THE HEALTH OF YOUTH

FACTS FOR ACTION

YOUTH AND REPRODUCTIVE HEALTH

The process of becoming mature is central to adolescence. It is a physical as well as a social process and affects young people's relationships both with each other and with the people around them. If the process is healthy it is a positive force and provides a springboard for development in other areas.

Very often the signs of sexual maturation - in girls the onset of menstruation (menarche) - appear in advance of psychological or social maturity or indeed in advance of complete physical maturation. This means that young women may be able to conceive a child without being physically or psychologically ready. Childbearing during adolescence, especially early adolescence, therefore involves considerable health risks. Early sexual activity carries its own risks for young men as well.

Early marriage, early motherhood

In many parts of the developing world, especially in rural areas, girls marry shortly after puberty and are expected to start having children almost immediately.

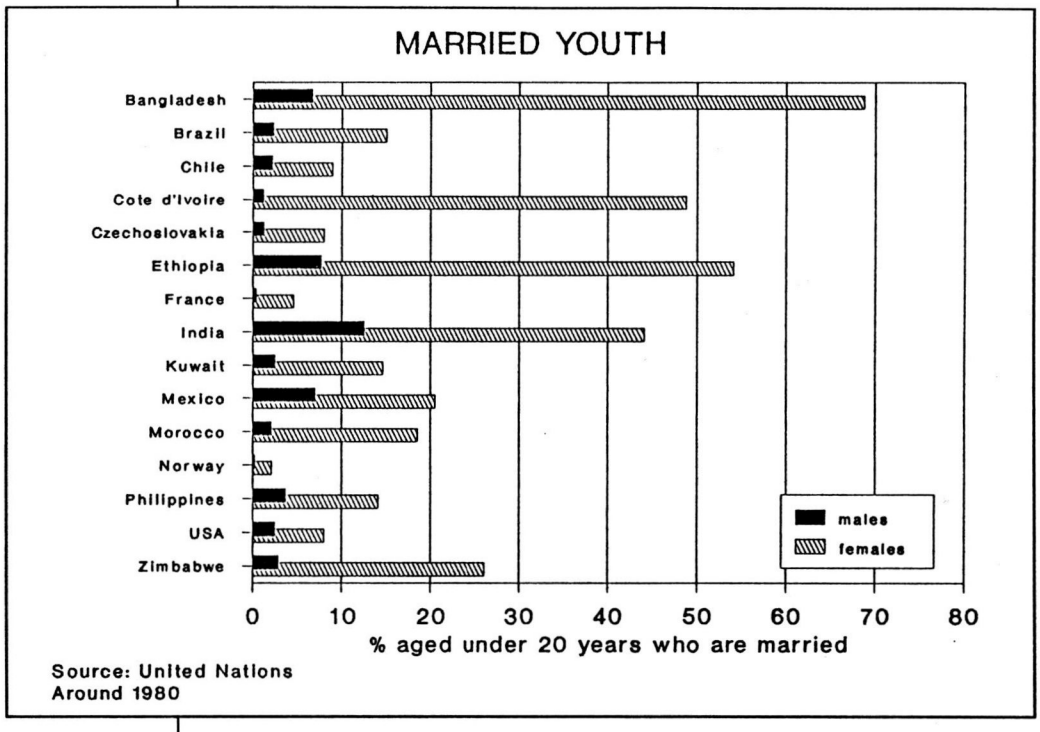
Surveys have found that for instance, in Bangladesh, 25% of 14 year-old girls were married, and in Nepal, 34% of 15 year-old girls were married. In South-East Asia 24%, in Africa 44% and in Latin America 16% of women under 20 are married. By contrast, the highest percentage of young men aged 15-19 who are married is 12% in India, and in most countries it is around 2% or 3% .

Many countries have raised the legal age for marriage but this has had little impact on traditional societies where getting married early and having children are considered the only proper roles for women. Indeed, in these societies high fertility confers status on a woman, so the earlier she starts having children, the more she will be valued in society.

The lifetime pattern of fertility is likely to be established during adolescence

Those who start having children early generally have more children, at shorter intervals, than those who embark on parenthood later. In addition to deleterious effects on the health of mothers and children, this has implications for population growth. Where girls marry at 15, the age gap between successive generations may be less than 20 years; this gap may widen to as much as 30 year where the age at marriage is 25.

