

Knowledge Brief

Health, Nutrition and Population Global Practice

SOCIOECONOMIC DIFFERENCES IN ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH: FAMILY PLANNING

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KEY MESSAGES:

- Safe and effective modern contraceptive methods prevent unplanned pregnancies and barrier methods can reduce sexually transmitted infections, including HIV.
- We found that the level of modern contraceptive use among adolescent women is low (below 10 percent) in all six countries studied, except for among ever-married adolescent women living in Bangladesh, Ethiopia, and Nepal.
- Contraceptive use is higher among married adolescents in urban areas in Bangladesh, Ethiopia, and Nepal, ranging from 26 percent among married, urban adolescent women in Nepal to 52 percent among their counterparts in Bangladesh.

Introduction

Adolescent Sexual and Reproductive Health (ASRH) is one of five areas of focus of the World Bank's Reproductive Health Action Plan 2010–2015 (RHAP), which recognizes the importance of addressing ASRH as a development issue with important implications for poverty reduction. Delaying childbearing and preventing unintended pregnancies during adolescence has been shown to improve health outcomes and increase opportunities for schooling, future employment, and earnings (Greene and Merrick, 2005).

Safe and effective modern contraceptive methods prevent unintended pregnancies and barrier methods can reduce sexually transmitted infections, including HIV, yet past research has found a high unmet need for contraception among adolescents in developing countries (Blanc, Tsui, Croft, and Trevitt, 2009; Chandra-Mouli, McCarragher, Phillips, Williamson, and Hainsworth, 2014; Prata,

Weidert, and Sreenivas, 2013). Adolescents face many barriers to obtaining contraceptives, including legal restrictions and social stigma against providing contraceptives to adolescents (Chandra-Mouli, et al., 2014; Williamson, Parkes, Wight, Petticrew, and Hart, 2009). Even when contraceptives are available to unmarried adolescents, social norms and lack of knowledge act as barriers to their use (Chandra-Mouli, et al., 2014. Marston and King, 2006; Williamson, et al., 2009). Relatively little is known about barriers to contraceptive use among married adolescents.

Regional data on the contraceptive prevalence rate between 2000 and 2011 indicates that among 15–19 year old girls who are married or in a union, 15 percent use contraception in South Asia; 16 percent in Sub-Saharan Africa; 41 percent in East Asia and the Pacific; and 53 percent in Latin America and the Caribbean (UNFPA, 2012).

This brief is part of a larger study whose overall purpose is to: (i) highlight the multi-sectorial determinants of ASRH outcomes; (ii) explore further the multisectoral supply- and demand-side determinants of access, utilization, and provision of services relevant to identified ASRH outcomes; and (iii) identify multisectoral programmatic and policy options to address critical constraints to improving ASRH outcomes. The goal is to incorporate the main findings and recommendations from these studies into existing and new World Bank lending operations while simultaneously informing ASRH policies, policy dialogue and interventions for inclusion in country strategies.

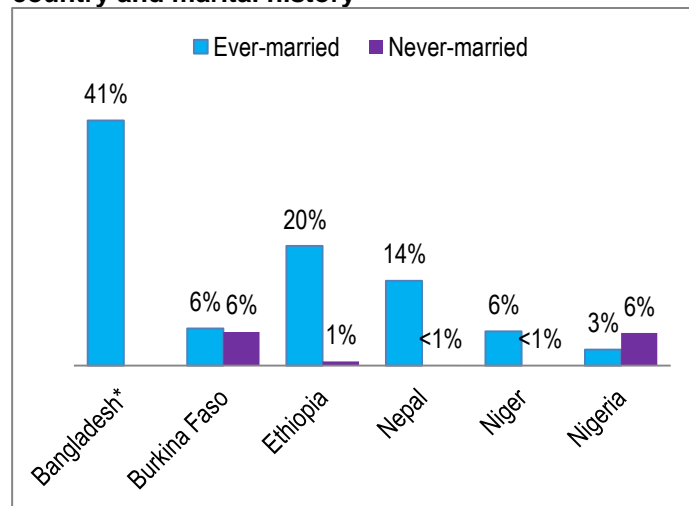
Using data from the most recent Demographic and Health Surveys (DHS) on female respondents aged 15–19, this brief examines the current status of adolescent use of family planning, and compares adolescent family planning use by socioeconomic status (SES) in 6 countries: Bangladesh, Burkina Faso, Ethiopia, Nepal, Niger, and Nigeria.

Cross tabulations between socioeconomic characteristics and family planning outcomes for never-married and ever-married adolescent women within each country were completed if at least 10 percent of the subpopulation (for example, never-married women in Nepal) reported family planning outcomes. Pearson’s chi-squared tests were used to assess the statistical significance of differences in family planning outcomes by rural/urban residence, education level, employment status, and household wealth quintile. Only differences significant at the 0.05 level (two-tailed tests) are discussed in this brief and all data are weighted.

