

## Sexual health provision for young people

Madam

We were interested in the article by Baraitser et al.<sup>1</sup> describing the setting up of an alternative model of sexual health provision for young people by adapting existing adult services, rather than providing health services dedicated to young people only. However we would like to ask the question: 'Where are the young men?' There was no mention in the study of any attendances by young men; a notoriously difficult group to attract into 'family planning services', but nevertheless having a crucial part to play in reducing teenage pregnancies and improving their sexual health and wellbeing.<sup>2</sup>

Research conducted by the Family Planning Association (fpa) confirms the exclusion felt by young men who find it difficult to discuss sexual health and access information and advice.<sup>3</sup> This situation would be compounded by the fact that around 70% of clients attending this clinic are aged 20 years and over and probably mostly female.

Our own service, which had reached 14 818 annual attendances of teenagers (34% boys), showed a 10% fall in numbers when circumstances forced a move so that the clinic was located next to the adult service. The subsequent needs of the attendees became more clinical and less educational. This may have been partly due to the decreased proportion of males and possibly due to the setting being less conducive to educational activities. The educational aspect of such services should not be undervalued.

We agree that certain qualities that make a good sexual health service, such as the non-judgmental attitude of clinic staff, should exist across all sexual health services. However these are not the only reasons young people like to visit services set up for them. Confidentiality is a major concern for this group and the idea that they may see an adult they know is a genuine concern and may discourage attendance.<sup>4</sup>

Although there was obviously an unmet need for services attracting teenagers in the area of the study, as illustrated by the sudden increase in numbers in this age group, attendances of 567 annually are still very low compared to the thousands that attend dedicated services (e.g. Warrington Youth Advice shop has approximately 10 000 visits annually, Manchester Brook 15 000 visits annually).

This type of service development would compliment existing specialist services for young people. However, providing this type of service as a replacement or an alternative model would go against all research and government recommendations. These recommendations clearly express the need for dedicated services 'setting an upper age limit of 25' and, if in primary care, running 'separate sessions for young people' to encourage access by younger teenagers and to meet their specific needs.<sup>5</sup>

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**Elaine Unsworth**, Teenage Pregnancy Co-ordinator, Warrington, UK

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### Author's reply

Madam

Answers to the questions raised by Brough et al. are as follows:

1. We agree that the ability of family planning services to attract young men is an important measure of their effectiveness. In the 6 months before the project started, attendance at the clinic by young men was 7.8%. In the third 6 months of the project this increased to 13.2%. At the time we only offered contraceptive and advice services to men but since November 2001 we also offer screening and treatment for sexually transmitted infections (STIs). As a result we expect attendance by men to increase substantially.
2. The concern that young people may meet an adult that they know when using a mainstream sexual health service is commonly cited as a reason to support the existence of dedicated young people's clinics. There is little high-quality published evidence to support the idea that not meeting older people at a clinic is important to young people and there is some evidence to refute this. For example, Clements et al.<sup>1</sup> showed that 77% of school pupils rated the fact that clinic staff would not tell parents about their visit as important only 11% supported limiting the clinic to young people. The report quoted by Brough et al. is 10 years out of date and may no longer be relevant.

We are concerned that the provision of dedicated youth services does not challenge the idea that sexual activity among young people is socially unacceptable and should be hidden from older people. The international literature shows that open discussion of sexual health issues is consistently associated with improved sexual health indicators among young people.<sup>2-4</sup> Service providers have some responsibility to respond to this evidence and to configure services so that they encourage open and positive attitudes to sexual activity among young people without breaching confidentiality. The idea of dedicated young people's services first gained support in the UK in the mid-1960s at a time of negative attitudes towards the sexual activity of young people.<sup>5</sup> This approach is possibly no longer appropriate now that these attitudes are potentially more susceptible to change.

3. The attendance rates given in the paper relate to a clinic serving a small area of London. One of the main aims of this project was to link the clinic to its local community (about one-third of the borough of Lewisham). A total of 68% of those using the service are resident in the three postcode areas adjacent to the clinic. To compare this with attendance at a clinic whose catchment area is the whole of the city of Manchester is inappropriate.

