



Essentials of adolescent sexual and reproductive health

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Key points

- Sexual activity is prevalent in adolescence.
- Knowledge of sexually transmitted infections is generally poor among adolescents.
- Delaying age of first sexual intercourse helps to reduce risk.
- Helping adolescents to use contraception, and to use contraception correctly, is essential in teenage pregnancy prevention.
- Adverse outcomes of adolescent birth can be minimised if high-quality support and care are provided.
- Effective sexual history taking is the cornerstone of a proactive approach to adolescent sexual and reproductive health promotion.

The general practitioner has an important role in promoting sexual health in adolescents. A proactive approach with high-quality support is essential.

Sexual activity in adolescence is a normal experience. The National Survey of Secondary Students and Sexual Health (SSASH) collected data from Australian adolescents every five years starting in 1992.¹ The results show that young people are starting sexual activity at a younger age than in previous generations. Most recently in 2013, 69% of secondary school students in years 10 to 12 (about aged 15 to 18 years) reported some sort of sexual activity; with about 34% reporting vaginal intercourse.¹

ADOLESCENT SEXUAL BEHAVIOUR AND EXPERIENCE

For most teenagers sexual activity is a positive experience; however, for a small number of teenagers it can lead to adverse health, emotional and psychological consequences. Teenagers are

not always well informed about the risks of sexual activity and when they are well informed they do not always personalise this information.

Knowledge of sexually transmitted infections (STIs) is generally poor among adolescents. For example, less than a quarter of adolescents in years 10 to 12 know that human papilloma virus (HPV) causes genital warts or that HPV can affect men.¹ Teenagers do not always protect themselves from sexual risk; in the most recent SSASH, 30% of sexually active adolescents reported not using a condom the last time they had sex,¹ and only 43% reported 'always' using a condom in the past year. Almost one quarter of year 10 students reported having had unwanted sex, with alcohol intoxication cited as the most common reason for having unwanted sex.¹

Sexting is also widely prevalent in this generation of young people, with more than half of

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all students in years 10 to 12 reporting having received a sexually explicit text message. Of sexually active adolescents, one half have sent a sexually explicit nude or nearly nude image of themselves and 70% have received such a photo or video.¹

THE ADOLESCENT CONSULTATION: TAKING A PROACTIVE APPROACH

Effective sexual history taking is the cornerstone of a proactive approach to adolescent sexual and reproductive health promotion. Adolescence is characterised by the need to belong in a peer group and by a developing ability to regulate strong emotions and desires. Adolescents are vulnerable to peer pressure and health risk behaviour is common. Therefore, every consultation with an adolescent should be seen as an opportunity to minimise sexual health risk; performing frequent risk assessments and acting appropriately on information provided can minimise sexual health risk. Doctors report that one of the main barriers to sexual history taking is perceived embarrassment for the patient;² thus overcoming this perception on the part of the GP is the first step in taking an effective sexual history. It should be noted that young people report high levels of trust in their GP, but only 30% of young people report doctors as a source of sexual health information.¹

Before starting with sexual history taking, it is important to begin with a screen for health risk and protective factors. Sexual health risk factors tend to co-occur in adolescence³ and include low self-esteem, a sense of hopelessness, poverty, poor academic performance, absence of positive role models, a family history of health problems, family separation and discord, and substance use.⁴ Factors that protect against risky sexual behaviour include good health, connectedness to a parent(s) or other significant adult, effective schooling, high aspirations with adult support and motivation to access resources.⁴ The HEADSS (Home, Education, Activities, Drug use, Sexual behaviour, Suicidality) assessment is a useful screening tool that can be used for adolescent health risk assessments (Table).^{5,6} History taking in this

context is often most effective when performed in a casual, nonconfrontational way with an understanding of confidentiality clearly stated. A thorough HEADSS assessment, including setting up confidentiality, also helps to establish the doctor–patient relationship on a basis of trust. This process lays the foundation for effective sexual history taking.

Confidentiality

When undertaking a consultation with an adolescent, a secure environment in which the adolescent feels comfortable to seek help and discuss sensitive matters is beneficial. A high percentage of adolescents will refrain from seeking medical advice about sexual health matters if they are concerned that their parents may find out. Therefore, adolescents should be routinely seen on their own.

