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REPRODUCTIVE HEALTH IN THE SAHEL

YOUTH IN DANGER

*Results of a regional survey
in five West African countries*



METHODOLOGICAL NOTE

The research presented in this booklet included both a qualitative component and a quantitative component.

The qualitative component enabled each of three countries (Burkina Faso, Mali and Niger) to conduct 18 "focus groups" for adolescents, 6 "focus groups" for the mothers and fathers of adolescents, and 27-30 individual interviews with key informants (e.g., family planning service providers, religious leaders, village heads, teachers).

All the information was transcribed and analyzed through TALLY software. A national report is available for each of the three countries included in this component.

The quantitative component centered on an in-depth analysis of contraceptive data collected in the sub-region: the Demographic and Health Surveys (DHS) carried out in Mali (1987), Niger (1992), Senegal (1992-3), and in Burkina Faso (1993); The Gambian Study on Contraceptive Prevalence and Fertility Determinants (1990), and the Preliminary Study for the Promotion of the National Logo for Family Planning in Mali (1994).

The heads of family planning programs and demographers from the five countries in the study were of great assistance in the preparation of the preliminary draft of this booklet during a workshop hosted by CERPOD in Bamako on the dissemination of results.

This final version, the product of a group effort, is the result of a specific methodological approach. An instructional format was adopted to facilitate its use in activities designed to raise awareness and inform.

Cover Photo : Kaly/ENDA

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INTRODUCTION

This booklet is one of the outcomes of a survey initiated by CERPOD (Center for Applied Research on Population and Development) on the reproductive health of adolescents (ages 15 to 19) in the Sahel region. Specifically, the study was conducted in five of the CILSS (Permanent InterState Committee for Drought Control in the Sahel) countries: Burkina Faso, Gambia, Mali, Niger, and Senegal.

Why study the reproductive health of adolescents in the Sahel rather than the reproductive health of all women of childbearing age?

While adolescent girls have problems that they share with older women, those that are specific to them must be taken into account by the different people whose actions or decisions can affect their health and well-being. Among the problems to take into account are the following:

- ▶ *adolescence is a period of physical immaturity during which adolescents are more exposed to risks if they become sexually active too young or begin having children too soon. Risks include miscarriages, premature or difficult births, complications, permanent side effects, etc.*

- ▶ *adolescence is the period when a girl is still too young to face the responsibilities of motherhood. Problems that might arise include unwanted pregnancies, lack of medical attention during pregnancy, illegal abortions in unsafe conditions, infanticide, interruption of studies, rejection by a society in which a transgression of moral norms has occurred, etc.*

AIDS has shattered all the realities of sexual behavior. Before the advent of AIDS, a youthful mistake might lead to STDs. Today, the same mistake may cost a life. This especially holds true for adolescent girls who are more vulnerable.

Beyond these medical, economic, and social considerations, the demographic dimension of the problem of adolescent mothers, proven by studies carried out over the last few years, justifies the priority focus that should be given to this group.



Within the nine member countries of the CILSS, whose population totals approximately 49 million, the sub-group consisting of adolescents represents one fifth of the women of childbearing age (2.4 million).

The survey was designed to better know and understand the importance of adolescent sexual behavior: the evolution and differences in sexual behavior; knowledge and attitudes towards family planning (FP), reproductive health, and AIDS; differences in use of contraceptives between single and married adolescent girls over the last 15 years; and finally, the differences in use of contraceptives among married adolescent girls and other married women.

The results presented here highlight the complexity, sensitivity, and urgency of the problems pertaining to adolescent reproductive health. They do not, however, answer all the questions. They are addressed to a certain number of key actors in Sahelian society: health care workers, teachers, religious leaders, decision makers, researchers, youth group leaders, parents, and adolescents. For this reason, within each of the themes covered in this booklet, two or three discussion topics have been framed to inspire the reader to discuss these issues with other people.

Through existing family planning programs and programs for the prevention and treatment of STDs, the research results should contribute to the design of appropriate strategies to improve the reproductive health of adolescents in the countries covered in the study. It is for this purpose that the heads of family planning programs in Burkina Faso, Gambia, Mali, Niger, and Senegal, representatives of financial partners, and interested NGOs were involved in the dissemination phase of the project.

The study on the reproductive health of adolescents in the Sahel received financial support from USAID's Bureau for Africa/HHRAA (Health and Human Resources Analysis for Africa) Project through the SARA (Support for Analysis and Research in Africa)/AED Project. Technical assistance came from the following SARA Project subcontractors: Africa Consultants International, Macro International, Population Reference Bureau, and Tulane University. Additional support was provided by researchers from Johns Hopkins University, Department of Population Dynamics.

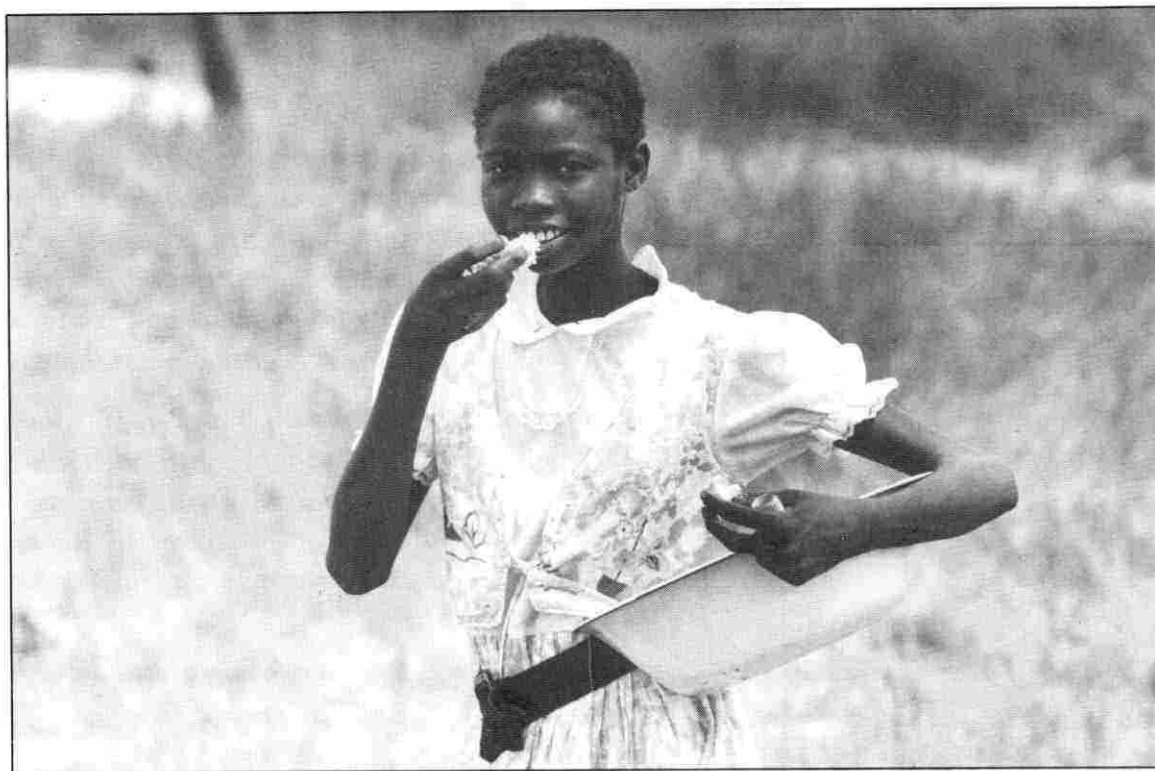


Photo UNICEF/G. Pirozzi



REPRODUCTIVE HEALTH IN THE SAHEL
YOUTH IN DANGER

THEME 1

AGE AT FIRST MARRIAGE

Owing to customs and practices, the age at first marriage in the Sahel is among the lowest in the world.

Different studies highlight two facts linked to reproductive health:

- ▶ there is a high proportion of early marriages, especially in rural environments; and
- ▶ there is a tendency among women to delay marriage, mostly in urban environments.

Owing to customs and practices, the age at first marriage in the Sahel is among the lowest in the world.

Marriage is generally followed by a pregnancy when an adolescent girl is still physically immature and has a pelvis that is not yet fully developed. The medical consequences of these early marriages are considered public health problems: abortions and premature or difficult labor leading to high rates of C-sections; torn perineum and other complications such as fistula; genital infections that may often cause sterility; newborn trauma; and low birth weight. Furthermore, cancer of the uterus is more frequent among women who become sexually active (or marry) before the age of 17.

Research increasingly points to the fact that an adolescent girl (aged 15-19), due to her physiological immaturity, is more vulnerable to the HIV virus (the virus that causes AIDS) than an adult if she has sex with an infected person.

Despite their importance, these consequences are too often ignored by a large proportion of the population in the Sahel. Young age at first marriage is often even perceived as a factor contributing to the stability of a community.

EARLY MARRIAGES

LEVELS

In rural areas

In rural areas in the Sahel, a substantial number of marriage celebrations still occur before the age of 15 among the younger generations: 17 percent in Gambia and 19 percent in Senegal. In Niger, almost one out of every two marriages (45 percent) is celebrated before the age of 15. **(Graph 1.1a)**

In the capitals

Early marriages (before the age of 15) are very rare among the younger generations in Dakar (3 percent) and Ouagadougou (5 percent). However, the level is significantly higher in Niamey (12 percent) and Bamako (16 percent). **(Graph 1.1b)**

In other cities

In other cities in Burkina Faso, Gambia and Senegal, the current situation is comparable to that of the capitals. Only 5 to 6 percent of girls who attain their fifteenth birthday are married. On the other hand, in other cities in Niger, it is estimated that one quarter of the girls get married before they turn 15.



Drawing by Samba FALL

*** Woman:** "Since I had my first child when I was 12, I have not been able to retain my urine. My husband has taken a second wife!"

Man: "...she's the one who cast a spell on you! The spirit's tell me so..."

Incontinence urinaire après accouchement

LE DRAME DES FEMMES FISTULEUSES

Elles sont devenues presque des parias de la société, alors même que c'est cette société (en fait leur entourage immédiat) qui les a mises dans un tel état; une situation on ne peut plus douloureuse. Elles ? Ce sont ces femmes victimes de ce qu'on appelle les **fistules uro-génitales** ou dans d'autres cas, des **fistules recto-vaginales**. Leur cauchemar est pratiquement méconnu du grand public, et ces femmes ont un dénominateur commun : c'est qu'elles perdent en permanence de l'urine (parfois mélangée à de la matière fécale) qui, plus est, pas par la voie normale (l'orifice), mais par le vagin. En effet, par définition, les fistules uro-génitales se présentent comme une communication anormale entre les voies urinaires et les voies génitales, entraînant de ce fait la perte continue des urines par le vagin. Dans certains cas, on note également la perte des selles (matières fécales) par le vagin. On parle alors de fistule recto-vaginale. Qu'il s'agisse de l'une ou de l'autre, les victimes sont «complexées» par l'odeur qu'elles dégagent... Elles sont nombreuses ces femmes (en majorité mère de famille) qui souffrent, dans notre pays, de telles complications. Actuellement, on compte une trentaine de patientes à l'Hôpital national de Niamey; et il y en a aussi au CHU. Ce sont d'ailleurs les deux principaux hôpitaux qui interviennent sur les fistules.

L'incontinence urinaire est un sérieux handicap pour les femmes qui en sont victimes. Responsables de la santé, assistants sociaux ne cachent pas leur amertume pour souligner que l'odeur liée aux fistules uro-génitales constitue apparemment un facteur de marginalisation dans la société. Il est douloureux en effet de constater que la plupart des «fistuleuses» hospitalisées sont abandonnées par leurs maris et même leurs parents. Cet état de fait nous a été confirmé par les patientes elles-mêmes que nous avons rencontrées à l'hôpital de Niamey : **Baraka A.** a aujourd'hui 30 ans, elle a été mariée à l'âge de 16 ans dans son village de Douthi. L'année d'après son mariage, elle a eu sa première grossesse et des complications ont surgi au moment de l'accouchement. D'où sa fistule qu'elle traîne depuis lors car Baraka est à son deuxième séjour à l'hôpital de Niamey. Son mari ? «Depuis que je suis là, il n'est jamais venu me voir, nous avons une fille.» En fait ajoute-t-elle avec un sourire crispé, «j'ai appris que j'ai une coépouse». Il convient de noter que, outre l'absence de visites de son mari, B.A. est seule à l'hôpital. Ceux qui l'ont accompagnée ont depuis longtemps regagné le village et ne sont plus revenus. «Je veux bien retourner à la maison, dit-elle mais pour faire quoi tant que je ne me suis pas débarrassée de mon mal.»

Baraka n'a pas eu la même chaleur affective et conjugale que **Halima I.**, originaire elle du Nigéria (Kanguwa) qui, mariée à l'âge de 15 ans, a eu sa première grossesse 3 ans plus tard et dont l'accouchement s'est soldé par une césarienne (opération chirurgicale pour sortir l'enfant). Halima, est à son deuxième séjour pour traitement et est à l'hôpital depuis six mois. Elle est ac-

Résultat des mariages précoces

Le traitement des fistules uro-génitales est toujours chirurgical. Il consiste, explique le Dr Ganda Oumarou, à supprimer la communication, entre la vessie et le vagin. Il peut être simple avec un taux de réussite élevé. Il existe des fistules complexes ou la guérison ne pourra être obtenue qu'après plusieurs opérations (de 2 jusqu'à 10 fois). Mais malgré tout dit-on, les récurrences sont fréquentes, ce qui fait que certaines malades sont pratiquement condamnées à vivre le restant de leurs jours dans un centre hospitalier. Véritable tragédie décidément pour un mal qu'on peut

SAHEL DIMANCHE/
1er MARS 1991
(NIGER)

* Urinary incontinence following childbirth
THE TRAGEDY OF WOMEN WITH FISTULA

(Headline translated from Sahel Dimanche, Niger, March 1, 1991, a daily french language from Niamey.)

