are associated with harmful gender norms and inequalities at home, in schools in communities and these factors shape adolescent girls' vulnerability to poor health, education and life outcomes now, in future adult life and for the next generation of children.[46] Many of these structural factors pose additional risks to adolescent mothers, further complicating their immediate life circumstances, adding pressures related to social expectations, and placing them at a distinct disadvantage compared to their peers.[47] While more research is illuminating pathways to health and wellbeing for this at-risk group, it is important to interrogate the legal, policy and cultural domains that influence adolescent experiences of pregnancy and the transition to adulthood in HIV-endemic communities.

Access to services is a facilitating factor for the fulfilment of the right to health for all. Pregnant girls and adolescent mothers with their children are often treated as minors and subject to mistreatment at health facilities, in part due to the stigma and discrimination they experience when they try.[48] Consequently, many adolescent girls and young women fail to access sexual and reproductive health services and information including HIV testing services. A recent review of HIV-specific laws in sub-Saharan Africa identified only seven countries, of 28 included, that had reduced the age of consent for HIV-testing and service access to below 18 years in their legislation. In the same review the South African Children's Act was cited as an example of good practice, safeguarding rights to HIV testing from the age of 12 with no parental consent.[49] Furthermore, among eight countries (Comoros, Democratic Republic of Congo, Kenya, Madagascar, Mauritius, Niger, Sierra Leone, Togo) that had set the legal age of consent above 18 years, only Kenya and Sierra Leone enabled pregnant or parenting adolescents under 18 to access to HIV-testing services.[50]

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[44] Updated from a scoping review: Toska et al. 2020. Adolescent mothers affected by HIV and their children: A scoping review of evidence and experiences from sub-Saharan Africa. Global Public Health. https://www.tandfonline.com/doi/pdf/10.1080/17441692.2020.1775867

[45] UNAIDS JUNP on H. *Miles To Go: Closing Gaps, Breaking Barriers, Righting Injustices*. Geneva, Switzerland; 2018. doi:10.1111/j.1600-6143.2011.03542.x

[46] Petroni S, Yates R, Siddiqi M, et al. Understanding the Relationships Between HIV and Child Marriage: Conclusions From an Expert Consultation. *J Adolesc Heal.* 2019;64(6):694-696. doi:10.1016/j.jadohealth.2019.02.001

[47] UNESCO. 2017. *Early and Unintended Pregnancy & the Education Sector (ED/IPS/HAE/2517/01 REV)*. Paris.

[48] Wood K, Jewkes RK. 2006. Blood Blockages and Scolding Nurses: Barriers to Adolescent Contraceptive Use in South Africa. *Reproductive Health Matters.* 14(27):109-118.

[49] Eba PM, Lim H. Reviewing independent access to HIV testing, counselling and treatment for adolescents in HIV-specific laws in sub-Saharan Africa: Implications for the HIV response: Implications. J Int AIDS Soc. 20(1):1-10. doi:10.7448/IAS.20.1.21456

[50] Eba PM, Lim H. Reviewing independent access to HIV testing, counselling and treatment for adolescents in HIV-specific laws in sub-Saharan Africa: Implications for the HIV response: Implications. *J Int AIDS Soc.* 20(1):1-10. doi:10.7448/IAS.20.1.21456

Return-to-school policies: Regionally, there are divergent school-related practices for adolescent mothers. In South Africa, a recent draft policy represents a strengthened effort to promote sexual education and encourage school return for adolescents who give birth. The policy clearly outlines steps through which adolescent mothers can remain in school for as long as possible, without threats to their health. Similarly, in Zimbabwe, the Ministry of Education allows young mothers to return to school following delivery.[51] These examples contrast sharply with Tanzania, where the government ruled that girls who become pregnant cannot return to school at all,[52] though the ban was recently lifted. However, despite campaigns to support re-enrolment, there are challenges in consistently applying and implementing policies; sometimes girls are obliged to apply to a different school, enrol in evening programmes or undergo a minimum 'waiting period' before they can re-enrol.[53] Coupled with stigma, discrimination, childcare challenges and few or none financial support, many young mothers struggle to return to school at all, even in contexts where the reintegration is theoretically endorsed.[54]

SRHR services and contraception: Adolescents and young people need adolescent friendly, individualised SRH services from non-judgmental staff, as well as services that facilitate autonomy and remain confidential.[55] In addition, young women need skills in negotiating contraceptive use[56] mental health support and involvement and support from partners and influential family members to have open communication about sex and SRH in households.[57] There are a number of barriers to AYP accessing contraception, which include:

- contraceptive side effects;
- stigma, myths and misconceptions which surround contraceptive use (e.g., "contraception cause infertility");
- low knowledge on family planning;
- lack of confidence in facilities, and misconceptions about cost and access; and
- stigma and staff refusal to provide contraceptives to AYP

In addition, the high mobility rates of AYP living in LMICs result in the lack consistent use of contraception, especially in pregnant women and decreases their likelihood in participating in community contraceptive programming.[58] Mental health, low self-esteem and self-efficacy are additional barriers to accessing and using contraception by AYP. With the lack of proper family planning and contraception use, comes unintended pregnancy. AYP with higher education levels experienced fewer pregnancies and knew more about contraception compared to those with lower education levels. A relationship between an abortion decision and educational level was noted, a young woman who opted for abortion felt their future would be protected by securing an education and more economic and social empowerment by not raising a child. Lack of information remains a challenge, suggesting that current practice in evidence-based interventions is very limited. Without knowledge, many young women still resort to dangerous solutions when most of these services are accessible, another signal of both system and structural failures inherent in existing services. This calls for not only a re-think in the existing strategies but also surrounding who the other key stakeholders are who must take much

