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IMAP Statement on sexual and reproductive health services for very young adolescents

Introduction

Very young adolescents (10-14 years) are a rapidly growing population worldwide, especially in Sub-Saharan Africa, Asian and Latin American countries. Adolescents (10-19 years) comprise 1.3 billion (16% of the world's population), and very young adolescents constitute almost half of this group. [1] They are also increasingly being affected by humanitarian crises (408 million youth), climate change and natural disasters (approximately 175 million children every year). [2] In addition to their general health and well-being, they need sexual and reproductive health services to mitigate potential devastating health consequences; the second leading cause of death globally among adolescent girls is complications of pregnancy and childbirth [3], and children born to adolescent mothers face more significant health risks than those born to older women. Adolescents under 15 years of age have the highest risk of adverse pregnancy outcomes, including maternal and perinatal mortality, compared to women aged 20-24. [4] Restrictions on access to comprehensive abortion care also contribute to their increased share of maternal mortality as adolescents are less likely to obtain safe abortions, more likely to seek abortions later in pregnancy, and delay seeking care for complications. [5] In addition to poor reproductive outcomes, young adolescents from sexual minority populations are more likely to suffer from ill general and mental health. [6-8]

This IMAP statement aims to present the sexual and reproductive health needs of very young adolescents, explain the barriers they face when accessing the services, and explore factors can help facilitate pathways to rights-based services.

Barriers to very young adolescents in obtaining sexual and reproductive health services

Structural barriers to accessing sexual and reproductive health and rights of very young adolescent girls can be divided into (1) legal; (2) health system barriers; and (3) sociocultural.

1. Legal barriers

Very young adolescents face multiple legal barriers to access sexual and reproductive health services. In many countries, the age of consent to health services is the same as the age of the majority, whereas age of sexual consent might be younger or they may engage in sexual activity much earlier. [9] In some countries, additional legal "capacity assessments" exist for adolescents, allowing them to participate actively in their care. The need for parental or guardian consent in many settings among this age group applies not only to therapeutic decisions but also to participation in research, making it additionally challenging to obtain the data with regard to behaviour, knowledge, values, and preferences of sexual and reproductive health services of 10-14-year-olds. [10]

2. Health system barriers

Early adolescence is considered one of the healthiest periods of life and a time when one is least likely to acquire a disability or die prematurely. [3] This is also the age, usually between 10-14, when puberty and physical maturation are initiated. Impediments include the absence of adolescent- and youth-responsive services, shortages of preferred methods of contraception, poor-quality or poorly managed services, lack of privacy, denial of services and care offered by judgmental providers.

A 2021 systematic review of factors that influence access to and utilisation of youth-friendly health services [11] found that institutional barriers such as providers' negative attitudes, shortages of trained staff, and lack of dedicated space to ensure privacy were common barriers. Providers may lack understanding of the diversity of young people, in terms of their sexual activity, marriage status, gender, and sexual identity, and their comfort, confidence and education level in seeking health services. While these barriers are common for all adolescents, they may be particularly insurmountable for the youngest, and exacerbated by the presence of intersecting issues, such as among those with a disability and living in humanitarian settings. [12]

3. Sociocultural barriers

For many very young adolescents, first sexual intercourse happens due to coercion or violence. Between 3% and 23% of adolescent females aged 13–17 report experience of sexual violence in the past year; it is 0–13% among adolescent males. Very young adolescents are at higher risk of coercion and sexual violence, especially in places where child, early, forced marriage or early unions are a cultural norm. [13-15]

Forced marriage constitutes any marriage in which one or both partners enter it "without full, free, and informed consent" and generally involve an age or power imbalance. Child marriage refers to any formal marriage or informal union where at least one of the parties is under 18 and has not reached the age when they can express full, free, and informed consent. Both forms of marriage violate an individual's rights, including rights associated with bodily autonomy and integrity. Child marriage is a form of gender-based violence and discrimination. It is also a powerful, long-lasting constraint on the agency of girls. [16]

