Orientation Programme on Adolescent Health for Health-care Providers

Handout for

Module J

Pregnancy prevention in adolescents

This handout presents background information to complement the material in module J entitled *Pregnancy prevention in adolescents*. The facilitator may refer to the text in this handout during the sessions and you may be asked to read some extracts.

THIS HANDOUT PROVIDES INFORMATION ON THE FOLLOWING:

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1. Why adolescents need pregnancy prevention methods

Use of contraceptives among adolescents

Millions of individuals around the world begin their sexual activity during their adolescent years. They do so often without adequate knowledge about sexuality, and without using modern contraceptives or protection against STIs including HIV. For example, demographic and health survey data from sub-Saharan Africa reveal that, in a number of countries, 80% of women have had sexual intercourse before age 20 *(1)*. While these women may know of one or more contraceptive methods, in many sub-Saharan African countries fewer than 30% of sexually active women have ever used a contraceptive method *(1)*.

Few unmarried adolescents use contraception during their first sexual experience. For example, only 4% of sexually active women aged 15 to 24 in Ecuador reported using contraceptives, and the corresponding figure in Uganda was only 6%. In the developing world, with some notable exceptions – such as in Latin America – few young women use contraception between marriage and first pregnancy. Most women who marry young have at least one child before age 20 *(1)*. Sexually active young people are less likely to use contraception than adults even within marriage. Unmarried adolescents, who face additional barriers to obtaining contraceptives, are even less likely to use contraception than married adolescents.

Studies in the USA suggest that there tends to be a delay of one year, on average, between the initiation of sexual activity and the first use of modern contraceptives *(1)*. Thus premarital sexual activity often results in unintended pregnancy. In Mexico City, nearly two-thirds of women aged 18 to 19 with premarital sexual experience reported that they had been pregnant at least once. In Zimbabwe, 46 % of women aged between 11 and 19 who had been sexually active before marriage had been pregnant (*1*). Many unintended pregnancies occur within a year of first sexual intercourse.

Whether they are married or unmarried, adolescents can face potentially serious physical, psychological and social consequences from unprotected sexual relations. These include too-early and unwanted pregnancy and childbirth, unsafe abortion, and STIs including HIV/AIDS. These events can also limit educational and job opportunities and negatively affect social and cultural development, especially of adolescent girls *(2)*.

Barriers to contraceptive use among adolescents

Adolescents in general – and unmarried adolescents in particular – often find it difficult to obtain the contraceptives they need. The most important reasons that adolescents cite, in a variety of different settings, for not using contraceptive methods when they are sexually active are (*3*):

- The unexpected and unplanned nature of sexual activity
- Lack of information and knowledge about contraceptives and where to get them
- Embarrassment and fear of lack of confidentiality
- Fear of medical procedures
- Fear of judgemental attitudes and resistance from providers
- Inability to pay for services and transport
- Displacement – refugees, or political strife
- Fear of violence from partner or parents
- Pressure to have children.

There is much that can and must be done to address these and other barriers.

In many parts of the world, laws and policies prohibit the provision of contraceptive information and services to adolescents. Restrictive societal norms add to this by hindering both their provision to and their utilization by adolescents. Working to reform these restrictive laws and policies, and to overcome societal resistance will help improve the availability and accessibility of contraceptive services to adolescents.

In many places, adolescents lack information about sexuality, and specifically about contraception. To add to this, health-care providers are often unaware of the special needs of adolescents, and further, contraceptive services are not geared to meeting the needs of adolescents. There is a pressing need to provide adolescents with the information they need. Alongside this, concerted efforts are required to help health-care providers understand and respond to the special needs of adolescents, and to reorient health services to meet those needs and preferences. In addition to the biomedical issues, it is important for health-care providers to be aware of the wider social issues, such as inequitable gender norms, that affect the adolescent's ability to obtain and use contraceptive services. Broader issues (such as gender norms and violence) often influence an adolescent's ability to access and effectively use contraception. Further, violence, either as a result of domestic abuse or political strife, can disproportionately affect the ability of women to access and use contraceptive services. In addition to their role as service providers, health-care workers should, where they can, contribute as change-agents, to the actions that are needed at the community and societal levels, to address these issues. These initiatives will help prevent the consequences of too-early and unprotected sexual activity in this important population group.

