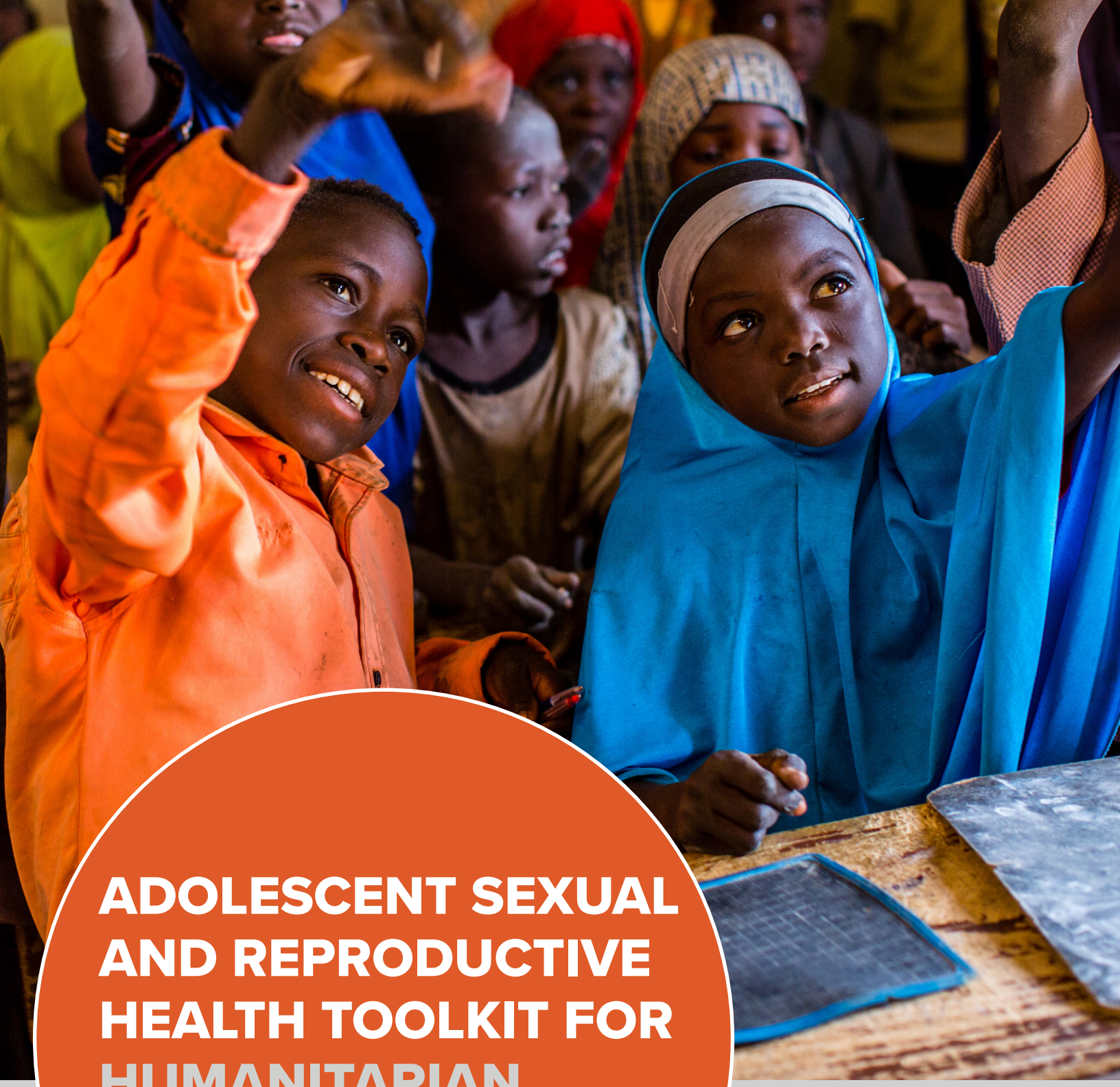

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH TOOLKIT FOR HUMANITARIAN SETTINGS

2020 EDITION

A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings

IAWG
Inter-Agency Working Group on Reproductive Health in Crises

Photo : : Hanna Adcock

ACKNOWLEDGMENTS

The Inter-Agency Working Group on Reproductive Health in Crises (IAWG) is appreciative of the many organizations and individuals that participated in the revision of the Adolescent Sexual and Reproductive Health (ASRH) Toolkit for Humanitarian Settings. IAWG is particularly grateful to the leadership of the IAWG ASRH Sub-Working Group (SWG) and all of the individuals on the revision team who drafted, edited, and assisted with pre-testing the revised tools and guidance. IAWG acknowledges the significant assistance from the Government of Netherlands Ministry of Foreign Affairs, whose funding supported the development, graphic design, and dissemination of the Toolkit. Additionally, IAWG thanks all of the youth networks and organizations, as well as individuals from sectors outside of health, who provided feedback throughout the revision process.

Consultation & Review Process: The ASRH Toolkit for Humanitarian Settings—developed in 2009 and released in 2012—was updated in 2019/2020 in accordance with changes to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings and Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations. In late 2018/early 2019, the IAWG ASRH SWG conducted a desk review to collect information on new guidance, interventions, best practices, and developments in ASRH in emergencies since 2012. In addition to findings from the desk review, the SWG consulted with 15 IAWG agencies and one youth network in early 2019 to develop inputs for a consultation workshop. A small revision team comprised of IAWG ASRH SWG members discussed the gathered inputs and developed a work plan and structure for revising the Toolkit, which was later presented and approved by the larger SWG in April 2019. During 2019, the team revised and drafted new content according to the work plan and shared the revised version in January 2020 with IAWG networks and ASRH humanitarian and development stakeholders. The revision team incorporated two rounds of feedback from ASRH stakeholders at global, regional, and country levels. To ensure meaningful engagement from adolescents and youth, the SWG held four webinar series in Arabic, English, French, and Spanish, comprised of four sessions and covering the most salient youth topics of the Toolkit. The four webinars consulted with more than 90 young people, representing more than 30 organizations/networks across at least 17 countries, to gather and incorporate feedback, case studies, and tools into the revised Toolkit. The IAWG ASRH SWG presented the revised Toolkit and received endorsement from the IAWG Steering Committee in September 2020, prior to translation and dissemination.

In total, throughout the entire revision process, the IAWG ASRH SWG consulted and collected feedback from more than 130 people (approximately 68% young people; 12% field-based staff; 20% regionally-based staff) across 75 organizations and representing specialties in ASRH in humanitarian and development contexts, as well as the humanitarian sectors of child protection, education, food and livelihoods, gender-based violence, humanitarian operations and management, and mental health and psychosocial support.

