



## ***Understanding the Adolescent Family Planning Evidence Base***

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## **Executive Summary**

The International Center for Research on Women (ICRW) reviewed the literature to identify what is known about adolescents' demand for and access to family planning information and services. The review aimed to identify the barriers to and programmatic approaches for increasing adolescents' access to and use of family planning services, and to identify gaps in the evidence that require further research and/or investment. The literature search was limited to articles and reports published since 2000, with a particular emphasis on systematic reviews of evaluations of interventions that include the provision of adolescents with family planning information or services. For the purposes of this study, adolescents are identified as aged 10-24, in order to capture the most comprehensive range in the literature. One limitation of this research is the fact that interventions with adolescents may not demonstrate measureable behavioral results until after the end of the program or evaluation. Further, few adolescent initiatives are specifically defined as "family planning" programs and instead fall within a more comprehensive framework of sexual and reproductive health and rights. Our analysis took these constraints into account.

A conceptual framework was developed to guide our analysis of the evidence, based on past conceptualizations of reproductive health barriers and programmatic approaches, including ICRW's "Women's Demand for Reproductive Control" paper.<sup>a</sup> It postulates that adolescents must achieve three demand-side objectives and two supply-side ones, in no particular sequence, in order to reach the ultimate goal of sustainably and effectively using family planning to achieve their desired reproductive outcomes. These are:

### **Demand-side Objectives:**

- 1) Desire to avoid, delay, space, or limit childbearing
- 2) Desire to use family planning
- 3) Agency to use family planning

### **Supply-side Objectives:**

- 4) Access to family planning services
- 5) Provision of quality, youth-friendly services

For each objective, we identified both key barriers that adolescents face and rigorously evaluated programmatic approaches (both direct and indirect) that were designed to address, and in some cases, have been shown to overcome, barriers specific to the objective.

In regard to the findings about programmatic approaches, in general, we found that interventions were better able to achieve measurable improvements in knowledge and attitudes than behaviors. Of those that were able to impact behavior, interventions were more likely to change contraceptive behavior than sexual behavior. Programs that involved adolescents in program design tended to be more successful than those that did not. Programs that were able to increase contraceptive use usually had a health services component. Programs seemed to be most effective when they combined individual education, improvement of services, and community outreach or mobilization to both inform community members about available services and to increase the acceptability of adolescents' use of reproductive health services. Some of the most effective programs included educational interventions,

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<sup>a</sup> <http://www.icrw.org/publications/womens-demand-reproductive-control>

mass media, interpersonal/peer-to-peer communication and education, conditional cash transfers (CCTs), and improvements of health services.

Some of the programmatic interventions that have been most successful in achieving **Objective 1** (*Desire to avoid, delay, space or limit childbearing*) are indirect approaches that increase school enrollment, which, in itself, contributes to a delay in marriage and pregnancy. In particular, programs that offer CCTs, incentives or support in the form of school uniforms or supplies lower barriers to school attendance and increase the opportunity cost of missing school and getting pregnant. While there is not as much evidence for their effect on reproductive desires, youth development programs are also able to build adolescents' self-confidence and provide them with a greater sense of life opportunities other than parenthood, which can indirectly discourage early marriage and pregnancy.

For **Objective 2** (*Desire to use family planning*), both informational and communication programs have been successful in providing adolescents and community members with information regarding adolescents' reproductive health, family planning methods, and increasing the social acceptability of using contraception. For school-based educational programs to work, we find that they must be appropriately designed, and that teachers need to be appropriately trained and feel comfortable with the material. Some communication programs that target specific contraceptive method use and deliver messages through multiple media channels, increasingly including the Internet, mobile phones, and social networking services, have been shown to be effective. These programs were most successful when they addressed the gender norms, such as those that shape boys' notion of masculinity and limit girls' control over sex, as well as those that pressure girls to quickly and frequently produce children.

Informational, and specifically peer-to-peer education programs, have been most successful at enabling adolescents to achieve **Objective 3** (*Agency to use family planning*), as they increase adolescents' communication and negotiation skills, including about their reproductive desires. Indirectly, youth development programs have also been successful in building adolescents' self-confidence and empowering them to advocate for their rights and beliefs.

While there is some evidence around the use of community-based distribution/outreach, vouchers and social franchises to increase adolescents' access to family planning methods and achieve **Objective 4** (*Access to family planning services*), more research is needed on how best to increase such access specifically for adolescents.

For **Objective 5** (*Provision of quality, youth-friendly services*), services are most successful when they increase their "youth-friendliness" by training providers how to respond to adolescents' needs, ensure privacy, confidentiality and respect for adolescent clients, and have a consistent supply of multiple contraceptive methods. Specifically, vouchers have shown some success in increasing the privacy and confidentiality of services as well as increasing providers' competence in providing needed services and counseling.

Finally, programs with multiple components of demand creation and social norm change, service improvements, and promotion and education around available services were most effective and had a greater impact than any of these programmatic components on their own.

This analysis provides a synthesis of the evidence base in regard to interventions that have worked, directly or indirectly, to impact the family planning knowledge, attitudes and practices of adolescents in the developing world. While we have only scratched the surface in terms of understanding the various

advantages and limitations of the many types of unique and diverse interventions that have been implemented over the years, we feel confident that there is a path forward. This path leads toward creating a more supportive enabling environment and toward overcoming both the “demand-side” and “supply-side” barriers to enabling adolescents to more effectively and sustainably use family planning information and services to achieve their fertility desires over the course of their lives.

In conclusion, we provide specific recommendations that respond to gaps in the evidence base, as well as what we heard from a range of donor institutions we surveyed. These donors felt that attention to and investments in adolescent reproductive health are disproportionately small compared to the tremendous needs that exist.

## **Introduction**

### **Purpose**

The International Center for Research on Women (ICRW) reviewed existing literature to identify what is known about adolescents' demand for and access to family planning information and services. This review aimed to identify what works in increasing adolescents' access to and use of family planning information and services and to identify gaps in the evidence that require further research and/or investment. In addition, ICRW conducted a "light-touch" donor scan, with the aim of understanding the current and future priorities of important donors in regard to adolescent reproductive health, as well as to capture their perspectives on gaps in this field.

The review aimed to answer the following questions:

- What does the evidence show regarding the barriers to and facilitators of adolescents' access to and use of family planning information and services?
- What do we know about the best ways to overcome these barriers and leverage these facilitators, including in which contexts, and with which sub-populations of young people?
- What are the most important evidence gaps to address? What do we still need to know?

### **Methodology**

The United Nations system defines "adolescence" as those aged 10 - 19 years.<sup>1</sup> The term "young people" includes this same age cohort, as well as those a few years older, for a range of 10 – 24 years.<sup>2</sup> In order to capture the most comprehensive range addressed in the literature, we define adolescents for the purposes of this paper as those aged 10-24. Importantly, only a few surveys and studies incorporate sufficient data on very young adolescents (10-14 years), despite recent research suggesting that this population is often sexually active and/or in the process of establishing important behaviors, as well as the attitudes and values that define and influence their later sexual and reproductive decisions.<sup>3</sup>

To highlight the most recent findings in the field, our search was limited to articles and reports that have been published since 2000. We began our review by examining papers that provided an overview of the general barriers that adolescents face in demanding, accessing and using contraception, both from what can be considered the "demand-side" and the "supply-side." Building on this large array of literature, including ICRW's work on reproductive control, we conceptualize *demand* as the nuanced understanding of how gender dynamics underlying adolescents' lives define not only how many children they want to have and whether and when they want to have them, but also whether they want to use various options to control their fertility, and have the agency to do so effectively. We define *supply* as the provision of reproductive health and family planning services that are appropriate for adolescents' needs and are available in a way that is accessible to them. Accessibility in this context includes issues such as an appropriate contraceptive method mix, infrastructure, health systems and provider knowledge, attitudes and competence.<sup>4</sup>

To ensure the inclusion of those studies that had been reviewed at a fairly high level of rigor, we focused our attention primarily on systematic reviews. Specifically, we examined 24 systematic reviews of evaluated programs, all of which included only studies that used experimental or quasi-experimental methods. While not all of the systematic reviews were focused specifically on adolescents and family planning (i.e., some included family planning for adults or focused on sexual health education for HIV prevention purposes), they all included some level of attention to family planning information or

services for adolescents. The findings from these systematic reviews were then supplemented with single peer-reviewed articles and grey literature that identified best practices, more recent findings and innovative solutions for different types of programmatic approaches.

ICRW also conducted a brief scan of engagement by ten donors in the adolescent reproductive health field, who shared information about their current and planned giving in the area of adolescent reproductive health, their perspectives on what strategies are most successful in increasing access to family planning by adolescents, and finally, what gaps they see in the area of adolescents and family planning. The findings from this donor scan supplement our technical findings of what works, allowing us to better understand where the field is going and where new donors might play a catalytic role, particularly in expanding the evidence base.

The topic of study posed several challenges. First, it is important to note that the impacts of interventions that occur during adolescence may not demonstrate measureable results, particularly in the form of behavior change, until long after the program ends and evaluations are conducted. Educating adolescents about family planning, for example, may result in short-term measurable changes in knowledge and attitudes, but if the adolescents are not yet sexually active, the impact of such interventions when they become sexually active are typically outside the scope of most studies. Further, since the International Conference on Population and Development (ICPD) Programme of Action in 1994, few initiatives, particularly those targeting adolescents, have been defined specifically as “family planning” programs.<sup>5</sup> Rather, as suggested by many of the donors interviewed for this study, programs that are most successful in reaching adolescents with information and services tend to be placed within a more comprehensive framework of sexual and reproductive health and rights, and tend to involve multiple components, making the differential impacts of singular program components more challenging to assess. Our analysis took these constraints into account and focused as much as possible on citing evidence that demonstrates ways to most successfully achieve the ultimate goal of enabling adolescents to sustainably and effectively use family planning to achieve their desired reproductive outcomes.

## **Roadmap for this Paper**

This paper first provides an analysis of why it is important to focus on adolescents and family planning. Next, we present a conceptual framework that captures how we categorize the different objectives related to demand and supply that must be achieved in order for adolescents to be able to effectively use family planning services over the course of their reproductive lives. We then provide evidence from the literature regarding the barriers that adolescents face in achieving each demand-side objective and what the evidence shows regarding programmatic approaches to achieve these objectives. This is followed by the relevant evidence for barriers and programmatic approaches for the supply-side objectives. The barriers are differentiated by those faced by girls and by boys and the programmatic approaches are differentiated by direct approaches and indirect approaches.

While we believe that demand and supply barriers and approaches are very interdependent, there is tremendous overlap in the evidence and types of approaches that have targeted each the demand-side objectives and the supply-side objectives. We have divided the sections of the report in this manner for ease of flow and to reduce repetition.

We then discuss some of the findings from our donor scan, summarizing what various donors are supporting and where they see gaps in the field. Next, we provide an assessment of the gaps in

programming and research that are both identified in the research by ICRW as missing from the evidence base. Finally, we offer conclusions and some recommendations as to how donors may best be able to advance the field of adolescent family planning demand, access and use.

## **The Importance of Family Planning for Adolescents**

About 1.8 billion of the more than seven billion people in the world are between the ages of 10 and 24 years old, representing roughly one quarter of the global population.<sup>6</sup> These youth comprise the most well-informed and well-connected generation ever seen, yet far too few have access to the health care information and services they need to not only survive, but to thrive. As the international community builds a new architecture for global development, and as the reproductive health community takes action on the commitments of the July 2012 London Family Planning Summit, young people must not only be seen as subjects for increased programming and investments, so too must they be engaged seriously in moving these efforts forward.<sup>7</sup>

A large number of adolescents, both married and unmarried, are sexually active. A 2005 study of sexual behavior in different regions of the world found that by age 15, nine to 21 percent of girls had had sex, compared to 12 to 31 percent of boys.<sup>8</sup> By age 18, this had increased to 41 to 59 percent for girls and 40 to 73 percent for boys. By age 20, the vast majority of both young women (61 to 77 percent) and young men (61 to 87) had had sex, regardless of marital status.<sup>9</sup> This study also found that one-third of *unmarried* adolescent girls under age 19 in sub-Saharan Africa and nearly one-quarter in South America had ever had sex.<sup>10</sup>

Marital status is a factor that cannot be overlooked. Currently, one-third of girls in developing countries are married before age 18, and one in nine is married by the age of 15.<sup>11</sup> While both married and unmarried girls are sexually active, some 90 percent of the births experienced by adolescent mothers occur within marriage.<sup>12</sup>

Adolescents' reproductive desires are strongly influenced by social norms and expectations of gender roles. The belief that a girl's primary value and role in society is that of a wife and/or mother can impact greatly her family planning desires and decisions. Early marriage often exacerbates these pressures. While early marriage can provide social recognition and approval for sexual relations, it also places pressure on girls to prove fertility and bear children.<sup>13</sup> Child marriage is associated with low use of contraception prior to the first child, followed by multiple, shortly spaced pregnancies.<sup>14</sup> Additionally, double standards related to what is socially acceptable in regard to pre-marital sex place pressure on boys to engage in sexual activity and girls to remain chaste.<sup>15</sup> This can lead to girls who engage in pre-marital sex feeling embarrassment and shame in regard to seeking to use family planning methods. In many cultures, girls are taught to be passive, to not think for themselves or voice their opinions, and rather are instructed to do as they are told.<sup>16</sup> The immense pressure that these and other social norms and expectations place on girls can constrain their ability to understand and exercise their right to make decisions around their own sexual and reproductive health, including family planning.

Still, some adolescents do want to avoid, delay, space or limit their pregnancies and are successfully able to access and use contraceptives. A review of DHS data from 31 countries found that, on average, 25 percent of married women and unmarried sexually active women had used contraceptives before age 19.<sup>17</sup> The study also found that during adolescence, contraceptive use was higher among those who were unmarried than those who were married (for example, 60 percent vs. 38 percent in Kazakhstan, and 45 percent vs. 4 percent in Nigeria, respectively).<sup>18</sup>

But while some adolescents are using contraception, many are unable to meet their reproductive desires. National and regional DHS data indicate that there is demand for contraception among married adolescents aged 15-19, but this demand is often unfulfilled.<sup>19 b</sup> In South and Southeast Asia, 44 percent of married adolescent girls wish to avoid becoming pregnant for two or more years, but more than half of them (24 percent) are not using any method of contraception.<sup>20</sup> In Latin America, 79 percent want to delay or avoid their next pregnancy, yet a quarter of these women (26 percent) are not using contraception.<sup>21</sup> In Sub-Saharan Africa, 39 percent wish to avoid pregnancy for two or more years, but one quarter are using no form of contraception.<sup>22</sup>

In general, married adolescents aged 15-19 experience greater unmet need than “all” married women.<sup>23</sup> On average, unmet need is greater among unmarried adolescents than among married adolescents. And among unmarried adolescents, unmet need is significantly higher among those aged 15-19 compared to those 20-24.<sup>24</sup> (See Annex for graphs illustrating rates of unmet need.)

