Securing contraceptives for young people

Key action points

- Governments should collect more data about the sexual and reproductive health status and needs of young people, disaggregated by age, marital status, gender and economic status to inform and improve policy, budgeting and programming decisions.

- Remove legislative barriers that prohibit young people, especially unmarried young women, from accessing sexual and reproductive health services and family planning.

- Lift all legislative, economic and social barriers that prevent girls and young women from attending or completing school, for example because of marriage, pregnancy, menstruation, son bias and other factors.

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Contraceptive security and securing contraceptives for young people

Over 3.5 billion people – or 52 per cent of the world’s population – are under the age of 30, and 1.2 billion are currently aged between 15 and 24; 187.5 per cent2 of these young people live in the developing world. This is the largest generation of young people the world has seen, and will significantly increase the demand for sexual and reproductive health services in years to come. This increase in demand will present many challenges, especially in countries where young people do not have ready access to comprehensive sexual and reproductive health information and services, including contraceptive services, to meet their needs at different stages throughout their lives.

Placing health and lives at risk

There is very little data available on contraceptive use among young women, particularly unmarried young women and younger adolescents. Increased data about adolescent behaviour is required to ensure that there is appropriate budgeting, policy and programming in place. Age of consent legislation further complicates data collection. However, there are ethical issues to consider, and it is critical that young women are not stigmatized or criminalized.

The data available indicates that 67 per cent of married adolescent girls in sub-Saharan Africa who wish to avoid a pregnancy3 in the next two years are not using any method of modern contraception. This results in 2.2 million unintended pregnancies per year among adolescent women in sub-Saharan Africa. Adolescent women also account for one in four of the unsafe abortions that occur in the region.4

Failing to meet the needs of young women who wish to use modern methods of contraception places their health and lives at risk. Maternal incidents are the highest cause of death among women aged 15–24.5 Young women between the ages of 10 and 14 are five times more likely to die in pregnancy or childbirth than young women aged 20 to 24, while young women aged 15 to 19 are twice as likely to die. The vast majority of these deaths take place within marriage.6

Three pillars of intervention

Young women need to have the best possible start in life, and to grow up into autonomous and empowered individuals who can contribute to the social, economic and political life of their communities. For this to happen, it is vital that they have access to information and services that will enable them to choose if and how they protect themselves from unintended pregnancies and sexually transmitted infections.

If supported by appropriate policy, financing and programming, there are three pillars of intervention that will improve young women’s access to contraceptives, and their health and development outcomes at this critical juncture in their life. These three pillars are youth-friendly services; comprehensive sexuality education; and social, political and legal change.

Youth-friendly services: reflecting young people’s needs

A study of four African countries indicates that over one third of young men and women surveyed did not know where to obtain contraceptives.7 This means they did not know they could go to a reproductive health clinic or the local government clinic. Many young people, concerned about stigma from service providers or a breach of confidentiality, prefer to visit a pharmacy, a traditional healer or purchase contraceptives from a shop. In South Africa, emergency contraception is available to all over the counter. However, research indicates that about half of pharmacists do not believe that emergency contraception should be supplied to girls under the age of 18.8

Although young people’s knowledge about and use of contraceptives are increasing, there is still much to be done to identify and respond to their contraceptive needs and to ensure that services are youth friendly. The contraceptive needs of a woman aged 16 are likely to be different to her needs at the age of 35. This must be reflected in services offered to young people, focusing on the contraceptive methods available as well as the advice provided.

Comprehensive sexuality education: reflecting our changing world

Today’s young people live in a changing world, one that is very different to that of the previous generation. They are getting married at a later age and are more likely to have sex before marriage. To ensure they make informed and empowered choices about their sexual lives and contraceptive use, they need access to information and comprehensive sexuality education.

Young people’s access to comprehensive sexuality education is limited in many countries. This is partly because of the incorrect belief that such education will encourage sex and ‘promiscuous behaviour’. However, there is now clear evidence that sexuality education programmes can help young people to delay sexual activity and make informed decisions about contraceptive use when they begin to have sex.9

The right to comprehensive sexuality education is enshrined in binding internationally-recognized conventions and agreements, such as the United Nations Convention on the Rights of the Child.10 Although ratified by all UN member states, with the exception of the United States and Somalia, many countries still fail to provide this fundamental aspect of a young person’s education.
In countries where comprehensive sexuality education is taught in schools, girls are often the ones who miss out on this valuable part of their education. In many countries, girls are withdrawn from school when they marry. In Africa, UNICEF estimates that 42 per cent of girls are married before the age of 18. However, in some African countries the figure is much higher, such as in Niger where 76 per cent of girls are married before the age of 18. In addition, in many settings, girls are not allowed to attend school while menstruating, which further limits their access to important courses, including sexuality education.

