Pop it up! The suitability and acceptability of community-based pop-up sexual health screening for men who have sex with men

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Introduction

Bournemouth has one of the highest rates of HIV in the UK, rising from 2.79 per 1000 in 2011 to 3.08 per 1000 in 2014, where localised outbreaks of syphilis and gonorrhoea are also prevalent among men who have sex with men (MSM). A diverse community associated with high rates of partner change and complex, hard-to-reach sexual networks [1].

Historically, the focus of public health interventions has been towards reducing onward transmission through earlier diagnosis and treatment of both sexually transmitted infections (STIs) and HIV [2]. However, an emphasis has now been placed on the availability of community-based screening programmes in order to increase testing coverage [3] particularly among identified most-at-risk populations (MARPs).

In order to achieve optimal coverage, local authorities have been encouraged to consider investing in innovative HIV-testing activities. However, striking the balance between what is considered cost effective and delivering high levels of care continues to be a challenge for many service providers.

Methods

Since 2012, a local lesbian, gay, bisexual and transgender (LGBT) NHS health initiative, Over the Rainbow, has provided on-site sexual health screening at Bournemouth's annual gay pride festival, Bourne Free.

The fixed costs of the event are relatively low at around £6000 for staff, publicity and marquee hire, with the majority of the expenditure being allocated towards laboratory costs, which vary depending on the number of tests performed. While this number cannot be predicted beforehand, the success of the overall event has been judged on the uptake of screening and the associated positivity rate. This article aims to explore the effectiveness of pop-up sexual health screening in increasing screening uptake amongst hard-to-reach communities such as MSM.

In 2015, a total of 79 screens were performed from a pop-up clinic that had been set up within the main arena at Bourne Free. Individuals were offered an opportunistic screen by a team of 'inviters' made up of undergraduate nurses from the local university. Once registered via a self-triaging registration form, each person was tested for syphilis and HIV via venepuncture and performed their own rectal and pharyngeal tests while collecting their own urine samples in designated specimen collection booths. Acknowledging that consent to be tested could be affected by increased levels of alcohol consumption; it was decided to only offer screening opportunities between the hours of 1300 and 1800. Anyone thought to be unable to consent to being tested was not screened at the event. Test results were sent to patients via text within the next 7–10 working days, as it was felt that point-of-care testing would not be appropriate at a celebratory event.

Results

The results presented in Table 1 report five positive tests in 2015 including one new HIV diagnosis, comparing favourably with testing in conventional GUM and other local community sexual health settings.

Within this community HIV testing proves extremely cost effective. People who are diagnosed late with HIV have higher mortality rates [4], in addition to higher healthcare costs in the first year after diagnosis [5]. Earlier detection of the virus brings with it knowledge of its existence to individuals who might otherwise unknowingly transmit it to others. It has been shown that those diagnosed with HIV reduce risky behaviour [6], bringing further savings due to the reduction in onward transmission.

To further support patients' sexual well-being needs, the pop-up clinic also featured a health promotion area providing attendees with free condoms and lube in addition to the opportunity to discuss any concerns with a team of health promoters and advisers. In 2016, the service worked in conjunction with the local needle exchange service, which in the previous year had given out 50 sets of needles to MSM during the pride weekend. The prevalence of chemsex is widely documented within MSM communities [7], therefore, providing this service at community level during the pride event proved particularly relevant.

MSM are well known as a hard-to-reach population and can be unwilling to attend conventional sexual

Table 1: Pop-up clinic attendance and diagnosis rates 2012–2015

Outcome	'By Royal Appointment' 2012	'The Big Screen' 2013	'Disco Screen' 2014	'Gays and Dolls' 2015
Total number screened (*N*)	69	57	91	79
Full screen (HIV, syphilis, gonorrhoea and chlamydia) (*n*)	52 (75%)	48 (84%)	80 (88%)	75 (95%)
Chlamydia positive (*n*)	6 (9%)	4 (7%)	3 (3%)	2 (2%)
Gonorrhoea positive (*n*)	1 (1%)	1 (2%)	3 (3%)	2 (2%)
Syphilis positive (*n*)	5 (7%)	–	–	–
HIV positive (*n*)	1 (1%)	–	1 (1%)	1 (1%)
Lymphogranuloma venereum (*n*)	–	1 (2%)	–	–

health services for testing [8]. Providing pop-up sexual health screening among communities which are traditionally looked upon as being hard to reach can also present opportunities in which to further explore the factors that enhance or inhibit clinical attendance to pre-existing services. During the 2012 pride screening event, individuals were asked to comment on factors that would deter them from presenting to a clinic for screening. Inconvenient and highly visible locations, hospital-based clinics and staff familiarity were considered to have a negative impact on their decision-making processes. However, event-based screening and same-day results from clinics that were conveniently located were more likely to promote attendance [9].

