

Adolescent health, global guidelines versus local realities: the Sub-Saharan Africa experience

Kudakwashe Dube, Marc Van der Putten, Nitaya Vajanapoom

Thamassat University, Faculty of Public Health, Thailand

Abstract

As the field of adolescent sexual and reproductive health (ASRH) evolves, further discussion and documentation of national policy and aspects of its implementation is needed to ensure effectiveness of interventions. Further research is required to foster beneficial shifts in policy advocacy, including resource allocation, and in the prioritization of adolescent programs in health and education systems, in communities and in workplaces. Adolescents are exposed to diverse interventions across all the countries under discussion; however there exist obstacles to realization of ASRH goals. In some countries, there exist a *conflict of interest* between national laws and global policy guidelines on ASRH; moreover national laws and policies are ambiguous and inconsistent. In addition, there have been strong negligence of vulnerable groups such as HIV positive adolescents, pregnant street youth; young sex workers; orphans; adolescents in conflict areas; adolescent refugees; adolescent girls working in the informal sectors and very young adolescents, likewise many adolescents in rural areas remain largely underserved. Furthermore there are consistently less disaggregated data available on adolescents' key indicators for comparative purposes signifying considerable knowledge gaps. There are multiple obstacles to the realization of ASRH and need for research combining both qualitative and quantitative approaches to determine the extent to which factors are either conducive or impeding to consistency between global guidelines, national ASRH policies, and actual policy implementation.

Introduction

Globally, societal shifts and behavioral patterns aggravated by developmental vulnerabilities create a convergence of factors that place today's adolescents at increased risks of adverse consequences for health.¹ Nearly half of the world's population are under the age of 25.² More than one in five people alive today,

are adolescents aged 10 to 19 years, and approximately 85 percent of them live in developing countries.³ Notwithstanding global guidelines on adolescents sexual reproductive health (ASRH), Sub-Saharan Africa continues to face difficulties in translation of these guidelines into national policies and action.

Adolescent sexual and reproductive health: a public health issue

By age 20 years, about 77% of young people in Sub-Saharan Africa would have had their first sexual intercourse.⁴ For a substantial number of adolescent females, and even males, early sexual activity is not consensual - case studies suggest that small percentages of young males (under 10%) and considerably more females (up to 40%) reported a sexually coercive experience and a large proportion of reported rapes occur to adolescents.⁵ Many of these adolescents do not use contraceptives, have multiple or older partners and lack adequate knowledge on avoiding sexually transmitted infections (STIs) and pregnancy. Failure to deal with reproductive health problems at this stage in life sets the scene for later health and developmental problems.⁴ Furthermore contraceptive use among adolescents is associated with inconsistent use.⁶ Additionally about 16 million adolescent girls aged 15-19 years give birth each year, accounting for more than 10 per cent of all births worldwide.⁷ Adolescent pregnancy is dangerous as illustrated by the fact that mothers aged 10 to 19 years account for 11 percent of all births worldwide, yet they bear 23 per cent of the overall burden of disease due to pregnancy and childbirth. Furthermore at least 2.5 million adolescent pregnancies every year lead to unsafe abortions. Similarly, many unintended pregnancies end in abortion. Accordingly, girls between the ages of 10 and 14 are five times more likely to die in pregnancy or childbirth than women aged 20 to 24 and girls aged 15 to 19 are twice as likely to die.⁸ Moreover sixty-five per cent of all cases of obstetric fistula occur in girls under the age of 18.⁷ Other problems related to adolescent pregnancies include anemia, postpartum haemorrhage and mental disorders, such as depression.⁹ Adolescent pregnancy is dangerous for the infant as well; stillbirths and death in the first week of life are 50 per cent higher among babies born to mothers younger than 20 compared to infants of mothers aged 20 to 29, and rates of premature birth, low birth weight, and asphyxia are high among infants born to mothers under 18.³

As illustrated in Table 1 (UNAIDS unpublished estimates, 2010), Sub-Saharan Africa

Correspondence: Kudakwashe Dube, Thammasat University, School of Global Studies, Academic Service Building 33, Klong Luang, Pathumthani 20121, Thailand.
E-mail: Kuda.dubek@gmail.com

Key words: adolescents sexual reproductive health, global guidelines, national policy, Sub-Saharan Africa.

Acknowledgments: we would like to thank the Global Health Studies, team, for their help, support, interest and valuable input.

Conflict of interests: the authors declare no potential conflict of interests.

Received for publication: 13 October 2012.

Revision received: 30 May 2013.

Accepted for publication: 1 June 2013.

This work is licensed under a Creative Commons Attribution NonCommercial 3.0 License (CC BY-NC 3.0).

