Title: Understanding the sexual and reproductive health of adolescents in developing countries: a review of the evidence on risk-taking behaviours and dual protection from a WHO Research Initiative

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Introduction and Background

The transition to adulthood poses significant sexual and reproductive health challenges for adolescents. The vast majority of adolescents live in developing countries yet the available evidence on adolescent sexual and reproductive health has, until recently, largely come from developed countries. The choices adolescents make regarding sexual and reproductive health will have significant repercussions for the rest of their lives; poor decision-making during adolescence has life-long ramifications. Early pre-marital sexual debut has been shown to have adverse consequences including an increased number of lifetime partners which in turn increases the risk of exposure to STIs such as HPV, a precursor to cervical cancer, and HIV (Ludicke et al, 2001). In addition, increased exposure to unprotected sexual activity increases the risk of unwanted pregnancy and consequently to unsafe abortion, where access to safe abortion is highly restricted.

Traditional scripts for reaching adulthood have been significantly affected by the forces of economic development and the rapid pace of globalization. These have led to shifting norms and practices in adolescent sexual activity, as social, economic, and nutritional changes have altered the traditional timing of key reproductive health events - menarche, marriage, and sexual initiation - in the life course of young people. Lacunae remain in our understanding of the challenges and obstacles experienced by adolescents in developing countries as they shape their expectations of appropriate sexual behaviour and negotiate safe sexual behaviour within intimate partnerships, all of which are defined by gender norms and socialization. In particular, improved understanding of the factors that influence risk-taking behaviours and the use, or not, of dual protection is essential to providing services that meet adolescents' needs. To contribute to the evidence on these issues, this review paper highlights and synthesizes key findings from 41 studies on adolescent sexual and reproductive health in developing countries supported by the Special Programme of Research, Development, and Research Training in Human Reproduction (HRP) at the World Health Organization, Geneva.

To address research gaps in knowledge about the sexual and reproductive health needs of young people in developing countries, HRP launched a social science research initiative targeting under-researched priority areas during the period 1998-2003 and supported over 40 case studies addressing a wide range of priority issues over the past decade. The overall aim of the initiative was to provide evidence for the development of adolescent-focused reproductive health policies and programmes in developing countries through studies that explored adolescents' vulnerability to poor reproductive health decision-making and the factors that inhibit or enhance protective behaviours. The initiative also sought to identify and understand community norms and practices, such as gender double standards, that limit choices available to adolescents. In addition, the initiative encouraged exploration of under-researched issues in greater depth by focusing on populations of adolescents that were under-studied or poorly understood.

Local investigators were often among the first in their communities to explore priority issues related to adolescent sexual and reproductive health. All case studies included in the review focused on youth and data were gathered specifically to address research questions on the perspectives and behaviours of young people on sexual and reproductive health. Study methodologies ranged from small qualitative studies to larger community surveys and most often a combination of research methods was used. Given the sensitive nature of the research questions,

qualitative methods in particular were used to explore and probe individual perspectives and experiences as well as group norms. Study designs were primarily cross-sectional, although some studies were part of larger longitudinal projects. In addition, a few intervention studies were conducted.

Study contexts and settings varied greatly and reflected a wide range of settings, including secondary schools, universities, clinics, neighborhoods, resettlement communities, factories, vendors, and urban and rural areas. Study populations were diverse and included not only unmarried, in-school adolescents, but also adolescents from vulnerable populations, such as migrants and refugees, and out-of-school adolescents. Some studies included questions on same-sex experiences, particularly as they relate to sexual coercion, a few looked at married adolescents, others investigated the perspectives and behaviours of young men, while still other studies explored provider perspectives. WHO defines adolescents as aged 10-19, youth as aged 15-24 and young as aged 10-24 years, although the age range of the study populations varies given that the legal age of majority and perceptions of the status of minors varies by country.

The studies took special care to ensure that all research procedures followed national legal and ethical guidelines. Parental consent was sought and provided where legally required and where appropriate. All participants were assured of confidentiality and referral information for contact with a health professional was provided. In addition, special attention was paid to the training of interviewers so that a rapport could develop between the interviewers and the young people participating in the study.

Major themes

The diversity and depth of the case studies permits analysis of patterns and themes that transcend study populations and countries. Given the wide range of study designs and methodologies, however, findings cannot be directly compared and contrasted. It is also not possible to identify trends over time since the studies are largely cross-sectional. The paper synthesizes the evidence across countries on two interconnected areas of adolescent sexual and reproductive health: the factors that inhibit or enhance risky behaviours and adolescent perspectives on and practice of dual protection. Here, we provide a brief overview of the major themes emerging from a review of the studies and the conclusions that can be drawn from this rich collection of research papers.

Risky Behaviours

The formation of early sexual partnerships is often accompanied by risk-taking behaviours that increase the odds of unwanted pregnancy and infection. Although all adolescents typically have reduced perceptions of personal risk from unsafe sexual activity, social context is an important marker of the extent of risk taking. In every social setting in the studies in this review, adolescents with strong family ties and educational achievement were more likely to have the life skills to better able cope with the challenges of negotiating safe sexual activity. In contrast, the studies show that vulnerable adolescents – those living in poverty, out-of-school youth, refugees, migrants, those living in the midst of social conflict – face increased risks to their reproductive health.

Several studies examined the context of risk taking behaviour among adolescents experiencing social exclusion, resettlement, migration, or structural violence in the community. For example, study of young refugees in Cape Verde showed that the social exclusion and stigmatization of these young males led to greater risk taking in their sexual behaviour. In South Africa, adolescents living in poverty, experiencing violence, and social instability demonstrated a significant inability to link health knowledge and perceptions of risk to their own actions.

