The Manual for

Sexual Health Advisers

Society of Sexual Health Advisers (SSHA)
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Theories and principles

HEATHER WILSON

Health promotion is a developing field. An understanding of the theories and definitions of health and health promotion are essential to good practice.

The Ottawa charter is presented as a framework for health promotion within the health adviser role.

The ethical considerations of health promotion practice are reflected upon.

DEFINING HEALTH

The official World Health Organisation definition of health was agreed in 1946 as: "a state of complete physical, mental and social well being and not merely the absence of disease."[1] Health, therefore, is multi faceted and encompasses the whole person, not just their physical body.

The WHO definition above could realistically allow us to intervene in any aspect of a person's life and justify it as health promotion. Their 1985 discussion paper of the principles health promotion contains the following useful definition:

> *"Health is, therefore seen as a resource for everyday life, not the objective of living; it is a positive concept emphasising social and personal resources, as well as physical capacities."* [2]

The debate about how to define health was very helpfully summarised by Seedhouse. [3] He identifies four groups of theories:

- Health is an ideal state
- Health is the physical and mental ability to do socialised daily tasks
- Health is a commodity, which can be bought or given
- Health is a personal strength or ability, physical, metaphysical or intellectual

After discussing the problems with each approach he provides a useful model, whereby there is a limit within which there is a full sense of health, but the boundaries of this limit are necessarily fuzzy. The central core provides the 'Foundations of Achievement' for the individual. This he argues work for health must be enabling, allowing individuals to build on their foundations.

Seedhouse believes that health workers are "under the spell of medicine" and remain bound to the medical model. He argues that the problem is the popular view of health as beginning with disease and not as a quality in its own right. [4]

Other writers have argued that the problem is that health workers are often accountable to clinicians. If medical personnel set priorities, then the health promoter is often required to concentrate on the medical flavour of the month.[5] Tannahill describes an experience of teaching medical students; when he asked them to define health they suggested "the absence of clinical signs". However, when they were asked to define their own personal health they were concerned with self esteem, physical fitness and mental and social well being. They did not mention illness of disease. When asked to consider the dilemma of 'straight jacketing' patients within a medical definition, yet defining their own health in positive terms, they could offer no defence. [6]

With such flexible and broad definitions of health, the problem for health promoters can be in essence deciding what to promote. If health encompasses a broad spectrum of well being, including psychological and social, confusion and conflict of interest can arise. Health professionals of all disciplines, and even those working in other agencies such as welfare, could make the case that they do health promotion, particularly if they believe that resources will be allocated as a result. An example is given by Yeo,[7]whereby a Canadian health department guidelines document places transplant programmes under the heading of health promotion.

DEFINING HEALTH PROMOTION

Health promotion theory has a multi disciplinary background. There has been much debate about what makes it a unique activity whereby some tasks will fall within the criteria laid out in accepted theory. There has been a paradigm shift in recent years from health education to health promotion. Some models view health education as one of the activities of health promotion. Health education became tainted with the criticism that it was tantamount to victim blaming.

Tannahill describes health promotion as three spheres of activity, health education, health protection and prevention. [8] Other theorists, such as Seedhouse [9], Tones [10] and French also subscribe to the idea of health education being the teaching arm of health promotion. French contends:

> *"Health Education is a practical endeavour focused on improving understanding about the determinants of health and illness and helping people to develop the skills they need to bring about change. Health Promotion is a convenient conceptual tool which enables us to order our understanding of those often diverse elements within society that have the potential to promote health."* [11]

DEPRIVATION AND HEALTH

The Black Report, [12] published in 1982, firmly established the link between poverty and ill health. For health educators it became untenable to continue to simply promote lifestyle change, particularly as the Report demonstrated a link between poverty and heart disease. This added to the growing discomfort about health education programmes that merely stressed behaviour change. With the clear link between deprivation and poor health established, it becomes salient to ask why certain causal factors are selected for intervention and not others, for example putting resources into a stop smoking campaign instead of improving the quality of public housing.

"Words like "lifestyle" and "behaviour change" are now on the lips of every ambitious health professional, and there is a growing research industry busily investigating why human beings (especially the ubiquitous social classes four and five) persist in the perverse pursuit of bad health". [13]

Health advisers need to be mindful of the complex social and psychological factors that may be contributing to the 'persistent perverse pursuit of bad health.' This is especially important in our one to one work with the patients who present regularly with reinfection or multiple infections, or young people who continue to risk pregnancy. Sir Donald Acheson's Inquiry into Inequalities in Health in 1998 discusses the higher risk of teenage pregnancies in young people from deprived areas. The report points to an overemphasis on the individual factors associated with teenage pregnancy rather than programmes that aim to reduce inequity. [14]

This concern that 'lifestyle' based health promotion can be tantamount to victim blaming was shared by health professionals globally. The first International Conference on Health Promotion in 1986 addressed this concern and the result was a new framework for health promotion, which would become the international guideline for good practice.

THE OTTAWA CHARTER

In 1986 Jake Epp, the Canadian Minister for National Health and Welfare released a framework for health promotion which addressed the fact that people have unequal opportunities and achieving health is often due to factors beyond the individual's control. His framework defined health promotion as a multi faceted activity that sought to reduce inequities and increase prevention. It was presented at the International Conference of health promotion in Ottawa and later became known as the Ottawa Charter. [15]

The WHO has since regarded the Ottawa Charter as a working document. It is a consensus opinion about health promotion and the framework that it proposes is considered to be good practice for health promotion strategy. It sets out five key areas for practice:

- Building healthy public policy
- Creating supportive environments
- Strengthening community action
- Developing personal skills
- Re orientating services [16]

As Yeo argues, the Charter transcends the individual versus the public health debate and overcomes the problem of victim blaming. It does this by bridging the individual and the community and providing what he describes as "an ethic of empowerment or enabling." [17]

APPLYING THE PRINCIPLES OF THE OTTAWA CHARTER TO HEALTH ADVISING

Building healthy public policy

The Teenage Pregnancy Strategy and the Sexual Health Strategy are examples of healthy public policy, as is the Healthy Schools Scheme. Health advisers should be involved with the implementation of these on a local level. In those areas that have a Teenage Pregnancy Co-ordinator, the health adviser should meet with them and be involved in any appropriate initiatives, or work with other agencies and colleagues to develop initiatives.

Health advisers can be involved in the development of and ongoing support for sexual health promotion or condom distribution schemes in relevant services or support groups, such as those for young people, gay men or African communities.

It is good practise for health advisers to liaise with their local public health colleagues wherever possible. This is important if there is a local outbreak of an STI but it can also provide an opportunity to contribute to local public health policy, such as the Heath Improvement Plan. (HIMP)

Creating supportive environments

Health adviser's work in the community can help to create environments conducive to the promotion of sexual health. This begins with the clinic environment. Clinic services need to be developed according to local needs. For example, young people's clinics have been established after very large surveys in local schools identified how the young people wanted the clinic to be set up. [18] It is important to identify gaps in provision. If a clinic is attracting significantly more of a particular client group, and this doesn't reflect the local population, then the groups who aren't attending need to be asked how the environment can be changed to suit them. For example, mixed waiting rooms may be difficult for some cultures, and intimidating for some young people.

Health advisers can be involved in other settings, such as youth clubs, drop in centres or outreach projects, which aim to create a supportive environment to their client group. An example of good practise is the provision of a youth work or social work session within a young people's clinic.

