



OVERLOOKED AND UNINFORMED: YOUNG ADOLESCENTS' SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

THE REALITIES:

- In a number of countries, one-quarter or more of both boys and girls become sexually active before their 15th birthdays, often involuntarily.
- For girls in many developing countries, early sexual initiation occurs within arranged marriages. For boys this is virtually never the case.
- Whether married or not, young sexually active girls are especially vulnerable to sexually transmitted infections (STIs), HIV/AIDS, and unsafe pregnancy.
- All young people need information and skills to protect themselves from harm and to make free, informed, and responsible sexual and reproductive decisions.
- Early and universal access to accurate and comprehensive sexuality education in the schools is rare but essential.
- Health services rarely recognize or meet the needs of young adolescents before, or even after, they become sexually active.

Adolescents 10 – 14 years old make up 9 percent of the world’s population and as much as 15 percent in some low- and middle-income countries.³ Recognizing the realities of young adolescent girls’ and boys’ lives—and particularly their need to know about their bodies and their sexual rights and responsibilities—is crucial for building the foundations of a safe passage through adolescence into adulthood. Commentaries on the sexual and reproductive health and behaviors of adolescents or young adults often refer to those ages 15 – 19 or 15 – 24, however, and programs and policies are typically designed for these older age groups. This informational brief focusing on the overlooked and uninformed aspects of young adolescents’ sexual and reproductive lives aims to inform policymaking and programming for this pivotal new generation.

WHY FOCUS ON YOUNG ADOLESCENTS?

Early adolescence marks the onset of puberty with all the physiological and emotional changes this period entails, such as rapid physical growth, the emergence of sexual arousal and interests, and the maturation of the sexual body. It is a time of intense socialization into gendered sexual attitudes and behaviors. Boys and girls of this age have a high capacity for enthusiasm, energy, and idealism and are growing in social and intellectual competence. At the same time, they face a number of risks

to their sexual and reproductive health which are highly gendered in their nature, causes, and consequences.

- Girls in most developing countries are now maturing physically at earlier ages than previously due to improved nutrition and living conditions. In settings as varied as Brazil, Chile, Dominican Republic, Mexico, Venezuela, Egypt, Iran, India, Indonesia, and Thailand, girls of higher socioeconomic status are starting their menstrual periods at an average age of 12.5 or younger—the same age as (or even earlier than) their European and North American counterparts.⁴ The first visible signs of sexual maturation such as breast budding may appear as early as age 9 or 10.⁵
- The onset of the menses is a very poor marker of a girl's physiological or psychological preparedness for sexual intercourse. A girl's skeletal and muscular growth is still incomplete, and gains in height and weight, the full development of the pelvis, breasts, and uterus, and the maturation and lubrication of the cervix and vagina occur mostly *after* menstruation begins.
- Sexual intercourse prior to a girl's full maturation can be extremely painful—especially when forced—due to the small diameter, short length, inelasticity, and lack of lubrication of the vagina, quite apart from the emotional shock it may cause when violence is used. Abrasions and tearing increase the risk that a girl will acquire STIs such as syphilis or the human papilloma virus (HPV) and HIV from an infected partner.⁶
- Precocious pregnancy before the pelvic bones and birth canal are fully developed exposes girls to heightened risks of early miscarriage and obstetric complications such as pregnancy-induced hypertension, obstructed and prolonged labor, vaginal tearing, obstetric fistula, postpartum hemorrhage, and maternal death.⁷ It is also a cause of premature delivery, low birthweight, stillbirth, and the death of the newborn.
- Boys begin puberty and enter the developmental phase of maximum growth in bodily height and weight as well as in cognitive capacity on average about 1.5 to two years later than girls do.⁸ A boy's first conscious ejaculation at about 13 – 15 years of age is generally considered a marker of male puberty equivalent to the onset of menstruation in girls. Strong hormonal jolts of testosterone during puberty affect male sexual awareness and arousal and are linked with socially constructed notions of male dominance and risk-taking in complex and mutually reinforcing ways.⁹
- Young adolescents of both sexes, but especially girls, are vulnerable to violations of their sexual rights by peers and by adults, including members of their own families. At the same time, a desire for social acceptance combined with notions of infallibility lead some, especially boys, to engage in sexual and other risk-taking behaviors in remarkable disregard of the consequences to themselves and others.

WHO ARE “YOUNG ADOLESCENTS”?

