Orientation Programme on Adolescent Health for Health-care Providers

Handout for

Module C

Adolescent sexual and reproductive health

This handout presents background information, which is the foundation for the optional modules on *Adolescent sexual and reproductive health*.

This handout provides information on the following:

1. Definitions of sexual and reproductive health

Sexual health

The term sexual health is used to describe the absence of illness and injury associated with sexual behaviour, and a sense of sexual well-being. It has been defined as follows: "… the positive integration of physical, emotional, intellectual and social aspects of sexuality. Sexuality influences thoughts, feelings, interactions and actions among individuals, and motivates people to find love, contact, warmth and intimacy. It can be expressed in many different ways and is closely linked to the environment in which people live." (*1*)

Reproductive health

WHO defines reproductive health as "...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 to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right to access appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases." (*2*)

2. Puberty

Adolescence is a period of transition from childhood into adulthood. It is marked by dramatic physical, psychological and social changes. The onset of puberty "announces" an important step on the road to adulthood. Puberty refers to the physiological changes that occur in early adolescence (sometimes beginning in late childhood) which result in the development of sexual and reproductive capacity.

Physical growth and development manifest in a growth spurt during which there are marked changes in the size and shape of the body. Differences between boys and girls are accentuated. For instance, girls experience breast development and hip enlargement, whereas in boys, there is the appearance of "man-like" musculature.

These changes are accompanied by others such as the appearance of the axillary and pubic hair in both boys and girls, and the change in the pitch of the voice and the appearance of facial hair in boys. There is rapid maturation of the sexual organs. The onset of menstruation and the initiation of sperm production are important milestones at this time.

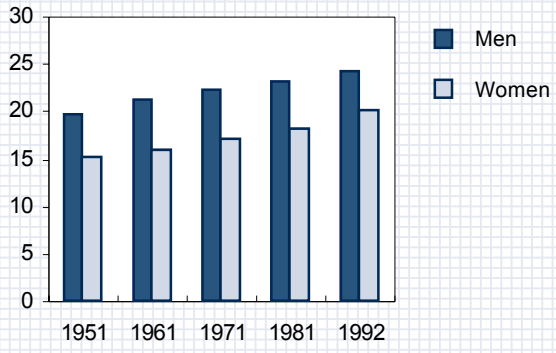
In many traditional cultures, elaborate rituals were carried out to commemorate the onset of puberty, to "announce" sexual readiness and to celebrate the "arrival" of an adult into the community. Even in modern times, the onset of puberty is a defining moment in an individual's life, and in the way in which his/her place and role in the family and community are perceived.

In both developed and developing countries, puberty is occurring at an earlier age than it did in previous generations. This is attributed to improved nutrition and health status (*3*). The changes generally occur over a 5-year period, but range from 18 months to 6 years. In general, girls start puberty about 18 months earlier than boys. Girls today enter puberty between the ages of 8 and 13, and boys between 9 and 14 years (*4*).

In many parts of the world, both in developed and developing countries, girls are reaching puberty at earlier ages. Most of the change is attributed to improved health and nutrition status. Declining trends in the age of onset of puberty are accompanied in many countries by increasing age at marriage (Figure 1). This has important implications for sexual and reproductive health of adolescents.

FIGURE 1

Average age at marriage in India, 1951-1992



Source: Reference (6)

3. Initiation of sexual relations in adolescents

As their bodies change and mature, many adolescents will develop an interest in sex. A recent synthesis of behavioural case studies in 20 developing countries in Africa, Asia and Latin America points to the fact that adolescence is the period during which sexual activity is initiated in a substantial proportion of individuals (*6*). The report goes on to say that "much of this activity is risky; the practice of contraception and condom use is often erratic, and unwanted pregnancies and unsafe abortions are observed in many settings. Sexual relations are not always consensual: force and coercion are far from unknown. While young people tend to be generally well informed, they have only patchy in-depth knowledge of issues related to sexuality. Moreover expressed norms often conflict with behaviour. Lastly, there are wide gender-based differences in sexual conduct, and in the ability to negotiate sexual activity and contraceptive use". (*6*)

Studies from around the world confirm that a larger percentage of boys report being sexually active than do girls of the same age. Further, boys report that they begin sexual activity earlier (Table 1).

