Sexual health assessment in a general practice travel clinic

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Sexual health and travel health are two distinct areas yet they are linked in the context of a travel health consultation. Sexual health provision within general practice is inconsistent and dependent on the attitudes and training of practice nurses and GPs – some of whom may be too embarrassed to discuss sex. However, if practice nurses are to provide holistic and comprehensive travel advice, sexual health, its language and its challenges must be embraced and applied in the consultation.

Introducing sexual health assessment into travel health consultations supports three of the major aims of The National Strategy for Sexual Health and HIV (Department of Health, 2001a):

- To reduce transmission of HIV and sexually transmitted infections (STIs);
- To reduce prevalence of undiagnosed HIV and STIs;
- To reduce unintended pregnancy rates.

Practice nursing involves giving advice about vaccine-preventable diseases and health protection to people who are intending to travel abroad. An audit of the author’s general practice was undertaken to determine the age and sex of patients attending travel clinics and the countries they planned to visit.

It found that 228 patients (116 female, 112 male) were seen in a 12-month period by three whole-time equivalent nurses (Fig 1). The audit concentrated on those travelling beyond Europe but it is recognised that many people visiting European and even UK – destinations remain at risk yet are unlikely to seek travel advice. This is a topic for further consideration within clinical practice.

The national strategy (DoH, 2001a) suggests that the nurse’s role in the field of sexual health is expanding. Its importance is well recognised and many argue for its inclusion in primary care (Smallacombe, 2003; Watson, 2003; Stokes and Mears, 2000). Similarly, the role includes a focus on effective travel health advice, which is a continuously developing field (Hainsworth, 2004) and an emerging specialty (Townend and Howell, 1999). While the two areas are distinct specialisms, they do have overlapping boundaries. Rogstad (2004) suggests that travel advice should include information on safer sex and the health risks associated with sex abroad. Likewise, Townend and Howell (1999) argue that travel clinic staff need to ensure travellers are aware of risks and encourage safer sex. Clearly there is overwhelming evidence to support the inclusion of sexual health assessment in travel consultations, which is in accordance with current sexual health policy and recommended practice.

Influences on sexual behaviour

Research suggests that sexual behaviour in a new environment is associated with increased risk taking. Rogstad (2004) claims that people are at an increased risk of acquiring an STI while on holiday, due to a number of factors including:

- Exposure to new sexual networks;
- The rate at which partners are changed while away;
- Lack of condom use;
- Consumption of alcohol.

Fletcher (2003) highlights the fact that holidays present new opportunities to find sexual partners and links behavioural changes with alcohol consumption. Driver (1999) states that tourists often abandon precautions that they would always take at home and identifies the factors for modified sexual behaviour as youth, travelling alone and longer trips. In addition, Griffiths (1999) highlighted a study that found one-third of tourists had had sex with a new partner on holiday but only 42 per cent used condoms consistently. Most authors agree about the risk of STIs yet there is no mention in the literature of unintended pregnancy as an alternative or simultaneous consequence. All possible outcomes need to be considered, as unwanted pregnancy can result in emotional and physical distress.

High-risk destinations

Risk-taking behaviour does not represent the entire problem. Certain destinations have high rates of STIs, exposing travellers who engage in unprotected sex to a statistically higher rate of infection. Fisher and Holmes (2000) recognise STIs as a worldwide problem reaching epidemic proportions in some countries. The World Health Organization, which identifies areas of high prevalence and incidence, says South and South-East Asia have the highest prevalence, with 50 people having STIs per 1,000 population and a total of 151 million infections in 1999 (WHO, 2001) (Table 1, p34).

REFERENCES


The audit revealed that of 228 patients, 71 (31 per cent) were heading for South and South-East Asia and a further three were travelling the world. Of this group, 21 were visiting Thailand, a country known for sex tourism and high rates of infection (DoH, 2001b). The male average age was 33, which is within the age range of those most likely to contract an STI (WHO, 2001).

In addition to the risks patients face abroad, the practice is located in an area with high rates of STIs. According to the Health Protection Agency (HPA, 2004) the south east of England has the second

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### REFERENCES

- Department of Health (2001b) Health Information for Overseas Travel. London: DoH.