World Health Organization
Geneva, 1989



Source: United Nations
Around 1980

In all regions, educated women tend to marry later, delay childbearing and practice family planning more than those without education. They generally have fewer and more widely-spaced births. Women with no schooling have almost twice as many children on average as those with seven or more years' schooling.

Menarche to marriage - the widening gap

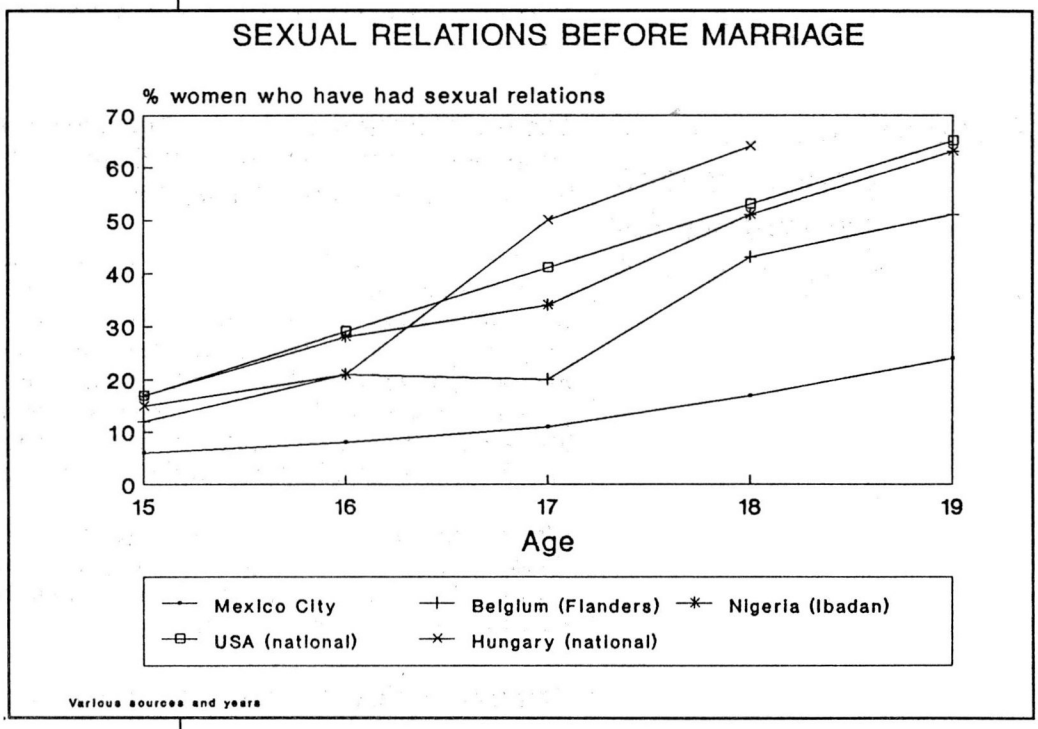
The average age of menarche has fallen in the world, and there is a trend towards later marriages, especially in urban areas of the developing world.

The decline in age at menarche documented among European populations, some Asian countries and parts of Africa is generally attributed to better health and nutrition. Later marriage is due to a complex variety of factors including education and employment opportunities, urbanization, exposure to foreign values through increased tourism and the mass media, and changing family structures. These changes contribute to the possibilities for sexual encounter before marriage.

Reflecting differences in cultural and social values, there is variation in the age at which young men and women begin sexual relations both within countries and from one region to another.

A much higher percentage of men have premarital sex than women. Recent studies show that in Brazil, 64% of 15-17 year-old men had engaged in sex before marriage as against only 13% of women. In the Republic of Korea, 16% of men aged 15-17 had had premarital sex, as against 5% of women in the same age group. For the age group 20-21, the percentages were 91% for men and 46% for women in Brazil, and 51% for men and 12% for women in the Republic of Korea.

Although there are very few national studies in developing countries, it would appear that sexual activity before marriage among young women is more common in developed countries and in Africa and the Caribbean than in Latin America, Asia or the Middle East. In the late 1970's in England and Wales, France, the Netherlands and the United States of America, 40%-50% of women had had intercourse by the age of 17. In Mexico, 13% of women and 43% of men aged 15-19 had premarital sex. More than 20% of girls in a Nigerian study had had sexual intercourse for the first time under the age of 15, and more than 50% when under the age of 16. In the United States of America, the average age of first intercourse throughout the country is 16. By contrast, in the Republic of Korea and Thailand, less than 6% of unmarried young women are sexually active by the age of 19.