We define all girls and boys between the ages of 10 and 14 as *young adolescents*. Some reports refer to 10 – 14-year-olds as *very young adolescents*, while others make different distinctions.¹ The Pan American Health Organization labels the years from 9 – 12 among girls as *preadolescence* and 12 – 14 as *early adolescence*, compared with 10 – 13 and 13 – 15 for boys.² Statistical data are almost never presented in this way, however. For convenience, age 10 – 14 is used here to refer to early adolescence with the understanding that the nature, timing, and pace of sexual, emotional, cognitive, and bodily development vary between males and females, across populations and social groups, and from one individual to another.

The assumption that boys and girls under 15 are “too young” to need sexual and reproductive health information and services ignores these realities and denies them the practical knowledge and skills they need to protect themselves and their partners from STIs/HIV, pregnancy, unsafe abortion or childbirth, and sexual abuse or violence. Young adolescents have a right to receive comprehensive information, education, health services, and other social and legal supports during this highly formative stage of their lives.

EARLY SEXUAL INITIATION

Evidence on what young adolescents know, feel, believe, and do (or have done to them) with respect to their bodies and their emerging sexual interests is scarce. Research on sexual attitudes and behaviors is highly sensitive or even taboo in some countries and parents, teachers, policy makers, health-care providers, and other gatekeepers often object to such inquiries. Nevertheless, some interesting findings have emerged.

- Qualitative studies in diverse settings find that young adolescent boys and sometimes girls consider participatory sexual activities that include oral or anal sex as “play” or “fun” or as “nothing special.”¹⁰ Moreover, girls and some boys are especially vulnerable to sexual coercion during early adolescence.¹¹ Gendered norms of male behavior can also encourage boys to be perpetrators at this age. Exposure to sexual coercion and violence, which is associated with social, economic, and personal tensions and deprivations in the family and community, can contribute to subsequent episodes of nonconsensual and unprotected sex, multiple partnerships without protection, STIs/HIV, unintended pregnancy, damaged self-esteem, and other negative physical, social, and emotional consequences.¹²
- Demographic and Health Surveys (DHS) conducted in about 60 developing countries show that *25 percent or more of girls ages 15 – 19 were initiated into heterosexual vaginal intercourse before age 15* (almost all within marriage) in Niger, Guinea, Central African Republic, Mozambique, and Bangladesh, and 10 percent or more (within or outside marriage) in many other countries in sub-Saharan Africa, India, much of Latin America and the Caribbean, and Sweden, and the United States.¹³
- Among 15 – 19-year-old boys, *25 percent or more had intercourse before age 15* in Gabon (48 percent), Mali, Zambia, Malawi, Kenya, and Namibia as well as in Haiti, Nicaragua, Jamaica, Brazil, and the United States and 10 percent or more did so in many other countries. Studies in Jamaica, Brazil, and the United States reveal substantial numbers of boys from low-income households having (or claiming to have had) sex at age 12 or younger.¹⁴

High proportions of 15-19-year-old male and female adolescents had sexual intercourse before age 15 in some regions and countries of the world

(Medians and range across countries within region)

| | M intercourse | F intercourse | F marriage | F birth | M/F #countries |
|---------------------------------|---------------|---------------|------------|---------|----------------|
| Western and Central Africa | 11% 4-48% | 20% 3-30% | 8% 0-27% | 3% 0-7% | 12/15 |
| Eastern and Southern Africa | 14 0-39 | 14 3-28 | 5 0-14 | 2 0-5 | 12/15 |
| Northern Africa and Middle East | 1 0-1 | 1 1-2 | 1 1-2 | 0 0-0 | 2/5 |
| Central Asian Republics | 6 | 0 0-1 | 0 0-0 | 0 0-0 | 1/4 |
| South and Southeast Asia | 3 0-20 | 5 0-26 | 5 0-26 | 1 0-6 | 3/8 |
| Latin America and Caribbean | 16 15-34 | 10 5-14 | 4 2-10 | 1 1-3 | 5/8 |

Source: Demographic and Health Surveys

- In addition, at least one girl in ten ages 15 – 19 was already married or living in an informal union at age 14 or younger in Niger, Mozambique, Bangladesh, India, Nepal, Dominican Republic, and Nicaragua, placing them at particularly high risk of life-threatening precocious pregnancy.

WHAT DO YOUNG ADOLESCENTS KNOW?

