Options UK

effective solutions and design for health

NHS Hampshire

Comprehensive Sexual Health Needs Assessment

NHS Hampshire

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20-23 Greville Street
London
EC1N 8SS
www.options.co.uk/uk

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1 Executive Summary

Following a Rapid Assessment visit by the Department of Health's National Support Team (NST) for Sexual Health to NHS Hampshire in March 2009 and a subsequent recommendation made by the NST in their follow-up report, NHS Hampshire commissioned Options UK to undertake a Comprehensive Sexual Health Needs Assessment (SHNA) in April 2009, with a particular emphasis on user engagement and consideration given to preferred models of future service delivery, as expressed by both users and stakeholders.

This SHNA report and its findings should be read in conjunction with the findings presented in the NST report of March 2009, and should help inform the development of a Hampshire-wide sexual health vision and strategy, and the development of future sexual health services across Hampshire.

Key findings and overarching themes

Throughout the current and potential service user engagement, key themes about access to sexual healthcare emerged, which could be useful to inform future service development. These included:

- There was a widespread perception that more could be done to encourage access to HIV testing, either through primary care or pharmacy settings. STI campaigns, such as the chlamydia screening programme, had 'de-stigmatised' access to STI testing, though there was still a felt need for HIV testing to be integrated into other 'non-stigmatising' tests, such as cholesterol testing.
- There was a consistent demand for more contraception and sexual health services available through GP services. Some respondents reported difficulties accessing LARCs through GPs, and supported sessions being run by staff from specialist integrated services in GPs' surgeries.
- Many respondents said they felt that commercially available condoms were expensive and thus less likely to be accessed in venues where they might be needed (clubs, pubs and so on). This may be important for people from vulnerable or high-risk groups, such as BME communities, and military personnel.
- Some young people in the user engagement could name a variety of sexual health service providers. However, sexual health service provision in schools seemed to lack attention to the continued need for discreetness to encourage access: ***"A lot of people don't really want to go because it's embarrassing because it's right in front of where everybody sits and plays ping pong and stuff"*** (Young Woman). Young people had optimal service access through 'youth friendly' venues (such as sexual health outreach teams working in youth clubs) where they were among their own social networks.
- Many of the informational gaps about services that young people identified in the user engagement would be addressed by knowledge of the 'Get it On' website; however, awareness of it among young people was patchy. Young people suggested more advertising of the website to make it more widely known, such as through posters at bus stops, distribution of information (such as small cards with the relevant URLs) and through tutors at schools, or "anywhere that teenagers go". Young people also advocated making more comprehensive information available to a younger age group, such as those from 11/12 years upwards. A few respondents also felt that the style of the website was off-putting, ***"They need to change it because you want to get the young people's attention and graffiti is not actually helping".***
- Of note, some of the adult respondents felt that they also had a need for a website targeting a more adult audience, and providing information about contraception and sexual health services available throughout Hampshire.

From a stakeholder perspective key findings were:

- A passion and commitment to the field of sexual health work and a willingness to consider integrating services, but some stakeholders felt there would be resistance to this
- Effective partnership working, especially with commissioners and public health
- Geographical inequalities between service provision, felt to be “excellent in the South East” and “poor in the North East and West”
- An identified desire in Primary Care to “do more” around LARCs
- Inequalities within the current NHS Hampshire abortion care pathway, including geographical and before- and after-care inequalities, as well as access to Early Medical Abortion
- Inequalities in psychosexual services provision across Hampshire
- Good HIV services, although geographically fragmented in terms of expertise, but no structured Network for HIV Care and Support yet in place, despite the recommendation made by the H&IOW HIV/AIDS needs assessment of 2005–2006
- The absence of one overarching Hampshire-wide sexual health network
- Little priority given to prevention and behaviour change work
- A desire to see more services open on a Saturday

Options UK hope that we have been able to paint a clear picture of sexual health services in NHS Hampshire in order to highlight strengths, weaknesses, gaps and needs. This SHNA was completed in the light of current national and regional policies and directives on sexual health in England.