[51] *Education Amendment Bill 2018.* Harare, Zimbabwe: Ministry of Primary and Secondary Education; 2018:1-7.
[52] Bjerregaard A. *FORCED OUT: Mandatory Pregnancy Testing and the Expulsion of Pregnant Students in Tanzanian Schools*. Nairobi, Kenya; 2013.
[53] Farida M, Bali T. Exploring Experiences of Pregnant and Mothering Secondary School Students in Tanzania. *Res Humanity Social Science.* 2014.
[54] UNESCO. *Early and Unintended Pregnancy & the Education Sector (ED/IPS/HAE/2517/01 REV).* Paris*;* 2017.
[55] Baxter, S., Blank, L., Guillaume, L., Squires, H., & Payne, N. 2011. Views of contraceptive service delivery to young people in the UK: a systematic review and thematic synthesis. BMJ Sexual & Reproductive Health, 37(2), 71-84.
Shrestha, D. R., Bhadra, R., & Dangal, G. 2020. Use of Contraceptives among Adolescents: What Does Global Evidence Show and How Can Nepal Learn? Journal of Nepal Health Research Council, 18(4), 588-595.
[56] Closson, K., Dietrich, J. J., Lachowsky, N. J., Nkala, B., Palmer, A., Cui, Z., & Kaida, A. 2018. Sexual self-efficacy and gender: A review of condom use and sexual negotiation among young men and women in Sub-Saharan Africa. The Journal of Sex Research, 55(4-5), 522-539.
[57] Chandra-Mouli, V., & Akwara, E. (2020). Improving access to and use of contraception by adolescents: What progress has been made, what lessons have been learned, and what are the implications for action?. Best Practice & Research Clinical Obstetrics & Gynaecology.
Kassa, G., Arowojolu, A., Odukogbe, A., & Yalew, A. 2018. Prevalence and determinants of adolescent pregnancy in Africa: a systematic review and Meta-analysis. *Reproductive Health,* 15(1). doi: 10.1186/s12978-018-0640-2.
[58] Sarkar, A., Chandra-Mouli, V., Jain, K., Behera, J., Mishra, S. K., & Mehra, S. 2015. Community based reproductive health interventions for young married couples in resource-constrained settings: a systematic review. BMC Public Health, 15(1), 1-19.

more critical roles, also keeping in mind the significant differences in barriers among the different categories of adolescents.

HIV and other STIs

While there has been a decrease in new HIV infections by 34% annually, adolescent and young people (AYP) are still disproportionally affected by HIV globally and particularly in sub-Saharan Africa. In 2020, there were around 1.5 million [1.0 million–2.0 million] newly infected people with HIV, with adolescents account for 11% of these new infections.[59] The highest number of adolescents living with HIV are in sub-Saharan Africa, followed by Asia and Latin America.[60] Unfortunately, global reduction in HIV infections among young people is uneven, there have been steep reductions in countries in eastern and southern Africa, but limited progress among young key populations in most countries.[61] More than 50% of the population is projected to live in urban areas by 2030, indicating that more young people will be at a higher risk of HIV and other STIs (considering that HIV prevalence tends to be higher in major cities).[62]

Additional barriers such as the criminalization of transgender identity and same-sex sexual acts, stigma in health facilities, denying rights to information and HIV services, including the need for parental consent to test for HIV, and the lack of mental health support, all remain major concerns for the future HIV responses to achieve the global AIDS targets by 2030, especially in Eastern and Central Europe and Middle East and North Africa.[63]

These statistics highlight a need for differentiated programmatic attention for AYP by the global community, as well as the need for locally appropriate interventions in regions of the world with increasing HIV incidence such as Central Asia and Europe, providing tailored and dynamic interventions.[64] While young women are amongst the most vulnerable to HIV and other, STIs, more tailored interventions for young men and boys are needed, including prevention education and counselling tailored to the needs of adolescents. There is also a need for combination interventions, which could prove more effective with key or marginalised populations, including biomedical and behavioural interventions as well as components that address structural factors affecting HIV preventions and transmission. Some of the aforementioned populations may include sex workers and their clients, gay men and other men who have sex with men, people who inject drugs, transgender.[65] Some of the key biomedical prevention methods include HIV testing, STI detection and treatment, pre-exposure prophylaxis (PrEP), particularly in combination therapies with contraception. While behavioural prevention methods include peer-education-based interventions which can facilitate the uptake of HIV-related knowledge, as well as interventions initiated by schools have shown to be important venues for reaching adolescents with information and skills in order to protect themselves against HIV.[66]

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[59] UNAIDS. 2021. Global HIV & AIDS statistics. Fact sheet. https://www.unaids.org/en/resources/fact-sheet

[60] UNICEF.2020b. Adolescent HIV prevention. Retrieved from https://data.unicef.org/topic/hivaids/adolescents-young-people/

[61] UNAIDS (2021). Young people and HIV. Retrieved from https://www.unaids.org/sites/default/files/media_asset/young-people-and-hiv_en.pdf

62 Lieber, M., Chin-Hong, P., Whittle, H. J., Hogg, R., & Weiser, S. D. 2021. The Synergistic Relationship Between Climate Change and the HIV/AIDS Epidemic: A Conceptual Framework. AIDS and Behavior, 1-12.

