Youth-centred research to help prevent and mitigate the adverse health and social impacts of pregnancy amongst young Papua New Guineans

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Abstract: Despite persistent international attention, adolescent pregnancy remains a major public health concern in low- and middle-income countries, like Papua New Guinea (PNG), where health inequities related to social and cultural norms, gender power imbalance, education and socio-economic deprivation affect young and unmarried women in particular. In PNG – where there is high adolescent fertility, high early childbearing and high maternal mortality ratio, and evidence of high rates of unintended pregnancy and abortion among young women – adolescent pregnancy is a policy priority. Yet there are no youth-specific sexual, reproductive and maternal health services or community-based outreach programmes. There is limited in-depth qualitative data on young women’s and young men’s experiences of pregnancy, the social contexts within which these pregnancies occur, young people’s contraception practices and experiences with existing sexual, reproductive and maternal health services. These issues inhibit the design and delivery of youth-friendly health services and outreach support programmes that could prevent or mitigate adverse health and social outcomes associated with adolescent pregnancy. In this commentary article, we propose the need for novel youth-centred research to inform the development of policies, health services and outreach programmes that pay honest and respectful attention to young people’s lived experiences of pregnancy. Whilst we focus on the situation in PNG, these ideas are relevant to diverse low resource settings where the harmful impacts of health inequities among young people persist and are particularly detrimental. DOI: 10.1080/09688080.2018.1512297

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Introduction
Adolescent pregnancy is a major public health concern in low- and middle-income countries (LMICs). In Asia-Pacific countries such as Papua New Guinea (PNG), health inequities include, for example, a greater likelihood of unintended pregnancy, less consistent use of modern long-term acting contraceptives, and increased likelihood of complications arising during pregnancy and childbirth among young unmarried women compared to other women. There is also higher prevalence of childbirth among younger (<18 years), rural, less educated girls and those from the poorest households. These health inequities are driven by contextual and structural factors such as gender relations between young people that constrain young women’s agency in sexual experiences and relationships; social, cultural and religious values and norms that discourage sexual activity and pregnancy outside marriage and inhibit communication with peers and adults about sexual health; a lack of access to youth-specific sexual, reproductive and maternal health services, and the provision of short- and long-term acting contraception; and limited comprehensive sexuality education. As well as driving health inequities, these factors systematically enhance young women’s vulnerability to pregnancy. Further disadvantage occurs as a result of pregnancy, especially for young women, due to consequent health and socio-economic outcomes.

In PNG, where there are no current youth-specific health services, the Youth and Adolescent Health Policy highlights the prevention of adolescent pregnancy as a national priority but notes the lack of strategic information to guide implementation. As with other LMICs, young women and young men in PNG who experience pregnancy – as two people who have conceived a child, lost or aborted a child, as parents, or as mother and father who are not together – are rarely consulted for their thoughts and personal expertise about strategies to prevent or mitigate the harmful impacts of pregnancy at a young age.

Given ongoing international concern about adolescent pregnancy, and increasing attention to actively engaging young people in decisions about their health, we propose the need for novel youth-centred research. This is needed to inform the development of policies, health services and outreach programmes that pay honest and respectful attention to young people’s – both female and male, and aged between 10 and 24 years – lived experiences of pregnancy. Here we focus on PNG, as this is where our new adolescent pregnancy study is about to commence. However, our commentary is relevant to diverse international settings where the harmful impacts of pregnancy among young people persist.

Adolescent pregnancy as a global and regional concern
Adolescent pregnancy is identified as a global priority in the Sustainable Development Goals, the recent Guttmacher-Lancet Commission on sexual and reproductive health and rights for all and the Lancet Commission on adolescent health and well-being. Health inequities and inequalities relating to adolescent pregnancy between national settings are well documented. Young women aged 15–19 years account for 11% of all births worldwide, of which 95% occur in LMICs. In Asia-Pacific countries, one in seven girls give birth by the age of 18, often within contexts of the high unmet need for modern contraceptive methods, inadequate provision for youth, sexual and reproductive health services, lack of skilled care during delivery, and high rates of partner violence. Regional fertility rates are higher where early marriage is prevalent, and among girls living in rural areas. Based on available national-level data, in the Pacific up to 43% of pregnancies among 15–19 year olds are unwanted.

