

A never-before opportunity to strengthen investment and action on adolescent contraception, and what we must do to make full use of it: **Part I**

V Chandra-Mouli, P Parameshwar, M Parry, C Lane, G Hainsworth, S Wong, L Menard-Freeman, B Scott, E Sullivan, M Kemplay, L Say



1. What is this ‘never-before’ opportunity?

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Reproductive Health

COMMENTARY

Open Access

A never-before opportunity to strengthen investment and action on adolescent contraception, and what we must do to make full use of it



Venkatraman Chandra-Mouli^{1*}, Pooja S. Parameshwar¹, Matti Parry¹, Catherine Lane², Gwyn Hainsworth³, Sylvia Wong⁴, Lindsay Menard-Freeman⁵, Beth Scott⁶, Emily Sullivan⁷, Miles Kemplay⁸ and Lale Say¹

Increased global attention on adolescent health



SUSTAINABLE DEVELOPMENT GOAL 3
Ensure healthy lives and promote well-being for all at all ages

SUSTAINABLE DEVELOPMENT GOAL 5
Achieve gender equality and empower all women and girls

“The updated Global Strategy includes adolescents because they are central to everything we want to achieve, and to the overall success of the 2030 Agenda.”
-Former United Nations Secretary General Ban Ki-moon

Increased global attention on adolescent contraception



BILL & MELINDA
GATES foundation



Concept Note

Family Planning Summit – 11 July 2017

“Today, there are 1.2 billion adolescents aged 10-19 years living across the world. As the generation of the future, it is our collective responsibility to empower them to thrive, & doing so is central to achieving the FP2020 & broader Sustainable Development Goals...”

“In order to meet the diverse needs of youth & adolescents, countries & all stakeholders must examine their policies & programs, develop a process of evaluation & re-evaluation that genuinely reflects a youth perspective & implement evidence-based programs that work.”

This 'never-before' moment for action to increase adolescent contraceptive use takes into account three critical factors.

1. Millions of adolescents who wish to postpone or space childbearing are not using an effective form of contraception.

2. Even where contraceptive use increases, adolescent use does not increase as much as among other age groups.

3. Even when adolescents do have access to and begin using contraceptives, challenges still persist. Adolescents are more likely than adult women to discontinue contraception, with unmarried adolescents exhibiting the highest levels of discontinuation.

"Leaky Bucket" Analogy

1. Bucket is only half full
2. Bucket does not fill up as quickly
3. Even when filled, bucket is leaking

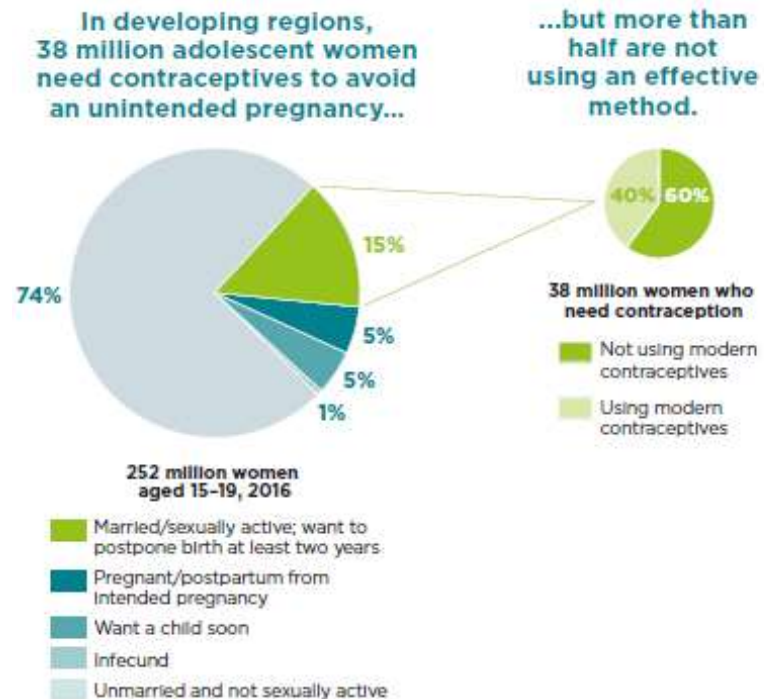


Many millions of adolescents who want to postpone birth are not using an effective method of contraception

- Meeting the unmet need for modern contraception of women aged 15-19 would reduce unintended pregnancies among this group by 6 million annually. That would mean averting 2.1 million unplanned births, 3.2 million abortions & 5,600 maternal deaths.
- The dramatic reduction in unintended pregnancies would spare women & their families the adverse consequences of early child bearing, reap savings in maternal & child health care, & boost women's education & economic prospects.

FIGURE 2

CONTRACEPTIVE NEED AND USE



SOURCE: reference 10.