63 UNICEF.2020a. Reimagining a resilient HIV response for children, adolescents and pregnant women living with HIV. Retrieved from https://reliefweb.int/sites/reliefweb.int/files/resources/2020%20World%20AIDS%20Day%20Report%20Final.pdf

Toska, E., Pantelic, M., Meinck, F., Keck, K., Haghighat, R., & Cluver, L. 2017. Sex in the shadow of HIV: A systematic review of prevalence, risk factors, and interventions to reduce sexual risk-taking among HIV-positive adolescents and youth in sub-Saharan Africa. *PloS one, 12*(6), e0178106.

UNAIDS (2020). We've got the power – Women, adolescent girls and the HIV response. Retrieved from https://www.unaids.org/sites/default/files/media_asset/2020_women-adolescent-girls-and-hiv_en.pdf

[64] Desrosiers, A., Betancourt, T., Kergoat, Y., 1. Servilli, C., Say, L., & Kobeissi, L. 2020. A systematic review of sexual and reproductive health interventions for young people in humanitarian and lower-and-middle-income country settings. *BMC Public Health*, 20, 1-21.

Khalifa, A., Stover, J., Mahy, M., Idele, P., Porth, T., & Lwamba, C. 2019. Demographic change and HIV epidemic projections to 2050 for adolescents and young people aged 15-24. *Global Health Action, 12*(1), 1662685.

[65] WHO. 2021. Sexually transmitted infections (STIs). https://www.who.int/news-room/fact-sheets/detail/sexually-transmitted-infections-(stis)

[66] Desrosiers, A., Betancourt, T., Kergoat, Y., Servilli, C., Say, L., & Kobeissi, L. 2020. A systematic review of sexual and reproductive health interventions for young people in humanitarian and lower-and-middle-income country settings. BMC Public Health, 20, 1-21.

Gender-based violence and intimate partner violence

Adolescents are vulnerable to all forms of gender-based violence and have arguably been overlooked in policy and programming relating to intimate partner violence in particular. Worldwide, more than 1 in 3 women and girls have experienced physical and/or sexual violence from an intimate partner.[67] While girls are the adolescents most vulnerable to gender-based violence, including intimate partner violence, there are a number of other population groups who are at risk of these types of violence. There are a number of key populations who are at an increased risk for GBV, including members from the people of diverse SOGIEC, LGBTQIA+, sex workers, women and girls living with disabilities. The vulnerability of the members of the aforementioned populations are due to punitive legal policies, criminalization, and societal attitude.[68] The LGBTQIA+ population for example, specifically adolescents who are students within this community, are more at risk than their non-LGBTQIA+ peers. Adolescent girls and young women who marry before the age of 18 are more likely to be beaten or threatened by their husbands than girls who marry later, and are more likely to describe their first sexual experience as forced. Women and adolescent girls face barriers to accessing services, because of cultural norms that restrict their mobility; domestic responsibilities that keep them isolated in their homes. This was heightened with the COVID-19 pandemic and related mobility restrictions; women could not easily access GBV-related support including counselling, healthcare and legal services.

In some regions, women and girls who have suffered intimate partner violence are 1.5 times more likely to acquire HIV than women who have not suffered such violence. Seven out of 10 women are exposed to gender-based and sexual violence in conflict setting and in refugee populations. Social and cultural norms play a major role in the incidence of gender-based violence and intimate partner violence. There are a number of interventions that can be considered to reduce the prevalence and incidence of GBV. Social safety nets (SSNs) can help reduce violence, especially IPV and violence against children it can help reduce poverty-related stress, empower women, shift gender norms toward greater equality and can strengthen their social networks.[69] In addition, there are a number of other promising interventions including, but not limited to, psychosocial support and psychological interventions for survivors of intimate partner violence; combined economic and social empowerment programmes; cash transfers; working with couples to improve communication and relationship skills; community mobilization interventions to change unequal gender norms; school programmes that enhance safety in schools and reduce/eliminate harsh punishment and include curricula that challenges gender stereotypes and promotes relationships based on equality and consent; and group-based participatory education with women and men to generate critical reflections about unequal gender power relationships.[70]

Integrating GBV into SRHR and primary healthcare services is critical to identifying clients at greatest risk of violence exposure and outcomes. However, current approaches may not be sufficient to reduce incident violence,[71] and addressing long-term structural drivers of violence is vital, particularly in the context of pandemics, such as COVID-19, which exacerbate the socio-economic situation of many IPPF clients. GBV and IPV perpetration is closely linked to adverse childhood experiences, particularly violence. Linking violence prevention to SRHR services is critical, most SRHR includes sexual violence response, but not general violence

[67] UNAIDS. 2021. Young people and HIV. Retrieved from https://www.unaids.org/sites/default/files/media_asset/young-people-and-hiv_en.pdf

[68] Meinck, F., Pantelic, M., Spreckelsen, T.F., Orza, L., Little, M.T., Nittas, V., Picker, V., Bustamam, A.A., Romero, R.H., Mella, E.P.D. and Stöckl, H. 2019. Interventions to reduce gender-based violence among young people living with or affected by HIV/AIDS in low-income and middle-income countries. Aids, 33(14), pp.2219-2236.

