

CONTRACEPTION COUNSELLING AND PROVISION

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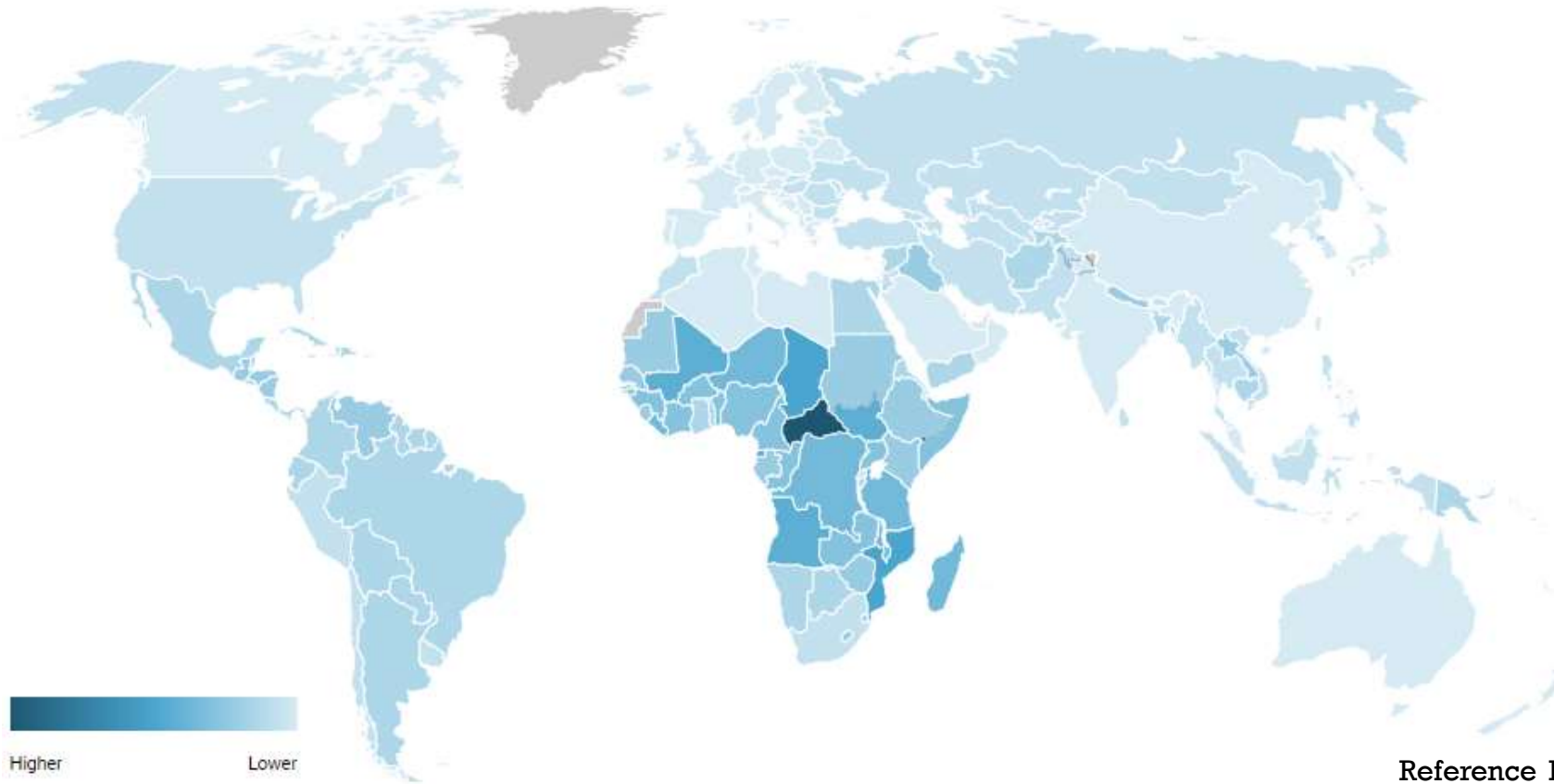
DEFINITION

