Training course in adolescent sexual and reproductive health 2020

Approaches to ensuing the continuity of SRH information and services provision to adolescents in the context of the COVID 19 crisis: and using the opportunity of COVID-19 to build back better

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Question 1.1

Name one issue described in the FP2020/IAAH statement that hinders adolescents' access to SRH information and services in your country.

Adolescents' access to SRH services is a complex issue governed by several demand and supply side factors. In India, issues like **early marriages** (26.8% girls are married off before attaining the legal age of marriage[i]), **adolescent pregnancies resulting in poor birth outcomes** (14% adolescent pregnancies resulted in abortions/ miscarriages/ still births [i]) and **unmet need for contraception** (22.2% adolescents have unmet need for contraception [i]) **are all results as well as cause** of **poor education** levels, **prevalent societal norms** and **provider bias** in rendering adolescent friendly services[ii]. The recent COVID pandemic has intensified these problems further. Loss of income and food insecurity is forcing the adolescents (especially girls) to drop out of school and are married off early to ease the financial burden of the family[iii]. Further, movement restrictions and school closures owing to the lockdown has snatched away the limited social support that the adolescents had. On the supply side, general providers' mindset considering adolescents to be a healthy group and overlooking their health needs is not uncommon (only 7.6% unmarried girls were told about contraception by health care worker [i]). Lastly, the prevalent cultural norms and pre-marital sex being frowned upon restrict the adolescents in seeking services freely.

Question 1.2

Describe briefly what approach you would use to overcome this issue.

Interestingly, most of the factors and issues mentioned above are **interrelated and command a multi-pronged approach** to address them for making SRH services more relevant and accessible to the adolescents. On the supply side, **a 'Sensitivity training'** must be made a part of the counselling/ service delivery package for adolescent SRH services as a conscious step towards alleviating provider bias, maintaining confidentiality and making services adolescent friendly in a true sense. The mandate for **parental consent** in obtaining comprehensive abortion services for adolescents (as per MTP act) **needs to be re-considered**. Further, utilizing **youth as change agents** in the community (while supporting both adolescents and other members of the community during pandemic) can go a long way in overcoming the way adolescent needs are perceived. Also, additional **incentives (both monetary and vocational)** for keeping adolescents in schools and completing education may prove supportive as then the families do not need to worry about the financial cost of education.

Question 2.1

Which recommendation(s) on CSE does the example from Education as a Vaccine Nigeria illustrate?

Since 'Education as a Vaccine Nigeria' uses online platforms and social media complemented with radio jingles and retraining of counselors, it illustrates an example of provision of CSE through mass media and digital media to which adolescents have access as well as equipping healthcare workers with up-to-date information that they can share with the adolescents.

Question 2.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

This example is partially relevant to the Indian context as adolescents in India is a heterogenous group. With the advancement in technology, social media is easily accessible and there is an increase in use of online platforms, especially among urban adolescents[iv]. However, with consequences of COVID-19 (loss of income, disrupted education etc.), exclusive use of phones by adolescents has reduced. Also, considering the cultural silence and inhibitions, introducing a mass media campaign on ASRHR would be a challenge.

Question 3.1

Which recommendation(s) on contraception does the example from RFHA Fiji illustrate?

RHFA Fiji illustrates a multiple recommendation like informing adolescents where and how to access contraceptive services (during the COVID response), establishing alternate contraceptive delivery modalities that are more accessible to adolescents (through peer educators and mobile outreach) and setting up hotlines for adolescents, providing information on contraception self-use, side effects and other questions on SRHR.

Question 3.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

This example is feasible in India; it is also evident from implementation of similar interventions by multiple youth organizations (like the YP foundation and Love Matters) which are supporting Government of India. The support of peer educators and local youth networks is taken for delivery of contraceptives and providing psycho-social support to the adolescents. Further, helplines/ WhatsApp chatbot have been established to support and resolve queries that the adolescents might have.

Question 4.1

Which recommendation(s) on comprehensive abortion care does the example from FRHS India illustrate?

FRHS India demonstrates recommendations like ‘Informing adolescents where and how to access comprehensive abortion care, to the full extent of the law and post-abortion care, through appropriate channels’ as well as ‘Counseling adolescents on, and provide, post-abortion contraception to avoid rapid repeat pregnancy’. It further illustrates recommendation of ‘relaxing policies to avoid unnecessary visits by clients’.

Question 4.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

This intervention being implemented in India is a testament to its feasibility in the country. However, factors like financial cost, conflation of laws (MTP act and POCSO act), provider

bias, concerns regarding confidentiality and fear of discrimination limit the accessibility of safe abortion services to the adolescent girls (especially unmarried girls). Addressal of these issues can go a long way in improving SRH for adolescents in the country.

Question 5.1

Which recommendation(s) on maternal care and mental health does the example from the University of Nairobi and the Nairobi City Council in Kenya illustrate?