Most research probing the sexual and reproductive knowledge, attitudes, and practices of young adolescents (usually ages 12 – 14) compared with older adolescents reveals a widespread lack of information, skills, and cognitive preparedness for sexual intercourse among the younger groups.¹⁵ Although older adolescents also need more information about their sexual and reproductive health and rights, younger adolescents are more likely to have

- a limited understanding of the meanings of some of the questions asked, plus considerable misinformation about various sexual practices and their risks;
- lower levels of information and many misconceptions about ways of preventing pregnancy and contraceptive methods;
- reliance on equally uninformed peers or slightly better informed older siblings or cousins for sexual information rather than on media sources or trusted adults;
- a fairly high knowledge of HIV/AIDS but very little knowledge of symptoms, modes of transmission, and prevention of HIV and other STIs;
- a limited understanding of the concept of reproductive health and low levels of information about anatomy and reproductive physiology;
- very little condom use, awareness of where to obtain condoms, or knowledge of how to use them correctly among those who are sexually active;
- a higher tendency among younger boys to cite peer pressures, physical gratification, or curiosity rather than relationships with girlfriends as the reason for having sex;
- a greater likelihood among younger boys and girls that their sexual initiation was unwanted or coerced by an older person;
- stronger attachments to conventional gender roles and standards of sexual behavior;
- a lower sense of self-efficacy with respect to their rights over their own bodies.

Young male and female adolescents in virtually all countries and social groups are eager to learn about the changes they are experiencing in their bodies, their sexual and reproductive capacities, and about love and romantic relationships. A Reproductive Health Education program for adolescents ages 12 and over in Bangladesh, for example, found that both boys and girls wanted to know about menstruation, pregnancy, STIs and HIV, family planning, male and female sexual desire, romantic love, and choosing a partner, even though many young people will have their partner chosen for them.¹⁶

POLICY AND PROGRAM RESPONSES

International agreements affirm that *all* adolescents—including the young—have the right to receive age-appropriate sexual and reproductive health information, education, and services that will enable them to deal in a positive and responsible way with their sexuality.¹⁷ Formal and informal education should promote relationships based on gender equality and mutual respect as well as enabling adolescents to protect themselves

from early and unwanted pregnancy, STIs/HIV, and sexual abuse and violence.

According to such agreements, adolescents' access to information and services is *not to be restricted* by discriminatory legal, regulatory, or social barriers based on age or marital status or by the negative attitudes of health-care providers. All programs are to safeguard adolescents' rights to privacy, confidentiality, respect, and informed consent.

Sexuality education: Effective, comprehensive, and ongoing sexuality education that is based on principles of human rights and gender equality and that answers young adolescents' questions is urgently needed in schools and other venues, including out-of-school programs. Additional modes of communication and learning include the print media (especially popular teen magazines); radio and television programs targeted at adolescents; telephone question-and-answer hotlines; and the Internet.

- Curriculum-based sexuality and relationships education should begin in early primary grades and intensify at the upper primary and middle school levels.¹⁸ At age 12 more than 85 percent of all children in developing countries are in school.¹⁹ Attendance can drop off quickly after age 12, however, resulting in widening inequalities based on gender, household wealth, and rural-urban residence.²⁰
- Programs that stress abstinence from sexual intercourse as a positive choice for girls and boys under age 15 (assuming that choice is possible) should also provide accurate and non-judgmental information about STI/HIV and pregnancy prevention.
- Age-graded curricula that reach boys and girls *before* they become sexually active by any definition need to address not only the physiological aspects of sexuality and reproduction but also the emotional aspects of intimate relationships, diversities of sexual expression, self-esteem, and negotiation and decision-making skills.²¹
- Adolescents under age 15 need information, practical skills, and family, social, and legal supports that will enable them to make informed decisions—including the refusal of forced marriage—and to protect themselves from all forms of sexual harassment, coercion and violence in their families, schools, and communities. Younger adolescents—both boys and girls—need safe spaces where they can ask questions, talk with one another and with trusted adults, and gain the information and support needed to reinforce positive changes in their attitudes and behaviors.

Sexual and reproductive health services: Providers of sexual and reproductive health care services such as contraception, STI and HIV testing and counseling, condoms, and abortion care are often reluctant to serve young adolescents (or any unmarried persons) and may refuse them altogether.²² In some cases this discrimination is based on policies restricting minors' access to health services without parental consent; in others it is based on cultural values, unawareness or denial of need, or the fears of providers themselves.