Strengthening community action

Community health advisers and health advisers who work in outreach projects, such as those for commercial sex workers, need to consider their role and the style of community work they are practising.

For example, a community development approach usually means involvement with a community group for a certain length of time, with the aim of enabling and, eventually, empowering them to support themselves. Peer education is an example of this, but it can also work in outreach projects, such as with commercial sex workers in stable environments such as sauna's or flats. Some projects have helped sex workers organise their own condom distribution scheme and enabled some sex workers to educate their peers about sexual health and encourage their use of services. This approach requires intensive work initially, but

contact can be reduced once the client group are supporting themselves, thus allowing the outreach workers to move onto intensive work with other clients.

The community action approach, as developed by such workers as Alinsky, requires the worker to become part of the community. Alinsky and his colleagues used to live in the communities they worked in, which were deprived neighbourhoods in the USA. The locals would regard them as "one of them" and work with them to effect change, such as improving housing. [19] These ideas can be usefully adapted to community health advising or outreach work. While working as a sexual health professional requires very strict boundaries, many health advisers are in post for a number of years, and very effective outreach work can be done by building up trusting relationships with and being regarded as an advocate for the groups you are working with. Health advisers have successfully used this approach in community settings, such as support groups, drop in centres or youth clubs.

Developing personal skills

Health advisers have a unique opportunity to do this. The skills we are most likely to be promoting are condom use and negotiating safer sex. Handing out condoms isn't good enough. We are frequently reminded in our work of the internal and external factors that make condom use complicated for the individual. Demonstrating and teaching correct technique is an empowering tool but it must be accompanied by consideration of the situation for that individual and their relationships. "It is important for the counsellor to show that they understand the reservations that the client may have, while still projecting a positive image of condoms". [20] Interventions which aim to enhance self esteem, build skills and develop the community have proved to increase condom use significantly compared control groups who are just provided with condoms. [21] The Center for Disease Control (CDC) community condom demonstration project intervention in the USA, which had a study population of 15,205 people, found a significantly greater use of condoms in their intervention community than their control community. [22]

Health advisers work with a large number of individuals and are skilled at making quick assessments. This volume of experience means that we are realists and able to work from where the patient is at. It is usually not good practise to "tell people what to do." Often patients are able to disclose to the health adviser behaviours or partners that they have felt unable to discuss with other health professionals. We accept and acknowledge their personal strategies for their own sexual health. Health advisers are aware that there is nothing to be gained by making blanket statements or demands, which place unrealistic expectations on our patients.

Our own values about sexuality and sexual behaviour need to be reflected on and not allowed to impede our work. Dealing with our own experiences is also important. "If workers have unresolved anxieties, distress or anger around some of their own issues and experiences, this may prevent them from being able to offer support to young people in these areas." [23]

Re-orientating services

Health advisers can play a vital role in encouraging services to become sexual health promoting. Training workers is often the best use of oneself as a resource. For example training youth workers or school nurses in sexual health promotion and being available to them to support their ongoing work. Community health advisers work with primary care and are in a position to support sexual health promotion at GP's surgeries. Again running training programmes for GP's, practice nurses, and reception staff may be the best way to achieve this.

Health advisers usually take the lead in their own clinic for sexual health promotion. This includes leaflets and other resources, which need to be kept up to date, and reflect the demographics of the clinic attenders. This is an expensive and time consuming task if not undertaken with the support of health promotion and it is helpful to work in partnership with them.

The clinic service needs to be orientated to suit the needs of the local community, and to facilitate access for disenfranchised groups. This requires effective networking with local services and fast track services where appropriate. For example, fostering links with residential units for looked after children and providing a fast track service for the residents.

Working within educational settings.

Health educators who wish to overcome the problem of "victim blaming" while working within the framework of education have used the methods developed by Paolo Friere. During the 1950's, while implementing a successful literacy programme for those living in shantytowns in Brazil, Friere developed a process of critical consciousness raising that he named "conscientization". The community educator would be the facilitator for a community to identify their own problems and priorities. The facilitator would encourage critical thinking, requiring the community to explore the causes of their problems. They would then consider solutions, although the focus was on the learning process and long term goals were encouraged. The final stage would be an action stage, followed by reflection. Friere based his process on his belief that education can never be neutral, it occurs within the context of people's lives:

"Conscientization occurs simultaneously with the literacy or post literacy process. It must be so. In our educational method, the word is not something static or disconnected from men's existential experience, but a dimension of their thought language about the world" [24]

These methods have been applied to health education programmes, and are particularly applicable in peer education. They have been used in the USA to work with school students on substance misuse prevention. [25]

It is good practise to be involved with local peer education initiatives. These can be much more empowering than "giving a talk" to an assembly. Health advisers have limited time for schools work. The most effective use of that time is to work with those who spend the most time with the students. That is, the teachers, school nurses, parents, and, most effectively, their peers. As the facilitator for a student group the health adviser is a resource that the group can utilise to develop their own programmes and health promotion resources. The teacher working with the group can assist them in distributing the resources to the other students, and to other schools in the area.

The 'Healthy Schools Scheme' is a WHO project which encompasses schools all over Europe. Most local boroughs will have a scheme whereby schools work toward awards, which grant them the title of a "Health Promoting School" in a particular area, such as psychological health, drug misuse, or sexual health. It is a very appropriate use of health adviser resources to be involved with the sexual health module of the local scheme. The health adviser can contribute to the preparation of the material for the module and support schools who are working toward the award. Some schools may ask the health adviser to run workshops for pupils in the area of sexual health or contraception. If you have the resources to do so, this should be undertaken with the collaboration of health promotion, who often have the most useful training materials, and the school nurse. It is important not to duplicate or undermine the work already being done by the scheme in your area.

How people learn

Anyone who has stood in front of a class or assembly and attempted to talk about sexual health or contraception will be aware of how ineffective the "talk and chalk" method of teaching is. Learning theory has shown that students need to spend as little time as possible on the passive tasks of listening and reading, and as much as possible on activities and participatory exercises. Because there is so much information in the world, which is easily retrievable, learning has become focused on processes, such as problem solving and logical thinking, rather than memorising facts. [26]

It is good practise to keep up to date with health promotion resources and training materials. The expertise of local health promotion colleagues is very useful when planning a workshop or lesson.

Health advisers are sometimes asked to show slides of different infections, such as warts and herpes to students. This is not good practise. It has been shown that negative images just lead to denial in those seeing them and a sense of "it won't happen to me." They can also be very distressing. There is no advantage to this approach, as we aren't promoting self diagnosis, and symptoms are often much less extreme than those shown in medical pictures. A recent meta analysis of sex education in schools concluded:

> *" Adolescents have suggested that sex education should be more positive with less emphasis on anatomy and scare tactics; it should focus on negotiation skills in sexual relationships and communication."* [27]

A study of an intervention where a person with HIV gave talks to students about their diagnosis found that this just caused the students to feel distressed. Although they may find it "interesting" to meet someone with HIV, this may be of limited educational value. Asking any person to talk about their own experience must be considered very carefully, as it can be voyeuristic and upsetting for those listening. [28]

ETHICAL AND PHILOSOPHICAL CONSIDERATIONS IN HEALTH PROMOTION

What are we promoting?

Reflecting on how we define health and how this affects our practise raises an ethical dilemma for health advisers.

