Contraception and Young People

Statistics

- Although the legal age for consent to sexual activity is 16, surveys suggest that one in three teenagers have had sexual intercourse before this time.[2]

- Teenage pregnancy rates in the UK are currently at their lowest since records began; however, the UK still has the highest teenage pregnancy rate in Western Europe. A 10-year government strategy of halving teenage pregnancy from baseline rates in 1998 showed improvements by 2010, but significantly less than the target. Under-18 conception rate remains one of the three sexual health indicators in the Public Health Outcomes Framework (2013-2016).[3]

- In England and Wales, the estimated number of conceptions to women under 18 fell to 27,834 in 2012 compared with 31,051 in 2011, a decrease of 10%.

- The estimated number of conceptions to women aged under 16 was 5,432 in 2012, compared with 5,991 in 2011, a decrease of 9.3%.

- Teenage pregnancy rates show a similar decline in Scotland, with rates falling between 2010 and 2011 in the three age groups of under 16, under 18 and under 20. Presented as pregnancy rate, there were 30.6 per thousand women under 18 in 2011 compared to 35.9 in 2010.[4]

- Conception data are not available for Northern Ireland due to the lack of complete data surrounding abortion.

- Across the rest of the UK, percentage of pregnancy, in those aged under 18, leading to legal abortion is 40-50%, and up to nearly 62% in the under-16 age group.[6]

- Successful reduction in teenage pregnancy is achieved where an open, tolerant, pragmatic attitude to sexuality is adopted with effective programmes of sex education and confidential contraceptive advice. The main concern of young people is that their interview should be confidential and fears over lack of confidentiality are the main reason for not attending the GP. For this reason, provision of the community family planning clinic may also be an important feature of an effective service. Government strategy for ongoing reduction of teenage pregnancies past 2010 involves ensuring:[6]

  - Comprehensive information, advice and support from parents, schools and health professionals.
  - Provision of accessible young-person-friendly sexual and reproductive services.

Adverse effects of teenage pregnancy

- Teenage pregnancy is a serious social problem. Having children at a young age can damage young women's mental and physical health, limit their education and career prospects, and increase their risk of living in poverty and social isolation.

- Children born to teenagers are much more likely to experience a range of negative outcomes in later life. Children born to teenage parents are also much more likely to become teenage parents themselves.

- Abortion carries its medical and emotional adverse effects, whilst continuing pregnancy carries a higher risk of maternal and fetal disadvantage.

- Women pregnant in their teens are more likely to suffer anaemia, eclampsia, puerperal endometritis and postnatal depression.[7] The fetus is at risk of higher rates of perinatal mortality, low birth weight, sudden infant death syndrome and substance dependence.[8]

Pregnancy risk factors
Rates of teenage pregnancy vary widely within the UK with much higher rates in areas of social deprivation. Teenage girls particularly at risk are those who:  
- Have been, or are in care.  
- Are homeless.  
- Are underachieving at school.  
- Are involved in crime.  
- Are themselves children of teenage mothers.  
- Are from certain ethnic minority groups.

Fears that sex education will make them more likely to experiment have been shown to be unfounded. There is little evidence about the best method, but it has been shown that education does reduce unintended pregnancies in adolescents.

Under-16s

GMC guidance states that the duty of confidentiality is the same for children and young people as it is for adults. Confidentiality may only be breached in order to protect the adolescent or others from serious harm - for example, where issues such as child abuse and child protection are involved, or where required by law. In this situation the adolescent should be informed of the disclosure and the reasons for it. Guidance also states that 'any competent young person, regardless of age, can independently seek medical advice and give valid consent to treatment'. See also separate article Consent to Treatment in Children (Mental Capacity and Mental Health Legislation).

Contraceptive advice or treatment can be provided to a competent young person aged under 16 years, without parental consent or knowledge, using the Fraser criteria. A health professional needs to be satisfied that:
- The young person could understand the advice and have sufficient maturity to understand what was involved in terms of the moral, social and emotional implications.  
- They could neither persuade the young person to inform the parents, nor to allow the health professional to inform them, that contraceptive advice was being sought.  
- The young person would be very likely to begin or to continue having sexual intercourse with or without contraceptive treatment.  
- Without contraceptive advice or treatment, the young person's physical or mental health or both would be likely to suffer.  
- The young person's best interests required the health professional to give contraceptive advice or treatment or both without parental consent.

