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REGIONAL PAPER

A FOCUS ON
ADOLESCENT ACCESS TO MODERN CONTRACEPTIVES

“A Briefing Paper in the SAT SRHR Evidence Series”
ONCE THAT LIVING LOVE IS DESTROYED BY CONTRACEPTION, ABORTION FOLLOWS VERY EASILY.
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KEY MESSAGES

- Every year, an estimated 21 million girls aged 15 to 19 years become pregnant in developing regions.\(^1\)
- About half of pregnancies among adolescents aged 15–19 living in developing regions are unintended, and more than half of these end in abortion, often under unsafe conditions.
- Globally, adolescent girls aged 15-19 die from pregnancy complications while 3.9 million girls of the same age undergo unsafe abortions.
- Preventing unintended pregnancy is essential to improving adolescents’ sexual and reproductive health and their social and economic well-being.
- Meeting the unmet need for modern contraception of women aged 15–19 would reduce unintended pregnancies among this age-group by 6.0 million annually. That would mean averting 2.1 million unplanned births, 3.2 million abortions and 5,600 maternal deaths.\(^2\) The dramatic reduction in unintended pregnancies would spare women and their families the adverse consequences of early childbearing, reap savings in maternal and child health care, and boost young women’s education and economic prospects.
Across the region, many young women become sexually active, marry and give birth in just a few short years between ages 15 and 19, often without having the information and services they need to protect their health and delay childbearing if they desire\(^3\). Of the 252 million adolescent women aged 15–19 living in developing regions in 2016, an estimated 38 million are sexually active and do not want a child in the next two years. About 15 million of these adolescents use a modern contraceptive method, while 23 million have an unmet need for modern contraception and are thus at elevated risk of unintended pregnancy\(^4\).

Gender inequality means that adolescent girls often lack the autonomy or ability to postpone marriage and childbearing. Pregnancy during adolescence greatly alters young women’s life trajectory and those of their children. Complications of pregnancy and childbirth are the second leading cause of death among 15–19-year-old women, and babies born to adolescent mothers face greater health risks than those born to older women. Moreover, adolescent childbearing is associated with lower educational attainment, and it can perpetuate a cycle of poverty from one generation to the next\(^5\).

Issues and impacts associated with adolescent pregnancy include:

- Pregnant adolescents are more likely to have preterm or low birth-weight babies;
- Babies born to adolescents have higher rates of neonatal mortality;
- Girls who become pregnant often have to leave school (short and long term effects).

Ensuring that adolescent girls and young women are able to avoid unintended pregnancies can have far-reaching benefits for them, their children and societies as a whole.

Adolescent girls constitute one-fifth of reproductive-age women in Africa. A 2014 study, found that the unmet need among women aged 15–49 wanting to avoid pregnancy in developing regions was estimated at 26%\(^6\). This figure is higher in Africa.

Modern contraceptives refer to “A product or medical procedure that interferes with reproduction from acts of sexual intercourse”\(^7\). It is important to note that classification “modern” does not address concepts of contraceptive effectiveness or efficacy; “modern” should not be equated with higher efficacy. There are five categories of modern contraceptives:

1. **Barrier methods** comprise male condoms, female condoms, contraceptive sponge, diaphragm, cervical cap and spermicides.
2. **Long acting reversible contraceptives** divided into intrauterine devices (IUD) and implants.
3. **Hormonal methods** divided into short acting hormonal methods (injectable contraceptives and oral progestin-only pills) and combined hormonal methods (combined oral contraceptives, contraceptive patch and the vaginal ring).
4. **Emergency contraception**: emergency contraceptive pill and Copper IUD
5. **Sterilisation comprises** tubal ligation and contraceptive implant for women and vasectomy for men.

The United Nations (UN) family in collaboration with the World Bank developed a Global Accelerated Action for the Health of Adolescents (A A-HA!). \(^8\) Adolescent Sexual Reproductive Health (ASRH) has been overlooked historically, despite the high risks that countries face for its neglect. Some of the challenges faced by adolescents across the world include early pregnancy and parenthood, difficulties in accessing contraception, safe abortion, and high rates of HIV and sexually transmitted infections [STIs].
BARRIERS TO USE

In developing regions, adolescent girls and young women who want to avoid a pregnancy often encounter many barriers to using contraception. They might feel social pressure to have a child, especially if they are married, or they might find it difficult to access and use contraceptive services. 214 million women of reproductive age in developing countries who do not want to be pregnant are not using a modern contraceptive technology. Reasons for the low uptake includes:

- Limited choice of modern contraceptive technologies and methods
- Lack of access to information on reducing the risk of unwanted pregnancy: adolescent girls need better information about modern contraceptive methods, including the range of methods from which to choose
- Limited access to contraception, particularly among young people
- Fear, or experience, of side effects – this was raised as a reason for condom use as a contraceptive in southern Africa, with adolescents believing that the use of hormonal contraceptives leads to long term infertility and having concerns about the side effects or health risks of contraceptive methods
- Cultural or religious beliefs and cultural norms: opposition to contraception may reflect religious or personal beliefs or concerns about the methods themselves
- Poor quality of available services
- Gender-based barriers e.g. disempowerment, inequalities, stigma and discrimination, inequalities emanating from structural causes related to political and economic systems founded on the colonial legacy result in the formulation of laws, policies and practices that entrench discrimination and exclusion
- Inability to discuss sexuality with peers or contraception with a sexual partner: research points to communication between partners favouring the use of contraception
- Service obstacles that adolescents face, such as judgmental attitudes of providers, a lack of confidentiality, limited contraceptive options, and the lack of policies and guidelines for protecting adolescents’ rights to information and services
MAKING A CASE FOR ACCESS

The Guttmacher Institute Report posits that if all 23 million adolescent women with an unmet need for modern contraception were to receive improved contraceptive services, unintended pregnancies would drop by 59% from current levels, or by an estimated 6.0 million per year. (Unintended pregnancies would not be eliminated altogether because some users would experience contraceptive failure—especially those using condoms and other short-term methods that rely on users’ actions.)

Compared with current levels of contraceptive use, there would be:

- 2.1 million fewer unplanned births (a decline of 62%);
- 3.2 million fewer abortions (a decline of 57%), including 2.4 million fewer unsafe abortions;
- 700,000 fewer miscarriages of unintended pregnancies (a decline of 60%);
- 5,600 fewer maternal deaths related to unintended pregnancies (a decline of 71%). Most of the maternal deaths averted (4,800) would be in Africa, the region with the highest maternal mortality.

Improvements in contraceptive services leads to improved outcomes in other areas of sexual and reproductive health. For example, young women who access contraceptives can be educated about the availability and importance of antenatal and delivery care, and can be connected to testing, counselling and treatment services for HIV and other STIs. Reducing adolescent fertility can also contribute to the “demographic dividend.” (the economic boost that can occur when birth rates decline and the share of the working-age population grows relative to the dependent population).
Adolescents who use contraceptives in developing regions most commonly rely on male condoms (38%), the contraceptive pill (27%), and injectables (19%); few adolescents are using long-acting reversible methods such as implants and IUDs, which have higher rates of effectiveness. Failure of contraceptives is an important concern. A 2014 review of the most recent surveys in 43 developing countries found that women younger than 25 years had much higher rates of contraceptive failure during the first year of use for all methods than women older than 25 years. Part of the reason for these patterns is that providers typically offer condoms or other short-term methods to adolescents; many believe that long-acting methods such as IUDs and implants are inappropriate for women who have never had a child. However, the Global Consensus Statement on Expanding Contraceptive Choice for Adolescents and Youth asserts that there is no medical reason to withhold long-acting reversible methods from adolescents. Additionally, emergency contraception and female condoms could meet some adolescents’ needs, but they are often not available.

<table>
<thead>
<tr>
<th>CONTRACEPTIVE</th>
<th>MECHANISMS OF ACTION</th>
<th>ACCESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Condom (Male and Female)</td>
<td>• Barrier methods</td>
<td>• Wide access of male condoms. Available beyond health points</td>
</tr>
<tr>
<td>• Limited access to female condoms</td>
<td></td>
<td>• Can be used for 3-5 years</td>
</tr>
<tr>
<td>• Subdermal implants</td>
<td>• Prevents ovulation</td>
<td>• Health care provider must insert and remove</td>
</tr>
<tr>
<td>• Subdermal implants</td>
<td>• 99% effective</td>
<td>• Irregular vaginal bleeding common</td>
</tr>
<tr>
<td>• Placed under skin of upper arm; contains progestogen only</td>
<td>• Taken daily</td>
<td></td>
</tr>
<tr>
<td>• Oral contraceptives</td>
<td>• Prevents ovulation</td>
<td>• Available from health care provider</td>
</tr>
<tr>
<td>• Combined Oral Contraceptives</td>
<td>• 99% effective with correct and consistent use</td>
<td></td>
</tr>
<tr>
<td>• Progestogen only Pills (POPs)</td>
<td>• Taken daily</td>
<td></td>
</tr>
<tr>
<td>• Injectable</td>
<td>• Prevents ovulation</td>
<td>• Available from health care provider</td>
</tr>
<tr>
<td>• Combined injectable contraceptive (CIC)</td>
<td>• 99% effectiveness</td>
<td></td>
</tr>
<tr>
<td>• Progestogen only</td>
<td>• Injected monthly CIC</td>
<td></td>
</tr>
<tr>
<td>• Injectables</td>
<td>• Injected 2 – 3 months</td>
<td></td>
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<tr>
<td>• Emergency contraceptive pills</td>
<td>• Continuously releases 2 hormones – a progestin and an estrogen directly through the skin (patch) or from the ring.</td>
<td>• Available from health care provider</td>
</tr>
<tr>
<td>• Patches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modern Contraceptives</td>
<td>Description</td>
<td>Availability</td>
</tr>
<tr>
<td>-----------------------</td>
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<td>--------------</td>
</tr>
<tr>
<td>Sterilisation (Male and Female)</td>
<td>Permanent contraception to block or cut the vas deferens tubes that carry sperm from the testicles&lt;br&gt;Permanent contraception to block or cut the fallopian tubes</td>
<td>Available from health care provider</td>
</tr>
<tr>
<td>Interuterine devices (IUD)</td>
<td>Small flexible plastic device containing copper sleeves or wire that is inserted into the uterus&lt;br&gt;A T-shaped plastic device inserted into the uterus that steadily releases small amounts of levonorgestrel each day</td>
<td>Available from health care provider</td>
</tr>
<tr>
<td>Diaphragms and cervical caps</td>
<td>Barrier method</td>
<td></td>
</tr>
<tr>
<td>Spermicide agents (gels, foams etc)</td>
<td>Barrier method</td>
<td></td>
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<tr>
<td>Vaginal Rings</td>
<td></td>
<td></td>
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<tr>
<td>Sponge</td>
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Table 1: Modern Contraceptives
Meeting adolescent girls and young women’s contraceptive needs is a critical component of strategies to improve their health and that of their children and to eliminate poverty. A focus on access to modern contraceptives needs to be part of a strategy that includes tackling gender inequality—for example, ending child marriage, addressing sexual and gender based violence, inequalities in education and other opportunities.