High levels of unmet need for contraception result in unintended pregnancies. In Sub-Saharan Africa, 35 percent of pregnancies among 15-19 year-olds are unwanted or mistimed.<sup>25</sup> Of these unintended pregnancies, an estimated two-thirds end in childbirth and a third result in induced abortion. As adolescents often lack access to legal, high quality abortion services, many of these abortions are unsafe. Of the estimated 18.5 million unsafe abortions that occur in developing countries each year, 2.5 million (nearly 14 percent) occur in women under the age of 20.<sup>26</sup> The adolescents who choose to carry their pregnancy to term experience a host of challenges and morbidities. Early pregnancy can be harmful to the health of both the mother and the child. Pregnancy-related complications are consistently among the leading causes of death among girls aged 15-19 in developing countries.<sup>27</sup> While recent findings suggest that the difference in the magnitude of risk of maternal mortality among teen mothers compared to older mothers may not be as great as previously thought, the morbidities associated with pregnancy in smaller, less developed girls still pose great danger.<sup>28</sup> For example, research in Ethiopia found that girls who had given birth between the ages of 15 and 19 were twice as likely as those aged 20-24 to experience obstetric fistula, and three times as likely as those aged 25-29.<sup>29</sup> Additionally, a child born to a young mother (12-20 years old) is at greater risk of dying before the age of five, being stunted, being under weight, and suffering from anemia.<sup>30</sup>

While adolescence has traditionally been viewed as a “healthy” phase of life, we now know that it is fraught with challenges to adolescents’ sexual and reproductive health.<sup>31</sup> The 16 million girls aged 15 to 19 who give birth each year, in addition to the two million more under the age of 15, face a variety of complications that come with early pregnancy, as noted above.<sup>32</sup> In addition, 40 percent of all new HIV infections occur in people between the ages of 15 and 24.<sup>33</sup>

Investing in adolescents can change these statistics and also has the potential to transform societies. When girls grow up healthy, educated and empowered, they become productive and effective leaders, earners, providers and mothers. This, in turn, has a ripple effect on their children, households, communities and nations. And when boys are provided with education, information and services to protect their sexual and reproductive health, they can improve their health attitudes and behaviors now and for decades to come. For example, data show that if condom use is established during adolescence,

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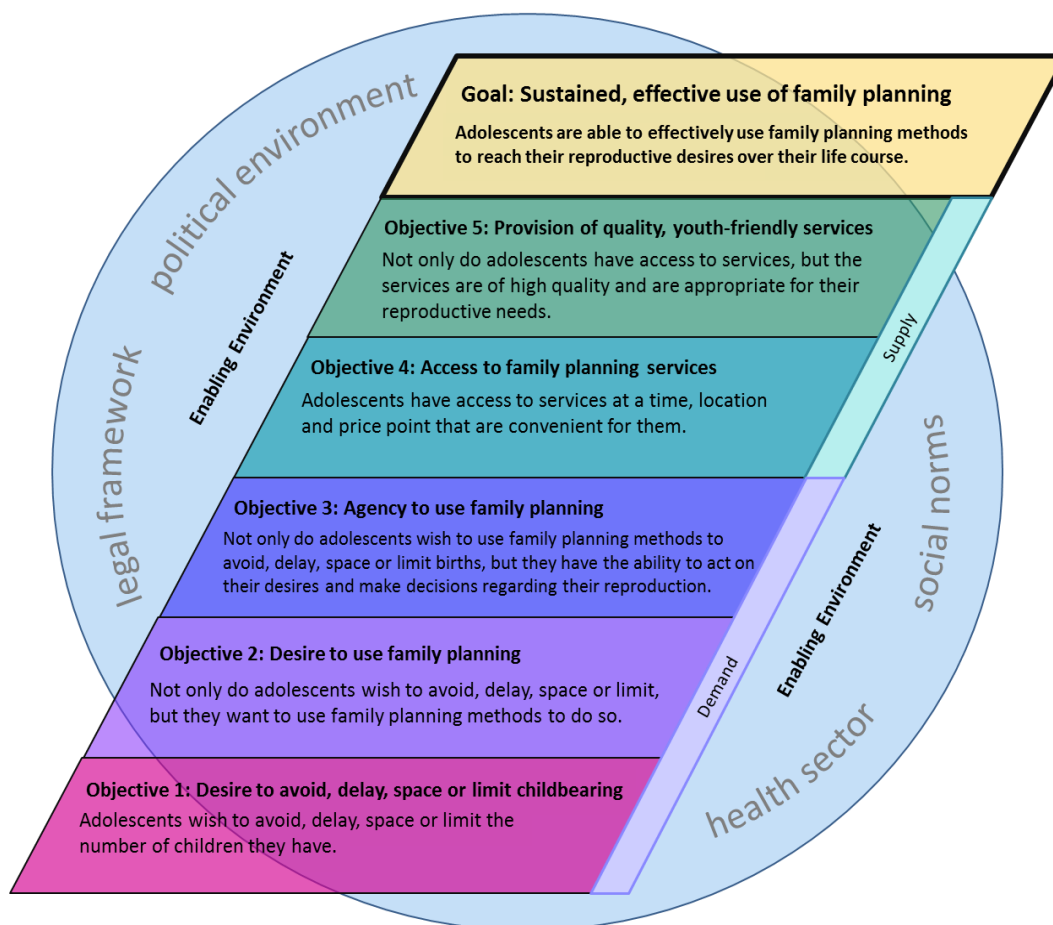
<sup>b</sup>The DHS defines *demand for family planning* as the number of married women who do not wish to become pregnant for two or more years over the total number of married women and *unmet need* as the number of women who do not wish to become pregnant for two or more years, but are not currently using any form of contraception over the total number of married women.

individuals are more likely to use condoms in the future.<sup>34</sup> Because of this, it is critical that we understand adolescents' reproductive desires and enable them to achieve these desires by providing them with the necessary information and services. At a macro level, improving the sexual and reproductive health of adolescents can contribute to creating healthier communities, and ultimately, can help to achieve Millennium Development Goals 4, 5, and 6.<sup>35</sup>

Many adolescents in developing countries are sexually active. Many want to avoid, delay or limit pregnancy, but many do not even have the agency to make decisions regarding their reproduction. Both socio-cultural and structural barriers stand in their way, and as a result, they often face unintended and unhealthy pregnancies. In order to help adolescents use family planning services to achieve their reproductive intentions, we must understand the barriers they face in defining these intentions, and in demanding, accessing and using contraceptives. And we must understand what works in empowering them to overcome these barriers.

## Adolescents and Family Planning – What the Evidence Shows

### A. Conceptual Framework



The above conceptual framework reflects the evidence on the barriers that adolescents – both females and males – face in demanding, accessing and using family planning and the programmatic approaches to successfully overcome these barriers. The framework builds on years of research and framing of the interconnected concepts of demand and supply in reproductive health services, as well as theories of women’s empowerment that emphasize the importance of women having a conscious choice and control over reproductive decisions.<sup>36</sup> It also builds directly on ICRW’s framework for women’s demand for reproductive control, focusing on the states of demand that are most relevant for adolescents, while adding necessary elements related to supply.<sup>37</sup>

The framework postulates that adolescents need to achieve five objectives in order to reach the goal of sustained, effective use of family planning over the course of their reproductive lives. Achievement of **Objective 1** signifies that adolescents want to avoid, delay, limit or space their pregnancies. They understand the benefits of waiting to initiate sexual activity or have [more] children and want to control their reproduction.

With **Objective 2**, adolescents not only want to avoid, delay, limit or space their pregnancies, but they want to use family planning methods to do so. This requires a basic understanding of how reproduction

occurs, how contraceptive methods work, and how use of such methods will be perceived in the community. However, a desire to use family planning methods is not sufficient to enable adolescents to actually use them. Adolescents need to be able to achieve **Objective 3** in order to have the agency to actually use contraceptives. The concept of agency encapsulates the empowerment, skills and self-efficacy needed to make and act on one's decisions.<sup>38</sup> While we have categorized Objective 3 as a "demand-side" factor, it can also be viewed as the bridge between the traditional demand-side and supply-side components of contraceptive use. Even if adolescents have the desire to use family planning methods and there are high-quality, youth-friendly methods available, if they do not have the confidence to walk into the clinic and ask for contraceptives, they will not be able to use them.

Objectives 4 and 5 represent the "supply-side" components. Achievement of **Objective 4** means that adolescents have access to contraceptive methods at a location, time and price that is feasible and convenient. **Objective 5** is reached when services are not only available for adolescents, but they are of high quality, youth-friendly and offer a variety of methods that are appropriate for adolescents.

The ultimate goal reached by achieving all of these objectives is that adolescents are able to effectively use family planning methods in line with their fertility intentions throughout their life course. This is an important distinction, as the desires and appropriate methods will change over the course of one's reproductive life.

While the framework is presented as a series of objectives, these are not necessarily sequential. Demand and supply objectives could be achieved simultaneously, or supply-side facilitators, such as the provision of youth-friendly services, could be present before it is socially or culturally acceptable for adolescents to use contraceptives in a particular context. Additionally, as an adolescent's reproductive desires shift, the required agency and type of services needed will shift. For example, while it may be acceptable for an unmarried adolescent to want to avoid pregnancy, societal views may shift once the adolescent gets married, and then shift again after the first birth. The achievement of these objectives is not only dependent on the individual adolescent, but is also influenced by many societal factors. The enabling environment, including but not limited to the legal framework, political environment, health sector and social norms, has a strong influence on adolescents' ability to achieve the various objectives of family planning demand, access and use. While this framework is presented with a focus on an individual adolescent, the roles of the individual's partner, parents, family, peers and community are important in the formation of his/her desires and their achievement.

## **B. Why Adolescents are not Demanding, Accessing and Using Family Planning and What the Evidence Shows Regarding How to Address these Challenges**

Our conceptual framework lays out a series of objectives, not necessarily linear, that adolescents must achieve in order to use family planning effectively and sustainably in meeting their fertility goals. For each objective, we highlight a number of key barriers that adolescent girls and boys face as well as programmatic approaches (both direct and indirect) that have been evaluated and in some cases, shown to overcome barriers specific to the objective (see Table 1).

**Table 1: Barriers and Programmatic Approaches that Influence Adolescents' Ability to Demand, Access and Use**

Objective	(1) Desire to avoid, delay, space, or limit childbearing	(2) Desire to use family planning	(3) Agency to use family planning	(4) Access to family planning services	(5) Provision of quality, youth-friendly services	GOAL: Sustained, effective use of family planning
	DEMAND			SUPPLY		
Barriers for Girls	<ul style="list-style-type: none"><li>Gendered roles/ expectations<ul style="list-style-type: none"><li>Wife/mother</li><li>Remain chaste</li></ul></li><li>Need to prove fertility</li><li>Path to adulthood</li><li>Low value of childbearing alternatives</li><li>Religious values</li><li>Son preference</li><li>Desire to secure a relationship</li></ul>	<ul style="list-style-type: none"><li>Stigma: accessing and using methods and adolescent sexuality</li><li>Taboos: communication</li><li>Lack of understanding of:<ul style="list-style-type: none"><li>Reproductive health</li><li>Family planning methods, including side effects</li></ul></li><li>Cultural taboos in providing reproductive health and family planning information to adolescents</li></ul>	<ul style="list-style-type: none"><li>Limited decision-making autonomy and power</li><li>Early marriage</li><li>Family pressure to have children/not use a method</li><li>Poor partner communication</li><li>Sexual coercion and other forms of violence</li><li>Transactional sex</li><li>Limited self-efficacy</li></ul>	<ul style="list-style-type: none"><li>Lack of awareness of services</li><li>Inaccessible location/ limited mobility</li><li>Inconvenient operating hours</li><li>Long wait times</li><li>Costs</li><li>Lack of access to financial resources</li></ul>	<ul style="list-style-type: none"><li>Lack of provider quality/ competence</li><li>Provider reluctance to provide contraceptives to adolescents</li><li>Unavailability of appropriate methods</li><li>Stock-outs</li><li>Restrictions on use</li><li>Gender biases in service provision</li><li>Lack of privacy/ confidentiality</li></ul>	
Barriers for Boys	<ul style="list-style-type: none"><li>Gendered roles/ expectations<ul style="list-style-type: none"><li>Father</li><li>Sexually active</li></ul></li><li>Need to prove sexual prowess and fertility</li><li>Religious values</li><li>Son preference</li></ul>	<ul style="list-style-type: none"><li>Stigma: accessing and using</li><li>Taboos: communication</li><li>Lack of understanding of:<ul style="list-style-type: none"><li>Reproductive health</li><li>Family planning methods</li></ul></li><li>Lack of perceived responsibility in family planning use</li></ul>	<ul style="list-style-type: none"><li>Limited self-efficacy</li></ul>			
Direct Programmatic Approaches	<ul style="list-style-type: none"><li>Information<ul style="list-style-type: none"><li>Appropriate roles/ options for girls</li><li>Benefits of avoiding, delaying, spacing and limiting</li></ul></li><li>Mass media<ul style="list-style-type: none"><li>Acceptability of avoiding, delaying, spacing, and limiting childbearing</li></ul></li></ul>	<ul style="list-style-type: none"><li>Information (School/ curriculum-based education, workplace-based education, interpersonal/ peer-to-peer education, new media)<ul style="list-style-type: none"><li>Sexual and reproductive health</li><li>Family planning methods</li></ul></li><li>Mass media and social marketing<ul style="list-style-type: none"><li>Acceptability of method use</li></ul></li></ul>	<ul style="list-style-type: none"><li>Information (School/ curriculum-based education, interpersonal/ peer-to-peer education)<ul style="list-style-type: none"><li>Alternative roles/options for girls</li><li>Sexual activity negotiation skills</li></ul></li></ul>	<ul style="list-style-type: none"><li>Information &amp; mass media<ul style="list-style-type: none"><li>Where/how to access services</li></ul></li><li>Community-based distribution/ outreach<ul style="list-style-type: none"><li>Links/referral with schools</li></ul></li><li>Youth centers</li><li>Vouchers and coupons</li><li>Youth-friendly services</li><li>Social franchises</li></ul>	<ul style="list-style-type: none"><li>Youth-friendly services</li><li>New media (information)<ul style="list-style-type: none"><li>How methods work</li><li>Best methods for each adolescent's needs</li></ul></li><li>Community-based distribution</li><li>Youth centers</li><li>Vouchers</li><li>Social franchises</li></ul>	
Indirect Programmatic Approaches	<ul style="list-style-type: none"><li>Youth development</li><li>CCTs/incentives</li></ul>		<ul style="list-style-type: none"><li>Youth development</li></ul>			

In discussing key barriers and programmatic approaches, it is first important to understand that many factors influence adolescents' family planning desires, decisions and actions. While these factors may not always be changed or influenced by programmatic approaches, they need to be taken into consideration when designing and implementing programs. These factors may include the individual characteristics of the young person; the peers and (potential) sexual partners with whom they interact; the families and adults in the community; institutions, such as schools, workplaces, and religious organizations; and communities through which social expectations about gender norms, sexual behavior, marriage and child bearing are transmitted.<sup>39</sup> These external forces can influence adolescents' decisions regarding wanting to control their fertility, as well as their actual use of contraception.

Risk factors that reduce the likelihood of engaging in behaviors that lead to healthy outcomes, and protective factors that increase the chances of engaging in such behaviors also mediate an adolescent's ability to demand, access and use family planning.<sup>40</sup> At the individual level, potential risk factors associated with lower contraceptive use include being married, being an older adolescent, having a partner with lower education and having no children. Potential protective factors at the individual level include having more years of education, knowledge of contraception, desiring fewer children, being visited by a reproductive health/family planning worker, and attending family life education classes. At the partner level, general spousal communication, having a partner with a professional job and discussing sex and contraception with partner were all protective factors.<sup>41</sup>

With increasing international recognition of the importance of establishing healthy sexual and reproductive attitudes and behaviors among adolescents, new data have emerged regarding the programs and strategies that are most effective in influencing these outcomes for adolescents. Across the world, diverse programs targeting adolescents have been able to reduce many key barriers, as well as leverage facilitators, in order to stimulate demand and improve adolescent access to quality family planning services. There is limited evidence, however, about which strategies and programs are most effectively reaching different groups of adolescents as compared to others, such as married and unmarried, rural and urban, and younger and older. The evidence base is particularly thin regarding effective strategies for reaching very young adolescents (i.e., those aged 10-14 years).

There are important lessons that can be learned from the substantial investment and attention to HIV prevention among adolescents over the past decade, as these programs often target the same set of social norms and challenges as efforts to increase adolescent family planning use. While the end goal of HIV programs may be different, interventions that have successfully changed adolescents' sexual behavior, condom use or negotiation skills can be adapted for family planning outcomes. We have therefore included relevant findings from adolescent HIV prevention programs in this review. We also include programs that address education, youth development, life skills and broader sexual and reproductive health, insofar as they discuss outcomes relevant to family planning and fertility intention.

We have organized the following section as follows: First we focus on the three "demand-side" objectives from the conceptual framework, examining the barriers for girls and boys in achieving each one, and then the programmatic approaches identified from the literature that align with each objective. This is followed by a similar analysis and presentation for the two supply-side objectives.<sup>c</sup>

Looking primarily at systematic reviews that analyzed evaluations using experimental or quasi-experimental methods provided a standardized minimum threshold for evaluation rigor. We particularly

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<sup>c</sup>We do not want to over-emphasize a supply/demand dichotomy, but rather have used this division for organizational purposes.

highlight findings where programmatic approaches were able to demonstrate statistically significant changes in knowledge, attitudes or behaviors related to adolescent family planning, contraceptive use, sexual behavior, service use and other reproductive health-related outcomes. This method, while contributing a solid level of rigor, likely excludes some promising approaches that have not yet been rigorously evaluated, reported on, and/or included in systematic reviews.

Within our discussion of the findings from evaluated programmatic approaches we highlight specific examples, some of which, as indicated, cut across more than one objective. As mentioned earlier, our discussion of the barriers and programmatic approaches are primarily drawn from the evidence documented by a number of recent systematic reviews and select individual studies.

