Dismantling Inequities in Adolescent and Young Adult Health through a Sexual and Reproductive Health Justice Approach

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Abstract

This article provides an overview of the social determinants of adolescents and young adults' (AYAs') sexual and reproductive health (SRH), from a global health perspective. The status of AYAs' SRH constitutes leading health indicators across nations and globally, and reveals the well-being of this population. Throughout the article, AYAs' SRH is approached from a health equity perspective, which includes SRH health rights and reproductive justice. Using this health equity lens, salient topics are presented: sexual abuse/assault among AYAs; immigrant and refugee populations; child, early, and forced marriage; human trafficking; and female genital mutilation. The article also discusses access to SRH services and comprehensive education. Practical implications and resources are offered for healthcare providers for their daily encounters with AYAs, as well as for community, institutional level, and advocacy action. Healthcare providers are well positioned to advance AYAs SRH through mitigating inequities and in so doing, they are assuring the health of the population and future generations.

Keywords
- adolescent and young adult
- sexual and reproductive health
- inequities
- reproductive health justice
- global health

Adolescents and young adults' (AYAs') sexual and reproductive health (SRH) is a critical public health concern worldwide, given the number of young people who suffer SRH-related inequities and its severe, although preventable, sequelae.[1,2] The majority of AYAs suffer victimization such as sexual violence, stalking, and intimate partner violence, before the age of 25 years. Therefore, prevention and screening during this life stage is of utmost importance.[3]

In contemporary medicine and public health, SRH is commonly defined from a human rights-based perspective. The World Health Organization (WHO) asserts that "reproductive health implies that people are able to have a

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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."[4] WHO defines sexual health as "fundamental to the overall health and well-being of individuals, couples and families, and to the social and economic development of communities and countries. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence."[5]

The framework for practice to ensure these rights is known as *sexual and reproductive health justice*. This framework includes an SRH policy agenda that ensures all AYAs have access to SRH services and education and preventive health care that is accessible and culturally sensitive.[6] In our increasingly diverse societies, and especially in the context of providing and assuring healthcare to AYAs, these equity-based perspectives are critical to their health and well-being.

The term "adolescents and young adults" refers to the population between the ages of 10 and 24, which captures stages of adolescence as well as the transition to early adulthood. This age range is commonly referred to by global health organizations, and in many parts of the world, AYAs constitute a large segment of the population.[7–9]

Healthcare providers can make a difference in fostering AYA's SRH at the individual/clinical and community/population levels and thereby can prevent and mitigate health inequities among youth. Herein, we provide an overview of the social determinants of AYA's SRH and include a global health perspective on AYA's SRH. Furthermore, critical domains of risk and protective factors will be discussed. These can serve to increase provider awareness, and readiness to take action in healthcare and community settings. Clear implications for these actions from a practice and advocacy perspective are also provided. The intention is to amplify current knowledge about the state of prevention as well as highlight risk conditions as they relate to health equity and to encourage healthcare providers to champion for equity in SRH for AYAs.

Sexual and Reproductive Health Equity in AYAs

According to the U.S. health objectives for the nation, SRH goals constitute part of the public health leading health indicators, meaning that SRH is vital for the health of the country: "Improving reproductive and sexual health is crucial to eliminating health disparities, reducing rates of infectious diseases and infertility, and increasing educational attainment, career opportunities, and financial stability."[10]

Youth development and public health scientists articulate that sexuality is a normative part of the AYAs' development and identity, and as such should be approached from an assets-based or positive development perspective.[11] One's sexuality is not limited to expression in sexual activity per se, but rather is manifested in a range of behaviors that also include personal appearance and communication. Furthermore, AYAs do not experience their sexuality in a vacuum; rather, they are experiencing their sexuality within the contexts of daily living, e.g., in program and school contexts, in neighborhoods, and across settings (including virtual worlds) where social norms exert influence. So as young persons in their social environments, they carry their sexuality, and also the whole of their identities (e.g., race/ethnicity, gender, sexual orientation) with them; and these identities are shaped by their environments.[11]

In addition to human rights based on positive developmental perspectives, AYA's SRH must also be viewed in terms of health equity. According to the CDC, "Health equity is achieved when every person has the opportunity to attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.[12] This framing allows for an appreciation of the vast health inequities within SRH domains that affect a significant proportion of AYAs, more specifically, health risks, morbidity, and mortality that are disproportionately borne by those who are more likely living with social marginalization; e.g., those who identify as a social minority race/ethnicity, LGBTQ+, have undocumented status, poverty, and the intersection of these statuses.[10,13]

In this article, the following sections briefly review selected topics and/or special population foci where AYAs suffer inequalities from the social determinants of health (SDOH). This SDOH concept is closely aligned with health equity as it refers to those "… non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems, and racism and social privilege."[14] It is important to note that social determinants as risk factors do not include social-demographic and cultural attributes of AYA identities, as it is recognized that gender, sexual orientation, and race/ethnicity are risk factors in and of themselves; rather they are risk markers due to oppressive and marginalizing social forces such as racism, classism, and homophobia that elevate AYA population risk.[15] These forces create an unequal distribution of those social or political determinants of health among those persons with nondominant culture identities. It is for this reason that in the following sections, we bring attention to different inequities within AYA's SRH from a lens rooted in an understanding of culture, social class, race, and gender.

