

FOCUS on Young Adults: Adolescent Reproductive Health Questions & Answers (Qs & As)

This is the first in a series of Adolescent Reproductive Health Qs & As designed to address the major issues and interests brought to the attention of the FOCUS on Young Adults program by the staff of intermediary organizations, health and family planning practitioners and adolescents. Intermediary organizations include the field representatives of USAID, USAID cooperating agencies, and other partner organizations that advise developing country professionals on design, development, implementation and evaluation of programs, that make decisions on funding Young Adult Reproductive Health (YARH) programs, or both. These Qs & As are also intended for developing country professionals, such as planners, managers and service providers or practitioners, who may have limited training in adolescent reproductive health and limited experience with adolescents, who are sometimes confronted with questions by adolescent clients. Many of these people have fundamental questions themselves on adolescent reproductive health, sexual growth, development and behavior (related to contraception, teen pregnancy, sexually transmitted infections [STIs], sexuality, etc.) or need their information updated. These Qs and As are not only meant to complement quality professional training, but can also be used by those professionals responsible for developing training content and curricula.

The questions below therefore cover a range of YARH issues and interests, including counseling, contraception, growth and development, and sexual behaviors and decision making. FOCUS staff and partners in the field have assisted in providing the answers to the questions. These Qs & As will be posted on the FOCUS Web site, and a limited number of hard copies will be available. We plan to add Qs & As to this initial list quarterly, and we will continue to seek input from professionals in the field and from adolescents themselves. Please feel free to contact us for additional information or to submit questions you would like to have answered at www.pathfind.org/focus.htm.

Our Qs & As series is patterned after Dr. James Sheltons (Sr. Medical Scientist, USAID) Contraceptive Pearls, now widely available in the international population and health professional community. Dr. Sheltons Pearls can be accessed at <http://www.jhuccp.org/pearls/index/stm> or <http://www.info.usaid.gov>.

Counseling

Q. What are the best strategies for counseling adolescents about delaying sexual intercourse?

A. When counseling adolescents, the following strategies should be taken into consideration:

- Recognize for themselves as providers, and share with the adolescent client, that sexual interest and desire during adolescence is normal and natural.
- Explore with the client the client's personal values and those of his or her family regarding sexual activity, taking into account his or her age, gender, marital status, social norms and expectations.
- Encourage the adolescent to have discussions with family or significant others in his or her life, if appropriate.
- Ask the adolescent to discuss how far he or she is willing to go with respect to intimate sexual contact with his or her partner.
- Ask the adolescent to identify the pros and cons of becoming sexually active (including health and social risks) and the potential effect of sexual activity in general, and sexual intercourse in particular on themselves, their partners, their family, and others.
- Discuss and provide information on how to say no to unwanted or unprotected sexual activity. Suggest and explore possible responses to pressure from partners and peers. One way to do this might be through role-playing real life situations so that the adolescent develops the language and skills needed to negotiate with a partner or peers.
- Help the adolescent set realistic life goals, and discuss how an unplanned pregnancy might disrupt the accomplishment of those goals.
- Provide complete information about preventing pregnancy and STIs, including AIDS, and information about where to obtain additional information and services, should the adolescent choose to become sexually active.

Q. What needs to be known about the physical and psychosocial development of young clients to more effectively reach, serve and counsel them?

A. It is important to know the following facts about adolescent development:

Physical Development

- Providers need to understand puberty and the accompanying body changes experienced by both boys and girls.

- Girls begin menstruating and boys reach puberty at earlier ages than in previous decades. That, in many cases, means an increase in the time between the onset of puberty and marriage and a greater period of possible sexual activity and risk for pregnancy and STIs.
- Among younger female adolescents, the lack of physical maturity may put them at greater risk for complications during pregnancy.