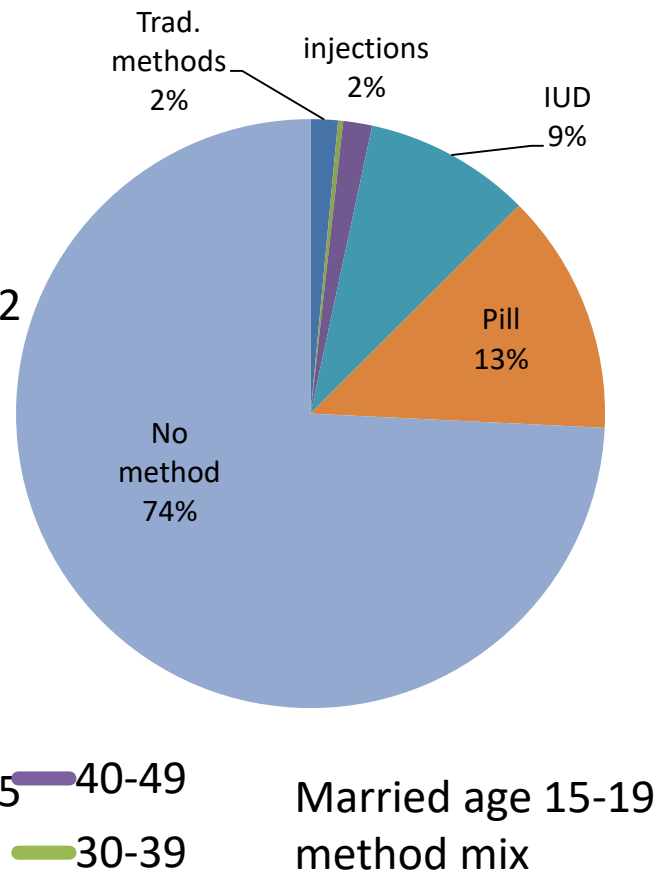
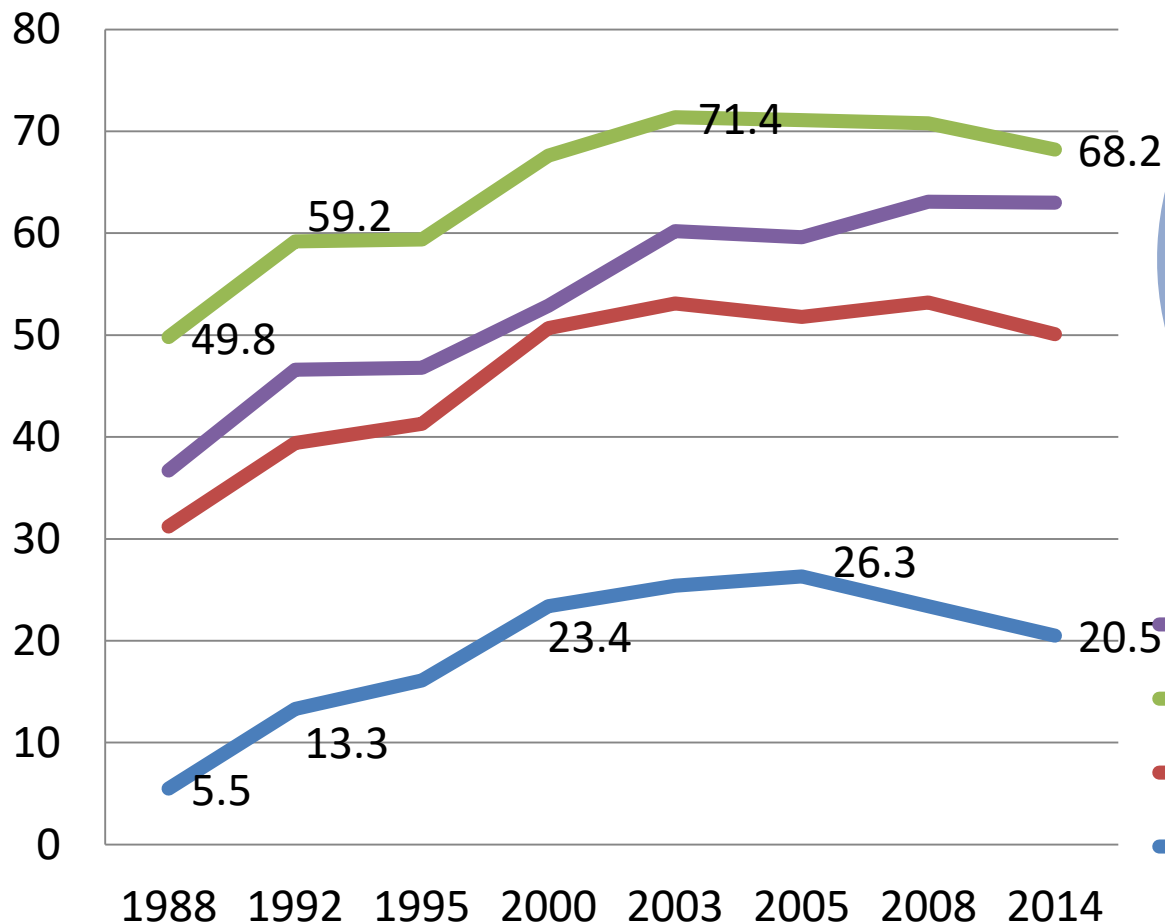
ADDING IT UP:
Costs and Benefits of Meeting the Contraceptive Needs of Adolescents



Jacqueline E. Darroch, Vanessa Woog, Akinrinola Bankole and Lori S. Ashford

Even when contraceptives are available & accessible, levels of use are less in younger than in older women

Egypt contraceptive use by age



2. Why are adolescents still unable to obtain and use contraceptives?

Many adolescents are not able to obtain the contraceptives they need

- ❑ Contraceptives are not available at all, or are out of stock
- ❑ Contraceptives are available but laws & policies prevent their provision. Even when there are no legal or policy restrictions, health workers do not provide them because of their biases
- ❑ Adolescents do not know where they can get contraceptives, cannot afford them or cannot get to a service-delivery point easily



Even if they can obtain contraception, many adolescents are not able to use them – at all/consistently

Even when adolescents are able to obtain contraceptives, they may not use them/use them correctly because of:

- ❑ Pressure to have children
- ❑ Stigma surrounding obtaining/proposing contraceptive use
- ❑ Fear of side effects

Even when adolescents use contraceptives, they may do so incorrectly/inconsistently



3. What do we need to do – or do differently - to increase correct and consistent contraceptive use by adolescents?

Understand the demand- and supply-side objectives to increase contraceptive access and uptake by adolescents, as well as contextual factors influencing these objectives



Demand for contraception

- Desire to avoid, delay, space or limit child bearing
- Desire to use contraception
- Agency to use contraception

Supply of contraception

- Access to contraceptive services
- Provision of adolescent-friendly services



McCleary-Sills A, Sexton M, Petroni S, Kanesathasan A, Edmeades J, Warner A, et al. *Understanding the Adolescent Family Planning Evidence Base*. ICRW. Washington DC, 2014.

