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Sexual and reproductive health programmes and policies for adolescents

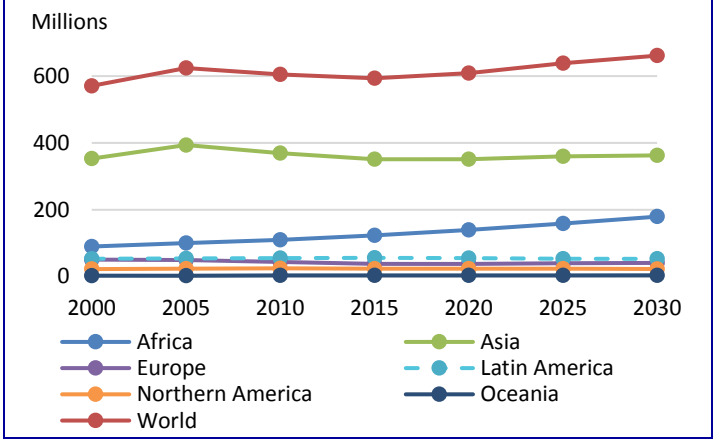
1. What is adolescence?

Adolescence is the period between childhood and adulthood that is considered to begin with puberty. For girls, the marker of puberty is menarche — the first menstruation — which usually occurs between ages 12 and 13 years (Patton and Viner, 2007). Since legal provisions generally set the age of majority at 18 years, adolescence is often identified with the period between ages 12 and 18 years. In practice, and owing to considerations related to statistical convenience, persons aged 15 to 19 are considered to be adolescents. Adolescence is a critical period of neuronal and psychosocial changes when many health behaviours carry implications for later stages of life.

2. Globally, nearly one in ten persons are adolescents

In 2015, the number of adolescents globally was 594 million, or 8 per cent of the world population (United Nations, 2017a). The majority of adolescents worldwide live in Asia (59 per cent).

Figure 1. Number of adolescents (aged 15 to 19) by region, 2000 to 2030 (millions)



Data source: United Nations (2017a).
Note: Latin America refers to Latin America and the Caribbean.

By 2030, the number of adolescents is projected to reach 661 million globally. Most of this growth (83 per cent) is projected to take place in Africa.

3. Improving the sexual and reproductive health of adolescents is central to the 2030 Sustainable Development Agenda

The 2030 Agenda for Sustainable Development contains several targets related to the sexual and reproductive health (SRH) of adolescents. Specifically, target 3.7 calls for ensuring universal access to sexual and reproductive health-care services, including for family planning, information and education. Likewise, target 5.3 calls for eliminating child, early and forced marriage, while target 5.6 calls on countries to ensure universal access to sexual and reproductive health and reproductive rights in accordance with the ICPD Programme of Action.

Improving adolescents' SRH can have positive spill over effects on many other SDG goals and targets, including those related to maternal health, education and gender equality (United Nations Population Fund, 2014). Women who have their first pregnancy at a very young age are more likely to suffer complications during pregnancy and childbirth. They are also at a greater risk of maternal death. Further, the children of very young mothers have higher levels of morbidity and mortality. Taken together, reducing adolescent childbearing while providing universal access to sexual and reproductive health-care services can have important health and social consequences both for adolescent girls and for the children they bear. A recent study shows that each dollar of 'investment' in adolescent health and wellbeing is estimated to yield 10 times as much in measured economic benefits[1] (Sheehan et al., 2017).

4. Governments have a number of policy tools to improve the SRH of adolescents

Adolescents have specific SRH needs that require age-specific and culturally sensitive policy measures. Governments have developed several dedicated policy programmes and measures to improve the SRH of adolescents. Key strategies consist of raising or enforcing the minimum age at marriage, providing school-based sexuality education, and, more broadly, expanding girls' access to, and retention in, secondary education (Fathalla et

al., 2006; Bearinger et al., 2007; Chandra-Mouli et al., 2015; Manlove et al., 2015).

Other policy measures include ensuring access to appropriate contraceptive methods without limitations related to age or marital status, and providing accessible, acceptable and age-appropriate clinical services, adolescent-friendly clinics and community outreach services.

5. Globally, more than 9 in 10 governments have adopted at least one policy measure to improve the SRH of adolescents

Globally, 91 per cent of governments have at least one policy or programme aimed at improving the SRH of adolescents (figure 2). Among the policy measures reported are raising or enforcing the minimum age at marriage, expanding girls' secondary school enrolment or retention, and providing school-based sexuality education.

