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CHAPTER FOUR

Adolescent Reproductive Health

Contents

1 Introduction

Adolescence is one of life's most fascinating and complex life stages and is accompanied by special reproductive health (RH) needs. Adolescents are resilient, resourceful and energetic. They can support each other through peer-to-peer counselling, education and outreach and contribute to their communities through activities such as assisting health providers as volunteers, providing care to people living with HIV/AIDS (PLHIV), and expanding access to quality RH services for their peers at the community level.

Humanitarian emergencies are accompanied by inherent risks that increase adolescents' vulnerability to violence, poverty, separation from families, sexual abuse and exploitation. These factors can disrupt protective family and social structures, peer networks, schools and religious institutions and can greatly affect the ability of adolescents to practise safe RH behaviours. Their new environment can be violent, stressful and/or unhealthy. Adolescents (especially young women) who live under marginalized circumstances are highly vulnerable to sexual coercion, exploitation and violence, and may have no choice but to engage in high-risk or transactional sex for survival.

On the other hand, crisis-affected communities may also be exposed to new opportunities, including access to better health care, schooling and learning new languages and skills, which may place adolescents in privileged positions they would not have had in a non-crisis environment. Adolescents often adapt easily to new situations and can learn quickly how to navigate through the new environment.

RH officers, RH programme managers and health-care providers working in humanitar-

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ian settings must consider and address the special needs of adolescents who are transitioning to adulthood in very complex and difficult settings. They must also consider especially vulnerable adolescents, including former child soldiers, children heading households, adolescent mothers and young girls who are at an increased risk of sexual exploitation.

2 Objectives

The objectives of this chapter are to:

- provide guidance to RH officers, programme managers and service providers on effective adolescent reproductive health (ARH) approaches in humanitarian settings;
- list the principles and resources that inform RH officers, programme managers, service providers and community members on how to involve adolescents in RH programmes;
- ensure the provision of youth-friendly RH services and create an environment where adolescents can develop and thrive, despite the many challenges they face throughout a crisis.

While this chapter refers to adolescents (ages 10-19), the services described here can be extended to a broader cadre of young people (ages 10 to 24) that can also benefit from youth-friendly services.

3 Programming

At the onset of an emergency, implement the Minimum Initial Service Package (MISP) for reproductive health (See Chapter 2: MISP). The MISP does not address all of adolescents' needs and it may not be possible to incorporate all ARH principles when implementing the MISP. MISP implementation, however, must be done in a way that is sensitive to the needs and preferences of adolescents. Incorporate the following as part of the initial response:

- Make condoms, both male and female, available in places where adolescents meet, preferably in private, accessible locations where they can access them clandestinely.
- Ensure adolescent girls are safe when carrying out household tasks such as collecting firewood, water or food.
- Ensure pregnant adolescent girls have access to emergency obstetric care services and referral mechanisms when necessary.
- Establish clinical care and referral services for survivors of sexual violence that are sensitive to adolescent needs and respect confidentiality.

3.1 Needs assessment

As the situation stabilizes, conduct a needs assessment in coordination with other RH and child health actors to inform the programme design process and develop an action plan to improve the youth-friendliness of existing health services based on the assessment. Involve adolescents in

this process, who can identify their own vulnerabilities as well as capacities. Use youth-friendly service assessment tools to determine whether health services meet the needs of adolescents. Also assess protective community resources. Gather information on:

- **prevalence of RH issues among adolescents,** including pregnancy, maternal and neonatal mortality and STI/HIV;
- **adolescent vulnerabilities and harmful practices,** including exposure to sexual violence and exploitation, trafficking, transactional sex and traditional practices such as female genital mutilation/cutting;
- **protective community resources,** such as supportive parents and teachers, and youth programmes with connections to caring adults;
- **adolescent services,** including professional and traditional services. Any reasons for gaps in the provision of and access to services should also be identified;
- **perceptions of ARH:** the adolescent and community perceptions of ARH needs, and of providing RH services and information to adolescents;
- **barriers to accessing existing services,** including insecurity, cultural norms, lack of confidentiality/privacy and lack of same-sex health-care professionals.

