

Young teenagers' attitudes towards general practitioners and their provision of sexual health care

RICHARD BURACK

SUMMARY

Background. *Pregnancy rates in under-16-year old teenagers and sexual risk-taking are both increasing. Ensuring that teenagers access health care — particularly sexual health care — appropriately is problematic.*

Aim. *To find out the opinions and attitudes of 13- to 15-year-old teenagers towards general practice-based sexual health care services.*

Method. *A quantitative survey, using a questionnaire completed during school hours.*

Results. *One thousand and forty five children aged 13 to 15 years completed questionnaires. The majority (709 [68%]) were aware of the sexual health services offered by general practitioners (GPs), and 786 (75%) were positive about being given helpful advice at a consultation. However, 567 (54%) teenagers believed they had to be over 16 years old to access sexual health services and 604 (58%) were concerned about their confidentiality not being preserved by their GP. They were also concerned about GPs not having the time or skills to deal with their problems (314 [30%]).*

Conclusions. *This study suggests that work is needed to improve teenagers' access to, and use of, primary care sexual health services. In particular, identifying strategies that improve teenagers' awareness of services and general practitioners' approaches towards teenagers are priorities.*

Keywords: *teenagers; sexual health; teenage pregnancy.*

Introduction

TEENAGERS' elusiveness and reluctance to use health care services is well documented.^{1,2} Their sexual behaviour and attitudes to sexual health have major effects on the health service. Nationally, the number of teenagers engaging in unsafe and unprotected sexual behaviour is increasing and the age of first intercourse is falling.³ The number of children aged 13 to 15 years who become pregnant is rising.⁴ Those who engage in sexual intercourse before the age of 16 report more high-risk behaviour, including having more sexual partners than older teenagers.⁵

Observational studies suggest that these teenagers are at an increased risk of performing less well than their peers in social, economic, and educational terms⁶⁻¹⁰ and to have more health problems, including infertility,¹¹ HIV infection, cervical cytology abnormalities,¹² and pregnancies.

Accessibility and confidentiality issues are major concerns for teenagers wishing to use services to discuss sexual health

issues.¹³⁻¹⁵ Using lowered conception rates and increased contraceptive uptake as performance indicators, designated youth-orientated clinics have been shown to be better than other providers of sexual health services.¹⁶⁻¹⁷ However, general practitioners (GPs) are among the most accessible and available health providers for teenagers and also the most cost-effective way of delivering contraceptive services.¹⁸ Unfortunately, attempts to persuade teenagers to attend GP surgeries or designated clinics have been generally unsuccessful.^{19,20}

Specific targets for reducing teenage pregnancy rates were set in the *Health of the Nation*²¹ yet these have not yet been met. More recently, the Green Paper *Our Healthier Nation*²² has highlighted teenage sexual health as a priority area. There is some evidence to suggest that such services should take local circumstances and needs into account.²³ This paper describes a study of 13- to 15-year-old teenagers' views on the availability and accessibility of local sexual health care provision by GPs.

Method

Derivation of questionnaire and pilot

The methods used in the study have been described in detail elsewhere.²⁴ A quantitative survey was carried out using a questionnaire that was based on a previously used questionnaire²⁵ and with some locally relevant questions included. It was initially piloted in two secondary schools in a neighbouring district. Face validity and acceptability of the questionnaire (such as running time, presentation, legibility, question interpretation, and understanding) was confirmed by interviewing 20 of the 247 teenagers who piloted the study. After appropriate modification, this was used for the main study. The Barking and Havering Research Ethics Committee gave their approval for the study.

