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Contraceptive options for women in selected circumstances

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Young women under the age of 16 years require special consideration when requesting contraception. Such young women can give voluntary consent, which enables prescription and supply providing that the practitioner has determined that the minor is sufficiently mature to understand the details of the method and its use. All reversible methods may be appropriate but it is necessary to provide information in a form that is fully understood.

For women with pre-existing medical conditions including obesity, the benefits and risks of the use of individual methods needs to be weighed against the risks of pregnancy for that woman.

In developed countries, the median age of young women at their first intercourse is 16 years with 20–30% reporting sexual intercourse before the age of 15 years.[1] Early age at first intercourse is significantly associated with pregnancy under 18 years. Comprehensive sex education, which includes information about all contraceptive options and their optimal use is essential. Services for young adolescents need to be confidential, youth friendly and culturally appropriate with time allocated for development of rapport and to address contraceptive, sexuality and broader health issues.

Consent

Any competent young person, regardless of age, can give voluntary consent to medical treatment. [2] Young people under the age of 16 years must have sufficient understanding and maturity to fully comprehend the contraceptive options available and the benefits, risks and consequences of using the proposed method. Ideally, young women should be encouraged to inform parents or allow the clinician to do so. If this is not possible, then the clinician must assess the competency of the young woman to make the decision, the likelihood of intercourse continuing with or without contraception, whether

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her physical or mental health could suffer if contraception was withheld and if it is in her best interests to provide contraception without parental consent.[2]

In recent years, the number of contraceptive options available has increased but very young women are not being given the option of choosing methods other than condoms or the combined oral contraceptive pill.[3] Both the World Health Organization Medical Eligibility Criteria (WHO MEC) 2009[4] and guidelines from the Faculty of Family Planning and Reproductive Health Care (FFPRHC) 2009[5] state that age should not act as a barrier to any reversible contraceptive method for young adolescents. Individual health factors, contraceptive needs and wishes as well as lifestyle, pregnancy and sexually transmitted infection (STI) risk need to be taken into account when assisting young people in choosing a method. Insistence on intrusive examinations that is, breast, pelvic examination or Pap smear can be a barrier to young women accessing contraception. Careful history taking to exclude contraindications is sufficient to ensure safe provision.

Condoms

Condoms protect against pregnancy and STIs, require no medical or parental involvement, are readily available, relatively inexpensive, safe, easy to use and have no systemic effects. Contrary to prevailing beliefs, condoms have low breakage and slippage rates estimated to occur in 1.6–3.6% of coital acts[6] and a pregnancy rate of 2% for perfect use and 15% for typical use.[7] Although an ideal method for adolescents, who are more likely to have short serially monogamous relationships,[8] very young adolescents are less likely to use condoms consistently. Most failures occur from inconsistent use.

Polyurethane condoms are thinner, looser, conduct body heat better and can be used with oil-based lubricants. A Cochrane review (2006)[9]concluded that although they were associated with a higher rate of clinical breakage, they were still a feasible alternative for people with a latex allergy, although contraceptive efficacy required more research.

Both sexes should receive counselling about condoms, prevention of pregnancy, STIs and negotiating condom purchase and use. Instruction in correct condom use is essential as failure rates are highest in the first months of use.

Adolescents who choose to use hormonal contraceptives should be aware that these methods do not protect against STIs and are encouraged to use condoms as well if they change partners or have multiple partners.[10]

Combined oral contraceptives

Combined oral contraceptives (COCs) should not be prescribed prior to menarche. Smoking is not a contraindication in young women. There has been concern about a possible increased risk of breast cancer in women starting COCs before age 20 and continuing for more than 8 years. A large population-based study recently demonstrated no overall relationship between COC use and breast cancer, including starting before age 20, duration of use, hormonal dose and positive family history.[11]

Acne is a major problem for many young women. A Cochrane review[12] found that COCs reduced acne count lesions, severity grades and self-assessed acne compared with placebo. However, differences in the comparative effectiveness of COCs containing different progestogens were less clear. For women with mild-to-moderate seborrhoea or acne, any low-dose oestrogen-dominant COC can be used. Monophasic preparations of EE 30 μg plus norgestimate, desogestrel or gestodene are preferable for the 10% of women in whom acne deteriorates with levonorgestrel combinations. In recalcitrant or severe acne, preparations containing an anti-androgenic progestogen are indicated.

Since only 26% of adolescents 14 years and under take their pill daily compared to 40% in other age groups, they require careful counselling about starting their pill, taking it regularly, how to ensure they do not forget and how to deal with missed pills.[13] They should understand that nausea, breast tenderness and breakthrough bleeding (especially if they miss pills) are common in the first few cycles and encouraged to persist for 3 months until their pill use is reviewed.