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Do safeguarding concerns deter young people's access to condoms? Issues about integrating sexual health services online

Condoms have been distributed freely, and regionally across England, since the 'Teenage Pregnancy Strategy' (Social Inclusion Unit, 1999) which highlighted England as having one of the highest rates of unplanned teenage conceptions in Western Europe. With the aim of making more accessible contraception and sex safer resources and protecting against infections, young people can obtain free condoms through selected registration and distribution points (Evans, 2005; Hadley and Evans, 2013). In 2003, England and Wales founded the National Chlamydia Screening Programme (NCSP) in response to high levels of Chlamydia trachomatis found in young people aged between 15 – 24 years (DH, 2012).

Key messages for young people in the prevention of Chlamydia infection are:

- Consistently use condoms during vaginal, anal or oral sex
- Don't share sex toys without washing them between use or covering with a fresh condom
- Consistently use latex dams for cunnilingus (oral sex on a female) and oro-anal sex (rimming) (NHS, 2013)

While Chlamydia screening has mirrored advancements in technology with mobile phone applications (i.e. apps) and websites for ordering Chlamydia tests, access to condoms remains stagnant with few local condom programmes enabling young people to order free condoms for home delivery.

One rationale against easier condom provision is that commissioners and service providers have fears providing condoms through ordering online as it could be a potential safeguarding risk for those under 16 years. Eligibility checks do exist for registering for condoms online, however, they are self-monitored and potentially people younger than 16 could order condoms through the Internet without a face-to-face consultation.

This article explores implications of online access to free condoms, safeguarding practices, and potential benefits co-delivering condoms and Chlamydia screening programmes could have for young people, and especially for young men.

Young people, Chlamydia testing and Internet use

The Office for National Statistics (2014) reported that nearly 90% of young people access the Internet daily for activities such as social networking and playing games. Young people are the fastest growing group of users of the Internet. Sexual health services have recognised this growth and seen it as an opportunity for providing virtual support; however, many developed websites that are solely educational are static, i.e. no interaction or service delivery and for information-giving only (Whiteley et al., 2012). Generally, sexual health websites are focused on four themes: encouraging safer sex; motivating young people to use condoms consistently; increasing knowledge for preventing sexually acquired infections (SAIs) and pregnancy, and supporting young people to

make informed choices. Research outlined below indicates that computer-based interventions are as efficient, and at times more effective, as face-to-face interventions in maintaining behaviours such as regular condom use, whilst additionally offering significant cost benefits (Noar, Black and Pierce, 2009; Bailey et al., 2012).

Woodhall et al. (2012) identified how access to Chlamydia testing through websites had continually increased across England and Wales since 2006 and was specifically reaching young men with a high positivity rate of infection. Internet screening also attracted young people with similar risk factors to those accessing sexual health clinics, and access via online was equally spread across socio-economic status (Whiteley et al., 2012). Woodhall et al. (2012) reported that young people who use the Internet for their sexual health treatment are at a higher risk of infection than those that access General Practitioners (GPs) and at least similar to those accessing sexual health services. Accordingly, to reduce onward infection, similar principles should apply to Internet screening as is standard in any sexual health clinic. Chlamydia screening, with an offer of condoms, could then be provided.

However, before exploring the benefits of co-delivering Chlamydia screening and free condoms through the Internet, we must first explore the barriers to providing free condoms online.

