

Analysis of clinic attendances by under-14s to sexual health clinics in Gwent, South Wales, UK

Louise Cook, Charlotte Fleming

Abstract

Objectives To determine the gender, sexual history and reason(s) for visit for under-14s (young people) attending the authors' sexual health clinics.

Methods Analysis of case notes of 242 young people who made a total of 598 visits to a sexual health clinic in Gwent, South Wales, UK between 1 January and 31 December 2003.

Results Of the 242 young people studied, 41% were male and males were responsible for 42% of visits. There was no written record relating to 7% of the total visits. Median age at both first registration and first heterosexual intercourse (when recorded) was 12 years for males and 13 years for females. Some 57% of females and 30% of males were already sexually active at first registration. Details relating to a young person's partner and their experience of sex (e.g. willingness, autonomy and consensual nature of sex) were infrequently recorded, especially for males. 96% of males requested condoms

and 99% received them, whilst 72% of females requested condoms and/or hormonal contraception and 86% received them. 35% of females were seen for the consequences of sex (i.e. pregnancy testing, emergency contraception, screening and/or treatment of sexually transmitted infections and unplanned pregnancies). 80% of these subsequently received condoms and/or hormonal contraception. The majority of young people saw a nurse exclusively (96% males, 71% females).

Conclusions Of the young clients seen, 41% are male. Sexual history details are infrequently recorded, particularly for males. The majority of young people accessing the authors' service are taking action to protect their sexual health and most will see a nurse exclusively.

Keywords clinic attendance, contraception, sexual health, sexually transmitted infections, young people

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Introduction

Under the Sexual Offences Act 2003¹ all teenagers, including those aged under 13 years, are entitled to receive confidential sexual health advice and contraception. The Bichard Inquiry has called for vigilance when consulting with sexually active young people with the reporting of all suspected criminal activities to the police.² Bichard himself has subsequently emphasised that these recommendations were not intended to criminalise young people in non-abusive teenage relationships.³ London and Sheffield Area Child Protection Committees require that health professionals automatically report all sexually active under-13s and the partners of teenagers aged under 16 years to the police.⁴ However, a multi-agency response to these proposals warns against such compulsory reporting, but stresses the importance of making an appropriate 'risk assessment' of potentially vulnerable young people.⁵

In 2003, the authors' service held a meeting with police, outreach and social services at which concerns were raised over the vulnerability of a minority of young people who attend its clinics. In response, we undertook a review of the case notes in order to determine how much we know about our clients' sexual histories and their use of our services. Under-14s were chosen because they fall below the Welsh national average age at first heterosexual intercourse (sexual debut) of 14.3 years.⁶ This is lower than the UK average and may reflect a lower age at sexual debut with lower social class;⁷ teenage motherhood is higher in Wales than England and cultural expectations may be different.

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Key message points

- Record keeping needs refocusing to be gender neutral and to prompt recording of sexual history.
- The majority of young people accessing the authors' services are taking action to protect their sexual health.
- Nursing staff see the majority of under-14s; training resources need to be directed accordingly.

Also the method of questioning (examination setting in Welsh youth survey) may have encouraged different responses to those in other surveys. This paper reports the findings relating to a young person's sex, their sexual history and reason for visit. Data relating to identifying the risk of sexual abuse and exploitation and to the recording of compliance with Fraser competence is reported elsewhere.⁸

Background

Gwent Sexual Health Service provides 47 walk-in clinics at 26 sites each week. Of these, 13 are young peoples' clinics (YPCs) catering to under-25s. The remaining family planning clinics (FPCs) can be accessed by clients of any age. The C-card scheme, funded by the Welsh Assembly Government, distributes free condoms and supporting literature to young people aged 14–25 years. Although independent of our own clinics, we facilitate its operation and the scheme often shares a session with a YPC.

Methods

Case notes of all under-14s (young people) who attended a clinic between 1 January and 31 December 2003 were reviewed and the data were recorded on a data collection template. The data were analysed using Microsoft Excel™.

Results

Some 242 young people made a total of 598 visits to a sexual health clinic during 2003. Males accounted for 41% of young people and 42% of total visits. Males were more likely to attend a YPC than an FPC (62% vs 38%). There was less variation for females (46% vs 54%).