At the regional level, the share of governments with at least one measure to improve the SRH of adolescents ranges from a high of 100 per cent in Northern America to 84 per cent in Latin America and the Caribbean.

6. Globally, three quarters of countries provide school-based sexuality education

In terms of the specific policy measures considered, providing school-based sexuality education is the most prevalent type of intervention, employed by 76 per cent of governments globally.

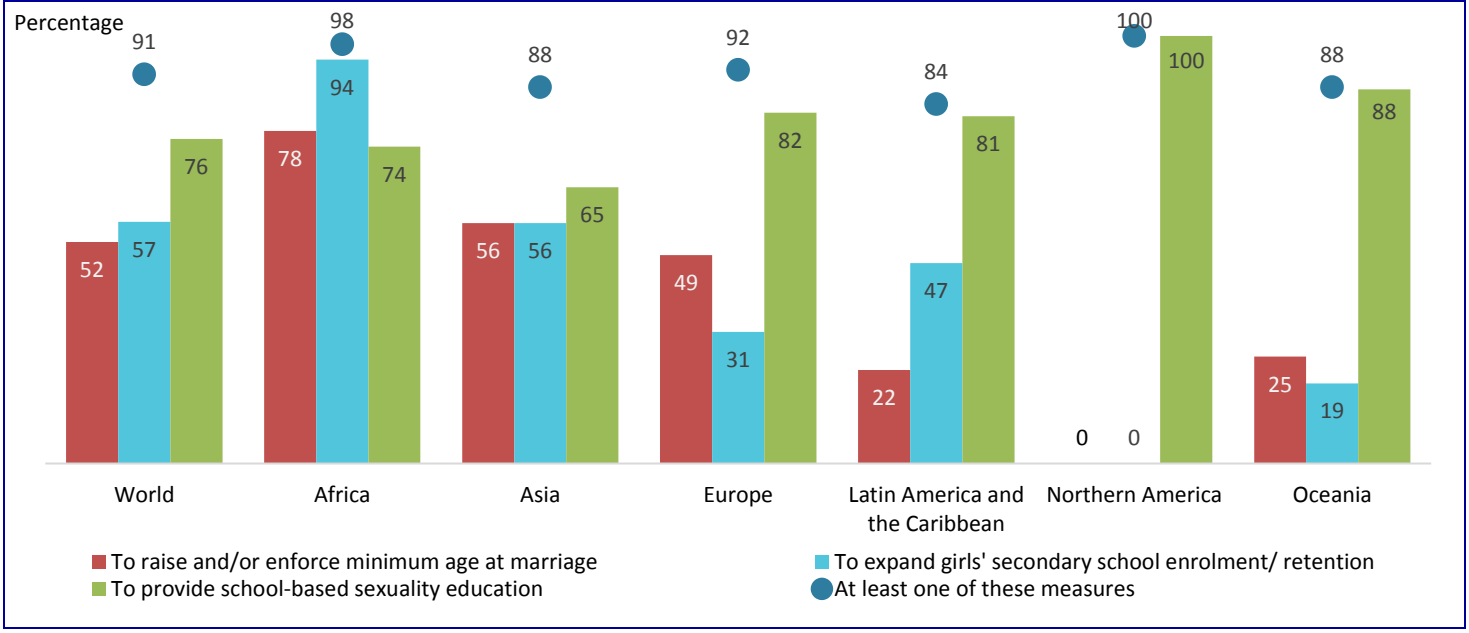
Yet, there are significant differences by region. Northern America has the highest percentage of governments that provide such programmes (100 per cent), followed by Oceania (88 per cent) and Europe (82 per cent). In Asia and Africa, however, the proportion of countries with policies to provide school-based sexuality education is lower, 65 per cent and 74 per cent, respectively. This is important given that Asia and Africa have the largest and most rapidly growing adolescent populations, respectively. The lack of accurate and timely information about sexuality has been shown to have a key influence on adolescents' sexual and reproductive behaviour (see Kirby, 2011).

7. The prevalence of measures to expand girls' secondary education varies by region

Globally, 57 per cent of governments have policies to expand girls' enrolment or retention in secondary school. Close to 94 per cent of governments in Africa have such policies, followed by Asia (56 per cent). Such measures are less prevalent in the developed regions, where enrolment in secondary school tends to be high.

