# BACKGROUND PAPER

# Adolescent Fertility: Socio-cultural Issues and Programme Implications*

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# PART I - SOCIO-CULTURAL ASPECTS OF ADOLESCENT PREGNANCY

"I was having stomach pain and my mother decided we should go to the hospital. It happened not long before my 14th birthday. I didn't know what the doctor meant when he told mama I was expecting soon. And I certainly didn't know that it was because of doing the thing with that boy who'd been my friend. He said it would be fun and everyone had to do it. Rea, my daughter, came soon after. It was like having a dream. I kept saying, "Madi, wake up, wake up!" but it's Rea who wakes me up with her crying for feeding."

Madeleine, Senegal
WHO, Safe Motherhood, 1996: 22 (3)

## INTRODUCTION

In the past few years the issue of adolescent pregnancy has been increasingly perceived as a problem. The International Conference on Population and Development (ICPD) identified the adolescents as a distinct target group in need of ad hoc reproductive health programmes and services. In many developing countries, government officials working in the social sectors readily identify it as one of the pressing social issues. However, this perception is rarely translated into programmes intended for adolescents, or into programmes which, although intended for them, effectively reach them. As a group, they have been overlooked due to a lack of awareness of their needs and the cultural specificity of these needs. Moreover, there are methodological issues that hinder the setting up of appropriate programmes, such as obtaining appropriate data, given that the data available --usually grouped in five year age groups-- hides enormous heterogeneity and widely differing needs.

The purpose of this paper is to provide an insight in the cultural dimension of adolescence and very early pregnancy and to propose ways in which it can be translated into operative programmes. It intends to show that adolescents need specific strategies in order to be effectively reached, for they have distinct social and psychological characteristics that vary greatly across cultures, and that if the cultural dimension is overlooked, programmes will lose effectiveness. The paper will look into how the concept of adolescence has been constructed culturally, with its meanings and characteristics varying across cultures. The aspect of gender and power relations between the genders will be dealt with in some detail, for it plays a crucial role in adolescent fertility and its differential consequences for adolescent girls and boys.

## 1. The specificity of adolescence and adolescent pregnancy from a cultural point of view

The concept of adolescence is relatively new in historical terms (the word, for example, was introduced in the French language in the 13th century and in English only in the 15th [1]). In most of the evolution of humankind, adulthood started very early on for full economic, social and familiar responsibilities, many times including marriage, started at puberty, after a rite of passage that marked the end of childhood. Thus, there was no *period of transition* from childhood to adulthood as experienced today [2]. This period has been expanding in duration

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1 The roots of the word adolescence indicate a transition by nourishing (*alere:* prefix *ad*) and growing (*alescere*) into the adult stage (*adultus*, grown up).

2 This, however, does not refer to the physiological transition from puberty to the end of physical maturation. Athough all human beings undergo this biological process, there is no recorded evidence of its social meaning, i.e. it does not have a social reflection, such as in rites of passage.

and is increasingly characterized by a culture of adolescence that is being developed with the aid of the mass media.

In a number of contemporary societies it does not make sense to talk about adolescence. In many rural areas of the developing world, for example, adult responsibilities including family formation and labor force participation are taken on very early in life, without any significant transition period. In many languages, neither the word nor the concept exist. In India, for example, adolescence is a controversial notion. It is viewed as an artifact of the extended formal education in the West, and language-wise females are "girl children" until they marry (Greene, 1997). *Adolescence itself is a cultural construct that varies across settings and contexts.*

The preparation time for entry into adulthood has greatly increased with the specialization of tasks and the increasing education needed to perform them, which have been related to the process of urbanization. At the same time that the attainment of economic independence has been postponed due to the longer time devoted to education, the attainment of biological adulthood has either not changed much (boys) or is starting earlier, through a significant decrease in the age at menarche [3]. In some societies, the *duration* of adolescence has been increasing and can plausibly continue to increase. How long is the period of transition? In rural societies with very early marriage and little or no education necessary for performing adult roles the period is either inexistent or very short, while in an urban milieu the standard definition comprises ages 10- 19 [4], and in post-industrial societies suffering from acute problems regarding entry into the labor force among the young it might be expanding into the early twenties.

As the culture of adolescence being constructed in some societies --including norms of conduct, dress code and language-- becomes more visible, it is easy to assume its universality and to infer its existence in every culture. However, the fact that adolescence itself is a cultural construct that varies significantly from society to society and across time, has to be kept in mind when designing policies and programmes directed to the adolescents, for needs vary with the different contexts and so should approaches. The incorporation of a socio-cultural component will aid in the identification of needs and in the determination of the most effective approaches.

*Definition*

Although the references to adolescence have become widespread in the literature on reproductive health and psychology, many times they allude to different phenomena, for the definition of adolescence presents serious obstacles. Being culturally determined and presenting large cross-cultural variations, it does not make much sense to talk about adolescence as a world-wide phenomenon. Due to the difficulties to provide a meaningful definition, the result is that for the most part, the adolescents are defined as all of those belonging in a particular age group (whose limits vary). This is a definition that makes little sense from a cultural point of view. Available data, however, is usually organized by five-year age groups, restricting the possibilities of more profound analysis. The classical 15-19

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3 Earlier menarche is attributed to a steady improvement in the levels of nutrition

4 WHO, Health needs of adolescents, Geneva, 1977 (WHO Technical Report Series No. 609).

grouping that demographers tend to use hides enormous heterogeneity from the health, social and psychological points of view. The meaning of a pregnancy for an unmarried 15 year old, for example, is entirely different from that for a 19 year old married woman [5].

When setting up programmes or formulating policy, it is important to have an appropriate definition of their target group, and in the case of adolescents this definition is context-dependent. A national adolescent policy should be sensitive to the specific needs of groups such as rural adolescents (in those places where it makes sense to talk about rural adolescents rather than young adults), urban school-going adolescents, urban school drop-outs, young married mothers, unmarried mothers, refugees, displaced persons and the like.

## Adolescent pregnancy

If adolescence is a cultural construct, adolescent pregnancy is one aspect of it that is especially sensitive to cultural context. The meaning assigned to teenage pregnancy varies among different cultures, as do its implications and consequences. In places where it is accepted behavior -- usually related to whether it occurs within marriage--, socially defined appropriate age at marriage tends to be low and childbearing is frequently the single most important element of women's status, in particular to produce a male heir. In these contexts, teenage pregnancy is socially accepted, founds identity, is a source of status, and reaffirms entry into adulthood. More and more frequently, however, pregnancy among very young mothers is viewed as a social problem, especially when in occurs out of wedlock and it interferes with expectations regarding education, self-realization, prospects for mariage and economic prosperity.

### *Age at marriage*

In most contexts, acceptability of teenage pregnancy is associated with marriage. In several countries of sub-Saharan Africa, for example, adolescent fertility is sanctioned and valued within the adequate ritual framework (marriage), but strongly condemned when out of wedlock (Bledsoe and Cohen, 1993). In a few countries, however, mostly those in the infertility belt (Central African Republic, South-west Sudan, Congo, Gabon and Cameroun), a pregnancy constitutes a prerequisite to marriage, and adolescent girls who cannot prove their ability to conceive, find no partners. In some of the Andean cultures also, the custom of *serviñacu*, used to be (Balán, 1996) a sort of trial period before marriage (about one year) to prove fitness of the couple, fertility being one core aspect.

Early marriage in fact is favoured in different contexts to prevent the undesired effects of premarital sexual activity and pregnancy. In the Gambia, for example, age at marriage has been reported to be as low as 10 years (Jeng and Taylor-Thomas, 1985). In rural Ghana early marriage shortly after puberty rites is the norm to ensure chastity and genital mutilation, performed at several ages, would provide proof of virginity and guarantee long time fidelity (Bulley, 1984). In rural Niger, 47% of women aged 20-24 during the DHS survey, had married before 15 and 87% before 18. In this context, where early pregnancy is welcome, 53% of the women had had children before age 18. In the Islamic areas of Africa, early

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[5] Both WFS and DHS use the 15-19 age group. Because of this, given that they are major sources of demographic information, this paper also is restricted into using it for some of the analysis.

marriage is favored in order to prevent extramarital pregnancies (Locoh, 1994).

Legal codes governing family law usually establish the minimum age at first marriage, but they sometimes conflict with each other. For example, in Tanzania the Penal Code states that anyone of African or Asian descent may marry or allow the marriage of a girl under age 12 as long as it is not intended that the marriage be consummated before she is 12. At the same time, the Law of Marriage Act establishes 15 as the minimum age at first marriage for women (CRLP, 1997). In spite of the existing legal minimum ages for marriage, more often than not these are not enforced, especially in the rural areas. The cultural definitions of acceptability usually have much more force in the resulting outcomes than those imposed by law and removed from the realities of the people they are supposed to apply to.

Age at marriage is a significant factor in women's lives, not only because of its association with overall completed fertility and with the meaning and consequences of adolescent fertility, but also due to its relation with the status of women. Early marriages are usually performed without the informed consent of the girl and often involve important age differences with the spouse, one element of unequal power relations between the spouses and of difficulty for empowerment (see section on gender relations).

Cultures also define who is entitled to access reproductive health services, sometimes by social control and sometimes by laws, policy restrictions or other measures. In many African societies only married women have access to family planning and other health services, and unmarried pregnant adolescents are particularly affected (Bledsoe and Cohen, 1993). In Gambia, provision of contraceptives is legally restricted to married couples and unmarried women with at least one child (Jeng and Taylor-Thomas, 1985).

Three current processes have had a particularly strong influence on teenage fertility outcomes: globalization, urbanization and education, in particular girl's education. As an overall effect, the three tend to postpone age at first marriage or union, without postponing initiation of sexual relationships [6]. During these processes the binding force of the traditional social controls on women's premarital sexuality is weakened, but no alternative control mechanisms have been generated and the result is an increase in unplanned pregnancy (although not necessarily in the absolute numbers of pregnancies) that is unwanted and socially not accepted, a rise in illegitimacy rates and in abortion, mostly unsafe (cf. section on gender). Among the same groups, the same event, a pregnancy, that would have generated status and respect, can generate stigma for the woman and/or her family if it happens out of the traditional norms of accepted behavior. It can also have dire health consequences, for access to health services is in this case limited by cultural restrictions.

