Training course in adolescent sexual and reproductive health 2019

Contraception counselling and provision

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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 West Africa, countries exhibit diverse patterns between the age of first sex, age of marriage, and age of first birth. In Africa, adolescents and youth ages 15-24 make up 41% of all men and women of reproductive age, while ages 25-49 make up the rest of the population. The median age for key life events is represented by the age at which 50% of women aged 25-29 had experienced their first sexual intercourse and first marriage. Figures based on Demographic and Health Survey (DHS), 2012 show that Ghana's median age of first sex is 18.6, while the median age of marriage is 22.4. For Niger, figures show that the median age of first sex is 15.9, while the median age of marriage is 16.

Empowering young people with tools they need to thrive is central to achieving both FP2020 goals and the SDGs. Therefore, understanding the lives of young people and their information and service needs are critical for understanding and developing effective health programs that are context-specific in approach. In the graphic, you can see that Ghana's long period between the median age at first sex and the median age at first marriage, highlighting the importance of widespread access to health services and health education for adolescents and youth. In Niger early marriage is common, and more than half of women marry by the age of 16. Efforts to delay marriage and delay first birth are critical in these contexts for a host of reasons, including improvements in maternal health outcomes, increasing girls' education, and empowering women.

Question 2:

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

Reliable information about sexual behaviour is essential to the design and assessment of interventions to improve sexual health, to the understanding of the aetiology of sexual ill health, and the development of appropriately targeted sexual health services. An understanding of trends and patterns in sexual behaviour is essential to the design of effective interventions aimed at improving sexual health status and assessing progress towards goals. However, there are many challenges of gathering information on sexual activity in unmarried couples.

One challenge is that in many countries, particularly in Asia and North Africa, unmarried persons (including those ages 15- 24) are excluded from surveys about sexual and reproductive health due to sensitivities about sexual activity outside marriage. When included in surveys, unmarried youth may be reluctant to report sexual activity, particularly when interviewed in home settings. When young adults, ages 15 – 24 are included in surveys, face-to-face personal interviews are the most common method of collecting data on sexual behaviour. Unmarried youth may be reluctant to report sexual activity, particularly in home settings due to the 'eavesdroppers' effect as other household members may be listening in. Therefore,

better methods of confidentiality and anonymity should be considered when facilitating personal disclosure.

A second challenge is that in countries that do collect data among unmarried sexually active men and women, the classifications of sexual activity used in standard reporting may obscure understanding of youth contraceptive use. In most survey analyses, an unmarried person is only considered to be sexually active if they've had sex within the last month; in contrast, all married people are considered sexually active regardless of how recently they've had sex. Yet in many countries, the percentage of youth who have had sex but *not in the last month* is equal to or greater than the percentage of youth who are currently sexually active. For example, in the Democratic Republic of Congo, women ages 15 - 19 and 20 - 24, are interviewed based on their marital status, whether they have had sex within the last 30 days, the last 3 months, the last year or never. Only 12% of unmarried women aged 15 - 19 are currently sexually active, whereas an additional 7% were sexually active in the last 2–3 months and an additional 5% were sexually active in the last 4 - 12 months. These data suggest that women who are *not c*urrently sexually active should be examined together with those who are currently sexually active to better understand the behaviors and needs of unmarried women for developing effective programs.

Question 3:

A health professional can prescribe/dispense the same contraceptive methods to adolescents as in adults. True, False or Unsure. Explain your answer.

True, a health professional can prescribe or dispense the same contraceptive methods to adolescents as in adults. According to 'Medical eligibility criteria for contraceptive use' (5th edition), the safety of contraceptive methods is dependent upon the context of an individuals' health condition(s) and characteristics rather than to a specific age group. Age is not a limiting factor for contraceptive choice, and a comprehensive history and discussion of available options can enable adolescents to make an informed choice, so long as they adhere to the Fraser guidelines.

