Introduction

What is adolescence? Adolescence is defined as the period between 10 and 19 years of age. It is a continuum of physical, cognitive, behavioral and psychosocial change that is characterized by increasing levels of individual autonomy, a growing sense of identity and self-esteem and progressive independence from adults.

Adolescents are learning to think abstractly, which allows them to plan their futures. Experimentation and risk-taking are normal during adolescence and are part of the process of developing decision-making skills; adolescents are both positively and negatively influenced by their peers, whom they respect and admire. Adults play an important role in this regard and can help adolescents weigh the consequences of their behaviors (particularly risky behaviors) and help them to identify options. The influence of at least one positive adult and a nurturing family are protective factors during this period of development and can help adolescents cope with stress and develop resilience.

At one end of the continuum are very young adolescents (10 to 14 years of age), who may be physically, cognitively, emotionally and behaviorally closer to children than adults. Very young adolescents are just beginning to form their identities, which are shaped by internal and external influences. Signs of physical maturation begin to appear during this period: pubic and axillary hair appear; girls develop breast buds and may begin to menstruate; in boys, the penis and testicles grow, facial hair develops and the voice deepens. As young adolescents become aware of their sexuality, they may begin to experiment with sex. They also may experiment with substances such as alcohol, tobacco or drugs. Adolescent sexual and reproductive health (ASRH) programs should develop strategies that specifically target very young adolescents, tailoring interventions that are appropriate to their level of maturity, experience and development.
Adolescence is one of life’s fascinating and perhaps most complex stages, a time when young people take on new responsibilities and experiment with independence. They search for identity, learn to apply values acquired in early childhood and develop skills that will help them become caring and responsible adults. When adolescents are supported and encouraged by caring adults, they thrive in unimaginable ways, becoming resourceful and contributing members of families and communities. Bursting with energy, curiosity and spirit that are not easily extinguished, young people have the potential to change negative societal patterns of behaviour and break cycles of violence and discrimination that pass from one generation to the next. With their creativity, energy and enthusiasm, young people can change the world in astonishing ways, making it a better place not only for themselves, but for everyone.


During **middle adolescence** (15-16 years of age), adolescents begin to develop ideals and select role models. Peers are very important to adolescents in this age group and they are strongly influenced by them. Sexual orientation develops progressively and non-heterosexual individuals may begin to experience internal conflict, particularly during middle adolescence.

At the other end of the spectrum are **older adolescents** (17 to 19 years of age), who may look and act like adults, but who have still not reached cognitive, behavioral and emotional maturity. While older adolescents may make decisions independently — they may be employed, their sexual identities are solidified and they may even marry and start families — they still benefit from the influence of adult role models as well as family and social structures to help them complete the transition into adulthood.

**Children, adolescents, youth and young people**

The terms used to refer to people in the age range of 0 to 24 years vary depending on the context and the source of information. International definitions are summarized in Table 1, but comprehension of the terms varies widely according to countries, cultures and groups.

The United Nations Convention on the Rights of the Child (CRC) encompasses all individuals from birth to 18 years in the category of “children.” Therefore, adolescents are covered under the protection of the CRC until they reach 18. The category of “youth” includes older adolescents, aged 15 to 24 years.

“**Young people**” comprise adolescents between 10 and 24. These two terms reflect the continued development and maturation of individuals during the period after 18 years of age, prior to entering adulthood.

### Table 1

<table>
<thead>
<tr>
<th>Term</th>
<th>Age Range</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>0-18 years</td>
<td>Convention on the Rights of the Child</td>
</tr>
<tr>
<td>Adolescent</td>
<td>10-19 years</td>
<td>UNFPA, WHO, UNICEF</td>
</tr>
<tr>
<td>Very young adolescent</td>
<td>10-14 years</td>
<td>UNFPA, UNICEF</td>
</tr>
<tr>
<td>Youth</td>
<td>15-24 years</td>
<td>UNFPA, WHO, UNICEF</td>
</tr>
<tr>
<td>Young people</td>
<td>10-24 years</td>
<td>UNFPA, WHO, UNICEF</td>
</tr>
</tbody>
</table>