Health advisers often work with the 'worried well' These people will present with an anxiety about illness that is overwhelming. Their quality of life has become impaired by this anxiety, yet they usually have an absence of disease, which, in itself, is not enough reassurance. In contrast, there are the individuals who have multiple medical problems, yet describe themselves as 'well' and enjoy a quality of life which may surpass the worried well. This situation can be paradoxical and frustrating if health is viewed as an absence of disease. "There is, in a word, "care" as well as health to consider. Even just listening to, and attending to, the worried well is part of healthcare." [29]

The person who feels that condom use causes psychological or psychosexual problems for them can highlight the ethical problems of the individual vs. the public health that is inherent in the health adviser role. However, while a demonstration of correct condom technique may be of some benefit, a holistic view of the individual and their health needs fosters consideration of the power and self esteem questions that are linked to their psychological

health. It can then be more helpful to explore these questions and consider that the patient may have chosen to place their psychological needs above potential physical harm. Health advisers will often choose to discuss harm minimisation or risk reduction techniques in this situation.

Truth is relative

Although scientific method is design to reveal "facts" in an empirical way by objective observation, this doesn't mean that research, even if it meets stringent scientific standards, has uncovered the "truth". Popper argued that at best we can only hypothesise and we are only ever left with our own truths about our own version of the world. His theory of Falsification posits that a scientific "fact" is only true until it is disproved or "falsified". He maintained that the greater the empirical claims of any theory, the more falsifiable it is. [30]

The production of knowledge is fraught with difficulty and conflicting ideas. For example the social sciences may believe that qualitative research produces useful information, but for some scientists only quantitative objective methods, such as randomised controlled trials, are considered worthwhile. Talbot [31] has helpfully summarised this debate and he points out that most scientists will reluctantly admit that there is no such thing as "objective scientific knowledge".

Health advisers need to keep up to date with the latest research and guidelines about sexual health. Sometimes patients will be confused by changes in protocols or regimes; cervical screening guidelines over the past few years are a good example of this. This also happens in community messages, such as advice about thicker condoms, which has failed to be endorsed by clinical research. An appreciation of the fluid and occasionally subjective nature of scientific knowledge, allows for a helpful presentation of the current "facts". The latest thinking and guidelines on a subject can be summarised in an accessible way, with the aim of enabling the patient to understand the reasoning behind the advice they have been given.

Medical Ethics

> *"Experts have no special prerogatives entitling them to make judgements for the rest of humankind."* [32]

Do we regard good health as a goal in itself? It is reasonable to assume that for most of us, death is a negative state and we value the states of being alive and of being healthy. With this as a value base, health advisers will promote behaviours and treatments that we believe are in the best interests of our patients. "It is common to feel that one's own preferences reflect value's that reasonable people adopt; one can hardly regard oneself as unreasonable" [33]

However our patients may not share our regard for their own health, or indeed our definition of what it is for them to be healthy. While we may be motivated by beneficence, the desire to do good, our actual practice is vulnerable to paternalism. Is it paternalistic to give selective information to patients? It would be impractical to belabour all the possible negative side effects of an antibiotic when discussing treatment, but is the decision not to do so pragmatic or paternalistic? We have probably all heard the argument from colleagues that they don't wish to give upsetting information to patients. For example, they may brush over asymptomatic transmission of the herpes virus, or health promotion leaflets and materials will often simply promote condoms to prevent infections such as herpes or warts, without explaining that they can only partially protect against these infections. [34] Is this motivation non-maleficence, (not doing harm) or is it again paternalistic?

The problem of victim blaming in health promotion is intensified in the field of sexual health. Not only are we attempting to educate and empower our patients to protect themselves from contracting STIs, we are also at the forefront of trying to prevent the spread of infection and are involved in surveillance and monitoring with our public health colleagues. Thus we can be in the invidious position of the individual feeling that they are being blamed for their own misfortune, but also for the spread of infection to others. As health professionals we need to resist the idea of the 'innocent party'. Whilst supporting people to protect themselves from infection or unwanted pregnancy, it is important to focus on their personal strategies rather than 'risky' or 'dodgy' sexual partners. I have discussed earlier how the principles of the Ottawa Charter help to overcome the problem of victim blaming, yet it is our dual role, working for the individual and the public health, and the ethical dilemma's within, that provides a further challenge when planning or undertaking sexual health promotion.

CONCLUSION

Health Promotion is a growing field of theory and practice. This chapter has aimed to explore how health advisers can apply health promotion theory to their work as well as reflecting on the ethical dilemma's inherent in health promotion practise. The following chapter provides detailed protocols and guidelines for developing and implementing sexual health promotion in both clinic and community settings.

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Chapter

31

Standards and guidelines

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Based on a document written for the SW London HIV/GUM Network Sexual Health Promotion Subgroup.

The aim of this chapter is to:

Set out good practice guidelines and recommendations for developing sexual health promotion within genitourinary medicine (GUM) services

Maximise the opportunities for, and the effectiveness of, interventions that promote the sexual health of clinic attendees

Outline best practice standards based on evidence of good practice and national and local recommendations for service developments.

They are in line with national strategies for HIV prevention and sexual health promotion

STRATEGIC FRAMEWORK

Sexual health promotion work in the GUM setting needs to be developed in line with national and local strategies. Each clinic will be working towards meeting several key targets outlined in the following different strategies:

National strategy for sexual health and HIV[1]

There are 5 main aims of this strategy:

- Reducing the transmission of HIV and sexually transmitted infections (STIs)
- Reducing the prevalence of undiagnosed HIV and STIs
- Reducing unintended pregnancy rates
- Improving health and social care for people living with HIV

- Reducing the stigma associated with HIV and STIs

This includes the following key actions for GUM clinics to work towards:

- Developing the health adviser's role
- All homosexual and bisexual men to be offered hepatitis B vaccine on first attendance at GUM clinics
- Increasing the offer and uptake of HIV and STI testing through a range of measures
- Each PCT will be leading on local implementation, with the strategic health authority overseeing and performance monitoring the process.

African HIV Prevention Strategy (National AIDS Trust/African Policy Network) [2]

This strategy may be used to inform HIV prevention programmes and GUM clinic services as they are developed. It is important to ensure that information and HIV prevention activities are accessible to this patient base and that they are culturally and linguistically appropriate.

The strategy identifies the following needs:

- The need for knowledge (basic HIV and STI information)
- The need for skills
- Building a safer sex culture (gender and age specific issues)
- The need for accessible and appropriate services (including condoms)

Making It Count – Gay Men's HIV Prevention Strategy [3]

This is a theory, ethics and evidence based health promotion framework for HIV prevention with gay and bisexual men that has been adopted as the best model for prevention work, and includes the following key aims:

- Men are able to choose who they have sex with and what kind of sex they have
- Men are equipped and competent to negotiate sex
- Men are knowledgeable about HIV, its exposure, transmission and prevention
- Men are aware of the possible HIV related consequences of their sexual actions for themselves and their sexual partners
- Men are free to choose whether or not to test for HIV
- Men are knowledgeable about HIV testing and the meaning of HIV test results
- Men have access to quality HIV testing services
- Clear and unambiguous naming and labelling of condoms and lubricants
- Men are knowledgeable about STIs, their transmission and prevention

- Men are knowledgeable about clinical sexual health services

- Men have access to quality clinical sexual health services

There is a range of methodologies outlined in the framework and key settings are identified, including sexual health services. Factors that influence the reduction of unprotected anal intercourse include:

- Reducing the barriers to sexual choices and increasing the control men have over the sex they have

- Increasing men's sexual negotiation skills and their access to condoms

- Educating men about HIV, its exposure, transmission and prevention, for example, reducing condom failure

- Raising men's awareness of when their engagement in unprotected anal intercourse might be sero-discordant

Teenage Pregnancy Strategy

Each local authority area has developed a teenage pregnancy strategy with the dual aims of:

- Reducing the number of under 18 conceptions by 50% by 2010, by improving sex education for young people, improving services, and targeting prevention work to young people most at risk

- Increasing the support available to teenage parents, and increase the number of teenage parents in education, training or employment

- Each area has a local teenage pregnancy co-ordinator who can liaise with clinics and help to ensure that any outreach work with young people, schools or community groups is co-ordinated

WHAT IS SEXUAL HEALTH PROMOTION?

