

Adolescent reproductive and sexual health in the developing world

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At the International Conference on Population and Development in Cairo in 1994, a programme of action for the next 20 years was agreed upon. This programme attempted to shift the focus away from demography and targets towards reproductive health, empowering women, education and choice. The definition of reproductive health as agreed at the conference is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes'.

Reproductive health includes the ability to have a satisfying and safe sex life and the freedom to have children if, when, and how often one decides. It therefore involves the right to be informed of, and have access to safe, effective, affordable, and acceptable family planning methods and access to appropriate health-care which will ensure safe pregnancy and childbirth, and healthy infants.

The Cairo programme acknowledged that particular attention needs to be given to the reproductive health needs of adolescents as a group, as previously their need for reproductive health services had largely been ignored. To rectify this situation, the programme called on governments to make accessible to young people information and services on sexuality and how to protect themselves from unwanted pregnancies and sexually transmitted diseases (UN, 1994).

The five-year review of the Cairo programme of action ("ICPD +5") states:

In order to protect and promote the right of adolescents to the enjoyment of the highest attainable standards of health, provide appropriate, specific, user-friendly and accessible services to address effectively their reproductive and sexual health needs, including reproductive health education, information, counselling and health promotion strategies. These services should safeguard the rights of adolescents to privacy, confidentiality and informed consent, respecting their cultural values and religious beliefs and in conformity with relevant existing international agreements and conventions. (UNFPA website: paragraph 73a)

Adolescent Reproductive health issues

There is a great diversity of challenges faced by young people in regard to their reproductive health, and the issues of critical importance to them vary greatly depending on their cultural and geographical backgrounds. These issues include forced early marriage, lack of opportunities, unwanted pregnancy, early childbearing, the spread of HIV/AIDS and other sexually transmissible infections (STIs), and female genital mutilation. For all young people, however, the need for accurate information, non-judgmental counselling and affordable and accessible services are paramount in overcoming these challenges and helping them to avoid unwanted pregnancies, care for their sexual health and take advantage of education and other opportunities.

Early pregnancy

One in every ten births worldwide is to teenage mothers (Youth Coalition for ICPD). Decreasing the number of adolescent pregnancies is a priority for a number of reasons. Early pregnancy impacts on a girl's education, economic well-being and health. Adolescent mothers often fail to complete their education, which in turn affects their future job prospects and their economic well-being and that of their child. Pregnancy before the age of 18 is also carries greater medical risks for the mother. The risk of dying from complications related to pregnancy or childbirth is 25 times higher for girls under 15, and two times higher for those aged 15 - 19, than for women in their mid-twenties (UNFPA web site). The combination of immature bodies, poverty, lack of education and lack of access to medical care carries grave risks. Over four million women aged 15-19 have abortions every year, 40 per cent of which are performed under unsafe conditions. Early pregnancy also has a global impact as adolescent mothers will have more children than those who start childbearing later. The UNFPA (2001) estimates that raising the mother's age at first birth from 18 to 23 could reduce population growth by over 40 per cent.

STIs and HIV/AIDS

Each day 500 000 young people are infected with an STI. Half of all HIV infections (8000 a day) occur in people under the age of 25. While most STIs are not fatal, they can lead to major pregnancy complications, infertility and general ill health, and they have also been identified as a predisposing factor in the transmission of HIV (Temin, *et al*, 1999).

The high rates of infection among adolescents are largely due to lack of information or myths about how STIs and HIV are spread, many young people receiving most of their information about these issues from friends, TV, and magazines (Rwenge, 2000). Society's attitudes and expectations also contribute to the high rates of infection. Studies have shown that girls are often socialised to be motivated to begin sexual activity for reasons of love, intimacy, commitment and to have a relationship, whereas they equate condoms with multiple sex partners, distrust and disease (Machel, 2001). For young men, having multiple partners and being sexually experienced are important marks of masculinity, and lead to more risky behaviour (Nzioka, 2001).

Women and girls

Socially accepted gender roles and the position of females in many societies have a strong impact on the needs of adolescent girls. The rate of HIV infection is 2.5 times higher among young women than young men – 68.4 per cent of cases (Machel, 2001). The Executive Director of the UNFPA, Thoraya A. Obaid, has stated “we know that girls between the ages of 15 and 19 are five to eight times more vulnerable [to HIV transmission] than boys of the same age. Part of this is due to the physiology of women. But the other part is exactly related to the socio-cultural context in which women, or little girls, are brought up. For example, women do not know anything about their body and how it functions and their sexuality. They’re not allowed to think about it. They’re not allowed to understand it.” (UNFPA website, p.5)

For some young women, sexual relationships are not entered into willingly, but come about as the result of force or abuse, including incest. They may have no control over whether, whom or when they marry, sometimes before they have even reached puberty. In some countries, over 50 per cent girls under the age of 18 are married, often in response to poverty or fear of out-of-wedlock pregnancy. For example, in the Democratic Republic of Congo 74 per cent, Niger 70 per cent, Afghanistan 54 per cent and Bangladesh 51 per cent.