TRENDS

In the different rural areas (**Graph 1.1a**), there is no distinctive trend pointing towards a decrease in the number of early marriages, despite the high levels which are generally observed there.

In Bamako, Niamey and Dakar, there is a marked decrease in the number of marriages before the age of 15. (**Graph 1.1b**)

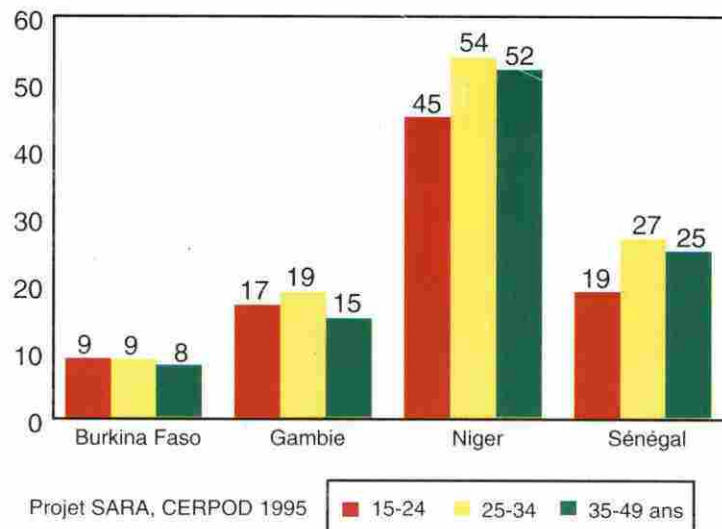
This decreasing trend varies widely in other cities:

► In Niger and in Senegal, there is an important decrease in the frequency of early marriages,

► However, this trend is harder to establish in Gambia.

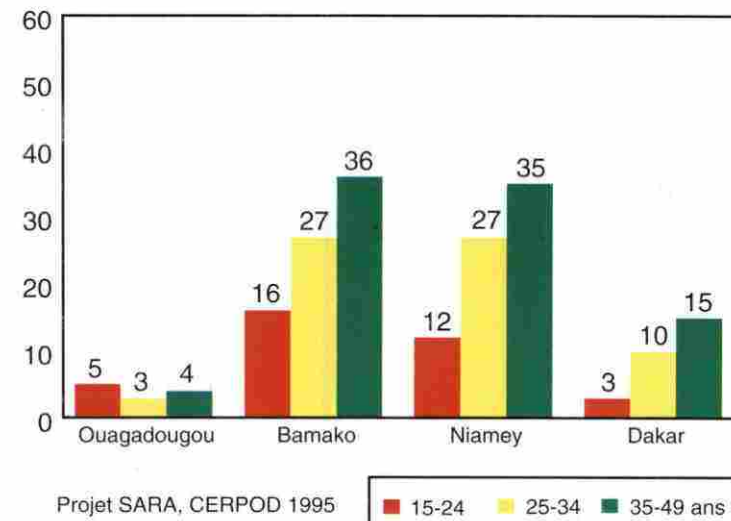
In Burkina Faso, whether in urban or rural areas, the number of early marriages has always been very low. Even for the oldest generations, the estimates do not reach 10% in the countryside nor in the towns.

GRAPH 1.1a - PROBABILITY THAT GIRLS IN RURAL AREAS WILL MARRY BEFORE THE AGE OF 15 FOR THREE AGE GROUPS (15 TO 24, 25 TO 34, AND 35 TO 49)



1. Early marriages are generally common in rural areas in the entire Sahel region. However, there are sharp contrasts between countries. It is a much more common occurrence in Nigerian rural areas than anywhere else.
2. Data do not show a definite trend towards a reduction in the number of early marriages in rural areas.

GRAPH 1.1b - PROBABILITY THAT GIRLS IN CAPITALS WILL MARRY BEFORE THE AGE OF 15 FOR THREE AGE GROUPS (15 TO 24, 25 TO 34, AND 35 TO 49).



1. Note Ouagadougou, where the number of early marriages is very low regardless of the age group.
2. In all other capitals, the number of early marriages is higher for the 35 to 49 age group, indicating that early marriages are becoming less frequent over time.

In rural as well as in urban areas, girls who attend school are far more likely to avoid early marriage than girls who do not.

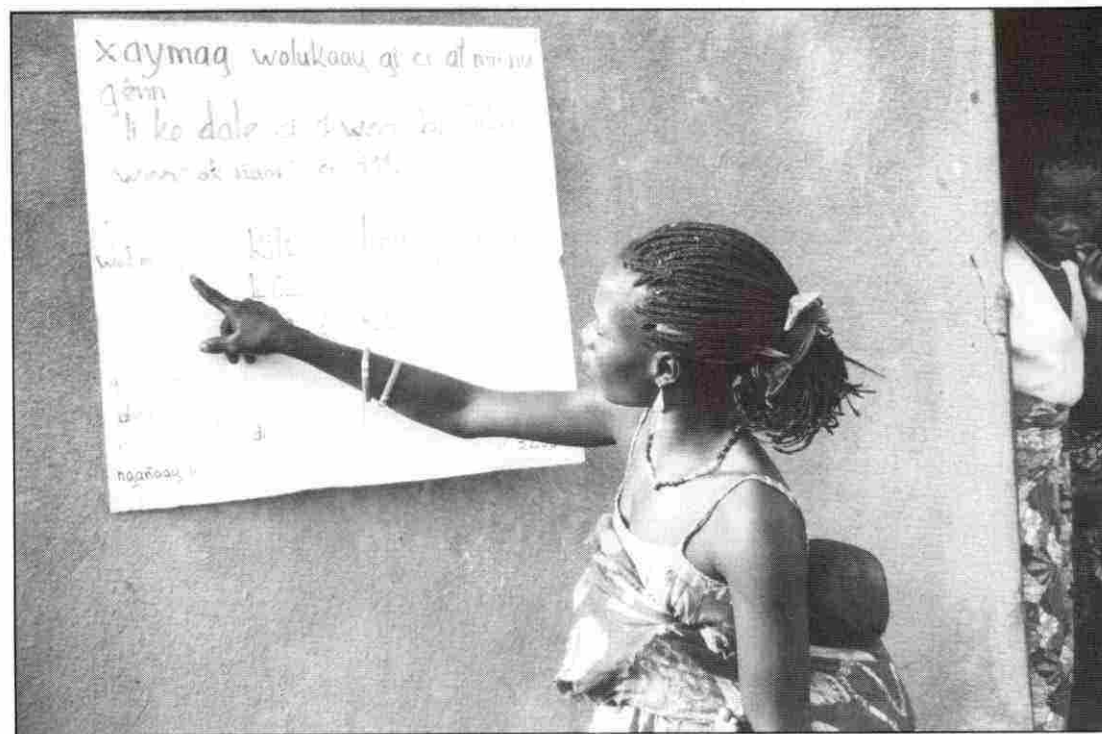


Photo UNICEF/G. Pirozzi

EARLY MARRIAGES AND GIRLS' SCHOOLING

In the countries as a whole, in rural as well as urban areas, girls who attend school are more likely to escape early marriage than girls who do not. The prevalence of early marriage is particularly high in Nigerian rural

areas. Among girls attending school, the percentage of marriages is approximately 26 percent versus 51 percent among girls not attending school who have reached their fifteenth birthday.

DISCUSSION TOPICS



■ What advantages do societies derive from early marriages?

■ Given the dangerous impact of early marriages on the health of mothers and children, how should the problem of early marriages be addressed, especially in rural areas?

*With urbanization,
there is an increasing
number of single women
aged 20 and over*

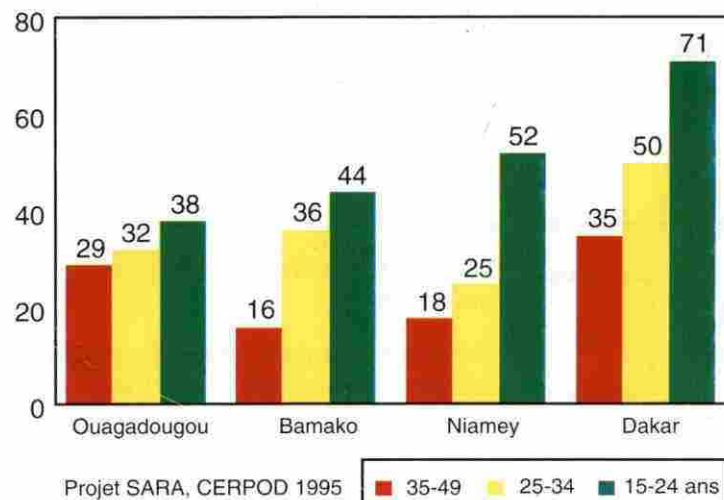
TWENTY YEAR OLD SINGLE WOMENS

In traditional Sahelian societies, it was rare to find girls who were still single at 20. Society had a difficult time accepting that a woman should be unmarried at that age, unless she was handicapped or seriously ill. Divorcees and widows were encouraged, and often

forced, to remarry. But with urbanization, an increasing number of women are still single at 20.

Among these single women, a growing number is sexually active. This exposes them to unwanted pregnancies, abortion and its consequences, STDs, and, increasingly, AIDS. On a social level, these problems can lead girls to interrupt their studies, which represents a loss for the individual, the family, and the community. This phenomenon can translate into an increase in the number of single mothers with all its inherent difficulties: financial hardship, difficulty educating children,

GRAPH 1.2 - PERCENTAGE OF YOUNG GIRLS IN CAPITALS NOT YET MARRIED BY AGE 20



1. Note the very high percentages of young girls not yet married by age 20 (in all the capitals) in the group of youngest generations (ages 15 to 24).
2. The highest percentage is recorded in Dakar, the largest metropolis in the countries covered by the study.

Very large numbers of 20 year old single women are found among the younger generations in the capitals. **(Graph 1.2)**

- 38 percent in Ouagadougou;
- 52 percent in Niamey;
- 71 percent in Dakar

The estimates that appear in **Graph 1.2** show that this phenomenon first appeared a number of years ago in Dakar. The same observation can be made for the other cities, although to a lesser degree.

However, in rural areas, the number of 20 year old single women remains very low. With the exception of Senegal and Gambia where the trends do not appear very clear, it would seem that the number of 20 year old women who are single has hardly changed over a number of years.

As for marriage before the age of 15, there is a strong association between schooling and the number of women who are still single at age 20. This link is very strong in the capitals and other cities, as well as in Senegalese rural areas, and to a lesser extent, Burkina Faso rural areas. However, it is barely a factor in Nigerian

DISCUSSION TOPICS



- What are the factors, other than schooling, that contribute to the increase in the number of single 20 year old women (and older) in urban areas?
- How might society's different institutions (family, health, education, religion, etc.) adapt to this new phenomenon?

THEME 2

SEX BEFORE MARRIAGE

Most of the adults and older people who were questioned in Burkina Faso, Mali and Niger believe that the intensity of the sexuality of adolescents (ages 15-19) is much higher today than it was during their own youth. The words of a Burkinabe mother "As soon as two young people meet, they jump into bed!" illustrate this perception.

However, based on traditional demographic surveys, it is difficult to judge accurately how widespread premarital sex is in Sahelian societies. It is difficult for a single young woman to tell the surveyor she is no longer a virgin. Results thus obtained must, therefore, be interpreted with caution. Nevertheless, these surveys have the merit of, at least, having tried to pose the questions.

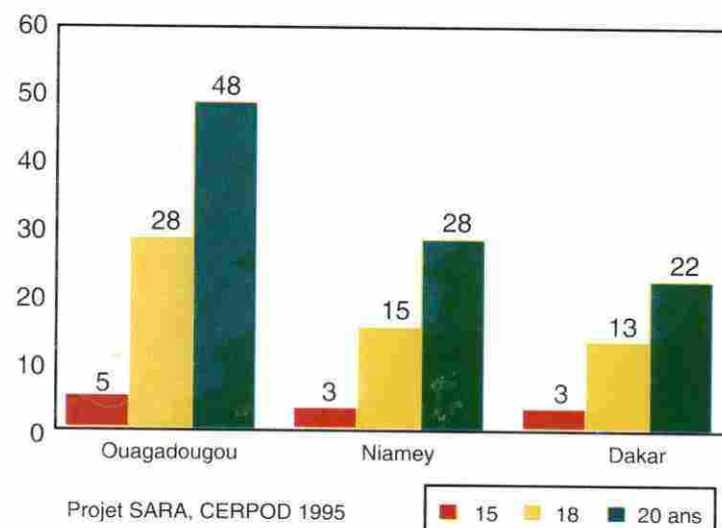
IN URBAN AREAS

Despite their weaknesses, information extracted from the Demographic and Health Surveys (DHS) in Niger, Burkina Faso and Senegal, show that between 22 and 48 percent of the women in capitals reported having premarital sex before age 20 (**Graph 2.1a**). These

numbers are undoubtedly lower than the reality of the situation.

It should be noted that the level of urbanization does not necessarily explain the prevalence of premarital sexual activity: Dakar, which is the largest Sahelian metropolis, not only records the lowest numbers of adolescent marriages, but also the lowest prevalence of premarital sex.

GRAPH 2.1a -PROBABILITY OF PREMARITAL SEX BEFORE THE AGES OF 15, 18, AND 20 IN THE CAPITALS.



1. Premarital sexual relations are much more frequent in Ouagadougou than in Niamey and Dakar.

Between 22 and 48 percent of the women in capitals claimed to have had premarital sex before age 20.

These numbers are undoubtedly lower than the reality of the situation.

*Adolescents who attend
school are not the only ones
to engage in premarital sex.*



Photo UNICEF/G. Pirozzi

There is not a very big difference between the percentage of adolescents attending school who have had premarital sex and the percentage of adolescents who are not receiving any schooling who have had premarital sex.

In the Senegalese capital, 22 percent of single women have had sexual relations. These estimates are lower than those recorded for Niamey (28 percent), and Ouagadougou (48 percent). Once again, these numbers are probably under-estimated.

IN RURAL AREAS

The levels of sexual activity recorded in rural areas are much lower than those recorded in urban areas. However, there are important differences among the different rural areas observed.

