

## Barriers of Asian Youth to Access Sexual Reproductive Health Information and Services: A Literature Review

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### Abstract

#### Background

Despite recommendations from the World Health Organization in most Asian countries, young people's sexual and reproductive health (SRH) needs are poorly provided and understood. The aim of this review paper is identifying barriers as well as improving strategies to access SRH information and services among Asian youth.

#### Materials and Methods

We conducted a review study and the databases used to search for articles include: Web of Science, Scopus, Medline, EMBASE, and the Cochrane Library, WHO, UNFPA, and UNESCO. The search terms "sexual health", "reproductive health", "reproductive health service", "information", "knowledge", "sex education", "barrier", "challenge", "strategy", "promotion" were used and combined with "Asian", "adolescent", "teenager", "youth" and "young people". In this study we sought both qualitative and quantitative articles published between Jan 2008 and Jan 2019.

#### Results

Limited knowledge on SRH among youth, lack of youth friendly services, socio-cultural, legal, policy, leadership and political factors were the main obstacles of Asian youth to access SRH information and services. Culturally sensitive community based intervention, involving religious and social leaders, reforming health services and policies, considering integration of refugee youth's SRH needs into policy of local governments in Asian critical areas and use of new media for distribution of information were identified as effective strategies for improving youth SRH.

#### Conclusion

Socio-cultural and structural barriers are the most important challenge of Asian youth to access health services. Restructuring health system and policies, culturally appropriate sex education are required to improve youth access to SRH services.

**Key Words:** Asian Youth, Barriers, Sexual Reproductive Health, Information.

\*Please cite this article as: Najafi-Sharjabad F, Haghightajoo S. Barriers of Asian Youth to Access Sexual Reproductive Health Information and Services: A Literature Review. *Int J Pediatr* 2019; 7(12): 10541-551. DOI: **10.22038/ijp.2019.14012**

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Received date: Mar.17, 2019; Accepted date: Oct.22, 2019

## 1- INTRODUCTION

According to definition of World Health Organization (WHO) adolescents are defined as individuals in the 10-19 year age group and youth as the 15-24 year age group. Whereas young people include the age range 10-24 years. This period is associated with rapid cognitive, biological, and psychosocial development, and physical changes of puberty that lead to sexual maturity. The formation of norms, values, identity related to sexuality and gender is characteristic of this period. Such changes lead to new health needs and risks, and consequently more information and services related to sexual and reproductive health (SRH) are needed (1, 2). About 20% of the total world population is adolescents. In developing countries, including the Middle East their number is estimated to reach 1.12 billion by the year 2025 (3).

In 2016 in developing countries 21 million pregnancies have occurred among adolescent girls aged 15–19 years. About 43% of the pregnancies in Asia were unintended (4, 5). It has been estimated that 23 million adolescents have an unmet need for modern contraception which can result in risk of unintended pregnancy (5, 6). Approximately, one-fifth (21%) of unintended pregnancies among adolescents in Asia end in unsafe abortion (6). Young people are vulnerable to different peer, cultural, and social pressures that may lead them to earlier sexual activity (1). Although the spread of HIV/AIDS and various sexually transmitted infections (STIs) is decreased with delaying sexual activity until marriage, the sexual activities among young people have been reported to be rising in the world (7). Annually, marriage before the age of 18 years occurs among 15 million girls, and 90% of pregnancies occur in young married women, aged between 15 and 19 years old (8, 9). In Arab countries the legal minimum age for marriage of girls differs

from nine years in Gaza to 20 years in Libya (3). In spite of several Indian policies for delaying marriage, about half of women 20–24 years are reported to marry before the legal age of 18 (10). On the other hand, the couples after marriage are under social pressure to begin childbearing very soon. It is not surprising that 30% of Indian women gave birth before age 18, and 53% do so by age 20 (3, 10). It has been estimated a 10% reduction in child marriage could contribute to a 70% reduction in maternal mortality rate (11). In Asian cultures taboos surrounding sexuality exist and non-marital sex is disapproved (12). This is the case in Muslim countries particularly in relation to girls, because their chastity denotes their families' honor (13). In the majority of Muslim countries sexual relationships are forbidden outside of marriage.