- **Contraception is the intentional prevention of pregnancy by artificial or natural means.**
- **It enables people to attain their desired number of children, & to determine the spacing of their pregnancies by delaying or preventing child bearing.**
- **Contraceptive methods are designated by duration & context of use (permanent, long acting, short-term or emergency) & by mode of operation (hormonal, non-hormonal, barrier or fertility awareness-based).**

RATIONALE – 1/2

- **Early pregnancies, both intended or unintended, among adolescents are an important problem:** An estimated 21 million girls aged 15-19 years become pregnant.¹ An estimated 12 million girls aged 15-19 years and 2.5 million girls under age 16 in LMICs give birth every year.^{1,2} Approximately half of pregnancies to girls aged 15–19 years in developing regions are unintended.¹
- **Early pregnancies among adolescents have major health and social consequences:** Pregnancy & childbirth complications are the leading cause of deaths among girls aged 15-19 years globally.³ Girls aged 10-19 face higher risks of eclampsia, puerperal endometritis and systemic infections than women aged 20-24.⁴ An estimated 5.7 million girls aged 15-19 have an abortion, the majority of which are unsafe.¹ Babies born to mothers under 20 years of age face higher risks of low birth weight, preterm delivery and severe neonatal conditions.⁴

Adolescent birth rate per 1,000 women aged 15-19 years



Central and Southern Asia	26.2
Eastern and South-Eastern Asia	20.4
Latin America and the Caribbean	63.0
Northern Africa and Western Asia	40.5
Sub-Saharan Africa	104.4

Reference 2

RATIONALE — 2/2

- **Promotion of contraceptive use to address early pregnancies among adolescents has been shown to be effective:** When correctly & consistently used, contraceptives can prevent unintended pregnancies & thereby reduce maternal & newborn mortality & morbidity. Male & female condoms can protect against both unintended pregnancies & HIV/STI.
- **Laws & policies, & the provision of good-quality services need attention:** 14 million girls aged 15-19 years have an unmet need for modern contraception.¹ Contraceptive use in sexually active adolescents is lower than in other age groups because of lack of knowledge, knowledge gaps and misconceptions, difficulties in being able to obtain contraceptive services/commodities, & difficulties in wanting to/being able to use them correctly & consistently.



HUMAN RIGHTS OBLIGATIONS

- States are obliged under human rights law to provide contraceptive information & services to adolescents, & to adopt legal & policy measure to ensure their access to affordable, safe and effective contraception.
- Contraceptive information & services should be free, confidential, adolescent-responsive and non-discriminatory; barriers such as third party authorization requirements should be removed.
- Adolescents should have easy access to the full range of contraceptive; such access must not be hampered by marital status or providers' conscientious objections.

KEY CONCEPTS TO CONSIDER - 1/2

- **Laws & policies prevent the provision of contraception based on age or marital status in many countries:** Critical to adolescent-friendly service provision are laws & policies that support their access to contraception regardless of age or marital status, & without third-party authorization/notification.
- **Many adolescents have misconceptions about contraception or do not know where & how to obtain contraceptive information & services:** CSE is an effective way to reach & inform adolescents about contraception. It should be complemented by reaching out to parents, teachers & other gatekeepers.

KEY CONCEPTS TO CONSIDER – 2/2

- **Contraceptive services & health-care providers are often not adolescent friendly:** There is a need to overcome health-care provider biases and misconceptions regarding contraceptive use by adolescents.
- **The contraceptive needs of adolescents are diverse & evolving:** Complementary strategies must be used to respond to the differing needs & preferences of adolescents. Additionally, programmes must address the needs of special population of adolescents (e.g., those with disabilities, migrants and refugees).

