

Synthesis of WHO's recommendations on adolescent contraception

1) Definition of contraception:

Contraception allows people to prevent unintended pregnancies, attain their desired number of children and determine the spacing of pregnancies. Numerous contraceptive options exist and are listed in (WHO, 2015).

2) Rationale and epidemiology:

Significant numbers of adolescents give birth. Globally, the adolescent birth rate in 2015 was 44.1 per 1,000 adolescent girls aged 15 to 19 (WHO, 2017c). Very young adolescent females aged 10 to 14 had an estimated 777,000 births in 2016 (Woog and Kagsten, 2017). In 2015, 19.4 million births were among adolescents aged 15 to 19 but there were still 0.48 million births to girls younger than the age of 15 (GBD 2015 Maternal Mortality Collaborators, 2015).

There are high levels of unmet need for contraception and unintended pregnancies among adolescents. Of adolescents aged 15 to 19, 23 million have an unmet need for modern contraception and are at risk of unintended pregnancy. Among adolescents aged 15 to 19 about half of pregnancies are unintended (Darroch et al., 2016). *Adolescent pregnancy has negative health and social effects.* Adolescent pregnancy increases health risks for both the adolescent girl and her infant. Adolescent pregnancy may also prejudice the girl's future education and employment opportunities (Nove et al., 2014).

Maternal causes are a major contributor of mortality in adolescents. Maternal health remains a key cause of disease burden for adolescent girls (The Global Burden of Disease Child and Adolescent Health Collaboration, 2017) and in earlier data, maternal causes ranked as second among causes of death for girls aged 15 to 19 (WHO et al., 2015). In 2015, maternal mortality was highest for those aged 10 to 14 (GBD 2015 Maternal Mortality Collaborators, 2015).

3) Relevant WHO guidelines:

a) WHO guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries. 2011. Available from:

http://www.who.int/maternal_child_adolescent/documents/preventing_early_pregnancy/en/

These guidelines, which are specific to adolescents, have strong recommendations that include:

Policy:

- Advocate for adolescent pregnancy prevention among all stakeholders through interventions such as contraceptive counseling and service provision and the creation of supportive environments.
- Undertake efforts with political leaders and planners to formulate laws and policies to increase access to contraceptive information and services, including emergency contraception.

Community:

- Undertake interventions to influence community members to support access to contraceptives.

Health facility:

- Implement interventions to improve health service delivery to facilitate access and use of contraceptive information and services.

Individual:

- Offer and promote post-partum and post-abortion contraception through multiple home or clinic visits. Ensure contraceptive information and services, whether or not the abortion was legal.

Research questions from the guidelines specific to adolescents include:

Policy:

- Identify feasible and effective interventions to formulate laws and policies to increase access to contraceptive information and services.

Community:

- Identify and evaluate interventions that influence community members' support for access by adolescents to contraceptives.
- Identify feasible and effective interventions that aim to involve adolescent and adult males in decisions about contraceptive use by partners as well as by themselves with interventions to transform gender norms.
- Identify effective interventions to reduce pregnancy among girls under age 20.
- Evaluate the effect of employment and school retention on adolescent pregnancy.
- Evaluate the effectiveness of social support to reduce repeat pregnancies.
- Identify feasible and effective interventions to improve the availability of over-the-counter hormonal contraception.

b) WHO. Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations. 2014a. Available from:

http://www.who.int/reproductivehealth/publications/family_planning/human-rights-contraception/en/

These guidelines have adolescent-specific recommendations, which include:

- Provision of sexual and reproductive health services, including contraceptive information and services, for adolescents without mandatory parental and guardian authorization/notification.
- Eliminating financial barriers to contraceptive use by adolescents and other poor, marginalized populations.
- Interventions to improve access to comprehensive contraceptive information and services.

Additionally, these guidelines have recommendations that are not adolescent-specific but relevant to adolescents with the following topics:

- Non-discrimination in provision of contraceptive information and services.
- Availability, accessibility, quality and acceptability of contraceptive information and services.
- Informed decision-making, privacy and confidentiality, with participation and accountability.

c) WHO. Medical eligibility criteria for contraceptive use, Fifth edition, a WHO family planning cornerstone. 2015. Available from:

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

These guidelines, which are not specific to adolescents, assess the safety of each contraceptive method. The guidelines provide information on whether the contraceptive method creates additional health risks or whether health conditions affect the effectiveness or safety of the contraceptive method. All contraceptive options listed have similar safety profiles for adolescents as for adults with three exceptions:

- 1) *Male and female sterilization*, where it is noted that, “given that sterilization is a surgical procedure that is intended to be permanent, special care must be taken to assure that every client makes a voluntary informed choice. Particular attention must be given in the case of young people, nulliparous women, men who have not yet become fathers. All clients should be carefully counseled about the intended permanence of sterilization and the availability of alternative, long-term, highly effective methods. This is of extra concern for young people” (p. 232). Sterilization is a Category C i.e. caution should be used for sterilization for young women and men, as studies show that those sterilized at a young age later regret this decision.
- 2) *DMPA/NET-EN* for adolescents under the age of 18 as this contraceptive method is a 2 i.e. a condition where the advantages of using the method generally outweigh the theoretical or proven risks.
- 3) *Oral combined hormonal contraception*, especially those with low dose formulations, which have unknown risks of reduced bone mineral density (BMD) in later life, with the potential for increased risk of fractures. The quality of the evidence is low and no studies had evaluated the use of oral combined contraceptive use versus non-use in adolescents.

d) WHO. *Selected practice recommendations for contraceptive use. 2016. Available from:* http://www.who.int/reproductivehealth/publications/family_planning/SPR-3/en/

These guidelines, which are not specific to adolescents, include recommendations relevant to adolescents concerning how to use contraceptive methods safely and effectively once they are found to be medically appropriate, classification of exams and tests prior to initiation of contraceptive methods, contraceptive eligibility and programmatic implications for introducing guidelines into national programs. New clinical recommendations are listed for various contraceptive options.

e) WHO. 2017b. *Guidance statement: Hormonal contraceptive eligibility for women at high risk of HIV.*

This Guidance Statement, while not specific to adolescents, is relevant to adolescents who want to prevent pregnancy and who are at high risk of HIV acquisition.

f) WHO. *Consolidated guideline on sexual and reproductive health and rights of women living with HIV. 2017a. Available from:* http://www.who.int/reproductivehealth/publications/gender_rights/srhr-women-hiv/en/

These guidelines have recommendations specific to adolescents living with HIV, as well as recommendations relevant for adolescents living with HIV, which include:

- The need for adolescent friendly services
- Consider recommendations for which contraceptives can be used when a woman is asymptomatic or with severe or advanced HIV clinical disease and/or with which antiretroviral therapy.
- Provide access to integrated and tailored comprehensive sexual and reproductive health and HIV services.

4) What are specific adolescent issues?

Inform, educate and keep adolescents in school. An effective way to reduce adolescent pregnancy is to keep girls in school (WHO, 2011). Human rights bodies have called on states to ensure timely and affordable access to good quality health services, including for adolescents, delivered in a way that ensures informed consent, respects dignity, guarantees confidentiality (WHO, 2017a).

Build social understanding and support for contraceptive provision to adolescents. There is an urgent need to implement programmes that both meet the needs of adolescents and remove barriers to services (WHO, 2015).

Increase adolescent access to contraception. Age alone does not constitute a medical reason for denying any contraceptive method to adolescents (WHO, 2016).

Specific groups of adolescents may have particular needs. Adolescents living with HIV who suffer from food insecurity may be vulnerable to transactional sex and support for resources is needed to support their ability to make decisions and exercise their sexual and reproductive rights (WHO, 2017a). Adolescents living with HIV who inject drugs are in particular need of services which combine harm reduction with non-stigmatizing sexual reproductive health services (WHO, 2017a). Transgender adolescents need access to sexual and reproductive health information, in addition to nonjudgmental and non-stigmatizing services. (WHO, 2017a).

Additional data on adolescents is needed. There is a need to disaggregate data by age and sex and other factors and analyze this data in order to ensure equity and non-discrimination (WHO, 2014a), and acquire data on the SRH of adolescents aged 10 to 14 as many women report that their first experience of sexual intercourse occurred before age 15 (WHO, 2017b).

5) In addition to the WHO guidelines, five key documents:

- a) WHO, Population Council and UKAID. 2017. Family planning evidence brief, reducing early and unintended pregnancies among adolescents.
- b) WHO. Leading the realization of human rights to health and through health: Report of the High-level Working Group on the Health and Human Rights of Women, Children and Adolescents. 2017b. Available from: <http://www.who.int/life-course/publications/hhr-of-women-children-adolescents-report/en/>
- c) WHO and UNAIDS. A tool for strengthening gender-sensitive national HIV and Sexual and Reproductive Health (SRH) monitoring and evaluation systems. 2016. Annex 9: Sexual and reproductive health: gender analysis, a gender analysis of adolescent fertility in Senegal. Pp. 92-106.
- d) Population Reference Bureau. 2017. Youth contraceptive use: Effective interventions, a reference guide. Washington, DC: <http://www.prb.org/Publications/Reports/2017/Youth-Contraceptive-Use.aspx>
- e) USAID et al. ND. Global consensus statement for expanding contraceptive choice for adolescents and youth to include long-acting reversible contraception.

6) **Example of applying guideline as a story:** “I dropped from school because of unwanted pregnancy. I am a mother through very painful condition. I was 16 years, I gave birth at 17 years. I feel so bad for the young ones, the young girls. At least I counsel...I try to counsel them not to be like me” (Annet Nbizizi, volunteer, Reproductive Health Uganda, Mbale, Uganda on podcast from the Guardian, July 6, 2017).