There are a number of definitions about what constitutes sexual health. The following from the World Health Organisation is probably the most useful in considering health promotion in the GUM service.

> *"Sexual health comprises:*
>
> - *Capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic*
>
> - *Freedom from fear, shame, guilt, false beliefs and other psychological factors inhibiting sexual response and impairing sexual relationships*
>
> - *Freedom from organic disorders, diseases and deficiencies that interfere with sexual and reproductive functions"* [4]
>
> *In it's widest context sexual health promotion can include "...any intervention that improves a person's physical or psychological sexual well-being."* [5]

It is recommended that the following standards be endorsed by each clinic to underpin the further development of sexual health promotion. The standards are taken from Effective Sexual Health Promotion [6] and provide a useful framework to underpin future work. In order to be effective, sensitive and appropriate in meeting the multiplicity of needs within communities, all sexual health promotion work, including that in GUM clinics:

Have an ideal values base which:

- **Ensures sexual health promotion is accessible to all and takes account of particular needs:** for example in terms of people whose first language is not English and people with a visual or other sensory impairment
- **Affirms diversity:** for example in terms of sexuality, ethnicity, age or ability and reflects this in all practice
- **Ensures that individuals and groups are able to resist coercion**, pressure, exploitation, abuse, harassment and bullying
- **Supports the development of self-esteem**. Self esteem plays a vital role in enabling individuals, groups and communities to negotiate equally and to make choices and decisions that will enhance rather than detract from their sexual health and well-being
- **Builds a clear sense of rights** of individuals, groups and communities to positive sexual health and to services which support this
- **Enables people to develop practical skills**
- Is grounded in **a positive and holistic model of sexuality and sexual health**

Supportive methods of working:

- **Promote collaborative and multi-agency work** including partnerships with the voluntary and community sector
- **Actively counter and challenge discrimination, stigma and prejudice.**
- Acknowledge and support the **rights and responsibilities** of individuals, groups and communities in relation to their sexual health and well-being
- **Create opportunities for discussion**, reflection and exploration of issues, attitudes, values and beliefs in relation to sexual health
- **Are informed by a research and evidence base** which ensures maximum effectiveness and best use of resources
- **Engage people's intellect, experience, thoughts, and feelings** to create a positive culture, which is more tolerant, affirming and celebratory about sexual health and sexuality as a vital element of human experience

Quality services and support would:

- **Be offered in non-judgemental, respectful and sensitive ways**

- **Provide clear, accurate, up to date information** in attractive and accessible forms and languages

- **Offer support** and information which will enable people to make healthy sexual choices and relationships

- **Are provided by staff who are aware of the values base described here** and who are trained, skilled and confident to work in ways which exemplify this

EFFECTIVENESS OF HIV PREVENTION HEALTH PROMOTION INTERVENTIONS

HIV prevention initiatives have been reviewed for evidence of effectiveness for the Health Development Agency. [7] The authors found that the review-level-evidence was heavily skewed to non-UK research about a narrow range of individual/ group-level interventions, which were relatively easy to control and so lend themselves to experimental evaluation. The report states that it is important to emphasise that no evidence does not equal evidence of ineffectiveness, and has produced research recommendations to supplement the existing evidence base. The review focused on the priority populations for the sexual transmission of HIV in the UK, namely men who have sex with men, African communities, commercial sex workers and people with HIV. The following policy and practice recommendations are made:

1. Men who have sex with men. There is some evidence that community level interventions involving peers and popular opinion leaders can be effective in influencing the sexual risk behaviours for men who have sex with men. There is also some evidence that cognitive behavioural group work focused on risk reduction, sexual negotiation and communication skills training (and rehearsal, for instance through role play) can be effective. However, it is questionable how generalisable these interventions may be to the UK and/ or non-white, non-educated men who have sex with men. Interventions with men who have sex with men are more likely to be effective if they are:

- placed within the broader context of men's lives, addressing the range of factors which influences at both the personal level (for example- knowledge, skills) and the structural level (for example discrimination towards gay men, gay community norm towards condoms)

- tailored and targeted to specific sub-populations of men who have sex with men, for example black gay men and working class gay men

- multi-component (using small group work), focusing on risk reduction, sexual negotiation and communication skills training and rehearsal (for example through role play or identifying 'triggers')

2. Commercial sex workers. Interventions delivered at a community level, particularly peer-led can be effective in influencing the sexual risk behaviours for commercial sex workers.

3. African communities in the UK. Small group interventions delivered at community level can be effective in influencing the sexual behaviours of black and ethnic minority women, however it was not possible to transfer the findings to the UK's African population.

4. HIV counselling and testing. There is some evidence that suggests that counselling and testing can influence sexual risk behaviours particularly amongst serodiscordant couples,

where one partner learns that they have HIV. However the effect of an HIV negative diagnosis may be detrimental where people may have a false sense of security, perhaps leading to increased risky behaviour. The review concludes that current evidence suggests that voluntary counselling and testing should be targeted only at high risk individuals who are likely to be positive.

The evidence suggests that the main features of effective health promotion and education interventions:

- Incorporates theoretical models of behaviour change, or components of these models, as a basis or intervention development and implementation
- Provides basic, accurate information about the risks of unprotected intercourse and methods of avoiding unprotected intercourse
- Use a multi-faceted approach, including a number of components- such as skills development, motivation building and attitude change in addition to factual information. Information provision alone is insufficient to influence behaviour change. Personal and structural factors such as attitudes towards safer sex and condoms, motivation, the influence of significant others, wider social influences, as well as practical skills all play an important part in the ability to change behaviour
- Incorporate specific behavioural skills training, for example, how to use condoms
- Are based on detailed understanding of background behaviours, beliefs and risk perceptions of the target population. Formative research can be useful in developing programmes which are appropriate to the target population in terms of age, gender, sexual experience and culture
- Make use of peer educators
- Place emphasis on promoting condom use, rather than abstinence. Telling people not to have sex is unlikely to be an effective intervention
- Are of appropriate duration. It requires considerable time and multiple activities to change long established sexual risk-taking behaviour

SEXUAL HEALTH PROMOTION IN THE GUM SETTING

It is important to acknowledge that patients are not generally attending the clinic for advice about behaviour change. In order for opportunities for sexual health promotion to be maximised the following issues need to be considered:

- The raising of sexual health promotion issues is generally opportunistic, recognising the need to first address the concerns for which the patient has attended
- Ideally there are regular opportunities for skill sharing, training and the dissemination of good practice in health promotion and the needs of different patient groups
- There is a need to acknowledge that the pressures of time and the need to perform other tasks during the consultation will limit interventions

- The approach to health promotion is best patient led and acknowledges the need to prioritise the patient's presenting problem

IDENTIFYING SEXUAL HEALTH PROMOTION NEEDS

Sexual History Taking

A full sexual history is usually taken for all GUM patients at their first visit and with re-attenders as appropriate. If undertaken in a planned way sexual history taking is an essential tool for risk assessment for targeted sexual health promotion work and for partner notification when indicated.