Study Findings

Figure 1 presents the percentage of ever-married and never-married adolescent women who are currently using a modern contraceptive method, including oral contraceptives, intrauterine devices (IUD), injections, diaphragms, condoms, female sterilization, male sterilization, implants, lactational amenorrhea, female condom and foam/jelly. Use of a modern contraceptive method is most common among ever-married women in Bangladesh (41 percent), followed by Ethiopia (20 percent) and Nepal (14 percent). Less than 10 percent of ever-married women use a modern contraceptive method in Burkina Faso, Niger, and Nigeria.

Figure 1. Percentage of women aged 15–19 who currently use a modern contraceptive method, by country and marital history

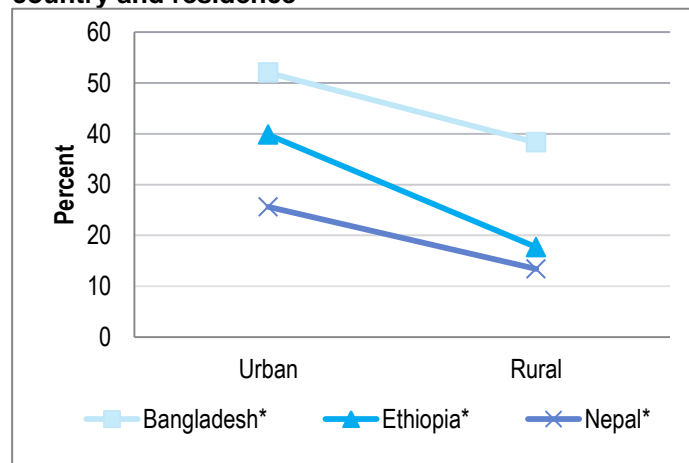


*Only ever-married women were surveyed in Bangladesh.
Source: Bangladesh DHS 2011; Burkina Faso DHS 2010, Ethiopia DHS 2011, Nepal DHS 2011, Niger DHS 2012, Nigeria DHS 2008.

Among never-married women, almost none (1 percent or less) are using a modern contraceptive method in Ethiopia, Nepal, and Niger. About 6 percent of never-married women are using a modern contraceptive method in Burkina Faso and Nigeria.

Socioeconomic differences were found in the use of modern contraceptive methods for ever-married women in Bangladesh, Ethiopia, and Nepal. In all three countries, the percentage of ever-married adolescent women who currently use a modern contraceptive method is higher in urban than rural areas (Figure 2).

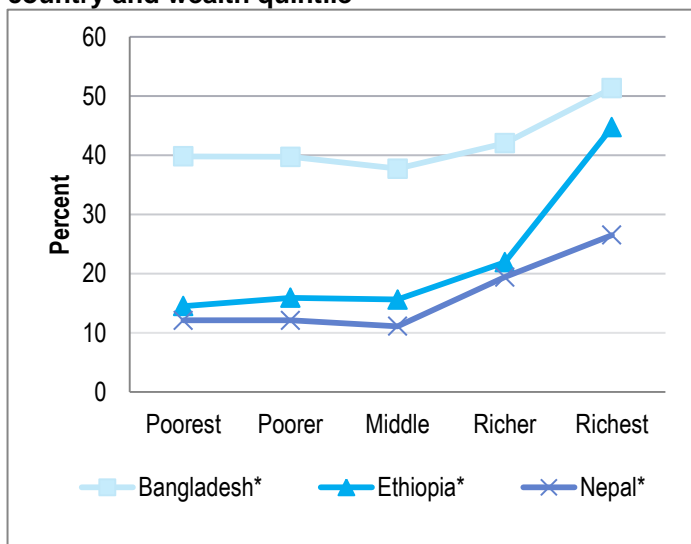
Figure 2. Percentage of women aged 15–19 who currently use a modern contraceptive method, by country and residence



*Statistically significant difference (p<.05)
Source: Bangladesh DHS 2011; Ethiopia DHS 2011, Nepal DHS 2011.

In Bangladesh, Ethiopia, and Nepal the percentage of ever-married adolescent women who currently use a modern contraceptive method varies little across the poorest, poorer, and middle-income households (Figure 3). However, the use of modern contraceptive methods increases for ever-married adolescent women in the top two wealth quintiles. The wealth differential is particularly dramatic in Ethiopia where 45 percent of ever-married adolescent women from the richest households use a modern contraceptive method, compared with 22 percent of those from richer households and 15 percent of those from the poorest households.

