

## UNIT 5: Very Young Adolescents

### *INTRODUCTION:*

Adolescents and young people in general are frequently stigmatized, discriminated against, and underserved because of their age. Particular sub-populations of young people are further marginalized or ignored completely. One such sub-population is very young adolescents (VYAs), or adolescents aged 10-14. Very little data exists on VYAs, which are almost entirely excluded from the Demographic and Health Surveys (DHS), and while there is growing interest in this age group, it has yet to translate into many sexual and reproductive health programs and services for VYAs.

Many providers and programs are uncomfortable providing SRH information and services to VYAs, and this is particularly true in the case of VYAs with disabilities. But it is important to remember that in some LMICs, including West Africa and South Asia, early or child marriage is common, and one in nine girls marry before age 15. Pregnancy related concerns are still a major cause of morbidity and mortality for adolescents in many countries. For many VYAs, services are unavailable, of poor quality or, when it comes to VYAs with disabilities, often inaccessible.


### *UNIT TRAINING OBJECTIVE:*

To discuss concerns about appropriateness of providing services to very young adolescents and promote good practice in service provision as social protection.




### *SPECIFIC LEARNING OBJECTIVES:*

By the end of the unit, participants will be able to:

1. Discuss the sexual and reproductive health needs and vulnerabilities of very young adolescents.
2. Identify WHO standards of care that are relevant to the SRH of very young adolescents.
3. Identify appropriate services and interventions for very young adolescents.

 *TOTAL TIME: 4 HOURS 25 MINUTES*

### *UNIT OVERVIEW:*

<b>Session</b>	<b>Methods</b> 	<b>Materials</b> 	<b>Time</b> 
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5.1	Group brainstorm Trainer presentation	Flipchart and markers Slides 5.1-5.9	1 hour 30 minutes
5.2	Trainer presentation Group discussion	Flipchart and markers Slides 5.1 – 5.9 Participant handout 5A	1 hour
Unit Summary	Reflection		10 minutes



**WORK FOR TRAINERS TO PREPARE IN ADVANCE:**

- Review Slides 5.1-5.9
- Prepare Participant Handout 5a



**MAJOR REFERENCES AND TRAINING MATERIALS:**

ACPF (African Child Policy Forum). 2010. *Breaking the silence: Violence against children with disabilities in Africa*. Addis Ababa: ACPF.

Center for Development and Justice. 2017. *Uncovered realities: Exploring experiences of child marriage among children with disabilities*. Plan International.

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Groce, N. and Kett, M. 2014. *Youth with disabilities*. Working Paper 23. London: Leonard Cheshire Disability and Inclusive Development Centre, University College London.

Jones, L., Bellis, M.A., Wood, S., Hughes, K., McCoy, E., Eckley, L., Bates, G., Mikton, C., Shakespeare, T. and Officer, A. 2012. Prevalence and risk of violence against children with disabilities: A systematic review and meta-analysis of observational studies. *Lancet* 380(9845): 899–907.

Jones, N., Presler-Marshall, E. and Stavropoulou, M. 2018. *Adolescents with disabilities: Enhancing resilience and delivering inclusive development*. London: Gender and Adolescence: Global Evidence

Igras, Susan M., M. Macieira, E. Murphy, and R. Lundgren. 2014. Investing in very young adolescents' sexual and reproductive health. *Global Public Health* 9(5): 555-

569. May 2014.

Institute for Reproductive Health. 2010. *Reaching Very Young Adolescents (VYAs): Advancing Program, Research and Evaluation Practices*. Washington, DC: Georgetown University Institute for Reproductive Health.

Interagency Youth Working Group. 2014. Very young adolescents. *YouthLens on Reproductive Health and HIV/AIDS #39*. Durham, NC: FHI360.

Pathfinder International. 2013. *GREAT Project Scalable Toolkit*. Watertown, MA: 2013.

UNESCO. 2009. *International Technical Guidance on Sexuality Education: Volume II, Topics and Learning Objectives*. Paris: UNESCO.

UNICEF. 2014. *A Statistical Snapshot of Violence against Adolescent Girls*. New York: UNICEF.

WHO: Essential Training Package for a 2-dose schedule HPV vaccine introduction: [http://www.who.int/immunization/diseases/hpv/2dose\\_schedule/en/](http://www.who.int/immunization/diseases/hpv/2dose_schedule/en/)

WHO and World Bank. 2011. *World report on disability*. Geneva: WHO.

