Training course in adolescent sexual and reproductive health 2020

Priorities to build on the progress made for the next 25 years, with a particular focus on the SDGs

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Question 1.1

What are two factors that deter the provision of contraception by health workers to adolescents?

The following two factors that deter the provision of contraception by health workers to adolescents[1]:

1. ***Judgmental attitude of health workers****:* The judgmental attitude the health providers due to their insensitivity and lack of understanding for sexual and reproductive health issues of adolescents is a barrier towards providing quality health services. Being socially vulnerable to access the health services especially related to SRH such attitude of health providers become a barrier
2. ***Inadequate knowledge and skills****:* Adolescents have peculiar need of services in the area of ASHR issues. This is due to the fact that they are vulnerable, curious, have risk taking behavior, medically have different needs as compared to adults and use contraception for shorter time period. The health providers should have knowledge and skills to address to these issues. E.g. A the preferred contraceptive for young adolescent girls is emergency contraceptives instead of regular hormonal contraceptives which are preferable for adults. Hence the service provider should have the knowledge and adequate skills to provide services.

To make the services adolescent friendly and respectful the above factors need to be improved.

Question 1.2

What are two actions that could be taken to address these factors?

1. ***Attitude and behaviour change of health care providers:*** In order to ensure that adolescents get friendly services the service provider has to ensure that they don't indulge into moral policing and become judgmental when an adolescent especially the unmarried girls and boys come to them for SRH services. The providers should make a friendly rapport with their adolescent clients and give enough time. To develop change in attitude they should be sensitized towards the issues through role plays, real life stories, conversation with other successful service providers and training process.
2. ***Knowledge based skill building informative trainings:*** The health provider should be trained about different methods of contraception available for adolescent age group. They should be confident and have all the skills required to provide these services. They should also be trained in the counseling for healthy life cycle approach which shall include building life skills in adolescents especially that affect their SRH issues[1]. After providing adequate sensitization, knowledge and skills the health providers should also be held accountable to provide quality SRH services to adolescents.

Question 2

When adolescents use contraceptives, they are more likely to use them for shorter periods than adults. They are also more likely than adults to discontinue use. One reason for this is that they are particularly sensitive to side effects. Another reason is that they may not receive proper counselling and therefore may not know what to anticipate regarding side effects. What are two implications of this for health workers who are supporting adolescents to sustain contraceptive use?

A health worker who is sensitized and has a non-judgmental attitude towards providing contraceptive use faces a lot of adverse reactions from a conservative society like India:

1. ***Gatekeeper-related implications****:* The influential adults and society around the boys and girls who come to seek services related to sexual health create a challenging environment for such health workers. These gatekeepers are suspicious of health workers who talk to young adolescents about sex and contraception. Hence many a times the health workers have to approach these gatekeepers such as mother in laws, husbands, fathers, and teachers and convince them the necessity for contraceptive services. Only then they are allowed to contact the adolescents seeking services. There is a huge lack of family support on taking contraceptive related counselling services for the young couples. This becomes more challenging in case of unmarried adolescents.
2. ***Other health provider related implications****:* The health providers who are not sensitized to the SRH issues have a judgmental attitude towards those health providers who give ARSH services without hesitation. They feel that such people talk dirty with their clients and force their colleagues to adopt to moral policing with such clients. They try to destroy the credibility and respect at community level of such workers. The above implications are serious as they tend to demotivate the service providers[2].

Question 3.1

Which one of the emerging opportunities noted in Paper 4 do you feel has the most potential to advance ASRHR in your country? Briefly explain your answer.

Out of the many emerging opportunities noted in 'Paper 4', I feel that ***"Increased school enrollment"*** has the most potential to advance ASRHR in my country. This is because in India, 85% of children age 6-17 attend school, including pre-primary school. The gross attendance ratio (GAR) is 85 percent at the primary school level and 80 percent at the secondary school level[3]. The increase in school enrollment has opened the doors to address the school going adolescents and sensitize them on topics related to ARSHR issues. This also gives opportunity to health care providers to work in close coordination with education sector. The health care policy makers in India have acknowledged the importance of this emerging opportunity. This is reflected by the launch of "School Health Program" in India on February 12, 2020. The objective of the program is to spread awareness about the preventive health aspects. Under the ambit of this program two teachers will be identified in every government school as 'health and wellness ambassadors' and they shall sensitize adolescents of the school and make them 'health and wellness messengers.' This shall empower them to develop life skills to address the issues like SRH, substance abuse, mental health, etc, that concern them the most.

