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Adolescent sexual and reproductive health: The global challenges

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ABSTRACT

Adolescent sexual and reproductive health (ASRH) has been overlooked historically despite the high risks that countries face for its neglect. Some of the challenges faced by adolescents across the world include early pregnancy and parenthood, difficulties accessing contraception and safe abortion, and high rates of HIV and sexually transmitted infections. Various political, economic, and sociocultural factors restrict the delivery of information and services; healthcare workers often act as a barrier to care by failing to provide young people with supportive, nonjudgmental, youth-appropriate services. FIGO has been working with partners and its member associations to break some of these barriers—enabling obstetricians and gynecologists to effect change in their countries and promote the ASRH agenda on a global scale.

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1. Introduction

Adolescent sexual and reproductive health (ASRH) comprises a major component of the global burden of sexual ill health. Although overlooked historically, international agencies are now focusing on improving ASRH and providing programmatic funding. ASRH rights are based in various legal instruments: in 2002, the UN General Assembly Special Session on Children recognized the need to develop and implement health policies and programs for adolescents that promote their physical and mental health [1]; in 2003, the Committee of the Convention on the Rights of the Child issued a General Comment recognizing the special health and development needs and rights of adolescents and young people [2]. Other supporting instruments are the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the right to health—a concept included in various international agreements such as the Universal Declaration of Human Rights and the international Millennium Development Goals, which include indicators to reduce pregnancy rates among 15–19 year olds, increase HIV knowledge, and reduce the spread of HIV among young people [3–5].

Various terms are used to categorize young people: "adolescents" refers to 10–19 year olds (divided into early [10–14 years] and late [15–19 years] adolescence); "youth" refers to 15–24 year olds; and "young people" refers to 10–24 year olds. In the world today, approximately half of the population is under 25, with 1.8 billion people aged between 10 and 24 years—90% of whom live in low- and middle-income countries (LMICs) and many experiencing poverty and unemployment [6,7]. While sexual initiation and sexual activity vary widely by region, country, and sex [8], in all regions young people are reaching puberty earlier, often engaging in sexual activity at a younger age, and marrying later [9–11]; consequently they are sexually mature for longer before marriage than has historically been the case.

The risks of neglecting ASRH are great; a painful or damaging transition to adulthood can result in a lifetime of ill effects. For girls, early pregnancy/motherhood can be physically risky and can compromise educational achievement and economic potential. Adolescents—girls in particular—face increased risk of exposure to HIV and sexually transmitted infections (STIs), sexual coercion, exploitation, and violence. All of these have huge impacts on an individual's physical and mental health, as well as long-term implications for them, their families, and their communities.

An adolescent's sexual and reproductive health is strongly linked to their particular social, cultural, and economic environment. In addition to regional variation, experiences are diversified by age, sex, marital status, schooling, residence, migration, sexual orientation, and socioeconomic status, among other characteristics. Access to health care and sources of education, information, and support also varies widely. The variations demand country-level analyses of patterns but despite these variations, key issues, barriers, and challenges, as well as potential solutions, can be identified across the board.

2. The global challenges

2.1. Pregnancy, contraception, and abortion

Sixteen million girls aged 15–19 give birth each year, which is approximately 11% of all births worldwide [12]; 95% of these births occur in LMICs. Important regional differences exist; for example, births to adolescents as a percentage of all births range from approximately 2%

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in China, to 18% in Latin America and the Caribbean, to more than 50% in Sub-Saharan Africa [13]. Pregnancy among very young mothers is a significant problem; in LMICs, almost 10% of girls become mothers by age 16, with the highest rates in Sub-Saharan Africa and South Central and Southeast Asia [13]. Pregnancies among unmarried adolescent mothers are more likely to be unintended and end in induced abortion; coerced sex (reported by 10% of girls who first had sex before age 15) contributes to unwanted adolescent pregnancies, among a plethora of other negative consequences [13].

Adolescents face a higher risk of complications and death as a result of pregnancy than older women. For example, in Latin America, the risk of maternal death is four times higher in adolescents under 16 years old than women in their twenties [12]. In terms of complications, anemia, malaria, HIV and other STIs, postpartum hemorrhage, and mental disorders, such as depression, are associated with adolescent pregnancy [13,14]. Pregnancy and delivery for girls who have not completed their body growth expose them to problems that are less common in adult women; 9% — 86% of women with obstetric fistula develop the condition as adolescents, with traumatic, often lifelong consequences [15]. Low socioeconomic status, substance abuse, and likelihood of receiving low and/or inadequate prenatal care are associated with pregnant adolescents, and poor outcomes for the offspring of adolescent mothers are well documented and include higher rates of preterm birth, low birth weight and asphyxia, and perinatal and neonatal mortality [10,12,16].