2. Providing adolescents with information and education on sexuality and contraception

For decades, education on sexuality and reproductive health for adolescents has been a controversial issue in developed and developing countries alike, because of concerns that knowledge would lead to earlier or increased sexual activity among unmarried adolescents. However, a review of studies from around the world which examined the impact of sex education programmes on adolescent knowledge and behaviour, found no support for this contention *(4).* If any effect is observed, almost without exception, it is in the direction of postponed initiation of sexual intercourse and/or effective use of contraception. The report stated that failure to provide adolescents with appropriate and timely information represents a missed opportunity for reducing the incidence of unwanted pregnancy and STIs and their negative consequences (*4*).

Sexual and reproductive health education programmes need to tailor their messages to suit the needs of adolescents who have not begun sexual activity, and those who are already sexually active. Also, because some adolescents begin sexual activity during early adolescence, formal sex education programmes need to begin during this stage *(4*).

Research into the sexual and reproductive health of young people clearly points to the fact that information provision and education alone do not necessarily lead to behaviour change[1]. Increasing awareness and understanding is only the first step in preventing unwanted pregnancy and STI/HIV. In addition, adolescents must know where to find services and be comfortable in using them. This important issue is addressed in this handout.

[1] A discussion on other issues that contribute to changes in behaviour, e.g. social norms, are beyond the scope of this paper.

3. Providing adolescents with contraceptive services

Dual protection provided by available contraceptive methods

Some adolescents may have temporary sexual relationships and multiple partners, which puts them at a high risk of STIs/HIV. Sexually active adolescents need to be aware of the importance of protection against both pregnancy and STIs/HIV. When used correctly and consistently, male condoms are the most effective method of preventing STIs including HIV/AIDS and can be highly effective in protecting against pregnancy as well. Another approach for simultaneous protection against pregnancy and STIs is the "dual use method", that is to use condoms in conjunction with another method that has more contraceptive typical-use failure rates such as combined oral contraceptives or injectables.

The following Table 1 lists the effectiveness of the available contraceptive methods in preventing pregnancy and in providing protection from STIs including HIV *(5).*

Medical eligibility for available contraceptive methods

WHO places a high priority on ensuring that adolescents and young people worldwide have access to safe and high-quality reproductive health and family planning services. The publication *Improving access to quality care in family planning: Medical eligibility criteria for contraceptive use (6)*, provides recommendations of an expert scientific working group for appropriate contraceptive use in the presence of various medical conditions. It provides essential information for the provision of contraceptives safely to adolescents, while at the same time ensuring that they are not denied access to contraception based on unfounded "contraindications".

A brief review of method-specific medical, service delivery and counselling considerations for adolescents is provided below in Table 2. This table covers issues that are most important when providing contraceptive methods to adolescents. For a more thorough discussion of the medical eligibility criteria, please refer to *Improving access to quality care in family planning: Medical eligibility criteria for contraceptive use*. For more information on methods, such as mechanism of action, correct use, management of problems and side effects, and contraceptive benefits, see *The essentials of contraceptive technology: A handbook for clinic staff (7).*

Healthy adolescents are medically eligible to use any of the methods of contraception that are currently available. Age alone does not constitute a medical reason for denying any method to adolescents. However, age is an important social factor to take into account when considering irreversible contraceptive methods, such as male or female sterilization. It is also true that some concerns exist regarding the use of certain other methods by adolescents (for example, progesterone-only pills), but this must be balanced with the advantages of avoiding pregnancy. Many of the method-specific eligibility criteria that apply to older clients also apply to young people. Some conditions such as circulatory system diseases, that may limit use of some methods in older women, will not often apply to young people, since these conditions are rare in this age group.

