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MEETING THE NEED, FULFILLING THE PROMISE: YOUTH AND LONG-ACTING REVERSIBLE CONTRACEPTIVES

1%

The failure rate of long-acting reversible contraceptives (LARCs).

51%

The share of unsafe abortions in sub-Saharan Africa attributed to women under age 25.

33
MILLION

The number of young women in low- and middle-income countries who want to delay or limit childbearing but are not using contraception.

Globally, 25 percent of the world's population—1.8 billion—are youth (ages 10 to 24).¹ This large and diverse group will shape demographic, economic, social, and political futures and should be the focus of investments to help them and their countries achieve their potential. The highest proportion of young people today—89 percent—live in developing countries. In some sub-Saharan African countries, where fertility remains high, we can expect growing cohorts of children and youth, unless fertility needs can be met.² Addressing the sexual and reproductive health of this large youth population is critical to support their universal right to health—including access to contraception—and to contribute to efforts to expand education, provide meaningful employment, and reduce poverty.

Fortunately, the importance of providing reproductive health information and services to youth is gaining worldwide attention. In 2015 the Global Consensus Statement on youth and long-acting reversible contraceptives (LARCs) was launched and more than 50 influential organizations and governments have signed on.³ The Consensus Statement (see Box 1) states that ensuring young people's access to LARCs will help to prevent unintended pregnancies, reduce maternal and infant morbidity and mortality, decrease unsafe abortions, and ensure full and informed contraceptive choice for youth. This brief discusses the advantages and challenges of providing LARCs—specifically contraceptive implants and intrauterine devices (IUDs)—to youth, and provides case studies from Ethiopia and Madagascar. It also outlines actions for policymakers and donors to make youth access to LARCs a reality.

BOX 1

Global Consensus Statement: Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting Reversible Contraception

Global efforts to prevent unintended pregnancies and improve pregnancy spacing among adolescents and youth will reduce maternal and infant morbidity and mortality, decrease rates of unsafe abortion, decrease HIV/sexually transmitted infection (STI) incidence, improve nutritional status, keep girls in school, improve economic opportunities, and contribute toward reaching the Sustainable Development Goals. We recognize and commit ourselves and call upon all programs promoting the SRHR of adolescents and youth to ensure full and informed choice of contraceptives, by:

- Providing access to the widest available contraceptive options, including LARCs (implants and IUDs) to all sexually active adolescents and youth (from menarche to age 24), regardless of marital status and parity.*
- Ensuring that LARCs are offered and available among the essential contraceptive options, during contraceptive education, counseling, and services.
- Providing evidence-based information to policymakers, ministry representatives, program managers, service providers, communities, family members, and adolescents and youth on the safety, effectiveness, reversibility, cost-effectiveness, acceptability, continuation rates, and the health and nonhealth benefits of contraceptive options, including LARCs, for sexually active adolescents and youth who want to avoid, delay, or space pregnancy.

Read the full statement, “Global Consensus Statement: Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting Reversible Contraception,” at www.familyplanning2020.org/resources/10815.