**Why focus on adolescent sexual and reproductive health?**

Although adolescents make up a large proportion of the population in the developing world, where most humanitarian emergencies occur, their sexual and reproductive health (SRH) needs are largely unmet. In 2000, 29% of the population in developing countries was of adolescent age; in the least developed countries, adolescents accounted for 32% of the total population.¹ Worldwide, adolescent females and males are reaching puberty sooner, marrying later and having more premarital sex.² The unmet need for contraceptives among adolescents, however, is more than twice that of married women.³ One third of women worldwide give birth before the age of 20,⁴ with deliveries by women under 20 totaling 15 million annually.⁵ Pregnant adolescents are at increased...
risk of morbidity and mortality due to complications during pregnancy and childbirth, including obstructed labor, preterm labor and spontaneous abortion. Five million adolescents between the ages of 15 and 18 have unsafe abortions each year\(^6\) and 70,000 abortion-related deaths occur among this age group every year.\(^7\) Half of new HIV infections occur in 15-to-24 year olds, and one third of new cases of curable sexually transmitted infections (STIs) affect people younger than 25.\(^8\)

Why is adolescent sexual and reproductive health important in emergency situations?

As they transition from childhood to adulthood, adolescents normally benefit from the influence of adult role models, social norms and structures and community groups (peer, religious or cultural). During natural and man-made humanitarian emergencies, however, family and social structures are disrupted: adolescents may be separated from their families or communities, while formal and informal educational programs are discontinued and community and social networks break down. Adolescents may feel fearful, stressed, bored or idle. They may find themselves in risky situations that they are not prepared to deal with and they may suddenly have to take on adult roles without preparation, without positive adult role models or support networks. The loss of livelihood, security and the protection provided by family and community places adolescents at risk of poverty, violence and sexual exploitation and abuse (SEA). In crisis situations, adolescents (especially girls) are vulnerable to rape and sexual exploitation at the hands of fighting forces, community members, humanitarian workers and uniformed personnel because of their lack of power, their lack of resources, and because rape may be used as a method of war. Many adolescents, including younger ones, resort to selling sex to meet their own or their families’ needs. They may also be at risk of recruitment into armed forces or groups, which can increase their vulnerability to sexual exploitation and abuse, HIV/STI infection, and unwanted pregnancies due to high mobility and an increase in risk-taking behaviors (including alcohol/drug abuse). Adolescents who live through crises may not be able to visualize positive futures for themselves and may develop fatalistic views about the future; this may also contribute to high-risk sexual behaviors and poor health-seeking behaviors.

The disruption of families, education and health services during emergencies, either due to infrastructure damage or to the increased demands placed on health and social-service providers during a crisis, adds to the problem and may leave adolescents without access to SRH information and services during a period when they are at risk.

The lack of access to SRH information, the disruption or inaccessibility of SRH services, and the increased risk of SEA as well as high-risk sexual behaviors among adolescents during emergencies, puts adolescents at risk of unwanted pregnancy, unsafe abortion, STIs and HIV infection.

What sub-groups of adolescents are at particularly high risk and require special attention?

Certain sub-groups of adolescents, including those who are very young, pregnant, or marginalized are considered to be high-risk. Other adolescents fall into high-risk subgroups as a result of the crisis situation.

Sub-groups that are at risk by definition:

- **Very young adolescents (10-14 years), especially girls,** are at risk of SEA because of their dependence, lack of power, and their lack of participation in decision-making processes. Because of their limited life experience, they may not recognize the sexual nature of abusive or exploitative actions.
Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings

• **Pregnant adolescent girls**, particularly those under 16, are at increased risk of obstructed labor, a life-threatening obstetric emergency that can develop when the immature pelvis is too small to allow the passage of a baby through the birth canal. Delay in treatment can lead to obstetric fistula or uterine rupture, hemorrhage and death of the mother and child. Emergency obstetric care services are often unavailable in crisis settings, increasing the risk of morbidity and mortality among adolescent mothers and their babies.

• **Marginalized Adolescents**, including those who are HIV+, those with disabilities, non-heterosexual adolescents, indigenous groups and migrants may face difficulties accessing services because of stigma, prejudice, culture, language and physical or mental limitations. They are at risk of poverty. In addition, they are at risk of SEA because of their lack of power and participation.

**Sub-groups that become at-risk during a crisis situation:**

- **Adolescents separated from their families (parents or spouses) and adolescent heads of household** lack the livelihood security and protection afforded by the family structure, which puts them at risk for poverty and SEA. Separated adolescents and adolescent heads of household may be compelled to drop out of school, marry or sell sex in order to meet their needs for food, shelter or protection.

- **Survivors of sexual violence and other forms of gender-based violence (GBV)** are at risk of unwanted pregnancy, unsafe abortion, STIs including HIV, as well as mental health, psychosocial problems and social stigmatization.

- **Adolescent girls selling sex** are at risk of unwanted pregnancy, unsafe abortion, STIs and HIV. They are at risk of abusing drugs and alcohol and of SEA. For adolescents below age 18, this is considered to be sexual exploitation of children.

