

MOSA Guideline

Contraception and Sexual Health

(N.B. The school doctor is referred to throughout as 'he'. 'He or she', 'himself or herself' should of course be understood as appropriate.)

Principles

1. The UK has the highest teenage pregnancy rate in Western Europe. Despite government initiatives, the number of pregnancy terminations in teenagers continues to rise annually. In 2007, there were a record 42,784 in girls aged 15-19, and 1,171 in girls under 15.
The primary aims of the Teenage Pregnancy Strategy are to provide high quality advice and support and to ensure equitable access to the full range of contraceptive methods.
Most young people become sexually active at the age of 16 or 17, and 80% of conceptions in under-18s occur in 16- and 17-year-olds. It is vitally important that this age group has access to effective contraception. The factor cited as having the biggest impact in reducing the conception rate among teenagers is the provision of young-person-focused contraceptive and sexual health services.
2. The School Doctor and Nurse have vital roles in: i) promoting the sexual health of young people, ii) attempting to reduce the number of teenage pregnancies, iii) minimising the risk of sexually transmitted diseases and iv) providing contraception, including emergency contraception where appropriate.
3. The School Doctor should discuss his position with regard to contraceptive advice and provision with the school as soon as is convenient after his appointment. He should be aware of the possibility of religious and ethical conflict, especially in faith schools.
Frank and open discussion of general principles, revisited from time to time, will ideally enable the agreement of a policy with which the doctor, school, governing body and parents are comfortable. It will reduce the likelihood of conflict, and the danger of compromising confidentiality, when difficulties arise in an individual case.
4. Effective and early **sex and relationship education (SRE)** is an effective way of improving the sexual health of young people. Ideally this would begin at home, but it should always be reinforced by age-appropriate education at school, from Year 6 onwards.
Ofsted (2007) has noted that the main source of sexual information for young people was education at school. SRE should cover not just the mechanics but the emotions of sex: how to choose it, use it and say no. The school doctor and nurse are in ideal positions to contribute to the school's SRE policy and content.
5. The environment in the School Medical Centre should be open and friendly so that young people feel happy to discuss, **in complete confidentiality**, their concerns about sexual health matters and contraception. Appropriate leaflets and posters should be available.
Medical centre staff should themselves be comfortable with talking about sex and sexuality. Pupils should not have to explain their reason for consulting the school doctor or nurse to teachers or house staff.
6. The **school nurse** is an invaluable resource in providing education, information and confidential consultation on sexual matters to pupils. Full training and appropriate updating in contraception and sexual health should be enabled and encouraged.
7. The school doctor should be prepared to offer advice on all forms of contraception, to any pupil, and prescribe as necessary. Doctors must provide time and support to enable young people to make an informed choice with regard to contraception and sexual health matters.

8. The school medical service should acknowledge the requirement of The Children Act 1989 that a pupil must be able to choose to see a doctor of the same gender. Under the NHS, pupils have a right to see any general practitioner for the provision of contraceptive services, not just the doctor with whom they are registered.
9. The risk-taking behaviour of young people should be recognised and the doctor should recognise situations where sexual activity between pupils is more likely, for example on school trips, and be prepared to advise and act accordingly.
10. When considering a request for contraception, the school doctor must satisfy himself that the pupil has a full understanding of his or her actions, the available options, and their likely consequences. An assessment of the pupil's maturity should be made.
In the case of a young person under 16, the doctor must be able to demonstrate that he has made every effort to persuade the young person to discuss the matter with a parent or other responsible adult. (See MOSA Guideline No. 9, June 2006).
11. Refusal by the pupil to talk to his or her parents must not prevent the doctor from providing advice and/or contraception, if he judges that such action would be in the child's best interest. Only in the most extreme circumstances should he consider breaching confidence by telling the parents or the school that contraception has been sought.
12. Young people are concerned about confidentiality and the school doctor must be aware that his duty of confidentiality applies to a patient of any age. Confidence should only be breached in the most extreme circumstances, for example if the doctor considers the pupil to be a victim of sexual abuse, or at risk of exploitation or coercion by a person in authority.
If the doctor intends disclosing a matter against a patient's wishes, the patient must be informed of the doctor's intention, and the reason for it, and a full record made.
13. When providing contraceptive advice for a young person under sixteen, the school doctor should observe guidelines issued in July 2004 by the Department of Health. Since 1985, following Lord Fraser's judgment in the case of *Gillick v. West Norfolk And Wisbech AHA* and the DHSS, the **Fraser Guidelines** have defined the legal criteria for doctors to offer contraception and contraceptive advice to young people under the age of 16 without parental consent:
 - That the young person understands the advice being given, as well as the alternatives available and their respective consequences, and has sufficient maturity to understand what is involved.
 - That the doctor could not persuade the young person to inform her parents nor to allow the doctor to inform them.
 - That the young person would be very likely to begin, or to continue having, sexual intercourse with or without contraceptive treatment.
 - That without contraceptive advice or treatment the young person's physical or mental health would suffer.
 - That it would be in the young person's best interest to give such advice and/or treatment without parental consent.If the doctor is satisfied on these five points, the young person is said to be "Fraser (or Gillick) competent" and this fact should be recorded in the medical records.
The 2004 guidelines do not change the legal framework but place greater emphasis on the need for doctors to make every effort to help young people find another adult to provide support if parents cannot be involved, particularly if termination of pregnancy is being considered.
14. Young people under the age of 13 are deemed not to be capable of informed consent. In such instances, where it is clear that a child under 13 is having or is planning to have sex, there must be a discussion with the child protection service lead (this need not involve naming the child in the first instance). The discussion must be documented. Referral to social services may or may not

