Adolescent Sexuality and Premarital Counselling

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It is increasingly recognised that the good reproductive health really begins in adolescence. Nearly 1 out of every 6 persons are adolescents and 85 per cent live in developing countries. (UNFPA and Adolescence-1997). Sexuality is a natural instinct and sexual activity may start even premaritally putting the adolescents at risk. Each year about 15 million adolescents between the age 15 to 19 years give birth and as many as 4 million undergo abortions. Besides, 100 million are infected with sexually transmitted disease. It is unfortunate that 40 per cent of all new HIV infections (human immunodeficiency virus) occur among 15-24 year old. The recent estimates are that 7000 of these young people are infected each day. (UNAIDS Global HIV/AIDS epidemic 1997.) According to Alan Guttmacher Institute, women in age groups of 15 to 19 years are responsible for 6 per cent of all births world-wide each year and in less developed countries excluding China, it is 8 per cent of births. (Population Today, 1998.)

These problems arise as adolescents lack basic reproductive health information and the parents, teachers, doctors, and social workers have not taken up this challenging problem seriously. Good counselling could prevent many of these problems and help them to develop healthy lifestyle. We need to understand the adolescent sexuality and give the necessary premarital counselling in an effective and interesting manner. It is necessary to understand the socio-cultural factors and the cultural norms regarding gender and sexual relationships. In some parts of India marriages are arranged for girls even younger than 14 years old. Older men often seek young girls as sexual partners to protect themselves from STD's. In Thailand an estimated 800,000 prostitutes are under age 20 and one fourth are younger than 14 years. (PATH Adolescent Girls and their rights,1997.)

Adolescent Sexuality.

In preadolescence from 9 to 11 years there is curiosity and increase in physical and sexual drive and certain degree of aggressiveness. In early adolescence from 11 to 14 years, there is increased interest and sexual behaviour may be experimental. Between 14 and 17 years the adolescents may begin to experience heterosexual relationships. In late adolescence, between 17 and 20 years the young girl develops her identity and responsibility if well educated and counselled. Sexual activity is at its height during this biological peak of energy, and we need to recognise this problem and tackle it with sensitivity. A healthy attitude towards healthy sexual interaction, and awareness of their behaviour and needs, followed by counselling can prevent many traumatic consequences.

Consequences of adolescent sexuality

The teenagers could maintain abstinence or could indulge in sexual relationships. Unprotected sex carries the risk of sexually transmitted diseases and of pregnancy and the young girl may have to undergo termination of pregnancy or continue the pregnancy which may be associated with medical and psycho-social problems. Some of them may develop sexual dysfunction. Abortions may endanger their lives specially if termination is delayed upto second trimester or is carried out in clandestine places.

Sexually transmitted diseases are becoming a major concern. A spectrum of infection ranging from trichomoniasis, candida, gonorrhoea, syphilis, herpes simplex and human papiloma virus could be responsible for various problems. Chlamydia trachomatis as well as other organisms responsible for pelvic inflammatory disease lead to chronic pelvic pain and infertility and infection with human immunodeficiency virus (HIV) can cause AIDS syndrome. Sexual and drug experimentation and risk taking atitude make the adolescents most vulnerable to infections. Besides, interruption in education and social and economic problems would modify her life pattern permanently. At times she may choose marriage under duress or may decide to be a single parent where the child often has the disadvantage of negligence and abuse.

Factors influencing the sexual behaviour

The sexual behaviour of the adolescent is influenced by personal factors such as education, social class, ethnic

group, knowledge and availability of contraception. The family background, parental values, attitude and control, the stability of parent's marriage and domestic violence also have tremendous influence. Interpersonal relationship and social factors such as peer pressures, mass media, religious teaching, culture and tradition and sex education also play an important role. Millions of children on the streets in the developing countries are involved in 'survival sex' where they trade sex for food, money, protection or drugs. (WHO fact sheet No: 51, 1998.)

Indian Studies

Family Planning Association of India has conducted a study of knowledge, attitudes, beliefs and practices among educated Indian youth keeping in mind the milieu and sensitivity of the people. (Watsa -1993.)

