Knowledge Brief

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CHALLENGES FOR ADOLESCENT'S SEXUAL AND REPRODUCTIVE HEALTH WITHIN THE CONTEXT OF UNIVERSAL HEALTH COVERAGE

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KEY MESSAGES:

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

Introduction

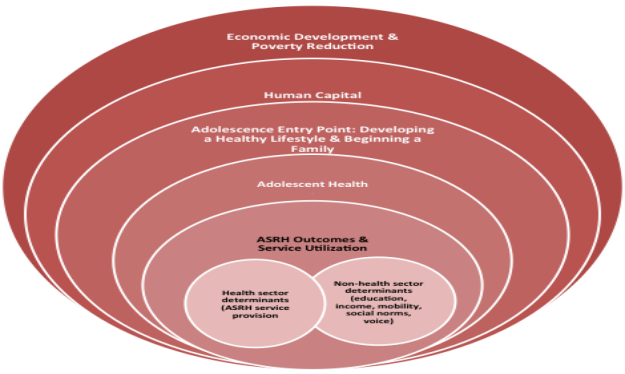
Young people (10-24 years of age) (WHO, 1986), around the world face tremendous challenges to meeting their sexual and reproductive health (SRH) needs. Inadequate access to health information and services, as well as inequitable gender norms, contribute to a lack of knowledge and awareness about puberty, sexuality, and basic human rights which can have serious implications on their health and welfare as well economic development and poverty reduction – key priorities for the World Bank Group (WBG).

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

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

To conceptualize the multi-sectorial set of factors that impact adolescent health, the WBG used the following conceptual framework (figure 1) tailored to each country context.

Figure 1. ASRH within the context of development



Source: World Bank Group. ASRH within the context of development. Concept note: Paving the Path to Improved Adolescent Sexual and Reproductive Health.

Key ASRH issues analyzed included (but was not limited to): sexual activity, family planning, sources of family planning information, sexually transmitted infections (STIs), adolescent marriage, adolescent childbearing, gender norms and standards, and gender-based violence. The countries (Bangladesh, Burkina Faso, El Salvador, Ethiopia, Lao PDR, Nepal, Nicaragua, Niger, and Nigeria) were selected based on each country's high ASRH burden to inform operations and policy dialogue in ASRH at the country level.

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

Global Trends and Challenges

SEXUAL ACTIVITY

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

FAMILY PLANNING

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

SOURCES OF FAMILY PLANNING INFORMATION

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

SEXUALLY TRANSMITTED INFECTIONS

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

ADOLESCENT MARRIAGE

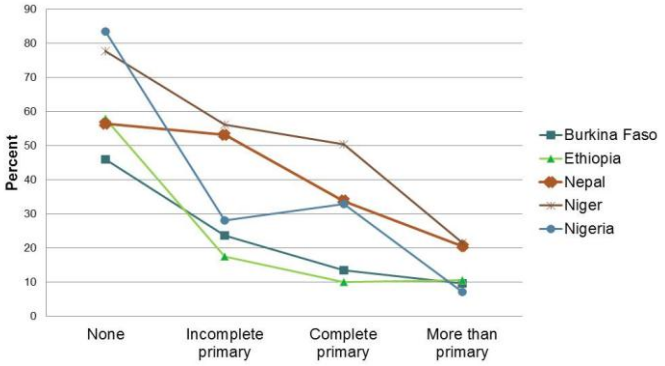
Early marriage is prevalent in all countries studied. Over 25% of adolescent women are married in all countries. Rates of adolescent marriage (including marriage before 15 years of age) are highest in Niger (64%). Marriage – at any age and before age 15 – is more common in rural areas and among those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

ADOLESCENT CHILDBEARING

Adolescent childbearing except in LAC, is closely tied to marital status. In all countries, approximately half (from 42% in Nepal to 55% in Nigeria) of ever-married adolescents gave

birth, while non-marital childbearing is rare. Less than 10% have given birth before age 15. In Bangladesh and Burkina Faso, childbearing among ever-married adolescents is positively associated with rural residence, less wealth, and less education.

