

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?

There are significant regional differences in the data on key life events of adolescents and youth in west Africa [1]. In Ghana, median age of first sex is 18.6 years and median age of first marriage is 22.4 years [1]. There is a delay of nearly 4 years between initiation of sex and marriage, suggesting that adolescents and youth require access to comprehensive sexual health education and services. In comparison, for adolescents and youth in Niger, median age of first marriage is 15.9 years and median age of first sex is 16.0 years [1]. These adolescents may benefit most from efforts to delay marriage and first birth, as the delay of these life events is associated with improved outcomes in maternal health, the empowerment of women and their education. These diverse patterns in the data emphasize the need for the development of varied approaches that are tailored to social patterns.

Question 2:

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

There are many challenges faced when gathering information on sexual activity in unmarried adolescents. Often, in an attempt to be sensitive about cultural dissent on sexual activity outside marriage, unmarried women are excluded from surveys on sexual and reproductive health [1]. In addition, when unmarried youth are enrolled in surveys, they may be reluctant to report sexual activity, especially if data is being collected in-home [1]. These measurement challenges must be taken into consideration when assessing data on adolescents and youth.

Question 3:

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

The World Health Organization (WHO) recommendations on adolescent sexual and reproductive health emphasize that there should be no restriction to adolescents seeking any method of birth control, except sterilization [2]. Therefore, aside from sterilization, my answer is 'true', that health professionals can prescribe or dispense the same contraceptive methods to adolescents as in adults.

The WHO stresses this point, because healthcare providers often promote a condoms or pills - only approach to adolescents, thereby limiting access to the wide range of contraceptive options [2]. In some cases, medical eligibility and safety considerations must be applied [2]. In the case of sterilization, counselling on the permanency of the method and alternatives should occur. In addition, for young women less than 18 years and with a body mass index less than or equal to 30 kg/m² depot medroxyprogesterone acetate/norethisterone enanthate has potential effects on

bone mineral density [2]. This form of contraception may be used if the advantages of using this method outweigh the potential risks, and additional follow-up may be appropriate with young women. Similar potential effects on mineral bone density are seen with combined hormonal therapy in women less than 40 years old; however, they may use these contraceptives without restriction [2].

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.

Although adolescents may have access to contraception, they may not be willing to use contraception due to several factors. This is specifically seen in Northern India, with the following three possible reasons: societal or family pressure to have children, the stigma surrounding the use of contraception, and a fear of side effects [3]. It is apparent that providers must work beyond making contraceptives available and must work to break down physical and socioeconomic barriers to adolescent contraceptive use.

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 Plus project's analysis of family planning policies for adolescents suggests that there are improvements to be made in Malawi [3]. Despite the existence of policies enabling access to contraceptives, adolescents continue to find it difficult to obtain them. If I was the national reproductive health programme manager in Malawi, I would emphasize the importance of improving the implementation of these policies by taking the following three actions. Firstly, I would attempt to understand adolescents' needs and problems by involving them at the stage of programme development, in a similar way to the YP Foundation's work engaging young leaders in the Sunder Nagar Nursery community, in New Delhi, India [3]. Secondly, I would initiate an evaluation of the programme's implementation to analyze short-comings and how they might be improved. The intention would be to inform strategic actions to improve existing programmes. Finally, I would attempt to design a system with access to technical expertise as exemplified in the Busy Generation programme organized in Mozambique. In such systems, there is collaboration across sectors allowing the delivery of programmes through community-based organizations [3].

References

[1] Family Planning 2020. FP2020 special analysis on adolescents and youth data [Internet]. Washington (DC) [cited 2019 Sept 17]. Available from:
http://progress.familyplanning2020.org/content/measurement#anchor-sub_chapters-205

[2] WHO. Recommendations on adolescent sexual and reproductive health and rights. Geneva: World Health Organization; 2018.

[3] Chandra-Mouli V, Parameshwar PS, Parry M, et al. A never-before opportunity to strengthen investment and action on adolescent contraception, and what we must do to make full use of it. *Reprod Health*. 2017;14(85). DOI: 10.1186.