©Copyright K. Dube et al., 2013

Licensee PAGEPress, Italy

Journal of Public Health in Africa 2013; 4:e12

doi:10.4081/jphia.2013.e12

(SSA) adolescents are more vulnerable to HIV exposure compared with other global regions. Of the 2 million estimated cases globally, more than 1,500,000 were from Sub-Saharan Africa.¹⁰ Moreover about half of all people infected with HIV are under the age of 25, and in developing countries, up to 60 per cent of all new infections are among youth, among these there are twice as many females as males. Likewise adolescent girls are at higher risk of STIs than boys because they reach puberty earlier, have older partners more often, and are physiologically more vulnerable to infections however most adolescents do not have access to acceptable STI services.^{3,11} By and large adolescent's vulnerability is perpetuated by a combination of factors such as their biology, early sexual debut, low contraception use, structural barriers to access reproductive services and information among other factors. These vulnerabilities will result in STIs, poor maternal and child health; disempowerment of girls, increased school drop outs as well as predisposing adolescents to poverty. With these vulnerabilities, it will be difficult to make sustainable progress on Millennium Development Goals (MDGs) and hinders adolescent's ability to realize their full potential in addition to reduced life expectancy. These vulnerabilities also results in reduced life expectancy and hinders adolescent's ability to realize their full potential.¹⁰

The relevance of adolescent sexual and reproductive health to global health

Adolescence is a dynamic period in life with both great opportunities and great risks. Several changes take place through exposure to new challenges, roles, behaviors, responsibilities, and relationships. Economic and cultural globalization has a significant influence on adolescents' values and lifestyles worldwide. As argued by Dahlbäck (2006) changes in cultural values are brought about by rapid socio-economic changes (*globalization, urbanization, widespread availability and use of communication technologies, improved communication and transportation, trade and tourism*). Moreover, poor reproductive health is both a cause and consequence of poverty. Poverty and reproductive health are intricately related. Poverty is associated with high-risk behaviors, such as coerced sex, rape, and unsafe sex in exchange for monetary incentives. These behaviors put young women at risk of unintended pregnancy and of HIV and sexually transmitted infections, which in turn can affect their reproductive health.¹²

Most SSA countries adopted key components of global ASRH guidelines including the comprehensive International Conference on Population Development (ICPD) 1994, definition of ASRH and ratified, signed or acceded the ICPD, Convention on the Elimination of Discrimination against Women (CEDAW), Convention on the Rights of the Child (CRC) as well as the MDGs and made some clear guidelines in addition to setting priorities towards the implementation of the global guidelines on ASRH. The goals of the ICPD recognized reproductive rights as among fundamental human rights and put universal access to safe, affordable, and effective reproductive health care on the international agenda. Governments agreed to work together with partners to achieve universal access to education, especially for girls, to reduce infant, child and maternal mortality and to guarantee reproductive health, including family planning by 2015. Delegates from all regions in the ICPD agreed that *Every person has the right to sexual and reproductive health and that empowering women is a highly important end in itself that is essential to improving the quality of life of everyone*.¹³

The ICPD was further reinforced by the follow up Fourth World Conference on Women, Beijing, 4-15, September 1995, also signed by all five countries, the Beijing Declaration and Platform for Action also recognized that girls especially adolescents are at risk of receiving contradictory and confusing messages on their gender roles from their parents, teachers,

peers and the media and recommended that, society needs to work together with youth to break down persistent gender stereotypes, taking into account the rights of the child and the responsibilities, rights and duties of parent.¹⁴

Additionally, the rights of adolescent's reproductive health are reinforced under the MDGs that were signed by all the countries under discussion. To achieve all the MDGs, addressing adolescents' sexual reproductive health becomes of paramount importance. The UNDP's Millennium Project document titled, *Public choices, private decisions, sexual and reproductive health and the Millennium Development Goals*' also highlighted that sexual and reproductive health is fundamental for attainment of all MDGs, as all population dynamics influence each of all MDGs.¹⁵ Furthermore, in the Lancet 2012 series on family planning, published ahead of the London Summit on Family Planning, it came out strongly that, it will be extremely difficult to make sustainable progress on MDGs without universal access to family planning, the series reiterated that access to family planning contributes to; improvement of maternal and child health; economic empowerment women; enables investment in child education; decelerates population growth and allows governments to expand investment in human capital, reduction of poverty and hunger, conservation of natural resources, tackling climate change and environmental dilapidation.¹⁶

