



In September 2013, HC3 conducted a program scan and review of available grey and peer literature on adolescent sexual and reproductive health (ASRH), with a focus on urban populations. The review included roughly 90 articles and reports from 2003-2013, and sought to examine the SRH behavioral drivers, barriers, and contextual factors and identify social and behavior change communication interventions.

Research shows there are key contextual factors that influence the conditions and motivations of urban youths' first sexual encounters. For example, results from a three-country, multi-city study conducted in sub-Saharan Africa (Speizer et al, 2012) show that education level, religion, employment status, and school enrollment can all be determinants of urban youths' sexual debuts. The study also highlights that country- and city-specific differences are important to consider when designing programs. Factors such as a locale's HIV rates and prevention activities, monetary wealth of the youth, and location-specific social norms all influence ASRH behaviors, and therefore the nature of the interventions that might have an optimal impact there.

Further literature included in the review emphasizes a heterogeneity of behaviors within a given adolescent population and few conclusions are reached as to what factors are responsible at which levels for observed differences.

Most observed risks for ASRH include: being married; older age; employment and being part of a workforce (for males); alcohol consumption; abuse of drugs and tobacco; absence of a biological parent between the ages of 11 and 15 years (Ngom et al, 2003); unstable family environment; poor academic performance, having peers who are sexually active (Blum and Mmari, 2009; Mmari and Sabherwal, 2013); having had forced sex with first sexual partner; orphan status and urban residency (Mmari and Sabherwal, 2013), although some studies have identified that urban youths are more likely to use condoms at first sex than their rural counterparts (Banakole, 2007; Robinson and

Seiber, 2008).

Most observed protective factors for ASRH include: greater educational attainment, openly discussing reproductive health issues and contraception/condom use with a partner and with peers; closeness to at least one parent (Robinson and Seiber, 2008; WHO, 2007; Hutchinson et al, 2012, Wight and Fullerton, 2013); open communication with a parent about sex, in particular mothers, and parental positive role-modeling (Banakole, 2007; Hutchinson et al, 2012) and high self-efficacy to refuse unsafe or unwanted sex (Blum and Mmari, 2009).

The main ARSH related behaviors addressed by the literature include: sexual activity (sex initiation and ever having had sex); condom and contraceptive use; number of sexual partners; pregnancy and childbearing; and STIs and HIV.

Although there is a recent increase in literature addressing sexual coercion, this is still limited to enable any broad conclusions. Literature on abortion is also lacking significantly. These gaps are worrying, considering that one third of women worldwide report forced sexual initiation (Krug et al, 2002) and that 14% of unsafe abortions in developing countries occur among women under the age of 20 years (Bearinger et al, 2007).

Most studies focus primarily on risk and protective factors at the individual level, however there is recognition that community-level factors influence behavior, especially at the neighborhood level (Robinson and Seiber, 2008; Campbell et al, 2005). Studies have identified how neighborhood effects mitigate the influence of risk factors, however this appears to be true for young men but not for young women (Robinson and Seiber, 2008). Little is known about what neighborhood effects are influential in ASRH behaviors and more research could help better tailor preventative and behavior change interventions.

At the relational level, positive social connectedness is linked to healthy behaviors in adolescents while social exclusion and

Table 1: Identified Protective and Risk Factors for Main Behaviors Addressed in Literature		
Behavior	Protective Factors	Risk Factors
Sexual Initiation /Ever having had sex	<ul style="list-style-type: none"> • Being in school. • Cognitive competence, in particular academic achievement and IQ (House et al, 2010). 	<ul style="list-style-type: none"> • Having a higher perceived risk of HIV acquisition. • Being an orphan (particularly for females), having a sister with a premarital pregnancy. • Dropping out of school.
Condom and Contraceptive Use	<ul style="list-style-type: none"> • Open communication about condoms, contraception and sex (Mmari and Sabherwal, 2013; House et al, 2010). • Higher educational attainment (House et al, 2010; Mmari and Sabherwal, 2013). • Higher educational attainment of partner (Mmari and Sberhwal, 2013). • Closeness to at least one parent and open communication with parent about sexual issues (Hutchinson et al 2012; Wight and Fullerton, 2013; Banakole, 2007). 	<ul style="list-style-type: none"> • Perceived lack of parental support for condom use. • Lower educational attainment of partner. • Fear of possible side effects from contraception (Abiodun and Balogun, 2009). • Ignorance about risks associated with pregnancy and STIs (Adedimeji et al, 2007).
Number of Sexual Partners	<ul style="list-style-type: none"> • No protective factor identified (Mmari and Sabherwal, 2013). 	<ul style="list-style-type: none"> • Perception that friends are having sex. • Drinking alcohol. • Being employed (for men). • Frequenting a social venue on a regular basis (Yamanis 2010).
Pregnancy and Childbearing	<ul style="list-style-type: none"> • Living with both parents. • Cognitive competence (House et al, 2010). 	<ul style="list-style-type: none"> • Having experienced maternal death (for young women). • Experience of sexual coercion at first sex. • Alcohol consumption and smoking.

marginalization are predictive of poor health outcomes (Erulkar and Ferde, 2009). An association has been found between positive family and peer connections and a decreased likelihood of sexual experience and potentially risky behaviors (Karim, 2003; Kumi-Kyereme A et al, 2008). Interventions targeting urban youths should consider peer connections and neighborhood influences on behaviors.

ASRH issues affect young women disproportionately. Even when protective factors are identified for young men, women continue to be at higher risk (Robinson and Seiber, 2008). Further, social norms for premarital romantic relationships are often stricter for females than males (Hindin and Hindin, 2009) thus potentially affecting young women's ability to protect themselves and make informed decisions. Gender contexts and cultural practices and institution contribute to sexual double standards and gender-discriminatory behaviors that

affect women's sexual health and contribute to their disempowerment. In order to target interventions effectively and according to gender, it is important to address how gender power dynamics are supported by social beliefs and norms (Jewkes et al, 2010; Bermudez, 2010) and to explore how and which community influences affect female and male behaviors differently.

A full report of the review will be available in November 2013.

About HC3

HC3 is led by the Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU-CCP) in collaboration with Management Sciences for Health, NetHope, Population Services International, Ogilvy PR, Forum One and Internews. It is also linked to a network of organizations throughout Africa, Asia and Latin America.