Open discussion of related sex issues or within families is often taboo and unacceptable. Due to culture of silence surrounding sexuality, young people demonstrate limited information on SRH issues (12, 14, 15). In Jordan the majority of youth face substantial challenges in addressing their SRH needs, including prevention of STIs and unintended pregnancy, sexual coercion and violence, and early marriage (14). Early pregnancies have negative social and economic effects on adolescents, their families and societies. Early pregnancy exposes them to a greater chance of violence within marriage or a partnership (16). Many girls experienced sexual violence because of the gender inequality that exists between men and women in the Middle East (3). It has been estimated that 5 to 33% of adolescents between the ages of 15 and 24 who drop out of school experience violence as a result of early pregnancy or marriage (17). Decrease in the average age of menstruation and puberty, increase in premarital sex due to the increase in age of marriage and decrease in age of onset of

sex relationship are contributing factors of increasing adolescents' pregnancies (3).

Despite recommendations from the WHO in the majority of countries in the Middle East, adolescents' SRH needs are poorly acknowledged and provided (3). Human crisis has caused many Syrian refugees in Lebanon, Turkey, and Jordan to become vulnerable and suffer from SRH issues. Because of economic pressures, social norms and community dynamics, young girls experience poor SRH outcomes, such as early pregnancy, unplanned pregnancies, child marriage, sexual assault, gender-based violence, infant morbidity, preterm birth, poor contraceptive use, and menstrual irregularity (14, 18-20).

Due to sensitivity of topics like extra marital sexual relationship among Muslim countries, denial of non-marital sex is an important barrier to combating HIV/AIDS (12). All young people, regardless of their marital status, need access to quality, comprehensive information on puberty and SRH services to support this transition to adulthood. SRH services are also crucial to reduce the potential risks associated with unsafe sexual behavior, such as: STIs, sexual violence, and unintended pregnancy (21). Studies have shown young people face many challenges to seeking and gaining access to SRH services and information. They experienced several barriers such as, poor awareness of SRH and services, socio cultural barriers like stigma, shame, social disapproval, health system challenges, confidentiality concerns, long waiting hours and negative attitude of health staff (22-25).

There is a limited number of published papers on barriers of youth access to sexual and reproductive health information and services within the context of Asian culture. Exploring influencing factors that promote or inhibit youth access to SRH information and services would have some implications for policy making, designing

and implementation of reproductive health programs and services for youth population in Asian countries with the similar socio-cultural contexts. The purpose of this article was to review barriers of Asian youths' access to SRH services and information as well as improving strategies to their access to the services.

## 2- MATERIALS AND METHODS

The current study is a review survey which was conducted to evaluate barriers of Asian youth to access sexual reproductive health information and services. The following databases were used for searching terms which include: Web of Science, Scopus, Medline (via PubMed), EMBASE, Cochrane Library, World Health Organization (WHO), United Nations Educational, Scientific and Cultural Organization (UNESCO), and United Nations Population Fund (UNFPA). In addition, a manual search was conducted in Google motor engine, Google Scholar, and bibliography of relevant articles. In the first step of searching, two independent researchers screened the articles and texts. In the next step full texts of relevant articles and texts were summarized and categorized and based on the results were presented.

The search terms "sexual health", "reproductive health", "reproductive health service", "information", "knowledge", "sex education", "barrier", "challenge", "strategy", "promotion" were used and combined with "Asian", "adolescent", "teenager", "youth" and "young people". In this study we sought both qualitative and quantitative studies. Finally, 52 articles published between Jan 2008 and Jan 2019 were reviewed and language of publications was restricted to English. In the initial review, 314 articles were found. Of the found articles, 262 documents were excluded in several steps by processes of article selection. Finally, a total of 52

studies were included in this review. English-language articles and studies in the young age group (15 to 24 years) were included in this review paper. Studies that did not meet the inclusion criteria, or studies conducted in non-Asian populations were excluded.

