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 Ghana, the median age of first sex is 18.5 years and the median age of marriage is 22.4 years (difference of 3.9 years). In Niger, the median age of marriage is 15.9 years, followed quickly by first sex at 16 years.

This has many implications. Ghana has a fairly long period between first sex and first marriage. Adolescents and youth during this period, and beyond, need access to SRH and FP services. Due to cultural, economic and structural reasons, unmarried adolescents may have greater difficulty accessing SRH/FP services. Girls who become pregnant before marriage may face discrimination and violence by their partners or families. They also have more limited education and employment opportunities.

In Niger, it is clear that early marriage is widespread, with first birth happening on average two years later at age 18. Adolescents have a great need for family planning, but modern contraceptive prevalence is very low. Firstly, there is a need to work with leaders, parents, adolescents and youth to reduce child marriage and adolescent pregnancy. Once a girl is married, cultural norms favoring large families and for married couples to start having children right away may make it more difficult for adolescent girls and young women to access FP. Her husband or in-laws may forbid it, and the social pressure for married couples to start having children is high. Even some health providers exhibit bias against married adolescents using family planning, noting that contraception should not be used until the girl has had her first child[i]. Early pregnancies lead to maternal mortality, morbidity, and risks for newborns. Babies born to mothers under 20 are at greater risk of low birth weight, prematurity, and malnutrition. Adolescent pregnancy accounts for 34% of all deaths among girls aged 15-19 in Niger[ii]. Child marriage often happens between young girls and older men, which is associated with higher risk of intimate partner violence, HIV and other STIs. Early marriage and pregnancy also make it more difficult for adolescent girls to finish school, which perpetuates the cycle of poverty. In many poor countries, the earlier girls and women start having children, the more children they have, often with insufficient spacing between births, at great cost to their health. Young married adolescents, pregnant adolescents and adolescent mothers are also quite socially isolated and have little agency, falling through the gaps of community programming.

Question 2:

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

Two challenges in gather information on sexual activity in unmarried adolescents are that (1) in some countries, they are excluded from surveys and (2) they may be unwilling to report on sexual activity when the survey takes place at home where their parents and other family members are present.

In many countries, especially parts of Asia, Northern Africa and the Middle East, there are taboos around sex outside marriage, which has made it impossible to collect this data. Yet, in these countries sexual activity often starts before marriage, which leads to a significant data gap.

Given that most unmarried adolescents and their parents do not have open conversations about sex, the reliability of these adolescents' responses in a household survey setting is problematic. Since, in many cases, a parent or guardian must consent before their child participates in the survey, this can also put the adolescent ill at ease to respond to certain questions. Difficult wording and the sex of the interviewer can also be barriers.

The exclusion of unmarried sexually active women in surveys, and underreporting of sexual activity by adolescents, lead to underestimations of unmet need for contraceptives.

Question 3:

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

True. Generally speaking, adolescents can use any contraceptive method, hormonal or non-hormonal, regardless of their age. Health care workers should assess adolescents' health, as there are some health conditions that may affect their eligibility for a particular method. For instance, adolescents who opt for sterilization should be cautioned that this is permanent, and there are alternative, long-lasting and highly effective methods. In other cases, adolescents over a certain body mass index may not be eligible for DMPA injections, as it may disturb insulin levels and glucose metabolism[iii].

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.

Even if contraceptives are available to adolescents free of charge in this young woman's community, her own beliefs and biases may result in lack of demand for family planning. She might be too embarrassed or timid to go to the clinic and ask for family planning. Even though laws and policies enable contraceptives to be provided, individual health care workers may have their own biases and make her feel ashamed for being sexually active. If this young woman is unmarried, the stigma around having sex outside marriage is a major constraint to accessing family planning. If she is married, she may face pressure from her husband, family and society to start having children; she probably lacks status and decision-making power in her new family. She may also desire children, as it is a cultural norm to have children young. Myths about contraception, e.g. that they cause sterility, or fears about side effects, can also cause her unwillingness to use FP.