- **Children Associated with Armed Forces and Armed Groups (CAAFAG)**, both boys and girls, are often sexually active at a much earlier age and face increased risk of exposure to HIV. Members of armed forces and groups in general, including adolescents, are at high risk of HIV infection given their age range, mobility, and risk-taking attitudes.

Female combatants, girls associated with fighting forces, abductees and dependants also are frequently at high risk, given the widespread sexual violence and abuse. They are at risk of mental health and psychosocial problems as they may have committed or witnessed acts of extreme physical or sexual violence or may themselves be survivors of sexual violence. Girls may have been forced to have sex with commanders or with other soldiers. They are at risk of unwanted pregnancy, unsafe abortion, STIs and HIV infection.

Regardless of the source of their vulnerability, all at-risk sub-groups of adolescents require particular attention and targeted interventions to ensure that their SRH needs are met during times of crisis.

**What special considerations should be taken when implementing ASRH programs in emergency settings?**

Most of the existing models for ASRH interventions are relevant to the development context; there are few field-tested models for ASRH interventions in emergency situations. This does not mean that development models are not valid in emergencies; in many cases they are, but they must be adapted to the emergency context. In an acute emergency, for example, life-saving interventions are the priority. Even in an emergency, every attempt should be made to involve the beneficiary population in program planning, implementation and monitoring, but the degree of participation that is attainable may be less than in a stable or protracted situation. Once the acute emergency is stabilized, field-tested development-like interventions, with broader participation of stakeholders, should be introduced.

Special considerations for ASRH programs are summarized below. It should be noted that each of these considerations is valid in both the emergency and non-emergency setting, but they may be overlooked in the emergency context. Further details are provided in the Fact Sheets and individual tools.

In this document, the phrases "humanitarian settings", "crisis settings" and "emergency settings" are used interchangeably.
Human Rights, Ethical and Legal Concerns: Under international law, adolescents have rights through the Convention on the Rights of the Child (CRC) until they reach 18 years of age. These include the right to reproductive health (RH) information and services and they provide protection from discrimination, abuse and exploitation. Health staff, adolescents, community members (including parents) and humanitarian workers should be aware of the rights of adolescents and work together to ensure that these rights are protected even in times of crisis.

In addition, certain ethical considerations must be taken into account when designing and implementing interventions with adolescents. Program activities and interventions should demonstrate respect for adolescents and their right to self-determination; the benefits of the interventions should outweigh the risks; and participation of adolescents should be encouraged and their opinions respected.

Finally, local, national and international laws should be followed to the maximum extent possible. In all situations, however, it is important that the best interests of the adolescent are prioritized.

Making Interventions Accessible, Acceptable and Appropriate to Adolescents: Even in non-emergency settings, adolescents face inter-related barriers that prevent them from accessing facility-based RH services. These include: individual barriers, such as feelings of shame, fear or anxiety about issues related to sexuality and reproduction, lack of awareness about the services available, poor health, or advice-seeking behaviors and the perception that services will not be confidential; socio-cultural barriers, such as social norms which dictate the behavior and sexuality of both young men and women, stigma surrounding sexually active adolescents, cultural barriers which limit the ability of women, girls or certain sub-sets of the population from accessing health services, educational limitations, language differences, the attitudes of health care providers towards adolescents or their unwillingness to attend to their RH needs; and structural barriers, such as long distances to health facilities, lack of facilities for clients with disabilities, inconvenient hours of operation, long waiting times, charging fees for services and lack of privacy.

The barriers to accessing services that are experienced by adolescents are increased during a crisis, when health services and infrastructure such as communications and transportation are disrupted, when health services are overburdened by high patient loads, when insecurity leads to restrictions of movement, and when other activities, such as securing food and shelter, take priority over RH concerns.

To reach adolescents during emergency situations, RH programs must take innovative approaches to make services acceptable, accessible and appropriate for adolescents, taking cultural sensitivity and diversity into consideration. Adolescents should be involved as much as possible in the design, implementation and monitoring of program activities, so that programs are more likely to respond to their RH needs and priorities and so that interventions are acceptable to them. Introducing adolescent-friendly health services and involving adolescents in the both the design and monitoring of these services will make facility-based RH services more accessible and acceptable to adolescents. In addition, program managers, together with health providers, adolescents and community members should consider alternative implementation strategies such as community interventions that will make it easier to reach adolescents with RH information and services.

Community and Parental Involvement: Community and parental acceptance and involvement in ASRH programs are crucial for the success and sustainability of the programs. Community members and parents, along with adolescents, should be involved from the earliest stages of program design and if possible, should contribute to program implementation.