Provision of advice or treatment

- If you are not the patient's usual doctor and the patient has significant medical problems, you may need to obtain permission from the patient to obtain medical and family history from their GP before treating.  
- Allow adequate time for counselling with discussion about relationships, sexually transmitted infections and general health matters.  
- It may help to provide information of all methods of contraception, their benefits and risks to allow informed choice. If the partner is present, involve them.  
- Most reversible methods may be suitable for young, fit women.  
- A range of methods, including the latest communication technologies, is helpful for young people accessing advice about contraception. These include social networking sites, websites such as Brook or the Family Planning Association (FPA), leaflets, telephone/text helplines such as "Ask Brook" as well as one-to-one explanation and advice.

Methods of contraception

Age alone should not limit contraceptive choices, including intrauterine methods. Provided that there are no medical contra-indications, young women should choose whichever method of contraception they prefer, but:
- Before menarche, condoms are preferred for contraception and to prevent sexually transmitted infections. Hormonal methods of contraception are not advised.  
- For young women using a hormonal or intrauterine contraceptive, condoms should also be used to prevent sexually transmitted infections.
• Vaginal ring: the combined contraceptive vaginal ring is not recommended for women below 18 years of age because safety and efficacy have only been established for women aged 18 to 40 years.

Choice may be affected by:

• How discreet the method is.
• How easy the method is to forget.
• Effectiveness.
• Safety.
• Side-effect profile.
• Invasiveness.
• Ease of use.
• Knowledge and understanding of the options available.

Lack of adherence and discontinuation are more likely to be issues in young people. Long-acting reversible contraception (LARC) methods are less user-reliant and therefore have lower failure rates. Benefits of LARC options should be highlighted.

Oral contraceptives

• The combined oral contraceptive pill (COCP) offers non-contraceptive advantages in terms of irregular menstrual cycles, premenstrual symptoms and heavy or painful periods. Treatment courses can also be run together to avoid menstruation during examinations, etc.
• Effectiveness depends upon taking the pill as instructed and in typical use associated with a pregnancy rate of 90 per 1,000 women per year.[14] Teenagers are particularly at risk because of missed pills.
• COCPs may improve acne vulgaris. Co-cyprindiol (Dianette®) is indicated for severe acne which has not responded to oral antibiotics; however, it has a higher risk of venous thromboembolism.
• Progestogen-only contraceptive pills (POCPs) are less suitable because of the need for them to be taken regularly, although desogestrel POCPs may be the most appropriate for this group, as the missed pill window is 12 hours rather than 3.

Depots and implants

• Depot injections are reliable and provide a contraceptive effect for 8-12 weeks. However, because of loss of bone mineral density, medroxyprogesterone acetate (Depo-Provera®) should be used in adolescents only when other methods of contraception are inappropriate.
• The etonogestrel-releasing implant (Nexplanon®) may be a suitable option and provides effective contraception for up to three years.

Intrauterine devices

• The copper-based intrauterine contraceptive device (IUCD) and the progestogen-releasing intrauterine system (IUS) may be considered, although it may be difficult to insert a coil into a nulliparous uterus and there is no protection against sexually transmitted diseases.
• There is a small increase in risk of pelvic infection in the 20 days after IUCD insertion, but there is no increased risk after the first 20 days.

Barrier methods

• A diaphragm may be suitable for some girls in stable relationships, but storing and transporting the device may be difficult if not telling parents.
• Male and female condoms are relatively unreliable if used alone.
• Condoms, if combined with other methods, enhance effectiveness and protect against sexually transmitted diseases.
• Information should be given about how to obtain free condoms. Male and female condoms are free from contraception and sexual health clinics and young people’s services, and some general practices and genitourinary medicine (GUM) clinics.

Emergency contraception

• There are now three methods of emergency contraception (the copper IUCD, levonorgestrel and ulipristal acetate) but the IUCD is the only one which provides ongoing contraception, and should be offered.[15]
This provides a good opportunity for contraception advice and counselling for the future. Progestogen-only emergency contraception can be provided by community pharmacies. In some parts of the UK this is free; in others it must be purchased.

Further reading & references


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4. Teenage pregnancy - Year ending 31 December 2011; Information Services Division (ISD) NHS Scotland, 25 June 2013
5. Factsheet. Teenage pregnancy; Family Planning Association (FPA), 2010
6. Teenage Pregnancy Strategy: Beyond 2010; Dept for Children, Schools and Families and Dept of Health
9. Trivedi D, Bunn F, Graham M, Wentz R; On behalf of NICE. Update on review of reviews on teenage pregnancy and parenthood. 2007. Addendum to the first evidence briefing 2003
11. Under-16s: consent and confidentiality in sexual health services factsheet; Family Planning Association (FPA), 2009
12. 0-18 years guidance: Principles of confidentiality 0-18; General Medical Council
13. Contraceptive services with a focus on young people up to the age of 25; NICE Public Health Guidance (March 2014)
14. Trussell J; Contraceptive failure in the United States, Contraception, 2011

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