

‘By the way....how’s your sex life?’ – A descriptive study reporting primary health care registered nurses engagement with youth about sexual health

Rhiannon Martel RN, MN, PGDip Health Sci;¹ Ruth Crawford RN, PhD;² Helen Riden RN, MN³

¹ Macleans College,
Auckland, New Zealand

² Faculty of Health, Whittireia
New Zealand, Porirua,
New Zealand

³ Hawkes Bay District Health
Board, Omaha Road,
Hastings, New Zealand

ABSTRACT

INTRODUCTION: Youth rates of sexually transmitted infections in New Zealand are among the highest in the Organisation for Economic Cooperation and Development. Registered nurses employed in primary healthcare settings (PHC RNs) may lack confidence engaging with youth about their sexual health.

AIM: To identify what facilitates PHC RNs to discuss sexual health with youth.

METHODS: This descriptive study was undertaken in two phases. In phase one, 23 PHC RNs completed an online survey. Phase two followed up the survey with semi-structured interviews with seven PHC RNs.

RESULTS: Most PHC RNs are female, aged between 40 and 60 years old and identify with New Zealand or other European ethnicity. Participants identified specific educational needs relating to youth sexual health that are not being met: legal and ethical issues (65%); cultural issues (65%); youth sexual (44%) and psychological (52%) development; and working with gay, lesbian, bisexual or transsexual youth (48%). Lack of time was cited as a barrier to engaging with youth about sexual health by 30% of the participants. Ongoing support practices such as regular debriefing, reflections of practice and case reviews with colleagues (74%); support from other sexual health providers (87%); and access to educational materials about youth sexual health aimed at health professionals (100%) were perceived to be useful to increase confidence in discussing sexual health with youth.

DISCUSSION: The PHC RNs lacked knowledge and confidence engaging with youth about sexual health. PHC RNs need resourcing to provide culturally safe, effective sexual health care to youth.

KEYWORDS: Youth sexual health; registered nurses in primary health care; educational needs; ethnic stereotyping; professional; legal and ethical responsibility

J PRIM HEALTH CARE
2017;9(1):22–28.

doi:10.1071/HC17013

Published online 29 March 2017

CORRESPONDENCE TO:

Rhiannon Martel
Macleans College,
2 Macleans Road,
Bucklands Beach, Auckland
2145, New Zealand
rh@macleans.school.nz

Introduction

New Zealand youth have among the highest rates of sexually transmitted infections (STI) and poor sexual health of Organisation for Economic Cooperation and Development (OECD) countries.^{1–3} Evidence suggests the complex sexual health needs of New Zealand’s youth population are not addressed during visits to

primary healthcare (PHC) providers. Young people want access to reliable, accurate and non-judgemental management and education with regard to their sexual health.⁴ However, many PHC providers do not believe they have enough education, experience or confidence to manage youth health, leading to difficulty engaging with youth about sexual health.⁵

Youth sexual health is given little priority in PHC policies or in the daily practice of PHC providers.⁴ International studies have found that even at government level, sexual health is seen as a low priority.^{3,6,7} In New Zealand, there has been inconsistent funding of successful evidence-based sexual health initiatives, such as the national condom use campaign,³ resulting in lack of attention to and prioritisation of youth sexual health in PHC.^{3,6-8}

Youth respect their PHC providers as valid and trustworthy sources of health information and want them to provide education on issues such as sexual health.⁹⁻¹¹ However, PHC providers do not initiate discussions about sexual health with youth.^{5,8,10,12-16} Previous studies suggest that nurses believe patients do not expect to discuss sexual health issues with a nurse in PHC.^{17,18} However, the literature reports that youth would welcome discussions and education about sexual health, if the subject was initiated by health professionals.⁹⁻¹¹ Unless sexual health issues are the reason for young people's visits, many doctors think that their consultation is not the place to discuss these issues.¹⁹ Doctors believe that registered nurses employed in PHC settings (PHC RNs) are best able to provide sexual health education and information to youth.¹⁹ Role confusion and misperception of patient expectations have been barriers to PHC RNs addressing sexual health issues for more than 15 years.^{17,18,20-22}

PHC RNs are well placed to discuss sexual health with youth, as they hold an established health education and promotion role.⁷ Patients perceive nurses as being approachable and as having more time available than other health providers to engage in discussions about their sexual health. However, there is concern among RNs that their own discomfort or lack of knowledge about youth sexual health may lead to their being unable to address some youth health sexual issues.⁶ Health professionals in PHC, including RNs, have identified their need for further education in youth health^{7,9,13,19} and in sexual health issues,^{6,7,9,13,19} but education is of little use if providers do not feel confident to use this knowledge in their daily practice.^{17,23}

WHAT GAP THIS FILLS

What is already known: Registered nurses in New Zealand primary health care are not comfortable discussing sexual health with youth and require further education regarding youth sexual health.

