

Original
article

A novel condom policy for young attenders at a sexual health clinic

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Objectives: To review the uptake of a new service for condom provision in the under 16s.**Methods:** A retrospective case note review of attenders at an inner London sexual health clinic.**Results:** The service was audited over a 3 month period in the spring of 2000. There were 97 individual attendances, 94% (92) male and 6% (5) female. 89% (87) had never attended a sexual health service before. When asked how they had heard of the clinic 88% (86) said a friend had told them about the clinic. 66% (64) claimed not to be sexually active.**Conclusions:** A novel policy of condom distribution to groups of boys has been successfully piloted at an inner London sexual health clinic. This policy appears to be overcoming the reluctance of teenage boys to access sexual health services.

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Keywords: condoms; teenagers; men

Introduction

The paper by Burns *et al*¹ describes the establishment and resounding success judged by the attendances of the young people's clinic (YPC) at the Archway Sexual Health Clinic (ASHC). However, it was noticeable that as the reputation of the YPC developed locally that young schoolboys and, on occasions, schoolgirls were coming in to the clinic to take advantage of the ASHC policy to give free condoms out at reception. Initially, the boys often attended in large groups and were disruptive and sometimes intimidating to staff and other service users. When condoms and accompanying leaflets were given out, they would be frequently found opened and abandoned within the hospital grounds. This caused disappointment to the clinic staff and much negative sentiment towards the sexual health service within the hospital.

The clinic staff felt therefore that a change in the operational policy was needed and that these young attendees needed in a more proactive sexual health education forum. This led to the development of the under 16s condom policy. The aim of the policy was to provide condoms within a context of a health education setting. It was hoped that this would encourage young boys to engage in safer sex practice and encourage open discussion about sex and sexual health.

The policy

When a group of schoolboys attended at reception requesting condoms, a health adviser or nurse would see them individually or in small groups of up to four in an interview room. During the session, the general service and aims of the clinic were explained—that is, screening of sexually transmitted infections. Reassurance was given regarding their confidentiality. Discussion on sexual health, contraception, and safer sex was initiated. A condom demonstration was given. It was important to

make the sessions as engaging as possible so anatomically accurate condom demonstrators were used and examples of contraceptive devices were available. Time was given to allow questions and general group discussion on issues regarding sex and sexuality in general and sexual health in particular.

As the policy deals with under 16 year olds, there were concerns that there may be some objections from parents or schools to giving condoms, sexual health, and contraceptive advice to this young group. As with all attendees under 16 years old, Fraser/Gillick competence needs to be assessed to ensure that the best interests of the young person are being met. This is usually done individually, but in this case the boys were seen in small groups of up to four and so Fraser/Gillick competence was assessed in this manner. The following checklist was used when assessing the individuals within the group.

- Understands advice and implications
- Sufficient intellectual maturity
- Parental discussion
- Considering/continuing intercourse
- Physical and mental health
- Best interests of the young person.

Once the young person had participated in the session with the health adviser or nurse, they were issued with a personalised club card that they could present at reception when they next wanted condoms; they then did not have to see the health adviser or nurse unless they wanted to. It was agreed that one condom per week would be given if they were not sexually active. Advice was sought from the trust lawyers regarding assessing Fraser/Gillick competence, in groups. The advice was that this is a grey area and as yet no test case has arisen from this situation. However, it was felt that each individual in the group needs to be Fraser/Gillick assessed and information documented in a similar way to individual assessment. It was also felt that the work we were

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Table 1 Age distribution and sexual active by age

Age	Number	% claiming to be sexually active
11	1	0
12	5	0
13	35	8
14	24	62
15	19	36
16	10	60
17	3	66

doing was not causing any harm. Providing information and a condom was felt not to be detrimental in any way to this young group, and could only be of benefit.

Results

The service was audited over a 3 month period in the spring of 2000. There were 97 individual attendances, 94% (92) male and 6% (5) female; 89% (87) had never attended a sexual health service before, 7% (7) stated they had and 4% (4) that information was not recorded. Eighty eight per cent (86) were told about the clinic by a friend. Camden and Islington Health Promotion service had told one young person about the clinic. School had informed 3% (3) of the service. This information had not been recorded in 5% (5) of attendees; 66% (64) claimed not to be sexually active. The age of the attenders and their sexual activity is shown in table 1.

Discussion

Burns *et al*¹ stress few young men or boys attend this service. This is true also for our other clinic sessions, regarding teenage males. While there is much emphasis on promoting sexual health and providing services to young women, young men and boys can be left out.² This new policy of accepting groups of young men if the wish to be seen together seems to have gone some way to overcoming this reluctance to access services. It has been suggested that a "bad" experience with condoms during a young man's first sexual experience may affect his view on future condom use. By having easy access to condoms before sexual activity starts may allow young men to practise and masturbate using condoms, thus, become more familiar and confident with them.³

Many boys brought friends who were keen to sit in on the sessions. This opportunity was used to allow these boys to engage in peer education under supervision. Peer education has now been validated as an effective means of sex education in several studies.^{4,5} Activity based as opposed to information based workshops facilitated by peers who reflect their audience was found to be the most effective model in at least one study. Not surprisingly, peer education has been shown to benefit both the audience and the peer educators, with reports of increased self esteem and motivation among the peer educators.³ These group sessions gave

Key messages

- The United Kingdom has the highest figures for unwanted pregnancies and sexually transmitted infections in western Europe in the young aged 16–19. There is an urgent need to address this situation and encourage safer sexual practice and awareness of sexual health in both males and females.
- Traditionally there has been more sexual health, and particularly contraceptive services, for young women. Boys and young men have been mostly ignored and their needs not addressed. By addressing this imbalance, it is hoped that young men will be more empowered and inclined to use condoms and practise safer sex and access sexual health services in the future.
- By capturing the interest of the young who drop in for free condoms after school, but are not yet sexually active, and providing condoms within a health education setting, it is hoped that open discussion about sex and relationships will promote increased awareness of sexual health and contraceptive matters.
- A formal framework must be used to guide and protect staff working with the very young, especially those under 16 years old. Some parents may object to their children being given information about sex and being provided with condoms.

an opportunity to dispel some myths and correct misinformation. It is important that staff use language that the young people would understand, the aim being to use the same language as that the young people did as long as it felt comfortable to do so.

The questions regarding sexual activity were asked within the group during the session with the health adviser or nurse. There may therefore be a doubt about how honest the young people were about their sexual activity in front of their peers. There may also be a question as to what young people understood by sexually active.

In conclusion this pilot has been judged successful by both patients and staff.

Contributors: SW and RT planned and carried out the intervention and audited the service; PK assisted in the preparation and editing of the manuscript.

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