



## Editorial

## Supporting Adolescent Sexual and Reproductive Health Rights Through Innovative Research Approaches



International health care governing bodies define the ability to achieve and maintain sexual and reproductive health (SRH) as a fundamental human right [1–3]. This rights-based paradigm places at its core—for individuals of all ages but especially for adolescents and young adults [4]—the ability to access accurate SRH-focused information and education, as well as to receive developmentally appropriate, SRH-focused preventative counseling and clinical care [5,6]. A rights-based framework also both recognizes that many young people face multiplicative barriers to adequate care based on social or economic factors (e.g., gender-based, race-based, or sexual identity–based discrimination, poverty, residential instability, migration, military conflict) [7–9]. As health professionals who operate in a political environment that continually threatens the well-being of young people, we are well aware that both marginalized and disenfranchised youth experience the greatest problems every day to obtaining SRH services [10] and suffer the highest cumulative burden of downstream consequences in adulthood when SRH care needs are not met [11,12]. Now more than ever, we must double down on our efforts to be front-line defenders of adolescent and young adult SRH rights. Such active stewardship requires us to pay careful attention—as clinicians, as educators and as researchers—and continually commit ourselves to engaging in evidence-based approaches that highlight how and when interlocking sources of disadvantage create unique vulnerabilities in young people’s access to SRH [13].

One way in which we expand our evidence base in ways consistent with a sexual rights perspective is choosing data analysis techniques that are deliberately intended to model the overlap in factors known to create obstacles to SRH [14,15]. In this issue of the *Journal of Adolescent Health*, Hill et al. [16] provide an important application of these principles, using latent class analysis (LCA) to identify how syndemic patterns—or clusters of co-occurring behavioral, socioeconomic, and environmental factors [17–19]—interact to increase vulnerability to sexually transmitted infection (STI) among young adults in the United States. The idea of looking for examining “causes” of STI risk factors is not a new concept in sexual and reproductive research. However, common statistical approaches to identify “sets” of risk factors (e.g. factor analysis or analysis of variance) are typically

variable focused, meaning that they assume groupings of risk factors confer the same level of average STI risk for all people [20]. In contrast, LCA is a person-focused approach that categorizes people into different classes (e.g., different “profile” or “types” of STI risk) based on their response patterns to multiple variables (e.g., different risk factors measured from National Health and Nutrition Examination Survey data) [21]. In this way, Hill et al. are able to directly analyze how the interactive effects of different risk factors uniquely contribute to different STI risk across subgroups [22].

Although an exhaustive technical review of LCA is beyond the scope of this article (see Lanza and Cooper [23] for an excellent overview on developmental research), it is worthwhile to point out ways in which the use of LCA by Hill et al. supports a SRH rights framework. LCA provides understanding of profile characteristics—we are able to glean both the number of different STI profiles, the patterns of overlapping behavioral, social, and economic factors that uniquely define each profile, and the STI odds associated with each profile. In other words, these data tell us the general extent to which risk is heterogeneous (more classes) or homogeneous (fewer classes) in a given population, how the specific types of risk are substantively linked to this variability, and the likelihood of acquiring an STI based on which group an individual is classified. For example, while Hill et al. showed that highest STI risk for men was associated with behavioral risk factors, highest STI risk for women co-occurred within socioeconomic disadvantage, mental health, substance abuse, and sexual behavior factors. Moreover, when controlling for race/ethnicity within gender, black and Hispanic women had lower behavioral risk factors and more social risk factors as compared with white women but reported nine times higher STI odds as compared with white women.

These nuanced differences of what drives STI risk and the magnitude of STI risk is crucially important to advancing adolescent and young adult SRH rights. The work by Hill et al. is a timely demonstration that there is not a “one-size-fits-all” STI intervention solution—programming designed to increase the precision of infection reduction efforts needs to be systematically guided by a better understanding of how young people’s lived experiences drive the SRH access. For example, as the authors

---

See Related Article on p. 319

point out, efforts to risk behavior reduction in young women are likely to fail unless they also acknowledge how poverty and mental health, as well as minority-based stressors, exacerbate individual women's participation in risk behaviors. Conceptualizing STI within a syndemic framework represents one example of what the next generation of an evidence-based, youth-centered prevention framework should look like [24]. Leaving no adolescent or young person in our community behind means that we continually identify the underlying inequities that impede their sexual well-being, and we design inclusive solutions that promote their dignity, their choice, their agency, and their equity [5].