WHO GUIDELINES

- *WHO guidelines on preventing early pregnancy & poor reproductive outcomes among adolescents in developing countries (2011)*
- *Medical eligibility criteria for contraceptive use, 5th edition (2015)*
- *Selected practice recommendations for contraceptive use (2016)*
- *Ensuring human rights in the provision of contraceptive information & services: guidance & recommendations (2014)*
- *WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights (2019)*
- *Consolidated guideline on sexual & reproductive health & rights of women living with HIV (2017)*
- *Guidance statement: hormonal contraceptive eligibility for women at high risk of HIV (2017)*
- *WHO recommendations on health promotion interventions for maternal & newborn health (2015)*
- *Responding to children & adolescents who have been sexually abused: WHO clinical guidelines (2017)*
- *Responding to intimate partner violence & sexual violence against women: WHO clinical and policy guidelines (2013)*

COMPLEMENTARY GUIDELINES TO WHO'S GUIDELINES

- [Medical eligibility criteria application for contraceptive use \(WHO, 2019\)](#)
- [Medical eligibility criteria wheel for contraceptive use \(WHO, 2015\)](#)
- [Family planning: a global handbook for providers, 2018 edition \(WHO, 2018\)](#)
- [Information note on self-administration of injectable contraception \(WHO, 2020\)](#)
- [Training resource package for family planning \(WHO, 2021\)](#)
- [Task sharing to improve access to family planning/contraception: summary brief \(WHO, 2017\)](#)
- [Compendium of WHO recommendations for postpartum family planning \(WHO, 2016\)](#)
- [Reducing early and unintended pregnancies among adolescents: evidence brief \(WHO, 2017\)](#)
- [Adolescents and family planning: what the evidence shows \(ICRW, 2014\)](#)
- [High-impact Practices \(HIPS\) in family planning: Adolescent-friendly contraceptive services - mainstreaming adolescent-friendly elements into existing contraceptive services \(USAID, 2015\)](#)
- [Youth contraceptive use: effective interventions- a reference guide \(PRB, 2017\)](#)
- [Global consensus statement for expanding contraceptive choice for adolescents and youth to include long-acting reversible contraception \(FP 2020, 2017\).](#)



Specific measures for delivery of services in the context of COVID-19 – 1/2

- Inform adolescents where and how to access contraceptive counselling and services, including changes, if any, to service delivery times, location, etc. during the COVID-19 response.
- In health facilities, ensure that adolescents have access to the full range of contraceptive methods, including condoms and emergency contraception.
- Ensure that forecasting for commodities and procurement planning are taking adolescents' needs into account, and adjust for potential alterations in method choice.
- In case the preferred method is not available, support the adolescent to identify an alternative method that meets his/her needs and preferences.
- Consider waiving restrictions (if restrictions exist), such as those based on age, marital status or parental/spousal consent, and providing services free of charge within the relevant legal jurisdiction and in line with international guidelines.



Specific measures for delivery of services in the context of COVID-19 – 2/2

- Consider providing multi-month supplies with clear information about the method and how to access referral care for adverse reactions.
- Counselling and services should continue to be provided discreetly and confidentially to adolescents, especially if someone else accompanies the adolescent to the consultation’.
- Consider establishing alternative delivery modalities for contraceptives that are more accessible to adolescents (such as through pharmacies, shops or community-based delivery).
- Consider setting up hotlines for adolescents providing information and advice on contraception self-use, side effects, method choice and other questions on SRHR.



Considerations for resumption of normal services in the context of COVID-19

- Enable adolescents who had to pause contraceptive use or change methods, because their preferred method was unavailable, to return to it.
- Where possible, promote the institutionalization of good practices in improving accessibility and quality that were put in place during the period of closures and disruption.



I believe contraception should not be given to young women until after they've had their first child

Trainer

Not true. It is safe for all young women to use contraception, even if they are not married or haven't had a child

Yes, and it can help them to avoid unwanted pregnancies

CONTRACEPTION , COUNSELLING AND PROVISION

A REGIONAL PERSPECTIVE

Access to contraceptives for adolescents has been shown to promote autonomy and decision-making abilities, improve partner communication, and empower young women to lead healthy and productive lives (UNFPA, 2013).