An evaluation undertaken by 58 individuals at a pop-up screening event in July 2015 found 100% satisfaction with the appropriateness of the venue, range of services available and professionalism of staff.

The acceptability of both accessing and providing community-based screening programmes, as demonstrated in Table 2 is clear. Patients were happy to be offered screening outside mainstream sexual

Table 2: Pop-up patient satisfaction rates 2015

Survey statement	Survey responses (*N*=58)					
	1 Unhappy	2	3	4	5	4–5 Happy
The clinic was well advertised	0	0	3 (5%)	22 (38%)	33 (57%)	95%
The venue was appropriate	0	0	0	16 (28%)	42 (72%)	100%
There was enough privacy for discussion	0	2 (3%)	3 (5%)	15 (26%)	38 (66%)	91%
There was enough privacy for taking the tests	0	1 (2%)	2 (3%)	11 (19%)	44 (76%)	95%
The staff were welcoming	0	0	0	4 (7%)	54 (93%)	100%
The staff were professional	0	0	0	5 (9%)	53 (91%)	100%
The information given by the staff was helpful (*N*=57)	0	0	1 (2%)	11 (19%)	45 (79%)	98%
Other information provided (such as leaflets) was helpful	0	0	4 (7%)	15 (26%)	39 (67%)	93%
The range of services provided was good	0	0	0	13 (22%)	45 (78%)	100%
I would use a pop-up clinic again	0	0	2 (3%)	5 (9%)	51 (88%)	97%
I would advise a friend to attend a pop-up clinic	0	0	0	6 (10%)	52 (90%)	100%

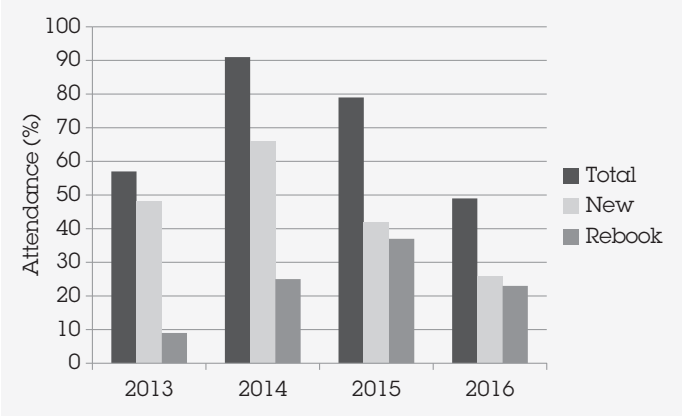

Figure 1: *Pop-up attendance rates 2013–2015*

health services and did not feel that the quality of their care was compromised by using a pop-up facility. Out of those surveyed, 100% would promote attending a pop-up clinic to their friends, whilst 97% would feel comfortable re-using a pop-up clinic in the future.

On analysing the attendance data for subsequent pride events it is apparent that the availability of pop-up sexual health screening is popular across both new and repeat attendants (Figure 1).

As a reactive agency of health promotion, pop-up clinics can provide individuals with both the opportunity and access to be instantly tested, immediately after being exposed to key health promotion messages that encourage them to do so. While this can assist in increasing uptake to screening, pop-up screening can also encourage re-attendance, particularly among people who become reliant on the convenient nature of its availability and particularly if it coincides with their day-to-day life. Integrating testing opportunities within social arenas such as Pride can help to destigmatise attendance that is traditionally associated with accessing hospital-based GUM services.

In a recent service review, a questionnaire was distributed to patients attending the clinical services provided by Over the Rainbow, within an LGBT community setting. With cuts to government funding, the main aim was to establish where people would be happy to access sexual health services (Figure 2).

As shown in Figure 2, the majority of patients demonstrated a preference for a community-based clinic over their local GUM department or contraception and sexual health (CASH) service. Few would attend their GP surgery, with even fewer feeling happy to access screening opportunities presented within their local pharmacy.

More recently, online testing has seen an increase in popularity with the use of home-testing kits, which are particularly useful for members of hard-to-reach communities who often do not like to access GUM services [10]. However, many MSM are not able to take information pertaining to their visit home with them, and therefore harbour the same unease at the prospect of home-testing kits being delivered to their house.

The survey was also later made available online. 80% of the respondents had previously accessed the LGBT-specific services provided by Over the Rainbow (Figure 3).

Results indicate that even fewer (44–56%) would not be happy to attend either a mainstream GUM clinic, CASH or GP clinic for STI screening, while a similar proportion would not be happy to attend alternative community settings including local HIV organisations.