## C. The “Demand-Side”

### 1. Barriers

**Table 2: Demand-side Barriers**

Objective	(1) Desire to avoid, delay, space, or limit childbearing	(2) Desire to use family planning	(3) Agency to use family planning
Barriers for Girls	<ul style="list-style-type: none"> <li>Gendered roles/ expectations <ul style="list-style-type: none"> <li>Wife/mother</li> <li>Remain chaste</li> </ul> </li> <li>Need to prove fertility</li> <li>Path to adulthood</li> <li>Low value of childbearing alternatives</li> <li>Religious values</li> <li>Son preference</li> <li>Desire to secure a relationship</li> </ul>	<ul style="list-style-type: none"> <li>Stigma around accessing and using methods and adolescent sexuality</li> <li>Taboos around communication</li> <li>Lack of understanding of: <ul style="list-style-type: none"> <li>Reproductive health</li> <li>Family planning methods, including side effects</li> </ul> </li> <li>Cultural taboos in providing information about reproductive health and family planning to adolescents</li> </ul>	<ul style="list-style-type: none"> <li>Limited decision-making autonomy and power</li> <li>Early marriage</li> <li>Family pressure to have children/not use a method</li> <li>Poor partner communication</li> <li>Sexual coercion and other forms of violence</li> <li>Transactional sex</li> <li>Limited self-efficacy</li> </ul>
Barriers for Boys	<ul style="list-style-type: none"> <li>Gendered roles/ expectations <ul style="list-style-type: none"> <li>Father</li> <li>Sexually active</li> </ul> </li> <li>Need to prove sexual prowess and fertility</li> <li>Religious values</li> <li>Son preference</li> </ul>	<ul style="list-style-type: none"> <li>Stigma around accessing and using methods</li> <li>Taboos around communication</li> <li>Lack of understanding of: <ul style="list-style-type: none"> <li>Reproductive health</li> <li>Family planning methods</li> </ul> </li> <li>Lack of perceived responsibility in family planning use</li> </ul>	<ul style="list-style-type: none"> <li>Limited self-efficacy</li> </ul>

#### OBJECTIVE 1: Barriers to Desire to Avoid, Delay, Space or Limit Childbearing

While many adolescents, especially married adolescents, experience “wanted” pregnancies, more research is needed to understand the social pressures that encourage girls to express a desire for these early pregnancies.<sup>42</sup> Social norms and societal pressures about **gender roles** make it difficult for girls in many contexts to even consider it acceptable to have a small family and/or to start families later in life. In many societies, socio-cultural beliefs place value on girls’ **roles as wives and mothers** at the expense of other potential roles, limiting the opportunities that are available and seen as appropriate for them. Thus, many girls have a desire to **prove their fertility** and fulfill their roles as mothers.<sup>43</sup> Additionally, girls, both within and outside of marriage, may view pregnancy as a **path to adulthood**, or a way to gain power and respect.<sup>44</sup>

Similarly, there is pressure on adolescent boys in many societies to prove manliness and virility by engaging in sexual activity and producing children.<sup>45</sup> **Fatherhood** may be viewed as an affirmation of

“masculine maturity and strength.”<sup>46</sup> For boys, traditional initiation ceremonies and coming of age rituals may emphasize the importance of **sexual prowess and fertility** as core components of being a man, encouraging boys to become sexually active as soon as they reach puberty.<sup>47</sup>

Societies may view education, skill building and investments in girls as a waste of time and money. The **low value placed on girls’ education**, and the resulting low levels of girls’ school enrollment in older adolescence, can also lead to poor reproductive health outcomes. A recent study found that girls with no education had a birth rate (192 per 1,000 girls) more than four times the rate of those with the highest level of education (47 per 1000).<sup>48</sup> In general, teens who are in school are less likely to have sex and more likely to use contraception. In fact, each additional year of a girl’s education increases contraceptive use and reduces fertility by ten percent.<sup>49</sup>

Early evidence suggests that for both girls and boys, **religious values** may contribute towards attitudes that accept “what God gives them” when it comes to pregnancy and the number of children they have.<sup>50</sup> The practice of **son preference** may also pressure adolescents to not use family planning methods until they have produced a male child.<sup>51</sup> Further, among both married and unmarried girls, having a child may be a way to **secure a relationship**, and in the case of a transactional relationship, a child may secure further financial assistance.<sup>52</sup>

## **OBJECTIVE 2: Barriers to Desire to Use Family Planning Methods**

Even when girls want to prevent, limit or delay their pregnancies, there are many barriers that inhibit them from wanting to use contraceptives even when they are available. General **stigma** around adolescent sexuality makes it difficult for adolescents to gain needed information and services about reproductive health. Adolescents may be too embarrassed to talk about sexuality with parents and experience **communication difficulties** with their sexual partner, leaving them unable to articulate their reproductive desires.<sup>53</sup> This is particularly true for girls, who also are subject to norms governing gender-appropriate expression of sexual needs and desires. Girls report experiencing fear, shame and embarrassment because of the stigma they encounter in seeking family planning information and services and using contraceptives. Specifically, in many sub-Saharan countries, condoms are often associated with promiscuity, making girls reluctant to use them as male partners might view them as having “loose morals.”<sup>54</sup> For adolescent boys, condom use may also be stigmatized, given its association with a lack of masculinity, distrust of partner, or carrying a disease, resulting in boys being reluctant to use them.<sup>55</sup> Also, beliefs that condoms will decrease sexual pleasure, lack of knowledge of how to use condoms, or fear of rejection by a partner discourage adolescent boys from using condoms.<sup>56</sup>

Adolescents may feel stigma related to needing health services for a problem that is linked with being sexually active and fear of the stigma associated with entering a family planning clinic can inhibit adolescents from accessing services.<sup>57</sup> A study in four sub-Saharan African countries concluded that facility-based or provider-based improvements will not be sufficient to increase use of services on their own, since social stigma associated with accessing services is so high that it will stop adolescents from even walking through the clinic door.<sup>58</sup> An evaluation of youth-friendly services in Zambia found that positive changes in social and community-level factors were as important in improving adolescents’ use of reproductive health information and services as making services youth-friendly.<sup>59</sup>

Far too many adolescents **lack comprehensive sexual and reproductive health information** and understanding of how to make informed decisions about family planning. Many adolescents lack

adequate information about how their bodies work, how pregnancy occurs, how to prevent pregnancy and where and how they can access contraceptives.<sup>60</sup> Due to poor quality sexuality education programs and programs that focus on only specific aspects of sexual health, such as HIV transmission, adolescents are left with an incomplete understanding of their sexual and reproductive health and rights. For example, in the Amhara region of Ethiopia, while nearly all teens knew that unprotected sex could lead to HIV infection, less than 45 percent knew that it could also lead to pregnancy.<sup>61</sup>

While a high percentage of adolescents across the developing world report knowledge of at least one method of contraception, many do not have detailed knowledge or did not know that they could get pregnant the first time they had sex.<sup>62</sup> In Central America, for example, almost one-third of adolescents did not know that pregnancy could occur the first time a girl had sex, and in a study of four sub-Saharan African countries, among 15-19 year old males who had heard of condoms, between one-third and one-half did not know three key points about correct use, including that a condom should only be used once.<sup>63</sup>

In fact, many adolescents have an **incorrect understanding of how contraceptive methods work**. Many believe that hormonal contraceptives can cause infertility, and both providers and adolescents lack a clear understanding of how emergency contraception (EC) works.<sup>64</sup> Additionally, teens may believe that modern methods of contraceptives are ineffective, due to high failure rates from incorrect and inconsistent use of specific methods.<sup>65</sup> This lack of comprehensive information, confusion and stigma may lead to a sense of ambivalence among adolescent girls - they do not want a child, but do not know how to go about controlling their fertility.<sup>66</sup> Fear of side effects, real or exaggerated, and lack of understanding of the full range of contraceptive methods, can also inhibit girls from desiring to access contraception.<sup>67</sup>

Even when adolescents are able to start using contraceptives, this lack of comprehensive understanding contributes to high failure and discontinuation rates, hindering adolescents from effectively controlling their reproduction. Adolescents experience much higher rates of discontinuation and contraceptive failure than older women, in part due to inadequate information about side effects, lack of method choice and inappropriate guidelines regarding their use.<sup>68</sup> Further, because of adolescents' varying sexual lives, they are more likely to inconsistently use contraceptives and thus experience higher rates of failure than older women.<sup>69</sup> On average, failure rates for adolescents were 25 percent higher than those for older women and in almost every country, a greater portion of 15-19 year olds than women aged 20-49 reported experiencing a contraceptive failure within a year of starting the method.<sup>70</sup>

**Cultural taboos** inhibit parents and teachers from talking about sexuality and reproduction, perhaps driven by an inaccurate belief that providing this information will make adolescents more promiscuous.<sup>71</sup> Studies have shown that despite the fact that adults worry that explicit information will encourage early sexual activity, young adolescents disagree and actually crave this information.<sup>72</sup> Teachers may also shy away from providing sexual and reproductive health content, as they themselves do not feel comfortable talking about and teaching the material.<sup>73</sup>

The fact that adolescent boys often see **contraceptive use as the girl's responsibility** creates a barrier for both boys and girls. Boys do not proactively seek information or services, forcing girls to struggle with the various barriers associated with contraceptive use. Even if boys are curious about family planning use or preventing, delaying, limiting or spacing children, they feel they cannot raise such issues due to social constructs of what is their responsibility and what is "manly."<sup>74</sup>

### OBJECTIVE 3: Barriers to Having the Agency to Use Family Planning

Societal systems of patriarchy, gender inequality and interpersonal dynamics can lead girls to have **limited decision-making autonomy** over their own reproduction. In addition to the limited decision-making power girls have in their everyday lives, they often experience significantly **less power** in their sexual relationships. Particularly in the case of **early marriage**, older husbands exhibit authority over their younger wives, and girls who enter polygamous relationships as the second or third wife have little to no say in family planning decisions.<sup>75</sup> Unmarried girls often have little power in their relationships and may feel the need to succumb to their partner's desires, as is often seen in "sugar-daddy"-type relationships.<sup>76</sup> Mothers-in-law may influence a young wife's family planning decisions, particularly with recently married girls or young women who have yet to prove their fertility or bear a son.<sup>77</sup> Similarly, husbands may **pressure** young wives to reject family planning, as they may want more children to prove their manliness, to help with household chores, or to guarantee a son.<sup>78</sup> In some cases, however, the husband may not necessarily want more children, but due to **poor ability to communicate** about family planning intentions, the wife or partner may perceive that is what he wants.<sup>79</sup> In such imbalanced relationships, girls have even less negotiating power in deciding whether and when to have sex and whether to use any form of contraception. Women who characterize communication with their husbands as difficult and/or infrequent are far more likely to use or attempt to use contraception covertly.<sup>80</sup> Similarly, women in **violent relationships** are more likely to experience unintended pregnancies and to seek abortion.<sup>81</sup> **Transactional sex**, or even the use of a child as a motivation to keep the partner around, may force young girls to give up even more power in the relationship. Such power imbalances are often intensified in cases of early marriage, and limit girls' ability to demand the use of family planning, even if she desires it.

Social norms, pressure, and relational power imbalances leave adolescent girls with **limited self-efficacy** which inhibits them from believing that they can effectively take action to access and use contraceptives. Boys also experience limited self-efficacy in that they may be unsure about how to use a condom or initiate or negotiate condom use, and may be uncertain as to whether they will actually be able to purchase or obtain condoms.<sup>82</sup> The fact that boys often do not view family planning as their purview may further limit their perceived ability to access and use methods.<sup>83</sup>

## 2. Programmatic Approaches

**Table 3: Demand-side Programmatic Approaches**

Objective	(1) Desire to avoid, delay, space, or limit childbearing	(2) Desire to use family planning	(3) Agency to use family planning
<b>Direct Programmatic Approaches</b>	<ul style="list-style-type: none"> <li>Information <ul style="list-style-type: none"> <li>Appropriate roles/options for girls</li> <li>Benefits of avoiding, delaying, spacing and limiting births</li> </ul> </li> <li>Mass media <ul style="list-style-type: none"> <li>Acceptability of avoiding, delaying, spacing or limiting births</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Information (School/curriculum-based education, workplace-based education, interpersonal and peer-to-peer education, new media) <ul style="list-style-type: none"> <li>Sexual and reproductive health</li> <li>Family planning methods</li> </ul> </li> <li>Mass media and social marketing <ul style="list-style-type: none"> <li>Acceptability of method use</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Information (School/curriculum-based education, peer-to-peer education) <ul style="list-style-type: none"> <li>Appropriate roles for girls</li> <li>Sexual activity negotiation skills</li> </ul> </li> </ul>
<b>Indirect Programmatic Approaches</b>	<ul style="list-style-type: none"> <li>Youth development</li> <li>CCTs/incentives</li> </ul>		<ul style="list-style-type: none"> <li>Youth development</li> </ul>

### OBJECTIVE 1 – How to Increase Desire to Avoid, Delay, Space or Limit Childbearing

Programs that aim to increase the value of girls and promote the benefits and cultural acceptability of delaying sexual activity and first pregnancy, and ultimately, having smaller families, directly target the barriers that inhibit girls from wanting to avoid, delay, space or limit their childbearing.

#### Direct Approach: INFORMATION

Informational approaches are most successful when they reach adolescents with information about the benefits of smaller families through a variety of venues, such as in-school, out-of-school, at work and in both urban and rural settings.<sup>84</sup> Effective informational or educational programs take into consideration larger social norms around reproductive decision-making, and include discussions of social standards and beliefs, choice of partner, love, partner responsibilities, emotions and the role that is played by material interests in sexual relationships.<sup>85</sup> While most of the systematic reviews emphasize the importance of comprehensive sexuality

#### **India: Information on Delaying and Spacing - Addressing Objectives 1, 2 & 3**

Pathfinder International's *PRACHAR* program in India aims to: 1) increase girls' age at marriage, 2) delay first pregnancy after marriage until 21, and 3) ensure spacing of at least three years between the first and second births. The program uses educational sessions with adolescents (both married and unmarried), behavior change communication such as billboards and flyers, and door-to-door personal visits by health workers to convey important health messages. The messages communicated by these many channels include the importance of spacing, reproductive health education, family planning methods, HIV/AIDS and STDs prevention, education for traditional birth attendants, and more. *PRACHAR* has been able to successfully delay the age of marriage as well as the age of first birth among its program participants.

(Rahman & Daniel. 2010; Wilder & Daniel. 2005)

education, the *TeenStar* program in Chile that encouraged abstinence only by stressing the importance of the biological and physiological aspects of fertility, was also particularly effective in significantly decreasing rates of pregnancy among participants, compared to non-participants.<sup>86</sup>

Informational approaches have the ability to provide adolescents with a comprehensive picture of reproductive health, including the benefits of avoiding, delaying, spacing and limiting pregnancies. Teaching adolescents about the medical, social and economic benefits of waiting to have children may increase their demand for avoiding, delaying, spacing and limiting pregnancy. However, educational programs rarely include this information, and thus there is little evidence on the effectiveness of such approaches.

### Direct Approach: MASS MEDIA

Mass media approaches have been shown to be effective in addressing a variety of social norms, including the ideal timing and size of families. Mass media campaigns have the potential for expansive reach and the ability to address taboo issues in an entertaining or informative way.<sup>87</sup> Mass media programs disseminate information through various sources such as TV, radio, hotlines, posters, billboards and wall paintings, print, SMS messaging, street theater, community dialogues and social media.<sup>88</sup> While there are many mass media programs that focus on ideal family size, few evaluated programs targeted adolescents with messages related to the acceptability of avoiding, delaying, spacing and/or limiting births. This leaves a gap in the evidence, which, if filled, would enable program implementers to understand how to better target services to increase adolescents' understanding and achievement of their reproductive desires and use of family planning services.

In general, interventions involving mass media can be difficult to measure due to the challenge of differentiating those who have been exposed to the various messages and in what intensity.<sup>89</sup> The systematic reviews concluded that while mass media can clearly influence adolescents' knowledge and attitudes, there is less evidence that these programs consistently and directly influence sexual behavior.<sup>90</sup> Studies further suggest that large-scale, more broadly targeted campaigns are most effective when coordinated with other interventions, such as school-based or clinic-based programs, and when they are developed and implemented through multiple channels with mutually reinforcing messages.<sup>91</sup> Many studies have found that changes in knowledge varied by program exposure, with the greatest changes occurring in those who were exposed to messages through various forms of media, such as a radio broadcast, an informational booklet, or a billboard.<sup>92</sup>

#### **Egypt: Multi-channeled Communication Program - Addressing Objectives 1, 2 & 3**

The *Mabrouk* ("Congratulations") program used a multi-pronged communication strategy—including television, radio, variety show, information booklets, and group wedding celebrations—to inform newlyweds about family planning, pregnancy, safe delivery, and postpartum care. The program also conveyed messages on key decisions regarding having children, spousal communication and appropriate birth spacing. It especially aimed to address social taboos around communication and discussion about reproductive health issues and the stigma related to contraceptive use among young people. As the program recognized the deeply entrenched social norms related to first births within marriage, it focused on increasing the social acceptability of spacing births. *Mabrouk* has been successful in increasing contraceptive use among young couples with one child from 20 percent in 1995 to 50 percent in 2005. (Salem et al, 2008; McCleary-Sills, McGonagle, & Malhotra 2012)

While radio and television campaigns have the potential to reach the largest number of people, because of the financial and human resources needed to produce and broadcast high quality programs, they may

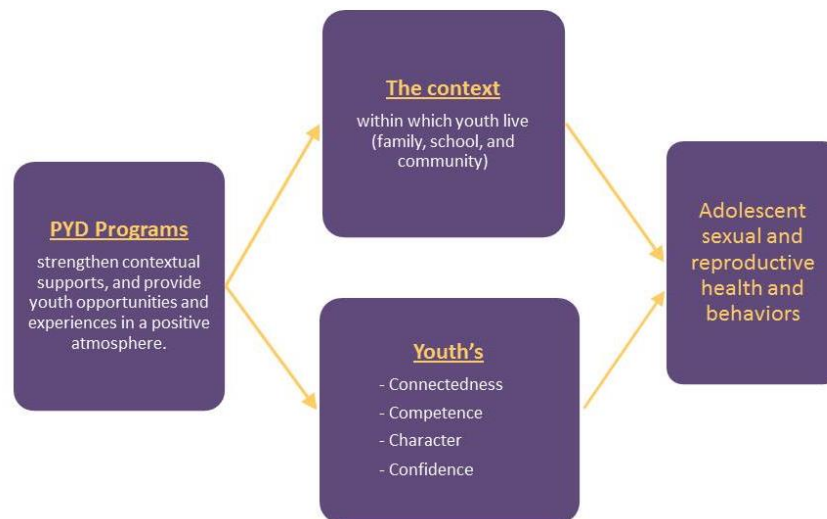
be a less cost-effective approach.<sup>93</sup> Radio may work well where access to television is limited; however, among a population where there is high access to TV, it may be more difficult for radio-based interventions to capture necessary attention. Which type of media to use depends on the media habits and preferences of the intended audience, audience members' access to media (as this may be particularly limited for adolescents), and the costs involved in programming.<sup>94</sup>

### INDIRECT APPROACHES

Many researchers have hypothesized that because adolescent pregnancy is deeply rooted in socio-cultural norms, it may be easier to impact distal, rather than immediate contributing factors.<sup>95</sup> For example, many programs have been challenged to delay first births among married adolescents. As 90 percent of adolescent pregnancies occur within early marriage, efforts may be more effective in delaying the marriage in the first place, which would then lead to a delayed first birth. Similarly, programs that keep girls enrolled in school may indirectly decrease the likelihood that they will get married, as well as decrease their chances of becoming pregnant. Therefore, it is important to look at some of these indirect programmatic approaches.