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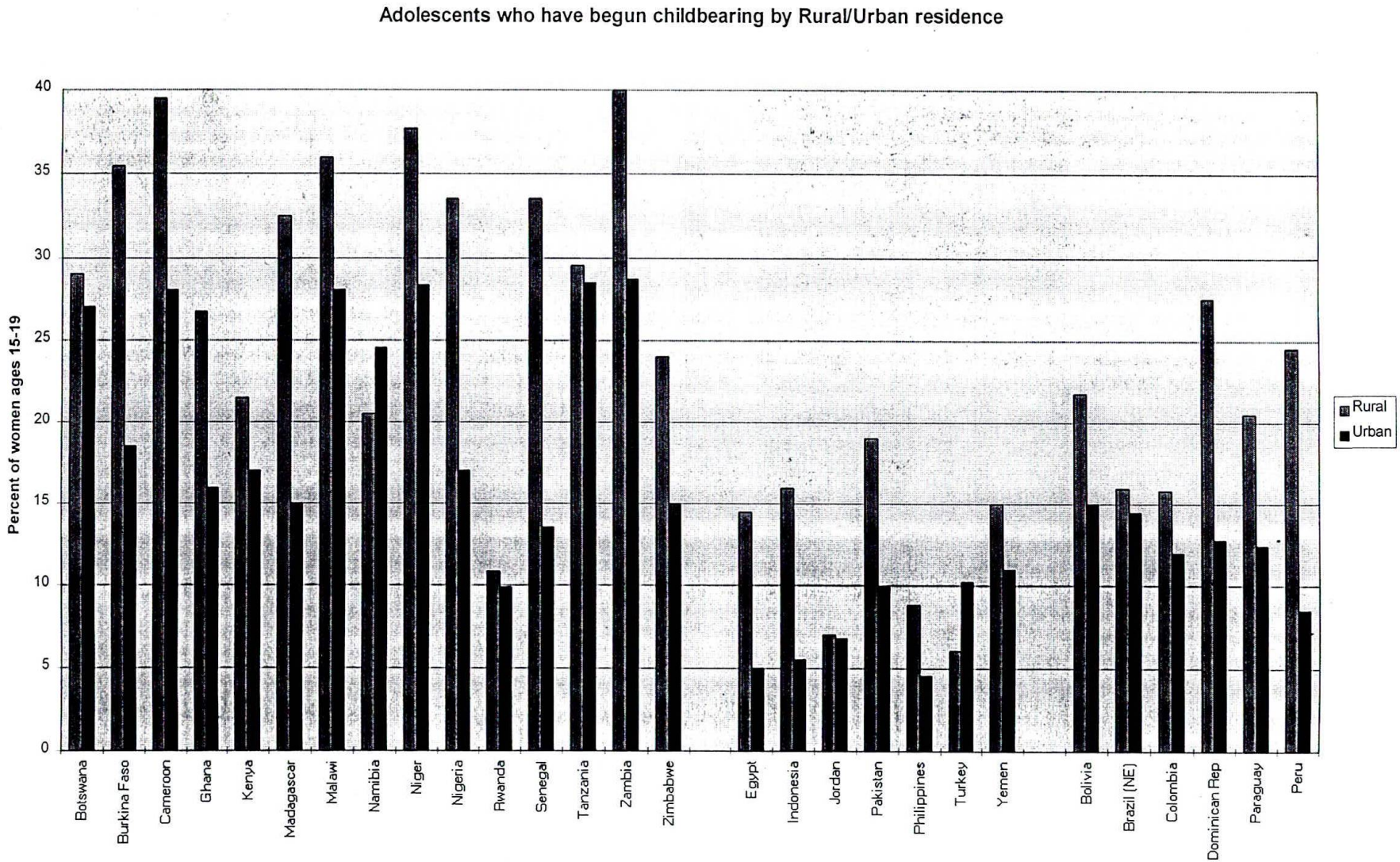
6 There is however some recent evidence that among more educated women the age at first intercourse would be slightly postponed (MacCauley and Slater, 1995).




Source: US Bureau of the Census, 1996

*Impact of westernization and urbanization*

The process of urbanization and the increasing influences of western cultural precepts on many population groups, but especially the young, are seen to be responsible for thebreakdown of traditional customs. In this sense, the increase in premarital sexuality and the increase in unmarried teenage pregnancy is seen by many authors as a consequence of the introduction of "western" values and ways of conduct, which expand more easily in the urban context and through the media available in this context. In Botswana, for example, until about 30 years ago, traditional teachings and social practices including strict gender segregation for certain activities, taboos, and a universal social disapproval of teenage pregnancy, made it a very rare phenomenon. Urbanization and detribalization have loosened those social practices, and in the process sexual behavior among youths has become more extended and unmarried teenage pregnancy more frequent (Linchwe, 1992). The disappearance of polygamy, too, has been cited as a factor in the higher prevalence of premarital sexual activities in Botswanian society (Letamo, 1993). Westernization has had an important influence in the disappearance of certain taboos and certain practices like initiation ceremonies, and in the transformation of the family structure, generalising the nuclear family.

In Senegal, where women traditionally acquire full status only through marriage and childbearing, although unmarried motherhood is considered a disgrace, a survey among 764 urban working women aged 16-21, showed that a significant proportion (31%) were unmarried mothers. In this case, economic factors are seen as largely responsible for the rejection of traditional customs, given that due to unemployment and economic hardship marriage ís postponed and premarital sexual relationships rise (Jean-Bart, 1985).

In the process of urbanization, two factors are especially relevant in the changes in sexual practices and outcomes: education (see next section) and the *changes in the traditional systems of social controls*. In Latin America, the enormous rural-urban migration flows of the 60s and 70s provided young women a physical way to escape the traditional controls on their sexuality, for with the change of location, young women (who comprised most of the flows) were able to flee the controlling eye of the father, the local priest and the community. While entering the labor market as domestic servants, a large proportion became single mothers.

With urbanization the socialization processes shifts from being entirely the responsibility of the direct or extended family to being partially dominated by social institutions like the school, under the ever stronger influence of the media. The introduction of western systems of thought --within the power relationship that is generated by a dominant culture-- often destroys local taboos, along with the elements that legitimize them within the local belief systems. In the same manner, other forms of social control lose relevance, as the weight of western values, attractive to the young, cannot be countered by local propositions.

Early marriage and childbearing continues to be mostly a rural phenomenon (Figure 1). In the urban areas young women have their first child significantly later, although this does not necessarily mean later first pregnancies, for abortion is much more widely practiced among urban adolescents. Urbanization has meant later marriages and first births, but for those who do become young mothers, higher proportions of children born out of wedlock.

Source: US Bureau of the Census 1996

*Impact of education*

Although there is still much to be said regarding the reasons for it to happen, education has been proven to have the undisputed effect of delaying the age at marriage and first union. With the postponement of first union, and even if no significant change in sexual practice takes place, the exposure to the risk of premarital pregnancy is greatly increased. On the other hand, with higher levels of education, as data from the DHS for all surveyed countries shows, the incidence of adolescent pregnancy decreases (see Figure 2). However, part of this reported decrease may be just an effect of attrition, given that pregnancy usually leads to the end of the educational process for the girls.

Locoh (1994), links the decline in the number of very early marriages and pregnancies present in most of the African countries where survey data is available for more than one year to urbanization and school attendance rather than to any specific policy measure.

The lower rates of pregnancy and births are due to the fact that educated women are more likely to use contraceptives, and are also more likely to resort to abortion, rather than to a significant difference in the exercise of sexuality. One of the determining factors in this outcome is the way in which the woman projects herself into the future, and the extent to which she feels she guides her own destiny, i.e. that she can have control over what happens to her own life. Education provides alternate means of creation of status for women, as well as a source of self-esteem and self-value. It thus provides the motivation to use contraception, facilitates its putting into practice, as well as the motivation to terminate the pregnancy if unwanted. The programme implications of this are clear: a) education should be made widely available for teenage girls --not a new proposition, of course--, and b) programmes that are specifically targeted to the reduction of adolescent pregnancy should build on the factors that the educational system provides and that have been shown to be effective (for example, to build on self esteem and self value), without going through the entire educational process when this is not possible (see more on this in the programme implications section).

*The ethnic factor*

The importance of ethnicity has been largely overlooked in relation to adolescent fertility. Few studies address it directly, most of them carried out in the United States, where it is sometimes undifferentiated from the racial factor, and where recent events have made it a piercing political issue. Ethnicity is of prime importance in defining age at marriage, acceptability of sexual behavior, initiation of sexuality, use of contraception, and the resolution of pregnancies when these occur.

A study of Nepal, singled out ethnicity as the single most important factor in the determination of the timing of marriage and of the first birth, much more important than education, religion, urban/rural childhood residence and ecological region. Women's mean age at marriage varied from 13.5 among the Brahmins to 17.8 among the Tamangs, while the difference among the literates and illiterates was very small (15.4 and 15.2 respectively), as well as that for the ecological region (14.8 for the *terai* to 15.7 for the mountains) (Thapa, 1989). Other studies for other parts of Asia have reported similar findings (Hirschman, 1985; Rindfuss, Parnell and Hirschman, 1983).

In Kenya, where adolescent fertility is reported to be among the highest in Africa, sexual custom varies greatly among ethnic groups, with differing values on virginity, consequences of premarital pregnancy, practice of genital mutilation, level of knowledge and use of contraception, among other characteristics. While among the Luhya and the Luo the woman who remained virgin until her wedding was given gifts of goats and cash, among the Kamba, women were ritually deflowered by elder men from whom they received sexual teachings. Contraceptive knowledge varied from 56% among the Kalenjin to 94% among the Kikuyu, and while contraceptive use also varied greatly along ethnic lines, it was much lower than knowledge for all groups (Ocholla-Ayayo et al., 1993).

In the United States, African American teenagers are much likelier (about five times) to have a child before the age of 19 than are whites (Furstenberg, 1987), even after controlling for socio-economic background factors (Maxwell and Mott, 1987). A study on ethnic differences between non-Hispanic whites and Mexican American female adolescents (Aneshensel *et al.*, 1990) concluded that the Mexican Americans who had been born in Mexico tended to initiate sexual intercourse later than the non-Hispanic whites, but that they had the highest rate of early births because they were the most likely to become pregnant if sexually active and the least likely to terminate the pregnancy. The non-Hispanic whites had the lowest rate of early births and the US born Mexican Americans were in between. Other studies corroborate these differences, adding the effects of family structure, age at first conception, family size, education and the fact of having a working mother (Cooksey, 1990; 1988). The effect of social controls in the initiation of sexual intercourse was found to be significant among whites but not among African Americans (Udry and Billy, 1987). Indexes of acculturation (language spoken at home, place of birth of individual and father and residence) were found to be more important than socio-economic background for fertility expectations (Sorenson, 1985).

