**FCDO’s approach to sexual and reproductive health
20 April 2023**

**Sexual and reproductive health and rights for younger adolescents (with a focus on early adolescent pregnancy)**

**Executive Summary:**

In response to this call for evidence by the International Development Committee we provide evidence and policy recommendations in relation questions 1-4 related to this enquiry. In particular, this submission addresses **Question 1**:

*Is the FCDO’s approach to sexual and reproductive health programming in lower-income countries sufficiently responsive to the needs of communities in lower-income countries, including in its new Sexual and Reproductive Health and Rights programme?*

The relevance of evidence to other questions is flagged throughout the document.

Our response addresses the need for a greater focus on sexual and reproductive health in early adolescence, and has a particular focus on the issue of early adolescent pregnancy.

**Key findings:**

* Sexual activity commences early in many parts of the world, but the majority of research and programmes on adolescent sexual health have focussed on those aged 15-19 years. In many contexts, a significant number of adolescents are already sexually active before this age, resulting in negative consequences including pregnancy. In many countries pregnancy in early adolescence is a common consequence.
* Despite some growing acknowledgement of the importance of addressing sexual health and pregnancy in younger adolescents this is still an overlooked area by donors (including FCDO), as well as national governments. Greater focus and resources are needed to understand and prioritise the needs of this vulnerable and underserved group, particularly as pregnancy in this younger age group (which carries high risks for both mother and infant) is particularly concentrated amongst the poorest and least educated women and girls. We strongly argue that a focus on early adolescent Sexual and reproductive health and rights [‘SRHR’] is vital to improving the responsiveness of programming in many low- and middle-income countries, particularly for the poorest and most marginalised populations.
* Equally, adolescents are not a heterogenous groups and approaches to improving adolescent SRHR need to recognise the cognitive and emotional differences between younger and older adolescents and acknowledge that different strategies and interventions may be required to reflect the evolving capacity and increased need for protection of younger girls.

**Key recommendations:**

* We recommend that FCDO highlights the needs and vulnerabilities of very young adolescents within it’s SRH strategy, and explore opportunities to support and advocate for research, policies and programmes to address the needs of this group. We also suggest the importance of acknowledging the needs and vulnerabilities of younger adolescents within wider SRH policies.
* FCDO has a significant role in encouraging the development of an enabling environment that enables younger adolescents to develop their capacity to make safe choices regarding their sexual and reproductive health within a supportive and protective environment through supporting appropriate interventions within the health, legal, social development, child protection and gender sectors that promote the rights of these young girls.

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**The response**

***1.1 The need for greater focus on early adolescent sexual health***

In many countries a high proportion of girls are sexually active before the age of 15 years (see figure 1), yet the SRH needs of this group has been largely overlooked. Reasons for sexual activity among very young adolescents (VYA) vary significantly: some may be sexually active because of an informed choice to commence a consensual sexual relationship; others are married very young and therefore expected to be sexually active and bear children; while other young adolescents experience sexual activity as part of traditional initiation rites, or transactional, coerced or forced sex (Munthali, Chimbiri and Zulu, 2004).

Figure 1: % women aged 20-24 years who reported sexual debut before age 15 years (most recent DHS survey) [[1]](#footnote-1) - Source: DHS [STATcompiler](https://www.statcompiler.com/en/).

This clearly illustrates how an enabling environment to promote the sexual and reproductive health and rights (SRHR) of younger adolescents needs to be placed with a wider context that incorporates health care, education, legal and child protection processes and societal norms and values and explores issues of young people’s evolving capacities, competencies, rights and vulnerabilities (*relates to Q 4 of inquiry: integrated programming).* It also illustrates a heterogeneity within the wider adolescent age range which is rarely recognised.

***1.2 The burden of very young adolescent pregnancy***

Early adolescent fertility is not a marginal issue. In some countries births to women below the age of 16 years[[2]](#footnote-2) remain common: it has been estimated that up to 2.5 million girls give birth before this age globally each year. Rates are particularly high in many countries within West and Central Africa, with four countries (Chad, Mali, Niger and Central African Republic) reporting more than 20% of women having their first birth before 16 years. However, some countries in south and South Asia and East Africa also report over 10% of women have become mothers before their 16th birthday. In addition young adolescent mothers are likely to have repeat adolescent pregnancy: a recent study of multiple west African countries found women who entered motherhood at age 14 and younger had between 2.1 to 3.3 births on average before their twentieth birthday while those who entered motherhood between ages 15-17 had between 1.5 to 2.1births (Garbett, Perelli-Harris and Neal, 2021).The study also found that because of repeat adolescent childbearing, girls who start childbearing at younger ages contribute much more to the overall burden of adolescent fertility than those who start at ages 18 and 19. The fertility of women who had their first births in both middle (15-17 years( and early adolescence(<15 years) accounted for more than three quarters of total adolescent fertility (Garbett, Perelli-Harris and Neal, 2021).