Studies on adolescent sexual behaviour in different parts of the world show that young people's premarital sexual encounters are generally unplanned, infrequent and sporadic.

How many young women are having children at an early age?

Worldwide, fertility rates for women under 20 are declining, as are those other age groups. Total numbers of births to adolescents, however, are increasing.

This is because the adolescent population is increasing. In 1985 there were 245 million women aged 15-19, 82% in developing countries and 75% in Asia. In the year 2020, it is estimated that there will be more than 320 million women of this age group. In Africa, the number of women in this age group will triple between 1985 and 2020.

The number of children born to women under 20 ranges from four per 1000 in Japan to 239 per 1000 in Niger. In most countries, fertility patterns among young women reflect age at marriage. In countries where women marry young, such as Bangladesh, fertility rates among women aged 15-19 are high - over 200 per 1000 women in the age group. Where women marry later, as in developed countries and most countries of the Middle East and East Asia, fertility rates among women aged 15-19 are lower.

In Africa and Latin America, up to 40% of adolescent childbearing takes place before the age of 18, and in Asia the percentage is around 31%. In the United States of Amercica, 38% of early childbearing concerns women under 18. In Cameroon, Côte d'Ivoire, Kenya, Lesotho, Senegal and the Syrian Arab Republic there has been an increase in the early adolescent (14-17 years) total fertility rate since 1975.

Does pregnancy have greater health consequences for young women?

The lower the age of the mother, the greater the risk associated with pregnancy and childbirth, particularly if there is inadequate prenatal care.

Childbearing at any age involves some risk. Maternal mortality rates in the developing countries average about 450 per 100 000 live births, compared with 30 per 100 000 in the developed countries. The risk increases for young women. In Jamaica and Nigeria, it has been found that pregnant women younger than 15 are 4-8 times more likely to die during pregnancy and childbirth than pregnant women age 15-19. In the United States of America in 1977 the maternal death rate among mothers under age 15 was 2.5 times higher than the rate among mothers age 20-24.

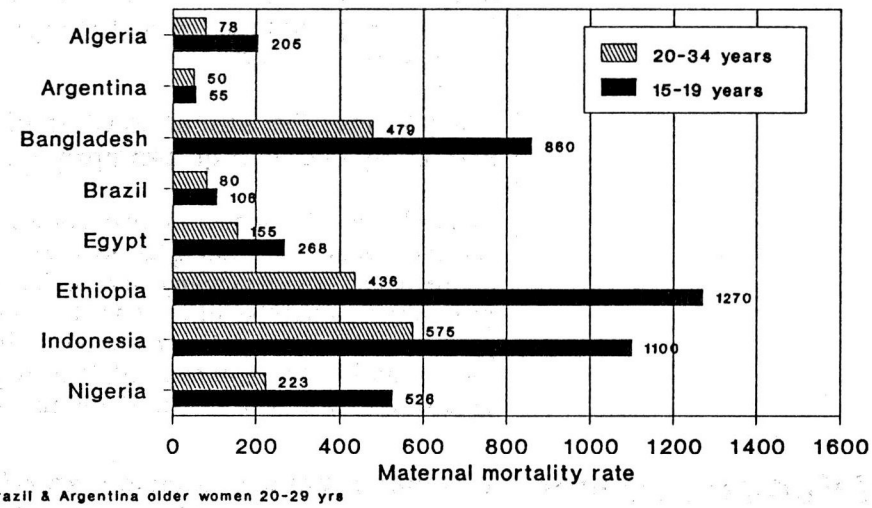
Women who become pregnant when aged 15-19 in Algeria, Bangladesh, Ethiopia, Indonesia and Nigeria run a greater risk - sometimes twice as high - of dying from pregnancy-related causes than pregnant women in their twenties and early thirties.

Some complications are more common in the adolescent

Hypertensive disorders of pregnancy, if untreated, can lead to eclampsia which is often fatal. In Nigeria, 17% of adolescents pregnant at 14 years or younger developed eclampsia, compared with 7% at 16 and only 3% at 20-24 years.

