

Sexual and reproductive health care for adolescents

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Introduction

Adolescence is a unique developmental period with specific health and developmental needs and rights, influenced by physical and psychological changes. All societies recognise that there is a difference between being a child and becoming an adult. How this transition is defined and recognised differs between cultures and countries.

Adolescence is a phase in which the person starts to develop intellectual knowledge and skills, learns how to manage emotions, relationships and understand sexual identity. One of the characteristics of adolescence is that risky and reckless behaviours are higher than at any other period of development.

Fundamental to quality youth-friendly sexual and reproductive health (SRH) services include healthcare providers (HCP) who are trained to work with this population, as well as easy access to the services. Barriers to youth-friendly clinics are summarised. Health education programmes should offer accurate, comprehensive information that may help adolescents know how their bodies function, and how to build skills for negotiating safe sexual behaviours.

Definitions

The term *puberty* refers to the onset of physical and sexual maturation of boys and girls.

According to the World Health Organization (WHO)¹ *adolescence* is the period of human growth that takes place between puberty and adulthood, which encompasses both physical and psychological development. Persons between the ages of 10–19 years are called *adolescents*.²

Physical and psychological changes in adolescence

The trigger for onset of puberty in both boys and girls is the production of gonadotrophin-releasing hormone (GnRH) from the hypothalamus. GnRH stimulates the pituitary gland

to release follicle stimulating hormone (FSH) and luteinising hormone (LH). These hormones enable the ovaries and testicles to begin the developmental processes which will lead to sexual maturity.³

In females: As puberty progresses, a girl's ovaries begin releasing oestrogen and progesterone. Growth hormones stimulate growth spurts, the development of pubic and underarm hair, form breast mounds, and menarche occurs. Physical and sexual development happens earlier in females than males.

In males: During puberty the testicles will start secreting testosterone, causing the testes to mature and spermatogenesis to begin. Growth hormone and testosterone result in increased sex drive, enlargement of the larynx, deepening of the voice, and increased axillary, pubic and facial hair growth. The adolescent boy's height increases, and during late adolescence the skeletal muscles enlarge and bones become heavier.

The hormones causing physical changes also influence psychological and emotional development. Adolescents have increasing cognitive and intellectual capabilities; begin to think abstractly, and to be concerned with philosophical and social issues. She or he usually wants some independence from parents/guardians. Peer influence and acceptance, relationships and sexuality are significant features of the age.¹

Understanding sexual identity

Adolescence is the age to explore and understand sexuality, to be curious about sexual activities.

Insecurity regarding sexual orientation or gender identity may be issues that concern some adolescents.⁴ Sexual identity is based on three factors:

1. *Biological sex:* Based on genetic XX or XY chromosomes, and the presence of biological characteristics, namely breasts and vagina or testes and penis.

2. *Gender identity*: Gender roles are society's expectations of how people should act based on their biological sex. However, a person's innermost concept of self as female, male, a blend of both, or neither is how we feel about being female or male, and begins at about age three, when children realise she or he is different from the opposite sex. One's gender identity can be the same, or different, from their sex assigned at birth.⁴ If a person identifies with the gender that is opposite from the sex he or she was assigned, that person may wish to change; this is called transgender. It does not mean that a transgender person is homosexual.⁵

3. *Sexual orientation*: Refers to the biological sex that we are attracted to romantically, namely heterosexual, bisexual or homosexual. Sexual orientation is a continuum – people cannot change at will, but may change over time.

Sexual and reproductive health risks

Compared to people of other ages, adolescents are more likely to indulge in high-risk behaviour, often driven by peer pressure, to experiment with alcohol and drugs, to expose themselves to possible harm, and to participate in unprotected sex.