While sexual health promotion activity is usually recorded in clinic notes, there is a need to develop a standard format for recording sexual histories, including sections on discussing prevention for both nurses and health advisers.[8]

By collecting detailed information, the most appropriate sexual health promotion work can be undertaken dependent on a patient’s risk, for example, for pregnancy or for STIs. A full sexual history needs to include the following to enable an accurate assessment of risk:

- Partners in the past three months (and how long ago was their previous sexual relationship if only one partner in the last three months)

- Gender and sexual orientation and enquiry about previous ‘same sex’ relationships

- Type of sex, for example vaginal, anal and/or oral (different information asked dependant on patient’s sexual orientation)

- Nature and context of their sexual relationships, for example duration of the relationship and whether partners are ‘regular’, ‘known’, ’casual’, ‘wife’ etcetera

- Contraception/ barrier protection/ safer sex/ risk reduction information. It is important to raise the use of contraception with all sexually active heterosexuals

- Specific risk factors for HIV/ blood borne infections for example whether the patient is, or has had a sexual partner who is a man who has sex with men (MSM), an injecting drug user (IDU) or has had sexual contact with a person from an area of high prevalence, blood transfusion recipient prior to screening or a has had sexual contact with a partner known to be HIV positive)

- Previous STIs and relevant contact information, for example contact slips/ information gained from cross referencing of notes

- Previous vaccination or known natural immunity, for example gay men for hepatitis A or B

- For people under the age of 16 it is also essential to undertake an assessment of competence using the Fraser guidelines and for patients under 18 it is important to be aware of the requirements of the Children Act, and to be aware of the local child protection and referral procedures (see chapter on young people)

Risk Assessment

Demographic details collected at registration may highlight the need for a discussion on increased risk of STIs, for example:

- Young age, especially under 16s [9]

- Country of origin, for example, people from countries with a higher prevalence of HIV such as South Africa, Sub Saharan Africa

- Ethnicity, for example, identifies as 'Black' [10] [11]

It is recommended that clear protocols and referral processes are identified in each clinic to ensure that targeted health promotion be offered to all patients who are perceived to be at increased risk of an STI or unwanted pregnancy. This is a clear requirement of the national Sexual Health Strategy, which aims to reduce the number of undiagnosed people with STIs, including HIV, in the population.

TEAM ROLES IN SEXUAL HEALTH PROMOTION

The following is based on work done by the Society for the Advancement of Sexual Health (SASH). [12] In order to promote sexual health effectively a multi disciplinary team needs to:

- Recognise the importance of sexual health promotion

- Develop a shared philosophy

- Seek to develop trusting, non judgmental and respectful relationships with service users

- Be pro-active when appropriate

- Aim to develop consistency in messages and information regarding sexual health

- Have a clear understanding of the different roles within the team and refer appropriately

- Respect and value each others skills and experience

- Be keen to develop knowledge, skills and attitudes

- Recognise diversity amongst individuals and communities and aim to make the service accessible to all service users

The key to developing health promotion within the clinic is the ability to work effectively as a multidisciplinary team. In order to achieve this, it is important that team roles in health promotion are clearly defined and co-ordinated and the different skills within the team are valued and maximised.

The recommendations on staff roles in sexual health promotion in this paper have been adapted from "Developing a sexual health promotion strategy in the GUM Service" Camden and Islington Community Health Services Trust January 1994. [13] While these are still useful guidelines, successful implementation will depend on the issues particular to each clinic, such

as clinic size, structure, current staffing levels, and perceived needs of attendees and availability of resources.

As stated in The Camden and Islington document:

> *"Attendance at a GUM clinic involves the patient having one to one contact with a health professional which allows for detailed discussion about the sexual behaviour of that individual. GUM clinics are therefore ideal settings for sexual health promotion to take place, complementing other existing strategies to deal with STIs in the community."* [14]

Doctors, nurses, health advisers and receptionists all have a role in health promotion. These roles need to be clearly defined and co-ordinated. If roles are not clearly defined there is a danger of either overloading the patient with advice or missing out health promotion altogether.

Clear documentation of health promotion related discussion means that duplication can be avoided and team members can build on previous interventions. If members of the team are giving different messages about sexual health, for example risks of transmission attached to sexual activities patients will be confused and less likely to follow any advice given. Where good practice is not shared, methods of promoting sexual health which have been shown to have little impact may be used, for example, giving out 'standard' information rather than relating it to the individual. While all clinic attendees are ideally given the opportunity to discuss prevention and related issues, it is important that team members use their skills and experience to assess the appropriateness, relevance and timing of any intervention.

Doctors

Sexual health promotion is an integral part of the GU doctor's role. The routine GUM consultation presents numerous opportunities for HIV/STI prevention. It is considered good practice that doctors discuss HIV/STI prevention with all new patients and with re-attendees as appropriate.

To fulfil this role doctors:

- Identify how they will fit explicit sexual health promotion routinely into their role
- Recognise that patients presenting with an infection or potential infection may be particularly receptive to sexual health promotion advice and harm reduction messages.
- Evaluate current sexual behaviour, using a standard and recommended approach to sexual history taking
- Advise about risks attached to different sexual activities
- Discuss condom use, identifying potential problems and refer for condom demonstration/ discussion where appropriate
- Help the patient reflect on personal situation and encourage them to make changes which will minimise risk
- Identify whether there is a need for referral or further discussion with another team member as per clinic protocol, for example health adviser, psychologist, outside agency

- Discuss prevention and HIV testing regardless of whether the patient raises HIV testing or health promotion themselves. The national Sexual Health Strategy includes a target to increase the uptake of HIV and STI testing, and states that all GUM attendees are to be offered an HIV test on their first screening for STIs, and subsequently according to risk

- Undertake follow up prevention work as appropriate with re-attendees

Nurses

It is considered good practice that all nurses are able to perform a health promotion role when the opportunities for discussion arise. The level of health promotion activity undertaken by the nurses will partly depend on acceptance within the clinic that this is part of their role. Issues of the amount of time the nurses spend with the patient and the lack of privacy for discussion also need to be taken into account.

In order to fulfil their role in sexual health promotion nurses need to be able to:

- Take the lead in giving advice and information on hepatitis B vaccination and human papilloma virus (HPV) and cytology/colposcopy

- Evaluate current sexual behaviour, using a standard and recommended approach to sexual history taking

- Give basic, clear safer sex advice, with reference to risks attached to different sexual practices

- Help patient reflect on personal situation and encourage them to make changes which will minimise risk

- Talk about and demonstrate condom use and routinely offer condoms to patients where appropriate

- Identify patients who need referral onto a health adviser

- Act as a 'safety net' by checking out the patient's understanding and satisfaction with the information/advice given

- Be able to raise and answer questions about HIV testing and identify patients for referral to the health adviser in line with clinic protocols

The family planning trained nurse will also perform a health promotion role in line with the above. In addition the role of the contraceptive nurse will include:

- Advice/information on all forms of contraception, including information on efficacy, advantages and disadvantages and side effects

- Ensure the patient has the relevant information to enable them to make an informed choice

- Check out that the patient is fully aware of how to use their chosen method

- Identify patients requiring emergency contraception

- Identify patients who need referral to a doctor or health adviser

Health Advisers

Health promotion is an integral part of the health adviser's role. The health adviser will discuss safer sex with all patients and offer more in depth prevention work, where this is appropriate. It is therefore important that referral to health advisers be consistent and includes referral for in-depth prevention work based on a clear and consistent assessment process by other team members.