Key facts from the Region

Key Indicators

- I. The Eastern Mediterranean Region has the **second lowest contraceptive prevalence rate (CPR) (48%)** and the **second highest unmet need for family planning (FP) globally**, after the African Region.¹
 - I. Ten Member States have an **unmet need for FP** exceeding 20%.
 - II. Nine Member States (Afghanistan, Djibouti, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan and Yemen) have a lower **CPR** than the regional average.¹
- II. Much of the unmet need for FP in the Region is among married women and girls. This is compounded by the **high rate of early marriages** (women aged 20-24 who are married or in union before the age of 18) in many Member States like Somalia (45.3%), Sudan (34.2%), Yemen (31.9%), Afghanistan (28.3) and Iraq (27.9%).²
- III. Sudan (87), Yemen (67), Somalia (64), and Afghanistan (62) have the **highest adolescent fertility rate** (15-19 years) per 1000 girls in the Region.³

Policy and programmatic situation in the Region

- I. Three countries in the Region have a national policy/guideline on contraception that prohibits access to adolescents on the basis of age.⁴
- II. Only 7 out of 16 surveyed countries in the Region have contraception policies that require the disaggregation of data for the adolescent age group.⁴
- III. The Region has the lowest proportion of countries that include adolescent health in pre-service training for clinicians, nurses, and community health workers (33%).⁵