SRH Equity through a Social Justice Lens

Reproductive justice has been defined as "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."[16] Furthermore, this definition is operationalized to include the principles that sexual and reproductive rights are human rights and access to the full

spectrum of SRH services is necessary.[17] While abortion access is critical, the full range of SRH services and supports include "contraception, comprehensive sex education, sexual transmitted infection (STI) prevention and care, alternative birth options, adequate prenatal and pregnancy care, domestic violence assistance, adequate wages to support our families, safe homes, and so much more."[16]

This framework examines AYAs' ability to determine their reproductive destiny and recognizes this destiny is beyond the control of individual choice and access and directly related to the SRH, the opportunities for healthy living in their daily lives.[14]

SRH Equity through a Gender Lens

One of the most important concepts to understand in advancing SRH for AYAs is "gender." In the 1970s, the term "gender" emerged in English language as a social construct to make a distinction with the biological concept of "sex."[18] While sexuality refers to "culture-bound conventions, roles, and behaviors involving expressions of sexual desire, power, and diverse emotions, mediated by gender and other aspects of social position (e.g., class, race/ethnicity)," gender refers to the social construction of those conventions as well as "relations between and among women and men and boys and girls."[18] Importantly, within health, the construction of gender must be understood to differentially interact with sex, which can subsequently have differential impact on a health or disease exposure and/or its subsequent outcome.[18] Stated more simply, gender is complex; it must be understood through a societal lens of power and privilege, is not necessarily synonymous with biological sex, and has an impact through different pathways on a young person's health.

Gender, and ideas around gender, may shape and be shaped by both external and internal forces. There is no time more transformative for how these forces shape an individual than during adolescence and young adulthood. Extrinsically, gender norms are constructed beliefs or expectations about how a "young man" or "boy" or "young woman" or "girl" should act or present.[19] Gender norms ascribe societal value to what it means to be masculine, feminine, or somewhere along the spectrum. This varies in different contexts and is externally viewed through gender expression or self-presentation. Intrinsically, gender identity is how a young person understands themselves based on cultural, normative gender ideas, and their interpretation of their biology.[20] In the past, this construct has been described as binary (i.e., male or female). However, there is increasing understanding on the fluidity of this spectrum, such as explicitly recognizing genderqueer,[21] a term describing gender identity outside the binary limits. Killermann's Genderbread model is a helpful tool to visualize how sex, gender, and identity relate and interact in a young person's life.[22]

Once we recognize the intricacies of the idea of gender, we can better understand why applying a gender lens is critical in AYA's health and beyond. Applying a gender lens is necessary to untangle the gender bias inherent in all of our institutions, including health and medicine.[23] Public health scholars such as Krieger and Fee describe the evolving understanding of sex as well as race in biomedical literature, and further raise awareness of how social class intersects with these ideas and subsequently health outcomes.[24]

Importantly, a gender lens calls us to recognize differential health risks according to gender identity when providing services for AYAs. Our understanding of the socially constructed nature of gender reminds us that, for example, AYAs SRH females and males have different risks for violence, mental health, and other causes of morbidity and mortality.

Within the AYA age group, a gender lens raises the importance and centrality of sexuality, which is deeply connected to culture, relationships, development, and identity. Therefore, SRH services and education must be explicit in positively centering the lived experiences of young people.[11] Moreover, there is often a missed opportunity to ensure AYA's SRH services are gender affirming in health care and science curricula.[25] Being mindful of gender allows for consideration of possible gender-related sexual and reproductive vulnerabilities. One of these vulnerabilities is lack of consent to sexual activity.

Consent for Sex: Central to SRH Rights and Justice

Consent for sex is an active agreement of both partners to engage in sexual activity with the clear understanding of what the agreement includes. Partners must give and obtain consent every time they engage in sexual activity and accept that either partner can change their mind at any time.[26]

The legal age for an individual to consent to sexual contact defines the minimum age at which one is deemed mentally capable of consenting to sexual activity. It aims to protect adolescents from abuse and from consequences they may not be fully aware of when engaging in early sexual activity. Sexual activity with a person under the age of sexual consent is considered nonconsensual and constitutes statutory rape, a criminal offense.[27] Statutory rape laws worldwide intend to discourage adults from pursuing sexual relationships with developmentally immature minors.[27,28]

The rationale for a minimum age of sexual consent is to protect adolescents from situations of dependency and power imbalance, which can lead to lack of resistance without genuine and fully informed consent. These situations include adults exercising a form of authority or offering other benefits to obtain sexual favors from underage children, older peers blackmailing sexual activity for inclusion in a group, or other forms of recognition.[28] It also aims to protect adolescents from the multiple risks associated with early sexual activity, such as sexually transmitted diseases and early pregnancy, which have lifelong consequences on their health and development.

There is no international standard that indicates what the minimum age for sexual consent should be. The Committee on the Rights of the Child has considered 13 years to be very low.[28] However, this age aims to avoid the over-criminalization of adolescents' behaviors. The age difference between the partners involved should be of greater determination in terms of power imbalance. Any legislation making sexual activity illegal under an age where most adolescents are

already sexually active risks preventing them from accessing critical sexual and reproductive healthcare and education. For this reason, some countries have close-in-age exemption laws in addition to legally defined minimum age for sexual consent.

There is wide variation on age of consent law both within and between countries. In the United States, the age of consent differs between 16 and 18 years according to individual state regulations. For example, the state of Ohio statutory rape law is violated when a person has consensual sexual intercourse with an individual under age 16 whom they are not married to. However, when marriage is used to legalize sex with an underage child, the concern of power imbalance and inability to consent remains. Ohio law also allows minors aged 13 and older to consent to a partner under age 18. However, the state of Indiana has a broader regulation to the best interest of adolescents depending on the situation. The Indiana close-in-age exemption may completely exempt close-in-age couples from the age of consent law, or it may merely provide a legal defense that can be used in the event of prosecution.[29] In Canada, the age of sexual consent is 16 years with two additional close-in-age exemptions: sex with minors aged 14 to 15 is permitted if the partner is less than 5 years older, and sex with minors aged 12 to 13 is permitted if the partner is less than 2 years older.[29,30]

In Europe, the lowest age of sexual consent is 14 years (14 countries), whereas the highest age of consent is 18 years (Malta, Turkey, and Vatican City). Most of the countries in Europe do not have a close-in-age exemption law, but when the age of consent is as low as 14 years, close-in-age exemptions may not be as crucial as it is in the countries having higher age limits.[29] In the countries where child marriages are still widespread, keeping the age of consent at a higher age also aims to prevent child marriages, but the lack of a close-in-age exemption in the law fails to differentiate between the forced marriage with an adult and consensual sexual activity of older adolescents.[31] The advocacy for close-in-age exemption laws in such countries should be strengthened to focus on the best interests of adolescents and mitigate health inequities in AYA's SRH. Healthcare providers should be informed of the consent laws in their particular localities.