Demographic and Health Surveys (DHS) data indicate that the reported ages of sexual debut for boys are generally decreasing in nearly all countries for which DHS data are available, while the reported ages at first sexual experience for girls has decreased in only a fifth of these countries (*7*). The earlier age of puberty, combined with the delayed age of marriage and the declining age of first sexual experience (for some groups of adolescents) means that many more adolescents are having sexual relations before marriage.

TABLE 1

Premarital sexual intercourse in Latin America and the Caribbean

Country and year of survey	Females		Males	
	% reporting intercourse age 15-19	Mean age at first intercourse	% reporting intercourse age 15-19	Mean age at first intercourse
Brazil, 1989	16	16.8	69	15.1
Chile, 1988	19	17.9	48	16.0
Costa Rica, 1991	19	17.9	48	16.0
Guatemala, 1986	12	16.7	65	14.8
Jamaica, 1993	59	15.9	75	13.9
Mexico, 1985	13	17.0	44	15.7

Source: Reference (4)

Sexual expression

Sexual relations are often seen to be only those which involve penetrative sexual intercourse. However, there are many other ways of expressing sexual feelings that do not involve penetration and that are safe in terms of preventing pregnancy and infection from STIs and HIV. These behaviours include holding hands, hugging, kissing, body rubbing, masturbation and mutual masturbation.

Another factor which is often overlooked in discussions of sexual relations is that of same sex relationships. Providers of sexual and reproductive health-care services often assume that all clients are heterosexual. Yet research shows that adolescent same-sex experimentation is probably more common than is believed, especially among boys (*6*).

4. Protective and risk factors influencing adolescent sexual behaviour

A range of factors influence aspects of adolescent sexual behaviour (such as the initiation of sex, type and number of sexual partners, and the use of any form of contraception). These factors include characteristics of the adolescents themselves, those of their families, friends and communities, as well as the relationships of adolescents to these entities. Some of these factors are protective for adolescent sexual behaviour and others are not.

Table 2 presents results from studies carried around the world, of factors that influence the early initiation of sexual activity (*8*). They suggest that protective and risk factors can explain differences in adolescent behaviour, even after accounting for variables such as age, sex, ethnic group and socio-economic status.

FIGURE 2

Early sexual initiation

Risk or protective factors for adolescents	Africa	Asia	Caribbean	South America	North America
A positive relationship with parents	+	+	+	+	?
A positive relationship with teachers	+	+	?	+	Not significant
Friends who are sexually active	-	?	-	-	?
Engaging in other risky behaviours	-	?	-	?	?
Having spiritual beliefs	?	+	+	?	+

Key: + protective factor; - risk factor; ? not measured.
Source: Reference (8).

From the table we can conclude that:

- Families matter: Adolescents who have a positive relationship with parents are less likely to start sexual intercourse early.
- Schools matter: Adolescents who have a positive relationship with teachers are less likely to start sexual intercourse early.
- Friends matter: Adolescents who believe that their friends are sexually active are more likely to start sexual intercourse early.
- Beliefs matter: Adolescents who have spiritual beliefs are less likely to start sexual intercourse early.
- Risk behaviours are linked: adolescents who engage in other risk behaviours, such as using alcohol and drugs, are more likely to start sexual intercourse early.

Clearly, an individual's experience of sexual relations is mediated by biological factors (such as the age of puberty), cultural norms (such as the age of marriage) and social factors (such as power relations between men and women). Perhaps the most profound societal influence on an individual's sexuality comes from prescribed gender roles – the social norms that shape the relative power, responsibilities, and behaviour of women and men (*9*).