Sample size and frame

As there were no comparable data on which to base a sample size estimate, a pragmatic decision was made to sample 10% of the 13 894 pupils aged 13 to 16 years (school years 9 to 11), attending state schools in Barking and Havering. To increase validity and reduce sample bias, the decision was also made to focus analysis onto 13- to 15-year-olds only. This was because data on (a) the majority of those sampled fell into this age group and so sample size would not be adversely affected, and (b) by the age of 16 years some teenagers may have already left school so the sample we collected might not truly reflect the views of all 16-year-olds. The 26 secondary schools in the area were geographically divided into eight clusters based on the percentage of pupils with special educational needs, proportion receiving free school meals, percentage of children obtaining five or more GCSEs, average class size, unauthorised absentee rate and geographical locality. This had been devised by the Barking and Havering Health Authority Public Health Department for a previous school based survey, to ensure adequate geographical representation across the Health Authority. One school from each of these clusters was randomly selected. Within each school, a number of classes, proportional to the size of the total school roll, were

R Burack, MRCP, research associate, Barking and Havering Academic Team, Department of General Practice and Primary Care, Queen Mary Westfield College, London.

Submitted: 14 July 1998; Editor's response: 10 December 1998; final acceptance: 16 March 2000.

© *British Journal of General Practice*, 2000, **50**, 550-554.

selected to complete the questionnaire. Thus larger schools were required to sample a larger number of pupils than smaller schools. No school had classes streamed; therefore, the schools' Personal Health and Sex Education (PHSE) co-ordinator randomly selected classes. Children attending these schools who lived outside of the Health Authority boundaries were not included as ethical approval and funding had only come from within.

Implementation

The questionnaires were administered during PHSE sessions. The questionnaire was answered in 'examination style' conditions to ensure pupils' privacy. This was supervised either by outside facilitators or by school form tutors. Detailed instructions were provided for the supervisors to ensure consistency across sites. The questionnaires did not include any identifying marks that could link them to individual students. All pupils were aware that participation was voluntary, confidential, and anonymous and that if any question was felt to be too intrusive or offensive, they did not have to answer it. The questions were aimed at identifying pupils' opinions and attitudes towards school sex education, their own perceived knowledge on sexual health issues, their declared sexual behaviour, and their opinions and knowledge about community and GP sexual health care provision.

The study took place between January and March 1996. The schools informed all parents of the questionnaire and offered an opportunity for them to withdraw their child from the survey.

Data analysis

Analysis was carried out using Statistical Packages for the Social Sciences (SPSS) for Windows. Any out of range values were coded as missing. Examining outlying responses from three blocks of questions identified responders answering the questionnaire in a random or playful manner. Data analysis was performed using chi-square analysis and confidence interval analysis was performed using statistics with confidence.²⁶

Results

Of the 1300 questionnaires given to schools, 1280 were completed by pupils from school years 9 to 11 (98%). Following parental requests, two children did not participate on religious grounds and no children directly objected themselves. Absenteeism on the days the study took place was similar to the seasonal average.

None of the outlying responses in the three groups of check questions had come from the same individuals and so no individual's responses were excluded. Twenty-seven of the 1280 questionnaires did not have either their age/gender or geographical locality specified and so were excluded from processing. Of the remaining 1253 questionnaires, 1045 were completed by teenagers aged 13 to 15 years. Although the precise number of 13- to 16-year-olds was known, via the school rolls, an exact figure for 13- to 15-year-olds was not available. However, the high response rate means any effect on completion rate should be minor.

The principal responses are summarised in Table 1. The majority of teenagers surveyed were aware of most of the sexual health services offered by GPs. Three quarters were aware that GPs provided a contraception service and a pregnancy testing service. Significantly more sexually active girls were aware of pregnancy testing compared with sexually inactive ($\chi^2 = 6.2$, $P < 0.05$). Eighty-five per cent of girls and 74% of boys were aware of the provision of smear testing and over half of teenagers were aware of GPs providing abortion counselling. A third believed that free condom provision was available.

Table 1. Thirteen- to 15-year-old teenagers' awareness of GP-based sexual health services.