### **3-RESULTS**

The results of 52 selected articles showed, young people face several obstacles to access SRH services and information.

#### **3-1. Barriers to access SRH information and services**

##### **3-1-1. Lack of SRH knowledge**

Poor SRH knowledge was the main barrier for female youth reproductive health (26). Young people receive little SRH education, and often rely on their peers for sexual information (27). A systematic review among Middle Eastern female university students showed there is insufficient SRH knowledge (28). In critical areas of Middle East studies have shown most Syrian refugee youth lack basic SRH information or access to health care provider (19, 29). Studies among the South East Asia region also showed lack of adequate knowledge of SRH among youth. In a study in Sri Lanka youth showed poor awareness on existing health services and boys were totally unaware of available youth health services. Girls often sought out sexual information from their friends, while boys were reluctant to talk about their problem with anyone (30). A review of studies among Malaysian adolescents indicated lack of SRH knowledge (31) and in Sri Lanka less than 1% of school going adolescents indicated acceptable SRH knowledge levels (32). From the viewpoint of students and key informants in a qualitative study in a university of Iran, poor understanding of SRH among youth can be related to the lack of sexual health awareness courses at

universities and lack of coverage of sexual and reproductive health problems by the media. Majority believed sexual information received from friends is not a reliable source. Many students demanded to incorporate sex education into university curriculums (23).

##### **3-1-2. Lack of youth friendly reproductive health services**

One of the major barriers to accessing SRH services is lack of privacy and confidentiality; youth are reluctant to use health facilities that do not respect privacy or are not open to them at the convenient time (12, 15, 33). Inaccessible location, lack of provider sensitivity, inconvenient operating hours, long waiting times, costs, unwillingness of health workers to offer contraceptives to adolescents, unavailability of the contraceptives or out of stock, and gender biases were other obstacles in youth access to SRH services (34, 35). Policy ambiguity and insufficient organizational structures were noted as the main barriers of Iranian youth to access SRH services (36). Jordanian youth cited concerns that health staff treated them like children and did not take them seriously, they do not know what information is needed for youth and in their view the questions of youth are inappropriate (37). A study in Sri Lanka showed that young people are reluctant to go to the crowded clinics and discuss sexual issues with health staff (30). Qualitative studies among Jordanian and Syrian youth indicate that they believe that existing family planning services are low quality, unpleasant and unprofessional (37, 38). In critical areas of the Middle East, Syrian refugee women in Lebanon, Turkey, and Jordan face challenges in accessing health services. Challenges faced in providing health services include overloaded public or private hospitals, cost, a lack of medical professionals, female physicians, exhausted medical personnel, and no care coordination (20).

### 3-1-3. Social and cultural barriers

The potential influence of different cultures and religions on reproductive health matters have been well documented (12, 36, 39). Adolescents may be ashamed to talk about sexual topics with parents and experience communication difficulties with their sexual partner (34). Moreover, cultural taboos inhibit parents and teachers from talking about sexuality. They are concerned that providing sexual education in school may encourage young people to engage in early sexual activity and providing sexual information will make adolescents more promiscuous (12, 39). Religious authorities in Iran perceived access to SRH information or sexual education encourages youth to participate in pre-marital sexual activity (36).