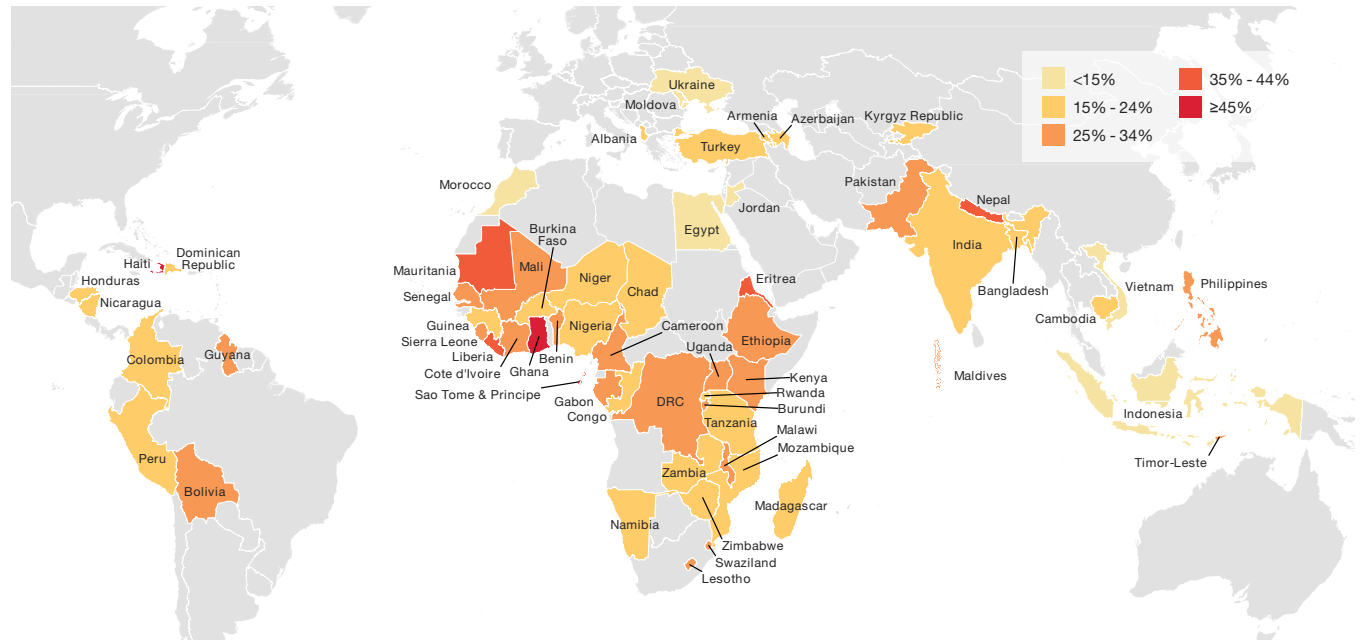
*Parity is the state or condition of being equal, especially regarding status or pay.

Source: Pathfinder International, Evidence 2 Action (E2A), Population Services International (PSI), Marie Stopes International, FHI 360.

FIGURE 1

Almost Two-Thirds of Young Married Women With Unmet Need Live in One of 10 South and Southeast Asian Countries.

Unmet Need for Family Planning Among Married Women, Ages 15-24



Source: Kerry L.D. MacQuarrie, *Unmet Need for Family Planning Among Young Women: Levels and Trends*, DHS Comparative Reports No. 34 (Rockville, MD: ICF International, 2014).

Challenges and Unmet Need Must Be Addressed

Multiple challenges to addressing youth sexual and reproductive health and rights (SRHR) persist. Many girls and young women are forced into early marriage and childbearing, especially in developing countries where societal norms enforce it. Early marriage and early childbearing cut off a young woman's education and limit her social engagement, and carry serious health risks for mother and child. Young women, especially those who are unmarried, also face substantial risk of unsafe abortion.⁴ In sub-Saharan Africa women under age 25 account for 51 percent of unsafe abortions.⁵

Yet many young people want to be able to control their fertility. Recent data show that an estimated 33 million young women ages 15 to 24 across 61 low- and middle-income countries have an unmet need for contraception—they want to delay, space, or even in some cases limit childbearing, but are not using a contraceptive method. Sixty-four percent of young married women with unmet need reside in one of 10 South and Southeast Asian countries, 16 percent are in West and Central Africa, and 12 percent are in East and Southern Africa (see Figure 1).⁶ Addressing unmet need would make a substantial contribution to increased contraceptive use and slower population growth around the world.

Youth encounter significant barriers to accessing and using any contraceptive method. These barriers include: limited knowledge of their contraceptive options; myths and misconceptions around methods; provider bias as to which methods are appropriate for adolescents; lack of family, partner, and community support; negative social norms; and lack of access to resources to get to service sites or to pay for services. These barriers are magnified for LARCs (see Box 2, page 3).