The probability of adolescent premarital sex in Nigerian rural areas is notably lower than in Burkinabe rural areas: 9 percent of single women in rural areas in Niger and 36 percent in Burkina, have already had sexual relations (Graph 2.1b).

SCHOOLING AND SEX BEFORE MARRIAGE

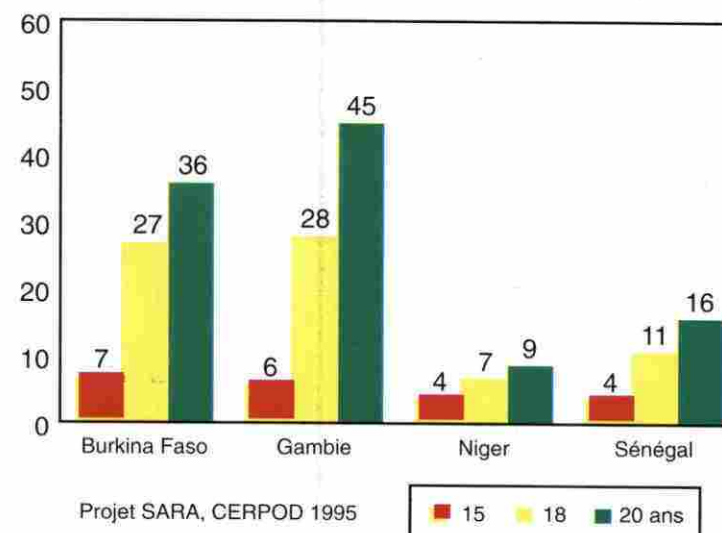
The study results also show that premarital sex is not limited to adolescents attending school. In the countries in the study, there is not much difference in the prevalence of premarital sex among adolescents attending school, and those who do not.

TRENDS

Has the intensity of sexual relations before marriage increased in the Sahel in the last 15 or 20 years? Data issued by DHS do not allow an easy answer to the question, but the postponement of marriage until a later age will probably lead to an increase in premarital sex.

In the absence of reliable quantitative data, the qualitative component of the study helped to better define the perceptions of adolescents, as well as those of the parents and other community leaders regarding sex.

GRAPH 2.1b - PROBABILITY OF PREMARITAL SEX BEFORE THE AGES OF 15, 18, AND 20 IN RURAL AREAS.

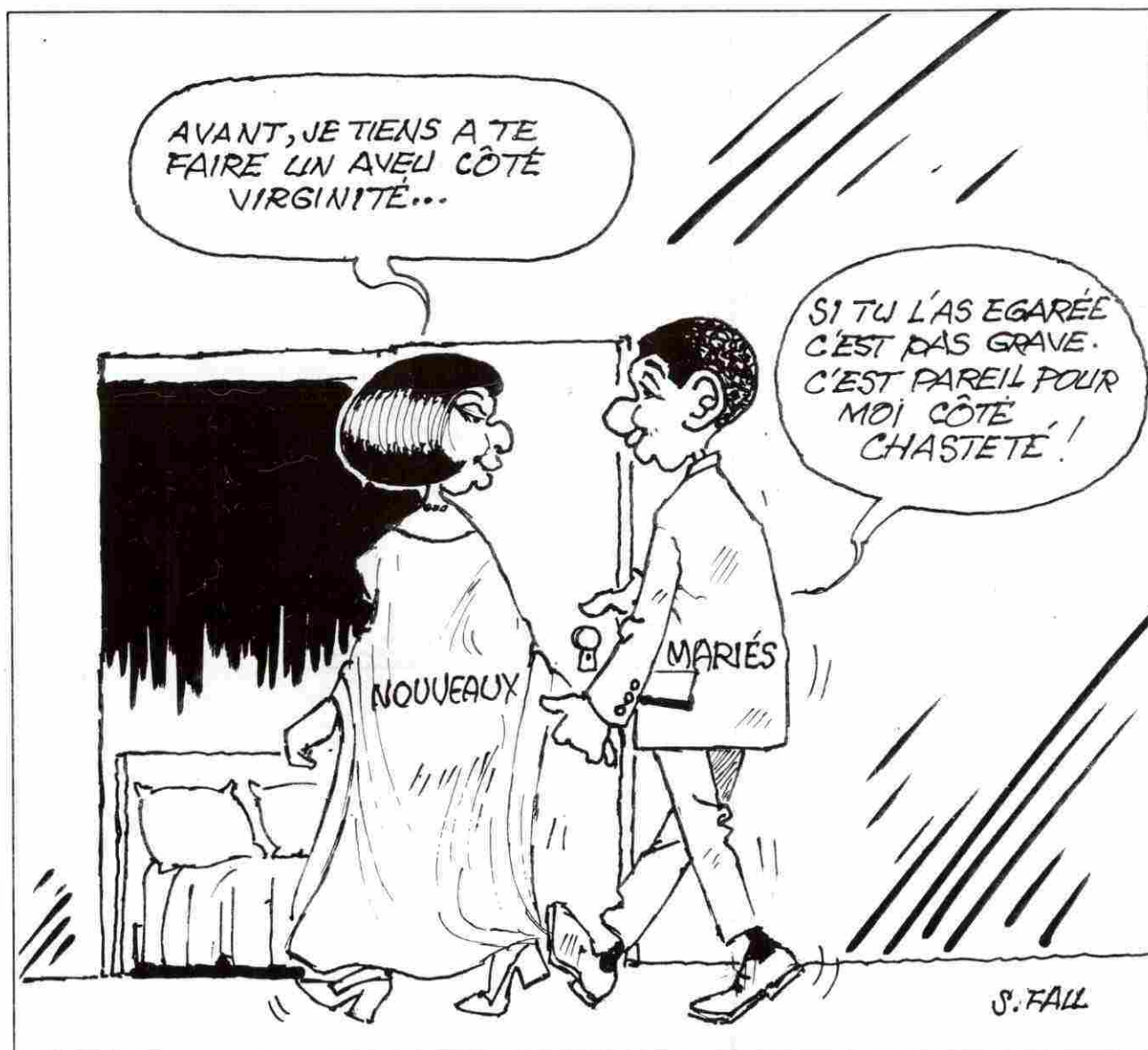


1. With the exception of premarital sex before the age of 15, the level is lower in rural areas than in the capitals.
2. The levels of premarital sex in rural areas are much lower in Niger and in Senegal than in Burkina Faso and in Gambia.

*Many adolescents believe that
"nowadays virginity is very
rare and very difficult".*

*** Woman:** "Beforehand, I'd like to make
a confession regarding the virginity issue."

Man: "If you've misplaced it, it isn't
important. It's the same thing for me
where chastity is concerned. ..."
(The signs on their backs read "Newly
Married")



Drawing by Samba FALL.

"...The aspect which I condemn is that, on the one hand, men want to have sex outside of marriage (which they do), and on the other hand, they want to marry a girl who is a virgin. It's very contradictory."

VIRGINITY

Opinion of the adolescents

The discussions held with adolescents in Burkina, Mali and Niger demonstrate that one of the principal motivations for chastity is the fear of not being a virgin when they marry. Nevertheless, most adolescents believe that "nowadays, virginity is very rare and very difficult". An adolescent girl even pointed out that "there is no longer any punishment if the girl is not found to be a virgin when she marries."

Most adolescents who were surveyed reported that they would like to marry a virgin. This desire, often a requirement, is much stronger in Niger than in Mali and far less important in Burkina. However, some adolescents are more pragmatic. An adolescent in Niger maintains that if in the past men sought to marry young virgin girls, nowadays, the emphasis is more on finding young girls who have not yet had children.

Opinion of the key informants

To key informants, virginity is a social norm to which the symbols of purity and honor are attached. It mainly concerns girls. Chastity, which would be the equivalent for boys, does not seem to be very important. It therefore has little social value. "Virginity is something which has a certain traditional value for us in Africa. And within a marriage, it confers a certain image upon women, from their mate's perspective and from the perspective of society."

But the virtue of virginity is not the same in all the countries in the study. Ethnic perceptions can be different: "In the environment where I am...the Mignanka environment, virginity isn't a problem....When a girl is married, it is not at all a problem for them whether she is a virgin or not."

Despite its value and social importance, virginity is still waning. The permissiveness encountered in boys, and the gradual disappearance of early marriages, in addition to the current exposure of adolescents to the influence of information on sexuality, are wearing down the social institution of premarital chastity. "I am no longer for people thinking that a girl can get married as a virgin... Nowadays, our girls go to school, sometimes until they are 23, 25 and even 30. I therefore do not think that it is fair to ask these girls to remain virgins while they wait for a husband."

These differences in the perception of sexuality in sub-Saharan Africa, especially in the Sahel, range from indifference to condemnation: "...The aspect which I condemn is that, on the one hand, men want to have sex outside of marriage (which they do), and on the other hand, they want to marry a girl who is a virgin. It's very contradictory."

ADOLESCENT SEXUALITY

Opinion of parents

In Burkina Faso, Mali and Niger, parents of adolescents who participated in the discussion groups in rural and urban areas display an almost general disapproval of boys and girls keeping company. This attitude is based on three principal factors:

Parents are aware that they have little control over the changes that affect their children.

1. The behavior norms when they themselves were young. Parents' points of view are often a result of their own sets of values. Parents of adolescents, in both rural and urban areas, admit that these values are losing ground.

They are also aware that they have little control over the changes that affect their children. The traditional scheme of things that most of them brought up during the discussions resembles nostalgia for bygone days: "In our time, we were given wives. Nowadays, it is a matter of free choice and you know that they cannot mix without having sex."



Photo Hamidou COLY/ENDA

2. Lack of economic power that would enable them to enforce the education standards in effect in their societies. The need for money can push adolescents to become sexually active.

Several testimonials excerpted from the group discussions emphasize this point: in Burkina Faso, "it is the 'Grottos' phenomenon that is often mentioned in Côte-d'Ivoire that is very present here...It is a person who has financial means, who has material possessions and who can offer motorbikes...or transportation means to those girls";

In Mali, one person brought forward the following argument to explain adolescent sexual activity: "I look at the depravity of moral standards within an economic framework because parents can no longer provide for their children; so, in that case children are obliged to manage as best they can."

Parents recognize that there is a lack of communication between themselves and their children.

3. The feeble authority or lack of authority of parents. It is often expressed in the form of guilt: "But often the fault comes back to parents who are failing to properly watch their children", or they have given up: "Using the excuse that they cannot provide for their families, people have given up. Parents are the ones who have given up." "Moral standards are slacking off simply because parents are quitters."

Opinion of key informants.

The majority of well-informed key informants show understanding towards the sexual behavior of adolescents for which they offer several explanations:

- ▶ **biological mutation:** "...The human species is entering puberty at an increasingly earlier age".
- ▶ **idleness caused by the economic crisis:** "Girls and boys find themselves without employment and their families are unable to support a household. Therefore, it is difficult to say that a man and a girl will act in a certain manner until they are of age to marry";
- ▶ **down-to-earth considerations such as:** "...Adolescents have always been lively. Their organism is full of vigor. So I think that they are more tempted than adults to have sex."

SOURCES OF INFORMATION

Parents recognize the lack of communication between themselves and adolescents. "The problem is that at the level of our societies, parents do not discuss sex with their children. Girls get pregnant early...And all this is because they were not given information ahead of time."

Mothers seem better able to assume their role than fathers: "We talk to our children. If a girl has grown, we ask her to behave in a proper manner." "Your peers are already married, so if you find a boy who loves you, he better find you at home. You must watch who you go out with." "Whether she accepts it or not, you will give your daughter advice. She can get as angry as she pleases."

Fathers do not always fulfill their role regarding the education of adolescents. There are several reasons for this behavior. Feelings of abdication and the expression of traditional patriarchal power are perceived in their words. "As a father, it is not my duty to discuss things with my children." "We ourselves do not do it often, but that is to be expected. For girls, it is mothers who must provide guidance, and they do not. The education of a boy is the father's responsibility. But people avoid sitting down and talking with their children or those of their neighbors..."

What emerges from these conversations with parents is the fact that adolescents also carry a share of the responsibility for the inadequacy or absence of communication. They do not seek to establish communication.

They do not seek communication. "...If young people give us the opportunity to do it, we do. If not, there is nothing you can do...it is up to the child to come to the father. It is up to him to come up to his father and say "this is my problem" and you can then guide him..." "Young people feel that the advice they receive from them is "old fashioned" or "antiquated."

Given the lack of communication between parents and adolescents, it is not surprising that they would look for information outside the family circle. Discussions on sexuality show that adolescents, especially girls, have several sources of information:

- ▶ Discussions between adults, especially between older brothers and sisters, are secretly listened to whenever possible.
- ▶ Photo novel magazines, certain movies or television programs and pornographic movies are some of the other sources mentioned by adolescents.



Drawing by Samba Fall, published in the Daily "Le Soleil", Senegal.

DISCUSSION TOPICS



■ What are the factors that encourage early sexual activity among adolescents?

■ Given the increase in premarital sex among adolescents, and the dangers to which they are thus exposed, what are the health, education and communication strategies that should be put into effect?

■ How can parents and adolescents be brought to talk about sex?

* *Girl:* Mother, I am going to my classmate's house. We are going to review our lessons.
Boy: And do some "practical exercises".

THEME 3

BIRTHS BEFORE MARRIAGE

If the loss of virginity is a difficult thing for adolescents (ages 15-19) and their families to accept, a birth outside of marriage is even harder. The moral, social, and economic consequences are sometimes insurmountable. Infanticide is not a rare occurrence as demonstrated by court cases and articles in the Sahelian press.

The levels of births before marriage recorded in the five countries are relatively low compared to those in other regions of Africa. However, unlike what one might expect in countries where religious and social norms prohibit reproduction outside marriage, they are not inconsequential.

Study results indicate that there is not necessarily a correlation between the reported pervasiveness of premarital sex and the widespread number of births before marriage.

