EVIDENCE SERIES

Sexual and Reproductive Health of Adolescents and Youth
Situation Analysis

About 19% of girls in developing countries become pregnant by age 18, and 3% by age 15. Countries in West and Central Africa have the largest proportion of women who give birth during adolescence (UNFPA 2013). Maternal mortality – which includes deaths due to complications during pregnancy or childbirth, unsafe abortions, and maternal suicide – remains a leading cause of death among girls aged 15-24 in developing countries (Nove et al. 2014, Patton et al. 2009). Girls who give birth during adolescence have a greater risk of death than women who have children in their early 20s, and their babies tend to have lower birth weight, more health complications, and greater risk of neonatal death (Chandra-Mouli et al. 2015b).

In the developing world, pregnancy during adolescence is closely linked to early marriage: 90% of births to adolescent girls occur within a marriage or union (UNFPA 2013). One in three girls in developing countries is married by age 18, but the marriage rate varies widely by country. In all regions, girls who are less educated or illiterate, poor, live in remote areas, or are otherwise marginalized are more likely to be married and/or become pregnant than other girls (UNFPA 2013).

Still, there is evidence that a large proportion of unmarried adolescents are sexually active and also in need of information about sexual health and risks and access to contraceptive products and services (Guttmacher Institute 2015). Unmet need for contraception is higher among unmarried adolescents compared to their married peers (Guttmacher Institute 2015).

CONTRACEPTIVE PREVALENCE RATE

The overall contraceptive prevalence rate (CPR) among female adolescents aged 15-19 in the developing world is about 21% for all methods (modern and traditional). CPR is highest in Latin America and the Caribbean (51%) and East Asia and the Pacific (38%), and far lower in West and Central Africa at 7% (Loaiza & Liang 2013). Among unmarried, sexually active adolescents 15-19, CPR ranges from 21% to 64%; for the married, from 6% to 67% (Chandra-Mouli et al. 2014).

Nearly a quarter of adolescent girls 15-19 in the developing world report an unmet need for contraception, ranging from 7%-62% among married adolescent women and 34%-67% among unmarried women (Chandra-Mouli et al. 2014). Across regions, unmet need is higher among those who are unmarried, who reside in urban areas, and who come from wealthier households (Guttmacher Institute 2015). Unmet need is associated with age, particularly among married women: 25% of married girls 15-19 report unmet need; compared to 11-20% of married women aged 20-49 (Loaiza & Liang 2013).

METHODS AND SOURCES OF CONTRACEPTION

Girls under 25 are 10-17 times more likely to use short-acting contraceptive methods such as oral contraceptives, condoms and injectables, than long-acting methods such as IUDs and implants (SHOPS 2015). Condoms, injectables, and oral contraceptive pills dominate the method mix for adolescents aged 15-19 in all regions. In LAC and sub-Saharan Africa, there is a correlation with marital status: most unmarried adolescent girls use condoms, while married girls tend to use injectables (Abt Associates 2015). Roughly half of girls 15-19 who use modern contraception obtain their methods from the private sector, while a greater proportion of older women rely on the public sector. Unmarried adolescent girls use the private sector more than married adolescent girls (Abt Associates 2015).

UNINTENDED PREGNANCY AND ABORTION

Unintended pregnancies comprise more than half of pregnancies among adolescents younger than 20 in Latin America and the Caribbean (LAC), and more than 40% in many parts of sub-Saharan Africa. Unintended pregnancy is overall less common in Asian countries, but varies widely between 1% and 32% (Guttmacher Institute 2015).

There is little and varied data on abortion among adolescents. The annual rate of unsafe abortions is estimated at 16 per 1000 adolescent girls aged 15-19; this rate is higher in Africa (26) and LAC (25) than in Asia (9). Reasons adolescents may seek unsafe abortion include barriers to accessing safe services, a desire for greater confidentiality, and lower cost (Guttmacher Institute 2015).

1 PSI uses the World Health Organization’s definitions for adolescents (10-19 years old), youth (15-24 years old) and young people (10-24 years old). In this document, unless age is specified, the terms adolescents, youth and young people will be used interchangeably, largely referring to the population of 10-24 year olds.