#### Indirect Approach: YOUTH DEVELOPMENT

Youth development programs provide young people with skills that give them access to other life opportunities, as well as build and support protective factors in their families, schools and communities.<sup>96</sup> As adolescents develop interests and see their potential for income generation and alternatives to marriage and parenthood, they may begin to prioritize or idealize other adult roles. Examples of youth development programs include vocational skills training, community-based programs to improve neighborhoods and create safe spaces, clinic settings where youth participate in clinic management, mentoring or tutoring.<sup>97</sup> Youth development programs often focus on life options, educational aspirations, employment considerations and psychosocial development needs, as well as promote a safe environment for youth to develop.<sup>98</sup>



A conceptual framework for positive youth development programs promoting adolescent sexual and reproductive health. Adapted from Durlak et al. (2007).<sup>99</sup>

While some evaluations of such programs taking place in the developing world have been conducted, these programs run the risk of selection bias, as the more progressive, involved adolescents may be the ones who volunteer for participation.<sup>100</sup> Still, studies have found that youth development programs have

contributed to changes in the desired age of marriage, intended fertility and career aspirations. Some interventions have resulted in female participants marrying at an older age and having fewer children; being more likely to have participated in formal schooling; being more likely to be employed and earning cash; having greater confidence and self-efficacy; and having higher rates of contraceptive use, antenatal care, hospital deliveries and use of oral re-hydration solutions compared with girls with no program exposure.<sup>101</sup> Gavin and Catalano reviewed the existing evidence and engaged a panel of experts to consider youth development as a strategy to promote adolescent sexual and reproductive health in the United States.<sup>102</sup> Their findings may suggest lessons to be taken up in other countries. Specifically, they concluded that “youth development programs can help youth develop the motivation, skills, and confidence needed to make healthy decisions.”<sup>103</sup> By “combining youth development approaches with the provision of accurate, age-appropriate, and evidence-based sex education, as well as access to clinical reproductive health services,” they argue that “the nation is far more likely to achieve and sustain a high degree of sexual and reproductive health among its youth.”<sup>104</sup>

#### **Guatemala: Equipping Girls - Addressing Objectives 1, 2 & 3**

Population Council’s *Abriendo Oportunidades* program in Guatemala aims to increase indigenous Mayan girls’ (ages 8-18) social support networks, connect them with role models and mentors, build a base of critical life and leadership skills, and provide hands-on professional training and experience. Community-based girls’ clubs are formed with a cascading leadership structure and there is a continuous training and mentoring process. Workshops are conducted with girls and their mothers on topics such as self-esteem, life skills, developing aspirations and planning for the future, sexual and reproductive health and HIV/AIDS prevention. One hundred percent of program participants completed the sixth grade and a higher percentage of girls remained childless among participants compared to non-participants. (Catino, Colom & Ruiz, 2011)

#### **Indirect Approach: CCTS/INCENTIVES**

Conditional cash transfers (CCTs) and incentive programs have been proven successful in decreasing school drop-out, early marriage and early pregnancy. CCTs that are conditional on school enrollment/ completion or delayed marriage increase the opportunity cost of dropout or getting married, thus providing a financial incentive to keep girls in school and delay marriage, both of which ultimately contribute to delaying pregnancy.<sup>105</sup> Similarly, incentive programs often provide support for school enrollment in the form of school fees or uniforms. With the financial barriers to school enrollment removed, families are more likely to send their daughters to school, which contributes to both delayed marriage and delayed pregnancy. School not only provides a protective force against early marriage and early sexual activity, but also provides adolescents with access to information, skills and resources.

Education is also associated with more equitable gender-role attitudes and more reproductive health communication.<sup>106</sup> Educated girls exhibit increased autonomy and decision-making skills, enabling them to make better-informed decisions about childbearing and to act on their reproductive desires.<sup>107</sup> One program in Ethiopia, *Berhane Hewan*, found that forming girls’ groups, providing school materials to keep girls in school, holding community conversations about child marriage, enlisting adult mentors to support girls, and awarding families with a goat or sheep for keeping daughters in the program improved girls’ school enrollment, age at marriage, reproductive health knowledge and contraceptive use. However, the impact on school enrollment and delaying marriage was much greater among those aged 10-14 than those 15-19, suggesting that different approaches may be needed with different age groups. Additionally, while marriage was delayed, marriage rates spiked as soon as families received the goat.<sup>108</sup> Interestingly, unconditional cash transfers (UCTs) have also been shown to be successful in

changing reproductive health outcomes.<sup>109</sup> While more research is needed, this may be due to their potential to provide needed financial support to the most vulnerable girls.

Due to the nature of the intervention, CCTs tend to be among the most rigorously designed and evaluated studies, yielding the most straightforward and significant results.<sup>110</sup> Unlike many of the other interventions contained in the systematic reviews we considered, in the area of CCTs, researchers were able to measure both immediate and long-term behavioral outcomes, including contraceptive use and fertility.<sup>111</sup> One systematic review found CCTs to be very effective in not only changing the age of marriage, but also in reducing adolescent pregnancy and fertility.<sup>112</sup> However, it is important to consider the high cost and challenges in regard to the sustainability of CCT approaches. Further, the concept of financially incentivizing people to change behaviors regarding reproduction is quite different from an ethical perspective than encouraging behavior change regarding schooling or even age of marriage. As history has instructed, governments and donors must use caution in providing incentives to low-income and vulnerable populations (including adolescents), such that they do not coerce people to use contraception against their will.<sup>113</sup>

#### **Malawi: Zomba Cash Transfer Program- Addressing Objective 1**

The World Bank conducted the *Zomba Cash Transfer Program* that included a conditional cash transfer (CCT) as well as an unconditional cash transfer (UCT) in Malawi. The study involved one arm that received a cash transfer conditional on school enrollment and the other arm received a cash transfer regardless. Researchers compared the effect of the two arms on the outcomes of school enrollment, school performance, age of marriage, teenage pregnancy, and self-reported sexual activity. While the CCT had a larger impact on school enrollment and English reading comprehension, the UCT had a substantially larger impact on reducing teenage pregnancy and marriage. This difference is primarily due to the UCT's impact on the most vulnerable girls who had dropped out of school.

(Baird, McIntosh & Ozler, 2011; Baird, Chirwa, McIntosh & Ozler, 2010)

Other unintended effects of CCTs must also be considered. For example, one study in Honduras found that providing a CCT conditional on pre-natal care and preventative health care for new babies may have actually contributed to an increase in fertility among eligible women.<sup>114</sup> While CCTs may have a proven track record in changing knowledge and behaviors, the cost and the unintended consequences – both positive and negative – of such interventions must be carefully considered. Further, when exploring the effectiveness of CCTs in regard to influencing desired fertility, it should be noted that CCTs do not typically take into account participants' previous compliance or intent to comply with the conditional behavior, such as the likelihood of school enrollment, making it difficult to measure both effectiveness and cost-effectiveness against behavior change.<sup>115</sup> Additional research is needed to determine the correct price point that will be sufficient to motivate the behavior, while still being economically feasible.

#### **OBJECTIVE 2 – How to Increase the Desire to Use Family Planning Methods**

Programs that disseminate information about reproductive health and family planning methods are essential to increasing adolescents' understanding of how fertility and pregnancy prevention work. This information, along with programs that change social norms around the cultural acceptability of adolescents' use of methods, can enable adolescents to overcome barriers to wanting to use contraception. . In order to be successful, such programs need to be sure to provide both adolescent

boys and girls with reproductive health information that is culturally appropriate and relevant to them.<sup>116</sup>

### Direct Approach: INFORMATION

#### ***School/Curriculum-based Education***

One of the most popular types of informational approaches used to influence adolescents' family planning knowledge, attitudes and behaviors is school or curriculum-based programs. School-based educational programs have the potential to reach a large number of youth, especially in places where school enrollment is high.<sup>117</sup> In fact, school may be the only place that many adolescents can access this information, as parents often do not talk to their children about sexual and reproductive health because they are confused, ill-informed or embarrassed.<sup>118</sup> The structured school environment is conducive to sending educational messages to youth and for providing a potential captive audience.<sup>119</sup> To be effective, however, teachers must be adequately trained so that they both know the information and feel comfortable teaching the information; unfortunately, this is often not the case.<sup>120</sup> An example of a curriculum that successfully incorporates a right-based, gender-sensitive, participatory focus is the "It's All ONE" curriculum developed by the International Sexuality and HIV Curriculum Working Group.<sup>121</sup>

#### **Key Components of Successful Sexuality Education Programs**

*Kirby et al (2007)* define the key characteristics of effective ASRH education program as follows:

##### Development of curriculum:

- 1) Involved multiple people with varied backgrounds
- 2) Assessed relevant needs and assets of the target groups
- 3) Used a logic model approach that specified health goals and other objectives and activities
- 4) Designed activities consistent with community values and available resources
- 5) Pilot-tested the program

##### Overall design and teaching strategies of the curricula themselves:

- 6) Focused on clear goals of preventing HIV/STI and/or pregnancy
- 7) Focused on specific behaviors leading to these health goals (e.g., abstaining from sex or using condoms or contraception) and gave a clear message about those behaviors
- 8) Addressed psychosocial risk and protective factors affecting those sexual behaviors
- 9) Created a safe environment for youth
- 10) Included multiple activities to change the targeted risk and protective factors
- 11) Employed instructionally sound teaching methods that actively involved the participants and helped them personalize the information
- 12) Employed appropriate activities and messages (for participants' culture, age, sexual experience)
- 13) Covered topics in a logical sequence

##### Implementation of the curricula:

- 14) Secured at least minimal support from authorities
- 15) Selected educators with desired characteristics, trained them, and provided ongoing monitoring and support
- 16) Recruited youth if necessary and retained them
- 17) Implemented virtually all activities as designed

The evidence strongly indicates that while age and developmentally-appropriate school-based programs – with certain key characteristics – can increase knowledge and improve attitudes, delay or decrease risky sexual behaviors, and/or increase condom/contraceptive use, they are much more likely to change knowledge and attitudes than impact sexual behaviors.<sup>122</sup> While some school-based education

interventions have been able to increase contraceptive use, due to the low intensity and short-time frame of the intervention, these impacts may not be sustained over the long-term.<sup>123</sup> For example, an in-school sexuality education program in Jamaica was able to significantly increase contraceptive use among participants compared to non-participants one year after the program ended, but the difference was no longer significant after two years.<sup>124</sup> In general, few educational programs have collected longitudinal data on participants' attitudes and behaviors to determine the long-term impact of these programs. Additionally, educational programs that provide information without also increasing adolescent girls' agency to act on their reproductive desires may fall short of increasing actual uptake of contraceptive methods.

Successful sexuality education programs must contain several key components that fall into the categories of curriculum development, curriculum content, and program implementation (*see above box*).<sup>125</sup> Additionally, the systematic reviews found that school-based programs led by adults appear to be more successful than peer-led programs, particularly in regard to impacting sexual behavior.<sup>126</sup>

Importantly, some curriculum-based programs have proven to be successfully replicated, demonstrating changes in knowledge both at initial implementation and when implemented at a new site.<sup>127</sup> The fact that these programs and their successful results can be replicated provides further evidence that school or curriculum-based educational approaches can be effective at some level.

### ***Workplace-based Education***

Reaching youth with sexual and reproductive health information at out-of-school sites is essential, given that over 70 million adolescents across the developing world do not attend school.<sup>128</sup> Youth who are out of school often have less education, less access to information and are more likely to practice risky sexual behaviors than in-school youth.<sup>129</sup> Programs that target youth through workplace-based education initiatives hold promise in areas where a significant proportion of young workers are in the formal work sector, as in parts of Latin America and Asia, and among specialized populations, such as in the military and among sex workers.<sup>130</sup>

The systematic reviews found that workplace-based programs can greatly impact adolescents' reproductive health knowledge and attitudes, and have the potential to impact sexual behavior as well. One systematic review found that some of the workplace-based educational interventions resulted in increased condom use.<sup>131</sup> While this type of program shows promise, determining the specific impact of workplace-based interventions is not always possible due to concurrent, external factors that also influence reproductive health knowledge, attitudes and behaviors.<sup>132</sup>

### ***Interpersonal and Peer-to-Peer Education***

Interpersonal communication programs that recruit and train a core group of youth to serve as role models and sources of information for their peers are often called peer-to-peer programs. Peer-to-peer communication can consist of one-on-one discussions, small group sessions and facilitator-led, curriculum-based programs where youth share information, values and behaviors with members of a similar age or status group.<sup>133</sup> Such programs can take place within schools, the workplace and the community and are often facilitated by peers, often with the assistance of teachers or expert trainers.<sup>134</sup> Through these programs youth spread information among their peers and in some cases also distribute contraceptives.<sup>135</sup> These youth educators and mentors often work within existing structures, such as schools or youth centers, or they may conduct community-based outreach.<sup>136</sup>

The systematic reviews found that peer-to-peer education programs most frequently measured short-term outcomes and were found to be effective in changing adolescents' knowledge and attitudes. There is less evidence to suggest that peer approaches improve behaviors related to family planning and fertility outcomes.<sup>137</sup> Other studies have shown that the peer educators themselves gained substantial increases in knowledge and improved attitudes regarding reproductive health, as well as leadership skills, but their effect on other peers was less significant.

Parents are often among adolescents' only source of information on topics of sexual and reproductive health, but they are often unequipped to provide accurate and unbiased information. A study in Uganda found that parents were girls' main source of information regarding sexuality and HIV/AIDS, however 40 percent of girls also reported they had

difficulties discussing sexual issues with their mother due to fear and shyness.<sup>138</sup> To this point, programs that encouraged discussions between parents and adolescent children about reproductive health, sex and HIV were effective in changing both knowledge and protective behaviors.<sup>139</sup>

### **New Media**

In addition to traditional communication channels, programs are increasingly looking to integrate new digital media, such as SMS messages, social media and websites to distribute information to adolescents. New media, defined as being user-controlled and sharable, provides an innovative way to spread information and taps into the media channels that youth are already frequently using.<sup>140</sup> The integration of mobile telecommunication technologies and the health sector have led to mHealth initiatives that disseminate health information via mobile phones.<sup>141</sup> New media and mHealth initiatives present both advantages and challenges when it comes to privacy and confidentiality. On the one hand, adolescents are able to readily access information and ask questions in a discreet manner. However, there are concerns about whether other family members can view search histories or whether program sites will keep

#### **Nepal: Adolescent IPC Program - Addressing Objectives 1 & 2**

The *Building Demand for Reproductive Health Awareness (BuDRH)* in Nepal program worked to shape attitudes and behaviors among unmarried adolescents through peer education. The program provided information and messages on optimal birth spacing, as well knowledge on delaying marriage, ways to avoid pregnancy, and contraceptive methods. After one year, among those who were exposed to the program, there was an increase in the percentage of respondents who thought family size should be determined by the husband and the wife from 73 percent to 80 percent. There was also an increase in knowledge of the oral contraceptives from 83 percent to 99 percent, and an increase in knowledge of the benefits of spacing births from 84 percent to 92 percent. By changing these attitudes among adolescents, the program hopes to stimulate a new, more accepting social norm that leads to increased family planning use when they become sexually active.