To sum up, this section has shown that culture determines the meaning of pregnancy among young women, as well as its consequences such as those regarding social status, health and gender relations. The defining principle is not so much the age at which it occurs, but the cultural acceptability of the pregnancy, and this is often linked to marriage. Age at marriage is thus a central variable for analysis, both the actual age at which it takes place in different settings, as well as the prescribed legal age and the differences between the two. The norms of behaviour and the way in which specific behaviour is interpreted are cultural constructs and vary over time. Major sources of change have been education, urbanization and globalization, for they have a direct impact on the values, beliefs and practices. These processes have had a much stronger effect in the determination of age at marriage than on the initiation of sexuality, creating a separation in which pregnancy becomes unacceptable.

## 2. Trends in adolescent fertility: some interesting evidence

In most of the countries for which historical trend data can be found, the evolution in the age-specific fertility rates of the 15-19 year group marks a clear difference with that of all other age groups. While the analysis of these trends is beyond the scope of this paper, a few examples will illustrate the way in which they are different in order to bring attention to the fact that specific policy and programme interventions are needed.

In Latin America, the kind of difference between the evolution of the 15-19 fertility and that of the other age groups seems to be linked with the country's stage in the demographic

transition. Although all age groups have reduced their fertility significantly since 1950, the 15-19 group has shown relatively much lower reductions than the others, especially in the countries that are more advanced in their fertility transitions. To name one typical example, in Costa Rica, while the 15-19 group reduced its age-specific fertility by 18%, the 20-24 group reduced it by 46%, the 25-29 group by 50% and the 45-49 group by 80% (see Figure A2 in the annex). In three countries, those that have finished their transitions and have very low fertility (Cuba, Argentina, Uruguay) there have been *increases* in the fertility rate of the 15-19 year olds (Figure A3).

In the poorest countries, those least advanced in their demographic transitions, the fertility rates of adolescents either decreased *more* than other young age groups (Haiti and Guatemala)-- probably due to an initial postponement in age at marriage, or had almost not varied at all (Nicaragua, El Salvador) in the four decades studied (see Figure A1).

Although adolescent pregnancy is currently considered a pressing and increasing social problem in Latin America, neither age-specific fertility rates nor absolute numbers of births have increased in the last decades. However, due to the lower fertility reduction in the 15-19 group compared to all the others, the *proportion of births* to very young mothers has been increasing, quite sharply in some countries. Cuba, the country with the lowest fertility is at the extreme. In 1985-90 almost one of every four children (23%) born in the country had a mother in the 15-19 age group, while in 1950-55 only 8% of births occurred in those ages. At the other extreme, in Haiti, least advanced in the demographic transition, the proportion of all births to adolescents has remained constant during the past decades. In average, the proportion of births to young mothers has increased 25% since the 1950s in all the region.

In other regions no consistent pattern is found. Fertility in the 15-19 year group has remained remarkably constant throughout several decades in countries like Egypt, Thailand and Sri Lanka, while it shows a clear downward trend in others like Tunisia and Malaysia. (See graphs in the annex).

The only common characteristic to most countries seems to be that the pattern and evolution of fertility among the 15-19 year olds is clearly different from that of other age groups. While fertility has decreased in a more or less smooth way responding to social and economic development in groups above 20, the fertility behavior of the 15-19 year olds is unique, seems to respond more to cultural, social and psychological factors, and has shown resilience to overall socio-economic development. Moreover, this indicates that reproductive health programmes have failed to effectively reach this age group.

### 3. Gender issues in adolescent pregnancy: unequal relations and unequal consequences

Gender is culturally constructed [7], and much of this construction is related to sexual definitions and sexual behavior. During adolescence, expected and sanctioned behavior for young women begins to be widely differentiated from what is expected and sanctioned for young men. The conditions of initiation, timing, related expectations, values, and meanings of sexuality diverge enormously between the genders. Moreover, the consequences of adolescent sexuality are

[7] Unlike sex, which is determined biologically, gender and gender relations are defined by the culture and are subject to change.

clearly gendered, with the adolescent girls bearing most of the negative social consequences, and most of the health and economic consequences when pregnancy results. This section looks into the interactions between gender aspects and adolescent pregnancy.

In every country covered by the DHS surveys, boys are reported to start sexual activity on average before girls, and at every age, a higher proportion of adolescent boys than girls have sexual relations. Boys are more likely to have multiple partners and to have sex with casual acquaintances, while girls more often report having sexual relations only with a steady boyfriend (Berganza et al, 1989; Stycos, 1990; Kiragu, 1991; Morris, 1988). Peer pressure among adolescent boys has been reported to be an important factor in the initiation of sexuality. A survey of 1269 youths aged 12-19 in the USA, for example, showed that the strongest predictor of sexual activity was the person's assumptions about his peer's sexual activity. Among adolescent girls, there is evidence that peer pressure may be increasingly a factor in early initiation (Villarreal, 1989).

The extent to which the initiation and practice of sexuality is a matter of choice varies strongly along gender lines. Among girls, the early initiation of sexual activity is more likely to be associated with coercion, exploitation and violence than among boys (Mahler, 1997). In Uganda, almost half of the girls (49%) who became sexually active while in primary school reported to have been forced into sexual intercourse. In fact, the younger the woman when she starts having sexual relations, the higher the chances that it was done in a coercive situation (AGI, 1994). Sexual abuse of female children was also found to be an important factor in the incidence of adolescent pregnancy. Adolescent women who had been abused during childhood were found to start sexual relations on average a year earlier than their peers (Boyer and Fine, 1992).

In spite of recent rapid increases in male prostitution, prostitution has overwhelmingly affected women, bearing lifelong consequences, especially when initiated during the adolescent years. As with other factors related to sexuality, prostitution takes place within cultural norms and values. Cultural attitudes that encourage sexual activity among men and virginity among women create a demand for prostitutes. The greater the asymmetry, the greater the stigma on adolescent girls having sex and the greater the demand for prostitutes. In the other hand, cultural norms combined with socio-economic conditions may account for a supply of young women for prostitution (Mahler, 1997). In Thailand, for example, where according to Thai family norms, daughters are partly responsible for their family's economic well-being, 44-55% of prostitutes said that the main reason for their becoming prostitutes was their parents' financial need (Boonchalaksi and Guest, 1994). The rural migrants to Thai cities employed in the sex industry send sizeable remittances to their rural families, far above those that could be earned in the formal sector (Archavanitkul and Guest, 1994).

Most societies develop sophisticated mechanisms to control sexuality (norms, values, restrictions, dress codes, social controls) and these are particularly visible in the case of women. Because adolescence is a time when the dangers of premarital sex or out-of-wedlock pregnancy are greater, many social controls are practiced during adolescence. One of the most extreme is female genital mutilation (FGM), widely practiced in 28 African countries, and in some of the Arab peninsula, mostly during adolescent years although sometimes earlier, with the objective of reducing or annulling the woman's sexual desire and thus insure fidelity. Other forms of controls on women's sexuality derive from a system of values which places

restrictions on the times they may go out, the places they may go to and the type of persons they may go with.

Age difference between sexual partners may constitute an important factor in adolescent pregnancy outcomes. With an older or much older man, an adolescent girl may not feel she can demand the use of a condom to be protected against STDs or pregnancy. With greater age differences between the partners, power relations tend to be more unequal and this may mean lack of empowerment for the woman to put into practice her own desires regarding number and spacing of children. Age difference is also an important factor in the spread of AIDS, for men seek younger women who they think to be likelier to be free from the virus. As a consequence, women are becoming HIV infected at significantly earlier ages than men, in average five to ten years before them (du Guerny and Sjöberg, 1993).

In several parts of sub-Saharan Africa, the role of "Sugar Daddies" is important in the sexual activity of adolescent girls. They are older men (usually of the father's age) who give money, gifts or other perks like education fees in exchange for sex. In Kenya, for example, a growing expectation for gifts or money is reported to be found among sexually active adolescent girls. Survey data showed that 54% of girls believed that sex is for money and gifts. "These days, a girl would not feel humiliated if it was known that she had accepted money or some gift for sex, but perhaps she would be if she had not been offered any" (Ocholla-Ayayo *et al.*, 1993, p. 391). In Uganda, 22% of interviewed adolescent girls anticipated receiving gifts for sex. In the predominantly rural Transkei subregion of South Africa, teenagers with poor economic prospects, often resort to offering sex in return for financial assistance from older men (Chimere-Dan, 1996). The phenomenon of Sugar Daddies is on the rise and has also been associated with risk of HIV/AIDS (du Guerny and Sjöberg, 1993a).

The age difference with the partner is important in understanding pregnancy outcomes in adolescent women. A large age difference indicates not only greater vulnerability of the woman, but is frequently associated with more deprived households. Using data from the National Maternal and Infant Health Survey, it was found that, although most children of adolescent mothers are fathered by men of a similar age, the younger the mother, the higher the likelihood of having an older partner (Duberstein et al., 1997) and that adolescent mothers with older partners were likelier to come from poorer households (Lamb, 1986).

Another gender issue related to pregnancy outcomes among adolescents is the perception by many males that contraception is a woman's responsibility. In different parts of the world, it has been found that young men are more likely than young women to indicate lack of knowledge as a reason for not using contraceptives and to consider that it is their partner's responsibility (McCauley and Salter, 1995).

*Value of virginity and gender*

Many societies value very highly women's virginity and at the same time construct masculinity around sexual activity, generating an unequal situation in which adolescent girls have either to counter their male peer's pressure to initiate sexuality or to face the social consequences of losing virginity. Out of all the defining traits of masculinity, sexual activity may be the most consistent one cross-culturally, perceived by both adolescent boys and girls as well as older people. In Thailand, for example, a study reported girls to say that a boy that does not visit

prostitutes must be homosexual (McCauley and Salter, 1995). In fact, a study found that 65% of rural Thai men under 20 years of age had visited a prostitute at least once (Brown and Xenos, 1994).

The value of female virginity is one cultural characteristic that shows a very intricate pattern of gender relations. It is frequently related to the importance of ensuring the legitimacy of the child, by knowing who the father is. Although it would seem that this value relates to women alone, it may arise from the male's fears and insecurities regarding sexuality. As the following group of quotations from in-depth interviews of Costa Rican high school adolescents[8] show, the value of virginity in this case is related to the men's fear of sexually underperforming other men. Women's virginity would insure that men cannot be sexually compared to others. This is an instance in which, a social control on women has the function of protecting males. However, if virginity is lost, it is the woman who suffers the consequences.