Barriers to online ordering of condoms

Online ordering of free condoms operates in a similar way to Chlamydia screening online. Young people aged 16 years and over register with the website, log-in and read through a condom demonstration leaflet before being able to order. They are then allowed to request two packs of six condoms per month sent to their home. People younger than 16 years, or over the upper age limit for the programme (variable depending on locality), are referred to their nearest venue for a face-to-face registration or sexual health clinic. The consultation allows for a full assessment to be conducted including Fraser Guidelines and Child Sex Exploitation (CSE) Assessment (PHE, 2014a). While the online process has safety checks in place, people younger than 16 years could potentially register through altering personal details entered to meet the access requirements. As a result, providing condoms to those under 16 years without a proper assessment can be viewed as a potential safeguarding concern as is it below the legal age of consent (IPPF, 2014). However, it is not illegal for under 16s to have, or purchase from local shops, condoms for their own use. Advocates for condoms suggest that very young men should be given condoms with which to practice masturbation as a method of reducing anxiety and influencing attitudes towards condoms (Yamey, 1999). Availability of condoms online has not developed in a similar way to Internet screening programmes which separates treatment and prevention programmes online.

Face-to-face consultation: Pros and Cons

Health professionals accept that many barriers exist for young people accessing sexual health services for condoms. Stigma, embarrassment, shame, lack or breach of confidentiality, and the chance of running into someone that they know while accessing sexual health services are all reported as significant obstacles for young people (Bell, 2009; IPPF, 2014). Klein et al. (2001) found that the young people who choose not to access a service, and in doing so circumnavigate the risk assessment, prefer to buy condoms or have their more confident friends provide them. Both Bell (2009) and The International Planned Parenthood Federation (IPPF, 2014) reported that young people, to avoid the embarrassment they feel in talking about sex with a health care professional, often prefer not to use condoms at all or purchase them rather than using a free condom scheme. Despite the evidence, national guidelines recommend face-to-face registration, and re-registration for younger people, to gain access to a service (PHE, 2014a). Face-to-face consultations have important objectives that allow professionals to ensure young people understand their rights and responsibilities, feel safe in their relationships, and that the sex is consensual (PHE, 2014a). The consultation is also an opportunity to provide information on local services, sexually shared infections and discuss what to do in an emergency such as a condom breaking (PHE, 2014a).

Analysing the barriers young people face indicates that it is most likely only those who are self-confident, knowledgeable and who have the skills and protective attitudes will access condoms through face-to-face consultations. Young people exhibiting these qualities are

viewed as self-sufficient and strong individuals, who are probably at less risk of abuse as they are already beginning to care for their sexual health. Young people who are shy, vulnerable and lacking self-esteem may be at greater risk and as a result in more need of the services but less able to access. For these young people their anxieties outweigh their confidence to overcome the barriers to access, and as a result, the young person goes without the service.

Young men and their use of sexual health services

In visits to sexual health services young men are still noticeable by their absence. Sometimes young men make up as little as 20% of the total accessing a service (Pearson, 2003; Forrest, 2007). Reasons for their non-attendance include fears that challenge masculinity, personal pride and confidentiality (Evans, 2005; Akre, Michaud and Suris, 2010). Engaging young men in preventative sexual health is important to reduce the prevalence and the onward transmission of Chlamydia infection, unplanned conceptions, and all other sexually shared infections. The NCSP (2009) reported that despite high levels of risk, less than half tested for Chlamydia are young men. However, access to Chlamydia screening through the Internet has been reported as a growing area and one that is readily acceptable to young men (Woodhall et al., 2012; Lorimer and McDaid, 2013). Young men possess high levels of anxiety and difficulty in trusting venues they do not perceive as confidential, consequently prefer to access their screening online bypassing their fears (NCSP, 2009). As a result, more young men could benefit from accessing their condoms with Chlamydia screening through online services, or vice versa, as their preferred method of accessing services.

For young people in rural areas and some Military settings, the barriers to accessing sexual health services are heightened by embarrassment and a perceived lack of confidentiality by service providers (Evans and Watson, 2015). Young women in rural towns, where everyone is well acquainted, can find it very socially difficult to access condoms, with the fear of being labelled "a slag" (Bell, 2009, p.386). Such stigma can have implications on one's reputation and dating prospects. Village gossip, a lack of anonymity and an unwillingness to trust the professionalism of the service deters young people in rural areas from accessing GPs and sexual health services (Bell, 2009; Tomnay, Bourke and Fairley, 2014). explored the acceptability of online screening for Chlamydia with rural young people; despite some barriers in receiving kits at home by younger people, many were in favour of free online testing.