The health consequences of pregnancy for young women in LMICs are severe. Globally, among young women aged 15–19 years, pregnancy and childbirth contribute almost 25% to the burden of ill health. Complications during pregnancy and childbirth remain among the leading causes of death of young women aged 15–19 years in LMICs, with risks most heightened for those aged under 16 years. Unsafe abortion is associated with high rates of morbidity and mortality. Around half of global unintended pregnancies end in induced abortion, which can lead to considerable morbidity and mortality in settings where the majority of abortions are unsafe and where legal abortion is
restricted, as it is in PNG. There is increased risk of stillbirth and neonatal mortality, and higher rates of low birth weight and pre-term birth, among young women aged 10–19 years, compared with infants of women who give birth between the ages of 20 and 29 years. Socio-economic outcomes for girls and young women include early cessation of education, reduced educational attainment and limited livelihood opportunities. These in turn have significant implications for gender equality and women’s empowerment in decision-making related to accessing health services for themselves and their children.

Almost one billion young people aged 10–24 years live in Asia and the Pacific, comprising 27% of the total regional population. Given the magnitude of this young population, working with and learning from young women and young men who have experienced pregnancy offers unprecedented opportunity to improve their sexual, reproductive and maternal health, and population health more generally.

Adolescent pregnancy and health inequities in PNG

PNG has one of the highest adolescent fertility rates among Asia-Pacific countries, with 65 births per 1000 women aged 15–19 years. In PNG, half of the young women (50%) and men (53%) aged 15–19 years have ever had sex; smaller numbers are involved in sexual activity before 15 years (5%, 4% respectively), some with multiple partners (2%, 13%). The proportion of 20–24 year old females who gave birth by the age of 15 (3%) and 18 (11%) points to high early childbearing (<18 years of age). Adolescent pregnancy is a priority in the PNG Population Policy and the PNG Youth and Adolescent Health Policy.

There are limited data on adolescent pregnancy and young people’s contraception practices in PNG. One study in antenatal women found that unintended pregnancy was significantly more frequent among unmarried women, women whose first sexual encounter was under the age of 20, and those having early onset of sex (<15 years). In PNG, like other LMICs, low contraceptive use amongst young people is a key reason for high unintended pregnancy. Globally, contraceptive prevalence rates (any modern method) are exceptionally low at 2.6% and 4.5% respectively amongst young women and men aged 15–19 years, and 12.4% and 16.8% amongst those aged 20–24 years. Further, in one study women under the age of 20 years experiencing unintended pregnancy in PNG were significantly more likely to report not using a modern method of contraception or using it inconsistently compared to women over 20 years. When contraception is used, short-term acting, user-dependent methods are more common, increasing risk of contraceptive failure and unintended pregnancy.

With regard to the consequences of pregnancy among young people, PNG also has one of the highest maternal mortality ratios in the world, and the highest in the Pacific region, with an estimated 733 maternal deaths per 100,000 live-births. Sepsis due to unsafe abortion is one of the leading causes of maternal mortality. The legal environment inhibits the provision of safe abortion services to women due to legislation restricting induced abortion to situations where two doctors confirm that there would be a significant maternal risk, and that terminating the pregnancy carries less risk than continuing it. In this context, most abortions that occur are performed outside the health service and are unsafe. Although unintended pregnancy and abortion is documented amongst young women in PNG, there are no national-level abortion data. Two studies indicate health inequity associated with being younger and unmarried. One prospective survey of cases of complications of induced abortion (using misoprostol, traditional herbs or mechanical means, outside of health-care settings) presenting to Goroka General Hospital, Eastern Highlands Province, in 2011 included 15–19 year olds (19%) and 20–34 year olds (70%). Another study in the same hospital found that 24% of women seeking post-abortion care was due to induced, rather than spontaneous, abortion; these women were significantly more likely to be younger (<20 years), single, or enrolled in formal education, and report the pregnancy as unplanned.