What this study adds: Registered nurses in New Zealand primary health care lack knowledge and confidence engaging with youth about sexual health. They want more support, resources and ongoing professional development regarding youth sexual health.

Registered nurses have a responsibility to ensure they practice in accordance with relevant legislation, to maintain the human rights of people in their care, to practice within the guidelines for cultural safety, and to meet standards of care set by the Nursing Council of New Zealand and the World Health Organization (WHO). Lack of confidence discussing sexual health with youth could lead PHC RNs to unwittingly breach legal, ethical and professional responsibilities.

This study was undertaken in response to research recommendations. The aim of this study is to identify ways to facilitate PHC RNs engaging with youth in discussions about sexual health.

Methods

Ethical approval for this study was received from a regional Institute of Technology Research Ethics and Approval Committee.

Data were collected in two phases: in phase one, quantitative data were collected using an online survey from a purposive sample of 23 PHC RNs, recruited from three primary healthcare organisations (PHOs). An invitation to participate in the study was placed in LOGIC (Linking Opportunities Generating Inter-professional Collaboration), the official journal of the New Zealand College of Primary Health Care Nurses, distributed free to members. Quantitative data were analysed using descriptive statistical methods to show percentages.

In response to some contradictory replies to the online survey, phase two of the study was conducted following analysis of the survey data. Seven individual semi-structured interviews were undertaken to clarify participants' perceptions. The PHC RN participants were recruited using the snowball sampling method, beginning with one PHC RN acquaintance of the lead researcher (RM). Participants consented to a 30-min interview that the researcher recorded and transcribed. Interview questions were designed to address inconsistent data from the phase one online survey to provide clarity and enhance the validity of the study. Qualitative data were analysed independently by RM and two research supervisors. Data were grouped into themes identified within the narrative, which were categorised into broader themes, summarising the principles identified in the data. These broader themes were then grouped into four major topics presenting the main ideas in the data.

Results

Phase one

Participants were all female and most were aged between 51 and 60 years. Most participants had been RNs for 21–30 years, with a hospital certificate as their first nursing qualification. Over half of the participants identified as New Zealand or Other European. Sexual health education was not provided in the pre-registration education of most participants and many had not completed any professional development in sexual health in the past 5 years.

Three-quarters ($n = 18$) of participants felt confident in their knowledge of contraception, STIs and their ability to take a sexual history from youth. However, some participants (26%, $n = 6$) lacked confidence in their understanding of legal and ethical issues regarding the provision of sexual health care to youth. Ethnic and cultural differences between RNs and patients were sources of discomfort (35%, $n = 8$) when engaging with youth about sexual health, as was lack of time (30%, $n = 7$).

Sixty-five percent ($n = 15$) of participants agreed that professional development in cultural, legal

and ethical issues regarding providing sexual health advice to youth would increase their comfort level in discussing sexual health with youth. Almost half (48%, $n = 11$) wanted more education about working with gay, lesbian, bisexual or transsexual youth. Over half the participants (52%, $n = 12$) believed that education about youth psychological development would be helpful.

Access to a screening tool or computer template as a guide for asking questions was seen as potentially increasing comfort levels of participants in discussing sexual health with youth. Access to educational resources on sexual health (100%, $n = 23$), support from other health professionals (87%, $n = 20$) and regular reflection and supervision (74%, $n = 17$) were also regarded as beneficial.

Apart from initiating the topic of sexual health early in discussions with youth, almost all of the participants self-reported effective communication skills when providing sexual health care to youth.

Phase two

Registered nurse sexual health education

Some participants reported that sexual health education during their pre-registration programme was minimal.

'It was probably just one or two lessons on one paper. So it's not a lot really.' [RN7]

There were participants who, despite not remembering sexual health education in their pre-registration programme, had not undertaken any professional development education in sexual health within the last 5 years. Unavailability of courses in youth sexual health contributed to some participants' lack of further sexual health education.