Family or Community Re-integration: While not specifically an RH issue, successful re-integration of adolescents into families or the
ABOUT THE ASRH TOOLKIT FOR HUMANITARIAN SETTINGS

The ASRH Toolkit for Humanitarian Settings provides information and guidance to advocate for ASRH and implement adolescent-inclusive SRH interventions. The toolkit is meant to accompany Chapter 4 “Adolescent Reproductive Health” of the Inter-Agency Field Manual on Reproductive Health in humanitarian settings, IAFM. The tools have been conceived to operationalize this chapter by providing guidance on what should be done to ensure that sexual and reproductive health interventions put into place during and immediately after a crisis are responsive to the needs of adolescents.

While the best way to ensure that ASRH needs are met is to mainstream ASRH into the emergency RH response, mainstreaming is a process that requires planning and co-ordination and often implementing agencies do not have the time, resources or capacity to do this during an acute emergency.

Recognizing that mainstreaming approaches to mainstreaming ASRH in emergencies have not yet been standardized, this ASRH Toolkit has been designed to help program managers at implementing agencies ensure that the sexual and reproductive health needs of adolescents are addressed during all emergency situations, be they natural or man-made. It also provides selected tools specifically for health providers so they can more effectively provide and track services for adolescents at the clinic and community levels. The tools are designed to be user-friendly so that service providers who have never been trained to work with adolescents can feel comfortable treating them during an emergency.

Each humanitarian situation is unique, and it is expected that the tools will be adapted to suit the particular needs on the ground. It is also expected that the Toolkit will be used to raise awareness about the SRH needs of adolescents and as an initial step of mainstreaming ASRH into emergency RH responses.

The community is crucial to minimizing their SRH risk. Preventing adolescents from becoming separated from their families is a priority during an emergency situation, and creating safe spaces and beginning education activities during a crisis can minimize idle time among adolescents and aid in preventing them from being abducted or otherwise targeted in an armed conflict. Awareness raising and sensitization sessions on HIV for receiving communities should begin well before reintegration of adolescents commences to counter any stigma or discrimination from the communities. Strong protection measures and strengthening community-based approaches to livelihoods and education can also contribute to the prevention of re-recruitment or harmful behaviors such as selling sex.

**Sexual and Reproductive Health Needs of Adolescent Boys:** Adolescent girls are most at risk during emergency situations, but addressing the needs of adolescent boys is equally urgent; ASRH programs should recognize the specific SRH needs of adolescent boys. Adolescent boys have an important role to play in improving the health situation for adolescent girls. Including both boys and girls in discussions on power and gender equality can reduce the risk of GBV and can lead to changes in the existing gender norms that contribute to GBV and exclusion of girls from health services. Adolescent boys face high rates of STI and HIV/AIDS (although not as high as females.) By providing boys with information about sexual health and ensuring that they have access to high-quality, adolescent-friendly SRH services, high-risk sexual behavior among adolescent boys may be mitigated. Boys also are targeted for recruitment to armed forces and armed groups, where they are at risk of being subject to and committing exploitation and abuse, in addition to being induced or pressured toward risk-taking behaviors.
SUGGESTED READING:


A Human and Child Rights Framework

Human rights violations are common in both natural and man-made crisis situations. States are responsible for protecting the human rights of their citizens, but during crises, states may be temporarily incapable of providing protection (in the case of a natural disaster, for example), or may be failed (in the case of an armed conflict). The right to health — including sexual and reproductive health — is not suspended during an emergency, and it is the responsibility of states to ensure that those who are marginalized or most at-risk in the population are provided with safe access to shelter, water, food, cooking fuel and healthcare.

Figure 1 illustrates the sexual and reproductive rights of adolescents in relation to human rights:

Figure 1: Human Rights that Protect the Sexual and Reproductive Rights of Adolescents

How are human rights and legal considerations related to adolescent sexual and reproductive health during emergency situations?

The human rights of adolescents, including vulnerable sub-groups, are protected under several declarations and conventions in international law.

The Universal Declaration of Human Rights (UDHR) mentions the right to health under the right to the highest attainable standard of living (UDHR Article 25). The Constitution of the World Health Organization defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity and declares that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition (WHO, 1946).

This was expanded during the 1994 Cairo International Conference on Population and Development, which defined reproductive health and the right to reproductive health as: a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

The right to reproductive health includes the right to complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

ICPD, 1994

The 1995 Beijing Women’s Conference expanded the definition of reproductive health to include sexuality:

The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.