In addition, RH officers, programme managers and service providers must be familiar with national legislation and policies pertaining to adolescent reproductive health in the countries in which they work. Considerations should include:

- What are the laws or policies that restrict or protect adolescents' access to RH information and services?
- What is the age of majority? What is the age of consent for sex? What is the age of consent for marriage? Is it different for boys/men and girls/women?
- Are there requirements for marital, parental or guardian approval for providing health information and services to children? And to non-child adolescents?
- Is the evolving capacity and best interest of children taken into consideration in laws/policies/protocols regulating their access to RH services, information and education?
- Are there national or local laws or policies regarding sexual violence and other forms of abuse against children both within and outside of the family?
- Are there mandatory requirements for health-care providers to report child abuse (including sexual abuse) and/or sexual assault? If yes, to whom and what happens once the case is reported?
- Who is allowed to gather forensic evidence in the health sector in cases relating to sexual violence against a child and who is allowed to testify about this evidence in court?
- What are the local children's rights and women's rights organizations that work to support the access of children and adolescents to RH information and services?

3.2 Principles for working with adolescents

When working with adolescents, it is important to consider:

1. management principles

2. service provision principles.

3.2.1 Management principles

Adolescents are not a homogeneous group: Their needs vary by age, sex, education and marital status. RH behaviour change messages need to be age (10 to 14 years old and 15 to 19 years old) and sex appropriate.

Engage in meaningful adolescent participation: The primary principle in working effectively with adolescents is to promote their participation, partnership and leadership. Because of the barriers adolescents face when accessing RH

services, they should be involved in all aspects of programming, including design, implementation and monitoring. For example, it is helpful to identify youth who served as youth leaders or peer educators in their communities. These youth can help address the needs of their peers during programme design and can assist with implementing activities, such as condom distribution, peer education, monitoring of youth-friendly health services and referrals to gender-based violence counsellors. Services will be more accepted if they are tailored to needs identified by adolescents themselves. Adolescents may be helpful in ensuring that the MISP also addresses their needs, for example, by identifying culturally sensitive locations to make condoms available.

Community involvement: Understanding the cultural context and creating a supportive environment is critical to advancing RH services for adolescents as these may be affected by community values regarding adolescent reproductive and sexual health. Adults frequently become especially protective of cultural norms and the process of socializing youth when an emergency occurs. At the onset of the humanitarian response, it is important to make priority RH information and services available, including for adolescents, as outlined in the MISP (see Chapter 2). As soon as possible, focus on involving communities in issues that affect adolescent health, as this can lead to more sustained, positive health impacts. Community members, including parents, guardians and religious leaders, must be consulted and involved in developing programmes with and for adolescents.

3.2.2 Service provision principles

Privacy, confidentiality and honesty: Adolescents presenting to health providers often feel ashamed, embarrassed or confused. It is important for providers to create the most private space possible in which to talk. Information is disseminated rapidly among adolescents and if their confidentiality is breached even once, youth will not access available services.

Linking HIV prevention, treatment and care, and reproductive health: When adolescents access health services seeking HIV information, testing and care, there is an opportunity to promote comprehensive RH services such as:

- safer sex, including the use of dual protection
- family planning methods
- STI counselling and treatment

Conversely, offer all adolescents accessing family planning or other RH services the opportunity to learn about their HIV status, provided that care and treatment are available (see Chapter 5: Family Planning, Box 24, p. 108: Contraceptive Considerations for Adolescents).

Sex of the service provider: Whenever possible, an adolescent should be referred to a provider of the same sex, unless they prefer otherwise. Ensure that adolescent survivors of gender-based violence who are seeking support and care at a health facility have a female support person present in the examination room when a male provider is the only person available. This is essential when the survivor is an adolescent girl, but it is important also to give this option to adolescent boys who are survivors of gender-based violence.