A key component to ensuring youth SRHR and reducing unmet need is to make the full range of contraceptive methods available, including LARCs which have a very low failure rate (less than 1 percent). Data from Demographic and Health Surveys (DHS) highlight that youth who use contraceptives generally do not choose the most effective methods, much less LARCs. More than 50 percent of the youngest age group (ages 15 to 19) uses traditional methods and condoms, followed by contraceptive pills and injectables. The 20-to-24-year-olds show a slightly higher use of hormonal methods and IUDs (see Figure 2, page 4).⁷ In addition to the challenges of using less-effective methods, the evidence clearly confirms that in developing countries, as well as in the United States, young people do not use any contraceptive methods as effectively as older women.⁸ Yet, the gap in use-effectiveness between youth and older users is less for LARCs (see Figure 3, page 5). Since LARCs are more reliable, they are a good method of choice to provide

young women with safe, reversible options for meeting their need for contraception and realizing their fertility aspirations.

Health care providers worry about whether LARCs are safe for youth, and if their use could undermine the ability to bear children in the future. In some countries, laws and policies have been enacted that could specifically restrict youth's access to LARCs, particularly young women who have not yet had a child (known as nulliparous) or who are not married.

Yet several major medical governance bodies have issued statements affirming the safety and appropriateness of offering LARCs to adolescents and youth, and the World Health Organization (WHO) states that LARCs (both IUDs and implants) can be used safely by adolescents and nulliparous women.⁹ In October 2015, Family Planning 2020 (FP2020) published the critically important "Global Consensus Statement for Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting Reversible Contraception (LARCs)."¹⁰

Clearly, challenges do persist in expanding youth access to and use of LARCs. However, examples of facilitating young people's ability to use LARCs are emerging. Recent interventions have tested ways to address some of the challenges—specifically focusing on improving provider skills and using e-vouchers to improve ease of access.¹¹ One program in Ethiopia built on a youth-friendly model to improve provider skill and overcome biases; and a second in Madagascar tested a system to use mobile phones and e-vouchers to support access to services and LARCs.

Ethiopia: Testing a Service-Delivery Model for Offering LARCs to Youth

Like many other sub-Saharan African countries, Ethiopia is experiencing substantial growth in its youth population. Approximately one-third of Ethiopia's population is younger than age 25 (about 33 million).¹² Among Ethiopians ages 15 to 19, 12 percent of young women have started childbearing and only 5 percent are using a modern contraceptive method, despite high unmet need (30 percent) for spacing among married adolescents. Although modern contraceptive use has risen among youth, the vast majority of them are still using short-acting methods. Among all women ages 20 to 24, only 5 percent are using implants, while 23 percent are using injectables.¹³

To expand access to the full range of contraceptive methods among youth, the Evidence to Action (E2A) Project tested an intervention to offer young clients contraceptive counseling and services. E2A, in collaboration with Integrated Family Health Program Plus (IFHP+), assessed a service-delivery model at 20 youth-friendly health service sites in the Amhara and Tigray regions of Ethiopia across a 10-month period. Half of the sites received expanded information and counseling as well as access to LARCs, while half received regular contraceptive services as part of the IFHP+ youth-friendly initiative.

BOX 2

Barriers to Increased Use of LARCs

To better understand the barriers to and facilitators of young people's access to full method choice and use of LARCs, the E2A project conducted a cross-country analysis in Tanzania, Niger, Mozambique, Bangladesh, and Ethiopia. All five countries had similar barriers:

- Most young people were not aware of LARCs.
- Among those who were, myths and misconceptions clouded the perception of LARCs; fear of side effects was a major deterrent.
- Substantial provider bias existed across all five countries, with providers refusing to offer LARCs because clients were too young, had not had a child, or were unmarried.
- Countries had social norms and stigma around adolescent sexuality and use of contraception, particularly LARCs, that prevented adolescents and youth from choosing the method of contraception they want to use.
- Significant policy-level barriers created obstacles. For example, in Bangladesh only married adolescents could access contraception in the public sector. Newly married couples in Bangladesh could get an implant, but young women had to have a child to get an IUD.