The UN Convention on the Rights of the Child:

Adolescents are entitled to rights under the Convention on the Rights of the Child (CRC) until age 18. These rights are listed below, with examples of how they relate to ASRH:

- The right to the highest attainable standard of health, Including the right to reproductive health.
- The right to impart and receive information and the right to education, Including complete and correct information about SRH.
- The right to confidentiality and privacy, Including the right to obtain RH services without consent of a parent, spouse or guardian. Conducting a virginity (hymen) examination on an adolescent without her consent would also be a violation of this right.
- The right to be free from harmful traditional practices, Including female genital cutting and forced early marriage.
• The right to be free from all forms of physical and mental abuse and all forms of sexual exploitation, including sexual violence, domestic violence and sexual exploitation.

• The right to equality and non-discrimination, including the right to access RH services, regardless of age or marital status and without consent of parent, guardian or spouse.

• All actions taken should be in the best interest of the child. For example, requiring parental consent for contraception or obstetric care, or refusing services because of age would not be in the best interest of the adolescent.

Under international humanitarian law and international human rights law, children are protected from recruitment and use by armed forces and groups. The recruitment and use of children under 15 in armed forces and groups are war crimes. In addition to the UN Convention on the Rights of the Child, international and regional instruments including the Optional Protocol to the Geneva Conventions and the Additional Protocols, the Rome Statue establishing the International Criminal Court, and the African Charter on the Rights and Welfare of the Child, offer a legal framework for the protection of children.

Although most adolescents (those between 10 and 18 years of age) are considered to be children under international law, the evolving capacity of the child is also recognized. Simply stated, as children progress through adolescence and gain life experiences, they become more capable of taking important decisions independently. This is very important when considering issues related to ASRH, particularly in relation to providing ASRH services without requiring the consent of a parent or spouse.

The issue of whether adolescents themselves can provide informed consent for SRH interventions such as counseling and testing for HIV, clinical care after sexual assault, treatment of STIs and maternity care can be sensitive. In 2003, the UN Committee on the Rights of the Child issued General Comment No. 4, which describes adolescents’ rights to health and development in the framework of the Convention on the Rights of the Child (UN Committee on the Rights of the Child, 2003). The comment provides adolescents with the right to information related to SRH, “regardless of their marital status and whether their parents or guardians consent” (paragraph 28). It also states that if parents or guardians provide informed consent, the adolescent should be allowed to express his/her views and those views should be given weight. It recognizes the evolving capacity of the child by giving adolescents who are “of sufficient maturity” the right to provide informed consent “for her/himself, while informing the parents if that is in the ‘best interest of the child’” (paragraph 32). Health providers have the obligation to provide adolescents with private and confidential advice so that they are able to make informed decisions about treatment (paragraph 33).

Finally, adolescents with disabilities are protected under the UN Convention on the Rights of Persons with Disabilities. Ten percent of the world population lives with disabilities and 80% of people with disabilities live in developing countries (UNFPA, 2007). During emergencies, the number of adolescents with disabilities may increase due to physical or psychological injury or mental health conditions that manifest as a result of crisis.

Adolescents with disabilities include those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others

UN Convention on the Rights of Persons with Disabilities

The disabled are as sexually active as people without disabilities, but they are three times more likely to experience sexual violence, putting them at increased risk of unwanted pregnancy, STIs and HIV. People with disabilities have less access to health (including mental health and psychosocial support) and legal services. Adolescents with disabilities are at increased risk of other human rights violations such as rape, SEA, forced sterilization, forced abortion and forced marriage.
The Convention on the Rights of Persons with Disabilities says that states **shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others.** It further states that people with disabilities have the right to the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes (United Nations, 1997).

How should ASRH programs prevent or address human rights violations in emergency settings?

ASRH programs should engage other sectors to ensure that health staff, adolescents, community members, and other humanitarian actors are aware of the rights of adolescents, particularly as they relate to RH. All efforts should be made to ensure that adolescents, including marginalized groups and those with disabilities, have access to RH information and services and that they are not subjected to human-rights violations. Suspected or known violations of adolescents’ human rights during an acute emergency or while providing comprehensive RH services, should be reported to the UN agency overseeing the humanitarian response (the Global Health Cluster, UNOCHA, UNHCR, etc.).

National laws regarding the rights of adolescents may conflict with international law. It is very important that humanitarian staff are familiar with the national laws and that they know how to handle situations that might arise when national and international law do not agree. Remember, the most important factor in taking a decision is to prioritize the best interests of the child (or adolescent).

**SUGGESTED READING**