Regional challenges in provision of contraceptive services

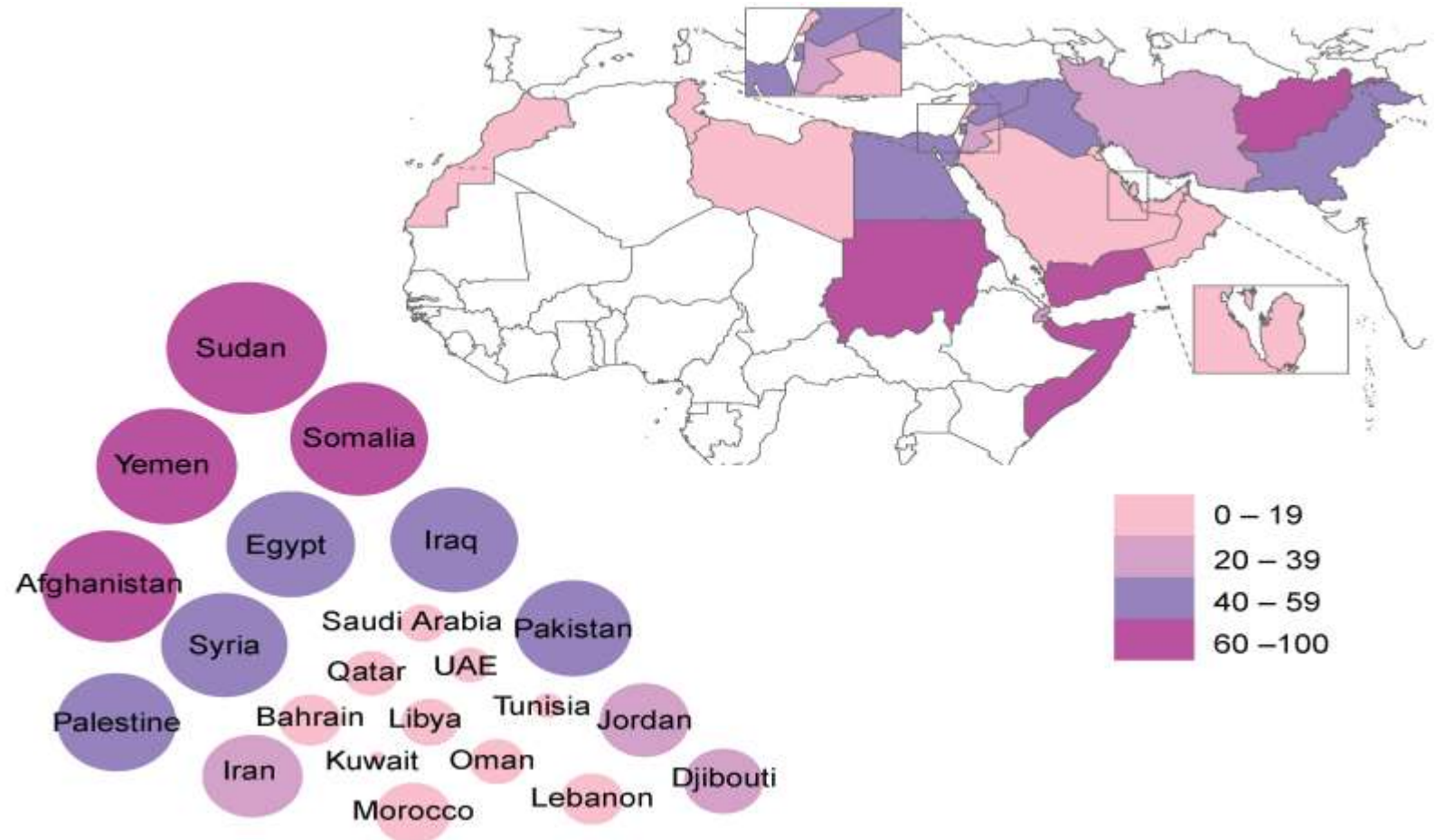
Sociocultural challenges

- I. **High rate of early marriages:** As noted on slide 2, much of the unmet need for FP in the Region is among married women and girls. This is a particular challenge as the Arab Region is home to 40 million young brides,⁶ and a number of countries have high rate of early marriage including Somalia (45%), Sudan (34.2%), Yemen (32%), Afghanistan (28%) and Iraq (27%).²
- II. **Sociocultural barriers:** Social norms and myths and misconceptions about contraception are important barriers to the provision of contraceptive services in the Region. For example, there is strong belief that young married couples should not use any contraception before they have their first baby. Likewise, many people believe that long-acting hormonal methods and intra-uterine devices adversely affect fertility in young people. Similarly, many people believe that condoms are the only safe contraceptive method.^{7,8}
- III. **Humanitarian crises:** More than 62 million people across the Region are in need of health care as a result of political conflict and humanitarian crises.⁹ Interruption of health services for adolescents, including the provision of contraceptive services, increases the risk of unintended pregnancies, STIs, and unsafe abortions.¹⁰