Contextual Factors

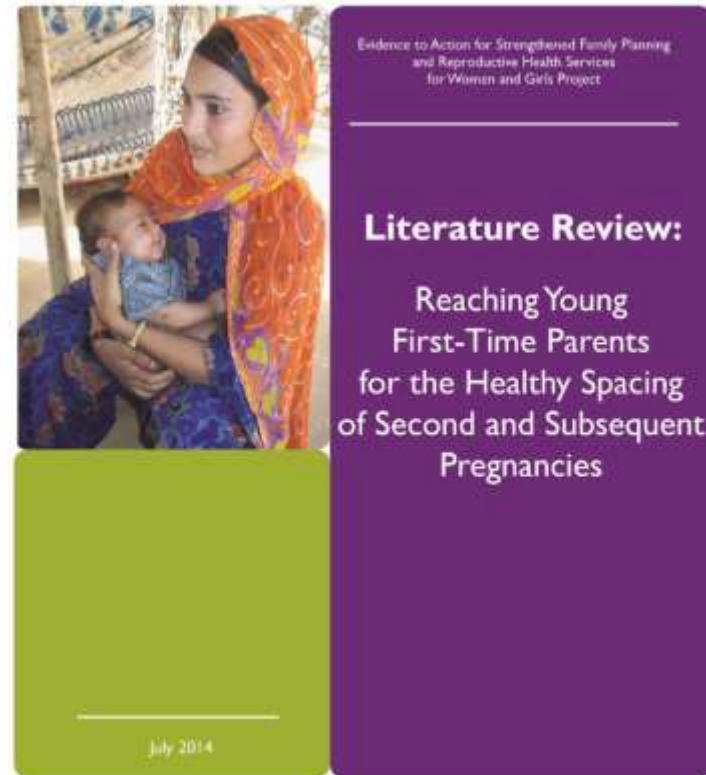
1. If early child bearing within marriage is socially accepted & even encouraged, interventions targeted at **increasing contraceptive knowledge & availability, would do little to prevent wanted pregnancies.**
2. Development agencies should continue their general economic & social development efforts to **address the systematic poverty & disadvantage which breeds adolescent child bearing, including gender inequality, which can lower girls' bargaining power over contraception & fertility decisions within marital & other sexual relationships.**

McQueston, Silverman, Glassman. *Adolescent Fertility in low & middle income countries: Effects & Solutions*. Centre for Global Development, 2012.

What we need to do differently to improve access to and provision of contraceptive services to adolescents

1. **We must move from a one-size-fits-all approach to one that responds to the varying needs of different groups of adolescents**

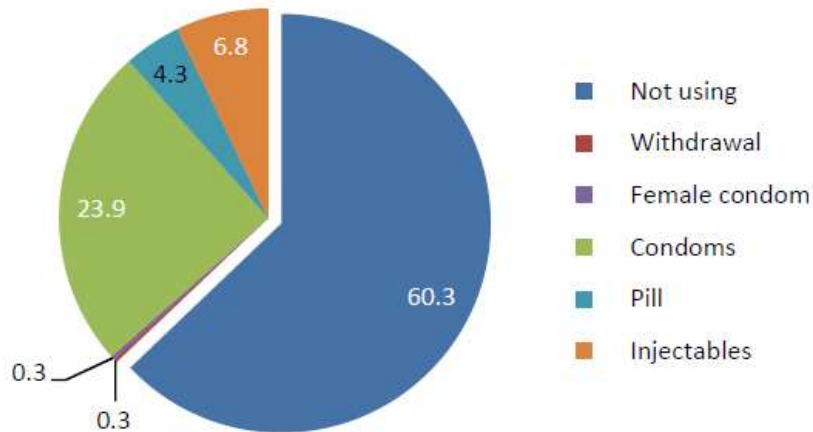
Examples: Unmarried ones & those married/in union, newly married ones, first-time parents, those living with HIV, & those who are disabled.



Adolescents – a heterogeneous group

United Republic of Tanzania: Adolescent contraception (WHO fact sheet based on DHS 2010)

Figure 1. Contraceptive use and non-use: unmarried girls, aged 15 to 19 years



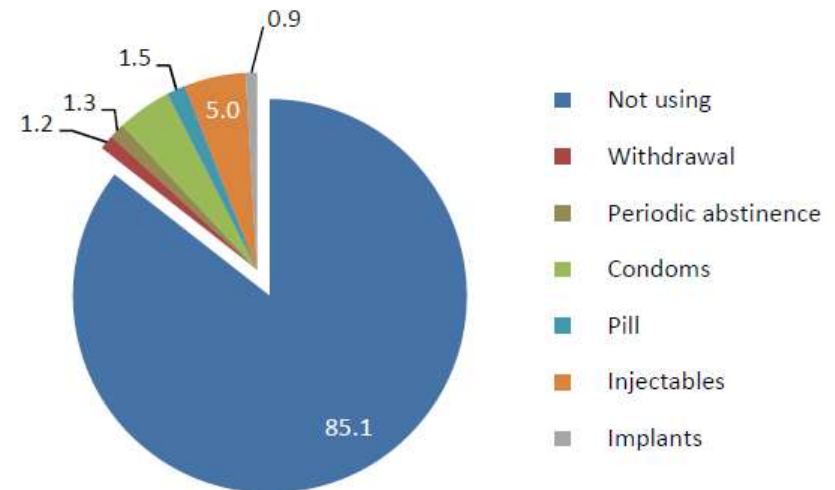
Main reasons for non use:

Infrequent sex, not married, fear of side effects

Main sources:

Shops, friends

Figure 2. Use and non-use of contraception: girls in a union, aged 15 to 19 years



Main reasons for non use:

Currently breastfeeding, not having sex, fear of side effects

Main sources:

Government facilities, shops

What we need to do differently to improve access to and provision of contraceptive services to adolescents

1. We must move from a one-size-fits-all approach to one that responds to the varying needs of different groups of adolescents.

2. We must expand the range of contraceptive choices offered to adolescents from 'condoms only' to a full range of methods.



The World Health Organization/Department of Reproductive Health and Research (WHO/RHR) has contributed to the technical content and review of this statement.

GLOBAL CONSENSUS STATEMENT FOR EXPANDING CONTRACEPTIVE CHOICE FOR ADOLESCENTS AND YOUTH TO INCLUDE LONG-ACTING REVERSIBLE CONTRACEPTION

"Age alone does not constitute a medical reason for denying any method to adolescents."

