How contraception nurses can improve teenage sexual health

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The rising incidence of unwanted pregnancies and sexually transmitted infections among teenagers has made teenage sexual health a government priority. Contraceptive nurses can play a key role in advising young people about sexual health issues and contraception. This article discusses the factors affecting teenage sexual activity and how nurses can help young people take responsibility for their sexuality.

Reducing the number of pregnancies and sexually transmitted infections (STIs) among those aged under 16 is a government priority due to rising numbers of both (Department of Health, 1999; 2001; Social Exclusion Unit, 1999). Contraceptive nurses have a key role as they are in a unique position to give clients the opportunity to talk about intimate areas of their sexual life and anxieties in a non-judgemental environment (Everett, 1998).

Unwanted pregnancy and STIs

Each year in England nearly 90,000 conceptions occur among teenage girls, of whom approximately 7,700 are under 16 years of age and 2,200 under 14. Approximately 60 per cent (56,000) of teenage conceptions result in live births (SEU, 1999). The incidence of STIs has increased in 16–19 year olds in recent years. Between 1995 and 1997 the incidence of chlamydia in this group increased by 53 per cent. In 1997–98, gonorrhea infection increased by 52 per cent in males and 39 per cent in females compared with the previous year. The government aims to halve conceptions in under-16s by 2010 (DoH, 1999) and to reduce the incidence of HIV infections and other STIs (DoH, 2001).

The SEU (1999) has developed an action plan to improve general understanding of sexual health issues. The plan targets a number of at-risk groups:

- People under 25 years old;
- People aged 25 and over with new sexual partners;
- People with two or more sexual partners during the previous 12 months;
- People using non-barrier methods of contraception;
- People who already have an STI.

Sexuality and young people

Young people are exploring their sexuality increasingly early in their lives, and one-third of those under 16 in the UK are now sexually active (SEU, 1999). There are numerous reasons why sexually active young people are vulnerable to unwanted pregnancy and STIs, some of which relate to factors in their lives, and others to access to family planning and contraceptive services.

Lack of educational achievement can lead to low self-esteem, poor job prospects and fear for the future, giving young girls no reason to avoid pregnancy (SEU, 1999). Acheson (1998) found that low educational achievers are likely to leave school with no qualifications and are 40 per cent more likely than others to be teenage mothers.

Ignorance has a major effect on contraceptive use among teenagers (SEU, 1999). Winn et al (1995) found that many young people, particularly boys, know little about reproduction, contraception and how to access family planning services.

However, Marie Stopes International (2000) argues that many teenagers understand contraception but do not know where to access advice and help, whether it is legal to obtain the pill at 16, how to use condoms, and how to say ‘no’ to sex. They also believe sexual myths, for example that they cannot get pregnant the first time they have sex or if they do it standing up.

Young people want to be accepted by their peers, and this can lead them to binge-drink, abuse drugs and have unprotected sex (Sutherland, 1997; Family Planning Association, 2003), making them vulnerable to pregnancy and STIs.

Fear about their confidentiality being breached is one of the reasons why young people do not access contraceptive services (Mackereth, 1998). Hadley (1998)
deduced that this is a major reason why only 1 in 10 of those who are sexually active and aged under 16 visit a family planning clinic. They do not realise that confidentiality can only be broken in exceptional situations, such as when their health, safety or welfare may be at risk (RCGP and Brook, 2000).

Young people who do not have secure accommodation are also vulnerable (Sex Education Forum, 1999). Low self-esteem in homeless young people can mean they do not believe they have the right to decline sex or do not have the confidence to access services.

Sexually transmitted infections

Between one-third and one-half of teenagers do not use contraception in their first experience of intercourse (SEU, 1999), putting them at risk of STIs.

In a single act of unprotected sex with an infected partner, teenagers have a one per cent risk of acquiring HIV, a 30 per cent risk of contracting genital herpes and a 50 per cent risk of contracting gonorrhoea (MSI, 2000). Contraceptive nurses can help young people to protect themselves by educating them about STIs, their signs, symptoms, treatment and how to access it, and the complications that can occur in men, women and even neonates if STIs are left untreated (Duncan and Hart, 1999; Stevens, 2000).

Young people also need to understand that some STIs, such as chlamydia, may be symptomless or result in non-specific symptoms (Box 1) (Stevens, 2000). Some 50 per cent of men and 70 per cent of women with chlamydia are asymptomatic (Stevens, 2000).

A self-screening programme for chlamydia is available to sexually active people aged 15 and under, and can be repeated as often as required (DoH, 2003). Clients are given a package with a specimen kit and instructions on how to take their own specimen. Those who test positive must be advised to abstain from all sexual contact while waiting for their result (McLean and Keane, 2000).

Contraception negotiation

Teenagers need to be aware of the possible consequences of unplanned pregnancy and be given information on all methods of contraception.

They should also be made aware that only condoms offer protection against STIs, while girls who use the Pill should be advised to use the ‘Double Dutch’ method, in which their sexual partners use condoms. This not only gives both partners protection against STIs but also ensures boys take responsibility, rather than leaving it as a female-only concern (MSI, 2000).