## SPECIFIC OBJECTIVE 5.1: DISCUSS THE SEXUAL AND REPRODUCTIVE HEALTH NEEDS AND RISKS OF VERY YOUNG ADOLESCENTS.



### *TIME*

1 hour 30 minutes



### *METHODS*

- Group Brainstorm
- Trainer Presentation



### *MATERIALS NEEDED*

- Flipcharts and markers
- Slides 5.1-5.9



### *STEPS*

1. Introduce the topic. Remind participants of the importance of respectful disagreement and active listening. Take the time to revisit the ground rules for the training if you've set them.

#### **Time: 30 minutes**

2. Tell participants that as challenging as it can be to provide sexual and reproductive health services to older adolescents aged 15-19, it can be even more challenging to think about, talk about, or advocate for the sexual and reproductive health needs of very young adolescents aged 10-14.
3. Tell participants that gender and disability represent other key factors to be taken into account when it comes to dealing with the challenges of thinking, talking about or advocating for the sexual and reproductive health needs of very young adolescents.
4. Tell participants that you're going to start today's session with a quick brainstorm. Remind them that there are no "right" or "wrong" answers, and that they are not responding to each other right now, just volunteering their own ideas and experience. On a flipchart at the front of the room, write "10-14 Years Old."
5. Ask participants to help brainstorm some examples of the types of messages young people in this age group **hear** from their societies, cultures, families and peers about sexuality, gender, disability, and sexual and reproductive health. Jot down their answers on the flip chart. If the discussion is slow to start, add your own example to the chart: "you're too young to be thinking about that now."
6. Once participants have run out of ideas or slowed down, remove the flipchart paper and post it on the wall. On the next blank flipchart paper, again write "10-14 Years Old."

7. Ask participants to brainstorm again, this time about the health, gender, disability and social messages that they think young people **need** when they are this age. Remind participants again that there are no “right” or “wrong” answers and there is no need to respond to each other, just share their own ideas. If it is helpful, start with another example: “Information about puberty.”
8. When participants are done with this brainstorm, move the second flip chart to the wall. Ask for a volunteer to reflect back to the group how they feel about the idea that 10-14-year-olds might need sexual and reproductive health information and services. Ask participants to reflect on the following questions, either silently or to the group if they are comfortable.
  - a. What has been your experience – if any – in providing information or services to a young person in this age group? Were they boys or girls? Did they have a disability or not?
  - b. What are your concerns about providing information or services for this age group? Do you have different/additional concerns related to the gender and/or disability of very young people?
  - c. What reactions do you think you’d get from your community if you actively provided services to this age group? Do you think you would get a different reaction if you provide services to boys? To girls? Very young adolescents with disabilities?

**Time: 1 hour**

9. Introduce the presentation **Content: SRH Needs of Very Young Adolescents** (Slides 5.1-5.9), below. Tell participants that many health providers don’t know how to provide information or services to this age group, that lack of information and experience is even more significant when it comes to very young adolescents with disabilities, and that this presentation is designed to provide information that will enable them to interact with this age group taking into account not only their age but also their gender and disability. Pause for questions frequently between slides to allow for clarification and discussion.

***Content: SRH Needs of Very Young Adolescents (Slides 5.1-5.9)***

***Slides 5.1-5.2: Information***

Very young adolescents need *accurate, unbiased* information about sexuality and reproductive health from their service providers and parents. Overall, young people have limited access to comprehensive sexuality education or other sources of reliable information about their sexual and reproductive health, and this is particularly true for adolescents aged 10-14, girls who are married before age 15, and VYAs with disabilities.

Very young adolescents are exploring their values and beliefs around their emerging sexuality, including what it means to be a man or a woman. It is during this period

of life that young people adopt and establish their gender roles and identities. They are very receptive to information about the following topics:

- What changes to expect during puberty, including information about menstruation and nocturnal emissions.
- Gender roles, gender norms, and expressions of gender.
- Relationships.
- Violence, consent, and bodily autonomy.
- Sexuality, body image, personal values, tolerance, respect, and inclusion.
- For girls who are married, contraception, healthy timing and spacing of pregnancy, and healthy pregnancies.

### ***Slide 5.3: Gender***

A growing body of evidence suggests that providing positive messages on gender roles and promoting gender equitable behaviors and practices are particularly important for very young adolescents.

This is an important time to reinforce the following messages:

- Both young men and young women need time and space to determine who they want to be and how they want to get there.
- Violence towards other people is not “manly.”
- Violence and abuse against very young boys and girls with disabilities is not acceptable.
- Men do not need to experiment sexually to be “real men.”
- Women can also experience attraction and sexual desire without being “bad girls.”
- No partner in a romantic relationship, independent of their age, gender or disability should have physical, social, or economic power over the other.
- Both young men and young women with and without disabilities should have knowledge and information about their bodies and their health and how to prevent unintended pregnancy, STIs or HIV.