2 Introduction

This report presents the findings of a Comprehensive Sexual Health Needs Assessment (SHNA) conducted by Options UK between April and August 2009 for NHS Hampshire. Outputs from the needs assessment will help to inform the writing of a new Sexual Health Strategy for NHS Hampshire and will help staff make informed strategic and operational decisions about how and where services are delivered in the future to best reduce health inequality and to help meet national targets and the needs of the local population. The report may also highlight particular areas for further research and analysis.

How this report is organised

Key findings and overarching themes are outlined in the Executive Summary and Section 3 outlines the principal methodologies used in this SHNA. It is through these different methodologies that the main body of the report is structured. Section 4 presents the local context and analysis of sexual and reproductive health data, Section 5 the findings from the service visits. The mapping and timetabling of services across NHS Hampshire is presented in Section 5, followed by the findings from the qualitative work engaging harder to reach groups. The final section covers strategic and operational findings from the interviews carried out with key informants.

Who are Options UK?

Options UK is the UK programme of Options Consultancy Services Ltd, a leading provider of technical assistance, consultancy and management services in health and the social sectors. Options UK was launched in early 2006 to provide technical expertise to service providers, policy makers and commissioners in the UK. With expertise in sexual health, adolescent health, service design, needs assessments, monitoring and evaluation, policy and practice and user consultation the multidisciplinary Options UK team provide fresh, innovative and practical advice, support and solutions to providers and commissioners of adolescent and sexual health services.

To learn more about Options UK and other projects visit www.options.co.uk/uk

Special thanks go to Rob Carroll and Kate Donohoe of NHS Hampshire for their time and support in carrying out this Needs Assessment.

3 Methodology

Local Context and Sexual Health Data Review

In order to build up a snapshot of the local context, data was collected and analysed on local demographics, deprivation, migration, and other notable social characteristics of the area. This was then complemented by analysis of data on STI diagnoses through GUM, National Chlamydia Screening Programme, patients accessing care for HIV, Notification of Infectious Diseases (NOIDs), under-18 conceptions, abortions, data from community contraceptive services and GP prescribing data.

Service Reviews

During the course of the SHNA, the service design team visited a selection of GUM, CaSH and abortion services in NHS Hampshire to carry out interviews with service users and providers. Service users were interviewed immediately after their consultations. The exit interviews aimed to capture the views of the service user regarding their care pathway, giving them an opportunity to suggest service improvements, both for existing services and for the future of sexual health services in NHS Hampshire. This analysis does have its limitations, as those who participated in the exit interviews may not necessarily be representative of all users of each service. The location of the clinics where interviews took place may also influence responses.

In-Depth Potential and Current User Engagement

Existing and potential service users were sampled using a purposive sampling, contacted through a variety of service providers and community-based organisations. They were engaged through qualitative methods, which allowed a full exploration of their perceptions of gaps and health needs. A total of 121 individuals participated in the in-depth engagement. The groups and numbers engaged with are outlined below in Table 1. Small numbers of people in these social groups were engaged with to allow full exploration of the issues.

Table 1: Breakdown of participants engaged with using qualitative methods

Group		Number of groups	Gender	No. of participants
Young People		2	Male and Female	12
Young Mums		2	Female	15
BME	Young People	1	Male and Female	5
	Adults	2	Male and Female	10
People Living with HIV		1	Male and Female	11
Men who have sex with men (MSM)		2	Male	17
People with Disabilities	Staff	1	Male and Female	5
	Interviews with PLDs	n/a	Male and Female	8
Military		4	Male and Female	22
Gypsies and Travellers	Interviews	1FGD + Interviews	Male and Female	16
			Grand Total	**121**

Key Informant Interviews

Forty-six key informants involved in commissioning, management, public health, clinical practice and community work were interviewed throughout the project. In order for key informants to provide and open and honest account of services, quotes have been anonymised to protect the respondents' identity.