***1.3 Why should there be greater focus on early adolescent pregnancy?*** *(link to Q2: preventing avoidable mortality)*

These younger childbearing adolescents will obviously face very different experiences and risks to older adolescents. Several studies highlight that the negative health consequences of adolescent motherhood are more severe for both mothers and infants in this when births take place below the age of 16. One Latin American study found that after adjusting for confounding factors such as economic status, parity and maternal health care, girls aged 15 or under had an odds ratio for maternal death four times higher than women aged 20–24. Girls aged 16–19, however, did not experience increased risk (Conde-Agudelo, Belizán and Lammers, 2005). An earlier study from Bangladesh found that girls aged 15–19 had a maternal mortality rate nearly twice that of women aged 20–24 and the rate for girls aged 10–14 was nearly five times higher(Chen *et al.*, 1974). Newborns also have a markedly higher rate of mortality if their mother is under 15 years compared to either older adolescents or women aged 20-29 years. Despite the introduction of an SDG on early adolescent fertility rate (10-14 years) current statistics for adolescent childbirth are still rarely disaggregated by age, meaning very early adolescent motherhood is often a hidden problem.

In addition to the increased health risks associated with very young births, very young adolescent mothers are further disadvantaged in that they are particularly concentrated among the poorest and least educated populations. For example, in Kenya women in the poorest quintile are just over twice as likely to have a first birth aged 18/19 years than those in the richest quintile, but the poorest are nearly 6 times more likely to have a first birth <16 years than the richest(Neal, Chandra-Mouli and Chou, 2015). Addressing early adolescent pregnancy and sexual health is clearly an issue of equity. A further point is that they are less likely to be married or in union that older adolescents (Neal, Chandra-Mouli and Chou, 2015), which in many contexts leaves them at risk of being stigmatised or ostracised from their families and communities. There is often marked geographical variation within countries in the prevalence of very early adolescent motherhood, and mapping can highlight small “pockets” where rates are very high even in countries where the overall aggregate rate is quite moderate (Neal *et al.*, 2016, 2019).

While some countries have made clear progress in reducing births to this younger age group, in other countries, particularly within sub-Saharan Africa, progress has been much more limited. A study of 20 east and west African countries found on average very little reduction had been made in reducing births to women under the age of 16 years: in fact in several countries (e.g.,, Benin, Ethiopia and Mali) births to very young adolescents had increased despite some evidence of modest declines among older adolescents (Neal et al. 2015).

**2.0 *Responding to the SRH needs of very young adolescents: the need to information and comprehensive sexuality education*** *(refers to Q2: effectiveness of family planning education and information)*

Comprehensive sexuality education (CSE) is a s a curriculum-based process of teaching and learning about the cognitive, emotional, physical, and social aspects of sexuality. Evidence suggests that CSE can improve SRH outcomes for adolescents and reduce risky behaviour including early sexual debut(Browne, 2015). It **is designed to be taught over several years** using a progressive curriculum aimed at four age groups (5-8 years; 9-12 years; 12-15 years and 15-18+ years)**that accounts for the developing capacities of young people.**

The programme must be started at a young age to ensure that information is provided before the young person becomes sexually active. It is also important that the programme is begun in primary as in many countries a significant proportion of young people do not progress to secondary education.

While there is growing acknowledgement young adolescents’ need for information and inclusion within comprehensive sexuality education, there is still resistance to providing knowledge on sexual health to younger teens because of unfounded concerns this may lead to experimentation. Many young people report that the information they receive is “too little, too late and too biological”, with deliveries at a later time than young people would find valuable and do not sufficiently address broader emotional, moral or social issues (The International Planned Parenthood Federation (IPPF), 2016). Many do not receive any sexuality education until after they have become sexually active, clearly rendering it less effective.

***2.1 Access to sexual health services for adolescents – balancing the right to choice and protection*** *(refers to Q2: effectiveness of contraceptive supplies and healthcare services)*

Realistically, early sexual debut cannot be entirely prevented, yet sexually active younger adolescents are rarely recognised within sexual health strategies, including contraceptive provision. Health care policies in many countries may rigidly restrict access to sexual health services below a certain age (or for unmarried adolescents). Legislation and policy are major barriers to accessing SRH services for young people, including a requirement of parental/third party consent (Strode and Essack, 2017). Even if legislation is not in place there may be assumptions that access to services is linked to other legal processes e.g. minimum age of consent. Many adolescents respond to these restrictions by misrepresenting their age, thus masking their potential vulnerability. Societal censure and stigma may also create barriers for all adolescents, particularly younger adolescents, seeking services.

Understandably, the provision of sexual health services to very young adolescents without parental consent is controversial, with concerns raised about the appropriateness of sexual activity for very young adolescents and how the best interests of the young adolescent may best be served. It can be argued that enabling access to contraception can be viewed as a “harm reduction” approach that prevents some of the very real potential negative consequences of early sexual activity.