Men believe that they are everything, that they are the greatest, and if he knows that his wife is comparing him sexually with another man who is better -- or whom he believes to be better-- he is going to feel inferior and won't like it at all. That is why they want to marry virgins. Male, 11th grade UM[9]

Us men, we fear to be compared, we fear that they will take our woman away ..., because we believe that women can find other men that are better than us, that is what we fear. Male, 10th grade UU

For a man, there is nothing worse than to be compared with other men by a woman. Female, 10th grade UU

More than anything else, *machismo* is a feeling of insecurity. Male, 11th grade. UM

The danger of contracting AIDS has increased the value (including the commercial value) of virginity. In Thailand, sex workers were reported to have lost their virginity in exchange for a substantial fee that they or their families had received (Boonchalaksi and Guest, 1994). In different parts of Africa, there is a belief that havign sex with a virgin will actually *cure* the disease. In Morocco, for example, after having demanded a virginity certificate to marry a much younger woman, a man with AIDS left her the legacy of HIV after his death (Fraser and Restrepo-Estrada, 1998). Gender inequality has been shown to be an important factor in the spread of the HIV infection (du Guerny and Sjöberg, 1993a; Mason, 1994).

*Unequal expectations*

Expectations of sexuality vary along gender lines. The reasons why adolescents engage in sexual relations are different for young men and women. The in-depth study in Costa Rica, for example, showed that adolescent boys were more likely to be motivated by peer pressure, while adolescent girls tended to give in to their boyfriend's insistence by fear of losing him.

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[8] In-depth interviews were carried out among 180 adolescents in three different high schools: one rural (R), one urban middle class (UM) and one urban upper class (UU). Both girls and boys were interviewed. (Villarreal, 1989).

[9] See previous footnote for explanation of signs.

In many countries in Latin America, as well as in other regions, it is not uncommon for young men to put pressure on their girlfriends, threatening to leave them if they do not "prove their love" by engaging in sexual relationships. At the same time, as the following excerpts show, the adolescent boys' motivation was to get a proof of the girlfriend's moral inflexibility (and thus a guard against future infidelity).

My cousin says that if a woman does not accept to have sexual relations with him even if he insists for six months, he will marry her because she is not of the easy type. Male, 8th grade UU

If a woman gives herself to a man, she feels more committed, while the man only wants to satiate his desire. The woman is tied to him because after that no other man is going to want her. She is going to be humiliated by society because society punishes more what it sees than what was really done. M 11th grade R

If she has had boyfriends and she gave in easily to one, then it is logical to think that she did the same with the others and so one looks down on her. M 11th grade R

[He will think] that she is too easy and that after marrying her she will do it with anyone in spite of being married. Female, 9th grade UU

If I really loved her, I wouldn't do it to her. In the case that she gave in I wouldn't like it because I would end up despising her, I wouldn't consider her my girlfriend, she would be like a loose woman (*una mujer cualquiera*). M 11th grade R

If you have a girlfriend and you love her a lot and you ask her to do it and she says yes, I would think, *diay*, if she says yes to me, she could say yes to any other. Male 10th grade UM

The "proof of love" combined with another cultural perception, one that links use of contraceptives to the woman's infidelity, may end up in adolescent pregnancy. In other regions of the world, sexual initiation among girls due to the partners' pressure is not uncommon. Among black South African teenagers in KwaZulu/Natal, "girls find it hard to refuse boyfriends who take full intercourse for granted, and who soon threaten to abandon girls who refuse to comply" (Preston-Whyte, 1994: 243). And the negative consequences of pregnancy tend to be disproportionately borne by adolescent girls. These consequences are mainly related to health, social, and economic aspects.

*Unequal consequences*

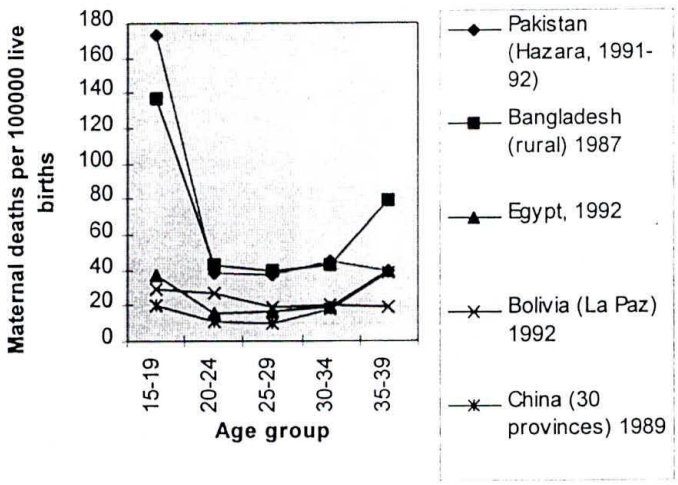
"I thought that getting together with a man would bring peace, quiet, happiness and some freedom, but things are not that way, they change. For example, I married when I was 16 and by 17 I was a mother, taking on a big responsibility, like that of older people: to bring up a child, look after it when it is sick, cook, wash the husband's clothes, duties, ... at 18 I regretted it. Yes, I regretted it because at that age I wanted to work, to get an education and I couldn't because I had a child. I felt like trapped. Marriage was not for me. I wanted to leave, but I couldn't because it was my duty to be there, beside the husband, beside the child. My son wiped out everything I ever wanted to be." Gabriela, Peru

Cardich, R, Visiones del Aborto, Nexos entre sexualidad, anticoncepción y aborto, Movimiento Manuela Ramosy The Population Council, Lima, 1993

*Health consequences*

Adolescents tend to have a higher maternal mortality rate than older women, especially when the pregnancy occurs before age 15 (see graph below). In fact, the risk of death during childbirth is 2-4 times higher for mothers younger than seventeen than for those older than 20 (McCauley and Salter, 1995). This risk is much higher in the rural areas, where, as the graph shows, it can be 4-6 times larger than for poor urban areas. Young women, especially when they are pregnant, have a higher likelihood to be malnourished and to have anaemia, an important risk factor. In rural Egypt, for example, cultural patterns that favor older males in the distribution of food, result in a higher incidence of anaemia among girls and women (Lane, 1992). In Singapore, the transformation of the social standards of the population is reported to have produced an escalation in the number of pregnancies to unmarried teenagers, which tend to show poor intrauterine growth, low birth weight and a resulting five-fold increase in perinatal mortality (Kurup et al., 1989). A younger start in sexual relations is also associated with more partners, with a higher danger of sexually transmitted diseases (McCauley and Salter, 1995).

**Maternal mortality ratio by age of mother**




Source: WHO, Safe Motherhood, 22 (3) 1996

A large proportion of the negative health consequences for adolescent girls is related with induced abortion. Given the social restrictions on adolescent sexuality and the cultural unacceptability of premarital pregnancy, abortion is a likely outcome, and is responsible for at least a part of the increased maternal mortality. Adolescents tend to search for abortion later and to do it in clandestine, unsafe conditions, increasing the health risk. In addition, it is more difficult for them to get the financial resources needed (Singh and Wulf, 1993). It is estimated that 1-4.4 million abortions per year take place among adolescents in developing countries (Center for Population Options, 1992). In Kenya, abortions among adolescents account for 28-64% of hospital abortions, and strict abortion laws make many resort to illegal ones (Ojwang and Maggwa, 1991). In one teaching hospital in Ilorin, Nigeria, adolescents accounted for 74% of all induced abortions, which made up 60% of all gynaecological admissions. More than

50% of the girls were subsequently expelled from school (Adetoro et al., 1991). In Zambia, the number of abortions among adolescents are reported to have been increasing quickly. Most patients (80%) with abortion-related complications were under 19. In this country, contraceptives are made available only to married adolescents (Likwa, 1989). In India, 30% of all hospital abortions were performed on women under 20 years of age. Although the great majority of abortions are carried out in the first trimester, among teenagers most of them occur in the second trimester, most of those among unmarried adolescents (Solapurkar and Sangam, 1985).

The health consequences of teenage pregnancy, as these cases show, are closely linked with the social and cultural context that determines accessibility to information, to contraceptive services (by legal restrictions), to adequate nourishment and to safe abortion.

The decision to terminate a pregnancy among adolescents has been associated with the opportunity cost of the mother's time and expectations. Women with career plans and higher socio-economic status tend to resort more frequently to abortion (King et al., 1992).

*Social consequences*

Pregnancy can bring status for married adolescents in cultures where motherhood is a core aspect of the definition of women's identity. Moreover, as previously mentioned, in countries where infertility is widespread, a pregnancy may constitute a prerequisite for marriage. However, when social controls over unmarried adolescent girl's sexuality fail, the social consequences are unbending for her, and can be also strong for her family and can even affect a larger group of reference, such as the clan. Among the Luhya and the Luo communities in Kenya, for example, traditionally, a woman who got pregnant before marriage would be an embarrassment for the whole clan and would be married off to an old man. Nowadays, pregnant unwed adolescents are abandoned or chased from the home and have no guaranteed means of support for the child (Ocholla-Ayayo et al., 1993). In Algeria, recent mass raping of adolescent girls by one of the armed groups, were perpetrated to disgrace the girl's family, by dishonouring her father. In this case the woman's body is a vehicle for an aggression by one male to another. This is not an uncommon situation during armed conflicts, in which rape is used to humiliate the male by putting in evidence his failure to perform his protective role, and at the same time by using the woman's body to "plant" the genes of the dominator.

Social consequences are many, but usually do not affect the male who made the woman pregnant. In the words of Costa Rican adolescents:

Women lose everything and men don't lose a thing. Male, 11th grade UU

(If she agrees to have sex upon insistence) I would think she is not a serious person, she doesn't make herself be respected. She has to think what would happen to her with a pregnancy, and what would happen to the child too. She should ask him to marry her instead, anything but that, because it would be very damaging for her. If she is somebody's girlfriend and gets pregnant, he would leave her, so she has to think about how she is going to maintain the child. Male, 9th grade, R

*Economic consequences*

Studies in Latin America have shown that an adolescent mothers are more likely to be poor and to remain poor throughout their lifetime, and that their children also have a higher probability of being and remaining poor than children from older mothers. Moreover, daughters of adolescent mothers will be adolescent mothers themselves in a higher proportion than daughters of mothers above 20 years of age (Buvinic et al., 1992).