Lack of accurate information can result in misconceptions about contraception. Young people often hear incorrect information from their friends or others in the community, and have no reliable source to verify the information. A recent study in Uganda revealed that many young men and women held misconceptions about the effectiveness and side-effects of contraceptives, which generated fear that affected their decision-making. For some young women, the fear of contraceptive side-effects outweighed their fear of unintended pregnancy. This was further compounded by concern about negative reactions from the church and their families.

This lack of accurate information and access to education makes it hard for young women to negotiate contraceptive use with their partner. Research from Zambia and 17 other African countries indicates that there is a link between the level of education and the ability to negotiate condom use. The more education a young woman received, the more likely she was to negotiate condom use. Girls who have little or no access to education are in a vulnerable position; often unable to negotiate condom use with their partners, they are at risk of unintended pregnancy or contracting a sexually transmitted infection, including HIV. In sub-Saharan Africa, women aged 15 to 24 are eight times more likely than men of the same age to be HIV-positive.

Social, political and legal change: creating opportunities

Social, political and legal change is needed if young women are to participate fully in educational and economic life. Unintended pregnancy can add to the list of obstacles that prevent young women from attending school. In some countries, pregnant adolescent girls are prohibited from attending school. In Tanzania in 2005, one in five girls in secondary school became pregnant and was forced to leave school. Dropping out of school can have serious consequences for a young girl’s economic and social opportunities and will permanently shape the rest of her life.

In addition to the social and cultural barriers that inhibit young people’s ability to make informed choices about their reproductive health, there are legal and policy barriers that prevent them from accessing contraceptives. Laws that stipulate an age of consent to sex, and requirements for parental or spousal consent to treatment and care for legal minors, present significant obstacles and create uncertainty among young sexually active people as well as health professionals. In the Central African Republic, adolescent girls under the age of 18 are prohibited from accessing contraceptives. The legal age of marriage for girls is 18, so this means that unmarried adolescents under 18 are not legally entitled to contraceptive services.

In South Africa, adolescent girls can access contraceptive services from the age of 12 without parental consent. In practice, however, research indicates that nurses often felt uncomfortable giving contraceptives to adolescents, especially young adolescents. They would ask intrusive questions about the girls’ sexual behaviour and lectured them about being too young for sex. This made the girls feel ashamed and afraid. In some instances, the nurses would not carry out the policy; they refused to give the girls contraceptives even though they were legally entitled to receive them.

An approach to policy, programming and budgeting that prioritizes the provision of youth-friendly services and comprehensive sexuality education is needed in order to ensure that young people across the world are able to make informed sexual and reproductive health decisions and to act on those decisions.

Targeting pregnant schoolgirls: case study

The Tanzanian Education Act 1978 allows the expulsion of pregnant girls from school and does not make provision for them to continue with their education. In response to this, the IPPF Member Association UMATI set up youth centres based in Dar es Salaam and in the Southern Highland Zone. The centres targeted their services at pregnant young girls no longer in school. They offered vocational training, income generating activities and drama groups, and provided sexual and reproductive health and rights information and services. They also helped prepare the girls to sit for their final school exams.

While providing these services, UMATI advocates worked with decision makers to raise their awareness of the devastating impact that expulsion from school can have on the life of a young girl, and how working with the girls could make a really positive impact on the girl’s life and her future. As a result, the Ministry of Education and Vocational Skills has commissioned a study to assess the magnitude of the problem and it has started reviewing the law and policy based on the findings.
References

4. Ibid.

Glossary

Comprehensive sexuality education refers to an education that seeks to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality – physically and emotionally, individually and in relationships.

Adolescents refers to young people aged between 10 and 19.

Youth refers to people aged between 15 and 24 years.

Young people refers to those aged between 10 and 24 years.18

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