1 Mort tragique à Boghé



H , âgée de 16 ans, est la fille d'un respectable commerçant à Boghé Less. Elle est e classe de 6^oAF à l'Ecole I de Boghé. Le jeudi 14 d' cembre, elle se rend compte qu'elle est enceinte de mois suite à une relation amoureuse qu'elle entre ait discrètement avec un certain Mama Cissé. Ce dernier, âgé 33 ans, marié et père de famille, se trouve être le chauffeur sénateur Baro Alassane, personnalité très respectée dans Boghé. Mis au courant du malheur dont il est coupable, cr nant le scandale, Mama Cissé propose un avortement dar discrétion. Avec un billet de 1000 UM, il envoie une cop son amie, Mariam Hawo Sourour, acheter 50 comprim Nivaquine à la pharmacie Unicef du dispensaire de Boghé comprimé de Nivaquine est vendu à 3 UM.

1- Tragic Death in Boghe

16 year old girl dies after swallowing pills to abort the child of a 33 year old married man

2 Arrêtée pour tentative d'infanticide

La mère indigne qui, dans la nuit d' au 5 août dernier, avait abandon bébé de sexe masculin sur un été retrouvée hier par le commissariat du ter Thies!

3 Infanticide : 6 ans par contumace à Sarata

Le SOLEIL
(Sénégal)

Le CALAME (Mauritanie)

2- Arrested for attempted infanticide

3- 6 years sentence for Sarata condemned for infanticide

4 C.K. : 15 ans, élève

Ma première histoire d'amour a commencé en 1995. Et elle a tourné au cauchemar car je suis tombée enceinte la même année quand je préparais mon examen fin d'année.

tout ma mère qui m'a beaucoup grondée. Heureusement pour moi, mon petit copain travaille, et il est bien rémunéré. J'étais un peu imprégnée des réalités de la sexualité, mais je n'y croyais pas. Maintenant la leçon est bien assimilée.

Le N° 42 - GRIN GRIN
le magazine des jeunes
(mali)

4- 15 years old schoolgirl

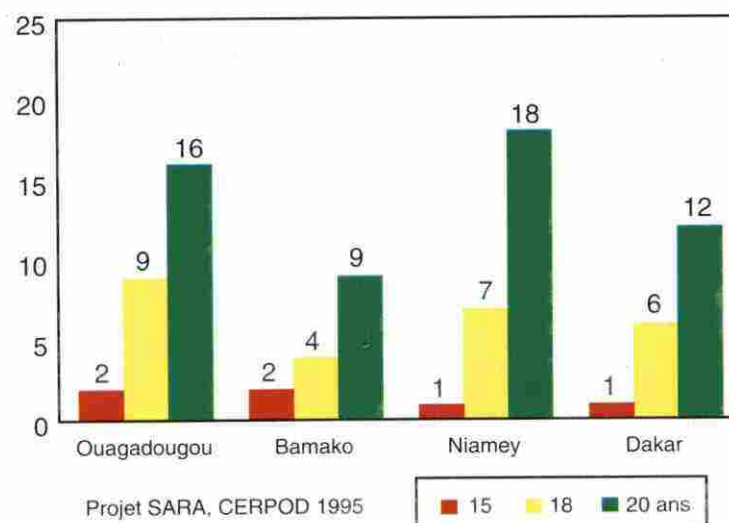
gets pregnant after first affair while

The proportion of single women who have experienced a birth varies between 9 and 18 percent. (**Graph 3.1a**). As for premarital sex, conception before marriage is less frequent in rural areas than in urban areas (**Graph 3.1b**). The results indicate that there is not necessarily a correlation between the reported pervasiveness of premarital sex (**Graphs 2.1a and 2.1b, pages 7 and 9**) and the widespread number of births before marriage.

An explanation of these results could be that:

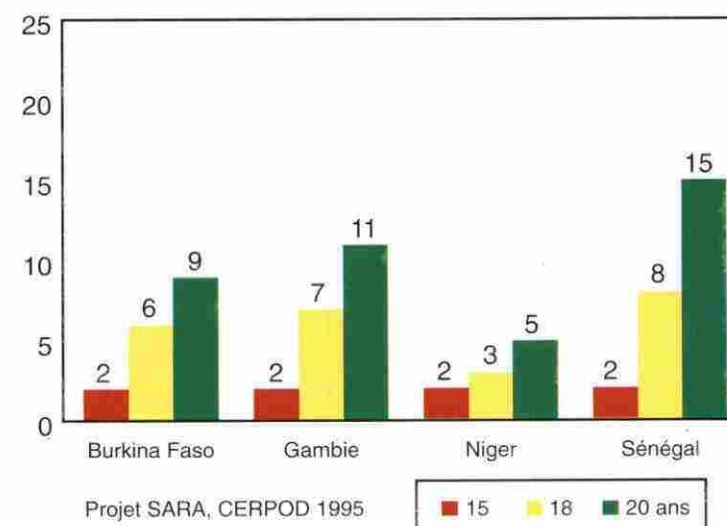
- ▶ People in the survey were reluctant to talk openly about sex;
- ▶ The level of accessibility or use of contraception differs from country to country.
- ▶ Recourse to abortion varies

GRAPH 3.1a -PROBABILITY THAT GIRLS WILL GIVE BIRTH BEFORE THE AGES OF 15, 18, AND 20 IN CAPITALS



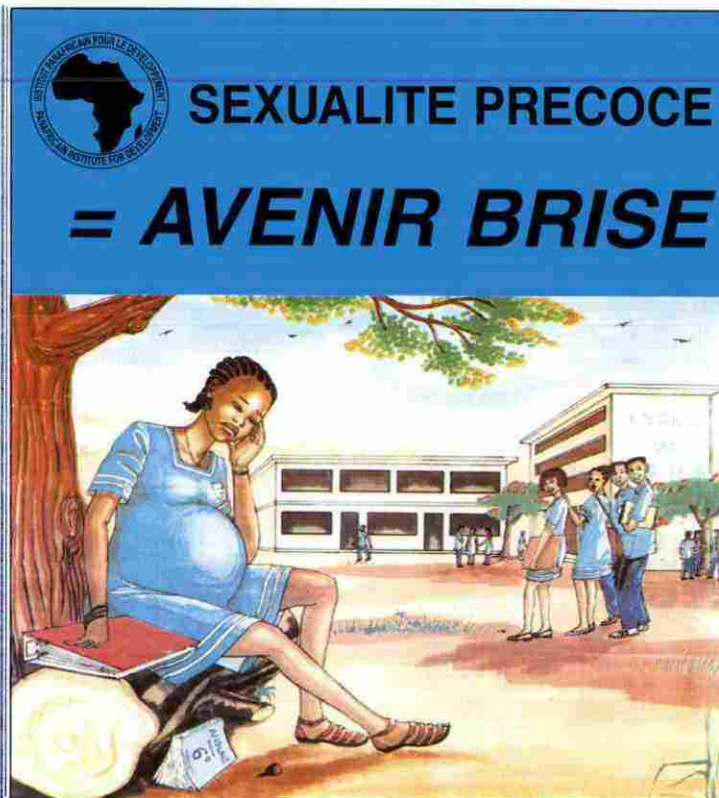
1. Differences observed between the different cities are not exactly comparable to those recorded for the levels of premarital sex (Graph 2.1a). A more active premarital sex life does not necessarily lead to higher levels of premarital fertility.

GRAPH 3.1b -PROBABILITY THAT GIRLS WILL GIVE BIRTH BEFORE THE AGES OF 15, 18 AND 20, IN RURAL AREAS.



1. The gap between the level of premarital sex (Graph 2.1b) and that of premarital births is much greater in Burkina than in Niger and Senegal.

2. The level of premarital sex in Senegalese rural areas was the lowest, except for that of Nigerian rural areas, yet led to the highest level of premarital fertility.



Poster from Women and Health Project -IPD.AOS

Among interesting cases, the following should be noted:

- ▶ Niamey has lower levels of reported premarital sex than Ouagadougou, yet similar levels of premarital births;
- ▶ Dakar, where the levels of reported premarital sex are the lowest recorded for all the capitals, has levels of births before marriage comparable to those of all the other capitals;
- ▶ Senegalese rural areas, where levels of reported premarital sex are very low, also have levels of premarital births comparable to those of other rural areas in the sub-region.

The high level of urbanization in the countries in the sub-region means that there are increasing numbers of single mothers.

DISCUSSION TOPICS



- What strategies should be adopted to prevent adolescent births before marriage?
- What attitudes should be encouraged among providers, parents, and educators towards single adolescent mothers and their children?
- What actions should be undertaken to benefit single adolescent mothers and their children?

THEME 4

FAMILY PLANNING AMONG ADOLESCENTS

Until very recently, family planning programs showed little interest in adolescents (ages 15 to 19). This was justified by the fact that there was almost no demand from married women and the cultural and religious norms prohibited reproduction outside marriage for single women.

Among **single adolescent girls**, those who are sexually active are not only exposed to early pregnancy, but also to the risks of premarital pregnancy, abortion, and all of the social and economic consequences that ensue.

Married adolescent girls, in response to societal pressures, begin reproduction as soon as their marriage is consummated. However, due to their physical and psychological immaturity, and because they are subject to the ill effects of early maternity, adequate birth spacing should be observed among adolescent mothers.

Only 41 percent of married Senegalese adolescent girls in rural areas approve of family planning.



Photo Stanley STANISKI

PREFERENCES AND ATTITUDES TOWARDS FAMILY PLANNING

Among married adolescent girls

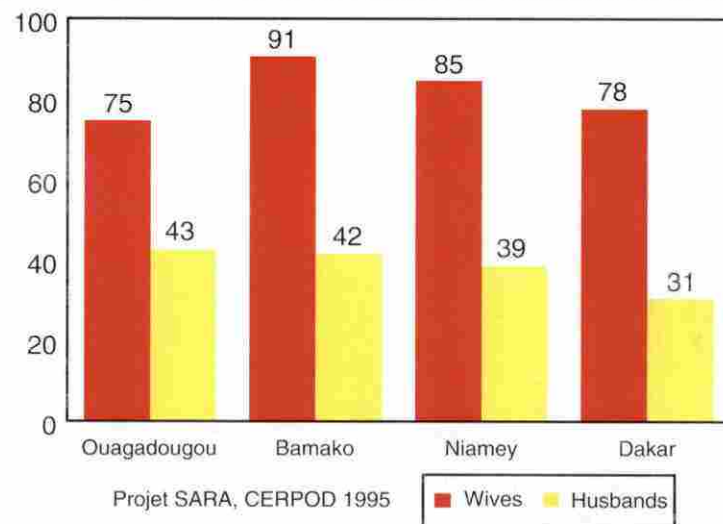
Thanks to the results of different studies, it is possible to form a picture about the attitude of married adolescent girls and their partners towards family planning.

With few exceptions, married adolescent girls show slightly less approval for family planning than do older

married women, and the levels of approval recorded are always higher in urban areas than in rural areas. The most notable difference is recorded in Senegalese rural areas, where only 41 percent of married adolescents approve of family planning.

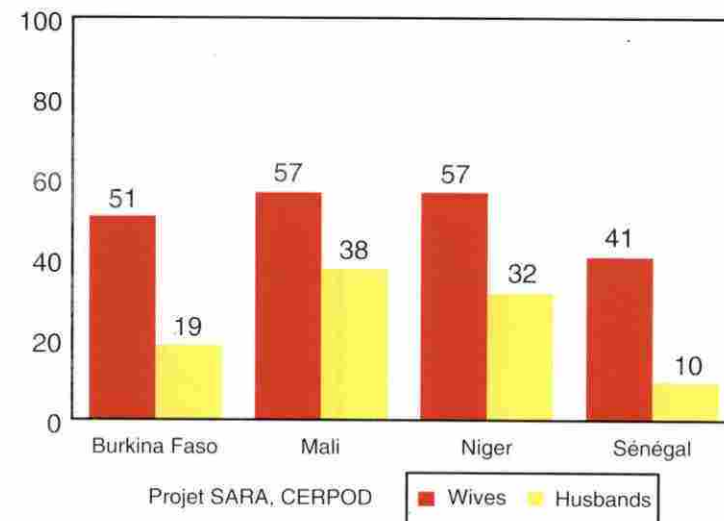
In rural as well as urban areas in every country, there are considerable gaps between the levels of approval shown by girls and those shown by their spouses (**Graphs 4.1a and 4.1b**). With the exception of Ouagadougou, the percentage of adolescent girls who approve of family planning is 2 to 4 times higher than

GRAPH 4.1a -PERCENTAGE OF MARRIED ADOLESCENT GIRLS AND THEIR SPOUSES (ACCORDING TO THE GIRLS) IN THE CAPITALS WHO APPROVE OF FAMILY PLANNING.



1. The percentage of married adolescent girls who approve of family planning is very high, regardless of the city (between 75 and 91 percent).
2. Regardless of the city, the percentage of married adolescent girls who approve of family planning is much higher than that of their spouses.

GRAPH 4.1b -PERCENTAGE OF MARRIED ADOLESCENT GIRLS AND THEIR SPOUSES (ACCORDING TO THE GIRLS) IN RURAL AREAS WHO APPROVE OF FAMILY PLANNING.



1. The percentage of married adolescent girls who approve of family planning is noticeably lower in rural areas than it is in the capitals (Graph 4.1a)..
2. The estimated percentage for the husbands of adolescent girls in rural areas is also much lower than that of husbands in capitals (Graph 4.1a).
3. Senegal, which is the most urbanized country, has the lowest approval ratings.

***-Woman:** I'd like to propose (family) planning to my husband, but I'm sure he will never accept it!

Man: Will my wife agree to (family) planning? No, I don't think she will.

Poor communication between spouses is one of the problems frequently cited in research studies.



