

## UNIT 9:

### CONTRACEPTION AND RISK REDUCTION COUNSELING FOR ADOLESCENTS

#### *INTRODUCTION:*

Adolescents often do not have access to sexual and reproductive health information and services. This lack of access often results in misinformation and a limited ability to make responsible and appropriate decisions about protecting themselves from disease and pregnancy. Providers and counselors have an important role to play in both educating young people and facilitating responsible decision-making.

Protection against infection and pregnancy involve many of the same strategies and services. Adolescents need to be able to first assess their risk of STI/HIV or of an unintended pregnancy, and then identify steps they can take to protect their sexual health and mitigate risk. Providers need to be able to comfortably discuss sexual health and sexual activity with adolescents, and to provide accurate information on risks that may be associated with sexual activity as well as actions young people can take to reduce their risk. One important action that providers can take is to dispel myths and correct misinformation about contraception such as commonly held concerns around the side effects of contraceptive methods. This can help to ensure that the adolescent client will choose to use a method of contraception and continue to use it properly.

**Trainer's Note:** *This unit is designed to be delivered with youth trainers. The lesson and activities can be modified for an adult provider-only participant group, but trainers are strongly encouraged to include youth participants. The participation of youth trainers with different types of disabilities is essential to ensure the perspectives of clients with disabilities are included in the training. Accommodation (sign language interpretation and/or Computer Aided Real-Time Transcription (CART)<sup>3</sup> personal assistants, braille, large print, easy to read materials, etc.) should be provided according to the needs to ensure full participation of young trainers with disabilities*

#### **UNIT TRAINING OBJECTIVE:**

To prepare providers to effectively counsel adolescents on safer sex including contraception.


#### **SPECIFIC LEARNING OBJECTIVES:**

By the end of the unit, participants will be able to:




12. Identify reasons why adolescents may not use protection and effectively dispel misinformation and rumors.
13. Discuss safer sex messages and actions to prevent STIs, HIV, and unintended pregnancy, including contraceptive options available to adolescents.
14. Demonstrate how to counsel adolescents, including young men, about contraception and dual protection strategies to prevent STIs, HIV, and unintended pregnancy.

---

<sup>3</sup> CART is a method to provide access to spoken communication for people with hearing, cognitive or learning disabilities. CART refers to the instant translation of the spoken word into text using a stenotype machine, notebook computer and real-time software. The text produced by the CART service can be displayed on an individual's computer monitor, projected onto a screen, or made available using other display systems.

 **TOTAL TIME: 3 HOURS 45 MINUTES**

**UNIT OVERVIEW:**

Session	Methods 	Materials 	Time 
9.1	Brainstorm  Trainer presentation	Slides 9.1-9.5  Index cards  Flipcharts and markers	40 minutes
9.2	Trainer presentation  Group discussion	Slides 9.6-9.21  Participant Handouts 9a  Contraceptive cue cards	1 hour 15 minutes
9.3	Role plays	Participant Handouts 9a and 9b  Contraceptive cue cards  IEC materials (if available)	1 hour 30 minutes
Unit Summary	Feedback discussion		20 minutes



**WORK FOR TRAINERS TO PREPARE IN ADVANCE:**

- Review Slides 9.1-9.21
- Work with youth co-trainers to plan delivery
- SO 9.1 Index cards (5 per participant)
- SO 9.2 Prepare copies of Pathfinder’s Cue Cards for Counseling Adolescents on Contraception for each participant. The cue cards can be downloaded here: <http://www.pathfinder.org/publications/cue-cards-for-counseling-adolescents-on-contraception/>. They can also be found in hard copy in Handout 9b.

- SO 9.2 Prepare Participant Handout 9a: BCS+ Algorithm
- SO 9.3 Prepare Participant Handout 9b: ASRH Counseling Role Plays
- SO 9.3 Collect or ask participants to bring in existing IEC materials on contraceptives from their clinics.



## MAJOR REFERENCES AND TRAINING MATERIALS:

Jones, N., Presler-Marshall, E. and Stavropoulou, M. 2018. Adolescents with disabilities. Enhancing resilience and delivering inclusive development. London: Gender and Adolescence: Global Evidence

Population Council, 2015. *Balanced Counseling Strategy Plus: A Toolkit for Family Planning Service Providers Working in High STI/HIV Prevalence Settings; Trainer's Guide, Third Edition*. Washington, DC: Population Council.

UNAIDS. 2017. *Disability and HIV*. UNAIDS. Available at [https://www.unaids.org/sites/default/files/media\\_asset/JC2905\\_disability-and-HIV\\_en.pdf](https://www.unaids.org/sites/default/files/media_asset/JC2905_disability-and-HIV_en.pdf)

WHO medical eligibility criteria wheel for contraceptive use – 2015 update.  
[http://apps.who.int/iris/bitstream/handle/10665/173585/9789241549257\\_eng.pdf?sequence=1](http://apps.who.int/iris/bitstream/handle/10665/173585/9789241549257_eng.pdf?sequence=1)

## SPECIFIC OBJECTIVE 9.1: IDENTIFY REASONS WHY ADOLESCENTS MAY NOT USE PROTECTION AND DISPEL MISINFORMATION AND RUMORS



### TIME

40 minutes



### METHODS

- Group brainstorm activity
- Trainer presentation



### MATERIALS NEEDED

- Index cards (5 per participant)
- Flipcharts and markers
- Slides 9.1-9.5



### STEPS

#### Time: 20 minutes

1. Introduce the activity by explaining to participants that there are many reasons why adolescents are particularly at risk for STIs/HIV and unintended pregnancy. There are also many reasons why it is particularly important to help adolescents avoid STIs, including HIV, and unintended pregnancy. Say that some adolescents will seek services because they want to prevent pregnancy, while others may want to prevent HIV. Explain that every service session with an adolescent is a chance to integrate information on STIs, HIV, and pregnancy prevention and to promote dual protection: protection against infection and pregnancy.

➤ **Trainer's Note:** *If there is a youth co-trainer, have them lead/facilitate this activity.*

2. Pass out 5 index cards to each participant. Tell them that first we're going to try to put ourselves in the mindset of an adolescent, because we can better plan for counseling adolescents if we understand the context in which they make decisions about sexual behavior.
3. Have participants write one reason why adolescents have unprotected sex on each of their index cards. Give them **5 minutes** to complete their cards.
4. Collect the cards and group them according to similar responses. The youth facilitator should at this point supplement participants' responses with their own responses, and any missing content you judge important from **Supplemental Content: Reasons Why Adolescents May Have Unprotected Sex**.

#### **Supplemental Content: Reasons Why Adolescents May Have Unprotected Sex**

- May think they are not vulnerable to pregnancy or STIs/HIV. "It can't happen to me" or "I don't have sex often enough to get pregnant or contract a STI/HIV."

- May not have adequate or accurate information about sexuality or protection.
- Sexuality education is often non-existent or inadequate in both schools and the community.
- Parents and others are reluctant to provide practical information and may believe that providing information encourages sexual activity. (Research shows this is not true: sexuality education actually facilitates safer behaviors.)
- Media promotes unrealistic notions of sexuality (“sex sells”) and usually omits any mention of risk or protection.
- Don’t know what methods are available.
- Don’t know where, how, or when to get methods.
- May not be aware of the need for protection during every sex act (i.e. may think that oral or anal sex are “safe” alternatives to vaginal sex).
- Believe their peers are not using contraception or protection.
- In addition to the above mentioned factors, which can be common to all adolescents, adolescents with disabilities face additional barriers in accessing information about methods and need for protection, which increase their risk of engaging in unsafe behavior. These include not only communication barriers but also attitudinal barriers at the service providers, school, community or family level based on the widespread lack of understanding of sexuality and disability and the misconception that adolescents with disabilities are not sexually active and, therefore, do not need to access SRH information.

### **Misinformation or Misconceptions**

- May have misinformation or myths about methods and their side effects. Myths about the dangers of contraception are common and difficult to correct.
- May not believe that protection is needed with a regular partner.
- May not believe that protection is needed if their partner looks healthy.
- May think that STI/HIV transmission only occurs among "certain people" (for example, commercial sex workers, poor people, "other" ethnic groups) and not among others (for example persons with disabilities).
- May be under social pressure to “prove” their fertility.
- May believe that social norms associate use of contraceptives with “planning for sex” and promiscuity.
- May be using ineffective or potential harmful traditional remedies for pregnancy or STIs.
- Believe that sexual desire is uncontrollable or could result in injury or illness if not fulfilled.

