Contraceptive Choices in adolescent

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Summary: **Choosing an approprate contraceptive for adolescents is a challenging task, influenced by many factors, discussed in this article. Oral contraceptives should be used with caution for very young girls. In them other methods are preferred till regular menstruation is established. After onset of regular menstruation OC pills may be prescibed since the social, medical and psychological consequences of pregnancy or abortion outweigh any physiological considerations. The possible long term sequelae still need further attention. A low dose combined pill should be chosen. Injectable contraceptive have the same side effects and the adolescent should be fully informed about possible delay in the return of fertility. Post-coital steroidal contraception should be made available for easy use, only as an emergency contraception. It may be publicised widely. Follow-up visit is essential to check that no pregnancy has occurred. Counselling about future contraceptive need is vital.**

IUCD are to be used with caution in those who have never had a child or have multiple sex partners. Younger adolescents are at greater risk of PID as they may have multiple sex partners.

Diaphragms are good for highly motivated adolescents, they must be adequately trained to use these contraceptives. Spermicide use along with diaphragm is recommended as this may be protective against STD\PID.

Condoms constitute one of the most suitable methods of contraception for this age-group. They are widely available. Their effective use requires motivation & adequate sex knowledge. Spermicide with barriers ensures high effectiveness & is protective against some STD|PID.

Withdrawal alone have high failure rates and require full information about the technique. Abstinence is difficult to use for those who have occasional sexual intercourse.

There is no one method which is ideal for all adolescents. Nor contraceptives can be ranked in a single order of preference. It is clear that all currently available methods of contraception have shortcomings, especially for this age-group individuals.

Adolescence = Time to grow up = A period of life of a not uniformly defined length of time. A period of life between puberty and adulthood.

Contraception = prevention of conception by any method.

Factors affecting adolescent contraception are

1. Maturity,
2. Attitude,
3. Experience,
4. Stability of the individual's background,
5. Social
6. Geographical area.

All these may result in different requirements among people of similar age and not age in isolation.

Although it can be presumed that most teenagers have some knowledge of contraception, the psycho-social factors may affect their ability to obtain & use it (Bury, 1986). Some will be quite mature and experienced, some naive and warranting special consideration. There is considerable political, legal & moral controversy regarding the provision of contraceptives for this age group & whether or not they should be advised or even given information on this issue. The important issue of how to provide good care to adolescent as they do attend for advice, information or even supply of contraception is side tracted. When they have chosen to attend, they are entitled to a hearing and to proper professional consideration of their problem. This is a very demanding aspect of reproductive health care in adolescent as some come for counselling, some come for information & some for prescription of a method before embarking on sexual intercourse. Their motivation to attend, as an insurance measure, is to be commended. Some started intercourse

without using a reliable method and are now looking forward for effective method and they should be helped.

Lord Fraser in his judgement stated that the girl's best interests require the doctor to give her contraceptive advise, treatment or both without parental consent. Contraception should be made more accessible to potential users, particularly the young, who are at great risk of unwanted pregnancy.

Opinion among teenagers & their parents is in favour of more sex education at school. He further stated that efforts should be directed towards providing young people with better education on sex & contraception.

Contraception is saving the lives of women around the world from the hazards of unwanted pregnancy. Optimal child-bearing is also contributing to infant & child survival. Contraceptive safety is a major public health concern. The risk \ benefit assessment will differ for different populations & even for the same individual at different period of life. In India, in 1991 increasing rate of teenage pregnancy remained a major social problem as well as a hazard. Apart from the consequences of early marriage in childhood, there is an increase in teenage sexual activity and teenage sex can be viewed either as a normal development \ transition from childhood to adulthood or a risky behaviour so natural to this age group people. It may be for a individual an establishing independence or a capacity of intimacy or rejecting \ objecting to social conventions or even a proof of poor socio - economic status. Promiscuity may also be due to direct \ indirect media effect, aggressive marketing of contraceptives on radio \ T. V. or other advertising technique.

It is known that when non-judgement attitude prevails or is wide spread, when there is easy access to contraceptive services, either free or at low cost for adolescent and when there is good comprehensive sex education during childhood, there is low rate of teenage pregnancy. Teenagers may see themselves as actors & may believe "it won't happen to me" (Elkind, 1978).