(Tamang, Tamang & Yadav, 2005; McCleary-Sills, McGonagle & Malhotra, 2012)

#### **Mozambique: mCenas!- Addressing Objectives 1 & 2**

Pathfinder International's *mCenas!* program in Mozambique seeks to identify and address myths and misconceptions related to family planning among the youth. Youth 15-24 are targeted with SMS messages containing informational material and stories. Role model stories are developed to cover parenting and non-parenting among boys and girls, as well as topics related to the issues youth face in choosing to start or continue a family planning method. There is also a "Frequently Asked Questions" section that allows youth to receive messages on pregnancy, STIs, HIV and family planning methods. While this project is in the pilot stage and no results have been measured, it provides an innovative example of how new media can be used to disseminate family planning messages to adolescents. (Pathfinder, mCenas!)

contributions anonymous.<sup>142</sup> Additionally, lower access to mobile phones and the internet among females and those living in rural areas makes these interventions less effective in reaching and impacting particular disadvantaged populations.<sup>143</sup>

The evidence base specific to new media and adolescent family planning is scant. What is known suggests that, to be successful, program implementers must understand their target audience and pre-test messages to ensure they fit their audience's preferences in regard to technology use, language and health needs.<sup>144</sup> Additionally, program implementers need to be able to communicate how to use the technology and troubleshoot any problems that arise.

A systematic review of interventions that used new media in mHealth initiatives found that most studies demonstrated changes in knowledge related outcomes. The two studies that measured behavioral outcomes found a significant reduction in sexual initiation among participating male and female high school students.<sup>145</sup>

### Direct Approach: MASS MEDIA AND SOCIAL MARKETING

Unlike the above programs that primarily provide adolescents with information, mass media approaches are used to change the cultural acceptance of adolescents' use of family planning methods. Social marketing campaigns that use mass media, aim to increase the uptake of a particular contraceptive method (most often condoms) by changing attitudes around the use of such methods. These campaigns may present the use of condoms as "cool," for example by using slogans such as "Real men use condoms" or the cricket-themed "It's your wicket, protect it."<sup>146</sup> Social marketing campaigns often segment their target audience and thus can provide specific messages and methods for adolescents.

The systematic reviews found that mass media programs have been largely successful in contributing to changes in knowledge and communication around contraceptive use.<sup>147</sup> The studies also found that both mass media and social marketing campaigns are modestly effective in persuading male and female adolescents to change risk behaviors, specifically, increasing condom use.<sup>148</sup> The Soul City campaign in South Africa, for example, used TV, radio and booklets to change social norms, such as the belief that boys or men have the right to have sex with their girlfriends if they buy them gifts, and also tackled the

#### ***Nicaragua: Mass Media to Educate - Addressing Objectives 1, 2, 3 & 4***

*Somos Diferentes, Somos Iguales*, a program of Nicaragua-based Puntos de Encuentro, successfully utilized education-entertainment, including a social soap opera, radio programming, local capacity building, context-specific materials, and community outreach to reduce stigmatizing and gender-inequitable attitudes, increase knowledge and use of HIV-related services, increase interpersonal communication about HIV prevention and sexual behavior, and strengthen youth leadership, among other outcomes. Results of rigorous evaluations suggest the program contributed to significant increases in knowledge about and reported use of condoms in sexual relations with casual partners. (Solorzano et al, 2008)

expectation that a woman should have sex with a man without a condom. Condom use was shown to increase with program exposure.<sup>149</sup> As with many other approaches, studies found that mass media approaches were most successful when combined with other programmatic components, including interpersonal communication, which increased adolescents' agency and decision-making abilities.<sup>150</sup> Programs that incorporated multiple types of media were the most successful in changing not only knowledge, but also behaviors.<sup>151</sup> One systematic review that differentiated between the types of media used in different interventions found that radio-only campaigns only changed knowledge of services, while radio and other media (including print materials, posters, street theater, hotlines, listening groups and promotional materials such

as T-shirts & hats) campaigns changed knowledge of services and sometimes significantly changed skills and social norms.<sup>152</sup> Several programs that combined radio, television and other media improved knowledge and skills, and also positively changed social norms, such as about discussing condom use with peers, partners, or parents, as well as about beliefs related to expectations of sexual relationships.<sup>153</sup>

In general, for all programmatic approaches aiming to achieve Objective 2, working with adolescents' family members, teachers, religious leaders and key gatekeepers is critical to creating an enabling environment that fosters acceptance of adolescent decision-making around avoiding, delaying, spacing and limiting births, as well as acceptance of adolescent use of family planning services. Programs have successfully built community support work through both informational approaches and social norm change campaigns.<sup>154</sup>

### OBJECTIVE 3 – How to Increase Agency to Use Family Planning

Even when adolescents want to use family planning methods to avoid, delay, space, or limit their childbearing, they often lack the agency to act on their desires and make their own decisions. Agency-building programs can aim to increase adolescent girls' capacity to negotiate sexual behaviors, comfort with discussing issues related to reproductive health, and self-confidence to not only choose their own path for the future, but also effectively pursue it. Such programs help girls overcome many barriers to actually using family planning methods. Programs that promote multiple, positive roles that girls can play in society reinforce the fact that girls have the power to choose what they want and that they need not be limited by traditional norms. Increasingly, evidence suggests that working directly with married adolescent girls and their families can improve their agency within relationships as well.

#### Direct Approach: INFORMATION

##### ***School/Curriculum-based Education***

The systematic reviews found that it is critical that educational programs not only provide students with sexual and reproductive knowledge, but that they also teach them negotiation and communication skills.<sup>155</sup> While educational programs also have the potential to teach students about the various roles that girls can play in society, and thus give them the confidence to make reproductive health decisions based on what they want for their future, there is little evidence as to what types of approaches work best. Adolescents have suggested that sexuality education programs should be more positive, with less of an emphasis on anatomy and scare tactics, and more of a focus on negotiation skills in sexual relationships and communication.<sup>156</sup> Educational programs that teach students to challenge gender roles and dynamics and how to negotiate or say no to sex are also seen as having a positive

#### **Tanzania: Peer Education and Empowerment- Addressing Objective 3**

The *Vitu Newala* project ("Newala Youth Can") in Tanzania engaged youth in the participatory research process to understand and address the risks faced by adolescent girls in Newala. Girls ages 18 to 24 were trained to be researchers and to conduct sessions with younger girls (ages 12 to 17) to discuss their aspirations and roadblocks to achieving them. Adolescent boys and girls were engaged in activities such as dramatic plays, learning sessions and discussions ranging from reproductive health to goal setting. Through this process, young researchers sought to empower youth to advocate for themselves and reduce their vulnerability to HIV. Through its participatory approach, *Vitu Newala* was able to improve adolescents' knowledge and self-efficacy for discussing sex and family planning with parents and other adults, with friends, and with (potential) partners. (McCleary-Sills et al, 2011)

impact.<sup>157</sup> Although not specific to adolescents, Do & Kurimoto found positive associations between empowerment and contraceptive use in Namibia, Zambia, Ghana, and Uganda.<sup>158</sup>

### ***Peer-to-peer Education***

Peer-to-peer programs allow youth to address social norms, expectations and pressures within their own social and economic context. When interacting with a peer educator, adolescents may feel more comfortable sharing their feelings and discussing taboo topics, ultimately contributing to increased knowledge and empowerment.<sup>159</sup> Peer educators are often able to reach the most vulnerable populations and can motivate healthy behaviors by changing social norms.<sup>160</sup> Peer educators also serve as positive role-models who can demonstrate the agency needed to interact with peers and navigate sexual pressures and behaviors.<sup>161</sup> Peer-to-peer education evaluations looked primarily at short-term outcomes, such as knowledge, attitudes and intentions; few looked at behavioral outcomes.<sup>162</sup> Thus, although such programs often aimed to increase adolescents' capabilities to act on their reproductive desires, little is known about their effectiveness in doing so. Studies have found that peer-to-peer education programs are strengthened by networks to other resources, and were most successful when linked to wider socio-cultural and economic health promotion strategies.<sup>163</sup> This finding supports the need for provision of comprehensive reproductive health and family planning education, potentially through schools, as well as developmental approaches to increase agency and self-efficacy. These programs are also likely to be more successful when embedded in community-based approaches that enhance the support peer-educators have at the household and community levels. This is particularly true when coupled with training on negotiation skills and more gender-equitable decision-making processes.

Peer-to-peer education programs have not been shown to be cost-effective, however, as resources are required to train and support peer leaders, though this depends in part on the number of individuals that peer educators reach. Due to the intensive training required by peer leaders, the primary impact of the program may be on the peer educators themselves rather than on their peer contacts.<sup>164</sup> Further research is needed to understand how peer-to-peer education can most effectively – and most cost-effectively - be used to spread information and increase youth's agency to act on their reproductive desires.

### **INDIRECT APPROACHES**

In addition to the direct impact that education can have on teaching girls negotiation skills and influencing social norms related to acceptable roles for girls, the general sense of empowerment that comes with education has the potential to increase both girls' and boys' agency to act on their reproductive desires. When adolescents are confident and have access to resources, they are more likely to make their own decisions and carry out the necessary actions to achieve their goals.

#### **India: Sports for Development- Addressing Objective 3**

ICRW's *Parivartan* program in Mumbai, India engages cricket coaches, peer mentors, and the community to promote gender-equitable norms that promote respect and prevent violence. The program aims to raise awareness about abusive and disrespectful behavior, promote gender-equitable, non-violent attitudes, and teach boys skills to speak up and intervene when witnessing harmful and disrespectful behaviors. The program uses "teachable moments" during cricket games to discuss and challenge norms. An evaluation of the program found that participants demonstrated a positive shift in gender attitudes, and reported a decline in sexually abusive behavior. The gender equitable norms and increased communications skills enable boys to feel more comfortable sharing their feelings as well as respecting the desires of others. This lays the foundation for both boys and girls to have the agency to make and act upon their reproductive decisions.  
(Das, Miller & Verma, 2012)

### Indirect Approach: YOUTH DEVELOPMENT

Both educational approaches and youth development interventions have the potential to provide girls and boys with skill sets that enable them to have the agency to act on their desires. Interventions that promote acquisition of new skills and opportunities, coupled with opportunities for reflection and dialogue regarding social norms result in sustained reductions in behaviors that jeopardize health for girls and boys.<sup>165</sup> Studies have shown that surrounding young people with protective factors, strengths or assets in their unique social and environmental context can achieve even greater improvements in outcomes than focusing on risk reduction.<sup>166</sup> Youth development and life-skills approaches that improve social, thinking, and negotiations skills have been endorsed by several United Nations agencies (WHO, UNFPA, UNICEF, UNESCO) as a method to improve sexual and reproductive health outcomes.<sup>167</sup> Such programs have been able to successfully increase the age of marriage, increase school enrollment, retention and completion, lead to a higher likelihood of employment, and improve reproductive health outcomes, including higher rates of contraceptive use and lower overall fertility rates.<sup>168</sup>

## D. The “Supply-Side”

### 1. Barriers

***Table 4: Supply-side Barriers***

Objective	(4) Access to family planning services	(5) Provision of quality, youth-friendly services
Barriers for Girls	<ul style="list-style-type: none"><li>• Lack of awareness of services</li><li>• Inaccessible location/ limited mobility</li><li>• Inconvenient operating hours</li><li>• Long wait times</li><li>• Costs</li><li>• Lack of access to financial resources</li></ul>	<ul style="list-style-type: none"><li>• Lack of provider quality/ competence</li><li>• Provider reluctance to provide contraceptives to adolescents</li><li>• Unavailability of appropriate methods</li><li>• Stock-outs</li><li>• Restrictions on use</li><li>• Gender biases in service provision</li><li>• Lack of privacy/ confidentiality</li></ul>
Barriers for Boys		

#### OBJECTIVE 4: Barriers to Accessing Family Planning Services

Even when adolescents want to use contraceptives, have accurate information about different methods, and are empowered to use them, barriers may prevent them from being able to access services. First, many adolescents **do not know where to obtain contraceptives**.<sup>169</sup> A study in Burkina Faso, Ghana, Malawi and Uganda found that among adolescents aged 12-19, 22 to 49 percent of females and 25 to 41 percent of males did not know of any source to obtain a contraceptive method.<sup>170</sup> Even when adolescents know where to access contraceptives, logistical constraints often stand in their way. **Long distances** to clinics, coupled with **limited mobility** among adolescents, particularly among married female adolescents, make getting to services difficult.<sup>171</sup> **Inconvenient hours**, such as only being open during times when adolescents are in school, pose another barrier.<sup>172</sup> **Long wait times**, especially when adolescents are trying to discreetly use services, can also discourage use.<sup>173</sup> Additionally, the **costs** of traveling to the family planning service provider, as well as the costs of the methods themselves, may hinder adolescents' use.<sup>174</sup> Due to inconsistent sexual behavior, teens are more likely to use short-term

methods, such as condoms, which are cheaper per use, but which may cost more over time and be less effective in preventing pregnancy.<sup>175</sup> In general, adolescents **lack access to financial resources**, and married adolescent girls may be particularly financially dependent on their husbands.<sup>176</sup>

#### **OBJECTIVE 5: Barriers to Accessing High Quality, Youth-Friendly Services**

Even if adolescents can overcome obstacles to accessing services, they may encounter services that are of **poor quality** and that do not respond to their unique needs as young people. Providers may be **reluctant to provide contraceptives**, especially emergency contraception or long-term methods, to adolescents.<sup>177</sup> In Kenya, Lao PDR and Zambia for example, almost half of providers indicated that they were unwilling to provide *any* contraceptives to adolescents.<sup>178</sup> Even when providers are willing to give adolescents contraceptives, the specific types of contraceptive **methods available may be inappropriate** to their specific desires or needs, or the users may not be informed that they can change their method if they find it unacceptable. For example, some locations may offer access only to permanent methods, such as sterilization, while other methods that require consistent access or consumption, such as the pill, may be logistically challenging for adolescents.<sup>179</sup> This lack of a comprehensive, consistent method mix can create challenges for adolescents. Additionally, clinics in developing countries often experience **stock-outs** of various contraceptive methods, making it difficult for women of all ages to regularly access and use their method of choice.<sup>180</sup>

Providers may discourage and stigmatize adolescents' use of contraceptives, or they may place or enforce **unnecessary restrictions**, such as parental or spousal consent.<sup>181</sup> In some countries, policy or legal provisions, such as age of consent laws, may limit providers' ability to offer contraceptives to adolescents. Even in places where there are no such restrictions, providers and clients may perceive there to be restrictions based on age, parity or marital status, or they may impose restrictions based on their own moral judgments of what is and is not appropriate for young people.<sup>182</sup> Additionally, **providers may be poorly trained** in delivering sexual and reproductive health services in general, and especially to adolescents.<sup>183</sup> Providers may be **biased** in what methods they offer and how they discuss family planning options differently with males and females.<sup>184</sup>

#### **Overarching Goal: Barriers to Sustained, Effective Family Planning Use**

**Lack of privacy and confidentiality** are often cited as major barriers to accessing sexual and reproductive health services; adolescents may not use facilities that do not offer such privacy or that are not open at convenient times for them.<sup>185</sup> Adolescents' need for privacy may be so strong that they are willing to utilize higher costs services and/or travel long distances to access services at private facilities; this, in addition to the fact that adolescents may tend to avoid clinics altogether.<sup>186</sup> Finally, even if adolescents want to use contraceptives and have access to the information and services they need, there may still be barriers that hinder them from effectively using contraceptives to achieve their reproductive desires. It is also important to note that reproductive desires and intentions change over a person's lifetime. As such, discussions about adolescent reproductive health should be infused with a clear life course perspective, which recognizes that reproductive desires, intentions and the barriers to achieving these change with age and life circumstances. Very little research has incorporated this perspective, relying instead on static measures that do not accurately reflect the dynamic nature of reproductive decision-making.<sup>187</sup> It is critical to account for the "contraceptive environment" and how this shifts over time in response to individual, interpersonal and social change.<sup>188</sup> By applying this lens,

we allow for a more nuanced understanding of how social influences shape women’s experience of barriers at each of the levels discussed above.