Whilst there is some epidemiological data available documenting adolescent pregnancy, in-depth qualitative data about young women’s and young men’s experiences of pregnancy, and the social contexts within which these pregnancies occur, are currently unavailable in PNG. This lack of qualitative data inhibits the design and delivery of health services and outreach support programmes that are appropriate for and responsive to young people’s specific needs to prevent or mitigate adverse health outcomes associated with adolescent pregnancy.

This gap is the target of a new qualitative youth-centred study being led by our group in PNG. Our
study, funded by the Australian National Health and Medical Research Council, specifically examines the experiences of pregnancy among young women and young men aged 10–24 years. It will also explore the systematic “structuring of young people’s vulnerability” to pregnancy-related risks and health inequities, the strategies young women and men already use to prevent or cope with pregnancy, and what they think should be done. Before discussing our youth-centred approach, we clarify a definitional issue relating to pregnancy among young people.

**Pregnancy is a sexual, reproductive and maternal health issue**

First, pregnancy among young women and young men is a *sexual health* issue. Unintended pregnancy, abortion, sexual and gender-based violence, and sexual health education are key elements of the World Health Organization’s (WHO) working definition of sexual health. This definition also highlights the importance of physical, emotional, mental and social well-being in relation to sexuality, a positive and respectful approach to sexuality and sexual relationships, the possibility of pleasurable and safe sexual experiences, and the protection and fulfilment of people’s sexual rights. Accordingly, to better understand pregnancy as a sexual health issue, it is important to adopt a sex-positive approach to working with young people, exploring the ideal conception and pregnancy experiences as well as examining the immediate and long-term ill health, sadness and harm that unexpected pregnancy might bring.

Second, pregnancy is a *reproductive health* issue. As specified by WHO, reproductive health addresses the reproductive processes, functions and system at all stages of life. In addition to understanding the range of positive and negative consequences associated with pregnancy, young people also have the right to reproduce, and freedom to decide the number and spacing of children; to information about, and access to, safe, effective, affordable and acceptable methods of fertility regulation; and to health care services to support safe pregnancy and childbirth. Whilst sexual health was defined as part of reproductive health in the Programme of Action of the International Conference on Population and Development in 1994, in recent years this relationship – whereby sexual health is a component of reproductive health – has been questioned. Instead, sexual health is now perceived as a broader concept and is considered a necessary condition for the achievement of reproductive health throughout the lifespan.

Third, pregnancy is a *maternal health* issue. WHO specifies that maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. This includes a focus on issues such as the avoidance of maternal health complications during and after childbirth and associated with unsafe abortion, reducing maternal death, and ensuring that more women have positive experiences throughout pregnancy, labour, childbirth and the postpartum period.

As specified in the recent Guttmacher-Lancet Commission on sexual and reproductive health and rights for all, an essential package of sexual and reproductive health services and information includes – irrespective of age and marital status – comprehensive sexuality education; counselling and services for a range of modern contraceptives; antenatal, childbirth and postnatal care; safe abortion services and treatment of complications of unsafe abortion; and information, counselling and services for sexual health and well-being.

However, we outline each of these three definitions as a deliberate reminder to inform appropriate and holistic responses to pregnancy among young women and men. “Adolescent sexual and reproductive health” programmes and services tend to focus narrowly on sexual (i.e. STI prevention) and reproductive (i.e. family planning and contraception) health issues. The maternal health dimension is often forgotten, meaning that there is insufficient recognition that young women (pregnant or not) and young men require information about, and access to, appropriate maternal health services for when they experience pregnancy, and whatever happens consequently.