Global Aspects of AYA's SRH Inequities

In this section, inequities in SRH for AYAs in a global context are examined, focusing on sexual abuse/assault among AYAs; immigrant and refugee populations; child, early, and forced marriage; human trafficking; and female genital mutilation. These topics have been chosen due to the significant health inequities in SRH among AYAs, not only in the United States but also worldwide.

Sexual Abuse and Assault among AYAs: Inequities in Reporting, in Identifying Those at Risk, and in Access to Prevention and Treatment Programs

One important risk facing AYAs is sexual assault and abuse. The WHO defines child sexual abuse as "the involvement of a child or an adolescent in sexual activity that he or she does not fully comprehend and is unable to give informed consent to, or for which the child or adolescent is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society."[32] The sexual abuse of children and AYAs, including rape and assault, is a global problem that has devastating short- and long-term effects on individuals, their families, and their communities. The prevalence of childhood and AYA sexual abuse around the world is difficult to estimate due to a myriad of factors, including differing definitions of "abuse" and "assault" in research, methodological differences among studies, discrepancies between self-reporting and "officially reported" sexual abuse incidents, and underrepresentation in research among some areas of the world[33–35]; it is likely that research vastly underestimates the true prevalence of childhood and AYA sexual abuse worldwide. That said, the available research that includes studies conducted globally estimates a worldwide prevalence of childhood sexual abuse at approximately 11.8%,[33] between 8 and 31% for girls and 3 and 17% for boys.[34] It is also noted that around the world, AYAs are reportedly four times more likely to be victims of sexual assault than women in all other age groups.[36] Additionally, at least one in five women suffer rape or attempted rape in their lifetime, often by an intimate partner.[37] Another population to consider is that of college and university students, as this population is also at high risk. According to the American College Health Association: "Sexual and relationship violence comprise a continuum of behaviors, including but not limited to sexual/gender harassment, sexual coercion, sexual abuse, stalking, sexual assault, rape, dating violence, and domestic violence."[38] Sexual assaults, predominantly perpetrated against young women, are reported as high as 20 to 28% in this population.[39,40] However, the totality of sexual violence among this young adult population is much greater than reported in assault statistics.

Although sexual violence is known to affect people of all ages and backgrounds, women, children, and adolescents are disproportionately affected worldwide.[32–34] In many countries, it has been noted that greater victimization is seen in children and youth raised in families with lower socioeconomic status,[35,41] those with disabilities,[42–44] individuals who identify as racial or ethnic minorities[45] including African Americans and Indigenous populations,[46–48] and children and youth who identify with the LGBTQ2S+ community.[49] Moreover, children, adolescents, and young people living in locations with ongoing war and conflict have been sexually abused as a weapon of war.[37] While it is essential that these special populations be highlighted in research worldwide, there remains significant imbalances in identifying risks in certain populations and locations. Without more data on the prevalence of sexual abuses in underrepresented populations, there is a lack of information about who is at risk, making prevention and treatment programs incredibly challenging to implement.

Several systematic reviews, meta-analyses, and original studies have linked childhood and AYA sexual abuse with an increased risk of multiple negative medical, psychosocial/

behavioral, and psychiatric sequelae.[35,44,50–56] For example, a history of sexual abuse in childhood has been linked to higher rates of unintended pregnancy and induced abortion,[40] functional gastrointestinal disorders,[53,57] as well as chronic pain,[53,54] most notably chronic pelvic pain.[53,57,58] There is also a noted increased incidence of engaging in risky sexual behaviors,[35,59] earlier onset of consensual sexual activity,[59] as well as increased rates of STIs, including HIV.[54] Moreover, a history of sexual abuse in childhood and/or adolescence is associated with an increased risk of multiple psychiatric diagnoses, including anxiety disorders, eating disorders, posttraumatic stress disorder, conversion disorder, borderline personality disorder, and depression.[54,55] Substance misuse, nonsuicidal self-injury, and suicide attempts are notably high in those with a history of sexual abuse,[54] as are the risks of involvement in sex trade work[60] and revictimization.[44] Importantly, there is also increased risk for the perpetration of childhood sexual abuse in those with a history of sexual abuse themselves,[61] which underscores the intergenerational cycle of abuse.[56] Treatment for abuse depends on the symptoms and challenges that one experiences; counseling, therapy, and support groups are often the cornerstone of individual treatment.[37] It is important to note that similar to research that explores the prevalence of childhood and AYA at risk for sexual abuse, there is a paucity of research in some locations regarding outcomes; and without information about outcomes in certain regions, treatment and support programs are of course lacking. Even in countries where there are more well-established support and treatment programs, inequities exist in access especially for those living in rural areas and those who cannot afford to pay for specialized services that may not be free.

Tackling the burden of childhood and AYA sexual abuse around the world requires more equitable and inclusive representation in funding and research. Areas with the greatest burden of health inequities should be prioritized and include epidemiology and surveillance, and innovations in intervention development and treatment. Intervention development must involve communities and those with lived experience, from conceptualization through evaluation, to improve ecological validity and scientific rigor.[62]

Research needs to better explore the cultural nuances that affect the definition of sexual abuse and assault around the globe and the alternate views as to what constitutes sexual abuse in different regions (i.e., female genital mutilation, child marriage) to build culturally educated treatment for survivors and their families. Community members, policymakers, government and law enforcement services, researchers, and health care providers must recognize and combat the aforementioned health inequities, to create effective sexual abuse primary prevention programs, trauma-informed screening practices, and culturally competent and evidenced-based treatment.