The data cleared a number of misconceptions and beliefs about the sexuality of the young people. Indian youth face a dilemma between the traditional Indian norms and western patterns of expression especially because of the absence of systematic and correct counselling in matters of sex and sexuality.

The study covered 4,709 respondents in the adolescent, early adulthood and late adulthood reflecting the three stages of youth. The analysis showed that these respondents received information about sex for the first time at an average age of 13 years. Their sources of information were mostly mass media and friends and were not reliable. Only one third of the respondents could ask their teachers to clear their doubts on sex and sexuality and the teachers were ill equipped to explain these matters. AIDS as STD was widely known in over 70 percent and sexual abstinence as a method of preventing STD infection was stated by 16.4 per cent males and 13.1 per cent of female respondents. Large numbers of adolescents stated the importance of avoiding sex with strangers. Premarital sex was more acceptable to boys than girls. Most girls (63.3 Per cent) felt that sexual relations should begin only after marriage, but only 38.4 per cent boys felt so. On an average males were 16 years and females 18 years when they had their first sexual experience, and around 4 percent of male respondents had sexual contact with prostitutes. A study conducted in Pune showed that 75 percent of those attending disease clinic were between 18-19 years. (Urmil et al- 1989.)

Jeejeebhoy studied the adolescent sexual and reproductive behaviour in India and noted that unlike most other countries adolescent fertility in India occurs mainly within the context of marriage. (Jejeebhoy – 1996.) As a result of early marriage about half of all young women are sexually active by the time they are 18, almost 1 in 5 by the time they are 15. The magnitude of teenage fertility in India is therefore considerable and over half of all women between 15 and 19 years have experienced a pregnancy or a birth . Between 20 and 30 percent of all males and 10 per cent of all females are sexually active during adolescence before marriage Both married and unmarried women are vulnerable to being unprotected from pregnancy and STD's. and are unlikely to have decision making power. Jeejeebhoy (1996) emphasises that the need for sexual and reproductive health service remains unmet and the service should be structured to respond to these needs, taking into consideration the cultural, economic and social constraints. The International Family Planning Perspectives (1998) has reported that the average age of the first sexual intercourse is 17.6 years in the 10 000 sexually active adults studied in developed and developing countries, the age in America is 15.8 years, in Hongkong it is 19 years.

Contraceptive counselling

It is essential that the counsellors develop appropriate skill and also build community support when they plan the programme strategies. A combinaion of approaches is most often effective. Youth oriented clinic services provide a wide range of clinical and social services specially in United States of America, Western Europe and Latin America. They provide facilities for counselling for pregnancy and STD prevention and also treat those who need clinical care. The school-based clinics are available in some developed and developing countries but the services provided vary considerably. In most of the developing countries, restrictive policies, personnel shortages, and lack of private areas for counselling limit these services . These multiple service youth centers should also offer contraceptive services as part of comprehensive programmes for youth, which include education, recreation and employment

preparation. Community based outreach programmes are especially important for youth which are out of school and girls who have limited freedom to leave their community. Youth groups such as girl guides can be provided reproductive information. It has been found that girls who participate in sports are mentally and physically healthier and have improved self esteem, lower stress and depression rates and make healthier decisions. (WHO/UNFPA/UNICEF Outlook-1998)

While providing contraceptive conselling the physical, emotional and social needs have to be considered. The risk of promiscuity and sexually transmitted diseases and threat to future fertility and even cancer of the cervix should be discussed. Besides the risk of pregnancy and termination of pregnancy have to be well explained.

Confidentiality is extremely important and all the methods of suitable contraception should be explained and offered. Although condoms and oral contraceptives are most suitable, some teenagers may need injectable steroid contraceptives or even IUD at times. Diaphragms and spermicides are not suitable for teenagers and periodic abstinence and coitus interruptus are unpractical and have high failure rates. Sterilisation is used at times for the mentally retarded. The role of emergency contraception has to be explained very well.

