Report

RISK AND PROTECTIVE FACTORS AFFECTING ADOLESCENT REPRODUCTIVE HEALTH IN DEVELOPING COUNTRIES

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CHAPTER 1: INTRODUCTION

INTRODUCTION

As is true for every age group, youth* today live in multiple social centers that shape their attitudes and behaviours. One such force is globalization of both the "youth culture" and the world's economy. But there are other forces as well – forces that are more proximal to individual young people including changes at the national and community levels (e.g., the shift from rural to urban living), and in the family, schools, and the workplace.

All of these environments are interconnected in shaping how young people act and interact; and each can be a source of risk or protection to young people. Historically, the field of adolescent health has focused on those risk factors that predispose to health and social problems such as HIV/STI acquisition or early pregnancy; and interventions have focused on reducing risk and risky behaviours that lead to poor outcomes. There is a growing body of research, however, that suggests that one may achieve greater improvement for youth by focusing not only on those factors that predispose to risk, but also on those factors that protect young people from harm. However, to optimize outcomes for young people we need to know both those factors that predispose to risks and those that are protective. Such is a risk and protective framework. By definition, factors are called "protective" if they increase the likelihood of positive health behaviours or outcomes (e.g., using condoms and contra-

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* While the WHO defines youth as being between 15 and 24 years of age in the present report we use adolescence and youth interchangeably.

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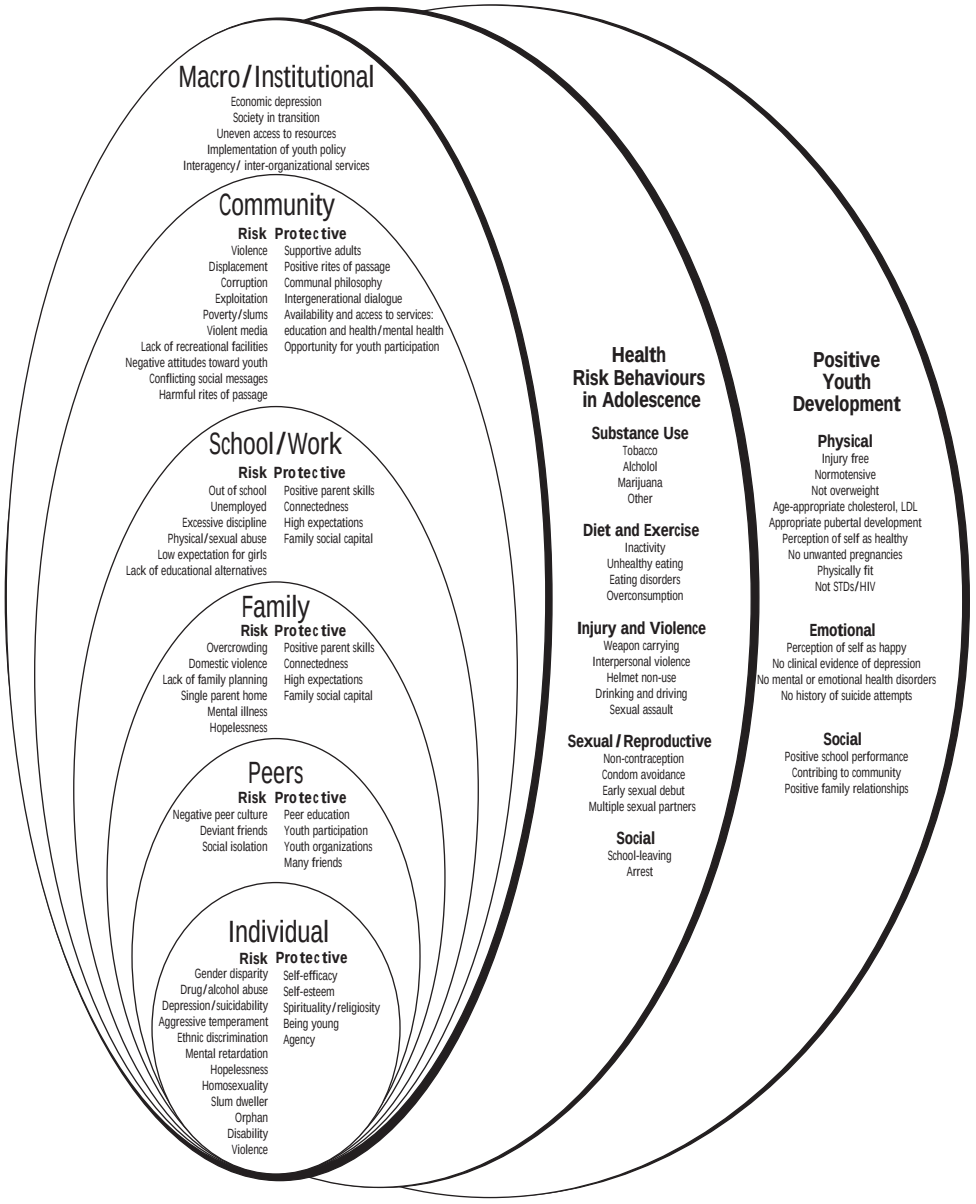
ception) or moderate and discourage behaviours that might lead to negative health outcomes (e.g., having sex with many partners, having an unwanted pregnancy). Similarly, factors are labeled "risk" if they increase the likelihood of negative health behaviours and outcomes or discourage positive behaviours that might prevent them (Kirby, 2002). Given the tremendous individual and societal burdens of many risky adolescent sexual and reproductive health behaviours (e.g., commercial sex work, failure to use a condom when having sex, abusive relationships, polygamy), we need to better understand what research from developing countries has taught us over the past 15 years and where we need to be headed.