SRH Inequities among Immigrants and Refugees

In the last two decades, international migration has become one of the emerging issues challenging the health of youth around the globe. Today's world is inhabited by the largest generation of 10 to 24 years old in human history.[63] The unique external forces surrounding this generation during their development are also new and not well understood: population mobility, global communications, and the most massively displaced movement of people in history due to natural disasters or war. Around 70% of those on the move are women and those aged less than 18 years, and it is estimated that 12% of the world's 15- to 24-year olds are migrating across borders.[64,65] Development at this age is anchored in identity, which is a dynamic and nonlinear process highly influenced by context.[13] Due to the recession in 2008, many countries' increased nationalism threatens to undermine the ethnic and racial development of the most marginalized nondominant racial groups of AYAs.[66]

This increase of "hate toward the other," in this case xenophobia, has been translated into migration policies and practices that trespassed on the human rights of AYAs, who with their families or on their own were in search of survival, escaping abuse and exploitation.[67] This significant context created the perfect antecedent for a myriad of preventable vulnerabilities, such as xenophobic attacks (scapegoats) and discrimination, and increased vulnerability, such as physical harm, psychological trauma, and sexual and economic exploitation, limited access to basic needs, including reproductive preventive methods, and, when at the World's borders, immigration raids and detention.[13,68]

More women are migrating alone and with others outside their families, usually for work in domestic care, entertainment, and factories—where wages and working conditions are lower than those for men, who are more likely to find highly skilled jobs. Women's (including AYAs') migratory journey is a continuum of potential reproductive vulnerabilities that can be divided into three main stages: pre-migration, during migration, and post-migration. Pre-migration vulnerabilities include gender-based violence as the force propelling migration, and being left behind in the migration journey, due to hostile conditions of travels. Reproductive vulnerabilities during the migration journey include different types of assault, including sexual assault, so well-known that most women coming from Central America are started on Depo-Provera or a long-acting reversible contraception (LARC) method, before the journey begins. Among those migrant AYAs who crossed borders, there is another more violent challenge awaiting, detention and deportation, sending some of them back to the vulnerable context that initiated their migration response. In the United States, detention in the last years has constituted a repository of human rights violations for both AYAs and their families. Post-migration reproductive vulnerabilities go from health risks related to facing an unfamiliar and complex healthcare system, mostly oriented to deliver care using the values and preferences of the mainstream culture of the host country, to risks of human trafficking and sexual exploitation.[63]

These migration patterns have also created a series of challenges to the provision of SRH services in the host countries. The increasing numbers of AYAs who have

undocumented status face challenges with access to healthcare, especially in countries where access to healthcare is not a right.

Studies have explored the influence of transnational culture's impact on the construct of SRH.[69] These studies show how parents and AYAs maintain cultural and religious values regarding SRH, and therefore may encounter cultural barriers in seeking healthcare, adding to the already existing (e.g., institutional, financial, legal) obstacles of how to access those services.

Research had started to highlight the need to shift emphasis from a health belief (knowledge–attitude–practice) model of reproductive health behavior toward an ecological model of health for migrant and immigrant AYAs, which explores the influence of personal, family, community, and societal (political/economic systems) factors on SRH.[70] One model for this is the U.S. nationally recognized Aqui Para Ti/Here for you Clinic Model, caring for Latinx adolescents and their families, which uses a health equity inclusive model of care to shift the focus from reproductive health to integrative healing-oriented care that considers cultural identity and hope as determinants of agency and reproductive health. The clinic has shown an increase in contraceptive use, particularly LARCs, compared with all other health and patient care services in the same hospital.[71] This provides evidence that favorable outcomes can be achieved utilizing comprehensive approaches to SRH for this population.

Child Marriage

Child marriage, often synonymously referred to as early marriage, is a pervasive practice globally. Defined by the United Nations as the formal marriage or union of an individual before the age of 18, it is most discussed in reference to females (the girl child) because of its prevalence.[72] Child marriage is also closely identified with forced marriage, a union without free and full consent of both parties (regardless of age)[73]; these often-overlapping understandings of marriage may have different names in different contexts (e.g., arranged, quasi-arranged). An estimated 650 million girls and women alive today married before their 18th birthday; in fact, 1 in 5 girls and women married before the age of 18 years.[72] In contrast, 115 million boys and men married early, before the age of 18 years.[74] Approximately 12 million girls marry early each year, and therefore violate the human rights and Sustainable Development Goal (SDG) 5 Target 3, which calls for the elimination of all harmful practices including child, early, and forced marriage. Additionally, there is a growing evidence base supporting global consensus on the negative consequences of girl child marriage. In this section, we describe statistics of girl child marriage, provide evidence on why the practice persists, and share information on how it can create inequities in AYA's SRH.

More than a decade ago, rates of girl child marriage were highest in South Asia, disproportionately driven by high rates in India. Today, the percentage of young women who married as children (before 18) is highest in West and Central Africa (41%), which has seen a much slower decline, followed by Eastern and Southern Africa (35%), South Asia (30%), Latin America and the Caribbean (25%), and the Middle East and Northern Africa region (17%).[72] Rates of girl child marriage are much lower in Eastern Asia and Central Europe (11%) and East Asia and Pacific (7%).[72] More recent data also indicate that child marriage exists in high-income countries; for example, a recent study found that nearly 300,000 minors younger than 18 years were legally married between 2000 and 2018 in the United States.[75]

Girl child marriage persists for several reasons with some differences across geographies and cultures. Reasons commonly identified include poverty, or limited economic opportunities, low education levels, lack of laws or their enforcement, cultural practices believed to protect a female or her family's honor, and social norms.[76–79] In some contexts, religion may play a role in shaping norms that drive girl child marriage,[80] and migration may also influence marital decision.[81] A forthcoming review particularly underscores the intersecting nature of social norms, poverty, and economic factors.[82] More recent evidence has raised the strong role of gender and gender-discriminatory norms, including control of adolescent females' sexuality, as a key reason the practice continues.[83] Importantly, marriage at early ages is often not the choice of the young spouses; there continues to be debate on AYA's ability to consent given the legal age of majority, as well as norms, pressures, and economic realities within a young person's context.[73]