Service provision	n	Percentage	95% CI
Sexual health advice			
Male	482	77	73–81
Female	486	74	70–78
Sexually active	144	81	74–88
Sexually inactive	579	74	70–78
Contraceptives			
Male	453	74	70–78
Female	453	75	71–79
Sexually active	135	72	64–80
Sexually inactive	569	73	69–77
Smear tests			
Male	452	74	70–78
Female	469	85	82–88 ^a
Sexually active	139	79	72–86
Sexually inactive	573	80	77–83
Pregnancy testing			
Male	478	90	87–93
Female	486	92	90–94
Sexually active	147	93	89–97
Sexually inactive	594	90	88–92
Abortion counselling			
Male	446	56	52–60
Female	439	55	50–60
Sexually active	138	62	54–70
Sexually inactive	547	53	49–57
Pregnancy testing			
Male	438	38	33–43
Female	417	34	29–39
Sexually active	130	43	34–52
Sexually inactive	537	35	31–39

^a $\chi^2 = 18.5$, $P < 0.001$.

Table 2. Thirteen- to 15-year-old teenagers' beliefs about GP accessibility.

Belief	n	Percentage	95% CI
Needing to be over 16 to obtain contraception			
Male	508	59	55–63
Female	491	54	49–58
Sexually active	158	38	30–46 ^a
Sexually inactive	616	61	57–65
Needing to be over 16 to see GP on your own			
Male	505	34	30–37
Female	484	27	23–31 ^b
Sexually active	160	34	27–41
Sexually inactive	615	27	22–32
GPs would be helpful in providing contraception			
Male	509	80	74–84
Female	498	77	74–81 ^c
Sexually active	158	73	66–80
Sexually inactive	620	79	76–82
GPs would be helpful in sexual matters/advice			
Male	523	76	72–80
Female	502	68	64–72 ^d
Sexually active	160	69	62–76
Sexually inactive	628	73	69–77

^a $\chi^2 = 26$, $P < 0.0001$; ^b $\chi^2 = 4.76$, $P < 0.05$; ^c $\chi^2 = 9.3$, $P < 0.01$; ^d $\chi^2 = 15.9$, $P < 0.001$.

Knowledge on service accessibility, as summarised in Table 2, showed that over a quarter believed they had to be over 16 years of age before they could see their GP on their own; more boys believed this to be true than girls. Sexually active girls also significantly felt this to be true (35%) compared with sexually inactive girls (23%) ($\chi^2 = 5.6, P < 0.05$). Over half believed that they had to be over 16 years of age to obtain contraception from their GP, with no significant gender difference identified. However, sexually inactive teenagers were under this impression significantly more than sexually active ones, both boys and girls. Over three-quarters believed that their GP would be helpful in providing sexual health advice or contraception, with significantly more boys believing this than girls.

Their preferences for how to access GP services are shown in Table 3. Significantly more boys than girls preferred to see their GP on their own (68% versus 39%). This was partly accounted for by a female preference for seeing a GP with a friend (43% versus 18%). Just over 13% of teenagers would choose to see their GP accompanied by their parents, with significantly more girls — in particular those who were sexually inactive ($\chi^2 = 9.3, P < 0.01$) — choosing this preference.

Table 4 shows that a strong preference was expressed to see a GP of the same sex for consultations involving sexual health issues, with significantly more girls than boys and more sexually inactive than active teenagers expressing this preference. In particular, sexually inactive girls expressed this preference compared to sexually active girls ($\chi^2 = 6.6, P < 0.01$). Similar responses were obtained where significantly more girls preferred a doctor of the same sex than boys if examination was required. There was no difference in teenagers with regards to their sexual activity.

Service satisfaction from GPs is summarised in Table 5. Despite over 75% of teenagers feeling GPs would be helpful towards them if they were seeking advice about contraception or sexual health issues, over half remained concerned about their confidentiality not being preserved, with more girls than boys (62% versus 54%) remaining concerned about this. A third of teenagers believed their GP was too busy to deal with their problems and, in addition, would not understand their problems any-

Table 3. Thirteen- to 15-year-old teenagers' preferences for accessing GP services.

