Training course in adolescent sexual and reproductive health 2019

Contraception counselling and provision

Janie Shen

Plan International, Stockholm, Sweden

janie.shen@plansverige.org

Question 1:

What are the differences between Ghana and Niger in terms of age of first sex and age of marriage? What are the implications of this?

In Ghana, the age of first sex is 18.6 whilst age of first marriage is 22.4. This indicates that the majority of young people are sexually active before marriage, and for a long period of time (nearly four years). This means that it's critical for young adolescents (as early as possible) to have access to CSE and information about contraceptives so they understand how and why they should use contraceptives (demand-side), and for adolescents and young people to have access to health services and contraceptives without restrictions and barriers (supply-side).

In Niger, the age of first sex (16) and age of marriage (15.9) is very closely aligned, which means that young people have sex in connection with their marriage which in this case is very early. More than half of the women in Niger are married before 16, and working on preventing child and early forced marriage and delaying the age of marriage to 18 is critical. A later age of marriage, would mean more educational opportunities for adolescent girls, better maternal and child mortality outcomes, and more control and empowerment in the hands of girls and young women. This also means we need to ensure that health services and contraceptives are accessible for married adolescent girls, and as married adolescents have very limited agency and may be restricted by her spouse, family etc to access these services it is critical to reach out to these gate-keepers on sexuality education.

Question 2:

Identify two challenges of gathering information on sexual activity in unmarried adolescents?

1) In many countries in Asia and North Africa, unmarried adolescent women are simply excluded from surveys gathering information on sexual activity. For example Indonesia and Pakistan, which has large adolescent population data is only available for married adolescents. In these countries it is considered 'taboo' for young women to be sexually active outside of marriage, so young women are not asked these questions out of sensitivity to local custom.
2) However, in contexts where unmarried adolescents are consulted on their sexual activity, even when they are asked, they may be reluctant to report sexual activity. Sexual activity before marriage is considered a taboo in many places, and young people may be unwilling to disclose their sexual activity due to stigma and shame they might face, especially if these surveys are conducted at home, or through interviews.

Question 3:

A health professional can prescribe/dispense the same contraceptive methods to adolescents as in adults.

True. WHO's *guideline on medical eligibility of criteria for contraceptive use* provides recommendations on safe use of contraceptives and shows not distinction for adolescents. Contraceptive methods eligibility varies depending on whether the use of contraceptives will affect a person's health and vice versa, age is not a factor. The guidelines state that in general,

"adolescents can use any hormonal or non-hormonal contraceptive method (including emergency contraception), regardless of age"

Question 4:

A young woman in a rural North Indian community is able to obtain contraceptives free of charge from a government clinic in her community, but is unwilling to use it. Identify 3 possible reasons for this.

1. Social norms around fertility. If she is married, she may face pressure to have children from her spouse, her family and community. The social pressure to conceive and bear children soon after marriage will probably hinder her from considering contraception until well after her first or second child. She may also want, and choose, to have children. If there is general lack of educational and livelihoods opportunities available for her, having children could improve her social standing, and may seem like a good choice, among a set of very limited choices.
2. Stigma around non-marital sexual activity and/or contraceptive use: If she's unmarried, she may not be considering contraceptives unless she was in stable relationship. There is a lot of shame and stigma towards female sexuality and pleasure. In my places, a girl who is sexually activity before marriage may be considered "promiscuous". Thus even though she is able to access services and contraceptives, she may be not want to reveal that she's sexually active or she may feel too embarrassed to ask for contraceptives.
3. Misconceptions on use of contraceptives are still common. Adolescents and the wider community may not have the right information and understanding of immediate and long-term side effects of contraceptive methods. A common misconception is that using family planning methods can lead to infertility. She may have these fears, and then chose not to use any contraceptive methods but instead consider ineffective methods such as withdrawal or traditional remedies.

Question 5:

There is a report of an evaluation of the Health Policy Project in Guatemala, Malawi and Nepal. Name three actions you would take if you were the national reproductive health programme manager in Malawi.

I'd work with the 2009 National SRHR Policy, which highlights young people as one of the policy themes. I would focus on setting up some structure and a national plan for activities that aim on reducing adolescent pregnancy, through a multi-sectoral and multi-pronged approach that works on several layers: providing comprehensive sexuality education, adolescent-responsive SRHR services and more targeted support for adolescent mothers/pregnant adolescents.

1. Set up, or improve (if these mechanisms already exist) the coordination systems to ensure communication and multi-sectoral collaboration with relevant governmental entities that deal with adolescent health, such as the Ministry of Health, Ministry of Education and Ministry of Youth and Sports. This coordination is not only critical for the implementation of the plan, but also for ensuring that the national policy framework remains supportive to young people's SRHR needs and continues to advocate for better policies such as access to safe abortion.

2. Conduct an assessment of Malawi's Family Life Curriculum together with strong civil society organizations and partners, and in close collaboration with young people. To ensure quality CSE is being delivered, I would prioritize to review the curriculum content and delivery to understand how it compares to global and national standards, and ensure that youth perspectives are taking into consideration, for both in school and in out of school programs. I would also form strong partnership with CSOs to build and refresh teacher skills in CSE. As young people are not a homogenous group, I'd also review their differentiated needs and concerns in partnership with youths themselves, in close partnership with young people's organizations and networks. Through youth participation and co-creation, we would be able to design and implement more targeted and differentiated programming around SRHR services and outreach that would suit the unique needs of each group. For example, married and unmarried adolescent girls have very different preferences towards contraceptive use in Malawi, and face different barriers when accessing services.
3. I'd also invest in quality monitoring and evaluation frameworks from the onset, so I can better keep track of these programmes and its progress. Period monitoring and evaluation, together with rigorous collection of data and qualitative research that shows disaggregate data by local areas can help understand why certain strategies are working and not, and in a timely manner so that adjustments can be made, for example half-way through the plan in order to ensure that we can reach our goal.