Unit 9: Contraception and Risk Reduction Counseling for Adolescents
RUMORS

Rumors are **unconfirmed stories** that are **transferred** from one person to another **by word of mouth**. Increasingly, rumors are spread on social media. Rumors are common among adolescents. In general, rumors arise when:

• An issue or information is important to people, but it has not been clearly explained.
• There is nobody available who can clarify or correct incorrect information.
• The original source is seen to be credible.
• Social taboos prevent adolescents from seeking correct information from trusted adults.
• People are motivated to spread them for political or social reasons.
MISCONCEPTIONS

• A misconception is a mistaken interpretation of ideas or information. If a misconception is filled with details and becomes a fanciful story, then it acquires the characteristics of a rumor. Rumors can play a big role among adolescents’ perceptions and beliefs because they are often cut off from or denied information about sexual and reproductive health and are eager to fill "in the blanks."

• Rumors and misinformation can also come from other sources in the community: the media is often a source of misinformation or incomplete information for all members of the community. Parents, faith leaders, teachers, and community leaders may not possess correct information on or understanding of adolescents and sexual and reproductive health and may perpetuate potentially dangerous stereotypes and misconceptions about adolescent sexuality and sexual risk.
MISCONCEPTIONS

• Rumors or misconceptions may even be spread by health workers who may be uninformed about adolescents and their abilities to use certain methods. They may hold beliefs pertaining to contraception and adolescent sexuality that are influenced by their culture or religion which they allow to affect their professional conduct.

• The underlying causes of rumors have to do with people's knowledge and understanding of their bodies, health, medicine, and the world around them. Often, rumors and misconceptions about contraception make sense to clients and potential clients, especially to young people.
METHODS FOR COUNTERACTING RUMORS AND MISCONCEPTIONS

• When a client mentions a rumor, always listen politely. Don't laugh. Take the rumors seriously.

• Define what a rumor or misconception is. Normalize the rumor or misconception through statements like “A lot of people have that belief” or “I can see why you’d think so, but...”

• Find out where the rumor came from and talk with the people who started it or repeated it. Check whether there is some basis for the rumor.

• Explain the facts using accurate information but keep the explanation simple enough for young people to understand.

• Use strong scientific facts about contraceptives and sexual risk to counteract misinformation.
METHODS FOR COUNTERACTING RUMORS AND MISCONCEPTIONS

• Always **tell the truth**. Never try to hide side effects or problems that might occur with various methods. **Never overstate or exaggerate** the level of risk associated with sexual behaviors.

• **Give examples of people who are satisfied users** of the method (only if they are willing to have their names used). This kind of personal testimonial is most convincing.

• **Reassure the client** by offering STI/HIV and/or pregnancy testing or routine sexual and reproductive health exams and discuss the findings.

• **Counsel** the client about all available contraceptive methods.

• **Use visual aids and actual contraceptives** to explain the facts. Remember to provide the accommodations needed by the persons with disabilities in the room to ensure full participation.
GLOBAL STATISTICS

Adolescents seek services for multiple reasons: maybe they are concerned about HIV infection, or preventing unintended pregnancy. Maybe they’re experiencing symptoms that could be an STI or a similar infection. Some adolescents will come for ante-natal visits or because they are already pregnant or have given birth. Some will come for post-abortion care or because they have an infection from an unsafe abortion. According to WHO:

• About one half of all people infected with HIV are under the age of 25.
• About half of all new HIV infections occur among young people aged 15-24.
• An estimated 1 in 20 youths contract STIs each year and one-third of all STIs occur among 13-20-year-olds (110 million STIs/year).
GLOBAL STATISTICS

• In many African countries, up to 20% of all births are to women 15-19 years old.
• Anywhere from 40-70% of women have become pregnant or mothers by the end of their teens in many African countries.
• In many Latin American countries, 35% of women hospitalized for septic abortion are under age 20.
• In some countries, maternal deaths are 2-3 times greater in women 15-19 years old than in women 20-24 years old.
• Condom use among young people is greater than among older people.
• Similar SRH global data disaggregated by age and disability are not yet available. On HIV, the data available from sub-Saharan Africa suggests an increased risk of HIV infection of 1.48 times in men with disabilities and 2.21 times in women with disabilities compared with men without disabilities. It is possible to assume that adolescents with disabilities are exposed to the same or even a higher increased risk.
GLOBAL STATISTICS

These statistics show that young people are vulnerable when it comes to their sexual and reproductive health. Every interaction with an adolescent client is an opportunity for service integration, in particular when it comes to protection against infection and unintended pregnancy. Because young women already seek care because of pregnancy and abortion care, we may have the opportunity to educate, prevent and treat STIs in this setting. Young men may be more likely to come for STI/HIV testing and should be counseled on contraception and sexual health.
ABSTINENCE

Sexually transmitted infections are infections that are spread through sexual contact, including vaginal, anal, and oral intercourse. Some can be spread through touching and kissing. Sexual protection is anything that can be done to lower the risk of sexually transmitted infections, including HIV, and pregnancy. Sexual protection reduces risks and can be practiced without reducing pleasure.
ABSTINENCE