### **Denial**

- "Sex just happened."
- "I only had sex once."
- Believe "sex should be spontaneous" or are under social pressure to behave as though sex is/was spontaneous.
- They don't think they will get pregnant or contract a STI.

### **Lack of Access**

- Access to contraceptive services (including protection) for adolescents is limited by law, custom, or clinic/institutional policy.
- Availability and high cost of certain methods.
- Irregular supply of methods.
- Social pressure that associates contraceptives with promiscuity.
- Adolescents believe/ behave as though sex is spontaneous so are less likely to have a method available when sex happens.
- Judgmental attitudes or personal beliefs of the provider may prevent them from distributing certain methods to adolescents.
- Some vulnerable or marginalized groups of adolescents often face additional barriers to accessing contraceptive information and services. In the case of adolescents with disabilities, these include but are not limited to physical, communication and attitudinal barriers. See the chapter "Adolescents with Disabilities" for additional information on disability-based barriers.

### **Coercion**

- Partner or family wants pregnancy.
- Partner won't let her/him use protection or insists that use of contraceptives is a sign of mistrust.
- Sex is forced or coerced.
- Belief that condoms ruin sex or are unromantic.
- Partner agrees to use contraceptives or protection but then refuses to follow through.

### **Fear**

- Rejection by partner.
- Lack of confidentiality at the place where they obtain methods.
- Fear of the unknown - of using something that they have never used before.
- Side effects.
- Limited understanding of how to properly use protective methods.
- Where to keep protective methods so that no one sees/discovers them.
- Something may go wrong if they start using certain methods or products in adolescence.
- Their parents will find out they are having/planning to have sex.
- Their peers will know they are sexually active.
- Concerns over a physical examination, especially pelvic exam.
- Being asked questions by medical staff.
- Being labeled as "cheap" or "loose" or "bad."
- Being seen entering a clinic.

### **Embarrassment**

- Service providers are sometimes judgmental and/or moralistic about adolescent sexual activity. This is particularly true in the case of adolescents with disabilities because of the widespread misconceptions and lack of knowledge on sexuality and disability.
- Embarrassed to buy condoms.
- Retail outlets often place protective methods behind the counters so that customers must request them.
- May be embarrassed to use a method at the time of sex.

### **Other factors**

- Stopped using contraceptives because of the side effects.
- Sex may be spontaneous or unplanned.
- In some instances, adolescents want to conceive. Girls/young women may see pregnancy as a way to keep a relationship or a boyfriend; for a boy/young man, pregnancy may be seen as a way to prove manhood.
- May lack the communication and negotiation skills to discuss contraception/protection.
- Thinks the partner "is taking care of contraception."
- Feels ambivalent about becoming pregnant.
- Does not know how to dispose of condoms.

5. Have the group discuss the following questions in plenary (*Ensure that youth facilitators/participants with and without disabilities are leading the discussion and are encouraged to respond to any assumptions or misconceptions expressed by participants*):
  - a. Which of these reasons are internal to the adolescent (that is, based on their own self-awareness or self-perception)?
  - b. Which are external (that is, based on social norms or cultural barriers)?
  - c. What are some counseling strategies you could use to help an adolescent express his or her concerns or misconceptions? (*Trainer's note: select individual cards and ask for specific strategies or techniques. Use a flip chart during this question and the next to create a record for participants.*)
  - d. What other support could you provide?
6. Close the discussion by asking youth participants/facilitators for their reactions and advice for providers. Ask participants/facilitators with disabilities in the room for their specific insights and experiences on disability-based barriers and advice for providers.

### **Time: 20 minutes**

7. Move to the trainer's presentation. *This presentation should be delivered by both the lead trainer and a youth counterpart, if available. The trainers should work together beforehand to decide how best to divide the information, with a preference towards the youth trainer delivering more of the content.*
8. Start the presentation by explaining that rumors and misconceptions about contraception, about how they will be treated at clinics, and how the community perceives their actions, are some of the reasons why adolescents and even adult clients fail to access available services. Service



providers working with adolescents need to be prepared to address the myths, misconceptions, and rumors that clients may express to best counsel them on dual protection.

9. Present **Content: Rumors** (Slides 9.1-9.5) below.

***Content: Rumors (Slides 9.1-9.5)***

**Slide 9.1: 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.

10. Pause and ask participants to think of some common rumors in their community.

11. Return to the presentation with **Slide 9.2: Misconceptions** below.

**Slides 9.2-9.3: 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. Rumors or misconceptions may even be spread by health workers who may be misinformed 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.

### Slides 9.4-9.5: 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.

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.

12. Conclude your presentation by asking participants to look back at the flip charts from the previous discussion with strategies for counteracting rumors. Ask them to think about which they've used, and if there are any new strategies they'd like to try when they go back to their clinics.

## SPECIFIC OBJECTIVE 9.2: DISCUSS SAFER SEX MESSAGES AND TECHNIQUES IN THE PREVENTION OF STIS AND UNINTENDED PREGNANCY, INCLUDING CONTRACEPTIVE OPTIONS AVAILABLE TO ADOLESCENTS



### TIME

1 hour 15 minutes



### METHODS

- Trainer presentation



### MATERIALS NEEDED

- Slides 9.6-9.21
- Participant Handout 9a: BCS+ Algorithm
- Participant Handout 9b: Contraceptive Cue Cards



### STEPS

- **Trainer's Note:** *This presentation should be delivered by both the lead trainer and a youth counterpart, if available. The trainers should work together beforehand to decide how best to divide the information, with a preference towards the youth trainer delivering more of the content. The participation of youth trainers with different types of disabilities is essential to ensure the perspectives of clients with disabilities are included in the training. Accommodation should be provided according to the needs to ensure full participation of young trainers with disabilities.*

#### Time: 45 minutes

1. Start by reminding participants that addressing adolescent clients' misconceptions is only the beginning of the service relationship. Explain that this session will contain a lot of information, and in the next session the group will practice putting both their strategies for addressing misconceptions and the information and methods contained in this session into practice.
2. Begin the presentation **Content: Adolescent SRH Landscape** (Slides 9.6-9.21) below.

#### Slide 9.6-9.8: 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).
- 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.

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.

3. Pause and ask participants to reflect on the following terms. Go around the group in a circle and ask them to share the first thing that pops into their head when you say each of the terms. Encourage participants to freely say the first thing that pops into their heads and not worry about “right” or “wrong” answers:
  - Unprotected sex
  - Risk behavior
  - Safe sex
  - Protected sex
4. Ask the group if they noticed any trends in the answers. Were there positive responses associated with safe sex? Protected sex? What about unprotected sex? Were there negative responses associated with safe or protective sex? If so, ask why participants think the responses were so varied. If responses weren’t varied, ask why not. Is there a dominant cultural norm associated with these terms?
5. Return to the presentation.

### **Slides 9.9-9.11**

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.

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.

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.

#### **Slide 9.12: 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.

#### **Slide 9.13: 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.

#### **Slide 9.14: 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.

### Slide 9.15: 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.

### Slide 9.16: 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.

**Time: 30 minutes**

6. Pause for questions. While taking questions, distribute **Participant Handout 9a: BCS+ Algorithm**.
7. Introduce the handout. Explain that this session will cover the basics of the Balanced Counseling Strategy +, which is a counseling method developed by the Population Council and their partners, and one that Pathfinder recommends for service providers.



There are more tools available on Population Council's website:  
<http://www.popcouncil.org/research/the-balanced-counseling-strategy-plus-a-toolkit-for-family-planning-service>

### 8. Present **Slide 9.17: The BCS+ Approach**

#### **Slide 9.17: 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.

It is important to remember that adolescents particularly benefit from dual protection information and strategies. Allow adequate opportunity for them to ask questions and provide quality, non-judgmental information.