3.3 Programming considerations for adolescents

It is important for programme managers to remember the following factors that may increase the vulnerability of adolescents during an emergency:

- **Adolescent girls have greater vulnerabilities compared to their male counterparts:** Existing power differences in relations between men and women can be heightened during an emergency. Adolescent girls are frequently expected to sustain social or cultural norms, such as being submissive to men, caring for the family, staying at home

and marrying young. Moreover, changing power dimensions created as a result of mixing of displaced and host populations can place adolescent girls at increased risk. Economic hardships lead to increased exploitation, such as trafficking and the exchange of sex for money and other necessities, with their related RH risks (HIV, STIs, early pregnancy and unsafe abortion). Adolescent girls are vulnerable to gender-based violence, including sexual violence, domestic violence, female genital mutilation/cutting and forced early marriage. The risks of a pregnancy for an adolescent girl can be exacerbated by pre-existing health conditions such as anaemia. Young married girls often lack voice and decision-making power within the household due to the power inequalities with their husbands.

- **Social norms and social supports are disrupted in a crisis situation:** The breakdown of social structures can be protective if harmful practices are discontinued, but it can also be a risk to adolescent health. The use of free time of adolescents in crisis settings may not be subjected to the same kind of scrutiny that would be under normal circumstances. When adolescents are separated from family, friends, teachers, community members and traditional culture, there is less social control of risky behaviour. Without access to adequate information and services, adolescents are more likely to be exposed to unsafe sexual practices, that could result in unwanted pregnancy, unsafe abortion, STIs and HIV.
- **Humanitarian crises can disrupt youth-adult partnerships at a time when role models are essential:** In stable settings, adolescents usually have role models in the family and community; such role models may not be obvious in crisis settings. Service providers and youth club leaders may become important role models and must be aware of their potential influence.
- **Humanitarian crises usually disrupt not only daily life, but adolescents' future perspectives:** For adolescents this may manifest in a fatalistic view on life and lead to increased risk taking, such as violence, substance use and/or unsafe sexual activity. Adolescents who attend activities or programmes assisting them to plan for the future should be provided with immediate reasons to consider the consequences of unsafe sexual activity and the need to take responsibility for their actions. Training in improved decision-making, negotiation and other life skills can be effective in encouraging adolescents to think through how to improve their current situation.
- **Adolescents can take on adult roles, in**

Box 19: Vulnerable Groups among Adolescents

Vulnerable groups among adolescents include:

- Very young adolescents (10 to 14)
- Girl mothers
- Orphans and vulnerable children
- Child heads of households
- Young married girls
- HIV-positive adolescents
- Child soldiers (including girls) and other children associated with fighting forces (in noncombatant roles)
- Adolescents engaged in transactional sex
- Adolescent survivors of sexual violence, trafficking and other forms of gender-based violence
- Adolescents engaging in same-sex intercourse

emergencies: Adolescents may be forced to take on adult roles and need coping skills that far exceed their years. Humanitarian crises may cause adolescents to wield more power than their adult counterparts, which leads to further social confusion.

- **Vulnerable groups:** Attention should be paid to age-, gender-, marital status- and context-specific vulnerabilities (see Box 19).

3.4 Services for adolescents

3.4.1 Provision of RH services at health facilities

Health services can play an important role in promoting and protecting the health of adolescents, yet there is abundant evidence that adolescents see available health services as not responding to their needs. Adolescents mistrust and avoid services or seek help only when they are in desperate need of care. One important strategy in facilitating adolescent access to and use of RH services is to ensure that they are of high quality and "youth-friendly". At the same time, adolescents need to be made aware of the availability of youth-friendly services. Youth-friendly RH care services have characteristics that make them more responsive to the particular RH needs of adolescents, including the provision of contraceptives, emergency contraception, safe abortion care, STI diagnosis and treatment, HIV counselling, testing and care, and antenatal and postnatal care.

