

## **Statement on Contraception and STI/HIV Protection for Adolescents**

### **Introduction**

The World Health Organization defines adolescence as the period between 10 and 19 years of age. However, the growth process differs between individuals, as does the cultural and socio-economic context in which they live. A large proportion of adolescents are sexually active and adolescent sexuality should be acknowledged. Childbearing under the age of 16 carries high risks of morbidity for both mother and offspring; and early parenthood tends to curtail opportunities for education and employment, hampering social and cultural development especially in the mother. Young women often fall victim to unsafe abortion, through lack of information and lack of access to services. Sexual practices of adolescents may include vaginal, oral, and anal intercourse, with a partner of the opposite sex or the same sex; thus, contraception and methods to prevent sexually transmitted infections (STIs), consistent with sexual behaviour, are crucial to the sexual and reproductive health of this group. Services for adolescents, which should cater for males as well as females, need to be coupled with effective sex education and access to information.

### **Sexuality Education and Youth Friendly Services**

Whether sexually active or not, adolescents wish to feel comfortable about their bodies and their sexuality. The aim of sexuality education is to help them explore their values and acquire the knowledge and confidence to make decisions about their sexual behaviour – including the decision not to engage in sexual intercourse until ready to do so. Sexuality education should discuss sex within its social and emotional context. In this process the different needs of young men and women must be addressed. Whenever possible, sexuality education should be done with parental support; indeed, parents should be encouraged to participate. A successful programme will enhance the independence and self-esteem of adolescents, providing them with the skills to negotiate relationships and safer sexual behaviour.

• Youth friendly contraceptive and STI/HIV protection services should be made easily available to adolescents irrespective of their age, marital status, or financial

situation. Service providers should be aware that adolescents often face special difficulties of access. Inconvenient hours, legal hurdles, inaccessibility, and high costs are among the factors that can severely curtail adolescents' ability to use the services. When services are being designed, implemented, and evaluated, every effort should be made to involve adolescents.

Clearly, adolescents feel most comfortable when staff members are welcoming and friendly. Moreover, a supportive and encouraging environment will spare them embarrassment when requesting contraceptive counselling or services. Privacy and confidentiality are essential, and adolescents should be given explanations of what confidential care entails. Service providers must not be judgmental and should show respect towards adolescents. They must take pains to build good rapport with the adolescent, using language that he or she understands. Clinical procedures such as pelvic examinations should be avoided except when essential, since they may discourage adolescents from requesting contraceptive services. All service providers should receive special training in dealing with the problems and needs of adolescents.

Contraceptive discontinuation rates for adolescents are higher than those for older users, for all methods. Reasons could include unexpected side-effects, cost, or even fear of the service provider. These issues need to be addressed from the moment an adolescent contacts the service, complete information being given on how methods work and what side-effects are to be expected. Whatever the method of pregnancy or infection prevention, counselling sessions are an opportunity for the service provider to give information on how the body works. An understanding of menstrual function and of pregnancy risks is an important foundation for further contraceptive knowledge. Adolescents should be encouraged to contact their service provider if they have any concerns or questions.

## **Choice of Methods**

When considering a method of contraception, personal, cultural, and environmental factors, as well as sexual lifestyle and access to health services, should be taken into account. Highly effective contraception is particularly important where safe back-up abortion services are not easily available or acceptable to the client.

While many methods of contraception are suitable for sexually active adolescents, condoms are the only method that protects against both pregnancy and STI/HIV. Adolescents should be encouraged to use condoms correctly with every act of intercourse whenever there is a possible risk of STI/HIV, even if the female partner is already using another form of contraception. **Hormonal contraceptives (including**

**emergency contraception), intrauterine devices, withdrawal, periodic abstinence, and sterilisation, do not give any protection against STI/HIV.**

Information on various contraceptive methods, and protection against STI/HIV, is contained in other International Medical Advisory Panel statements. \* This statement deals with the specific advantages and disadvantages of different methods of contraception for adolescents.

## Condoms

Male condoms are the only method that, when used correctly and consistently with every act of intercourse, has been proven highly effective against both unwanted pregnancy and STI/HIV. Therefore, condoms constitute one of the most important methods of contraception for this age group.