Unwanted and violent sexual relations may also result from these early or forced marriages. Although the young and powerless of either sex may fall victim, young girls and women are most likely to encounter sexual exploitation and, with it, the risk of unwanted pregnancy and infection, including HIV/AIDS. In countries where it is practiced, female genital mutilation, in addition to violating a woman’s right to bodily integrity and ability to ever experience sexual pleasure, can lead to severe health consequences, including infections, painful sexual relations, prolonged and obstructed labour, and even death. Two million young girls are at risk of female genital mutilation each year (see UNFPA website).

Adolescent reproductive health needs

Adolescents and youth face multiple barriers to accessing reproductive and sexual health services and maintaining their reproductive health. These include lack of information and education, lack of youth-specific services, concerns about confidentiality, affordability and access to services, and social pressures and taboos (see UNFPA website).

Education and information

Education programmes are recognised as an effective means of addressing the sexual and reproductive health needs of adolescents. Strong opposition to such programmes still remains in many parts of the world, particularly from religious leaders, decision makers, and the media (see UNESCO website). This can be partly attributed to the myth that sex education teaches young people to have sex, which globally is of particular concern in every religious or traditional society where pre-marital sex is prohibited. Many studies have debunked this myth, and a review commissioned by UNAIDS (1997), based on the analysis of 68 research reports on sexual health education from diverse countries concluded that:

- education about sexual health and/or HIV does not encourage increased sexual activity;
- quality sexual health education either delayed the onset of sexual activity, reduced the number of sexual partners or reduced unplanned pregnancy and STD rates;
- responsible and safe behaviour can be learned; and
- sexual health education is best started before the onset of sexual activity.

The review, summarizing a large body of evidence, concluded that effective education programmes share certain features. They work from a focussed curriculum, give clear statements about behavioural aims and clearly delineate the risks of unprotected sex and methods to avoid it. They use learning activities to address social and media influences and to enhance communication and negotiation skills. Effective education programmes also encourage openness in communicating about sex.

There is, however, a gap between the awareness raised by education programmes and the practice of safe sex, particularly because of the mixed messages sent by society. A study of adolescent boys in Kenya showed that definitions of male sexuality – social prescriptions of male prowess, early sexual experience and having more than one partner – mean that, although most boys know they should use condoms, in reality they often do not practise safe sex. Furthermore, some of the boys surveyed said that contracting a curable STI (such as gonorrhoea and syphilis) was acceptable as a mark of masculinity and sign of experience (Nzioka, 2001). Thus, it is evident that, on their own, information and education on safe sexual behaviour are not enough, there is a need to change attitudes and beliefs about sexuality and gender relations in general, in order to effect change.

Appropriate services

Reproductive and sexual health services can play an important role in both health promotion and prevention. However, in many countries such services are inaccessible, inappropriate or unaffordable to young people. A study in South African showed that many such health services are either physically inaccessible or have opening times that prevent easy access for youth. Staff attitudes – ranging from judgemental, to treating adolescent requests for services with hostility, to denying them services – also impact on adolescents' utilisation of services (Dickson-Tetteh, 2001).

A survey of adolescents in Nigeria showed that those who contracted an STI would go to a traditional healer rather than use reproductive health services. They were unlikely to seek treatment from doctors because of the high cost and slow service, with some stating that negative provider attitudes and a perceived lack of confidentiality drove them away. Some feared being ridiculed by hospital staff, being asked too many questions, or even being put under house arrest for having an STI (Temin, *et al.* 1999).

Services in countries where pre-marital sex is prohibited or frowned upon are also regularly denied to unmarried adolescents. A study of family planning providers in Ghana showed that service restrictions were enforced if the client was unmarried, or could not demonstrate spousal consent, and for young people (Stanback and Twum-Baah, 2001).

Social status of women and girls

A comparative study of safe sex practices among girls at a private school and government school (indicative of socio-economic status) in Mozambique showed that 56 per cent of the girls from the private school always used condoms, compared to just 32 per cent from the government school. In addition, fewer girls at the private school were sexually active (52 per cent), and those that were tended to have only one sexual partner, whereas at the government school 82 per cent were sexually active, and were more likely to have had multiple partners. Girls at both schools had received information at school about HIV/AIDS. The study concluded that the reason for knowledge, skills and attitudes not being translated into safe behaviour can be attributed to the willingness and ability of the girls to challenge patriarchal behaviour and attitudes. The middle-class girls were more willing to do so (Machel, 2001).

