

Setting up mobile clinics to improve young people's sexual health

This article outlines an initiative to bring sexual health services closer to patients who need them most

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Increasing the amount of outreach work in sexual health is key to tackling the rise in sexually transmitted infections in the UK. This article describes some of the research on the benefits of outreach work. It then outlines how mobile sexual health clinics were set up to help young people engage with services and reduce the incidence of STIs.

INTRODUCTION

The Practice, a primary care company, was commissioned by Buckinghamshire PCT to provide level 2 sexual health services across the county. Our service was set up to complement the existing level 3 service at the local hospital's genitourinary medicine (GUM) department and to help the trust meet government targets for sexual health.

Level 2 sexual health screening can be carried out in any primary care setting (Department of Health and Medical Foundation for AIDS and Sexual Health, 2005). It involves a full genital examination and taking swabs for all STIs. All samples are sent to the hospital laboratory and results are sent back to us.

Our new level 2 sexual health clinics are located in a variety of settings, including a young people's drop-in centre. The clinics are nurse-led and run by specialist staff who are experienced in working with young people and recognising their specific needs.

Staff work within strict guidelines, engage positively with young people, and help empower them to talk to their parents about sex. We also have a GUM consultant offering expertise on difficult cases.

RATIONALE FOR OUTREACH CLINICS

Our objectives were to improve the sexual health of young people aged under 25, reduce the prevalence of chlamydia in this age group and increase awareness of the importance of using condoms to prevent STIs.

To address this we developed the idea of outreach work and have set up a number of mobile sexual health clinics at local colleges and universities.

It is important to look at the reasons why young people are at an increased risk of contracting STIs compared with other age groups.

In a study by Wellings et al (2001), more than one-quarter of young people reported having sex while under the age of 16. Kane et al (2003) found that the earlier the age of first sexual intercourse, the higher the association with high-risk behaviour.

Safer sex

Research on condom use among young people found that two-thirds reported inconsistent use, and their use for oral sex was rare because this practice was perceived as less risky (Hatherall et al, 2005).

When young people have low self-esteem this tends to affect safer-sex practices as they do not have the skills to negotiate protective behaviours. They are then more likely to take unacceptable risks (Hatherall et al, 2005).

In particular, girls face difficulty in negotiating condom use as they have strong emotions around romantic love, which complicates their assessment of risk and leads them to continue unprotected sexual activity.

East et al (2007) researched literature on condom use and factors influencing this. They found there is often a lack of knowledge about STIs and transmission.

While it is teachers who often give sex education lessons in schools, Brook (2008) reported that most young people would prefer sex and relationship education (SRE) to be taught by a youth worker rather than a teacher.

Experimentation with drugs and alcohol is another factor that puts young people at an increased risk of STIs, as these impair judgement, decision-making and practical skills for putting on a condom correctly (Leigh, 2002).

Outreach work

The aim of outreach work is to improve the sexual health of high-risk groups that do not normally access mainstream sexual health services, offering STI screening and education.

Young people are often not receptive when health messages are delivered in clinical settings. However, Ford et al (2004) argued that these messages are more likely to be internalised if they are directly applied to adolescents' lifestyles and reinforced by peers in an environment in which they feel relaxed.

IMPLICATIONS FOR PRACTICE

- Young people may not access mainstream sexual health services because public transport can be expensive and time-consuming. Taking services to them overcomes this problem.
- These outreach clinics are used to their full capacity. Students feel comfortable accessing sexual health services in familiar surroundings.
- Many students in campuses are from overseas. In particular, the practice serves a large population from Africa. Many are not familiar with how to access health care and come from high-risk areas for HIV and other STIs. Taking testing to them has enabled these students to be screened and treated for any STI.



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BACKGROUND

- Over the past decade the Health Protection Agency (2008) reported a huge rise in the incidence of STIs in the UK.
- In 1998–2007, there was a 66% rise in new STI diagnoses. Syphilis soared by 1,828% (although the actual number of people infected remains small); gonorrhoea

increased by 42%; genital warts by 28%; herpes by 51%; and chlamydia by 150%.

- Young people aged 16–24 have the highest rates of STIs. Although they represent only 12% of the population, they account for nearly half of all STIs diagnosed in GUM clinics.

According to Brook (2008), government data shows that vulnerable young people most at risk of teenage pregnancy or contracting an STI are the least likely to access mainstream sexual health services. Hayter (2005) said young people often cite judgemental attitudes from mainstream service providers as a reason why they do not access services. Other important factors include concerns over confidentiality and problems with travel.