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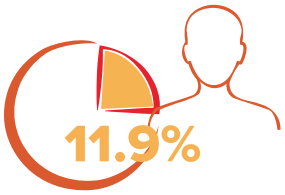
ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
ASRH	Adolescent Sexual and Reproductive Health
BEmONC	Basic Emergency Obstetric and Newborn Care
BHM	Bureau of Humanitarian Affairs
BPRM	Bureau of Population, Refugees, and Migration
CDC	Centers for Disease Control and Prevention
CEFM	Child, Early, and Forced Marriage
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CERCA	Community-Embedded Reproductive Health Care for Adolescents
CERF	Central Emergency Response Fund
CHW	Community Health Worker
CMR	Clinical Management of Rape
CSC	Community Score Card
CSE	Comprehensive Sexuality Education
EC	Emergency Contraception
ECHO	European Commission of Humanitarian Aid
EmONC	Emergency Obstetric and Newborn Care
FCDO	Foreign, Commonwealth, and Development Office
FDG	Focus Group Discussion
GATHER	Greet, Ask, Tell, Help, Explain, Return
GBV	Gender-Based Violence
GPS	Global Positioning System
HIV	Human Immunodeficiency Virus
IAFM	Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings
IASC	Inter-Agency Standing Committee
IAWG	Inter-Agency Working Group on Reproductive Health in Crises
IDP	Internally Displaced Person
IEC	Information, Education, and Communication
IPPF	International Planned Parenthood Federation
IPPA	Indonesia Planned Parenthood Association
IRA	Initial Rapid Assessment
IRC	International Rescue Committee
KAP	Knowledge, Attitudes, and Practices
LARC	Long-Acting and Reversible Contraception
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual +

M&E	Monitoring & Evaluation
MHM	Menstrual Hygiene Management
MHPSS	Mental Health and Psychosocial Support
MICS	Multiple Indicator Cluster Surveys
MISP	Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations
MOH	Ministry of Health
NFI	Non-Food Item
NGO	Non-Governmental Organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PAC	Post-Abortion Care
PEP	Post-Exposure Prophylaxis
PMTCT	Prevention of Mother-to-Child Transmission
PSEA	Prevention of Sexual Exploitation and Abuse
RH	Reproductive Health
RHRC	Reproductive Health Response in Conflict Consortium
SAC	Safe Abortion Care
SBC	Social and Behavioral Change
SOGIE	Sexual Orientation and Gender Identity and Expression
SR/MNCAH	Sexual and Reproductive Health and Maternal, Newborn, Child, and Adolescent Health
SRH	Sexual and Reproductive Health
STI	Sexually-Transmitted Infection
SWG	Sub-Working Group
TBA	Traditional Birth Attendant
TOR	Terms of Reference
TOT	Training of Trainers
TPI	Training Partnership Initiative
UN	United Nations
UNAIDS	Joint UN Programme on HIV and AIDS
UNFPA	UN Population Fund
UNHCR	UN High Commissioner for Refugees
UNICEF	UN Children's Fund
UNISDR	UN Office for Disaster Risk Reduction
USAID	United States Agency for International Development
VCAT	Values Clarification and Attitude Transformation
VSS	Virtual Safe Space
VYA	Very Young Adolescents
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization
WRC	Women's Refugee Commission

Photo : Plan International

Humanitarian crises around the world are growing in magnitude, frequency, and duration, as is the need for assistance—including in meeting the sexual and reproductive health (SRH) needs of adolescent boys and girls.



Of the nearly **168 million** people in need of humanitarian assistance globally, approximately **20 million** are adolescents and young people.

Natural disasters, human-made emergencies, public health emergencies, and protracted conflicts disrupt the support systems that many adolescents rely on, such as family, social, and economic structures. In these settings, education, social support, and health systems are suspended or unavailable, leaving many adolescents without access to SRH information and services when they need them most.

The global community recognizes the unique vulnerabilities and SRH rights of adolescents and has developed guidelines to address their needs; however, the SRH needs of adolescents continue to go unmet during emergencies. The barriers to meeting the SRH needs of adolescents vary across contexts, but the global community is in agreement that more must be done because these barriers are creating obstacles for adolescents to achieve their dreams.

A toolkit for adolescent SRH (ASRH) in humanitarian settings: helping humanitarian organizations prioritize and implement effective programs to address and fulfill adolescents' SRH and rights.

The Toolkit's vision is for all adolescents to exercise making informed and autonomous decisions about their SRH, have their SRH rights guaranteed, and be able to reach their full potential—no matter what circumstances they are living in. This Toolkit provides strategies and tools to help close the SRH service provision gap for adolescents by building upon the advocacy endeavors and lessons learned from the past decade to advance SRH prioritization for adolescents in humanitarian contexts. The Toolkit does not promote a one-size-fits-all approach; instead, it calls on humanitarians to prioritize life-saving SRH services throughout the entire program cycle and humanitarian continuum—not only during the crisis phase, but also before its onset, during the recovery, and beyond, toward long-term development.

Ready to dive into the Toolkit now?

Let's get started! Chapter 1: Introduction provides the foundation for the Toolkit, explaining what adolescence is, the unique needs, barriers, and capacities of adolescents, and why we should prioritize ASRH activities during humanitarian crises. Chapter 2: Roadmap for Using the ASRH Toolkit illustrates how the rest of the Toolkit is organized and provides information on how to navigate and use the Toolkit.

Photo : Save the children

CHAPTER 1: INTRODUCTION

In this chapter, humanitarian responders will learn about adolescence, the unique needs, capacities, and sexual and reproductive health (SRH) barriers facing different groups of adolescents, and how those factors are different in emergency settings. The chapter comprises two sections, divided up by the following questions: **what is adolescent sexual and reproductive health (ASRH)** and **why should we prioritize ASRH during emergencies?**

Chapter 1: Learning Objectives

After reading this chapter, readers should be able to:

- Understand what adolescence is and define the SRH rights of adolescents
- Describe the capacities of adolescents to shape their own health outcomes
- Distinguish the unique risk factors and SRH needs of different groups of adolescents
- Explain the unique SRH needs and barriers adolescents face during humanitarian emergencies
- Describe why humanitarians should prioritize ASRH activities from the onset of an emergency

What is ASRH?

What is adolescence and who exactly are adolescents?

Adolescence is the period between childhood and adulthood—beginning with puberty and transitioning from dependence on caregivers to self-sufficient adult members of society. During this period of life, adolescents develop knowledge and skills, begin to understand how to manage emotions and relationships, and develop traits and capabilities to enjoy their adolescent years and transition to assuming adult responsibilities. While the official age bracket of adolescence varies across countries, the United Nations (UN) defines this period as between 10 and 19 years of age. It is important to note that the age when puberty begins varies greatly among individuals and may begin earlier; it usually occurs during early adolescence, while the transition to adulthood is taking longer due to a number of factors. This **transitional** period between childhood and adulthood is marked by changes to adolescents' physical, cognitive, behavioral, and psychosocial characteristics. During this time, adolescents experience increasing levels of individual autonomy, a growing sense of identity and self-esteem, and greater independence from adults. Adolescence is a critical time for shaping behavior and norms, including prevention of health problems and strengthening future resiliency of the next generation.

Age is not the only way to define adolescence—sex and gender are also important variables for adolescent development. Adolescent girls typically develop faster (up to two years ahead of adolescent boys), with gender norms varying significantly between adolescent boys and girls across the world. Age is just one way of specifying adolescence and is typically used to define and compare biological changes adolescents are experiencing, not the social transitions, which can differ based on the social and cultural norms and values of their environment. The biological changes for adolescents do not start at 10 years or end at 20 years. There are changes, such as producing hormones, that begin earlier than 10 years and other changes that extend into a person's early twenties, which is why recent work has expanded the definition and timeframe of adolescence to include young adulthood—often up to 24 years old. However, this Toolkit focuses on individuals from 10 to 19 years of age. To help compare these changes, practitioners have broadly categorized adolescents into two groups—very young adolescents (VYAs) (10–14 years old) and older adolescents (15–19 years old); however, several changes are happening throughout adolescence and do not always occur at the same time for every adolescent.

Overlapping Definitions

There are several terms that overlap with "adolescence", including "children", "youth", and "young people". While these terms are explicit, they are understood and applied in many different ways, depending on countries, cultures, and groups.

