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Teenage sexual health and contraception

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Original article

Adolescent Pregnancy, Birth, and Abortion Rates Across Countries: Levels and Recent Trends

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ABSTRACT

Purpose: To examine pregnancy rates and outcomes (births and abortions) among 15- to 19-year olds and 10- to 14-year olds in all countries for which recent information could be obtained and to examine trends since the mid-1990s.
Methods: Information was obtained from countries' vital statistics reports and the United Nations Statistics Division for most countries in this study. Alternate sources of information were used if needed and available. We present estimates primarily for 2011 and compare them to estimates published for the mid-1990s.
Results: Among the 21 countries with complete statistics, the pregnancy rate among 15- to 19-year olds was the highest in the United States (57 pregnancies per 1,000 females) and the lowest rate was in Switzerland (8). Rates were higher in some former Soviet countries with incomplete statistics; they were the highest in Mexico and Sub-Saharan African countries with available information. Among countries with reliable evidence, the highest rate among 10- to 14-year olds was in Hungary. The proportion of teen pregnancies that ended in abortion ranged from 17% in Slovakia to 69% in Sweden. The proportion of pregnancies that ended in live births tended to be higher in countries with high teen pregnancy rates ($p = .02$). The pregnancy rate has declined since the mid-1990s in the majority of the 16 countries where trends could be assessed.
Conclusions: Despite recent declines, teen pregnancy rates remain high in many countries. Research on the planning status of these pregnancies and on factors that determine how teens resolve their pregnancies could further inform programs and policies.
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IMPLICATIONS AND CONTRIBUTION

Adolescent pregnancy rates declined since the mid-1990s in most developed countries with reliable trend data, but the rate remains exceptionally high in the United States. Rates are even higher in Sub-Saharan Africa and in some former Soviet countries where data quality is variable. The proportion of pregnancies ending in abortion varies widely across countries.

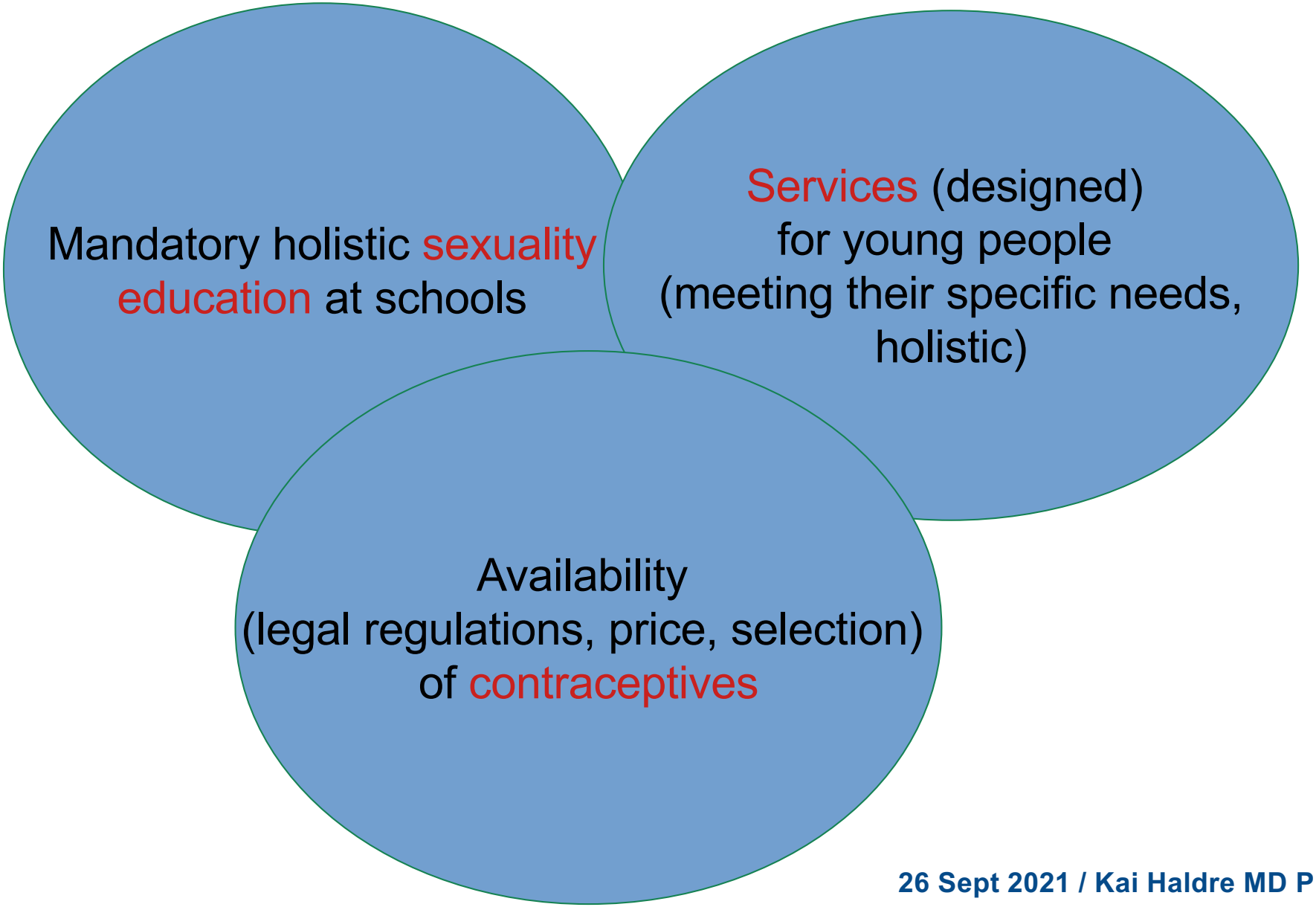
Mid-1990s-2011: steepest annualized percentage change (- 4%) in the decline of teen pregnancies took place in Estonia