[69] Botea, Ioana; Coudouel, Aline; Heinemann, Alessandra; Kuttner, Stephanie. 2021. Safety First: How to Leverage Social Safety Nets to Prevent Gender Based Violence. Washington, DC: World Bank. © World Bank. https://openknowledge.worldbank.org/handle/10986/35641 License: CC BY 3.0 IGO URI: http://hdl.handle.net/10986/35641

70 World Health Organization. 2021. Violence against women [Fact sheet]. https://www.who.int/news-room/fact-sheets/detail/violence-against-women.

[71] Stark, L., Seff, I., & Reis, C. 2021. Gender-based violence against adolescent girls in humanitarian settings: a review of the evidence. The Lancet Child & Adolescent Health, 5(3), 210-222.

prevention. There is strong evidence on effective violence prevention strategies, including the INSPIRE package,[72] and emerging evidence on sexual violence prevention.[73]

Humanitarian and conflict settings

There remains low accessibility of SRH services in many LMICs and humanitarian settings, particularly for young people. Regions experiencing humanitarian emergencies and crises, typically have limited resources and infrastructure to support SRH services-resulting in poor SRH outcomes and service utilization. Young people experiencing humanitarian crises are often at higher risks of developing mental health problems, which can further exacerbate poor SRH outcomes.[74] There is currently an estimated 235.4 million people worldwide who are in need of humanitarian assistance and protection,[75] including an estimated 34 million are adolescent girls and women of reproductive age are in need of humanitarian assistance.[76] With this need in mind, the minimal initial service package (MISP) was developed to respond to reproductive health needs at the onset of a crisis with the following objectives: identifying an organization to lead MISP implementation, preventing sexual violence and responding to the needs of survivors, preventing the transmission of and reducing morbidity and mortality due to HIV and other STIs, preventing excess maternal and new-born morbidity and mortality, preventing unintended pregnancies and planning to integrate comprehensive SRH services into primary health care, including services such as safe abortion care to the full extent of the law.[77] Despite the development of the aforementioned system and the drive to improve its availability and uptake, there remains unmet SRH settings, especially dire for young people. Additional support is needed to address GBV in humanitarian settings, including preparedness checklists, screening in safe spaces integrated into service delivery, etc.[78] To ensure that this right is met, they should have enabling environment and access to comprehensive SRH information and services so they can make free and informed choices.[79] The following builds towards an enabling environment; the right to access safe, quality, affordable services that are appropriate and acceptable to a population, a human right that continues in a state of crisis or instability.

Mental, physical and cognitive challenges, including severe disability

Experiences of violence, stressors linked to poverty, and the impact of unequal gender norms can all have bearing on poor mental health; they are also linked to poorer SRH outcomes. Similarly, lack of satisfaction with available SRH services can lead to poorer mental health, especially for young people who are eager to make

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[72] World Health Organization. 2016. INSPIRE: Seven strategies for Ending Violence Against Children https://www.who.int/publications/i/item/inspire-seven-strategies-for-ending-violence-against-children

[73] Ligiero, D., Hart, C., Fulu, E., Thomas, A. and Radford, L., 2019. What Works to Prevent Sexual Violence Against Children. http://clok.uclan.ac.uk/31565/

74 Desrosiers A, Betancourt T, Kergoat Y, Servilli C, Say L, Kobeissi L. 2020. A systematic review of sexual and reproductive health interventions for young people in humanitarian and lower-and-middle-income country settings. BMC Public Health. 2020 May 12;20(1):666. doi: 10.1186/s12889-020-08818-y. PMID: 32398129; PMCID: PMC7216726.

75 Global Humanitarian Overview 2021 | Global Humanitarian Overview (unocha.org)

76 United Nations High Commission for Refugees (UNHCR). Global Trends: Forced Displacement in 2017. 14th Edition, 2018. Accessed at: https://www.unhcr.org/globaltrends2017.

United Nations Population Fund (UNFPA).2018. Humanitarian Action Overview 2018. https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_HumanitAction_2018_Jan_31_ONLINE.pdf

77 Fatusi A. 2016. Young people's sexual and reproductive health interventions in developing countries: making investments count. J Adolesc Health. 59: S1–3.

IAWG | Inter-Agency Working Group on Reproduction Health in Crises (iawgfieldmanual.com)

[78] For resources on GBV response and support among adolescent girls and young women in humanitarian settings, please visit: https://gbvresponders.org/resources/#ADOLESCENTGIRLS.

79 IMAP Statement on sexual and reproductive health services in humanitarian settings (2018) IPPF_IMAP_SRH_in_Humanitarian_Settings.pdf

decisions about their own SRHR.[80] Evidence indicates that depression is a risk factor for poor SRH, as poor mental health can affect young people's ability to seek SRH care and services; young women in particular have been identified as likelier to experience depressive symptoms and diagnoses. Depression is associated with higher rates of unintended pregnancy, linked to poorer condom negotiation and motivation,[81] and this group may require differentiated responses tailored to their specific circumstances and resources.[82] Links between SRH and mental health have been identified in other populations of at-risk adolescents. Among adolescents in humanitarian and post-conflict settings[83] including refugee camps,[84] psychosocial interventions and other services prioritizing education, gender equity, and safety may be critical to improve SRH outcomes and reduce risks of early marriage and early pregnancy. Other approaches prioritizing harm reduction,[85] violence prevention, and life skills may be able to improve SRH care-seeking as well as gender attitudes, although more research is needed.