Globally, it is estimated that more than 220 million women in LMICs have an unmet need for family planning [18]. Overall, little progress has been made in increasing uptake of contraception. While increases in use have been slightly higher with adolescents than older women, this group are more affected by contraceptive failure and discontinuation rates, and use of traditional methods of contraception are still notable [11,17]. Adolescent girls who have ever had sex or are currently sexually active are more likely to be or have been married than boys in the same categories [19]. Married adolescents often do not want a pregnancy, but have low contraceptive rates; in fact, recent data have shown that current use of contraceptives is often lower among sexually active, married adolescents [11]. For example, in Bangladesh contraceptive use among women aged 10–49 years rose from 49% — 61% from 1996–2011, while for married adolescents aged 15–19 years it rose from 33% — 47% in the same time period [20]. Similarly, in Malawi, contraceptive use among married women aged 15–49 years increased from 13% — 46% from 1992–2010, whereas among married adolescents aged 15–19 years it rose from 7% — 29% [20]. Unmet need for both married and unmarried adolescents is therefore still extremely high [8]. Research suggests that current contraceptive use prevents approximately 272 000 maternal mortalities per year, and if current family planning needs were met, another 104 000 lives would not be lost [21], many of which would be adolescents' lives saved.

One major outcome of unmet need for family planning is unwanted pregnancy and, consequently, high levels of unsafe abortion. Complications from pregnancy and childbirth are the leading cause of death in girls aged 15–19 years in LMICs where almost all of the estimated three million unsafe abortions occur [16]. Worldwide, mostly as a result of unintended pregnancy, nearly 4.5 million adolescents undergo an abortion each year, with approximately 40% performed under unsafe conditions. Regional differences exist; for example, 15–19 year olds account for 25% of all unsafe abortions in Africa, but the proportion in Asia and in Latin America and the Caribbean is much lower [22]. In Nigeria, adolescents account for up to 74% of all induced abortions—approximately 60% of all gynecological hospital admissions. In Tanzania, approximately half the number of adolescent patients seeking abortions were aged 17 years or younger [19]. Adolescents are more seriously affected by complications than older women [12]. The physically devastating potential consequences of unsafe abortion include cervical tearing, perforated uterus and bowel, hemorrhage, chronic pelvic infection and abscesses, infertility, endotoxic shock, renal failure, and death. The long-term sequelae include ectopic pregnancy, chronic pelvic pain, and infertility [23]. Potential discrimination and rejection by family or community members, psychosocial stress, forced marriage, and violence often impact these young women [19].

2.2. HIV/AIDS and STIs

Young people are currently the group most severely impacted by HIV/AIDS. In 2009, young people aged between 15 and 24 years accounted for 41% of all new HIV infections among adults over the age of 15 and it is estimated that worldwide there are five million young people (15–25 years) living with HIV. Most of these young people live in Sub-Saharan Africa, most are women, and most do not know their status. Globally, young women make up more than 60% of all young people living with HIV, and in Sub-Saharan Africa that rate jumps to 72% [24] with prevalence among teenage girls in some countries five times higher than among teenage boys [25]. Rates of STIs also show the highest prevalence among 20–24 year olds, followed by 15–19 year olds, again often with adolescent girls bearing the higher burden [26]. Biologically, the immature reproductive and immune systems of adolescent girls translate to increased susceptibility to STIs and HIV transmission [9,25]. In addition to biological vulnerability, cultural and socioeconomic factors—particularly social inequality and exclusion, as well as having older partners—increase their susceptibility.

Treating STIs is essential because they can facilitate the transmission of HIV as well as causing lasting damage. Only a minority of adolescents have access to any acceptable and affordable STI/HIV services. In most countries, comprehensive and accurate knowledge about HIV is low and HIV testing in this age group is rare [27]. Outcomes for young people with HIV are poor; while a recent analysis estimated a 32% decrease in AIDS-related deaths among non-adolescents (aged 0–9 years and aged 20 and older) between 2005 and 2012, among adolescents (aged 10–19 years) there was a 50% increase in AIDS-related deaths, especially among boys [28].