4. An important aim of this research was to challenge the existing Government guidelines cited by Brough et al. since they are supported by very little evidence. A close reading of the review articles commonly cited to support these guidelines reveals a lack of evidence for the effectiveness of dedicated young people's services and a paradoxical tendency for authors to cling to the assertion that this is in fact the way forward. For example, the National Health Centre (NHS) Centre for Reviews and Dissemination<sup>6</sup> comments that: 'there is not the sort of clear evidence of the effectiveness of different approaches to contraceptive counselling and contraceptive service provision that could provide a firm basis for decision making', but goes on to cite a single study to support the implementation of 'youth-orientated clinics'.

Similarly, Peckham<sup>7</sup> acknowledges that: 'there has only been limited research on the value of specialist advice centres for young people which include the provision of contraceptive services', but goes on to suggest that this is the most effective approach.

There is currently a lack of good quality research to support the arguments on both sides of this debate. We aim to address this deficit. We are currently evaluating an expanded version of this pilot project and will publish further data in the near future to contribute to this debate. In the meantime, service providers and commissioners should maintain an open mind about the relative merits of dedicated young people's clinics and youth-friendly mainstream services.

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- 6 National Health Service (NHS) Centre for Reviews and Dissemination. Effective health care: preventing and reducing the adverse effects of unintended teenage pregnancy. NHS Centre for Reviews and Dissemination 1997; **3**: 1-12.
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## Social marketing of condoms – an unconventional approach

Madam

In August we embarked on an unconventional pilot, which we believe to be of interest to your readers, to sell packs of three condoms for £1 through 60 vending machines as an additional source of supply for condoms. This does not replace clinic provision. Instead it aims to reach 14-19-year-olds, in areas of high teenage pregnancy. Although social marketing of condoms is not new, the combination of unconventional factors in this pilot have

warranted it being given national pilot status by the Teenage Pregnancy Unit.

For reasons of convenience, confidentiality, lack of relationship stability and availability, condoms are very popular with teenagers. With under 16s, they are the single most popular method of contraception. Young men, in particular, find vending machines convenient and anonymous, in contrast to the discomfort many feel within a clinic.<sup>1</sup> In the UK, machines are widely available, although predominantly in licensed premises and therefore aimed at the 18+ age group. Cooper et al.<sup>2</sup> found that many respondents thought that condoms were overly expensive. A recent survey shows that this remains true, with a vended two-pack costing £2, although now less than 50% thought them 'too expensive'.

- Rather than marketing under an impersonal high street brand that has failed to capture their imagination, we have partnered Galaxy 102, Manchester's main youth-focused commercial radio station. Both the pack and machine are branded as a 'Galaxy' product. This provides us with access to the target group through paid advertising, sponsorship and, importantly, their disk jockey's endorsement. Such twinning allows the product to benefit from every pound Galaxy spend promoting their station.
- Some packs contain 'winning tickets' to encourage 'just in case' purchases. Sixsmith and colleagues note that these could influence the decision to purchase or not.<sup>3</sup>
- This price offers affordability. Pricing too low damages credibility; too high prohibits young people from regular purchases. Our research suggests this price is 'about right'.
- In this survey<sup>3</sup> young people were asked where they wanted the machines. Chosen sites ranged from outside petrol stations, to an Internet café, and a hostel for homeless young people.
- By custom printing the packet and insert leaflet, links have been made to provision of free advice and contraception, including emergency contraception through pharmacists.

This pilot will run for 12 months. Success will be measured through a repeat of the baseline audit. Vending is not cheap and provides very limited scope for giving advice. Yet it has the potential to be accessible to young people, for more hours of the day and in more locations, than we have ever had before.

**Steve Penfold**, General Manager, Family Planning Service, Central Manchester Primary Care Trust, Palatine Centre, 63–65 Palatine Road, Manchester M20 3LJ, UK

**Rosemary Kirkman**, Senior Lecturer, Family Planning, University of Manchester, Manchester, UK

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- 2 Cooper P, Diamond I, High S, et al. A comparison of family planning provision: general practice and family planning clinics. *Br J Fam Plann* 1994; **19**: 263–269.
- 3 Sixsmith J, Lewis S, Griffiths J, et al. Young people and contraception: a survey in Manchester (personal communication).