follow. The guidelines warn doctors to be aware of the risk of sexual abuse, citing the fact that it is unusual for 11- and 12-year-olds to be having sex.

15. Under The Sexual Offences Act of 2003, in England and Wales, a person cannot legally consent to sex before their sixteenth birthday, whatever their sexual orientation. The Act makes it an offence for anyone to engage in sexual activity with a girl under the age of 16 but doctors, having a duty of confidentiality to their young patients, would need strong justification to share the information, especially if (as is usually the case), the girl was having consensual sex with a boy who was not much older.
16. However, if it seems likely that a girl under 16 is being abused or exploited and remains vulnerable, doctors must take every action to protect her That might include informing her parents, the police or local child protection teams. Good practice would be always to record the age of a girl's partner in the medical records.
17. In responding to a request for contraception, the school doctor or nurse should use the opportunity for a fuller discussion of sexual health issues, including the prevention of sexually transmitted infections.

Contraceptive choices

When a young person requests contraception, all options should be discussed, including, as recommended by NICE guidelines (2005) long acting reversible contraception,

- **Combined Oral Contraceptive Pill (COC):** this remains the most popular method in teenagers. If taken properly, efficacy is very high; it also protects against pelvic infection and often solves period problems. All types carry a similar (very small) risk of venous thromboembolism (VTE), which is higher in smokers or those with high BMI (avoid if BMI over 30). It is contraindicated when there is a history of migraine with aura or VTE. A low dose levonorgestrel or norethisterone product should be the usual first choice. A continuous preparation (eg microgynon ED) may help with compliance. Desogestrel-, gestodene- or drospirenone- based products may help acne; drospirenone is useful if fluid retention is a problem. Once pill use is established, and in the absence of other problems, annual monitoring of BP is sufficient.
- **Transdermal patch (EVRA):** a useful alternative in those who forget pills; it is changed weekly for 3 weeks out of 4. It is more expensive, and is disliked by some because it is visible.
- **Progestogen only pill:** suitable when oestrogens are contraindicated (migraine with aura, high risk of VTE). Desogestrel (Cerazette) is the most efficacious and therefore first choice in this age group.
- **Implants (Etonogestrel – Implanon):** long acting (3 years), extremely efficacious and easily removed, Problems with irregular (light) bleeding may deter teenagers though amenorrhoea occurs in 25-30%.
- **Injections (Depot medroxyprogesterone acetate - Depo-Provera):** CSM 2004 advice is that, because of uncertain effects on bone density, this should be used as first line contraception in adolescents only if other methods are unacceptable or not suitable. In practice it is often a preferred option in teenagers, and is freely used by family planning professionals where there are no significant risk factors for osteoporosis (consider diet, smoking, lack of exercise). The high incidence of amenorrhoea may be welcomed; prior warning about increased appetite reduces the risk of weight gain.
- **Intra-Uterine Devices (IUDs - copper):** a good long acting method, though not commonly popular in this age group. Nulliparity is not a contraindication, though fitting may be more difficult. Pregnancy, expulsion and infection rates are all higher in teenagers. It is important to exclude infection by swabs, including chlamydia, prior to insertion.

- **Intra-Uterine System (IUS – Mirena):** a good choice in teenagers (though see IUDs above) since there is no added infection risk, greater efficacy, and lighter (but unpredictable) bleeding.
- **Condoms:** ALWAYS promote ‘double Dutch’ approach – the use of condoms in addition to other contraception, to reduce infection risk. High failure rate if used alone – but a lot better than nothing! Consider ease of availability in schools – see below. Education in their use should form part of SRE.

Condom availability in schools : it is now common practice for condoms to be made freely available to pupils in schools. This understandably remains a sensitive subject and one which will require discussion with the school. Although sexual activity on school premises may be officially prohibited, the behaviour of teenagers off (or on) the premises needs to be recognised, in order to minimise the risk of adverse consequences to their health.

Emergency Contraception

The **Progestogen Only Emergency Contraceptive (POEC – Levonelle)** is the method of choice within 72 hours of intercourse. It is most effective when taken as early as possible, (though may occasionally be used up to 120 hours afterwards, if the user understands the higher risk of failure and that use is off- license).