Sedgh G. et al. Adolescent Pregnancy, Birth, and Abortion Rates Across Countries: Levels and Recent Trends. Journal of Adolescent Health. 2015;56(2):223-230.

Determinants of teenagers' sexual health

- Social and cultural (distribution of income and power, religiosity, gender roles, sexual morals and values, access to education including sexuality education, access to services)
- Interpersonal (family structure and stability, violence, partner relations, peers)
- Individual (risky health behaviours, substance abuse, chronic illness, knowledge, self-esteem, age at first sexual intercourse)

Prevailing sexual ideologies in a society determine whether, at all and what kind of sexual health services and information are provided to people


Mandatory holistic sexuality education at schools
Services (designed) for young people (meeting their specific needs, holistic)
Availability (legal regulations, price, selection) of contraceptives

Why services for teenagers?

- Social skills are different
- Non-judgemental, respecting autonomy, no extended waiting times
- Personnel aware of their power position
- Sexuality and sexual relations of teens are not the same as for adults
- Peer influence – social media
- Networking (other specialities, schools)
- Easy referral in the case of pregnancy

Influence of social media

Information about fertility, contraception (and misinformation)

Online environments provide ample opportunity for excessive reassurance seeking, co-rumination, positive and negative influences from others who may subscribe to unhealthy,

self-harming behaviours. *(Littman, 2018)*

Eating disorders, self-harming, body tuning, identity, gender issues

Littman L (2018) Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. PLOS ONE 13(8): e0202330. https://doi.org/10.1371/journal.pone.0202330

Violence in children's and teenagers' worlds:

- witnessing family violence by adolescents seems to have the same effect on sexual risk-taking as direct violence (van Rosmalen-Nooijens et al, 2017; Haldre et al, 2009)
- childhood sexual violence and low self-esteem are related to intimate partner violence and ineffective contraception use (Nelson et al, 2017)

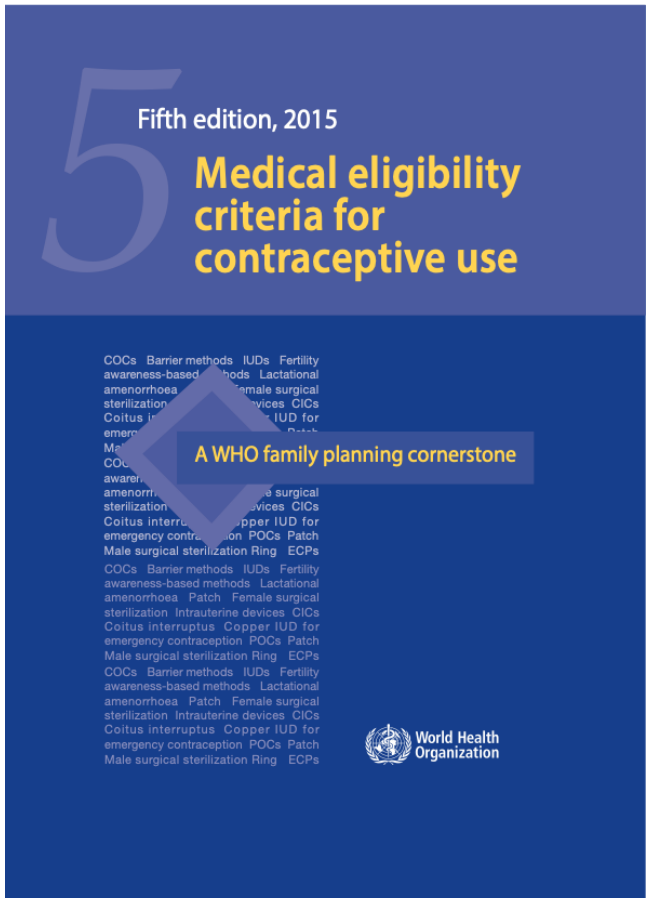
van Rosmalen-Nooijens, K. A. W. L., et al. (2017). Does witnessing family violence influence sexual and reproductive health of adolescents and young adults? A systematic review. Psychology of Violence, 7(3), 343–374.
Haldre K, et al. Individual and familial factors associated with teenage pregnancy: an interview study. Eur J Public Health 2009;19:266–70.
Nelson DB, et al. Preventing Unintended Pregnancy Among Young Sexually Active Women: Recognizing the Role of Violence, Self-Esteem, and Depressive Symptoms on Use of Contraception. J Womens Health (Larchmt). 2017;26(4):352-360.