Young men often believe that sexual initiation affirms their identity as men and provides them status in the male peer group. For many adolescent boys worldwide, sexual experience is seen as a

rite of passage to manhood and an accomplishment or an achievement. In some cultures, sexual "conquests" are often shared with pride within the male peer group, while doubts or inexperience are frequently hidden from the group (*10*). On the other hand, the prescribed role of girls and women in sexual relations is often to be passive. They are not encouraged, or given support, to make decisions regarding their choice of sexual partners, to negotiate with their partners the timing and nature of sexual activity, to protect themselves from unwanted pregnancy and disease, and least of all to acknowledge their own sexual desire (*9*).

5. Sexual abuse and commercial sexual exploitation

Adolescent girls often lack the power, confidence and skills to refuse to have sex or to negotiate safer sex. Gender norms can place them at high risk of sexual violence including coerced or forced sex (*11*).

Sexual abuse, coercion and rape are tragic realities that affect young people in developing and developed countries alike. They can and do result in problems such as unwanted pregnancy and sexually transmitted infections, including HIV, in addition to having long-lasting psychological consequences. The extent to which young people worldwide fall victim to non-consensual sex and sexual coercion is difficult to measure because surveys vary greatly in the way in which they define involuntary sex.

Economic hardships can force young girls and boys to leave home and seek a livelihood and support elsewhere. Commercial sexual exploitation and prostitution are sometimes consequences of this. In other instances, the adolescent may leave home because of abuse by family members and end up living on the street, or in sexually exploitative relationships.

6. Consequences of unprotected sexual relations

Whether they are married or unmarried, and engage in heterosexual or homosexual acts, adolescents can face potentially serious physical, social and economic consequences from unprotected sex. Some of these consequences are described below (*12, 13*).

Health risks to both adolescent males and females

Sexually transmitted infections

At the time of first sexual contact, adolescents often lack knowledge about sexuality and reproduction. Indeed first sex is often experimentation and adolescents generally do not prepare for it by obtaining and using condoms or contraception, even if they know where to and can get them. Adolescent girls may lack the power, confidence and skills to refuse to have sex. The gender roles of the submissive female and the dominant male make it more difficult for the girl to say no. In some places, gender norms condone early initiation of sexual activity by adolescent boys (by older women including sex workers) and encourage sex with multiple partners. Some adolescents are subject to sexual abuse of varying degrees, including incest or rape.

If contraceptives, particularly condoms, are not readily available, or are not used, adolescents of both sexes risk getting sexually transmitted infections and girls risk having an unwanted pregnancy. Many young women do not even know they have contracted a sexually transmitted infection because they have no symptoms or because they are unaware of them. Undiagnosed and untreated, the disease continues to plague them into adult life and may lead to pelvic inflammatory disease, ectopic pregnancy and eventually infertility, as well as damaging eyesight and general health of any children they may have.

Another disease of women – cervical cancer – shows itself only in later life but research shows that a woman's risk of this disease is doubled if her first sexual activity was in early adolescence.

Health risks to the adolescent mother

Too early pregnancy

Many adolescents have healthy pregnancies and healthy babies. They give birth without complications and enjoy their role as mothers. But all too many do not. Although their bodies may be mature enough to become pregnant, some adolescents are not sufficiently physically developed to have a safe pregnancy and delivery.

Pregnant adolescents are more likely to suffer eclampsia and obstructed labour than women who become pregnant in their early twenties. In the early adolescent years, a girl is still growing and her pelvis has not reached its full adult size. Pregnancy increases the body's nutritional needs and can slow down the girl's growth. Obstructed labour is far more likely if a girl's pelvis is not full size at childbirth.

A particularly devastating complication of obstructed labour is obstetric fistula, a hole between the vagina and the bladder or rectum. The woman constantly leaks urine or faeces, smells offensive and is often ostracized both by her family and by the community. Studies in Asia and Africa show that adolescents having their first baby are much more likely to suffer obstetric fistula than older women giving birth for the first time (*12*).

Girls who become pregnant in their adolescent years are less likely to seek prenatal care than older women. Yet pregnant adolescents are more likely to have health problems than women over 20. Studies in several countries have shown that the risk of death during childbirth is higher among adolescents than among older women (*14*).