Translation of global guidelines into national policies and action

The ICPD and its subsequent pronouncements as well as all cited global ASRH guidelines regurgitated countries' efforts that were already in place to offer ASRH services, especially efforts on family planning and prevention of STIs, but with a pragmatic shift from

reproductive health services for achieving demographic targets to reproductive health services as human rights. However, according to (Dube unpublished data, 2012), in some SSA countries, waning political support for adolescents family planning services, strong religious beliefs as well as socio-cultural practices and negative attitudes of service providers, resistance from teachers as well as parents, lack of resources, legacy of racial and geographical inequalities and dysfunctional health systems are major obstacles to adherence to global ASRH guidelines. Likewise, in most of SSA countries, ASRH laws are not equally implemented throughout the country and not equally among all population groups, moreover laws are often complex, confusing, conflicting, ambiguous, inconsistent and overlapping and thus not upholding ASRH global guidelines. For example, Zimbabwe follows a dual legal system, the general law (Roman-Dutch law) and customary law; interface of these two laws creates problems and loopholes that restrict adolescents' access to reproductive health services. Particular worrisome is the Zimbabwean constitution; chapter III section 20 which; *Renders the rights of adolescents under the age of 18 to receive or impart reproductive health information subject to parental control*.^{17,18} On the other hand, the Uganda AIDS Control Policy Proposal of 1996 recognized that as many 70% of both males and females were sexually active by the age of 17 years and therefore encouraged all sexually active populations to adopt responsible use of condoms; to seek early diagnosis and competent treatment of STI and for service providers to improve accessibility of HIV testing and counseling to adolescents. Conversely in the same country, the Penal Code (Amendment) statute of 1990, makes it an offence to have sexual intercourse with girls under 18 or attempt to do so, breach of that is regarded as a felonious act and perpetrators are liable to death and eighteen years imprisonments services.^{19,20} Additionally, in various SSA countries there exists a conflict of interest between

Table 1. Adolescents aged 10-19 years living with HIV, 2009.

Region	Estimates		Total
	Female	Male	
Eastern and Southern Africa	760,000	430,000	1,200,000
West and Central Africa	330,000	190,000	520,000
Middle East and North Africa	22,000	9700	32,000
South Asia	50,000	54,000	100,000
East Asia and the Pacific	27,000	23,000	50,000
Latin America and the Caribbean	44,000	44,000	88,000
CEE/CIS	9000	3900	13,000
World	1,300,000	780,000	2,000,000

CEE/CIS, Central and Eastern Europe/Commonwealth of Independent States.

national laws and global guidelines on ASRH, against the background of certain clauses in global guidelines that gives national laws precedence. Furthermore, there has been strong negligence of vulnerable groups such as HIV positive adolescents, street youth, young sex workers, orphans, adolescents in conflict areas, adolescent refugees, very young adolescents and adolescent girls working in the informal sectors. Coupled with limited skills and training of service providers, lack of program prioritization, coordination and evaluation, there are multitudes of impeding factors to congruency between national ASRH policies and actual implementation across all countries. Another major shortcoming is the lack of ASRH program evaluations in addition to consistently less availability of disaggregated data on ASRH key indicators for comparative purposes (Dube *et al.*, unpublished study, 2012) In broad terms, these findings are consistent with recent studies by Patton *et al.* and Cottingham *et al.* which have shown that data sources on adolescent's health are incomplete and lag behind those of children and youth, with SSA having the worst adolescents health profiles. These studies also demonstrated the existence of multiple obstacles to the realization of ASRH.^{21,22} Equally important is that, apart from global guidelines and national policies, adolescents continue to face obstacles in realizing the promises of reproductive health rights. By and large, there still remains a huge gap in fully understanding factors conducive or impeding consistency of national ASRH policies and ARSH global guidelines.

Conclusions

We therefore reiterate that statistics on adolescence sexual reproductive health bears witness to different socio-economic, political cultural contexts in SSA. Although SSA countries have signed or ratified the global ASRH guidelines, their ASRH reproductive outcomes remain poor and point to the gendered nature of ASRH such as HIV transmission. We argue that there is a conflict of interest between global guidelines and national policies. Moreover, there are consistently less disaggregated data available on adolescents' key indicators for comparative purposes signifying considerable knowledge gaps. Additionally there is a dearth of evidence on effectiveness of ASRH interventions. Likewise vulnerable groups are neglected; moreover many adolescents in rural areas remain largely underserved. Equally important is that, apart from global guidelines and national policies adolescents continue to face obstacles in realizing the promises of reproductive health rights. We also argue that governments have a legal obli-

gation to do all they reasonably can to put these measures in place as a matter of urgent priority. If they fail to do so without compelling justification, they are in breach of their legally binding international human rights commitments in relation to health, contraceptive information and services, and women's equality. Furthermore, we raise questions on the process of policy-making and power in the global-local interface, potential conflict between national legal frameworks and ASRH policy aims, as well as the role of governance in ASRH policy enforcement in these countries. It is our argument that the roles of power, politics and policy making process are central in the making of global ARSH guidelines as well as translation into national policies and action and often defines who owns the problems and the solution. Power, politics and the process, can lead to guidelines that are vague and ambiguous leaving room for different interpretation as well as adoption of national policies in conflict with global agreements on reproductive rights, on other hand there is a potential threat for governments and non-governmental organizations to depend on aid, which is often conditional, thus not upholding agreed global guidelines. We also maintain that ASRH behavior is multifaceted and coupled with the complexities surrounding global guidelines and national's policies, realization of ASRH will take a little bit longer thereby derailing progress towards the achievement of the MDGs.