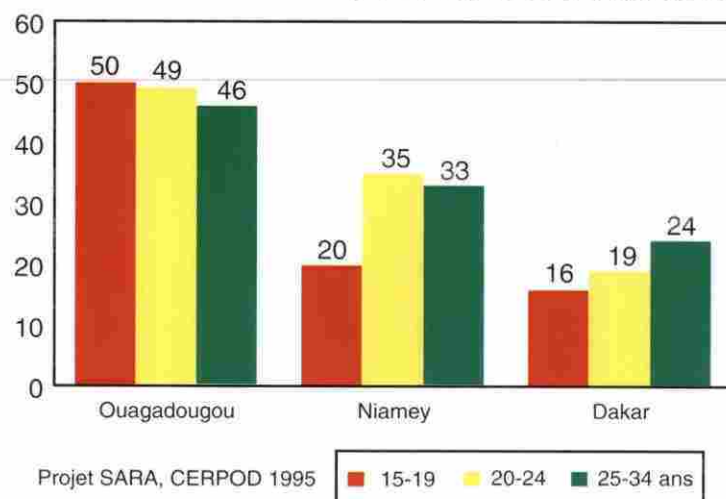
that which is estimated for their husbands. Thus, many adolescent girls who approve of family planning erroneously believe, or are certain, that their husbands are against it.

Communication about family planning between married adolescent girls and their husbands.

Poor communication between spouses is one of the problems often cited in research studies. Research

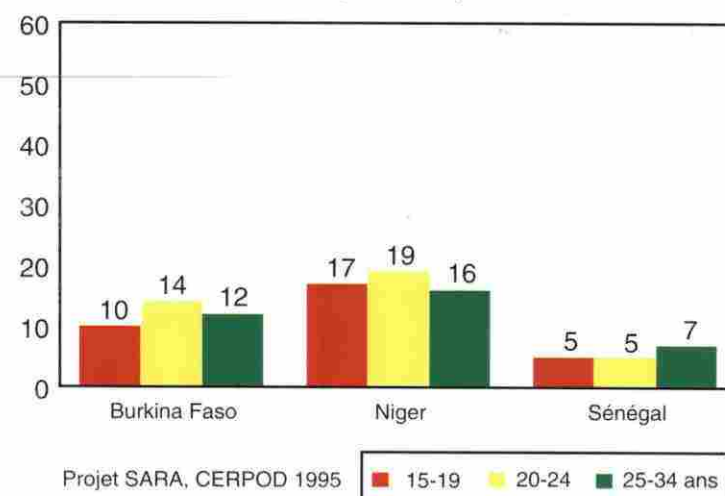
shows that this is also the case for married adolescent girls. Very few adolescent girls discuss family planning with their mate. The situation is critical in rural areas: the highest percentage of married adolescent girls who have discussed family planning with their spouses is recorded in Burkina Faso and in Mali (54 percent).

GRAPH 4.2 a -PERCENTAGE OF COUPLES IN THE CAPITALS WHO HAVE HAD DISCUSSIONS ABOUT THE NUMBER OF CHILDREN THEY WANT, BY DIFFERENT GENERATION GROUPS OF WOMEN (15 TO 19, 20 TO 24, AND 25 TO 34).



1. Regardless of the generation group, favorable attitudes are relatively higher in Ouagadougou than in Dakar.
2. Contrary to what is recorded in Ouagadougou where the difference between generation groups is not very important, the percentages recorded in the other capitals for adolescents are lower than those recorded for other generation groups.

GRAPH 4.2 b -PERCENTAGE OF COUPLES IN RURAL AREAS WHO HAVE HAD DISCUSSIONS ABOUT THE NUMBER OF CHILDREN THEY WANT, BY DIFFERENT GENERATION GROUPS OF WOMEN (15 TO 19, 20 TO 24 AND 25 TO 34).



1. The contrast between rural areas and the capitals (Graph 4.2a) is very pronounced. Levels recorded in rural areas are very low.
2. The results do not reveal any major differences between generation groups.

A woman, or a man, who receives schooling is more likely to approve of family planning.

Discussions between married adolescent girls and their spouses about the number of children they want to have

The percentage of adolescent girls who have discussed the number of children they want is even lower than that of adolescents who have discussed family planning with their spouse. It varies between 16 percent for Dakar and 50 percent for Ouagadougou, and between 5 percent for Senegal and 17 percent for Niger in rural areas (see Graphs 4.2a and 4.2b).

Even if schooling emerges as a factor that encourages discussion, educated adolescents also experience difficulties in communicating. It is only in Ouagadougou that 43 percent of adolescents attending school have discussed the number of desired children with their partners. In Niamey and Dakar, the percentages are barely 16 percent and 5 percent.

For single adolescent girls

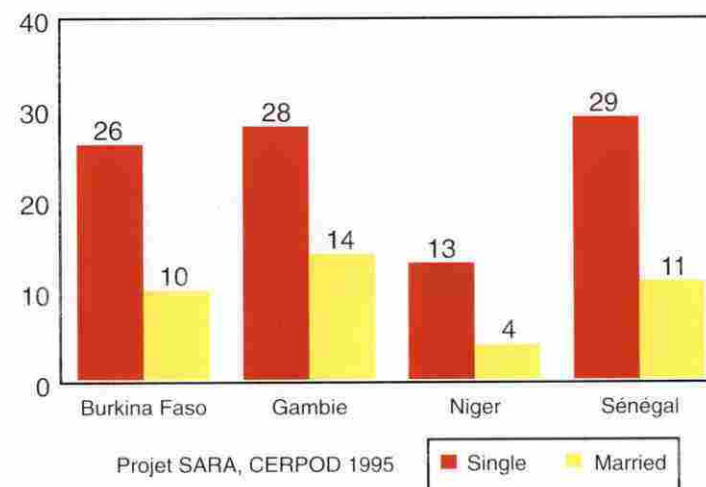
Focus groups conducted in Niger, Mali and Burkina lead to the conclusion that most sexually active single girls would use modern contraceptives, at least to prevent pregnancy, if they had the information and the means to do so.

Judging from the results that are available, their motivation to avoid pregnancy is stronger than the motivation of married women to space or limit births.

Schooling and attitudes towards family planning

One of the characteristics that influences approval towards family planning for both men and women is schooling. A woman, or a man, who receives schooling is more likely to approve of family planning.

GRAPH. 4.3 -PERCENTAGE OF SEXUALLY ACTIVE SINGLE WOMEN AND MARRIED WOMEN WHO HAVE ALREADY USED MODERN METHOD OF CONTRACEPTION.



1. In all the countries, single women use modern contraceptive methods much more than married women do.

More unmarried women have used modern contraceptive methods than married women.

CONTRACEPTIVE USE

Based on available research results, it appears modern contraceptive use in the Sahel is among the lowest in the world. However, national indicators hide very important differences. In certain rural areas, the recorded level is almost nil, but in some capitals, it is close to 20 percent. **(The table with demographic indicators is on page 44).**

Graph 4.3 shows that the use of modern contraceptive methods is markedly higher among single women than among married women.

Unmarried adolescent girls.

Owing to the small numbers on which they are based, available data do not always make it possible to estimate specific indicators for unmarried adolescent girls. However, it is possible to make a certain number of observations:

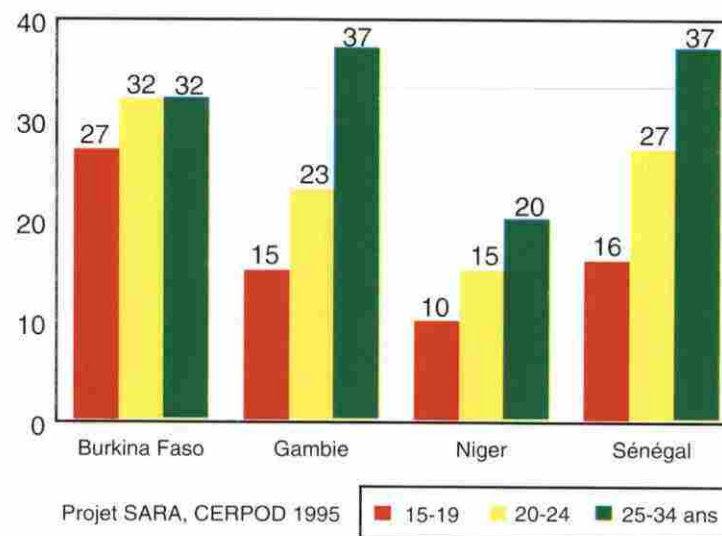
- ▶ In all countries, sexually active unmarried girls show lower levels of modern contraceptive use than older unmarried women **(Graph 4.4).**

- ▶ Sexually active unmarried girls in Burkina Faso show higher levels of use than do identical groups in other countries.

Parents perceptions of contraceptive use by teenagers

Generally speaking, parents are aware that adolescents know about contraceptive methods, particularly modern ones: "Boys will use condoms and girls the pill".

GRAPH 4.4 -PERCENTAGE OF SEXUALLY ACTIVE UNMARRIED WOMEN WHO HAVE USED MODERN CONTRACEPTIVE METHODS, ACCORDING TO AGE.



1. Sexually active Burkinabe adolescent girls have used more modern contraceptive methods than their sisters in the other countries.
2. Sexually active unmarried adolescent girls, regardless of the country, show lower levels of contraceptive use than older unmarried women (ages 20 to 24 and 25 to 34).

In urban areas, they most often refer to condoms and the pill. Other methods are mentioned, such as spermicides, IUDs, and injectables.

In rural areas, traditional methods are most often mentioned. These are preparations made by traditional practitioners and objects made by marabouts (such as belts). "There are mothers who go to see traditional healers and marabouts to get medication which will ensure that their daughters don't get pregnant."

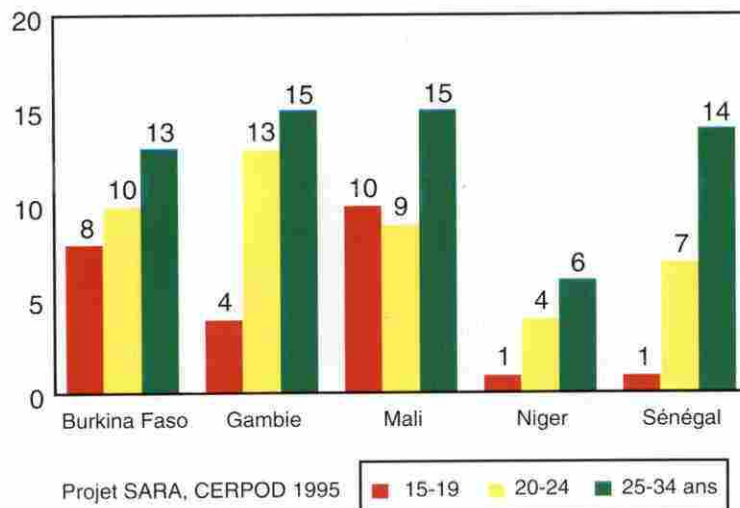
Methods referred to by parents are the same as those mentioned by adolescents during interviews.

Married adolescent girls

Married adolescent girls show much lower levels of use of modern contraceptive methods than older married women, whether in the past or present (**Graphs 4.5 and 4.6**).

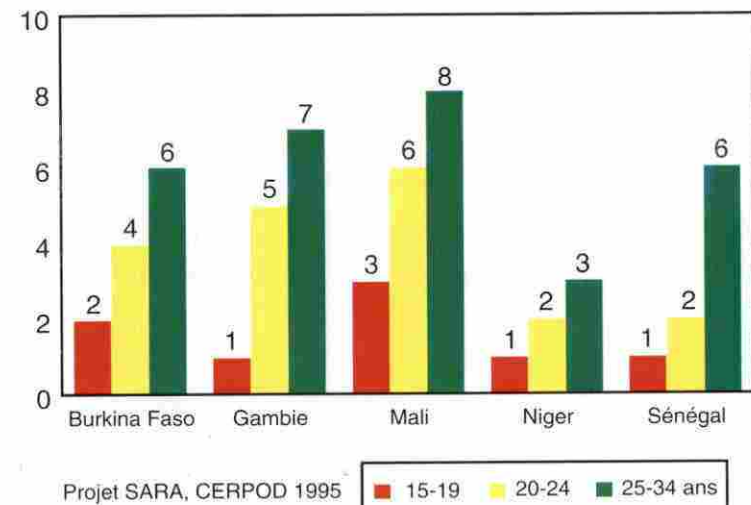
Although these levels of use are low for Burkina and Malian adolescent girls, they are nevertheless higher than for Nigerian and Senegalese adolescents.

GRAPH 4.5 -PERCENTAGE OF MARRIED WOMEN WHO HAVE ALREADY USED A MODERN METHOD OF CONTRACEPTION, ACCORDING TO AGE.



1. The percentage of married adolescent girls in Burkina and Mali who have used modern contraceptive methods is higher than in other countries.
2. Married adolescent girls show lower rates of use than older married women (ages 20 to 24 and 25 to 34)

GRAPHI 4.6 -PERCENTAGE OF MARRIED WOMEN WHO WERE USING A MODERN METHOD OF CONTRACEPTION AT THE TIME OF THE STUDY, ACCORDING TO AGE.



1. The percentage of married adolescents using modern methods at the time of the study is very low in all the countries (only between 1 and 3 percent).
2. As for the two preceding graphs, the rates for married adolescents are always lower than those for older married women (ages 20 to 24 and 25 to 35).

OBSTACLES TO FAMILY PLANNING ACCESS

Adolescents' Point of View

It is difficult for both married and unmarried adolescent girls to get to family planning clinics to obtain modern methods of contraception. This observation is confirmed by conversations with adolescents that indicate the following:

- ▶ they are embarrassed and afraid to meet older people they know at the health clinics;
- ▶ they claim not to be welcomed by the service providers;
- ▶ they are sensitive to rumors about certain contraceptive methods;
- ▶ they do not have adequate financial means

Point of View of Key Informants

Adolescents' claims of being embarrassed and receiving poor service are confirmed by the results of qualitative research conducted with key informants.

According to key informants, the main obstacle to family planning service centers are adolescents themselves. "Many young people, feeling embarrassed, prefer to get their information through the radio and television rather than go to family planning clinics where people might see them."

Unfriendly reception in clinics is a real problem confronting adolescents. "...The midwife herself, who has kept a certain frame of mind, will not welcome the young girl with open arms, and the young girl will be embarrassed. It is likely that a midwife might say to a young girl "you are not married, what are you doing here?"