Child marriage has been associated with negative consequences for girls' and women's health, particularly across SRH. It has been strongly associated with early age at first birth, decreased modern contraceptive use, short birth spacing between pregnancies, increased unintended pregnancies, and increased likelihood of stillbirth or miscarriage.[84,85] Girls who marry earlier will often have more children in their lifetime, and early childbearing, through early marriage, may also negatively impact the health and developmental outcomes of both the young mother and children born to those young women.[86,87] Girl child marriage has also been associated with poorer health-seeking behavior, for example, among pregnant adolescents, reduced number of antenatal visits, and lower likelihood of delivery by a skilled attendant.[84] Moreover, girl child marriage has been negatively associated with mental health and psychosocial well-being,[88,89] and with broader non-health outcomes including reduced education and high cost for countries,[86] which may further exacerbate inequities for AYA's SRH. Providers should also be aware that girl child marriage may also increase risk for intimate partner violence.[90]

Because of its potentially harmful consequences, including both the health and rights violations of girls and women, it is important to be aware of young peoples' rights to determine if, when, and whom they marry. There are opportunities to further close research gaps, particularly in understanding causal pathways toward impact. Providers in low-, middle-, and high-income contexts should be aware of the potential consequences associated with child, early, and forced marriage, particularly among female AYAs. The WHO has guidelines on preventing early pregnancy and

poor reproductive health outcomes among adolescents in developing countries.[91] This resource continues to be updated with explicit reference to child marriage, and can serve as a resource for healthcare providers.

Human Trafficking and Sexual Exploitation: Highlighting Inequities

Human trafficking is a global health concern. It is defined as "The act of recruitment, transportation, transfer, harboring or receipt of persons … by means of threat or use of force or other forms of coercion, of abduction, fraud, of deception, of the abuse of power, or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person … for the purpose of exploitation."[92,93] Examples of exploitation may include forms of sexual exploitation, forced labor, slavery or servitude, and selling of organs.[92,93] The foundation of human trafficking is a predator taking advantage of a power differential and preying on another individual's vulnerabilities. These vulnerabilities highlight the inequalities and oppression created by society and social constructs as trafficking victims and survivors are most often those who have been given less power by society.

Human trafficking for the purposes of sexual exploitation occurs globally regardless of national economic development status and is the most common form of trafficking.[93] According to the United Nations, most sex trafficking occurs within a specific country,[93] although international trafficking is also an important concern.[94] In the United States, sex trafficking is a significant public health problem and occurs in every region of the country.[95] The majority of victims have been seen by a health care provider while being trafficked, and therefore there are opportunities for intervention.[96]

Sex traffickers around the world specifically target poor communities and individuals who have been marginalized, knowing that people living in poverty are more vulnerable in their need for financial resources. The vast majority of victims of human sex trafficking are women and girls.[92,94,97] Many women are involved in human trafficking, not only as victims but also as traffickers. Very often former victims have become perpetrators. Traffickers also lure women in poor regions with false opportunities to improve their circumstances.[92,94,98,99] Immigrant AYAs in particular are vulnerable to sex trafficking.[100]

In addition to poverty, gender inequality plays a large role in human sex trafficking, in particular in areas of the world and within countries, where women's rights are not as well recognized. Similarly, racism is a notable factor in sex exploitation. Systemic racism around the world has led to instances of discrimination and marginalization (e.g., not being allowed access to schools, reduced employment opportunities due to racism, reduced level of power in a community) that put individuals at high risk for exploitation.[47,48,92,101]

Other examples of risk factors for sex trafficking include a history of childhood sexual abuse, living within the foster care system or being homeless, identifying with the LGTBQ2S+ community (includes Native American two spirit communities),[102] and/or having a substance abuse disorder.[103,104]

Victims and survivors of sex trafficking suffer a range of poor health consequences.[105,106] For example, sexually transmitted infections, unplanned pregnancies, and forced abortions are common among young women forced into sex trafficking.[97,99] Moreover, trafficking victims are often exposed to physical violence which frequently leads to multiple physical and mental health sequelae.[99] In recent years, the internet and digital technology have enabled the massive growth in sex trafficking and sexual exploitation across the globe, and trafficking is a lucrative enterprise.[100,101,107]

The international community has developed resources to combat trafficking. The UN Office on Drugs and Crime (UNODC) publishes a global report on trafficking in persons, as does the U.S. Department of State.[92] The Counter Trafficking Data Collaborative (CTDC) is one of a kind global data hub on human trafficking with access to global map, demographic snap shots, and graphs which highlights age, gender, and sectors in which people are exploited.

The UNODC document reports that only 125 of the 155 participating countries have passed laws that mitigate the problem of human trafficking. National justice systems vary in their capacity to address trafficking. The number of convictions is increasing, but not in countries where trafficking is remarkably high. Patterns of traffic vary across the world. Europe is the destination for victims from the widest range of origin countries, while victims of Asia are trafficked to the widest range of destination countries. The Americas are prominent for both origin and destination of victims. Both the U.S. Department of Health and Human Services and the U.S. Department of State offer resources for professionals who may encounter AYAs at risk (see ►**Table 1**).

Female Genital Mutilation

Female genital mutilation (FGM) is a violation of girls' and women's human rights which refers to "all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for nonmedical reasons."[108] The number of girls and women worldwide who have undergone FGM is estimated to be over 200 million with the available prevalence data.[109] There has been an overall decline in the percentage of adolescent girls between 15 and 19 years of age who have undergone FGM worldwide over the last three decades but not all countries have made progress.[110]

The large-scale representative surveys showed that FGM is highly concentrated in a swath of countries from the Atlantic coast to the Horn of Africa, in areas of the Middle East and in some countries in Asia. However, FGM is a global human rights issue occurring in many other countries worldwide with large variations in terms of the type performed, circumstances surrounding the practice. It is also found in some localities of Europe, Australia, and North America which have been destinations for migrants from countries where FGM is still prevalent.[110,111] Girls in immigrant communities could be at risk if their parents adhere to the beliefs and practices from their home countries where FGM is common.

