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CEDIL Evidence Brief 3

Structural interventions to enable adolescent contraceptive use in low and middle income countries: What has been evaluated and how should future interventions be developed?

Centre of Excellence for Development Impact and Learning

Background

Adolescent pregnancy rates in low- and middle-income countries (LMICs) are high and reducing these rates is an indicator for Sustainable Development Goal (SDG) 3.[1] Enabling contraceptive use amongst sexually active adolescents is an important way to help address this. Most interventions tend to focus on providing contraceptives and family planning services or information and education to encourage girls to use contraception. However, these interventions do not usually address the broader factors that affect girls' ability to access and use contraception. Structural interventions are those that address this broader context, such as interventions that aim to increase girls' education, reduce poverty and/or increase their economic empowerment, or shift social norms around gender, adolescent sexuality or fertility.

This brief summarises the findings of an evidence synthesis that examined structural interventions to enable adolescent contraceptive use in LMICs. We identify which structural interventions have been evaluated and offer recommendations on how future interventions could be developed to optimise their impact.

Methodology

We conducted a comprehensive search of the published and unpublished literature to identify studies that assessed the impact of structural interventions on adolescent contraceptive use and fertility in LMICs. We screened the identified studies and only included those that met certain criteria, such as being conducted in an LMIC, being an evaluation of a structural intervention, and reporting outcomes relating to adolescent pregnancy, fertility desires and contraceptive use or desire.

After mapping the range of studies, a more in-depth analysis focused on a subset of studies which measured contraceptive use and compared the intervention group to a control group.

We used qualitative comparative analysis (a method that has rarely been used in the development field) to explore the methodological heterogeneity of the studies reviewed. We also used intervention component analysis, a case-based method, to synthesise the included studies.

1 There are 17 SDGs. SDG 3 is to 'ensure healthy lives and promote well-being for all at all ages' (https://sdgs.un.org/goals/goal3). SDG indicator 3.7.2 is the adolescent birth rate per 1,000 women (https://sdg-tracker.org/good-health#targets).

Findings

We identified 40 studies that evaluated structural interventions. The majority of interventions were evaluated in Africa (24 studies), followed by Asia (eight studies), South America (six studies) and the Middle East (three studies).

Most interventions (29) involved activities that aimed to increase girls' economic empowerment, such as cash transfers, financial literacy training, vocational or livelihoods training, microfinance interventions, the creation of savings accounts for girls, or the provision of employment opportunities. Seventeen interventions aimed to encourage participation in school, including through legislation changes, cash transfers or other support, and 13 interventions aimed to change gender-related social norms, through active engagement with the community.

For our in-depth analysis, we then focused on 17 studies which reported contraceptive use and had either baseline data or compared outcomes between an intervention group and a control group.

We found a great deal of diversity in the study designs and methods used to evaluate the interventions. Different measures were used to capture contraceptive use: for example, some studies asked girls if they had ever used contraception, others asked about current contraceptive use, or asked about condom use separately from hormonal contraception. The population groups that that were asked about their contraceptive use also varied across the studies: for example, in some studies, only married girls were asked, in others only girls who were 'sexually active' or who 'had ever had sex' were asked. Some studies asked only adolescents who had participated in the intervention, whilst in others, adolescents from the community were asked, regardless of whether they had participated in the intervention.

We found methodological issues in both effective and ineffective interventions. For this reason, we are unable to identify which specific activities or contexts are associated with increased contraceptive use. However, through a detailed exploration of the studies, alongside existing frameworks for contraceptive use and empowerment, we propose three steps that may be important for developing successful adolescent contraceptive interventions.

Recommendations for intervention developers

We propose a three-step process that should be undertaken when planning structural adolescent contraceptive interventions.

Step 1: Tailor interventions to specific adolescent life stages

Only five of the 17 interventions took account of different life stages, either focusing specifically on a subgroup of adolescents (e.g. married) or providing different interventions depending on whether they had children and/or marital status. Given that girls at different life stages (e.g. married or unmarried, with or without children) will be in different situations, they are likely to need different interventions. For example, whilst married girls may feel pressure from their family to have children, unmarried girls may be expected to avoid sexual activity. Both may find it difficult to use contraception, but for different reasons.

