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Meeting the need: youth and family planning in sub-Saharan Africa

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Abstract

Background: The need for a concerted effort to address the gaps in family planning services for youth in sub-Saharan Africa has been underreported and underexplored.

Study Design: Trends in fertility, childbearing, unmet need for family planning options and contraceptive prevalence (CP) among youth are described with data from six African countries with four consecutive Demographic and Health Surveys. Estimates of exposure to risk of pregnancy and number of new contraceptives users needed to maintain and double CP in 2015 are calculated using current CP and projected youth population size in six African countries.

Results: The youth population is expected to range from approximately 3 to 35 million in six African countries by 2015. Accounting for population growth and current estimates of sexual activity among youth, family planning services will need to absorb more than 800,000 and 11.3 million new contraceptive users total to maintain and double CP, respectively, in 2015 in those six African countries alone.

Conclusion: Our findings support existing literature that calls for a reorientation of family planning policies and programs, especially improved access to modern contraceptive methods among African youth.

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Keywords: Youth; Contraceptives; Sub-Saharan Africa; Unmet need

1. Introduction

With nearly one in five people between the ages of 15 and 24 years worldwide, there are more youths in the world than ever before [1]. The majority of young people live in developing countries, and the 10 countries with the youngest populations are found in sub-Saharan Africa (SSA) [2]. In fact, 41 of SSA's 42 countries have a median age less than or equal to 25 years [3]. Investments made in youth to promote healthy transitions to adulthood are critical to both health and development in SSA. By 2015, the deadline for meeting Millennium Development Goals (MDGs), the population of youth (15–24 years old) is expected to reach 200 million in SSA [4]. Their ability to make healthy and informed decisions about childbearing and birth spacing now will yield high returns in the region well beyond 2015.

The objective of this paper is to illustrate the need for a concerted effort to address the gaps in family planning services for youth in SSA. To do so, we describe trends in

youth fertility and childbearing, unmet need for family planning options and contraceptive prevalence (CP) among youth in SSA. We then provide estimates of exposure to the risk of pregnancy and the associated need for contraception among youth, as well as estimates of the number of new contraceptives users necessary to maintain and double CP among youth by 2015.

1.1. Background

Family planning is pivotal to ensuring the health and development of youth, reducing unnecessary health risks and improving their opportunities for education and productive livelihoods. Research has shown that the majority of this young adult population engages in voluntary sexual activity, with an estimated 75% of females having had at least one sexual experience by the age of 20 years in SSA [5,6]. In general, girls begin sexual activity at a younger age than their male counterparts [7]. Although there are regional differences, trends indicate that increasingly more youth in SSA are delaying marriage, while the age at onset of sexual activity remains low in many settings [8,9]. In Ethiopia, premarital sex is uncommon [10], yet in Tanzania, the rise in

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female age at marriage is linked to longer time between sexual debut and marriage [11]. Overall, there is a growing gap between age at time of first intercourse and marriage [12,13]. Desire for later childbearing is also becoming more common, even among married African youth [8]. Married adolescents want to delay, space or limit their births [14], but many are not using contraception [15]. Despite the growing and changing need for family planning among youth, family planning programs in SSA have not been given the necessary emphasis in the last decade [8,16,17]. This neglect has tremendous consequences for individuals, societies and the global community.

High unmet need for family planning is correlated with high fertility. Presently, 15 African countries are experiencing stalled fertility decline [18], and many countries in SSA are facing rapid population growth (annual growth of 2% or more, resulting in a doubling of population size every 36 years) [19–21]. This rapid population growth has led international experts from diverse disciplines to question the ability of these countries to achieve any of the MDGs by 2015 [20,22]. Consequently, there is increasing momentum to reposition family planning as a priority on national agendas in SSA [23]. As efforts are made to revitalize family planning programs, it is imperative to address the expanding needs for contraceptives among African youth, specifically. Data on need for pregnancy spacing indicate that the family planning needs of youth are 2.3 times higher than those of the adult population [24]. At more than double the global average birthrate among young women, the average of 143 births per 1000 women ages 15 to 19 years in SSA is startling [9]. In fact, a study of 40 African countries found that the contribution of adolescent fertility to total fertility has changed little over time in most of the countries, accounting for 10–16% [25]. In light of the youth bulge in the population pyramid in SSA, the contribution of total fertility rate by youth will continue to rise unless efforts are taken to decrease the prevalence of pregnancy among young people.

