FAMILY PLANNING

EVIDENCE BRIEF

Reducing early and unintended pregnancies among adolescents

→ **Interventions to reduce unmet need for contraception and early and unintended pregnancies among adolescents should be critical components of family planning programmes in developing countries.**

The 1.2 billion adolescents aged 10–19 years around the world make up 16% of the world's population *(1)*. The majority (86%) of adolescents live in developing countries. By the time they are 19 years old, half of adolescent girls in developing countries are sexually active, about 40% are married, and close to 20% have children *(2)*.

There were 21 million pregnancies among adolescent girls aged 15–19 years in developing countries in 2016; nearly half (49%) were unintended (43% in Asia, 45% in Africa, and 74% in Latin America and the Caribbean) *(2)*. An estimated 12 million girls aged 15–19 gave birth. Additionally, 777,000 girls under the age of 15 gave birth in the same year *(3)*. An estimated 23 million adolescent girls have an unmet need for modern contraception and are at risk of unintended pregnancy *(2)*. About one-fifth (21%) of unintended adolescent pregnancies in Asia, and about half of unintended pregnancies in Latin America and the Caribbean (49%) and in Africa (46%) end in unsafe abortion *(4)*.

Early and unintended pregnancy among adolescent girls is influenced by contextual factors at the individual, interpersonal, community, and societal levels. It is also associated with adverse health, educational, social, and economic outcomes that may impose a substantial burden on the economies and health systems of developing countries *(1, 5–12)*. Repeat pregnancy amongst adolescents can compound these adverse outcomes *(13)*.

Interventions that combine demand-creation activities and provision of contraceptive services have the potential to increase contraceptive uptake among adolescents *(14–17)*. Both the demand for and supply of contraceptives to adolescents can, however, be negatively influenced by several barriers that require appropriate programmatic responses.

POLICY AND PROGRAMME CONSIDERATIONS

- → Collect, analyse, and use accurate and up-to-date data.
- → Formulate or revise national laws and policies.
- → Develop national adolescent sexual and reproductive health strategies.
- → Implement strategies with careful monitoring.
- → Conduct periodic programme reviews.

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STEP UP STRENGTHENING EVIDENCE FOR PROGRAMMING ON UNINTENDED PREGNANCY
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Table 1. Barriers and potential approaches to increase the demand for and supply of contraception among adolescents

OBJECTIVE FOR ADOLESCENTS	BARRIERS	SUCCESSFUL PROGRAMME APPROACHES	EXAMPLES
DEMAND FOR CONTRACEPTION			
To foster the desire to avoid, delay, space, or limit childbearing	• Gendered roles (e.g., expectations to be a wife and mother) • The need to prove fertility • Religious values • Norms of the path to adulthood	Direct (e.g., school-based SRH education) and indirect (e.g., conditional cash transfers) programmes that enhance the acceptability of avoiding, delaying, spacing, and limiting childbearing.	Conditional cash transfers have transformed life trajectories of girls in Mexico and Malawi.
To foster the desire to use contraception	• Stigma • Taboos (communication and cultural) • Lack of understanding (including fear of side-effects)	SRH education and information programmes that improve the understanding of contraceptive methods and SRH.	Life-skills education and vocational training programmes in Uganda and India have been shown to increase contraceptive use.
To foster a sense of agency in relation to contraceptive use	• Early marriage • Family pressure • Sexual coercion and/or violence • Limited decision-making autonomy and power	Direct (e.g., school-based education on sexual negotiation) and indirect (e.g., youth development) programmes that increase the sense of agency among girls and women to exert control over their lives and make their own decisions.	Engaging adolescents directly – as well as their communities – in Bangladesh and India has been shown to improve girls' agency and to prevent early marriage.
SUPPLY OF CONTRACEPTION			
To provide access to contraceptive services	• Lack of awareness of services • Inaccessible location • Inconvenient operating hours • Costs • Waiting times	SRH education and information on where and how to access services and contraceptive service provision to increase access to contraceptive services.	Community-based outreach involving provision of information and services through the national Health Extension Program (HEP) led to remarkable improvements in uptake of modern contraception among adolescents in Ethiopia.
To provide adolescent-friendly services	• Lack of provider sensitivity • Provider reluctance to offer contraceptives to adolescents (due to bias) • Gender biases • Lack of privacy/confidentiality • Contraceptives unavailable or out of stock	SRH information and services programmes to increase provision of high-quality, youth-friendly services for adolescents, tailored to meet adolescents' needs.	Making services responsive to the needs of adolescents has been shown to improve contraceptive use, thereby preventing first pregnancies in China and repeat pregnancies in Kenya. Evidence from studies and projects has been applied at scale in Colombia, Estonia, and Malawi.