Can young people consent to treatment? Fraser guidelines (UK law):

- the young person understands the professional's advice;
- the young person cannot be persuaded to inform their parents;
- the young person is likely to begin, or to continue having, sexual intercourse with or without contraceptive treatment;
- unless the young person receives contraceptive treatment, their physical or mental health, or both, are likely to suffer;
- the young person's best interests require them to receive contraceptive advice or treatment with or without parental consent.

FSRH Service Standards on obtaining valid consent in SRH services 2018

WHO criteria: young age - any method: no restrictions



MEC categories for contraceptive eligibility	
1	A condition for which there is no restriction for the use of the contraceptive method
2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks
3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method
4	A condition which represents an unacceptable health risk if the contraceptive method is used.

http://www.who.int/reproductivehealth/publications/family_planning/MEC-5/en/

UKMEC categories based on age

Table 2 *UK Medical Eligibility Criteria for Contraceptive Use* (UKMEC) categories based on age[1]

Method	Age	UKMEC Category
Combined hormonal contraception (combined oral contraception, vaginal ring, patch)	Menarche to <40 years ≥40 years	1 2
Progestogen-only pill	Menarche onwards	1
Progestogen only implant	Menarche onwards	1
Progestogen-only injectable (DMPA or NET-EN)	Menarche to <18 years 18–45 years >45	2 1 2
Barrier methods (condoms, diaphragms, cervical caps)	Menarche onwards[a]	1
Copper-bearing intrauterine device	Menarche to <20 years ≥20 years	2 1
Levonorgestrel-releasing intrauterine system	Menarche to <20 years ≥20 years	2 1

[a]The CEU recommends that condoms can be used before menarche if required.
DMPA, depot medroxyprogesterone acetate; NET-EN, norethisterone enantate.

https://www.fsrh.org/ukmec/

Is there an ideal contraceptive for young people? Is this a valid concept? Who says?

- *Pill + condom?*
- *LARC?*

- Teenagers are not a homogenous group!
- Choice of a contraceptive method should always be made by the one who will use the method
- Good education, information and counselling are key!

Review

The ethics of state-sponsored and clinical promotion of long-acting reversible contraception

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ABSTRACT

Objectives To review ethical aspects of the promotion and provision of long-acting reversible contraception (LARC). Specifically, to examine (1) the tension between informational exchange and the active promotion of LARC methods to new and existing contraceptive users by healthcare professionals; and (2) the distinct ethical issues arising from the promotion of LARC methods by state-sponsored actors and healthcare professionals.

Methods Narrative review and ethical analysis.

Findings There is an ethical difference between raising awareness/informational provision and actively promoting or prioritising specific contraceptive methods. It matters whether

Key messages

- Long-acting reversible contraception (LARC) offers many advantages but should not be promoted as an unqualified good to all.
- Raising awareness, informational exchange and the active promotion of LARC methods give rise to distinct ethical and professional considerations.
- The identity/role of the agent promoting the fertility control option is important.
- Clinical relationships generate specific professional obligations in the context of fertility control.

Wale J, Rowlands S. *BMJ Sex Reprod Health* 2020;**0**:1–7. doi:10.1136/bmjsrh-2020-200630

Table 26-1 Percentage of women experiencing an unintended pregnancy during the first year of typical use and the first year of perfect use of contraception and the percentage continuing use at the end of the first year. United States.