A comprehensive response would include:

a) tackling the legal barriers and environment;
b) providing information and increasing knowledge to enable adolescents and young adults to make informed choices and decisions;
c) youth facing services that provide a range of modern contraceptives;
d) antenatal and delivery care;
e) special focus on addressing political, religious, social and cultural barriers to adolescent access to modern contraceptives:

- Challenging how traditional gender norms—the societal and cultural expectations of what it means to be a man or woman—impact sexual behaviour and the use of contraceptives. Women often have less power than their partners in relationships, especially if they are much younger than their partners, and this makes it difficult to negotiate sexual activity and use of contraceptives, particularly condoms.
- Boosting girls’ education can increase their knowledge and their ability to make autonomous decisions; studies have shown that adolescents who are in school are less likely to have sex and more likely to use contraceptives when they do have sex. Early marriage and pregnancy are also important—and preventable—reasons girls may drop out of school.17
- Building social understanding and support for contraceptive provision to adolescents. There is an urgent need to implement programmes that both meet the needs of adolescents and remove barriers to services.18

b) providing information and increasing knowledge to enable adolescents and young adults to make informed choices and decisions:

- Providing adolescents with critically needed access to age-appropriate sexual and reproductive health information before they are sexually active. This can be addressed through policies that acknowledge the needs of this age-group and through implementation of comprehensive sexuality education. CSE should include discussions about gender equity and gender relations, delaying sexual initiation and effective methods of pregnancy prevention.19
- Providing counselling around contraceptive methods, where services are offered (for example, health clinics, pharmacies or community settings). All adolescents need correct information about their risk of becoming pregnant and about the choices of contraceptive methods that are most suited to their circumstances. Counselling must include complete and accurate information about the possible side effects of modern methods and what to do about them, including switching methods when desired.
- Informing, educating and keeping adolescents in school.20 Is an effective way to reduce adolescent pregnancy.

c) youth facing services that provide a range of modern contraceptives:

- Providing sexual and reproductive services to adolescents includes a combination of health worker training; facility improvements geared towards welcoming adolescents and protecting their privacy; and information dissemination through schools, communities and the media. Adolescent participation enhances community buy-in and service elements that are youth centred and appropriate. Guttmacher Institute caution that two approaches commonly pursued, (stand-alone youth centres and peer education) have not been shown to be effective in changing young people’s sexual and reproductive health behaviours.4 Large-scale evaluations have found that youth centres (often designed for recreation) serve too few young people with health services to be cost-effective, and peer education programmes, while valuable for information sharing, have not resulted in...
in measurable behaviour change.

- Ensuring timely and affordable access to good quality health services for adolescents, delivered in a way that ensures informed consent, respects dignity, guarantees confidentiality.

d) antenatal and delivery care.

- Providing accessible services to adolescents who become pregnant including antenatal and delivery care and access to safe abortion services.
- Providing post abortion care for adolescents with complications from unsafe abortion
- Following a birth or an abortion, adolescents should receive contraceptive services to help them avoid becoming pregnant again too soon or having repeated unintended pregnancies.

e) Addressing the needs of specific groups of adolescents who have particular needs. Adolescents living with HIV who suffer from food insecurity may be vulnerable to transactional sex and support for resources is needed to support their ability to make decisions and exercise their sexual and reproductive rights. Adolescents living with HIV who inject drugs are in particular need of services which combine harm reduction with non-stigmatising sexual reproductive health services. Transgender adolescents need access to sexual and reproductive health information, in additional to non-judgmental and non-stigmatising services.
RESOURCES


- WHO. Synthesis of WHO’s recommendations on adolescent contraception

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19. Darroch JE et al. (2016)

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