TABLE 1

Dual protection of available contraceptive methods

Method	Effectiveness against pregnancy		Protection against STI/HIV	Comments and considerations
	As commonly used	Used correctly and consistently		
Abstinence and non-penetrative sex	Not effective	Very effective	Protective against STI/HIV	Most effective method for dual protection. Only provides dual protection when used correctly and consistently.
Male condom[1]	Somewhat effective	Effective	Protective against STI/HIV	Only provides dual protection when used correctly and consistently.
Female condom	Somewhat effective	Effective	Protective against STI/HIV, although data is limited	Only provides dual protection when used correctly and consistently.
Spermicide[2]	Somewhat effective	Effective	May protect against gonorrhoea and chlamydia, no protection against HIV	Only provides limited dual protection when used correctly and consistently. Not recommended for use alone. Not recommended for frequent use (may cause genital lesions).
Diaphragm with spermicide	Somewhat effective	Effective	May protect against gonorrhoea and chlamydia, no protection against HIV	It is not clear to what degree the diaphragm, when used with a spermicide provides protection against STIs. Only provides limited dual protection when used correctly and consistently. Spermicide not recommended for frequent use (may cause genital lesions).
Combined Oral Contraceptives (COCs)	Effective	Very effective	Not protective	Only protective against pregnancy when used correctly and consistently. If at risk of STI/HIV, recommend switching to condoms or using condoms along with this method.
Progestin-Only Pills (POPs)	Very effective (during breastfeeding)		Not protective	
Long-Acting Hormonals:Injectables or Implants	Very effective		Not protective	If at risk of STI/HIV, recommend switching to condoms or using condoms along with this method.
Copper Intra-uterine Device (IUD)	Very effective		Not protective Insertion of an IUD in a woman with an STI increases the risk of PID	Use of IUDs among women at risk of STI/HIV is generally not recommended (unless other, more appropriate methods are not available). If an IUD user becomes at risk of STI/HIV, recommend switching to condoms or using condoms along with this method.
Fertility Awareness-Based Methods	Somewhat effective	Effective	Not protective	Only protective against pregnancy when used correctly and consistently.If at risk of STI/HIV, recommend switching to condoms or using condoms along with this method.
Lactational Amenorrhoea (LAM) during first 6 months postpartum	Effective	Very effective	Not protective	
Withdrawal	Somewhat effective	Effective	Not protective	
Male and Female Sterilization	Very effective		Not protective	If at risk of STI/HIV, recommend using condoms along with this method.

[1] At present, dual protection applies only to condoms. The evidence for the effectiveness of condoms for STIs/HIV prevention is substantially greater for male condoms than it is for female condoms.

[2] Spermicides containing nor oxynol-2 do not appear to protect against chlamydia infection or gonorrhea.

TABLE 2

Medical, service delivery and counselling considerations for adolescents

Method	Dual protection	Age Restriction	Availability/ Accessibility	Side Effects	Other important counselling points for adolescents	Comments/ considerations
Abstinence and non-penetrative sex	Yes	No age restriction	Available at anytime to anyone	None	Can be used even by those who have already begun sexual activity To prevent pregnancy, avoid vaginal intercourse To prevent STI/HIV, also avoid anal intercourse and oral sex Examples of safe sexual activities: hand-holding, hugging, massaging, kissing, mutual masturbation Emphasize need to use condom or other method if penetrative sex is initiated	Most effective method for dual protection Requires high level of motivation and self-control Counselling can help with issues of motivation and peer pressure
Male condom	Yes	No age restriction	Easily available in most places	Usually no side effects (local irritation possible)	Explain and demonstrate correct use Requires partner communication / negotiation Requires supplies at home (fear of discovery may be an issue)	Important method because provides dual protection
Female condom	Yes (data limited)	No age restriction	Availability limited in many places High cost may be a constraint	Usually no side effects (local irritation possible)	Explain and demonstrate correct use Use can be controlled by woman Requires supplies at home (fear of discovery may be an issue)	Important method because provides dual protection
Spermicides	Yes (protective against some STIs, not HIV)	No age restriction	Easily available in many places	Usually no side effects (local irritation possible)	Explain and demonstrate correct use Recommend use with condom or diaphragm Requires supplies at home (fear of discovery may be an issue)	Not recommended for use alone Not recommended for frequent use (may cause genital lesions)
Diaphragm with spermicide	Yes (protective against some STIs, not HIV)	No age restriction	Requires a clinic visit for fitting Availability limited in many places	Usually no side effects (local irritation possible)	Explain and demonstrate correct use Requires supplies at home (fear of discovery may be an issue)	It is not clear to what degree the diaphragm, when used with a spermecide provides protection against STIs Spermicide not recommended for frequent use (may cause genital lesions)
Low Dose Combined Oral Contraceptives (COCs)	No	No age restriction	Requires clinic visit in many places May be available through community-based distribution	Side effects may include nausea or headache	Explain and demonstrate correct use Recommend also using condom if at risk of STI/HIV Requires daily regimen Requires supplies at home (fear of discovery may be an issue)	A widely-used method among adolescents, although correct and consistent use may be an issue