A clinician should always consider starting consultations by informing adolescents about their right to confidentiality that will be adhered to, except in extraordinary circumstances such as disclosure of intention to self-harm or harm others. The right to confidentiality limits what the clinician can disclose to parents; however, in the interests of a trusting and cooperative relationship with parents, as well as the patient, all reasonable attempts should be made to encourage adolescents to be honest and open with their parents.

There is a caveat to confidentiality: the possibility of sexual abuse or assault must be considered if an adolescent has had a sexual relationship with an older person. Sexual activity under the age of 16 years is commonplace, despite the law regarding the legal age of consent.

Consent

The age at which an adolescent is legally considered old enough to make decisions about medical treatment varies from state to state, and clinicians should familiarise themselves with laws in the state where they practice. As a general rule, adolescents can make decisions about their health care when they are assessed by a medical practitioner

to be ‘Gillick competent’.⁷ Gillick competency in minors is determined as follows: ‘... whether or not a child is capable of giving the necessary consent will depend on the child’s maturity and understanding and the nature of the consent required. The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent’.⁸ It should be noted that in general a minor cannot provide consent to special medical procedures (e.g. sterilisation) or refuse lifesaving treatment.

The Fraser Guidelines, arising from the concept of Gillick competency, have particular bearing on contraceptive advice: ‘...a doctor could proceed to give advice and treatment provided s/he is satisfied in the following criteria:

- that the girl (although under the age of 16 years of age) will understand her/his advice
- that s/he cannot persuade her to inform her parents or to allow her/him to inform the parents that she is seeking contraceptive advice
- that she is very likely to continue having sexual intercourse with or without contraceptive treatment
- that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer
- that her best interests require her/him to give her contraceptive advice, treatment or both without the parental consent’⁹

The assessment of competency can be challenging, in particular with young adolescents, so good medical note keeping is important and a second opinion from a colleague may be required if uncertainty exists.

The same principles that constitute valid consent for any medical procedure also apply to abortion in young women under 16 years of age, although in some states parental consent is required or the dependant minor must obtain a court order from the Children’s Court to waive this requirement.¹⁰

Consent for abortion is only valid if the person is competent to give consent, and if the consent is given voluntarily – that is, without any coercion. Seeing the adolescent alone may be essential to obtain valid informed consent as some adolescents may wish to continue their pregnancies, but may be coerced to terminate by partners, relatives or the social context in which they live. If pregnancy termination occurs as a result of coercion, then feelings of regret and mental health disturbance as well as repeat pregnancy are not uncommon.

It is worth noting that misinformation and myths about abortion abound. Therefore, the clinician should check that the young woman understands the nature of the procedure, the risks involved and whether she truly wants to terminate the pregnancy. For example, the adolescent must be aware that financial and social support for pregnant and parenting teenagers exists and she should be provided with this information.

CONTRACEPTION

Motivating sexually active adolescents to use contraception, and to use contraception correctly, is essential when discussing pregnancy prevention. Doubting the need for contraception or having concerns about the side effects are common.^{11,12} Less than half of adolescents who conceive used contraception, with three-quarters of pregnant adolescents not intending to become pregnant.^{13,14}

Before hormonal contraception is prescribed to adolescents, contraceptive counselling should be given and couples should be encouraged to attend together.¹⁵ Contraceptive options available include condoms, the oral contraceptive pill, long-acting contraception (such as contraceptive implants), and the emergency contraceptive pill (ECP; now available over the counter in pharmacies). That young adolescent women are the most frequent users of the ECP in Australia¹⁶ reflects the unplanned nature of adolescent sexual encounters and pregnancies. The ECP is safe and if taken early is reasonably

TABLE. HEADSS ASSESSMENT^{6*}

Topic	Possible opening lines
Home and environment	Where do you live and who lives there with you?
Education and employment	Are you in school? What are you good at in school? What is difficult for you? What grades do you get?
Activities	What do you like doing most? What things do you do with friends? What do you do with your free time?
Drug use and abuse	Many young people experiment with alcohol or cigarettes. Have you or your friends ever tried them? What have you tried?
Sexual behaviour	Are you, or have you been, involved in a relationship? How is/was that experience for you?
Suicidality and depression	How do you feel in yourself at the moment on a scale of 1 to 10?