9. Pause for questions and to give participants time to review the handout. While discussing any questions, distribute Adolescent Contraceptive Cue Cards to participants.
10. State: Pathfinder believes that sexually active adolescents should have access to the full range of contraceptive methods, including LARCs. The World Health Organization Medical Eligibility for Contraceptive Use supports this belief, stating that age and parity are not contraindications for any method. In fact, users of short-acting methods, particularly adolescents aged 15 to 19, are more prone to contraceptive failure than users of LARCs.
11. Say: These Contraceptive Cue Cards describe the various forms of contraception that are commonly available and should be discussed with adolescents. However, we know that not all of these methods may be available in your clinics or community, and in some cases there may be legal or policy restrictions on which methods adolescents may obtain.

**12. Present Slide 9.18: Contraceptive Methods.**

**Slide 9.18: 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.

13. Say: the BCS+ method requires you to be aware of which methods are available **and** which methods are best for adolescents based on their current and future pregnancy desires. Counseling and discussion will reveal which contraceptive methods are likely to be best suited for individual adolescent clients, but you should be aware of the following general recommendations:
  - All adolescents need to be counseled on the importance of using dual protection against STIs, HIV, and unintended pregnancy. Condoms can prevent pregnancy, STIs and HIV, or adolescents can choose to use a contraceptive method for effective prevention of pregnancy and a barrier method (condoms).
  - LARCS are a medically acceptable and recommended strategy for adolescents, which can be used to both delay and space pregnancy.

- All adolescents regardless of gender should be counseled on their risks and responsibilities for their sexual and reproductive health, including prevention strategies for STIs and unintended pregnancy.

**14.** Return to the presentation with **Slide 9.19: Side Effects and Their Effect on Clients.**

#### **Slidess 9.19-9.21: 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.

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 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.



- 15.** Ask participants to list some of the side effects that clients have expressed concern about. In small groups, have participants discuss and compare the side effects for the methods of contraception available in their clinics, using the Contraceptive Cue Cards. Ask if there are any side effects they are unfamiliar with, or methods they would like to review in further detail. Take time to discuss any concerns or questions.
  
- 16.** Conclude the presentation by informing participants that the next session will be focused on practicing using the information learned so far.

# Algorithm for Using the Balanced Counseling Strategy Plus

THIRD EDITION, 2015



## PRE-CHOICE STAGE

- 1 Establish and maintain a warm, cordial relationship.
- 2 Inform client (and partner, if present) that there will be opportunities to address both health needs and family planning needs during this consultation.
- 3 Ask client about current family size and current contraceptive practices. Counsel client on Healthy Timing and Spacing of Pregnancy using counseling card.
  - a) If client is currently using a family planning method or delaying pregnancy, ask about her/his satisfaction with it and interest in continuing or changing the method.
  - b) If partner is present, use the male services and support card.
- 4 Rule out pregnancy using the Checklist to Make Reasonably Sure a Woman is not Pregnant card to be reasonably sure the woman is not pregnant.
- 5 Display all of the method cards. Ask client if she/he wants a particular method.
- 6 Ask all of the following questions. Set aside method cards based on the client's responses.
  - a) Do you wish to have children in the future?  
If "Yes," set aside vasectomy and tubal ligation cards. Explain Why.  
If "No," keep all cards and continue.
  - b) Have you given birth in the last 48 hours?  
If "Yes," set aside combined oral contraceptives (the Pill) and combined injectables. Explain why.  
If "No," continue with the next question.
  - c) Are you breastfeeding an infant less than 6 months old?  
If "Yes," set aside the combined oral contraceptives (the Pill) and combined injectable cards. Explain why.  
If "No," or she has begun her monthly bleeding again, set aside the lactational amenorrhea (LAM) card. Explain why.
  - d) Does your partner support you in family planning?  
If "Yes," continue with the next question  
If "No," set aside the following cards: female condom, male condom, Standard Days Method®, Two Days Method®, and withdrawal. Explain why.
  - e) Do you have any medical conditions? Are you taking any medications?  
If "Yes," ask further about which conditions or medications. Refer to WHO Medical Eligibility Criteria Wheel or current national guidelines and set aside all contraindicated method cards. Explain why.  
If "No," keep all the cards and continue.
  - f) Are there any methods that you do not want to use or have not tolerated in the past?  
If "Yes," set aside the cards the client does not want.  
If "No," keep the rest of the cards.



## METHOD CHOICE STAGE

- 7 Briefly review the methods that have not been set aside and indicate their effectiveness.
  - a) Arrange the remaining cards in order of effectiveness (see back of each card).
  - b) In order of effectiveness (highly effective to not effective), briefly review the attributes on each method card.
- 8 Ask the client to choose the method that is most convenient for her/him.
  - a) If client is adolescent use the counseling card to inform her that she can get any method
- 9 Using the method-specific brochure, check whether the client has any condition for which the method is not advised.
  - a) Review "Method not advised if you..." section in the brochure
  - b) If the method is not advisable, ask the client to select another method from the cards that remain. Repeat the process from **Step 8**.



## POST-CHOICE STAGE

- 10 Discuss the method chosen with the client, using the method-specific brochure as a counseling tool. Determine the client's comprehension and reinforce key information.
- 11 Make sure the client has made a definite decision. Give her/him the method chosen, a referral, and a back-up method depending on the method selected.
- 12 Encourage the client to involve partner(s) in decisions about/practice of contraception through discussion or a visit to the clinic.



## SYSTEMATIC SCREENING FOR OTHER SERVICES STAGE

- 13 Using information collected previously, determine client's need for postpartum, newborn, infant care, well-child services or post abortion care.
  - a) If client reported giving birth recently, review the Promoting Healthy Postpartum Period and Promoting Newborn and Infant Health card with client. Provide or refer for services, if needed.
  - b) For clients with children less than 5 years of age, ask if children have been taken to well-child services. Provide or refer for immunizations and growth monitoring services, if needed.
  - c) If client reported a recent abortion, review the Post Abortion Care card with the client. Provide or refer post abortion care services, if needed.
- 14 Ask client when she had her last screening for cervical cancer (VIA/VILI or pap smear) or breast cancer.
  - a) If her last Cervical Cancer screening was more than 3 years ago (\*6-12 months if she is HIV positive) or she doesn't know, ask if she would like to have a screening today. Review the Screening for Cervical Cancer card. Provide or refer for services.
  - b) If her last Cervical Cancer screening was less than 3 years ago continue with next question.
  - c) Review Breast Cancer Information and Awareness counseling card with client.
- 15 Discuss STI/HIV Transmission & Prevention and dual protection with client using counseling cards. Offer condoms and instructions on correct and consistent use.
- 16 Conduct STI and HIV risk assessment using the counseling card. If symptoms are identified, treat her/him syndromically.
- 17 Ask client whether s/he knows her/his HIV status.
  - a) If client knows s/he is living with HIV,
    - Review Positive Health, Dignity, & Prevention counseling card with client.
    - Refer client to center for wellness care and treatment.
  - b) If client knows s/he is HIV negative,
    - Discuss a time frame for repeat testing.
  - c) If client does not know her/his status,
    - Discuss HIV Counseling and Testing (HCT) with client, using counseling card.
    - Offer or initiate testing with client, according to national protocols.
    - Counsel client on test results. If client is living with HIV, review Positive Health, Dignity, & Prevention counseling card and refer client to center for wellness care and treatment.
  - d) Counsel client using Women's Support & Safety Card.
    - If client shows any major Intimate Partner Violence (IPV) triggers, refer her for specialized services.
- 18 Give follow-up instructions, a condom brochure, and the brochure for the method chosen. Set a date for next visit.
- 19 Thank her/him for the visit. Complete the counseling session.



*HANDOUT 9B: CONTRACEPTIVE CUE CARDS*

The contraceptive cue cards were updated in 2020 to include DMPA-SC and to ensure they appropriate reflect most up-to-date global guidance. They can also be downloaded at <https://www.pathfinder.org/publications/cue-cards-for-counseling-adolescents-on-contraception/>

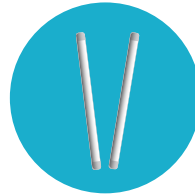
# Cue Cards for Counseling Adolescents on Contraception

## About the Cue Cards

This set of contraceptive counseling cue cards was developed to support a range of providers (such as facility-based providers, community health workers, pharmacists, outreach workers, counselors, and peer providers) in counseling young people on their contraceptive options. The cue cards provide information that is particularly relevant to adolescents (10–19 years), but can also be used with young people over age 19. The cards can be adapted to meet local circumstances and contexts.