4
Local Context and Sexual Health Data review

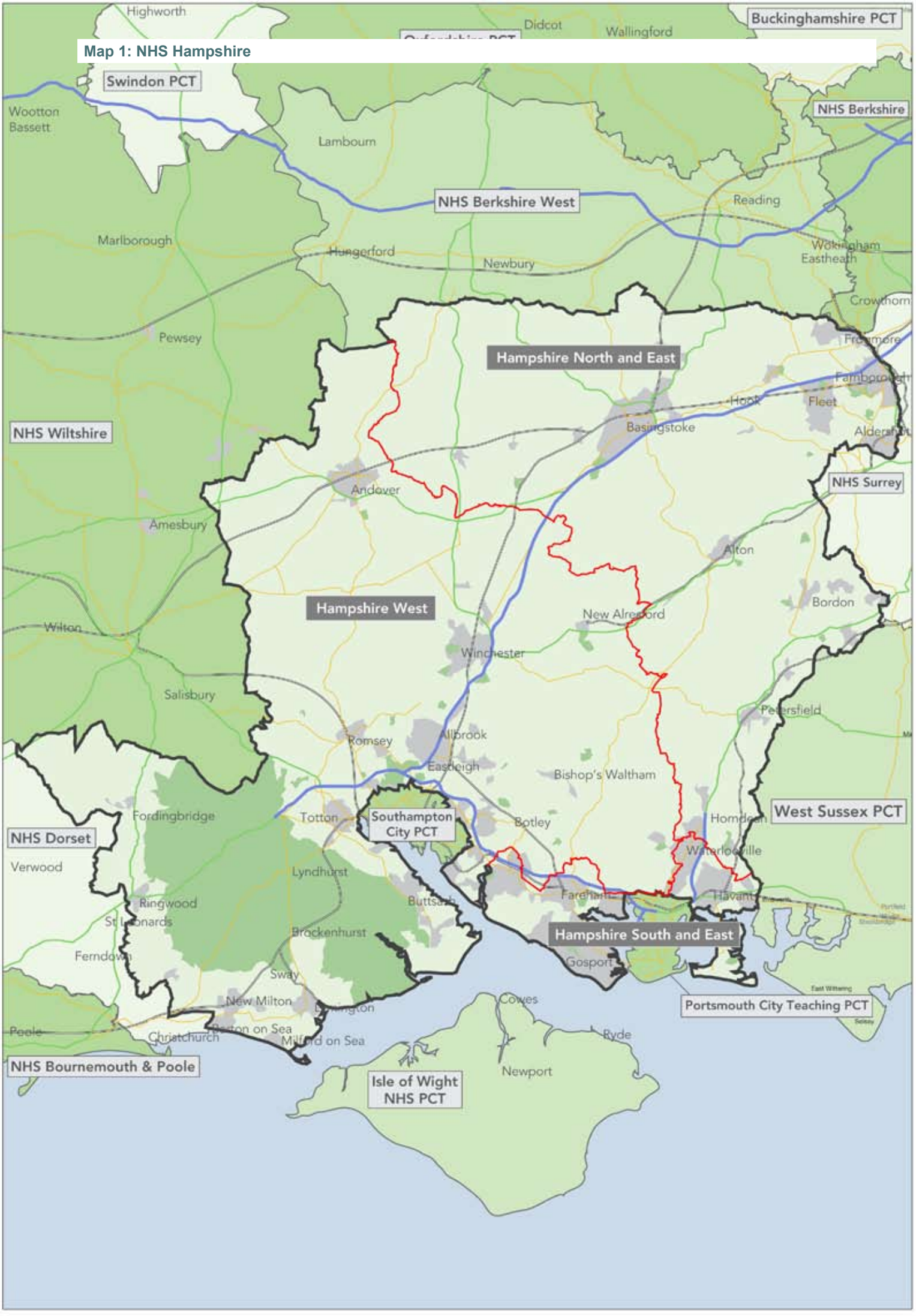
4.1 The Local Context

4.1.1 Introduction

NHS Hampshire was established in October of 2006, when seven smaller Primary Care Trusts combined to form Hampshire PCT.[1] Hampshire is the largest PCT in England and also one of the most complex. On average, residents of Hampshire are quite affluent and significantly healthier than the rest of England. However, there are disparities within the PCT.

1. The following PCTs merged: Eastleigh & Test Valley South; New Forest; Mid Hampshire; Blackwater Valley & Hart; North Hampshire PCT, East Hampshire, and Fareham and Gosport PCTs.