The present report is guided by a risk and protection framework that views a young person as nested within multiple contexts (e.g., nation, community, family, etc.) To the right is an illustration of the framework showing the more distal factors in the outer rings and the more proximal factors in the inner circles. Such a framework is meant to show that the more distal factors also affect the more proximal behaviours of the individual. For example, national laws and policies about adolescent health may affect adolescents' access to reproductive health services, their perceived knowledge and atti-



tudes to reproductive health services, and motivation to get treatment or contraceptive services. In this framework, many of the more distal non-sexual factors first affect the more proximal factors, which in turn will affect the sexual behaviours of adolescents.

To identify the risk and protective factors that are associated with adolescent sexual and reproductive health in developing countries, the World Health Organization's Adolescent Health Programme, Department of Child and Adolescent Health commissioned the WHO Collaborating Centre at the University of Minnesota's Center for Adolescent Health to review the literature from developing countries on risk and protective factors as they relate to adolescent sexual and reproductive health, to synthesize that literature and to identify what is known and where future work is needed. The project was divided into two phases, the first of which was a complete review of the published and unpublished literatures on a set of adolescent sexual and reproductive health topics from 1990 to the present. For this phase, the University of Minnesota worked with ETR Associates to create a comprehensive database on the world's literature that related to adolescent reproductive health. The database currently contains over 11,000 references from every region of the world. To retrieve the relevant articles to this review, the following selection criteria were used:

- Conducted in a developing country
- Examined the risk and protective factors for the initiation of sex, number of sexual partners, condom use, contraceptive use, pregnancy, childbearing, HIV and other sexually transmitted diseases (STDs)
- Included a sample of at least 100 young people, aged 10-24 years
- Published in 1990 or later
- Used multivariate analysis to analyse the association between risk and protective factors and the outcome

From the database, a total of 289 articles were retrieved that appeared to meet the above criteria. For the second phase, all 289 articles were reviewed to ensure that they actually did meet the criteria. Once this was completed, 158 articles were more thoroughly reviewed and synthesized. For more details on the methodology, please refer to Appendix 1.

CRITERIA FOR RISK AND PROTECTIVE FACTORS

To be considered a key risk or protective factor in this report, more than one study had to find the factor to be significantly associated with the outcome. In studies that examined the factors in several countries, each country that found it significant was also incorporated into the overall count of studies that found the factor significant.

A few points of caution should be noted by the reader. Although the majority of studies in the review focused on unmarried adolescents, there were several studies that included married adolescents and adults in the sample, as well as a few that only sampled married adolescents. This was particularly evident for the studies on contraception and childbearing. For example, for contraception, there were four studies that sampled only married adolescents, eight studies that sampled only unmarried adolescents, and nine studies that included both married and unmarried adolescents and adults in the sample, but did not stratify them into separate groups. Clearly, married and unmarried adolescents have different levels of unmet need for contraception and the factors related to contraceptive use are theoretically different between married and unmarried. However, since the majority of studies did not

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stratify the studies according to marital status, the findings on risk and protective factors are applied to both married and unmarried adolescents. The same is true for childbearing.

Similarly, although factors that influence sexual risk behaviours differ greatly between males and females, the majority of studies in the review did not separate the two groups in the analyses. Under the "Description of Studies" presented with each outcome in this report, the number of studies that stratified males and females, and the number that sampled either just males or females will be listed. What is clear is that there were too few studies that conducted separate analyses among males and females for us to make any definitive conclusions on specific gender differences. The one exception is sexual initiation, which was the most studied outcome in this review, and a chart illustrating the gender differences is presented.

THE MAJORITY OF STUDIES WERE CONDUCTED IN SUB-SAHARAN AFRICA. THE EXCEPTIONS WERE PREGNANCY AND CHILDBEARING, LARGELY CONDUCTED IN LATIN AMERICA AND SOUTHEAST ASIA.

Finally, before this review was conducted, it was anticipated that risk and protective factors would be analysed according to world regions. However, because there was an uneven regional representation of studies available for this review, it was not possible to do this. For most of the outcomes, the majority of studies were conducted in Sub-Saharan Africa. The exceptions were pregnancy and childbearing, for which the majority of studies were conducted in Latin America and Southeast Asia, respectively. Thus, readers should note that these findings are not representative of all developing country regions.

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