### Informed consent for *Chlamydia trachomatis* testing

Madam

I was a little curious to read the study by Basarab et al.<sup>1</sup> and to know what the hospital ethics committee thought of this research proposal. Although the authors suggest that 'it was assumed that a young man who had consented to

give a urine specimen had given consent to screening for all relevant pathogens', I would suggest that such a view is naive and misfounded.

*Chlamydia trachomatis* infection is a sexually transmissible agent and will inevitably raise the issue of fidelity for that patient and his partner.

In a department of genitourinary medicine (GUM) we see first hand how disruptive to a relationship this can be and find it difficult to condone the paternalistic attitude of 'let's test now and not talk to them about it and only tell them if they've got a positive result'. In my experience patients are not always glad to be told that they had got a sexually transmitted infection (STI) and we see frequent relationship breakups arising out of perceived or actual infidelity. We may not as a profession agree that ignorance is in the patient's best interest but surely the patient has a right to choose before we do specific tests on them without their understanding of the implications of the test.

However well intentioned this study may have been, I feel it is regrettable that more active steps were not taken to involve patients and obtain their informed consent prior to testing.

**Chris Valentine**, Consultant in Genitourinary Medicine, Ravenscraig Hospital, Greenock, UK

#### Reference

- 1 Basarab A, Browning D, Lanham S, et al. Pilot study to assess the presence of *Chlamydia trachomatis* in urine from 18–30-year-old males using ELA/IF and PCR. *J Fam Plann Reprod Health Care* 2002; **28**: 36–37.

### Authors' reply

Madam

On submission of this article we stated that we had not sought ethical approval for our study. Although we understand that not all would agree with our action, we would put forward a number of arguments in favour of our decision.

We take the view that submission of a specimen is a consultation to assist in diagnosing the cause of a patient's symptoms and signs. It seems illogical to omit testing for one of the commonest causes of sterile pyuria in this age group. By failing to do so, we miss an opportunity to interrupt transmission of an infection which has potentially serious sequelae, e.g. sterility and neonatal disease. Extending this point further, patients may well have a valid argument against us if we omit to test for *Chlamydia trachomatis*, and therefore permit transmission of an infection that the patient was actively seeking to avoid.

The argument of not testing urine for the presence of *C. trachomatis* is inconsistent with the standard handling of other specimens. For example, we are sometimes asked to look for fastidious organisms as uncommon causes of urinary tract infections. This involves using chocolate agar, which also supports the growth of *Neisseria gonorrhoeae*. If this were grown, it would be reported even if it had not been specifically requested as a test investigation. Furthermore, the presence of *Trichomonas vaginalis* on a wet film from a high vaginal swab would be reported by microbiology laboratories, and has the same sexually transmitted infection (STI) implications as identification of the presence of *C. trachomatis*. Finally, routine testing of sterile pyuria samples from this age group for *C. trachomatis* is already established in some laboratories.

We notified all local general practitioners (GPs) and our local genitourinary medicine (GUM) clinic of our new testing procedure and since the publication of our study we have received only one GP complaint regarding testing without specific consent to look for *C.*

*trachomatis*. We have the full support of our local GUM department for our approach.

This is a controversial area and we are glad for the opportunity to debate it in your journal.

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### Testing for STIs in gynaecology and general practice

Madam

The survey carried out by Griffiths et al.<sup>1</sup> is relevant, especially in the light of the national strategy for sexual health and HIV that aims to improve the sexual health of the nation.<sup>2</sup> The authors have mentioned the types of swabs that were used for the diagnosis of sexually transmitted infections (STIs), but have neither mentioned the technique of taking the endocervical swab for chlamydia and gonorrhoea nor the transport medium used. They have also not mentioned the storage and transport of these swabs out of hours. Both chlamydia and gonorrhoea are intracellular organisms and swabbing technique is important in order to obtain epithelial cells for diagnosis. It is recommended that the cervix should be cleaned of mucus or discharge, then a swab should be inserted into the cervix 1–2 cm deep and rotated several turns to obtain columnar cells. It is recommended that swabs for chlamydia culture be stored in the refrigerator at 4°C.<sup>3</sup> *Neisseria gonorrhoeae* is a fragile organism which only survives best at a temperature of 37°C, hence swabs for its detection should be kept at room temperature and inoculated onto a culture plate as soon as possible. Alternatively, they can be sent in Stuart or Amies medium if available.