– Medical Eligibility Criteria for Contraceptive Use, World Health Organization

"Adolescent-friendly services should offer low-cost or free contraception, including male and female condoms, emergency contraception, and a full range of modern methods, including long-acting reversible methods, according to adolescents' preferences and needs."

– UNFPA 2013 State of World Population Report

What we need to do differently to improve access to and provision of contraceptive services to adolescents

1. We must move from a one-size-fits-all approach to one that responds to the varying needs of different groups of adolescents.
2. We must expand the range of contraceptive choices offered to adolescents from 'condoms only' to a full range of methods.
3. We must move away from separate health services for adolescents, and instead make existing health services more adolescent friendly e.g. antenatal clinics & HIV care clinics.

- Separate services have been shown to be difficult to scale up and sustain in resource-constrained settings, so focusing on strengthening existing services is a pragmatic approach to reach large numbers of adolescents
- We must make existing health services more adolescent friendly i.e. welcoming, non judgemental & guaranteeing confidentiality.

HIP

FAMILY
PLANNING
HIGH IMPACT
PRACTICES

Adolescent-Friendly Contraceptive Services:
Mainstreaming Adolescent-Friendly Elements Into Existing Contraceptive Services

What is the program enhancement that can intensify the impact of high-impact practices in family planning?

Incorporate adolescent-friendly service delivery elements into existing contraceptive and health services.



What we need to do differently to improve access to and provision of contraceptive services to adolescents

1. We must move from a one-size-fits-all approach to one that respond to the differing needs & preferences of different groups of adolescents.
2. We must expand the range of contraceptive choices offered to adolescents from 'condoms only' to a full range.
3. We must move from separate health services for adolescents, and instead make existing services more adolescent friendly e.g. antenatal clinics & HIV care clinics.
4. We must work more actively with pharmacies & shops to expand contraceptive access and uptake.

- Adolescents in many places seek contraceptive information and services from pharmacies and shops. This is especially true for unmarried sexually active adolescents, & for products not easily obtained from government clinics e.g. emergency contraception.



What we need to do differently to improve access to and provision of contraceptive services to adolescents

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2. We must expand the range of contraceptive choices offered to adolescents from 'condoms only' to a full range of methods.
3. We must move from separate health services for adolescents to making existing services more adolescent friendly.
4. We must work more actively with pharmacies & shops to expand contraceptive access and uptake.
5. We must move from one-off in-service training for providers to a package of actions to ensure that all levels of health workers respond to adolescent clients effectively and with sensitivity.

- One-off training programmes (even if well conducted) have limited & short-lived effects
- We need a package of actions - clear job descriptions, good quality training, desk reference tools, supportive supervision & collaborative learning.



A never-before opportunity to strengthen investment and action on adolescent contraception, and what we must do to make full use of it: **Part II**

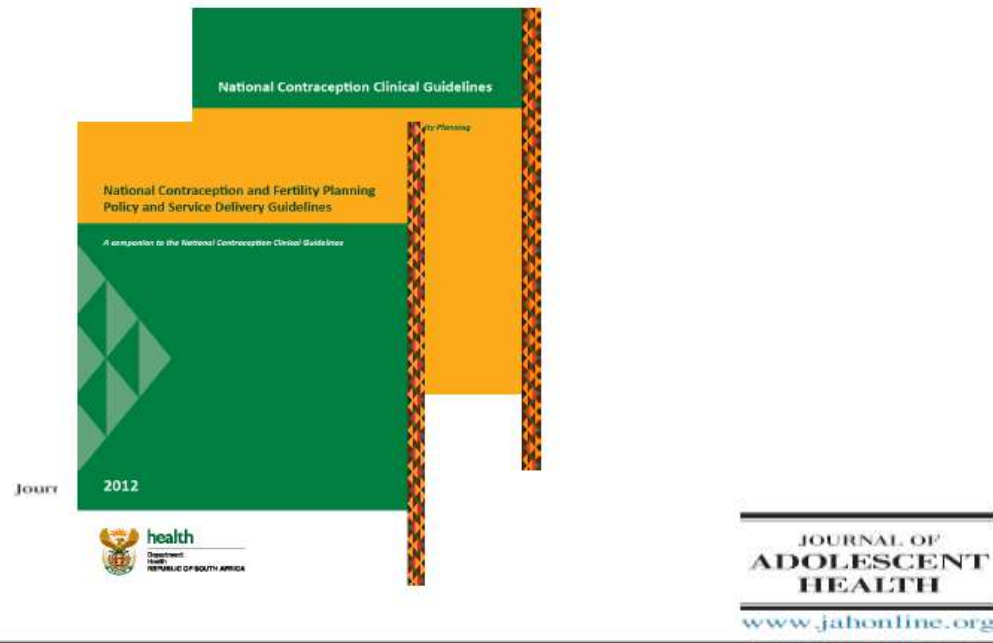
V Chandra-Mouli, P Parameshwar, M Parry, C Lane, G Hainsworth, S Wong, L Menard-Freeman, B Scott, E Sullivan, M Kemplay, L Say



**4. Expanding access to quality contraceptive services to adolescents, with equity:
What do we want to see in countries ?**

Expanding access to quality contraceptive services to adolescents, with equity: Five things we want to see in countries

i. Develop national laws and policies that require health workers to provide contraceptive services to adolescents without restrictions, and communicate them widely



Original article

An Analysis of Adolescent Content in South Africa's Contraception Policy Using a Human Rights Framework



Andrea J. Hoopes, M.D., M.P.H.^a, Venkatraman Chandra-Mouli, M.B.B.S., M.Sc.^{b,*}, Petrus Steyn, M.D., M.Phil., D.F.F.P.^b, Tlangelani Shilubane, M.Sw.^c, and Melanie Pleaner, M.Ed.^d