Choice	n	Percentage	95% CI
To see GP on their own			
Male	486	68	64–72
Female	464	39	34–44 ^a
Sexually active	151	60	52–68
Sexually inactive	587	54	50–58
To see GP with a friend			
Male	486	18	15–21
Female	464	43	38–47 ^b
Sexually active	151	31	23–39
Sexually inactive	587	30	26–34
To see GP with a parent			
Male	486	11	8–14
Female	464	16	12–18 ^c
Sexually active	151	8	4–12 ^d
Sexually inactive	587	14	11–17
To see GP with 'other'			
Male	486	3	1–5
Female	464	2	0–3
Sexually active	151	1	0–2
Sexually inactive	587	2	0–3

^a $c^2 = 82, P < 0.0001$; ^b $c^2 = 70, P < 0.0001$; ^c $c^2 = 4.2, P < 0.05$; ^d $c^2 = 4.2, P < 0.05$.

way. Over two-fifths of teenagers had decided not to visit their GP for fear of wasting either their time or the GP's time, with more sexually active teenagers having expressed this. More sexually active girls than boys expressed this view ($\chi^2 = 3.9, P < 0.05$).

Discussion

The results were obtained from a questionnaire survey from eight schools within the London Boroughs of Havering, Barking, and Dagenham. School selection was random and based on locally pre-determined clusters. The sample obtained was 10% of the children aged 13 to 15 years at the selected schools. There is good reason to believe that it was representative of the local 13- to 15-year-old population.

The majority of teenagers were aware of services provided by GPs. Not surprisingly, girls were more likely than boys to be

Table 4. Thirteen to 15-year-old teenagers' preferences on GP gender.

Gender preference	n	Percentage	95% CI
Same sex as them when discussing sexual health			
Male	460	73	69–77
Female	479	98	97–99 ^a
Sexually active	147	81	75–87
Sexually inactive	587	87	84–90 ^b
Same sex as them when medically examined			
Male	477	61	57–75
Female	486	98	97–99 ^c
Sexually active	155	77	70–84
Sexually inactive	599	82	79–85

^a $c^2 = 100, P < 0.0001$; ^b $c^2 = 6.44, P < 0.05$; ^c $c^2 = 196, P < 0.0001$.

Table 5. Thirteen- to 15-year-old teenagers' concerns about GP service provision.

Concerns	n	Percentage	95% CI
That confidentiality would not be kept			
Male	517	56	52–60
Female	499	63	59–67 ^a
Sexually active	159	53	45–61
Sexually inactive	621	60	56–64
That GPs would not understand their problems			
Male	486	35	31–39
Female	493	33	29–37
Sexually active	157	36	28–44
Sexually inactive	607	34	30–38
That GPs are too busy to deal with their problems			
Male	491	33	29–37
Female	487	32	28–36
Sexually active	157	42	34–50 ^b
Sexually inactive	606	44	40–48
Had decided not to see their GP for fear of wasting their time			
Male	486	42	38–46
Female	489	47	42–52
Sexually active	156	53	45–61 ^c
Sexually inactive	606	44	40–48

^a $c^2 = 4.91, P < 0.05$; ^b $c^2 = 6.6, P < 0.05$; ^c $c^2 = 4.33, P < 0.05$.

aware of pregnancy testing, smear tests, and contraception provision as these are directly relevant for them. Teenagers were also positive about how helpful they felt GPs would be if they needed help with contraceptive or other sexual health services. However, despite this positive perception over half the teenagers surveyed felt they would have to be over 16 years of age to access the service. This indicates a lack of knowledge by teenagers on their rights and perhaps a lack of effort from GPs and primary care health services to publicise them effectively. Understandably, sexually inactive teenagers would be less likely to be aware of contraceptive access issues as shown but, interestingly, sexually active teenagers, particularly the girls, were more likely to believe that they had to be over 16 to see their GP on their own. This might have implications on teenage pregnancy rates for those girls who are already sexually active, and who might not access services, such as obtaining emergency contraception, because they thought they were not able to attend on their own.