2 More information about types of modern and traditional methods can be found in the WHO Fact Sheet 351: “Family Planning/Contraception.”

3 The DHS Program’s definition of unmet need is “the percentage of women who do not want to become pregnant but are not using contraception.”
Barriers to Use

Global health practitioners often use an ecological model to understand the reasons for unmet need for contraception and other sexual and reproductive health (SRH) services among adolescents. The model recognizes that utilization of contraception is not only a decision made at the individual level, but is influenced by peers and parents, community norms, accessibility and affordability of services, provider attitudes, and policies and regulations (UNFPA 2013, Svanemyr et al. 2015). Barriers at each level challenge adolescents’ ability to seek and receive services. Strategic interventions that work across the different levels of the social ecology (policy, institutional, community, interpersonal and individual levels) can create an environment in which adolescents are provided with accurate information about their SRH and supported to make informed decisions about the SRH products and services that are best for them.

POLICY LEVEL

Policies on the rights of people under age 18 determine whether adolescents have the agency to make their own decisions regarding sexual and reproductive health or whether they need parental or spousal consent (Glinski et al. 2014). Often, however, policies in place are often poorly enforced and can be easily overruled in practice by parents, communities, and providers.

For instance, most countries now have laws prohibiting child marriage, but these are often violated in favor of community traditions. Fewer countries have laws to protect adolescents’ right to safe abortion services, and even in those that do, providers may choose to deny abortion, post-abortion care and other services based on their own attitudes or beliefs (Svanemyr et al. 2015, Glinski et al. 2014).

Regulations on pricing and points of service can limit young people’s access to SRH products and services. Several cases have demonstrated that regulatory changes allowing the sale of contraception over the counter at pharmacies and shops expand access for adolescents (Chandra-Mouli et al. 2014, Glinski et al. 2014).

Cost poses a large barrier for adolescents, who are usually financially dependent on their parents, or in the case of married adolescent girls, their husbands. They may not seek services because they cannot ask for money for that purpose and cannot afford to pay on their own. Concerns about confidentiality – that someone might see them or the provider might tell their parents – are another reason why adolescents shy away from services (Glinski et al. 2014).

COMMUNITY LEVEL

Globally, societies are unaccepting of early sexual initiation, although they tend to be more permissive of boys’ sexual behavior than girls’. Stigma around youth sexual activity discourages adolescents from seeking information or services related to reproductive health, and these may not be readily offered to them. Teachers and parents may be unwilling to discuss sexual health with adolescents, believing that they don’t need such information or that doing so will encourage them to become sexually active (Glinski et al. 2014).

Community-level barriers to contraceptive use depend on adolescents’ marital status. For unmarried adolescents, community attitudes toward contraception stem from the stigma around sexual activity. Young people may hesitate to seek family planning services for fear of their communities finding out, and those who do may be refused service by the provider. Although condoms are the most accessible and affordable contraceptive method for most adolescents, in many contexts both boys and girls can be discouraged from carrying condoms because of their association with promiscuity and distrust (Chandra-Mouli et al. 2014, Glinski et al. 2014).

Married adolescents, on the other hand, may feel social pressure to have children. Use of family planning is
discouraged for married women until after a child is born, or in some cultures, until after a son is born (Chandra-Mouli et al. 2014, Glinski et al. 2014). Other times a community’s religious beliefs may find contraceptive methods objectionable even after marriage (Glinski et al. 2014).

In many instances, married adolescent girls report that they want to become pregnant, but this sentiment may be driven by family or community pressure to become a mother rather than the girl’s own preference (UNFPA 2013).

INTERPERSONAL LEVEL
Parents, in-laws and other close family members may present barriers to information and programming for youth. Parents’ wealth, education, religion, and attitudes toward gender roles, as well as their own sexual/relationship experiences, influence their expectations for their children (UNFPA 2013).

For adolescent girls in relationships, particularly those who are younger, recently married, or are in polygamous relationships, the partner (and his family) will often exert authority over FP use (Glinski et al. 2014).