Girls who are married young face social and psychological barriers to accessing reproductive health services. A study of girls married before the age of 18 in Maharashtra state in India showed that many of them are confronted with such barriers because of their social position. They face great pressure to begin childbearing soon after marriage, and after taking up residence with their husband's family, they find themselves in a subordinate position as a stranger. As well, these girls are exposed to a range of reproductive health problems they would not have encountered prior to marriage. The study showed that the majority do not seek treatment for sexual/reproductive health problems, for several reasons: shame and embarrassment; not being taken seriously by those with influence (husband and mother-in-law); lack of influence; and lack of financial independence (Barua and Kurz, 2001).

What programs are being run for adolescents?

The UNFPA is working to address the reproductive health needs of adolescents through programmes in a wide range of countries.

Information and education

In Bangladesh, the UNFPA supports a programme for young couples and newlyweds, to encourage the use of family planning, spacing and timing of births. Young couples rarely seek any reproductive health services as early childbearing is strongly encouraged, particularly to prove the woman's fertility. The programme provides orientation sessions, attended by the couple and close family members, as well as one-to-one counselling and education aimed at breaking down the social and psychological barriers to use of modern contraceptive methods. Contraceptive use among newlyweds in this programme jumped from 19 percent in 1993 to 39 percent in 1997.

The use of peer educators is recognised as crucial to getting messages and correct information across to young people, so many programmes focus on training peer educators and peer counsellors, who provide information on sexual health and family planning in classrooms, on the radio, through theatre and discussion groups. In Colombia, the UNFPA has supported a government programme to train educators as part of the National Project for Sexuality Education.

Youth-Friendly Health Services

In Bolivia, Dominican Republic, and Malawi programmes have been run to provide reproductive health services for adolescents, addressing the needs of specific groups, such as indigenous peoples and out-of-school adolescents (Bolivia and Malawi respectively), and specific health needs such as prevention of teenage pregnancy (Dominican Republic).

Supportive Communities - Enabling Adults to Help

Other programmes recognise the need for parents, teachers and service-providers to be given the skills and knowledge to pass on to their young people. The UNFPA supports various such programmes: training of service providers in Algeria; sensitisation and dialogue with community leaders, youth, their parents and families in Cameroon to help the community understand and be supportive of the critical sexual and reproductive health needs of youth; research into and production of education booklets by the Iranian government and non-school based classes on reproductive health; and addressing the needs of young Somali refugees in Kenya.

Adolescent girls

Recognising the particular disadvantages that girls experience in much of the world, many UNFPA programmes are targeted at empowering girls and promoting gender equality and equity. The aim is to increase girls' knowledge of modern contraceptive methods (for example, in Djibouti, where a 1995 survey showed that less than 1 per cent of adolescent girls knew of modern family planning methods); and to encourage them to make use of health care facilities, particularly for family planning and reproductive health care services.

IPPF-supported programmes

Through its member organisations (family planning associations), the International Planned Parenthood Foundation also supports a wide range of programmes aimed at addressing the reproductive and sexual health needs of young people. In some countries peer educator programmes, young leaders' groups, and youth advocacy movements have been established. A peer educator programme run by the Bulgarian Family Planning and Sexual Health Association has targeted young people with special needs, including girls with a criminal record, and children with disabilities. In Thailand, young people run a counselling centre for adolescents with the support of the Planned Parenthood Association of Thailand. In Rwanda, where sex is still a taboo subject and many people did not know how to talk to young people about contraceptive methods, young people have talked to religious leaders to help them to understand their needs and to break down the barriers to talking about sexual and reproductive health.

Funding

The ICPD 1994 Programme of Action is a comprehensive strategy to improve the reproductive well-being of individuals. To achieve its goals, governments agreed that US\$17 billion would be needed annually by the year 2000 for reproductive health services in developing countries and countries with economies in transition.

Two-thirds of this cost was to be met by developing country governments, who today spend about two-thirds of this (UNFPA 2001). The Programme of Action pledged donor governments to expand their share of funding for population and development activities to make up the other third; however they currently only provide US\$2 billion a year, which is one-third of the required US\$5.7 billion. It was estimated that donors of population assistance would need to increase their contributions to US\$5.7 billion in 2000, US\$6.1 billion in 2005; US\$6.8 billion in 2010 and US\$7.2 billion in 2015 (all in 1993 US dollars). The amounts needed for population assistance could be achieved by meeting two targets that have already been agreed internationally. The first is that official development assistance (ODA) donors should give at least 0.7% of their gross national product (GNP) as ODA. The second is that population activities should be allocated 4 per cent of all ODA.

Despite recent initiatives to increase population assistance, Australia is far from the most generous of ODA donors. Australia's ODA as a proportion of GNP is now 0.25 per cent – the lowest level ever and well below the UN target of 0.7 per cent (ACFOA, Overseas Aid Budget Analysis Overview). To respond to the many reproductive health needs of young people as outlined in this paper, more must be done in terms of both financial and political commitment.

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