

REACHING THE YOUNGEST ADOLESCENTS WITH REPRODUCTIVE HEALTH PROGRAMS

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More than 500 million youth age 10–14 years live in developing countries, constituting more than 10 percent of the world's population.¹ Studies suggest that the age of sexual initiation among some adolescents is low in a number of developing countries,^{2,3,4,5,6} ranging from 9–13 years for boys and 11–14 years for girls.* In some places, age at first sex is dropping.⁷ Age at menarche—often associated with earlier age at marriage and first sex⁸—is also decreasing.⁹ There is increasing recognition that 10–14 year-olds are an important age group to reach.

What are the benefits of reaching the youngest adolescents?

Reaching young people early is more effective. Introducing basic information about reproduction and sex at puberty or before can delay first intercourse among adolescents who are not sexually active.^{10,11} No evidence exists that sex education encourages earlier sexual behavior.^{12,13} Efforts to delay marriage can encourage the delay of first sex and first birth. Reaching youth early can also preserve resources when negative reproductive health (RH) outcomes, such as early pregnancy, are prevented.

Working with this age group can positively shape the transition to adulthood. Life skills—such as those related to decision making and problem solving, creative and critical thinking, communication and interpersonal relations—can help young people better handle risky sexual situations.¹⁰ Youth who are aware of and know how to prevent sexual violence may be less likely to fall victim to coercive situations. It is also possible to influence young adolescents' perceptions of gender roles so that these norms do not hinder their development.

Programs that help guide youth through puberty can improve self-esteem and confidence. The experience of puberty goes beyond issues of RH, and improving knowledge and understanding of puberty are beneficial.

More opportunities may be available to reach this age group. Younger adolescents are more easily reached through schools, as many youth—especially girls—drop out of school as adolescence progresses. Younger adolescents may also be more receptive and enthusiastic about participating in programs than older youth.

How are the youngest adolescents different from older youth?

Younger adolescents are different cognitively and emotionally. They may lack the ability to use abstract thought to project their actions to the future or to understand the consequences of their behavior. Some may have distorted perceptions about the risks of pregnancy or about acquiring sexually transmitted infections (STIs).¹⁴ Younger adolescents may not readily associate emotional issues with puberty and are often unable to articulate questions that reflect how they feel.¹⁵ They may have more difficulty understanding or integrating information that is not immediately relevant to them.

Younger adolescents may be more vulnerable to sexual coercion. Young girls are more likely to regret first sex, suggesting that they may have been coerced. In many regions, trafficking in girls is an increasing concern. Evidence suggests that older boys and men intentionally seek younger partners whom they think are not HIV positive. Sexual abuse in both boys and girls is linked to increased chances of multiple sexual partners and non-use of contraception during adolescence.^{16,17}

Younger adolescents often have different concerns about sex and RH. Youth in this age group are most concerned with issues of puberty and body image and are developing interest in boy-girl relationships. Boys tend to be especially concerned with masturbation. In Colombia, a study revealed that 6th and 7th graders were more concerned with puberty-related events than older students.¹⁸ Adolescents' rate of development in relation to their peers is also important to them.¹⁹ In addition, early adolescence is a time when young people are concerned about clarifying their values and morals, including those related to sex and sexuality.

* This refers to studies conducted in Nigeria, Sierra Leone, Namibia, Zambia and Jamaica.

Sexually active youth of this age are faced with greater health risks. Younger girls have a higher per-contact risk for STI and HIV infection because of greater propensity for vaginal tearing and the immature cellular composition of the cervix. A greater chance of physical injury exists if sex is forced. When girls are married early, cultural norms may encourage early childbearing, posing risks to both infant and mother.²⁰ If girls who are not fully developed become pregnant, they can experience damage to the reproductive tract, delayed or obstructed labor, ruptures in the birth canal, and increased risks of maternal mortality.^{21,22,23} Girls may also face mental and emotional problems related to too-early sexual initiation.

