IDENTIFYING AND OVERCOMING BARRIERS THAT ADOLESCENTS IN LOW AND MIDDLE INCOME COUNTRIES FACE IN OBTAINING AND USING CONTRACEPTION

Barriers

Adolescents – especially unmarried ones - in low and middle income countries (LMIC), face barriers in obtaining and using contraception (1). While adolescents experience many of the same barriers that adults do when it comes to obtaining contraceptives, some are specific to them.

In many poor communities of LMIC, contraceptive methods are not available to adults or to adolescents. Even when they are available, laws and policies exclude their provision to unmarried adolescents or to those under a certain age. Other access barriers include cost, health facilities that are difficult to reach and health workers who do not provide contraceptives even though there are no legal or medical restrictions to do so. Health workers in many places refuse to provide unmarried adolescents with contraceptive information and services because they do not approve of premarital sexual activity. Even when they do so, they limit the contraceptive methods they provide (to condoms only) wrongly believing that long acting hormonal methods and intrauterine devices are inappropriate for nulliparous women.

Even when contraception is available and obtainable for adolescents, they may not use it for a variety of reasons. In many places young married women are under pressure to conceive and bear children. Contraception is considered only after a first child is born. Also, the stigma surrounding contraception prevents use by adolescents who are not in stable relationships. Proposing the use of a condom or carrying one can lead to a woman being considered 'loose' in many places. Finally, even when adolescents are able to get modern contraceptive methods and to use them, they may not want to do so. Adolescents in many places have misconceptions about the immediate and long-term side effects of contraceptive methods on their health and their future ability to bear children. Due to the resulting fears and concerns they consider ineffective methods, such as withdrawal and traditional remedies, more acceptable. Furthermore, because of a poor understanding of how contraceptives methods work and how they should be used, they use them incorrectly.

Improving access and use

In 2011, the WHO issued guidelines on preventing early pregnancy and poor reproductive outcomes in adolescents in developing countries (2). These guidelines were based on reviews of published systematic reviews and of individual studies and the collective judgment of an expert panel. Increasing access to and use of contraception was one of the four outcomes to prevent early pregnancy. The studies that met the inclusion criteria for this outcome were conducted in a number of LMIC. Some focused exclusively on condom use, while others looked at hormonal contraceptives and emergency contraception (EC). Some examined the use of contraception as a primary outcome while others examined it as secondary to outcomes such as HIV prevention or changing knowledge and attitudes. Some focused on health system actions (such as over-the-counter or clinic provision of contraception) while others focused on actions directed at community leaders and members. Collectively, they demonstrated increases in contraceptive use (including condoms, hormonal contraceptives and EC) as a result of actions directed at multiple levels – laws and policies; individuals, families and communities; and health systems. The interventions discussed below are drawn from the WHO's guidelines.

MAKING LAWS AND POLICIES SUPPORTIVE: In many countries, laws and policies restrict the provision of contraception to unmarried adolescents or those below a certain age. Policy makers must intervene to reform these laws and policies to ensure that adolescents are able to obtain contraception information, counseling and services. Policy makers should also consider providing adolescents contraception at no or reduced cost (2).

MAKING SOCIAL AND GROUP NORMS SUPPORTIVE: In many societies premarital sexual activity is not considered acceptable and there is considerable resistance to the provision of contraceptive information and services to unmarried adolescents. To overcome this barrier, it is important to improve the understanding of influential community leaders and of the community at large on adolescents' needs for information and contraception, including the risks to their wellbeing of not responding to these needs (2).

In many places, social and group norms hinder discussion between couples about contraception. In addition, knowledge gaps and misconceptions prevent use or proper use of contraceptive methods. Mass media (radio and television programmes), peer-education and inter-personal communication and information education communication materials (such as posters and leaflets) have been used successfully to communicate health information to adolescents and to influence their norms. In recent years, the ways adolescents communicate have changed radically. Mobile phone technology, the Internet and social media are increasingly being used, even in LMIC. These technologies are potentially valuable for communicating contraceptive information and options to adolescents conveniently and confidentially (3).

IMPROVING KNOWLEDGE AND UNDERSTANDING: The evidence of the benefits of curriculum-based comprehensive sexuality education is strong. The most successful sexuality education programmes provide accurate and age-appropriate information and in addition, develop life skills and provide support to deal with thoughts, feelings and experiences that accompany sexual maturity (e.g. falling in love, refusing unwanted sex proposed by a friend firmly but without creating hostility). They are also linked to contraceptive provision and services (4).

Although policies requiring sexuality education for adolescents are in place in many countries, they are poorly imple-

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Text Box 1. Components of adolescent friendly health services

To be considered adolescent-friendly, health services should be accessible, acceptable, equitable, appropriate and effective, as outlined below:

- Accessible: Adolescents ***are able to*** obtain the health services that are available.
- Acceptable: Adolescents ***are willing to*** obtain the health services that are available.
- Equitable: ***All adolescents, not just some groups of adolescents***, are able to obtain the health services that are available.
- Appropriate: ***The right health services (i.e. the ones they need)*** are provided to them.
- Effective: The ***right health services are provided in the right way*** and make a positive contribution to their health.

mented, if at all. Health and education policy makers and managers must ensure that curriculum-based sexuality education is widely and effectively implemented. Complementary efforts are needed to reach the many adolescents who are not in school.

IMPROVING ACCESS TO CONTRACEPTION: Adolescents in many places are unwilling to visit facilities providing contraception because they view them as unfriendly. There is growing evidence of the value of making health services adolescent friendly (see text box 1) (5).

To improve access to contraception, health facilities must be made easy to get to and welcoming, they must have unbroken stocks of a range of contraceptive methods and adolescents must be supported to choose the ones that meet their needs and preferences by empathetic and competent health workers.

Contraceptive education, counseling and provision could be integrated into other health services used by adolescents – including sexually transmitted infection management, HIV counseling and testing, comprehensive abortion care services and postpartum care. For many adolescents, contact with these services may be their first opportunity to have a face-to-face discussion about contraception with a competent person. Integration into postpartum services offers the opportunity to reach first-time mothers with information on birth spacing so they can delay a second pregnancy.

In making health services adolescent friendly, it is important to build on what already exists - modifying general health facilities and building the competencies and attitudes of existing health-service providers, rather than setting up new facilities and assigning some health-service providers exclusively for adolescents. Having said this, dedicated health facilities could be useful to reach marginalized groups of adolescents (such as sex workers) who may be reluctant to use a service-delivery point open to all.

Even if health facilities are adolescent-friendly, they are unlikely to attract all adolescents. Therefore, contraception should be provided through a variety of outlets. Outreach to adolescents in venues where they socialize can improve their access to contraceptive information and services – on the spot or through referral. Making pharmacies and shops adolescent friendly could greatly expand ready access to over-the-counter contraceptive methods. Some countries have begun to task-shift contraceptive services to community-level providers in response to shortages of qualified medical personnel (6). Adolescents could benefit from these efforts if confidentiality can be assured.

Summary

In summary, there is fairly good evidence, from research studies and small-scale and time limited projects, on effective ways of increasing access and use of contraception by adolescents. They include favourable laws and policies; multifaceted communication programmes directed at community leaders and members and at adolescents - that inform, educate and create supportive norms for the provision and use of contraception; accurate and age-appropriate curriculum based sexuality education; and the provision of a wide range of contraceptive methods through different adolescent-friendly outlets. The real challenge is to build on these small-scale and time-limited initiatives to build large scale and sustained programmes.

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