Persistent taboos about sex and sexuality are reinforced by social norms and attitudes. Schools are places where very young adolescents socialise and learn about sexual health and well-being; however, many do not provide comprehensive sexual education or sexual education at all. In some settings, pregnant girls may even be expelled or suspended from schools rather than supported to continue their education. Additionally, family and school environments might reinforce harmful practices and discrimination against adolescent girls with nonconforming gender identities, leading to poor health and negative outcomes. [14-16]

Facilitators to sexual and reproductive health services

Comprehensive sexuality education

Education leads to transformative outcomes that positively affect sexual and reproductive health, especially for adolescent girls. Evidence from systematic reviews on interventions with demonstrated impact on reducing child marriage suggests that economic interventions (cash or asset transfer aimed at keeping girls at school) had a significant impact on decreasing the rate of child marriage or increasing age at marriage. Comprehensive sexuality education has been shown to contribute to informed choices by very young adolescents, including decreased early, unprotected sex; increased use of contraceptives, reduced unintended pregnancies and combating forms of gender-based violence. Comprehensive sexuality education promotes knowledge, values and attitudes and life abilities needed to protect themselves and respect others. Many low-middle income countries have national policies and curricula that support comprehensive sexuality education in primary schools. For example, in Mexico, Mexfam has been one of the leading sexual and reproductive health service providers for adolescents with its long-standing 'Gente Joven' programme that promotes dialogue on sexuality with adolescents. [17] The programme is a school-based comprehensive sexuality education by peers and young people and emphasises adolescents' access to sexuality education as well as collects adolescent-level data on sexual and reproductive health attitudes and information-seeking behaviours of very young adolescents, to understand their health needs better. In addition, as evidence suggests that comprehensive sexuality education can increase access to contraceptives, the programme collaborates with pharmacies to provide health promotion and distribution of methods, including emergency contraception and pregnancy tests. The programme has filled a critical gap in service, as only 37.9% of young women in the intervened areas/municipalities previously had access to contraception. [18] This collaboration addresses very young adolescents' lack of trust in sexual and reproductive health clinics and is contributing to changing the norms and conducts of health providers; indeed, the programme has been used by the government to design centers targeted to adolescents with trained personnel.

Age-appropriate comprehensive sexuality education should continue throughout adolescence, both in and out of school. It should also include age-appropriate information on positive sexuality, sexual orientation and gender identities. Through education and skills development, very young adolescents can be equipped with tools to address systemic gender oppression, discrimination and harmful social norms. Comprehensive sexuality education is also essential for very young adolescents in conflict settings and may enhance their ability to contribute to community reconstruction efforts that facilitate lasting peace. [19]

Education on menstrual health can decrease period-related stress, increase school engagement and improve self-efficacy for very young adolescent girls. [20] Most effective efforts ensure that menstrual health is addressed holistically as a human right and not only as a hygiene issue. In Malawi, recognising the stigma and economic barriers that affect adolescent girls' access to menstrual pads and how menstruation can affect girls' school attendance, Family Planning Association in Malawi (FPAM) volunteers initiated the 10+ Her Period Her Pride Project [21], which trains schoolgirls to manufacture reusable menstrual pads. These programs, in addition to UNFPA's supply of menstrual cups, ensure a range of dignified choices for menstrual hygiene products.

Promotion of gender equality

Policymakers and public health practitioners must strengthen efforts to delay age at marriage or unions and childbirth to protect the physical and emotional well-being of very young adolescent

girls, as early marriage can be one of the most important predictors of adverse sexual and reproductive health outcomes. Early adolescence can be an optimal time for working with younger adolescents on gender-transformative interventions. [11] Facilitating dialogues about mutual respect and perceived gender roles and identities can promote equality in relationships and can be initiated within comprehensive sexuality education programs.