Adolescent pregnancy is thus an important factor in the intergenerational transmission of poverty. In this case, poverty is associated with low levels of education, given that most teenage mothers do not finish secondary education either because the school does not allow them, or because they feel awkward and different from others and do not want to continue. Low educational levels are associated with precarious access to the labor force. Moreover, both low education and early childbearing are associated with higher fertility and higher overall parity.

A fair amount of evidence worldwide shows that pregnant adolescents, more often than not, do not return to school. In some countries legal restrictions prevent it, but in most cases it is due to social or religious constraints, and these vary along a number of lines such as area of residence. A study in Botswana showed that rural adolescent women were about as likely as the urban ones to leave school due to a pregnancy, but less likely to be readmitted afterwards (20% and 27% respectively) (Letamo, 1993). In Kenya, it is estimated that 10,000 girls are expelled from school every year due to pregnancy, but no action is taken with the students who father the children (McCauley and Salter, 1995).

In rural areas of developing countries, where both educational and labor force opportunities are low, an early pregnancy may not worsen adolescents' economic prospects (McCauley and Salter, 1995). In fact, a pregnancy may be something to look forward to where the value of children is defined by their potential labor force contribution.

## 4. IEC: The need for a culture-based approach

Throughout the world, a significant proportion of the births to young mothers are either mistimed or unwanted. DHS data for selected countries shows that among women less than age 20, in many countries of Africa and Latin America up to one half of current pregnancies were unintended while in Asia and North Africa the figures were about one third and one fifth respectively (see Annex ). In the United States, about 82% of the one million pregnancies occurring to adolescents every year are unintended (MacCauley and Salter, 1995). This is in spite of the fact that most of teenage pregnancies world-wide still take place within marriage. Unmet need for contraceptives is high in this age group.

In spite of relatively high levels of knowledge about contraception, use tends to be low in a number of different cultural contexts. In Uganda, for example, although the majority of a sample of 15-24 olds from urban and rural areas had appropriate knowledge on contraception and a favorable attitude towards its use, only a small proportion of the sexually active was using it at the time of the survey. Similarly, in spite of the majority being knowledgeable about STDs, only a few were using condoms (Agyei, Epema and Lubega, 1992). A high incidence of abortion was reported among the Ugandan adolescents (Agyei and Epema, 1990). In

Nigeria, a survey found most young urban Nigerians to be sexually active, but only 15% of them were practising contraception (Makinwa-Adebusoye, 1992). In Kenya, more than 50% of a sample of 3000 unmarried adolescents were sexually active, most of them having initiated intercourse between 13 and 14 years of age, and the vast majority (89% of the active) had never used contraceptives (Ajayi, Marangu, Miller and Paxman, 1991). In a Botswana study, 88% of the teenagers said they had become pregnant by accident and 94% said they viewed teenage pregnancy as a problem (Letamo, 1993).

These data show the existence of an important gap between knowledge and behaviour regarding reproductive health. It constitutes a pressing obstacle to reproductive health programs, for most IEC interventions are designed to target knowledge, assuming that an increased amount of knowledge will lead to changes in reproductive behaviour. Grasping the determinants of behaviour is a pivotal factor for the design of successful programmes.

The issue is *why* adolescents are getting pregnant if they do not want to in spite of knowing how to avoid pregnancy. The reasons for this are grounded in cultural norms, attitudes, myths and in power relations, as well as psychological particularities of adolescents. A full understanding of these reasons should be the basis for programmes and for IEC interventions.

In a study of the Machakos district in Kenya, where only 3% of the sexually active young people had used contraceptives, 79% of the girls and 69% of the boys felt that sex is not enjoyable when planned for and 80% thought that family planning methods are dangerous and that it is sinful to use them (Ocholla-Ayayo et al., 1993).

Among black teenagers in KwaZulu/Natal, in the process of the construction of masculinity, based on traditional polygynous society, sexual conquests are important, but proof of the ability to father children is a centerpiece. The adolescent girls face the pressure to engage in sexual relations, and once they do, they feel the need to prove their fertility by having a baby. At the same time, young women see the role models of older women who frequently head households and who can 'go it alone' and get the message that having a child before marriage is not the end of the world. The interplay of lack of disincentives with the positive dimensions of childbirth is the basis of early sexuality in this region (Preston-Whyte, 1994).

Among adolescents, conflicting attitudes and ambivalent feelings are very frequent, and are often related to pregnancy outcomes. High educational expectations may coexist with positive attitudes toward early pregnancy. Very frequently adolescents who get pregnant have not thought about the consequences for their lives and the long-term implications for their future. Interviews in Costa Rica showed that many of the teenage girls expected to undertake a major career such as law or medicine, wanted to work before marriage in order to gain work experience, and to stop working after marriage to devote themselves to their children, following a cultural norm that expects married women to be at home. At the same time, they expected to be married by age 21 (Villarreal, 1989). More often than not, adolescents have not created a consistent self-image projected into the future. When they have given any thought to the future, they have ideal images of different aspects that do not fit when put together. Building a strong, coherent self-image would help them take appropriate action (such as using contraceptives) to avoid events that would interfere with their plans.

Another very important issue to address in IEC programmes is *where* teenagers get their information on sexuality and contraception. It is widely assumed that the most important sources of information are parents, school and peers, but in certain societies this may be far from reality. Among the Kaguru of Morogoro (Tanzania), the *dgubi* dance, to which women are introduced at puberty serves as a means to educate and socialize them in issues of sexual initiation, reproductive knowledge, as well as in notions of female dependence and expected behaviour (van de Walle and Franklin, 1996). In Kenya, the traditional role of sex education was performed in the "grandmother house" by grandparents or aunts, where the boys and girls stayed while growing up. Parents seldom undertook this function. With increasing migration, friends have become a prime source for knowledge and for the provision of contraceptives, frequently with poor information on their use (Ocholla-Ayayo, 1993).

Traditional sources of information, together with traditional modes of conveying messages (where they still operate) are invaluable resources to tap on to while setting up effective programmes.

Gender differences are also important in the determination of the source of information. While in Ecuador and Chile male adolescents were more likely to name friends as the most frequent information source, young women tended to name their mothers (McCauley and Slater, 1995).

Increasingly, throughout the world, the media is becoming a prime source of information regarding sexuality, as well as a source of influence regarding values and behaviour of adolescents. As the television broadcasts of the United States reach the most remote corners of the world, their influence cannot be disregarded. An average teenager in that country sees around 9200 scenes of suggested sexual intercourse (Center for Population Options, 1984). The prevailing images imply that sex is risk-free, widespread and that planning interferes with romance (Strasburger, 1993). When these images are transplanted into a socio-cultural context that does not provide the framework of significance, they cannot be interpreted and given the appropriate weight. For example, while US adolescents know that not all in the society have the lifestyle portrayed in "Dynasty" (although they may desire it), it will be much more difficult for an adolescent in a small city of the developing world to see it in relative terms.

In order to tackle the gap between knowledge and behaviour, a culture-sensitive approach is needed and frequently lacking in reproductive health programmes. It is important to know the cultural meanings of adolescent pregnancy, their positive and negative connotations, the reasons why they are getting pregnant if they do not intend to, and why they are not using contraception. Power relations between the genders and the cultural connotations of sexuality need to be more thoroughly understood.

A culture-specific strategy needs to be designed and different audiences identified. Next, it is necessary to determine meanings from an *emic* point of view (from within the culture) in order to develop messages that can be effectively grasped by the audience. An appropriate methodology to transmit the contents also needs to be identified. Examples of communicative initiatives that have failed to convey the message due to cultural insensitivity or to vertical top-down approaches are numerous. Adolescents have particular relationships with authority, and information or communication systems that are perceived to be authoritarian usually fail to reach them (see more on this in the Programme Implications section).

## PART II - PROGRAMME IMPLICATIONS

### Improvement of programmes through a socio-cultural perspective

The previous sections attempted to show that adolescent's needs regarding pregnancy-related reproductive health services vary according to the cultural context. This section proposes ways in which programmes can be improved through the incorporation of a socio-cultural dimension in the approach of adolescent pregnancy. It also draws on the lessons learned derived by several sources throughout years of putting in practice adolescent reproductive health programmes in a variety of contexts (Koontz and Conly, 1994; Amana, 1997; McCauley and Salter, 1995; Senderowitz, 1995 and 1996).

*Identify the problem*

The first step is to *characterize the problem* in the particular area of the programme intervention, for which a knowledge of the cultural context is needed. Adolescent pregnancy, for instance, is not in itself a problem. It may be a problem if, for example, it is not accepted socially, or if appropriate health services cannot be accessed, or if it interferes with educational possibilities. Or it may be that the socially prescribed age at marriage is too low. Thus, the nature of the problem has to be clearly understood within its cultural context and this should be used to define the objective and approach of the programme. A programme that seeks to lower adolescent pregnancy because of its health risks among married rural women will necessarily have a different approach than one that seeks to lower it because of its association with the intergenerational transmission of poverty among unmarried urban women.

The identification of the problem presupposes the delimitation of the group of people to which the programme is oriented. It does not make sense to design programmes for 'the adolescents of the country', given the enormous heterogeneity among them and the wide variation of the meaning of pregnancy according to context.

*Assess the socio-cultural context*

The assessment should aim to obtain a clear understanding of the cultural aspects that affect adolescent sexuality and pregnancy. This includes ascertaining norms, myths, cultural constraints on access to reproductive health services or information and behavioral traits regarding practice of sexuality. Some factors that should be looked into are:

- Age at marriage: legal, ideal, practiced
- Conditions of initiation of sexuality for each gender
- Acceptability of teenage pregnancy
- Meaning of pregnancy among young women: source of identity, status, affirmation of entry into adulthood or obstacle to self-realization
- Pregnancy as proof of fecundity as a prerequisite for marriage

- Existence of unequal gender relations that favor early pregnancy: wide age differentials between husband and wife, little communication between them, dis-empowerment of women, sugar daddies, sugar mummies

- Differences regarding socially expected and accepted sexual behavior among men and women (e.g. value of virginity vs. demonstration of sexual performance as defining traits of femininity and masculinity)

- Extent to which men are seen as co-responsible for reproductive outcomes

- Myths and taboos regarding fertility, use of contraception and health care services

- Legal or social bans on access to health services for unmarried young women

- Consequences of adolescent pregnancy: health, social, economic, educational

- Variation of these factors along ethnic lines

Data gathering: Cultural biases and accuracy of information

Gathering data to build a culture-sensitive programme has limitations that arise from culture itself. Cultural norms that favor early sexual activity among males but scorn it among females, for example, will have the effect of overreporting sexual experience for the first and underreporting it for the latter. One study found that boys were likely to report what they perceived as being the sexual behavior of their peers instead of their own. So the real extent of the practice of sexuality and risks is likely to be unknown (when the more frequent ways of collecting data are used), hindering the setting up of effective programmes.

