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Evaluating sexual health services in the UK: adapting participatory appraisal tools with young people and service providers

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- ## Introduction

In 1997 Trent Regional Executive of the UK National Health Service funded a project called 'Evaluating Sexual Health Services: a Community Approach'. This project was based in the South Humber Health Authority area in Northern England. This is a largely rural area, but with two large towns, which has a history of relatively high local rates of teenage pregnancy and where sexually transmitted infections continue to be a real threat to young people's sexual health. The project worked with health service providers and young people to evaluate local sexual health services and built on several years experience gained whilst developing participatory appraisal tools and techniques with young people in order to learn about sexual health issues from their perspective.

Young people in the South Humber region defined a sexual health service as 'somewhere that young people can go for information or advice about sexual health or where they can get contraception'. This wide definition meant that informal services, such as youth centres and outreach projects, were included in the evaluation, along with more formal services such as government family planning clinics. After finding out what young people meant by sexual health services, the project worked with them to find out what they thought would make 'successful' sexual health services. Consistently prioritised were criteria under the headings of confidentiality, privacy, positive staff attitudes, locations that young people could easily get to, opening hours which were suitable for young people, a good mix of services and no cost for users.

Having found out what young people thought was important for a sexual health service to work for them, the project offered participatory evaluation training to service providers who wanted to work with young people to evaluate their own services. Initially, some service providers were sceptical that a participatory approach would work. However, all hoped that by building a working and trusting relationship with young people, and by using indicators developed by them, this type of evaluation would have a positive impact on their services.

20 service providers undertook training in participatory appraisal and evaluation from 13 individual services. Seven of these participants were from GP practices, three were youth workers, four were community support team members, two were nurses, two were managers, one worked for a voluntary agency and one was a member of the local library service.

Altogether, over 300 young men and women between the ages of 13 and 21 years, in either mixed or single sex groups, gave their thoughts and ideas about local sexual health services. Approximately 150 of these were accessed in local senior schools, 50 in colleges and 50 in youth centres. A further 50 young people were accessed by the trained service providers as part of their normal jobs, including a number who were in local authority care. As the evaluations continue and develop independent of the project, this total continues to grow steadily.

A whole range of participatory tools were used during training and subsequent evaluations. Tool adaptation and creation, along with non-rigid use of tools was very much emphasised

throughout the whole process. Four of these tools are highlighted below. The first three are examples of young people and workers adapting tools to suit a particular situation. The last one is a traditional tool which a group of young people used to illustrate something important, and which had an outcome not expected by the facilitator.

A timeline/trendline

One of the service providers who had been trained in participatory evaluation by the project worked at a rural youth centre. She had seen that numbers of young people using the centre were steadily dropping. This was a concern because the youth centre was one of a very limited number of places that local young people could go for sexual health information or just to talk about issues in confidence.

Initial discussion with some local young people seemed to suggest that the attendance at the centre had decreased primarily because of intimidation caused by increasing violence

and aggression amongst some of the members. The youth worker used a time/trendline (see Figure 1) to explore the level of conflict and aggression at the centre and to see whether there was any link between this and the other activities.

It is noticeable that the line indicating conflict and aggression reaches its highest points during peaks of other physical and social activity. An example of this can be seen during the initial scramble for equipment; whilst sports are taking place; because of unresolved disputes at the end of the evening. Some of the conflict taking place at the same time as other social interaction was thought to have carried over from school, or to be drug/alcohol related.