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.

The Health Policy Project's evaluation[iv] found that Malawi had a very supportive policy context, in stark contrast with key FP indicators. 17% of girls have had sex by 15; by age 18, 60% have had sex. Fourteen percent of girls aged 15-19 give birth every year. Ten percent of girls are married before age 15, and half are married before 18, with men who are on average 10 years older. There has not been much progress in reducing child marriage, although the 2015 Marriage, Divorce and Family Relations Act raised the minimum age of marriage to 18. For 18% of 15-19 year old girls, their first sexual experience was forced, and 18% of girls in this age group have experienced sexual violence. Contraceptive use in unmarried sexually active women aged 15-19 is 30%, and 26% in married girls of this age. Only 37% of girls aged 15-19 have completed primary education.

Three actions I would take would be:

1. Develop a costed, multi-sectoral operational plan, with adolescent and youth involvement, that sets clear targets and interventions tailored for different age groups (10-14, 15-19, 20-24), married and unmarried, to be implemented in communities, schools and health facilities. I would ensure an adequate budget line for adolescent and youth SRH/FP activities (see below # 2 and 3) in the health, education, and gender/children sectors, including funding and/or collaboration with civil society and youth organizations. I would also build in monitoring and accountability systems, including supportive supervision; committees that include adolescents/youth, parents, leaders and educators; and quarterly and annual progress reviews.

2. I would ensure a package of interventions to ensure that adolescent girls have a supportive environment that reduces their vulnerability to early marriage, pregnancy, violence and STIs. Recognizing that secondary school has a protective factor against many of these issues, and that cultural norms and economic constraints lead parents to marry their daughters early, I would implement a social and behavior change communication strategy involving parents and leaders to hold group debates, led by trained facilitators, on child rights, early marriage, and the importance of keeping girls in school, especially secondary education. I would ensure that vulnerable families have access to funds to facilitate secondary school education for girls (school materials, uniforms, transport, and conditional cash transfers).

3. Within primary and secondary schools, and in communities (for out-of-school adolescents), I would train youth facilitators (peer education) intensively on an evidence-based curriculum for adolescents (boys and girls) aged 10-14 and 15-19. For 10-14 year olds, the importance of delaying sexual debut should be emphasized, as well as gender, violence and consent, healthy relationships, child rights, puberty, as well as how to prevent pregnancy and STIs. For 15-19 year olds, the content should be tailored based on the fact that a large percentage are sexually active, and some are married, and address existing barriers on both the supply and demand side for FP. Within schools and communities, safe spaces should be created for the most vulnerable adolescents (e.g. those who are out of school, extremely poor, pregnant teens,

already married or mothers, victims of violence, living without a parent/caregiver, etc.), where mentors can provide them with life skills, SRH services and referrals, and other support. This program would ensure better access to the health sector, with adolescent-friendly corners created in schools and communities where trained professionals can provide counselling, condoms are available, and health professionals visit twice weekly to provide adolescent-friendly SRH counselling and methods, and referrals to health facilities when needed. Within health facilities, a friendly SRH space should be created (e.g. separate from the maternal and child health ward), with male and female health staff who are trained to work with adolescents.

[i] Samandari G, Grant C, Brent L, Gullo S. "It is a thing that depends on God": barriers to delaying first birth and pursuing alternative futures among newly married adolescent girls in Niger. Reproductive Health. 2019 Jul 16; 109
[ii] Ibid.
[iii] Mahoney D. "Depo Provera May Raise Insulin in Obese Teens". Adolescent Health. 2006 May; 22.
[iv] Rosen, J.E., S. Pappa, A. Vazzano, and E. Neason. 2017. Comparative Analysis: Policies Affecting Family Planning Access for Young Women in Guatemala, Malawi, and Nepal. Washington, DC: Palladium, Health Policy Plus.