* For more information, see The Royal Australasian College of Physicians website: <http://www.racp.edu.au/index.cfm?objectid=B56658DA-08B2-14E3-0EE26F1635D1314E>⁶

effective. All adolescents should be made aware of this option.

Long-acting contraceptives are safe, relatively inexpensive and remove the risk of missed pills. They are highly effective in the prevention of rapid repeat adolescent pregnancy^{13,14} and are the most appropriate contraceptive option for many adolescents.¹⁵ However, irregular bleeding is a common but poorly tolerated side effect.

Contraceptive methods that are coital-dependent, such as condom use, and contraceptive methods that require daily action, such as the oral contraceptive pill, have higher failure rates than methods that are administered less frequently.^{13,14} Condom use is inconsistent among Australian adolescents.¹⁷ Research suggests that many young Indigenous women lack the confidence and negotiation skills to communicate with their partners about condom use.¹⁸

PREGNANCY IN ADOLESCENCE

The human costs and economic impact of teenage pregnancy are high.¹⁹ In 2011 in Australia, there were 11,344 births to mothers aged 19 years and under.⁸ Teenage fertility (births to teenage mothers) was 15.5 babies per 1000 young women in 2013, a higher rate than in many developed

countries. The annual number of teenage pregnancies in Australia is more than 20,000 with about half of these ending in abortion.²⁰ Indigenous adolescents are particularly at risk of teenage pregnancy, with a fertility rate for young Indigenous women of 69 babies per 1000, more than five times that for young non-Indigenous women (13 babies per 1000).⁸

The negative outcomes associated with teenage births can to a large extent be ascribed to the adverse environmental context in which these pregnancies commonly occur.^{21,22} An adolescent mother is more likely to have lower self-esteem and/or depression, be using illegal substances, have lower educational attainment and/or be living in poverty.²³ Pregnant and parenting adolescents can also experience high levels of intimate partner violence.²⁴ Children born to adolescent mothers are at higher risk of:

- becoming adolescents of lower educational attainment
- having lower income levels later in life
- having mental illness and/or substance abuse problems
- becoming adolescent parents themselves.^{25,26}

Early age of first intercourse increases the risk for unintended pregnancies.²⁷

Therefore, prevention efforts aiming to delay first sexual intercourse in at-risk teenagers, although challenging, are important.²⁸ In addition, more than 50% of adolescent pregnancies occur within six months of first sexual intercourse,¹⁵ reinforcing the need for access to effective contraception, even before first intercourse. Younger age at first sexual intercourse is also associated with a range of high-risk behaviours, such as inconsistent use of contraceptives,^{29,30} alcohol and illicit substance use, and unwanted sexual activity.¹¹ Evidence suggests that 60% of Australian adolescent mothers used alcohol before they conceived.¹³ Therefore, effective contraception use must be evaluated in sexually active young teenagers.

About half of teenage pregnancies are terminated, which is higher than in any other reproductive age group. This reflects the unplanned nature of adolescent sexual

encounters and pregnancies, the adolescent's attitudes and beliefs about pregnancy,³¹ and the social and demographic context in which the pregnancies occur. Adolescents may be misinformed about abortion and not empowered to make informed decisions.³² Ideally, all unplanned pregnancies should be prevented; however, when they occur informed consent is imperative because pregnancy termination is not without risk and is not the right option for all teenagers.

PREGNANCY MANAGEMENT

As important as pregnancy prevention is in adolescents, the occasional adolescent patient may wish to become pregnant. Encouraging the adolescent to consider the impact that pregnancy may have on her and her family may be beneficial, but for the female adolescent who strongly feels that she wants to become a mother, ensuring

that she understands and can access good prenatal care may be more appropriate.¹⁵

Adverse health outcomes may be minimised if high-quality support and care are provided.³³ Comprehensive, multidisciplinary support for teenage mothers before and after pregnancy is associated with markedly improved long-term outcomes for both the mother and the child.³³⁻³⁵ Comprehensive services can help adolescents to meet their social, economic, health and educational needs.²³ Continuing education can significantly diminish the risk of welfare dependence³⁴ and the intergenerational cycle of teenage pregnancy. In addition to offering medical care, services offered to pregnant adolescents should include social support, mental health services, parenting classes and methods to connect with each other.³⁶

To achieve improved pregnancy outcomes for adolescents, support should be

delivered in culturally sensitive, developmentally appropriate ways.²³ Effective support services can be school based,³⁷ community/home based or healthcare related. For example, home visitation by a nurse or midwife, in the antenatal and postnatal period for up to two years, can also improve outcomes for the mother and child.³⁸

Comprehensive support services for pregnant adolescents are not available everywhere in Australia. Where referral is not an option due to geography or distance, the motivated individual clinician can potentially make a difference by developing and/or co-ordinating pregnancy care for their young patients with available local expertise and goodwill.