This problem of unfriendly reception is also linked to legislation -where legislation exists at all- which hampers service provision to all categories of sexually active men and women. "If you have to reach age 23 in order to be eligible for contraception, there is a gap, and the consequences, such as unwanted pregnancies, will be many" underscores a participant from Niger.

DISCUSSION TOPICS



■ How can communication about family planning between married adolescent girls and their spouses be improved?

■ How can birth spacing be promoted among married adolescent girls?

■ What are the advantages and inconveniences of sexually active but unmarried adolescent girls' access to contraceptives?

THEME 5

SEXUALLY TRANSMITTED DISEASES (STDs) AND AIDS

In addition to the problems already mentioned that are created by early sexual activity, there are also the risks of sexually transmitted diseases and AIDS. In the Sahelian context, where the prevalence rate of HIV (the virus which causes AIDS) is constantly increasing, the group of adolescent girls ages 15 to 19 seems to be more exposed to infection than other women of childbearing age.

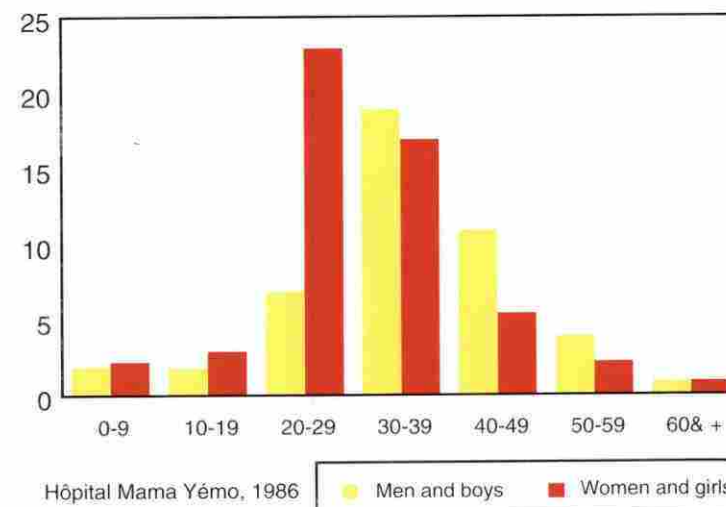
vulnerable to HIV infection in cases of unprotected sex with an infected partner. Economic dependence is a factor that encourages adolescents to have sex with older men for money or other material rewards.

Due to their physiological immaturity, adolescent girls are more vulnerable to HIV infection in cases of unprotected sex with an infected partner.

Results of a study conducted in 1986 on the first 500 cases of AIDS diagnosed at the Mama Yémo Hospital in Zaire show that the largest number of AIDS cases among women were found in the 20 to 29 age bracket. Given the incubation period of the virus, this would almost certainly mean that the girls were infected between the ages of 10 and 19, probably during their first sexual encounters. The results of this first study are similar to those of several other studies conducted in hospitals in other countries.

This could be explained in part by the results of numerous studies which suggest that due to their physiological immaturity, adolescent girls are more

GRAPH 5. -THE FIRST 500 CASES OF AIDS DIAGNOSED AT THE MAMA YÉMO HOSPITAL IN KINSHASA, ZAIRE IN 1986



Source : Mama Yémo Hospital , 1986 in Young Women : silence, susceptibility and the HIV Epidémie, PNUD, 1992

AIDS has drastically changed the realities of sexuality. Before the advent of AIDS, a youthful mistake could lead to an STD. Today, it can cost a life.

Interactions between AIDS and STDs are an important fact. It has now been established that people suffering from an STD have stronger chances of becoming infected during unprotected sexual intercourse with an infected partner than people not suffering from an STD. Another less known fact is that a person infected with HIV and suffering from an STD produces more of the virus during sexual intercourse than a person only infected with HIV. Finally, research has shown that AIDS aggravates STDs and makes them more resistant to treatment.

AIDS has drastically changed the realities of sexuality. Before the advent of AIDS, a youthful mistake could lead to an STD. Today, it can cost a life.

Given the vulnerability of adolescents to infection with HIV and AIDS, and the multiple interactions between HIV and STDs, it is important to analyze the information available regarding the knowledge and sources of information of adolescents, as well as the methods of prevention and the obstacles to treatment. The complexity of the problem makes it important to know the views of parents of adolescents and of other actors such as service providers, religious leaders, and village heads.

KNOWLEDGE OF STDs

Group discussions in Burkina Faso, Mali and Niger highlighted the incomplete nature of the knowledge adolescents have of sexually transmitted diseases.

In the three countries where research was conducted, the STDs most frequently named by adolescents were gonorrhea, syphilis, and wet chancres. They did not

always know how these are transmitted nor could they identify the symptoms or manifestations of the diseases they had named.

They also associate many other diseases with STDs, some of which (bilharziose and hemorrhoids) can affect intimate body parts. They indiscriminately refer to whooping cough, leprosy, urinary tract diseases, stomach pains, kidney pains, rheumatism, and boils, none of which are STDs.

KNOWLEDGE OF AIDS

AIDS was mentioned by most adolescents in the three countries. But knowledge about AIDS is better among those in urban areas than rural areas and among those attending school.

AIDS is the STD for which adolescents can name the method of infection and its manifestations. "To recognize a sick person: his face is full of big pimples. His hair becomes as smooth as that of a new born and falls out. Furthermore, he has diarrhea, his nerves stick out. He loses weight and you can't stand to look his chest; you can count his bones. Even if he swallows an entire pharmacy, he will not be cured."

The question must still be asked as to whether adolescents are aware that it is impossible to identify a healthy person living with HIV by simple observation.

In addition, this type of misinformation also carries over into certain improbable methods of transmission. "A fly can land on the wound of a person with AIDS and if it also lands on your wound, then the gig is up, you have AIDS."

Answers by some people even included misinformation and denial of the existence of the disease. In Mali, "adolescents in rural areas have heard that AIDS was invented by the West in order to slow the growth of the African population."

STD PREVENTION

Adolescents who participated in focus groups in Burkina Faso, Mali, and Niger spoke of several ways to prevent STDs:

- ▶ **They felt abstinence was the best form of prevention.** "The best medicine is to avoid



Photo Sié Offi SOME

women", "You calm down and watch yourself, you listen to your parents, you stay at home. This might be a way for you to be spared from these diseases."

- ▶ **Girls' virginity:** this point was evoked in Niger where adolescents feel it protects you from STDs.
- ▶ **Being faithful to one partner** in cases where abstinence is not an option.
- ▶ **Male condoms:** "If you must do it, limit yourself to one man, or demand that your partner use a condom, it's the only thing that can protect you."

The use of condoms is not always fully accepted because the man often refuses to use them. "If you bring condoms, it might give him a reason to hit you. Now, if women could wear condoms, they would be happy to, but if it's up to the man, there is nothing you can do if he refuses to wear one."

PARENTS' PERCEPTIONS

Suggestions made by parents reveal their sense of helplessness. Their words convey their awareness of the dangers adolescents face if they are not protected against sexually transmitted diseases (STDs). Thus, parents imply their acceptance of the use of methods by adolescents and a desire to preserve their lives.

Parental concerns are expressed in the following manner: "In these times, I think you must allow them to have access to contraceptives to allow them to protect themselves for the future." "They are in contact with these realities. They must be given the message or allowed direct access, to be treated in order to be spared." "The essential thing is for them to be sensitized, to talk to them about these diseases, and to tell them how they can catch these diseases..."

Among the sources of information on STDs that are least cited by adolescents are health care providers, and biology and family life education teachers.

"I believe we must continue to provide these services, otherwise, disease will kill them."

However, opinions contradict each other. Some parents are not favorably inclined to provide adolescents with contraceptives. "In any case, I do not agree with this, because it is not a good thing and giving them access to it would encourage loose morals." "They should no longer be taught about these things, and should no longer have access to them. Once these measures have been taken, [girls] will be obliged to stop."

SOURCES OF INFORMATION

Information sources regarding STDs are not radically different from those for sexuality or family planning.

The source for information on STDs the least mentioned by adolescents is the family.

At first glance, modern methods of communication (the media) represent the most common way for adolescents to obtain information about STDs.

Communication among youths themselves is also important:

- ▶ in school (cited in all three countries);
- ▶ in the Houses for Youth and Culture in Niger;
- ▶ in the "grins", which are discussion groups in Mali;
- ▶ and during tea parties in Burkina Faso.

Health care providers, and biology and family life education teachers are among the least mentioned sources of information on STDs.

OBSTACLES TO THE TREATMENT OF STDs.

- ▶ **Shame:** for family planning, the main obstacle to the treatment of STDs in adolescents is cultural. "...A young Malian has problems getting treatment for an STD because of the fear of humiliation. Youths do not want anyone to know that they have those diseases."
- ▶ **Lack of anonymity:** adolescents complain about the lack of anonymity in some health centers for patients suffering from "shameful diseases". "Some prefer to go to local healers because they are ashamed people might find out what disease they have." They also mention the confidentiality guaranteed by the traditional therapists.
- ▶ **Lack of money** is another difficulty that limits adolescents' access to the appropriate sources of health care. If they contract an STD, they find out that "health, which is invaluable, actually has a cost" that they cannot meet without help. In health centers, hospitals, and clinics, available treatments are out of their reach even if they are effective. Consequently, many adolescents turn to pharmacies and traditional practitioners. "I would first go to a charlatan, and if the treatment failed, I would then go to a dispensary." Cost affordability is an important factor for adolescents.

*HMM! MMM!

Huh.... Hello Ma'am

What is this!

Ah... well.... I

OK, decide what you want to say! I've got work to do. First of all, how old are you?

Ah, I'm 16...

Here, this place is for women, not for a young thing of your age!

Well .. what I'm trying to say is.....

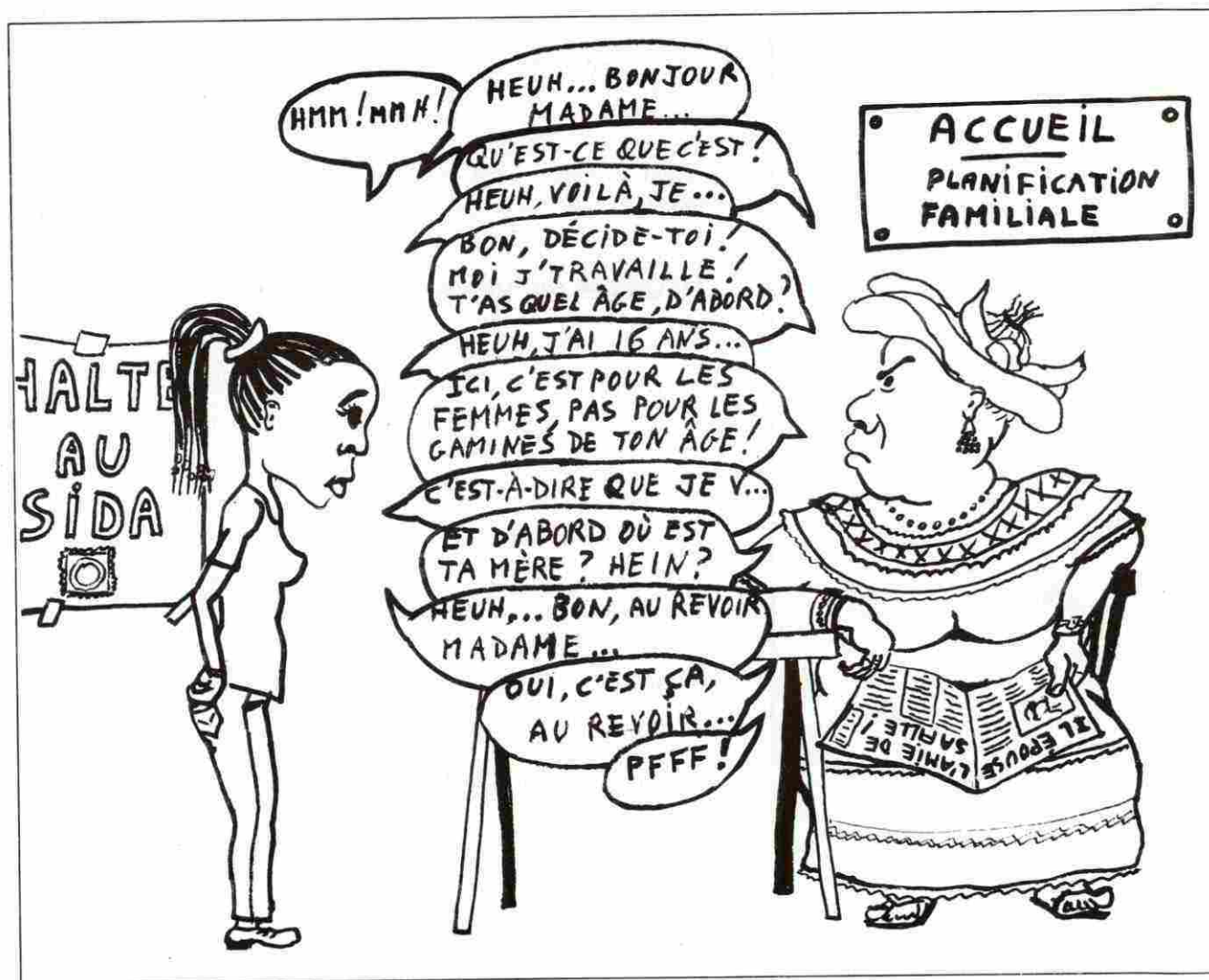
And anyway, where is your mother? Huh?

Ah,... OK, Good-Bye Ma'am

Yes, this is good bye.....

Hrrmpf.....

*According to adolescents,
the greatest obstacle to
access to information and
services is the attitude of the
medical staff.*



Drawing by Philippe BOCQUIER

► **The attitude of the medical staff** is the greatest obstacle. Adolescents' understanding is that the staff's role should be to "listen, reassure, enlighten, and heal..."