Young people in all five countries expressed a desire to delay and space births, and liked the idea of a discreet, easy-to-use method, such as the IUD or implant, that allowed them to effectively prevent a pregnancy for a long time.

Source: Callie Simon, "Shaking Up the Conversation About LARCs for Youth," (February 2016), accessed at www.pathfinder.org/blog/shaking-up-the-conversation.html, on Aug. 29, 2016.

The expanded service-delivery model included:

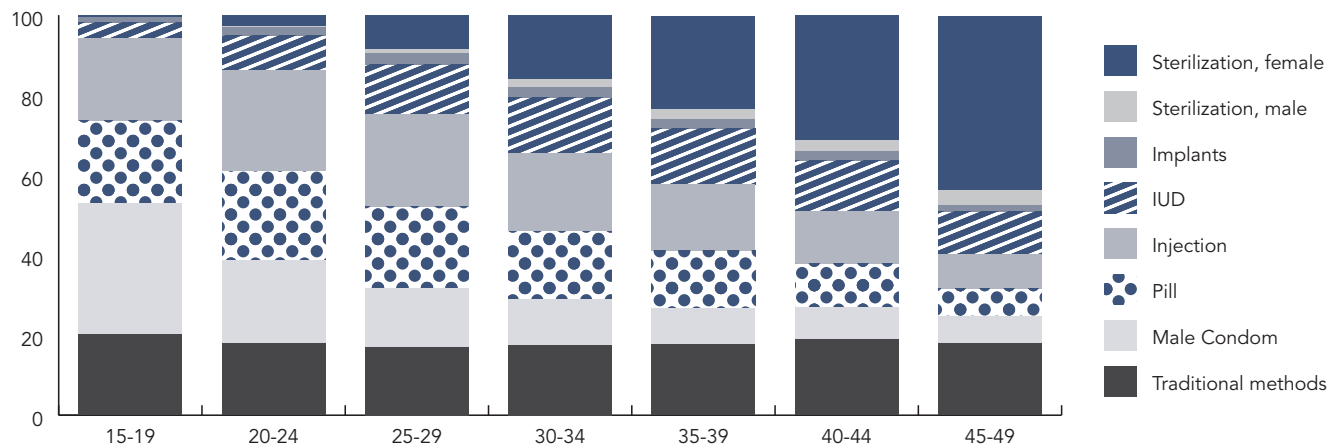
- Competency-based provider skills training on implant and IUD insertion, removal, and infection control.
- Refresher training for peer educators to counsel on safety and effectiveness of LARCs, to dispel myths and misperceptions, and to refer young people for services.
- Supportive supervision for providers.

Findings suggest that when youth-friendly service providers are trained to provide IUDs and implants in a safe and

FIGURE 2

Youth Who Use Contraceptives Generally Do Not Choose the Most Effective Methods.

Method Mix Among Youth and Older Ages



Source: John Ross, Jill Keesbury, and Karen Hardee, "Trends in the Contraceptive Method Mix in Low- and Middle-Income Countries: Analysis Using a New 'Average Deviation' Measure," *Global Health Science and Practice* 3, no. 1 (2015): 34-55.

competent way, youth may be more likely to adopt these methods. The results during an eight-month postintervention period showed this impact clearly:

- Young women who received information and counseling on LARCs were more likely to choose LARCs. After the intervention, for every 100 females who adopted LARCs at the nonintervention sites, 130 females adopted LARCs at intervention sites.
- New clients were less likely to choose short-acting methods after the intervention. During the postintervention phase, only 93 females in the intervention sites chose short-acting methods for every 100 who chose them at the control sites.

These results were especially interesting given that at baseline the sites chosen for the intervention had even fewer women adopting LARCs than at the control sites (70 vs 100).