Map 1: NHS Hampshire



4.1.2 Local Government

NHS Hampshire shares the same borders as Hampshire County Council. Within these borders there are 11 local authorities:

- Basingstoke and Deane
- East Hampshire
- Eastleigh
- Fareham
- Gosport
- Hart
- Havant
- New Forest
- Rushmoor
- Test Valley
- Winchester

As NHS Hampshire covers such a large geographical area, it has been divided into three localities for planning and service delivery purposes. We have used these localities for much of the mapping in this report. These are:

- Hampshire North and East
- Hampshire West
- Hampshire South East

4.1.3 Demographic Profile

The Office for National Statistics estimated that Hampshire PCT served approximately 1,276,700 residents (2.5% of national population) in 2007. Of these residents 625,400 were male (49.0%) and 651,300 were female (51.0%). In total there are 1,235,910 residents registered with a GP in NHS Hampshire.[2] The proportion who registered is high (96.8%), but slightly lower than the national proportion (99.6%) registered.[3]

2. GP List Populations of Primary Care Organisations. The Health and Social Care Information Centre. 2009.

3. Office for National Statistics (ONS). Mid-2007 Population Estimates.

Figure 1: Population pyramid for Hampshire PCT (2007)

Figure 1 depicts the age structure of Hampshire, highlighting how the population is middle-heavy due to the concentration of individuals between 35 and 64 years of age. There is also a large proportion of younger individuals. The male to female ratio is 0.96, which is fairly balanced. However, it is apparent that more females than males are surviving in the oldest age groups. In the youngest age groups, there are more males than females.

Table 2: Demographic profile of specific groups in NHS Hampshire, 2007

2007	No.	% of total pop
Young People (<15 yrs)	226200	17.7%
Young People (15-24 yrs)	152000	11.9%
Women of childbearing age (15-49 yrs)	291000	22.8%

Table 2 illustrates that young people (under 19 years of age) represent 24% of the population in Hampshire. Young people are an important demographic because they are not primary income earners and contribute to the dependent population. Young people between the ages of 15 and 24 represent 12% of the Hampshire population.

Young people are an important demographic because they are not primary income earners and contribute to the dependent population. Young people between the ages of 15 and 24 represent 12% of the Hampshire population.

Women of childbearing age (15–49) represent 23% of the population. These women have specific sexual and reproductive health needs.

The following series of maps represent GP-registered populations of young people aged between 15 and 24 years. Practices are ranked on the proportion of young people registered with them, a figure which ranges from 7% to 26%. This can be taken as a proxy marker of areas with high numbers of young people; areas where service provision for young people should be targeted. There is one map per locality.

Map 2: Map detailing the proportion and actual numbers of GP population aged 15 – 24 years in Hampshire North and East

Map 3: Map detailing the proportion and actual numbers of GP population aged 15 – 24 years in Hampshire West

Map 4: Map detailing the proportion and actual numbers of GP population aged 15 – 24 years in Hampshire South East

4.1.4 Ethnic Profile

The population of Hampshire PCT is predominantly 'White'. ONS data from 2007 indicate that 92% of the population is 'White British', which is higher than the national average of 84%. 'White other' comprises 4% of the population. 'Asian or Asian British' is the next largest group, although this group only constitutes 1.7% of the population. The remaining 0.3% of the population is 'Black Caribbean', 'Black African', 'Black Other', 'Chinese or Other' or 'Other Mixed'. The largest minority group in Hampshire is the 11,300 people (0.9%) who declare themselves 'Asian or Asian British: Indian', yet this is below the national average of 2.6%.

The male and female population is evenly distributed among ethnic groups in Hampshire. However, two groups stand out. The 'Chinese or Other' group, has sex ratio of 0.83 and 'White: Other or Mixed' has a sex ratio of 0.85.

Table 3: Ethnic Groups in NHS Hampshire, Mid-2007 estimates (thousands)[4]

Ethnic Group	Males	Females	Total	%
White	597.6	622.7	12220.3	95.6%
Mixed	6.7	7.0	13.7	1.1%
Asian or Asian British	10.8	10.4	21.2	1.7%
Black Caribbean	1.7	1.8	3.5	0.3%
Black African	2.7	2.8	5.5	0.4%
Black Other	0.4	0.4	0.8	0.1%
Chinese or Other	5.3	6.4	11.7	0.9%

4.1.5 Migration

Net migration has steadily increased in Hampshire between mid-2001 and mid-2007, except in 2004–05 when it dipped slightly. Figure 3 describes the net volume of migrant in- and outflow per 1,000 people in Hampshire. It is apparent that both sexes exhibit similar patterns of migration in NHS Hampshire. Winchester (1.2 per thousand), New Forest (1.2 per thousand) and Fareham (1.1 per thousand) have the highest levels of net migration. Rushmoor is the only local authority to have a negative migration rate (-0.2 per thousand) in its population.