The youth worker was able to act on this information, using further solutions suggested by young people to reduce the potential for conflict, aggression and violence at the centre. This improved the environment so that young people felt safe enough to return and use it as a resource to improve their sexual health.
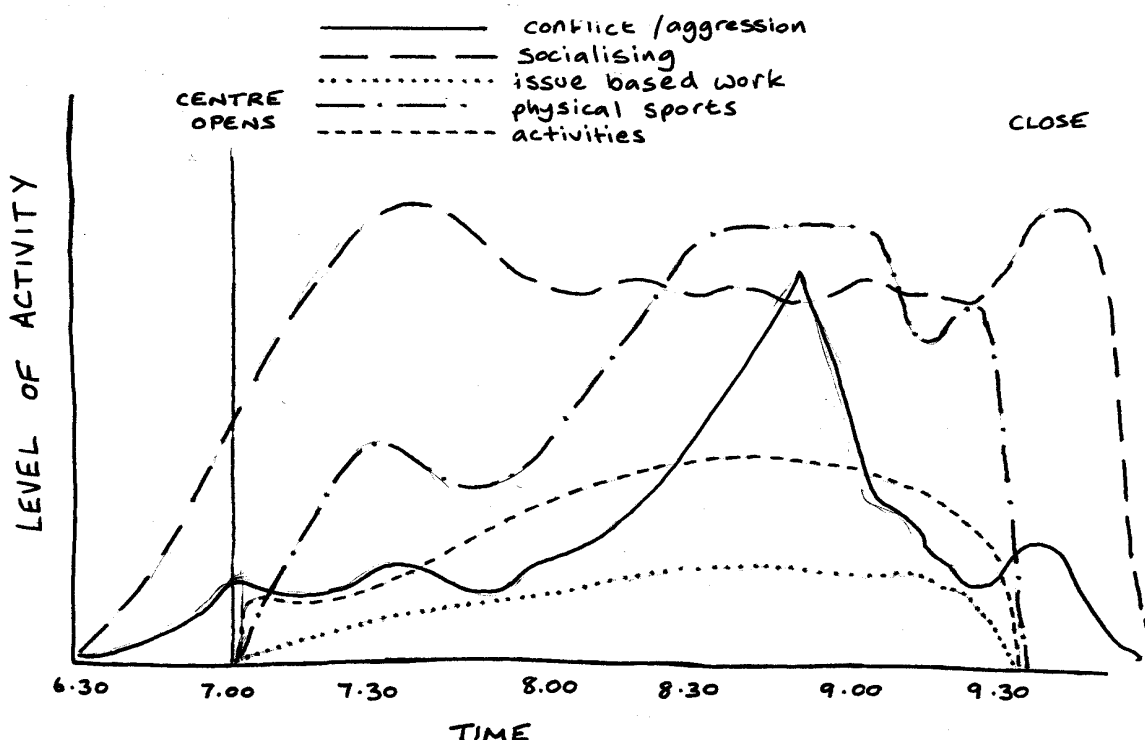

Figure 1. Time/trendline exploring levels of conflict and agression

A barriers wall

Working in a school, a group of young people came up with this visual method of highlighting and addressing barriers to accessing existing sexual health services (See Figure 2). They made a 'wall', using a large sheet of paper and different sized self-adhesive cards for 'bricks'. The cards could be moved, replaced or enlarged several times during discussion. Each brick then represented one specific barrier to using a local service, in this case a government clinic which they felt was particularly inaccessible. Types of barriers included: being embarrassed or scared; not having the skills/information to use a service; not knowing what to expect when using a service; lack of privacy or confidentiality; and not knowing that the service exists.

The group of young people talked about the visual tool they had created. They said that separate walls could be built for different services. The higher the wall, the more the barriers. Large barriers could be represented by more than one brick, or a larger brick. Therefore it is important to have different sized adhesive cards to use as bricks! They demonstrated how the bricks can be taken out of the wall as solutions are found. For example, as a solution for not knowing what to expect when visiting a service, the young people suggested that visits could be arranged by the school, or that service providers could come and talk to young people, either at school or in youth centres. They also suggested that where young people are embarrassed or afraid to use a service, service providers should encourage them to bring their friends with them for moral support.

Using this tool, young people can literally 'knock the wall down' or knock holes in it, perhaps leaving only the barriers which they feel are not significant enough to prevent the service being used. It was recognised that this tool could also be used to monitor how young people feel about a particular sexual health service as changes are made in response to the evaluation.
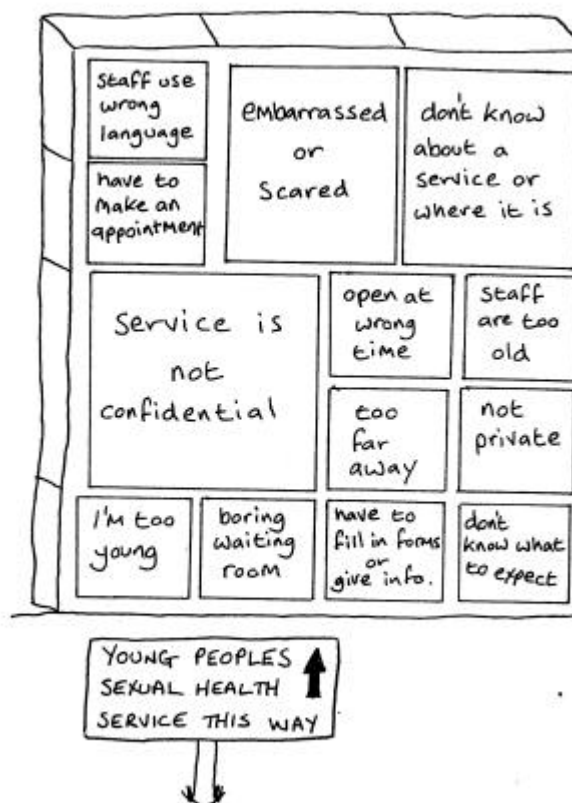

Figure 2. A barriers wall

A time-clock

Young people used this tool to show the times during the day when they would be able to use a sexual health service. It was produced by a group of young people during a youth club session who were asked to find a way to show when services for young people should be open and available for use. No further instructions were given, and the facilitator left the group to come up with something of their own.