At the same time, elevated fertility rates and high unmet need correspond with heightened risk of unwanted pregnancy and related morbidities and mortalities [20,26]. In the most recent national maternal mortality study conducted in Egypt, women ages 15–24 years accounted for 24% of the total maternal mortality [27]. In general, current age-specific maternal mortality data are limited, but it is well established that pregnancy-related complications are the leading cause of death among women ages 15 and 19 years in developing countries [28–31]. A recent study of global patterns of mortality among youth found maternal health problems were a leading cause of death among young females, accounting for 15% of deaths of females 10–24 years old worldwide [32]. In SSA, estimates show that adolescent mothers comprise about 20% of maternal deaths, most of which are due to complications of unsafe abortion [33].

The high maternal mortality ratio among youth may be related to a higher burden of unintended pregnancy, possibly due to lower access to family planning services. Significant

differences exist with respect to unintended pregnancy, when comparing women who died and those who survived. In the Egypt National Maternal Mortality Survey (2000), 22% of pregnancies were unwanted among all women who died, compared to those who survived where only 13% of pregnancies were unwanted [27]. Hubacher et al. [34] calculated that from 2005 to 2010, 27.5% and 25.8% of total births among women 15–19 and 20–24 years of age, respectively, were unintended in the 42 mainland countries in SSA. It is no coincidence that abortion rates are highest among women in their 20s and that the 15–19 years old subset of women account for the largest portion (57%) of the unsafe abortion in SSA [31]. In Zambia, it was found that 80% of women admitted to an obstetric ward for management of abortion complications were less than 19 years of age [35], and in Nigeria, a cross-sectional study of university students found that 25% of those who had been sexually active had ever been pregnant, and 90% had terminated the pregnancy [36]. In a review of the literature, Olukoya et al. [37] found that adolescent women are more likely to delay seeking termination, enlist unskilled providers and use dangerous methods to induce an abortion than adults. While improved access to safe abortion for youth is still necessary, reducing levels of unintended pregnancy among young women would decrease their dependency on unsafe abortion to control their fertility.

Early childbearing has also been linked to higher rates of child mortality and morbidity [25,28]. In a review of 40 African countries, adolescent mothers had some of the highest rates of infant and child mortality. In fact, high age-specific adolescent pregnancy was associated with the highest rates of neonatal mortality and mortality under age 5 years [25]. Infants born to teenage mothers are 50% more likely to die in the first week of life than those born to mothers 20 to 29 years old [28]. Teenage mothers are also more likely to have preterm and low birth weight babies than older women [28]. Pregnancy and childbearing among young women is closely linked to poor maternal, newborn and childhood health outcomes and necessitates a public health response. Progress in family planning access can make substantial contributions to reducing maternal and child mortality and morbidity, especially among the youth.

By highlighting the contraceptive needs of the growing youth population and the tremendous impact of their unmet need, we hope to demonstrate that family planning programs must focus on this generation. At the same time, governments, nongovernmental organizations (NGOs) and donors must take great care in planning and preparing to meet the contraceptive needs of youth in years to come.

2. Methods

For the purposes of this paper, the term *youth* will refer to individuals 15–24 years of age, in accordance with the World Health Organization definition, whereas the term *adolescents* and *young people* will refer to 10–19 and 10–

24 years of age, respectively. The data sources used for these analyses were extracted from the Demographic and Health Surveys (DHSs) using STATcompiler. We tracked trends in six countries in SSA that met the following criteria: (a) Four rounds of DHSs available; (b) most recent DHS conducted in 2006 or later; (c) has high unmet need for family planning (>20% for youth); (d) DHS data for tracking age-specific fertility, sexual activity and CP available and (e) is currently experiencing a stall in fertility decline according to Bongaarts' recent study of fertility transitions in developing countries [18]. The countries and survey years of the DHSs selected for this paper are (a) Ghana: 1993, 1998, 2003, 2008; (b) Kenya: 1993, 1998, 2003, 2008–9; (c) Mali: 1987, 1995–6, 2001, 2006; (d) Nigeria: 1990, 1999, 2000–1, 2006; (e) Uganda: 1988–9, 1995, 2000–1, 2006 and (f) Zambia: 1992, 1996, 2001–2, 2007. The availability of these surveys enables us to examine trends during four successive periods. The four rounds of DHS data are referred to as DHS 1–4, with DHS 4 being the most recent.