3.4.2 Provider questionnaire for adolescents

It is good practice to screen all adolescents who enter the health system for sexual and RH issues, substance use and mental health concerns. In doing this, the health-care provider will send a message to the adolescent that he or she cares about their needs and that the health centre is a safe place to discuss RH-related is-

Table 9: Youth-friendly Health Service Characteristics

Health Facility Characteristics	Provider Characteristics	Administrative Characteristics
Convenient hours for adolescents	Respect for adolescents	Adolescent involvement
Convenient location	Nonjudgmental attitude	Boys and young men welcomed
Adequate space and sufficient privacy	Privacy and confidentiality honoured	Necessary referrals available
Comfortable surroundings	Peer counselling available	Affordable fees
	Same-sex providers when possible	Drop-in clients welcomed
	Strict confidentiality maintained	Publicity and recruitment that informs and reassures adolescents
	Staff trained in youth-friendly health service characteristics	

sues. In addition, the information can be used by health providers to provide appropriate counseling and referrals.

Before collecting information from adolescents, consider the services available for referrals. Only ask sensitive questions if appropriate responses to potentially harmful situations can be provided, otherwise more damage may be done. A possible adolescent psychosocial assessment that will help guide health providers to ask age-appropriate questions and adequately assess adolescent needs follow the pneumonic HEADSSS: Home, Education/Employment, Activities, Drugs, Sexuality, Suicide and Depression, Safety.

3.4.3 Provision of RH services in the community

Community-based provision of services and information offers opportunities for adolescents to demonstrate leadership and gain new skills through volunteerism while gaining youth-adult partnerships. The community is also an ideal setting to receive RH information where adolescents are comfortable and open to dialogue and personal risk assessments.

Peer educators

Peer education offers many benefits since peers are usually perceived as safe and trustworthy sources of information. Well-designed, curriculum-based peer education programmes and supervised peer educators can be successful in improving adolescents' knowledge, attitudes and skills about reproductive health and HIV prevention. To ensure quality in peer education programmes:

- Provide high-quality, intensive training to peer educators, including regular assessments and reinforcement of their capacities, so they can provide accurate information to their peers.
- Use standardized checklists in the development and implementation of peer education programmes to improve quality.

Community-based distribution

Youth trained as community-based distributors (CBD) are young people who have been trained to provide contraceptive counselling to their peers in the community. They typically focus on the provision of RH information, oral contraceptives, condoms and information on HIV, and refer clients to the health centre for other contraceptive methods and services. Youth CBDs can effectively integrate RH and HIV information. Since many barriers preclude adolescents from accessing RH services at clinics, training youth CBDs is a successful strategy to increase adolescents' access to RH services and information while giving the youth CBDs themselves leadership roles in the community. Youth CBDs often become allies of facility-based health services, through working with service providers on improving the quality of youth-friendly services.

Community dialogue

In addressing the principle of community involvement, use community dialogue to gain support from and build the skills of community members. Adults need information, skills and encouragement not only to support ARH programming but also to feel more comfortable in providing information to adolescents.

3.4.4 Provide RH services in schools

Make ARH services and information available in formal and non-formal schools as well as at vocational training centres. Link with educators to advocate for the creation of an enabling environment to ensure the provision of RH services for adolescents.

Sex-specific hygiene facilities

Adolescents are likely to be uncomfortable and embarrassed about sharing hygiene facilities with the opposite sex, and even with younger children. This is especially likely for girls during menstruation. Also, mixed-sex bathroom facilities are often cited as the location of school-related gender-based violence. A lack of

sex-specific hygiene facilities, as well as a lack of feminine hygiene products, will discourage adolescent girls from attending school. In order to minimize school absenteeism and school-related sexual harassment and assault, and to promote a safer learning environment:

- Ensure safe, sex-specific hygiene facilities in schools.
- Provide girls with cloth or other culturally appropriate sanitary materials for use during menstruation.

Curricula-based life skills education

Sexuality and HIV education programmes based on a written curriculum and implemented among groups of adolescents are a promising intervention to reduce adolescent sexual risk behaviours. Programme managers often tailor curricula to fit the local context. Characteristics of life skills curricula that have an impact on adolescent behaviours are outlined in Table 10.

RH officers and programme managers can provide technical assistance to teachers and community educators to ensure they are comfortable in addressing the topics and choosing appropriate lessons for life skills curricula (see Box 20).