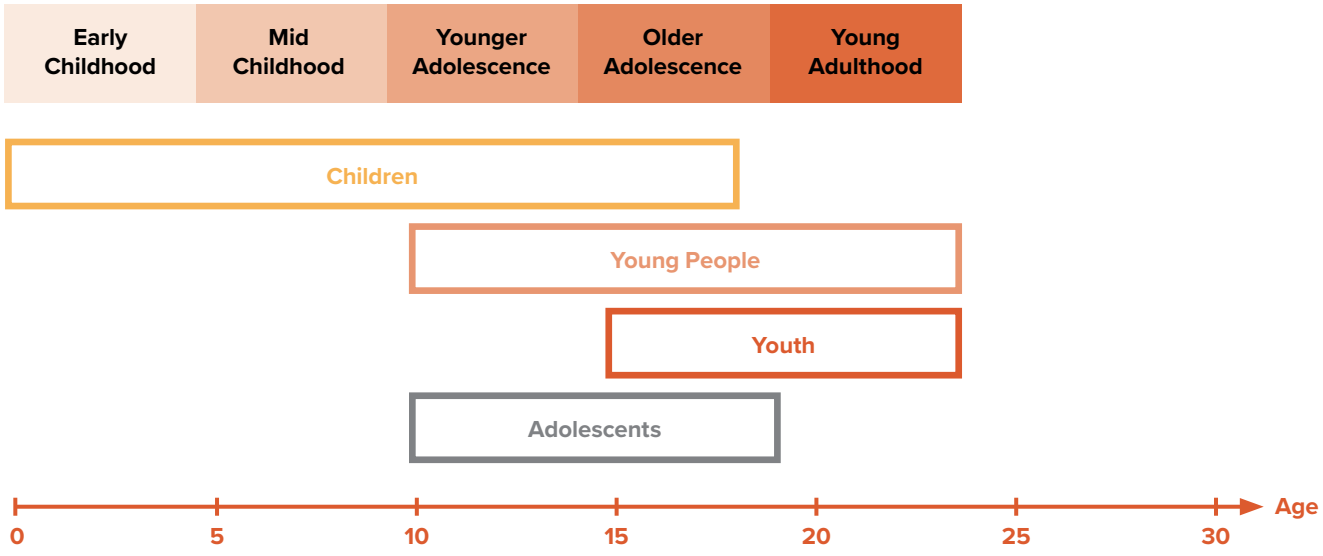
Children: The UN Convention on the Rights of the Child categorizes all individuals from birth to 18 years as "children". Therefore, adolescents are covered under its protection until they reach 18.

Youth: The category of "youth" includes individuals aged 15 to 24 years old.

Young people: "Young people" comprise individuals between 10 and 24 years of age.

Understanding the definition of adolescence is important. The very few SRH programs in humanitarian settings that have addressed adolescent health needs have predominantly targeted older youth and rarely designed activities appropriate for younger populations.

Figure A: Adolescent or Young People?



At the onset of puberty, we start to see physical changes begin, such as growth spurts, sex organ development, and sexual characteristics. These changes may cause anxiety or be a source of excitement and pride for the adolescent. Less obvious are the adolescent's internal changes. The adolescent's brain is undergoing significant changes: the number of brain cells can nearly double in just a year, while their brain's connections are undergoing swift reorganization. For more on adolescent brain development, see "The Science Behind Investing in Adolescents". VYA girls and boys are becoming more aware of their gender and may begin changing their behavior or appearance to fit in with perceived gender norms. They may participate in or become a victim of bullying, as well as feel confused about their identity and their roles and rights according to shifting societal pressures. A global adolescent study on VYAs reveals common themes about gender roles as children enter adolescence: girls are viewed as vulnerable, weak, and requiring protection from boys, whereas boys are seen as powerful and projecting strength, which can sometimes be seen as threatening. Girls are expected to stay at home and complete the duties of marriage and motherhood, while boys experience a new level of independence and freedom of mobility. Boys also experience increased expectations to provide financially for their families. This evidence shows us that early adolescence provides a critical opportunity for reaching adolescents with preventative programming to improve their gender and health outcomes. Intervening early with VYAs helps adolescents and young people understand the benefits of proactively seeking services and avoiding engaging in risky health behaviors.

VYAs should be provided a safe atmosphere—surrounded by nurturing adults at home and in the community—to understand, accept, and ask questions regarding the cognitive, emotional, sexual, and psychological changes occurring at this time. With pervasive social taboos and norms regarding puberty, it is important that VYAs receive all the information and access to services they need related to their SRH (what is puberty and menstruation, how to protect against sexually transmitted infections [STIs], prevent early pregnancy, etc). For too many adolescents, this critical information is given too late, or not at all, when their lives have already been impacted and their development and welfare have been comprised.

As adolescents mature, they begin setting long-term goals, questioning experiences, and developing moral reasoning. They also experience several social and emotional changes, such as higher self-involvement and increased desire for independence, and begin exploring their sexual identity, which, without support from peers, family, or community, can be stressful. Sexual orientation develops progressively and non-heterosexual individuals may begin to experience internal conflict, particularly during this stage, due to potentially heteronormative and oppressive environments where divergent sexual orientations, gender identities, and expressions are seen as negative. During adolescence, individuals are moving from self-exploration of their sexuality to forming stable relationships, with mutual and balanced sexual relations (when surrounded by a supportive environment).

Research has shown that risk-taking behaviors—often a defining characteristic of adolescents—can be a way in which adolescents bolster their social reputation by showing how courageous they are to others; however, if positive opportunities for demonstrating courage are available (such as through sports, drama, civic engagement, and activism), adolescents are likely to use these activities to elevate their social reputation. Such activities can have positive effects on the adolescents' health and identity development, as well as prevent antisocial behaviors and self-injury. The influence of peers begins to diminish as the adolescent gets older and gains more understanding of and confidence in their identity and opinions; their tendency to engage in risk-taking behaviors decreases as their ability to assess risk, delay gratification, plan for the future, and make conscious decisions progresses. In many contexts, older adolescent girls are at higher risk of negative health outcomes compared to adolescent boys, and these risks are intensified by gender-based discrimination and abuse. Turning to positive aspects, adolescence is also marked by opportunity, idealism, and promise. Adolescents are beginning to move away from child-parent/guardian relationships to more equal adult-adult

relationships. Older adolescents may enter the workforce, further their education, gain a firm sense of their own identity and perspective of the world, as well as begin influencing the world around them.

Scientific evidence of adolescent brain development provides a compelling case for investing in adolescence to improve health, education, and social and economic outcomes (see The Science Behind Investing in Adolescents breakout box for more information). Conversely, the consequences of not addressing SRH needs and health conditions of adolescents can affect both their physical and mental health into adulthood and compromise their ability to lead fulfilling adult lives.

The Science Behind Investing in Adolescents

Numerous changes and learning experiences occur during the transition from childhood to adulthood. The transition begins with puberty (from age 10 for girls and 12 for boys) and creates a window of opportunity where life trajectories can be shifted based on negative or positive experiences. The pubertal transition begins a significant reorganization of neural circuitry, impacting neural circuits involved in processing emotions, risks, rewards, and social relationships. These neural developmental changes do not occur in a vacuum—that is, biological changes do not determine behavior. Rather the biological changes lead to increased tendencies to behave in particular ways, and the actual behavioral patterns that emerge depend to a large extent upon the particular social context. Moreover, it is the emergence of these patterns of behavior, beginning during the developmental window of puberty, that can lead to cascading impact and the alteration of longer-term health trajectories. Understanding the interactions between social, emotional, and learning processes in adolescent interventions points to insights into both diminishing vulnerabilities for difficult-to-change negative spirals and enhancing opportunities to establish positive spirals.