Consent for Treatment and the Law

While the age of consent for sex is 16 in the UK, younger people have a right and can consent to sexual health services if deemed competent. Competency is ascertained through an assessment called 'The Fraser Guidelines'. The Fraser Guidelines follow these lines of enquiry (FPA, 2009):

- Does the young person understand the advice being provided?
- Has the Healthcare Professional encouraged the young person to talk to their parent(s) or guardian?
- Will the young person continue having sex regardless of advice?
- Could the young person suffer poor physical or mental health if they do not receive treatment?
- Is the treatment in their best interest?

While the law is clear that young people can access condoms, it is considered 'best practice' to complete a Fraser assessment before providing contraceptive services. More recently the British Association for Sexual Health and HIV (BASHH) and Brook published 'Spotting the Signs: A national proforma for identifying risk of child sexual exploitation in sexual health services' (2014). The publication is suitable for use with young people under 18 years in identifying child sex exploitation and/or gang-related sexual violence. The assessment is a much more inquisitive assessment, administered through a conversational approach, which was rated acceptable by young people. However, neither assessment is a legal requirement to access condoms, and it is important to emphasise that **there is no national age restriction on the commercial trade of condoms**. While the importance of safeguarding young people is imperative, it could be suggested that an alternative opportunity be sought that does not prevent access to preventative services (Yamey, 1999; Evans, 2005). Condoms are so fundamental for the prevention of many long-term outcomes such as unplanned pregnancy, SAIs and HIV,

that all barriers to condom provision should be addressed first and foremost (Hadley and Evans, 2013).

Young people, and potentially those younger than 13, prefer to purchase condoms inexpensively and discreetly from vending machines, where no questions are asked, or from local shops where no judgments are made (Bell, 2009; IPPF, 2014). Klein et al. (2001) reported that although 49% of young people knew where to get free condoms, only 14% intended to do so and most opted to buy in pharmacies, despite them being more expensive, because they were openly on display and avoided interactions. Avoidance behaviour was further researched by Bell (2009) who reported that embarrassment should not be underestimated as a deterrent to obtaining condoms and is a "key risk factor in young people's sexual behaviour" (p.370). With unlimited access to purchased condoms through alternative venues at relatively low cost, it is difficult to ascertain what the protective practices professional place on access to free condoms is achieving.

Associations between sex, the Internet and condoms

A further, more clandestine, obstacle that could be preventing the development of delivering condoms and Chlamydia screening online for young people is the association that the Internet has with sex and pornography. 'Sex' is the most commonly searched word on the Internet (Griffiths, 2001) and the high amount of sexual content that can be found, or stumbled upon, can make it a dangerous place for young people. Griffith (2004) reported that two-thirds of media coverage on the Internet is negative and one-quarter is about child pornography, which invariably heightens parents' fears of the Internet.

Media headlines that focus on pornography, and more recently grooming for sexual activity offline, create a moral panic felt by those in positions of responsibility for young people (Lawson and Comber, 2000). Lawson and Comber (2000) reported that the dualistic nature of the Internet, for both educational potential and access to inappropriate materials, forces schools in particular, to introduce strategies to safeguard children. Safeguarding strategies to protect young people from online pornography need to ensure that the Internet is presented as an important route for young people to access sexual health and education services that do not censor sex and by association condoms.

What is the Risk?