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For related articles on this subject and links to relevant websites see [www.nursingtimes.net](http://www.nursingtimes.net)
highest rate of genital herpes in males and females and the third highest rate of female chlamydia in England. Therefore, while travellers are at risk of acquiring an STI or unintended pregnancy, there is also the potential for them to infect others – indeed, Townend and Howell (1999) believe that travellers must also consider the effect of their visit upon the local population.

While no assumptions are made about planned activities, the audit and evidence described above identifies the relevance of sexual health assessment during travel consultations in identifying individuals who need advice or access to contraceptive services prior to travel.

Infection rates are rising. Recent figures from the HPA (2004) show there had been an eight per cent increase in chlamydia in the previous year (HPA, 2004), causing the government to announce an advertising campaign to raise awareness of STIs (DoH, 2004). However, the government cannot be relied upon as sole educator, so practice nurses must learn from reflecting on their feelings and attitudes and realise that it is a skill that comes with experience. Duffin and Nash (2001) reiterate the need for time, practice and expertise that nurses will gain with each patient encounter.

Clearly there is a need for education to overcome fears and develop expertise – Stokes and Mears (2000) found that 62 per cent of practice nurses had undertaken at least one sexual health course in the previous five years and that these nurses had more positive attitudes in discussing sexual health.

**Problems in practice**

Having established the importance of sexual health assessment, consideration must be given to why it is not routine. Many new practice nurses gain experience on the job from experienced staff (Fletcher, 2003) and may not be required to address sexual health as part of travel assessment. While many advocate incorporating sexual health assessment into a travel clinic, reading about a topic will not necessarily change clinical practice.

Addressing sexual health is a daunting prospect to nurses with all levels of experience – Nelson (2001) suggests they are afraid of their ignorance, have inadequate language and do not wish to offend. Peate (1998) identifies a lack of knowledge as a major factor. A nurse with such feelings will find sexual health assessment difficult; however, nurses must learn from reflecting on their feelings and attitudes and realise that it is a skill that comes with experience. Duffin and Nash (2001) reiterate the need for time, practice and expertise that nurses will gain with each patient encounter.

**Barriers to communication**

Common assessment difficulties are not confined to inexperience or fear. A popular misconception is that a patient does not fit the stereotype of a sex tourist or one seeking casual sex (Fletcher, 2003) found that 62 per cent of practice nurses had undertaken at least one sexual health course in the previous five years and that these nurses had more positive attitudes in discussing sexual health.

**Table 1. Estimated prevalence and annual incidence of curable STIs by region**

<table>
<thead>
<tr>
<th>REGION</th>
<th>POPULATION aged 15–49 (million)</th>
<th>PREVALENCE (million)</th>
<th>PREVALENCE per 1,000</th>
<th>ANNUAL INCIDENCE (million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North America</td>
<td>156</td>
<td>3</td>
<td>19</td>
<td>14</td>
</tr>
<tr>
<td>Western Europe</td>
<td>203</td>
<td>4</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>North Africa and Middle East</td>
<td>165</td>
<td>3.5</td>
<td>21</td>
<td>10</td>
</tr>
<tr>
<td>Eastern Europe and Central Asia</td>
<td>205</td>
<td>6</td>
<td>29</td>
<td>22</td>
</tr>
<tr>
<td>Sub Saharan Africa</td>
<td>269</td>
<td>32</td>
<td>119</td>
<td>69</td>
</tr>
<tr>
<td>South and South-East Asia</td>
<td>955</td>
<td>48</td>
<td>50</td>
<td>151</td>
</tr>
<tr>
<td>East Asia and Pacific</td>
<td>815</td>
<td>6</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>Australia and New Zealand</td>
<td>11</td>
<td>0.3</td>
<td>27</td>
<td>1</td>
</tr>
<tr>
<td>Latin America and Caribbean</td>
<td>260</td>
<td>18.5</td>
<td>71</td>
<td>38</td>
</tr>
<tr>
<td>Total</td>
<td>3,040</td>
<td>116.5</td>
<td>N/A</td>
<td>340</td>
</tr>
</tbody>
</table>