One side of the card serves to remind the provider of important information about the contraceptive method, such as the effectiveness, advantages, and disadvantages. The provider should use this information to guide a dialogue with an adolescent client about the full range of available methods and support the adolescent client in choosing a method that is right for her/him. After the client chooses a method, the provider can turn to the other side of the card to give the client specific instructions on her/his method of choice. This side of the card includes information that the provider should tell the adolescent client about how to use the method, possible side effects, and reasons to return to the provider.

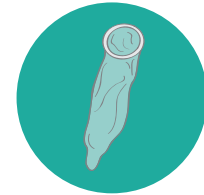
The cue cards cover the following methods:



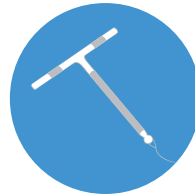
**Implants**



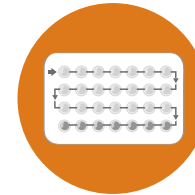
**Lactational Amenorrhea Method (LAM)**



**Male Condom**



**Intrauterine Device (IUD)  
both hormonal and TCU**



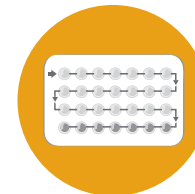
**Combined Oral Contraceptives (COCs)**



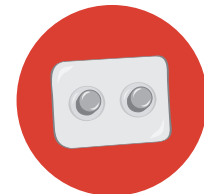
**Female Condom**



**DMPA (injectables)  
both DMPA-IM and DMPA-SC**



**Progestin-Only Pills (POPs)**



**Emergency Contraceptive Pills (ECPs)**

# Cue Cards for Counseling Adolescents on Contraception

## Counseling Tips

- **It is important to remember that adolescents—regardless of age, relationship, marital, or childbearing status—are eligible for the full range of contraceptive methods.** The World Health Organization’s (WHO) Medical Eligibility Criteria states that age alone is not a contraindication for any contraceptive method included in this set of cue cards, including long-acting methods. Providers have an obligation to provide adolescents with evidence-based and unbiased information about a full range of methods that might meet their needs. However, the provider should verify that the adolescent does not have any other condition that precludes use of a particular method per the WHO’s Medical Eligibility Criteria.
- **The cue cards can be used in any order based on the stated preferences and medical eligibility of the client.** They are arranged in order of method effectiveness (from most effective to least effective) to encourage you to include method effectiveness as a key component of client counseling and to reinforce the fact that long-acting methods are an appropriate option for adolescents.
- **Adolescent clients should have full information on a method, including potential side effects.** This can help minimize an adolescent’s concern if she/he does experience a side effect. However, adolescent clients also have more misinformation than adults about contraception and, as a result, often have greater fears about side effects. **Therefore, when counseling adolescent clients on possible side effects, be sure to start by mentioning that most adolescent clients do not experience any side effects.**
- **Make sure to emphasize that *only* male and female condoms offer protection from sexually transmitted infections (STIs), HIV, and pregnancy.** Therefore, if the client chooses a contraceptive method other than condoms, a condom must also be used to prevent pregnancy and STIs/HIV (often referred to as dual method use, double protection or dual protection).

### As you counsel adolescents remember to:

- ✓ Ensure privacy and confidentiality
- ✓ Be respectful of the client’s choices, culture, religion, and sexuality
- ✓ Listen actively and show interest
- ✓ Be attentive to the client’s questions and specific needs
- ✓ Use clear language the client can understand
- ✓ Avoid one-way communication and ask open-ended questions
- ✓ Avoid judgmental attitudes and behaviors—don’t lecture, scold, or tell the adolescent what he/she should do
- ✓ Provide unbiased, evidence-based information using the cue cards to ensure the adolescent has a choice of methods

# Implants

## What are they?

Implants are small flexible rods that contain the hormone progestin. The capsules are placed under the skin of a woman's upper arm and can prevent pregnancy for 3–5 years, depending on the type. There are several types of implants:

- **Jadelle:** 2 rods, effective for 5 years
- **Implanon:** 1 rod, effective for 3 years
- **Sinoplant:** 2 rods, effective for 5 years

## How effective are they?

Implants are 99% effective which means if 100 women use an implant, typically less than 1 becomes pregnant during the first year. Over the 3–5 years (depending on type), up to 1 pregnancy occurs per 100 women using an implant.

## How do implants work?

Implants work by thickening cervical mucus, blocking sperm from meeting an egg, and by preventing the release of the egg from the ovary.

## Not recommended for clients who:

- Have unexplained vaginal bleeding (requires examination)

**Check medical eligibility criteria if adolescent has other serious health problems.**



## Advantages

- Safe and effective
- Long lasting (3–5 years) and no daily action required
- Monthly bleeding becomes very light and often disappears after a year
- Can become pregnant again immediately after removing the implants
- Can be used while breastfeeding
- Doesn't interfere with sex
- May improve anemia
- Can be used discreetly

## Disadvantages

- Menstrual pattern will probably change
- Doesn't protect against STIs/HIV
- Requires a health provider to insert and remove
- May be the most expensive option

# Implants



Show the implants, let the client touch them and explain the following:

## How to use implants

- The small rods or capsules are inserted under the skin of the client's upper arm.
- If implant is inserted within 7 days of the start of monthly bleeding, there is no need for a back-up method.
- If implant is inserted more than 7 days after the start of monthly bleeding (or more than 5 days for Implanon), the client will need a back-up method for the first 7 days. Once inserted, an implant may be effective for 3-5 years. However, it can be removed at any time. If not removed sooner, the implant will need to be removed after 3–5 years depending on implant type and client's weight.
- If a woman is heavier than 80 kg, advise her that Jadelle will become less effective after 4 years of use.

## Possible side effects may include:

- Changes in monthly bleeding: irregular spotting or prolonged light to moderate bleeding in the beginning. Later, bleeding is likely to be lighter, less frequent, or stop altogether.
- Weight gain, breast tenderness, headaches, dizziness, nausea, mood changes.

## Reasons to return to the provider

- If the client wants to remove the implant.
- Pus, heat, redness, or pain at the insertion site that worsens or does not go away (could indicate an infection at the site)
- Migraine headaches with blurred vision
- Implant seems to be coming out
- In the event of significant weight gain, as this may reduce the long-term effectiveness of the implant
- Any time there is a problem or if either partner has been exposed to an STI
- A resupply of condoms is needed (never run out before returning)



**Implants do not protect against STIs/HIV:**  
To protect against pregnancy and STIs/HIV,  
use a condom every time you have sex.

Have the client repeat this information back to you.

# Intrauterine Device (IUD) (information for the TCU 380A and Levonorgestrel IUD)



## What is it?

An IUD is a small plastic and copper device that is inserted into the uterus to prevent pregnancy.

## How effective is it?

IUDs are 99% effective which means if 100 women use an IUD for 1 year, typically less than 1 woman becomes pregnant.

## How does the IUD work?

The IUD works by preventing sperm from joining with the egg. There are four ways: 1) IUD thickens the cervical mucus; 2) Changes the endometrial lining; 3) Interferes with the movement of the egg from the ovaries before the egg arrive in the uterine cavity and 4) Interferes with the ability of sperm to pass through the uterine cavity.

## Not recommended for clients who:

- Are 48 hours to 4 weeks postpartum
- Have postpartum sepsis or post-septic abortion
- Have unexplained vaginal bleeding (must do an examination before initiating method)
- Have active pelvic inflammatory disease, chlamydia, or gonorrhea (initiation only, continuation of method is acceptable)
- Have multiple sexual partners or whose partner has other sexual partners (at increased risk of STIs)
- Have AIDS and are not clinically well (initiation of IUD only)

**Check medical eligibility criteria if adolescent has other serious health problems.**

## Advantages

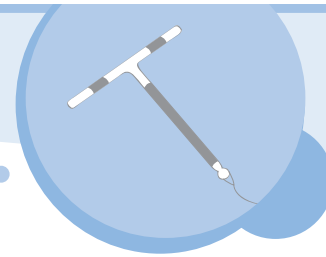
- Safe, effective, and long-acting (up to 12- years (for TCU 380A) and 5 years (for Levonorgestrel IUD) )
- Easy to remove (by the provider) if the client wants to become pregnant
- Rapid return to fertility
- No daily action required
- Doesn't interfere with sex
- Can be used discreetly—no visible clues that it is used (occasionally a partner may feel the strings during sex)
- Can be inserted immediately postpartum
- Doesn't interfere with breastfeeding
- Can be used by young women, including those who have never been pregnant
- The copper IUD can also be used as emergency contraception to prevent pregnancy if inserted within 5 days of unprotected sex.
- It is inexpensive, less than \$1 USD in most places.