Major advantages of condoms are that they are available without medical prescription and are well suited to community-based services. They are safe and have only a few occasional local side-effects. There are no medical contraindications to their use. A disadvantage is that they are less use-effective against unwanted pregnancy than hormonal methods or intrauterine devices (IUDs), because correct use requires good motivation and adequate knowledge. Education and counselling on proper use are therefore very important, and should include a demonstration of how to put on and take off the condom.

Female condoms offer an alternative, which can be initiated by women, particularly when a woman has difficulty negotiating male condom use. However, they may be less effective than male condoms against unwanted pregnancy and their effectiveness against STI/HIV needs more research. They are also more costly than male condoms - an important consideration for many adolescents.

With anal intercourse pregnancy is not a risk but condoms should be used to reduce the risk of STI/HIV.

Both adolescent girls and adolescent boys should be provided with skills to negotiate sex and condom use even in circumstances of unequal power relations (such as a young girl in a sexual relationship with an older man).

Easy access to emergency contraception is essential for adolescents who rely exclusively on condom use for dual protection, especially when safe abortion services are not available or not acceptable to the client.

## Oral Contraceptives

Oral contraceptives are suitable for adolescents, highly effective when used properly, and safe. Routine pelvic and breast examinations are not required before initiation of oral contraception; such physical examinations may deter adolescents from using the method. It is not necessary to wait for establishment of a regular menstrual cycle before initiating oral contraception. Irregular menstruation is common during adolescence and does not usually need to be investigated. Menses during adolescence may often be heavy and painful, and the combined pill can improve bleeding patterns and menstrual pain in addition to providing contraception. It can also lessen acne.

There is no evidence that the use of oral contraception causes premature fusion of epiphyses and young girls who take the combined pill continue to grow normally. Use of the pill during adolescence does not cause post-use endocrine disturbances.

Progestogen-only pills (POPs) demand more in terms of compliance than combined oral contraceptives (COCs) since they should be taken at the same time each day. Their use is often associated with irregular bleeding. However, if oestrogen is contraindicated and oral contraception is desired, the POP is a useful method.

Some adolescents find it difficult to take pills regularly. Since the effectiveness of COCs and POPs depends on such adherence, counselling should emphasize the need for

consistent and proper use of the method. Adolescents should also be informed that side-effects, such as breakthrough bleeding, are common in the first few cycles of oral contraceptive use and that these usually settle over time. They should be encouraged to persevere and return to the clinic if the side-effects remain troublesome.

## Hormonal Emergency Contraception

Adolescents are often in need of emergency contraception, because they have had sexual intercourse without using a contraceptive, or because their contraceptive technique has failed (e.g., condom breakage or forgetting to take the pill). In addition, they are commonly victims of sexual violence. Every opportunity should be taken to inform them about the use of emergency contraception and how to obtain it. The information can be given, for example, during a sex education or contraceptive counselling session. Adolescence is not a contraindication to emergency contraception, and programmes should explore ways to make it more easily accessible to this group. Emergency contraception should be available for use in cases of rape.

Two hormonal regimens have proved to be safe and effective for emergency contraception.

One is the use of combined oral contraceptives containing the oestrogen ethinyloestradiol and the progestogen levonorgestrel (or norgestrel) that can be taken in a regimen known as the Yuzpe method. This regimen consists of two 50 µg ethinyloestradiol/250 µg levonorgestrel pills, or four 30 µg ethinyloestradiol/150 µg levonorgestrel pills, taken as soon as possible within 72 hours after unprotected intercourse, followed by a second similar dose 12 hours later.

The other regimen consists of a pill containing 750 µg levonorgestrel taken as soon as possible within 72 hours after unprotected intercourse, with a second dose 12 hours later. This regimen is probably more effective, and has fewer side-effects than the Yuzpe regimen.

The adolescent should be aware of the importance of a follow-up visit to a family planning clinic or health care provider to check that no pregnancy has occurred. This visit offers a suitable occasion for counselling about future contraceptive needs.