Brook (2008) defined outreach work as 'taking the support and services that young people need out to meet them, in their community and their chosen venues, for example youth clubs, schools or sports facilities'.

Hayter (2005) said that the important issue in the location of sexual health outreach clinics is they should be in places that young people would normally attend for social reasons. This makes it easier for them to access sexual health advice, information and check-ups without having to make a special trip that would incur expense and require explanations to carers.

Parkes et al (2004) examined teenagers' use of sexual health services. Ability to access services depended on distance as well as a number of cultural and language barriers. The study highlighted that young people delayed using sexual health services until after they had had intercourse more than once and often with more than one partner. This underlines the importance

of outreach work for sexual health in helping young people to make informed, planned choices about sexual activity. For more details on outreach work, see Box 1, p14.

THE INITIATIVE

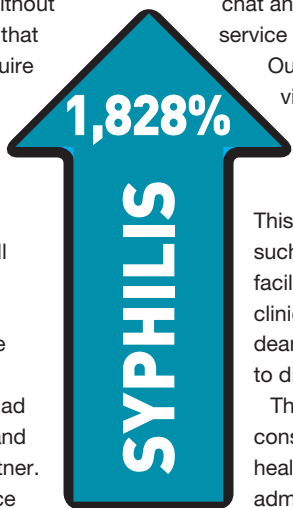
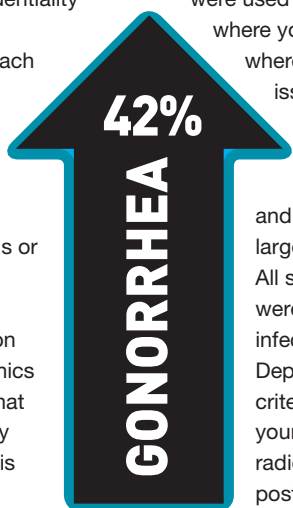
After I set up The Condom Café in 2005 at Bucks New University's Chalfont campus, it became apparent that sexual health services were used more when taken to venues where young people felt comfortable, and where there were no transport or cost issues in reaching services.

Mobile sexual health clinics are simply a continuation of this principle. I chose university and college sites as these had a large population of the target group. All sites chosen for outreach work were adapted to conform with infection control criteria and the Department of Health's (2005) quality criteria to make them welcoming for young people. This included using radios to help them feel at ease, posters and informal settings in reception areas to allow patients to chat and ask questions about the service in a relaxed atmosphere.

Our consultant and lead nurse visited local university sites to carry out a risk assessment of the rooms to be used for the mobile sexual health clinic.

This included infection control issues such as access to handwashing facilities, toilets and disposal of clinical waste. We liaised with deans and student welfare teams to discuss our project.

The team for the mobile clinics consists of a lead nurse, sexual health nurse and two reception/administration staff, with a



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consultant available on call for any difficult cases. We have laptops to enable staff to register clients on site. We transport all necessary equipment for examinations, and take away all clinical waste.

Student unions and welfare departments have been active in promoting the clinics. The week before a clinic takes place, a nurse and one of the administrative staff visit the university/college to promote the clinic, hand out flyers, answer questions about the sexual health check and take appointment bookings.

The clinics are held from 10am to 3pm, with 15–20 minute appointment slots. Some bookings are made before the day but most

CHANGING PRACTICE

people make opportunistic appointments. Sessions involve a private, confidential consultation with the nurse taking a full sexual history, and then full sexual health screening at level 2. The tests offered are for chlamydia, gonorrhoea, trichomonas, bacterial vaginosis, HIV, syphilis, and hepatitis B and C. If students do not want a full genital examination, we also offer self-testing for chlamydia. All specimens are taken to the local hospital for processing.

We operate a 'no news is good news' policy for the results – if we have not contacted patients by mobile phone within two weeks, they can presume all their results are negative. This policy is also used by our local GUM service, ensuring consistency.

Clients can telephone our service to ask about results if they are anxious. Any STIs detected can be treated at our local clinics or we can arrange treatment on site for most if transport is difficult.

Mobile clinics

The first mobile sexual health clinic was held in January 2008 at the Chalfont campus of Bucks New University. Other sites were Bucks' Wycombe campus, and at Aylesbury College and the University of Buckingham. In 2008 we held 19 mobile clinics in total, providing an average of two per term at each site, once the clinics were established.

