Supporting Youth Reproductive Health: Including LARCs in Youth-Friendly Services in Ethiopia

Globally, 25 percent of the world’s population—1.8 billion—are youth (ages 10 to 24). This large and diverse group will shape the demographic, economic, social, and political world of the future. The highest proportion of young people today—89 percent—live in poor countries, including 33 million children and youth, ages 0 to 24, in Ethiopia. In Ethiopia, fertility remains high. The total fertility rate (TFR) is 4.6 children per woman, with substantial variation by region: The TFR has fallen below replacement level (2.1 children per woman) in the capital Addis Ababa; it is 3.5 children per woman in the towns, and remains above 6 children per women in rural areas where 84 percent of the population resides. High fertility leads to ever larger cohorts of children and youth. It is critical to address the sexual and reproductive health of large youth populations to not only support their universal right to health—including access to contraception—but also to contribute to development efforts to expand education, provide meaningful employment, and reduce poverty.

Fortunately, the importance of providing reproductive health information and services to youth is gaining worldwide attention. It is key to provide the full range of contraceptive methods, including long acting, reversible contraceptives (LARCs) in the context of youth-friendly services. The FP2020 Global Consensus Statement on LARCs and Youth, launched in October 2015, highlights how this can be done. The Consensus Statement states that ensuring young people’s access to LARCs will help to prevent unintended pregnancies, reduce maternal and infant morbidity and mortality, decrease unsafe abortions, and ensure full and informed contraceptive choice for youth (see Box 1).

Box 1
Global Consensus Statement: Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting Reversible Contraception
Pathfinder International, Evidence 2 Action (E2A), PSI, Marie Stopes International, FHI 360

Global efforts to prevent unintended pregnancies and improve pregnancy spacing among adolescents and youth will reduce maternal and infant morbidity and mortality, decrease rates of unsafe abortion, decrease HIV/STI incidence, improve nutritional status, keep girls in school, improve economic opportunities, and contribute toward reaching the Sustainable Development Goals. We recognize and commit ourselves and call upon all programs promoting the sexual and reproductive health and rights of adolescents and youth to ensure full and informed choice of contraceptives, by:

• Providing access to the widest available contraceptive options, including long-acting reversible contraceptives (LARCs, for example, contraceptive implants and intrauterine contraceptive devices) to all sexually active adolescents and youth (from menarche to age 24), regardless of marital status and parity.
• Ensuring that LARCs are offered and available among the essential contraceptive options, during contraceptive education, counseling, and services.
• Providing evidence-based information to policymakers, ministry representatives, program managers, service providers, communities, family members, and adolescents and youth on the safety, effectiveness, reversibility, cost-effectiveness, acceptability, continuation rates, and the health and nonhealth benefits of contraceptive options, including LARCs, for sexually active adolescents and youth who want to avoid, delay, or space pregnancy.
Challenges and Unmet Need

There are multiple challenges to addressing youth sexual and reproductive health and rights (SRHR). Many girls and young women are forced into early marriage and childbearing, especially in developing countries where societal norms enforce it. Early marriage and early childbearing not only cut off a young woman's education and limit her social engagement, they carry serious health risks for mother and child. Young women, especially those who are unmarried, also face substantial risk of unsafe abortion. For example, in sub-Saharan Africa, women under 25 years of age account for 51 percent of unsafe abortions.

Yet many young people want to be able to control their fertility. According to the 2011 Demographic and Health Survey in Ethiopia, overall more than a quarter of women of reproductive age (26.3 percent) have unmet need for family planning—they want to delay, space, or even in some cases limit childbearing, but are not using a contraceptive method. However, among adolescent women, the proportion rises to nearly a third (32.8 percent).

A key component in ensuring youth SRHR and reducing unmet need is to make available the full range of contraceptive methods, including LARCs (such as IUDs and implants) which have a very low failure rate (less than 1 percent). However, youth still encounter significant barriers to accessing and using any contraceptive method. These barriers include: limited knowledge of their contraceptive options; myths and misconceptions around methods; provider bias as to which methods are appropriate for adolescents; lack of family, partner, and community support; negative social norms; and lack of access to resources to get to service sites or to pay for services. These barriers are magnified for LARCs (see Box 2).

Box 2
Barriers to Increased Use of LARCs

To better understand the barriers to and facilitators of young people’s access to full method choice and use of LARCs, the Evidence to Action (E2A) Project project conducted a cross-country analysis in Tanzania, Niger, Mozambique, Bangladesh, and Ethiopia. All five countries had similar barriers:

- Most young people were not aware of LARCs.
- Among those who were, myths and misconceptions clouded the perception of LARCs; fear of side effects was a major deterrent.
- There was substantial provider bias across all five countries, with providers refusing to offer LARCs because clients were too young, hadn’t had a child, or were unmarried.
- Countries had social norms and stigma around adolescent sexuality and use of contraception, particularly LARCs, that prevent adolescents and youth from choosing the method of contraception.