Among both, adolescents and adults, the suitability of contraceptive use may vary. This either depends on a persons' health condition(s) or inversely whether the individuals' health condition(s) affect(s) the effectiveness or safety of the contraceptive method. The safety of a contraceptive method is assigned a numeric category, from 1 to 4 with a graduation of increasing risk, to indicate whether a woman or a man is medically eligible. Category 1 refers to a condition for which there is no restriction for the use of the method. Category 2 refers to a condition where the advantages of using the method generally outweigh the theoretical or proven risks. Category 3 refers to a condition where the theoretical or proven risks usually outweigh the advantages of using the method. Category 4 refers to a condition, which represents an unacceptable health risk if the method were to be used. Some contraceptive methods are further assigned to categories; C, caution (with extra preparation and precautions); D, delay; or S, special.

In general, adolescents and adults can use hormonal and non-hormonal contraceptives, regardless of age, although DMPA/NET-EN (category 2), by definition, the advantages of using the method generally outweigh the theoretical or

proven risks, in some case requires additional follow up for young women (menarche to less than 18) due to its potential effects on bone mineral density in adolescents.

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.

There are millions of adolescents who wish to postpone or space childbearing that are not using effective forms of contraceptives. The Guttmacher Institute estimates that 38 of the 252 million adolescent women aged 15 to 19 living in developing regions are sexually active, and do not wish to have a child in the next two years. Among these adolescents, 23 million have an unmet need for modern contraception. However, even when contraceptive use increases, adolescent's use does not increase as much as amongst other groups. Even when adolescents have access and begin using contraceptives, challenges still persist. Adolescents are more likely than adult women to discontinue contraceptives, with unmarked adolescents exhibiting the highest level of discontinuation. The reason for this is availability, accessibility, and acceptability.

Many adolescents are not able to obtain the contraceptives they need. Although services may be available in theory, in practice the selective systems they operate may bar some categories of users. In countries in which sexual behaviour is tightly restricted, services may not be accessible to specific groups. In some areas, family planning services are not available to unmarried women. India, a country with strong social norms prohibit premarital sex, the negative attitudes of service providers as well as reluctance to report being sexually active limit access by unmarried youth.

Services may be available but under-utilized. The barriers that prevent potential users from accessing sexual health services have been well-documented. Accessibility depends on a range of factors, including convenience, level of publicity, and costs. Inconvenience is a major barrier to service use. Convenience implies practical opening hours, easy attendance with short waiting times (whether via an appointment system or drop-in services), swift referral, and easily accessible locations. Services for young people need to be open outside of school or college hours and services and services attended by young mothers need to be child-friendly. Services may also be inaccessible simply because potential service users are unaware that they exist.

Even when adolescents are able to obtain contraceptives, there may be an issue with acceptability, which can be viewed as two-fold. For many adolescents, not using contraceptives is that they don't have the desire to avoid, delay, space or limit childbearing because of gendered roles, need to prove fertility, religious values or path to adulthood, that stem from social pressures. In many places, there are very few educational and employment opportunities for girls, in such cases an early pregnancy or repeated pregnancy may be the only choice. Whilst, for many women, there is pressure to have children and the stigma surrounding obtaining/proposing contraceptive use. They do not have the autonomy of power to make decisions over when and if they use contraceptives due to early marriage, family pressures, sexual coercion/violence. Therefore, it is important to note that focusing on access is simply

not enough. We need to understand what effects demand and what effects supply of contraceptives, in order to increase the correct and consistent use of contraceptives among adolescents.

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.

There are many things that can be done to expand access to quality contraceptive services to adolescents with equality, which can be divided into five stages: policies, strategies, implementation, monitoring, and research.