Certain religious beliefs, parental authority, customs and traditions, marriage, reproduction and relationships can affect access to SRH and HIV services. In many Asian societies, adolescents are treated like adults if they are married (40). Maximizing fertility and ensuring early childbearing forms the basis of marital structure in Asia. Young married women are under cultural and social pressure to prove their childbearing ability to their families and spouses. As a result, few of them use contraceptives (10, 41). This has made it difficult to dispel this misconception in a country such as India, which has a high adolescent pregnancy rate in Asia (42). In a qualitative study in Iran using non-Islamic patterns for adolescents' sexual health education has been cited one of the main barriers by key informants. Muslims need to consider cultural and indigenous patterns based on religious doctrine when designing sexual health education for adolescents (12). Because of conservative sociocultural norms in the majority of Asian regions, especially in the Middle East, youth do not have access to high-quality, specific, and timely SRH information and services (14,

15, 35). Health care providers have a crucial role in counseling and promoting SRH within the religious and social context of Arab culture (41). Fear and distrust of providers can negatively impact on utilization of crucial services (43). Young people may be reluctant to attend health centers because of fear of social isolation, fear of family criticism, fear of abusive behavior or rejection from parents or spouse. Young people may experience discrimination and stigma from health staff if their behavior is outside the framework of social norms. This situation often marginalizes them (15, 35). In the South Asian region, access to health care for unmarried people has been restricted, young women and girls particularly in rural areas with strong traditional beliefs face challenges in accessing SRH services. Due to negative attitudes toward extra-marital sex, some health workers are reluctant to provide health services to young single people (40). In a study conducted in Nepal the majority of the participants believed health staff do not keep information confidential and do not behave nicely if sexual health problems are shared with them (39). A study in Jordan found that Health providers encourage young people not to use contraceptives by transmitting misconception and fear of infertility (44). In critical areas Syrian refugee women face social barriers in access to reproductive health services in Lebanon, Turkey, and Jordan. Social barriers include stigma, fear of reporting violence, unawareness, fear of discrimination or mistreatment, and difficulties obtaining legal status (20). A study among Syrian refugee women demonstrated the problem of supply and demand of contraceptives, such as provider bias in offering contraception and lack of awareness of women of where to obtain SRH services. Induced abortion has been reported by women as a result of provider refusal to offer emergency contraception post rape (45).

### **3-1-4. Legal barriers**

There is a disparity between the reality of young people's SRH needs and services available under restrictive laws and policies. In South Asia age restrictions on use of SRH services and information such as provision and use of contraceptives and HIV or STI testing impede youth from accessing the services. In the Philippines, the use of SRH services requires parental consent (40). In Indonesia, the condition for using SRH services is marriage and spousal consent (46). Fear of being arrested by police for illegal behavior such as drug use and sex work can be a major obstacle to accessing SRH services (40). Restrictive abortion laws for young people lead them to seek illegal abortion services at great risk to their health (47). The registration of births is required for access to health services, forced marriage of girls before legal age, and protecting youth from harassment by law enforcement officials. Lack of birth registration, especially for refugees, internally displaced persons, and youth without parents could deprive them of access to health services (40).

### **3-1-5. Leadership and political factors**

In favorable political context, welcoming youth participation in decision-making helps to overcome obstacles. Although there is no favorable political environment for youth participation, especially young women, in health planning and policy making. In contexts where the government is fragile, youth health issues have been marginalized. In Afghanistan due to social and political conflict and limited political authority of youth and women, very little attention has been paid to youth issues in the field of SRH and HIV (40). Youth access to SRH services has been affected by the humanitarian crisis in the Middle East. It has been estimated 1.2 million Syrian refugees living in Jordan, high population growth in residential areas have led to a dramatic increase in demand for

limited health resources. While increasing socio-economic deprivations such as geographical isolation, poverty, gender-based discrimination and government incompetence has led to further restrictions on access to SRH services (14).

## **3-2. Strategies to improve youth access to SRH services and information**

### **3-2-1. Provision and access to quality youth friendly services**

Specially designed youth-friendly services are required to encourage youth to seek information, counseling, and other health services which are necessary to protect their health (27). Young people's access to reproductive health services has four essential components: awareness of the SRH services and how to access them, a secure and convenient location, an affordable cost, convenient operating hours (34, 48). Well-trained health care providers e.g. pediatricians, school physicians and primary health care workers who are able to work competently and sensitively with young people is often considered the single most important condition for establishing youth friendly services (41).