Obstructed labour may result if pregnancy occurs soon after menarche when the pelvis has not had time to develop completely and is too small to allow the baby's head to pass through at delivery (cephalo-pelvic disproportion). If skilled attention is not available - and this is common in developing countries - mother and baby may die.

MATERNAL MORTALITY RATE
PER 100 000 LIVE BIRTHS:
A COMPARISON OF AGE GROUPS



Brazil & Argentina older women 20-29 yrs
Various sources and years

Female circumcision, especially the pharaonic type, may contribute to obstruction of labour when the opening of the birth canal is so narrow that the baby's head cannot pass without some form of intervention.

Vesico-vaginal fistula and/or recto-vaginal fistula may follow obstructed labour and, if not repaired, will severly affect the woman's life: urinary and faecal incontinence not only cause constant irritation, but may render her a social outcast. A high proportion of sufferers from fistula are adolescents: in Niger, 80% were aged 15-19, and in Nigeria 33% were younger than 16.

Babies of adolescent mothers have a lesser chance of survival.

Low birth weight is more common in babies of adolescent mothers. In Kenya, 40% of mothers aged 13-14 had babies of low birth weight, compared with 25% for those of 19 years. In Nigeria, the highest rate - 36% - was in the 15-19 years age group. In the United States of America, the rate at 15 years or less was twice that at 20-24 years.

Babies weighing less than 2500 grams at birth are much more susceptible to illness and infection than heavier babies. If they are much under that weight, they are likely to die.

Perinatal and infant mortality rates, especially in developing countries, are consistently higher where mothers are under 20 than when they are in their twenties and thirties. In Cuba, infant mortality rates were 33 per 1000 live births for mothers of 15-19 years and only 14 per 1000 for those aged 20-25.

Prenatal care can make a difference

Prenatal care can substantially reduce mortality and complications from pregnancy and childbirth, especially in very young women.

In a study of 22 000 Nigerian women, the death rate among mothers of 14 or younger who had received good prenatal care was 500 per 100 000 live births, whereas the rate in mothers of the same age who had not received care was 4300 per 100 000. Prenatal care is not available to many women in developing countries, and very young women are less likely to receive care than older women.

The younger the woman is when she gets pregnant, the less likely she is to go promptly for antenatal care.

In the United Kingdom, a study of adolescents coming for prenatal care showed that of those coming late for consultation - after the twelfth week of pregnancy - twice as many were under 16 as over 16 years old. This is probably for a number of reasons: they may not recognize the signs of pregnancy, they may not be informed, or they may not know where to go for advice. If they are unmarried, they may not want to believe they are pregnant, they may be ashamed and not want to tell anyone.

Social consequences are considerable

Whether or not a woman is married, being pregnant and having a child at a young age severely limits her education and employment propects.

In many countries of the developing world, marriage with inevitable childbearing marks the end of schooling for girls and young women. The resulting lack of education limits women's ability to make informed choices, and to find paid work. In a study in the United States of America, jobs which adolescent mothers held when they were in their twenties were lower in status than those of women who delayed childbearing. In the Caribbean, where one-third of pregnant women are under 19, a large proportion abandon their education and cannot be readmitted to school. In Costa Rica, 51% of pregnant adolescents gave up studies because of pregnancy and 61% gave up work. In Nigeria, a study showed that 52% of pregnant adolescents were expelled from school.

In many countries, unmarried adolescent mothers have additional problems of social and legal penalization because they are single.

Young women who bear their first child during adolescence are likely to fall pregnant again sooner than women who bear their first child when they are in their twenties. In a study of young mothers living in urban United States of America, 47% were found to be pregnant again within a year. Among older women, the rate was only 23%. Early pregnancy therefore has a tendency to lead to larger families, with serious consequences for their health and well being.

Early parenthood reduces economic opportunities for young men as well

Recent studies have shown that men who become fathers under the age of 19 are less likely to graduate and therefore have fewer employment opportunities than those who have children after the age of 24.

When pregnancy is unwanted

Many young women will seek abortion rather than continue an unwanted pregnancy.

In developed countries, in many of which abortion is legal, abortion rates among women aged 15-19 range from 5 per 1000 in the Netherlands to 44 per 1000 in the United States of America. Abortions to young women account for more than 10% of all abortions performed in most countries with complete records, and exceed 25% in several of these countries.