- The boundaries between adolescents' rights to make their own decisions and parents' rights to make decisions for them are contested almost everywhere. Yet evidence suggests that withholding crucial information and services from young people does not protect them from harm. Rather, it increases the likelihood that if and when sexual initiation does occur, it will be unprotected.²³
- Requests from young adolescents to health-care providers or suppliers such as pharmacists for information, services or supplies, including requests for condoms and other forms of contraception, indicate a capacity for making responsible decisions and should be respected without discrimination as to age, gender, or marital status.²⁴

Other policy and program responses: Interventions to promote the sexual and reproductive health and rights of young adolescents are needed in a variety of settings, not only the schools and health services but also at national and state levels of government and in communities, neighborhoods and families. The elimination of all forms of sexual abuse and trafficking in children wherever it is found and of forced and child marriage is an urgent priority. Greater attention is needed almost everywhere to specifying the needs of diverse groups of young people in order to design and implement holistic programs that will build their skills, confidence, knowledge base, and personal agency and to train teachers, social workers, health-care providers, law enforcement personnel, and others in the community to respond more effectively to young adolescents' needs and concerns.²⁵ The meticulous documentation of such efforts, including baseline research and systematic assessments of substance, processes, and outcomes, can help to build the evidence base for the next generation of sexual and reproductive health policies and programs on which the futures of so many young adolescents will depend.

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REFERENCES

¹ Erica Chong, Kelly Hallman, and Martha Brady, *Investing When It Counts: Generating the Evidence Base for Policies and Programmes for Very Young Adolescents, Guide and Tool Kit* (New York: Population Council, 2006).

² Pan American Health Organization (PAHO), *Youth: Choices and Change* (Washington, DC: PAHO, 2005).

³ Population Council, "A summary of selected DHS data on very young adolescents," <http://www.popcouncil.org/gfd/gfdcountries.html> (includes individual country tables).

⁴ Anne-Simone Parent et al., "The timing of normal puberty and the age limits of sexual precocity," *Endocrine Review* 24, no. 5 (2003): 668-693; Cynthia B. Lloyd, ed., *Growing Up Global: The Changing Transitions to Adulthood in Developing Countries* (Washington DC: National Academies Press, 2005).

⁵ J. M. Tanner. *Growth at Adolescent*, 2nd ed. (Oxford: Blackwell Scientific Publications, 1962).

⁶ M. Elizabeth Duncan et al. "First coitus before menarche and risk of sexually transmitted disease," *The Lancet* 335 (Feb. 10, 1990): 338-340.

⁷ Cynthia B. Lloyd, ed, *Growing Up Global: The Changing Transitions to Adulthood in Developing Countries*, (Washington DC: National Academies Press, 2005).

⁸ See notes 2 and 5 above.

⁹ J. Richard Udry, "Biological limits of gender construction," *American Sociological Review* 65, no. 3 (2000): 443-457.

¹⁰ Elizabeth Eggleston, Jean Jackson, and Karen Hardee, "Sexual attitudes and behavior among young adolescents in Jamaica," *International Family Planning Perspectives* 25, no. 2 (1999): 78-84; Rajani and Mustafa Kudrati, "The varieties of sexual experience of the street children of Mwanza, Tanzania," in *Learning About Sexuality: A Practical Beginning*, ed. Sondra Zeidenstein and Kirsten Moore (New York: The Population Council, 1996); Yvonne Szasz, "Masculine identity and the meanings of sexuality: A review of research in

Mexico,” *Reproductive Health Matters* 6, no. 12 (1998): 97-104; Lisa Remez, “Oral sex among adolescents: Is it sex or is it abstinence?” *Family Planning Perspectives* 32, no. 6 (2000): Special Report.

¹¹ Shireen J. Jejeebhoy, Iqbal Shah, and Shayan Thapa, *Sex Without Consent: Young People in Developing Countries* (London: Zed Books, 2005).

¹² Ibid.

¹³ Macro International. Demographic Health Surveys, “Statcompiler.” <http://www.measuredhs.com>; Shusheela Singh, Deirdre Wulf, Renee Samara, and Yvette P. Cuca, “Gender differences in the timing of first intercourse: data from 14 countries,” *International Family Planning Perspectives* 26, no. 1 (2000): 21-28 & 43.

