Challenges for Adolescent’s Sexual and Reproductive Health Within the Context of Universal Health Coverage

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Key Messages:

- Adolescent sexual and reproductive health (ASRH) is inseparable from all aspects of adolescent health, providing an opportunity for health gain or loss, and is key to poverty alleviation and economic development.
- Recent World Bank studies in Bangladesh, Burkina Faso, El Salvador, Ethiopia, Lao PDR, Nepal, Niger, and Nicaragua present findings on the multi-sectoral burden of ASRH:
  - 50 percent of adolescents (15-19 years of age) in most of the analyzed countries have given birth.
  - Less than 41 percent of adolescents use modern contraception in most countries.
- There is a lack of access to, demand for, and knowledge about ASRH health services among sexually active married and unmarried adolescent girls.

Introduction

Young people (10-24 years of age), around the world face tremendous challenges to meeting their sexual and reproductive health (SRH) needs. Inadequate access to health information and services, as well as inequitable gender norms, contributes to a lack of knowledge and awareness about puberty, sexuality, and basic human rights. This can have serious implications on young people’s health and welfare as well economic development and poverty reduction.

Decisions made during adolescence, particularly regarding SRH, have a long-term impact on human development. With the onset of puberty, young people face new challenges – initiating sexual activity, entering the age of risk-taking, entering unions and making decisions on family formation (WDR, 2007; WDR 2012) – that affect future health and opportunities, such as mental health, injuries, and non-communicable diseases (NCDs).

Given the importance of ASRH within the context of development as well as the paucity of data on the issue, the WBG conducted a global analysis and country case studies in order to: (i) gain a deeper understanding of the multi-sectoral determinants of ASRH outcomes; (ii) explore further the multi-sectoral supply and demand-side determinants of access, utilization, and provision of services relevant to identified ASRH outcomes; and (iii) identify multi-sectoral programmatic and policy options to address critical constraints to improving ASRH outcomes that can inform WBG lending operations and policy dialogue. Activities were generated to benefit cross-regional learning on ASRH by identifying both health sector and non-health sector factors and lessons learned, while strengthening the availability and analysis of data on adolescents in a standardized way. The aim is to incorporate the main findings and recommendations from these studies into existing and new WBG lending operations while simultaneously informing ASRH policies and interventions for inclusion in country strategies.

To describe the multi-sectoral factors that impact adolescent health, the WBG used the following conceptual framework (figure 1) tailored to each country context.
A global analysis using Demographic and Health Survey (DHS) data from 6 countries (Bangladesh 2011; Burkina Faso 2010; Ethiopia 2011; Nepal 2011; Niger 2012; and Nigeria 2008) examined socioeconomic differences in relation to most of the key ASRH issues mentioned above among adolescent female respondents (15-19 years of age). Data from regional studies (Latin America and the Caribbean [LAC]; West and Central Africa [WCA]; South Asia [SA]; and East Asia and the Pacific [EAP]) conducted by the WBG is also presented.

Global Trends and Challenges

SEXUAL ACTIVITY

In all countries, nearly all ever-married adolescent females have sexual intercourse while sexual activity outside of marriage is low. However, sexual activity among never-married adolescents increases with level of education and wealth in Burkina Faso and Nigeria. Further, over one third of ever-married adolescent females had sex before age 15 in Bangladesh (37 percent), Niger (37 percent), and Nigeria (38 percent). This is associated with rural residence, less wealth and less education. Evidence from regional data indicates that similar socioeconomic characteristics are found in LAC. However, adolescents in LAC, SA, and EAP are far more likely to initiate sex outside of marriage.

FAMILY PLANNING

Use of modern contraception is most common among ever-married females in Bangladesh (41 percent), followed by Ethiopia (20 percent) and Nepal (14 percent). Less than 10 percent of ever-married women use modern contraception in Burkina Faso, Niger, and Nigeria. Among never-married women, almost none use modern contraception in Ethiopia, Nepal, and Niger. Use of modern contraception is higher in urban areas, higher wealth quintiles, and with increased educational levels. Contraceptive prevalence among ever-married adolescent girls (15-19 years of age) in SA is the lowest in the world with 15 percent using contraception. Similar results are found in EAP (ranging from less than 10 percent in Kiribati, Timor-Leste, and Samoa to 48 percent in Indonesia).

SOURCES OF FAMILY PLANNING INFORMATION

Adolescent females most often hear about family planning through radio in all countries, except Bangladesh where TV is most utilized. Never-married adolescent women learn about family planning through media sources more often than ever-married women. This is associated with urban residence, more wealth and more education. Also, visits by family planning workers are relatively rare among adolescent women, regardless of marital history. In contrast, in El Salvador, adolescents are most likely to hear about family planning in school.

SEXUALLY TRANSMITTED INFECTIONS

Self-reported STIs and symptoms are low among adolescent women, regardless of marital history. Less than one third of adolescent females have comprehensive HIV/AIDS knowledge in all countries, regardless of marital status. Comprehensive knowledge of STIs is more common among never-married adolescents, higher wealth quintiles, and higher education levels. The proportion of adolescent females who have tested for HIV is higher among ever-married women in all countries, except Nigeria, and in urban areas, wealthier households, and higher levels of education. Similar global patterns related to comprehensive knowledge are found in SA and EAP.

ADOLESCENT MARRIAGE

Early marriage is prevalent in all countries studied. Over 25 percent of adolescent women are married in all countries. Rates of adolescent marriage (including marriage before 15 years of age) are highest in Niger (64 percent). Marriage – at any age and before age 15 – is more common in rural areas and among those with less wealth and education (figure 2). At the regional level, SA has the highest prevalence of adolescent marriage in the world (46 percent).