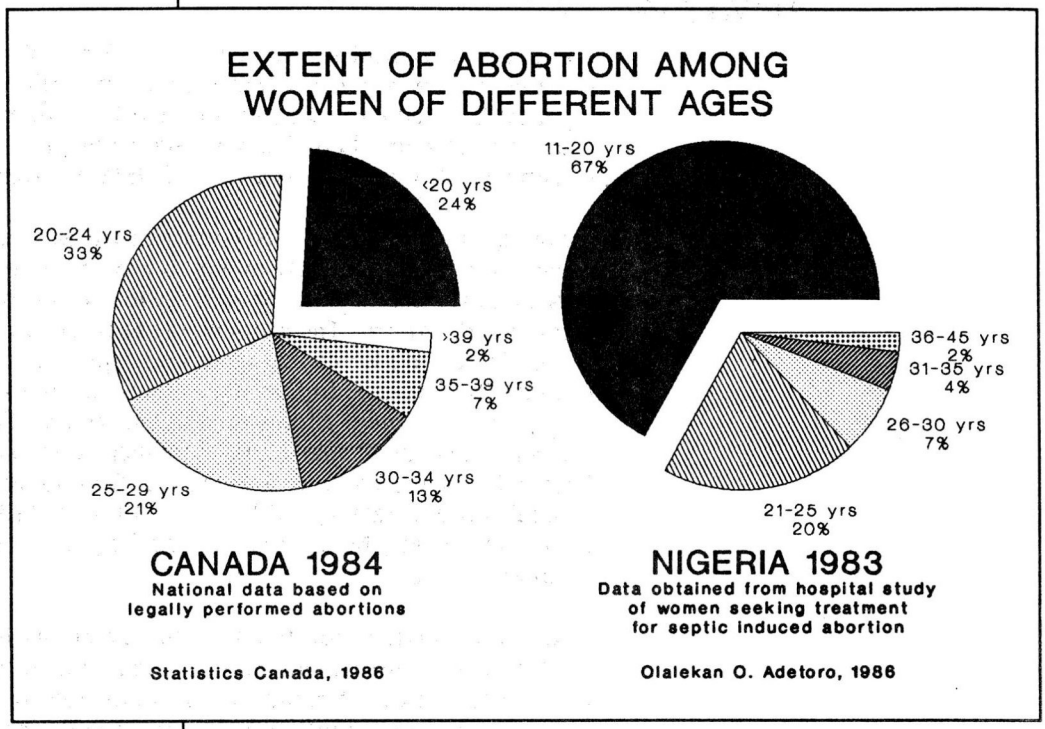
Young women in developed countries are less likely to become pregnant than in the past, probably owing to greater use of contraception. However, if they do, they are more likely to choose abortion than to carry the pregnancy to term. The proportion of adolescents who seek abortion has been increasing for all countries and especially among younger adolescents (15-17 years). In Denmark and Sweden, more than three-quarters of young, pregnant adolescents opted for abortion. However, abortion rates among 15-19 year-olds have fallen considerably in recent years in Canada, the Netherlands and the four Scandinavian countries, and have stabilized in England and Wales and the United States of America. In Czechoslovakia, New Zealand, and Singapore, rates have been rising, but are still low.

In countries where abortion is illicit - a majority in the developing world - it is impossible to document the extent of it among young women. The major source of information is hospital records of women treated for complications of abortion, but these records include only women who sought treatment and were hospitalized. Studies of such records in Congo, Kenya, Liberia, Mali, Nigeria and Zaire reveal that between 38% and 68% of women seeking such treatment are under twenty; in Malaysia it is more than 25%, and in Brazil, Chile, Guatemala, Peru and Thailand more than 10%.

Seeking an illicit abortion involves major health risks.

Between 150 000 and 200 000 women die every year from the complications of illicit abortion. In 10 hospitals in Zaire one in every 50 women admitted for complications of illicit abortion in 1982 and 1983 died in the hospital. A study in Nigeria showed that 16% of all maternal deaths were due to adolescent abortion. Other complications are pelvic infection, haemorrhage, uterine perforation and tetanus. Left untreated many of these complications can result in sterility, structural damage to the reproductive organs, and death.

Young women are at greater risk of severe complications of abortion because they often wait until well into the second trimester of pregnancy. Even where abortion is legal, the risk in the second trimester of pregnancy is four times higher than before the twelfth week. As with pregnancy, the younger the woman, the greater are the risks. A study in the United Kingdom showed that the risks associated with abortion were some three times higher in girls under 16 than in older adolescents. The risk of cervical laceration was particularly high.