Teenagers were very clear when asked about the choice of their GP and how they would prefer to see them. The majority stated a preference for seeing their GP either on their own (particularly the boys) or with a friend (especially the girls). Very few preferred the option of having their parents present and yet most of the consultations with under 16-year-olds are conducted with parents present.^{25,27} This could be because either parents or teenagers believe the presence of both parties is required for such consultations. Recent clarification of the law using 'Gillick Competence' as a criterion for enabling health professionals to see and treat under-16-year olds on their own should make it easier for these children to access appropriate advice.²⁸ However, the majority of teenagers in this study were aware that they could see their GP on their own. Perhaps parents are insisting on accompanying their teenage children to the doctor or perhaps are just refusing to allow them to go on their own. Perhaps the teenagers themselves do not feel able to tell their parents that they wish to see the GP on their own.

Alternatively, the problem may lie within general practice, with GPs being unaware of their teenage patients' rights or perhaps refusing to see the teenager without their parents present. Whatever the reasons, the wishes and views of the individual teenager do not appear to be understood or realised by parents or practitioners. Interestingly, the preference to see a GP with a parent was expressed more by sexually inactive teenagers, particularly the girls. This could be an indication that the sexually active teenager may have more confidence in choosing to see a doctor on their own or they may have an ability to access services without their parents being aware. Further studies looking at access issues would prove useful in helping to address this area of need.

Teenage boys preferred seeing their GP on their own, whereas teenage girls were split between seeing their GP on their own or with a friend. This could be owing to stereotyped gender roles that society often imposes and accepts, including where boys are expected to cope and deal with things on their own, such as seeking medical attention, whereas it would be necessary for women to need and prefer support from their friends.

However, another explanation may revolve around the restricted patient choice and not feeling entirely comfortable with the practitioner you are about to see. The majority of GPs (135 out of the 182 [75%]) in Barking and Havering are male so that, for teenage girls, the choice to consult with a female doctor remains limited. Significantly more girls than boys preferred their GP to be the same sex as themselves whether discussing general or sexual health issues, and particularly if they needed to be examined. Coupled with the lack of available female practitioners this could be a reason why, if given the choice, girls would prefer to consult with a friend rather than on their own.

Confidentiality in the doctor—patient consultation is an important issue for teenagers as the majority of them; despite being aware that they could see the GP on their own, they still had concerns that the GP would not keep the consultation confidential. This perception is likely to negatively influence their decision to access services, even if they need to. With teenagers believing that GPs did not understand the problems they faced and were too busy to deal with them anyway, it is not surprising that nearly half had made a decision not to visit the GP for fear of wasting their time. This suggests that there are teenagers who are not using services for which they have an expressed need.

General practice is a readily accessible service for teenagers with recent guidelines having highlighted the need for primary care to be more 'user friendly' and for sexual health provision for teenagers to remain a priority.^{21,22} However, many teenagers have concerns about trust, confidentiality, and accessibility of the service. This is likely to continue to adversely affect the use of services by teenagers unless proactive steps are taken to address these concerns.