Even if a pregnant adolescent is physically developed, she may lack the social and emotional maturity to cope with the experience of becoming a mother and the changes it means to her life. Her male partner, if he is an adolescent, is also not likely to be ready to shoulder the responsibilities of fatherhood.

Unsafe abortion

In cultures where early marriage is common, adolescent pregnancy is generally welcomed by the family, if not always by the adolescent girl. If the pregnancy occurs outside marriage, social sanctions may be severe and induced abortion often seems the only way of avoiding public shame and rejection. Adolescents account for a very high proportion of abortion complications, primarily because they are likely to obtain clandestine illegal abortions, or delay seeking abortion until late in the pregnancy.

Health risks to the baby

Babies born to young adolescent mothers also face more health risks than babies of older women. Babies of adolescent mothers are more likely to have low birth weight, run a higher risk of being premature and have a higher rate of perinatal mortality.

A major problem arises from "children having children". A young adolescent mother, barely out of childhood herself and certainly not an adult, may not have the parenting skills needed to raise a child.

Social costs of pregnancy to the adolescent mother

Unmarried pregnant young women run the risk of being rejected by family and community. One problem is often linked to others. Adolescents who have babies are often unable to continue their schooling. A young woman with a baby often has less chance of finding employment, and if she has not completed her education, she will be at an added disadvantage. Her income is likely to be low in comparison to most others. Poverty and poor health often go hand in hand, rendering the mother even less able to cope and setting the child back in its development.

The cost to the community

Early pregnancy has negative consequences not only for the mother and baby, but also for the community. The poor unmarried mother with little education is not only unable to contribute to the development of the community, but she and her family may become a burden on it. It is in the community's interest for all families – whether two-parent or single-parent – to be economically viable, and early pregnancy certainly does not help that to happen.

7. Promoting the sexual and reproductive health of adolescents

The UNFPA, UNICEF, WHO common agenda for action in adolescent health and development (*15*) calls for the implementation of a package of actions, tailored to meet the special needs and problems of adolescents and includes the provision of information and skills, health and counselling services, and the creation of a safe and supportive environment (*15*). Promoting the sexual and reproductive health of adolescents involves the implementation of the same set of actions.

- Information helps adolescents understand how their bodies work and what the consequences of their actions are likely to be. It dispels myths and corrects inaccuracies.
- Adolescents need social skills that will enable them to say no to sex with confidence and to negotiate safer sex, if they wish to. If they are sexually active, they also need physical skills such as how to use condoms.
- Counselling can help adolescents make informed choices, giving them more confidence and helping them feel in more control of their lives.
- Health services can help well adolescents stay well, and ill adolescents get back to good health.
- As adolescents undergo physical, psychological and social change and development, a safe and supportive environment in their families and communities can enable them to undergo these changes in safety, with confidence and with the best prospects for healthy and productive adulthood.

It is worth stressing that adolescents are a diverse group. For example, a boy of 12 is at a very different stage of personal development than a boy of 18. Similarly, he is different in psychological and social terms from a girl of 12, in addition to obvious physical differences. Social circumstances can influence personal development; for example, the health and development of a boy of 12 who is part of a caring middle-class family is likely to be very different from those of a boy of the same age who is fending for himself on the street. Finally, even two boys of the same age, growing up in very similar circumstances, may proceed through adolescence in different ways, and at different "speeds". The sexual and reproductive health service needs of adolescents are correspondingly heterogeneous. Adolescents who are not yet sexually active have different needs from those who are; sexually active adolescents in stable, monogamous relationships may have different needs from those in more casual relationships. Quite different needs characterize those faced with unwanted pregnancies or infection, or those who have been coerced into sex. It is important therefore to be aware of the diversity of sexual and reproductive health needs of adolescents, and to tailor our responses to their specific needs.

8. What can health-care providers do to improve adolescents' access to sexual and reproductive health information and services?