### Long-acting Hormonal Methods

Long-acting hormonal methods, which have the advantage of not requiring daily action, may be suitable for adolescents. They include the combined injectable contraceptives, the progestogen-only injectables, and subdermal implants. When adolescents are counselled on long-term hormonal contraceptives, they should be made aware of the possibility of changes in the menstrual pattern, including irregular or prolonged bleeding or amenorrhoea. They should also be advised about the possibility of other side-effects such as weight gain and acne. Other aspects of counselling and services related to the various types of long-acting hormonal methods will be found in the corresponding IMAP statements.

### Combined Injectable Contraceptives

Combined injectable contraceptives are suitable for adolescents, highly effective, and well tolerated. Although they may affect the menstrual bleeding pattern, they do so less often than progestogen-only injectables. They do not have any hypo-oestrogenic or androgenic side-effects.

## Progestogen-only Injectables (POIs)

POIs inhibit ovulation and are commonly associated with amenorrhoea. Because they partly suppress endogenous oestrogen, they may reduce bone mineral density. Thus, there are concerns that use in the first few years after menarche may prevent young women from reaching a normal peak bone mass. For this reason, other risk factors for osteoporosis such as body weight, smoking, and use of corticosteroids should be assessed before making a decision regarding use of POIs by under-18s.

If an adolescent is considering the use of POI, she should be informed of a high possibility of disruption of the normal bleeding pattern and a possible delay in the return of fertility.

## Subdermal Implants

The Norplant subdermal implant system, which provides contraceptive protection for up to five years, can be suitable for adolescents who seek long-term contraceptive protection. Weight gain and skin disorders such as acne are more likely to happen with Norplant than with other long-acting hormonal contraceptives.

It is especially important for this group that there are facilities where subdermal implants can be removed whenever the client requests this and for whatever reason.

## Intrauterine Devices

Although the IUD has commonly been regarded as contraindicated for adolescents, it can be a suitable method of contraception for adolescents who are not at high risk of STI. The IUD provides highly effective contraception for more than five years. If during that time the risk of STI should increase – for example because of a new sexual relationship – the use of condoms should be encouraged for dual protection. Since IUD insertion in adolescents can be difficult, it should always be done by a skilful provider. Nulliparous adolescents should be warned that they are at excess risk of IUD expulsion.

## Diaphragm

The diaphragm is suitable for adolescents, but the effective use of this method requires a high level of motivation and skill. Storage and washing may be troublesome if the adolescent wishes to maintain secrecy.

Diaphragms may provide some protection against cervical infection and cancer, although they have been associated with adverse changes in the vaginal flora and

urinary tract infections when used with spermicides; no protection against HIV has been demonstrated.

## **Spermicides**

Spermicides are usually easy to obtain. However, spermicides have lower effectiveness against pregnancy than other contraceptive methods and should not be recommended for use on their own. When used with diaphragms or condoms, they may increase effectiveness against pregnancy. None of the spermicides has proved to be effective against STI/HIV. Therefore, spermicides should not be promoted for use against HIV infection.

## **Withdrawal**

In some circumstances withdrawal, which is the removal of the penis from the vagina before ejaculation occurs, may be the only method available to an adolescent. Therefore adolescents should be fully informed about the technique. However, they should be encouraged to use a more effective method, especially condoms.

## **Periodic Abstinence**

Periodic abstinence relies on identifying the time of ovulation, is dependent on adherence with the practice of abstinence during the fertile period, and is difficult to use in the presence of irregular menstrual cycles. It is also likely to be difficult to use by those who only have occasional sexual intercourse.

## **Sterilisation**

Sterilisation is very rarely indicated in this age group, and should be considered only in exceptional medical circumstances.

*\*Other related IMAP statements:*

- Statement on dual protection against unwanted pregnancy and sexually transmitted infections, including HIV (2000)
- Statement on HIV infection and AIDS (1997)
- Statement on sexually transmitted diseases and reproductive health (1997) - Statement on steroidal oral contraception (1998)
- Statement on emergency contraception (2000)

- Statement on injectable contraception (1999)
- Statement on Norplant subdermal contraceptive implant system (1995) -  
Statement on intrauterine devices (1995)

*Statement developed by the International Medical Advisory Panel (IMAP), October 2000. Replaces the Statement on Contraception for Adolescents, 1993. IMAP reserves the right to amend this Statement in the light of further developments in this field.*

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