The onset of puberty initiates a period of social, emotional, physical, and cognitive development associated with important changes in learning. Insights have emerged from the study of the biological, cognitive, and behavioral changes that occur during adolescence. These changes provide adolescents with the knowledge, skills, and capacity to successfully transition into self-sufficient adults; this in turn enables adolescents to adapt to emerging aspects of their identity, to learn how to relate to themselves and others, to navigate complex social relationships, and to process abstract concepts and future consequences. Thus, adolescence is a critical time for learning and growth, characterized by a sensitivity to the feelings of belonging and being valued and linked to their greater search for finding meaning and purpose.

This learning can shape the adolescent's goals and priorities, such as their inspiration, creativity, and innovation and when exposed to a positive learning environment may also promote healthy trajectories and identity development. Recent progress in science provides unique insights suggesting that the onset of puberty may sensitize the brain to learning more through discovery than traditional instruction, tapping adolescents' burgeoning tendencies toward exploration—particularly in the realm of social and emotionally-arousing contexts. A crucial element is moving away from didactic education about health (ie "telling" adolescents how to change their behaviors) to a discovery-learning model (ie helping to scaffold positive learning experiences whereby adolescents explore and discover new levels of understanding for themselves).

Why should we worry about adolescent health? Isn't this the healthiest time of life?

Because investing in their health is both the right thing to do and the smart thing to do.

- **The right thing to do:** ASRH is embedded in basic human rights, which must be respected, protected, and fulfilled.

- **The smart thing to do:** Promotion of ASRH could avert deaths from preventable causes, could improve health outcomes, and add to broader development goals and early recovery, including socio-economic benefits.

Over the next several sections, the Toolkit will explain adolescents' right to SRH, as well as the beneficial health and societal outcomes for making SRH easily available and accessible to adolescents in emergency settings. Additionally, the Toolkit provides information on what happens if we continue to deprioritize ASRH in emergency settings.

Currently, there are more than 1.2 billion adolescents in the world. That number is expected to increase through 2050, especially in low- and middle-income countries where nearly 90% of adolescents live and where the majority of humanitarian emergencies occur. As discussed previously, adolescence represents a critical window of opportunity for societies to invest in and provide opportunities for adolescents to develop the knowledge, skills, social and economic assets, and resilience required to lead healthy, productive, and fulfilling lives.

During adolescence, communities can instill preventative strategies to enable adolescents to survive, thrive, and transform their communities. Promotion of healthy behaviors could avert the deaths of an estimated 1.4 million adolescents that die from preventable causes, primarily from road traffic accidents, violence, suicide, Human Immunodeficiency Virus (HIV), and pregnancy-related complications. Prioritizing ASRH can delay the first pregnancy, reduce maternal morbidities and mortalities, improve health outcomes, decrease poverty, and add to broader early recovery and development goals. Additionally, prioritizing adolescent health is essential for reducing negative health outcomes for the next generation, including prematurity and low birth weight among infants born to adolescent mothers.

Adolescence also presents a strategic time to empower adolescents. Adolescents are **creative**, **passionate**, **resilient**, and **capable** of exploring creative solutions in difficult situations; they have tremendous capacities that, when utilized appropriately and effectively, can play an instrumental role in their health outcomes. Several organizations have identified assets, as well as specific intervention components, to develop and reinforce adolescent empowerment programs and activities. These assets—or protective factors—include human and social assets (communication skills, literacy, self-esteem, peer networks, relationships) and financial and physical assets—resources that help create security and develop income generation opportunities (savings, access to loans, identity cards, land ownership rights). Results from the Population Council's development project in Ethiopia, which targeted out-of-school adolescent girls to receive literacy and life-skills training in safe spaces, found an increase in literacy scores and health service uptake after just six months of program implementation. These results highlight the potential for integrating SRH activities with life skills and empowerment programming for adolescents in humanitarian settings.

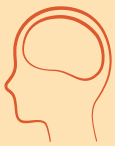
Looking beyond health arguments, there is strong evidence of the socio-economic benefits of investing in adolescents. Healthy young people entering the workforce with the right knowledge and skills can help stimulate the economy. Economists emphasize that focused investments, particularly in the health and education of girls that allow them to delay marriage and childbearing, could significantly impact economic development of the countries in which they live—through increased productive capacity, increased birth spacing between generations, and redistribution of the dependency burden. However, the opposite is also true: not investing in adolescent health and development can feed a vicious cycle of poor health and poverty.

The below statistics provide a snapshot of adolescents' health needs across the globe.

The leading cause of death for adolescent girls aged 15–19 years across the world is complications from pregnancy and childbirth. Approximately 11% of all births globally are to adolescent girls between 15 and 19 years old. These pregnancies put adolescent girls at greater risk of maternal mortality from intrapartum-related risks for term pregnancies and from complications related to unsafe abortions. Each year, an estimated 3.9 million adolescent girls aged 15–19 years undergo unsafe abortions. Adolescents are more likely to die from unsafe abortions than older women and bear the brunt of the negative repercussions of unsafe abortions—making up 70% of all hospitalizations from unsafe abortion complications.

Globally, interpersonal violence, or violence between individuals, was the third leading cause of mortality among adolescents as of 2018—responsible for one-third of all adolescent male deaths in low- and middle-income countries. Approximately 84 million adolescent girls 15–19 years old, or one in every three girls, suffered from one form of physical, sexual, or emotional abuse and controlling behaviors by an intimate partner in 2018.

The Joint UN Programme on HIV and Acquired Immunodeficiency Syndrome (UNAIDS) estimates that approximately 1.6 million adolescents were living with HIV as of 2019, with an estimated 190,000 newly infected cases and 33,000 AIDS-related deaths among adolescents. Despite an overall reduction of 35% in the number of AIDS-related deaths from 2005–2013, AIDS-related deaths among adolescents have tripled from 2000–2015, with AIDS representing the second highest cause of death globally and the first cause of death in Africa.



Mental health disorders disproportionately affect adolescents. Half of all mental health conditions begin by age 14, but the majority of cases go undetected and untreated. Depression is one of the leading causes of morbidity among adolescents, with suicide reported as the second leading cause of death for adolescents.

Why should we address the sexual and reproductive health of adolescents? Aren't they too young to have sex?

This is a common social taboo in many contexts—that adolescents should not be having sex. Regardless of one's personal beliefs or attitudes toward the appropriate age of sexual debut, adolescents have a right to SRH information and services that are equitable, accessible, acceptable, appropriate, and effective. The 2018 Guttmacher-Lancet Commission developed a comprehensive definition of the right to SRH. The definition states that:

KEY MESSAGE

Most people initiate sexual activity during adolescence, and adolescents must be prepared and supported to ensure good SRH choices, decisions, and outcomes.

SRH is a state of physical, emotional, mental, and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in promoting self-esteem and overall well-being. All individuals have a right to make decisions governing their bodies and to access services that support that right.

"All individuals" includes adolescents. As such, ASRH includes sexuality and reproductive health processes, functions, and systems of adolescents, their right to make decisions about their body, and to access services that support that right. Thus, provision of ASRH information and services is **rights-based**, as well as **lifesaving**. Promotion of ASRH includes:

- healthy and positive sexuality;
- maternal and newborn health;
- positive puberty, menstrual health, and hygiene;
- prevention and response to HIV, AIDS, and other STIs;
- prevention and response to unintended and unwanted pregnancy;
- prevention and response to gender-based violence (GBV);
- prevention and management of reproductive cancers;
- prevention and treatment of complications of unsafe abortion;
- and safe abortion care services.

What is the role of humanitarian actors in advocating for ASRH?