Step 2: Assess the baseline situation as regards barriers to contraceptive use

Most studies captured baseline data and mentioned some form of assessment of the local context to inform the development of or adaptation of the intervention. However, there was a lack of consistent capture of data on all the different barriers to contraceptive use, as set out in a framework[2] by the International Center for Research on Women (ICRW). This includes the following six factors:

1. the extent to which girls desire to delay, limit or space births;
2. their desire to use contraception;
3. their agency to use contraception;
4. their access to family planning services;
5. the quality and youth-friendliness of family planning services; and
6. an enabling environment (i.e. general support for adolescent contraceptive use in the local context, including supportive social norms and a supporting political environment, legal framework and health sector).

The lack of data about these barriers makes it difficult to assess whether the interventions evaluated targeted those aspects that were most in need of improvement in the given context.

2 A. Sexton, M. Petroni, S. *et al.* (2014) 'Understanding the Adolescent Family Planning Evidence Base', ICRW. https://www.icrw.org/wp-content/uploads/2016/10/FINAL-Understanding-the-Adolescent-Family-Planning-Evidence-Base-7.30.pdf.

Step 3: Select context-appropriate intervention activities to address the barriers identified at baseline

Although a range of activities were undertaken within the 17 interventions, the studies were rarely clear as to which barriers to contraceptive access and use they were addressing within the broader goal of increasing contraceptive uptake. Interventions most commonly aimed to increase the desire to use family planning, typically through information provision about contraception or sex education more broadly. Some interventions also aimed to increase girls' agency in regard to using contraception, through activities typically targeted at the individual adolescent girl, although in some cases activities were also targeted at adolescent boys, partners and families.

In terms of targeting girls, some interventions aimed to increase girls' aspirations or opportunities through livelihoods training, support to go to school or employment opportunities. in several studies, structural interventions were delivered through safe space groups, such as decision-making training within life skills programmes, or economic empowerment activities: for example, microfinance, cash transfers or savings schemes. These groups also helped girls who were social isolated to develop friendships and build social support.

Whilst some interventions directly involved adolescent boys, partners or parents in intervention activities (e.g. small group discussions around gender norms, healthy relationships or sexual and reproductive health and rights), others aimed to develop the girls' communication and negotiation skills.

It seems clear that an enabling environment is important for adolescent contraception interventions. There were two types of activities that aimed to foster an enabling environment. Firstly, active engagement with communities to change norms related to gender, fertility, adolescent sexuality or contraceptive use: for example, through community dialogues. Secondly, activities to demonstrate that adolescent girls should be valued not just for their current or potential roles as mothers, but for other skills and potential value that they can bring to their families and communities: for example, through income-generating activities.

Overall, structural intervention activities should be adapted to the specific population and context targeted. The activities that are most likely to be impactful are those that aim to develop girls' agency to use family planning and those that aim to foster an enabling environment. However, all barriers to contraceptive use that have been identified for that population and context should be addressed by either structural or non-structural interventions.

Recommendations for researchers

- **A consensus should be sought, amongst those conducting, funding and evaluating contraceptive interventions, regarding indicators, outcome measures and other aspects of study design**. Methodological issues around the evaluation of interventions should be discussed within the field. Reaching a consensus around which indicators and outcome measures to use, as well as other aspects of study design, such as the optimal duration of follow-up (particularly for interventions targeting very young adolescents), will enhance future studies and enable their synthesis. In particular, consensus around which indicators are most useful and feasible, as well as how best to assess specific aspects of contraceptive agency, are of critical importance.
- **Further research is needed to develop a better understanding of the pathways and mechanisms through which interventions work**. Specifically, it is important to develop a better understanding of how girls' agency in regard to using contraception can be increased in different contexts. Research is also needed into the most effective approaches to developing an enabling environment.