References

1. Winn S, Roker D, Coleman J. Knowledge about puberty and sexual development in 11-16 year olds: implications for health and sex education in schools. *Educational Studies* 1995; **21**: 187-201.
2. David HP, Morgall JM, Osler M, et al. United States and Denmark: different approaches to health care and family planning. *Study Family Planning* 1990; **21**: 1-19.
3. Johnson A, Wadsworth J, Wellings K et al. *Sexual attitudes and lifestyles, British survey*. London: Blackwell Scientific, 1994.
4. Office for National Statistics. *Birth Statistics*. [FM1 no. 23] London: HMSO, 1996.
5. Mellanby A, Phelps F, Tripp J. Teenagers, sex and risk taking. *BMJ* 1993; **307**: 25.
6. NHS Centre for Reviews and Dissemination. *Effective health care. Preventing and reducing the adverse effects of unintended teenage pregnancies*. York: University of York. Vol 3; No 1. February 1997.
7. Elliot H, Beazley J. A medical study of pregnancy in Beazley, Liverpool. *Br J Obstet Gynaecol* 1980; **1**: 139-143.
8. Scholl TO, Hediger ML, Belsky DH. Prenatal care and maternal health during adolescent pregnancy: a review and meta-analysis. *J Adolesc Health* 1994; **15**: 444-456.
9. Konje JC, Palmer A, Watson A, et al. Early teenage pregnancies in Hull. *Br J Obstet Gynaecol* 1992; **99**: 969-973.
10. Wellings K, Wadsworth J, Johnson A, et al. *Teenage sexuality, fertility and life chances. A report for the Department of Health using data from the National Survey of Sexual Attitudes and Lifestyles*. London: London School of Hygiene and Tropical Medicine, 1996.
11. Donovan, C. Adolescent sexuality. *BMJ* 1990; **300**: 1026-1027.
12. Elliot PM, Tattersall MH, Coppleson M, et al. Changing character of cervical cancer in young women. *BMJ* 1989; **298**: 288-290.
13. Malus M. A school based outreach programme in adolescent health. *Can Fam Physician* 1986; **32**: 2465-2467.
14. British Medical Association. *Confidentiality and people under-16*. London: BMA, GMSC, HEA, Brook Advisory Centre, FPA, and RCOG, 1993.
15. Jacobsen LD, Wilkinson CE, Owen P. Is the potential of teenage consultations being missed? A study of consultation times in primary care. *Fam Pract* 1994; **11**: 296-299.
16. Allaby MK. Reviewing family planning services: a method for population based outcome related needs assessment. *Br J Fam Plan* 1993; **18**: 102-105.
17. Allaby MA. Contraceptive services for teenagers: do we need family planning clinics? *BMJ* 1995; **310**: 1641-1643.
18. Hughes D, McGuire A. The cost-effectiveness of family planning service provision. *J Public Health Med* 1996; **18**: 189-196.
19. Malus M, La Chance PA, Lanny L, et al. Priorities in Adolescent Health Care: the teenager's viewpoint. *J Fam Pract* 1987; **25**(2): 158-162.
20. Epstein R, Rice P, Wallace P. Teenagers' health concerns: implications for primary health care professionals. *J R Coll Gen Pract* 1989; **34**: 247-249.
21. Department of Health. *The health of the nation: a strategy for health in England*. [Cm1986.] London: HMSO, 1992.
22. Department of Health. *Our healthier nation. A contract for health*. London: HMSO, 1998.
23. Ubido J, Ashton J. Small area analysis: abortion statistics. *J Public Health Med* 1993; **15**: 137-143.

24. Burack RJ. Teenage sexual behaviour: attitudes towards and declared sexual activity. *Br J Fam Plan* 1999; **24(4)**: 145-148.
25. Ryan H, Speed M, Rudut K. *Today's young adults*. Bath: Health Education Authority Publication, Bath Press, 1992.
26. Gardner MJ, Altman DG. *Statistics with confidence*. London: BMJ Books, 1989.
27. Donovan C, Mellanby AR, Jacobson LD *et al*. Teenagers' views on the general practice consultation and provision of contraception. *Br J Gen Pract* 1997; **47**: 715-718.
28. Dyer C. The Gillick judgement. Contraceptive and the under 16's House of Lords ruling. *BMJ* (Clinical Research Edition) 1985; **291(6503)**: 1208-1209.

Acknowledgements

Thanks are due to all pupils and teachers who participated in this survey, to David Brown for statistical support, Frances Haste for support and advice about the study design and conclusions, and Professor Yvonne Carter and Martin Underwood for their comments on earlier drafts of this paper. This study was funded by Barking and Havering Health Authority, Department of Public Health.

Address for correspondence

Dr Richard Burack, North Street Medical Care, 274 North Street, Romford, Essex RM1 4QJ.