Analyses in this paper, except for those related to teenage pregnancy and fertility planning status, compare observations of youth, 15–24 years old, between consecutive DHSs within each country over time. Because DHS data are reported separately for youth aged 15–19 years and those aged 20–24 years, we used weighted averages to combine the data for these age cohorts for the same country and year. To analyze trends in teenage pregnancy, we combined data from respondents 15–19 years into one age group specific per population-weighted average. For trends in fertility planning status, we combined data from <20 years and 20–24 years age cohorts into one weighted average. These averages were plotted by country and DHS round to illustrate trends over the years.

To determine the number of female youth at risk for pregnancy and the number of young adolescents, 10–14 years old, who may require family planning as they enter the age of sexual activity, we obtained population estimates from the US Census Bureau International Database and used the most recent DHS data estimates for the proportion of sexually active female youth and proportion of modern contraceptive users among female youth. We also calculated

the number of new young users of modern contraception needed to maintain current CP and to double CP by 2015 for the six African countries by using midyear estimates for 2011 and 2015 from the US Census Bureau International Database and the most recent DHS data on CP among youth in the respective countries.

3. Results

3.1. Fertility and childbearing

Table 1 shows that the size of the youth population in six African countries is expected to range from approximately 3 million youth in Mali to over 35 million youth in Nigeria by 2015. On average, youth will comprise an estimated 20% of the total population of the respective countries through 2015. With high fertility rates still common in many African countries, it is likely that the population of youth as a percentage of the total population has yet to peak in the region [24].

As the youth population continues to grow in SSA, meeting their family planning needs will also be a rising challenge. Although the percentage of sexually active African youth has gradually decreased over time, the declines between surveys have been modest. However, since the population of youth has increased over time, the crude number of sexually active youth has also increased. At the time of DHS 4, 20–43% of youth from these six countries were sexually active (data not shown). Zambia, Uganda and Mali have average birthrates of 146, 152 and 188 births per 1000 women ages 15–19 years, respectively, with Nigeria and Kenya not far behind at 121 and 103, respectively (Table 1).

Data in Table 2 indicate that teenage pregnancy has decreased between DHS 2 and DHS 4 in every country except Nigeria, which experienced a slight increase. Uganda saw the largest decline between DHS 2 (42.8%) and DHS 4 (25.0%); however, teenage pregnancy is still common. Over 20% of young women 15 to 19 years old in Mali, Nigeria, Uganda and Zambia were mothers or pregnant with their first child at the time of DHS 4 (Table 2).

Table 1

Size of youth population, total fertility rate and birthrates among females aged 15–24 years for six countries in SSA

	Youth population (thousands) ^a	Total population ^a (%)	Current fertility		
			Total fertility rate	Birthrate per 1000 women 15–19 years old	Birthrate per 1000 women 20–24 years old
Ghana	5335	19.8	4.0	66	176
Kenya	9058	20.7	4.6	103	238
Mali	3061	20.9	6.6	188	283
Nigeria	35256	20.0	5.7	121	225
Uganda	8155	20.5	6.7	152	309
Zambia	3090	20.6	6.2	146	274

Source: Data are from Population Division of the Department of Economic and Social Affairs. The World Population Prospects. The 2008 Revision. New York: United Nations 2009 [50].

Data are from most recent DHSs.

^a 2015 estimates.

Table 2

Trends in pregnancy, unintended pregnancy, use of modern contraceptives and unmet need for family planning among women aged 15–24 years in six countries in SSA with four consecutive DHSs: Ghana 1993, 1998, 2003, 2008; Kenya 1993, 1998, 2003, 2008–9; Mali 1987, 1995–6, 2001, 2006; Nigeria 1990, 1999, 2000–1, 2006; Uganda 1988–9, 1995, 2000–1, 2006 and Zambia 1992, 1996, 2001–2, 2007

		Ghana	Kenya	Mali	Nigeria	Uganda	Zambia
Percentage of women, 15–19 years old, who are mothers or pregnant with their first child	DHS 1	21.5	20.5	50.5	28.3	37.2	33.8
	DHS 2	14.1	20.9	41.5	21.9	42.8	30.7
	DHS 3	13.8	23.0	40.4	25.2	31.4	31.6
	DHS 4	13.3	17.7	35.5	22.8	25.0	27.9
Percentage of women, 15–24 years old, with an unintended pregnancy in the 5 years preceding the survey	DHS 1	47.3	47.0	–	9.2	–	30.5
	DHS 2	38.9	45.9	21.3	18.3	26.4	34.6
	DHS 3	45.9	41.7	18.0	15.0	34.2	36.9
	DHS 4	45.8	41.9	15.0	11.0	39.6	38.4
Percentage of current users of modern contraceptives among sexually active women, 15–24 years old	DHS 1	10.1	16.4	1.5	3.7	1.6	6.3
	DHS 2	13.7	22.2	4.6	6.6	5.7	13.5
	DHS 3	18.3	21.9	5.8	10.5	17.9	22.2
	DHS 4	19.4	29.7	7	11.7	22.2	32.8
Percentage of unmet need for family planning among married women, 15–24 years old	DHS 1	42.6	40.6	–	20.0	–	28.7
	DHS 2	43.1	28.1	28.3	20.0	27.4	26.8
	DHS 3	44.3	31.2	30.2	15.7	32.5	26.4
	DHS 4	45.5	30.0	30.7	20.6	34.9	24.3