Regarding age at marriage, when laws of minimum age at marriage exceed the age that is practiced within the culture, fear of legal sanctions will cause an overreporting of age at marriage.

Another source of potential bias when using survey data or designing interview or focus group questions, is the difference between the norm and the expectation for the self. A national representative survey carried out among Costa Rican adolescents asked if it was alright for a married woman to work. The answer was an overwhelming "totally agree" among both boys and girls. When boys were asked if it was alright for *their own wife* to work after marriage, the percentage of approval dropped to less than one third (Villarreal, 1989). Many times questionnaires ask for the culturally accepted norm, and get the norm as an answer. The distinction between norm and self is especially important among the adolescent age group, where norms and values are being formed and are subject to change. It can be assumed that the personal expectation will have an important influence on behavior, although the influence of the norm cannot be overlooked.

Therefore, regarding the gathering of appropriate data for setting up a programme, possible cultural biases should be taken into consideration in the design of the instruments. Usually, a combination of qualitative and quantitative methodologies is best to avoid this type of bias and participatory research techniques have been shown to give very reliable results. AIDS research

has developed innovative methodologies to look at the spread of the epidemic that could also be tapped into.

*Identify the specific needs of adolescents*

In order to identify adolescent's sexual health needs, their problems have to be seen from their own perspective. In this sense it is imperative to obtain the views of those to whom the programmes are intended to serve. Some key issues are:

- Reasons for initiation and practice of sexual activity by gender
- Reasons for not using contraceptives
- Reasons for not using available health services
- Extent of knowledge of pregnancy risks and consequences
- Access to information on sexuality and contraception

*Incorporate a true gender approach*

"In dating, we are misled by trying to live up to what others expect of us. A girl plays at sex for which she is not ready, because fundamentally what she wants is love, and the boy plays at love, for which he is not ready because what he wants is sex."

Plenise Semu, Female, 17, Tuvalu [10]

Most of the programmes to prevent adolescent pregnancy and to serve adolescent reproductive health needs have been directed exclusively to young women, ignoring the gender relations that frequently are at the core of the problem. Effective programmes need to be built with a true gender approach, starting with the understanding of the underlying gender relations and their relation to the occurrence of pregnancy and targeting them through intervention. Programmes should make sure to involve adolescent boys and to devise mechanisms for each gender to know about each other's expectations and motivations regarding sexuality as well as the differential consequences regarding pregnancy.

For example, using the Costa Rican example, if adolescent girls knew that the motivation of a boyfriend to insist on having sexual relations was not to obtain a proof of love, but to test her moral integrity and capacity to say no, it would probably be easier for her to refuse. Regarding adolescent boys, if they are more aware of the possibly damaging consequences of their insistence for someone they love, they would probably act differently.

Programmes should explicitly address power relations between the genders and their impact on unequal outcomes such as unwanted or unplanned pregnancy, STDs, etc.

*Reach out to young men*

Purposeful action has to be taken to effectively incorporate young men in programmes. In the

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10 Quotes in this section are from 1996 UNFPA International Youth Essay contest -- Promoting Responsible Reproductive Health Behaviour, The Youth Perspective.

same way as development programmes historically left women out without intending to, many reproductive health programmes leave men out because they do not devise a strategy to reach them. In the case of some young male adults, outreach may be the only effective way to do this.

The promotion of a responsible role in reproduction is an essential component of many reproductive health programmes. The best way to attain this will be determined by the assessment of the socio-cultural context, but it usually helps to show that behavior considered irresponsible is the reflection of a cultural norm, not due to males being inherently mean or irresponsible.

*Involve adolescents in all stages of the programme*

The assumption that experts or professionals know what is best for the adolescents is at the heart of many programmes. However, experience in different contexts has shown that when adolescents are not involved, these rarely have positive and lasting effects, so they should play an active role in the phases of planning, implementation and evaluation of RH programmes. Their involvement as peer educators, advocates, role models and advisers has been shown to be beneficial.

*Effectively communicate*

In order to convey information in a way that is meaningful to adolescents, it should address the relevant issues for them from their own perspective. This can only be done with an understanding of the way in which they view the problems and the way these relate to their own lives. This implies a clear differentiation of audiences and clear targets for the different messages, as well as participation of the young in generating the messages and expresing them (i.e. in their own language).

Given the gap between knowledge and behavior, effective strategies have to be developed to provide information that will change behavior, and not only increase knowledge. This can be achieved by a thorough understanding of the motivation of behavior and a method to generate changes in it. One avenue is to detect identification symbols and to use them to convey messages. For example, to target young men, a national football hero --or other widely recognised symbol of virility--, can be interviewed on the importance of developing good communication with his wife, or on the importance of not beating her. In this way, signs and symbols from within the culture can be used to generate a change in culturally accepted behavior.

*Develop skills to avoid risks*

"Although young people say they know about contraceptives, the use of contraceptives is not widespread, since sexual relations between teenagers are unplanned, they just happen depending on the situation. ... Another cause is a kind of thoughtlessness: It won't happen to me...." María Soledad Silva Cabrera, female 15, Paraguay

An unwanted pregnancy is many times the outcome of circumstances in which the adolescent girl cannot effectively manage the situation as she would like, due to lack of empowerment,

insecurity, feelings of ambiguity or the like. Programmes thus should emphasize self-esteem and self-value, provide elements to handle social and peer pressure, to control a situation, to negotiate with the partner and to communicate more effectively.

In addition, programmes should help the adolescents work out a life plan and to develop skills that will aid to put it into practice, including awareness of the consequences of events that might interfere with it, such as an unplanned pregnancy. They should be given skills to make them protagonists of their own destiny.

*Generate capacity to make informed decisions*

"If the youth is given access to correct details and facts, in all probability he/she will choose the correct option" H.M.A.H Warakaulle, Male, 17, Colombo Sri Lanka

In order to promote responsible behavior, adolescents should be given the elements (skills, awareness and appropriate information) to make decisions, and these should be then fully respected. Programmes should avoid the normative/impositive authority positions which adolescents frequently react against.

*Develop services that are accessible for adolescents*

Services that are separate from adult services and that insure privacy and confidentiality have had much higher success rates. If economic constraints avoid providing installations that are entirely separate from those intended for adults, schedules can be set in the adult services so that only adolescents attend during certain days (for example, during weekends) or certain hours. In addition, services should avoid the requirement of setting up appointments (so that no name has to be made public). Economic accessibility should also be taken into account, for adolescents seldom have enough money to pay the full cost of the services.

*Sensitize health personnel*

Health personnel should be sensitized about the specificity of adolescents' health needs, and should be taught appropriate techniques to deal with them according to the cultural context, with an emphasis on interpersonal communication skills. In many contexts, the authoritarian top-down teaching approach should be avoided. It should also be noted that not all service providers have the ability or the interest to deal with adolescents and this should be taken into account. In addition, the need to link with other sectors should be emphasized, in order to avoid a medicalized approach in dealing with problems that are rooted in social and cultural factors.

*Develop a multidisciplinary approach*

Adolescent's health problems should not be left to the health sector alone to deal with. Programmes will be more effective inasmuch as they promote a holistic approach by integrating education programmes, sports, entertainment and employment, *inter alia*. Sex education programmes should be promoted from a culturally sensitive and meaningful perspective, and teachers should be sensitized and trained taking into account their own cultural constraints to addressing sexual issues. The methodological aspect is a key one, for

the way in which sex education is taught is as important as the contents.

*Create an appropriate environment for the programme*

For a programme to work, it is important to take into consideration both the enabling and the impeding factors from the environment. Both of these are determined to a large extent by cultural factors, and should be studied when assessing the cultural context. A strategy to involve the local community members and leaders including parents, teachers, religious leaders and local authorities should be devised so that they are supportive of the programme. Financial, political and technical support networks are crucial elements of sustainability of the programme, as well as the ability to remain flexible and to adapt to changing needs.

Conclusion

The incorporation of a socio-cultural approach to reproductive health programmes for adolescents contributes largely to their appropriateness and to their ability to meet the needs of adolescents within their cultural specificity and context. This approach may seem to require a large amount of human and financial resources. However, this is not necessarily the case, for a socio-cultural assessment need not be lengthy (a variety of rapid assessment techniques are available) or expensive, and may, instead, insure effectiveness of the resources invested.

Socio-cultural research provides a means to change behavior, for it is based on the understanding of the determinants of this behavior, while traditional approaches frequently succeed in changing attitudes or increasing knowledge but much less frequently have an impact on actual behavior.

The socio-cultural approach increases cost-effectiveness of programmes by avoiding spending resources on areas that do not respond to felt needs or are not culturally relevant, or on approaches that do not adequately reach the intended audiences. In addition, it allows better monitoring and evaluation by providing a sound baseline. In the case of adolescent fertility it is particularly germane given that adolescence itself is culturally defined and that the health, social and economic consequences of very early fertility are culturally determined.