'They [courses on youth sexual health] are very few and far between.' [RN3]

Participants who had undertaken sexual health education reported that the education

was limited to anatomy, physiology, STIs and contraception. They considered that legal and ethical issues affecting the provision of sexual health care to youth, understanding youth health risk behaviours, and communication with youth would be more beneficial in increasing confidence discussing sexual health with young people.

'I can honestly say I have never had a lecture on the legal aspects...I have had lots of lectures on chlamydia, genital warts and whatever.' [RN1]

'But focusing on teenagers and youth sexual health would be good because we don't do any of that focusing specifically on the teenage issues.... and how to deal with teenagers.' [RN6]

Missing opportunities to discuss sexual health with youth

Some participants reported that they would not initiate the topic of sexual health during consultations with youth if a sexual health problem was not the reason for the consultation:

'I wouldn't have a teenager coming in for something else and just say 'by the way, how's your sex life?'" [RN2]

Several participants reported that they would instigate a discussion about sexual health only when youth presented with a related concern.

'When they already have the problem then you start educating them but of course for some of them by then it's too late.' [RN1]

'I haven't had many conversations with youth about their contraception, unless they come in for emergency contraception.' [RN2]

Some participants believed it was the doctor's responsibility to address sexual health care and education for youth and were not clear what information and education young people had received previously.

'It [contraception] will have been prescribed for them by the doctor so they will have already had that discussion with them supposedly. I don't know,

I'm not entirely sure but we don't go into all that conversation.' [RN2]

Barriers to RNs discussing sexual health with youth

According to some participants, addressing youth sexual health concerns was not a priority in PHC.

'We haven't got a [sexual health] screening tool, there's no priority from the PHO to reduce the [sexually transmitted] infection rate.' [RN7]

Most participants self-reported that communication with youth was difficult due to lack of time for consultations.

'We are very busy and I would not have even thought of going down that track of sexual health with a teenager who is coming into the health centre.' [RN6]

'I mean in general practice you don't have time to do a sexual health screening.' [RN1]

Many participants were unaware of the existence of sexual health policies, screening tools, computer templates and guidelines, although all these tools were perceived as useful in increasing RN confidence to discuss sexual health with youth.

'I guess there might be a sexual health screening tool. I mean that would be really useful. I would definitely use one if there was something like that available.' [RN7]

Challenging for participants was differentiating between their roles as parent and health provider, which could generate conflicts in their moral and professional values.

'Morally as the mother of a 14-year-old, I would just die if someone gave my daughter contraception... morally I would totally disagree with that.' [RN2]

Cultural and ethnic influences

When asked about cultural issues regarding the provision of sexual health to youth, many

participants thought that if they did not serve a large Asian, Māori or Pacific population, then cultural influences did not need to be considered.

‘So culturally, because we don’t have a huge Māori, Pacific population in our practice you know I don’t see a lot of them so I don’t think it’s [culture] that much of an issue.’ [RN2]

‘I think if they [Asian youth] are born over here it’s [having sex] not much of an issue.’ [RN3]

Participants instead described their perception of the attitudes of Māori and Pacific ethnicities towards youth sexual health:

‘I’ve seen more Māori and Pacific Islander girls come in pairs rather than European girls..... and it’s like normal behaviour to them.... All their [Māori and Pacific young women] friends have babies at a really young age and as far as culture’s concerned it seems to be more normal in those cultures, and accepted.’ [RN6]

Discussion

Participants in this study reported a lack of confidence in engaging with youth about sexual health due to lack of education, resources and support, combined with a lack of prioritisation and funding. Some participants were unclear about their role in providing sexual health care to youth in PHC. Participants also observed lack of policies, guidelines or screening tools regarding youth sexual health to guide their practice. They thought these would be beneficial in increasing their confidence in raising the subject of sexual health with youth.

Lack of confidence discussing sexual health with youth could lead to RNs struggling to meet standards of care such as principle 3.1 of the Nursing Council of New Zealand Code of Conduct:²⁴ ‘explain and share information with health consumers that they want and/or need’ and the WHO requirement that ‘health-care providers demonstrate the technical competence required to provide effective health services to adolescents.’²⁵

Participants whose moral values conflict with their role as health provider, and RNs who

develop discussions about sexual health on ethnic stereotyping, risk culturally unsafe practice. Cultural safety involves respect and understanding of cultural differences where culture includes ‘age or generation; gender; sexual orientation .. ethnic origin.’²⁶ Culturally safe practice is achieved through self-awareness, examination and understanding of personal attitudes and values, and the effect these could have when providing care to people of a different culture.²⁶