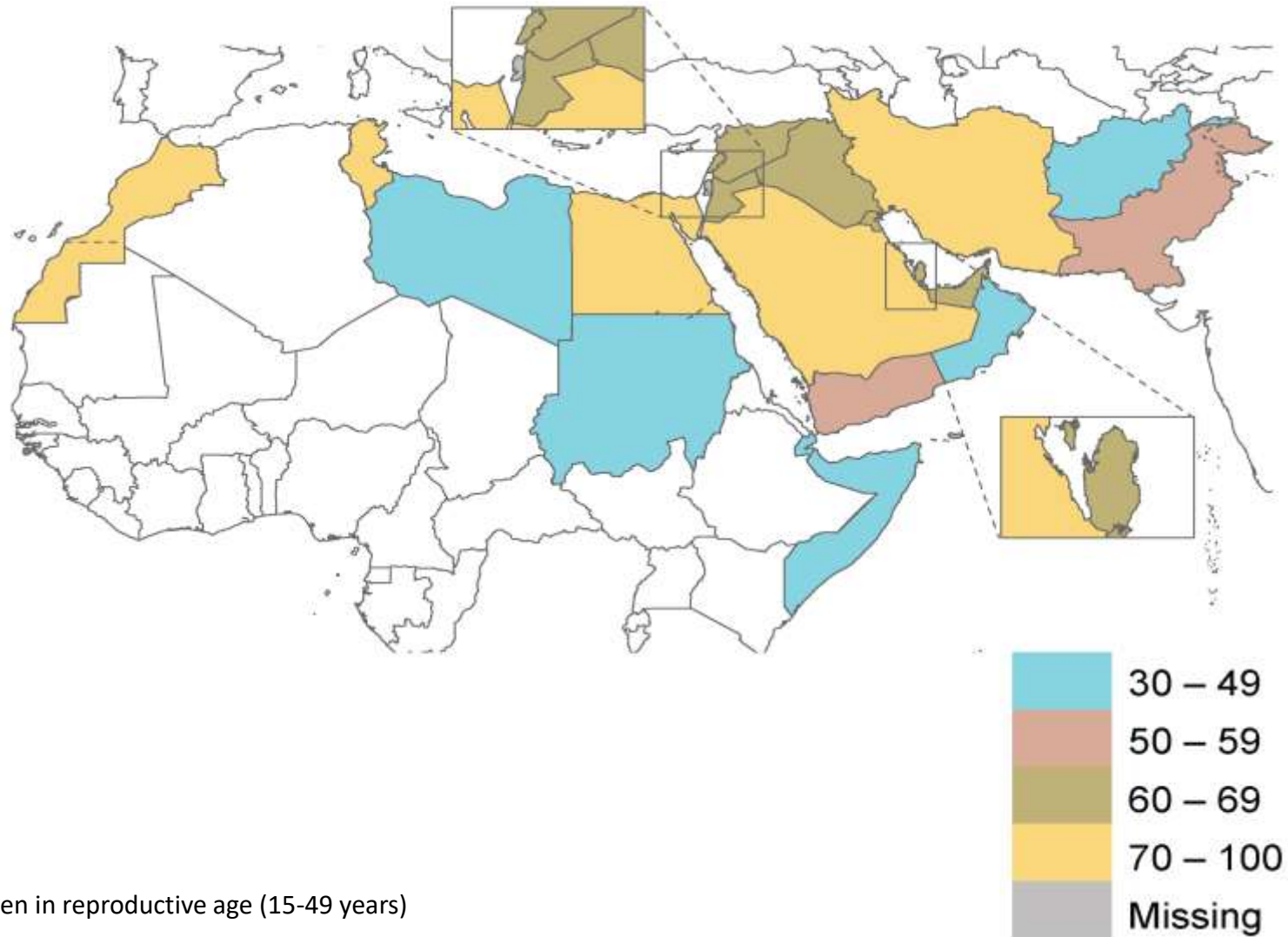
Policy and programmatic challenges

- I. **Laws and policies regarding provision of contraception:** Legal and policy restrictions related to age, marital status, parental/spousal consent, and provider authorization exist in many countries in the Region. For example, in Morocco there is a legal age for married adolescent to provide consent for emergency contraception without spousal consent.¹¹
- II. **Access to and quality of services:** Lack of infrastructure, supply shortages, provider biases and lack of competencies, and cost of contraceptive methods impede access to contraceptive services for adolescents in the Region.^{7,8}
- III. **Lack of data:** There is an important lack of age-disaggregated data on knowledge, attitudes and practices related to contraception, due to the sensitive nature of these issues in the Region. This impedes programme planning, monitoring, and evaluation.

Adolescent (15-19 years) fertility rate (per 1000 girls) ¹²



Demand for family planning satisfied with modern contraceptives in EMR countries (%)* 13



*Among women in reproductive age (15-49 years)

REGIONAL INITIATIVE

THE SOCIAL MARKETING CONTRACEPTION PROJECT IN EGYPT

The Family of the Future (FOF) Project was implemented by an NGO from 1979-1991, with financial support from USAID.¹⁴ It first focused operations in the greater Cairo area and then expanded to other urban areas in Egypt.