## Disadvantages

- Slight pain during the first few days after IUD insertion
- Heavier and/or longer periods, which normally decrease during the first and second years
- Doesn't protect against STIs/HIV
- Requires a health care provider to insert and remove



# Intrauterine Device (IUD) (information for the TCU 380A and Levonorgestrel IUD)



Show and let the client touch the IUD and explain the following:

## How to use the IUD

- The IUD is inserted by the provider once and can stay for up to 5 years (Levonorgestrel IUD) and 12 years (TCu 380A IUD). No additional follow-up is required after insertion (unless there is a problem).
- The client should come for a check-up 3–6 weeks after insertion, but no additional follow-up is required (unless there is a problem).
- Checking the strings is optional. The strings may be checked during the first few months and after monthly bleeding to see if the IUD is still in place. *Explain how to check strings.*

## Possible side effects may include:

- Heavier, longer, and/or irregular bleeding (usually decreases after first 3–6 months)
- More cramps and pain during monthly bleeding
- Increased vaginal discharge
- Pelvic inflammatory disease (PID) may occur if the woman has chlamydia or gonorrhea at the time of IUD insertion
- Possible infection
- Pain and cramping during insertion and the first few days after IUD insertion

## Reasons to return to provider

- Abnormal bleeding or discharge
- Pain (abdominal or pain with intercourse)
- Fever
- Strings are missing or you feel the hard plastic of an IUD that has partially come out.
- Any time there is a problem or if either partner has been exposed to an STI
- Any time a re-supply of condoms is needed (never run out completely before returning)

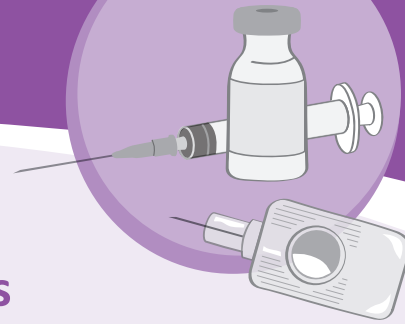


**The IUD does not protect against STIs/HIV:**  
To protect against pregnancy and STIs/HIV,  
use a condom every time you have sex.

Have the client repeat this information back to you.

# DMPA: Injectable Contraceptives

Depot Medroxyprogesterone Acetate  
(DMPA-IM and DMPA-SC).



## What is it?

There are different types of injectable contraceptive. This card refers to DMPA-IM and DMPA-SC not NET-EN or monthly combined injectables. DMPA, sometimes known as “the shot” or “Depo,” is an injection containing the hormone progestin. The injection is given every 3 months.

## How effective is it?

DMPA is 97% effective which means if 100 women use DMPA for 1 year, typically 3 become pregnant.

## How does DMPA work?

DMPA works by preventing the release of the egg from the ovary. Without an egg, a woman cannot become pregnant.

## Not recommended for clients who:

- Have unexplained vaginal bleeding (before evaluation)

**Check medical eligibility criteria if adolescent has other serious health problems.**

## Advantages

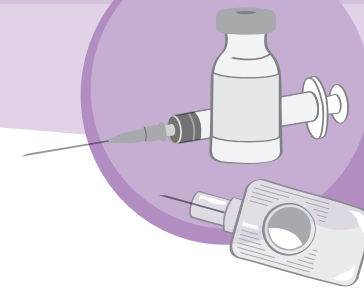
- Safe and effective
- Can be administered by non-physician trained health care workers
- Lasts for 3 months, no daily action required
- Discreet
- Monthly bleedings become very light and often disappear after a year of use
- Completely reversible—can become pregnant again after stopping DMPA, but there might be a delay of several months
- Can be used while breastfeeding
- Doesn't interfere with sex
- May improve anemia

## Disadvantages

- Monthly bleeding pattern will probably change
- Increased appetite may cause weight gain
- On average, a 4-month longer delay in ability to get pregnant after stopping DMPA compared to other methods
- Doesn't protect against STIs/HIV

# DMPA: Injectable Contraceptives

Depot Medroxyprogesterone Acetate  
(DMPA-IM and DMPA-SC).



Show and have the client touch the vial of DMPA and explain the following:

## How to use DMPA

- DMPA is given by injection every 3 months.
- Never be more than 4 weeks late for a repeat injection.
- DMPA is now available in a special formulation, called DMPA-SC, that is meant only for subcutaneous injection (just under the skin) and not for injection into muscle. This product may be particularly useful for community-based programs. Also, women can easily learn to give themselves subcutaneous injections with this system.
- Effective immediately if starting within 7 days after the start of monthly bleeding
- If starting more than 7 days after the first day of monthly bleeding, a back-up method (e.g., condoms) is needed for the first 7 days.

## Missed injection – What to do?

- Come immediately to get an injection and use a back-up method immediately until 7 days after the injection.
- If you can't come at the appointed time, but you can come earlier, it is possible to come up to 4 weeks early for your next injection.

## Possible side effects may include:

- Irregular spotting
- Prolonged light to moderate bleeding
- Bleeding is likely to become lighter, less frequent, or stop altogether.
- Possible weight gain, headaches, dizziness, mood changes

## Reasons to return to provider

- Heavy vaginal bleeding
- Excessive weight gain
- Extreme headaches with blurred vision
- Any time there is a problem or if either partner has been exposed to an STI
- Another 3-month injection or a resupply of condoms is needed (never run out completely before returning)



**DMPA does not protect against STIs/HIV:**  
To protect against pregnancy and STIs/HIV,  
use a condom every time you have sex.

Have the client repeat this information back to you.

# Lactational Amenorrhea Method (LAM)



## What is it?

The Lactational Amenorrhea Method (LAM) is the use of breastfeeding as a temporary contraceptive method. (“Lactational” means related to breastfeeding and “amenorrhea” means not having menstrual bleeding.)

## How effective is it?

LAM is 98% effective which means if 100 women use LAM correctly in the first 6 months after childbirth, typically 2 become pregnant. Women who choose to use this method are protected against pregnancy as long as they exclusively breastfed their babies in the first 6 months.

## How does LAM work?

LAM works by preventing ovulation because breastfeeding changes the rate of release of natural hormones.

## Advantages

- Effective in preventing pregnancy for at least 6 months
- Encourages the best breastfeeding patterns with health benefits for the mother and baby
- Can be used immediately after childbirth
- Doesn’t interfere with sex
- No direct cost for contraception or for feeding the baby
- No supplies or procedures needed to prevent pregnancy

## Disadvantages

- Reduced effectiveness after 6 months
- Requires frequent breastfeeding (day and night), which may be difficult for some mothers
- Does not provide protection against STIs, including HIV
- If the mother has HIV there is a chance that breast milk will pass HIV to the baby. It is recommended for mothers to exclusively breastfeed to reduce this risk.

# Lactational Amenorrhea Method (LAM)



Explain the following to the client:

## LAM *can* be used if all the conditions below are met:

- Monthly bleeding has not returned.
- The baby is not receiving other food besides breast milk and does not go for long periods (more than 4–6 hours) without breastfeeding, either during the day or night.
- The baby is less than 6 months old.

**Note: A complementary form of contraception can also be used at any point.**

## LAM *cannot* be used if any of the following conditions exist:

- Baby is 6 months of age or older
- Monthly bleeding begins
- Baby is receiving supplemental foods

**!** LAM does not protect against STIs/HIV:  
To protect against pregnancy and STIs/HIV,  
use a condom every time you have sex.