¹⁴ Eggleston, Jackson, and Hardee, “Sexual attitudes and behavior,” 78-84; Fatima Juárez and Teresa Castro Martin, “Partnership dynamics and sexual health risks among male adolescents in the favelas of Recife, Brazil,” *International Family Planning Perspectives* 32, no. 2 (2006): 62-70; Deborah A. Cohen et al., “Where and when do youths have sex?” [Southern United States] *Pediatrics* 110, no. 6 (2002).

¹⁵ See note 13 above. Eggleston, Jackson, and Hardee, “Sexual attitudes and behavior,” 78-84; Juárez and Castro Martin, “Partnership dynamics and sexual health risks among male adolescents,” 62-70; Ann K. Blanc and Ann A. Way, “Sexual behavior and contraceptive knowledge and use among adolescents in developing countries,” *Studies in Family Planning* 29, no. 2 (1998): 106-116; Alan Guttmacher Institute (AGI), *Adolescent Sexual and Reproductive Health in Burkina Faso: Results from the 2004 National Survey of Adolescents*, Occasional Report no. 21 (New York: AGI, 2006); *Ghana* (no.22), *Malawi* (no. 24) and *Uganda* (no. 25).

¹⁶ Sabina Faiz Rashid, “Communicating with rural adolescents about sex education: experiences from BRAC, Bangladesh,” in *Towards Adulthood: Exploring the Sexual and Reproductive Health of Adolescents in South Asia*, ed. Sarah Bott, Shireen J. Jejeebhoy, Iqbal Shah and Chander Puri (Geneva: World Health Organization, 2003).

¹⁷ Paragraphs on adolescence in the Plan of Action of the International Conference on Population and Development, Cairo, 1994 and the five-year review by the United Nations General Assembly; and the Platform for Action of the Fourth World Conference on Women, Beijing, 1995 and the five-year review by the United Nations General Assembly.

¹⁸ Deborah Rogow and Nicole Haberland, “Sexuality and relationships education: Toward a social studies approach,” *Sex Education* 5, no. 4 (2005): 333-344; Sexuality Information and Education Council of the United States (SIECUS), *Guidelines for Comprehensive Sexuality Education, Kindergarten through 12th Grade*, 3rd ed. (New York: SIECUS, 2004).

¹⁹ World Bank, *World Development Report 2007: Development and the Next Generation* (Washington, DC: World Bank, 2007).

²⁰ See note 6 above.

²¹ Andrea Irvin, *Positively Informed: Lesson Plans and Guidance for Sexuality Educators and Advocates* (New York: International Women’s Health Coalition, 2004); UNAIDS Inter-agency Task Team on Young People; David A. Ross, Bruce Dick, and Jane Ferguson, eds., *Preventing HIV/AIDS in Young People: A Systematic Review of the Evidence from Developing Countries* (Geneva: World Health Organization, 2006); Douglas Kirby, B. A. Laris, and Lori Rolleri, *Sex and HIV Education Programs for Youth: Their Impact and Important Characteristics* (Washington, DC: Family Health International and YouthNet, 2006).

²² Karl L. Dehne and Gabriele Riedner, *Sexually Transmitted Infections among Adolescents: The Need for Adequate Health Services* (Geneva: World Health Organization, 2005).

²³ Douglas Kirby, National Campaign to Prevent Teen Pregnancy, *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy*, 2001, <http://www.teenpregnancy.org>.

²⁴ Rebecca Cook and Bernard M. Dickens, “Recognizing adolescents’ ‘evolving capacities’ to exercise choice in reproductive healthcare,” *International Journal of Gynecology & Obstetrics* 70, no. 1 (2000): 13-21.

²⁵ UNAIDS Inter-agency Task Team on Young People; David A. Ross, Bruce Dick, and Jane Ferguson, eds., *Preventing HIV/AIDS in Young People: A Systematic Review of the Evidence from Developing Countries*. (Geneva: World Health Organization, 2006); Sue Alford, Nicole Cheetham, and Debra Hauser, *Science and*

Success in Developing Countries: Holistic Programs that Work to Prevent Teen Pregnancy, HIV & Sexually Transmitted Infections (Washington, DC: Advocates for Youth, 2005); Judith Bruce and Amy Joyce, eds., *The Girls Left Behind: The Failed Reach of Current Schooling, Child Health, Youth-Serving and Livelihoods Programs for Girls Living in the Path of HIV* (New York: The Population Council, 2006).

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