ADOLESCENT CHILDBEARING

Adolescent childbearing, except in LAC, is closely tied to marital status. In all countries, approximately half (from 42 percent in Nepal to 55 percent in Nigeria) of ever-married adolescents gave birth, while non-marital childbearing is rare. Less than 10 percent have given birth before age 15. In
Bangladesh and Burkina Faso, childbearing among ever-married adolescents is positively associated with rural residence, less wealth, and less education.

Figure 2. Percentage of women 15 through 19 years of age who have ever been married, by country and education level

![Graph showing percentage of married women by country and education level.]


West Central African countries face the highest adolescent fertility rates (AFR) in the world. Niger has an AFR of 204.8 births (per 1,000 females 15-19 years of age), followed by Mali at 175.6 births, and Chad at 152 births. Nigeria has an AFR of 119.6 births and Burkina Faso has an AFR of 115.4 births (per 1,000 females 15-19 years of age).

Country Case Studies and Findings

Quantitative and qualitative studies were conducted in El Salvador, Bangladesh, and Niger in order to highlight the multi-sectoral ASRH burden, and to inform WBG lending operations and country strategies.

IMPACT OF TRADITIONAL GENDER NORMS

In El Salvador, a quantitative household survey on ASRH was conducted among 1,258 adolescents aged 10-19 years (Cortez et al., 2014). Results indicate that despite El Salvador’s history of trying to meet human rights principles, adolescents and youth continue to face SRH violations. In fact, half of adolescents know about their sexual and reproductive health rights (SRHR), reducing the risk of becoming a parent by 66 percent and the risk of being mistreated by 46 percent.

Over 40 percent of adolescents in El Salvador have sex by 15 years of age. Use of contraceptive method at first sex is quite low (54 percent), while adolescent girls are less likely to use contraception (29 percent) in comparison to boys (10 percent) (figure 3). Also, adolescent girls in El Salvador have poorer SRH outcomes. An adolescent female is 8 times more likely to become a parent in comparison to her male counterpart, and more likely to experience abuse in comparison to boys (13.2 percent and 9.3 percent respectively), with older adolescents more likely to be abused than younger adolescents. Adolescent girls are at a 66 percent higher risk of being discriminated against for their sexual behavior and identity than boys.

Figure 3. Adolescent (10-19 years old) frequency of contraceptive use by sex (percent) in El Salvador

![Graph showing contraceptive use by sex in El Salvador.]


BARRIERS TO IMPROVED ASRH

A study in Bangladesh (Cortez et al., 2014) noted a powerful association between adolescent marriage, poverty, and poor SRH outcomes in four Dhaka slums. The study included a quantitative household survey, qualitative interviews, formative research, and donor interviews. Results indicate that adolescent females marry on average at 15 years of age, although their ideal age at first marriage is 18 years. Further, 70 percent of adolescent women give birth by the time they turn 19 years of age.

Figure 4. Current Use of contraception among adolescents (15-19 years of age) by number of living children and method (Percent)

![Graph showing current use of contraception by number of living children and method in Bangladesh.]


Use of modern contraception is low among adolescent females: 61 percent of adolescent females use contraception, 31.9 percent do not use contraception, and 6.6 percent use traditional methods. Use of contraception increases among women of higher parity (figure 4) and among adolescent girls employed in non - garment sectors. The study found that 70 percent of adolescent females deliver at home; although adolescent females with some
level of education are 4 to 7 times more likely to seek SRH services from a formal health care facility in comparison to those with no education.

Moreover, traditional gender norms continue to dictate a female’s access to health care in Dhaka as 55 percent of young women report that their husbands make decisions regarding their own health care.

HIGH AFR AND MATERNAL MORTALITY

In Addressing Adolescent Sexual and Reproductive Health in Niger, a recent analysis (Barroy et al., 2014) was conducted using DHS and Multiple Indicator Cluster Survey (MICS) data among female and male adolescents 10-19 years of age. In addition, a policy review, stakeholder interviews, and focus group discussions were held. Young women in Niger are more likely to initiate sex before age 15 than their male counterparts (24.5 percent and 1.1 percent respectively). Although 73 percent of female adolescents have fair knowledge about contraceptive methods, most do not use contraception. Coverage of SRH remains limited for adolescents and they face financial and geographic obstacles; although the proportion of pregnant women attending prenatal care has increased from 50.8 percent in 2006 to 90.6 percent in 2010.

Policy Challenges

ASRH is inseparable from all aspects of adolescent health, providing an opportunity for health gain or loss. It is at this time that the risk of injury and mental disorders are greatest, while behaviors associated with later-life NCDs, such as tobacco use, obesity and physical inactivity, are established. This affects the future health, social adjustment, and economic prospects of today’s adolescents as well as their capacity as parents and the health of their children. Within this context, ASRH investments are required and should be adapted to a country’s unique needs, by doing the following:

- Investing in universal access to integrated SRH;
- Investing in high-impact adolescent interventions in other sectors, and ensuring sustainability;
- Investing in poor and vulnerable young populations;
- Gaining policy and political will at the country level;
- Harmonizing technical and investment efforts among partners at the country level;
- Establishing country data systems to drive adolescent health policy and programming;
- Fully involving adolescents in the development of adolescent health programs; and
- Strengthening health systems to scale up access to quality adolescent user-friendly health services.

Conclusions

Despite international support to improve ASRH and SRHR, pervasive challenges remain. These studies highlight the importance of investing in young people’s SRH. Investment in the health, education, and rights of young people, and the alignment of policies, is important, as it will enable productivity and economic growth. Meanwhile, empowering young people in their healthy development, including SRH practices and rights, provides the right conditions so that they can enter adulthood with strong capabilities to ensure better productivity as well as the protection of their health and their family’s wellbeing.

References

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