There is additional evidence about maternal mental health of younger women In LMIC settings in particular, young mothers may lack the psychosocial resources and networks required to navigate this complex transition. A Zimbabwean study identified poor mental health among pregnant adolescents/young mothers,[86] which included young women of different marital statuses, and very few who were still in school. In this group, most pregnancies (approximately 60%) were unintended, affecting attachment and parenting -- roughly 40% of sample reported difficulties and lack of enjoyment in caring for their babies. Additional structural challenges include increased responsibilities for caretaking with inadequate social support, and relocation linked to marriage. Another study in Sri Lanka showed similarly poor mental health including significant anxiety, higher levels of unhappiness, and underutilization of health services in adolescent mothers, as 20% of first-time mothers surveyed were adolescents.[87]

When early motherhood overlaps with other risk factors, including HIV and violence, risks for poor mental health can also be heightened and intensified. A study in South Africa uncovered narratives of stress, emotional isolation, depressive feelings, and suicidal ideation, stemming from HIV, pregnancy, and violent relationships.[88] Importantly, these vulnerabilities are often interlinked, and interact to exacerbate one another. Interventions that target SRHR in youth living with HIV in low-resource settings may overlook broader structural factors that inhibit engagement in care[89]—meaning that holistic, multi-layered services are essential to reaching a broader cross-section of youth. To encourage positive mental health and wellbeing among young people, researchers and practitioners have adopted practices of engaging adolescents in research on the intersections between

80 Mbalinda, S., Kiwanuka, N., Kaye, D., & Eriksson, L. 2015. Reproductive health and lifestyle factors associated with health-related quality of life among perinatally HIV-infected adolescents in Uganda. Health And Quality Of Life Outcomes, 13, 170. https://pubmed.ncbi.nlm.nih.gov/26490047/

81 Shrier, L., Burke, P., Parker, S., Edwards, R., Jonestrask, C., Pluhar, E., & Harris, S. 2020. Development and pilot testing of a counseling-plus-mHealth intervention to reduce risk for pregnancy and sexually transmitted infection in young women with depression. mHealth, 6, 17. https://pubmed.ncbi.nlm.nih.gov/32270009/

82 Katz-Wise, S., Gordon, A., Burke, P., Jonestrask, C., & Shrier, L. 2020. Healthcare Clinician and Staff Perspectives on Facilitators and Barriers to Ideal Sexual Health Care to High-Risk Depressed Young Women: A Qualitative Study of Diverse Clinic Systems. Journal Of Pediatric And Adolescent Gynecology, 33(4), 363-371. https://pubmed.ncbi.nlm.nih.gov/

83 Desrosiers, A., Betancourt, T., Kergoat, Y., Servilli, C., Say, L., & Kobeissi, L. 2020. A systematic review of sexual and reproductive health interventions for young people in humanitarian and lower-and-middle-income country settings. BMC Public Health, 20(1), 666. https://pubmed.ncbi.nlm.nih.gov/32398129/

84 Ortiz-Echevarria, L., Greeley, M., Bawoke, T., Zimmerman, L., Robinson, C., & Schlecht, J. 2017. Understanding the unique experiences, perspectives and sexual and reproductive health needs of very young adolescents: Somali refugees in Ethiopia. Conflict and health, 11, 26. https://pubmed.ncbi.nlm.nih.gov/29163667/

85 Zhang, X., Zhang, J., Xie, R., & Zhang, W. 2020. Sexual and reproductive health correlates of polysubstance use among female adolescents who sell sex in the southwest of China. Substance Abuse Treatment, Prevention, and Policy, 15(1), 59. https://pubmed.ncbi.nlm.nih.gov/32807180/

86 Woollett, N., Bandeira, M., Marunda, S., Mudekunye, L., & Ebersohn, L. 2021. Adolescent pregnancy and young motherhood in rural Zimbabwe: Findings from a baseline study. Health & Social Care In The Community. https://pubmed.ncbi.nlm.nih.gov/33825254/

87 Agampodi, T., Wickramasinghe, N., Jayakodi, H., Amarasinghe, G., Warnasekara, J., Hettiarachchi, A., Jayasinghe, I., Koralegedara, I., Gunarathne, S., Somasiri, D., & Agampodi, S. 2021. The hidden burden of adolescent pregnancies in rural Sri Lanka; findings of the Rajarata Pregnancy Cohort. BMC Pregnancy And Childbirth, 21(1), 494. https://pubmed.ncbi.nlm.nih.gov/34233652/

88 Mathews, C. (2021). "As a Young Pregnant Girl… The Challenges You Face": Exploring the Intersection Between Mental Health and Sexual and Reproductive Health Amongst Adolescent Girls and Young Women in South Africa. AIDS And Behavior, 25(2), 344-353. https://pubmed.ncbi.nlm.nih.gov/32683636/

89 Pretorius, L., Gibbs, A., Crankshaw, T., & Willan, S. 2015. Interventions targeting sexual and reproductive health and rights outcomes of young people living with HIV: a comprehensive review of current interventions from sub-Saharan Africa. Global Health Action, 8, 28454. https://pubmed.ncbi.nlm.nih.gov/26534721/

sexual and reproductive health (SRH), sexuality, wellbeing and mental health, with evidence emerging from multiple regions of the world. Youth empowerment is a construct of positive mental health and wellbeing and can also be achieved through more routine agency in decision-making around SRH.[90] Men's health and self-care may also be an important area for further exploration, as gender equitable and responsive services are pursued.[91]