What are the challenges of reaching this age group?

Communities often initially resist RH programs for this age group. Many adults feel that programs for this age group are inappropriate or unnecessary. Sexual behavior may be viewed solely as a moral issue,⁹ and some adults wrongly believe that promoting sexual health leads to increased sexual activity among youth.^{24,25} In some cases, adults may simply be unsure of the best way to handle young people's sexual and RH needs.²⁶

Many adults (teachers, educators, parents, service providers) feel uncomfortable or unable to provide RH information and services to this age group. Even those who work with older youth may not know, or may be misinformed, about what is appropriate for this younger age group. Providers' attitudes in particular may prevent young adolescents from seeking services.

Involving youth this age in program planning is challenging. Because of their cognitive and emotional development, younger adolescents may lack the experience or maturity to contribute to programs in the ways older youth do.

Youth this age may feel stigmatized if they try to access RH services. Because RH services are often synonymous with family planning, young people who need immunizations, advice on nutrition, care for menstrual problems, treatment for reproductive tract infections and other RH care may be less likely to seek services. Those who are sexually active may feel especially uncomfortable seeking services.

Younger adolescents may lack autonomy, mobility and resources. The youngest adolescents may have difficulty obtaining transportation to programs or services. Girls in particular may be subject to close parental supervision and face restrictions in leaving the home to participate in programs. Family members may make more demands on the time of 10–14 year-olds than they do of older adolescents. Younger adolescents may also be less likely to have income to spend on services.

The issues in reaching this age group are complex and ever shifting in a rapidly changing social and economic environment. The experiences of youth in this age group vary greatly; one strategy may not meet the needs of all youth. For example, poverty or the absence of a father in the home may make girls more likely to seek sex for money, and street kids and youth in refugee and displaced populations may be especially vulnerable to early sex. Within cultures, males and females develop at different rates, behave differently, and are almost always treated differently by adults.¹⁰

Resources are limited. Funds and human resources for adolescent reproductive health (ARH) are limited. Many working in ARH may not have the experience or the skills to work with this younger age group.

Little is known about the needs of this age group or about what program strategies effectively reach them. Research on adolescents under the age of 15 years is rarely conducted because of concerns that questions about RH are not developmentally appropriate or because obtaining parental consent is too difficult. The scarcity of studies makes it difficult to understand the needs and behaviors of these young people and affects the ability to design and evaluate programs.

What approaches are effective in reaching this age group?

Provide basic, uniform information from multiple sources. Most youth in this age group need information, education and skills to help delay sexual initiation. RH programs in schools, youth clubs, religious organizations and social marketing campaigns should coordinate their efforts to convey targeted key messages. Some information sources should be anonymous, such as telephone hotlines.²⁷ For example, *Straight Talk* in Uganda reaches youth through an insert in a national daily newspaper with a circulation of 100,000. Recently, the program also developed *Young Talk* specifically for 10–14 year-olds; the right of children to protect themselves against sexual abuse is a major theme.

Encourage development of relevant skills. Adolescent development theory suggests that young people must develop a fundamental set of skills and competencies,²⁸ including personal communication skills and the ability to express thoughts, ideas, feelings and beliefs.²⁹ Skills-building interventions have improved self-reported health-seeking behaviors, mental health, self-esteem and communication with parents.²⁹ Research in the United States found that building skills through educational, job and community service opportunities contributes to positive RH outcomes.²⁵

Provide appropriate RH services in a youth-friendly environment. All youth in this age group should have access to counseling about sexuality-related concerns and

services such as treatment of menstrual pain, reproductive tract infections and tetanus toxoid immunization. Although most youth this age are not yet sexually active, services such as contraceptives and STI care should be available to those who are.