Psychosocial Development

- Adolescents are very concerned about being normal, and they may have a great deal of anxiety about the changes their bodies are going through.
- Adolescents respond to and integrate information differently on the basis of age, stage of development and level of maturity. For example, many adolescents may have difficulty grasping complex concepts or complicated medical terms, so information needs to be repeated several times or explained in different ways, using simple language and a variety of media.
- Adolescents may be at greater risk of STIs, including HIV, because of an inability to negotiate within relationships that are often with older adolescents or with adults.
- Lifestyles of many adolescents may not be conducive to the kind of routine or privacy necessary for consistent contraceptive use. Therefore, consideration needs to be given to the method that best fits the individual's lifestyle, or the provider needs to work with the adolescent to figure out how best to accommodate the method within his or her lifestyle.
- Many adolescents have engaged or are currently engaging in sex against their will, have been or are being abused, or are coerced into having sex in return for favors such as payment of school fees.
- Not all adolescent sexual relationships are heterosexual.
- To the extent possible, providers need to engage adolescents in discussions that help assess:
 - whether the adolescent is engaged or has engaged in sex for any of the reasons noted above;
 - his or her level of knowledge about preventing pregnancy and STIs and his or her perception of risk;
 - whether the adolescent practices safe sex every time;
 - if the adolescent has had multiple partners;
 - if the adolescent has engaged in same-sex sexual relationships; and
 - if the partner or partners of the adolescent is engaging or has engaged in same-sex sexual relationships.
- Adolescents may not be forthcoming with information, particularly about their sexual experiences, and it may take extra effort to establish a relationship conducive to getting the necessary information from them.
- Adolescents may face pressure from partners and/or peers to have sex.

Q. How is counseling young people different from counseling adults?

A. Counseling young people is different from counseling adults in the following ways:

- Youth may be less informed about their bodies, reproductive capacity, contraceptive methods, their risk for pregnancy and STIs and HIV/AIDS, and these issues may have to be brought up by the counselor.
- Adolescents may also have dangerous misconceptions or false beliefs because of inadequate or poor sources of information.
- Many societies tend to be less accepting and less tolerant of sexual activity among adolescents in general and those who are unmarried in particular. As a result, it may be more difficult for adolescents to admit to being sexually active and share important information, particularly if they perceive bias on the part of the provider.
- Adolescents may seek or accept greater guidance from a professional whom they hold in high regard.
- Adolescents are less likely to be in stable relationships.
- Adolescents generally require more counseling time to ensure that they understand information and instructions and have an opportunity to address other issues they may bring to the counseling setting.
- Adolescents may present a wider range of concerns-such as those related to their relationships with partners, peers and family members-as opposed to purely medical concerns or those related to contraception. They may also have questions or may need assistance with issues related to relationships with family members, school and employment. As a result, the counselor should be aware of available resources and be able to refer the adolescent.

Q. What are the most important points to cover when counseling adolescents about sexual behavior?

A. When counseling adolescents about sexual behavior, it is important to:

- Help them understand the physical and emotional changes that occur with growth and development.
- Stress the importance of clarifying one's personal values and having skills to ensure that unwanted sex does not occur.
- Dispel local and customary myths and practices that may be harmful or put the adolescent at greater risk for pregnancy or STIs.
- Ask questions that help assess risk, including STIs and possibly abusive relationships.
- Ensure that an adolescent understands his or her own risk for contracting, and how to protect against, STI/HIV infection and unplanned pregnancy.
- Stress the importance of communication and mutual respect in sexual relationships.
- Inform them of the location of other youth-friendly services and resources.

Fertility

Q. Does long-term use of contraceptives by adolescents affect future fertility?

A. No. In fact, contraception can have an important protective effect on future fertility by preventing unsafe abortions. An unsafe abortion frequently causes infection that can lead to infertility. The other major threat to an adolescent's future fertility is from STI's, particularly chlamydia (which is difficult to diagnose and often has no symptoms), gonorrhea, and pelvic inflammatory disease (which is an acute infection in the fallopian tubes as well as other organs in the pelvic cavity). The fact that many adolescents do not seek services until STIs are in advanced stages, if at all, further compounds the problem.

- Barrier methods and condoms have no direct effect on future fertility except that condoms and perhaps spermicides contribute to preserving fertility by preventing STIs.
- Long-term use of oral or injectable contraceptives does not affect future fertility. After stopping birth control pills, fertility returns almost immediately to most young women. After stopping the injectable DMPA (Depo-Provera), there is an average 3-month delay partly because of some residual hormone remaining in the system.
- IUDs also have no effect on future fertility if the client does not have or does not contract an STI. However, it should be noted that IUDs are typically not used with adolescents who have no children, because insertion is more painful and complications more frequent. Adolescents may be at higher risk for contracting an STI, and the consequences of contracting an STI may be higher.
- Long-term use of Norplant has no effect on future fertility.