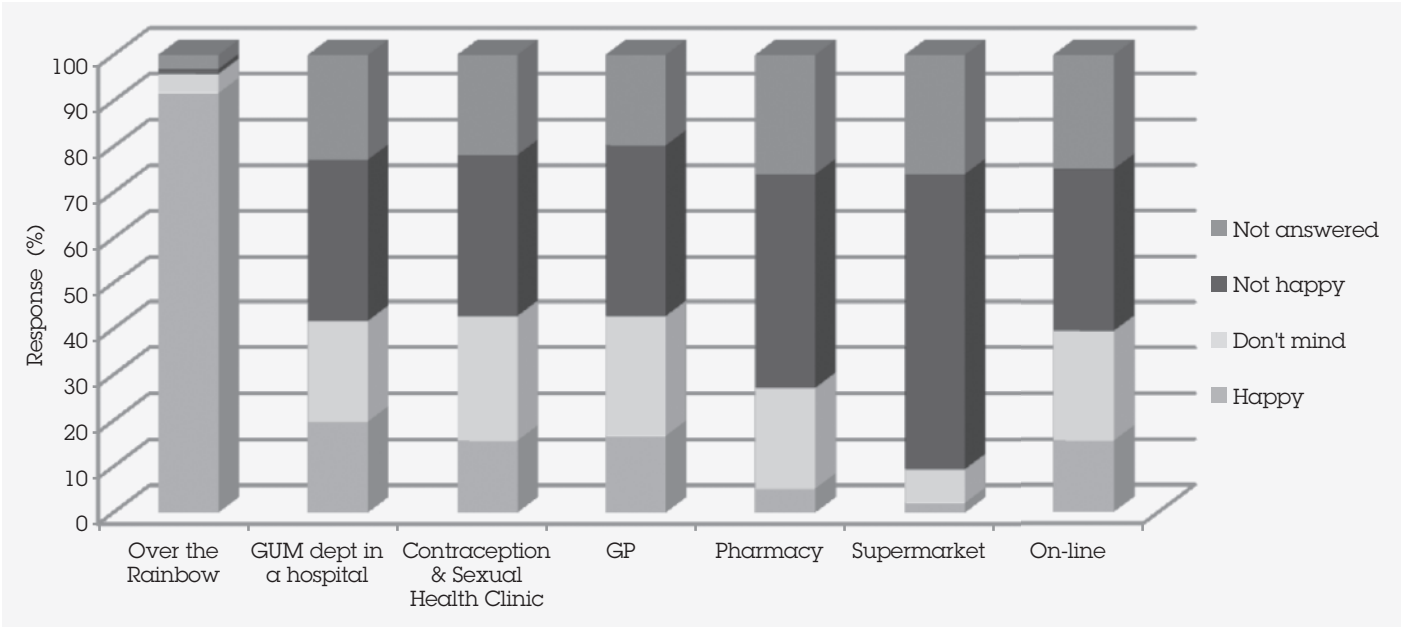

Figure 2: *Results of the clinic-based survey asking the question 'Where would you be happy to access sexual health screening?'*

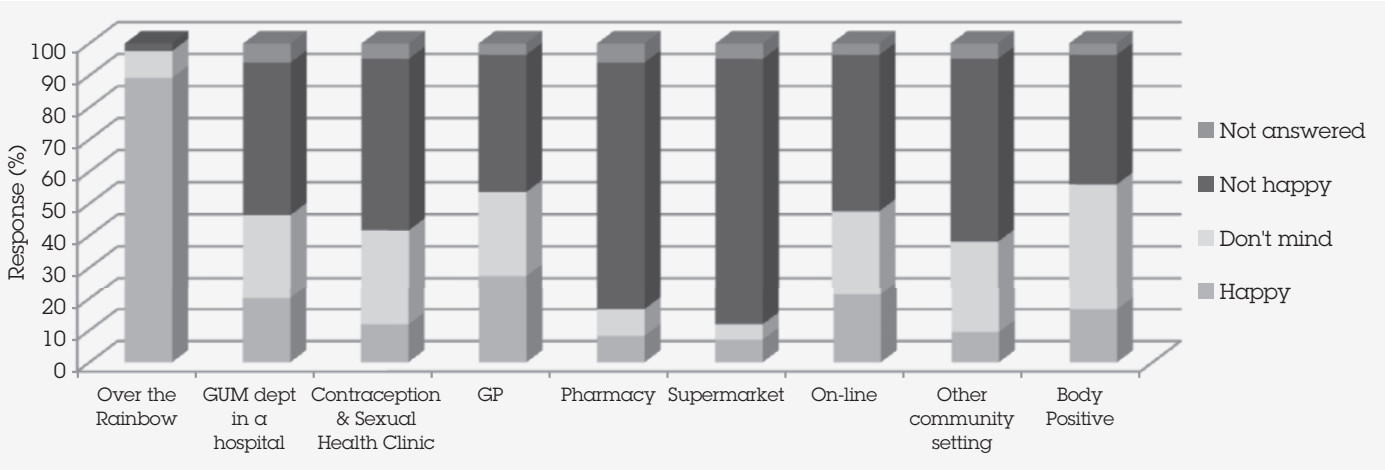

Figure 3: *Results of the online survey asking the question 'Where would you be happy to access sexual health screening?'*