## 2. Programmatic Approaches

***Table 5: Supply-side Programmatic Approaches***

Objective	(4) Access to family planning services	(5) Provision of quality, youth-friendly services
Direct Programmatic Approaches	<ul style="list-style-type: none"> <li>• Information &amp; mass media <ul style="list-style-type: none"> <li>◦ Where/how to access services</li> </ul> </li> <li>• Community-based distribution/ outreach <ul style="list-style-type: none"> <li>◦ Links/referral with schools</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Youth-friendly services</li> <li>• New Media (information) <ul style="list-style-type: none"> <li>◦ How methods work</li> <li>◦ What methods are best for each adolescent’s needs</li> </ul> </li> </ul>
Indirect Programmatic Approaches	<ul style="list-style-type: none"> <li>• Youth centers</li> <li>• Vouchers and coupons</li> <li>• Youth-friendly services</li> <li>• Social franchises</li> </ul>	<ul style="list-style-type: none"> <li>• Community-based distribution</li> <li>• Youth centers</li> <li>• Vouchers</li> <li>• Social franchises</li> </ul>

### **OBJECTIVE 4: How to Increase Access to Family Planning Services**

Adolescents’ access to family planning services requires four basic components: a convenient and secure location, an affordable cost, convenient operating hours, and knowledge of the services and how to access them. Access to services is a supply-side challenge, but approaches that work to increase adolescent demand, by improving knowledge and awareness, frequently increase knowledge of where and how to access services. Similarly, supply-side efforts to improve the quality of services often include components designed to improve access, and vice versa. Indeed, the evidence shows that efforts to increase young people’s access to services are most effective when linked to interventions in other settings that target young people’s knowledge, skills, attitudes and behaviors.<sup>189</sup>

#### **Direct Approach: INFORMATION & MASS MEDIA**

Both information and mass media approaches can be used to inform adolescents of where they can access services. Informational programs often refer participants to specific clinics and services, conveying specific information on hours, available methods and types of services, etc. Often, mass media campaigns that aim to change attitudes related to the acceptability of adolescents’ use of family planning methods will also refer potential clients to locations or networks (e.g., social franchises) where they can access contraceptive methods and other reproductive health services.<sup>190</sup> Although information and mass media programs have rarely been evaluated solely for the purpose of informing adolescents of where to access services, providing this information was a necessary component of actually increasing the uptake of services.<sup>191</sup>

#### **Direct Approach: COMMUNITY-BASED DISTRIBUTION/OUTREACH**

Community-based distribution, sometimes referred to as community outreach, involves the provision of family planning methods and services outside of a clinic setting by both clinical and non-clinical personnel. Programs can take place in a range of community settings, including workplaces, schools, youth centers, mobile clinics, detention centers and through door-to-door or street outreach.<sup>192</sup> The strength of the community outreach approach lies in its ability to reach young people—especially

members of marginalized populations, those who have dropped out of school, are married, or for other reasons are hard to reach—where they are. Not only do these programs eliminate the barrier of distance, they are also positioned to improve access by breaking down the stigma, distrust and alienation that drive many youth, especially those who are marginalized, away from seeking services.<sup>193</sup>

Systematic reviews have found some evidence that community-based distribution approaches can be effective in improving access to services and achieving positive family planning and reproductive health outcomes for adolescents, though there is a paucity of studies in this area.<sup>194</sup> Mobile clinic and home-based service delivery, as well as policies permitting pharmacies to sell emergency contraception (EC) without a prescription, were found to be some of the most effective approaches to increasing access. A study in Tanzania, Zimbabwe and Thailand found that 16 to 32 year olds used mobile clinics to access to HIV testing and counseling

three to 10 times more often than brick-and-mortar facilities; this may be a promising strategy for wider reproductive health service delivery.<sup>195</sup> CEDPA's *Better Life Options* program in India, which included a community-based distribution component, was found to increase adolescents' use of contraception, age at marriage, completion of secondary school, hospital births and decision-making power, though the recruitment methods for this program may have allowed for self-selection bias.<sup>196</sup> Finally, in France, Canada and Great Britain, policies allowing over-the-counter sale of EC at pharmacies were found to significantly improve young women's access to EC and decrease the amount of time between unprotected sex and use of EC – an important factor in the effectiveness of the method.<sup>197</sup>

#### **Ghana: Alternative Distribution Methods- Addressing Objectives 2 & 4**

The *African Youth Alliance* project in Ghana integrated condom distribution into local businesses. The program trained peer educators to provide reproductive health and family planning knowledge, as well as distribute condoms. These youth were also employed in a local trade such as sewing or hair dressing. This way, they were naturally involved in selling goods or services in a location that attracts young people, thus giving them an audience to disseminate information and distribute condoms. At the end of the five-year project, 58 percent of the more than 1,300,000 condoms that had been distributed were through non-traditional condom distributors. Clients found this to be more comfortable as it protected their privacy and confidentiality. (Burket, 2006)

#### ***Links/Referral with Schools***

Creating links or referral systems between schools and reproductive health services can increase adolescents' knowledge of and access to reproductive health services. While some studies have found such approaches can increase contraceptive uptake, the evidence suggests that programmatic impact may be dependent on specific qualities of both the school and the health facilities.<sup>198</sup>

#### **Direct Approach: YOUTH CENTERS**

Youth centers are able to provide adolescents with services in a comfortable environment. As youth centers and youth-friendly spaces typically serve as safe spaces in which adolescents can spend recreation time and associate with peers, they may also provide a convenient platform for reproductive health programming targeting youth. Youth centers that offer sexual and reproductive health services aim to provide a safe, non-threatening environment where adolescents can access information, contraceptives, preventive services and treatment. In practice, however, youth centers have been found to have only limited success in improving access to care or contraceptive use; they may be better positioned to improve reproductive health knowledge.<sup>199</sup> The potential for impact is often limited by the types of young people accessing the centers: in many places these centers have been found to be primarily used by young men, many of whom are older than the target population, and often only for

recreational purposes.<sup>200</sup> Uptake of services was also discouraging: a small number of young women—many of whom were also older than 24—and few men, utilized on-site sexual and reproductive health services.<sup>201</sup> On-site clinical services placed in youth centers are also costly to operate, so the cost-effectiveness of this approach is questionable.<sup>202</sup>

#### Direct Approach: VOUCHERS AND COUPONS

Voucher programs operate by providing targeted populations with paper or electronic vouchers or coupons to be redeemed at contracted providers for free or subsidized services or contraceptives. These interventions frequently target at-risk or hard-to-reach populations, in order to increase health equity and access to services for those who need it most. In addition to the free or discounted services or products they offer, vouchers break down practical barriers and encourage access by providing information about the service or product, locations, operating hours and cost.<sup>203</sup> Additional advantages of voucher programs may include adding

##### **Nicaragua: Vouchers for Services and Methods - Addressing Objective 4**

The Central American Health Institute (ICAS) took aim at low levels of family planning knowledge and use among adolescents through a voucher program for adolescents in Nicaragua. Each voucher entitled the adolescent to a free consultation and a follow-up visit for counseling, contraception, treatment of STIs or reproductive tract infections, pregnancy testing and/or antenatal care at any of the contracted clinics. Overall, contraception use doubled among girls who were sexually active but not pregnant. Among girls who were not yet mothers, contraceptive use increased from 24 percent to 57 percent and among mothers it increased from 47 percent to 82 percent. (Meuwissen et al, 2006c; McCleary-Sills, McGonagle, & Malhotra, 2012)

competition to the health services market to lower costs and increase consumers' choice, improving quality of services, and ease of data collection on voucher distribution and use.<sup>204</sup>

Several voucher and coupon programs have demonstrated improved uptake of services, including family planning, by adolescents, but more research is needed.<sup>205</sup> Adolescent voucher recipients from a school-based pilot program in Nicaragua, for example, demonstrated a significant increase in use of sexual and reproductive health services and knowledge, but contraceptive uptake did not increase.<sup>206</sup> The participants reported finding it easier to access services when practical obstacles (such as out-of-pocket cost, inconvenient hours of operation, and not knowing where to find a clinic) were removed, when providers did not require appointments, and when they had confidential access to services and a choice of providers.<sup>207</sup> A related intervention in Nicaragua resulted in a doubling of contraceptive uptake among sexually active, non-pregnant, adolescent voucher users, as well as a significant increase in condom use and utilization of reproductive health services.<sup>208</sup>

Despite easy collection of data related to how and where vouchers are distributed and used, more rigorous evaluations of voucher programs in developing countries are challenging due to the difficulty of locating recipients who did not redeem the voucher, or those who used the voucher and were promised confidentiality.<sup>209</sup> Further, there is a good probability that publication bias skews the literature in favor of more successful voucher programs, while less effective programs go unreported.<sup>210</sup>

## Direct Approach: YOUTH-FRIENDLY SERVICES

Regardless of what other approaches may be employed to improve adolescents' access to family planning and other reproductive health services, those services must be "youth-friendly" in order to meet adolescents' needs and be truly accessible. As listed in the adjacent box, several key components of "youth-friendly" services make them more logistically and practically accessible for adolescents, which studies of adolescents have validated. These include issues related to both the physical infrastructure and to quality of care, which is addressed further under Objective 5 below.<sup>211</sup>

The fact that there are very few "adolescent health" facilities and that few providers focus on adolescent health, hinders the provision of services. Unmarried adolescents often use child health facilities, which may not encompass reproductive health or family planning services. Married adolescents may use adult health services that fail to serve their unique needs.<sup>212</sup> Age and marital status influence adolescents' needs and concerns: in some settings older or married youth may be more comfortable entering a clinic, while very young, unmarried and non-sexually active youth may be more comfortable seeking services with separate entrances.<sup>213</sup> Seemingly simple considerations, like having toilets

available to patients and being open during "off" hours to accommodate young people's schedules and irregular sexual relationships, improve young people's perception of the accessibility and acceptability of services.<sup>214</sup> Understanding where adolescents prefer to access services should be researched on a case-by-case basis, as some studies have found that adolescents prefer seeking reproductive health care and contraceptives through established clinics and hospitals, while others have found that they prefer pharmacies and storefronts.<sup>215</sup>

It is not enough, however, to simply make services logistically "youth-friendly." To increase use, facilities that have a capacity for youth-friendliness must also spread the word.<sup>216</sup> Further, in some settings, community acceptance of youth access to any reproductive health services may be more important than the existence of "youth-friendly" elements.<sup>217</sup> Indeed, the most successful programs work within and develop the capacity of existing facilities and providers, and target outreach to adolescents as well as the community gatekeepers.<sup>218</sup> While many evaluations of supply-side interventions seek to measure

### UNFPA - Essential and Supportive Elements of Youth-Friendly Services - Addressing Objectives 4 & 5

Essential	Supportive
<b>Access:</b> <ul style="list-style-type: none"> <li>• Convenient hours</li> <li>• Reasonable waiting time</li> <li>• Affordable fees</li> <li>• Separate space and/or hours for youth, where needed</li> </ul> <b>Quality:</b> <ul style="list-style-type: none"> <li>• Specially trained staff</li> <li>• Respect for youth</li> <li>• Adequate time for client-provider interaction</li> <li>• Privacy and confidentiality</li> <li>• Package of essential services available</li> <li>• Referrals available</li> <li>• Sufficient supply of drugs and commodities</li> <li>• Range of contraceptives offered</li> <li>• Emphasis on dual protection/ condoms (male and female)</li> </ul>	<b>Access:</b> <ul style="list-style-type: none"> <li>• Outreach services available</li> <li>• Accessible location</li> <li>• Male and female youth welcomed and served</li> <li>• Publicity that informs and reassures young people</li> </ul> <b>Quality:</b> <ul style="list-style-type: none"> <li>• Comfortable setting</li> <li>• Adequate space</li> <li>• Youth input/feedback to operations</li> <li>• Educational materials available</li> <li>• Provision of additional educational opportunities</li> <li>• Peer providers/counselors available</li> </ul>

(Adapted from UNFPA, Expanding Access to Youth Services: <http://web.unfpa.org/adolescents/youthfriendly.htm>)

*In addition to these key characteristics of youth-friendly service provision, programs should be tailored to meet the specific needs and barriers of underserved youth in various settings. (Gay, 2010)*

increased use of services and improved quality of care and client satisfaction, fewer have attempted to quantify how improvements in service availability, accessibility, and cost impact unintended pregnancies and uptake of contraceptives.<sup>219</sup> This research is much needed.

### Direct Approach: SOCIAL FRANCHISES

Social franchises are networks of providers who use common marketing and branding techniques to provide health services. While social franchises can be used by government, not-for-profit and private sector providers, they are most frequently formed using private facilities and providers.<sup>220</sup> Providers pay a fee to participate in the franchise and in return, receive training, equipment, regular delivery of supplies, marketing and promotions, and other services.<sup>221</sup> Social franchises are often able to offer services at a lower price and guarantee higher quality standards.<sup>222</sup> As with many of the other supply-side approaches, social franchises have been found to be most successful when combined with community education through peer-to-peer, mass media and community education sessions.<sup>223</sup> Studies have shown social franchises are able to increase client volume and client satisfaction, and in some cases, they have also impacted client knowledge, attitudes, intentions and behavior.<sup>224</sup>

While social franchises have the potential to provide services to hard-to-reach populations, they are not always able to effectively do this. Some evidence shows that social franchises do not expand access to family planning services, but rather recruit providers away from other public or private facilities or shift users from one source of care to another.<sup>225</sup> Also, while social franchises may be able to provide services at a lower cost than other private facilities, their price points are often still too high for rural, poor populations.<sup>226</sup> More research is needed to understand what services, standards and prices are most effectively offered through social franchises, particularly for adolescents.

## OBJECTIVE 5: How to Increase Provision of Quality, Youth-friendly Services

In order for adolescents to effectively use family planning services, they must not only be logistically accessible, but they must also be of high quality and tailored to meet adolescents' unique needs. Providers must understand the nuances of adolescents' sex lives and be able to provide both counseling and the appropriate method to meet their need. A comprehensive and consistent method mix should be available, and providers should be able to explain how different methods work and their associated side effects. Family planning services should be private and confidential and be linked with other sexual and reproductive health services. Evidence suggests that programs that do all of these things increase both the

### **Information for Providers to Improve Quality of Services for Adolescents**

Many "youth-friendly" provider training curricula have been developed to enhance providers' technical, social and emotional skills for serving adolescent clients. A few of these curricula include:

**UNFPA/FHI:** Training Manual for Providers of Youth Friendly Services:

[http://egypt.unfpa.org/Images/Publication/2010\\_06/1a516311-653f-441e-9275-f875a58a6a3e.pdf](http://egypt.unfpa.org/Images/Publication/2010_06/1a516311-653f-441e-9275-f875a58a6a3e.pdf)

**Pathfinder International:** Cue Cards for Counseling Adolescents on Contraception

<http://www.pathfinder.org/publications-tools/cue-cards-for-counseling-adolescents-on-contraception.html>

**EngenderHealth:** Youth-Friendly Services: A Manual for Service Providers:

<http://www.engenderhealth.org/files/pubs/gender/yfs/yfs.pdf>

**IPPF:** Provide: Strengthening Youth-Friendly Services

<http://ippf.org/resource/Provide-Strengthening-youth-friendly-services>

general quality of reproductive health services, as well as the youth-friendliness of the services, as they respond to the specific needs and preferences of young people.

### Direct Approach: YOUTH-FRIENDLY SERVICES

In addition to addressing young people's barriers to access, many elements of "youth-friendly" service provision address quality of care (See Table 6). While adolescents can benefit from general service quality improvements, there are some elements that are specifically targeted to adolescents' needs. A recent systematic review encourages efforts to develop the existing infrastructure and build capacity within established facilities "rather than creating a parallel structure focused only on adolescents."<sup>227</sup> Programs that leverage partnerships with existing clinics to develop a network of youth-friendly service providers have found a dramatic increase in the number of youth seeking services at participating clinics.<sup>228</sup> Interventions that included other sectors, such as schools, have also been able to increase use of services.<sup>229</sup>

Providers need a detailed understanding of different contraceptive options in order to provide clients with comprehensive information and ensure informed choice. For providers, comprehensive technical and clinical trainings must be combined with strong counseling skills—especially those related to working with adolescents to understand their specific situations and be able to recommend a variety of options to meet their unique needs. This, in turn, will help adolescents to select the method that is best for them.<sup>230</sup> It is also crucial that providers understand the potential side effects related to each method and can clearly relay this to their clients. Adolescents often discontinue using a contraceptive method because they are ill-informed of the side effects – they may be concerned by missing a menstrual period or are discouraged by cramps and discomfort – so they must understand the normal, expected side effects in order to effectively continue using a method.<sup>231</sup> While not specific to adolescents, studies across a number of countries have found that providing doctors with training and information regarding quality counseling can increase method options offered and improve the comprehensiveness of information provided, leading to more informed choices made by clients, better follow-up over time and greater client satisfaction.<sup>232</sup>

In various studies, adolescent patients have ranked confidentiality and being treated with respect as two of their highest priorities when assessing the quality and youth-friendliness of reproductive health facilities and providers.<sup>233</sup> Providers should be trained to listen carefully to adolescents' needs and concerns, involve them in medical decisions and avoid placing unnecessary limitations on them because of their age. Young patients, like adults, should be treated as autonomous individuals, with a right to make decisions regarding their own reproductive health and care.<sup>234</sup>

It is important that providers consider the unique nature of each adolescent's sexual relationships and contraceptive needs when prescribing contraceptives.<sup>235</sup> Providers need to be adequately trained on the medical techniques and contraceptive options, counseling skills, and current, relevant legal

#### **Guatemala: Youth Providers - Addressing Objective 5**

*Tan Ux'il* in Guatemala recruited and trained young people (15-20) and staffed family planning clinics with them. These youth leaders inform, educate and raise awareness among their peers about responsible decision-making regarding sexual and reproductive health. The clinics have differentiated services supported by an interdisciplinary team sensitized in the care of adolescents. Through incorporating youth in service delivery, they have seen a dramatic rise in the number of youth served each week. Demand for more frequent and longer hours of operation has also increased. There has also been a growing demand for more such clinics (run by young people) throughout the country and *Tan Ux'il* is working with the Ministry of Health to execute this. (RTI International, 2010)

guidelines in order to provide high quality family planning services to adolescents.<sup>236</sup> As they also need to be responsive to the social and emotional needs of adolescents, interventions that utilize trained youth assistants have had some success.<sup>237</sup> Adolescents need to have access to a method that fits their needs, and in order for the method to be effective, adolescents need to be able to regularly obtain the method. Some adolescents may have short-term sexual relationships with multiple partners and may need dual protection from both STIs and pregnancy.<sup>238</sup> Clinics should therefore provide a range of reasonably priced contraceptive options to meet patients' needs.<sup>239</sup>

Finally, multi-component approaches can also be effective in increasing demand while simultaneously improving supply. Pathfinder's *Geração Biz* (Busy Generation) program in Mozambique has combined services and counseling, training of providers, school-based education that is linked with youth-friendly services, outreach to out-of-school youth, and empowerment for youth with life skills information to improve adolescent sexual and reproductive health outcomes. An evaluation of the pilot of *GeraçãoBiz* found that providers were well informed and were treating clients with respect; counseling and clinical services were of high quality; and there were significant increase in use of services by and distribution of condoms to adolescents.<sup>240</sup>

#### Direct Approach: NEW MEDIA

Increasingly, new media is being used to improve the quality of services by providing clients with reminders, social support and educational materials. While not specific to family planning, interventions that have used new media to provide health service appointment reminders and follow-up on services have been very effective. A study in China found that sending SMS reminders to clients regarding general health doctors' appointments led to a significant improvement in attendance.<sup>241</sup> Another found that using two-way communication, such as having a nurse text a patient, wait for a response and then follow-up accordingly, was most effective in optimizing patients' antiretroviral treatments.<sup>242</sup> While these examples come from different health fields, they may be applicable to family planning and reproductive health.