Gender norms and discomfort discussing the topic can affect how young partners discuss contraceptive use together. Girls may be unable to negotiate family planning with their male partners, especially if the man is much older (UNFPA 2013). Some men and boys, however, particularly those with low levels of knowledge about FP, may see contraceptive use as the girl’s responsibility (Glinski et al. 2014).

INDIVIDUAL LEVEL
Knowledge of reproductive health services and where to access them has been found to be a critical factor in met need for family planning – many adolescents don’t know where they can find products and youth-friendly services (Glinski et al. 2014). Although studies show that most adolescents have heard of contraception and some types of methods, a far smaller proportion is able to demonstrate detailed knowledge about reproductive health, pregnancy prevention, and how to use certain methods.

Fear of side effects and the experience of side effects of contraceptive methods are the most common reasons for non-use or discontinuation (UNFPA 2013). Discontinuation of family planning methods is more common among girls 15-19 than older women due to inconsistent access and lower tolerance for side effects, while inconsistent condom use in longer-term relationships is often a result of partners’ growing trust and perceived less need for protection (Blanc et al. 2009, Chandra-Mouli et al. 2014).

Evidence shows that individual-level interventions are better able to achieve measurable improvements in knowledge and attitudes than in behaviors. Interventions that do change behavior tend to be more effective at increasing contraceptive use than changing sexual practices (Glinski et al. 2014).
Interventions with Youth

In order to address the multiple levels of barriers that contribute to high unmet need and low contraceptive use among youth, the most effective interventions combine supply-side interventions – like training providers and making youth-friendly facility improvements – with demand generation activities in the community. Demand-side activities must address the factors that influence adolescents’ (especially girls’) agency to make decisions about sex, marriage, and contraception (Denno et al. 2015). In general, programs sustained over longer periods of time are able to achieve greater results (Gottschalk & Ortayli 2014; Glinski et al. 2014). Buy-in from youth and their communities can create the potential for programs’ longevity and success (Villa-Torres & Svanemyr 2014).

PRODUCTS

Per WHO’s eligibility criteria, adolescents can use the same contraceptive methods as adults – age alone does not bar a woman from using any method (WHO 2015). However, an individual adolescent’s need for discretion, tolerance for side effects, or preference for methods that do not require daily reminders may make one method a better fit than another. Information must be made available for young people to understand the risks and benefits of each method, and providers must be trained to counsel clients effectively so that they can make a voluntary and informed decision about what method best suits their needs (Chandra-Mouli et al. 2014).

SERVICE DELIVERY

Because adolescents’ contraceptive use is so heavily influenced by institutional-level factors, programs that include a health services component (rather than product supply alone) tend to achieve the greatest improvements in contraceptive use (Glinski et al. 2014). Most supply-side interventions aim to make service facilities more attractive by offering a set of youth-friendly features – a convenient and safe location, affordable cost, convenient operating hours – as well as training for health providers (Glinski et al. 2014, Denno et al., 2015). Offering transportation to health facilities and ensuring adequate stocks of a range of products have not been published (Glinski et al. 2014). Introducing complementary points of service (e.g. mobile or community-based outreach) may alleviate young people’s fears about confidentiality – a particularly important consideration for vulnerable groups, such as those who are engaged in transactional sex (Denno et al. 2015, Chandra-Mouli et al. 2014).

Youth-friendly approaches can build on existing services and facilities but incorporate a better understanding of adolescents’ unique barriers and needs (Chandra-Mouli et al. 2014). Training providers to understand and communicate with youth can expand the offering for young people and encourage them to seek services. Providers classified as youth-friendly in Uganda and Nigeria reported more visits and use of condoms by young clients than other providers (Denno et al. 2015). Interventions should incorporate input from adolescent clients or hire peer counselors to ensure that young people’s perspectives are heard (Glinski et al. 2014).