The number of clinics depended on negotiation with university staff for room availability and time constraints for the sexual health team. Dates of mobile clinics were announced in university newspapers and emailed to students. We are working towards offering mobile clinics once a month at all sites.

In each mobile clinic, we have seen 15–20 students per session. We have diagnosed and treated chlamydia, bacterial vaginosis, candida and one case of

infectious hepatitis B that was referred to level 3 services and the Health Protection Agency.

Feedback from students is collated using a patient-satisfaction questionnaire.

Feedback has been positive, particularly about the convenience of having on-site testing.

OUTCOMES

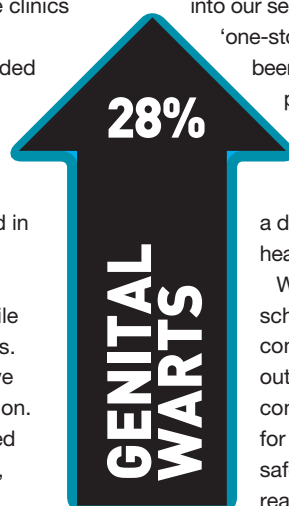
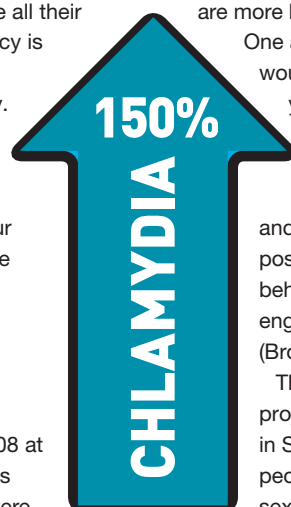
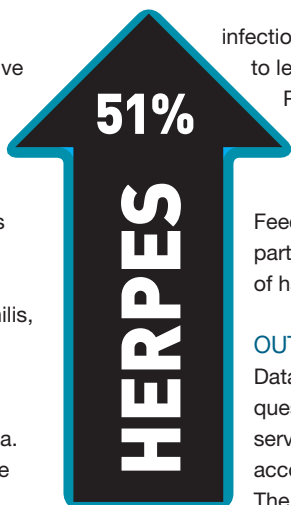
Data from the patient satisfaction questionnaire is used in auditing the service, enabling us to change it according to young people's needs. The government's (2005) green paper recommended services should be developed using young people's input. If they are involved in developing a service, they are more likely to engage with it.

One area for practice development would be to consider enrolling young people as peer educators to support outreach sexual health work. Peers have a strong influence on behaviour, and this can be channelled in a positive way to help young people behave more responsibly and engage in fewer high-risk activities (Brook, 2008).

This has been used in a Sheffield project known as Peer Activities in Sexual Health. This involves people aged 16–19 delivering sexual health education to young people in primary and secondary schools, and youth groups.

Another area for practice development would be to integrate contraception services into our sexual health clinics. This model of 'one-stop shops' (DH, 2008) has recently been evaluated with extremely positive feedback. Putting sexual health screening together with contraceptive services changes the approach from a disease-led service to a positive health approach.

We have introduced a 'C-Card' scheme in our area, where condoms can be obtained in outlets other than traditional contraception clinics. It is easier for young people to engage in safer sex if condoms are free and readily available.



BOX 1. OUTREACH WORK

Outreach work involves taking information, support and clinical services out to venues that young people usually visit and in which they feel comfortable.

This will make them more receptive to safer-sex messages and more likely to understand the possible negative effects of high-risk behaviours on their long-term physical and mental health.

Young people should feel empowered to be able to use mainstream services with confidence.

Brook (2008) said: 'Outreach builds young people's confidence, knowledge and self-esteem, in turn allowing them to make good decisions about their sexuality and sexual health.'

CONCLUSION

Research has found positive evidence for the benefits of outreach work in sexual health to help young people reduce risk-taking behaviour. This outreach work can take the form of mobile sexual health clinics in places that young people visit, such as universities and youth clubs.

Outreach work should be opportunistic and proactive, using and adapting to any environment in which young people feel safe and comfortable. Areas used must fulfil certain criteria regarding confidentiality and infection control.

Peer involvement in assessing areas to be used is a good tool to increase the success of any programme. It is important to involve young people in designing and improving services.

We recommend that other PCTs take up the idea of mobile sexual health clinics. Their success shows that health care should be more flexible and delivered in more community-based settings in order to reach the target population and maximise use of services. ■

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