Research repeatedly shows that the increased availability of condoms has not resulted in an increase in the sexual activity of young people, or decreased the age at which young people become sexually active (Sellers, McGraw and McKinlay, 1994; Schuster et al., 1998). Young people who are under 13 years are also freely able to access condoms through unregulated vending machines in public venues (Bell, 2009) and it is not illegal for them to purchase or have condoms on their person despite it being illegal for them to have sex. Consequently, the restrictions health professionals place on access pushes young people to use alternative avenues that do not involve assessments, thus avoiding health promotion or the opportunity for continued support. Accessing condoms through vending machines or shops could be viewed as placing the young person at more risk than through a website which actively encourages referral to services, provides information on where to get help and knowledge-sharing on SAIs and contraception. One could argue that not having an online condom service could be considered as putting the young person at more of a safeguarding risk than accessing a service for which they are considered too young.

Why combine access to Chlamydia Screening and Condoms online?

Condom provision is a minimum requirement for all Levels 1, 2 and 3 sexual health service provision in the UK, as described by the Faculty and Sexual and Reproductive Healthcare (2014), however, it is not yet a requirement for the delivery of Chlamydia and SAI screening online. Despite such apparent confusion, Public Health England (PHE, 2014b) highlighted that the process of having Chlamydia screening significantly increased the intention by young people to use a condom at their next sexual encounter. Research reported in this article has shown those accessing Chlamydia screening through the Internet have higher reported risk factors for infection and are more likely to be infected with Chlamydia than those accessing GPs and community services. Consequently the point of requesting a screen makes it a prime

opportunity for ensuring condoms are available and offered, thus supporting a co-delivery model for both programmes. DH (2012) also promoted integration of facilities or services as a "cost-effective" form of delivery. The 'Framework for Sexual Health Improvement in England' (DH, 2013) highlights 'integration' as a key element in providing efficient sexual health services that are patient-focused for the future.

Additionally condom acquisition still carries much stigma and, therefore, the normalisation of the Chlamydia screening through the National Chlamydia Screening Programme makes it an ideal opportunity for the normalisation of accessing, carrying, and talking about condoms. The disparity between how young people can access condom and Chlamydia services, making preventative methods harder to acquire, leaves many young people at more risk of not only Chlamydia but other SAIs and unplanned pregnancy.

Globally, there is a lack of research on the trends in condom acquisition (Reece et al., 2010) with a majority of research solely focussed on motivators and inhibitors to consistent use. Rarely considered is how young people acquire condoms; where this is considered, free access through the Internet has not been part of the assessment and, therefore, missing from the evaluation. This lack of primary research would indicate that more investigation into the integration of online sexual health services is urgently needed. The new research could therefore provide valuable insight into those currently using the integrated online services and those who may use them in the future. In collaboration with young people, suitable online sexual health services can then be developed that are integrated and holistic in their approach for the future.

Conclusion

Integrating our sexual health services, creating better links between services, and reducing the pathway between services, are all national aims within the Framework (DH, 2013) and online services should not be exempt from these agendas. As Internet access continues to grow, young people, in particular, will benefit from the sexual health services and information that will be available to them online (Habel et al., 2011). The NSCP is an excellent example of young people using the Internet with the online element of programme diagnosing high levels of infection and reporting high levels of risk activity (Woodall et al., 2012). While condoms remain the main barrier method against Chlamydia, other SAIs, HIV and unplanned conceptions, these services are not yet being provided in tandem online as is standard across sexual health services. Instead, accessing condoms through a face-to-face encounter, with Fraser Guidelines or CSE assessment, is best practice but may still prove a stigmatising experience for many young people.

Safeguarding procedures are in place to protect young people by ensuring professionals are looking out for vulnerable young people, signs of abuse, grooming or exploitation. However, we must consider that those who choose not to use this route because of the anxiety, shame and embarrassment felt by the assessment, may be at more risk. Research into the barriers young people face to accessing sexual health services such as embarrassment, should not be underestimated as they can deter young people from what is usually their first step into adulthood: accessing condoms (Bell, 2009). As a result, alternative opportunities should be sought for our safeguarding and CSE assessments, removing barriers to preventative programmes and widening access through integrating online services.

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