Table 10: Characteristics of Effective Life Skills Programmes*

Curriculum development	Curriculum content	Curriculum implementation
• Involve people with different backgrounds • Assess needs and assets of the target group • Design activities consistent with community values and available resources (e.g. staff time and skills, facility space, supplies) • Pilot-test the program	• Focus on clear goals (e.g. prevention of STIs and/or pregnancy) • Give clear messages on behaviours that lead to these goals (e.g. abstain from sex, use condoms and/or other contraceptives) • Address risk and protective factors affecting sexual behaviours • Use sound teaching methods and include multiple activities (appropriate to culture, age and sexual experience) that actively involve participants and help them personalize the information • Cover topics in a logical sequence	• Train educators who can relate to youth • Secure support from authorities, such as ministries of health, school districts or community organization • Create a safe environment for youth to participate • Recruit youth and overcome barriers to their involvement (e.g. publicize the program, offer food, obtain parental consent) • Teach the full curriculum

**Adapted from Kirby, D et al.* Impact of Sex and HIV Education Programmes on Sexual Behaviors of Youth in Developing and Developed Countries*. Youth Net, Youth Research Working Paper No. 2, 2005.*

Box 20: Life Planning Skills

Life planning skills education includes:

- Physical and emotional changes to expect during puberty
- Family planning
- Mental health
- Age-appropriate life skills for younger adolescents such as identifying values, understanding consequences of behaviours
- RH life skills, such as condom self-efficacy, negotiating safe sex, refusing unwanted sex
- Sexuality and gender (including socially constructed gender norms)
- Health literacy and fertility awareness
- HIV/AIDS prevention
- Prevention of gender-based violence
- Linkages to health facilities, encouraging adolescents to seek out these services
- Other life skills, such as decision-making, critical thinking, creativity, establishing values, communication, coping with emotions and stress

3.5 Coordinating and making linkages with youth programmes

Making links and coordinating between youth programmes will enable the provision of more comprehensive services.

- **Link RH services with community services for adolescents:** Adolescents often seek out adults they trust in safe spaces where they feel information can be shared in confidence. Often, these people are working at the community level. Put in place referral systems to ensure that adolescents receive the appropriate treatment for problems that might be revealed outside the clinical setting (e.g. sexual violence, unwanted pregnancy or unsafe abortion).
- **Ensure multisectoral programming:** RH practitioners may not be able, or have the skills, to include livelihood components in their programme. In coordination with the health cluster/sector, liaise with camp management and other cluster coordination groups to establish links between youth programmes, health and protection, psychosocial services, education and livelihood opportunities. Support the implementation of vocational training and skills development for adolescents; this will enhance their feeling of control and optimism for the future, and is essential to reconstruct and rehabilitate their social networks and communities, both during and after a humanitarian crisis. Collaborate with adolescent skills-building programmes as a source for referral and to integrate RH information into livelihood programmes.
- **Engage men and boys as agents of social change:** Rigid male social norms have been linked to increased sexual risk-taking, which can lead to higher STI and HIV transmission, as well as increased substance use and gender-based violence. Conditions in humanitarian settings may challenge men who might feel under pressure to play out their traditional roles as providers and protectors, where they are dependent on external assistance. Resulting frustration and humiliation can lead to increased risk-

taking behaviour and domestic violence. Adolescent boys need safe environments where alternative male norms can be modelled while deconstructing traditional social norms. Gain the support of men and boys: give them the opportunity to address their own needs and actively engage them in reproductive health, thereby benefitting both adolescent girls and boys.

- **Girls' empowerment and socialization:** Working with girl-only groups is an ideal way to also challenge female social norms of passivity, sub-service and inferiority to men. Encourage girls to find their voice and solidify their beliefs and values, thereby enhancing their potential to be equal contributors to society. Humanitarian settings often make communities protective of the traditional roles of women. Design programmes to empower girls with this in mind.

3.6 Advocacy

Sensitize and orient influential people who are part of the relief/development community as well as the community being served to the RH vulnerabilities, specific needs and rights of adolescents. RH officers, RH managers and service providers must be change agents and:

- advocate for information and services for adolescents that ensure available services are youth-friendly;
- be involved in awareness-raising activities in the community, such as "open days" and community dialogues;
- highlight the needs of adolescents with officials and policy-makers.