Adolescents seek information and clues about sexual life from a variety of sources – parents, siblings, peers, magazines, books, the mass media, etc.. Whilst they receive a great deal of information from diverse sources, not all of it is correct and complete. Many adolescents lack information concerning the physical changes that occur during adolescence, their implications, and how to take care of themselves. This is often because the subject of sexuality is a sensitive one in many societies.

As a health-care provider, you can be a valuable source of accurate information and support to the adolescents you serve. You can present them with facts, respond to their questions, and provide reassurance. You can also work with your colleagues to make your services more sensitive and responsive to the needs of the adolescents you serve. For more information on this, please refer to module D. *Adolescent-friendly health services.*

In many societies, parents and other community members are concerned that the provision of information on sexuality can do more harm than good. As a health-care provider, it is important that you are very well aware that this is not true. A review of scientific studies from around the world, conducted by UNAIDS in 1997, evaluated the impact of sex education programmes on adolescent knowledge and behaviour and found half of the studies that evaluated sexual health education and HIV/AIDS education initiatives neither increased nor decreased sexual activity and attendant rates of pregnancy and STIs. Moreover, 41% of the studies reported that HIV/AIDS and/or sexual health education either delayed the onset of sexual activity, reduced the number of sexual partners, or reduced unplanned pregnancy and STI rates. Little evidence was found to support the contention that sexual health and HIV education promote sexual activity. If any effect is observed, almost without exception, it is in the direction of postponed initiation of sexual intercourse and/or effective use of contraception. Failure to provide adolescents with appropriate and timely information represents a missed opportunity for reducing the incidence of unwanted pregnancy and STIs, HIV and their negative consequences (*16*).

In conclusion, it would be useful to recall a statement made by Dr Gro Harlem Bruntland, the former Director-General of WHO, at a ministerial conference on Population and Development (The Hague, Netherlands, 1999): *"Young people need adult assistance to deal with thoughts, feelings and experiences that accompany physical maturity. By providing this help, we are encouraging responsible life styles. Evidence from around the world has clearly shown that providing information and skills on human sexuality and human relationships helps avert health problems, and creates more mature and responsible attitudes."* She then went on to stress that health-care providers and other adults have a major role to play in promoting adolescent sexual and reproductive health: *"Think of the costs of failing to ensure that young people – our common future – have the knowledge, skills and services they need to help them make healthy choices in their sexual and reproductive health lives."*

9. References

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Annex 1

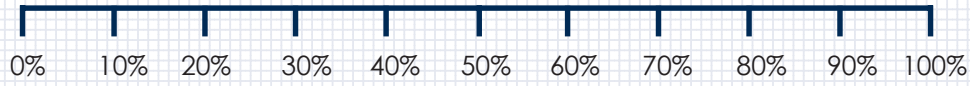
Spot checks

Session 1: ACTIVITY 1-2

SPOT CHECK 1

What percentage of your male adolescent patients do you think are sexually active by the age of … years ?

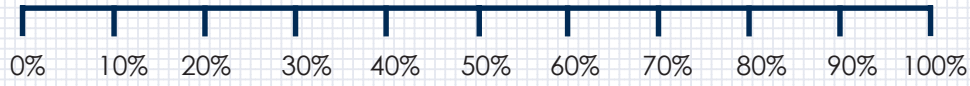
please mark your estimate with a spot anywhere along the line



SPOT CHECK 2

What percentage of your female adolescent patients do you think are sexually active by the age of…?

please mark your estimate with a spot anywhere along the line



SPOT CHECK 3

Adolescents engage in sex because...

please fill in the blanks

SPOT CHECK 4

Adolescents can get the information and health services they need

please answer with one spot and give one reason for your answer

- Yes, because ...
- No, because ...
- Don't know ...
- Not sure ...

SPOT CHECK 5

The problems that too early sexual activity in adolescence can result in are:

please fill in the blank spaces

-
-
-
-
-
-

Orientation Programme on Adolescent Health for Health-care Providers

Annex 2

Case studies

Session 5: ACTIVITY 5-1

CASE STUDY 1

Aloo, a 14-year old in Kenya, attended a girl's boarding school and was the top pupil in her class. Her closest friend, Maria, was in the same class and they were the two star students in their class. Aloo came from a rural village in Western Kenya. Maria was the daughter of a prosperous businessman in Nairobi.