Table 1 Age of young person at first registration with service and at each visit during 2003

Age (years)	Age at first registration with service ^a				Age at visit during study period			
	Males		Females		Male visits		Female visits	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
<11	2	2	3	2	0	0	1	
11	10	10	9	6	3	1	7	2
12	47	47	27	19	85	33	29	8
13	41	41	103	73	154	61	271	79
14 ^b					12	5	36	11
Total	100	100	142	100	254	100	344	100

^aRefers to first registration with service which may have taken place prior to or during 2003.^bSome young people who attended during 2003 were seen both before and after their fourteenth birthday.**Table 2** Frequency distribution of visits made by both sexes during 2003

Gender (<i>n</i>)	Frequency of visits (<i>n</i>)																	Total (<i>n</i>)
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	
Male	40	29	16	5	2	2	1	1	0	1	0	0	1	2	0	0	0	100
Female	72	28	14	9	5	8	2	1	0	0	1	0	0	0	1	0	1	142
Total	112	57	30	14	7	10	3	2	0	1	1	0	1	2	1	0	1	242

Median age at first registration for males was 12 (range, 10–13) years and for females 13 (range, 8–13) years. One third of males and 10% of females were aged 12 years or younger when seen in 2003 (Table 1). The median number of visits for males was two (range, 1–14) and for females one (range, 1–17). Twelve young people were responsible for 5% of the visits, each being seen on seven or more occasions (Table 2).

Sexual status at first registration with the service was recorded for 78% of males and 93% of females, with 30% of males and 57% of females already sexually active. Age at sexual debut was identified for 23% of males and 44% of females (Table 3). A further 9% of both sexes became sexually active between first registration and a follow-up visit in 2003. Median age at sexual debut (when recorded) was 12 years for males and 13 years for females.

Where the young person was known to be sexually active, the number of partners could be determined for 9% of visits, 70% of these related to female clients. For this 9%, median number of partners for females was two (range, 1–5) and for males one (range, 1–3).

Age of partner was recorded at 29% of visits. For the majority of young people, partners were of similar age or 1–3 years older. Females were more likely to have an older partner (Table 4). For 6% of visits where age of partner could be identified, the partner was four or more years older than the young person concerned.

Heterosexual intercourse was stated to have been consensual at 5% of visits; one visit related to a male client. At two visits, both female, sexual intercourse had not been consensual. For the remaining 95% of visits there was no

Table 3 Age at sexual debut, when recorded, for both sexes

Age at sexual debut (years)	Males		Females	
	<i>n</i>	%	<i>n</i>	%
Not recorded	77	77	79	56
10	0	0	2	1
11	4	4	5	4
12	14	14	19	13
13	5	5	35	25
14	0	0	2	1
Total	100	100	142	100

record as to whether or not sex was coerced. Alcohol history was recorded for 19 (8%) clients; one was male. For seven females alcohol was stated as having been a causal influence in sexual activity.

The main reason for each visit and the activities that took place (outcome) were determined. There was no record relating to 26 visits by males (10%) and 13 visits by females (4%). Condoms were requested by 96% of males and received by 98%. In comparison, 36% of females requested condoms, 26% hormonal contraception and 10% both condoms and hormonal contraception. Of these, 67% of females received condoms, 18% hormonal contraception and 37% both. Overall, 35% of females were seen for the consequences of sex [i.e. pregnancy testing, emergency contraception, sexually transmitted infection (STI) testing and/or treatment and unplanned pregnancies] and 80% of these subsequently received condoms and/or hormonal contraception (Figure 1). Twelve percent of females were seen solely for the consequences of sex, with a further 8%

Table 4 Comparison of age of young person with age of partner, when recorded, per visit

Age of partner (years) ^a	Age of young person (years) for male visits (<i>n</i> = 55) ^b				Age of young person (years) for female visits (<i>n</i> = 117) ^b				Total	
	11	12	13	14 ^c	11	12	13	14 ^c	<i>n</i>	%
Younger than	0	0	0	0	0	1	1	0	2	1
Same age	2	13	19	1	0	1	31	5	72	42
1–3 years older	1	10	8	1	2	10	54	1	87	51
4 years older	0	0	0	0	0	3	4	0	7	4
5+ years older	0	0	0	0	0	0	4	0	4	2
Total	3	23	27	2	2	15	94	6	172	100

^aTerm 'partner' does not necessarily imply 'sexual partner' as it was not always possible to determine this from the case notes.^bAge of partner not recorded at 426 visits (male = 199, female = 227).^cRefers to young people who were seen both before and after their fourteenth birthday during 2003.