Q. Does long-term use of contraceptives have any positive or negative health effects on adolescents?

A.

- Oral contraceptives and injectables can help preserve the fertility of young women. Contraceptive pills also reduce the risk of benign cysts in the breast.
- Both oral and injectable contraceptives can help protect women from pelvic inflammatory disease (PID), an infection that damages the fallopian tubes and can cause infertility or an ectopic pregnancy.
- Use of contraceptives may reduce the risk of ovarian and endometrial cancer, may protect against ectopic pregnancies, may prevent iron-deficiency anemia, and may reduce acne and menstrual cramps. Use of pills and injectables appear also to have most of these benefits.

- Copper IUDs result in lower risk of ectopic pregnancy compared with using no method.
- There is the potential for infection with an IUD in the first 21 days after insertion if exposed to STIs.
- There are no negative effects of long-term use of Norplant.

Q. What is the importance of nutrition for young girls who have not yet given birth?

A.

- In many developing countries, girls suffer forms of discrimination that put them at nutritional risk, including discrimination in food allocation (boys and men receive more), less medical care than boys, a heavy work load from a very early age, and food taboos, particularly during menstruation and pregnancy. Nutrition is very important during adolescence because it is a time of rapid growth in height, weight and body fat (50% of adult weight is achieved in the two or three years around the pubertal growth spurt).
- In girls, the growth rate is especially rapid in the year preceding menarche, usually between the ages of 10 and 13. If a girl does not get adequate nutrition during this time, menarche may be delayed, and she can suffer growth retardation and be more prone to disease.

Contraception

Q. What contraceptive methods are medically safe and/or appropriate for adolescents?

A. There are no medical reasons based on age alone to restrict contraceptive method choices. However, which method is most appropriate may be influenced by the personal preference and social context, including the risk of STIs, HIV/AIDS, stability of the relationship, and marital status.

Q. Should there be any age requirements or restrictions for certain methods on the basis of medical criteria?

A. No.

- There are no **medical** reasons on the basis of age to restrict contraceptive method choices for young women at risk of pregnancy. However, Depo-Provera (DMPA) is permitted but less preferred before age 16 because of possible negative effects on bone density. Theoretical concern exists that adolescents under the age of 16 years who use DMPA may have an increased risk of developing osteoporosis later in life. Early adolescence is an important time for bone formation, as peak bone density normally is reached in women at about age 16. Use of DMPA before the age of 16 could result in lower peak bone density. World Health Organization (WHO) medical eligibility criteria consider DMPA to be generally acceptable for women aged 16 or younger, because the benefits of using the method (i.e., avoidance of unwanted pregnancy) outweigh the theoretical risk. There are no restrictions for the use of DMPA after age 16.
- The one-month combined injectable will not have any effect on bone density.
- IUDs are less preferred because of the risk of STIs and greater side effects, including higher expulsion rates, particularly for women who have never been pregnant.

Q. Can any type of oral contraceptive be used for emergency contraception?

A. No.

Only the progestin only formulations or those combined oral contraceptives that contain the progestin levonorgestrel or norgestrel have been shown to be effective for emergency contraceptive use. Pills containing other progestins may be effective, but they have not been studied. Either low-dose pills containing 30 mcg of estrogen or higher-dose pills with 50 mcg of estrogen may be used. In some places, emergency contraceptive pills have been packaged specifically for that use. A total of 8 low-dose

pills or 4 higher-dose pills are taken in two equal doses, 12 hours apart, within 72 hours of unprotected intercourse for the complete emergency contraceptive regimen.

Q. Can oral contraceptives or injectables be safely prescribed to adolescents without a gynecological examination?

A. Yes.

Both can be used safely without a gynecologic examination. Conditions that would restrict the use of oral or injectable contraceptives can be identified through questions about the adolescent's medical history. (Refer to Hatcher, et al., *The Essentials of Contraceptive Technology: A Handbook for Clinic Staff* checklist or contact FOCUS for this information.)

Behavior and Decision Making

Q. Are there methods that are more or less appropriate for adolescents who have multiple partners or whose partners have multiple partners?