Findings also suggested that a growing number of women who had not yet started childbearing sought contraceptive services and often chose long-acting methods. During the study period, 63 percent of women who attended youth-friendly services had not yet had any children, and 81 percent of women at intervention sites who chose a long-acting method for the first time had no children.¹⁴ Overall, the study found that better provider skills and counseling related to LARCs was essential to uptake among young people, while peer counselors did not appear to play a strong role in encouraging young people to use LARCs.

Madagascar: Family Planning E-Vouchers Improve Equity and Access to LARCs

To address unmet need for family planning among young people, UNFPA partnered with Marie Stopes Madagascar and Sisal to implement an e-voucher program.¹⁵ The main objective was to use mobile phone technology to increase access to and use of integrated services—family planning (FP) and STI/HIV—and among the most at-risk youth. The program offered free FP and/or STI information and payment vouchers through text messages (short-message service or SMS).

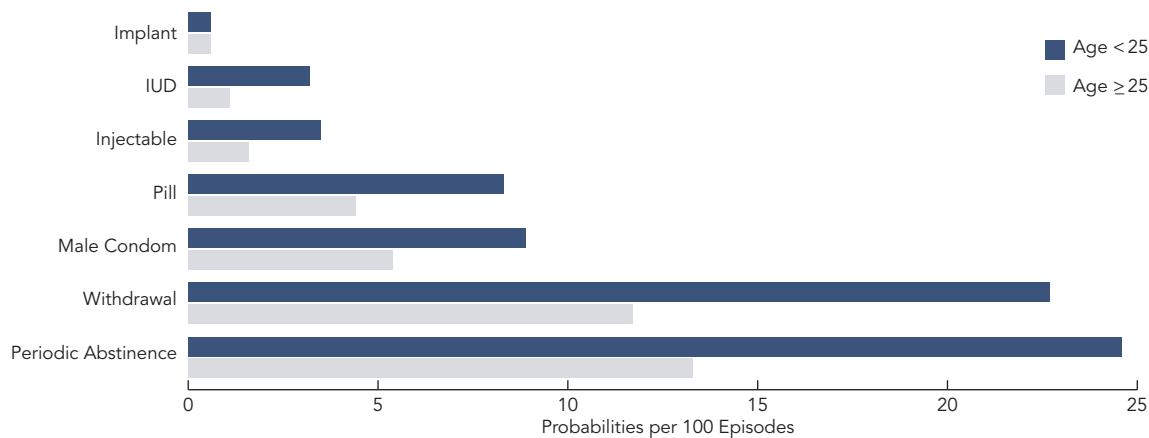
According to a 2013 survey, one in three adolescent girls under age 18 in Madagascar had already given birth or was pregnant.¹⁶ Early childbearing is particularly prevalent among poorer and less-educated girls, highlighting the challenges of inequitable access to sexual reproductive health information and services. Mobile phone services and ownership have grown significantly in recent years, and in focus groups young people recommended using mobile phone services as an effective strategy to disseminate SRHR information. Service providers reported that mobile payment would be an effective incentive to maintain high-quality service delivery.

Combining these two trends, Marie Stopes launched a two-year youth initiative in southern Madagascar in 2013. Twelve peer educators provided information to young people, distributed e-vouchers, and referred youth to Marie Stopes and BlueStar clinics.¹⁷ Young clients received a code via text to use for free FP services. To ensure services were provided to all young people, peer educators used their own phone to receive an e-voucher

FIGURE 3

Young Women Do Not Use Contraceptive Methods as Effectively as Older Women.

Twelve-Month Failure Rates, by Age (pooled estimates)



Source: Chelsea B. Polis et al., *Contraceptive Failure Rates in the Developing World: An Analysis of Demographic and Health Survey Data in 43 Countries* (New York: Guttmacher Institute, 2016).

code that they gave to clients who did not have a mobile phone. The BlueStar clinics in turn used the same text codes to claim reimbursement from Marie Stopes via mobile money.