Investments in girls' education, in addition to having a positive impact on the SRH of adolescents, can also help lift households, communities, and nations out of poverty (World Bank, 2017). Better educated women tend to be healthier, participate more in the formal labour market, earn higher incomes, have fewer children, and contribute to better health care and education for their children, should they choose to become mothers.

Figure 2. Percentage of governments with at least one policy measure to improve the SRH of adolescents by type of policy measure and region, 2015



Data source: United Nations (2016).
Notes: Based on 191 countries with available data.

8. Half of governments have policies to raise or enforce the minimum age at marriage

Fifty-two per cent of governments worldwide have measures to raise or enforce the minimum age at marriage. Regionally, 78 per cent of countries in Africa and 56 per cent of countries in Asia have such measures. However, legislation alone is often insufficient to eliminate the practice of early and child marriage, which owing to deep-rooted cultural beliefs and practices, continues to take place with parental or judicial consent (Heymann and McNeill, 2013; Mortimer, 2015)

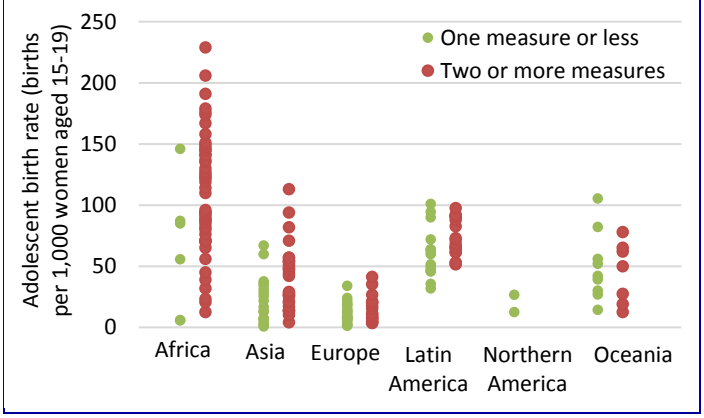
Child marriage, defined as marriage before the age of 18, entails risks for the SRH of adolescent girls (see Kalamar et al., 2016, for a review). In less developed regions, 40 per cent of women who are 20 to 24 years old were married before the age of 18 (UNICEF, 2018). Child marriage is most common in Southern Asia and sub-Saharan Africa. Childbearing among adolescents is often highest in countries or areas where marriage occurs at a very young age.

9. Countries with higher levels of adolescent fertility often have multiple policies to improve the SRH of adolescents

Levels of adolescent fertility remain high in many parts of the world. Yet many of the governments where the adolescent birth rate (ABR)[2] is high are adopting a proactive approach to address it.

Among countries where ABR is 25 per 1,000 or higher, 71 per cent of governments have adopted two or more policy measures to improve the SRH of adolescents, compared to 42 per cent among countries with ABR below 25 per 1,000. Among countries where ABR is 100 per 1,000 or higher, 90 per cent of governments have adopted two or more policy measures to improve the SRH of adolescents.

Figure 3. Adolescent birth rate by region and number of policies to improve the SRH of adolescents (one dot = one country)

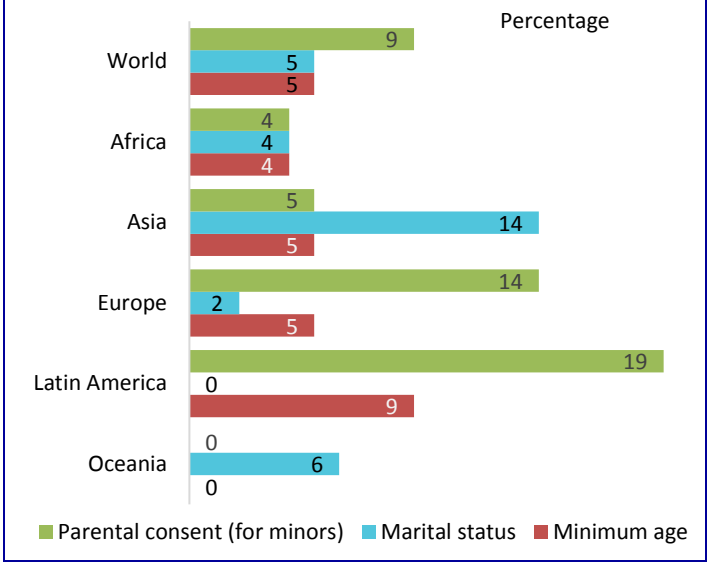


Data source: United Nations (2016, 2017b).
Notes: Based on 195 countries with available data. Latin America refers to Latin America and the Caribbean.

