Targeting Adolescents for Family Planning and Post Abortion Care.

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Abstract

Context: Adolescent sexuality and its outcome in developed and developing countries differs most significantly at the point of prevention of adverse reproductive outcome.
Objective: This article reviews the role of health care providers in meeting the peculiar challenges of the adolescent population in developing countries.
Method of literature search: A review of journal articles and electronic databases (Medline and Popline)
Conclusion: Health care providers are at a unique advantage in improving adolescent reproductive health. The focus should be the provision of information and contraception maximizing the windows of opportunity created by the contact of young people to the healthcare system and follows illegal abortion services.

Key Words: **adolescents, sexuality, developing countries, information, contraception**

Introduction

The adolescence as a unique stage of development in the life of the individual has only recently received the recognition it has long deserved. This is plausible as the adolescent in many respect to reproductive health care is a special case. In contrast, reproductive health care services targeted at this population to meet their changing physical, emotional and social status are often lacking. The gap between need andservices further heightens the reproductive health vulnerability of the adolescent. The implication of thisis most obvious in the proportion of adolescents dying from pregnancy related causes or suffering permanent disability as a result of same.[1-3] Developing countries most often typifies the above scenario. Here, ignorance as well as paucity of funds influences adversely the prioritization of adolescent reproductive health services. To achieve the reverse, there is a need for health care providers to understand the peculiar needs of the adolescents. This will no doubt be a crucial step in facilitating the provision of adolescent friendly services especially with regards to the prevention of unwanted pregnancy and sexually transmitted diseases.

Adolescence

The World Health Organization (WHO) defines an adolescent as one between the ages of 10 and 19 years while young people are regarded as those between the ages of 10 and 24 years[4]. The adolescent period may also be described in line with certain characteristics that encompasses biological, psychological and social development. From a biological perspective, it encompasses the period from the onset of puberty to full sexual and reproductive maturity. Psychologically, it encompasses the period between the change from the cognitive and emotional patterns of childhood to those of adulthood. It may also be described as an emergent stage, from the childhood state of total socioeconomic dependence to one of relative independence[4] with reference to social development.

Adolescents comprises a large proportion of the world's population[5]. A United Nations estimate put current adolescent population at a little over 1.1 billion, almost a fifth of the world's population[5]. In the Nigerian national population census of 1991, the adolescent population accounted for over a third of the Nigerian populace. The adolescent populace is by no means a homogenous group. There are a number of possible categorization to which adolescents may belong; male/female; rural/urban; in-school/out-school; early/late; sexually active/sexually non-active; and married/unmarried. These distinctions are important when the needs of adolescence with regards to family planning and post abortion care are considered.
Extensive reference is often made as to issues of sexuality and fertility among adolescents[6,7]. Data as to actual magnitude are however largely inadequate especially in developing countries.

Table I:
Magnitude of adolescent sexuality in selected countries[8]

Country	Age (years)	Ever had sexual intercourse *Male (%)*	Ever had sexual intercourse *Female (%)*
Australia	20	58	47
W. Germany	16	35	30
Isreal	14 -19	42	11
Japan	16- 21	15	7
Nigeria	14-19	68	43
Rep.of Korea	12-21	17	4

Table I illustrates the comparative magnitude of

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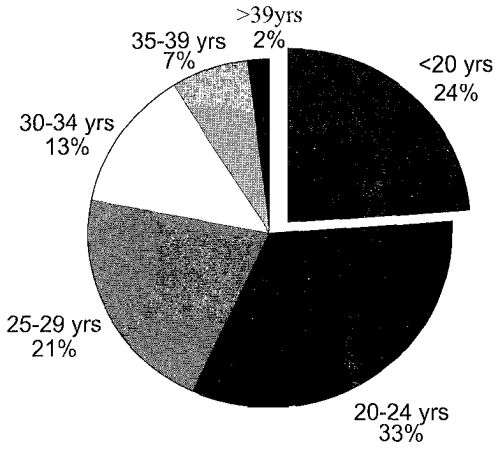
adolescent sexuality in some developed and developing countries[8]. The general trend is a high or increasing magnitude in adolescent sexual exposure. The rising prevalence of premarital sex and multiple partners Among the adolescent population is partly as a result of the delay in the age of marriage[8-10]. Sexuality in the adolescent is often one characterized by high-risk taking behavior. Sexually active adolescents tend to have multiple partners and relationships of short duration. In this context, adolescent sexuality may evolve along two principal patterns disaggregated by the provision of information on sexuality.