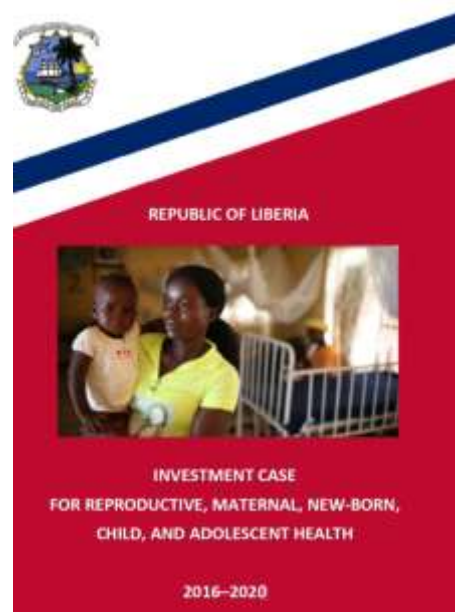


Expanding access to quality contraceptive services to adolescents, with equity: Five things we want to see in countries

i. Develop national laws and policies that require health workers to provide contraceptive services to adolescents without restrictions, and communicate them widely

ii. Design sound national adolescent SRH strategies that contain evidence-based and context-specific packages of interventions, budgets to deliver the package, and indicators to track progress that are disaggregated by age, sex, and socio-economic status

- Choosing interventions that address local determinants, are feasible to implement, and have demonstrated effectiveness
- Incorporating indicators to assess inputs, processes, and outputs



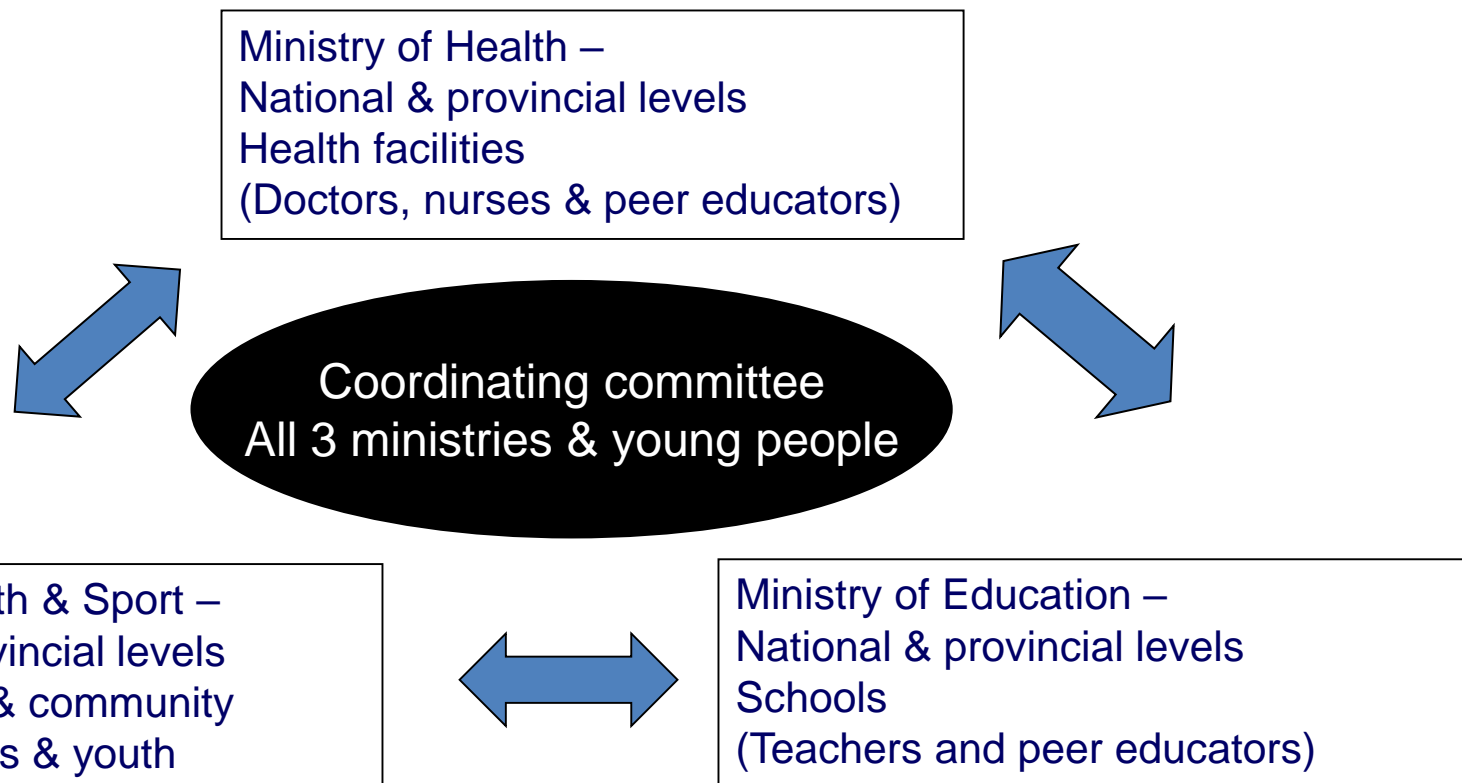
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iii. Implement strategies with fidelity and careful monitoring, through functional systems and with the participation of civil society groups (including networks of youth organizations)

The case of Mozambique



Chandra-Mouli et al. *Reproductive Health* 2015, **12**:12
<http://www.reproductive-health-journal.com/content/12/1/12>