Instead, "nurses and doctors make fun of people and often do not want to take care of them." An adolescent in Burkina Faso talks of the indiscreet attitude of a medical staff person who

called him over in front of everyone saying "Hey, you with the hot piss (gonorrhea), come here!" Another adolescent agrees "I think that aside from the shame, the problem is with the different members of the medical staff, because if you contract one of those diseases, when you arrive at the center, these health people are the first to insult you."

DISCUSSION TOPICS



- What are the obstacles that prevent sexually active adolescents from protecting themselves against STDs and AIDS?
- Given the dangers that sexually active adolescents are exposed to nowadays, what strategies should be put into place to protect them?

THEME 6

HEALTH OF THE ADOLESCENT MOTHER AND HER CHILD

Pregnancy at an early age represents a health risk for the mother and child. Given the high number of first marriages at a very young age in the Sahel region, fertility levels among adolescents (ages 15 to 19) are high. Demographic and health survey results show that even in Senegalese urban areas where there has been a significant postponement of age at first marriage, 7.7 percent of births are to adolescent girls. Estimates for Nigerian rural areas are much higher, around 16.1 percent.

NEONATAL DEATHS

Neonatal deaths (those occurring during the first month of life) are undoubtedly one of the best available indicators to illustrate the risks babies encounter due to the physical immaturity of the mothers.

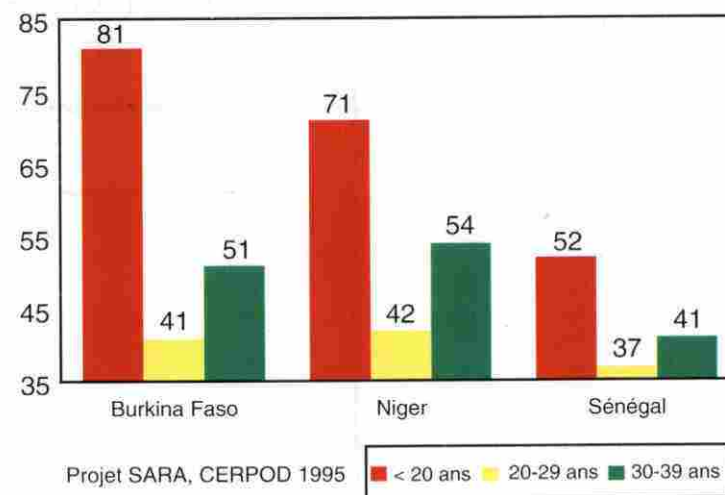
Demographic and health surveys in Burkina Faso, Niger, and Senegal show that high rates of deaths occur in the first months of life to children born of adolescent mothers (**Graph 6.1**). In Burkina Faso, these babies have a neonatal

death rate that is almost twice as high as that for babies whose mothers are between 20 and 29: 80.5 deaths per 1,000 live births versus 41.5.

- In Niger: 71.4 versus 41.5
- In Senegal: 52.2 versus 37

Pregnancy at an early age represents a health risk for the mother and child.

GRAPH 6.1-NEONATAL DEATH RATE (PER 1,000) ACCORDING TO THE AGE OF THE MOTHER AT THE CHILD'S BIRTH.



1. Regardless of the country, neonatal mortality among children born to adolescent mothers is much higher than among children born to older mothers.
2. The lowest levels of neonatal mortality are recorded among mothers ages 20-29.

These high mortality rates are primarily due to biological factors (mother's physical immaturity, narrow pelvis, low birth-weight).

USE OF HEALTH SERVICES

We were expecting that adolescent girls, because of their lack of knowledge of reproductive health matters, would not use health services as much as older mothers. However, results show that apart from a few exceptions, use of these facilities by teenage mothers is comparable to that of other women of reproductive age.

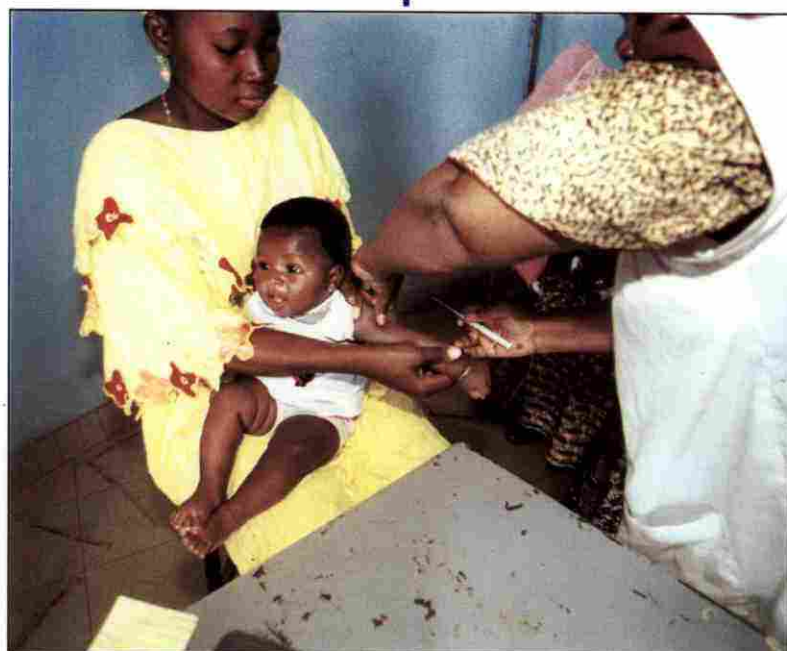


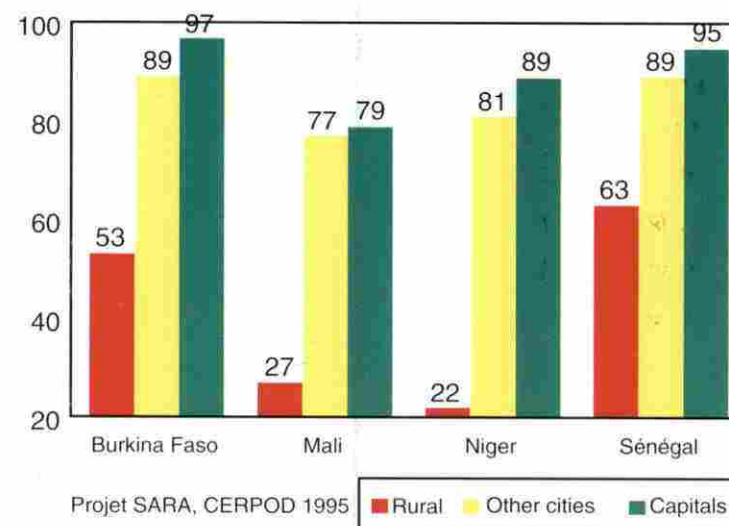
Photo Stanley STANISKI

PRENATAL CONSULTATIONS

Urban areas

Due to the high concentration of health centers in the capitals (Ouagadougou, Niamey and Dakar), over 90 percent of all births to adolescent mothers were preceded by at least one visit to a health worker (**Graph 6.2**).

GRAPH 6.2 - PERCENTAGE OF ADOLESCENTS WHO HAD AT LEAST ONE PRENATAL CONSULTATION, ACCORDING TO RESIDENCE.



1. The percentages in urban areas (capitals and other cities) are always significantly higher than those for rural areas.
2. While the situation of adolescent mothers in rural areas is never as good as that of mothers in urban areas, in Niger, the situation for adolescent mothers in rural areas is catastrophic.

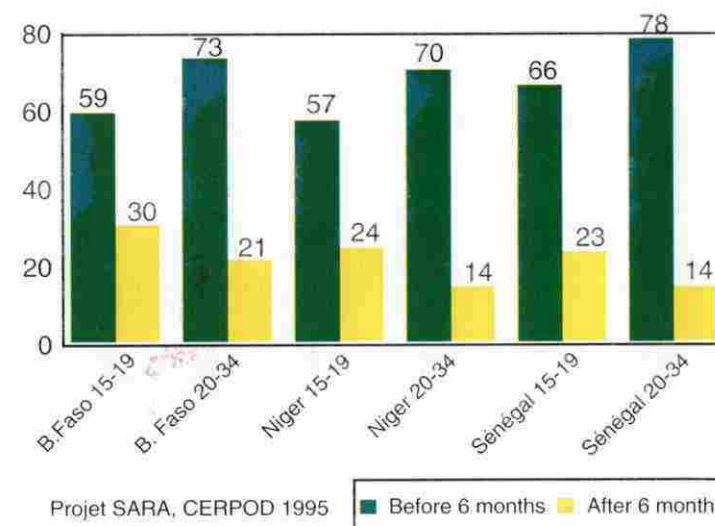
In urban areas, adolescents tend to wait longer before the first prenatal consultation (after the sixth month) than older mothers, especially compared to those aged 20 to 34.

In other cities, the level of prenatal consultations is similar to that observed in the capitals. Adolescents and older mothers consult medical personnel during their pregnancies. The frequency of these consultations is generally determined by the place of residence. However, in urban areas, adolescents tend to wait longer before the first prenatal consultation (after the sixth month) than older mothers, especially compared to those ages 20 to 34 (**Graph 6.3**).

Rural areas

As high as the level of prenatal consultations for adolescents and older women may be in urban areas, it remains low for all women in rural areas. The percentage of rural women who have never had a prenatal consultation is 27 percent for Senegal, 47 percent for Burkina, 73 percent for Mali, and 78 percent for Niger.

GRAPH 6.3 - PERCENTAGE OF MOTHERS WHO HAD A PRENATAL CONSULTATION BEFORE THEIR SIXTH MONTH, AND WOMEN WHO HAD IT AFTER.



1. Note that there are more adolescent mothers who have their first consultation after six months than older mothers.

The percentage of rural women who have never had a prenatal consultation is 27 percent for Senegal, 47 percent for Burkina, 73 percent for Mali, and 78 percent for Niger.

Link between schooling and level of use

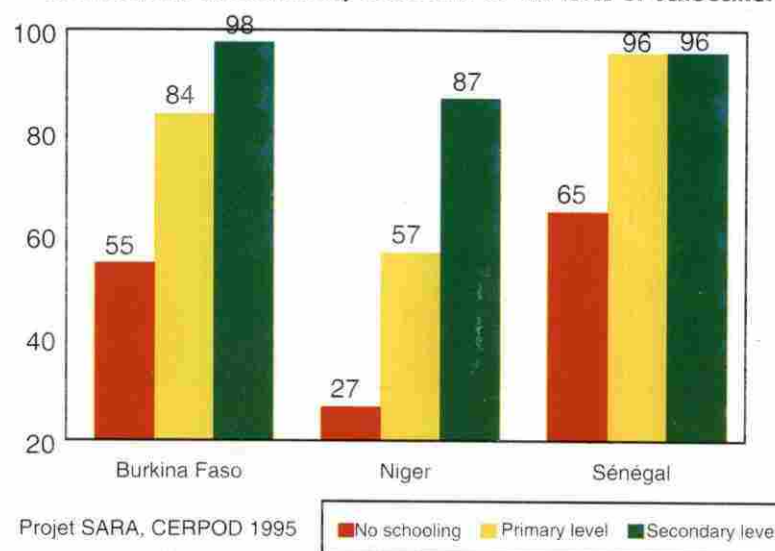
In both urban and rural areas, pregnancy care is strongly linked to the level of schooling achieved. In Niger, less than a third of women with no schooling have had a prenatal consultation. Among those who have reached grade school level, most have been in contact with trained medical staff. In Burkina and in Senegal, significant differences can be observed among women with different levels of instruction (**Graph 6.4**).

Childhood immunizations

Based on recommendations made by World Health Organization (WHO) in the context of their Broadened Vaccination Program (BVP), a child should receive a BCG, the vaccine against measles, three doses of DP (diphtheria, pertussis and tetanus), and three doses against polio before his first birthday.

In urban areas, particularly in capital cities, there is only a small proportion of children who have not been vaccinated at all. However, there is a significant number

GRAPH 6.4 - PERCENTAGE OF ADOLESCENT MOTHERS WHO HAVE HAD AT LEAST ONE PRENATAL CONSULTATION, ACCORDING TO THE LEVEL OF SCHOOLING.



1. The more schooling an adolescent receives, the more likely she is to give birth at a medical facility.
2. This difference can be explained in part by the fact that there are relatively higher numbers of adolescent mothers receiving schooling in urban areas than in rural areas.

of nonvaccinated children in rural areas, especially in Niger (63 percent among unmarried mothers and 70 percent among married mothers).

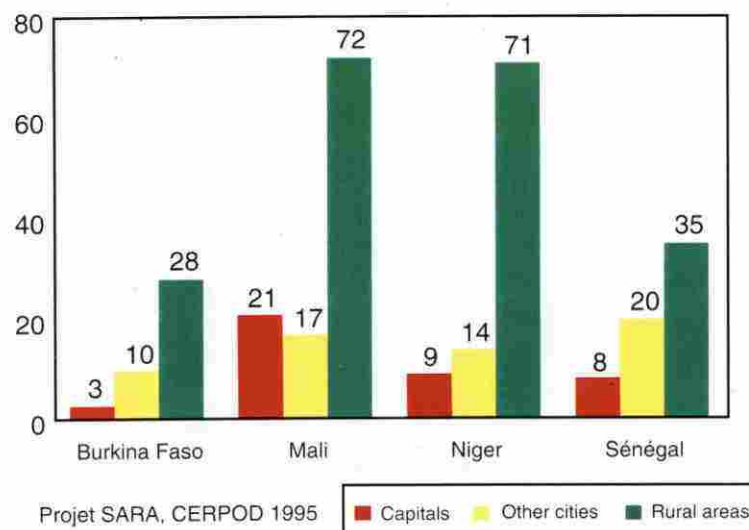
However, in the rural areas of Burkina Faso and Senegal, less than a third of the children are affected. This parallels the differences observed regarding prenatal consultations.

Children born to adolescent mothers do not find themselves in a less favorable situation than children born to older mothers.

In Dakar, it has been observed that more children born to adolescents are vaccinated. However, in Bamako, there is a higher proportion of children born to adolescent mothers who have not yet been vaccinated (**Graph 6.5**).