After discussion, the group drew a round clock face, marked on the hours and split the clock into 12 segments. In this example they chose to look at the twelve hours between 8:00 am and 8:00pm on a school day (see Figure 3). Later they drew another time clock which indicated when young people would be free at weekends.

In each specific segment they wrote and drew what they do during this period of time,

sticking a 'tick' in any segment when they felt that young people would be able to use a service. They then went on to give more details, verbally, about why they could use the services at these times. For example, the young people suggested that they could only use services in their spare time, or when they could easily justify to parents where they were. This explains why they said that one ideal time to use a service would be during the period between leaving school and arriving home in time for their evening meal.

Figure 3. Time clock showing the times young people would be available to use a sexual health service

Pairwise ranking

In this last example, a small group of students, visited at a local college, had used a number of participatory tools to come up with a list of criteria for 'successful' sexual health services. The facilitator wanted them to use pairwise ranking to discuss which of their five general criteria (good staff, confidentiality, privacy and discretion, appropriate opening times and good location) were most important.

As can be seen from the illustration (see Figure 4), the group found that it was too simplistic to complete the exercise as the facilitator had planned, because several of the criteria are related and inter-dependant. For example, one of the young people said, 'How can we choose between good staff and confidentiality? One of the qualities of good staff is that they are confidential!' Similarly, another said that it was not possible for them to distinguish which was the most important between good opening times and location because, 'It's no good a service being open at the right time if it's a long way away.' And, 'It could be right next door, but that's no good either, if it's only open when we're at school.'
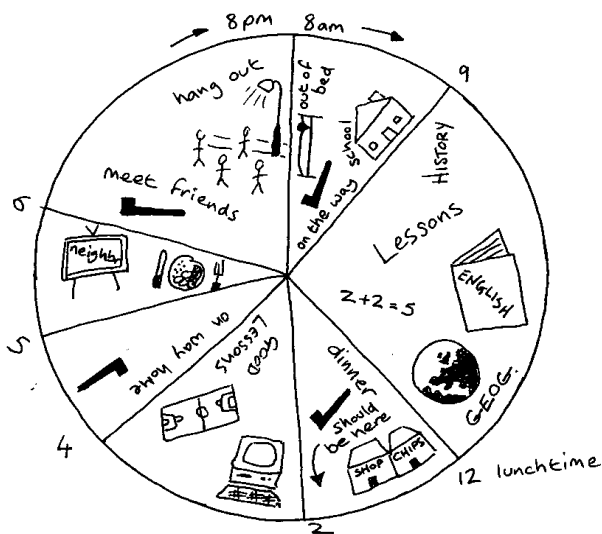

Figure 4. Pairwise ranking of criteria for 'successful' sexual health services

Here, pairwise ranking provided a valuable learning experience for the facilitator who had assumed that barriers would be discrete and have no relation to one another. The fact that the simplistic ranking 'did not work' showed that solutions to single barriers would rarely be sufficient to make a service work well for young people. Instead, the group showed that, when planning and developing sexual health services aimed at young people, all their important criteria need to be given equal consideration.

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• **Conclusion**

Valuable insight into what young people want from different sexual health services, how and when they would use services has been gained from the 'Evaluating Sexual Health Services: a Community Approach' project. Moreover, service providers involved have been enthused by a model that some initially found threatening. Some partnerships between service providers and young people have become solid enough for the provider to explain some of their own constraints to providing a young people friendly service. For example, a GP practice nurse was able to use the evaluation sessions which she had with a group of her young service users to explain that the 'no appointments' or 'drop-in' service could not operate every day. Once the young people realised that this system caused a greatly increased demand on the time of the doctor and nurses, and the subsequent cost implications, they understood why the system only operated on Mondays and Thursdays.

Perhaps the most important lesson learnt during this project with regard to using participatory tools, is not just that they are very powerful, but also that they are very flexible. If they are to be successfully used to enable young people to better understand their situations and plan for change, practitioners should be comfortable enough to use them in a way which is not too rigid or prescriptive. The examples here show the value of this principle, in these different and individual situations.

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