Question 3.2

Which one of the persistent and/or new challenges noted in paper 4 do you feel creates the biggest barriers to advancing ASRHR in your country? Briefly explain your answer.

According to me ***'Denial of adolescent sexuality'*** is the biggest barrier to address the ASRHR in India. Adolescent sexuality and sexual health is a 'Right' of this vulnerable population. But in India talking about sexual health especially of adolescents is still a taboo. The attitude to look down upon adolescent sexuality in relation to health concerns like early pregnancy, septic abortions, HIV, STI is unfortunate. In addition LGBT community of adolescents is stigmatized and criminalized. Here not only the parents, community but also the health care providers hesitate addressing sexual concerns of adolescents. Therefore probable and popular sources for gaining information about sex are peers and internet.[5] This is a serious concern. The attitude is much worse for the unmarried adolescents who actually need more help. The judgmental attitude the health providers and the society becomes a barrier towards providing quality sexual and reproductive health services. This is the reason that addressing adolescents on sexual health concerns through has National Health Programmes like Rashtriya Kishor Swasthya Karyakaram is still a challenge.

Question 4

What are two of the suggested actions that can be taken to mobilize and make full use of political and social support for ASRHR policies and programmes?

1. ***Advocacy of adolescent reproductive sexual health****:* The advocacy should start at the global level and percolate to the country and then the state level. Presently there are strong evidences of political and social concerns and prioritizations for ASRHR policies and programs that did not exist at the time of the ICPD in 1994. This has happened because of strong advocacy as advocacy can help to move agenda of ARSH as a health priority till the local level.
2. ***Planning and designing ARSHR programs****:* Appropriate planning and design to ensure equity, quality, accountability, multisectoral approach in consultation with the youth is essential for an effective ASRHR policies. The planning and he design should include evidence based interventions and lessons learnt across the regions. India can learn from examples of countries like Chile, England, and Ethiopia who have demonstrated success in reducing adolescent pregnancy by implementing above stratergies[4].

Question 5

Mention one suggested action each that can be taken to increase external funding AND domestic funding for ASRHR while making effective use of the available resources to demonstrate impact.

To increase external and domestic funding for ASRHR while making effective use of the available resources to demonstrate impact we need to have evidence based advocacy. Presently, the good news is that a lot of studies and research have been done for ARSHR. Many evidence

based interventions with measurable outcomes are available and defined. We must use them to advocate for policies that would address the grey areas of ARSHR like sexual violence, substance abuse, mental health etc. After being funded we must ensure continuous support to our intervention by showing positive results. To advocate for a continuous support for ARSHR, it is important for the scientific fraternity to demonstrate that any financing done for adolescents shall pay large dividends to the country as it is going to be the productive population in future[5].

Following points should be taken care of when planning the strategies:

1. The implementation should be cost effective.
2. Interventions should be designed for preventive and promotive services and should not only focus on curative services.
3. Health financing should be focused specifically on adolescent responsive services.

   For example: In Himachal Pradesh, it was the result of a robust advocacy that the state government funded 12 cr. for the Menstrual Hygiene Program under Rashtriya Kishor Swasthya Karyakaram. It was clearly demonstrated that distribution of sanitary napkins to girls at the cost of re1/- shall increase the usage of sanitary napkins. This shall be useful to increase menstrual hygiene among young girls and also decrease the incidences of Reproductive Tract Infections in them.

Question 6

What are two of the suggested actions that can be taken to develop, communicate, apply, & monitor enabling & protective laws/policies for ASRHR?

1. ***Building health promotion policies and laws***: To provide laws and policies for the adolescents we need to take robust steps to build an enabling environment. The policies and laws should focus on provision of accessible, equitable and non judgmental quality services to adolescents. Along with this we must ensure that the adolescents and their families are aware of their rights and can hold service providers accountable for the same. The Rashtriya Kishor Swasthya Karyakaram is such an example.
2. ***Effective implementation of laws and policies***: The government should ensure that the laws are implemented effectively by the law implementing agencies. The laws should be able to protect the weakest community as well. In ARSHR services, it is crucial that the services are accessible to the most vulnerable adolescents like unmarried, middle aged adolescents (14-16 years). Namibia's 2015 Child Care and Protection Act is an example of effective implementation and planning of laws for adolescents as this law allows HIV testing of young adolescents (14 years) without parental or spousal consent[6].