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# ANNEXES

Figure A4

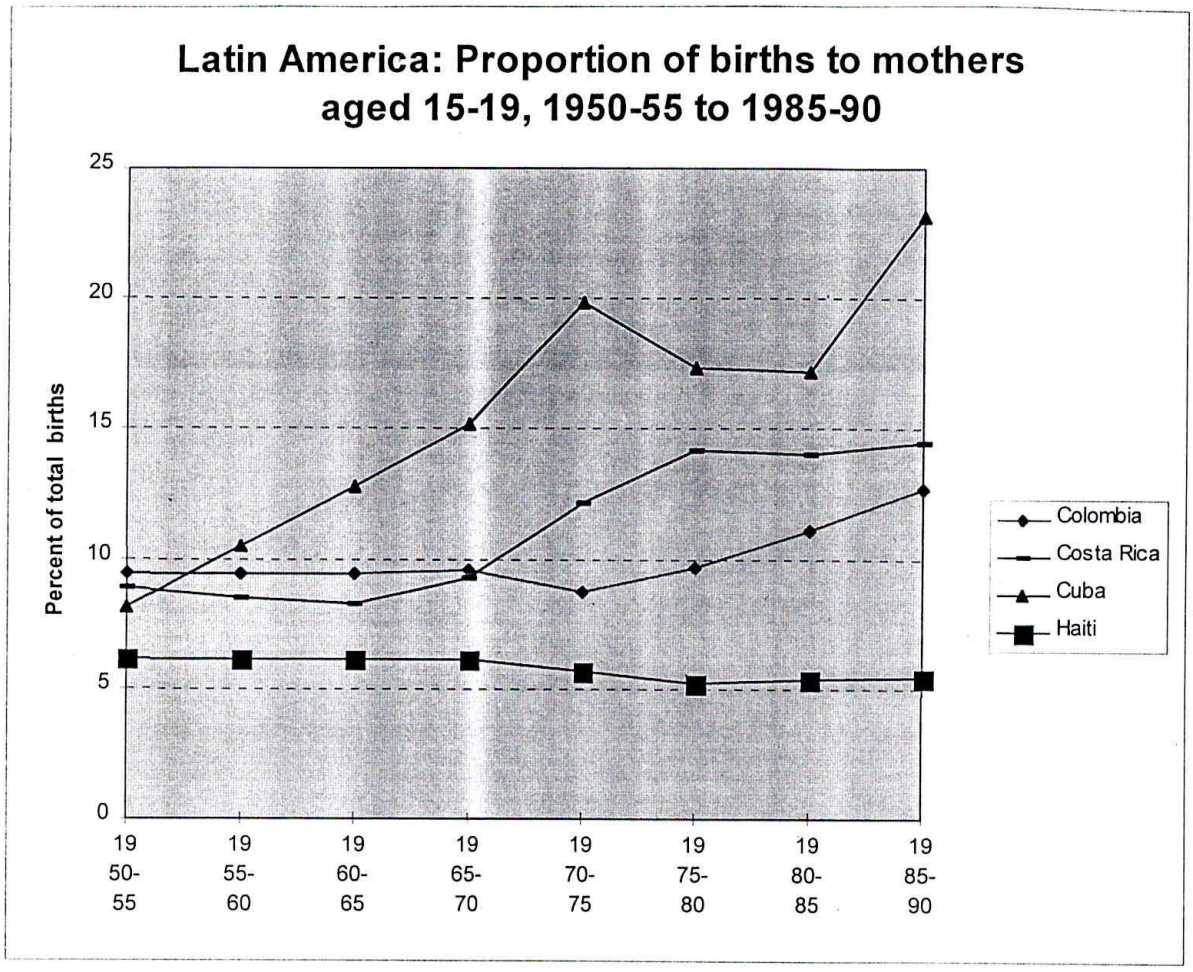

Latin America: Proportion of births to mothers aged 15-19, 1950-55 to 1985-90
Percent of total births
25
20
15
10
5
0
19 50-55
19 55-60
19 60-65
19 65-70
19 70-75
19 75-80
19 80-85
19 85-90
Colombia
Costa Rica
Cuba
Haiti

Figure A5
North Africa (selected countries): Proportion of births to mothers aged 15-19 and variation in the birth rate

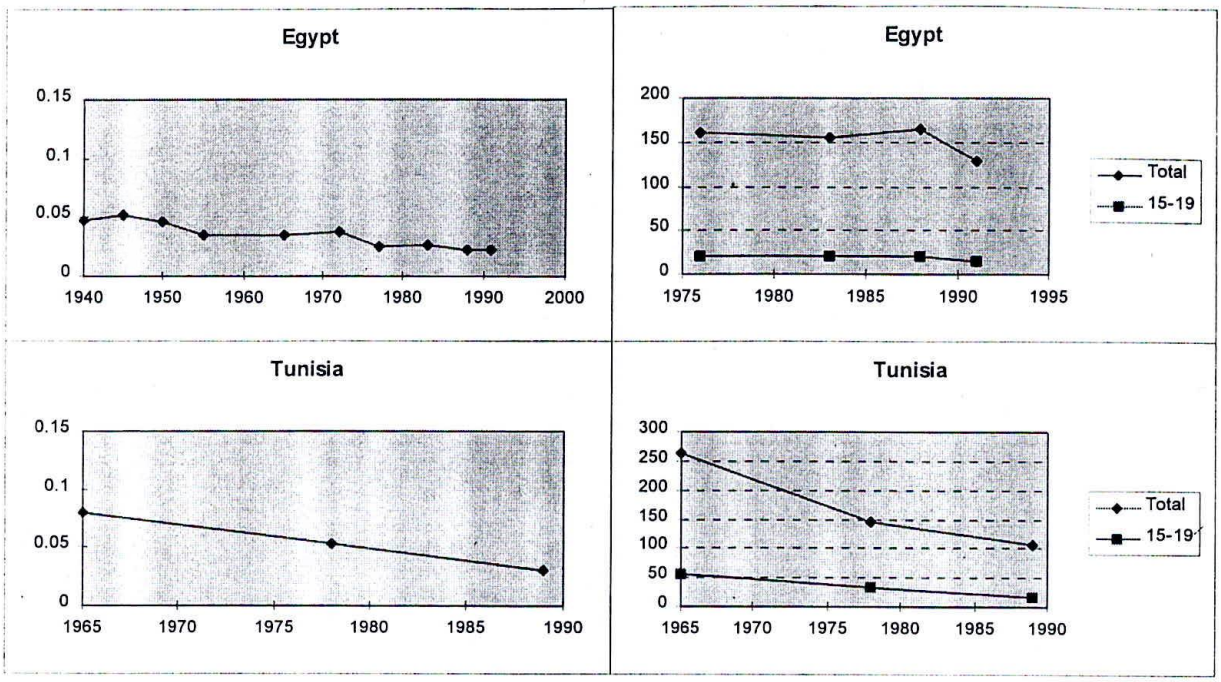
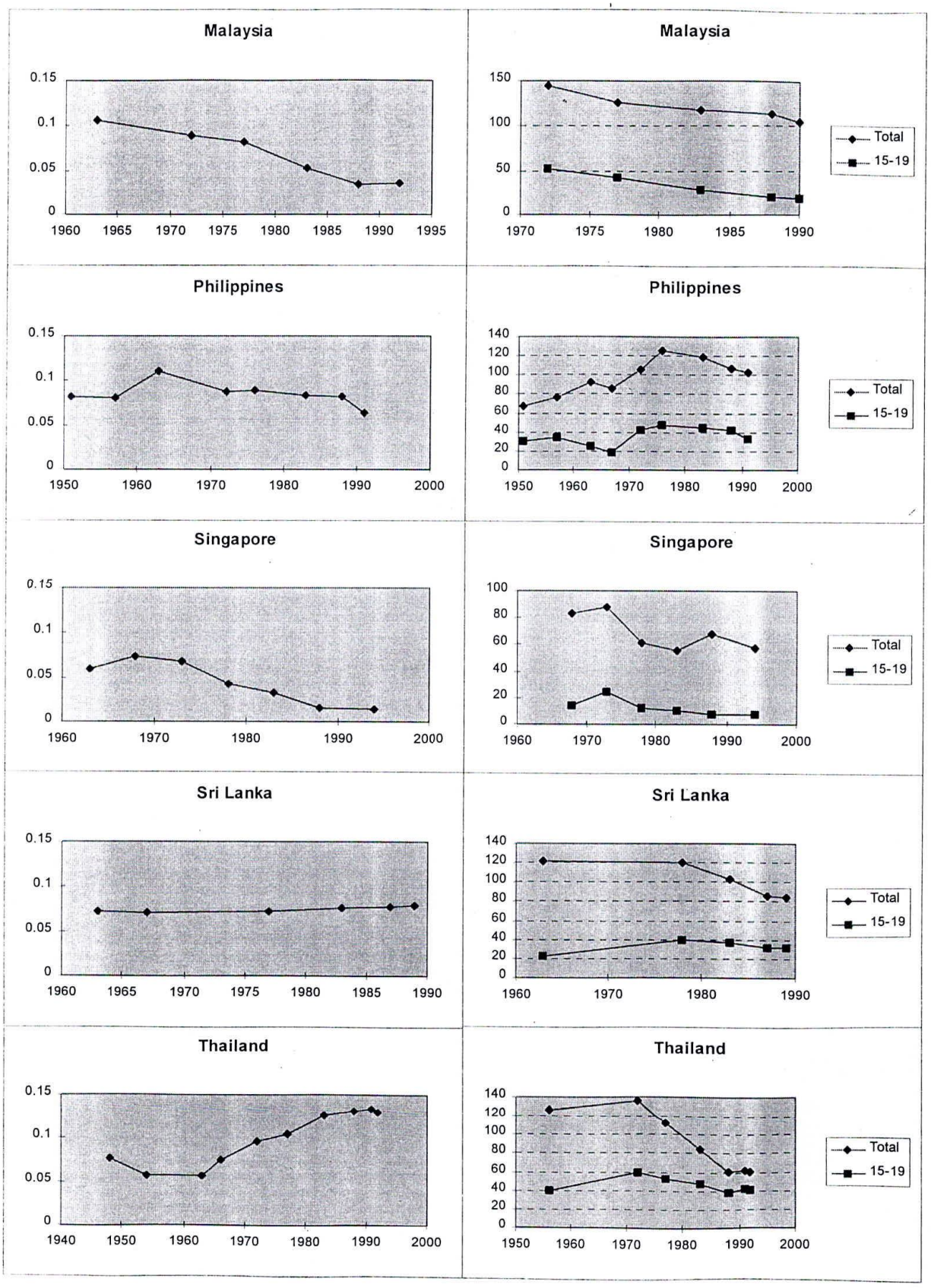