A 2016 study by the CDC estimated that 513,000 U.S. girls and women either had potentially undergone the practice of

FGM in the past or were at risk for undergoing it in the future.[111] A U.S.-based study reported that half of the women's health providers did not receive formal training about FGM and its complications, but a majority had cared for FGM-affected women in their practice.[112] Thus, a knowledge and practice gap exists for managing infibulated patients, and surgical defibulation procedures were not routinely offered. Authors have suggested that FGM content needs to be embedded in educational and training curricula with an ongoing clinical mentorship.

Despite the global recognition of FGM as a harmful practice of SRH and its illegal status in most countries, the involvement of healthcare providers in the performance of FGM still exists, which may create a wrong sense of legitimacy for the practice and can lead to its perpetuation. WHO has developed a global strategy to stop medicalization of FGM in collaboration with key stakeholders, including UN organizations and healthcare professional bodies.[113]

Health Justice in SRH Services and Education

In this section, services and education in SRH for AYAs are examined, focusing on access to contraception, abortion, and comprehensive sexual health education. These topics have been chosen due to the significant health inequities in SRH among AYAs, worldwide.

Health care and educational settings for AYAs can be a sanctuary for youth who have experienced sexual exploitation and/or who have unmet needs for SRH services.

In this final section, inequities in contraception and abortion access and health disparities in human papillomavirus (HPV) vaccination are discussed, as well as the need for comprehensive sexual health education. In total, these services provide a path to positive youth development, to health equity, and to empowering youth to make SRH decisions in their best interest, while considering the dignity and rights of others.

Contraceptive Access

Lack of access to sexual and reproductive healthcare, lack of opportunities and support for reproductive autonomy, decision making, and the ability of individuals to make the right sexual and reproductive choices for themselves and their families can lead to unintended pregnancies and STIs and associated negative developmental and psychosocial outcomes. Disparities in access to SRH services and education have had an important impact in every aspect of life in communities struggling with marginalization.

Access to contraception can lead to decrease in teen pregnancy rates.[114,115] However, women in underrepresented and lower socioeconomic status groups have less access to the most effective methods. Highlighting the ethnic and race inequities, in the United States white women use contraception at a higher rate than Hispanics and African Americans.[10]

In an analysis using the National Survey of Family Growth, the rates of no contraceptive method used in the last month was almost 32% among 15 to 19 years old sexually active women, followed by 19% in 20 to 29 years old. In terms of race differences, 16% of white women used no contraception during the last month, compared with 19% of Hispanics and 24% of African American women.[116]

In this same study, younger women, aged 15 to 19 years, used less effective methods in 21% of cases, compared with 22% of the 20 to 29 years old. Marked differences were noted for race across ages (15–24 years old): 14% white versus 18% of African American and 18% Hispanics. It should be kept in mind that women in this study are more advantageous than the population of women they represent, given the demands of responding to national surveys; so, true population rates are likely greater. Less effective methods included condoms, diaphragms/sponges, and spermicides.

Teenage pregnancy is mostly (75%) unintended and can lead to adverse health, educational, and economic outcomes for both the mother and the child. There are multiple social and health consequences of teen pregnancy including low birth weight, preterm delivery, and severe neonatal conditions. The children of teenage mothers have higher rates of school failure and incarceration, and are also more likely to give birth as a teenager, perpetuating the cycle of poverty. Teen mothers usually attain lower education and income with a lifelong impact of social and health inequities.[117,118]

Although teen pregnancy rates have declined in the United States over the last several decades, rates continue to be high compared with other developed countries, and marked disparities continue to persist: in 2018 (latest data available),[119] the birth rates of U.S. Hispanic 15- to 19-year-old girls (27/1,000) and non-Hispanic black teens (26/1,000) were more than two times higher than the rate for non-Hispanic white teens (12/1,000).[114]

At the same time, historical use of sterilization as a means to achieve fertility control in communities that have been marginalized up until the very recent past calls for a reproductive health justice framework and balance when approaching contraception in populations that have been historically marginalized.[120,121]

Access to Abortion

The historical journey to legal access to abortion in the United States was long and not without consequences. Abortion finally became legal in the United States in 1973 [Roe v. Wade].[122] Legal challenges to Roe v. Wade have failed to overturn it thus far, and in response many states responded with laws and regulations restricting access to clinics. Strategies employed by states included removing funding, publicizing overestimations of abortion risks, imposing regulations on hospital admitting privileges, increasing waiting times, and imposing unnecessary facility regulations. These actions not only made it more difficult for patients to access abortion services, but they also promoted violence aimed at patients, providers, and facilities, all the while being marketed as protecting the health of the women.[123] This restrictive abortion movement gained political support through the 1990s, and accelerated in the current political climate.

On the global scene, the United States used the expansion of the "global gag rule" as part of "the weaponization of U.S. foreign assistance to systematically target global sexual and

reproductive health and rights programs."[123] In countries where this funding was fundamental to provide access to abortion and contraceptive services, it not only restricted access but also devastated health infrastructures, taking an important emotional toll on the population.[124]

This policy action described earlier was recently rescinded by the current presidential administration but could be restored by Congress at any time.[125]

Most abortion patients in 2014 (75%) were poor (income below the federal poverty level of $15,730 for a family of two in 2014) or had low income (having an income of 100–199% of the federal poverty level).[126] Insurance does not always cover abortion services and even when it does, most patients pay out of pocket for many reasons including concerns about confidentiality. Current barriers have led to more inequities in abortion access and hardship for AYA already facing other obstacles to accessing healthcare in general.