Figure 2. Percent of women aged 15-19 who have ever been married, by country and education level



Source: World Bank Group and University of California San Francisco. Accelerating Progress for Adolescent Sexual and Reproductive Health: Results from a Multi-Country Needs Assessment. Washington, DC: World Bank & UCSF; 2014.

WCA countries face the highest adolescent fertility rates (AFR) in the world. Niger has an AFR of 204.8 births, followed by Mali at 175.6 births, and Chad at 152 births (per 1,000 females 15-19 years of age). Nigeria has an AFR of 119.6 births and Burkina Faso has an AFR of 115.4 births (per 1,000 females 15-10 years of age).

Country Case Studies and Findings

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

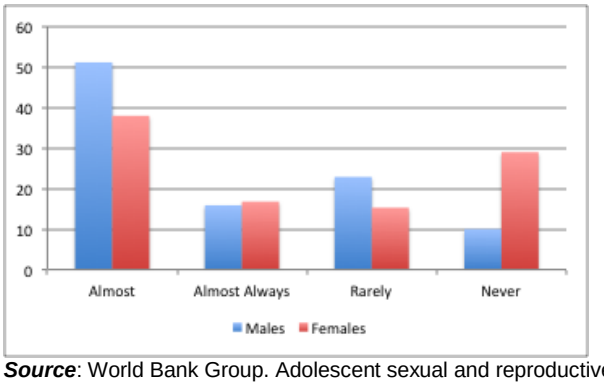
IMPACT OF TRADITIONAL GENDER NORMS

In **Adolescent Sexual and Reproductive Health in El Salvador**, a quantitative household survey was conducted among 1,258 adolescents (10-19 years of age). More information about the WBG's work in El Salvador can be found at the following link: https://www.youtube.com/watch?v=QQ0O5GmEacM&feature=youtu.be.

Results indicate that despite El Salvador's history of trying to meet human rights principles, adolescents and youth continue to face SRH violations. In fact, half of adolescents know about their sexual and reproductive health rights (SRHR), reducing the risk of becoming a parent by 66 percent and the risk of being mistreated by 46 percent.

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

Figure 3. Adolescent (10-19 years) Frequency of Contraceptive Use by Sex (percent) in El Salvador



Source: World Bank Group. Adolescent sexual and reproductive health and rights Survey: El Salvador. Health Focus. 2012. Data collection commissioned by the World Bank 2012.

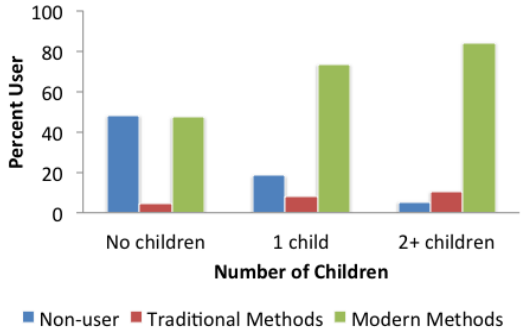
BARRIERS TO IMPROVED ASRH

Paving the Path to Improved Adolescent Sexual and Reproductive Health: Bangladesh notes the powerful association between adolescent marriage, poverty, and poor SRH outcomes in 4 Dhaka slums. The study included a quantitative household survey, qualitative interviews, formative research, and donor interviews. Results indicate that adolescent females marry on average at 15 years of age, although their ideal age at first marriage is 18 years. Further, 70% of adolescent women give birth by the time they turn 19 years of age.

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

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

Figure 4. Current Use of Contraception among Adolescents (15-19 years of age) by Number of Living Children and Method (Percent)



Source: World Bank Group and the International Center for Research on Women. Household Survey 2013: Adolescent Sexual and Reproductive Health in Bangladesh. 2013.

HIGH AFR AND MATERNAL MORTALITY

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

Policy Challenges

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

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

Conclusions

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

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This HNP Knowledge Brief highlights the key findings from a series of background reports produced under the World Bank Economic Sector "Paving the Path to Adolescent Sexual and Reproductive Health" led by Rafael Cortez (Task Team Leader).

The Health, Nutrition and Population Knowledge Briefs of the World Bank are a quick reference on the essentials of specific HNP-related topics summarizing new findings and information. These may highlight an issue and key interventions proven to be effective in improving health, or disseminate new findings and lessons learned from the regions.
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