### ***Slides 5.4-5.5: Early/Child Marriage***

- Girls from poor households are more likely to marry early than girls from wealthier households.
- Girls with more schooling are less likely to marry as children. Keeping girls in school is critical to increasing the age of marriage and age of first pregnancy.
- Pregnancy is still a leading cause of morbidity and mortality for adolescents, especially for those under 15.
- Child brides are more likely to contract HIV, because they often marry a much older, more sexually experienced man. Girls aged 15-19 are anywhere from 2 – 6 times more likely to contract HIV than boys of the same age in sub-Saharan Africa.

- Child brides are more likely to experience domestic violence, show signs of sexual abuse, and experience post-traumatic stress such as feelings of hopelessness, helplessness, and severe depression.
- Limited and scattered data show that in regions and communities where child marriage is a common phenomenon, children with disabilities are likely to be proposed for marriage around the same age as their peers without disabilities.
- Disability adds an additional layer of vulnerability to the practice of child marriage and further enhances a girls' likelihood of being forced into marriage.
- While the driving causes of child marriage are similar for children with and without disabilities, parents of children with disabilities see marriage as a way to secure the child's future.

### ***Slides 5.6-5.8: Protective Screening***

Very little data is available on very young adolescents need for sexual and reproductive health services, and when they are available, data are not often disaggregated based on disability. However, it is safe to assume that 10-14-year-olds, particularly girls, who need these services are likely to be highly vulnerable.

- 1 in 10, or approximately 120 million girls worldwide, have experienced forced intercourse or other forced sexual acts. (*Source: UNICEF 2014*)
- In 18 countries reporting, anywhere from 10 to 70% of girls who experienced forced intercourse or other forced sexual acts were under the age of 15.
- 15 million girls or one out of every three girls in developing countries are married before the age of 18 every year, and one out of nine are married by age 15.
- In 15 countries reporting, between 10% and 27% of girls said they were married before they turned 15. (*Source Interagency Youth Working Group 2014*)
- Adolescents with disabilities are particularly vulnerable to sexual harassment, violence and abuse (ACPF, 2010; WHO and World Bank, 2011). Such incidents are rarely reported and, as a result, accurate and comparable disaggregated data are unavailable. However, a systematic review estimated that children and adolescents with disabilities are nearly three times more likely to experience sexual violence than their peers without disabilities (Jones et al., 2012).
- The risk of sexual violence increases for girls as soon as they reach puberty with most incidents having taken place between the ages of 14 and 17. While boys with disabilities are also at risk of sexual violence and abuse, girls are more likely to experience it (ACPF, 2010; Groce and Kett, 2014).

Many of these girls will only be seen by health providers when they present with a pregnancy, with HIV or with complications from an undiagnosed STI. Girls with disabilities face additional barriers and are often denied access to services as they are often inaccessible, health providers have little knowledge about disability and

feel unable or unequipped to provide services to this group of young people. Providers should be able to screen and treat girls with and without disabilities for sexual violence in addition to sexual and reproductive health or maternal services. Sexual and gender-based violence screening and services will be covered in Unit 13.

#### **Slide 5.9: Preventative and Basic Services**

In addition to protective and emergency services, some sexual and reproductive health services are best delivered in early adolescence:

- The WHO recommends that all girls aged 9-13 should receive vaccination against HPV in a two-dose schedule at 0 and 6 months [*Note: Females  $\geq 15$  years at the time of first dose should receive: a 3-dose schedule (0, 1-2, 6 months)*].
- All girls aged 10-14 need information and supplies to appropriately prepare for and handle menarche and menstruation.
- Data compiled by the Interagency Youth Working Group (2014) showed that between 9 to 27% of girls and 2 to 31% of boys aged 15-19 report initiating sexual activity before the age of 15. Disability disaggregated data on the age of sexual debut are scattered and very limited.
- Adolescents need contraception and dual protection strategies whenever they become sexually active. These should be available and accessible to all adolescents, including adolescents with disabilities.
- Many girls experience forced or coerced sex or violence, so they should have access to services, including counseling, post exposure prophylaxis and emergency contraception. These should be available and accessible to all girls, including girls with disabilities.

- 10.** Close the presentation by reminding participants that while there is limited attention to services for this age group, there is also little demand. Ask participants to revisit the concerns and fears they listed at the beginning of the session. Ask if any of them think they are better equipped to respond to criticism about providing services for this age group now.