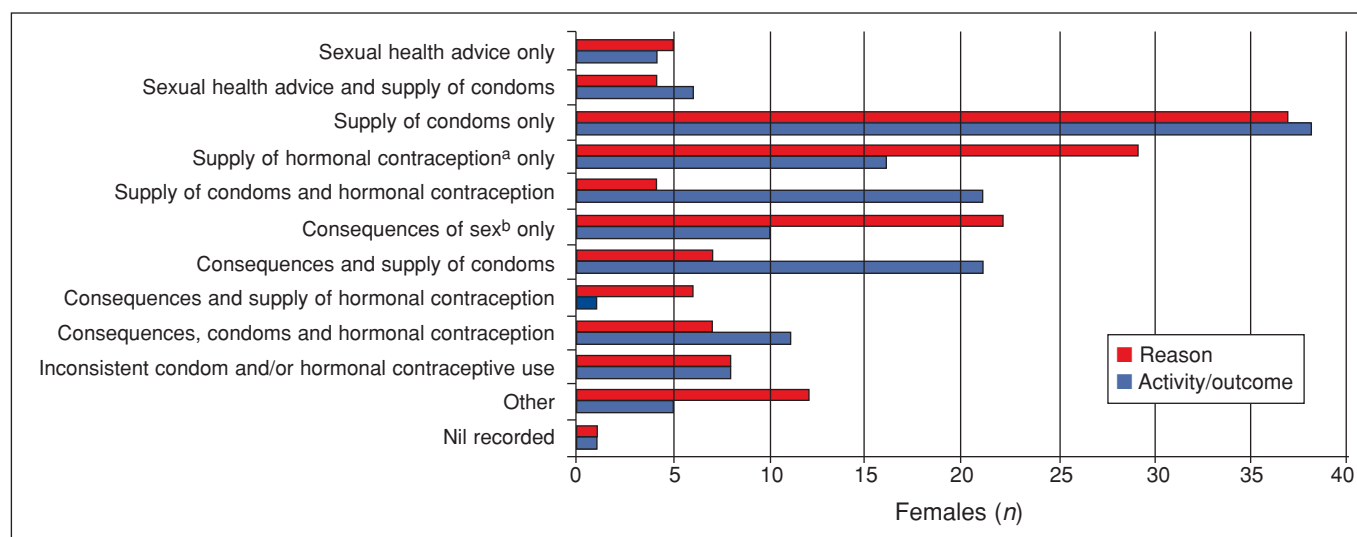


Figure 1 Reason for and outcome of visits of young females included in the study. ^aHormonal contraception: 40% of females received hormonal contraception (combined oral contraceptive, 68%; Depo-Provera®, 21%; progestogen-only pill, 7%; implant, 4%). ^bConsequences of sex included one or more of: pregnancy testing, emergency contraception, STI screening and/or treatment, and unplanned pregnancy

exhibiting inconsistent condom or hormonal contraceptive use by returning for further consequences of sex. No males were seen for the consequences of sex.

Overall, 96% of males and 71% of females were seen exclusively by a nurse. Of the new registrations, 93% of males and 53% of females saw a nurse only. At follow-up, 97% of visits by males and 57% of visits by females were dealt with by the nurse. Results relating to the identification of markers of sexual abuse and exploitation and to demonstration of compliance with Fraser guidance are reported elsewhere.⁸

Discussion

Young males are less likely to access sexual health services than females^{9,10} but their attendance is on the increase, primarily for the supply of condoms.¹⁰ Emphasis has been placed on targeting males to help reduce the incidence of STIs and unplanned teenage pregnancies^{11,12} and to making services more accessible to males.¹² The 41% male attendance observed in the present study compares favourably with that of others,¹³ and suggests that we are providing a user-friendly service. Our results indicate that young people, especially males, are more likely to use services directed at young people. In geographical areas where both YPCs and FPCs co-exist, 96% of male and 87% of female attendances for under-14s are at YPCs.