Source: Data are from most recent DHSs. Weighted averages for age groups 15–19 and 20–24 years.

DHS 1 data not available for Mali and Uganda for unintended pregnancy and unmet need for women 15–24 years old.

With widespread teenage pregnancy, the percentage of women 15–24 years old with a pregnancy that is unintended (wanted later or not at all) is also considerable (Table 2). At the time of DHS 4, four countries had over 38% of female youth report a pregnancy as wanted later or not at all in the 5 years preceding that survey. The data from DHS 4 in Ghana (45.8%), Kenya (41.9%) and Zambia (38.4%) only differ slightly from the percentage of unintended pregnancies found in DHS 3 — 45.9%, 41.7% and 36.9%, respectively. In Uganda, where there was the greatest decline in teenage pregnancy between DHS 2 and DHS 4, there was also the greatest increase in the percentage of unintended pregnancies between DHS 2 (26.4%) and DHS 4 (39.6%).

3.2. Unmet need for family planning

Among sexually active youth, wide regional variation in contraceptive use exists, with 32.8% of sexually active youth using a modern contraceptive in Zambia versus only 7.0% using a modern contraceptive method in Mali at the time of DHS 4 (Table 2). The trends in current use of modern contraceptives in Table 2 demonstrate low use and

stagnating or even declining performance, as is the case in Uganda. In these six countries, 21–46% of married females 15–24 years old have an unmet need for family planning (Table 2). Over four successive surveys, unmet need remained greatest in Ghana and least in Nigeria (20.6%), which closely mirrors the percentages of unwanted pregnancy; Ghana had the highest rate of unwanted pregnancy for three out of four surveys, and Nigeria had the lowest rate of unwanted pregnancy for all four surveys.

3.3. Meeting the need for family planning

Using the most recent DHS data on sexual activity and use of modern methods of contraception among sexually active female youth, the calculations in Table 3 estimate that between 479,079 (Ghana) and 5,538,170 (Nigeria) women aged 15–24 years may be exposed to risk of pregnancy and have a potential need for contraception in six African countries (Table 3). At the same time, between 885,750 (Zambia) and 2,316,521 (Nigeria) adolescent girls aged 10–14 years will become sexually active in those same countries (data not shown). Given the population growth and current

Table 3

Estimated number of females aged 15–24 years exposed to risk of pregnancy in 6 countries in SSA

	Female youth population (1)	Sexually active (2) (%)	Using modern contraception (3) (%)	Not using modern contraception (4)=100-(3) (%)	Number of female youth at risk (5)=(1)*(2)*(4)
Ghana	2,573,121	23.1	19.4	80.6	479,079
Kenya	4,015,953	29.4	29.7	70.3	830,025
Mali	1,370,858	49.9	7.0	93.0	636,174
Nigeria	15,223,284	41.2	11.7	88.3	5,538,170
Uganda	3,601,145	38.0	22.2	77.8	1,064,643
Zambia	1,396,133	55.3	32.8	67.2	518,825
Total	9,066,916				

Source: (1): US Census Bureau, Population Division: International Database, 2011 Midyear estimates [51]. (2) and (3): Most recent DHS data for each country.

Table 4

Estimated number of new youth family planning users needed to maintain and double modern CP by 2015 in selected countries in SSA

	CP (modern methods) (1) (%)	Youth population mid-2011 (millions) (2)	Estimated youth currently using modern methods (millions) (3)=(1)*(2)	Projected youth population mid-2015 (millions) (4)	Estimated number of new youth users to maintain CP by 2015 (5)=[(4)*(1)]-(3)	Estimated CP if double by 2015 (6)=(1)*2 (%)	Estimated number of new youth users to double CP by 2015 [(4)*(6)]-(3)
Ghana	19.4	5.2	1.0	5.3	19,400	38.8	1,047,600
Kenya	29.7	8.1	2.4	8.4	89,100	59.4	2,583,900
Mali	7.0	2.7	0.2	3.1	28,000	14.0	245,000
Nigeria	11.7	31.2	3.7	34.0	327,600	23.4	4,305,600
Uganda	22.2	7.2	1.6	8.3	244,200	44.4	2,086,800
Zambia	32.8	2.8	0.9	3.1	98,400	65.6	1,115,200
Total					806,700		11,384,100

Source: (1): Most recent DHS data for each country. (2) and (4): US Census Bureau, Population Division: International Database, 2011 & 2015 Midyear estimates [51].