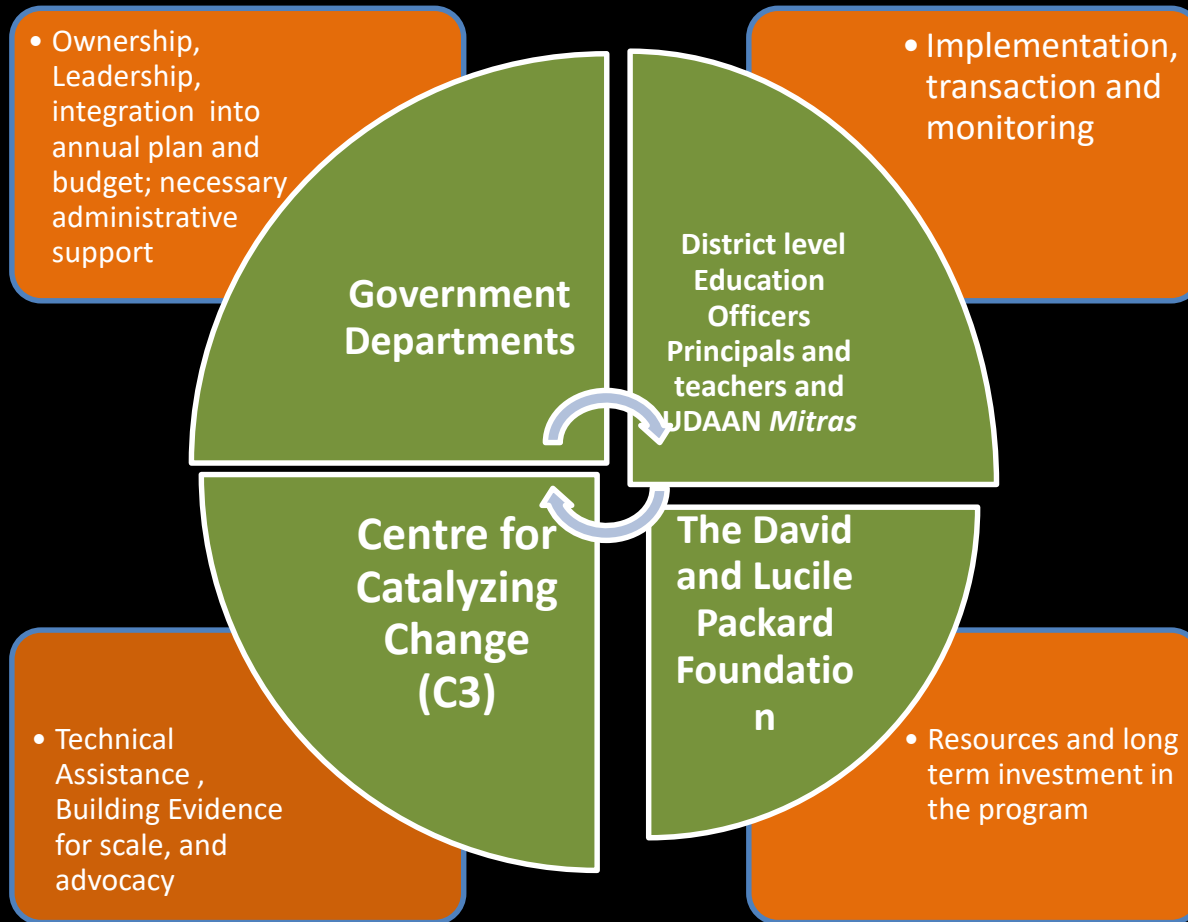
REVIEW

Open Access

Programa Geração Biz, Mozambique: how did this adolescent health initiative grow from a pilot to a national programme, and what did it achieve?

Venkatraman Chandra-Mouli^{1*}, Susannah Gibbs², Rita Badiani³, Fernandes Quinhas⁴ and Joar Svanemyr¹

Udaan, a school-based adolescent education programme in Jharkhand, India engaged different players to play complementary roles



Expanding access to quality contraceptive services to adolescents, with equity: Five things we want to see in countries

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iv. Conduct periodic programme reviews to build on strengths and address weaknesses

The case of England: Mid strategy review

Journal of Adolescent Health xxx(2016) 1–7



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Original article

Implementing the United Kingdom Government's 10-Year
Teenage Pregnancy Strategy for England (1999–2010):
Applicable Lessons for Other Countries

Alison Hadley, S.R.N., H.V.^{a,*}, Venkatraman Chandra-Mouli, M.B.B.S., M.Sc.^b, and
Roger Ingham, D.Phil.^c

A. Hadley et al. / Journal of Adolescent Health xxx (2016) 1–7

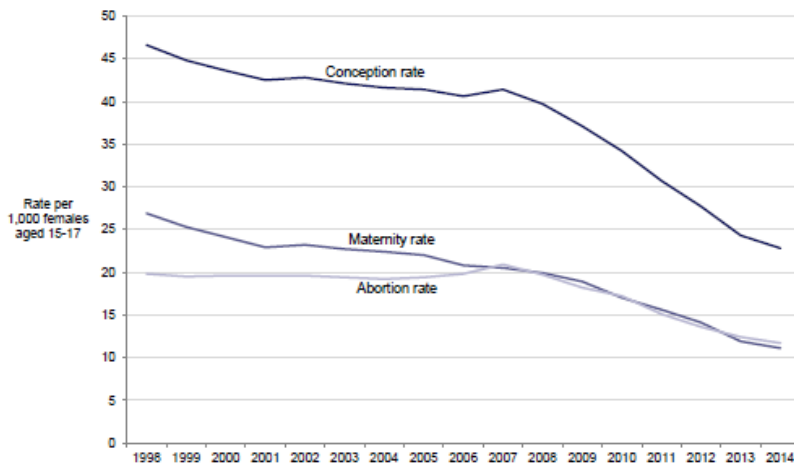
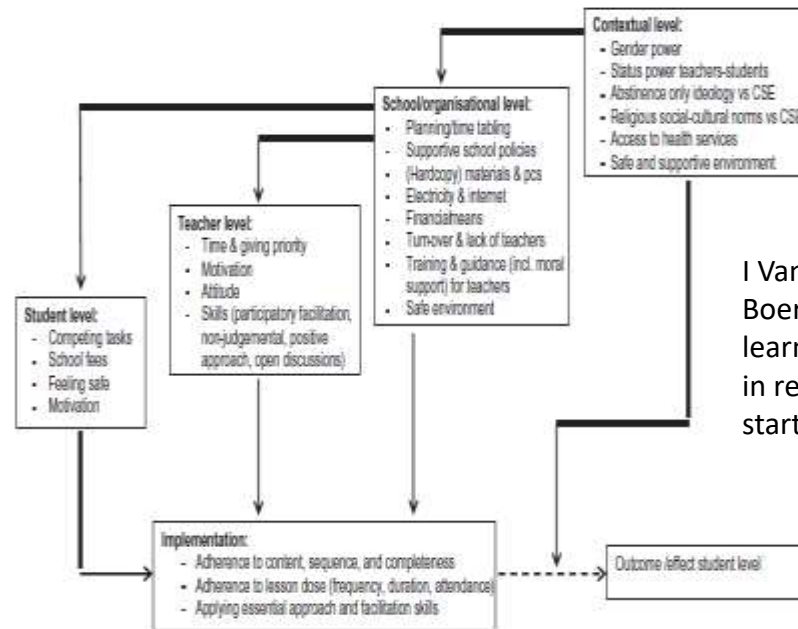
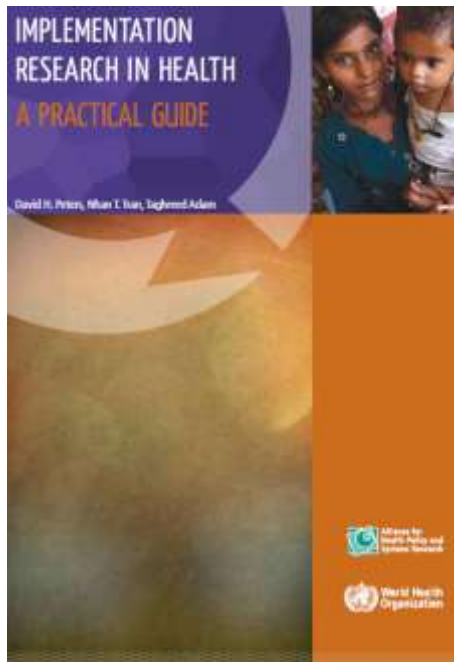


