Sexual health in young people

Harriett Latham-Cork

Charlotte Porter

Fiona Straw

Abstract

Sexual health encompasses 'sexual development and reproductive health, as well as the ability to develop and maintain meaningful interpersonal relationships; appreciate one's own body; interact with both genders in respectful and appropriate ways; express affection, love and intimacy in ways consistent with one's own values'. The 2008 World Health Organisation (WHO) consensus statement also noted that, 'responsible adolescent intimate relationships' should be 'consensual, non-exploitative, honest, pleasurable and protected against unintended pregnancy and sexually transmitted infections (STIs) if any type of intercourse occurs'. Young people (YP) must, therefore, be able to access sexual health information and services that meet their needs.

Such is the importance of improving sexual health that, in February 2017, the United Kingdom (UK) Government proposed "age appropriate" sex and relationship education (SRE) to be a compulsory element, and thus a legal requirement, of the national curriculum in both primary and secondary schools via amendment of the Children and Social Work Bill. This article gives an overview of the important aspects of sexual health in young people living in the UK in the 21st century and provides important context for healthcare practitioners who work with young people. It discusses sources of information, confidentiality, sexuality, gender identity, contraception, pregnancy and sexually transmitted infections.

Keywords pregnancy; safeguarding; sexual health; sexually transmitted infections; teenager; young people

Background

Sexual health is defined by the WHO as a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be achieved and continued, the sexual rights of all persons must be respected, protected and fulfilled. Sexual health requires a holistic approach throughout all stages of life, as with all aspects of healthcare.

The term YP in the UK law generally refers to anyone from 14 to 17 years of age. However we would argue that when considering health, and in particular sexual health, this should expand to 11–24 years of age. Our rationale for this is to cover the period from puberty, around 11 years of age when sexual awareness begins to develop, until full development of the pre-frontal cortex when risk taking behaviour associated with puberty and amygdala development is balanced by the reasoning of the prefrontal cortex, at around 24 years of age. In fact, most sexual health services run YP clinics for under 25s to meet their specific needs.

For most YP awareness of sexuality and interest in sexual activity coincides with puberty when there is increased awareness of sexuality and exploration both of themselves as individuals and with others. Most YP find this a confusing time. Therefore, it is important that health professionals are able to offer readily accessible advice regarding the wide range of sexual health issues, including sexuality, gender identity, choice of partner, contraception, pregnancy, protection against and the management of STIs in a positive, confident and accessible manner.

With the advent of the internet, YP have never had so much information and choice of resource available to them, and whilst there is strong evidence that young people who get information from their parents are likely to initiate sexual activity later than their peers who access information from their friends, there is also evidence that some YP would prefer to get sexual health information from health professionals. Therefore, it is essential that all health professionals who see YP have an awareness of sexual health issues, and know where to signpost or refer, should specialist sexual health advice and/or treatment be required.

Most adolescents have few physical health problems, so their medical issues largely come from risky behaviours. In the UK, YP have relatively poor sexual health compared with other similar European countries. Coitarche (the age of first sexual intercourse) in the UK is decreasing with just over 40% of 15-year-olds in the UK having had a sexual experience. Good sexual health provision also makes economic sense. It is estimated that every £1 spent on sexual health saves £12.50 being spent in the future by reducing the costs of unplanned pregnancy care, welfare payments and treatment of STIs.

Sources of sexual health information, social media and the internet

Social media and the internet are now ubiquitous. 90% of 16–24 year olds own smart phones and 93% of 16–24 year olds have at least one social media profile. Despite this, the internet is not the primary source of sexual health information for YP. 40% of men and women report school was the most common main source of information on sexual matters, followed by friends (24% for both genders) and parents; cited by females at 13.5% and only 4.3% of men spoke to a parent. In total 11.5% of men reported their first sexual partner as their main source, whilst amongst women it was 5.4%. Men were twice as likely as women (4% vs 2% of women) to cite the internet (excluding pornography) as their main resource. Only a small minority of men (3.4%) and very few women (0.2%) reported pornography as their main source.

Harriett Latham-Cork *BMBS BSc (Hons) is ST1 Community Sexual and Reproductive Health, Nottingham University Hospitals NHS Trust, Nottingham, UK. Conflict of interest: none declared.*

Charlotte Porter *MBBS MRCSP MRCOG MFSRH is Consultant in Community Gynaecology, Nottingham University Hospitals NHS Trust, Nottingham, UK. Conflict of interest: none declared.*

Fiona Straw *BMedSci, BMBS, MRCP (Paed) is Consultant in Community Paediatrics at Nottingham Children's Hospital, Nottingham, UK. Conflict of interest: none declared.*

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Although it is now easy to access high-quality sexual health information online, it is yet to become the primary source of information for YP. However it is clear that YP are increasingly able to access online content and inevitably sexually-explicit material and along with this comes the concern that the internet may create unrealistic expectations both about sex and relationships. YP increasingly conduct much of their social lives online and this raises concerns about online safety, and it is recommended that SRE should include information about the impact of pornography, safe use of technology, sexual consent, exploitation, abuse and violence in relationships.