CP, Table 4 presents estimates for the number of youth who will require family planning services to maintain current levels of modern CP and to double modern CP by 2015. Zambia, which has the highest CP, would need to increase family planning service provision to 98,400 and 1,115,200 new users to maintain and double CP by 2015. Ghana and Mali, which currently have low CP, would need to provide contraceptives to 19,400 and 28,000 new users to maintain current CP and 1,047,400 and 245,000 to double CP, respectively, by 2015. However, Nigeria, which has a low CP but the largest population, would need to provide contraceptives to 327,600 new users to maintain current CP and 4,305,600 to double CP by 2015.

4. Discussion

Our findings emphasize the importance of targeting youth in efforts to improve family planning services. The sheer size of the youth population in SSA demands immediate attention and action. Twenty to 43% of youth from the six African countries in this analysis reported being sexually active at the time of the last DHS. Although the percentage of sexually active youth decreased over the course of the four DHS surveys, a significant number of young people still need family planning services.

With birthrates of 66 and 176 births per 1000 women aged 15 to 19 years and 20 to 24 years, respectively, Ghana's birthrates were far less than the other countries. However, unsafe abortion also kills more women than AIDS does in Ghana [38,39], so this finding does not necessarily reflect improvements in family planning service delivery among youth in Ghana. More often, sexually unmarried adolescents are not seeking to become pregnant, and married adolescents do not want to become pregnant at a young age or, if they have already had a child, wish to delay a second pregnancy [14,15,40]. In fact, childbearing and marriage are increasingly unrelated [8]. This may be linked to the high levels of unintended pregnancy we found, which were greater than 38% in four countries. Our results were consistent with those of Hubacher et al. [34],

who found that young women 15 to 24 years old accounted for 43.9% of all unintended pregnancies among women of reproductive age from 2005–2010 in SSA. Understanding the pregnancy intentions of youth is paramount to understanding their contraceptive needs.

Youth appear to be using contraception increasingly in all six countries, yet the gains are not universal or sufficient. Regional estimates from SSA are similar to our findings, with less than 20% of all sexually active youth, married and unmarried, using any form of modern contraception [41]. Cleland et al. [14] found that 37% of unmarried, sexually active sub-Saharan women aged 15–24 years use contraception. Although most youth know of at least one modern contraceptive method, their practical and detailed knowledge regarding pregnancy and proper contraceptive use is quite low [7]. These low levels of reported contraceptive use and knowledge, coupled with a desire to delay childbearing, explain our finding that 24–46% of young women had an unmet need for contraception at the time of the last DHS.

Levels of contraceptive use and unmet need for family planning are often proxies of a country's success in the implementation and maintenance of family planning programs. Accounting for population growth and current estimates of sexual activity among youth, we found that family planning services will need to absorb more than 800,000 and 11.3 million new contraceptive users total to maintain and double CP, respectively, in 2015 in six African countries alone. While the calculations do not distinguish between the young women who would like to become pregnant and those who do not, they do underscore the considerable effort that is needed to ensure that sexually active youth have access to the tools they need to decide when or whether to have a child.

Current sexual and reproductive health services are not meeting the needs of the sub-Saharan adolescent population. In fact, even though the demand for family planning services is comparatively low in SSA, the percentage of youth whose demands are adequately satisfied is significantly lower [7]. Despite school-based sexual health education programs, a significant percentage of young people still never receive any type of information regarding their reproductive health,

especially if they never attended formal schooling [3]. Even among only adolescents attending school, less than 50% of young men and women reported receiving school-based reproductive health education either because such courses are not offered or are not mandatory [7]. Research has indicated that this lack of school-based education may be due to the fact that many adults believe that teaching sexual health to teenagers will actually encourage sexual promiscuity, although there is no evidence to support that claim [7]. Although practiced in SSA, direct parental teachings on sexuality issues can often misinform and misguide many youth [42]. This is often because the parents of many young Africans were not taught about sexual and reproductive health by their own parents or in school [43]. Thus, for the most part, parental role in sexual education is inadequate.