Discussion

Prior to 2001, HIV testing was largely confined to individuals presenting and requesting HIV testing in GUM clinics [11] where, traditionally, low levels of testing were mainly thought to be due to low numbers of tests being offered by clinicians rather than through lack of patient acceptance [12]. This low level of testing can be improved by offering community screening, which switches reliance to patient uptake rather than clinician initiation. While a hesitation to screen MSM in community clinics has historically been fraught with challenges [13] the evidence presented in this article supports previous research that suggests community testing is both feasible and acceptable to individuals, particularly those who may not otherwise have been tested [14].

Community testing is extremely flexible, and while it proves itself an effective strategy for MSM, it has a much wider scope for implementation. In particular, it has the potential to be used with other high-risk communities and health conditions that would benefit from an increase in screening uptake. However, further work needs to be done in exploring effective testing methods that will access harder to reach members of sub-communities of MARPS who may not necessarily be aware of the risks they are exposed to, or the need to be tested.

References

1. Chen MI, Ghani AC, Edmunds J. Mind the gap; the role of time between sex with two consecutive partners on the transmission dynamics of gonorrhoea. *Sex Transm Dis* 2008, **35**, 435–444.
2. Aghiazu A, Brown A, Nardone A *et al. HIV in the United Kingdom: 2013 Report*. Colindale: Public Health England, 2013. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/326601/HIV_annual_report_2013.pdf (accessed January 2017).
3. Yin Z, Brown AE, Hughes G *et al. HIV in the United Kingdom: 2014 Report*. London: Public Health England, 2014. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/401662/2014_PHE_HIV_annual_report_draft_Final_07-01-2015.pdf (accessed January 2017).
4. Health Protection Agency. *Testing Times. HIV and other sexually transmitted infections in the United Kingdom*. London: HPA, 2007.
5. Krentz HB, Auld MC, Gill MJ. The high cost of medical care for patients who present late (CD4<200 cells/microL) with HIV infection. *HIV Med* 2004, **5**, 93–98.
6. Marks G, Crepaz N, Janssen RS. Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. *AIDS* 2006, **20**, 1447–1450.
7. Bourne A, Reid D, Hickson F *et al. The Chemsex study: drug use in sexual settings amongst gay and bisexual men in Lambeth, Southwark & Lewisham*. London: Sigma Research, London School of Hygiene & Tropical Medicine, 2014. Available at: www.lambeth.gov.uk/sites/default/files/ssh-chemsex-study-final-main-report.pdf (accessed January 2017).
8. Dowson L, Kober C, Perry N *et al*. Why some MSM present late for HIV testing: a qualitative analysis. *AIDS Care* 2012, **24**, 204–209.
9. Clarke W, Turner K, Priestley C *et al*. Increasing the uptake of sexually transmitted infection screening in a high risk population (Abstract P87). *Int J STD AIDS* 2013, **24** (Suppl 1), 31–32.
10. Health Protection Agency. *Time to test for HIV: expanding HIV testing in healthcare and community services in England*. Colindale: HPA, 2011. Available at: http://webarchive.nationalarchives.gov.uk/20140714084352/http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1316424799217 (accessed January 2017).
11. British HIV Association. *UK National guidelines for HIV testing 2008*, London: BHIVA, 2008. Available at: www.bhiva.org/documents/guidelines/testing/glineshivtest08.pdf (accessed January 2017).
12. Harris J, Khatri R. *Late diagnosis of HIV in the United Kingdom: an evidence review*. Liverpool: John Moores University, Centre of Public Health, 2015. Available at: www.cph.org.uk/publication/late-diagnosis-of-hiv-in-the-united-kingdom-an-evidence-review/ (accessed January 2017).
13. Prost A, Chopin M, McOwan A *et al*. 'There is such a thing as asking for trouble': taking rapid HIV testing to gay venues is fraught with challenges. *Sex Transm Infect* 2007, **83**, 185–188.
14. MacPherson P, Chawla A, Jones K *et al*. Feasibility and acceptability of point of care HIV testing in community outreach and GUM drop-in services in the north west of England. *BMC Public Health* 2011, **11**, 419.

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