Advocating for ASRH in not a unique, standalone issue: it is embedded in basic human rights, which must be protected for all persons during humanitarian crises. These human rights include the right to:

- have their bodily integrity, privacy, and personal autonomy respected
- freely define their own sexuality, including sexual orientation and gender identity and expression*
- decide whether and when to be sexually active
- choose their sexual partners
- have safe and pleasurable sexual experiences
- decide whether, when, and whom to marry
- decide whether, when, and by what means to have a child or children, and how many children to have
- have access over their lifetime to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence**

*For more information on understanding the different components of sexual and gender identity, sexual orientation, and gender expression, please see Killermann's Genderbread Person—a teaching tool for breaking down gender.

**This includes the right not to be forced to marry early.

In addition to providing SRH information and services to adolescents, humanitarians should be collaborating and coordinating with other sectors and with ongoing efforts that interact with adolescents to address the multifaceted factors that contribute to both positive and negative SRH outcomes, such as:

- child, early, and forced marriage
- gender, education, and income inequality
- harmful traditional practices
- intimate partner and non-partner violence
- mental health
- nutrition
- substance abuse

Are we there yet with ASRH?

Not quite. SRH advocates and stakeholders have made significant strides in the past few decades to prioritize SRH and rights at the global, regional, and national levels; however, progress for adolescents is still lagging behind. The below areas of concern highlight some of the remaining gaps in achieving SRH and rights for all.

Unmet Need for Contraception

Globally, much of adolescents' SRH needs are unmet. Unmet need for contraception among adolescents is the proportion of adolescents who want to stop or delay childbearing but are not using any method of contraception. This indicator allows practitioners to assess the success of their reproductive health programming in meeting adolescents' demand for services.

As of 2019, an estimated 32 million adolescent girls aged 15–19 years old wanted to avoid pregnancy. However, nearly half of them—approximately 14 million girls—were not using a modern contraceptive method but were in need of one. Adolescents regularly face barriers to accessing contraception (including provider bias and limited range of accepted methods), leading to increased rates of pregnancy during adolescence and higher risk of dangerous complications during childbirth. If agencies were able to address the unmet need for modern contraception of adolescents aged 15–19 years old, the Guttmacher Institute estimates that the number of unintended pregnancies would decrease by 6.2 million annually—averting 2.1 million unplanned births, 3.3 million abortions, and 17,000 maternal deaths.

Lack of SRH Information

Despite evidence that increased access to SRH information and comprehensive sexuality education has a positive effect on SRH, adolescents and young people continue to face barriers in receiving the information they need. They frequently experience difficulties accessing SRH information and comprehensive sexuality education, which includes age-appropriate and scientifically accurate information about sexuality and reproduction, as well as information related to adolescents' gender and rights.

Myths and misinformation about SRH and sexuality information leading to increased sexual activity or encouraging sexual activity have limited adolescents' and young people's access to SRH messaging. Taboos, discomfort, and fear deter parents and other trusted adults—including teachers and educators—from educating adolescents about the changes their bodies are experiencing or where to access additional information. Furthermore, in some countries, the policies and/or perceptions of the policies restrict how teachers provide sexuality education to adolescents and young people. Even in countries where comprehensive sexuality education is mandated, there are gaps in how the policies are implemented on the ground.

Unwanted Pregnancy and Forced Marriage

Millions of adolescent girls are pressured to marry or have unwanted sex—increasing their risk of unintended pregnancies, unsafe abortions, STIs, and dangerous childbirth. Approximately 27% of women in the least developed countries gave birth before age 18, representing an estimated 12 million girls that delivered children during their adolescent years.

Child marriage and early childbearing are violations of human rights and have negative socio-economic effects by disrupting girls' education and reducing future economic opportunities during girlhood, adolescence, and into womanhood, in addition to the increased likelihood of abuse for vulnerable child brides. Adolescent pregnancy and childbirth are linked to adverse pregnancy outcomes, as well as reduced education opportunities for girls, higher health costs, and increased likelihood of lifelong female poverty. Immature development of reproductive and muscular systems of pregnant adolescent girls increases their risks of obstetric complications. For example, a life-threatening obstetric emergency can develop for adolescent girls under 16 years old when the immature pelvis is too small to allow a fully matured fetus to safely pass through the birth canal. Failure to promptly treat this condition can lead to obstetric fistula or uterine rupture, hemorrhage, and death of the mother and fetus. Adolescent mothers face higher risks of eclampsia, puerperal endometritis, and systemic infections, compared to women aged 20–24 years. Newborns to mothers under 20 years of age also face higher risks of low birth weight, preterm delivery, and severe neonatal conditions.

Not all adolescents are the same, right?

No. Adolescents are a diverse group of individuals. Their SRH needs and risk factors differ based on age, sex, gender identity, sexual orientation, health status, developmental stage, marital status, socio-economic conditions, and contextual and environmental factors. Some adolescents can be more vulnerable to health and social problems compared to other groups based on these varying conditions and/or needs.

For example, a 12-year old adolescent girl living in Canada has different health needs compared to a 19-year old adolescent boy who survived a typhoon in the Philippines. Even within the same country, adolescents

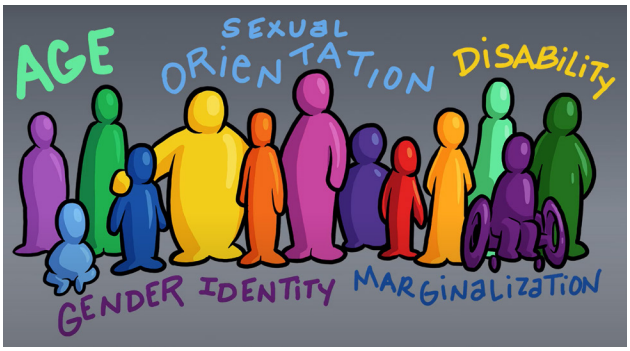


Image from "Adolescent Sexual and Reproductive Health in Emergency Settings" video

face different conditions, such as an adolescent in school versus out of school or an adolescent living in a rural part of the country compared to an urban area. Additionally, adolescents may have overlapping vulnerabilities that increase their risk of poor health outcomes; for instance, being a 15-year-old pregnant adolescent girl in a forced marriage/union.

Implementation of programs and services must be tailored to take into consideration the different characteristics and corresponding needs of adolescents. The Toolkit explains how SRH needs and risk factors differ between adolescent girls and boys, and also includes descriptions of particularly at-risk adolescent subgroups below. Throughout the Toolkit, there are breakout boxes on different considerations humanitarian actors should remember when working alongside adolescent populations.

Adolescent Girls:

Much of the physical, emotional, and social consequences vulnerable girls experience through adolescence are rooted in gender inequality and poverty. Globally, adolescent girls from poor households experience a higher proportion of the health burden compared to adolescent boys due to social vulnerabilities associated with gender inequality, discrimination, and poverty—with girls' disadvantaged social position at the heart of most of these vulnerabilities. There are health risks that exclusively and/or predominantly affect adolescent girls, including menstruation; child, early, and forced marriage (CEFM); unwanted and early pregnancy; disproportionate share of care and household work; harmful traditional practices (eg female genital mutilation or cutting); migration for work; school safety and drop out; and STIs. In sub-Saharan Africa, where HIV infection rates are the highest in the world, adolescent girls reported infection rates nearly twice as high compared to adolescent boys of the same age. Adolescent girls are disproportionately exposed to GBV (see breakout box for more information) and more likely to experience sexual harassment and abuse compared to adolescent boys; however, under-reporting is a critical issue across both sexes. These health risks for adolescent girls also correspond to social risks that impact their SRH outcomes. For example, economic difficulties can lead to increased exploitation, such as trafficking, including for sexual exploitation, and transactional sex—elevating SRH risks (STIs, unintended pregnancies, and unsafe abortions).