90 Guerrero, F., Lucar, N., Garvich Claux, M., Chiappe, M., Perez-Lu, J., Hindin, M., Gonsalves, L., & Bayer, A. 2020. Developing an SMS text message intervention on sexual and reproductive health with adolescents and youth in Peru. Reproductive Health, 17(1), 116. https://pubmed.ncbi.nlm.nih.gov/32736561/

91 Narasimhan, M., Logie, C., Moody, K., Hopkins, J., Montoya, O., & Hardon, A. 2021. The role of self-care interventions on men's health-seeking behaviours to advance their sexual and reproductive health and rights. Health Research Policy and Systems, 19(1), 23. https://pubmed.ncbi.nlm.nih.gov/33596921/

PROMISING APPROACHES

The above summaries highlight some of the approaches that will be important to the service design and delivery for Clients of 2030. Models that are based on promotive peer relationships, self-care interventions and cultural and norms-based transformation will be critical to ensuring that IPPF's clients of 2030 and beyond feel seen and served by healthcare systems and the societies they are a part of. Some of the promising models include:

1. self-care approaches and interventions which support access to medical and social services;

2. mHealth/ remote interventions, both as a way to facilitate self-care, and as part of a hybrid package with in-person specialised services;

3. peer-based interventions that can provide quality, sensitive and responsive knowledge, skills and linkages to products and services; and

4. integrated services through health system models such as adolescent-responsive clinics but also integrating SRHR into safe spaces.

Sex positivity and intimacy: There is growing evidence[92,93] that abstinence-only programmes are ineffective, whilst continually being heavily promoted in many contexts—and so the call to take on a sex-positive approach has become increasingly loud[94,95]. The World Health Organization[96] encourages a sexual health approach that favours physical health, personal choice, and a positive and respectful approach to sexuality and sexual relationships. A sex-positive approach promotes the idea that sex is healthy, pleasurable and avoids attaching moralistic judgements on sex. Where a sex-negative approach includes a focus on risk and the problems attached to sexuality, like prejudice toward certain sexual practices, sexism and homophobia, a sex-positive approach alternatively calls for acknowledgment that sex encompasses pleasure and can be rewarding; accepts the reality of sexual diversity and choice; and asserts that sex does not have to relate to procreation. Williams and colleagues[97] define a sex-positive approach as ''allowing for a wide range of sexual expression that takes into account sexual identities, orientations and behaviours; gender presentation; accessible health care and education; and multiple important dimensions of human diversity". Adolescent sex is often prescribed as deviant behaviour, morally wrong and socially problematic. Yet, the stigma attached to adolescent sex only continues to reinforce stigmatising attitudes and shame that prevents adolescents from approaching sex healthily, with all the tools and knowledge needed to ensure pleasurable, healthy, and protected sexual behaviours. Comprehensive sexuality education is central to foster accurate SRHR knowledge and to support the establishment of positive SRHR.

Comprehensive Sexual Education (CSE): Delivering of CSE which is honest, non-judgmental by well-educated health professional in a comfortable environment can provide the most successful outcomes. This type of facilitation can include youth friendly educators, separating boys and girls[98] for some of the aspects where they have followed up questions, encourage students to develop critical thinking skills so they can

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92 Brickman, J., & Willoughby, J.F. 2017. 'You shouldn't be making people feel bad about having sex': exploring young adults' perceptions of a sex-positive sexual health text message intervention, Sex Education, 17:6, 621-634, DOI: 10.1080/14681811.2017.1332582

93 Singh, A., Both, R., & Philpott, A. 2021. 'I tell them that sex is sweet at the right time' - A qualitative review of 'pleasure gaps and opportunities' in sexuality education programmes in Ghana and Kenya. Global public health, 16(5), 788–800. https://doi.org/10.1080/17441692.2020.1809691

94 Harden K. P. 2014. A Sex-Positive Framework for Research on Adolescent Sexuality. Perspectives on psychological science: A journal of the Association for Psychological Science, 9(5), 455–469. https://doi.org/10.1177/1745691614535934

95 Williams, D. J., Thomas, J.N., Prior, E.E., & Walters, W. 2015. Introducing a multidisciplinary framework of positive sexuality. J Positive Sex,1:6—11. http:// journalofpositivesexuality.org/wp-content/uploads/2015/02/ Introducing-Multidisciplinary-Framework-of-Positive-SexualityWilliams-Thomas-Prior-Walters.pdf

96 World Health Organization. 2015. Brief sexuality-related communication: recommendations for a public health approach. http://www.ncbi.nlm.nih.gov/books/NBK311023/

97 Williams, D. J., Prior, E., & Wegner, J. 2013. Resolving social problems associated with sexuality: can a "sex-positive" approach help?. Social work, 58(3), 273–276. https://doi.org/10.1093/sw/swt024

98 Notably, this approach does not take into account people with diverse SOGEAC or who identify as part of the LGBTQIA+ community. The appropriate CSE rollout model needs to be tailored and domesticated to the setting and community needs and priorities.