Objectives:

- I. To increase awareness and demand for family planning services through contraceptive social marketing, particularly among people, including young people, with lower socioeconomic status in urban settings in Egypt
- II. To establish and maintain a reliable supply of family planning commodities in pharmacies

Approach:

- I. Intensive media-based advertising and personal promotion to build support for the use of family planning and to educate the general public about contraceptive options
- II. Subsidized prices for contraceptive methods, as compared to commercial prices

Outcomes: (According to an audit report covering 1979-1981)

- I. Condom sales increased 260%, foaming tablet sales increased more than 320%
- II. IUD sales increased nearly 330%, driven largely by the introduction of the Copper 7 IUD (which accounted for 35% of this growth)
- III. Couple years of protection (CYP) provided by all contraceptive methods increased from 45,533 in 1979 to 190,831 in 1981, an increase of over 300%.

Opportunities for the Region

The Global Strategy for Women's, Children's, and Adolescents' Health, 2016–2030 ¹⁵

In 2016, WHO led the development of this Global Strategy, which provides an ideal opportunity to expand the availability and accessibility of contraceptive information, counselling, and provision for adolescents. Immediately after the launching of the global strategy, EMRO supported countries to develop their own plans in line with the strategy, taking into account future trends in contraceptive method use.

Accelerated Action for the Health of Adolescents (AA-HA)¹⁶

In 2017, WHO published global guidance for the countries on how to assess adolescent health needs, including with regard to contraception, and recommends evidence-based interventions for responding to these needs. Member States in the Region passed a resolution in 2017 to support national strategic planning for adolescent health, and many countries have since initiated the process of developing their plans accordingly .

Regional Implementation Framework for Newborn, Child, and Adolescent Health, 2019-2023 ¹⁷

The endorsement of this regional framework represents an excellent opportunity to advance adolescents health agenda in general and particularly SRH including family planning. Its strategic priorities include strengthening the integration of health programmes, multisectoral coordination and partnerships for the promotion of healthier newborns, children, and adolescents.

Regional considerations for the delivery of interventions related to adolescent contraception ¹⁶

- I. To prevent **child marriage**, legal protection for adolescent girls and young women should be provided through law and policy frameworks. Alongside this, programmes to eliminate gender discrimination should also be prioritized.
- II. To address **broad, cross-cutting determinants of adolescent health**, programmes should be implemented with other **relevant sectors**. For example, the health and **education** sectors should work together to influence knowledge, attitudes, and behaviors of adolescents related to sexual and reproductive health.
- III. To address stigma related to adolescent sexuality and address **myths and misconceptions about contraception, community engagement** e.g., with parents and religious leaders should be a central component of programmes.
- IV. To improve the **accessibility and acceptability of contraceptive services** for adolescents, countries should consider expanding the availability of **adolescent-friendly health services**, integrating contraceptive services **with primary health care services**,¹⁸ and using **mobile outreach services** to meet adolescents where they are.¹⁹
- V. To ensure **adolescents in humanitarian crisis contexts**, have access to contraceptive services and other priority interventions including for gender-based violence, STIs and HIV, and maternal and newborn care, the Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations should be implemented.²⁰
- VI. To expand the availability of **data on ASRH** and the **meaningfully engagement of young people** in the implementation and accountability of the Sustainable Development Goals, countries should consider establishing **youth-led data-collection** mechanisms that **disaggregate data by age** and other important characteristics

Impact of COVID-19 on contraceptive services (effects on demand, supply & access)

Effects on contraceptive supply: COVID-19 has affected supply by disrupting the manufacture of key pharmaceutical components of contraceptive methods and/or the manufacturing of the methods themselves (e.g., condoms), and by delaying transportation of contraceptive commodities.²¹

Effects on contraception demand: Increased demand for contraception has been observed over the period of pandemic, due to the consequences of lockdowns and movement restrictions.²¹

Closure and/or diversion of services: Equipment and staff involved in provision of sexual and reproductive health services have been diverted in some places to fulfill other needs, and many clinics that were considered non-essential were closed.²²