3. Barriers and challenges

A series of multifaceted barriers currently prohibits good sexual and reproductive health for adolescents. At the political level, ASRH is low priority and there are often restrictive laws and policies in place. Various societal, cultural, and religious factors create an inhibitive environment for discussion of ASRH as many societies hold a deeply embedded sense of disapproval of adolescent sexual activity; this is often demonstrated through the stigmatization of sexual health concerns, in particular STIs/HIV. Judgmental attitudes about sexual activity abound, especially for those out of marriage and sexually active girls and women. In some regions, accepted practices of early marriage and childbearing, age differences between partners, and societal pressure prohibiting use of contraceptive methods may also exist. Poor ASRH can be further confounded by conflict, migration, urbanization, and lack of schooling.

With regard to service-related barriers, poor health systems for sexual health, family planning, and maternal health are common, with unmarried adolescents ignored in some cases, married adolescents in others, and an overall deficiency of youth-friendly services. Lack of integration is seen where services that might address counselling and family planning fail to include HIV/STI care, etc. Services may also be hampered by corruption and lack/erratic availability of supplies and equipment. Economic and physical accessibility restrict adolescents' access to services where they do exist. On a personal level, young people's care-seeking behavior may be restricted because of fear (of people finding out and other confidentiality issues that may result in violence), embarrassment, lack of knowledge, misinformation and myths, stigma, and shame [11]. A range of people have an influence on adolescents' access to information and services, including peers, parents, family members, teachers, and healthcare workers. Some argue that the single most important barrier to care is provider attitude [29]. Many healthcare workers deter adolescents from using services because of their lack of

confidentiality, judgmental attitudes, disrespect, or not taking their patients' needs seriously.

4. Opportunities and potential solutions

Opportunities for improving ASRH come from myriad directions. With regard to services, we must ensure access to quality youth-friendly, integrated services, provided by healthcare workers who have been trained to work with adolescents. Sex education programs should be scaled up and offer accurate, comprehensive information while building skills for negotiating sexual behaviors [9]. Healthcare workers should be equipped to provide accurate, balanced sex education, including information about contraception and condoms so that young people have the means to protect themselves, provided within a context of healthy sexuality, without stigma or judgment.

Healthcare workers are also well placed to influence policy and ensure service provision for those who need it. For example, healthcare workers can work to ensure young pregnant women receive early and tailored prenatal services to address their high risk and specific problems of anemia, malaria, HIV, and other STIs, as well as giving them special attention during obstetric care, given that they are most at risk of complications and death. Many improvements require political and legal maneuvering and healthcare workers can be advocates for legal abortion, adequate postabortion care services for young people where abortion is restricted or adolescents have difficulty in accessing legal abortions, contraception provision for all who have unmet need, as well as other ASRH initiatives that can have a direct and strong impact on adolescent health.

5. What is FIGO doing?

To determine how best to lever its strengths to effectively contribute to improving adolescent health, FIGO commissioned a review of its ASRH activities and research including a literature review on adolescents' attitudes toward sexual and reproductive health and their perceptions of health professionals, ASRH programs and their level of effectiveness, and tools and guidelines available on ASRH. Utilizing its member associations, FIGO conducted a KAP survey (knowledge, attitudes, and perceptions) with obstetricians and gynecologists. The findings highlighted the important role FIGO could play by engaging more deeply and strategically in ASRH initiatives through strengthening the credible voice of obstetricians and gynecologists in support of increasing young people's access to high-quality contraceptive and safe abortion services. To do this, FIGO has been conducting regional workshops bringing together obstetricians and youth in Africa, Asia, Latin America, and Europe. These workshops provide space for obstetricians and gynecologists to meet with young people to discuss important issues, generate practical and innovative strategies for improving ASRH, and strengthen the capacity of obstetricians and gynecologists to advocate and provide better sexual and reproductive care for young people. FIGO hopes to continue these activities as well as build on its ASRH portfolio in the coming years.

6. Conclusion

Innumerable health and social challenges face young people in all countries; it is time to improve our understanding of this age group and to focus our energies on alleviating these problems. Political efforts need to be directed to providing youth-appropriate services, and the health establishment must follow a comprehensive, evidence-based approach that raises the capacity of health workers and implements bold initiatives for, and with, adolescents. Importantly, obstetricians and gynecologists—through their national associations and through FIGO at the international level—have an important role to play in the advancement of ASRH services so that healthcare workers move from being part of the problem to part of the solution. FIGO is committed to promoting ASRH. Addressing the global challenges of adolescent health is critical to the future of a country's health and must be led by those at the vanguard—the healthcare workers.

Conflict of interest

The authors have no conflicts of interest to declare.

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