The WHO recognises that current post-registration education in youth sexual health is not meeting the needs of RNs.²⁷ The National Youth Health Nursing Knowledge and Skills Framework²⁸ suggests that RNs require additional skills to provide youth sexual health care, including legal and ethical considerations, understanding of youth health, and ability to communicate effectively with youth. The framework recommends the Nursing Council competencies for RNs be supplemented to include ‘youth health-specific knowledge and skills an RN requires to deliver care to all young people.’²⁸

Sexual health care and sexually related education are recognised by RNs as important parts of holistic health care. PHC RNs are open to the idea of nurse-led sexual health screening programmes for youth.⁷ However, many PHC RNs do not initiate discussions about sex with patients.^{3,13,18,23} The current study has found that some RNs lack the resources and confidence to provide culturally safe, effective sexual health care to youth in primary health care.

Recommendations

Education

Findings from this study support the WHO recommendation that education in youth sexual health and sexuality should commence in undergraduate education and be mandatory in post-registration education of health professionals working in PHC.²⁷ The findings indicate that education needs to include cultural self-awareness, cultural influences on youth sexual health provision, legal and ethical issues regarding youth sexual health, the complexity of youth health needs, and skills for effective

communication with youth. This study supports the National Youth Health Nursing Knowledge and Skills Framework recommendation that Nursing Council competencies for RNs²⁹ incorporate the skills, knowledge, attitudes and experiences required by RNs to provide culturally safe, effective sexual health care to youth in PHC.

Clinical practice

Youth sexual health and wellbeing need to be prioritised in PHC services, with clear communication between health professionals regarding the role of PHC RNs in relation to the provision of youth sexual health care. We recommend improved support and resources for PHC RNs to provide youth sexual health care, such as longer appointment times, availability of sexual health screening tools and current, clear youth health-focused policies. Access and availability of professional development in youth sexual health needs to be improved. PHC RNs need to be confident to undertake opportunistic sexual health screening and to engage with youth about sexual health in PHC.

Strengths and limitations of this study

A poor response rate to phase one of the study may have been the result of survey saturation. To provide richer data, the survey included open-ended questions allowing the participants to add their own comments. The survey was piloted by seven RNs who were not included in the study sample and minor adjustments were made in light of the feedback received.

A study strength was the flexibility to add phase two to the data collection, to validate and confirm survey findings. The study participants were a representative sample of PHC RNs in New Zealand.³⁰

Conclusion

Registered nurses in PHC need to feel confident to initiate discussions about sexual health with young people. To provide effective sexual health care and effectively engage with youth in PHC,

RNs must have further education and be resourced, empowered and supported in their practice. Competencies for RNs should reflect the skills, knowledge, attitudes and experiences required by RNs to provide culturally safe, effective sexual health care to youth in primary health care.

References

1. Azariah S, McKernon S, Werder S. Large increase in opportunistic testing for chlamydia during a pilot project in a primary health organisation. *J Prim Health Care*. 2013;5(2):141–5.
2. Psutka R, Connor J, Cousins K, Kypri K. Sexual health, risks, and experiences of New Zealand university students: findings from a national cross-sectional study. *N Z Med J*. 2012;125(1361):62–3.
3. Terry G, Braun V, Farvid P. Structural impediments to sexual health in New Zealand: key informant perspectives. *Sex Res Soc Policy*. 2012;9(4):317–26. doi:10.1007/s13178-012-0089-y
4. Clark T, Fleming T, Bullen P, et al. Youth '12 overview: the health and wellbeing of New Zealand secondary school students in 2012. Auckland, New Zealand: The University of Auckland; 2013.
5. Denny S, Farrant B, Cosgriff J, et al. Forgone healthcare among secondary school students in New Zealand. *J Prim Health Care*. 2013;5(1):11–8.
6. Van der Meulen E, Oliver V, Flicker S, et al. Obstacles to sexual health services for youth: service providers' perspectives. *Can J Hum Sex*. 2010;19(4):185–90.
7. Hart C, Parker R, Patterson E, et al. Potential roles for practice nurses in preventive care for young people - a qualitative study. *Aust Fam Physician*. 2012;41(8):618–21.
8. Clark JK, Brey RA, Banter AE, Khubchandani J. The delivery of sexuality-related patient education to adolescent patients: a preliminary study of family practice resident physicians. *J Family Med Pri Care*. 2012;1(1):34–8.
9. Chaplick KC, Allen P. Best practices to identify gay, lesbian, bisexual or questioning youth in primary care. *Pediatr Nurs*. 2013;39(2):99–103.
10. Ham P, Allen C. Adolescent health screening and counseling. *Am Fam Physician*. 2012;86(12):1109–16.
11. Walker ZAK, Townsend J. The role of general practice in promoting teenage health: a review of the literature. *Fam Pract*. 1999;16(2):164–72. doi:10.1093/fampra/16.2.164
12. Kang M, Bernard D, Booth M, et al. Access to primary healthcare for Australian young people: service provider perspectives. *Br J Gen Pract*. 2003;53:947–52.
13. Gott M, Galena E, Hinchliff S, Elford H. "Opening a can of worms": GP and practice nurse barriers to talking about sexual health in primary care. *Fam Pract*. 2004;21(5):528–36. doi:10.1093/fampra/cmh509
14. Alexander SC, Fortenberry JD, Pollak KI, et al. Sexuality talk during adolescent health maintenance visits. *JAMA Pediatr*. 2014;168(2):163–9.
15. Haley N, Maheux B, Rivard M, Gervais A. Sexual health risk assessment and counseling in primary care: how involved are general practitioners and obstetrician-gynecologists? *Am J Public Health*. 1999;89(6):899–902. doi:10.2105/AJPH.89.6.899