4 Human rights and legal considerations

4.1 Human rights standards

The category of adolescent (10-19 years old) includes children, who are defined by the Convention on the Rights of the Child (CRC) as "every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier". The CRC lists the special protections to which children are entitled because of their status as children. It also recognizes the "evolving capacity of the child". This means that "as children acquire enhanced competencies, accordingly, there is a reduced need for direction and a greater capacity to take responsibility for decisions affecting their lives". Children have a right to express their views in all matters affecting them and these views must be given due weight in accordance with the age and maturity of the child.

In considering the issues of adolescents' health and development, the Committee on the Rights of the Child issued a general comment that interprets the CRC as obligating States parties to provide adolescents with access to sexual and reproductive information and services. This is based on a range of rights included in the CRC, including the right to nondiscrimination, the right to health, the right to information, the right to privacy, the right to expression of views and the right to protection from all forms of abuse, neglect, violence and exploitation, including harmful traditional practices. These rights are also included in other international human rights instruments. They apply to non-child adolescents as well, and may be violated when:

- adolescents do not have access to RH services and information because of their age;
- RH information and services are denied to unmarried girls because of their unmarried status;
- adolescents living with HIV are disadvantaged in formal and non-formal educational and social settings;

- girls are subjected to harmful traditional practices, such as female genital mutilation/cutting, forced and early marriage and virginity testing;
- parental (or guardian) consent is required for provision of RH services to adolescents;
- health workers disclose to a third party an adolescent's HIV status without obtaining legal consent to reveal such information;
- health workers disclose to a third party that an adolescent girl had an abortion or sought postabortion care without obtaining legal consent to reveal such information.

4.2 Challenges and opportunities

In some cases, RH programme managers and service providers may face difficult decisions or dilemmas. They may find that their ability to ensure the human rights of adolescents is restricted by national legislation, social or cultural norms or medical misconceptions. Such practices and laws can be in conflict with internationally accepted human rights principles. For example:

- Service providers may be asked by an adolescent's family to conduct a virginity (hymen) examination to determine whether she has engaged in sexual activity or has been raped. Such examinations have no medical validity and are a breach of the rights of the adolescent if done without her informed consent.
- Managers and service providers may be discouraged from initiating a programme that provides RH information or services to adolescents due to a common but wrong belief that having access to information on reproductive health and sexuality may encourage adolescents to engage in sexual activity. In fact, accurate and accessible information supports adolescents' ability to make healthy decisions and to refuse to provide this information to adolescents is a denial of their rights.

As an RH manager or service provider it is likely that you will find yourself facing difficult issues around provision of RH information and services to children and adolescents. You must be aware of your agency/organization position on these RH issues and include it as part of your analysis of the situation and possible next steps. If you find yourself facing a situation such as these described above, your first priority must be the best interest of your client- focusing on her/his safety and health. Your own safety and the safety of your colleagues are also critical to consider. Based on your assessment of the situation, you may then wish to:

- talk to your supervisor;
- discuss possible options with your client including, as appropriate, information about local child rights and women's human rights organizations that might be able to help her/him;
- explore ways of mobilizing community support for youth-friendly RH services;
- consider how you can support advocacy efforts if your agency is engaged in advocacy on the issue;
- while respecting the confidentiality of your client, identify with colleagues how to avoid/handle such situations in the future;
- raise these concerns in health coordination meetings.

5 Monitoring

To be sure that adolescents are making use of available RH services and receiving RH information, RH indicators should be disaggregated by age and sex. See Chapter 4 for selected indicators specific to adolescents. See below for key ARH indicators.

Key Adolescent Reproductive Health Indicators:

- Proportion of STIs among under 18 years old.
- Proportion of births under 18s.
- Condom use disaggregated by sex and age

6 Further Reading

Community Pathways to Improved Adolescent Sexual and Reproductive Health: A conceptual framework and suggested outcome indicators. Inter-Agency Working Group (IAWG) on the Role of Community Involvement in Adolescent Sexual and Reproductive Health, December 2007. http://www.unfpa.org/upload/lib_pub_file/781_filename_iawg_ci.pdf

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