### **3-2-2. Considering SRH needs and priorities in critical Asian regions**

In critical regions of Asia the reproductive health needs of refugee youth and their health priorities should be addressed by local government and health policy makers. Improving reproductive health in critical areas requires a multi-level approach to addressing social barriers and challenges to accessing health services. Conducting SRH needs assessment, and policy making can be effective in the long-term care of Syrian refugee women (20).

### **3-2-3. Involving religious and social leaders**

Approaching and involving social and religious leaders is fundamental for the success of progress in youth SRH

programs. Their participation guarantees the development of programs that are religiously and socially acceptable (12, 41).

#### **3-2-4. Provision culturally sensitive SRH education**

Sex education is defined as age-appropriate, scientifically accurate, non-judgmental, realistic information. The purpose of sex education is to empower young people to better understand their sexuality and relationships, which are in fact beyond the transmission of information on reproductive system, human physiology, and STI prevention. The ultimate goal of sexual health education is improvement of adolescents' sexual health and overall quality of life (49).

#### **3-2-5. Community-based distribution interventions**

The most successful community-based distribution interventions are those built on use of existing networks, such as youth organization and natural kinship, instead of building new infrastructure and networks. Such networks are able to focus their efforts more efficiently and achieve greater success without spending resources to construct a service delivery infrastructure (34).

#### **3-2-6. Community outreach approach**

The strengths of the community access approach are its ability to reach young people, especially those who have dropped out of school, those who are marginalized, married or those who are hard to reach. The community outreach programs eliminate the barrier of distance. These programs improve access to health care by removing the stigma and distrust of many young people (34).

#### **3-2-7. School/Curriculum-based Education**

Schools are an important place for informing adolescents about SRH. Most of the studies underline the importance of comprehensive and culturally sensitive sex education (12, 27). School-based educational programs have the capability to reach a large number of young people. Because of ambiguity, inadequate knowledge or embarrassment, most parents do not talk to their children about SRH matters, so school may be the only place where adolescents have access to this information. (34).

#### **3-2-8. Incentive programs**

It has been proven conditional cash transfers and incentive programs are successful in decreasing early marriage, pregnancy and school drop-out. It is more likely that families send their daughters to school if the financial barriers to school enrollment are removed, which will contribute to both delayed pregnancy and child marriage (34).

#### **3-2-9. Interpersonal and Peer-to-Peer Education**

Interpersonal communication programs that hire and educate a core group of young people to serve as role models and sources of information for their peers are often called peer-to-peer programs (50, 51). Peer education is an efficient way to enhance information and encourage positive behaviors by involving youth as communicators and audience members (27).

#### **3-2-10. Use of New Media**

In addition to traditional communication methods, health programs are earnestly looking to integrate new digital media such as text messaging, websites, social media, and information distribution for adults. New media, defined as sharable, user-controlled offers an innovative way of spreading information through media channels that young people are already using (33). Electronic-health and mobile-

health have promise. The effectiveness of a number of interventions through new communication technology has been reported by the WHO. Information disseminated through the Internet and new technologies has the potential to reach a large number of people (52).

#### 4- CONCLUSION

Limited reproductive health knowledge and information, lack of youth-friendly reproductive health services, social and cultural challenges, leadership, legal and political factors were the main obstacles to access SRH information and services among Asian youth. Culturally sensitive community based intervention, involving religious and social leaders, reforming health services and policies, considering integration of refugee youths' reproductive health needs into policy of local governments in Asian critical areas and use of new media to distribute SRH information were identified as effective strategies for improving youth SRH. It is hoped that this paper will encourage the Ministries of Health in Asian countries, managers, health policy makers, and health managers to reconsider the youth SRH policies and adopt religiously and culturally acceptable SRH policies and implement these in the near future.

**5- CONFLICT OF INTEREST:** None.

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