Data from DHS highlight that youth who use contraceptives do not generally choose the most effective methods, much less LARCs. More than 50 percent of the youngest age group (ages 15 to 19) use
traditional methods and condoms, followed by contraceptive pills and injectables. The 20-to-24-year-olds show a slightly increased use of hormonal methods and the IUD. These methods have higher failure rates than LARCs. In addition to the challenges of using less effective methods, there is clear evidence that young people do not use any methods as effectively as older women. Yet, this gap in use effectiveness between youth and older users is lower for LARCs.

Providers are often concerned about whether LARCs are safe for youth, particularly in terms of undermining their future ability to bear children. Laws and policies have been enacted in some countries that may specifically restrict youth’s access to LARCs, particularly young women who have not yet had a child (known as nulliparous) or who are not married. Yet several major medical governance bodies have issued statements affirming the safety and appropriateness of offering LARCs to adolescents and youth, and the World Health Organization (WHO) states that LARCs (both IUD and implants) can be used safely by adolescents and nulliparous women.

**Ethiopia: Testing a Service-Delivery Model for Offering LARCs to Youth**

Ethiopia is the second-largest country in Africa and has a predominantly young and rural society. With a 2016 population of approximately 99.4 million, Ethiopia is the most-populous landlocked country in the continent of Africa and the second-most populous country of Africa after Nigeria. Ethiopia is currently one of the fastest growing countries in the world, with a growth rate of 3.02 percent per year. Accordingly, the country is experiencing substantial growth in the youth population. Approximately one-third of Ethiopia’s population is younger than 25 years (33 million children and youth). If Ethiopia follows its current rate of growth, its population will double in the next 30 years, hitting 210 million by 2060.

Data from the DHS show that youth have a smaller desired family size than any other age group in the population (see Figure 1). Among Ethiopians ages 15 to 19, 12 percent of young women have started childbearing and only 5 percent are using a modern contraceptive method, despite high unmet need for spacing among married adolescents (30 percent). Although modern contraceptive use rates have risen among youth, the vast majority of them are still using short-acting methods. Among all women ages 20 to 24, for example, only 5 percent are using implants, while 23 percent are using injectables.
To support expanded access to the full range of contraceptive methods among youth, E2A conducted a longitudinal study to test expanded access to LARCs. From June 2014 to April 2015, in collaboration with the Integrated Family Health Program Plus (IFHP+), E2A assessed a service delivery model at 20 youth-friendly health service sites in the Amhara and Tigray regions of Ethiopia. The model offered youth clients contraceptive counseling and services. Half of the sites received expanded information and counseling as well as access to LARCs while half received regular contraceptive services as part of the IFHP youth-friendly initiative.

The service-delivery model being tested included:

- Competency-based provider skills training on implant and IUD insertion, removal, and infection control.
- Refresher training for peer educators to counsel on safety and effectiveness of LARCs, to dispel myths and misperceptions, and to refer young people for services.
- Supportive supervision for providers.

**Table 1: Percent Distribution of Family Planning Clients by Demographic Characteristics & Type of Site (Intervention and Non-Intervention) (June 2014 – April 2015)**

<table>
<thead>
<tr>
<th>Demographic Characteristics</th>
<th>Total %</th>
<th>Intervention %</th>
<th>Non-Intervention %</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAMILY PLANNING CLIENTS – All Adopters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;15 years</td>
<td>0.2</td>
<td>0.1</td>
<td>0.3</td>
</tr>
<tr>
<td>15 – 19</td>
<td>40.2</td>
<td>39.5</td>
<td>41.5</td>
</tr>
<tr>
<td>20 – 24</td>
<td>59.6</td>
<td>60.4</td>
<td>58.2</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>76.9</td>
<td>76.3</td>
<td>78.0</td>
</tr>
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The study findings suggest that when youth-friendly service providers are trained to provide IUDs and implants in a safe and competent way, youth may be more likely to adopt these methods. The results of the rigorous study with comparison groups during the 8-month post-intervention period showed this impact clearly. At baseline, the percentage of new LARC users among all new family planning users at intervention sites was lower than at non-intervention sites, while during the post-intervention phase, the percentage of new LARC users at intervention sites was greater than at non-intervention sites (see Figure 2).
In addition:

- After the 10-month intervention, for every 100 females who adopted LARCs at the non-intervention sites, 130 females adopted LARCs at intervention sites.
- New clients also were less likely to choose short-acting methods after the intervention. During the post-intervention phase, only 93 females in the intervention sites chose short-acting methods for every 100 who chose them at the control sites.

The study findings also suggested that a growing number of women who have not yet started childbearing sought contraceptive services and often chose long-acting methods. During the study period, 63 percent of women who attended youth-friendly services had not yet had any children, and fully 81 percent of women who accepted a long-acting method for the first time at intervention sites had had no children. Overall, the study found that better provider skills and counseling related to LARCs led to increased uptake among young people, while peer counselors did not appear increase the use of LARCs among young people.

**Acknowledgment:** Much of the content of this case study is adapted from *Testing a Service-Delivery Model for Offering Long Acting Reversible Contraceptive Methods to Youth in Ethiopia*, a policy brief from the USAID-funded Evidence to Action (E2A) Project. You can learn more about the project, and read the full policy brief, at [www.e2aproject.org](http://www.e2aproject.org).
Policy Communication Training Toolkit

Case Study: Youth and LARCS in Ethiopia (SC6E)

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