Figure A6
Asia (selected countries): Proportion of births to mothers aged 15-19 and variation in the birth rate



| ADOLESCENT DEMOGRAPHICS WORLDWIDE | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Country and survey year | % population 10-19, 1996 | % women 15-19 in rural areas | % women 20-24 who gave birth by 20 | % women 40-44 who gave birth by 20 | % births to women 15-19, 1996 | % births to women 15-19 unplanned | Median age at first sex 20-24 | Median age at first sex 45-49 | % women who have had sex 15-19 | % women who have had sex 20-24 | Median age at first marriage 20-24 | Median age at first marriage 45-49 | % ever used modern contracept ion 15-19 |
| **Sub-Saharan Africa** | | | | | | | | | | | | | |
| Botswana 1988 | 24 | 69 | 55 | 50 | 14 | 71 | 17.3 | 18.1 | 64 | 98 | 24.9a | 25.1 | 34 |
| Burkina Faso 1992/93 | 22 | 74 | 62 | 57 | 18 | 23 | 17.2 | 17.5 | 18 | 60 | 17.3 | 17.7 | 8 |
| Burundi 1987 | 23 | 96 | 27 | 39 | 6 | 36 | 19.2* | 18.8 | 2 | 8 | 19.5a | 19.7 | 4 |
| Cameroon 1991 | 23 | 58 | 67 | 64 | 19 | 24 | 16.1 | 15.7 | 44 | 87 | 17.3 | 16.0 | 12 |
| Central African Rep. 1994/95 | 22 | 52 | 61 | 59 | 20 | 23 | u. | u. | u. | u. | u. | u. | u. |
| Ghana 1993 | 23 | 54 | 48 | 50 | 15 | 58 | 16.8 | 17.6 | 47 | 83 | 19.0 | 19.0 | 21 |
| Kenya 1993 | 25 | 84 | 52 | 59 | 18 | 52 | 17.3 | 16.8 | 36 | 71 | 19.5a | 18.1 | 14 |
| Liberia 1986 | u. | u. | u. | u. | u. | u. | 15.5 | 15.4 | 72 | 98 | 18.2 | 16.6 | 6 |
| Madagascar 1992 | 23 | 79 | 53 | 60 | 1 | 21 | 17.0 | 16.0 | 36 | 67 | 19.5 | 17.1 | 3 |
| Malawi 1992 | 23 | 88 | 63 | 56 | 18 | 39 | u. | u. | u. | u. | 17.7 | 18.4 | 12 |
| Mali 1987 | 23 | 70 | 67 | 62 | 20 | 18 | 15.9 | 15.7 | 4 | 42 | 15.9 | 15.8 | 4 |
| Namibia 1992 | 23 | 70 | 42 | 38 | 15 | 50 | 18.7 | 20.1 | 37 | 73 | 24.9b | 23.3 | 33 |
| Niger 1992 | 23 | 89 | 75 | 63 | 21 | 11 | 15.0 | 14.9 | 6 | 27 | 15.1 | 15.1 | 1 |
| Nigeria 1990 | 23 | 71 | 54 | 49 | 17 | 10 | 16.6 | 16.5 | 26 | 66 | 17.8 | 17.3 | 2 |
| Rwanda 1992 | 25 | 93 | 25 | 36 | 7 | 40 | 20.2* | 18.4 | 5 | 17 | 20.9a | 18.7 | 9 |
| Senegal 1992/93 | 23 | 54 | 52 | 54 | 19 | 26 | 17.5 | 15.8 | 9 | 34 | 18.3 | 15.8 | 1 |
| Tanzania 1991/92 | 23 | 73 | 57 | 65 | 16 | 20 | 17.3 | 16.4 | 32 | 67 | 19.0 | 17.2 | 4 |
| Togo 1988 | 23 | 59 | 56 | 59 | 15 | 44 | 16.5 | 17.1 | 51 | 84 | 18.6 | 18.7 | 9 |
| Uganda 1988/89 | 23 | 86 | 68 | 69 | 22 | 35 | 15.9 | 15.3 | 36 | 72 | 17.8 | 16.7 | 5 |
| Zambia 1992 | 24 | 46 | 61 | 68 | 17 | 33 | 16.6 | 16.0 | 44 | 80 | 18.6 | 16.6 | 15 |
| Zimbabwe 1988/89 | u. | u. | u. | u. | u. | u. | 18.3 | 16.9 | 16 | 48 | 19.7 | 18.6 | 42 |
| Zimbabwe 1994 | 24 | 73 | 50 | 55 | 14 | 47 | u. | u. | u. | u. | u. | u. | u. |
| **North Africa & Middle East** | | | | | | | | | | | | | |
| Egypt 1992 | 22 | 56 | 29 | 40 | 13 | 16 | u. | u. | u. | u. | 19.9a | 18.3 | 19 |
| Jordan 1990 | u. | u. | u. | u. | u. | u. | u. | u. | u. | u. | 21.2a | 18.9 | 9 |
| Morocco 1992 | 22 | 55 | 19 | 39 | 6 | 22 | u. | u. | u. | u. | 22.3a | 17.6 | 40 |
| Sudan 1989/90 | 23 | 59 | 26 | 61 | 12 | 15 | u. | u. | u. | u. | 20.5a | 16.3 | 5 |
| Tunisia 1988 | 22 | 40 | 13 | 36 | 5 | 23 | u. | u. | u. | u. | 22.9a | 19.9 | 13 |
| Yemen 1991/92 | 23 | 77 | 41 | 35 | 11 | u. | u. | u. | u. | u. | 18.1 | 15.7 | 3 |
| **Asia** | | | | | | | | | | | | | |
| Bangladesh 1993/94 | 24 | 87 | 66 | 85 | 18 | 23 | u. | u. | u. | u. | 15.3 | 13.6 | 35 |
| India 1992/93 | 21 | 73 | 49 | 58 | 9 | 16 | u. | u. | u. | u. | 17.4 | 15.5c | 12 |
| Indonesia 1991 | u. | u. | u. | u. | u. | u. | 19.8 | 17.0 | u. | u. | 19.8 | 16.9 | 38 |
| Indonesia 1994 | 21 | 62 | 33 | 51 | 14 | 12 | u. | u. | u. | u. | u. | u. | 2 |
| Pakistan 1990/91 | 22 | 64 | 31 | 38 | 7 | 9 | u. | u. | u. | u. | 18.9a | 18.8 | |

| ADOLESCENT DEMOGRAPHICS WORLDWIDE | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Country and survey year | % population 10-19, 1996 | % women 15-19 in rural areas | % women 20-24 who gave birth by 20 | % women 40-44 who gave birth by 20 | % births to women 15-19, 1996 | % births to women 15-19 unplanned | Median age at first sex 20-24 | Median age at first sex 45-49 | % women who have had sex 15-19 | % women who have had sex 20-24 | Median age at first marriage 20-24 | Median age at first marriage 45-49 | % ever used modern contracept ion 15-19 |
| Philippines 1993 | 22 | 41 | 21 | 26 | 4 | 41 | 21.9* | 21.1 | under 1% | 2 | 21.8a | 21.1 | 16 |
| Sri Lanka 1987 | 21 | 86 | 16 | 31 | 8 | 28 | u. | u. | u. | u. | 23.2a | 20.0 | 16 |
| Thailand 1987 | 20 | 74 | 24 | 28 | 14 | 31 | 21.0* | 19.7 | u. | u. | 21.0a | 19.5 | 62 |
| Turkey 1993 | 20 | 42 | 25 | 42 | 6 | 22 | u. | u. | u. | u. | 20.0a | 18.3 | 17 |
| **Latin America & the Caribbean** | | | | | | | | | | | | | |
| Bolivia 1993/94 | 22 | 36 | 39 | 39 | 13 | 42 | 19.3 | 18.9 | 8 | 30 | 20.6a | 21.2 | 17 |
| Brazil 1986 | 20 | 26 | 31 | 31 | 17 | 50 | u. | u. | u. | u. | u. | u. | u. |
| Brazil (Northeast) 1991 | u. | u. | u. | u. | u. | u. | 20.0 | 19.7 | 7 | 19 | 20.6a | 20.2 | 58 |
| Colombia 1990 | u. | u. | u. | u. | u. | u. | 20.0 | 19.0 | 9 | 28 | 21.5a | 20.0 | 58 |
| Colombia 1995 | 21 | 25 | 37 | 36 | 16 | 43 | u. | u. | u. | u. | u. | u. | u. |
| Dominican Rep. 1991 | 21 | 32 | 33 | 52 | 18 | 36 | 19.9* | 17.8 | 5 | 9 | 19.8a | 17.7 | 45 |
| Ecuador 1987 | 22 | 40 | 35 | 39 | 15 | 27 | 19.9 | 19.1 | 4 | 16 | 19.8a | 20.5 | 24 |
| El Salvador 1985 | u. | u. | u. | u. | u. | u. | u. | u. | 3 | 3 | 19.1 | 19.1 | 32 |
| Guatemala 1987 | 24 | 63 | 50 | 48 | 17 | 20 | 18.4 | 18.4** | 4 | 10 | 18.9 | 19.1d | 7 |
| Mexico 1987 | 22 | 27 | 35 | 41 | 15 | 33 | 19.8* | 18.9 | 3 | 8 | 20.2a | 19.1 | 38 |
| Nicaragua 1992/93 | u. | u. | u. | u. | u. | u. | 18.2 | 17.8 | u. | u. | 18.6 | 18.2 | 14 |
| Paraguay 1990 | 22 | 50 | 37 | 34 | 14 | 22 | 18.9 | 19.5 | 17 | 48 | 20.8a | 21.0 | 39 |
| Peru 1991/92 | 22 | 21 | 27 | 36 | 12 | 52 | 19.7* | 19.2 | 9 | 23 | 21.8a | 20.7 | 23 |
| Trinidad & Tobago 1987 | 21 | 59 | 30 | 40 | 13 | 39 | 19.3 | 18.2 | 2 | 6 | 19.7 | 18.8 | 58 |
| **Developed Countries** | | | | | | | | | | | | | |
| France 1994 | 13 | 20 | 7 | 15 | 2 | 35※ | u. | u. | u. | u. | u. | u. | u. |
| Germany 1992 | 11 | 13 | u | u | 4 | u | u. | u. | u. | u. | u. | u. | u. |
| Japan 1992 | 13 | 17 | 2 | 4 | 1 | u | u. | u. | u. | u. | u. | u. | u. |
| United Kingdom 1993 | 12 | 10 | u | u | 7 | u | u. | u. | u. | u. | u. | u. | u. |
| United States 1988 | 14 | 24 | 19 | 23 | 14 | 73 | u. | u. | u. | u. | u. | u. | u. |

u. = unavailable

* Median is for women ages 25-29; median for 20-24 was not calculated since less than 50% had sex or had a birth.

** Women ages 40-44

a = Median is for women ages 25-29; median for 20-24 was not calculated since less than 50% had married

b = Median is for women ages 30-34 because median for younger groups was not calculated since less than 50% had married.

c = Women ages 40-49

d = Women ages 40-44

Source: DHS Surveys