A. Yes.

- Adolescents with multiple partners or whose partners have multiple partners have a higher risk of STIs. The most effective method for STI/HIV prevention is the male condom along with spermicide, followed by the male condom alone. The female condom combined with a spermicide provides another alternative.
- IUDs should not be used by young women with multiple partners or whose partners have multiple partners because of increased risk of STIs and PID. If an adolescent has multiple partners, providers should recommend using two methods: a primary method that is highly effective for pregnancy prevention, such as pills or injectables, and a condom for STI prevention. This is referred to as the dual method approach.
- An alternative approach to dual method use is to advise adolescents to use the male condom with spermicide as the primary method for both STI and pregnancy prevention.
- If the condom is not used for a particular act of intercourse, or if it breaks or slips off, the client can use emergency contraceptive pills (ECPs) afterward for pregnancy prevention. ECPs, however, will not protect against STI transmission.

Q. Are adolescents more at risk for STIs/HIV than adults? If so, why?

A. Yes.

- About seven of every ten STI infections occur among individuals age 15-24. Sexually active, unmarried adolescents are at high risk for STIs not only for psychological and behavioral reasons but also for biological and social reasons.
- Psychological factors that put many adolescents at increased risk for STIs include a general sense of invulnerability, the desire to try new experiences, and the willingness to take risks, including changing sexual partners often or having a partner who has multiple partners. In addition, many adolescents lack knowledge of STIs that contributes to risk-taking behaviors, find it difficult to use condoms consistently and correctly, or lack communication and negotiation skills, making condom use difficult.
- Female adolescents are probably more biologically susceptible to STIs than older women because of a condition called cervical ectopy. This is a normal condition that is present in most female adolescents and becomes less common with age. Cervical ectopy develops when the cells that line the inside of the cervical canal extend onto

the outer surface of the cervix. These cells are more vulnerable to infections such as chlamydia and gonorrhea. In addition, the risk of acquiring trichomoniasis, chlamydia, herpes and HPV (human papilloma virus) is possibly greatest at first exposure to the STI. Because first exposure often occurs during adolescence, both male and female adolescents are particularly vulnerable. Getting one STI makes it more likely that an adolescent may acquire other STIs.

- Social and programmatic factors can also increase risks associated with STIs. Programmatic factors include limited access to STI services, inconvenient clinic hours or locations, cost, lack of confidentiality, trained clinic staff or staff members with negative attitudes about adolescent sexual activity and contraceptive use, and legal restrictions. Social factors include adolescents relative lack of power in relationships with adults and others, who may be their partners. Some adolescents experience nonconsensual sexual relationships with older, more powerful partners with whom they may feel unable to negotiate safer sex practices.

Service Delivery

Q. Why is contraceptive use among adolescents low?

A. The reasons for low contraceptive use among adolescents are varied and often complex. They include psychological, social, and lifestyle factors. Adolescents have provided the following insights as to why they are poor contraceptors:

- Negative attitudes on the part of providers often pose a barrier to service use and continuation of contraception.
- They often don't plan and may not expect to have sex.
- They think they are not vulnerable to pregnancy, It can't happen to me.
- They fear rejection by their partner.
- Ambivalence about becoming pregnant and cultural expectations about marriage and motherhood or fatherhood may discourage contraceptive use.
- They fear being or becoming infertile because of contraceptive use or find it difficult to cope with pressure to prove their fertility.
- They receive inadequate information about reproduction, contraception or pregnancy risk.
- They don't know where to get contraceptives.
- They want to hide sexual relations or contraceptives from their parents.
- Costs of contraceptives may be beyond their ability to pay.
- They are embarrassed to buy condoms and other contraceptives.
- They believe that contraceptives, especially condoms, impede sexual pleasure.
- They lack the skill and expertise to negotiate condom or contraceptive use.
- They fear the side effects of contraceptives.
- They fear physical examination, especially the pelvic exam, often required to get contraceptives.
- They worry that their partners will think they have other sexual partners if they use contraception.

Many of these barriers require special skills on the part of the provider to identify the myths and misinformation the adolescent client may have, to provide the correct information, and to counsel the adolescent in a way that helps the client choose a contraceptive method compatible with his or her lifestyle.

Q. What factors influence whether adolescents use contraceptives effectively? How can a provider facilitate more consistent contraceptive use among adolescents?

A.