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TABLE 2

Medical, service delivery and counselling considerations for adolescents

Method	Dual protection	Age Restriction	Availability/ Accessibility	Side Effects	Other important counselling points for adolescents	Comments/ considerations
Progestin-Only Pills (POPs)	No	No age restriction	Requires clinic visit in many places May be available through community-based distribution	Fewer side effects than COCs or long-acting hormonals (injectables and implants)	Explain and demonstrate correct use Recommend also using condom if at risk of STI/HIV Requires strict daily regimen Requires supplies at home (fear of discovery may be an issue)	Stricter regimen than COCs Good option for breastfeeding women after first 6 weeks postpartum
Emergency Contraceptive Pills (POPs or COCs)	No	No age restriction	Requires clinic visit in many places May be available over-the-counter or through community-based distribution	Side effects may include nausea and vomiting (much less likely with POP regimen)	Not meant for repeated use Discuss initiation of a regular method	Important method when intercourse may be unplanned, unprotected
Injectables: Depo medroxy progesterone acetate (DMPA) and Norethisterone Enanthate (NET-EN)	No	Not first method of choice for those under 18, as there is a theoretical concern that bone development in general	Requires clinic visit every 2 or 3 months May be available through community-based distribution	Side effects may include irregular bleeding, amenorrhoea, or weight gain	Recommend also using condom if at risk of STI/HIV Often delay in return to fertility No daily regimen required No supplies needed at home (can be private)	May be a good option for those desiring a hormonal method, without a daily regimen Side effects the main reason for discontinuation and if they occur, method cannot be quickly discontinued
Combined Injectables: Cyclofem and Mesigyna	No	No age restriction	Requires clinic visit every month May be available through community-based distribution	Side effects may include nausea or headache	Recommend also using condom if at risk of STI/HIV No daily regimen required No supplies needed at home (can be private)	May be a good option for those desiring a hormonal method, without a daily regimen
Norplant Implants	No	No age restriction	Clinic visit required for insertion and removal	Side effects may include irregular bleeding or amenorrhoea	Recommend also using condom if at risk of STI/HIV No delay in return to fertility No daily regimen required No supplies needed at home (can be private)	May be a good option for those desiring a hormonal method without a daily or monthly regimen

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TABLE 2

Medical, service delivery and counselling considerations for adolescents

Method	Dual protection	Age Restriction	Availability/ Accessibility	Side Effects	Other important counselling points for adolescents	Comments/ considerations
Copper Intra-uterine Device (IUD)	No	Not first method of choice for those under 20, as risk of expulsion may be great in younger, nulliparous women	Clinic visit required for insertion and removal	Sides effects may include excessive bleeding or pain during menses	Recommend also using condom if at risk of STI/HIV No delay in return to fertility No daily regimen required No supplies needed at home (can be private)	Not a good choice for those at risk of STI/HIV (more than one sexual partner or whose partner may have more than one partner) Nulliparous women may be at higher risk of expulsion
Fertility Awareness-Based Methods	No	No age restriction	Available at anytime to anyone	No side effects	Explain correct use Recommend also using condom if at risk of STI/HIV Requires partner communication/ negotiation	Important for adolescents to understand their fertility May not be as effective in younger women whose menstrual cycles are irregular May be difficult to use for couples who have sex infrequently
Lactational Amenorrhoea (LAM)	No	No age restriction	Can be used during first 6 months postpartum when exclusively breastfeeding and amenorrhoeic	No side effects	Explain and demonstrate correct use Recommend also using condom if at risk of STI/HIV	Important method option for breastfeeding women
Withdrawal	No	No age restriction	Available at anytime to anyone	No side effects	Explain correct use Requires partner communication/ negotiation important	Important method to discuss, as may be only method available in some places
Male and Female Sterilization	No	No age restriction However, age at sterilization is a key risk factor for regret for both women and men	Clinic visit required for procedure	Minimal side effects, local infection possible	Recommend also using condom if at risk of STI/HIV Permanent method No daily regimen required No supplies needed at home (can be private)	Consider only in special circumstances after thorough counselling

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Counselling on sexuality

Adolescence is a period when individuals may test limits set for them by adults, experiment with new behaviours, and struggle with issues of independence, acceptance, and peer group pressure. Thus, a supportive, encouraging, non-judgemental environment, where confidentiality is ensured, is essential

when counselling adolescents. Health-care providers and others may benefit from special training in sexuality and in counselling skills, to enable them to deal with the needs, concerns and problems of adolescents.