The two girls shared many secrets. They were both virgins and members of the Christian Union. One weekend in their second year in high school, while attending a student camp, they became friends with two boys from a nearby school. They ended up having sex, their first time. This was one month before the school holidays.

The following month they both missed their menstrual periods. They were on vacation and did not share this secret until the school opened. Could they be pregnant? As the school was near Nairobi, Maria's mother used to visit her every month. On her next visit Maria disclosed to her mother the problem. The mother immediately understood what was going on. She asked for permission for Maria to attend a family emergency, took her home and arranged for an immediate termination of pregnancy by her gynaecologist. Maria was back in school that Monday.

Aloo remained in school and soon the teachers started suspecting that she might be pregnant. She had been frequently unwell and moody, her performance in class deteriorated, and the school nurse was summoned to examine her. Aloo had to miss class in order to get to the clinic during working hours. Pregnancy was confirmed and according to the school's policy she was immediately suspended and given a letter to take to her parents. Aloo was devastated. She had no money to go home. Her parents were elders in their church and would kill her if they heard what had happened.

Terrified, she went to the local clinic to seek help. Being the only young woman in the clinic, she felt self-conscious as all the adult patients and workers kept staring at her. She came up against a lengthy registration process that required the signature of her parents. The health-care provider scolded her for her immoral behaviour and told her that she would not receive any services without her parents' consent. She had to leave.

Maria gave her some money and Aloo left school and travelled to Nairobi to see her uncle, a construction worker who lived in one of the slums. When her uncle returned from work in the evening Aloo feigned sickness and told him that she had been sent away because of school fees. The uncle sympathized with her but could not raise any money. He therefore sent a letter by post to Aloo's parents, asking them to send the money.

Aloo was now four months pregnant and it became more difficult to hide. At six months her uncle's wife noticed the pregnancy. Her uncle was furious and chased her out of his house. Lonely, with no money and nowhere to go, Aloo accepted accommodation from a young man in their neighbourhood.

Two months later Aloo delivered a premature baby boy at a nearby health centre. The baby had to be kept in the nursery for two weeks. When Aloo was discharged from the hospital she found that the young man who had accommodated her had moved.

She was now desperate! A 15-year old with a premature newborn, no money and homeless. Aloo took refuge in the only place that could accept her. A businesswoman selling gin in the slum area employed her to help serve her customers. That became Aloo's life.

CASE STUDY 2

Surekha, a 12-year old girl, lived with two younger brothers and her parents in Ahmedabad, a city in Western India. Hers was a middle-class family, and her parents cared for and loved their children very much. Surekha was a happy child. She was a good student and was liked by her teachers and her class mates.

One day, when Surekha was in class, she noticed that her underpants were feeling wet and uncomfortable. When she looked down at her dress, she noticed that it was splotched with blood. The girl sitting beside her noticed this too and went and told the teacher about it. The teacher stopped the lesson, took Surekha to the staff room and asked her to use the toilet to clean herself and apply a pad. Surekha did not know what had happened to her, or what to do. She was in shock.

Her teacher explained the situation to the other teachers who were present, told her to sit in a corner of the staff room and went back to her class. None of the other teachers took any notice of her. Surekha sat in silence for two hours till the school day came to an end. She did not know what was happening to her, and prayed hard that there was nothing seriously wrong with her. After all the teachers had left, she tiptoed outside to check if the coast was clear, went to her class, took her things and walked home covering her soiled dress.

When she reached home, she burst into tears and told her mother what had happened. Her mother signalled her to be silent, shooed Surekha's brothers out of the room, and took her to the bathroom. Her mother told her that this was a sign that Surekha was no longer a girl. Her mother told her what to do, and said that the bleeding would last a few days. She also told her that this would happen every month for the rest of her life.

Surekha went to bed with her mind in a whirl. She had many, many questions, and decided to speak to Sita, a girl in a senior class whom she knew.