Devon J. Hensel, Ph.D.  
 Division of Adolescent Medicine  
 Indiana University School of Medicine  
 Department of Sociology  
 Indiana University Purdue University-Indianapolis  
 Indianapolis, Indiana

## References

- [1] International Planned Parenthood Federation. *Sexual rights in action: Case studies from around the world*. London. 2010.
- [2] Ghebreyesus TA, Kanem N. Defining sexual and reproductive health and rights for all. *Lancet* 2018;391:2583–5.
- [3] Starrs AM, Ezeh AC, Barker G, et al. Accelerate progress—sexual and reproductive health and rights for all: Report of the Guttmacher–Lancet Commission. *Lancet* 2018;391:2642–92.
- [4] Burke PJ, Coles MS, Di Meglio G, et al. Sexual and reproductive health care: A position paper of the Society for Adolescent Health and Medicine. *J Adolesc Health* 2014;54:491–6.
- [5] Orza L, Crone T, Mellin J, et al. Searching for the second R in sexual and reproductive health and... rights. *J Adolesc Health* 2017;60:S10–4.
- [6] Brittain AW, Williams JR, Zapata LB, et al. Youth-friendly family planning services for young people: A systematic review. *Am J Prev Med* 2015;49(2 Suppl 1):S73–84.
- [7] Morris JL, Rushwan H. Adolescent sexual and reproductive health: The global challenges. *Int J Gynecol Obstet* 2015;131:S40–2.
- [8] Ghavami N, Katsiaficas D, Rogers LO. Toward an intersectional approach in developmental science: The role of race, gender, sexual orientation, and immigrant status. In: Horn SS, Ruck MD, Liben LS, eds. *Advances in Child Development and Behavior*, Vol 50. Bingley, UK: JAI; 2016:31–73.
- [9] Schalet AT, Santelli JS, Russell ST, et al. Invited commentary: Broadening the evidence for adolescent sexual and reproductive health and education in the United States. *J Youth Adolesc* 2014;43:1595–610.
- [10] Svanemyr J, Amin A, Robles OJ, Greene ME. Creating an enabling environment for adolescent sexual and reproductive health: A framework and promising approaches. *J Adolesc Health* 2015;56(1 Suppl):S7–14.
- [11] Chandra-Mouli V, Svanemyr J, Amin A, et al. Twenty years after International Conference on Population and Development: Where are we with adolescent sexual and reproductive health and rights? *J Adolesc Health* 2015;56(1 Suppl):S1–6.
- [12] Bowleg L. The problem with the phrase women and minorities: Intersectionality—an important theoretical framework for public health. *Am J Public Health* 2012;102:1267–73.
- [13] Ferguson L, Desai S. Sexual and reproductive health and rights for all: Translating the Guttmacher–Lancet Commission's global report to local action. *Reprod Health Matters* 2018;26:1487621.
- [14] Patil PA, Porche MV, Shippen NA, et al. Which girls, which boys? The intersectional risk for depression by race and ethnicity, and gender in the U.S. *Clin Psychol Rev* 2018;66:51–68.
- [15] Jackson JW, Williams DR, VanderWeele TJ. Disparities at the intersection of marginalized groups. *Soc Psychiatry Psychiatr Epidemiol* 2016;51:1349–59.
- [16] Hill AV, De Genna NM, Perez-Patron MJ, et al. Identifying syndemics for sexually transmitted infections among young adults in the United States: A latent class analysis. *J Adolesc Health* 2019;64:319–26.
- [17] Singer MC, Erickson PI, Badiane L, et al. Syndemics, sex and the city: Understanding sexually transmitted diseases in social and cultural context. *Soc Sci Med* 2006;63:2010–21.
- [18] Singer M, Clair S. Syndemics and public health: Reconceptualizing disease in bio-social context. *Med Anthropol Q* 2003;17:423–41.
- [19] Singer M, Bulled N, Ostrach B, Mendenhall E. Syndemics and the biosocial conception of health. *Lancet* 2017;389:941–50.
- [20] Collins LM, Lanza ST. *Latent class and latent transition analysis: With applications in the social, behavioral, and health sciences*, Vol. 718. Hoboken, NJ: John Wiley & Sons; 2010.
- [21] Lanza ST, Rhoades BL. Latent class analysis: An alternative perspective on subgroup analysis in prevention and treatment. *Prev Sci* 2013;14:157–68.
- [22] Senn TE, Carey MP, Vanable PA. The intersection of violence, substance use, depression, and STDs: Testing of a syndemic pattern among patients attending an urban STD clinic. *J Natl Med Assoc* 2010;102:614–20.
- [23] Lanza ST, Cooper BR. Latent class Analysis for developmental research. *Child Development Perspect* 2016;10:59–64.
- [24] Ford JV, Ivankovich MB, Douglas JM Jr, et al. The need to promote sexual health in America: A new vision for public health action. *Sex Transm Dis* 2017;44:579–85.