HPV Vaccination Access

Disparities in HPV Vaccination

Implementation of publicly funded equitably delivered HPV vaccination programs offers opportunities to reduce health inequalities associated with cervical cancer. Fisher et al reviewed evidence of inequalities in HPV vaccine uptake in young women with a systematic review and meta-analysis including 27 studies—majority originated from the United States—that compared HPV vaccination initiation or completion by at least one ethnicity or socioeconomic-related variable in AYA. Their analysis strongly suggested that black AYA were less likely to initiate HPV vaccination compared with white peers. They also reported that in the United States, AYA without healthcare insurance were less likely to be vaccinated.[127]

There are also large disparities in HPV vaccination programs worldwide. Vaccination for HPV varies according to the income level of countries. While the HPV immunization programs in low- and middle-income countries are mostly nonexistent, the majority of the new cervical cancer cases and deaths occur in these countries. It is estimated that only 1% of women who had received at least one dose of the HPV vaccine through the publicly funded HPV vaccination programs were from the low-income countries. Thus, it is important to make HPV vaccination more affordable in all countries for narrowing the global inequalities in cervical cancer burden.[128]

Access to Comprehensive Sexual Health Education

Comprehensive sexual health education goes beyond reproductive biological facts to emphasize the relational, ethical, and developmental aspects of human sexuality with grade--level/age-appropriate content delivered in schools. This concept is perhaps best elaborated upon by the Sexuality Information and Education Council of the United States (SIECUS).[129] The basic curricular components of the SIECUS program are the following: human development, relationships, personal skills, sexual behavior, sexual health, and society and culture. SIECUS essentially provides a life skills framework for empowering children and adolescents to make responsible decisions about their sexual health and sexual behavior, within the context of human rights and dignity. Young people learn about the life behaviors of sexually healthy adults, where exploitation and manipulation are avoided and prevented. Culture and values and respecting developing identities such as gender and sexual orientation are part of the curriculum.[130]

Comprehensive sexual health education does not promote sexual activity, but rather it supports positive youth development and socially responsible behavior.[11] The SIECUS guidelines are especially useful given the trend by governmental funding and policy in many regions to exclusively support abstinence-only sexual health education, which has been found to be ineffective and even harmful to children and adolescents.[131,132]

The provision of comprehensive sexual health education in schools varies widely by region for many reasons, including funding, political influence, and cultural forces related to education about sexuality. In many areas of the world, only more socially advantaged adolescents have access to this resource, and in many cases the local educational governing bodies have to approve it. In the United States, there is a stark difference in availability of educational access to these curricula, which, when combined with access to contraception, results in regional differences in teen pregnancy rates.[133] In the United States, for example, any sexual health education (not necessarily comprehensive) is required in only 60% of the states; and among those states, most do not require the content be based on evidence.[134,135]

There is increased momentum among the United Nations Educational, Scientific and Cultural Organization (UNESCO) member organizations throughout the globe for comprehensive sexual education. In 2008, the Latin America and Caribbean regions of UNESCO reported that country-level leadership committed to delivering some form of SRH and sexual health education. Likewise, in 2013, there was commitment across 20 countries in Eastern and Southern Africa to improve both comprehensive SRH education and services for AYAs. There is an emphasis in these latter countries on life skills for HIV prevention.[136]

Healthcare providers can learn about aspects of the SIECUS guidelines and tailor their guidance to AYAs in clinical settings according to the needs of the youth. Furthermore, they can learn about the availability of sexual health education in areas, schools, and collaborate through their medical societies and with public health departments to expand availability of services. If schools are not receptive, sexual health education can and should also be provided within youth serving organizations. Such information serves to empower youth to make responsible sexual health decisions and further to protect their own health and safety and that of their peers.

Conclusion

In conclusion, human rights-based perspectives and positive developmental approaches are critical to sexual and reproductive healthcare with AYAs. Unfortunately, health inequities within SRH domains affect a significant proportion of

Table 1 Practical recommendations for action to reduce SRH inequities

Section I: At the individual level: in everyday encounters
• Address each visit within a reproductive justice framework:
- Always use a holistic approach that centers the reproductive and sexual health rights of adolescents and young adults (AYAs)
- Routinely assess AYAs' knowledge and attitudes toward "sexual consent" and provide education and counseling
• Identify AYA-specific SRH risk factors:
- Consider possibilities of sexual abuse, child marriage, human trafficking, and gender diverse/transgender equity concerns
- One-page decision tree from the national human trafficking center:[123]
- Use recommended screening tools for older than 18 years/o https://www.acf.hhs.gov/otip/training-technical-assistance/resource/nhhtacadultscreening validated 18–22 years/o ("youth friendly" as per authors) https://vcrhyp.org/client_media/Trafficking%20and%20Exploitation%20Tools/QYIT%20-%20Covenant%20House%20NJ.pdf (reference is https://www.sciencedirect.com/science/article/pii/S0190740918307540?via%3Dihub)
• Follow guidelines and tools developed by World Health Organization (WHO) to prevent early pregnancy and poor reproductive health outcomes (including child marriage) among AYAs in developing countries
- WHO guidelines:
https://www.who.int/maternal_child_adolescent/documents/preventing_early_pregnancy/en/
• Approach individuals and their families with a trauma-informed lens that acknowledges the role trauma may play in an individual's presentation/behaviors and relationships
- Clinical guidelines on responding to adolescent relationship abuse https://www.futureswithoutviolence.org/userfiles/file/HealthCare/Adolescent%20Health%20Guide.pdf
- The integrated care "Toolkit" from the National Child Traumatic Stress Network's Pediatric Integrated Care Collaborative includes a trauma-specific readiness assessment and links to other tools related to providers' trauma-related stress and resilience. http://web.jhu.edu/pedmentalhealth/PICC.html
- College age young people: The American College Health Association has resources for adult allies and providers including an informative brochure on sexual violence for young adults and a tool kit for the provision of services. https://www.acha.org/ACHA/Resources/Topics/Violence.aspx
Knowledge areas to mitigate individual AYA risk during daily encounters
• Become familiar with local community-based resources to support SRH, in particular community-based services geared for groups that have been marginalized
- Local health agencies often have resource directories for health education and other services in communities that they serve, e.g., NGOs, nonprofit organizations
• Know the age-specific local consent laws for AYAs and child protection laws, e.g., sexual abuse, to identify risks for exploitation, e.g., early/child marriage, human trafficking, relationship abuse
• Understand the legal reporting requirements in your area for healthcare providers who suspect children and AYAs who are victimized and/or exploited
• Be informed of best practices for internet and social media safety tips and review these with individuals and families; educate AYAs about protecting themselves from on-line exploitation
- From the American Academy of Pediatrics Family/Teen Guidance: **https://www.healthychildren.org/English/family–life/Media/Pages/Points-to-Make-With-Your-Teen-About-Media.aspx** - From Media Smarts: **https://mediasmarts.ca/digital-media-literacy/digital-issues/sexual-exploitation**
• Be cognizant of factors associated with inequities in access to sexual and reproductive health (SRH) services and education, e.g., health and education policy, funding, population poverty, racism, cultural hegemony, and populations living with social marginalization
• Utilize a culturally responsive, affirming model of care. https://www.hennepinhealthcare.org/clinic/whittier-clinic-and-pharmacy/aqui-para-ti-here-for-you/
Section II: At an institutional/community and advocacy level **Collaborate with medical and public health institutions to address the following:**
• Reaffirm commitment to preventing SRH inequities:
- Urge governments to sign, ratify, and implement policies and commit to recognizing and eliminate all forms of SRH inequities
• Get involved with public health campaigns to promote equity:
- Engage in public health campaigns to promote health equity and protection of the SRH rights of AYAs
• Advocate for close-in-age exemption laws