Collectively, findings from the studies show that these adolescents are less likely to have basic knowledge of contraception and reproduction, are more likely to experience or initiate risky sexual behaviours, including the inability to negotiate contraceptive use and protection from STI/HIV, and may be less able to protect themselves from sexual coercion and are more vulnerable to transactional sex. Adolescents in general face difficulties accessing sexual and reproductive health information and care but these challenges are exacerbated for adolescents in vulnerable populations, whose needs are not being met by available services.

Understanding adolescent perspectives on dual protection

In general, the studies show that the use of condoms with or without other forms of contraception for dual protection from disease and unwanted pregnancy remains poorly understood by adolescents and is infrequently practiced. For example, a community survey of adolescents in China found that awareness of the protective role of condoms was poorly understood by unmarried rural youth. Only 20% of all respondents reported knowing that condoms prevent STIs and HIV and among the subset of sexually experienced respondents, less than half (46%) were aware of the role of condoms in preventing infections.

Condom use is often viewed with suspicion and they are regarded as too expensive, too difficult or embarrassing to procure, or ineffective against STI/HIV. When condoms are used, pregnancy prevention is the primary motive. In the study in China mentioned above, few respondents (6% of young women and 10% of young men) reported infection prevention as an additional motivation. Findings from a study of out-of-school adolescents in Tanzania were similar; respondents were aware of condoms but were relatively unconcerned about the threat of sexually transmitted infection compared to the fear of unwanted pregnancy. Use was reported by only a few respondents and was erratic.

Even when adolescents understand the benefits of dual protection, resistance to condom use is strong. A study among male secondary school students in Kenya found that while the students were aware of the dual protective benefits of condoms, they imbued them with a variety of negative symbolic meanings (i.e., condoms are used only by adults or "bad" boys) that rendered them difficult, if not impossible, to use in their own intimate relationships. In other settings, condoms may be used for initial sexual encounters but use fades if the seriousness of the relationship increases; a stronger emotional bond creates the perception that the risk of infection or unwanted pregnancy is reduced. For example, a study in Cuba among adolescents in both urban and rural areas found that condoms were used early in a relationship but that the perceived need for condoms diminished as the relationship solidified.

Conclusions and recommendations

The collection of studies that comprise the WHO initiative on adolescent sexual and reproductive health in developing countries provides a rich source of data on the challenges young people face as they grow to adulthood and adapt to changing global circumstances. The largely qualitative studies shed light on how, in their own words, adolescents experience sexual initiation and help us understand how better to meet their reproductive health needs. Not long ago, menarche, marriage (usually arranged) and sexual debut were closely linked and took place within a fairly narrow time period in most developing countries. Advances in nutrition and health have led to earlier menarche while the mean age at first marriage is increasingly disconnected from the mean age of sexual debut for both young men and women, who are increasingly pursuing education and employment before marriage. This increased period of exposure to out-of-wedlock sexual activity requires programmes and policies that recognize that young people are sexually active and that are specifically designed to address the particular needs of adolescents.

Although the review paper highlights the many adverse events experienced by adolescents and the difficulties they face, it is important to note that in most studies, many adolescents do not report negative experiences and do make appropriate decisions about sexual activity. For example, although in general the studies show that contraceptive use is generally low among sexually active adolescents, sub-groups of young people are using contraception correctly and consistently. Nonetheless, the deficient or flawed knowledge displayed by some adolescents and the lack of negotiating power experienced by, in many cases, a majority of adolescents indicate a critical need to improve the status of adolescent reproductive health.

Several preliminary themes emerge from an overview of the studies. Adolescents demonstrate a vexing sense of ambiguity about their expectations for sexual partnerships, reflecting conflicting and gendered social norms about appropriate sexual activity. On the one hand, adult norms continue to promote sexual abstinence among unmarried adolescents and among girls in particular, but, on the other hand, male peer groups tend to encourage unsafe sexual activity and view its consequences, i.e. STIs and pregnancy, as proof of sexual conquest and masculinity. Adolescents appear to have mixed opinions about who is responsible for preventing unwanted pregnancy. Young men are often considered nominally "in charge" of protection from STIs and unwanted pregnancy yet they frequently do not adopt protective practices and, if a girl becomes pregnant, they are unwilling to take responsibility and are quick to assert that the responsibility for contraception lay with the young woman. Young women themselves face social norms that advocate acquiescence and submission should they become sexually active and provide little opportunity or support for negotiating for safe sexual activity.

The detrimental practices and gendered norms identified in these studies will remain entrenched until successful communication and dialogue on sexual and reproductive health takes root. There has been significant progress in many parts of the world in developing youth-targeted sexual and reproductive health programmes in response to overwhelming need. In many settings, however, helpful counsel is missing in the lives of young people and open communication on safe sexual behaviour is largely absent – between parents and adolescents, between teachers and adolescents, between adolescents in intimate relationships who are largely unable to communicate their reproductive health needs. A study in Tanzania of out-of-school adolescents found that out of 81 adolescents participating in in-depth interviews, not one reported having had an open discussion with their parents about sexual matters and the life skills needed to ensure safe sexual activity. When communication does take place, there is evidence that gender may play a significant role regarding whom adolescents prefer to seek out for discussion. In a study in Ghana, for example, young men were the least likely to feel they could approach parents for counsel on sexual matters while girls were more likely to feel they can discuss sexual issues with older female family members.

Family planning programmes must continue to advocate for accessible youth-centered services to enable adolescents to make safe and informed choices. Programmes should also address the needs of marginalized and vulnerable groups of adolescents, so that information and services reach all young people, including those who may not normally access standard health services. Finally, programmes for young people must also address detrimental gender norms that inhibit open communication about sexual and reproductive desires and intentions.