#### Direct Approach: COMMUNITY-BASED DISTRIBUTION

The most effective community-based distribution interventions are those built on existing networks, such as youth organizations and natural kinship, rather than creating new networks and infrastructure.<sup>243</sup> Such networks are able to focus their efforts more efficiently and achieve greater success without spending resources to construct a service delivery infrastructure. Because they work through trusted networks, community-distribution methods are often able to ensure the privacy and confidentiality that adolescents seek.<sup>244</sup> At the same time, however, such familiarity may diminish young people's perception of privacy and confidentiality, as discussed below.

#### Direct Approach: YOUTH CENTERS

While youth centers have the potential to increase the quality of services provided, these interventions rarely measure such changes. Most systematic reviews examining the provision of reproductive health services in youth centers focused on whether the interventions increased access and equity; in fact, few interventions addressed issues of quality of care other than issues of privacy and confidentiality. Issues of privacy and stigma were actually concerns raised by youth and staff; as other young people spend time at the youth center, space is often limited and the clinic areas on site are near the recreation facilities.<sup>245</sup> More research is needed to understand the role that youth centers can play in increasing the quality of adolescent family planning services.

### Direct Approach: VOUCHERS

To ensure that clients receive high quality service, voucher programs often require a minimum standard of service from contracted providers.<sup>246</sup> This can provide the benefit of improving quality of care for all patients who attend clinics that meet the requirements to participate in a voucher program. Vouchers also frequently provide information regarding patients' right to private, confidential care and guarantee that referenced services will meet these requirements—a consideration that is of particular value to many adolescents seeking family planning services.<sup>247</sup> A voucher program in Nicaragua found that patient satisfaction was higher for adolescent recipients of reproductive health vouchers than for adolescents in the control group who received care from non-voucher providers; continued monitoring of the contracted facilities showed sustained improvements in quality of service over time.<sup>248</sup> Meuwissen also found physicians at participating clinics demonstrated improved knowledge of contraceptives and ability to correctly diagnose STIs, further improving the quality of care.<sup>249</sup> Additional research is needed to further identify the potential for voucher programs to improve the quality of care provided to adolescents.<sup>250</sup>

### Direct Approach: SOCIAL FRANCHISES

Social franchises often contain a component of provider training, equipment upgrades and quality standards that should contribute to the provision of higher quality services. However, there has been little measurement of whether social franchises are able to actually increase service quality.<sup>251</sup> Further, as franchise networks grow, it can be difficult to monitor and maintain quality standards.<sup>252</sup> One study did find that private franchised clinics were of higher quality than non-franchised private services; however, the higher cost of these services made them less accessible.<sup>253</sup> Another study found that when a social franchise was specifically branded as providing services for adolescents and providers received training in youth-friendly service delivery, it was able to increase the number of adolescents seeking services.<sup>254</sup>

## E. Summary of What the Evidence Shows

There is a great deal of evidence regarding what works; hundreds of rigorous program evaluations have been conducted and several systematic reviews have synthesized the evidence on the effects of different programmatic approaches. However, many gaps and unknowns still remain. Much of this evidence is not sufficiently rigorous, and various evaluation findings present nuanced contradictions. As with so many other issues in global health, there is no singular programmatic approach or solution that is guaranteed to work; with so much depending on contextual factors, various approaches and combinations of approaches are necessary in different circumstances. Despite this challenge, several conclusions can be drawn from the evidence regarding which types of approaches and what specific components or characteristics of each work best to tackle the barriers to achieving the various objectives of adolescent family planning demand, access and use.

In general, interventions are better able to achieve improvements in knowledge and attitudes than in behavior.<sup>255</sup> Of those that are able to impact behavior, more are able to change contraceptive behavior than sexual behavior.<sup>256</sup> Programs that involve beneficiaries, such as adolescents, in program design are more successful than those that do not.<sup>257</sup> Programs that are able to increase contraceptive use usually have at least some health services component in the intervention.<sup>258</sup> On the whole, programs seem to be most effective when they combine education, improvement of services, and community outreach/mobilization to both inform community members about available services and to increase the acceptability of adolescents' use of family planning methods. Some of the most effective programs include educational interventions, mass media, interpersonal/peer-to-peer communication and outreach, conditional cash transfers (CCTs), improvements of health services, and, importantly, multi-component interventions that include a combination of these interventions.

Some of the interventions that have been most successful in achieving **Objective 1** are indirect approaches that increase school enrollment, thereby contributing to a delay in marriage and pregnancy. Programs that offer CCTs, incentives or support in the form of school uniforms and supplies have been found to lower barriers to attending school and increase the opportunity cost of missing school and getting pregnant.<sup>259</sup> While the evidence base is thinner regarding youth development programs, these have been proven to build adolescents' self-confidence and provide them with more life opportunities, which indirectly discourage early marriage and pregnancy.<sup>260</sup>

For **Objective 2**, both informational and mass media programs have been successful in both providing adolescents and community members with information regarding adolescent reproductive health and family planning methods, and in increasing the social acceptability of contraceptive use by adolescents. For school-based educational programs to have a positive impact, they must have specific characteristics, and teachers need to be suitably trained and feel comfortable with the material.<sup>261</sup> Mass media programs that target specific contraceptive method use and deliver messages through multiple media channels, including the Internet, mobile phones and social networking services, have been most successful.<sup>262</sup> These programs show a greater impact when they address gender norms, including those that shape boys' notion of masculinity and limit girls' control over sex, as well as those that pressure girls to quickly and frequently produce children.<sup>263</sup>

Informational programs, specifically peer-to-peer education interventions, have been most successful at enabling adolescents to achieve **Objective 3** by increasing their communication and negotiation skills to discuss their reproductive desires.<sup>264</sup>

While there is some evidence around the use of community-based distribution, vouchers and social franchises to increase adolescents' access to family planning methods and achieve **Objective 4**, more research is needed. Programs that work within existing health facilities to make them more youth-friendly—by creating hours that are convenient for adolescents, reasonable waiting times, and affordable fees—have been successful in increasing uptake of services, but only in combination with other supporting interventions.<sup>265</sup> Similarly, to achieve **Objective 5**, programs should focus on working within existing health facilities. Services are most successful when they increase their “youth-friendliness” by training providers how to both technically and socially respond to adolescents' needs, ensure privacy, confidentiality and respect for adolescent clients, and have a consistent supply of multiple methods.<sup>266</sup> Specifically, vouchers have shown some success in increasing the privacy and confidentiality of services, as well as in improving providers' competence in providing needed services and counseling.<sup>267</sup>

Finally, and perhaps most importantly, programs that involved multiple components of demand creation and social norm change, service improvements and promotion and education around available services were most effective and had a greater impact than any of these programmatic components on their own.<sup>268</sup>

## Gaps in Programming and in the Evidence Base

The field has made important strides toward developing, testing and evaluating approaches to improve adolescents' demand for and access to family planning information and services. Despite these efforts and what we have learned about "what the evidence shows," there remain a number of important gaps. Below, we outline several overarching gaps, as well as those related to the evidence base for each of the five objectives and the goal in our conceptual model.

***Table 6: Gaps in Programming and Evidence***

Objectives	(1) Desire to avoid/delay/space/limit childbearing	(2) Desire to use family planning	(3) Agency to use family planning	(4) Access to family planning services	(5) Provision of quality, youth-friendly services	Sustained, effective use of family planning
Overall Gaps	<ul style="list-style-type: none"> <li>• Rigorous, longer-term evaluations</li> <li>• How to most effectively delay first birth, including through delaying early marriage</li> <li>• How to most effectively delay or space pregnancies after first birth</li> <li>• Studying positive deviants to identify replicable characteristics</li> <li>• Reducing vulnerability to risky sexual behavior</li> <li>• Research disaggregated by different sub groups of adolescents, i.e., younger/older, urban/rural, in-school/out-of-school, married/un-married</li> <li>• How changes in adolescent fertility are related to other developmental outcomes</li> <li>• Evaluation of different program components</li> <li>• Better understanding of adolescents' reproductive needs, desires, barriers and intentions</li> <li>• Context-specific factors that contribute to adolescent fertility intentions and practice</li> <li>• Cost-effectiveness information</li> </ul>					
Gaps	<ul style="list-style-type: none"> <li>• Understanding "wanted" pregnancy</li> <li>• What works to change norms around motherhood, family size, girls' roles, timing of births</li> <li>• Delaying marriage</li> <li>• School enrollment and retention policies</li> <li>• CCTs— What works best and how?</li> <li>• How mass media can be used to change social norms</li> </ul>	<ul style="list-style-type: none"> <li>• How to address/change social norms around adolescent family planning use</li> <li>• Couple communication</li> <li>• Partner support</li> </ul>	<ul style="list-style-type: none"> <li>• How to better link changes in knowledge and attitudes and changes in behavior</li> <li>• Underlying social inequalities</li> <li>• How to increase adolescents' ability to articulate reproductive health desires</li> <li>• Coercion and violence</li> <li>• Male involvement</li> </ul>	<ul style="list-style-type: none"> <li>• Policies &amp; regulations</li> <li>• Effective infrastructure interventions</li> </ul>	<ul style="list-style-type: none"> <li>• Translating policies into practice</li> <li>• What types of youth-friendly services are most effective</li> <li>• Targeted training and services</li> <li>• Improved, desired method selection</li> </ul>	<ul style="list-style-type: none"> <li>• Why method failure and discontinuation</li> <li>• Long-term effects of interventions during adolescence (including early adolescence)</li> </ul>

### **A. Overall Gaps**

Given the tremendous needs that exist and the paucity of research that addresses the varied needs of diverse adolescents, various types of social science, operations and implementation research, testing and scaling-up are needed.<sup>269</sup> Specifically, there remains an important gap in regard to **rigorous, long-term impact evaluations** that document what strategies are most effective in preventing, delaying, spacing and limiting pregnancies, both for married and unmarried adolescents, as well as in understanding the protective factors that reduce unwanted and/or unsafe pregnancy for adolescents.<sup>270</sup> For example, in areas where rates of adolescent pregnancy are high, research could look at "**positive deviants**" to determine protective and resiliency factors.<sup>271</sup> Additionally more research is needed on methods that reduce adolescent's **vulnerability to risky sexual behavior** and poor reproductive health outcomes. Moving the field forward on these questions will require dedicated research using

longitudinal studies that allow for greater rigor, as well as attention to shifting desires and challenges throughout the **life course**.<sup>272</sup> Such studies will also allow for more nuanced analysis of the specific needs and varying effects of interventions on **subgroups** of adolescents (e.g. sex, age, marital status, socio-economic status, level of schooling, rural/urban residence). Longitudinal studies could provide compelling evidence about the **linkages between adolescent fertility and an array of development measures** such as: labor participation, income, productivity, and inter-generational patterns of marriage, fertility, etc.<sup>273</sup>

In assessing what works, it is also critical to **document why these approaches work**. There is a key gap in current program evaluations in delineating the relative contribution of each component of an intervention toward the intended outcomes.<sup>274</sup>

**Formative research** prior to developing interventions is essential to document and respond to the diversity and complexity of the needs, desires, barriers and reproductive intentions of adolescents in diverse sociocultural contexts.<sup>275</sup> By investing adequate resources in such **context-specific research**, intervention designs will be more closely aligned with the causes of adolescent fertility and better positioned to implement strategies that effectively address these.<sup>276</sup> Ideally, this gap will be filled with research that uses participatory approaches, placing adolescents in the role of active informants, rather than passive subjects.<sup>277</sup>

Very little attention has been paid to **assessing the cost-effectiveness of interventions** that aim to improve adolescent reproductive health.<sup>278</sup> From a programming and policy perspective, it is important to not only document what works in achieving the intended results, but also to compare the costs for producing a given effect. The collection and analysis of such data will allow for a concrete comparison of interventions across different contexts and will provide an objective assessment of each intervention's value for money.

#### **OBJECTIVE 1- Desire to Prevent, Delay, Space or Limit Childbearing: Gaps**

Understanding the motivations and restrictions adolescents face in terms of their reproductive behavior remains a critical gap in our ability to deliver effective programming that meets the needs of adolescents. As discussed above, the concept of **wanted or unwanted pregnancies** is far more nuanced than is often assumed by researchers and programmers, with the desires of adolescents often in a state of flux, varying depending on the specific contexts in which they find themselves, and strongly influenced by prevailing normative beliefs about gender-appropriate behaviors. More work is needed to understand what the real desires of adolescents are. In particular, we need to better understand the specific norms that influence reproductive preferences and how these change as adolescents age, begin the process of forming their own families and start to develop more concrete plans for their lives.<sup>279</sup>

More research is needed to identify and understand the **factors that make programs successful in challenging social norms** that encourage less healthy behaviors, such as early marriage, early pregnancy and inadequate spacing between births. In particular, it is critical to identify those interventions that successfully challenge gender norms around family formation, specifically norms that value girls' sexual ignorance and place an undue burden on "protecting" the virginity of girls, as these both place girls at greater risk and directly lead to harmful practices.<sup>280</sup> Identifying programmatic approaches that have been successful in changing these norms and in delivering information to adolescents on the benefits of delaying and spacing fertility remains an important area for additional research. Similarly, more research

is needed to better understand the most effective approaches in preventing **child marriage** and the broader implications this has for reproductive outcomes such as early and frequent pregnancies, unplanned pregnancy and the health of both mothers and children over time.

The strong association between schooling and improved reproductive health outcomes, particularly for girls, suggests that programs that effectively improve school attendance and retention are likely to have an effect on desired childbearing, among other factors. Better understanding of the **causality in the school-pregnancy relationship**, as well as of which **programmatic or policy approaches are most effective at increasing attendance and retention**, particularly for girls, remains a critical area for future research. One particularly promising approach to this has been the use of conditional cash transfers, however, more research is needed to understand why these appear to work, their cost-effectiveness and the importance of the conditionality aspect of the approach (e.g. which conditions work best, what level of incentive is required, and in which settings an unconditional transfer would be more appropriate).<sup>281</sup>

Finally, the use of **mass media to change social norms** around reproductive behavior and educate about safe behaviors appears to have great promise. However, it remains unclear to what degree these programs are actually effective in changing behaviors, what time frame is required for change, how cost-effective they are, and whether they are able to reach the more marginalized sectors of the population. Rigorous evaluations of such programs, including over longer periods of time, can better explicate these factors.

## **OBJECTIVE 2- Desire to Use Family Planning: Gaps**

The decision to use family planning is complex and is based on a number of overlapping goals, preferences and beliefs. Underlying this process are larger social norms guiding sexual and reproductive behavior, which are enforced through broader social mechanisms such as stigmatization of those who violate these norms. Adolescents in particular are subject to a number of overlapping norms related to their gender, age, marital status etc., and as such, are especially sensitive to the social consequences of non-normative behaviors, such as seeking out or using contraception. While the role of normative rules and sanctions in shaping behavior is well understood at a conceptual level, there remains little consensus as to what is the most effective way to **help adolescents both address and overcome social sanctions around their reproductive behavior**. Efforts to create youth-friendly services are a necessary step in terms of reducing the stigmatization of adolescents who seek family planning, but, as discussed above, this must be accompanied by other changes as well.