**References**

backpackers intend to have unsafe sex at every opportunity. Assumptions represent one of the challenges in identifying travellers needing advice. Most patients attend a travel clinic assuming that they are there for vaccinations (Hainsworth, 2002) and may be shocked and embarrassed at the introduction of sexual health advice. Dilloway and Hildyard (1998) found that some patients expect health professionals to raise sexual health during consultations. However, it must be remembered that the potential for embarrassment remains and measures to reduce the shock can be put in place. Many surgeries have a preclinic questionnaire and Fletcher (2003) suggests that relevant questions provide the format for the consultation and make the patient aware that such questions will be asked – although care must be taken to avoid drawing conclusions based on the answers. Convenient lead-in questions or cues will enable the nurse to initiate discussion and could include:

- Destination (may reveal popular partying hotspots or sex tourism cities);
- Purpose of trip – business or pleasure;
- Current methods of contraception and need for extra supplies;
- Travelling alone, with partner or friends;
- Alcohol consumption.

**Tailored assessment**

Many recommendations have been made on the sexual health content of a travel health consultation (Hainsworth, 2004; Rogstad, 2004; Driver, 1999) but again, little on the need for contraception. However, due to the diversity of sexual health, the one-size-fits-all attitude should be avoided. It would be inappropriate to ask patients if their intention is to become a sex tourist so the onus is on the nurse to use careful questioning in assessing patients and explaining the reasons for such questions.

Similarly, it is not good practice to have a list of questions to be asked, as this does not result in a tailored assessment. Bellfield (2004) believes there is the potential to influence decisions but it rests on what nurses say and the way in which they say it. For inexperienced nurses it is a daunting prospect and while they may have little experience in discussing sexual or travel health they must use good communication skills in order to be able to learn from consultations.

Access to up-to-date resources is vital to support consultations. Many leaflets are available and a number of travel websites contain sexual health advice with emphasis on using quality condoms (Box 1). These can be used to initiate discussion, encouraging patients to learn more about travel risks and should also be listed on any questionnaire.

**Evaluating sexual health assessment**

As it is unreasonable to expect that every patient will take advice and adapt their behaviour because of one consultation, it seems more appropriate to aim for informed choice rather than compliance (Ewles and Simnett, 1992).

Health promotion is difficult to evaluate and in a climate of targets and contract points it may be neglected, but it is vital to continue to evaluate practice and, through reflection and study, to identify areas for improvement so that advice is relevant and clinically sound.

Traditionally sexual health is measured by the number of teenage pregnancies or number of STIs reported to the HPA by genitourinary medicine (GUM) clinics. Due to confidentiality practice nurses will not know if a patient has attended a GUM clinic. However, since they are available following travel their patients will be more likely to report travel-associated problems as a relationship has been established. In such situations it would be possible to informally evaluate whether the advice helped.

**Conclusion**

Practice nurses have a privileged and enviable role in their ability to influence lifestyle and health choices and must ensure that they do not focus solely on vaccine-preventable diseases but also educate and advise on the consequences of sexual activity in a new environment.

The audit revealed popular travel destinations and it is vital to learn more about the countries and risks. Regular auditing is needed to monitor travel trends and ensure that resources are destination appropriate and will help identify learning needs.

Much remains to be done to improve travel services with lack of sexual health and travel health training identified as factors. This will require further study and development by the entire practice nurse team in addition to the chronic disease management training that is already considered essential.

Formal training and shared learning will enable nurses to develop core sexual health competencies. This will help promote the aims of the sexual health strategy, improve care to patients and enhance the skills of the nursing team.

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**REFERENCES**

Royal College of Nursing (2001)
Royal College of Nursing Sexual Health Strategy: Guidance for Nursing Staff. London: RCN.

Royal Society of Medicine (2005) ‘Consistently Rising’ Rates of STIs and HIV in Menopausal Women and Older Adults are ‘Ignored’. www.rsm.ac.uk/new/pr165.htm


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**BOX 1. ONLINE RESOURCES FOR PROFESSIONALS AND CLIENTS**

- www.fitfortravel.nhs.uk
- www.masta.org
- www.nathnac.org
- www.travelhealth.co.uk
- www.tripprep.com