question their context.[99] CSE can further assist with understanding gender and gender norms by the normalization of the LGBTQIA+ community, the reduction in stereotyping about gender expression and norms.[100] Furthermore, CSE can improve young people's knowledge and skills that support healthy relationships, attitudes, as well as programs which emphasize communication skills, and extending to other aspects of society including ethics and social justice and social emotional learning. Some of the successes in the area of CSE is reflected In a study done in four LMIC countries, and Ghana had the most comprehensive range of topics covered.[101] Inclusion of CSE in country policies and budgets for training teachers of CSE.[102] While there have been a number of successes, there remains a shortcomings related to CSE, such as the lack of sufficient monitoring and evaluation of CSE on both students (assessing learning) and teachers (assessing teaching).[103] In addition, most of the curricula for CSE in LMICs emphasizes on abstinence and lacks adequate information on topics such as contraception, STIs, gender and rights, abortion and sexual violence and harassment.104 Despite these shortcomings, CSE can be used as a very powerful tool In providing young people with the knowledge to better protect themselves as well as access to SRH services as a preventative measure. This can be done by:

- Using age-appropriate literature that challenges gender stereotypes and using a critical literacy approach to engaging the students
- Programs which focus on the importance of talking about taboo and difficult subjects
- Invite guest speakers from the LGBTQIA+ society to share personal stories
- Inclusivity across the curriculum – important in promoting a more accepting and welcoming environment for sexual minority youth
- Using approaches such as Social Emotional Learning through role plays, peer education, theatre focused on sexual coercion, pressure, date rape and exploitation Horizons project – emphasized ethnic and gender pride.[105]
- Making use of Interactive Digital Interventions.[106]

Self-care interventions

Self-care interventions in the field of sexual and reproductive health and rights goes hand-in-hand with advancements in self-administered family planning methods, self-testing and screening for STIs such as HIV and chlamydia, and self-administered abortions.[107] Self-care interventions, such as HIV self-testing, may be relevant in humanitarian settings that lack the following: sufficient trained health workers, have inadequate health infrastructure, and do not have evidence based sexual and reproductive health policies or practices.[108] Linkage to care following self-care SRH interventions can consider mobile phone apps, hotlines, health care liaisons, and

[99] Corcoran, J. L., Davies, S. L., Knight, C. C., Lanzi, R. G., Li, P., & Ladores, S. L. 2020. Adolescents' perceptions of sexual health education programs: An integrative review. Journal of Adolescence, 84, 96–112. https://doi.org/10.1016/J.ADOLESCENCE.2020.07.014

[100] Goldfarb, E. S., & Lieberman, L. D. 2021a. Three Decades of Research: The Case for Comprehensive Sex Education. In Journal of Adolescent Health (Vol. 68, Issue 1, pp. 13–27). Elsevier Inc. https://doi.org/10.1016/j.jadohealth.2020.07.036

[101] Panchaud, C., Keogh, S. C., Stillman, M., Awusabo-Asare, K., Motta, A., Sidze, E., & Monzón, A. S. 2019. Towards comprehensive sexuality education: a comparative analysis of the policy environment surrounding school-based sexuality education in Ghana, Peru, Kenya and Guatemala. Sex Education, 19(3), 277–296. https://doi.org/10.1080/14681811.2018.1533460

[102] Keogh, S. C., Stillman, M., Leong, E., Awusabo-Asare, K., Sidze, E., Monzón, A. S., & Motta, A. 2020. Measuring the quality of sexuality education implementation at the school level in low- and middle-income countries. Sex Education, 20(2), 119–137. https://doi.org/10.1080/14681811.2019.1625762/SUPPL_FILE/CSED_A_1625762_SM0291.DOCX

[103] Wangamati, C. K. (2020). Comprehensive sexuality education in sub-Saharan Africa: adaptation and implementation challenges in universal access for children and adolescents. Https://Doi.Org/10.1080/26410397.2020.1851346, 28(2). https://doi.org/10.1080/26410397.2020.1851346

[104] Keogh, S. C., Stillman, M., Leong, E., Awusabo-Asare, K., Sidze, E., Monzón, A. S., & Motta, A. 2020. Measuring the quality of sexuality education implementation at the school level in low- and middle-income countries. Sex Education, 20(2), 119–137. https://doi.org/10.1080/14681811.2019.1625762/SUPPL_FILE/CSED_A_1625762_SM0291.DOCX

[105] Haberland, N., & Rogow, D. 2015. Sexuality Education: Emerging Trends in Evidence and Practice. Journal of Adolescent Health, 56(1), S15–S21. https://doi.org/10.1016/J.JADOHEALTH.2014.08.013

[106] Bailey, J., Mann, S., Wayal, S., Hunter, R., Free, C., Abraham, C., & Murray, E. 2015. Sexual health promotion for young people delivered via digital media: a scoping review. *Public Health Research*, 3(13), 1–120. https://doi.org/10.3310/PHR03130

[107] Brady, M. 2018. Women's self-care: a new take on an old practice. Retrieved from https://www.path.org/articles/womens-self-care-a-new-take-on-an-old-practice/

[108] Logie, C. H., Khoshnood, K., Okumu, M., Rashid, S. F., Senova, F., Meghari, H., & Kipenda, C. U. 2019. Self-care interventions could advance sexual and reproductive health in humanitarian settings. *BMJ*, 365.

community outreach.[109] There are a number of barriers which exists around self-care interventions, including the need for parent consent, stigma as well as confidentiality concerns-especially in smaller communities and/or the need to travel to a clinic. There have also been a number of concerns raised by health workers related to self-care interventions, more specifically the use of over-the-counter emergency contraceptives (EC), i.e., increased risk behaviour, misuse or repeated use of EC and communication (concerns about discouraging the use of other contraceptives). While a number of barriers exist around self-care interventions, expanding the range of available options to adolescents and young people is critical especially given trends in healthcare seeking practices among Gen Z compared to older generations.