Photo : Souvid Datta

Vulnerabilities to GBV for Boys & Girls

Power and gender imbalances between men and women in society perpetuate inequalities and violence against women and girls, primarily by men and boys, but also between men and boys. Evidence shows that men who experience violence as children and/or who witness violence against their mothers are more likely to have negative attitudes toward gender equality and to use violence against others as adults. These power dynamics, gender norms, and other societal factors are the underlying factors that place adolescent girls at higher risk of sexual violence compared to boys. It is estimated that between 12–25% of girls experience sexual violence and 8–10% of adolescent boys experience sexual violence. For many adolescent girls, their first sexual activity is associated with coercion and/or violence, which can result in unwanted pregnancies and lead to unsafe abortions, in addition to the long-term mental and physical health consequences. Reports show that the majority of sexual violence cases among adolescent boys and girls are perpetrated by a relative or someone they know (friend, neighbor, teacher, etc). Intersecting vulnerabilities also heighten risks of GBV for girls and boys. For example, girls with disabilities are ten times more likely to experience GBV than those without disabilities; as well, girls with mental impairments are particularly vulnerable to sexual violence.

Regardless of the sexes of perpetrator and survivor, sexual violence is a form of gender-based violence, and though the majority of sexual violence incidents are experienced by women and girls, boys also experience sexual violence in gender-differentiated ways. Adolescent boys are less likely to share their experience of sexual violence with others compared to adolescent girls. In some cases, adolescent boys are less likely to report and/or seek services. Gender norms that associate feminine values with weakness, inferiority, and victimization create an extra barrier for boys who have experienced sexual violence. They may be punished for pushing against traditional notions of binary gender expression or presentation, or not behaving like "real" men/not adopting the social expectations of masculinity. Both examples highlight the need to examine gender norms in GBV programming. Furthermore, amongst adolescent boys there are overlapping vulnerabilities, such as street boys being at higher risk for sexual violence compared to other groups of boys.

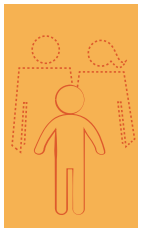
Adolescent Boys:

Interpersonal violence is the cause of death for one out of every three boys aged 15–19 years old. Across the world, men and boys are at higher risk of experiencing violence during adolescence and early adulthood than during any other time in their lives, which impacts young men's attitudes, perceptions, and normalization of violence. Adolescent boys aged 13–15 years old reported higher involvement in physical fights compared to adolescent girls 13–15 years old across several geographic regions. Looking at SRH risk factors, studies examining attitudes about gender and masculinity among adolescent boys and young men found that these beliefs significantly affected their sexual behaviors and decision to seek health services. Taboos surrounding health-seeking behavior related to dominant views toward masculinity negatively affect adolescent boys' and young men's decision to seek health services; however, reports of young and adult men with higher education and more equitable gender norms found a higher likelihood to seek STI testing—emphasizing how gender norms can positively shape SRH behaviors for boys and young men. Sexual exploitation, often under-reported across both sexes, is a critical issue for adolescent boys, with some countries reporting rates equal to or higher for boys compared to girls. A study in South Asia found that adolescent boys in South Asia had less legal protection (from abuse and exploitation, as well as legal recognition of rape, sexual harassment, and sexual exploitation) compared to girls of the same age, resulting in restricted access to services for boy survivors. In addition, stereotyped views of masculinity coupled with ingrained homophobia make it difficult for boys in some contexts to report sexual exploitation and abuse.

Figure B: Vulnerable Subgroups of Adolescents

VERY YOUNG ADOLESCENTS

Many VYAs do not have the knowledge and skills required to deal with the changes happening in their bodies and are discouraged from seeking information on puberty, sexuality, and other related topics due to social norms. Social taboos isolate VYAs from understanding their bodies, fertility, and barriers and benefits of using protective behaviors. VYAs are one of the groups at the highest risk of violence, while also typically receiving a minimal share of youth-serving resources and programs. VYAs also face increased vulnerability to sexual violence and coercion because of their limited life experience, which may result in not recognizing the sexual nature of abuse or exploitative actions in unknown settings.



ORPHANED ADOLESCENTS, UNACCOMPANIED MINORS, AND ADOLESCENT HEADS OF HOUSEHOLDS

Orphaned adolescents, unaccompanied minors, and adolescent heads of households report feelings of isolation, marginalization, trauma, and grief as a result of caring for themselves and/or their families on their own. These adolescents lack the livelihoods, security, and protection given to them from their family structure, putting them at greater risk from poverty and sexual exploitation and abuse. Orphan adolescents face economic stagnation as they seek work without adequate skills training; morbidity and malnutrition due to inability to meet basic needs; higher rates of HIV/AIDS; and increased risk of exploitation and abuse without adult protection. Adolescent heads of households and adolescents separated from families are ill-prepared to take care of family members, with adolescent girl heads of households at higher risk for exploitation and abuse. Adolescent boys and young men who are unaccompanied or separated from their families may face housing difficulties as a result of cultural limitations on having unrelated males in a household with females. Overall, adolescents separated from their families or adolescent heads of households may resort to marrying or selling sex to meet their needs for food, shelter, or protection.

ADOLESCENTS AT RISK OF SEXUAL EXPLOITATION THROUGH TRANSACTIONAL SEX

Children who are sexually exploited and young adults who engage in transactional sex are reported problems for both adolescent girls and boys in emergency contexts. Humanitarian crises can force households into poverty due to disrupted or destroyed livelihoods and leading to loss of property and decreased economic opportunities. Some families or adolescent heads of households may resort to transactional sex, or "survival sex", as a coping strategy during these circumstances. Transactional sex puts adolescents at higher risk of health, physical, and emotional harm, including unsafe sex practices, early sexual debut, multiple concurrent sexual partnerships, sexual exploitation and abuse, and inconsistent condom use. Transactional sex is associated with poor SRH outcomes, such as STIs, unintended pregnancies, and unsafe abortions.

MARRIED ADOLESCENTS

Beyond reducing future opportunities, married adolescents also experience social isolation, face higher risks of intimate-partner violence, forced sexual intercourse, and early pregnancy, and are less likely to receive medical care while pregnant compared to older married women.

PREGNANT ADOLESCENTS AND ADOLESCENT MOTHERS

As discussed previously, adolescent girls', especially VYA girls', lack of biological maturity puts them at greater risk for complications during pregnancy and childbirth. The risk of pregnancy-related mortality is twice as high for girls aged 15–19 years old and five times higher for girls aged 10–14 years old compared to women in their twenties. As well, pregnant adolescents are more likely to pursue unsafe abortions. In Africa, adolescents make up 25% of all unsafe abortions.

ADOLESCENTS WITH DISABILITIES

Adolescents with disabilities, as well as adolescents who have caregivers that have disabilities, are often hidden within communities and may face isolation. Security and physical barriers (damaged roads, lack of handicap-accessible structures), in addition to social and environmental hindrances (negative attitudes toward people with disabilities, lack of trained personnel) can limit their mobility and access to services. Some adolescents with disabilities may be less able to evacuate. Estimates show that for every child killed in conflict, three others are injured or permanently disabled, underscoring the long-term effects of conflict on children. Adolescents with cognitive delays or intellectual disabilities, acquired through injury, illness, or congenital conditions, appear to be at higher risk compared to those with other impairments. Adolescents with intellectual impairments are more likely to be excluded from services and support, and their parents' lack of disability information is often central to their poor access to care.