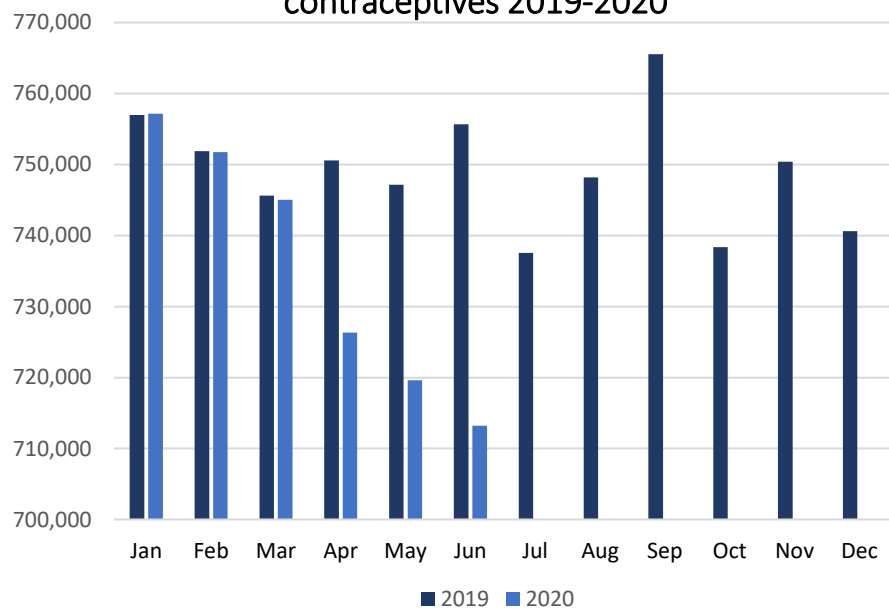
Estimated impact: **10%** global decline in use of reversible contraceptives leads to:²²

- **48,558,000** additional women with unmet need for modern contraceptives

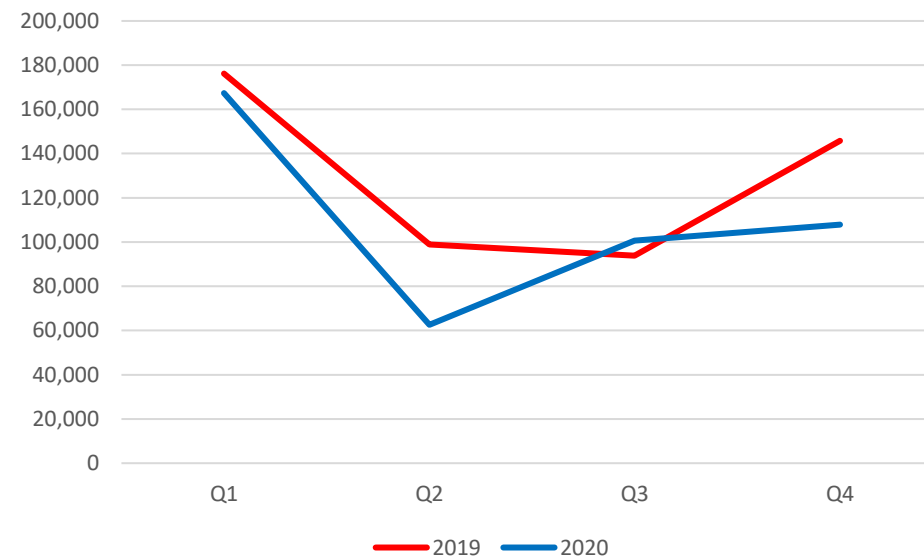
- **15,401,000** additional unintended pregnancies.

Disruption of FP services during the COVID-19 pandemic ²³

Pakistan: Number of clients who use oral contraceptives 2019-2020



Sudan: Number of women who received family planning services (5 types of contraceptives)



THANK YOU



a call for
solidarity
and action



World Health
Organization

REGIONAL OFFICE FOR THE Eastern Mediterranean

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