This system built on Marie Stopes' extensive experience with text-based reporting which was established for the BlueStar clinic network. Marie Stopes negotiated with mobile phone companies to get fair prices for text messaging services. Peer educators and providers were trained on the e-voucher process, on working with youth, counseling, and use of mobile phones to ask for an e-voucher code, and were provided with regular follow-up through refresher training and supportive supervision.

Data collected over 18 months highlight that this creative approach supported many young women to receive services they might not have known about or been able to otherwise afford:

- Number of young women who were given e-vouchers for free services: 2,714.
- Number of young women who used the services: approximately 2,000.
- Number of LARCs provided: 1,595.
- Unintended pregnancies avoided: 1,900.

Overall, the use of mobile phones and mobile money effectively expanded youth access to FP services, improved project management by providing real-time data (service provision and redemption), and increased financial and administrative efficiency by reducing travel, paperwork, and risks associated with cash transfers.¹⁸

Recommended Actions

Policymakers and donors can support ongoing efforts to expand and improve youth SRHR and increase the use of LARCs through several key actions:

Sign on to support and implement the Global Consensus Statement on youth and LARCs.

Countries and organizations committed to the FP2020 process—to provide contraceptives to 120 million new users by 2020—can help achieve this goal by assessing the needs of youth and building their access to full and voluntary choice of the most effective contraceptive methods. The examples from Ethiopia and Madagascar highlight that creative strategies can be employed to ensure youth have access to a full range of contraceptive methods, including LARCs, in the context of youth-friendly services.

Ensure that providers have adequate technical and counseling skills to support expanded LARC services.

LARCs are provider-dependent methods. Providers must have up-to-date guidance on their technical features, especially in regards to how they counsel youth and facilitate their method choice. Providers need to be nonjudgmental about sexual activity among unmarried clients as well as regarding the desire to postpone first pregnancy or space pregnancies among those newly married. Providers need to listen better to client's fertility goals and provide full information on all methods, which may require changing the way they present options. For example, if a young woman clearly states that she wants to avoid pregnancy so that she can complete schooling, then LARCs can be a good first option. However, it is also critical to be more intentional in addressing side effects of LARCs, such as changes in menstrual bleeding, so that potential users will

know what to expect. Changes in bleeding patterns can be problematic for young women who may face challenges going to school during menstruation. Providers also need to address high-risk behavior not just for unintended pregnancy, but also for HIV and other STIs to help young clients understand how contraceptives work as well as the role of condoms in preventing STIs and HIV. Finally, providers need to be trained in and open to removals on demand. Young people's fertility desires may change quickly; however a highly effective method for a short period of time may provide young people with better fertility control, even if removed earlier than user-dependent methods.

Work to change the social norms that inhibit sexually active unmarried or newly married youth from seeking and using reproductive health services.

Young women and men must be motivated to visit facilities and providers and services must be accessible. Health ministries and nongovernmental organizations need to ensure that providers and clinic staff adopt gender-equitable as well as age-appropriate and developmentally sensitive clinic guidelines that ensure confidentiality for youth who are seeking services. Community efforts need to support girls' empowerment, including the power to engage in healthy behaviors and to seek out health services as needed, and move young men toward more gender-equitable behaviors. Communities also need ongoing education about adolescent SRHR, as well as contraceptives, to redress ongoing rumors and misinformation. Finally youth must be involved in program development and implementation strategies and messages to ensure that these elements are relevant and understandable.

Make resources available to services and individuals.

LARCs require a greater initial investment, although over time their use may be more cost-effective. A recent study in Colorado in the United States of a program that provided free LARCs to adolescents estimated that every dollar spent on the initiative saved US\$5.85 for the state's government assistance program, which covers more than three-quarters of teenage pregnancies and births. In addition, enrollment in the federal nutrition program for women with young children declined by nearly a quarter between 2010 and 2013.¹⁹ To achieve the health and economic benefits of providing LARC services to adolescents, ministries of health and donors need to ensure sufficient investment in supplies and provider training as well as strategies, such as voucher programs, to make it easier for youth to access services.

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