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A sexual health outreach team found that combining educational sessions with testing increased uptake of screening among young people

Education to increase sexual health screening

In this article...

- Risks of sexually transmitted infections among young people
- The value of behavioural change models to reduce STIs
- How educational sessions increased uptake of STI screening

5 key points

1. There is a pressing need to improve the sexual health of young people aged 16-24
2. Encouraging this group to take up screening remains a major challenge
3. Evidence suggests that engaging with young people encourages behaviour change
4. The experience of a specialist team in Nottingham shows that education encourages young people to take up sexual health screening
5. Opportunities to reach young people through existing channels using education combined with screening should be exploited

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Abstract Wallis A (2012) Education to increase sexual health screening. *Nursing Times;* 108: 8, 20-21.
Rates of sexually transmitted infections among young people aged 16-24 years have soared in recent years. Opportunistic screening for chlamydia and other STIs identifies asymptomatic infection but encouraging this group to take up screening remains a major challenge.

National guidance recommends structured one-to-one discussions with young people to achieve behavioural change. Although opportunities for this are rare, the sexual health outreach team in Nottingham has developed an interactive educational module for use with groups of young people and combined it with sexual health screening, with initial positive results.

Developing effective health promotion/harm reduction strategies for sexual health, particularly among people under 25 years of age, is both a major and a difficult task. The barriers to talking about the issue and the consequences of poor sexual health in general are well documented (Bates, 2011).

Figures from the Health Protection Agency (2008) show that young people aged 16-24 are at greater risk than average of acquiring a sexually transmitted infection (STI), especially chlamydia and genital warts. Although they make up just 12% of the UK population, this group accounted for nearly two-thirds of chlamydia cases and over half of genital warts cases diagnosed in UK genitourinary medicine clinics in 2007 (HPA, 2008).

Despite years of local and national initiatives, the continuing high number of HIV diagnoses, especially among vulnerable groups, remains a concern (HPA, 2009). The need for innovative interventions to address this problem is more pressing than ever and recent statistics should drive the development of new initiatives.

The Nursing and Midwifery Council's (2008) code of conduct makes it clear that nurses have a responsibility to "promote the health and wellbeing of those in their care"; for nurses working in sexual health, this should clearly be a priority.

A local initiative

The sexual health outreach team at Nottingham University Hospitals Trust is involved in asymptomatic sexual health screening across Nottingham. The team has delivered educational/awareness sessions to groups of under 25s for over two years; these discuss the dangers of risk-taking sexual behaviour and STIs/HIV, and offer the opportunity to be screened for chlamydia, gonorrhoea, syphilis and HIV.

While sex and relationship educational sessions feature in the curriculum of some schools, evidence suggests that this is not

Condom distributors can offer screening

happening in all areas. The increasing demand for this service led the sexual health outreach team to develop a specialist educational module, which has been rolled out among various groups in different settings. The age of audiences has ranged from 14 to 22 years and venues have included schools and colleges, The Prince's Trust and the ESOL (English for speakers of other languages) group of young asylum seekers.

The outreach team have found that combining educational sessions with sexual health screening in these venues among this client group has led to significant improvements in the uptake of screening.

Contributing to the evidence base

A literature search to assess the evidence on this approach revealed very little, although a US study appeared to validate the idea of engaging with clients as a tool for achieving behaviour change (Kamb et al, 1998). The study, Project RESPECT, a multicentre, randomised controlled trial, demonstrated the efficacy of using a behavioural change theory model in encounters with people presenting at sexual health services for STI screening. The results were encouraging, with 30% of participants changing sexual behaviour to reduce risk of STIs after six months.

The National Institute for Health and Clinical Excellence's (2007) recommendations to reduce the incidence of STIs and unplanned pregnancy among young people included this approach of engaging with clients to achieve behaviour change to reduce risk. The British Association for Sexual Health and HIV course also endorses this approach as part of its harm reduction strategy and has promoted it in recent years as part of the BASHH Sexually Transmitted Infection Foundation (STIF) course (BASHH, undated).

Although the purpose, rationale and dynamics of Project RESPECT were different from the sexual health outreach team's work in Nottingham, the study results add weight to the importance of framing opportunistic sexual health screening in an educational context where possible. Indeed, as mentioned above, staff from the team have found that uptake of screening increases significantly after an educational session.

Session content

The sessions last for 45-50 minutes and include a PowerPoint presentation with graphic examples of the signs and symptoms of chlamydia, gonorrhoea, syphilis, HIV, human papilloma virus (HPV) and herpes simplex virus (HSV). They also:

- Examine the influences on sexual behaviour;
- Test individual knowledge of STIs;
- Discuss the consequences of unplanned/unprotected sexual intercourse;
- Give statistics to support the need to reduce the incidence and long-term effects of STIs.

A nurse demonstrates a condom; but sex education does not happen in all schools

The sessions are often light-hearted and humorous and are delivered in a non-judgemental style; they seek to promote the view that sex is a positive and creative aspect of life that also has negative aspects that can be avoided but are rarely considered.

Where possible, sessions are interactive, with time for questions and answers and to explore personal issues raised by the young people. This also provides the opportunity to identify specific concerns/needs of individuals within the group and, where appropriate, make referrals to other specialist services. To ensure confidentiality, staff can have more detailed discussions privately after the session when young people come forward for screening.

In addition to the sexual health outreach team's (SHOT) work, the contraceptive and sexual health (CASH) outreach service in Nottingham has offered a chlamydia screening and C-card (condom distribution) service to young people aged 13-24 in various venues for several years. The team reports a consistent trend of 20% uptake of the offer of screening when clients attend for condoms.

Screening uptake after teaching

An initial analysis of SHOT's data, which included five teach-and-screen sessions conducted over six months from October 2009 to March 2010, demonstrated a 65% response rate to the offer of screening services following teaching sessions.

A more detailed analysis of 23 sessions covering the period from April 2010 to March 2011 revealed that, out of 353 young people who attended teaching sessions, 128 (36%) took up the offer of screening after the session. While this figure is lower than the initial result, it is nonetheless higher than the 20% reported by the CASH outreach where no teaching is offered.

It should be noted that the "teach and screen" sessions have in the latter period been offered to a wider audience including people with learning difficulties and those whose first language is not English, where consent for testing could not be given.

Both teaching/supervisory staff and pupils/students alike have welcomed the sessions, which are recognised as an important tool to support young people at what can be a perplexing and pressurised time of their lives.

As well as encouraging young people to make use of screening services, these sessions, if promoted appropriately, might provide an opportunity to make an impact in some schools and youth services that have perhaps been resistant to addressing sexual health issues with pupils/young people.

Conclusion

A consistent 20% uptake rate for chlamydia screening is reported in services where education is not offered and it is recognised that much sexual health education is usually offered separately from STI testing.

The results of this project demonstrate the efficacy of combining asymptomatic sexual health screening with sexual health education and may provide a template for future work among young people who continue to be at risk of sexually transmitted infections. **NT**

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