Guidelines and protocols on which patients are referred to the health adviser need to be in place in all clinics with the aim of ensuring that those with particular issues around prevention receive the opportunity for in depth discussion, counselling and support.

Particular consideration needs to be given to including referrals to health adviser that are specifically for prevention counselling, for example, exploring harm minimisation strategies.

Prevention work is also an integral part of the following key health adviser functions:

- Counselling patients with STIs
- Partner notification
- Herpes simplex virus (HSV) counselling and support
- Safer sex support and counselling for patients with, or affected by, HIV
- Pre HIV test discussion and post-test counselling
- Counselling around unplanned pregnancy
- Referral to other services for example psychology, drugs/alcohol services, lesbian, gay and bisexual specific support services

Health advisers also have a key role in disseminating information on prevention and good practice in health promotion across the clinic team.

One of the actions of the national Sexual Health Strategy is to 'develop health advisers' roles and responsibilities within GUM services'. This will have an impact on the ability of health advisers to develop innovative and effective ways of working with different patient groups, including community outreach and support, but this also has clear resource implications.

Receptionists

While the reception team does not have a direct role in sexual health promotion, their importance as the first point of contact with the service ought not be underestimated. The following aspects of the receptionist's role will impact on the effectiveness of health promotion across the service:

- A friendly, non-judgmental approach to patients, in person and on the telephone
- Reassuring patients (where appropriate) about the confidentiality of the service
- Explaining the appointment procedure

- Dealing with difficult and/or anxious patients
- Giving out clinic leaflets or verbal information as to the range of services on offer
- Accessing appropriate members of the team to give information/advice over the telephone
- Being able to give patients a brief explanation of the different roles within the team
- Skills to triage patients presenting with urgent needs in a busy clinic to ensure they are appropriately referred or given appointments

SERVICE STANDARDS FOR WORKING WITH GAY MEN IN GUM

Health advisers may consider developing recommended service standards for GUM clinics to work towards in order to meet the needs of gay men using a framework. These may include the need for each clinic to:

- Have a clear protocol for clinic staff working with gay/bisexual men. This will ideally highlight key areas to discuss in the assessment process and the screening service to be offered, along with information about other relevant lesbian, gay and bisexual agencies
- Have a protocol for hepatitis A and B screening and vaccination
- Agree a process for recording information about sexual orientation of attendees that can be easily audited
- Identify methods for retrospective audit of HIV prevention with gay men. These may include assessment of sexual history taking, as per clinic protocol: identification of which tests have been offered to and taken up by gay/bisexual men; how hepatitis A and B screening vaccination and recall systems have worked; HIV risk discussion and testing; number and type of health adviser referrals, as per clinic protocol; level and amount of risk reduction discussion, support or counselling
- Develop a framework for a health adviser risk reduction interview, based on the 'Making It Count' framework [15] and the skills needed for current sexual relationships. This could include the provision of information about relevant external initiatives, for example the THT/ Healthy Gay Living Centre's (a London gay mens outreach HIV prevention organisation) planned workshop programme
- Ensure that information and/or campaigns provided by gay men's health promotion organisations are also accessible in clinic settings to complement outreach work with gay men and strengthen the impact and opportunity for follow up discussions

FACE TO FACE HEALTH PROMOTION METHODOLOGIES

The "Doing It" Toolkit (Sheffield Centre for HIV and Sexual Health) [16] identifies that in order to be 'effective, sensitive and appropriate', sexual health promotion needs to:

- Be person centred

- Be grounded in a positive, holistic model of sexuality and sexual health

- Create opportunities for discussion, reflections and exploration of issues, attitudes, values and beliefs in relation to sexual health

Implicit in this is that there is no 'one way fits all' method of discussing sexual health with patients. Effective health promotion is not simply about information giving. Practitioners will benefit from having a good range of communication skills and techniques they can employ to work effectively with a variety of patients.

Frameworks around the use of counselling skills

The term 'counselling skills' does not have a single definition, which is universally accepted. The British Association of Counselling (BAC) Code of Ethics and Practice for Counselling Skills states " 'counselling skills are distinguished from 'listening skills' and 'counselling'. Although the distinction is not a clear one, because the term 'counselling skills' contains elements of these other two activities, it has its own place in the continuum between them. What distinguishes the use of counselling skills from these other two activities is the intentions of the user, which is to enhance the performance of their functional role (as doctor, nurse, health adviser etcetera), the recipient will, in turn, perceive them in that role." [17]

The BAC goes on to state, " counselling is an activity with clear boundaries and the client will identify the helper as their counsellor."

In a clinic setting all professionals who have a health promotion role would be in a position to use counselling skills to enhance that role. In addition, members of the team (generally health advisers) with specific training and expertise would be able to offer (generally short-term) counselling sessions, where appropriate.

One does not need a particular theoretical perspective in order to use counselling skills effectively, however what underpins the practice of both counselling and the use of counselling skills is:

- Confidentiality

- Respect for the patient's own perception of their experience

- Support for the person in finding their own solution to their difficulties

In a health promotion context counselling skills can be used alongside other forms of interaction such as information and advice giving. A person centred approach to counselling skills would generally be informed by Rogers three conditions for successful counselling. [18] Egan's three stage skills model of helping [19] is another useful tool in a health promotion context. Both of these approaches are outlined in a number of books focusing on counselling/counselling skills, including 'Counselling: The Trainer's Handbook' Francesca Inskipp (1986) [20]

Heron's Six-Category Intervention Analysis (Heron 1986) [21] is a framework for identifying a range of possible interventions, and has often been used to explore the use of counselling skills within a health setting. As well as outlining the key points of this framework, 'Counselling Skills For Health Professionals' by Philip Burnard (2nd edition 1994) [22] offers a general overview of the use of counselling skills in a health setting including information about a range of theoretical stances.

While the following is neither an exhaustive list nor detailed explanation of different methodologies, it is meant as an overview of some useful frameworks or models for interacting with patients.

Personal strategy for sexual health

This is a model that was adopted by the Camden and Islington Sexual Health Promotion Group (SHPG). This model may be useful for doctors and nurses who are working within severe time constraints. This model offers the possibility of a routine structure in a consultation, even when taking a more patient centred approach. The SHPG recommends that, in order to help patients develop their personal strategy for HIV/STI prevention, doctors or other health professionals need to be able to carry out the following steps:

- Evaluate current sexual behaviour
- Advise about risks attached to different sexual activities
- Help patients reflect on their own personal situation
- Encourage them to make changes which will minimise risk
- Identify whether there is a need for referral or further discussion with another member of staff (French and George 1994) [23]

In The Communication Skills of Medical Staff in HIV Prevention (1998) Jo Mussen writes:

> *'This model requires a shift away from the traditional focus on the doctor (or other professional) giving expert information on, for example, the comparative levels of risk of different sexual activities and also possibly advising patients to use condoms. While expert information still has an important role to play it cannot stand-alone. The context of a person's life and relationships needs to be investigated and acknowledged if they are to be helped to develop their own personal strategy for sexual health. This model of sexual health promotion therefore takes less of a 'top-down' approach than the medical model. The patient is brought clearly into focus and involved in an interaction with the doctor. The model could be represented as an equation: information on safer sex + the context of the client's life and relationships = a personal strategy for sexual health'."* [24]

Motivational Interviewing

(Based on Miller and Rollnick "Motivational Interviewing", Guildford Press) [25]

This is a framework that enables the practitioner to support patients through the stages of lifestyle change. It identifies a 'change cycle', that each person will go through when considering behaviour change. The main elements of this cycle are:

- Not interested in changing
- Thinking about changing/deciding to try
- Trying to change/changing
- Relapse

Miller and Rollnick suggest it is useful to identify where in the change cycle the patient is, and offer a range of approaches that are appropriate to each stage. This approach also recognises

the importance of ambivalence and resistance within the change process and encourages the practitioner to work with these issues without imposing their own agenda on the client.