Question 7

Is there anything that surprised you in the score card for the country you selected? If you had the authority to make any changes to the laws and policies in the country, what are two changes you would make to improve young people's access to contraception?

The Population Reference Bureau on countries' laws and policies related to young people's score card for Ethiopia is as follows[7]:

S.No.	Domain	Color code
1.	Parental and Spousal Consent	Grey: Policy addressing the indicator does not exist.
2.	Age Restrictions	Green: Strong policy environment.
3.	Marital Status Restrictions	Green: Strong policy environment.
4.	Provider Authorization	Green: Strong policy environment.
5.	Access to a Full Range of FP Methods	Green: Strong policy environment.
6.	Comprehensive Sexuality Education	Yellow: Promising policy environment but room for improvement.
7.	Youth-Friendly FP Service Provision	Green: Strong policy environment.
8.	Enabling Social Environment	Green: Strong policy environment.

The fact that has surprised me in the policy score card of Ethiopia is that the country has ensured a policy in place for the accessibility of adolescents to contraception irrespective of age and marital status. However there is no robust evidence of any policy related to use of contraceptives without parental or spousal consent. This can become an obstacle to accessibility of contraceptive services in the country as the adolescents will depend on their parents or spouses for getting consent to take contraceptive services.

The two changes to ensure increased accessibility to contraceptive services that I would suggest for the country to improve upon are as follows:

1. ***Policy on no requirement of parental, spousal or a third party consent to use contraception for adolescents:*** This shall empower adolescents' especially young girls to use contraceptive services without any hesitation.
2. ***Accountability of service providers:*** The policy in the country ensures that the health providers providing contraceptive services should be adequately sensitized and trained to quit their judgmental attitude and provide contraceptive services with respect. However there is no policy to make the provider accountable for the lack of quality of these services. Hence there is an apprehension that the adolescents may encounter unfriendly services like breaches in confidentiality and disapproving attitudes relating to their concern on sexual activity and desire to use contraceptive services from the service providers.

Question 8

What are three of the suggested actions that can be taken to use & improve ASRHR data & evidence to strengthen advocacy, policies, & programmes?

There is an enormous data on ASRHR which is not being referred to in implementing decisions especially at the local level. To use the available ASRHR data for evidence to strengthen the designing of the programs related to ARSHR, following actions should be taken[4]:

1. ***Filling data gaps***: The data gaps should be filled by using examples and initiative of similar countries across the world. The countries should encourage population-based surveys like National Family Health Survey, District Level Health Survey (in India). Modern methods like google platforms and other online surveys should also be encouraged as they are quick and can be done all times. The research should be focused on finding probable cost effective interventions to the challenges related to SRH of adolescents.
2. ***Data analysis and simplification***: A detailed analysis of survey reports should be done and simplified interpretations of the results should be given. This can help the policy makers to easily use the results for advocating SRH agendas with the governments. We must ensure that data is analyzed with respect to variables that affect the outcome. E.g. Age and sex related distribution to access of SRH services.
3. ***Capacity building of decision makers***: The decision makers should have the ability to use data and plan their programs based on their local needs. Hence program officers, managers etc. should be regularly trained to use outcomes of surveys and studies.

Question 9

What are two of the suggested actions that can be taken to manage the implementation of ASRHR strategies at scale with quality & equity?

The ARSHR strategies should address to quality and equitability issues in order to be sustainable. They should have a multisectoral and evidence based approach.

The following two major actions should be taken to ensure extended coverage and relevance with the context of changing times:

1. ***Multisectoral approach:*** ASRHR strategies should be based on epidemiological evidences to be successful and relevant to the dynamic needs of the adolescent. The ARSHR should be strategically designed so that it could be scalable in the future. For this, it essential to involve and have close coordination with the sectors that has potential roles in implementation of these strategies. E.g. in India such sectors are education, social justice, civil societies, youth affairs etc. This creates a synergistic movement that smoothly addresses to the dynamic needs of adolescents.
2. ***Capacity building of delivering sectors:*** The sectors that are involved in providing services o adolescents should be sensitized, oriented and trained to the latest concerns related to SRH issues of the adolescents. There should be a robust delivery mechanism to build in these capacities. The health worker should be continuously motivated to deliver quality services. Once empowered they should be held accountable for the same. To ensure equality in the systems addressing SRH issues of adolescents we must ensure responsiveness of programmes to adolescents needs and preferences.

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