We recently did an audit looking at management of pelvic inflammatory disease (PID) in a hospital setting. We conducted telephone interviews with the junior doctors on call for gynaecology in all the hospitals in the Northwest of England and North Wales. They were asked details of swabs taken for patients suspected to have PID including the type of swab, technique of taking them, storage and transport. We found that all the doctors took a high vaginal swab (HVS) for culture and sensitivity and an endocervical swab for chlamydia. Although they used the correct swab and sent it in the correct transport medium for chlamydia (sodium azide), the correct technique of obtaining the sample was used by only 45% of doctors. A total of 48% of the doctors took a second endocervical swab for gonorrhoea testing, but sent it in a charcoal medium without specifying the need for urgent delivery to the laboratory. Only 21% of the doctors stored the swab for gonorrhoea at room temperature.

The Royal College of Obstetricians and Gynaecologists (RCOG) has recommended that every woman should be offered a screening test for chlamydia or receive antibiotic prophylaxis prior to insertion of an intrauterine device (IUD).<sup>4</sup> The authors found that only 58% of the general practitioners (GPs) surveyed offered this option.

It is surprising that 4% of the GPs referred women with a positive test result for chlamydia to gynaecology. These women should ideally be referred to a genitourinary medicine (GUM) clinic for screening for other STIs and contact tracing.<sup>5</sup>

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## Author's reply

Madam

We read with interest the letter referring to our recent paper.<sup>1</sup> The authors raise important testing issues that have significant training implications. The accuracy of tests for chlamydia and gonorrhoea depend upon the quality of the clinical specimen. In addition to accurate technique and correct choice of swab, the authors highlight the important need for information on specimen storage and transport. Evidently, from their audit, the results of our survey and other studies, there is a clear need for comprehensive guidelines and training to optimise testing. Furthermore, training is required not only on accurate specimen collection and storage but also in identifying clinical symptoms, history taking, information giving, treatment and follow-up care. The latter may involve contact tracing and counselling, or

clear information on the need to refer to genitourinary medicine (GUM) for these aspects of infection management and co-morbidity screening. An emphasis on the need to test at the time of intrauterine device (IUD) insertion and on emergency contraception is also required. As data from the UK pilot studies inform an imminent screening programme that will opportunistically test in primary care, these training issues become essential. Failing to optimise clinical practice may mean that screening will in fact do more harm than good. Finally, with the increased use of nucleic acid amplification tests (NAAT), and non-invasive samples such as urine, the need for clear guidelines and local agreement on how to organise testing is required to ensure effective use of resources.

**Catherine Griffiths**, *London School of Hygiene and Tropical Medicine, London, UK*

## BULLETIN BOARD

## Football helps the fight against HIV

During the course of a 90-minute football match, 400 young people aged 15 to 24 years will have contracted human immunodeficiency virus (HIV) worldwide. Around 100 children under the age of 15 will die from acquired immunodeficiency syndrome (AIDS) and another 400 will lose parents through AIDS. The United Nations Children's Fund (UNICEF) has joined forces with the International Federation of Association Football (FIFA) to use the power of football to educate young people around the world about HIV/AIDS. In Ethiopia and Kenya there are projects that involve a variety of football programmes. At half time players, coaches and health workers distribute brochures and information to supporters and opponents about preventing the disease. Young people are being encouraged in these programmes to play a role in the fight against the spread of HIV.

Source: [www.durexhealthcare.com](http://www.durexhealthcare.com)

## Proposal for health services in UK schools welcomed by fpa

Anne Weyman, the Chief Executive of fpa (previously the Family Planning Association), said: 'We welcome the Government's acceptance of the recommendation that health services should be available on site in schools. The rate of teenage pregnancy in this country is too high and action to bring it down is essential. Measures such as this are eminently sensible'. Ms Weyman went on to state: 'Young people need easy access to confidential and holistic health services that meet their needs and cover a range of issues, such as relationships with family and friends, emotional problems and general health as well as sexual health. Provision of such services is up to the school community of parents, teachers, pupils and governors but ideally we'd like to see them available in schools throughout the country'.