Where recorded, males were less likely to already be sexually active than females (30% vs 57%). In the present study, males start attending clinics at an earlier age than females, thus providing an opportunity to promote positive messages about sex and safe sexual practices and postponing its onset.

The circumstances at first intercourse (i.e. regret, willingness, autonomy and contraceptive use) determine the sexual competence of a young person, as defined by Wellings *et al.*⁷ Wellings *et al.* reported that 91% of females and 67% males aged 13–14 years were not sexually competent at first intercourse.⁷ We would expect to have recorded whether a young person was sexually active when they first register with our service. This was not the case for 13% of young people. We did not record whether condom use is consistent. We also recorded very little about a young person's sexual partners: their age, number, whether they are equally willing, if sex is autonomous or if coercion is involved, or whether sex is associated with later regret.

Reasons for poor record keeping might include time constraints, lack of understanding of what is required, concern that asking a young person too many detailed and intimate questions may deter their re-attendance, and health professionals may feel embarrassed about asking intimate questions. Also, the C-card scheme requires minimal information from a young person (i.e. details of sexual history are not required) and uptake of the scheme

History Sheet for Young People under 16 years of age					
Name				D.O.B.	
Height	Weight	BMI	BP		
Females					
Menarche	Pregnancy / TOP		Date(s)	Outcome	
Cycle	Yes / No				
Males and females (Please circle answers that apply)					
Sexually active at first visit?	Yes / No	Is this the first sexual partner?	Yes / No		
Age at sexual debut.....years	Aware of STI / Safe sex		Yes / No		
Age of present partner.....years	Condom use: Always / Sometimes / Never				
Does client feel able to say 'No' to sex?	Yes / No / Sex non consensual	Client lives with Parent(s) / grandparent / siblings / in foster care / other.....			
Features suggestive of 'grooming' e.g. Rewarded for having sex / domineering partner / restrictions on seeing friends / other – give details in notes	Yes / No	Does main carer suffer from mental illness / drug / alcohol problems? If yes, specify.....			
Use of internet chat rooms?	Yes / No	School attended regularly / truants / excluded Name of school.....			
Social history (Please circle answers that apply and record details where appropriate in notes)					
Smoking	Yes / No	If yes...../day	Do you see anyone else to talk to or for extra help at school or elsewhere?		Yes / No
Illicit drug use	Yes / No	Specify.....	If yes, may we have permission to contact them (name:.....)		Yes / No
Alcohol: Never / Occasional / Regular / Binges	units/week		Who is their trusted adult?.....		
Are alcohol / drugs influential in sexual activity?	Yes / No	Involvement with social services (past / present) or police (past / present)		Yes / No	
Medical history		Yes	No	Family history	
Migraine				Cancer (bowel/ovary/breast) or VTE	
Epilepsy				Allergies (medication/latex)	
VTE				Current medication	
Diabetes				Learning disability	
Heart disease					
STI					
Comments:					
If advice is given and/or only condoms issued, for Fraser Competence satisfy yourself that:					
• The patient is mature enough to understand the implications of treatment					
• I have encouraged patient to tell parents / let me tell them of patients contraceptive need					
• The patient is going to continue sexual activity with or without advice / treatment					
• Their health will suffer without treatment					
• Advice or treatment is in the patients best interests even without parental consent					
Comments:					
Signed:				Date:	

Figure 2 Under-16s gender-neutral history sheet developed by the authors

Cook and Fleming

is on the increase. It is operated mainly by youth workers who, via their links with education and other youth services, are likely to already know a lot about the young people using this service. In contrast, some nursing staff work within both systems. This may have influenced the lack of sexual history data recorded. It is also likely that where there was no record relating to a visit, condoms alone were supplied under the C-card scheme, as consultations either side of these dates were for this reason.

We were disappointed by our service's poor record keeping and recognise the need to develop tools to prompt the recording of sexual health data that is relevant to males and oriented to under-16s. We wonder if other services would find similar deficits. We are introducing a gender-neutral history sheet for all under-16s (Figure 2). As reported elsewhere,⁸ this will be combined with a section for assessment of Fraser criteria in addition to a checklist of potential markers of sexual abuse and exploitation. It is anticipated that this will be completed over a series of visits as we gain the young person's confidence.