Historically, transgender youth had to trade future fertility for gender-affirming medical care. Recent guidance from the World Professional Association for Transgender Health, however, now recommends that healthcare professionals who provide such services discuss the possibility of fertility preservation among those who opt for gender-affirming hormonal treatment, and to offer of puberty blockers for those who have yet to complete puberty, before proceeding with hormone therapy. Multidisciplinary teams should participate in the care of transgender and gender diverse youth. [22]

Conclusion

Ensuring access to non-judgmental, supportive sexual and reproductive health care is essential to allow very young adolescents to exercise their agency and rights to health and autonomy free of coercion and discrimination. Sensitive and accessible services can reduce excess morbidity and mortality in this age group and promote health and well-being. [23] A significant limitation to best practices for this age group is the lack of data disaggregation for very young adolescents or the exclusion of the group entirely from adolescent research. Data on knowledge, attitudes, and practices of very young adolescents around sexual and reproductive health is minimal, particularly in low-middle income countries, as data usually exist for a wide age range (i.e., young people (10-24), adolescents (10-19), youth (15-24)) that misses the specificity for very young adolescents. There is a need for more high-quality research and global studies to investigate interventions that positively influence sexual and reproductive health to inform global normative guidance for this age group.

Recommendations for Member Associations

1. Ensure meaningful participation of adolescents in all the interventions, policies and laws that are designed for them, including in humanitarian settings when they are among the most affected.

2. Support continuity of education for all adolescents by promoting evidence-informed interventions that keep adolescents in school (such as economic incentives) as well as address social norms that de-value girls' education.

3. Youth-responsive services and adolescent-responsive health systems are essential strategies for reaching very young adolescents in all their diversity. Adopting and adapting global tools, in addition to service promotion such as community outreach, health education and quality implementation standards and policies, can facilitate utilisation of services by adolescents and young people.

4. Provide/advocate for comprehensive sexuality education, including messages about positive sexuality, sexual orientation, gender identity and respectful relationships. Support young people, including those that are marginalized/disenfranchised, in understanding and upholding their sexual and reproductive rights as well as those of others.

5. Develop competences on strategic communication, reframing, and research aimed at understanding values and attitudes of key audiences on comprehensive sexuality education; increase capacity to track and respond to attacks related to comprehensive sexuality education by developing capacity to deal with crises, cyber bullying, physical

and digital safety and by including a rapid response budget allocation.

6. Align with parents and teachers to create and foster a strategic protective network of allies to intervene in case of opposition attacks.

7. Advocate for policies to respond to child, early and forced marriage addressing the root causes and ensuring the rights of girls already married.

8. Ensure that research on adolescents includes those below the age of 16, and that collected data can be disaggregated by age to include very young adolescents (i.e. 10-13, 14-16, 17-19).

References

1. United Nations Children's Fund (UNICEF). Adolescent Data Portal. UNICEF. (2022). Available from: https://data.unicef.org/topic/adolescents/overview/

2. IASC Guidelines on Working with and for Young People in Humanitarian and Protracted Crises. https://interagencystandingcommittee.org/system/files/2021-02/IASC%20Guidelines%20on%20Working%20with%20and%20for%20Young%20People%20in%20Humanitarian%20and%20Protracted%20Crises_0.pdf

3. World Health Organization. Mortality, morbidity and disability in adolescence. World Health Organization, (2013). Available from: https://apps.who.int/adolescent/second-decade/section3/page2/mortality.html

4. Kozuki, N., Lee, A.C., Silveira, M.F. et al. The associations of parity and maternal age with small-for-gestational-age, preterm, and neonatal and infant mortality: a meta-analysis. BMC Public Health 13 (Suppl 3), S2 (2013).

5. Woong, V., Singh, S., Browne, A., Philbin, J. Adolescent Women's Need for and Use of Sexual and Reproductive Health Services in Developing Countries. Guttmacher Institute. (2015).

6. Russell ST, Fish JN. Mental Health in Lesbian, Gay, Bisexual, and Transgender (LGBT) Youth. Annu Rev Clin Psychol. 2016;12:465-87.