Table 1 (*Continued*)

- To avoid over-criminalization of adolescents and to differentiate between the unbalanced power by an adult and self-engaged sexual activity of adolescents
• **Enact commitment to preventing FGM and other forms of SRH inequities by embedding it in educational and training curricula**
- Collaborate with school administrators and curricula designers to advocate for positive, affirming, and inclusive approaches to teaching about human sexuality in comprehensive school-based sexual health education
- Sexual Information and Education Council of the United States (SIECUS) https://siecus.org/
• **Advocate for increased research funding aimed at exploring the cultural nuances of data collection of global childhood/adolescent sexual abuse to better inform prevention strategies**
• **Advocate for more effective, affordable, culturally responsive, and accessible support systems for survivors of sexual abuse and exploitation**
- U.S. DHHS Administration for Children and Families https://www.acf.hhs.gov/trauma-toolkit/victims-sexual-abuse
Section III—An SRH ethos/guiding values to approach all levels of efforts described above
Reproductive Justice recognizes women's [and all AYAs] rights to reproduce as a foundational human right
This includes the right to be recognized as a legitimate reproducer regardless of race, religion, sexual orientation, economic status, age, immigrant status, citizenship status, ability/disability status, and status as an incarcerated woman [AYA] and encompasses the following:
A—Women's [and all AYAs] right to manage their reproductive capacity
1. The right to decide whether or not to become a mother and when
2. The right to primary culturally competent preventive health care
3. The right to accurate information about sexuality and reproduction
4. The right to accurate contraceptive information
5. The right and access to safe, respectful, and affordable contraceptive materials and services; and 6. The right to abortion and access to full information about safe, respectful affordable abortion services
7. The right to and equal access to the benefits of and information about the potential risks of reproductive technology
B—Women's [and all AYAs] right to adequate information, resources, services, and personal safety while pregnant include the following:
1. The right and access to safe, respectful, and affordable medical care during and after pregnancy including treatment for HIV/AIDS, drug and alcohol addiction, and other chronic conditions, including the right to seek medical care during pregnancy without fear of criminal prosecution or medical interventions against the pregnant woman's will
2. The right of incarcerated women [and all AYAs] to safe and respectful care during and after pregnancy, including the right to give birth in a safe, respectful, medically appropriate environment
3. The right and access to economic security, including the right to earn a living wage
4. The right to physical safety, including the right to adequate housing and structural protections against rape and sexual violence
5. The right to practice religion or not, freely and safely, so that authorities cannot coerce women to undergo medical interventions that conflict with their religious convictions
6. The right to be pregnant in an environmentally safe context
7. The right to decide among birthing options and access to those services
C—A woman's [and all AYAs] right to be the parent of her child includes:
1. The right to economic resources sufficient to be a parent, including the right to earn a living wage
2. The right to education and training in preparation for earning a living wage
3. The right to decide whether or not to be the parent of the child one gives birth to
4. The right to parent in a physically and environmentally safe context
5. The right to leave from work to care for newborns or others in need of care
6. The right to affordable, high-quality child care
Adapted from: Conditions of Reproductive Justice
By Rickie Solinger[138]

AYAs both in the United States and globally. These inequities lead to a myriad of negative outcomes in SRH and affect the quality of life-course of AYAs' health and well-being. Most of these SRH inequities are marked and pervasive within the specific groups of AYAs. There is much to be done in our daily encounters, utilizing some of the best practices and resources referenced in ►**Table 1**. Additionally, health professionals are also called upon to focus upstream addressing the SDOH through policy and advocacy, to combat SRH inequities within countries and across borders. Some of the recommendations and resources for action at the individual and community level are provided in ►**Table 1**.

Challenges to SRH inequities may be turned into opportunities by being cognizant about the risk factors and by promoting equity and health justice among AYAs. By joining together with our professional organizations and across health disciplines, with multidisciplinary public health and AYA advocacy organizations, we can promote the universal SRH rights of AYA and work for positive change in providing and expanding resources for combating SRH inequities. Collaborative efforts are urgently needed within countries and worldwide. When health professionals act to reduce SRH inequities in AYA collectively, they are investing in the future health of their country and of the world.[137]

Conflict of Interest

Y.E. is an employee of the Gates Foundation at the time of writing; however, the views expressed do not necessarily represent the views of the Gates Foundation.

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