Encourage continued schooling and delayed marriage. Evidence suggests that age at first sex increases with continued schooling, and school can provide a positive environment for youth to develop social skills. The Bangladesh Rural Advance Committee (BRAC) provides primary schooling for the most disadvantaged youth ages 11–15 in rural areas. The school’s family life education curricula encourages delay of marriage and covers topics such as hygiene, menstruation, pregnancy, contraception, STIs/AIDS, smoking and substance abuse, and gender issues.³⁰

Tailor programs to the needs and the realities of specific communities. Program planners should not underestimate young people’s life experiences at this age. Instead, they should carefully consider the context in which young people are growing up, address the specific risk factors in their environment, and build programs based on what youth already know. For example, the Guidance Center for Young Adults (CORA) in Mexico reaches younger adolescents according to their developmental phase with sex and RH education.³¹ CORA has developed books, booklets, comics and board games; provides workshops in and out of schools; and delivers medical and social services to youth and parents.³²

Provide support for youth to make active, responsible choices about sexuality. Programs must not be judgmental or provide only one model of how to behave. They should build skills in decision making and critical thinking so that, in addition to the message that it is better to wait to have sex, youth receive information on healthy relationships and what they need to know if they choose to become sexually active.

Devise alternative ways to involve youth this age effectively. Even if younger adolescents cannot always implement programs with the same effectiveness as older youth, programs can find meaningful ways to involve them. The Partnership for Adolescent Sexual and Reproductive Health project in Lusaka, Zambia, involved youth ages 9–18 in leading assessments that identified adolescents’ perspectives on their RH needs and concerns.³³

Involve adult family members. Adult family members can provide overall support for programs as well as individual support and guidance for adolescents.³⁴ Increasing the quality of communication between parents and youth—about any topic—can help delay the onset of sex.³⁵ Clarifying morals and values is also an important role for parents and adult relatives to play.³⁶ Adult supervision of youth can be an important factor in whether or not youth

take sexual risks.³⁴ Programs that involve families are often less likely to encounter political or community opposition.

Involve slightly older adolescents. Youth in their late teens are often ideal for reaching younger adolescents, as they are better at building trust and rapport than adults when providing information. Older youth can also serve as mentors and often provide important insights as they are still close in age but more able to reflect on their experiences.³⁷

Strengthen the community response to this age group. Feeling connected to adults and institutions outside the family—such as youth organizations, sports clubs and religious organizations—can protect youth from taking risks.³⁶ Schools are also an important venue to reach large numbers of youth in this age group. Community involvement in program development helps overcome community resistance to programs and can be an important part of resource mobilization. BRAC builds adult support for its program by holding discussions with parents, teachers, village organizations and religious groups.³⁰

Provide programs that are fun. Youth will be more enthusiastic about participating in programs that combine skills building with leisure opportunities. For example, the Kenya Scouts Association couples scouting with a family life skills project that targets younger out-of-school youth.³⁸

Develop strategies to meet the holistic needs of the youngest adolescents. RH programs for this age group can successfully combine or associate with income generation, life skills development, basic education and health services. In Mokattam, Egypt, the Adolescent Girls Project introduces new skills, social identities, and income-generating opportunities to girls whose livelihood is linked to the collection and sorting of garbage.³⁹ A health promotion scheme also trains girls as health workers in primary and RH care.

Have realistic time frames and expectations. It takes time to influence and shape individual development and behavior, and outcomes—especially behavioral change—should not be expected in the short term. The changing social and cultural context of adolescence, and how it may be negatively affecting the youngest adolescents, should also be taken into account.

What is still needed to effectively reach this age group?

Research and program evaluations focusing on effective approaches to reach the youngest adolescents, including longer-term evaluations designed to capture behavioral outcomes such as delayed initiation of sex, are needed. Studies about youth this age that identify factors that influence risk-taking or health-seeking behaviors are also required to design strong programs. More documentation and sharing of experiences among those working at the field

level with this age group would help identify promising approaches. Funding that is flexible, allowing programs to more holistically meet the needs of the youngest adolescents, would also help improve the design and implementation of programs.

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