DEMAND CREATION

COMMUNITY-BASED DISTRIBUTION

There is little evidence on the role of community-based outreach or distribution of products in reaching adolescents, but that which is available shows positive results for improving access to contraception. Community-based condom and contraceptive distribution that uses diverse channels and specifically targets young people is more effective in increasing access than standard distribution strategies (Denno et al. 2015). Adolescent girls exposed to community-based interventions have been found to be up to three times as likely to currently use or have ever used contraception (Gottschalk & Ortayli 2014).

COMPREHENSIVE SEXUALITY EDUCATION

Exposure to comprehensive sexuality education curricula has been associated with increased condom or contraceptive use in several contexts (McQueston et al. 2013; McQueston et al. 2012; Gottschalk & Ortayli 2014). In general, however, changes in behavior or health outcomes are relatively modest; sex education is more effective at improving knowledge and self-efficacy (Haberland & Rogow 2015).

Delivering curricula at school helps programs reach a concentrated group of adolescents and offers a source of sexual health information to students who may be reluctant to ask their parents or teachers. However, instructors must be trained to deliver the materials comfortably and be willing to engage with students on sensitive topics (Haberland & Rogow 2015). In addition, school-based programs do
not reach out-of-school youth. In 2012, the proportion of boys and girls in developing countries who were enrolled in secondary school was 61% and 49%, respectively. When regional differences in enrollment are considered, school-based programs fail to reach anywhere from one-quarter to two-thirds of adolescents.

Effective sex education requires the backing of policymakers in order to ensure that it is widely and fully implemented (Chandra-Mouli 2014). A 2011 UNFPA review of 14 countries found that half relied on abstinence-only curricula, a design that has been proven ineffective for reducing unintended pregnancy among youth (UNFPA 2013). It is recommended that curricula instead focus on clear goals and behaviors to change, while incorporating lessons about empowerment and sexual rights (Loaiza & Liang 2013, Chandra-Mouli et al. 2015b). Sex education is most effective when it is comprehensive: taking a gender focus, adjusting to cultural contexts, and using participatory learning techniques (Haberland & Rogow 2015, Chandra-Mouli et al. 2015b).

**MASS MEDIA**
There is a large body of evidence demonstrating the effectiveness of mass media for improving adolescents’ knowledge and attitudes toward family planning, but its impact on behaviors and health outcomes is not as clear (Glinski et al. 2014, Svanemyr et al. 2015). Mass media campaigns are more successful when they use multiple channels and are combined with other interventions delivered at clinics and schools – making messages about service-seeking more actionable. More evaluations are needed on how to incorporate messaging on where to access youth-friendly services, and how exposure correlates with service-seeking and uptake of family planning (Glinski et al. 2014).

**ENABLING ENVIRONMENT**
Even in the absence of sexual and reproductive health programming, school attendance can serve as an intervention by helping to delay marriage and pregnancy for adolescent girls. Incentives for school attendance, such as new uniforms or conditional cash transfers, have shown to significantly lower child-bearing because they raise the opportunity cost of dropout due to pregnancy (Glinski et al. 2014, McQueston et al. 2013, Svanemyr et al. 2015). While in school, students can gain communication skills and a sense of confidence that will help them assert themselves in relationships (Svanemyr et al. 2015).

Peer education and mass media campaigns that address cultural and gender norms have been effective for increasing adolescents’ agency to seek family planning services or negotiate contraceptive use or sex (McQueston et al. 2012, Glinski et al. 2014, Denno et al. 2015). Community-based interventions have also shown to improve the attitudes of community leaders, parents, boys, and men toward gender roles, sexual health topics, and contraception. Although revisions to policy and regulation are possible, their enforcement is what makes the difference for young people – favorable attitudes among policymakers and community leaders are needed in order to effect change (Svanemyr et al. 2015).

**INTERVENTIONS TAILORED TO UNIQUE AUDIENCES**
Early adolescence (age 10-14) is a key moment for preventative interventions – this is the time when puberty begins, gender roles are reinforced, and girls begin to get married and drop out of school (UNFPA 2013). Sex education is a promising intervention for young adolescents who may not yet be sexually active or even menstruating, and programs that highlight empowerment and gender roles may be especially valuable before gender dynamics begin to shift (Haberland & Rogow 2015).