ADOLESCENTS WITH DIVERSE SEXUAL ORIENTATIONS AND GENDER IDENTITIES

Adolescents with diverse sexual orientations and gender identities, such as adolescents who identify as lesbian, gay, bisexual, transgender, intersex, and queer+ (LGBTQIA+), are often targeted for sexual violence crimes by multiple perpetrators (landlords, drivers, neighbors, authority figures) due to their limited legal protections and double stigma as refugees/displaced persons and having a non-conforming sexual orientation/gender identity. These adolescents may be forced to live in poor quality, insecure housing and face threats of extortion and/or sexual exploitation. Refugee and migrant adolescent boys who identify as LGBTQIA+ reported sexual exploitation and abuse in Italy and/or in the journey to Italy.

ADOLESCENTS WITH DIVERSE SRH NEEDS

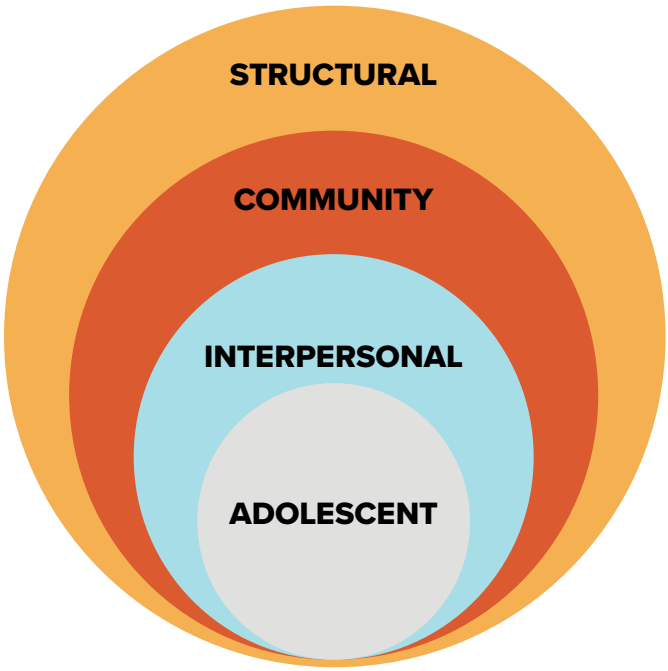
These adolescents include but are not restricted to former child soldiers; adolescent survivors of GBV; adolescents living with HIV/AIDS; adolescents belonging to indigenous or migrant groups; and widowed adolescents. Adolescents in these categories may face additional stigma, discrimination, and abuse, exploitation, and violence, in addition to having specific health needs, such as an adolescent living with HIV requiring antiretroviral medication. These adolescents often experience more difficulties accessing care due to cultural or social norms.

- Migrant and indigenous adolescents face additional risks and barriers in their travels, as well as difficulties accessing SRH services and information. Migrant adolescents can experience stigmatization, harassment, and violence depending on attitudes and beliefs in the host country toward their home country and/or their views toward the indigenous population. Migrant adolescents also face difficulties accessing services due to lack of registration and/or health insurance policies. Migrant adolescent boys and young men have experienced kidnapping, imprisonment, and violence, including sexual violence, en route to Italy from countries across Africa and the Middle East. Migrant adolescent girls are less likely to be informed about SRH compared to non-migrant adolescent girls. A study in Kenya also found that adolescent girls' migrant status and poor family support increased the likelihood of dropping out of school and getting married, which could then lead to early sexual initiation. Indigenous adolescents face the challenges of land dispossession, issues of birth registration, limited access to culturally appropriate SRH information, lack of access to judicial and other essential services, among others. Indigenous girls face elevated risk of violence, particularly in areas of intra- and inter-communal conflict and in communities that have deeply rooted patriarchal practices.
- Adolescents formerly associated with fighting forces may require additional mental health and psychosocial support (MHPSS) services and assistance in reintegrating into the community, along with other adolescents who may be shunned or ignored by community members—such as adolescents from indigenous or migrant groups, LGBTQIA+ adolescents, or widowed adolescents. Child soldiers are also at higher risk for STIs, particularly HIV, and risk-taking behavior, such as drug and alcohol use. Female child soldiers may also face health issues caused by violent sexual assault, including traumatic fistula, as well as unwanted pregnancy and unsafe abortion.
- Survivors of GBV face increased risk of unwanted pregnancy, unsafe abortion, STIs, including HIV, and social stigmatization. Survivors of GBV may also require additional MHPSS services.

What kinds of barriers need to be addressed to ensure adolescents are able to obtain the information and services they need?

Adolescents face many barriers to quality SRH, which are discussed below in the context of the Social-Ecological Model (Figure C). The social-ecological model illustrates the various types of influences adolescents face in obtaining SRH information and services. The model recognizes the need to address health at multiple levels and through a social empowerment lens. There are four levels to the model: individual, interpersonal, community, and structural, and there are different factors at each level that prevent or support adolescents in obtaining SRH information and services.

Figure C: Social-Ecological Model



Social-Ecological Model

Adolescent (individual level): At the center of this model are adolescents. Their biological and personal attributes, attitudes, beliefs, and experiences with obtaining SRH information and services within their families, communities, and the health system affect their ability to seek quality information and services. These include factors such as age, personality, sex, mental health, agency, and awareness, among others.

Interpersonal level (relationships): The relationships adolescents have with family members, partners, peers, community members, and other social networks play a role in adolescents' ability to seek SRH information and services. Their attitudes, beliefs, behaviors, knowledge, norms, and values influence how adolescents seek information and services. Other family-level factors include household income/wealth status.

Community level: Adolescents live and socialize in communities that are made up of schools, workplaces, and neighborhoods. At the community level, there are social and cultural norms that restrict or support access to SRH services, such as if it is taboo to discuss sex or cultural norms surrounding abstinence.

Structural level: This level refers to the infrastructure and systems surrounding adolescents. Their ability to obtain information and services is influenced by the availability of health facilities, the safety of their communities, as well as by policies and laws that restrict or support access to SRH services. In a humanitarian setting, however, the infrastructure and/or systems may be disrupted, partially functional, or non-existent.

Why Should We Prioritize ASRH During Emergencies?

With so much need and limited financial resources for the increasing number of humanitarian emergencies in the world, some may ask why ASRH should be prioritized when there are so many people in need of assistance. The answer is quite simple: we have a humanitarian mandate to save lives, and providing ASRH information and services—in coordination with adolescents themselves—is life-saving and has a compounding, positive impact on communities. The ASRH global community affirmed this charge in 2016. During the World Humanitarian Summit in 2016, humanitarian actors launched the Compact for Young People in Humanitarian Action, showing an unprecedented and collective commitment of over 50 humanitarian agencies to ensure that the priorities of young people are addressed and that they are informed, consulted, and meaningfully engaged throughout all stages of humanitarian action.

ASRH is a huge issue in humanitarian crises, but is often neglected or overlooked

Half of the 1.4 billion people living in countries affected by crises and fragile conditions are below 20 years of age. Today, with many of the current protracted crises lasting several years, adolescents can remain displaced or in need of humanitarian assistance for up to 20 years, extending well into adulthood and affecting their educational, economic, and health outcomes. Adolescents (and children who age into adolescence during a crisis) are tremendously impacted by humanitarian emergencies and require critical SRH services to prevent unwanted pregnancies and unsafe abortions; sexual violence and physical abuse, exploitation, and violence; mental health issues and disorders; STIs; and overall morbidities and mortalities.

