Providing specialist sexual health advice within adolescent diabetes services

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Government teenage pregnancy strategies aimed to reduce teenage pregnancies by half by 2010 (Social Exclusion Unit, 1999). With one in 15 births to mothers under the age of 20 years, paediatric and adolescent diabetes care teams need to recognise their role in this important health promotional strategy. There is an active need to prevent unplanned pregnancies within the adolescent diabetes population, as many have suboptimal glycaemic control for a successful pregnancy, coupled with the associated poor outcomes for both child and mother. This article discusses these associated factors and suggests how paediatric diabetes teams could access sexual health services for their patient population.

In 1999, the Government launched a strategy to reduce teenage pregnancy rates by half in relation to the 1998 baseline conception figures by 2010, and to increase the proportion of teenage parents in education, training or employment to 60% by 2010 (Social Exclusion Unit, 1999).

Current teenage conception rates for England are 41.7 per 1000 girls aged 15–17, which represents an overall decline of 10.7% since 1998. The 2007 conception rate for girls under 16 years of age in England was 8.3 per 1000 girls aged from 13–15 years. This is 6.4% lower than the teenage pregnancy strategy's 1998 baseline rate of 8.8 conceptions per 1000 girls aged 13–15 years (Office for National Statistics and Teenage Pregnancy Unit, 2009).

Teenage pregnancy is associated with a range of poor outcomes for both child and mother (*Box 1*). The *National Service Framework for Children, Young People and Maternity Services* (Department of Health and Department for Education and Skills, 2004) requires PCTs and local authorities to ensure that interventions to improve young people's sexual health and reduce teenage pregnancy are included in local health promotion strategies.

Why manage diabetes in pregnancy?

The 2005 Confidential Enquiry into Maternal and Child Health (CEMACH, 2005) report was the largest ever enquiry into diabetes and pregnancy undertaken in the UK. It examined the outcomes of 3733 women, accounting for 3808 pregnancies between 1 March 2002 and 28 February 2003. It found that a woman with diabetes is much more likely to (CEMACH, 2005):

Article points

1. The importance of the avoidance of unplanned pregnancies should be an essential component of diabetes education.
2. Intentions regarding pregnancy and contraception should be documented at each contact with the diabetes care team.
3. Young people should be directed to contraception services if they are not available within the clinic.
4. The *Sexual Offences Act* (2003) does not prevent healthcare professionals giving confidential advice and treatment to young people under 16 years of age.

Key words

- Contraception
- Pre-conception care
- Pregnancy
- Sexual health

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- Deliver the baby early.
- Require an induction of labour.
- Deliver by Caesarean section.

It was also found that babies of women with diabetes are:

- Five times as likely to be stillborn compared with babies from mothers without diabetes.
- Three times as likely to die in their first few months of life compared with babies from mothers without diabetes.
- Twice as likely to have a major congenital anomaly compared with babies from mothers without diabetes.

The management of pregnancy in an individual with diabetes is a highly intensive and interventional process, with the requirement of multiple injections and blood tests every day to maintain near normoglycaemia. Other medications have to be reviewed as they can cause fetal abnormalities, and high-dose folic acid is to be taken to help prevent neuro-tubal defects (CEMACH, 2005). With planning and specialist support services, a woman with diabetes can reduce these risks and have a normal birth (Department of Health, 2001).

In England and Wales there are approximately 650 000 births each year, of which 2–5% are complicated by diabetes. Of those births associated with diabetes, 7.5% are by women with type 1 diabetes and 5% by women with type 2 diabetes (NICE, 2008). One of the key elements to a successful outcome for a pregnancy complicated by diabetes is pre-conceptual care with screening for complications such as diabetic retinopathy and nephropathy, along with medication review and establishing good glycaemic control prior to conception. Unplanned pregnancies should be avoided (NICE, 2008).

Box 1. Outcomes for pregnant teenagers with diabetes.

Poor child health outcomes
Children born to teenage mothers have 60% higher rates of infant mortality, are at increased risk of low birth-weight (which impacts on the child's long-term health) and are more likely to have accidents and behavioural problems.

Poor emotional health and wellbeing experienced by teenage mothers
Teenage mothers are three times more likely than their older counterparts to suffer from post-natal depression and experience poor mental health for up to 3 years after the birth.

Teenage parents' poor economic wellbeing
Teenage parents and their children are at increased risk of living in poverty. By the age of 30, teenage mothers are 22% more likely to be living in poverty than mothers giving birth aged 24 or over, and are much less likely to be employed or living with a partner.

Continuation of the social trend
Children born to teenagers are more likely to experience a range of negative outcomes in later life, and are up to three times more likely to become a teenage parent themselves.

From: Department for Education and Skills (2006)

Teenagers with diabetes

As one in 15 of all births are to women under age of 20 years old (Department for Children, Schools and Families, 2009), it is imperative that those providing a service to all teenagers with diabetes actively address the sexual health of the individuals that they care for and follow national guidance. The importance of the avoidance of unplanned pregnancies should be an essential component of adolescent diabetes education.

The young person's intentions regarding pregnancy and contraceptive use should also be documented at each contact with their diabetes care team (NICE, 2008). This may prove difficult for teams to achieve if they do not have designated adolescent services. There may also be a lack of ability to have confidential conversations with the young person in some paediatric diabetes clinics. However, in view of the HbA_{1c} target for pregnancy of 6.1% (43 mmol/mol), and the recommendation that those with an HbA_{1c} level >10% (86 mmol/mol) should avoid pregnancy, many adolescents with diabetes have suboptimal control for pregnancy, and therefore need information and access to adequate contraception (NICE, 2008).