## How to make breastfeeding effective?

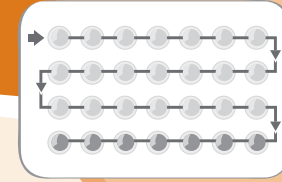
- Breastfeed whenever the baby wants to be fed, day and night.
- Feed from both breasts.
- Avoid intervals of more than 4 hours between any daytime feeds and more than 6 hours between any nighttime feeds.
- Breastfeed for 6 months.
- Don't use pacifiers, nipples, or bottles.
- Express breast milk if separated from the baby.
- Don't give the baby water or teas.

## Reasons to return to provider

- No longer fully breastfeeding and need another contraceptive method
- Any time there is a problem or if either partner has been exposed to an STI
- A resupply of condoms is needed (never run out completely before returning)

Have the client repeat this information back to you.

# Combined Oral Contraceptives (COCs)



## What are they?

COCs (also known as “the pill”) are tablets containing the hormones estrogen and progestin. A woman takes 1 pill daily to prevent pregnancy.

## How effective are they?

COCs are 92% effective, which means if 100 women use COCs correctly for 1 year, typically 8 become pregnant. There is a higher failure rate for adolescents than for all other ages because adolescents have trouble remembering to take pills regularly.

## How do COCs work?

COCs work by preventing the release of the egg from the ovary. Without releasing an egg, a woman cannot become pregnant.

## Not recommended for clients who:

- Gave birth less than 4 weeks ago (if not breastfeeding)
- Are breastfeeding a baby less than 6 months old
- Have migraine headaches with aura
- Have viral hepatitis with severe or acute flare-up
- Take Ritonavir-boosted protease inhibitor ARVs (If using any ARV, use COCs with at least 30 ug EE.)
- Take rifampicin or rifabutin for TB (If using rifampicin or rifabutin, use COCs with at least 30 ug EE.)

**Check medical eligibility criteria if adolescent has other serious health problems.**

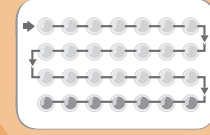
## Advantages

- Safe, effective, and easy to use
- Controlled by the woman
- Can be used before the onset of monthly bleeding
- Lighter, regular monthly bleeding with less cramping
- Possible to become pregnant again immediately after stopping COCs
- Don’t interfere with sex
- May be beneficial for adolescents who have irregular or heavy monthly bleeding, severe cramping, or acne
- Decrease risk of cancer of the female reproductive organs

## Disadvantages

- Must be taken every day to be effective, which can make it difficult or lead to discontinuation or incorrect use by some adolescents and young women.
- Not always discreet (someone could see the pills)
- Weight gain or unexpected bleeding/spotting in some adolescents
- Don’t protect against STIs including HIV

# Combined Oral Contraceptives (COCs)



Show and let the client touch the pill packet and explain the following:

## How to use COCs?

- Take first pill on the first day of monthly bleeding or any of the next 4 days.
- If taking the pill more than 5 days after the start of your monthly bleeding, use a back-up method for the first 7 days.
- Take 1 pill every day, at the same time of day. Keep the pills in a place that will help you remember, such as near where you wash at night.
- 28-day packet: After finishing the packet, begin next packet the following day. The last 7 pills do not contain hormones, but they are there to remind you to keep taking the pill.
- 21-day packet: After finishing the packet, wait 7 days and then begin the next packet.

## Missed pills – What to do?

- Missed pills may result in pregnancy.
- If you miss pills, ALWAYS take one as soon as you remember and continue to take the rest of the pills each day at the regular time.
- If you miss 3 or more pills, or start a pack more than 3 days late, continue taking the rest of the pills at the regular time *and* use a condom or avoid sex for the next 7 days.
- If you miss 3 or more pills in the third week of the pill packet, skip the inactive pills and start a new packet. Use a condom or avoid sex for the next 7 days.

## Possible side effects may include:

- Nausea, weight gain, breast tenderness, headaches, dizziness, mood changes
- Changes in monthly bleeding patterns, including unexpected bleeding or spotting

## Reasons to return to provider:

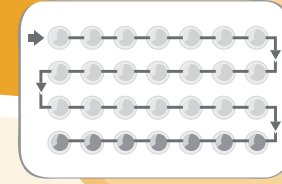
- Severe headaches (including headaches with blurred vision)
- Severe, constant pain in belly, chest, or legs
- Jaundice or yellowing of the skin
- Brief loss of vision, seeing flashing lights or zigzag lines (with or without bad headaches)
- Brief trouble speaking or moving arms or legs
- Any time there is a problem or if either partner has been exposed to an STI
- When a resupply of COCs (always have at least 1 back-up pack) or condoms is needed



**COCs do not protect against STIs/HIV:**  
**To protect against pregnancy and STIs/HIV,**  
**use a condom every time you have sex.**

**Have the client repeat this information back to you.**

# Progestin-only Pills (POPs)



## What are they?

POPs (also known as the “mini-pill”) are oral contraceptive pills containing only a very small amount of one hormone (a progestin). A woman takes 1 tablet daily to prevent pregnancy.

## How effective are they?

- POPs are very effective for breastfeeding women. POPs are 99% effective, which means if 100 breastfeeding women use POPs correctly for 1 year, typically 1 becomes pregnant.
- As typically used, they are less effective for non-breastfeeding women. If 100 non-breastfeeding women use POPs for 1 year, typically 3–10 women become pregnant.
- There is a higher failure rate for adolescents since adolescents have trouble remembering to take pills regularly.

## How do POPs work?

POPs work by thickening the cervical mucus, making it difficult for sperm to pass through, and by preventing the release of the egg from the ovary in about half of all menstrual cycles.

## Not recommended for adolescents who are:

- Taking ritonavir-boosted protease inhibitor ARVs
- Taking rifampicin or rifabutin therapy for TB

## Advantages

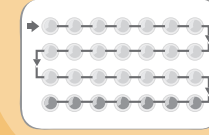
- Can be used while breastfeeding
- Good option for adolescents who can't use estrogen but want to use pills
- Can become pregnant again immediately after stopping
- Don't interfere with sex
- No need for health care provider or medical exam

## Disadvantages

- For adolescents (not breastfeeding), monthly bleeding patterns may change (including spotting and amenorrhea)
- Must be taken at the same time every day, which can be difficult for adolescents to remember—a delay of 3 hours is similar to missing a pill
- Not always discreet (someone could see the pills)
- Don't protect against STIs/HIV



# Progestin-only Pills (POPs)



Show and let the client touch the pill packet and explain the following:

## How to use POPs?

- If breastfeeding and monthly bleeding has not returned, can start POPs at any time without a back-up method.
- If monthly bleeding has returned, POPs can be started within the first 5 days after the start of monthly bleeding without a back-up method.
- If it has been more than 6 months since giving birth or if monthly bleeding has returned, but it is not within the first 5 days after the start of monthly bleeding, POPs can be started any time if you are reasonably certain you are not pregnant. But a back-up method, like a condom, should be used for the first 2 days.
- Take 1 pill every day, at the same time of day. When a packet finishes, start another pack the very next day.
- Don't miss a day or take the pill late. You may want to take the pill when you do something that you do every day, like washing your face or brushing your teeth.

## Missed pills – What to do?

- Take pill or pills as soon as you remember. You may take 2 pills at the same time or the same day.
- Continue taking the next pill at the usual time.
- Use a back-up method, like a condom, for the next 2 days.

## Possible side effects may include:

- Changes in monthly bleeding patterns, including amenorrhea, spotting, irregular or prolonged bleeding (for adolescents who are not breastfeeding)
- Breast tenderness, headaches, dizziness, mood changes, abdominal pain, nausea
- Breastfeeding adolescents may have a longer delay in return of monthly bleeding after childbirth.

## Reasons to return to provider

- Stopped breastfeeding and would like to switch methods
- Took a pill more than 3 hours late or missed one completely, and also had sex during this time, and want to consider ECPs (for women who have monthly bleeding)
- Severe headaches with blurred vision
- Any time there is a problem or if either partner has been exposed to an STI
- A resupply of POPs or condoms is needed (always have at least 1 back-up pack)



**POPs do not protect against STIs/HIV:  
To protect against pregnancy and STIs/HIV,  
use a condom every time you have sex.**

**Have the client repeat this information back to you.**

# Male Condom

## What is it?

The male condom is a thin sheath worn over the erect penis and used when a couple is having sex.