Studies of sexual health service inadequacy have identified five major barriers to adolescent sexual health care: lack of knowledge/misinformation, social–psychological issues, cost, transportation/lack of access and partner preferences [5]. Social–psychological issues, including fear, shame in utilizing sexual health resources, lack of patient privacy and provider bias, were commonly found to be the greatest barrier to obtaining reproductive health services for the youth population [5]. Even though youth hold government hospitals and health facilities in a very positive light and regard them as their preferred source of obtaining contraception, many are reluctant to actually utilize their services due to societal stigma [7,44]. This reluctance is further compounded by lack of access to such facilities and the costs of such services. Moreover, it is of importance to note that in a study of young people 12–19 years old, between 6% and 30% did not know of a place to obtain reproductive health services in Burkina Faso, Ghana, Malawi and Uganda [44]. Lastly, even in cases where young women desire and are willing to utilize modern contraception methods, their success in obtaining and using such services are sometimes severely hindered by their partners' preferences.

Our findings support existing literature that calls for a reorientation of family planning policies and programs, which currently target mainly married women and women who have been pregnant once [25,43,45]. This approach overlooks the contraceptive needs of young women before their first pregnancy, which, as we illustrated, is a misinformed strategy that does not consider the needs of the millions of sexually active African youth. Though our results do not directly highlight the effects of method availability and affordability on youth, policies and programs must recognize that large quantities of resupply methods will be necessary to meet their needs. While there is a movement among program planners and funders to promote longer-acting methods [46], these methods may not be suitable for young people who are initiating their sexual life, using contraception for the first time and, sometimes, practicing infrequent sex. Furthermore, current method mix among youth users indicates use of resupply contraceptive methods.

To improve access to information, social marketing programs should target young people with their mass media campaigns. However, many youth will not be able to afford the small fee associated with socially marketed commodities, and extra method subsidization may be necessary to maintain use among the poorest. While parent–child communication has not been shown to be successful in the past [42], we do believe that it is an important next step to develop, especially as the current youth generation prepares to educate their children. In addition, parent–child communication can be expanded such that one extended family member is responsible for educating the youth on sexual and reproductive health, bypassing parents and cultural stigma that may be associated with parent–child communication on sexuality. Finally, we recommend strengthening school-based comprehensive sexual education and services for youth attending school. However, for the young people not in school, it is important to have safe spaces where they can receive information and services. For example, youth clubs that offer a range of activities and services should include sexual and reproductive health.

There are several limitations to our study. The selection criteria, which were determined a priori to the analysis, resulted in the exclusion of Francophone countries, except for Mali. Our study could also be limited by the sensitive nature of questions related to sexual behavior and fertility, given that our analysis of DHS data relies on self-report. Youth may underreport sexual activity in settings in SSA where premarital sex is taboo [43]. Misreporting could be a result of campaigns promoting abstinence for youth at the time of the surveys, such as was the case in Uganda [47]. Another limitation of this study is that actual levels of unmet need among youth most often exceed those observed [48]. By including only married sexually active women instead of all sexually active women in indicators for unmet need in population surveys, there is an underestimation of the need for services. Because we are making assumptions about how many young people would use contraception in our estimates, these may not reflect the true contraceptive intentions of youth. Nonetheless, it is evident that to meet the rising demand for modern methods among youth, it is critical that future programmatic efforts provide methods that are both accessible and acceptable to young people.

5. Conclusion

The current state of reproductive health services in SSA is far from adequately meeting the needs of its youth population. Whereas the rest of the world, including other less developed regions, has witnessed a steady decline in the population of youth as a percentage of the total population; this proportion in SSA has remained relatively constant over the last 15 years [1]. The African youth of today have hopes of delaying marriage and childbearing in the pursuit of education and better livelihoods. It is clear that African youth

are at a high risk for pregnancy-related morbidity and mortality, and many of these pregnancies could be prevented with the expansion of youth-realistically accessible and affordable family planning services. Young women bear the greatest burden of pregnancy-related morbidity and mortality [29,30], and there is growing evidence to suggest the clear role of family planning in achieving the MDGs [20,21]. It is imperative that governments, NGOs and international donors understand the circumstances that shape the lives of youth, as well as the factors that affect their access to and uptake of family planning services. There is no one-size-fits-all solution, but the way forward is clear: improve access to modern contraceptive methods among African youth now.

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