7. Zaza S, Kann L, Barrios LC. Lesbian, Gay, and Bisexual Adolescents: Population Estimate and Prevalence of Health Behaviors. JAMA 2016.

8. Reisner SL, Greytak EA, Parsons JT, Ybarra ML. Gender minority social stress in adolescence: Disparities in adolescent bullying and substance use by gender identity. J Sex Res. 2015;52(3):243-256.

9. Manay,N., Collin-Vézina,D., Recipients of children's and adolescents' disclosures of childhood sexual abuse: A systematic review, Child Abuse & Neglect, Volume 116, Part 1, 2021.

10. Blum, R.W, Mmari, K., Moreau, C. It Begins at 10: How Gender Expectations Shape Early Adolescence Around the World. Journal of Adolescent Health 61. (2017).

11. Ninsiima, L.R., Chiumia, I.K. & Ndejjo, R. Factors influencing access to and utilisation of youth-friendly sexual and reproductive health services in sub-Saharan Africa: a systematic review. Reproductive Health 18, 135 (2021). https://doi.org/10.1186/s12978-021-01183-y

12. Global landscaping Assessment Contraceptive Services in Humanitarian Settings and in the Humanitarian-Development Nexus, Including during the COVID-19 Pandemic – A Global Landscaping Assessment (womensrefugeecommission.org)

13. Girls' sexuality and child, early and forced marriages and unions: A conceptual framework. https://www.girlsnotbrides.org/learning-resources/resource-centre/cefmu-sexuality-framework-/

14. Inter-Agency Standing Committee. Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery. (2015). Available from: https://gbvguidelines.org/wp/wp-content/uploads/2016/01/2015-IASC-GBV-Guidelines-main-book-without-table-spreads.pdf

15. World Health Organization. Making health services adolescent friendly: Developing national quality standards for adolescent friendly health services. World Health Organization. (2012). Available from: https://iris.who.int/bitstream/handle/10665/75217/9789241503594_eng.pdf

16. World Health Organization & UNAIDS. Global standards for quality health-care services for adolescents: a guide to implement a standards-driven approach to improve the quality of health care services for adolescents. World Health Organization. (2015). Available from: https://apps.who.int/iris/handle/10665/183935

17. Lopez Juarez A, Reid A. Gente Joven: a community program for Mexico's young people. Integration. 1989 Jul;(20):4-15. PMID: 12282142.

18. Zarate, L and Barranco, P. Solidarity Pharmacies: Strengthening the capacity of pharmacists to provide adolescents and young people with access to contraception and reproductive health in Mexico. (2021). https://d1c2gz5q23tkk0.cloudfront.net/assets/uploads/3084356/asset/IBPImplementationStories_TRANSLATIONS_Mexfam_ENG.pdf?1618937001

19. Inter-Agency Standing Committee. Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery. (2015). Available from: https://gbvguidelines.org/wp/wp-content/uploads/2016/01/2015-IASC-GBV-Guidelines-main-book-without-table-spreads.pdf

20. World Health Organization. WHO statement on menstrual health and rights. (2022). Available at https://www.who.int/news/item/22-06-2022-who-statement-on-menstrual-health-and-rights

21. International Planned Parenthood Federation. Pads are seen as luxuries – How Malawians are tackling period poverty. (2022). Available from: https://www.ippf.org/featured-perspective/pads-are-seen-luxuries-how-malawians-are-tackling-period-poverty

22. Coleman, E., Radix, A. E., Bouman, W.P., Brown, G.R., de Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F.L., Monstrey, S. J., Motmans, J., Nahata, L., ... Arcelus, J. (2022). Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. International Journal of Transgender Health, 23(S1), S1-S260.

23. World Health Organization. Making health services adolescent friendly: Developing national quality standards for adolescent friendly health services. World Health Organization. (2012). Available from: https://iris.who.int/bitstream/handle/10665/75217/9789241503594_eng.pdf

Who we are

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.

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