Beyond young adolescents, there is little evidence on how to tailor interventions to vulnerable subsets of adolescents in need of support and services. These include married adolescents, adolescents who are first-time parents, young people living with HIV, young men, out-of-school youth, and orphans (UNFPA 2013, Denno et al. 2015). Often there is a trade-off between reach and tailoring: programming delivered through schools and youth groups can reach a large proportion of adolescents, but in most cases exclude vulnerable youth who do not attend school or have strong peer networks (Haberland & Rogow 2015).
What not to do?

Youth centers were once a popular strategy for providing adolescents with reproductive health services alongside social, vocational, and recreational programs. However, recent reviews have found that youth centers are costly per beneficiary, have a narrow reach, are mostly used for recreation, and do little to improve uptake of contraception or other reproductive health services (Chandra-Mouli et al. 2015a).

Interventions that ask parents to talk to their children about reproductive health and family planning are somewhat effective for improving knowledge and intentions, particularly when they integrate messages about how to prevent HIV infection and pregnancy. Most parents, however, are misinformed and need support to first improve their own familiarity with the topics and become comfortable opening a conversation with their children (Glinksy et al. 2014).

Traditional peer education programs have been helpful for providing information and improving agency, but have done little to affect behaviors (Glinksy et al. 2014). It tends to be expensive to train peer educators, and often programs have a greater impact on the educators’ knowledge and behaviors than their peers’ (Glinksy et al. 2014, Svanemyr et al. 2015). More research is needed on how to leverage peer networks effectively and cost-effectively. It is possible that peer counseling may still be an effective part of comprehensive interventions as a means of referring adolescents to other counselors or service providers (Chandra-Mouli et al. 2015a).

Areas for future research

Literature on the topic of adolescent family planning use points to major gaps in understanding of how to effectively design and implement supply-side interventions to improve adolescents’ access to family planning products and services. Future research should explore how to integrate youth-friendly services into existing points of service and to ensure they are informed of and able to obtain a variety of methods, including LARCs (Decat et al. 2015, ASTRA Youth 2014, Chandra-Mouli et al. 2014). There is some evidence of the effectiveness of approaches such as vouchers and social franchising to serve youth, but these should be studied further and in more diverse settings (Glinksy et al. 2014). Research into issues of access should also examine how changes in pricing, policy, and provider attitudes enable or hinder young people’s ability to obtain the contraceptive methods that suit their needs (ASTRA Youth 2014).

There must be more and more rigorous evaluation of the effectiveness of demand-generation activities, either alone or part of multi-component interventions. Programs should also aim to identify and incorporate the many contextual factors that play into adolescent sexual health (Haberland & Rogow 2015, Gottschalk & Ortayli 2014, McQueston et al. 2013). Taking adolescents’ unique experiences into account will enable programs to craft messaging that is most relevant. For instance, adolescents who are younger or not yet sexually active may benefit from counseling that is tailored to topics like reproductive changes during puberty and delaying sexual debut, while new mothers may be interested in information about birth spacing to keep themselves and their babies healthy (Gottschalk & Ortayli 2014, McQueston et al. 2013, Evidence to Action Project 2015).

Currently, education and communications interventions have not demonstrated outcomes lasting more than a few years. Future research should study how interventions can achieve sustained impact, how they can be scaled up to achieve greater coverage without compromising quality, and how they can involve adolescents and other stakeholders in the design to promote ownership of the program (Chandra-Mouli et al. 2015a, Chandra-Mouli et al. 2015b, Gottschalk & Ortayli 2014, Villa-Torres & Svanemyr 2015).

Additional efforts should be made to determine how best to assess the results of interventions for young people. Most evaluations look at lower-level indicators like knowledge and contraceptive use, but they should consider measuring impact in terms of adolescent pregnancies averted where possible (McQueston et al. 2012). It is understood that multi-faceted interventions are the most effective, but evaluations should also aim to isolate the components that are driving change (McQueston et al. 2013, Gottschalk & Ortayli 2014).
References