10. Few governments restrict access to contraceptive services for adolescents

Globally, only 15 per cent of governments have policies restricting access to contraceptive services based on minimum age, marital status or parental consent for minors. Fewer than one in ten governments restrict access to contraceptive services on the basis on parental consent, while only five per cent of governments restrict such services based on age or marital status.

Figure 4. Percentage of governments restricting access to contraceptive services based on minimum age, marital status and parental consent, by region, 2015



Data source: United Nations (2016).
Notes: Based on 196 countries with available data. Latin America refers to Latin America and the Caribbean.

Latin America and the Caribbean (19 per cent) and Europe (14 per cent) have the highest percentage of governments requiring parental consent for minors to access contraceptive services, while Asia (14 per cent) has the highest percentage of governments restricting access to contraceptive services based on marital status.

Family planning services are a vital component of adolescents' SRH. For sexually active adolescents, access to modern contraceptive methods, such as male and female condoms, can help protect them from HIV and other sexually transmitted infections (STIs), as well as prevent unintended pregnancies.

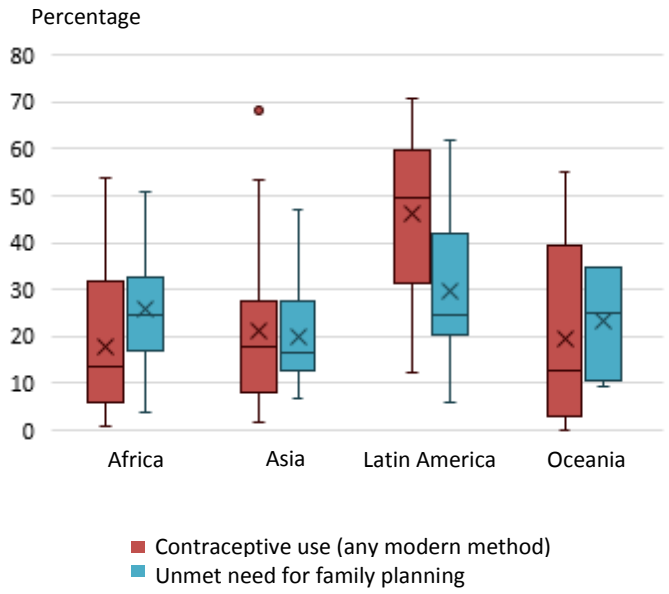
11. Contraceptive use among adolescent girls varies widely

In spite of the lack of legal barriers, use of modern contraceptives among adolescent girls varies widely across countries and regions. Modern contraceptive prevalence[3] among girls aged 15 to 19 who were married or in a union, was less than 30 per cent in nearly all countries in Africa and Asia with available data (United Nations, 2017c). In contrast, the prevalence of modern contraceptive use among married and in-union adolescent girls was above 30 per cent

in more than three fourths of the countries with available data in Latin America and the Caribbean.

Levels of unmet need for family planning among adolescents also vary by region. Unmet need for family planning[4] among adolescent girls, married or in a union, was above 20 per cent in over two thirds of countries with available data in Africa and Latin America and the Caribbean, compared to one third of countries in Asia.

Figure 5. Distribution of countries by percentage of women aged 15 to19, married or in a union, who are using a modern method of contraception or with unmet need for family planning, latest year available



Data source: United Nations (2017c).
Notes: Based on 102 countries or areas with available data. Latin America refers to Latin America and the Caribbean. Adolescents are persons aged 15 to19.

NOTES

[1] Benefits were valued in terms of increased gross domestic product and averted social costs.

[2] Measured as the number of births per 1,000 women aged 15 to 19.

[3] Contraceptive prevalence is the proportion of women who are currently using, or whose sexual partner is currently using, at least one method of contraception, regardless of the method being used.

[4] The unmet need for family planning shows the gap between women's reproductive intentions and their contraceptive behaviour. It is defined as the proportion of women who want to stop or delay childbearing but are not using any method of contraception. It is typically reported as a percentage with reference to married or in-union women of reproductive age (usually, ages 15-49).

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