Photo : Instituto Guttmacher

In fact, ASRH needs and risks intensify in times of crises. For example, during the COVID-19 pandemic, lockdown measures disrupted supply chains for contraceptives and restricted travel to health facilities, while economic declines related to the pandemic increased GBV, CEFM, and other rights violations—all further exacerbating SRH needs for adolescents.

Adolescents are exposed to a range of risks and hazards with which they are ill-prepared to cope. This includes violence, sexual violence, abuse, and exploitation; separation from families; gaps in accessible and affordable services; delays or disruptions in school attendance; a sudden loss of resources and the protection of family/social supports; and the breakdown of law and order. Their new environment can be full of new dangers, stressors, and unfamiliar conditions, including changes to marital norms and arranged marriages. These disruptions significantly affect adolescents' ability to protect themselves and engage in safe and healthy practices, including SRH behaviors. These challenges are discussed below within the structural level of the social-ecological framework.

Adolescent level (individual): Adolescents are often forced to assume adult responsibilities—such as taking care of their family members or seeking employment for which they may be unqualified or that pose dangers. They may be coerced or forced into marriage or transactional sexual relationships to generate resources that meet their basic survival needs and those of their families.

Interpersonal level (relationships): Families may see child marriage as a way to cope with economic hardship and to protect girls from violence. Nearly all ten countries where child marriage rates are highest are also considered either fragile or extremely fragile states.

Community level: Cultural or social norms can become more emphasized or even shift during humanitarian emergencies, which can have harmful effects upon adolescents' health. In Myanmar's ethnic conflict-affected communities, military and community leaders have discouraged young people from using contraception, restricted SRH education in schools and community institutions, and promoted childbirth and increasing the population to encourage ethnic culture and autonomy, as well as future military recruitment.

Structural level: Adolescents are often displaced from their homes and/or countries and have to confront issues related to legal status, as well as differing laws, religions, or cultural values that can affect their overall wellbeing. As well, adolescents will likely experience less secure physical environments, which increases their risk of physical harm. Health and other basic need services may be unavailable or difficult to access. Specialized services, such as obstetric care, are often harder to obtain or completely unavailable, which is a particular concern for adolescent girls who are at higher risk of pregnancy complications.

What do adolescents say?

Consultations held with refugee adolescents and youth in 22 countries found that many young people report poor access to adolescent-friendly and responsive healthcare, including psychosocial support. Refugee adolescents also cite few opportunities for their participation and/or involvement in responding to crises; no access or ability to engage with decision makers; high rates of gender inequality, exploitation, and violence; limited employment and livelihood opportunities; restricted freedom of movement; and discrimination, racism, and xenophobia—including for LGBTQIA+ adolescents—and an inability to acquire legal recognition and documentation of their status.

Certain adolescents face higher risks during emergencies

As described earlier, adolescents can have overlapping vulnerabilities, risks, and barriers based on a number of factors, including their living conditions. Humanitarian crises represent an additional layer of vulnerability for adolescents, who may already face risks or barriers due to their age, sex, gender identity, sexual orientation, health status, developmental stage, marital status, socio-economic conditions, and contextual and environmental factors.

Adolescent Girls in Humanitarian Settings are extremely vulnerable to GBV, female genital mutilation or cutting, CEFM, unwanted pregnancy, unsafe abortion, STIs (including HIV), and death. Sexual violence is a common tactic of war, which has a profoundly negative effect on adolescent girls' physical health (pregnancy, unsafe abortion, etc), emotional and mental health (depression, substance abuse), and social health (discrimination, exclusion, disrupted social networks). As many as one in five forcibly displaced women and girls will experience sexual violence, rape, or abuse. Adolescent girls are also at increased risk of human trafficking, forced prostitution, and sexual exploitation and abuse. They may also be more likely to engage in high-risk behaviors compared to adolescent girls in more stable settings.

61% of the women and adolescent girls who die every day from causes related to pregnancy and childbirth were from countries considered fragile because of conflict or disaster—representing **3/5** of all maternal deaths globally.

Adolescent Boys in Humanitarian Settings experience high rates of physical and sexual exploitation and violence, as well as harassment and potential detention and/or arrest by police or security forces, particularly if they cannot produce proper identification. Adolescent boys are also trafficked for child labor and as child soldiers and/or drug smugglers.

1/3 of the **89** Rohingya men and adolescent boys consulted in Cox's Bazar, Bangladesh knew a man or boy with direct experience of conflict-related sexual violence.

Adolescent boys and young men in Myanmar reported being forced to witness sexual violence against female family- and community-members, which resulted in severe mental trauma and fractured family relationships. Men and boys reported physical injuries and sexual violence, as well as feelings and thoughts of shame, powerlessness, and suicide while fleeing from Syria to Turkey.

Adolescents at Increased Risk During Emergencies

Certain subgroups of adolescents face increased risks and vulnerabilities compared to other adolescents (recall Figure B in the earlier section). The needs, risks, and barriers of these subgroups of adolescents are exacerbated during emergencies. This list is not exhaustive but shows the diversity of at-risk adolescents during humanitarian emergencies.

- Adolescents associated with fighting forces
- Adolescents born of rape in conflict
- Adolescents caring for persons with disabilities
- Adolescents experiencing homelessness or in temporary housing
- Adolescents engaged in (the worst forms of) child labor or forced labor
- Adolescents from minority linguistic, religious, and ethnic groups, including indigenous young people
- Adolescent heads of households
- Adolescents impacted by gang violence
- Adolescents in contact with the law, including those in detention
- Adolescents who are exploited in transactional sexual relationships
- Adolescents living with HIV and other chronic illnesses
- Adolescent mothers
- Adolescent survivors of GBV, including sexual violence, trafficking, and other forms
- Adolescents who bear children of rape in conflict
- Adolescents with disabilities
- Child brides
- Married adolescents
- LGBTQIA+ adolescents
- Orphaned adolescents
- Refugee and internally displaced adolescents
- Returnee adolescents
- Stateless adolescents
- Unaccompanied and separated adolescents
- Undocumented adolescents
- VYAs
- Widowed adolescents

Regardless of the source of their vulnerabilities, all at-risk subgroups of adolescents require particular attention and targeted interventions to ensure that their SRH needs are met during times of crises. Table 1 provides examples of the barriers, increased responsibilities, risks, and assets and capacities of a few at-risk subgroups of adolescents in humanitarian settings and compares these risks to an adolescent in a non-crisis setting. It is important to always remember and utilize the opportunities of adolescents' capacities and the assets of the community, even in a crisis.

Table 1: Risks and Opportunities Facing Adolescents in Emergencies

Population	Barriers	Increased Responsibilities	Risks	Assets & Capacities
Adolescent in non-crisis settings	Specific to SRH, sensitivities discussing SRH needs and stigma from community	• Going to school • Helping family, such as looking after siblings	• Road accidents • Risky behaviors (drugs, alcohol, unsafe sex)	• Adolescent (and youth) networks • Family support • Coping skills and positive identity
Pregnant adolescent in crises	Finding SRH services when normal facility operations have been disrupted	• Taking care of self and baby	• Birth complications for mother and baby	• Adolescent mothers club • Commitment to learning
Orphaned adolescent in crises	Receiving assistance /services without head of family or caregiver	• Finding food, shelters, health, and other services on your own	• Forced labor, human trafficking, including trafficking into armed group	• Adolescent programs • Girl-friendly center • Positive peer models
Adolescent with a physical disability in crises	Restricted mobility finding services from damaged roads and/ or insecurity	• Finding services and items needed in new setting	• Injury • Malnutrition • Isolation	• Caring community • Resistance skills

Photo : UNFPA