Source: *fpa press office June 2002*

## Perpetuating the negative attitude toward the intrauterine contraceptive device

The intrauterine device (IUD) has received a plethora of bad publicity since the 1970s and has been blamed for everything from pelvic infection to infertility and ectopic pregnancy. Studies since the 1970s, however, have shown that the risk of

infection is largely confined to the immediate time following insertion and that the ectopic risk overall is reduced. A recent study by Espey and Ogburn published in *Contraception* examined the information regarding the IUD in medical textbooks published between 1996 and 2001 in both Britain and the US. It was disappointing that over half of the textbooks published still mentioned these factors as risks associated with the IUD and suggested that the IUD should only be used as a last resort. The authors state that many of the teachers in medical schools also appear to be continuing to pass on these myths. It is clear that new evidence needs to be in the public and professional domain so that these myths can be dispelled.

Source: Espey E, Ogburn T, *Perpetuating the negative attitudes about the intrauterine device: textbooks lag behind the evidence*, *Contraception* 2002; **65**: 389–395

## New website for health care professionals caring for asylum seekers in the UK

A national website has been launched for health professionals and volunteers working with asylum seekers and refugees. This website can be found at [www.harweb.org.uk](http://www.harweb.org.uk) and provides a huge amount of useful information for all health care personnel involved in the management of the many health issues faced by asylum seekers. It covers issues related to men and women including emotional problems, genital mutilation and cultural issues. It has very useful link called 'communicate' that provides access to a multilingual appointment card. Name, address, consultant, place of appointment is typed in English and it is automatically translated into one of many languages. It can be used and printed online. This site will prove useful to anyone with an interest in issues facing asylum seekers.

Source: [www.harweb.org.uk](http://www.harweb.org.uk)

## New international society for sexuality and cancer

One of the hidden areas in relation to cancer, particularly gynaecological cancer, is sexuality and associated sexual problems. Patients often feel unable to talk to their doctor for a variety of reasons, and even when they do there is a lack of availability of trained professionals to work with them. This can have a negative impact on their

quality of life even when the cancer has been treated successfully. As a response to clinical observations and calls from service user groups, backed up by a recent peer-reviewed publication, a new international society is being formed which aims to focus on this area of clinical care. A core 'start-up' group formed by the UK, The Netherlands, Belgium, Israel and Australia is in the process of compiling a mailing list, preferably by e-mail. If readers require further information, or wish their names to be added to the list of interested professionals, they should contact Dr Susan Carr, Consultant in Family Planning and Reproductive Healthcare, The Sandyford Initiative, 6 Sandyford Place, Glasgow G3 7NB, UK, or e-mail the Journal at [www.ffprhc.org.uk](http://www.ffprhc.org.uk) and their e-mail will be forwarded on to the relevant parties.

Source: Susan Carr, Consultant in Family Planning and Reproductive Healthcare, The Sandyford Initiative, Glasgow, UK

## First phase of chlamydia screening programme announced in the UK

Thousands of women across the country will shortly be offered testing for chlamydia – the most common sexually transmitted infection (STI) according to new statistics published recently. The Department of Health has identified ten locations to take forward the first phase of a national chlamydia screening programme.

The screening programme, outlined in the National Strategy for Sexual Health and HIV, will tackle this bacterial infection which, because it often has no obvious symptoms, frequently remains undiagnosed. Although easily cured with antibiotics, if untreated chlamydia in women can lead to pelvic inflammatory disease (PID), ectopic pregnancy and infertility.

The ten sites will share £1.5 million additional funding to set up the screening programme which will take place in clinics where young people access sexual health services such as family planning and genitourinary medicine (GUM) clinics. Locations have been chosen to give an even spread geographically, to provide an urban/rural balance and reach minority ethnic groups. The ten sites will build upon earlier work carried out at two pilot schemes in Portsmouth and the Wirral and further inform the gradual roll-out of a nationwide programme.