Harm Reduction

(Adapted from Evolution: Can Harm Reduction Help in HIV Prevention Work with Gay and Bisexual men) [26]

The harm reduction model, in common with Motivational Interviewing, is based on a theoretical model of behaviour change. The Stages of Changing Behaviour (researched by Prochaska and DiClemente 1994) [27] identifies five stages individuals go through when they seek to change valued behaviour. These stages are:

- Pre-contemplation - not yet considering the possibility of change
- Contemplation - considers change and rejects it. Reasons for concern versus justifications for unconcern
- Planning and preparation - "I've got to do something about this problem"
- Action
- Maintenance - identify strategies and support to prevent relapse

This model would see relapse as a possibility within each stage of the cycle. Patients may step in and out of the cycle at any point like a revolving door, dependent on internal and external influences and their strategies for dealing with them.

The process of harm reduction involves considering 'external guidelines and personal issues relating to the quality of life'.[28] The value of behaviours in this context includes their significance in relationships, their potential for physical pleasure and fulfilment and their emotional, social and cultural value. The key stages of the harm reduction process are:

- Clarify the value attached to an activity
- Consider the risk attached to an activity
- Clarify how the value attached to the activity can be maintained while reducing the risk of the activity
- Consider what change is necessary to reduce the risk

Harm Reduction is a model of behaviour change that can be useful in reflecting on change in highly valued behaviour. In a sexual health context this is a way of exploring the value and meaning that unprotected sex or 'risky' behaviour might hold for the individual patient. The implications of this model for health promotion thinking are as follows:

- Behaviour change has five distinct identifiable stages of change
- Individuals do not go through the stages in a linear fashion
- At different points, an intervention must focus on different issues with different intensity

- Helping individuals reflect on their ambivalence is a key strategy for helping change

CONDOM DISTRIBUTION AND TEACHING

The aims of condom distribution within the GU clinic setting are:

- To reduce the spread of sexually transmitted infections
- To promote safer sexual practises
- To lower the risk of unplanned pregnancy

It is good practice to have a condom protocol. An example of a condom distribution protocol for GUM is one from Merton Sutton and Wandsworth GUM clinic written in 2001 and included as appendix. This protocol lists the aims and principles that help develop best practice.

Evidence has clearly shown that demonstrating condoms is effective and helps to minimise breakages, especially for younger and less experienced clinic attendees.

DOCUMENTATION OF SEXUAL HEALTH PROMOTION WORK

It is important that good practice is developed through written guidelines/protocols where appropriate, and patients' notes include documentation of health promotion related discussions. Documentation ought to give the next practitioner an indication of the work / discussion that has taken place to avoid duplication of the same messages, and enable them to build on work previously undertaken. Mechanisms need to be identified and agreed for audit of sexual history taking, but this will only be able to be undertaken if sexual health promotion work has been clearly recorded in patient notes.

The following gives ideas for suggested documentation of specific information:

- 'Safer sex discussion' may be measured by time, for example 'brief discussion re safer sex' or 'safer sex discussion 20 min'
- 'Condoms, lubricant given and demonstrated x3 ribbed, x3 extra safe x3 select'
- 'Declines condoms- aware of risk, risk reduction discussed'
- 'Offered (or suggested) referral to psychologist re risk reduction – declines at present'
- 'Concerns with condom breakages - technique discussed'
- 'Difficulty losing erection with condoms- explored when this occurs and will try ……'
- 'Safer sex negotiation discussion re how to use condoms when out 'drinking''

LEAFLETS

A variety of leaflets are used within the GUM setting, largely provided from public health departments, typically from Health Promotion England, the Family Planning Association (FPA), the Association of Genitourinary Medicine (AGUM), and in-house clinic leaflets.

Leaflets provide a useful tool to stimulate interest and discussions, and to emphasise information given, but need to be used in a planned and appropriate way. They need to be accessible to and appropriate for patients. Simply providing information is not enough to facilitate behaviour change for most people, but may provide a trigger for further work.

Ideally each clinic has a 'leaflet group', for example a health adviser, nurse and doctor. This group may then review the leaflets in the clinic to:

- Make the relevant leaflets available for patients attending GUM
- Standardise the leaflets being given out
- Standardise the leaflets available in waiting rooms
- Ensure they are appropriate to the clinical area they are displayed in
- Promote what leaflets are available and where more specialised leaflets can be found
- Ensure that the leaflets contain the correct and appropriate information and are up to date
- New leaflets are vetted by this group for their suitability, and to ensure they adhere to local guidelines about promotional literature and sponsorship
- Changes to the clinic's own written leaflets may be managed in the leaflets group and then sanctioned by the relevant heads of department meeting
- Clinic written leaflets will need to be checked by the Trust's patient information / liaison departments
- Ensure that leaflets are accessible to all in terms of language, culture, and that they display diverse images to reflect all members of the community

TARGETED DISPLAYS

A variety of posters/ leaflets/ display materials are available for use within the GUM setting. These materials are largely provided from public health departments, and some targeted campaigns are sent directly to the clinic, either from the sponsors or direct from Health Promotion England.

- Ideally each clinic has a person or team whom co-ordinates the clinic displays
- It is important that there are permanent notice boards for health promotion materials in waiting areas
- Notice boards for health promotion materials will need to be changed at least bi-monthly
- Clinic displays include the national campaign materials at the relevant time, for example for World AIDS Day or National Condom Week
- Each clinic needs to be aware of other national and local campaigns targeting specific patients, and display posters to complement these at appropriate times, for example

Community HIV/AIDS Prevention Strategy (CHAPS) campaigns which target gay men in community settings

RANGE OF REFERRAL ROUTES

For some patients accessing GUM services this will be an important first step in a process, which may involve other organisations to address their ongoing sexual and mental health needs. Referrals need to be patient centred, and take account of the fact that many people will feel ambivalent about referral to another agency. This ambivalence itself is an issue, which it may be appropriate to explore as part of the sexual health promotion process. The following are suggested as essential core components of sexual health promotion in GUM settings, in order to enable effective and appropriate referral for patients.

All staff needs to be aware of the range of specialist support services for sexual health promotion with different patient groups, for example:

- Gay men: for example lesbian, gay and bisexual health promotion, community and youth groups
- Sex workers: specific outreach and community projects
- Young people: specialist services for young people, other accessible places where free condoms are available
- Refugees/asylum seekers: appropriate community groups
- Injecting drug users (IDU): local drug services and needle exchange schemes

It is important to have information available on all these support services, and accessible to patients and staff.