16. Wimberly Y, Hogben M, Moore-Ruffin J, et al. Sexual history-taking among primary care physicians. *J Natl Med Assoc.* 2006;98(12):1924–9.
17. Magnan MA, Norris DM. Nursing students' perceptions of barriers to addressing patient sexuality concerns. *J Nurs Educ.* 2008;47(6):260–8. doi:10.3928/01484834-20080601-06
18. Magnan MA, Reynolds KE, Galvin EA. Barriers to addressing patient sexuality in nursing practice. *Medsurg Nurs.* 2005;14(5):282–9.
19. Stokes T, Mears J. Sexual health and the practice nurse: a survey of reported practice and attitudes. *Br J Fam Plann.* 2000;26(2):89–92.
20. Tsai L-Y, Huang C-Y, Liao W-C, et al. Assessing student nurses' learning needs for addressing patients' sexual health concerns in Taiwan. *Nurse Educ Today.* 2013;33:152–9. doi:10.1016/j.nedt.2012.05.014
21. Herson L, Hart K, Gordon M, Rintala D. Identifying and overcoming barriers to providing sexuality information in the clinical setting. *Rehabil Nurs.* 1999;24(4):148–51. doi:10.1002/j.2048-7940.1999.tb02162.x
22. Kotronoulas G, Papadopoulou C, Patiraki E. Nurses' knowledge, attitudes and practices regarding provision of sexual health care in patients with cancer: critical review of the evidence. *Support Care Cancer.* 2009;17:479–501. doi:10.1007/s00520-008-0563-5
23. Betony K, Yarwood J. What exposure do student nurses have to primary health care and community nursing during the New Zealand undergraduate Bachelor of Nursing programme? *Nurse Educ Today.* 2013;33(10):1136–42. doi:10.1016/j.nedt.2012.12.007
24. Nursing Council of New Zealand. Nurses - Code of conduct. 2012a. [cited 2013 September 24]. Available from: <http://nursingcouncil.org.nz/Nurses/Code-of-Conduct>
25. Youth Friendly Services Copenhagen, Denmark; WHO 2014. [cited 2014 July 29]. Available from: www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/adolescent-health/youth-friendly-services
26. New Zealand Nurses Organisation. Code of Ethics. 2010. [cited 2014 June 3]. Available from: www.nzno.org.nz/Portals/0/publications/Code%20of%20Ethics%202010.pdf
27. WHO. Core competencies in adolescent health and development for primary care providers: including a tool to assess the adolescent. Geneva, Switzerland: WHO Press; 2015.
28. Kekus M, Dawson D, Gilmer C, et al. National youth health nursing knowledge and skills framework. Auckland: National Youth Health Nurses Reference Group; 2014.
29. Nursing Council of New Zealand. Competencies for registered nurses- regulating nursing practice to protect public safety. 2012. Available from: www.nursingcouncil.org.nz/Nurses/Scopes-of-practice/Registered-nurse
30. Nursing Council of New Zealand. The New Zealand nursing workforce - a profile of nurse practitioners, registered and enrolled nurses 2012–2013. Wellington: Nursing Council of New Zealand; 2013.