Source: Adapted from Glinski et al. (2014) *(20)*.

Table 1 outlines a number of these barriers and responses, and mentions examples of studies and programmes that used some of these approaches to achieve progress in adolescent uptake of contraception in various regions of the world.

For example, Estonia implemented a school-based sexuality education programme that was linked to youth-friendly sexual and reproductive health (SRH) services and ensured a supportive policy environment. Rates of abortion and births to adolescents aged 15–19 years were substantially reduced *(18)*. Ethiopia achieved remarkable improvements in uptake of modern contraception among adolescents (from less than 10% in 2005 to about 25% in 2011) through the national Health Extension Program (HEP), which involved recruiting, training, and deploying an all-female workforce to provide health information and services at the local level *(19)*.

CONSIDERATIONS FOR REDUCING EARLY AND UNINTENDED PREGNANCIES AMONG ADOLESCENTS

Five elements must be in place in order to apply the evidence to large-scale, national-level programmes:

1. **Collect, analyse, and use accurate and up-to-date data** on health outcomes, contraceptive use and its determinants, programme performance, and adolescent sexuality/fertility to inform the development of laws, policies and strategies that are responsive to the varying needs of different groups of adolescents based on their social and economic status. For example, nine out of 10 births to girls aged 15–19 occur within marriage (21). However, in many places, sexually active unmarried adolescents have even higher rates of unmet need for contraception (5). The barriers adolescents face in accessing services are often very different for married and unmarried adolescents. Complementary strategies to respond to the various needs of different populations should be employed in order to leave no one behind.
2. **Formulate or revise national laws and policies** that enhance adolescent access to comprehensive SRH services. These include laws and policies to require health workers—in the public, private, and nonprofit sectors—to provide comprehensive SRH services including contraceptive and safe abortion (where permitted) services to adolescents, and those that promote access to skills-based health education, including comprehensive sexuality education. Communicate these laws and policies widely and support their implementation.
3. **Develop national adolescent SRH strategies** to include evidence-based and context-specific interventions, budgets to deliver the interventions, and indicators to track progress that are disaggregated by age and socioeconomic status.
4. **Implement strategies with careful monitoring** of activities, and with the input and expertise of key stakeholders including governmental officers at the national and regional level, civil society organizations, United Nations agencies, youth organizations and networks, donor organizations, parents, teachers, and community members
5. **Conduct periodic programme reviews** to identify lessons learned, build on strengths, and address weaknesses.

USEFUL RESOURCES TO INFORM COUNTRY-LEVEL SCALE-UP OF ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH PROGRAMMES

- Technical Guidance for Prioritizing Adolescent Health. Every Woman Every Child. 2017 https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_EWEC_Report_EN_WEB.pdf
- WHO recommendations on adolescent sexual and reproductive health and rights: http://www.who.int/reproductivehealth/publications/adolescent-srhr-who-recommendations/en/
- International technical guidance on sexuality education. An evidence-informed approach. Paris: United Nations Educational, Scientific and Cultural Organization (UNESCO), 2018. http://unesdoc.unesco.org/images/0026/002607/260770e.pdf

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This is one of seven Family Planning Evidence Briefs prepared for the Family Planning Summit held in London on July 11, 2017. The briefs highlight evidence and provide research and programme considerations for improving access to family planning and reducing unintended pregnancy. Programme considerations are based on the expert views of the authors, who undertook desk reviews drawing on existing evidence.

Family Planning Evidence Briefs

- Accelerating uptake of voluntary, rights-based family planning in developing countries *(overview)* (Updated October 2018)
- Family Planning Financing (Updated October 2018)
- Reducing early and unintended pregnancies among adolescents (Updated October 2018)
- Improving family planning service delivery in humanitarian crises
- Ensuring contraceptive security through effective supply chains
- Expanding contraceptive choice (Updated October 2018)
- Partnering with the private sector to strengthen provision of contraception

Family Planning Evidence Brief – Reducing early and unintended pregnancies among adolescents: WHO/RHR/17.10 Rev.1

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