Figure 2. England under-18 conception rate: 1998–2014.

- ❑ Data & qualitative research were regularly reviewed to identify potential risk factors for early pregnancy, or poor outcomes for young parents & their children
- ❑ Summaries were provided to local areas to inform targeted work, & strategy actions integrated nationally into relevant government programmes aimed at improving health and educational outcomes for the most disadvantaged young people.
- ❑ Steady but **slow decline** in national under-18 conception
- ❑ **Wide variation in progress** between local areas
- ❑ In depth review **comparing 6 areas** with similar populations and deprivation: **3 with increasing rates** and **3 with declining rates**
- ❑ **Areas with good reductions** were implementing the strategy effectively, supported by senior leadership
- ❑ Progress accelerated by **more prescriptive Government guidance**, and **Ministerial focus** and **additional support** for poor performing areas

Expanding access to quality contraceptive services to adolescents, with equity: Five things we want to see in countries

- i. Develop national laws and policies that require health workers to provide contraceptive services to adolescents without restrictions, and communicate them widely*
- ii. Design sound national adolescent SRH strategies that contain evidence-based and context-specific packages of interventions, budgets to deliver the package, and indicators to track progress that are disaggregated by age, sex, and socio-economic status*
- iii. Implement strategies with fidelity and careful monitoring, through functional systems and with the participation of civil society groups (including networks of youth organizations)*
- iv. Conduct periodic programme reviews to build on strengths and address weaknesses*
- v. Carry out research – with an emphasis on implementation research - to answer context-specific programmatic challenges**



I Vanwesenbeeck, J Westeneng, T de Boer, J Reinder, R van Zorge. Lessons learned from a decade implementing CSE in resource poor settings: The world starts with me. Sex Education, 2015.

Figure 1. Barriers to CSE implementation and effectiveness.²

 OPEN ACCESS

Scaling up sexuality education in Senegal: integrating family life education into the national curriculum

Katie Chau^a, Aminata Traoré Seck^b, Venkatraman Chandra-Mouli^c and Joar Svanemyr^d

Huaynoca et al. *Reproductive Health* (2015) 12:90
DOI 10.1186/s12978-015-0079-7



REVIEW

Open Access

Documenting good practices: scaling up the youth friendly health service model in Colombia



Silvia Huaynoca^{1*}, Joar Svanemyr², Venkatraman C. Chandra-Mouli² and Diva Jeaneth Moreno Lopez³

Kempers et al. *Reproductive Health* 2015, **12**:2
<http://www.reproductive-health-journal.com/content/12/1/2>



RESEARCH

Open Access

The success factors of scaling-up Estonian sexual and reproductive health youth clinic network - from a grassroots initiative to a national programme 1991–2013

Jari Kempers^{1*}, Evert Ketting^{2†}, Venkatraman Chandra-Mouli³ and Triin Raudsepp⁴

Hoopjes et al. *Reproductive Health* 2015, **12**:2
DOI 10.1186/s12978-015-0251-8

Reproductive Health

REVIEW

Open Access

Measuring adolescent friendly health services in India: A scoping review of evaluations



Andrea J Hoopjes^{1*}, Parag Agarwal², Sheena Bull^{3,4} and Venkatraman Chandra-Mouli⁵



We need sound data to shape and reshape our efforts

- ❑ Rates and outcomes of adolescent pregnancies
- ❑ **Contraceptive use & its determinants**
- ❑ Policies and programme performance
- ❑ **Adolescent sexuality and its context**



5. Outstanding examples of countries moving ahead with adolescent contraception

The case of Ethiopia



A widespread famine affected Ethiopia from 1983 to 1985.

In northern Ethiopia it led to more than 400,000 deaths...

Other areas of Ethiopia experienced famine for similar reasons, resulting in 10s of 1000s of additional deaths.

The tragedy as a whole took place within the context of more than two decades of insurgency & civil war.

