Prioritizing and targeting SBC investments to address adolescent pregnancy in USAID priority countries [4 pages]

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Early marriage is the predominant contributor to adolescent pregnancy. Effective SBC interventions will be tailored for the unique circumstances of unmarried adolescent girls and adolescent brides and mothers. A combination of factors related to adolescent childbearing should be considered to determine whether SBC investments should focus on addressing norms around early marriage, increasing demand for contraceptives, and/or reducing stigma around adolescent sexuality.
Background

Globally, there are approximately 20 million pregnancies a year among 15–19 year olds in developing regions. Reducing pregnancy among adolescents is a key objective of international agreements on the health and rights of children and a priority of USAID Global Health investments.

Likewise, providing youth access to FP/RH services is essential for reaching FP2020 goals and country commitments. Pregnancy presents many risks to adolescent girls and their children. Early childbearing is linked with higher maternal mortality and morbidity and increased risk of induced, mostly illegal and unsafe, abortions. It reduces girls’ likelihood of completing their education or acquiring vocational skills, which has a negative impact on their socioeconomic standing; perpetuating poverty from one generation to another. Children born to adolescent mothers are more likely to experience adverse health consequences, such as low birth weight, preterm delivery, severe neonatal conditions, and early neonatal death. They are also more likely to have poorer educational, behavioral, and health outcomes throughout their lives, compared with children born to older mothers.

Decision-makers often assume that most adolescent pregnancies are unintended and happen outside of marriage. While unintended pregnancy is a serious issue, decision-makers may underestimate the social pressures and other complexities that can lead girls to seek early motherhood to prove fertility and establish an accepted role in society. SBC interventions recognize such complexities and use tested communication principles and methods to promote healthy patterns of decision-making and behavior. Learn more about SBC interventions through the High Impact Practices for Family Planning at www.fphighimpactpractices.org.

A Closer Look

In Figure 1 on the next page, the further to the right a country sits, the higher the levels of adolescent childbearing. Along this axis, adolescent childbearing ranges from 7% in Rwanda to 39% in Mali. The higher up a country is situated, the greater the percentage of adolescent pregnancies that occur after marriage. The share of pregnancies that occur after marriage ranges from 23% in Rwanda (where premarital pregnancies are higher) to 88% in India (where premarital pregnancies are lower).

SBC Investment Options

There is wide variation among countries and the type of SBC programmatic investments needed to reach adolescents with effective SBC interventions. The figure suggests that decision-makers should consider the two dimensions together (when making programmatic decisions). While decision-makers should strive to lower rates of adolescent pregnancy and childbearing, it is unlikely that levels for either will ever reach zero.

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Decision-makers often assume that most adolescent pregnancies are unintended and happen outside of marriage. While unintended pregnancy is a serious issue, decision-makers may underestimate the social pressures and other complexities that can lead girls to seek early motherhood to prove fertility and establish an accepted role in society. SBC interventions recognize such complexities and use tested communication principles and methods to promote healthy patterns of decision-making and behavior. Effective SBC interventions are grounded in behavioral theory and recognize that behavior change is more likely to occur in an enabling environment where effective protective factors are promoted and barriers removed. To achieve this, a multi-component approach is necessary, and at multiple levels of influence: at the individual level to facilitate adolescents’ empowerment; at the relationship level to promote supportive relationships with partners, parents, and peers; at the community level to change social norms that enable adolescents to learn about their sexuality, access services, and challenge harmful practices; and at the societal level (policies, laws, and media campaigns) to create structural change that supports AYSRH.

Targeting the right audiences with the right set of messages is essential for SBC, especially when promoting complicated behavior change, like pregnancy prevention, birth spacing, and modern contraceptive use. One method for targeting programming for adolescents is by marital status: in settings where early marriage is the norm, it is the predominant contributor to adolescent pregnancy. Thus, the FP/RH needs of girls who have never been married are different than the FP/RH needs of girls who become brides and mothers during adolescence. Effective AYSRH interventions must consider and tailor their programming for the unique circumstances of girls in each situation.

In countries where most pregnancies happen after marriage, for example India, Ethiopia, Nepal, and Yemen, SBC investments should focus on delaying early marriage, addressing norms around early marriage, childbearing soon after marriage, and birth spacing. Other effective investments include promoting respectful relationships, and teaching husbands to be supportive partners.
Recommends for type of investment

1. **In countries where most pregnancies happen after marriage:** Focus on delaying marriage, addressing norms around childbearing soon after marriage, and birth spacing.

2. **In countries where pregnancies occur inside and outside of marriage:** A mix of investments are needed to address the wide range of needs among adolescent mothers. Investments should focus on addressing norms, increasing demand for modern contraceptives, and reducing stigma around adolescent sexuality. Supply side interventions to increase access to FP/RH services will also likely be needed.

3. **In countries where most pregnancies happen before marriage:** Focus on increasing demand for modern contraception, reducing stigma around adolescent sexuality, and promoting SRH care-seeking behavior among adolescents.

4. When childbearing levels are low, for example Rwanda, India, and the Philippines, programming should target sub-populations with higher rates of pregnancy. Formative research and further sociodemographic segmentation can identify such sub-populations with the greatest need and identify key drivers of early pregnancy and childbearing.

5. When childbearing levels are high, for example like in Madagascar, Liberia, Mali and Mozambique, SBC interventions that have wide reach across the adolescent population are likely to be more cost effective. Context specific research and evaluation on the diverse determinants of high rates of childbearing can inform promising opportunities for SBC and FP/RH investments.

**Methodology**

Each country’s placement on the figure is based on two data points calculated from the most recent DHS survey. The proportion of 15–19 year olds who have begun childbearing includes those who have already had a birth and adolescents who were pregnant at the time of the survey. The second indicator is calculated among 15–19 year olds who have begun childbearing and is based on the first pregnancy experience. For each first adolescent pregnancy, the timing of the pregnancy is calculated relative to when the adolescent got married. The results depicted represent the overall proportion of pregnancies in the country that happened after marriage. The inverse of this result would therefore be the percentage of pregnancies that happened before marriage. This measure does not indicate the timing of the actual birth. In some cases, 15–19 year olds who got pregnant before marriage got married before giving birth. Combining two indicators in the figure helps contextualize two important dimensions for adolescent pregnancy within a country. However, when considering investments within a country, additional data and information will be required to fully understand how to best target adolescent pregnancy.
References


2. WHO defines an adolescent as any person between ages 10 and 19. Some data in the text and all data in the figure are specific to 15-19 year olds. In such cases, the data are marked accordingly.


Acknowledgments
This programmatic research brief describes work led by Avenir Health under Breakthrough. The brief was developed in collaboration with Databoom, a consulting partner, and PRB a partner on Breakthrough RESEARCH.


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