The concept of emergency contraception has to be understood and accepted. The hormonal method is most commonly used where a combined contraceptive such as Ovral-each tablet containing Levonorgestrel I. P. 0.5mg and Ethinylestradiol I. P. 0.03mg, can be given within 72 hours after an unprotected coitus. Two doses of two tablets 12 hours apart are generally successful in preventing pregnancy in 95 per cent of cases. (Yuzpe et al-1974) The Yuzpe method of emergency contraception has been used for many years and yet there is not sufficient awareness. Bhatt (1998) studied the awareness about the emergency contraception in a survey of 1125 urban and 575 Rural women in reproductive age group. Only 8 per cent of Urban and 3 per cent of rural women knew about emergency contraception and only 30 per cent of gynaecologists had some knowledge about this.

Danazol levonorgestreal and mifepristone (RU486) have also been used. The effectiveness of antiprogesterone (RU486) is the highest and the side effects minimum. Two large-scale clinical studies by Glasier(1992) and Webb et al (1992) have shown comparative efficacy of mifepristone and Yuzpe method. The pregnancy rate was 1.5 per cent in 593 partients on the Yuzpe as compared to nil in mifepristone group. Though other drugs used for emergency contraception are available, there is need to spread the awareness amongst medical personal and women.

Insertion of Cu IUCD after unprotected coitus may be a useful method in some cases, although it is not a method of choice since it may increase the possibility of ascending infection.

<u>Premarital Counselling</u>

Counselling adolescent boys and girls in school, youth clubs, mahila mandals and clinics gives necessary confidence and information to the couple before marriage. However, it is important that the doctor can meet the bride and bridegroom together before marriage and give them scientific information. The anatomy and physiology could be taught with the help of diagrams and models and their question should be answered with confidentially to give them confidence to begin their married life.

<u>Holistic approach</u>

The WHO review of 19 studies found that sex education in school often delayed or decreased adolesent sexual activity, and led to more effective contraceptive use, and did not promote earlier or increased sexual activity in young people. (Sapire, 1996)

At the South Asia Conference on Adolescents, organised by UNFPA in New Delhi in 1998., representatives from seven Asian countries, NGO's, International Agencies as well as selected adolescents actively participated. It was considered Agencies as well as selected adolescents actively participated. It was that important that the young people are involved in developing a holistic, developmental and integrated programme. The diversity and the magnitude of the changes taking place in the lives of adolescents were revealed. Apart from sexuality and

reproductive health, equally important issues related to career opportunities for school drop-outs, exploitation of and violence against adolescents within and outside the family and work places were noted. (UNFPA CASA Bulletin 1998). Thus every opportunity has to be utilised to reach the message of reproductive health at various places, schools, community, Mahila Mandals, workplaces, sport groups and clinics. These programmes should combine conselling and clinical services so that the young people make healthy life choices. These programmes involve parents, teachers, religious leaders community leaders and young volunteers. Governments, non-government organisations (NGO's) gynaecological societies, Family Planning Association's and educationists can fulfil these needs to effectively use the available resources and achieve our goals. The counsellors have to consider the factors which influence the adolescent health, and behaviour such as poverty, malnutrition, displaced populations, peer pressure, gender inequalities and sexual exploitation as well as the cultural expectations about childbearing. They have to organise the programme in relevance to the need of the youth in each country with different culture and social pattern to make the programme meaningful. Organisations such as International Planned Parenthood Federation have created youth advisory panels to help shape programme ideas. The WHO programme on Substance Abuse recommends that the group working with street children should be aware of changing needs. There are nearly one billion adolescents worldwide(10-19 years old) and their decisions will greatly influence the future of world population, (FPAI 1998).

Our Federation has declared the year 1999 as the year for "Adolescent Girl-Education and Empowerment". Many health education programmes are being carried out and UNICEF as well as central and State governments have been co-operative. Brihanmumbai Mahanagarpalika (BMC), University Grant Commission, S. N. D. T. University as well as colleges in social science such as Tata Institute of Social Sciences have various programmes to support this effort. I am sure these effort will go a long way in understanding the adolescents and organising proper conselling services. There has to be sustained interest, long-term plans and commitment. In the ultimate analysis, any society will be judged by its ability to provide universal health care for all segments of its population.

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