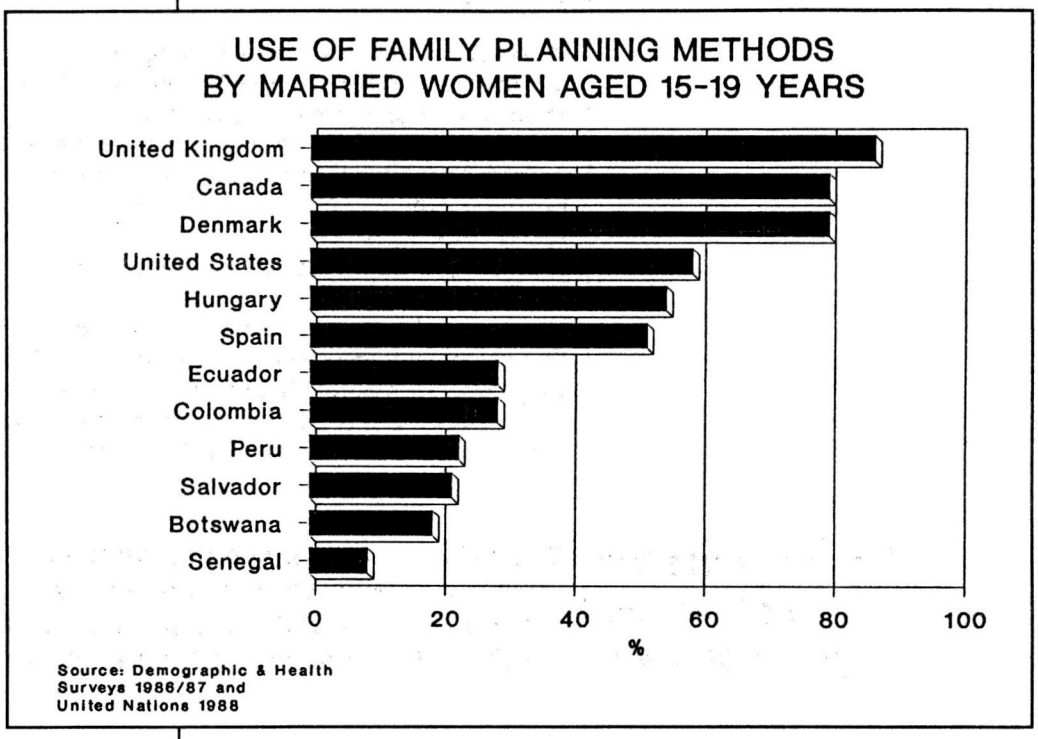
Preventing pregnancy through family planning

In developing countries, in keeping with cultural tradition, young women are expected to bear children early.

Less than 30% of married women aged 15-19 use family planning. In some countries it is as low as 2% or 3%. Except in Central and South America, few young women use contraception between marriage and first pregnancy. Thus in most countries at least 70% of women who marry young have at least one child before they are 20. By contrast, in developed countries the rates of contraceptive use by married women aged 15-19 vary from 52% in Spain and 59% in the United States of America to 87% in the United Kingdom.

Married or unmarried, young people in developing countries tend not to use contraception, or they use ineffective methods. For example, recent surveys have shown that in Colombia 47% of sexually active 15-19 year-olds were not using adequate contraceptive methods even though they wanted to prevent pregnancy (21% did not want a child yet, 17% had an unwanted pregnancy and 8% were using an inefficient method). In Liberia the majority of sexually active adolescents were not using any method to avoid or delay pregnancy. Reasons given for non-use of family planning methods include lack of knowledge about contraception, not expecting to have intercourse, not knowing where to obtain contraceptives, and not realizing it is possible to get pregnant, and believing that contraception effects the quality of sexual relations.

The use of contraceptive methods among unmarried young women is considerably greater in developed countries than in developing countries. Indications from surveys are that the rates vary from 7% in Spain and 19% in Hungary to 70% in Denmark and 91% in the United Kingdom.



Very few data exist on the extent of contraceptive use by young men. The information that does exist suggests low utilization. In Brazil and Jamaica respectively, 19.5% and 11% of men aged 15-24 used contraception at their first sexual encounter.