About this brief

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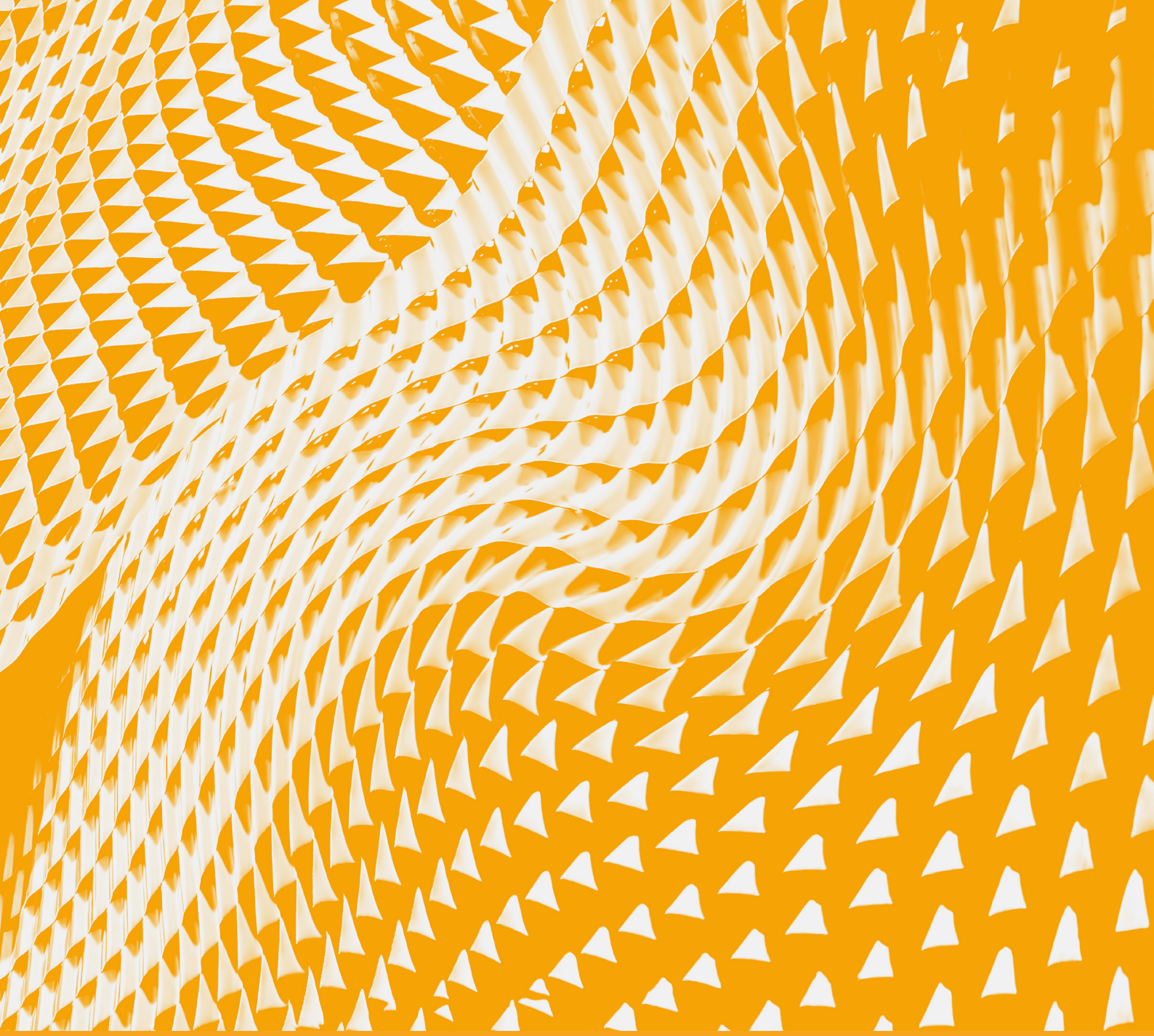

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