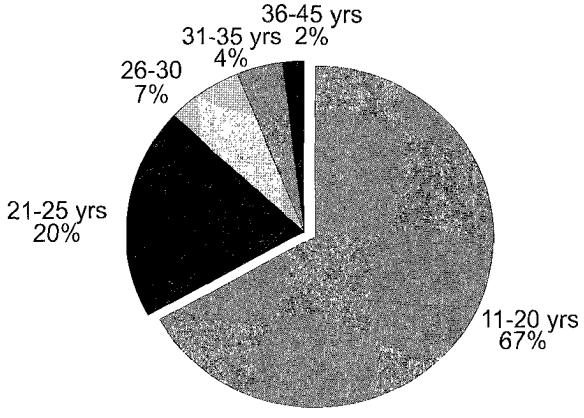
In many developing countries, lack of information on sexuality and contraception targeted at the adolescent populace has often translated to a high prevalence of unwanted pregnancies. In the context of prevailing social and legal constraints to sexuality information in many developing countries, an unsafe abortion is a prelude to subsequent repeat and multiple abortions[11]. In contrast to the more developed countries of the world, adolescent sexuality and a high prevalence of unwanted pregnancy invariably translates to a safe abortion and post abortion contraceptive use[12].Abortion is legal in many developed countries and rates among women aged 15 19 years range from 5 per 1000 in the Netherlands to 44 per 1000 in the United States. Abortion on young women account for more than10 percent of all abortions performed in most countries with complete records and exceed 25 percent in several countries[13]. Interestingly young women in developed countries are less likely to become pregnant than in the past probably owing to a greater use of contraception. In countries where abortion is illegal, it is impossible to document its prevalence among young people. *The major source of information on abortion is hospital records of women treated for complications of abortion[14]. This evidence though largely indirect, points to a high prevalence of abortion in the community. This is however without a concomitant increase in post abortion contraceptive use or contraceptive use in the general adolescent population.*[15,16] Illicit and unsafe abortion involves major health risk. Young women are at a greater risk of severe complications of abortion because they often wait until well into the second trimester of pregnancy[17,18]. Even in settings where abortion is legal, the risk of complications developing following a second trimester abortion is four times higher than before the twelfth week[18]. The complications that may arise include pelvic infection, haemorrhage, uterine perforation and tetanus. Left untreated, many of these complications may result in sterility, structural damage to the reproductive organs or death[19,20].

Figure 1, illustrates the relative distribution of abortion seekers and women with abortion related complications in a developed and developing country[13,14].

Fig.1



Canada 1984
Legally performed abortions



Nigeria 1983
Women seeking hospital treatment for septic abortion

Adolescents and family planning

In Africa, although sexual activity among unmarried teens is high, contraceptive use remains low. Percentages of teens that have ever used contraception range from a high of about 13 percent to a low of 1 percent in Nigeria and the Republic of Benin[21]. These figures are illustrative of the great hurdle to contraceptive use among the adolescent populace in developing countries. Two factors stand out to explain the low contraceptive utilization by adolescents, low education on contraception as well as a lack of access to effective contraception services. Education on adolescent sexuality is greatly limited by religion, cultural constraints as well as policy inertia. The same can be said of access to contraceptive services. A study conducted in Benin City, Nigeria revealed that

adolescents often source inappropriate medications as contraception from roadside patent medicine stores due to inaccessibility of formal distribution outlet as well as a lack of knowledge on issues of sexuality[3]. The above is further illustrated by the following extracts *" in the setting I work in Northern Nigeria...in the Zaria area...many girls marry between the ages of 10 and 15 and have two or three children by the time they are 18. In this setting, adolescents not only face the restrictions of civil law but also restrictions from cultural and traditional practices. In northern Nigeria, we do not just refuse adolescents access to contraceptive or abortion we also refuse them access to education about their bodies. In this setting, family life education is strictly prohibited in schools, yet this is an area where we need to educate these children about their bodies. Even if you do not give them contraceptives and you do not allow abortions at least, they should be able to have access to some family life education so they know what they are doing"*[22].