Many programs and governments promote abstinence until marriage as the only sexual protection option appropriate for adolescents, referring to abstinence as 100% effective. This is a false statement. Total abstinence from sexual activity will of course protect anyone from STIs and unintended pregnancy, but just like any other method of protection, abstinence has a failure rate. The failure rate for abstinence is higher for typical use than other contraceptive methods. For example, some programs narrowly define abstinence as abstaining from penetrative vaginal sex, which leaves adolescents with the mistaken impression that oral or anal sex, because they cannot result in a pregnancy, are “safe.” For an unacceptably high number of adolescent girls, sexual activity is forced or coerced, and public promotion of abstinence as the only method that is morally appropriate for young people can create feelings of shame and stigma. Abstinence is also an impractical standard to hold adolescents to; it can be encouraged for those who feel they are not yet ready for sexual activity but should not be held up as the only option for protection against STIs, HIV, and unintended pregnancy.
ABSTINENCE

The promotion of abstinence until marriage also discriminates against and excludes adolescents from sexual minority groups who may not legally be allowed to marry the partner of their choosing. Other programs promote "Safer Sex," which describes a range of ways that sexually active people can protect themselves from most STIs, including HIV. Practicing safer sex also provides protection from pregnancy. Counseling adolescents on safer sex and sexual protection focuses on first helping young people to assess the relative risk of various sexual practices.
NO RISK

There are many ways to explore your sexuality that are not risky. Some of them include hugging, holding hands, massaging, rubbing against each other with clothes on, sharing fantasies, masturbating your partner or masturbating together, as long as men do not ejaculate near any opening or broken skin on their partners.
LOW RISK

There are other activities that are mostly safe such as using a latex or polyurethane condom or other barrier for every penetrative act of sexual intercourse (penis, fingers, or other objects in vagina, anus, or mouth), and using a barrier (such as a latex dental dam, a cut-open condom or plastic wrap) for oral sex on a woman or for any mouth to anus contact. Most kissing is also safe, provided neither partner has any cuts or sores on, in, or around their mouths.
MEDIUM RISK

There are activities that carry some additional risk, such as introducing an injured finger or hand into the vagina or anus or sharing sexual toys (rubber penis, vibrators, etc.) without cleaning them.
HIGH RISK

There are activities that are very risky, because they lead to exposure to the body fluids in which most STIs, including HIV, live. These include having any kind of sexual intercourse without using a condom or having oral sex without a latex barrier. Sex which is coerced or non-consensual and forceful may also carry additional risk due to likelihood of small cuts or tears resulting from violence.
DUAL PROTECTION

Dual protection is the consistent use of a male or female condom alone or in combination with a second contraceptive method (e.g. hormonal or permanent). Adolescents who seek contraception may only be provided with a method that protects them from pregnancy. As providers, we should ensure that all adolescents are using a method or combination of methods that protect them from both pregnancy and STIs/HIV.
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THE BCS+ APPROACH

The BCS+ approach is divided into 4 stages:

• **Pre-Choice Stage** The service provider establishes a relationship with the client and learns about their current and desired family size, timing, and contraceptive choices.

• **Method Choice Stage** The provider counsels the client on available methods and empowers them to choose their preferred contraceptive option.

• **Post-Choice Stage** The provider reviews the client’s method of choice in detail, discusses side effects, and helps the client set a follow-up plan for continued contraceptive use.

• **Systematic Screening for Other Services Stage** The provider reviews the client’s risk for STIs, including HIV, discusses dual protection strategies, and addresses other reproductive health concerns.
CONTRACEPTIVE METHODS

Contraceptive methods are generally classified into one of three categories:

• Short-acting
• Long-acting reversible contraceptives (LARCS)
• Permanent methods

• Both short-acting and LARCs are appropriate for adolescent use. There is a growing international medical and advocacy consensus that adolescents should be able to obtain and use LARCs, given their effectiveness at preventing unwanted or unintended pregnancy.
SIDE EFFECTS AND THEIR EFFECT ON CLIENTS

Research has shown that the leading reason women, and especially young women, don’t use or discontinue use of a contraceptive method is due to misinformation about or mismanagement of side effects. Providers must fully inform their clients about potential side effects of their chosen method, how best to manage side effects and when to follow up with the provider for support in managing side effects or to switch methods.
SIDE EFFECTS AND THEIR EFFECT ON CLIENTS

It is important to emphasize that most side effects from modern family planning methods pose no health risk to clients. However, providers should take them seriously because they can be uncomfortable, annoying, or worrisome to adolescent clients.

• For example: A young woman who is using DMPA may experience spotting or amenorrhea. This side effect may lead her to believe that she is pregnant or, conversely that that she will not be able to become pregnant.

Some young women tolerate side effects better than others. Every woman’s experience (pain, discomfort, weight gain, etc) is very individual.

• For example: Some adolescents may not be bothered by weight gain but other young women may become very upset by a weight gain of even a few pounds (which may or may not be due to using a family planning method). Changes in menstrual patterns may bother some young women, while others may see it as a benefit.
SIDE EFFECTS AND THEIR EFFECT ON CLIENTS

Side effects are the major reason that clients stop using a method. Providers must:

• Not be dismissive of the adolescent clients concerns.
• Be patient and empathetic with all client complaints.
• Offer clients an opportunity to discuss their concerns.
• Reassure that side effects usually resolve in a few months.
• Differentiate side effects from complications.
• Offer clients good technical and practical information, and advice about how to deal with side effects.
• Provide information/handouts for the client on side effects in local languages.
• Recommend follow-up.