Recommendations

It is against this background that we recommend that: firstly there is a need to measure neglected aspects of ASRH, including neglected vulnerable adolescents and promote more uniform surveillance systems for comparability of data; secondly there is need for future research to determine the extent to which factors are either conducive or impeding to consistency between global guidelines, national ASRH policies, and actual policy implementation; thirdly there is need for evaluative studies evidencing effectiveness of ASRH interventions and finally there is need to conduct legal gap analyses and further explore the conflict of interest between national laws and global guidelines.

References

1. Bearinger LH, Sieving RE, Ferguson J, Sharma V. Global perspectives on the sexual and reproductive health of adolescents: patterns, prevention, and potential. *Lancet* 2007;369:1220-31.
2. UNICEF. Adolescents and youth - The big picture. New York, NY: UNICEF; 2009.

3. UNFPA. Young people and times of change. New York, NY: UNFPA; 2009.
4. Biddlecom AE, Hessburg L, Singh S, et al. Protecting the next generation in Sub-Saharan Africa: learning from adolescents to prevent HIV and unintended pregnancy. New York, NY: Guttmacher Institute; 2007.
5. World Bank. MTR World Health Organization, UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) Policy and Coordination Committee (PCC). Research RHA; 30 June – 1 July. Report No. 53 Geneva: World Health Organization, UNDP/UNFPA/WHO/World Bank; 2003. Available from: <http://who.int/hrp/publications/progress53.pdf>
6. Blanc AK, Tsui AO, Croft TN, Trevitt JL. Patterns and trends in adolescents' contraceptive use and discontinuation in developing countries and comparisons with adult women. *Int Perspect Sexual Reprod Health* 2009;35:63-71.
7. WHO. WHO Fact Sheet. Geneva: World Health Organization; 2008.
8. UN. We the Children: end-decade review of the follow-up to the World Summit for children: report of the Secretary-General. Contract No.: (A/S-27/3). New York, NY: United Nations; 2001.
9. WHO. Why is giving special attention to adolescents important for achieving Millennium Development Goal 5?. Contract No.: Fact Sheet WHO/MPS/08.14. Geneva: World Health Organization; 2008
10. UNICEF, UNAIDS, UNFPA, ILO, WHO. Opportunity in crisis: preventing HIV from early adolescence to early adulthood: United Nations children's fund. New York, NY: UNICEF; 2011.
11. FIGO. Adolescent sexual and reproductive health. Draft Final Report. London: International Federation of Obstetricians and Gynecologists (FIGO); 2009.
12. Rani M, Lule E. Exploring the socioeconomic dimension of adolescent reproductive health: a multicountry analysis. *Int Family Plan Perspect* 2004;30:110-7.
13. UN. Report of the International Conference on Population and Development, Cairo, 5-13 September 1994. New York, NY: United Nations; 1994.
14. UN. Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995. New York, NY: United Nations; 1996.
15. Mathur S, Greene M, Malhotra A. Too young to wed. The lives, rights, and health of young married girls. Washington, DC: International Center for Research on Women; 2003.
16. Habumuremyi PD, Zenawi M. Making family planning a national development prior-

- ity. Lancet 2012;380:78-80.
17. Garbus L, Khumalo-Sakutukwa G. HIV/AIDS in Zimbabwe. San Francisco, CA: AIDS Policy Research Center, University of California; 2002. Available from: ari.ucsf.edu/programs/policy/countries/Zimbabwe.doc
 18. UNGASS. National composite policy index (NCPI). New York, NY: UNGASS; 2007.
 19. Uganda Aids Commission. National aids control policy proposals. Kampala: Uganda Aids Commission; 1996.
 20. Alan Guttmacher Institute. Adolescents in Uganda: sexual and reproductive health. Washington, DC: Alan Guttmacher Institute; 2005.
 21. Cottingham J, Germain A, Hunt P. Use of human rights to meet the unmet need for family planning. Lancet 2012;380:172-80.
 22. Patton GC, Coffey C, Cappa C, et al. Health of the world's adolescents: a synthesis of internationally comparable data. Lancet 2012;379:1665-75.

Non-commercial use only