

Training course in adolescent sexual and reproductive  
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Contraception counselling and provision

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## **Introduction:**

Contraception is the intentional prevention of pregnancy by artificial or natural means (1).

The prevalence of early pregnancies both intended and unintended among adolescents has significant negative impact on their well-being and need immediate public health interventions. The early pregnancies can be reduced by delaying sexual intercourse and increasing contraceptive use among married and sexually active unmarried adolescents. While it is difficult to delay or stop sexual intercourse as sexual activities are very common, it is important to promote contraceptive use to address negative consequences of early pregnancies.

## **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?**

Ghana and Niger are showing a very contrasting pattern. Firstly, in Ghana, there is a long gap between age of first sex and age of first marriage, however, in Niger, both the events are overlapping. Secondly, early marriages are not common in Ghana whereas 50% of the women in Niger are marrying at age of 16. Thirdly, age of first sex in Ghana is 18.4 whereas in Niger it is around 16 years.

In Niger, early marriages are having negative impact on girls' overall mental, physical and cognitive development. Early marriages also lead to unintended pregnancies which put newborn at increased risk of low birth weight, malnutrition, abuse and infant death. It limits the chance of a girl to have proper education, health development, economic prospects while making her more vulnerable to domestic violence, forced sexual intercourse, high risk pregnancies and so forth. The country should focus on improving access to health services, education (especially health education for adolescents and youth) and empowering women.

Though Ghana's indicator related to key life events are best among West Africa, however, the country still need to focus on Comprehensive Sexuality education to adolescents and youth. It should also complement with quality family planning services including expansion of basket of choice of FP choices.

## **Question 2:**

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

1. **Current Exclusion of unmarried women (including those aged 15-24) in many countries:** In several countries, national surveys do not include indicators related to Sexual and Reproductive Health of unmarried adolescents due to community resistance or cultural beliefs related to sexual activities outside marriage. Thus making it a very complex and often sensitive issue.
2. **Unwillingness of unmarried adolescents:** Unmarried youth may be reluctant to report sexual activity in a household survey setting: In household survey settings, it is observed

that many adolescents are not willing to disclose their sexual activity making it difficult for an accurate estimate.

**Question 3:**

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

- True
- False
- Unsure

It is true that any health professional can prescribe/dispense the same contraceptive methods to adolescents as in adults. In general, adolescents are eligible to use all the same methods of contraception as adults, and must have access to a variety of contraceptive choices. Age alone does not constitute a medical reason for denying any method to adolescents (2). While, apprehension is reported on the use of some contraceptive methods, however, the benefits of preventing unintended pregnancy outweighs those concerns.

**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. **Lack of freedom for decision making:** In Indian communities, a woman is under constant pressure to conceive and bear children soon after marriage. Most likely, elder members of the family or male counterpart will take decisions on her behalf and expect to obey them unconditionally. Thus, even though she obtains contraceptives but the decision to use it does not lie with her.
2. **Lack of accurate information:** Mostly women especially in Indian rural settings have myths about the immediate and long term side effects of contraception on their health and child bearing ability in future. Some religious institutions in India also spread negative information regarding contraceptives due to which women perceive using contraceptives as an anti-religious act.
3. **Lack of consistent use:** Due to erratic information about how contraceptives are being used, women tend to use it incorrectly. Inconsistent use of contraception and relative inexperience often make leads to no use of contraceptives in future.

**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.**

At the outset, the policy environment in Malawi is conducive for adolescents in terms of availing family planning services. The Malawi Growth and Development Strategy II (MGDS-II) 2011–2016 laid down important aspects which will impact the health and wellbeing of adolescent in a holistic manner. However, for effective implementation of the strategies and policies, following points need consideration:

**Institutionalise convergence between Health, Education and other line departments:**

There is a need for regular coordination meetings with line departments such as Health, education, youth and sports, water and sanitation, women and child development etc. These meeting should address the common agenda points which will impact adolescent's health and wellbeing and it should happen at all administrative levels. While the role of all departments are crucial, it would be prudent if Health department takes lead in setting up systems of regular coordination meetings. Roles and responsibilities of all departments should be clearly delineated with indicators to monitor the progress.

**Involvement of Civil Society Organisations (CSOs) in implementation:** CSOs especially the local organisations having experience in dealing with adolescents should be involved in implementing policies at the ground level. CSOs bring expertise such as Trained Human Resource, Monitoring and evaluation strategies etc. which governments lack. The government should work in synergies with these organisations so that mutual goals are met and policies are implemented effectively.

**Implementation of Monitoring mechanism:** I always believe that what is monitored is implemented! So, regular monitoring on both short- and long-term basis with effective monitoring process provides ongoing, systematic information that strengthens implementation. The monitoring of programs will determine whether sufficient progress is being made toward achieving expected results in a specific time frame. All the implementation units will be held accountable and will be assessed through agreed indicators. The monitoring mechanisms also support in evidence based decision making.

**Advocacy with legislators and policy makers:** As we all know that resources are scarce and we should use it efficiently to get the desired results. In the light of competing priorities, it is very important to advocate for the health and wellbeing of adolescents. One must ensure that the family planning need of adolescents are always on the agenda of legislators and policy makers. For this, an advocacy plan is crucial with clear deliverables.

## **References**

1. Sexual health and its linkages to reproductive health: an operational approach. Geneva : World Health Organisation, 2017.
2. Medical eligibility criteria for contraceptive use:5th edition: World Health Organisation, 2015.