Developing a good rapport with adolescents is important, as is using language that they can understand and be comfortable with. Due to inexperience and possibly embarrassment, adolescents may be hesitant in expressing their needs. Providers need to be patient and take the necessary time when working with them.

Adolescents may have special information needs, such as a desire to understand the changes that are happening in their bodies as they mature, whether they are "normal" or not, and other information regarding sexuality and sexual function. Service providers who are not comfortable discussing these issues with issues with adolescents, should refer them to those who are. Also, parents should be encouraged – and given the necessary support – to communicate with their children/adolescents on sexuality.

Counselling should cover responsible sexual behaviour and needs to be directed at both males and females. Male adolescents should be encouraged to share the responsibility for contraception and STI/HIV prevention with their female partners.

Counselling for contraceptive method choice

While adolescents may choose to use any one of the contraceptive methods available to them, some methods may be more appropriate for adolescents for a variety of social and behavioural reasons. Many of the needs and concerns of adolescents that affect their choice of a contraceptive method are similar to those of adults seeking contraception. For example, using a method that does not require a daily regimen, such as oral contraceptive pills do, may be a more appropriate choice for an individual.

In helping an adolescent make a choice of which method to use, health-care providers must provide them with information about the methods, and help them consider their merits and demerits. In this way, they could guide their adolescent clients to make well-informed and voluntary choices of the method that is most suitable to their needs and circumstances (taking eligibility, practicality and legality into consideration). The information provided should address the following issues:

- The effectiveness of the method
- Information on protection against STIs including HIV
- The common side-effects of the method
- The potential health risks and benefits of the method
- Information on return to fertility after discontinuing use of the method
- Where the method can be obtained and how much it costs.

After a method is chosen, it is also important to discuss correct use of the method and follow-up information, such as signs and symptoms which would necessitate a return to the clinic.

Proper education and counselling at the time of method selection can help adolescents address their specific problems and make well-informed, voluntary decisions. Further, expanding the number of method choices offered can lead to improved satisfaction, increased acceptance and higher contraceptive prevalence.

Special considerations

Married adolescents

It is important to remember that many adolescents seeking contraception services are married. Their contraceptive needs are similar to those of married adults, but they may have other special information needs.

In terms of counselling issues, married adolescents may be particularly concerned about their return to fertility after discontinuing use of a method. Those desiring a quick return to fertility may prefer to avoid injectables such as Depo Medroxy Progesterone Acetate (DMPA), which can delay return to fertility. Young married women may in some cases feel a pressure to have children, and thus may want to keep their contraceptive use private from their spouse or in-laws. They also may knowingly or unknowingly be in a relationship where they are at risk for STIs including HIV/AIDS. This is an important, yet often difficult issue to discuss, and must be done with sensitivity.

Unmarried adolescents

Unmarried adolescents may be less likely to seek contraceptive services at health facilities because of embarrassment at needing or wanting reproductive health services, and because of fears that the staff may be hostile or judgemental or that their parents might learn of their visit. Adolescents need to feel that they are respected, that their needs are taken seriously, and that they have the right to use contraception if they desire.

For unmarried adolescents who do seek contraceptive services, it is important to discuss abstinence or non-penetrative sexual activity as options, even with those who have already had sexual intercourse. With support, individuals can delay sexual activity until they are older, and thus be better able to deal with its social, psychological and physical implications. This requires commitment, high motivation and self-control. Adolescents need support and encouragement to abstain from and/or delay the initiation or continuation of sexual intercourse.

For unmarried adolescents who want to have sexual intercourse, condoms – or condoms in combination with another method – are the best recommendation. For adolescents who are not in monogamous relationships, sexual activity may be sporadic and unplanned. In these circumstances, condoms are a good choice because they are widely available and can be used when needed.