**Learning from young people’s lived experience and unique expertise**

Young people have unique expertise to contribute to the design of sexual, reproductive and maternal health promotion strategies and services to ensure that these are specific to their needs. Gaps in community programme and service-based responses to young people’s sexual, reproductive and maternal health are well documented in PNG. These include urgent need for reproductive, contraceptive and family planning services; sexual and reproductive health education in community settings; abortion and post-abortion care services; and safe motherhood and birth-preparedness programmes. There is
international guidance on what constitutes “youth-
friendly”, 18 “adolescent friendly health care”17 or “ado-
lescent-responsive health care”.2 Yet in PNG, like many
other socially and culturally diverse LMIC settings,
there is limited context-specific evidence about what
constitutes “youth-friendly” to inform the develop-
ment and implementation of national quality stan-
dards of youth-friendly health services; effective
approaches for the delivery of youth-friendly sexual,
reproductive and maternal health services and out-
reach programmes, particularly at scale; and the
capacity of health workers to provide such services to
young people.

There have been increasing international calls
to involve young people as partners in the design
of youth-friendly sexual, reproductive and
maternal health programmes and services,2,3,8
some of which are based on the everyday strategies
young people use themselves to lessen risk and
reduce vulnerability.8,25 In PNG, there is limited
understanding of the everyday strategies that
young people use to prevent, reduce the risk of,
avoid, cope with, or mitigate the impact of preg-
nancy. Documented strategies include the use of
condoms to prevent premarital pregnancy,23 and
impact mitigation with a focus on unsafe abortion
strategies amongst young women.14,22,24

In any setting, it is important for research exploring
lived experiences of pregnancy to move beyond the
individual in order to examine the influence of social
contexts on young people’s vulnerability to sexual,
reproductive and maternal health risks. An under-
standing of social context illustrates the need to
move from individual behaviour change-focussed
adolescent pregnancy programmes to structural inter-
ventions that aim to modify distal (e.g. cultural
beliefs, gender norms, laws, legislation) and proximal
(e.g. interpersonal relationships, access to health ser-
\services) influences that affect the ability of young people
to protect themselves from pregnancy-related risks.

In PNG, some contextual influences affecting
pregnancy are already identified in the published
research. For example, studies have documented
religious influences that discourage condom use
and sexual relationships prior to marriage,23,26
and the gendered impact of cultural practices,
such as bride price, on premarital pregnancy.23
With regard to legislation, there is a paucity of
research to support the development and
implementation of national standards for youth-
friendly health services.2,3,7 Yet there is very little
understanding about the experiences of young
people within existing sexual, reproductive and
maternal health services, their access to and
experiences with contraception and family plan-
ning methods, or the influence of schools (other
than young people think that school-based sex
education fails to provide them with relevant in-
formation22,27). There is an urgent need for context-
specific qualitative programmatic research that
identifies opportunities for health promotion
interventions to reduce contextual influences that
enhance young people’s pregnancy-related risks
in PNG. This is particularly important given that
young people’s sexual, reproductive and maternal
health is affected by diverse cultural, traditional,
religious and linguistic influences, and highly vari-
able access to economic livelihoods, schools and
health services in rural and urban settings.26

At a more local level, we have little understand-
ing about the relational influences on adolescent
pregnancy. Engaging young men in efforts to
reduce harm associated with pregnancy at a
young age is important,1,3 as gender dynamics
are central to young people’s relational experi-
\ences of conception, abortion, childbirth and par-
\enting. Over half of young people in PNG are
estimated to be sexually active, and 19% of 20–
24 year old married females were married by the
age of 19, and 2% by the age of 15.3 Yet we
know little about the influence of gender relations,
nor the discussions and negotiations that occur
within young people’s intimate sexual and social
relationships. Current PNG research notes only lim-
ited communication between young women and
men about sexual health issues.26 Furthermore,
sexual and physical violence is associated with
higher rates of unintended pregnancy and abor-
tion, and rates of intimate partner violence are
extremely high in PNG and other Pacific Island
countries, with lifetime prevalence of violence
among women aged 15–49 years around 60–
77%.28 Despite evidence that young people experi-
ence sexual violence in PNG,22 there is no in-depth
qualitative research documenting the impact of
this on their experiences of pregnancy.