Adolescent development drives the changes in the disease burden between childhood to adulthood, including SRH problems, injuries and mental illness.¹ The sexual and reproductive behaviour may be related to their particular social, cultural, educational and economic environment.⁶

The following points are a brief summation of key findings regarding adolescents' sexual health risks in South Africa, according to the National Adolescent Sexual and Reproductive Health and Rights Framework⁷ and other studies:

- According to several sources an increased number (unspecified) of sexually active adolescents are below the age of 16.^{7,9}
- Some adolescents have multiple concurrent sexual relations and inter-generational sexual partners.^{7,9-11}
- Substance use and abuse (drugs and alcohol) may lead to unsafe sexual practices.^{7,12}
- Low levels of consistent condom usage during sex have been reported.^{7,9}
- Compromised quality of antenatal care for pregnant adolescent women appears to lead to higher levels of maternal mortality. Illegal or "backstreet" termination of pregnancy (TOP) remains a problem, especially amongst adolescents.^{7,13,14}
- Sources state that there are high levels of HIV and AIDS among young people, especially teenage girls.^{7,9,15}
- There are reports of increased levels of treatment of adolescents, especially females, for sexually transmitted infections.^{7,16}
- Vulnerability to sexual violence arising from contextual factors such as poverty and the disruption of the family continue to be high risks for adolescents.^{7,11,17}

On the plus side, there appears to be an increase in medical male circumcision in adolescent years conducted largely within hospital settings.^{7,9,18}

Unplanned pregnancies and STIs are two of the possible outcomes for adolescents who engage in risky unprotected sex.

Teenage pregnancy: Just before, or after the onset of menstruation, if the young woman is sexually active, she may get pregnant. Unplanned pregnancies can affect the health and wellbeing of adolescents. Possible negative effects of teenage pregnancy include not finishing school, thus limiting the girl's educational and employment opportunities. This can in turn cause poverty. It is often incumbent on adolescent girls or their families to carry the burden of child rearing.

Sexually transmitted infections (STI): Unprotected sex may result in STIs, some of which can lead to lifelong infections such as HIV, genital herpes and genital warts (caused by human papilloma virus which can trigger cervical cancer). Other STIs such as gonorrhoea and chlamydia may lead to infertility.

Adolescent sexual and reproductive health rights

The rights of all persons are outlined in Chapter Two of the Constitution of South Africa which contains the Bill of Rights.¹⁹ In the context of adolescent SRH, these include the rights to access health care including reproductive rights. Additionally, there are a number of acts and policies that safeguard adolescent SRH rights, namely:

- *Choice of Termination of Pregnancy Act*²⁰ which states "In the case of a pregnant minor, a medical practitioner or a registered midwife, as the case may be, shall advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated: Provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them".
- *The National Adolescent Sexual and Reproductive Health and Rights Framework*⁷ is aimed at persons aged between 10–19 years. It specifies adolescents' rights to access health education, information and healthcare services regarding SRH. It specifies that adolescents' decisions must be free of discrimination, coercion and violence. The document acknowledges and includes those under-served groups such as lesbian, gay, bisexual, transgender and intersex (LGBTI) persons, sex workers and HIV-positive youth.
- *The 2005 South African Children's Act*²¹ enables youth aged over 12 years to access services including contraception, TOP, STI management, HIV counselling and testing (HCT) and condom provision, without parental consent, and safeguards confidentiality.
- *The 2012 Integrated School Health Policy (ISHP)*²² states that learners in secondary schools should receive SRH counselling, and contraceptive services may be

provided for learners by an on-site nurse or via referral to a healthcare facility offering the services. However, the provision of SRH services in some schools has been contested by parents or school bodies.^{13,23}

Youth-friendly primary healthcare clinics

Ideal youth-friendly clinics are where adolescents feel free to access SRH services and information, and exercise personal choice. Access to a clinic should be at a time separate to the hours for the general clientele. Many clinics use afternoon time for teens. Some clinics are able to offer outreach programmes to a variety of groups, such as high schools.

Staff at all levels in the clinic must be friendly, knowledgeable, non-judgmental, approachable and available, to help in decision-making. Confidentiality assurance is very important.

Services offered at youth-friendly clinics should incorporate the following services:

Health education and counselling: SRH discussions with adolescent girls should include types of contraceptives available, including emergency contraception and access to TOP, the recognition of STIs and access to treatment. Focus groups and discussions with some adolescent girls show that they are not always able to negotiate safe sex.²⁴

Adolescent males seldom access clinic services, but SRH education should include information regarding possible STIs. Males of all ages in SA are notoriously ill-informed about female contraception.²⁴ This may result in female partner pregnancy and low rates of paternal responsibility and maintenance.

HCT must be easily accessible to educate, detect and manage HIV among young people.