The majority of our young people are attending for preventative care: 96% of males (condoms) and 72% of females 72% (condoms and/or hormonal contraception). The reputation of community clinics for STI testing is only recently beginning to develop and we do not have urine testing available. It was therefore unsurprising that no males attended for the consequences of sex (i.e. STIs). Since females become pregnant and have postcoital contraception options, it is inevitable that some will attend for the consequences of sex. Some 35% of females were seen initially for such consequences rather than to provide ongoing contraception, but 80% of these subsequently went on to receive regular contraception (condoms and/or hormonal contraceptives). Only 7% of young females were managed solely for consequences of sex, and a further 6% who had previously received contraception re-attended with further consequences. This would suggest that we are sending out the right messages to young people.

The Sexual Offences Act 2003¹ allows for non-physicians (including youth workers) to assess Fraser competence and we encourage this. As well as giving advice, condoms and performing pregnancy tests, nurses can also issue repeat supplies of hormonal contraceptives under patient-specific directions and hormonal emergency contraception under patient group directions. This is likely to account for nurses seeing the majority of under-14s exclusively. We are currently extending the nurses' role to include oral and injectable contraceptives. It is anticipated that this will increase the uptake of regular contraceptive use even further and encourage safer sexual practices.

Conclusions

Just over half of our clients are sexually active when first accessing our service. The majority are taking preventative action against the consequences of sex. Sexual health details that would allow us to make an appropriate 'risk assessment' of young people are incomplete in our service. This is particularly true for males who represent 41% of our clientele. It is anticipated that the introduction of a gender-neutral history sheet for under-16s will improve record keeping alongside a continuing education programme for all health professionals but particularly nurses who see the majority of these young people.

Statements on funding and competing interests

Funding None identified.

Competing interests None identified.

References

- 1 *Sexual Offences Act 2003*. London, UK: HMSO, 2003. <http://www.opsi.gov.uk/ACTS/acts2003/20030042.htm> [Accessed 14 March 2006].
- 2 *The Bichard Inquiry. An Independent Inquiry Arising from the Soham Murders*. 2004. <http://www.bichardinquiry.org.uk/> [Accessed 18 December 2005].
- 3 Batty D. Soham inquiry chief criticises teen sex interviews. *Guardian* 22 June 2005. <http://www.guardian.co.uk> [Accessed 18 December 2005].
- 4 Norfolk Area Child Protection Committee. *The Bichard Enquiry – ACPC Guidance* (Provisional). <http://www.acpc.norfolk.org.uk/> [Accessed 18 December 2005].
- 5 *Confidentiality of Adolescent Sexual Health Services: Joint Statement* (October 2005). <http://www.ffprhc.org.uk/admin/uploads/FinalSignedDJTStatement.pdf> [Accessed 28 January 2006].
- 6 *Health Behaviour in School-aged Children (HBSC) Survey*. HBSC Briefing Series: 3. Sexual Health. <http://www.cmo.wales.gov.uk/content/work/schools/hbsc3-e.pdf> [Accessed 19 October 2005].
- 7 Wellings K, Nanchahal K, Macdowall W, McManus S, Erens B, Mercer CH, *et al.* Sexual behaviour in Britain: early heterosexual experience. *Lancet* 2001; **358**: 1843–5180.
- 8 Cook L, Fleming C. Audit of under-14s who attend sexual health clinics in Gwent, South Wales, UK: identifying young people at risk of abuse and exploitation. *J Fam Plann Reprod Health Care* 2006; **32**: 27–30.
- 9 National Assembly for Wales. *A Strategic Framework for Promoting Sexual Health in Wales*. January 2000. <http://www.wales.gov.uk/> [Accessed 1 April 2005].
- 10 Pearson S. Men's use of sexual health services. *J Fam Plann Reprod Health Care* 2003; **29**(4): 190–194.
- 11 Social Exclusion Unit. *Teenage Pregnancy*. <http://www.socialexclusionunit.gov.uk/> [Accessed 18 December 2005].
- 12 National Assembly for Wales Welsh Health Circular. Best practice advice on the provision of effective contraception and sexual health advice services for young people. WHC (2001) 41.
- 13 Williams EC, Kirkman RJ, Elstein M. Profile of young people's advice clinic in reproductive health, 1988–93. *BMJ* 1994; **309**: 786–788.

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