Adolescents, especially those in monogamous relationships, may also desire to use other, longer-acting methods. Providers of contraceptives must support this decision. For these adolescents as well, the risk of STIs including HIV/AIDS must be discussed. Some of them may be at risk for STIs/HIV when they do not consider themselves to be, if their partner has other sexual partners.

Adolescents who have been coerced into having sex

In designing and providing services, it is crucial not to assume that clients are engaged in mutually consensual sexual relations. Adolescents who have been subjected to sexual coercion and abuse will require special care and support. Emergency contraception is part of a package of services that should be made available in such circumstances. Health-care providers need to be sensitive to these issues. They must also be well aware of how to access the health and social services that these adolescents may need.

SUMMARY

- In many parts of the world, adolescents are entering their reproductive years ill-prepared to protect and safeguard their sexual and reproductive health.
- For all adolescents, but especially for those who are sexually active outside the context of marriage, access to appropriate information and services – and the assurance of confidentiality – are particularly important.
- To help ensure contraceptive use among sexually active adolescents, contraceptive information and services must be made readily available through a variety of delivery points, including community-based points and outreach services.
- By providing quality services that respect adolescents' rights and respond to their needs, reproductive health programmes will contribute to the overall health and well-being of their adolescent clients and to their communities and societies.

4. References

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Annex 1

Spot checks

Session 1: ACTIVITY 1-2

SPOT CHECK 1

Which contraceptive methods should not be used by adolescents?

please mark all unsuitable methods

- Abstinence ○
- Male condom ○
- Female condom ○
- Spermicide ○
- Diaphragm with spermicide ○
- Combined oral pill ○
- Progestin-only pill ○
- Combined injectable ○
- Progestin-only injectable ○
- Progestin-only implant ○
- Intra-Uterine Device ○
- Fertility-awareness based methods ○
- Lactational amenorrhoea ○
- Withdrawal ○
- Sterilization ○

SPOT CHECK 2

Which contraceptive methods are protective against HIV/STI?

please write down two examples for each method

protective

not protective

SPOT CHECK 3

Which contraceptive methods are available in your local clinic?

please write down two examples

SPOT CHECK 4

Which contraceptive methods do not require the cooperation of the male partners?

please write down three examples

Annex 2

Role plays

Session 6: ACTIVITY 6-2

ROLE PLAY 1

You are a nurse-midwife in a district hospital. Along with the other members of your small Obstetrics-Gynaecology team, you run an antenatal outpatient clinic, twice a week (in the mornings). One Friday morning, as you walk into your clinic, you see two young women, in their late teens, huddled together in a corner of the waiting room. One of them is obviously crying, and the other appears to be trying to console her. You say to yourself that this is a sight you have seen several times before - yet another possible unintended, unwanted pregnancy… When it is their turn, your suspicions are proved right. The two young women are aged 15 and 16. They are students in a nearby secondary school. The one in tears tells you that her periods are delayed by four weeks, and she suspects that she is pregnant. On gentle questioning, she tells you that she had unprotected intercourse only once with a young man who is her neighbour. You carry out an examination and request a urine test for pregnancy. You ask them to wait for the results. An hour and a half later, a technician from the laboratory brings you the results: the urine test for pregnancy is negative. You call the two women into the room to share the news with them. Both of them start sobbing in relief.

Roles: Nurse-midwife, two adolescent girls 15 and 16 years old.

ROLE PLAY 2

You are a female doctor in your late 40s. Along with your husband, who is also a doctor, you run a private practice in a well-to-do suburb of a large city. Your clinic has been in operation for nearly 15 years and is a well-established one. Your husband and you are well-known in the neighbourhood, and in fact you live nearby. One evening, your nurse ushers in a young woman whom you have not seen before. The woman waits till the door is firmly shut and then leans forward to speak to you in a soft voice, which is almost a whisper. She says that she is 19 years old, just married and has moved into the neighbourhood to live with her husband and his extended family. She smiles when you congratulate her, and says that she is happy with her husband, but that she is under a lot of pressure from her in-laws to have a baby as soon as possible. She wants to wait for some time and asks for your advice. Apparently, her husband agrees but feels unable to resist the pressure of his parents…

Roles: Doctor, 19-years old young woman.