Figure 3. Percentage of women aged 15–19 who currently use a modern contraceptive method, by country and wealth quintile

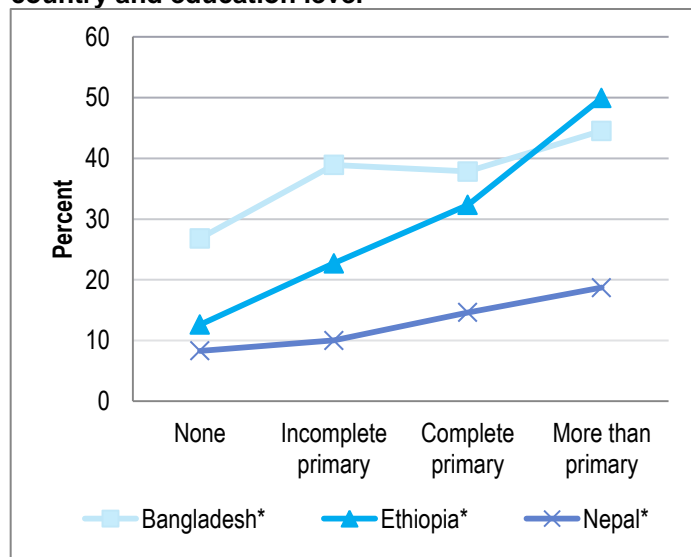


*Statistically significant difference ($p < .05$)
Source: Bangladesh DHS 2011; Ethiopia DHS 2011, Nepal DHS 2011.

In Bangladesh, Ethiopia, and Nepal, the percentage of ever-married adolescent females who currently use a modern contraceptive method increases with higher education levels (Figure 4). The education disparity is greatest in Ethiopia where 13 percent of ever-married adolescent women with no education use a modern contraceptive method, compared with 50 percent of those who have obtained education beyond primary school. The education gap in modern contraceptive use (and the overall rate) is substantially smaller in Nepal; 12 percent of ever-married women with no education in Nepal use a modern contraceptive method, compared with 27 percent of those with more than primary education.

In Ethiopia, ever-married adolescent women who are working are more likely to use modern contraceptive methods than their unemployed counterparts (29 percent versus 18 percent).

Figure 4. Percentage of women aged 15–19 who currently use a modern contraceptive method, by country and education level



*Statistically significant difference ($p < .05$)
Source: Bangladesh DHS 2011; Ethiopia DHS 2011, Nepal DHS 2011.

Policy Challenges

Most young people become sexually active during adolescence, however contraceptive use is generally low, particularly among adolescents from rural and poor areas, and with low levels of education. The barriers that young people face with contraception include, among others, a lack of access to and information about affordable family planning services, social and cultural norms, and restrictive legislation for adolescents. These barriers contribute to high rates of unplanned pregnancies, sexually transmitted infections, abortions, and maternal and neonatal morbidity and mortality. Promoting contraceptive access and use has health and economic benefits, including maternal health and child survival, poverty alleviation, and female empowerment. The WBG is working to improve ASRH through its RHAP by supporting better access to, and provision of, affordable ASRH services and strengthening monitoring and evaluation of these services and interventions. Post-2015, the WBG is working to ensure Universal Health Coverage (UHC) of SRH by helping countries to build healthier, more equitable societies. To do this requires the following, adapted to each country's unique needs:

- Scaling up the most effective ways to incentivize demand for ASRH, including family planning at the country level
- Delivering on the continued need to strengthen country capacity

- Leveraging the WBG's multisectoral advantage to improve ASRH outcomes, including SRH as a tool for women's empowerment
- Reaching the poorest, marginalized, and vulnerable populations to facilitate access to health services and promote UHC and equity

Conclusion

This brief highlights the limited contraceptive use among adolescent women and the socioeconomic disparities in family planning among this population. The results indicate the importance of investing in programs aimed at increasing access to safe and effective contraceptive methods and expanding adolescents' knowledge of modern contraception, particularly among adolescent women in rural and poor areas and/or those with limited or no education, regardless of marital status.

Further research is needed to understand the extent to which socioeconomic disparities in adolescent contraceptive use are driven by barriers to accessing contraceptives, social norms, and/or limited desire to use contraception among some segments of the population. Clearly, intentions to become pregnant may be strongest among adolescent women who are recently married and socially disadvantaged, given the relative lack of competing opportunities available to them. In addition, as the socioeconomic characteristics examined in this brief are interrelated, further research is needed to understand the relative influence of each one on adolescent family planning behavior. Continued investment should be made in female education and empowerment as a means to reach economic development goals, as well as related goals, such as an increase in adolescent contraceptive use to reduce the incidence of unplanned pregnancies.

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