4. Office for National Statistics (ONS). Resident Population Estimates by Ethnic Group, 2006.

Figure 2: Volume of migration for Hampshire PCT between 2001 and 2007 (mid-year estimates)

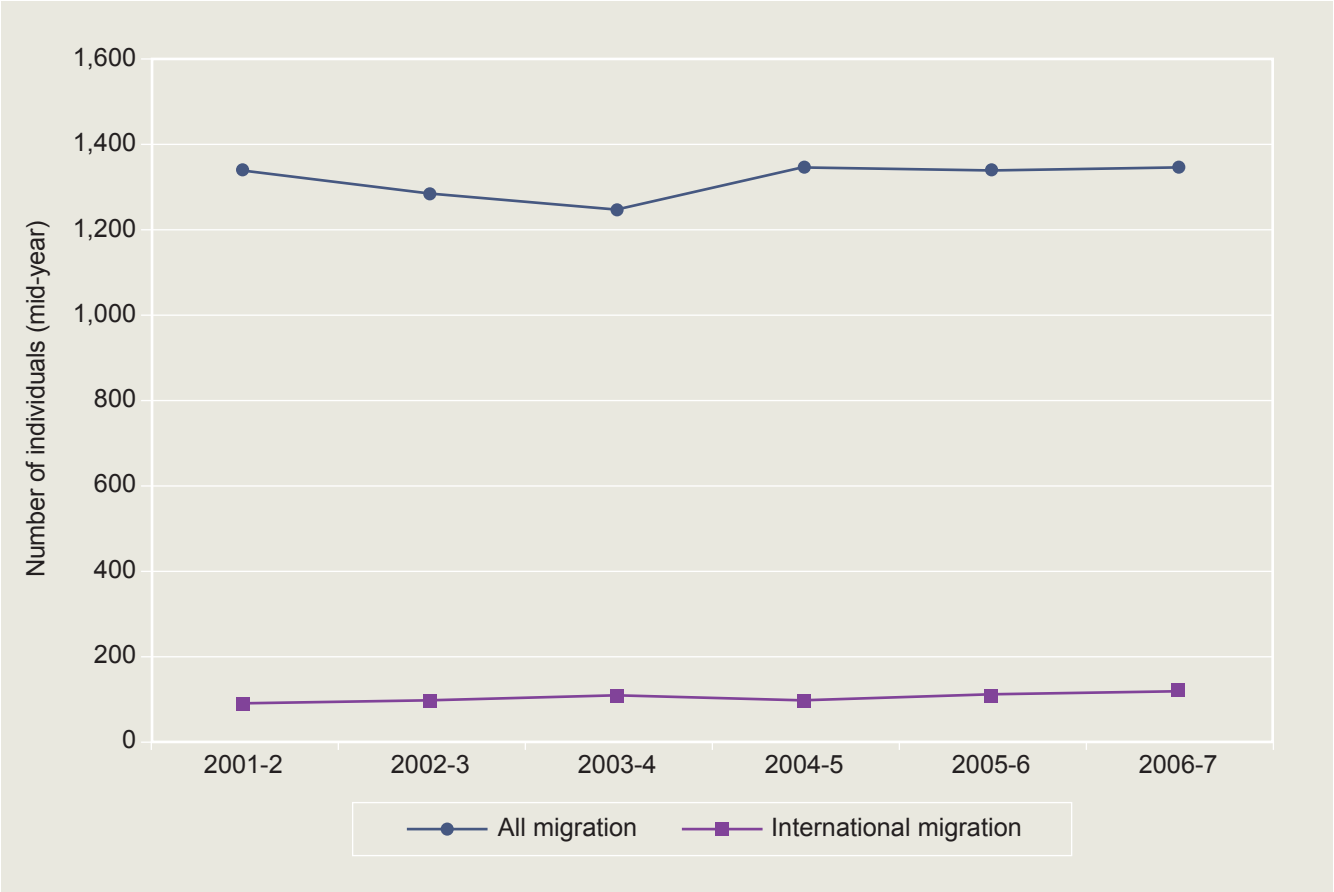
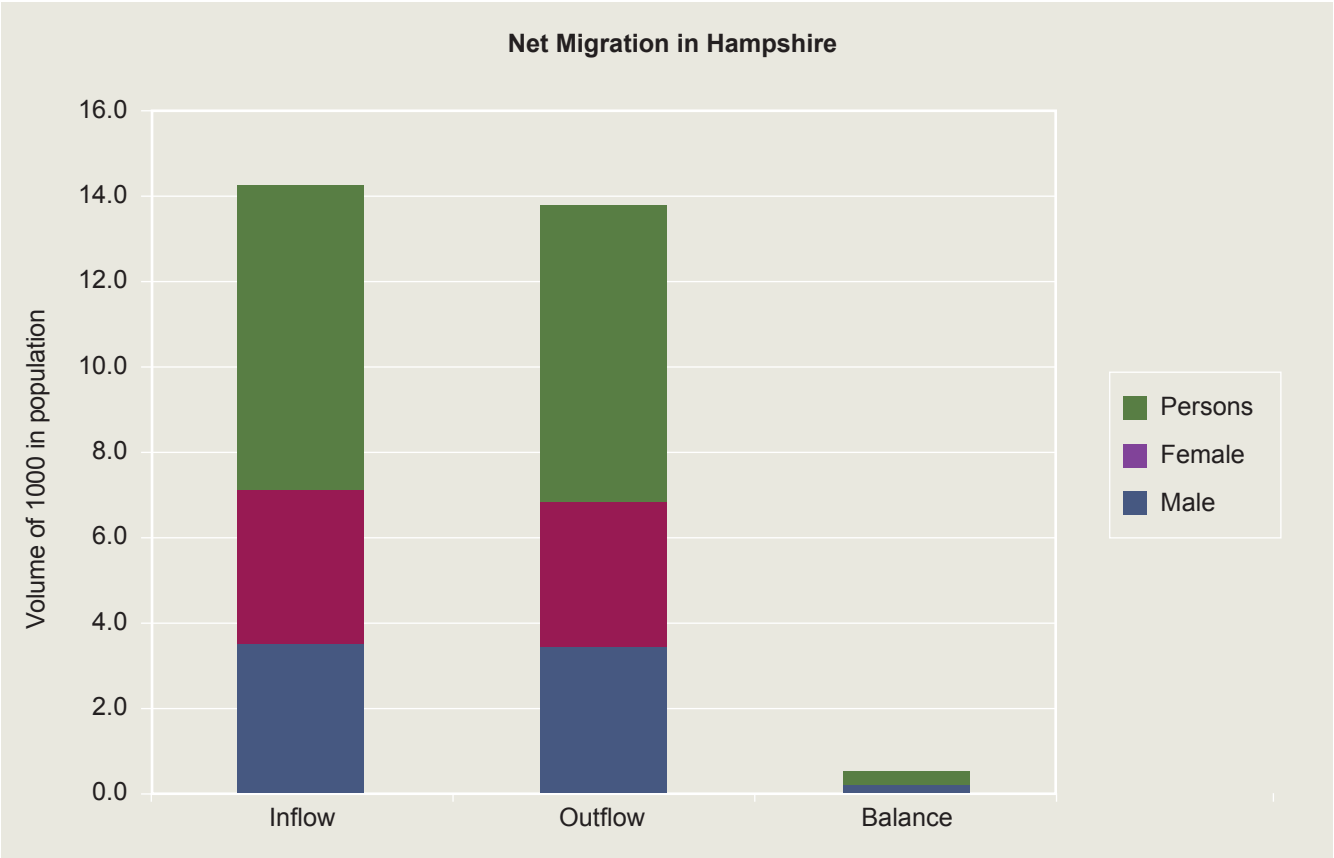