## How effective is it?

- The condom is 85% effective, which means if 100 couples use condoms for 1 year, typically 15 become pregnant.
- If used correctly with every act of intercourse, condoms are highly effective in protecting against most STIs (except herpes simplex and other genital ulcer diseases), including HIV.

## How do condoms work?

The condom catches the man's sperm so that no sperm can enter the vagina.

## Not recommended for clients who:

- Have a severe allergy to latex rubber

**!** **Note: Condoms are always recommended to prevent STIs/HIV.**  
If the adolescent feels s/he may not *always* be able to negotiate condom use, it is recommended that s/he also use an additional contraceptive method.



## Advantages

- Safe
- Doesn't require a prescription or medical examination
- Effective and easy to use
- Protects against STIs/HIV

## Disadvantages

- Interrupts the sex act
- May decrease sexual sensitivity in some men and women
- Requires communication and consent from both partners
- A new condom must be used each time the couple has sex
- A supply of condoms must be available before sex occurs

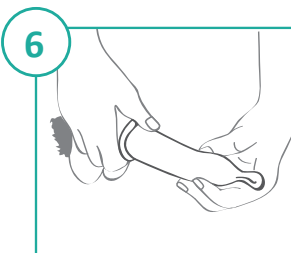
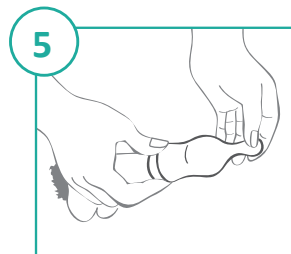
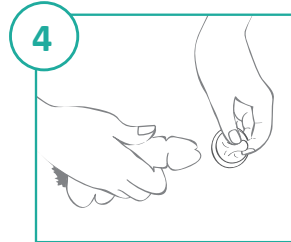
# Male Condom



Show and let the client touch the condom and explain the following:

## How to use a condom?

1. Check the expiration date on the condom package.
2. Open the package carefully so the condom doesn't tear.
3. Don't unroll the condom before putting it on.
4. Place the unrolled condom on the tip of the hard penis.
5. Hold the tip of the condom with the thumb and forefinger.
6. Unroll the condom until it covers the penis.
7. Leave enough space at the tip of the condom for the semen.
8. After ejaculation, hold the rim of the condom and pull the penis out of the vagina before it becomes soft.
9. Only use one condom at a time.
10. Always keep a supply of condoms readily available.



## Care of condoms

- Don't apply oil-based lubricants (like baby oil, cooking oil, petroleum jelly/Vaseline) because they can destroy the condom. It is safe to use clean water, saliva, or water-based lubricants.
- Store condoms in a cool, dry place. Don't carry them close to the body because heat can destroy them.
- Use each condom only once.
- Don't use a condom if the package is broken or if the condom is dry or sticky or the color has changed.
- Take care to dispose of used condoms properly.

## Possible side effects may include:

- A condom may break or come off during sex.
- A few men and women experience itching, burning, or swelling due to latex allergy.

## Reasons to return to provider:

- Any time there is a problem (condom breaks or unhappy with method)
- A resupply is needed (never run out completely before returning)
- Either partner thinks s/he may have been exposed to an STI

Have the client repeat this information back to you.

# Female Condom



## What is it?

The female condom is a thin lubricated sheath or lining made of a soft plastic film that fits loosely inside a woman's vagina. It has flexible rings at both ends. The ring at one end is closed and covers the cervix. A woman uses the female condom during intercourse to prevent pregnancy.

## How effective is it?

- The female condom is about 98% effective, which means if 100 women use the female condom for 1 year, typically 21 become pregnant.
- The female condom also effectively prevents many STIs including HIV when used correctly every time a woman and her partner have sexual intercourse.

## How does the female condom work?

The condom catches the man's sperm so that no sperm can enter the vagina.

**! Note: Condoms are always recommended to prevent STIs/HIV.**

If the adolescent feels s/he may not *always* be able to negotiate condom use, it is recommended that s/he also use an additional contraceptive method.

## Advantages

- Safe
- Effective
- Can be inserted up to 8 hours before sex
- Can be used with oil-based lubricants
- Can feel more natural during sex than male condoms
- Protects against STIs/HIV
- Reduces the chance of irritation or allergic reaction compared to latex condoms

## Disadvantages

- Costs more than the male condom
- May be noisy or awkward
- Is female initiated, but requires cooperation and consent of the male partner
- Can be difficult to insert

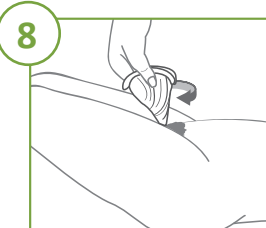
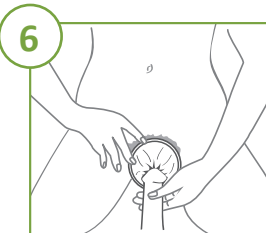
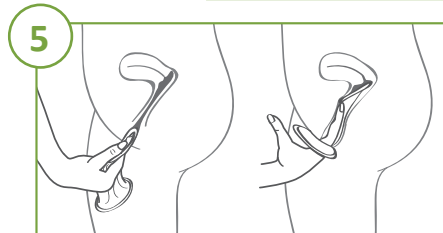
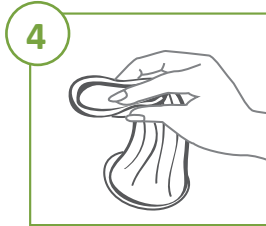
# Female Condom



Show the client the female condom and explain the following:

## How to use the female condom?

1. Check the expiration date on the condom package.
2. Open the package carefully so the condom doesn't tear.
3. Find the inner ring, which is at the closed end of the condom.
4. Squeeze the inner ring together.
5. Put the inner ring in the vagina and push up into the vagina with the finger. (The outer ring stays outside the vagina.)
6. During sex, guide the penis through the outer ring. (If it is outside the ring, it will not offer protection from pregnancy or STIs/HIV.)
7. Remove condom immediately after sex, before standing up.
8. Squeeze and twist the outer ring to keep the sperm inside the pouch.
9. Pull the pouch out gently.
10. Burn or bury the condom—do not put it down the toilet.



**Suggest that the client practice inserting and removing the condom before having sex with it for the first time and try different positions to see which way insertion is easiest.**

## Care of female condoms

- Store condoms in a cool, dry place. Don't carry them close to the body because heat can destroy them.
- Use each condom only once.
- Don't use a condom if the package is broken or if the condom is dry or sticky or the color has changed.
- Always keep a supply of condoms readily available.

## Possible side effects may include:

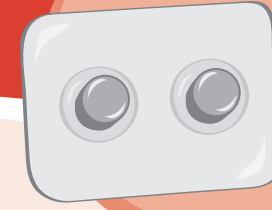
- Usually there are no side effects. Occasionally, a condom may break or slip out during intercourse.
- Very few adolescents may have itching, burning, or redness around the vagina (or partner's penis).

## Reasons to return to provider:

- Any time there is a problem (condom breaks or unhappy with method)
- A resupply of condoms is needed (never run out completely)
- Either partner thinks s/he may have been exposed to an STI

**Have the client repeat this information back to you.**

# Emergency Contraceptive Pills (ECPs)



## What are they?

ECPs are a hormonal method of contraception that can be used to prevent pregnancy up to 120 hours (5 days) following an act of unprotected sexual intercourse.

## How effective are they?

- ECPs are 98-99% effective which means:
- If 100 women use progestin-only ECPs, typically 1 becomes pregnant.
- If 100 women use combined (estrogen and progestin) ECPs, typically 2 become pregnant.
- ECPs are most effective when used shortly after unprotected sex.

## How do ECPs work?

- ECPs prevent a pregnancy from occurring. They do not disrupt an implanted pregnancy. ECPs prevent the egg from leaving the ovary and may thicken cervical mucus to prevent the sperm from meeting the egg.
- ECPs only prevent pregnancy from unprotected sex that occurs before the pills are taken. They do not prevent pregnancy from sex that occurs after the ECPs are taken.