Contraceptive methods: It is important to expand contraceptive use to sexually active adolescents, and most methods of contraception are suitable for adolescents. Long-acting reversible contraceptives (LARC) include:

- Copper intra uterine device (IUD), this can be inserted into nulliparous women in some cases.
- Sub-dermal contraceptive implants such as Implanon.

Other reversible contraceptives are:

- Combined oral contraceptives (COC) such as Trigestrel or Oralcon.
- Injectables, Depo-Provera/Petogen and Nur Isterate (NI).

Note: There is no evidence that NI should be given to adolescents instead of Petogen, both are suitable. Petogen does not have a detrimental effect on bone mineral density (BMD) in adolescents, and can be given to young women who are nulliparous. NI had traditionally been used for young women due to perceived anxieties regarding BMD issues, and the possibility of less menstrual chaos. If an injectable contraception method is chosen, Petogen is preferred due to cost and service delivery issues.²⁵

Contraceptive health education must include discussions about change in menstrual patterns, the return to fertility, possible side-effects of the methods. If adverse side-effects occur, a change of method should be initiated. Nurses should be aware of the likelihood and ability of adolescents to comply with a method of contraception, as this may depend on her age, her partner/s, pressure from peers or family, and most importantly, her knowledge of how the contraceptive may affect her.

Care for pregnant adolescents: This includes provision of antenatal care, or non-biased counselling and referral for TOP, as it is imperative to reduce levels of unsafe abortion through increasing access to safe abortion services.

The prevention and management of STIs including HIV: Prevention of STIs requires dual protection with condoms, and the awareness of signs and symptoms of STIs. Management of STIs involves assessment and the correct syndromic treatment of a person who has an STI.²⁶ Detection of asymptomatic STIs is a challenge, and all sexually active adolescents should be screened for STIs, regardless of age or clinical presentation. HCT can improve detection and management of STIs.²⁶

Barriers and challenges to the provision of youth-friendly health services

Research has identified several difficulties with delivery of successful youth-friendly facilities.

Lack of appropriately trained staff: It has been argued that the single most important barrier to care is provider attitude. Many HCPs deter adolescents from using services because of their judgmental attitudes, disrespect, or lack of consideration of their patients' needs.^{27,28} Misinformation about contraceptive methods, unacceptable side-effects, and provider biases are significant barriers to initial uptake.²⁷⁻²⁹ HCPs can also influence method choice and continuation, intentionally or unintentionally, through sub-standard or biased counselling. Almost all of the issues identified through research that are said to be barriers to contraceptive use or continuation, could be addressed through improved counselling and support from HCPs.³⁰ Some HCPs are concerned about potential contradictions in the law, specifically the Sexual Offences Act³⁰ which stated that children may only freely consent to sex at 16 years. The need to report under-age sexual activity has been extensively criticised, and the act has been amended, but some HCPs feel uncomfortable with these changes.^{30,31}

Confidentiality issues: Some adolescents may be restricted because of fear of peers, family members, or teachers finding out that they are sexually active, which may result in violence, embarrassment, misinformation, stigma, and shame.²⁸

Poor information regarding contraceptives: Many women, regardless of age, are influenced by myths, such as "contraceptives cause infertility", "they induce back up of blood", amongst many others. Young women who

experience side-effects, especially changes in menstrual patterns, are not always informed that menstrual chaos is a normal side-effect of most contraceptives.^{28,30}

Service-related supplies and space infrastructure: Services are often hampered by erratic availability of supplies and equipment. With the expansion of services, concerns regarding implementation, feasibility, effective service delivery and sustainability have been raised.^{13,28,30} Lack of integration is seen where services that might address counselling and contraception fail to include HIV/STI care. Clinic size and physical accessibility can restrict adolescents' access to existing services.^{28,30}

Lack of awareness: Adolescents are not always aware of SRH services at local and community level.

Conclusion

South Africa's laws, policies and guidelines on adolescent SRH care and contraceptive service provision in the public sector are progressive, and promote integrated, rights-based service delivery. Many adolescents are sexually active, so it is incumbent upon SRH providers to enable young people to maintain healthy sexual and reproductive organs to preserve procreative ability, as well as experiencing non-violent, safe sexual relationships. Clinics should strive to provide excellent youth-friendly SRH services staffed by well-trained HCPs.

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