Effective and appropriately timed referral will be facilitated if staff can give clear information about what the other service offers, explore and agree with the patient why they are making a referral, and how to access the service. Wherever possible arranging an appointment while the patient is still at the GUM clinic will also be useful, and is likely to increase uptake, especially by young people

ACCESS ISSUES

In order for effective sexual health promotion to take place with target groups and individuals in the GUM clinic, the service must obviously be accessible to all.

It is important that clinics provide information about their services and hours of opening in a clear and accessible format. This information needs to be widely distributed to community settings, via appropriate local networks and mailings. A method must be clearly identified in each clinic for reviewing, updating and informing other services of any changes in the clinic provision for example updating database information held by NHS Direct.

Several clinics could consider shared approaches to production of service information such as leaflet and internet information, for example, across primary care trusts (PCT) or the GUM/ HIV Network in South West London.

As a minimum, all services ought to have a leaflet/ flyer outlining what they provide and how to access the clinic, and need to consider how to advertise their services, for example in the Yellow Pages/ local phone directories/Thompson Local directories.

It is important to have a named member of staff who may be identified to facilitate outreach information sessions within community settings to promote and explain the clinic service. Under represented audiences in clinics are ideally targeted, for example sex workers. This will help to minimise unnecessary outreach and duplication of community sexual health promotion initiatives

Ideally each GUM clinic has an out of hours recorded telephone message, which includes the opening hours and how to access out of hours specialist advice.

A common approach to the use of interpretation and advocacy services for sexual health promotion work needs to be adopted.

In order to increase access for people who are at work, school or college and cannot take time off during the day all clinics will need to work towards having at least one evening session available (open until 7.30 pm).

MONITORING, EVALUATION AND AUDIT

The effectiveness and appropriateness of sexual health promotion in clinic settings is not easy to monitor and evaluate, but it is essential to inform service developments, to help to identify needs, and improve liaison with community sexual health promotion strategies. In order to compare data and different approaches across GUM services, it is recommended that the following minimum standards be worked towards by all clinics, using common approaches:

- Patient demographic data needs to include age, sexual orientation and ethnicity as a minimum, and this data is ideally collected in a way that enables it to be easily accessed and reported upon, and compared with other clinics

- Mechanisms need to be in place to enable clinics to report on numbers and types of STI by demographic data, for example age and ethnicity, to inform community sexual health promotion strategies

- Information must be recorded clearly in notes about sexual health promotion interventions to enable quality standards to be monitored and audited

- Referrals made out of the GUM service, and referrals received inwards will help to monitor and compare the amount of joint working

- A common list of sources by which patients have heard about the clinic may be developed and recorded. This may then be analysed by demographic data, for example for young heterosexual men. This will help to inform promotion and outreach strategies

- It is important that patient feedback mechanisms and complaints procedures are in place in all clinics, and clearly available to all patients

- Clinical audit is the systematic critical analysis of the quality of health care, including the procedures used for diagnosis and treatment, the use of resources and the

outcome for the patient, which is an essential component of medical practice. Audit provides education for all those involved and by questioning all aspects of practice enhances efficiency

APPENDIX

Sample condom distribution protocol

Merton Sutton and Wandsworth Condom Protocol for GUM written by David Shaw, Wendy Majewska, Dorinda Thirlby, Caron Bowen, 2001.

Nurses, doctors and health advisers should all be able to educate about condom use, and prompts/situations in which condom demonstration should always be provided should be clarified for all staff. Also needs to include information about where they are available in clinic, e.g. HAs only, or HAs/ nurse treatment rooms/ Dr consulting rooms.

AIM OF CONDOM DISTRIBUTION

The aims of condom distribution within the GU clinic setting are:

- To reduce the spread of sexually transmitted infections
- To promote safer sexual practises
- To lower the risk of unplanned pregnancy

Regular use of a good quality, kitemarked (or CE) condoms can help to reduce the chances of acquiring or passing on sexually transmissible infections. Therefore safer sex practise should be promoted with all clinic attendees. In appropriate circumstances, the benefits of condom use should be discussed and condoms offered. To that end the clinic will offer and supply condoms to all clinic attendees. Condom use will be particularly promoted in the following situations:

- In treatment of acute infection, clinic attendees are advised not to have sex, however they often will still have sex. In that case condom use is preferable to unprotected sex in terms of prevention of re-infection, therefore all clinic attendees being given treatment for an infection should be offered condoms
- Safer sex and condom use should be particularly emphasised when dealing with clinic attendees who are, or have a partner who is HIV, Hepatitis B or Hepatitis C positive
- Safer sex and condom use should be particularly emphasised if clinic attendees are in a high risk group and describe high risk sexual activity, or have a partner who is in these group and therefore are vulnerable to infection
- To reduce transmission of/exposure to chronic sexual infections, e.g. wart virus and herpes infection
- Condom use should be discussed and condoms offered to clinic attendees who are taking the contraceptive pill and have been prescribed antibiotics that may affect the efficacy of contraception

Safer sex is more than just condom use. The regular practice of safer sex requires knowledge, motivation and assertiveness. In addition practical skills and access to condom supplies is essential. Ideally therefore, condom distribution should be set within the context of:

- Giving information, ensuring the person has the facts about infections, conception/pregnancy, condoms, lubricants etc
- Encouraging conscious and constructive thought about sexual health options without prejudice or stigma
- Encouraging individuals to take personal responsibility for their sexual health and that of partners,

- Ensuring people have the skills by demonstrating when necessary proper condom/femidom technique, or addressing any difficulties they describe
- Raising awareness of the range of condoms available and encouraging a selective choice of the most appropriate condom for the situation/activity

Condom distribution therefore needs to be part of a dialogue with the individual. The health professional may need to:

- Initiate the interaction, in an open, facilitative way, demonstrating a non-judgemental approach to encouraging dialogue
- Establish the individual's experience of and attitude to condom use and safer sex. Where clinic attendees are condom naïve there will need to be extensive discussion and they should be offered a range of condoms to encourage personal preference
- Enquire about the requirements/preferences of the person/couple e.g. shape/size – standard, larger, smaller, thickness/thinness, spermicide required or not, oral/vaginal/anal use intended, history of allergy/sensitivity e.g persistent 'thrush'
- Give information about the range of condoms, different uses, lubricant use etc
- Establish if the person has the practical skills of condom use, demonstrate if necessary
- Dispense appropriate supplies and document in notes
- Give advice about how to get obtain further supplies

CONDOM DISTRIBUTION

- As a guide, 12 condoms per client per visit (but room for local interpretation). Supplies should be documented in the notes
- Condom naïve clinic attendees should be given a appropriate range of condoms
- Those clients perceived to be at increased risk make be given larger supplies
- Persons in high risk categories may be given larger supplies
- If a particular type is requested, these may be given, but the client should also be informed of others that are suitable
- Discuss the use of lubricant and give as appropriate
- Oil-based lubricants such as Vaseline, baby lotion/oil, massage oil etc. will weaken the condom and may cause it to break, as will certain pessaries and creams
- Nonoxynol-9 has now been shown not to inactivate HIV and other STI organisms and may cause mucosal irritation in some clinic attendees
- Advise re ongoing supplies from retail outlets, family planning clinics and mail order companies. If a female patient receives the oral contraceptive pill from a family planning clinic, she may also request condoms
- Give appropriate back-up leaflets

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