mHealth

Adolescents and young people have been early and enthusiastic adopters of digital technologies. In 2017, 1 in 3 adolescents used internet and this proportion will increase consistently over the coming decades.[110] Almost half of the world's population are connected to the internet, varying across region, gender and age. However, access to digital services remains uneven. In 2018 Only 11% of individuals in developing countries had fixed broadband subscriptions, which is very low as compared to 33% in developed countries.[111] The proportion of people using the internet in 2018 was around 80 percent in Europe, 25% only in sub-Saharan Africa, and 20% in the least developed countries. Estimates suggest that mobile phone access will increase rapidly over the next five years, with 100% of people in Asia and 67% of people in Africa having a cell phone by 2025.[112] With rapidly reducing cost of smartphones – now at $15 in low-resource countries and likely to reduce still further over the next decade – this may represent an increasingly population-level reach, although data costs and access may remain prohibitive. The success of providing access to mobile phone and internet constitute a major SDG aligned outcome.[113] It will be important that leadership is taken in Developing and implementing mHealth services that are youth-friendly and guarantee privacy and confidentiality – and that approach SRH through a respectful, pluralistic and rights-based lens.

Individually, these approaches may not be sufficient to attain SRHR among a large proportion of IPPF clients. It is important to identify which combinations may be critical for different groups of clients in different regions, including supplementary services for harder to reach and more vulnerable clients, such as people who sell sex and use drugs. An important element of these approaches is how to integrate considerations on sex positivity, intimacy and safety.

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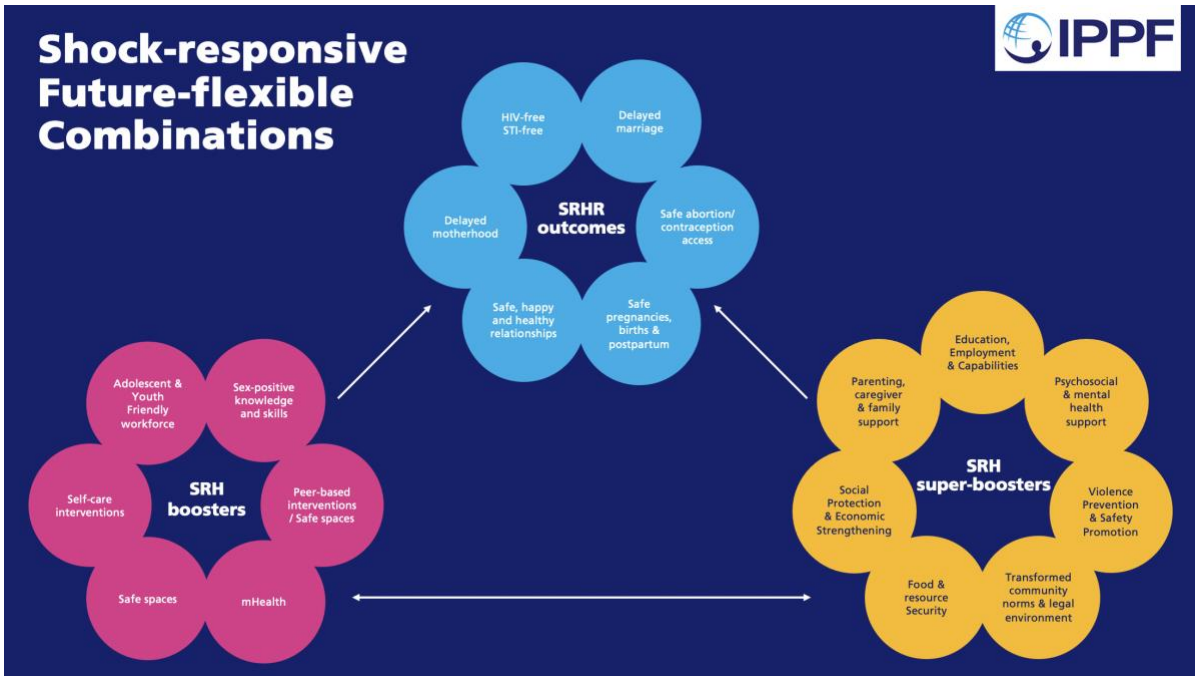
SHOCK-RESPONSIVE, FUTURE-FLEXIBLE COMBINATIONS

New evidence suggests exciting opportunities for improving SRHR in the next generations. We now have good data showing the effectiveness of key SRH services already promoted by IPPF: for example, adolescent and youth-friendly services, and sex-positive approaches. But we also have evidence that services previously considered to have a social and economic – rather than sexual health – focus, show important benefits for SRH. For example, economic support for poor families in the form of social protection or food provision, shows impacts on reducing sexual risk behaviour and violence victimisation for adolescent girls in the household.[114] Essentially they no longer need to find a boyfriend who can provide money or food for the family.[115] We also see impacts of violence prevention programs on reducing risk factors for SRH – for example reducing substance use, mental health challenges, and intimate partner violence.[116] These services improve SRH outcomes, as well as a range of additional SDGs in health, education and employment. They may provide new opportunities for IPPF to partner with other agencies, or with wider initiatives to deliver services that benefit SRH as well as other outcomes. The UCT/ IPPF team will develop a separate thought piece based on the concepts of SRHR boosters and SRHR super-boosters for dissemination and publication.



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