## SPECIFIC OBJECTIVE 5.2: IDENTIFY APPROPRIATE SERVICES AND INTERVENTIONS FOR VERY YOUNG ADOLESCENTS.



### *TIME*

1 hour 45 minutes



### *METHODS*

- Small group work



### *MATERIALS NEEDED*

- Flipcharts and markers
- Participant Handout 5a: Services for Very Young Adolescents



### *STEPS*

**Time: 1 hour 45 minutes**

1. Set up 4 flipcharts in the corners of the room, each with one of the following categories written on them:
  - a. Information
  - b. Healthy gender norms
  - c. Protection
  - d. Prevention and Basic Health
2. Pass out **Participant Handout 5a: Services for Very Young Adolescents** (below). Divide participants randomly into 4 groups by having them count off and assign each group to a flipchart.
3. Introduce the group work. Tell participants that each of the four groups should design a strategy to introduce the category of services listed on the top of the flip chart at their clinic for very young adolescents. Tell them that the handout they've received has some examples of types of services they may want to consider in each category but is not an exhaustive list. They can also consider the previous discussion on quality standards and statements.

When designing a strategy, they should consider: the SRH needs of very young adolescents, how to integrate services for this age cohort into their existing SRH services, where else such services can be provided, how to ensure quality of care, how to ensure these services are accessible to adolescents with disabilities, and if there are particular changes or stand-alone strategies they would need to add.

4. Give each group **25-30 minutes** to discuss and develop their strategy. The trainer should wander the room during this time and answer questions/clarify the assignment as needed.
5. Ask for a representative from each group to present back to the plenary. Give each group **five minutes** for their report back, then allow **10 minutes** for the whole group to respond and ask questions. After each group reports, the trainer can prompt responses from the whole group with the following questions:

- Would this strategy work in your clinic? What changes would you need to make if you wanted to introduce this kind of service? What changes would you need to make to ensure these services are accessible to adolescents with disabilities?
  - Does anyone already provide these services to this age group? Are they accessible to adolescents with disabilities? Are young adolescents with disabilities asking for them? What challenges do you have? What might be some ways to overcome the challenges?
  - Which of these services do you think are the highest priority for very young adolescents in your community? Which are less urgent? Do you think young adolescents with and without disabilities have the same or similar priorities? If not, why and how do you plan to address these differences?
6. Close the discussion by thanking all of the participants for their work during this unit. Acknowledge the difficulty of this topic and remind participants of resources available to them, including those listed at the beginning of this unit and others in their community.

*PARTICIPANT HANDOUT 5A: SERVICES FOR VERY YOUNG ADOLESCENTS*

**Information**

- Information about what changes to expect during puberty, including information about menstruation and nocturnal emissions.
- Information about gender roles and gender norms, including positive messages about gender equitable relationships, gender expressions, and social expectations of men and women.
- Information about violence, consent, and bodily autonomy.
- Positive messages about sexuality, body image, personal values, tolerance, respect and inclusion.
- Information on contraception including condoms.

**Healthy Gender Norms**

- IEC materials and behavior change interventions that address dominant gender roles, discrimination and violence based on gender, age, and disability.
- Stories, media, and films featuring positive depictions of masculinity, femininity, gender equality, women's empowerment, and inclusion.
- Counseling and social support for young people experiencing bullying or discrimination based on their gender identity or gender expression.

**Protection**

- Screening for violence or abuse (physical, emotional, or sexual) in the home, orphanages or other institutions.
- Screening for violence or abuse (physical, emotional, or sexual) in intimate relationships.
- Screening for violence or abuse (physical, emotional, or sexual) in the community (school, public spaces, rehabilitation centers, etc).
- Social support for married adolescents.
- Support for young adolescents with disabilities.
- Access to contraception, condoms, emergency contraception, safe abortion or post-abortion care, and HIV prevention including pre- and post-exposure prophylaxis.
- Counseling and support services for those who have experienced force, coercion, or abuse.

**Prevention and Basic Health**

- Information, training, and supplies for menarche and menstruation.
- HPV vaccinations.
- Access to information and supplies for contraception and dual protection for very young adolescents who are already or who are considering becoming sexually active.
- Screening for sexual abuse or violence.
- Information about and screening for STIs, including HIV.

## UNIT 5 SUMMARY



### *TIME*

10 minutes



### *METHODS*

Reflection



### *MATERIALS NEEDED*

None



### *STEPS*

1. Bring participants into a group and ask them to reflect on the following questions:
  - Why is it especially important to consider the SRH needs of very young adolescents? What is especially important to consider regarding young adolescents with disabilities?
  - What sort of resistance to serving very young adolescents might we face in our clinics and facilities?
  - What are some ways we could better determine the SRH needs of very young adolescents with and without disabilities and develop programs to serve them?