Nurses should teach both boys and girls how to use condoms, ensuring they know that they should squeeze air from the tip of the condom before application, hold the penis when withdrawing after sex to prevent semen spillage and avoid oil-based lubricants (DoH, 2003).

All information should be backed up with up-to-date leaflets. Girls should be encouraged to carry condoms, and to see it not as an indicator of promiscuity, but as good sexual health practice (MSI, 2000).

Contraception for the under-16s

Most agencies offering information, advice or services on sexual health to under-16s use the Fraser Guidelines (DHSS, 1986) as a framework for best practice. These are summarised in Box 2 (p36). New guidance has been issued by the DoH (2004), highlighting for the first time that where a young person under 16 years of age requests contraception, doctors and other health professionals should give him or her the time and support to make an informed choice.

Although the Fraser Guidelines were issued immediately after the House of Lords judgement in the Gillick case, and are now almost 20 years old, the new guidance does not change the legal framework established in the Gillick case – that health professionals are justified in giving confidential contraceptive advice and treatment to under-16s, provided certain conditions are met. The Royal College of General Practitioners and Brook (2000) advise that young people being exploited or abused may need counselling. Nurses should always ask young people whether sex is consensual and who and what age their partner is, and are advised to look out for signs of coercion, exploitation or abuse (DoH, 2003).

Young people may disclose abuse by family members or friends to nurses (DoH, 2003). In such cases it is vital to follow child protection protocols and involve the young person in the process of informing the necessary authorities (DoH, 1999).

Since very young people do engage in sexual activity, whether consensual or not, it is preferable to make services open to all ages (DoH, 2003). It is helpful for nurses to explore with them the benefits of waiting, and to explain the detrimental effects of early sexual intercourse, pregnancy and STIs (SEU, 1999).

### Box 1. Symptoms of Chlamydia

- Menstrual changes – intermenstrual bleeding, post-coital bleeding, breakthrough bleeding while using hormonal contraception
- Changes in vaginal discharge
- Deep dyspareunia
- Dysuria
- Urethral discharge (usually in male patients)
- Rectal pain
- Sore throat
- Mucopurulent cervical discharge
- Friable cervix
- Contact bleeding during cervical cytology sampling

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**References**


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Health care professionals have a duty of care and confidentiality to all their patients. They can therefore provide contraception, sexual and reproductive health advice and treatment to young people aged under 16 without parental knowledge or consent, provided:

- They understand the advice and its implications;
- The advice or treatment is in their best interests because their physical or mental health would otherwise be likely to suffer.

The duty of confidentiality is not absolute, however. Where a health professional believes that there is a risk to the health, safety or welfare of a young person or others that is so serious as to outweigh the young person’s right to privacy, they should follow agreed child protection protocols. In these circumstances, the overriding objective must be to safeguard the young person.

When a young person under 16 asks for contraception, professionals should establish a rapport, give support and enable the young person to make an informed choice by discussing:

- The emotional and physical implications of being involved in sexual activity;
- Whether the relationship is consensual or whether there may be coercion or abuse;
- The benefits of informing their GP and confiding in their parents or carers.

The duty of confidentiality owed to people under 16 is the same as that owed to adults. If services are not available for the under-16s, there should be arrangements in place for them to be seen urgently elsewhere.

If young people refuse to inform their GP and/or parents and carers, this decision should be respected. In the case of abortion, if a young woman is competent to give informed consent and refuses to involve her parents or carers, she should be helped to find an adult family member or specialist youth worker to provide support. She should also receive any additional counselling she requires (DoH, 2004).

**Other factors affecting sexual health**

Many parents – particularly fathers – find it difficult to discuss sex with their children (MSI, 2000; SEU, 1999). However, mother-adolescent discussion before the first sexual encounter greatly increases the probability of condom use and may defer the onset of sexual activity. The SEU (1999) action plan calls for professionals to educate parents on discussing sex and relationships with their children. Nurses could develop groups of parent educators who can support others.

Allen and Bourke (1998) revealed that the partners of teenage mothers had an average age of 23; a third were low educational achievers, were without jobs and were likely to have come from one-parent families. Most young men have their first sexual experience between 14 and 17 years of age. They are often motivated by a desire to lose their virginity, a perception that their male peers are sexually active and because they see sexual activity as giving them kudos within their peer group (Gleeson and Wilcox, 2003).

Nurses need to provide practical resources and relevant services to young people from ethnic minorities and other groups that have been identified as poor contraceptive service users (Yamey, 1999). This includes providing interpreters and information in languages other than English where appropriate. Vulnerable groups such as ‘looked-after’ and homeless children, those with disabilities and those in seclusion should also have access to sexual health education (SEU, 1999).

It is important to consider the impact of cultural and religious influences, as well as practices such as female genital mutilation.

Nurses should be able to identify young people experiencing psychosocial problems such as rape trauma, dyspareunia, dry vagina, loss of libido and premature ejaculation by observing their non-verbal communication, and encourage them to discuss their problems.

If appropriate, nurses can then screen teenagers for infection or refer them for counselling, support or treatment. It is also the nurse’s role to advise young people to respect other people’s sexuality (DFEE, 2000).