In addition to the broader influence of social norms governing reproductive behavior, family planning use is strongly influenced by many micro factors, such as the nature of the relationships that adolescents engage in. Adolescents are particularly vulnerable in terms of relationships, as they are typically just beginning their romantic and sexual lives, often are significantly younger than their partners and have little or no experience within relationships. Relatively little work has been done to assist adolescents in negotiating this period of their lives, and even less has been done to work directly with the romantic or sexual partners of adolescents. Furthermore, social norms may make effective communication about sexual matters particularly challenging for adolescents. **Understanding how adolescent couples communicate and negotiate** use of family planning is a glaring gap in the evidence base.

### OBJECTIVE 3- Agency to Use Family Planning: Gaps

The importance of promoting greater agency among adolescents to use family planning to achieve their reproductive intentions cannot be overstated. Yet much of the existing research focuses on changes in attitudes (in the short-term) or in family planning use (in the long-term). The **chasm between knowledge and behavior** is widely acknowledged, but the most promising approaches for overcoming this gap remain inadequately documented.<sup>282</sup> A primary question for additional research is how agency changes over the life-course, and what works best to optimize agency, starting in adolescence. This would include investigation of key areas of **interpersonal communication**, such as: how to improve safe, two-way communication between adolescents and their sexual partners/spouses about their reproductive desires; what works to promote **adolescents' articulation of their family planning desires** and needs to service providers; and whether and how interventions can address coercive behaviors and sabotage of family planning methods.<sup>283</sup> In the same vein, we need to know more about the types of interventions (and policies) that effectively reduce the acceptance and **practice of sexual, physical and emotional partner violence**, which inhibits women from expressing and acting on their reproductive desires.<sup>284</sup> It is also critical to document how fostering effective communication about reproductive health among peers, and between parents and adolescents, influences reproductive health outcomes and adolescents' sense of self-efficacy for acting on their intentions. Better documenting whether and how peer-to-peer education programs can increase adolescents' agency to act on reproductive desires is one example of an area in need of further research. While we know that it is important to **involve men and boys**, more research is needed to understand *how* to do so effectively to achieve better reproductive health outcomes for both males and females.

### OBJECTIVE 4- Access to Family Planning Services: Gaps

The potential role that governmental or institutional policy, including innovative financing mechanisms, can play in addressing the needs of adolescents in terms of access to family planning services is very significant. However, while policies such as lifting requirements for parental consent, requiring youth-friendly policies at clinics, or providing subsidies for services may have the potential to increase use, the degree to which these policies affect real 'on-the-ground' access is often unclear. Furthermore, there is little consensus on what the most important policy actions may be or whether the adoption of policies at the governmental level is more or less effective than focusing on policy changes at the more micro-level, such as within individual hospitals or clinics. Further research that can provide policy-makers with clear recommendations about both *what* policies are most effective in terms of encouraging use of family planning by adolescents and *how* to effectively implement these policies is needed. Country-level studies comparing laws and policies that are 'on the books' with their actual implementation 'on the ground' may be a useful way to address this question in the short-term. Further research is also needed to understand what types of **infrastructure interventions**, within existing services or in mobile or independent sites, will improve adolescents' access to family planning services.

### OBJECTIVE 5 - Provision of Quality, Youth-friendly Services: Gaps

While there is broad agreement that youth-friendly services should contribute to increased use of family planning among adolescents, the evidence for this is inconclusive. This is partly due to **inconsistent definitions of what constitutes "youth-friendly"** services and **inconsistent application of policy and**

**programs.** Much more research is needed to understand what **types of youth-friendly services** are most effective in terms of increasing access to family planning for adolescents, how youth view these services, and what specific barriers adolescents encounter to using these services. Specifically, more research is needed to understand what types of provider **training** programs best prepare them to serve adolescent clients, and what specific **services** adolescents demand most. Furthermore, it is critical that these services actually meet adolescents' perceived needs, meaning that achieving a clear understanding of those needs continues to be a critical research area. For example, while there have been increasing efforts to encourage the use of long-action reversible contraceptive methods among adolescents, these efforts have not been informed by research with adolescents to understand whether these **methods best suit their desires or needs**, or how these desires and needs may vary depending on age, relationship status or family formation stage, for example.

Along these lines, there is little agreement about what types of youth-friendly services are most likely to reach truly marginalized adolescent populations, including those in rural areas, married adolescents, out-of-school youth and disabled youth.<sup>285</sup> Finally, more research is needed regarding the specific impact of programs outside the formal health sector, such as school-based comprehensive sexuality education, on use of family planning over the long-term.

#### **Overarching Goal - Sustained, Effective Use of Family Planning: Gaps**

As discussed above, contraceptive failure and discontinuation rates are particularly high among adolescents, greatly reducing the efficacy of any contraceptive use and increasing the likelihood of unplanned pregnancy. While ineffective use of contraception by adolescents is a global phenomenon, there remains little consensus as to why adolescents are particularly effected. While the reasons are likely to be context-specific, more research is needed that focuses specifically on understanding why this happens and what steps are most effective at increasing fidelity to contraceptive regimes. For example, failure rates may be particularly high for certain methods. Is this due to the particular characteristics of that method, the fact that side effects had not been explained to them, the perception that they are not able to change methods after starting one, or does it simply not meet the needs of adolescents in some way? More broadly, the field requires greater understanding of the changing family planning needs and desires of adolescents as well as the **longer term effects** of interventions as they grow through this important development stage of life.

## **Conclusions and Recommendations**

This analysis provides a synthesis of the evidence base in regard to interventions that have worked, directly or indirectly, to impact the family planning knowledge, attitudes and practices of adolescents in the developing world. While we have only scratched the surface in terms of understanding the various advantages and limitations of the unique and diverse interventions implemented over the years, we feel confident that there is a path forward. This path leads toward creating a more supportive environment that enables youth to overcome the “demand-side” and “supply-side” barriers to more effectively and sustainably use family planning to reach their fertility desires over the course of their lives.

There is a great deal of evidence about what works to empower adolescents to reach their fertility desires over the course of their lives. However, many gaps and unknowns still remain. Much of the existing evidence is not sufficiently rigorous, and various evaluation findings present nuanced contradictions. As with many other issues in global health, there is no singular programmatic approach or solution that is guaranteed to work; with so much depending on contextual factors, various approaches and combinations of approaches are necessary in different circumstances. Despite this challenge, several conclusions can be drawn from the evidence regarding which types of approaches and what specific components or characteristics of each work best to tackle the barriers to achieving various objectives of adolescent family planning demand, access and use. We have tried to present those conclusions in this brief.

First, adolescents are a critical group that must be considered in designing and implementing reproductive health programs, including those which seek to expand the use of family planning. We believe that to be most effective, to most accurately reflect their needs and desires, and to respect their rights, adolescents should be involved in the design and implementation of programs that affect them. To further advance the field and the evidence base, we offer several recommendations.

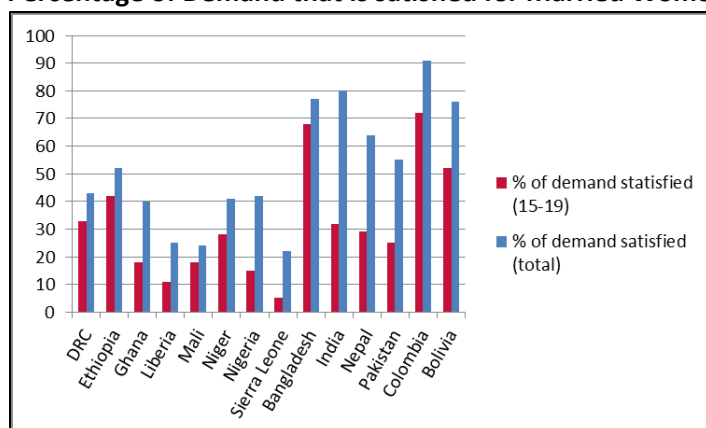
- 1) The reproductive health outcomes from interventions with adolescents may not be as readily visible as they would be with older cohorts. While recognizing that short-term investments can, in themselves, be tremendously valuable contributions toward improving the sexual and reproductive health of adolescents, **donors should also invest in long-term studies** that capture the results of interventions with adolescents over time, as their needs and fertility desires change. Where longitudinal studies may be challenging and resource-intensive, donors can **leverage existing or past program data** about program participants to understand the long-term effects of an intervention.
- 2) **Implementation research** that elucidates *how and why* certain programs are successful in certain places can help the field better understand whether particular interventions or program elements can be replicated and/or scaled up. This could apply to interventions that aim to influence both the “demand-side” and “supply-side” factors.
- 3) Future research should consider **multi-component interventions**, such as combining mass media programming and capacity building for local organizations with youth-friendly health services. This approach would enable analysis of programs that work on both demand and supply sides.
- 4) All programmatic interventions aimed at influencing adolescent sexual and reproductive health outcomes should strive to include a substantial **monitoring and evaluation** framework and strategy

from the beginning, so that the field can better capture and learn from the differential impacts of the various elements of interventions.

- 5) Advocacy is needed in both donor and developing countries to improve the relationship between articulated **policies and their implementation** in practice. Two examples follow:
  - a. **Comprehensive sexuality education (CSE)** with certain key characteristics can have positive impacts on reproductive health knowledge, attitudes and practices, including family planning; and school-based CSE has the potential to reach a significant proportion of adolescents, including very young adolescents. However, while many governments note the importance of CSE and have policies on the books pertaining to it, very few are investing adequately in it, and fewer yet utilize evidence-based curricula and/or training programs to build teacher capacity.
  - b. In many countries, governments' statements, policies and plans regarding **adolescents' access to contraception** are forward-thinking, but in practice, many government-supported service providers are reluctant to provide contraception to unmarried youth. Research in select countries on these inconsistencies can build evidence to inform country-level advocacy and policy change that has the potential to foster large-scale change in the short-term.
- 6) There are 70 million girls under the age of 18 who are currently married, and 14.2 million more are married each year. **Addressing child marriage** therefore has the potential to significantly impact family planning and other reproductive health outcomes. Within the context of addressing the social norms needed to improve all of the demand-side factors addressed in this paper, donors and implementers should work to prevent early marriage, and better understand how delaying marriage impacts first birth. At the same time, understanding how best to support married girls, including helping them to delay and/or space first, second and third pregnancies, would serve as a critical contribution to the field.
- 7) Finally, this study has demonstrated the tremendous need for **sharing data, information and resources** regarding adolescent reproductive health amongst a wide range of donors, researchers and implementing agencies. We hope that this report is but one contribution toward that goal.

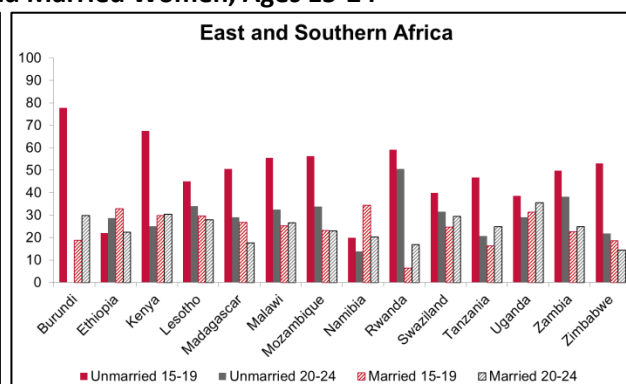
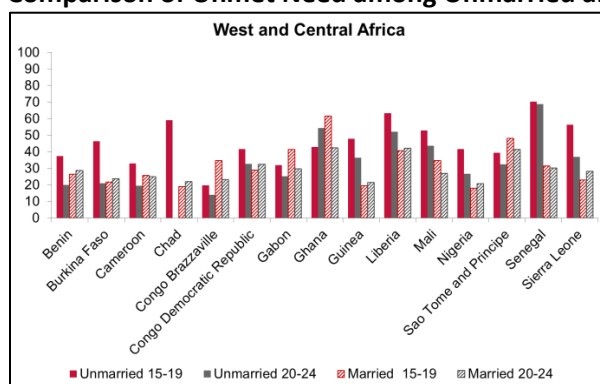
## Annex: Unmet Need

### Percentage of Demand that is satisfied for Married Women, by Age



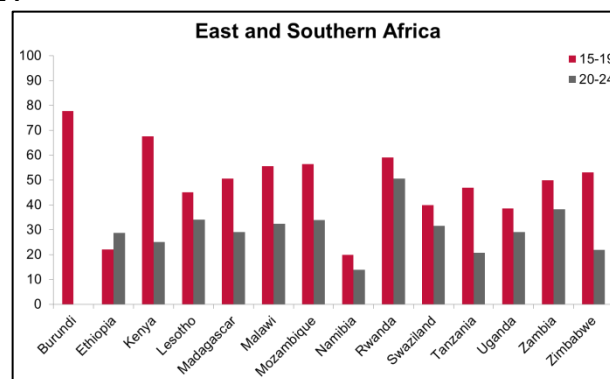
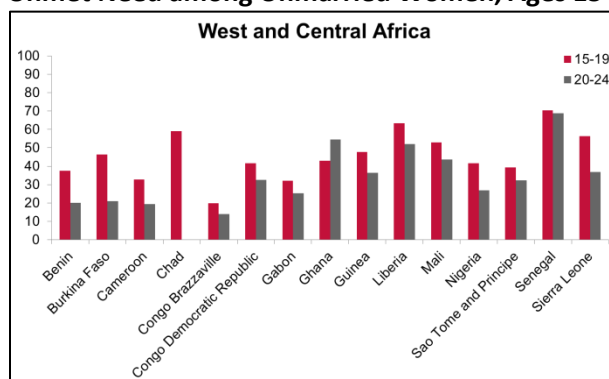
SOURCE: DHS Data (Presler-Marshall & Jones, 2012)

### Comparison of Unmet Need among Unmarried and Married Women, Ages 15-24



SOURCE: (MacQuarrie, 2014)

### Unmet Need among Unmarried Women, Ages 15-24



SOURCE: (MacQuarrie, 2014)

## Endnotes

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- <sup>4</sup> McCleary-Sills, McGonagle & Malhotra, 2012; Malhotra & Shuler, 2005; Bongaarts, 2008
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<sup>254</sup> Gay, Croce-Galis & Hardee, 2012  
<sup>255</sup> Speizer, Magnani & Colvin, 2003; McQueston, Silverman & Glassman, 2012; James-Traore et al, 2009; Kim & Free, 2008  
<sup>256</sup> McQueston, Silverman & Glassman, 2012  
<sup>257</sup> UNFPA, 2007; Kesterton & de Mello, 2010  
<sup>258</sup> McQueston, Silverman & Glassman, 2012  
<sup>259</sup> UNFPA, 2007; James-Traore et al, 2009; McQueston, Silverman & Glassman, 2012  
<sup>260</sup> Gavin, Catalano & Markham, 2010; Speizer, Magnani & Colvin, 2003  
<sup>261</sup> Gay et al, 2010; Kirby, Laris & Rolleri, 2007; UNAIDS Inter-Agency Task Team on Young People, 2006; Mwaikambo et al, 2011  
<sup>262</sup> UNAIDS Inter-Agency Task Team on Young People, 2006  
<sup>263</sup> UNFPA, 2007; James-Traore et al, 2009  
<sup>264</sup> UNFPA, 2007; James-Traore et al, 2009  
<sup>265</sup> Bearinger et al, 2007; UNAIDS Inter-Agency Task Team on Young People, 2006; Gay, Croce-Galis & Hardee, 2012; UNFPA, n.d., Youth friendly sexual and reproductive health services  
<sup>266</sup> Gay, Croce-Galis & Hardee, 2012; Mwaikambo et al, 2011; Bankole & Malarcher, 2010  
<sup>267</sup> Mwaikambo et al, 2011; Meuwissen et al, 2006a  
<sup>268</sup> Mwaikambo et al, 2011; Oringanje, 2009; UNAIDS Inter-Agency Task Team on Young People, 2006  
<sup>269</sup> Askew & Brady, 2013  
<sup>270</sup> McQueston, Silverman & Glassman, 2012; Hindin, Christiansen & Ferguson, 2013  
<sup>271</sup> Hindin, Christiansen & Ferguson, 2013  
<sup>272</sup> WHO, 2011  
<sup>273</sup> McQueston, Silverman & Glassman, 2012  
<sup>274</sup> UNAIDS Inter-Agency Task Team on Young People, 2006  
<sup>275</sup> Askew & Brady, 2013; Kirby, Laris & Rolleri, 2006  
<sup>276</sup> Bearinger et al, 2007; McQueston, Silverman & Glassman, 2012, Gay et al, 2010  
<sup>277</sup> McCleary-Sills et al, 2011  
<sup>278</sup> UNAIDS Inter-Agency Task Team on Young People, 2006; Speizer, Magnani & Colvin, 2003; Hindin, Christiansen & Ferguson, 2013  
<sup>279</sup> DiCenso et al, 2002; McCleary-Sills, McGonagle & Malhotra, 2012; Presler-Marshall & Jones, 2012  
<sup>280</sup> Gay et al, 2010  
<sup>281</sup> WHO, 2011  
<sup>282</sup> Haider & Sharma, 2013  
<sup>283</sup> Clark et al, 2008; Miller et al, 2010  
<sup>284</sup> Gay et al, 2010  
<sup>285</sup> Hindin, Christiansen & Ferguson, 2013; WHO, 2011

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