Method	% of Women Experiencing an Unintended Pregnanc within the First Year of Us		% of Women Continuing Use at One Year[3]
	Typical Use[1]	Perfect Use[2]	
No method[4]	85	85	
Spermicides[5]	21	16	42
Female condom[6]	21	5	41
Withdrawal	20	4	46
Diaphragm[7]	17	16	57
Sponge	17	12	36
Parous Women	27	20	
Nulliparous Women	14	9	
Fertility awareness-based methods[8]	15		47
Ovulation method[9]	23	3	
TwoDay method[9]	14	4	
Standard Days method[9]	12	5	
Natural Cycles[9]	8	1	
Symptothermal method[9]	2	0.4	
Male condom[6]	13	2	43
Combined and progestin-only pills	7	0.3	67
Evra patch	7	0.3	67
NuvaRing	7	0.3	67
Depo-Provera	4	0.2	56
Intrauterine contraceptives			
ParaGard (copper T)	0.8	0.6	78
Skyla (13.5 mg LNG)	0.4	0.3	
Kyleena (19.5 mg LNG)	0.2	0.2	
Liletta (52 mg LNG)	0.1	0.1	
Mirena (52 mg LNG)	0.1	0.1	80
Nexplanon	0.1	0.1	89
Tubal occlusion	0.5	0.5	100
Vasectomy	0.15	0.1	100

Emergency Contraceptives: Use of emergency contraceptive pills or placement of a copper intrauterine contraceptive after unprotected intercourse substantially reduces the risk of pregnancy. (See Chapter 10.)

Lactational Amenorrhea Method: LAM is a highly effective, *temporary* method of contraception.[9] (See Chapter 17.)

Source: See text.

Table 26-1 Percentage of women experiencing an unintended pregnancy during the first year of typical use and the first year of perfect use of contraception and the percentage continuing use at the end of the first year. United States.—*(continued)*

[1]Among *typical* couples who initiate use of a method (not necessarily for the first time), the percentage who experience an accidental pregnancy during the first year if they do not stop use for any reason other than pregnancy. Estimates of the probability of pregnancy during the first year of typical use for fertility awareness-based methods, withdrawal, the male condom, the pill, and Depo-Provera are taken from the 2006–2010 National Survey of Family Growth (NSFG) corrected for under-reporting of abortion. See the text for the derivation of estimates for the other methods.

[2]Among couples who initiate use of a method (not necessarily for the first time) and who use it *perfectly* (both consistently and correctly), the percentage who experience an accidental pregnancy during the first year if they do not stop use for any other reason. See the text for the derivation of the estimate for each method.

[3]Among couples attempting to avoid pregnancy, the percentage who continue to use a method for 1 year.

[4]This estimate represents the percentage who would become pregnant within 1 year among women now relying on reversible methods of contraception if they abandoned contraception altogether. See text.

[5]150 mg gel, 100 mg gel, 100 mg suppository, 100 mg film.

[6]Without spermicides.

[7]With spermicidal cream or jelly.

[8]About 80% of segments of FABM use in the 2006-2010 NSFG were reported as calendar rhythm. Specific FABM methods are too uncommonly used in the U.S. to permit calculation of typical use failure rates for each using NSFG data; rates provided for individual methods are derived from clinical studies. The Ovulation and TwoDay methods are based on evaluation of cervical mucus. The Standard Days method avoids intercourse on cycle days 8 through 19. Natural Cycles is a fertility app that requires user input of basal body temperature (BBT) recordings and dates of menstruation and optional LH urinary test results. The Symptothermal method is a double-check method based on evaluation of cervical mucus to determine the first fertile day and evaluation of cervical mucus and temperature to determine the last fertile day.

[9]However, to maintain effective protection against pregnancy, another method of contraception must be used as soon as menstruation resumes, the frequency or duration of breastfeeds is reduced, bottle feeds are introduced, or the baby reaches 6 months of age.

Women have different individual reasons for discontinuation!

http://www.contraceptivetechnology.org/wp-content/uploads/2013/09/Contraceptive-Failure-Rates.pdf

Women change contraceptive methods up to 10x during their fertile years (Trussell, 1999)

- Main reason – unpleasant side-effects
- Side-effects are in the socio-cultural context:
  - What kind of meaning is applied to side-effects?
- Choice of contraception – combination of different factors:
  - Previous experience + partner relation/opinion + how big is the “fear” of pregnancy; wish to benefit from positive side-effects, etc.

Trussell J, Vaughan B. Contraceptive failure, method-related discontinuation and resumption of use: results from the 1995 National Survey of Family Growth. Fam Plann Perspect. 1999 Mar-Apr;31(2):64-72, 93.

Health concerns of young people

- Weight gain
- Acne
- Mood changes
- Effects on sexual functioning
- Bleeding patterns
- Bone health
- Thrombosis
- Cancer
- Fertility

Health concerns and possible side effects should be addressed proactively with easy access to return for follow-up

Clinical issues

- Sexually transmitted infections
- Polycystic ovary syndrome
- Endometriosis
- Hyperandrogenaemia
- Eating disorders

FSRH Clinical Effectiveness Unit (CEU). FSRH Clinical Guideline: Contraceptive Choices for Young People (March 2010, amended May 2019)

Conclusions

3 pillars to meet young people's sexual health needs

- Holistic age appropriate sexuality education for all
- Services designed according to the needs and expectations of teenagers – EASY ACCESS
- Choice of contraceptive methods – EASY ACCESS