1. Develop national laws and policies that require health workers to provide contraceptive services to adolescents without restrictions, and communicate them widely
2. Design sound national adolescent sexual and reproductive health (SRH) strategies that contain evidence-based and context-specific packages of interventions, budgets to deliver the package, and indicators to track progress that are disaggregated by age, sex, and socioeconomic status
3. Implement strategies with fidelity and careful monitoring, through functional systems and with the participation of civil society groups (including networks of youth organizations)
4. Conduct periodic programme reviews to build on strengths and address weaknesses
5. Research – with an emphasis on implementation research - to answer context-specific programmatic challenges

The Health Policy Plus project on their analysis of family planning policies for young people in Guatemala, Malawi, and Nepal found that "All three countries have largely recognized the problems facing adolescent women, and they are trying to meet their family planning needs. These countries have many of the right policies already in place". However, all three counties, although having enabling policies that are supported at a national level and that dismantle external authorization, age restrictions, and marital status restrictions, adolescents still found it difficult to obtain contraceptives. While it is important that existing policies feed into sound strategies, what matters most is how well countries implement available policies.

In Malawi, two-thirds of its population is under 24. These young people have a right to high-quality sexual and reproductive services that are relevant, accessible, attractive, affordable, appropriate and acceptable to them. However, most of Malawi's youth are not well informed about their rights, and negative attitudes around providing sexual and reproductive health services to youth persist in many health facilities.

In the case of Malawi, to ensure fidelity of implementation (3), it is essential to have functioning systems and technical expertise drawing upon a range of players. The youth also, have the potential to be powerful agents for positive development and

socioeconomic change. Malawi would be better positioned if decision-makers prioritized family planning in polices, programs and funding across sectors. While, the health sector must provide leadership on the delivery of family planning services, ensuring that services are available and accessible to all Malawians requires a coordinated approach across sectors. Stakeholders should consider the following actions to accelerate progress.

1. Expand youth access to accurate and actionable information and family planning services, and promote youth rights to make their own fertility choices in order to address an unmet need.

As one of the fastest-growing countries in Africa, representatives from ministries in the Population Technical Working Group should promote collaborations on family planning at the policy, funding, programmatic and community level. Therefore, the government must advocate mobilizing resources for sexual and reproductive health and rights (SRHR) outreach services for hard-to-reach/marginalized adolescents. This can be done through training of health workers to ensure they are respectful, non-judgemental, friendly and most importantly mandated by law to provide services to youth aged 24 and younger, regardless of marital status. In addition, facilitate dialogue with parliaments to increase budgets for family planning and youth-friendly health services, including grants and funding opportunities in order to scale up delivery of integrated adolescent and youth-friendly health services in public and private facilities. Finally, dialogue with ministries and the media must be made to end child marriage (by raising the legal age of marriage to 18) and harmful practices that predispose adolescents to early pregnancies and childbirth, by highlighting the importance of keeping girls in school.

2. Strengthen district and community structures to facilitate youth engagement to support meaningful participation of young people in coordination and implementation of sexual and reproductive health programmes.

The government must advocate for effective coordination of youth-focused programs by district and community structure. This can then, facilitate active youth participation and leadership in the planning and implementation of youth-focused programmes. Youth must be engaged to popularize youth-friendly health services. Advocating with young people, guardians, teachers, and communities to develop positive attitudes towards youth-friendly health services are essential. In addition, the concept of contraceptive must be made desirable. Information on modern contraceptives in CSE must be integrated and CSE must be lobbied for in both public and private primary, secondary school and all tertiary institutions including standardised implementation of CSE in-and-out of school.

3. Support a coordinated and strategic multi-sectoral approach that focuses on investing in youth.

Youth have the potential to be powerful agents for positive development and socioeconomic change. Stakeholders must be convinced of the importance of investing in youth. To realise this potential, the Government of Malawi should focus on increasing youth access to education and health services, participation in decision-making and job creation. For many women, there are very few educational or employment opportunities for girls, in such cases, early or repeated pregnancy may be the only choice or a very small one of a very small set of base choices open to girls or

young women. This should include, supporting girls and young women's strategies, which includes enabling adolescents to continue their education after a pregnancy.