Training course in adolescent sexual and reproductive health 2021

Contraception counselling and provision

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Question 1

Contraception is provided free of charge at a government clinic in a rural Northern Indian community. However, a young woman in that community does not use them. Identify three possible reasons for this.

1. This lady could have false beliefs and misconceptions about contraception. She may even don't know where and how to obtain these services and information.
2. There is also a possibility that this lady lives in an environment where there are laws or policies that prevent the provision of contraception based on age or marital status (e.g. being young or unmarried).
3. She could have been seen by a health care provider who is biased, judgemental or has misconceptions regarding the use of contraception by young women that consequently alienated her.

Question 2

What are the five set of barriers to the uptake of contraception by adolescents as described in the International Centre for Research on Women Framework on adolescent contraception?

There are five barriers to the access and use of contraceptives among adolescent women. They are divided into three demand-side barriers and two-supply side barriers.

Demand barriers are 1- the lack of desire to avoid, delay, space, or limit childbearing. 2- the lack of desire to use contraception. 3- the lack of confidence, independence, autonomy and ability to seek/negotiate contraception use.

Supply-side barriers are 1- poor access to contraceptive services and quality- including respectful -service provision/ lack of competent, committed healthcare providers. 2- Laws and policies that prevent the provision of contraception services based on age and marital status.

Question 3

What are three things that Chile did to counter its high adolescent fertility rate?

Chile adopted the regional 2007-2013 Andean plan for the prevention of adolescent pregnancy. It has set a target of 10% reduction of the adolescent fertility rate through a ten year (2011-2020) national health strategy. To achieve this, they did the following:

1- A five-pronged approach to improve health systems' responsiveness to adolescents was developed for the ten years (2011-2020) National Health Strategy. This approach included the following: 1- training healthcare providers. 2-creating adolescent-friendly spaces in primary healthcare centres. 3- promoting a range of contraceptive methods 4- improving outreach activities and referrals 5-improving school retention and re-entry for pregnant adolescents and adolescent mothers.

2- New government circulars were issued on parental consent requirements, adolescents' autonomy, and protecting young people from sexual abuse in addition to several laws

that were consolidated into one framework which defined and mandated different stakeholders' roles and responsibilities.

3- The Ministry of Health's media department made data on progress available to journalists to publicise the positive results.

Question 4

Name three approaches to improving contraceptive uptake among adolescents that you believe would be most effective in your country context and explain why.

Based on the findings of a relatively recent study conducted in Palestine by Khader and Hamad (2018), I believe these approaches would potentially work in the Palestinian context.

From the ecological framework point of view, interventions/ approaches would operate at these different levels:

1. At the individual, interpersonal, organisational and community levels:

Conducting Health promotion sessions that target the adolescents themselves, their husbands, parents, mothers-in-law and other members of extended families. These sessions are essential to raising awareness, correcting false beliefs and misconceptions. Furthermore, health education is a well-known precursor to changing social norms, attitudes and behaviours. Health sessions can be school, university or community- based. These sessions can be conducted in collaboration between the health sector, the education sector and community-based organisations (CBOs). Furthermore, women's peer to peer education is essential to influence behaviour change since women's decision for contraceptive use is influenced by other women. This can be reinforced by engaging mass media (TV, radios and newspapers), social media, influential community entities, for example, mosques/churches or influential people to encourage the use of contraceptives.

2. Organisational level:

Filling the gaps in FP service provision by improving counselling and providers' attitudes. For example, this can be achieved by training healthcare providers to provide proper counselling for married adolescent women. They can also be trained to provide opportunistic counselling for adolescent women who show up in the clinic for whatever reasons, even when they present to register for Preconception care (PCC). Health professionals should also be provided with up-to-date evidence-based knowledge that will help them provide adolescent-friendly, non-biased and non-judgmental services.

3. Environmental or societal level:

Creating an enabling environment by setting policies that ensure equity and equal access to FP services as well as enacting laws that ban early marriage and gender-based violence.

Question 5.1

Name at least two service-delivery elements and one enabling environment element that are listed in the High Impact Practices brief on Adolescent Friendly Contraceptive

Services: Mainstreaming adolescent friendly elements into existing contraceptive services.

Service delivery elements: 1- Training and supporting providers to offer non-judgmental services to adolescents. 2- Enforcing confidentiality and ensuring audio and visual privacy

Environment-related elements: Ensuring legal rights, policies, and guidelines that respect, protect, and fulfil adolescents' human rights to contraceptive information, products, and services regardless of age, sex, marital status, or parity.

Question 5.2

Why is it important to mainstream adolescent friendly elements into existing contraceptive services, rather than to set up separate services for adolescents?

Because it has the potential to be both cost-effective and scalable as stand-alone services are difficult to scale up and sustain. It also expands the reach, access and uptake of high-quality contraceptive services to adolescents.

Question 6

Name three challenges to adolescent contraceptive services that are particularly relevant in the Eastern Mediterranean Region?

Sociocultural challenges:

1. The high rate of early marriage leaves the health services unable to meet the needs for contraceptives especially in the Arab region which is a home for 40 million young brides.
2. Social norms, false beliefs and misconceptions about contraception are important barriers to the provision of contraceptives. For example, in the EMR region, there's a misconception that women shouldn't use contraceptives before having their first baby because if they did, this will adversely affect their fertility in the future.
3. Humanitarian crises: the ongoing political conflict and humanitarian crises in the EMR region increases the demand for healthcare services which leads to interruption of many other services including contractive services.

Question 7

Mention three effects of COVID-19 on the demand for and supply of contraceptive commodities and services.

COVID-19 has increased the demand for contraception due to lockdowns and movement restrictions. It has also affected the supply of contraceptives by disrupting the manufacture of key pharmaceutical components of contraceptive methods and/or manufacturing some methods like condoms in addition to delaying the transportation of contraceptive commodities. Furthermore, health facilities and staff were diverted to respond to COVID-19 in many places which led to a disruption of many other health services including contraceptive services.

Question 8.1

What percentage of male and female sexually active students sampled in Lebanon University had used a contraceptive method?

Two-thirds of males and a quarter of females who had a sexual relationship used contraception.

Question 8.2

What was the most commonly used method of contraception among male and female sexually active students at Lebanon University?

The condom for males (86.1%) and oral contraceptives for females (56.3%).

Question 8.3

What methods of contraception were the male respondents from Lebanon University aware of?

Male respondents were aware of condoms, IUDs, cervical cap, vaginal diaphragm, oral contraceptives and spermicides. The knowledge about all these methods was statistically significant except for the knowledge about spermicides.

References:

Khader, A. and Hamad, B.A., 2018. *Family planning services in Palestine: Challenges and opportunities*. [s.n.] Available at: https://healthclusteropt.org/admin/file_manager/uploads/files/1/6-Final-FP-Study-English.pdf