In conclusion, it is clear that prenatal consultations are insufficient for all women in rural areas. But the consequences of this are more serious for adolescents and their children who represent an especially vulnerable group.

GRAPH 6.5 -PERCENTAGE OF CHILDREN OF ADOLESCENT MOTHERS WHO HAVE NOT RECEIVED ANY VACCINATIONS



1. In the capitals, few children born of adolescent mothers have not received any immunizations. However, the plight of children of adolescents is bad in rural areas in Senegal and Burkina and catastrophic in Mali and Niger (7 out of 10 have not been immunized at all).

DISCUSSION TOPICS



- What strategies should be used to expand maternal and infant services and make them available to all women, especially those in rural areas?
- How can vulnerable adolescent mothers be targeted for help, regardless of whether they are married?


CONCLUSIONS AND RECOMMENDATIONS

The reproductive health problems of adolescents are an urgent, complex, and sensitive matter for which there are no obvious solutions.

The main results outlined below reveal the different dimensions of the issue of reproductive health of adolescents in the Sahel. The problem is urgent, complex, and sensitive and the solutions are far from obvious. For this reason, a number of discussion questions have been raised for each theme. The different actors (health personnel, researchers, institutions working with youth, communication experts, AIDS programs, donors, and adolescents, etc.) are invited to think about these problems in the context of cultural, social, and economic realities.


YOUNG AGE AT FIRST MARRIAGE

- ▶ The age at first marriage is still very low in rural areas.

 **Given its dangerous impact on the health of the mother and child, how can this problem be addressed?**


SINGLE STATUS AT AGE 20


- ▶ An increasing number of young women in urban areas are not yet married by age 20. This exposes them during a longer period of time to the risk of premarital sexual activities and all its accompanying consequences.

 **How can society's different institutions adapt to this new phenomenon (family, health, education, religion, etc.)?**

SEX BEFORE MARRIAGE


- ▶ Parents are convinced that their sons and daughters have more sexual freedom than they did when they were young;
- ▶ Adolescents feel that virginity is desirable, but they recognize that it is difficult to remain chaste;
- ▶ Premarital sex is increasingly common in urban areas, and even exists in rural areas;
- ▶ Family, school, and religious institutions do not appear to sufficiently prepare adolescents to be sexually responsible. Sources of information on sexuality are usually friends, older siblings, the media, and pornographic films.


 **Which factors encourage early sexual activity among adolescents?**

 **Given the increase in premarital sex among adolescents, and the dangers to which they are thus exposed, what health, education, and communication strategies should be put in place?**

BIRTHS BEFORE MARRIAGE

- ▶ Although less predominant than in certain areas of sub-Saharan Africa, premarital births that occur before the age of 20 must be taken into account in the Sahel, despite the fact that religion and cultural norms there prohibit sex outside marriage;
- ▶ The populations that show the lowest levels of premarital sex do not necessarily show the lowest levels of births before marriage. These gaps may be due to the differences in contraceptive availability.

 Which strategies should be adopted to prevent births before marriage in adolescents?


 What attitudes should be promoted among health care providers, parents, and educators towards single adolescent mothers and their children?

 What actions should be taken in favor of single adolescent mothers and their children?


FAMILY PLANNING AMONG ADOLESCENTS

- ▶ The percentage of adolescent girls who approve of family planning is much higher than that of their spouses.
- ▶ The schooling of women and men increases their likelihood of approving of family planning.
- ▶ Very few adolescent girls discuss family planning or the number of children they want with their spouse.

- ▶ Modern contraceptive prevalence is higher among single women than it is among married women. However, among single women, prevalence is lower among adolescents.

 How can communication between married adolescent girls and their spouses regarding family planning be improved?


 How can the concept of birth spacing be promoted among married adolescent girls?


 What are the advantages and disadvantages of having access to contraceptive methods by sexually active but unmarried adolescent girls?

SEXUALLY TRANSMITTED DISEASES AND AIDS

- ▶ Studies show that adolescents have only partial knowledge of sexually transmitted diseases (STDs). The methods of transmission and the manifestations or symptoms are not always known. Knowledge of STDs is higher among boys than girls.
- ▶ AIDS was mentioned by nearly all adolescents, boys as well as girls. However, just as for STDs, the knowledge is superficial and often inaccurate.
- ▶ Condoms, abstinence, and fidelity are often referred to as methods to prevent STDs. However, certain adolescents also referred to the pill and spermicides as STD prevention methods.


- ▶ Sources of information about STDs are not very different from sources about sexuality and family planning (the media, communication between youths, etc.)

 **What are the obstacles that prevent sexually active adolescents from protecting themselves against STDs and HIV?**

 **What strategies can be developed to protect sexually active adolescents given the dangers to which they are exposed?**


OBSTACLES THAT PREVENT ACCESS TO FAMILY PLANNING SERVICES AND THE TREATMENT OF STDs


- ▶ Shame and shyness were referred to as obstacles that prevented access to family planning services and the prevention and treatment of STDs.
- ▶ An important number of adolescents condemned the attitude of some health care providers.
- ▶ The cost of family planning and the services for the prevention and treatment of STDs was often brought up as an obstacle.
- ▶ Parents very rarely talk about sexuality and family planning with their children.

 **How can obstacles preventing access to services for family planning and STDs be overcome?**

HEALTH OF THE ADOLESCENT MOTHER AND HER CHILD

- ▶ There seem to be very few differences in the use of maternal and child health services between adolescents and older women. It is disturbing, however, to see the number of adolescent mothers in rural areas and their children who do not have access to health services.
- ▶ In urban areas, adolescents tend to delay their initial prenatal consultation, waiting until their sixth month.

 **What strategies should be developed to increase the coverage and use of maternal and child health services for all women, especially those in rural areas?**

 **How can the more vulnerable adolescent mothers be targeted, whether they are married or not?**

RECOMMENDATIONS

Discussions with adolescents, parents, and key informants provided insights into their views regarding the different problems raised during the study. Moreover, a number of recommendations were gathered from a seminar which brought together family planning officials and donors in Bamako from October 9 - 13, 1995.

These recommendations are presented herewith, not to impose a set of solutions to the problems highlighted by these studies, but in order to enhance the dialogue.

SOLUTIONS OFFERED BY ADOLESCENTS

Three major recommendations came out of the discussions held with adolescents:

- ▶ **The opening of health services devoted exclusively to adolescents.** They explain that "a young person can look another person of his/her age straight in the eye, but cannot look at an adult in the same way. A young person who is knowledgeable can correctly answer another adolescent's question without there being any shame."
- ▶ **Services should be free or provided at reduced costs:** "we can only demand free care, or a slight contribution to the cost of the drugs."
- ▶ **Information specifically designed with adolescents in mind.** However, adolescents feel that information and sex education should be geared towards girls. "It truly is a big problem."

- ▶ **Everyone must be sensitized to these issues,** even in schools, all girls do not have this information." "Girls must be sensitized to the importance of abstinence and the use of condoms."

POINT OF VIEW OF KEY INFORMANTS

Suggestions to improve services for adolescents

The suggestions that were retained complement those offered by adolescents themselves. They present answers to the obstacles that were identified and can be summarized in the following manner:

- ▶ **Popularization of methods of contraception and prevention to help prevent adolescents who would seek these services from feeling embarrassed.** "The sale of condoms must be generalized and made routine...similar to the sale of peanuts...that way, no-one will pay attention to someone buying a condom."
- ▶ **Sex education should reach adolescents as well as their parents, and should especially emphasize all aspects of sexuality and not just sexual intercourse.** "There ought to be a human dimension, because man is not simply a sexual being. There is also the human, moral, and spiritual dimension. If these are lacking there is a vacuum." "If sex education were to be introduced in the programs, I think that the content should be geared towards informing children about relationships between men and women. It should inform them about the basic values of our society."

- ▶ **A new approach to service provision:** "we must now go to the young people, in the "grins" and in the families. Instead of trying to gather them over the airwaves, we must reach out to them." "If we could create associations/groups among the young that could inform them about these problems [sexuality], I think it would be better."

- ▶ **Finally, an integrated approach** that, because of its dynamic nature, would seem better suited to achieving results in the medium term. It seems to be the most innovative. "We can combine our forces by working with educators, with religious people, with parents. Let everyone do their share...in 5 or 10 years, you will see the results of these changes within our society."

POINT OF VIEW OF THE PARENTS

Some recommendations, formulated by parents, did not always achieve a consensus. Implementing these recommendations requires patience and the participation of different components of society:

- ▶ Create health centers where adolescents have access to reliable information.
- ▶ Create centers where adolescents could be taken in charge in cases of unwanted pregnancies.
- ▶ Introduce family planning classes in school curricula.
- ▶ Facilitate access to family planning services for adolescents. Create a structure that allows adolescents to have access to services at all times, without feeling fear or shame.

- ▶ Institute periodic medical examinations at schools to detect STDs and pregnancies.
- ▶ Create health centers in rural areas.

BAMAKO SEMINAR RECOMMENDATIONS

Quality of Service

- ▶ Encourage attitude and behavioral changes in service providers.
- ▶ Draw on the Burkinabe experience as a model of accessibility of contraceptive methods.
- ▶ Ensure the social marketing of condoms.
- ▶ Ensure that delivery of family planning services and the prevention and treatment of STDs for adolescents are free or that the cost is substantially reduced.
- ▶ Institute multi-purpose health visits for the young.

Communication

- ▶ Institute a multifaceted communication policy (e.g. cartoons, interpersonal communications...).
- ▶ Support the age group (10 to 14) that precedes adolescence.
- ▶ Train formal and informal educators, health experts, prostitutes, etc.
Favor communications between adolescents and

- ▶ the rest of society on subjects that are normally taboo.
- ▶ Reassert the values of the teaching profession (behavior, responsibility, morality).
- ▶ Sensitize the authorities who are responsible for family life education (FLE).

Adolescents

- ▶ In the different programs, be sure to involve the youth themselves in researching solutions to the problems that directly concern them.
 - ▶ Help adolescents realize the importance of their role in taking charge of their sexuality.
- Develop the concept of responsible parenting,

- ▶ both at the level of the adolescents and their parents.

Research

- ▶ Conduct more extensive research on the health and reproduction of adolescents, especially on the situation of adolescents in Dakar.
- ▶ Conduct in-depth research in order to better understand the point of view of married men towards family planning.
- ▶ Establish better indicators to measure the knowledge of family planning methods and sexually transmitted diseases.
- ▶ Complete data analyses for Mali as soon as data results from Mali's DHS II become available.



Photo CERPOD/Sié Offi SOME

WHAT NEXT ?

Can our societies afford the luxury of ignoring the reproductive health problems that our adolescents face today ? The stakes are nothing less than the future of our societies which will depend on these actors for tomorrow's development. Hopefully, these research results and discussion topics will encourage you to discuss possible solutions for the problems concerning the reproductive health of adolescents in the Sahel that have been identified. In order to advance even further, a certain number of additional questions need to be asked:

- Am I a potential actor in the arena of reproductive health care and what can I do at my level?
- Who are the other actors in this process?
- Who are the key people to implement the recommendations that will result from our discussions?
- Which crucial partnerships should be developed to ensure the implementation of these recommendations?
- What are the available human and material resources?
- Who are the adolescents who can become actively involved in the search for solutions? How can they become involved? How can they be prepared to assume the role of participant and leader?

MAIN SOCIO-DEMOGRAPHIC INDICATORS FOR BURKINA FASO, THE GAMBIA, MALI, NIGER AND SENEGAL

INDICATORS	BURKINA FASO	THE GAMBIA	MALI	NIGER	SENEGAL
TOTAL POPULATION (in thousands), Mid-1995	10 819	1 089	9 013	9 235	8 296
MALE POPULATION, AGES 15-19 (in thousands), Mid-1995	533	47	410	377	398
FEMALE POPULATION, AGES 15-19 (in thousands), Mid-1995	518	53	421	449	452
POPULATION, AGES 15-19, Mid-1995	1051	100	831	826	850
GROSS BIRTH RATE (per thousand)	45,3	50,5	46,6	52	48
GROSS MORTALITY RATE (per thousand)	16,4	21,2	19,5	20	19
TOTAL FERTILITY RATE	6,9	6,0	6,7	7,4	6,0
% WHO KNOW OF A MODERN METHOD (WOMEN LIVING WITH SOMEONE)					
URBAN	93,3	88,7	56,7	88,6	88,4
RURAL	57,1	69,6	19,1	53,0	61,6
TOTAL	63,3	73,3	28,6	58,0	70,3
% USING SOME TYPE OF CONTRACEPTIVE METHOD (WOMEN LIVING WITH SOMEONE)					
URBAN	26,0	26,2	11,4	14,1	16,1
RURAL	4,2	8,4	2,3	2,5	3,3
TOTAL	7,9	11,8	4,7	4,4	7,4
% USING MODERN CONTRACEPTIVE METHODS (WOMEN LIVING WITH SOMEONE)					
URBAN AREAS	17,1	16,5	4,7	8,6	11,8
RURAL AREAS	1,5	4,3	0,1	0,7	1,4
TOTAL	4,2	6,7	1,3	2,3	4,8
INFANT DEATH QUOTIENT					
URBAN	76,4	84,0	72	89,0	54,5
RURAL	113,0	102,0	119	142,6	86,7
TOTAL	107,6	97,9	108	134,5	76,0
INFANT AND JUVENILE DEATH QUOTIENT					
URBAN AREAS	148,4	114,0	182	210,3	101,8
RURAL AREAS	214,4	198,0	271	346,8	184,2
TOTAL	204,5	181,0	249	326,1	156,7

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The Centre for Applied Research on Population and Development (CERPOD) was established in 1988 by CILSS (Permanent Inter-States Committee for Drought Control in The Sahel) which gathers nine Member-States : Burkina Faso, Cape Verde, Chad, The Gambia, Guinea Bissau, Mali, Mauritania, Niger, Senegal.

CERPOD also intervenes in other countries in the African continent.

It is a structure under the trusteeship of the Sahel Institute (INSAH) headquartered in Bamako (Mali).