- A primary factor influencing effective contraceptive use is the interaction between the provider and the adolescent. Negative provider attitudes present one of the greatest barriers to service use by adolescents. It may, in fact, inhibit an adolescent's ability to seek or obtain services.
- Facilities are often under staffed and overwhelmed, and providers may lack sufficient time to explain methods and respond to the needs and questions of adolescents to the extent required.
- A physical setting that is not conducive to privacy and confidentiality can also make it difficult for adolescents to focus on new and often complicated information.
- Ambivalence on the part of the adolescent about getting pregnant can lead to inconsistent use of contraceptives.
- The availability of a provider to respond quickly to questions or concerns and method problems may decrease method discontinuation.
- If information is reinforced by various staff members who use a variety of mechanisms, including counseling sessions, Information Education and Communication materials, peer educators, and so forth, method discontinuation may decrease.
- If information sharing is an engaging process, giving adolescents an opportunity to repeat the information to ensure they understand what has been discussed, they may be more likely to continue to use the method.
- Adolescent lifestyles sometimes make correct and consistent use of contraceptives difficult. Providers should explore ways to make consistent and correct use easier and explain what to do in the event that the contraceptive is not used correctly or consistently.
- Common side effects of contraceptives and what to do about them should be fully explained to the client. Adolescents may be better able to tolerate side effects if they know what to expect.
- The adolescent's motivation to use contraceptives has a lot to do with how well he or she uses them. Because contraceptive use occurs within the context of relationships, providers should assess and provide opportunities to discuss the nature of the client's relationship(s), desires to get pregnant and other personal factors that may affect the adolescent's motivation.
- Youth need to know where to get affordable contraceptives in a safe and confidential place on a consistent basis.

Q. How can adolescents be effectively reached?

A.

This question deals with where to find adolescents as well as strategies for reaching them with information and services.

- With respect to locating adolescents, places where they naturally congregate, such as schools, workplaces, concerts, sports clubs, dance halls, and other locations that provide social or recreational services for adolescents, provide excellent opportunities to reach users and non users with reproductive health services and information.
- In terms of providing information and services, a holistic approach that recognizes and responds to the multiple service and information needs of adolescents has been found to be effective. This approach sees reproductive health as a part of an adolescent's universe, not in isolation from other realities they face.
- Involving youth directly in program development and implementation, as well as in the design of reproductive health messages has been found effective in expanding the scope and reach of information and services.
- Strategies that involve adolescents in roles such as educators, counselors, and CBD (community-based distribution) agents build on peer-to-peer relationships and increase adolescents access to information and services.

Q. What are the kinds of staff attitudes or behaviors that affect service delivery to adolescents?

A. Staff attitudes can be a major determinant of whether or not an adolescent understands and makes use of the information provided, returns for services, or refers peers. In this respect, staff refers not only to those providing clinical services but also to anyone providing any reproductive health information and services, including community workers, pharmacists, shopkeepers and others with whom the adolescent comes in contact. Among the most important characteristics of youth friendly staff are:

- being respectful, nonjudgmental and objective;
- showing a genuine interest in what the adolescent is saying by listening and responding to questions or problems; and
- maintaining privacy and confidentiality.

Q. What kind of support, referral services or networks should be available to adolescents?

A. It is suggested that the following support be available to adolescents:

- If resources permit, or if coordination of services is possible, supports that provide a range of services to meet the varied needs of adolescents-including education, employment, and counseling such as referrals for services that are not provided on site-benefit adolescents the most.
- Services and networks that are known to be friendly to adolescents are very important.
- Referral networks that include organizations known to be youth friendly.
- Services that are easily accessible, (i.e., via public transportation, telephone, Internet or other technologies) and available during hours when adolescents prefer to visit.
- Hotlines or radio and television call-in shows are popular ways of providing confidential information and referrals to youth-friendly service delivery sites.

Q. What interventions may be effective in helping adolescents delay sexual initiation?

A. Interventions may be effective that:

- Encourage positive development of self-esteem, responsibility and empowerment.
- Emphasize formal education, particularly for girls, as well as those that support delaying marriage.
- Provide support and practical skills to help adolescents say no to partner and peer pressure.
- Change social norms about early sexual initiation.
- Help adolescents discuss their personal and family values about sex.

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Please contact the FOCUS on Young Adults office for information on the resources used to respond to these questions.

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