**Some concluding thoughts on our youth-
centred approach**

By working with young women and young men
aged 10–24 years, robust qualitative research can
contribute much needed evidence to enhance
health promotion responses to pregnancy amongst
young women and men, and better understand
how to reduce health inequities associated with
being young and female. Starting from what young women and young men already know and do, our new youth-centred research study consists of several dimensions. First, we are documenting the diverse strategies young people adopt in their everyday lives to prevent pregnancy, and manage the harmful health and social outcomes associated with pregnancy. Second, we are seeking a holistic understanding of these issues which requires attention to the deliberate actions young women and young men make to become pregnant, and enjoy the pleasures and other socio-cultural benefits associated with parenthood. Third, to move beyond individual experience, we are trying to understand young people’s perspectives on the various relational, contextual and institutional influences that drive sexual, reproductive and maternal health inequities in their lives. Fourth, we are using qualitative, participatory and ethnographic research methods to access rich, emic understanding of young people’s lived experiences of pregnancy. Finally, we are supporting young people who experience pregnancy and live in the researched communities to govern the research process, alongside adult health and policy experts.

Our study draws on expert knowledge from young Papua New Guineans about their sexual, reproductive and maternal health strategies. We hope that our youth-centred research approach will enhance understanding of how to strengthen existing health services and community programmes, and identify new youth-led responses to reduce their sexual, reproductive and health risks. Beyond PNG, we believe our approach is relevant to diverse international settings where health inequities continue to enhance the systemic vulnerability of young people to pregnancy.

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Résumé
En dépit de l’attention internationale persistante qu’elles suscitent, les grossesses chez les adolescentes demeurent un problème majeur de santé publique dans les pays à revenu faible ou intermédiaire, comme la Papouasie-Nouvelle-Guinée où les inégalités sanitaires relatives aux normes sociales et culturelles, aux déséquilibres des rapports de pouvoir entre hommes et femmes, à l’instruction et à l’exclusion socio-économique touchent en particulier les femmes jeunes et célibataires. Dans ce pays, qui connaît un taux élevé de fécondité des adolescentes, une forte procréation précocé et un taux important de mortalité maternelle, les grossesses des adolescentes constituent une priorité politique. Pourtant, il n’y a pas de services de santé sexuelle, reproductive et de l’adolescent s’adressant spécifiquement aux jeunes, ni de programmes communautaires de proximité. On dispose de peu de données qualitatives détaillées sur les expériences.
qualitatives détaillées sur l’expérience de la grossesse chez les jeunes femmes et les jeunes hommes, les contextes sociaux dans lesquels ces grossesses se produisent, les pratiques contraceptives des jeunes et l’expérience avec les services de santé sexuelle, reproductive et maternelle existants. Ces problèmes inhibent la conception et la mise en œuvre de services de santé adaptés aux jeunes et de programmes de soutien de proximité qui pourraient prévenir ou atténuer les effets sanitaires et sociaux néfastes associés aux grossesses chez les adolescentes. Dans ce commentaire, nous soulignons la nécessité d’une recherche novatrice axée sur les jeunes pour guider la mise au point de politiques, de services de santé et de programmes de proximité qui accordent une attention sincère et respectueuse à l’expérience de la grossesse vécue par les jeunes. Nous nous centrons sur la situation en Papouasie-Nouvelle-Guinée, mais ces idées s’appliquent à diverses situations de faibles ressources où les répercussions négatives des inégalités de santé entre jeunes se poursuivent et sont particulièrement pernicieuses.