Source: Wikipedia

The case of Ethiopia

Main approach for general population

Health extension worker programme with national coverage

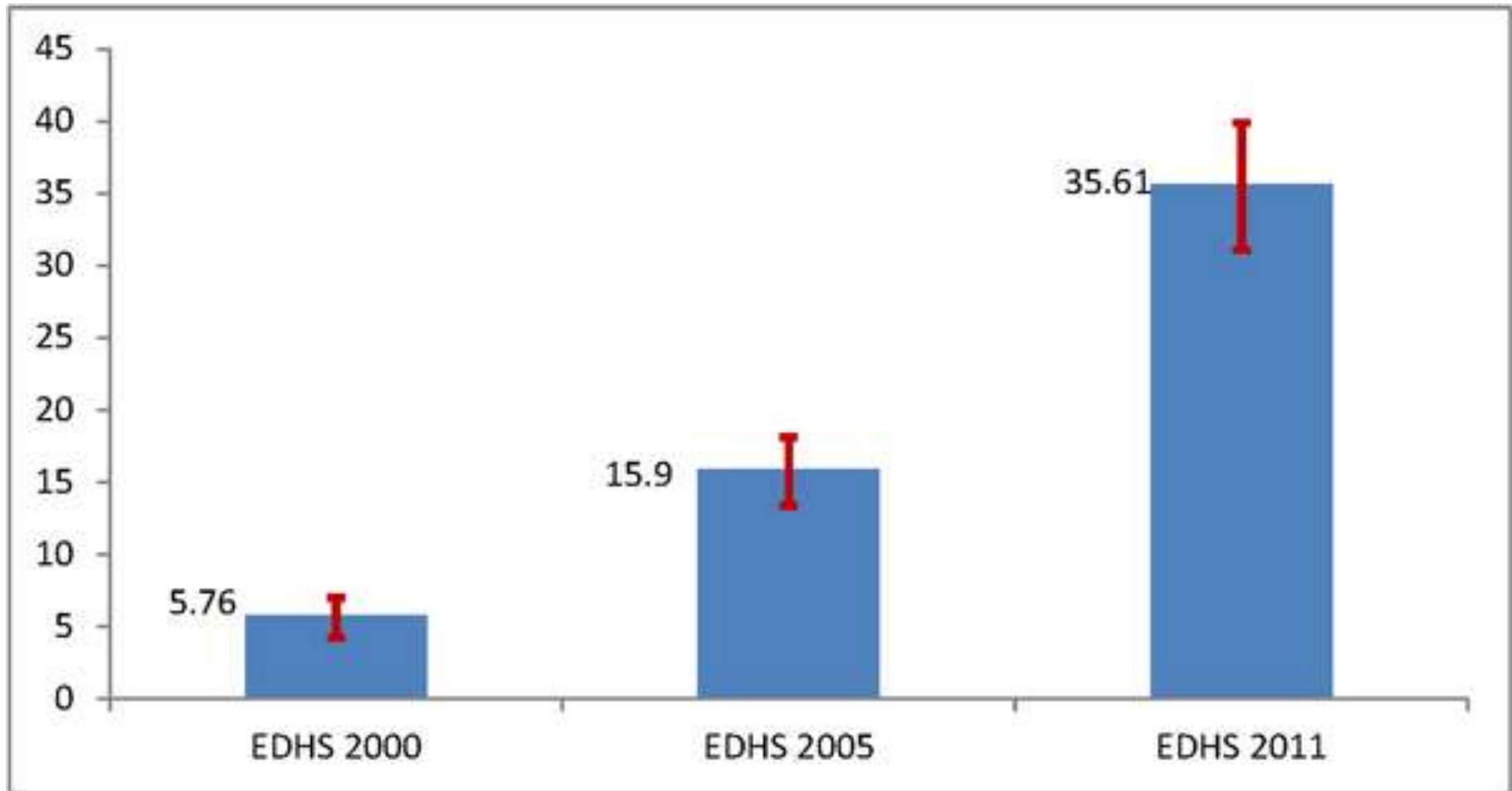
- ❑ Over 35000 trained since 2005
- ❑ Have received training in inserting implants since 2009
- ❑ Reaching married women – adults & adolescents

Adolescent specific features

- ❑ National adolescent strategy with minimum service package
- ❑ Training public and private providers to meet the needs of young people



Trends in contraceptive use among Ethiopian young married women in the past 10 years, Ethiopia Demographic and Health Surveys 2000–2011.



Bars Indicate 95% Confidence Interval

Worku AG, Tessema GA, Zeleke AA (2015) Trends of Modern Contraceptive Use among Young Married Women Based on the 2000, 2005, and 2011 Ethiopian Demographic and Health Surveys: A Multivariate Decomposition Analysis. PLOS ONE 10(1): e0116525.

<https://doi.org/10.1371/journal.pone.0116525>

<http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0116525>

The case of Ethiopia

Child Marriage and Female Circumcision (FGM/C): Evidence from Ethiopia



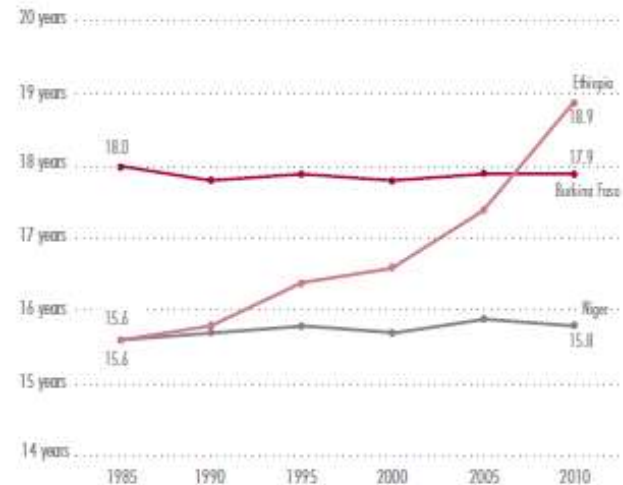
YOUNG LIVES POLICY BRIEF 21

July 2014 (revised December 2014)

"Remarkable progress has been achieved in reducing both child marriage & Female Genital Mutilation/Cutting in Ethiopia, due to favourable legal frameworks, political will & campaigns with support from donor agencies, international organizations, local civil society & the media, alongside broader forces of modernization".

In Ethiopia, young women are marrying later than their counterparts three decades ago

Median age at first marriage or union among women aged 20 to 24 years. In selected countries:



Source: UNICEF, 2014

Key Messages

We have a never-before opportunity to address adolescent health. The work of FP2020 and the Family Planning Summit have placed adolescent contraception high on the global agenda.

We have a much better sense of what needs to be done to meet the needs of adolescents, and to enable them to realise their rights and exert agency over their sexual and reproductive decisions.

The big questions now revolve around how to orchestrate and sustain large-scale implementation, how to respond to the diverse needs of different groups of adolescents, and how to involve adolescents in these processes. We must move with countries to scale up adolescent contraceptive services.

Some countries are already moving forward. We need to recognize and celebrate their successes and share them widely.