It is in the above context of dramatic social repression that millions of adolescent women in developing countries seek unsafe abortion each year. The risk young women in the developing world will run in order to control their fertility serve as a grim reminder of what could happen if legislation and legal decisions continue to whittle away at minimum reproductive rights currently allowed young women.

Contraceptive choice for the adolescent

In general, contraceptive choices for adolescents fall into the following categories: Preferred methods, acceptable methods, less acceptable methods and emergency methods. Preferred methods include condoms and oral contraceptive pills while acceptable methods are diaphragm, sponges, spermicides and injectables. The less acceptable methods are intrauterine contraceptive devise, periodic abstinence and surgical contraception. The emergency method, being the use of postcoital contraception. Acceptable methods and emergency methods are further discussed.

Condoms may be the most suitable method of contraception for adolescents. In addition to their effectiveness as contraception they also offer some protection against sexually transmitted diseases including the dreaded HIV virus. They have no systemic side effect and can be used without medical supervision. They are also relatively cheap and adolescents particularly unmarried ones may find condoms the most readily available method outside of a health care setting. The chief disadvantage of condom is that they reduce sensation and they must be used consistently. The combined oral contraceptive pill is popular among adolescents, as its use does not interfere with sexual activity, and it is almost 100% effective. Common side effects such as breakthrough bleeding or spotting, weight gain and fascial discolourations (chloasma) may worry the adolescents. Effective counselling on these unwanted effects often improve compliance and duration of use.

Postcoital methods of contraception are likely to be particularly sought after by adolescents, as these young women constitute a group for whom unplanned intercourse occurs fairly frequently. Although it is not to be recommended for use as a regular contraceptive procedure, it can be effective if it is instituted within 72 hours of unprotected intercourse. Health service providers should ensure that adolescents return for a follow up visit to check that they are not pregnant.

Role of health providers

Health providers working in developing countries face unique challenges in provision of adolescent reproductive health care. However the basis for future action and planning is the recognition that adolescents are a unique population with peculiar needs in terms of family planning and post abortion. This singular act would create a mass population of community leaders among health care providers identifying with their peculiar needs. There is a need for health care providers to play a pivotal role in advocacy targeted at changing existing polices. Such change will help facilitate the provision of an environment where issues of adolescent's sexuality, contraceptive services and post abortion care can be discussed. This is a necessary prerequisite at improving adolescent reproductive health care.

In the present context, health providers do have some access to the adolescent population. It is imperative that these opportunities be utilized to the advantages of adolescents. One possible approach in this regard is the adoption of an adolescent friendly attitude. Such will build trust between adolescents and health providers thus creating an avenue for the flow of information on issues of sexuality among adolescents and health providers when they arise. Similarly information and educational materials on abortion and post abortion care may also be channeled through such health centres.

Health care providers perform a significant portion of illegal abortion in many developing countries[23]. Denying access to information and post abortion care services at such crucial windows of opportunity is ethically and morally reprehensible. In the context of existing legal restraints such windows must be utilized to the advantage of these young people to prevent an evolving cycle.

To achieve the above, it is important that health care providers avail themselves of opportunities to develop skills necessary for the provision of family planning services. In particular there is a need to develop counselling skills that are applicable to adolescents. Similarly there is a need to further understand current family planning and post abortion care methods. This will form the basis for the provision of appropriate and reliable information, as well as services to the adolescents.

Conclusion

The current context of adolescent sexuality and the adverse reproductive health consequences especially in developing countries suggest the need for a more pragmatic approach to addressing family planning and post abortion services among adolescents. Health care providers are at a unique advantage in improving adolescent access to information and contraceptive use. It is imperative therefore they avail themselves of issues on adolescent sexuality. They in turn must utilize and create windows of opportunity to reach adolescent in improving adolescent health.

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