Generally, but especially in developing countries, young people are ill-informed about sexuality and its consequences.

For example, only 26% of young women interviewed in Mexico City knew when a woman's fertile period occurs. In Liberia only 38% of young women and 41% of young men students aged 14-17 knew that pregnancy could occur at first intercourse. Myths and misperceptions are common in all cultures. These include the belief that "douching", standing up after intercourse or taking vitamin pills will prevent pregnancy. Unfounded fear of the side-effects of contraception is also widespread.

A further problem of uninformed and unprotected adolescent sexual activity is the increased exposure to sexually transmitted diseases, including infection with human immunodeficiency virus (HIV), the causative agent of acquired immunodeficiency syndrome (AIDS). While data on incidence are not available on a global level, there are indications that age-specific rates of sexually transmitted diseases (STDs) are highest among 15-29 year-olds, with increases in age-specific hospitalization rates for pelvic inflammatory disease (at least in industrialized countries). Epidemiological data on patients with AIDS suggest that in many cases, infection with HIV was acquired during adolescence.

Most family planning services are not geared towards young people, especially if they are unmarried.

In most countries laws restrict young people's access to family planning information and services much more than that of older men and women. Even when there is no legal restriction, many family planning service providers disapprove of the unmarried being sexually active. A few countries prohibit all distribution of contraceptives to the unmarried or to young people. Less severe restrictions, such as requirements for parental consent, which exist in most countries, may discourage young people from seeking family planning advice.

Young people may also have an idealized view of sexual relations, feel that using contraceptives is not very "romantic", or may simply be unprepared. In a study in Mexico City of adolescents who did not use methods of contraception during their first sexual encounter, 43% of the women and 56% of the men said they had not been expecting it.

Implications for policy and programmes

The risks incurred by young people having sexual relations too early or without using measures to prevent unwanted pregnancy or sexually transmitted diseases, can be significantly reduced in a number of ways.

How can young people find out about healthy sexual behaviour?

Young people can obtain sound information about how to behave in a healthy way from many sources - older family members, teachers, youth leaders and health workers, who must themselves be well-informed, and able to communicate well with the young. Such training can be incorporated in professional preparation, or become part of continuing or general education.

Young people everywhere are heavily influenced through mass media and by popular figures in entertainment and sports. Many such figures are young themselves and can be very generous in helping to promote health by example and by communicating in meaningful ways with the young.

How can young people be helped to make better use of existing health services?

In virtually all societies services are available for family planning, antenatal and obstetric care, and to diagnose and treat sexually transmitted diseases. But young people who need such services must know about them, how to use them, and, must feel at ease when they do use them. Training of staff to respond sensitively to young people is essential.

Where services exist a multi-disciplinary approach seems to work best. Combining counselling with contraceptive services, for example, has been effective in the Caribbean, Central America and the United States of America, in preventing adolescent pregnancy and has helped to promote healthier and more equitable relationships between young men and young women.

Youth organizations increasingly include health as a major programme element and reach many young men and women before problems have developed.

Some of the most successful use the "youth to youth" approach, training young counsellors and encouraging young people to develop their own methods and materials to convey their messages. Youth theatre, songs, radio programmes, videos and films are all being used to encourage discussion about the importance of delaying pregnancy either by abstaining from sex or by using appropriate contraceptive methods and encouraging young men as well as young women to take responsibility for their choices.

How can policy and legislation be used most effectively?

Policies and legislation in many sectors affect young people's sexual and reproductive health. Laws which affect minimum legal age of sexual intercourse and marriage provide general standards even though they may not always be adhered to. Consent requirements and the degree of legal access to fertility regulating services for the young and especially for the unmarried, have an important impact on the prevention of unwanted pregnancy and parenthood. So do the policies and practices of non-governmental organizations and the private sector which interacts with public services to ensure availability.

For those adolescents who do become pregnant both legislation and programmes can help. In some countries, education authorities have prohibited the expulsion from schools of girls who become pregnant. In some countries of the Caribbean, young pregnant women are being helped to continue their education and training in special institutions where there are also classes for the babies' fathers. This has also been successful in delaying second pregnancies.

Existing policies and legislation, however, may not be fully known to the young person, or indeed to all service providers; and even when knowledge exists, the policies governing different sectors may hold some contradictions where young people's health is concerned. To be effective intersectoral cooperation, including the voice of young people, is essential at all levels of society.