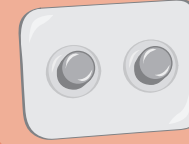
## Advantages

- Safe for women of all ages, including adolescents who may be less likely to prepare for a first sexual encounter
- Reduce risk of unintended pregnancy and need for abortion
- Appropriate for use after unprotected intercourse (including rape or contraceptive failure)
- Provide a bridge to the practice of regular contraception
- Drug exposure and side effects are of short duration

## Disadvantages

- Don't protect against STIs/HIV
- Don't provide ongoing protection against pregnancy
- Must be used within 120 hours after unprotected sex (and should be taken as soon as possible to be most effective)
- May change the time of the woman's next monthly bleeding
- Inappropriate for regular use (high cumulative pregnancy rate)

# Emergency Contraceptive Pills (ECPs)



Show and let the client touch the ECPs and explain the following:

## How to use ECPs

- For progestin-only ECP (dedicated product): When possible, take 2 pills at the same time within 120 hours of unprotected sex, or take 1 pill within 120 hours and 1 pill 12 hours later.
- For combined oral contraceptives (COCs): 1 dose of 0.1 mg ethinyl estradiol plus 0.5 mg levonorgestrel followed by a second identical dose 12 hours later.
- If vomiting occurs within 2 hours of taking ECPs, take another dose as soon as possible. If vomiting occurs after 2 hours, no additional dose is needed.
- To reduce nausea, take the tablets after eating or use anti-nausea medication.
- Do not to take any extra ECPs unless vomiting occurs. More pills will not decrease risk of pregnancy.

## Possible side effects may include:\*

- Nausea and vomiting
- Headaches or dizziness
- Cramping/abdominal pain
- Breast tenderness
- Changes in monthly bleeding or slight irregular bleeding for 1–2 days after taking ECPs

\* Most do not last for more than 24 hours.

## What to expect after using ECPs?

There will not be any immediate signs showing whether the ECPs worked. The next monthly bleeding should come on time (or a few days early or late).

## Reasons to return to provider:

- If next monthly bleeding is more than 1 week later than expected
- Any time there is a problem or if either partner has been exposed to an STI

## Contraceptive methods after taking ECPs

- Now may be good time to begin a regular contraceptive method. COCs and POPs can be started the day after ECPs are taken.
- DMPA, IUD, and male and female condoms can be started on the same day as the ECP.
- For the implant, you must return after the next monthly bleeding.



**ECPs do not protect against STIs/HIV:  
To protect against pregnancy and STIs/HIV,  
use a condom every time you have sex.**

Have the client repeat this information back to you.

### SPECIFIC OBJECTIVE 9.3: DEMONSTRATE HOW TO COUNSEL ADOLESCENTS, INCLUDING YOUNG MEN, ABOUT CONTRACEPTION AND DUAL PROTECTION TO PREVENT STIs AND UNINTENDED PREGNANCY



#### TIME

1 hour 30 minutes



#### METHODS

- Role plays



#### MATERIALS NEEDED

- Participant Handout 9a: BCS+ Algorithm
- Participant Handout 9b: Contraceptive Cue Cards
- Participant Handout 9c: AYSRH Role Plays



#### STEPS:

- **Trainer's Note:** *Work with the youth trainer or another trainer. The two trainers should use role play to demonstrate examples of what constitutes "poor" counseling and an "improved" counseling process. It is essential to ensure the participation of youth trainers with different types of disabilities within the training. Accommodation should be provided as needed.*

#### Time: 10 minutes

1. Set up two chairs at the front of the room. Demonstrate a role play with your youth co-trainer of a "poor" counseling and an "improved" counseling experience for an adolescent client. The demonstration of a poor procedure should come first, followed by analysis and feedback.
2. When performing the *improved* counseling role play, apply the BCS+ method, so that participants can observe an example of how that approach should work.
3. Ask participants to analyze the demonstration and provide feedback on what was positive or negative, what was missing, and whether there was wrong or incomplete information presented.
4. After the trainer demonstration, divide the participants into small groups of 3-5 for simultaneous role plays. Keep the number of groups to a size where the trainer(s) can observe role plays easily by moving around the room. For example, if there is one trainer, divide participants into fewer, larger groups. If there are multiple trainers and youth trainers, divide the participants into groups of three.

#### Time: 1 hour 20 minutes

5. Ask the participants to perform role plays, using information from **Participant Handout 9c:** AYSRH Counseling Role Plays, **Participant Handout 9a:** the BCS+ Algorithm, and **Participants Handout 9b:** Contraceptive Cue Cards, and local IEC materials if available. Each participant should participate in three role plays and play each of the following roles at least once (more if the trainer feels a participant needs more practice):
  - Client



- Provider
- Observer

➤ **Trainer's Note:** *If an exam or medical procedure would normally be done when providing a contraceptive method, participants should announce to the observers what they would do if they were in the clinic (i.e. now I would take the Blood Pressure).*

6. Each participant is expected to participate actively in the role play process, as both a player and observer, and in group discussions and feedback.
7. Trainers should rotate groups after the first one or two role plays to get as many trainer observations of individual participants' counseling skills as possible.
8. **Observe and assess each participant** for both counseling content, process, and participation in the exercise.
9. Allow *actors/players* about **10 minutes** to prepare, limit each role play to **5 minutes**, and allow about **15 minutes** for feedback and analysis of the process and content.
10. **Encourage and guide the participants in using constructive critique**, analyzing what was good about the way the **counselor** handled the counseling and suggesting what could be improved.
11. Remind participants not to confuse the actual participant with the **actor's** role, and that feedback and critique must not be personalized.
12. The trainer's role during feedback/ discussion should be to stimulate, guide, keep up discussion, and end the exercise when time is up.
13. The trainer may wish to provide general feedback at the end of participant discussion.
14. Summarize the major points observed in the exercise and respond to participant questions with the entire group.

*PARTICIPANT HANDOUT 9C: ADOLESCENT AND YOUTH SEXUAL AND REPRODUCTIVE HEALTH ROLE PLAYS*

**Role Play 1:** A 19-year-old woman comes to the clinic because she had unprotected sex last night. She is worried about becoming pregnant. How will the clinician respond?

**Role Play 2:** A 16-year-old woman with a three-month-old baby who is breastfeeding wants to postpone her next pregnancy. Her sister uses combined oral contraceptives (pills) and likes that method very much. She says she wants to use pills. How will the clinician respond?

**Role Play 3:** A 17-year-old young man comes to the clinic because he is concerned about an itchy discharge from his penis. He reveals that he and his girlfriend are regularly having sex but are not using condoms. How will the clinician respond?

**Role Play 4:** A young couple accompanied by the husband's mother comes to see the clinician. The couple has been married three months. The mother-in-law insists that they should have a child – preferably a son -- as soon as possible. The young woman is still in school and appears to want to postpone pregnancy for at least two years. How will the clinician respond?

**Role Play 5:** A 19-year-old young man comes for an HIV test. He reveals that he has both a female partner and a male partner, and that he regularly has unprotected sex with each of them. How will the clinician respond?

**Role Play 6:** A 15-year-old unmarried adolescent girl with a physical disability comes to the clinic. She reveals that she is having sex with a boyfriend and she does not want to become pregnant. How will the clinician respond?

**Role Play 7:** A 17-year-old young man comes for information. He is being pressured by his friends to have sex with his girlfriend. His girlfriend is also starting to say that he is not a real man because he wants to wait to have sex. He is worried about pregnancy, but he also has strong sexual feelings for her. How will the clinician respond?

**Role Play 8:** A young couple comes to the clinic because the young man has a discharge and a burning sensation when he urinates. The young woman attends the clinic regularly to obtain injectable contraceptives, but says they are not using condoms because she is already using contraception. The clinician suspects that he may have gonorrhea or chlamydia. How will the clinician respond?

**Role Play 9:** A 15-year-old woman with Down Syndrome comes to the clinic looking for information on contraception as she is planning to have sex with her boyfriend. How will the clinician respond?

## UNIT 9 SUMMARY



### *TIME*

20 minutes



### *METHODS*

Feedback discussion



### *MATERIALS NEEDED*

None



### *STEPS*

1. Ask participants to reflect on everything they've discussed as part of this unit. In plenary, ask youth co-trainers to provide feedback to participants using the following questions:
  - Did this session and training accurately reflect the experiences of young people in seeking health services? Are there key differences that providers should be aware of? Anything specific related to the need of clients with disabilities?
  - What would you like to see change as a result of this training?