It is important for paediatricians to be aware of the internet as a useful resource but also as potentially harmful both in terms of misinformation and as an entry point for CSE/CSA.

Confidentiality

Discussion of issues surrounding confidentiality is key to gaining trust in any consultation. If a YP believes that they will not have confidentiality it is likely that they will not share the full extent of their concerns and may not seek help at all. YP have the legal right to confidential healthcare unless they lack capacity or are at significant risk of harm.

Department of Health guidance recommends that all services for YP services should produce and display an explicit confidentiality policy, and that they should advertise that their services to YP are confidential.

The age of consent for all sexual activity (hetero/homosexual) in the England and Wales is 16 years; however, research suggests that at least a third of males and a quarter of females have had sexual intercourse by this age, and that the median age for coitarche is 16 years. The Sexual Offences Act 2003 England and Wales, brought together a legal framework designed to prevent and protect children from sexual abuse, including some new laws, for example, pertaining to grooming. The law is not intended to prosecute consensual teenage sexual activity between teenagers of a similar age, unless the activity involves abuse or exploitation, or for example making or the sharing of explicit images. It should be noted that the legal framework differs across the four nations of the UK, and clinicians should be aware of local variations.

In England, Wales and Northern Ireland, YP over the age of 13 can access contraception, if they are deemed to be 'Fraser Competent'. The Fraser Guidelines were introduced in 2001, replacing the previously applied formula for "Gillick competence". They enshrine the rights of YP to have access to sexual health advice and treatment, and demonstration of Fraser competence in sexual health services is key to the provision of safe and legal advice to YP who are theoretically under the age of consent. Full discussion of the application of the guidelines is beyond the scope of this review, but it is important that clinicians seeing teenagers are familiar with the guidance, and its application in clinical practice, according to Fraser Guidelines, outlined below (Box 1). Again, it should be noted that there is different legislation on sexual activity in Scotland and Northern Ireland.

Synopsis of the Fraser guidelines. When is it OK to prescribe contraception?

- The YP is over 13 years
- The YP understands the professional's advice
- The YP cannot be persuaded to inform his/her parents, with or without involving a doctor's help
- The YP is likely to begin, or to continue having, sexual intercourse with or without contraceptive treatment
- Unless the YP receives contraceptive treatment, his/her physical or mental health, or both, are likely to suffer
- The YP's best interests require them to receive contraceptive advice or treatment with or without parental consent

Box 1

Sexuality and gender identity

There is increasing media attention paid to gender and choice. The LGBT agenda has multiplied its acronyms to an "alphabet soup" recognising intersex, transgender, asexuality, pansexuality and omnisexual individuals. In its recent manifesto, the Green Party refers to LGBTIQA+, and it is important that professionals feel able to recognise the terms used (see https://lgbtiqa.greenparty.org.uk/acronym/ for a fuller discussion).

The acronym LGBTIQA+ stands for:

L – lesbian; G – gay; B – bisexual; T – trans; I – intersex; Q – queer; A – asexual, agender, aromantic; + – other diverse sexual orientations and gender identities.

Many young people display gender fluidity in their teenage years, and exploration of non-heterosexual sex and relationships is common. However, in terms of risk assessment the principles remain the same no matter what the chosen sexual identity. Discussing the types of sex- oral, vaginal, and anal, the number of partners, both male and female, and the date of last sexual activity are important in the risk assessment for pregnancy and sexually transmitted infection, and will highlight the need for preventative measures, such as initiating contraception, HPV and hepatitis vaccination, as well as the provision of barriers and contraception including condoms, femidom and dental dams.

Gender variance is not uncommon. A survey of 10,000 people undertaken in 2012 by the Equality and Human Rights Commission found that 1% of that population was gender variant to some extent. However not all of this 1% will have gender dysphoria, which is defined as discomfort or distress caused by a mismatch between a person's gender identity and their biological sex assigned at birth.

Research estimates that prevalence of gender dysphoria is increasing in the UK. In 2007, 20 per 100,000 people sought medical help for gender variance. This equates to 10,000 people of whom 6000 had undergone gender transition. Of these, 80% were birth-assigned males choosing to become females, increasingly however, referrals to gender identity services are for females wishing to reassign as male, and there is increasing evidence that this is association with diagnosis of autism.

By 2010, 12,500 individuals had presented for treatment and it is estimated that the number presenting for treatment is doubling every 6.5 years. Those presenting for medical treatment are believed to be a tiny fraction of those in the general population who are affected by gender dysphoria. Currently around 100 children and adolescents are referred each year to the UK's single specialised gender identity service for under 17s. The number of referrals for this age group, however, is said to have been rising by 32% per year in recent years.

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