SEXUALLY TRANSMITTED INFECTIONS

Young people are disproportionately affected by sexually transmitted infections (STIs) most notably with human papillomavirus, *Chlamydia trachomatis* and herpes simplex types I and II. Most of these infections are asymptomatic and go undetected; however, all can cause clinical disease and complications. Chlamydia can cause pelvic inflammatory disease, chronic pelvic pain and infertility and is the most common notifiable disease in Australia.³⁹ Chlamydia notifications have been increasing over the past two decades and continue to climb. In 2012, chlamydia incidence was 355.1 per 100,000 people, a 34% increase from 2008.⁴⁰ As most chlamydia infections are asymptomatic, current recommendations from the RACGP are to offer opportunistic screening and annual screening to sexually active women aged 29 years and under.⁴¹

All adolescents should be fully vaccinated against human papillomavirus and hepatitis B (both offered free in the national school immunisation program) well before they start sexual activity, or as soon as possible after onset of sexual activity. Although the delay of sexual activity is desirable in terms of STI prevention, it must be anticipated that many adolescents will become sexually active in their school years. Therefore sexually transmitted disease prevention ideally should be discussed in all consultations with

adolescents. To prevent the transmission of STIs, the use of condoms during all instances of penetrative sex should be encouraged, even when other forms of contraception are used. Adolescents should also be advised to think ahead and make sure that condoms are available when needed. This process of preparation can be challenging for some adolescents for developmental reasons and so easy access to condoms (for example, free condoms in clinics, at school and at home) may be helpful to adolescents.

EMPOWERING ADOLESCENTS TO MAKE HEALTHY RELATIONSHIP CHOICES

Adolescent sexual behaviour is influenced by the developing brain, which increases reward seeking (especially in the presence of peers). In addition, impulse control is not mature resulting in a reduced ability to modulate strong emotions and motivations.^{42,43} Young people benefit from support, guidance, caring and monitoring from responsible adults, rather than being left to deal with complex social situations alone or solely with peers.^{42,43} Parents of adolescents should be encouraged to focus on harm minimisation, where opportunities for immature judgement to harmful consequences are minimised, such as limit setting.⁴⁴ Where possible, the relationships between adolescents and their parents should be nurtured, because prosocial bonding (connection with parents and other adults) is conducive to improved sexual health outcomes in adolescents.^{45,46}

Adolescents should be encouraged to proactively identify potential situations where they may be putting themselves at risk and think about ways to avoid such situations. The GP has a role in providing adolescents with information and motivation and, where possible, instilling self-confidence and resilience to enable the adolescent to make healthy choices.⁴⁶

Finally, in the current cultural environment where adolescents can often feel that they are expected to be sexually active, there is a critical need for adults in positions of influence – for example, teachers and doctors – to give adolescents very direct

guidance that they are not expected to be sexually active, and that there are many sound medical, emotional and psychological reasons for delaying sexual activity.

CONCLUSION

The GP can play a central role in preventing harm and improving outcomes for adolescents. Risk assessment can be done using the HEADSS tool. STIs can be reduced and pregnancy prevented by applying strategies to delay first sexual intercourse and by ensuring timely and appropriate contraception advice. Pregnancy is best prevented, but pregnancy outcomes can be greatly improved by facilitating the provision of adequate pregnancy support. To optimise effectiveness, GPs need to be well informed about adolescent sexual and reproductive behaviour and health and have a proactive approach. **MT**

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A list of references is included in the website version (www.medicinetoday.com.au) and the iPad app version of this article.

COMPETING INTERESTS: Dr Schultz: None.

Associate Professor Skinner has received funds to reimburse travel to conferences and grants for researcher-initiated projects from GlaxoSmithKline Australia and GlaxoSmithKline Biologicals, Belgium and CSL Biotherapies.

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