They may not be aware of their personal right as individuals or be ambivalent about contraceptive or their partners may object. Guilt or fear may persist. Sex education programmes do not in anyway increase the promiscuity of teenagers (Alan Guttmacher institute, 1969). Neither does the increased availability of contraception make teenagers have more sex(Zabin, 1979). Adolesents themselves decide when to have sex & whether to use contraceptive or not,according to the circumstances. Once the adolescents have decided to use contraceptive-irrespective of their marital status- the role of physician is to guide in her \ his decision & maintain strict confidentiality. In India approximately 50% of adolescents over the age of 15 years are married.

Proper counselling, relevant sexual history taking, thorough physical examination, comprehensive explanation, follow up schedule & availability of trained personnel to respond to question are essential pre requisites. Psychological, motivational, moral, religious & peer group impact must be evaluated, weighed & balanced before prescribing any method.

Internal examination like per vaginal or per speculum, may be carried out at the first or at subsequent visits, depending upon willingness or the need for such examination. Particular attention be paid to any symptoms suggestive of STD \ HIV.

Hofmann (1984) suggested that an ideal contraceptive for adolescents should be:-

1. easy to use, 2. inexpensive, 3. completely protective & reversible, 4. separate from the coital act and 5. involve no health risk. Such an ideal one is yet to be found.
   Methods available for adolescents are many, none is suitable for everyone. They may be NPI. Unaided contraception like i) coitus interruptus, ii) natural contraception. Both are not practical for adolescents
2. Mechanical contraception like barrier method-for male condom, and for female cervical cap, diaphragm or female condom (femidom).
3. Contraception with locally active chemical spermicide, these are widely used by adolescents, they have higher failure rates, but no side effects.

4. Hormonal contraception are either monophasic, minipills, sequential biphasic triphasic pills or injectable with or without inhibition of ovulation.
   The combined pill is very safe form of medication for young women. A difficulty which arises fairly often is remembering to take the pill regularly in the context of adolescent's life-style. They should be encouraged not to smoke. The relative risk of breast cancer for prolonged use of O.C's before the first full term pregnancy by young women in developed world is 2.5 fold. Therefore, they should get their breasts examined before & after therapy. It is best to prescribe the lowest does OC preparations consistent with effective contraception & good cycle control. Always emphasise the importance of their consistent use. Depot preparation of progestagen are attractive proposals for adolescents, they may lead to disturbed patterns of menstruation & may delay conception for a variable period of time and they must be warned of the same .
   Emergncy contraception may be advocated in some who, however must pay a follow-up visit.
5. Inhibition of spermatogenesis \ chemical local use of spermicidal agent may be favoured by some.
6. IUCD. In women with monogamous relationship there appears to be no increase in PID, particularly those using Copper \ Silver bearing device. In others, it is associated with increased rates of pelvic infections & this is important in women who have never been pregnant or have multiple sex partners. IUCD is not the first method of choice in most adolescents.

Oral contraceptive pills and condoms with their known limitation come close to ideal contraceptive for adolescents. OC has advantage of dissociation from sex act & are very reliable Condoms, male and female, offer protection against STD \ HIV. A high degree of motivation is essential for both methods, which many adolescents lack. Spermicide impregnated sponges may be an alternate method.

IPPF records "One of the outstanding features of fertility today is the very high pregnancy rate among women under 20 years of age in all countries all over the world, both developed and developing. It appears that provision and use of contraceptives has not kept pace with sexual initiation. The resultant high pregnancy rates constitute a major risk for health and for the social well being of the younger women & their children." This study further states "growth of long bones and the functioning of reproductive tract is unaffected from the use of hormonal contraceptives at a younger age. It is important to protect the young women from unwanted pregnancy at this time." It has been found that contraceptives are more likely to be used effectively and adolescent pregnancy rates can be lowered in them.

Contraceptive service provided for young women can overcome or mitigate some of the difficulties adolescents seem to have in using contraceptives. Such services need to be provided separately from the general family planning clinics & need rather more resources and their approach of course, must be tactful.

Conclusion

IMAP (International Medical Advisory Panel) statement on choice of contraception for adolescents must be adhered to & be followed :-
No single method of contraception can be considered satisfactory for adolescents as a group.
Individual adolescent must be evaluated carefully considering the following:-
Personal, cultural, & environmental factors.
Sexual habits like frequency & number of sex partners.
The risk of infection and particularly STD \ AIDs \ PID
The risk of pregnancy or its termination
Medical contraindications.
Availability or else of back-up MTP services

Editors Note :
Due to the said demise of Dr. M. Y. Raval a few days after submitting this article, we were unable to get the list of references. However we are sure his article will give a lot of insight into this topic