However, it is highly likely that sex for many young adolescents will be coercive or abusive, which clearly raises ethical issues for both providers and policy makers. It is therefore important that the rights of a child to protection are also met. This will require the effective linkage of child protection services /gender-based violence services within sexual health services, with SRH staff adequately trained to identify abuse and refer to appropriate, effective and timely services based on clear policies and pathways. This may be problematic in some settings where child protection services may be very poorly developed, making it difficult for health workers to refer children they consider vulnerable.

**The Fraser Guidelines: supporting health workers in identifying the best interests of the child**

The UK has developed the Fraser Guidelines to support health care workers in making decisions about when it is appropriate to provide contraceptive services to adolescents under 16 years without parental permission. These guidelines draw on the principle of the child’s competency to understand the proposed treatment and give true consent, as well as outlines health care workers responsibilities in terms of child protection (including identification that all children seeking contraception below the age of 13 years should be referred to Social Services). Development of nationally-adapted guidelines for target countries with similar aims may support health care workers in creating an appropriate balance in their response to young adolescents.

***2.2 A wider enabling environment*** *(link with Q4: integration with other programme areas)*

The strong correlation between early adolescent pregnancy and poverty and lack of education indicate that a multi-sectoral approach is needed to tackle the drivers of poor sexual health among very young adolescents, as well as addressing gender norms and violence against women and girls. There are obvious synergies with programmes to address early, child and forced marriage: while often early marriage may precede early adolescent pregnancy, in some contexts it is actually the pregnancy that leads to the marriage (Girls Not Brides, undated), emphasising the integrated nature of the two issues and the need to address them simultaneously and in partnership.

A strong and well enforce legislative framework can also contribute to an enabling environment for early adolescents, and allow them to realise their sexual and reproductive health rights (including their right to protection and bodily autonomy). Governments must enact and enforce laws prohibiting physical and sexual violence against women and girls, including cultural practices that violate the sexual and reproductive rights of adolescents (including marriage before the age of 18 years). A realistic age of consent that is non-discriminatory on the grounds of sex or sexual orientation plays an important role in protecting younger adolescents from risk and experiences for which they are not yet ready. However, international guidance strongly discourages the criminalisation of close-in-age consensual sexual activity.[[3]](#footnote-3)

**3.0 *Summary of recommendations for developing an enabling environment for supporting SRHR for young adolescents***

* Acknowledge and highlight the different level of risks and vulnerabilities and the need for different programming approaches for older and younger adolescents in wider discussions on adolescent SRH, and place within the context of young people’s emerging capacities
* Support the development and implementation of high-quality, age-appropriate CSE for children and younger adolescents, including those out of school
* Promote dialogue among international and national stakeholders regarding strategies and approaches to ensure appropriate access to SRH services for sexually-active young adolescents which acknowledge their emerging capacities and their rights to make informed choices, as well as ensuring appropriate protection.
* Embed discussions on early adolescent sexual health in wider debates and strategies around education, social development and empowerment of women and girls.
* Strengthen the development of child protection services and promote their integration with SRH services, including improved training of health care staff and clear policies and pathways for identifying and supporting young people in coercive or abusive sexual relationships
* Promote the enactment and enforcement of legislation to prevent marriage below the age of 18 years, and set a realistic age of consent that is non-discriminatory on the grounds of sex or sexual orientation and does not criminalise close-in-age adolescent sexual relationships
* Support and encourage the development of national and sub-national indicators for early adolescent sexual health, including age at first sex and age a first pregnancy / birth, which are disaggregated by region, wealth, urban / rural residence and other relevant characteristics.
* Promote and support programmes for education and training for younger adolescent mothers who are currently out of school.

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1. Please note it is likely that these figures will be underestimates in some countries due to the well-documented phenomenon of girls overstating age at first sex due to social stigma [↑](#footnote-ref-1)
2. Very young or early adolescence is usually defined as 10-14 years. This is problematic when measuring pregnancy as it missed those who give birth at 15 years, which research suggests is also associated with the increased risk to mother and baby associated with mothers aged less than 15 years (*e.g.* Phipps and Sowers, 2002; Conde-Agudelo, Belizán and Lammers, 2005). In many countries markedly more girls give birth at 15 years old that before their 15th birthday, and therefore there is an underestimate of those who are most vulnerable to adverse health outcomes. Furthermore, using age specific fertility rates for 10-14 years (as used for the SDGs) is problematic as it produces a low rate due to the fact that the vast majority of the girls at the lower end of the denominator (i.e. 10-13 years) will not be sexually active and are therefore not exposed to the risk of pregnancy. [↑](#footnote-ref-2)
3. According to the Committee on the Rights of the Child, governments should avoid criminalizing consensual, non-exploitative sexual activity among adolescents of similar ages (UN CRC, 2016). [↑](#footnote-ref-3)