The *Sexual Offences Act* (2003) does not prevent healthcare professional from giving confidential advice and treatment to young

people under 16 years of age. This includes contraception if acting to protect that young person from sexually transmitted infections, preventing pregnancy, promoting emotional wellbeing and ensuring physical safety. The healthcare professional should be well versed with local safeguarding policies and take into account the young person's ability to consent to treatment and the Gillick competency using Fraser guidelines (Atherton, 2009).

Teenagers tend to be later in accessing maternity care than older individuals, with the average gestational age at booking being 16 weeks (Department for Children, Schools and Families, 2009). Often this is because they do not realise they are pregnant, or actively conceal the pregnancy while they try to come to terms with being pregnant, and their fear of others' reactions to the pregnancy (Department for Children, Schools and Families, 2009). NICE (2008) recommends that joint antenatal and diabetes care should start as soon as pregnancy is suspected, with booking ideally by 10 weeks at the latest; paediatric and adolescent healthcare teams therefore need to facilitate this early presentation.

In the author's local area, a sexual health advisor with additional training in diabetes attends the young persons' diabetes clinic working as part of the adolescent diabetes team to provide an integrated, confidential sexual health service to the young people attending the clinic. This is funded on a sessional basis from the acute paediatric budget. This person can facilitate referral into a wider network of sexual health services as and when required by the young person with diabetes. Their role and responsibilities are outlined in *Box 2,* with an example of practice in *Box 3*. Although the young person in the example did become pregnant, her ability to access specialist services enabled her to receive prompt specialist advice when she required it, and empowered her to address her own sexual health needs at the time.

This example is one of many ways that sexual health services can be integrated into adolescent diabetes services, but the author recognises that this model of care is not duplicated throughout the country. Local Authorities have made it a priority to develop comprehensive programmes of sex and relationship education in schools, with training for professional partners, such as Connexions, and youth and social workers. In every area there should be well publicised young-person-centred contraception and sexual health services (Department for Education and Skills, 2006), which young people can be signposted to from diabetes clinics.

Some school health services offer "Clinic in a Box" services that can also be used. "Clinic in a Box" is a mobile sexual-health service that is offered to young people in

Box 2. Principle resonsibilities of a sexual health advisor.

- To work as a member of the paediatric and adolescent diabetes team, ensuring National Service Framework standards and NICE guidelines are implemented.
- To advise and encourage a healthy social and sexual lifestyle to prevent ill health and unplanned pregnancies.
- To maintain confidentiality while being aware of child protection and safeguarding issues.
- To ensure the young person is competent to understand, and consent to, sexual activity.
- To give contraceptive and safe-sex advice, taking into account individual needs and preferences.
- To liaise with family planning clinics as appropriate.
- To explain the importance of planned pregnancy.
- To offer free pregnancy testing and speedy referral for termination of pregnancy or specialist maternity services.
- To provide a link with the local maternity unit in cases of ongoing pregnancy.
- To have excellent communication skills with adolescents, colleagues and other disciplines, liaising when appropriate.
- To issue condoms when required, and maintain stock rotation.
- To enable each young person to empower themselves to act independently and to take ownership for their decisions.
- To discuss the impact diabetes has on social interactions, for example alcohol, substance misuse and smoking.
- To refer to other agencies such as the genitourinary medicine clinic or drug team.
- To participate in the transfer from paediatric to adult services.
- To participate in any local, regional or national audit or research projects with the diabetes team.
- To listen.

a confidential setting, often at lunchtime in school. Initiated in North Staffordshire, and adopted in other areas, this service offers relationship and sexual health advice and support, condoms, pregnancy testing, emergency contraception, chlamydia and gonorrhoea screening (Atherton, 2009).

Conclusion

Sexual health advice and the need for planned pregnancies should be fully integrated into any paediatric and adolescent diabetes service, as the statistics show that young people within the age group we serve do conceive with all the associated risks of an unplanned teenage diabetes pregnancy. ■

Box 3. An example of practice.

A 16-year-old woman contacts the sexual health advisor on a Monday morning having been very drunk at a party on the preceding Friday night when she had unprotected sex. She had regretted the act the next day and had, appropriately, attended for and received emergency contraception, as she was aware from her previous conversations at the diabetes clinic with the sexual health advisor of the need for planned pregnancy. After discussions with the sexual health advisor she agreed to meet with the paediatric DSN for medication review. The young woman had the opportunity to discuss what she would do if she was pregnant, and at this time she was unsure of what she would want to do, and expressed that if pregnant she may wish for the pregnancy to continue.

The team, therefore, decided that to enable the best pregnancy outcome possible there was a need to intensify her insulin regimen immediately in an attempt to normalise her glycaema as her HbA_{1c} level was 8.5% (69 mmol/mol). Her basal analogue insulin was changed for an isophane insulin, along with her current rapid-acting insulin analogue. A fasting blood glucose target of 3.5–5.9 mmol/L and a 1-hour postparandial glucose target of 7.8 mmol/L were discussed, and she was commenced on 5 mg folic acid daily. Regular follow-up was arranged by telephone contact to help the titration of her new insulin regimen, and the team awaited her next menstrual period. Clinic follow-up was arranged for soon after this date to enable a pregnancy test to be carried out if required. She had good family support and the use of glucagon was revised. She had recently had annual retinopathy screening, and was negative for microalbiminuria. She was on no other medications.

Unfortunately for this young woman, emergency contraception failed and she was confirmed to be pregnant. She had improved her glycaemic control considerably on the new insulin regimen, and had kept regular contact with the team. She had had many discussions with the sexual health advisor and continued to be supported by her family. After considerable reflection since the first meeting, she decided on a termination of pregnancy. The team supported her and she was referred onto appropriate services to enable the termination to be carried out. She then reviewed her ongoing contraception requirements and attended the local family planning services.

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