Example from University of Nairobi illustrates two recommendations- 'use of Telemedicine for counselling and screening including for risk factors known to be increased in the context of COVID-19 and to which adolescents may be particularly vulnerable (e.g.: mental health issues and gender-based violence)' as well as 'targeted outreach strategies where coverage and care-seeking among pregnant adolescents have declined'.

Question 5.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

This example is possible in India as is evident from the recent **'Telemedicine Practice Guidelines'** issued by Ministry of Health, India[v], realizing the enhanced need of medical tele-consultation amid COVID Pandemic. Further, targeted outreach strategies are being considered under '***AYUSHMAN BHARAT'*** initiative to make primary healthcare accessible to all. However, implementation of these strategies needs evaluation, while making these strategies more inclusive, especially for adolescents, which seems to be missing currently.

Question 6.1

Which recommendation(s) on HIV does the example from the Zvandiri in Zimbabwe illustrate?

The example from Zyandiri illustrates three recommendations on HIV- Informing adolescents where and how to access HIV and other STI testing and care, where access is possible, through mass media and digital media; providing home-based HIV/ STI tests, as well as information about proper self-sampling; and modifying services to promote out-of-clinic delivery of elements of the advanced disease package of care.

Question 6.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

These strategies might be a challenge in India requiring considerable change in the existing National Guidelines on HIV testing and Management[vi] [vii] [viii]. Firstly, home based HIV testing/ self-sampling may require orientation of adolescents and invite a lot of social stigma and parental interference thereby defeating the purpose of the intervention. Further, out-of-clinic delivery may be possible through peer-educators/ youth leaders but require training of the healthcare workers to alleviate discrimination and maintain confidentiality.

Question 7.1

Which recommendation(s) on gender-based violence does the example from Centre for Catalysing Change in India illustrate?

Centre for Catalyzing Change demonstrated a multi-pronged approach on Gender-based violence in India. It included 'Informing adolescents where and how to get care, through mass media and digital media', 'Sensitizing health-care providers, community workers and support networks on increase in gender-based violence and ensuring awareness on adolescent vulnerabilities' and 'Establishing helplines for adolescents to seek help if needed'.

Question 7.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

The implementation of the project in India shows its feasibility. As mentioned earlier, many youth organizations are supporting Government of India in establishing helplines for adolescents for providing psycho-social support, during COVID pandemic. The issue of gender-based violence, however, is more complex and needs sensitization and awareness of both health care workers and adolescents (on their rights and duties). The strategies may be scaled up, taking lessons from the above-mentioned example.

Question 8.1

Which recommendation(s) on HPV does the example from the Ministry of Health of Laos illustrate?

The HPV example from Laos illustrates two recommendations- 'Informing health workers and others involved in different aspects of HPV vaccine delivery' and 'Informing adolescents and their parents about the importance of a full series of HPV vaccination, reassuring them about the efficacy and safety'.

Question 8.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

This strategy is feasible in India, with newly launched 'School Health Program (SHP)[ix]' and 'Adolescent Health Days[x]' under Rashtriya Kishore Swasthya Karyakram providing a robust platform for implementation. The orientation on HPV for teachers may be included in the existing SHP curriculum while AHDs can be a useful platform for orientation of adolescents. Since, parents are important decision makers in determining the health seeking behavior of the adolescent girls, their orientation is vital and platforms for same need to be explored.

Question 9.1

Which recommendation(s) on menstrual health does the example from the Footprints Foundation in South Africa illustrate?

Footprints Foundation in South Africa demonstrate two recommendations on Menstrual health, 'inclusion of menstrual products in the distribution of food or non-food items to girls

with limited movement' and 'Engage community groups to extend the availability of affordable menstrual products'.

Question 9.2

Do you think this example would or would not be feasible in your country? Briefly explain your answer.

This example is feasible in India, in fact, is being implemented in many rural areas of the country (though in a fragmented manner). In many states, women Self Help Groups (SHGs) are being involved to prepare menstrual pads[xi] [xii], generating livelihood for them and ensuring availability of affordable pads to the adolescent girls (through youth networks and peer educators).

Question 10

In what ways do you think COVID-19 might, in fact, present an opportunity for accelerating progress on ASRHR?

The COVID-19 pandemic has offered a unique opportunity to change the way health priorities are addressed. Accrual of knowledge and evidence on the determinants of health and related inequalities has provided the robust ground for the government's approach to health and well-being[xiii]. An increase in the use of online platforms among adolescents (Facebook, WhatsApp, Twitter etc.) due to unprecedented restriction in movements has provided a prospect to disseminate correct information on sexual and reproductive health (through chatbots, Facebook live etc.). Furthermore, increase in tele- health consultations and tele-follow ups during COVID pandemic has reduced the burden on healthcare system and proved beneficial in addressing the inhibitions of adolescents to some extent in seeking counselling and services without discrimination. Focus on **'Self-Care'** and use of short-acting contraceptive methods without intervention of health personnel has ensured active involvement and responsibility of adolescents in their own health. Last but not the least, involvement of youth networks for 'alternate contraceptive delivery/ delivery of essential commodities' during the pandemic has brought them in the forefront and shown how their services can be utilized.

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