Easy availability of the POEC is paramount. It may be useful for the doctor to agree a policy with the school on this. The use of patient group directions may enable it to be given by the school nurse.

The existence and availability of the POEC forms an important part of SRE

The **copper IUCD** (not IUS) may also be used as emergency contraception and can be effective if used up to 5 days after the earliest calculated ovulation day.

Sexually Transmitted Infections (STIs)

These are all increasing in incidence. The commonest are chlamydia non-specific urethritis (NSU) and wart virus. Chlamydia is present in >10% of asymptomatic 16 - 24 year olds. Pupils should be made fully aware of infection risks, both throughout their SRE, and during every consultation concerning contraception. The use of the ‘double Dutch’ method - a condom as well as other contraception - should be encouraged.

Chlamydia screening. In conjunction with national policy, chlamydia screening should be offered to all sexually active under 25 year olds. Most PCTs now have in place a screening policy, which should include pupils at independent schools. The school doctor should be aware of the policy in the school and should ensure screening is available to all. Self testing kits could be available from the medical centre and pupils informed of the website for obtaining self testing kits. (<http://freetest.me.uk> – N.B. no “www.”).

Human Papilloma Virus (HPV) vaccination. Since September 2008, there has been a national programme of routine immunisation of 12-13 and 17-18 year old girls, coupled with a two year catch-up campaign for those in the intervening age groups. The programme should substantially reduce the incidence of cervical cancer, which is attributable to HPV infection. PCTs are responsible for ensuring that all girls, including those in private schools, receive the vaccine, and are encouraged to ensure that girls are immunized in school even if this is in a different area to the girl’s home. The school doctor should ensure that arrangements are in place for giving the vaccine, and that parental consent is obtained in the usual way for those under 16. (Girls over 16 are deemed capable of consent, though it would be normal to inform the girl’s parents of the vaccination). A sample consent form is available on the DoH website.

References

- *Statement on Contraception and Teenage Pregnancy* DoH (June 2008)
www.dh.gov.uk/en/publications.statistics.
- *Contraception Today. A Pocketbook for GPs* (5th ed). John Guillebaud (2004) London: Martin Dunitz
- *Contraception: Your Questions Answered* (4th ed) John Guillebaud (2004) Oxford: OUP
- *Sex and relationships education in schools*. Ofsted (April 2002)
- *'What did you do at school today dear?'* The Journal of Family Planning and Reproductive Health Care)2007) 33. 4
- *Best practice guidance for doctors and other health care professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health* DoH (July 2004)
- *National Strategy for sexual health and HIV* DoH (2001)
- *Contraceptive choices for young people* The Journal of Family Planning and Reproductive Health Care (October 2004) 30 (No 4) 237 - 250
- *Long-acting reversible contraception (NICE Clinical guideline No.30)* National Collaborating Centre for Women's and Children's Health, commissioned by NICE (October 2005)
- *Non-oral contraceptive options: their efficacy and suitability* Prescriber (May 2008) 19 (No.9) www.escriber.com
- *Emergency Contraception* The Journal of Family Planning and Reproductive Health Care. (2006) 3:121 - 128. CEU of Faculty of FPRHC Guidance www.ffprhc.org.uk
- *Confidentiality and people under 16 - Guidance issued jointly by the BMA, GMSC, HEA, Brook Advisory Centres, FPA and RCGP* BMA Publications www.bma.org.uk
- *The National Chlamydia Screening Group: Results from first full year of screening* Sex Transm Infect (2004); 80: 335-341
- *Human Papillomavirus vaccination in the UK* DoH Guidance from Chief Medical Officer. 2.10.2008 and 22.7.2008 BMJ (2008); 337. ed

Useful Websites

Professionals

www.rcog.org.uk. Evidence-based college guidelines on all forms of contraception and other aspects of sexual health

www.ffprhc.org.uk. Faculty guidance on most methods

www.nice.org.uk. Useful for LARC guideline

www.fpa.org.uk Patient information and leaflets

www.ippf.org Online version of Directory of Hormonal Contraception

www.bashh.org National Guidelines for management of all STIs and a list of GUM clinics in UK

www.dh.gov.uk. Portal to Department of Health web resources

www.immunisation.nhs.uk NHS immunization website

Teenagers and Young People

www.brook.org.uk BrookAdvisory

www.ruthinking.co.uk Sexwise

www.fpa.org.uk Family Planning Association

www.mariestopes.org.uk Follow link to "Services for Young People"

www.likeitis.org From Marie Stopes International, aimed at 11-15 year olds

www.BPAS.org British Pregnancy Advisory Service

<http://freetest.me.uk/> (N.B. No www.) Postcode based links to sites where free Chlamydia screening is offered

www.teenagehealthfreak.com Advice for teenagers on all health subjects

Parents

www.parentlineplus.org.uk