Figure 3: Net migration rates for Hampshire PCT

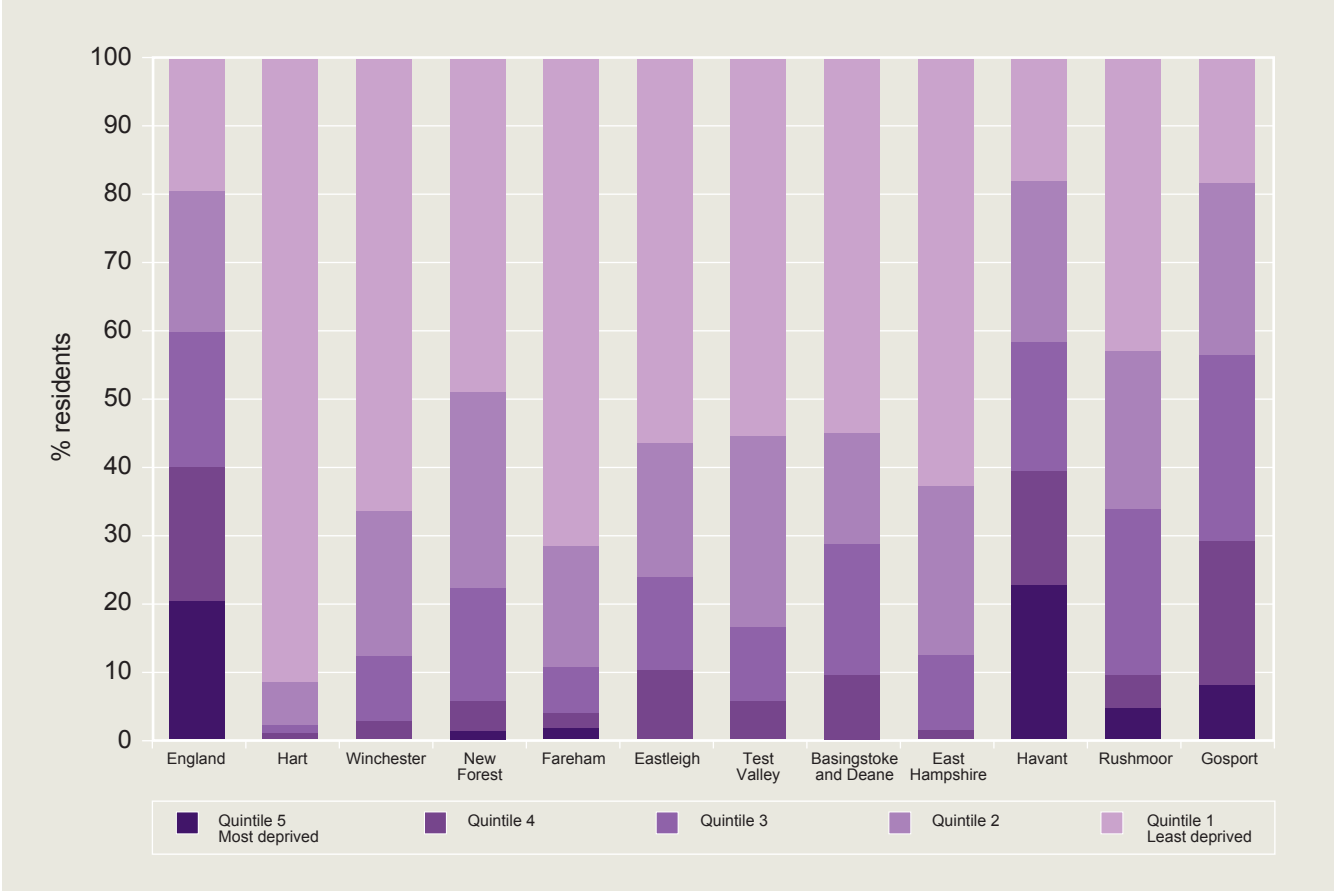


4.1.6 Deprivation

Levels of deprivation can have significant impacts on health, especially in STI and under-18 pregnancy rates in the population. As a whole, Hampshire PCT is relatively affluent, so it is no surprise that it ranked above the national average in all major health indicators in 2007 (see Appendix 1 for a detailed breakdown of health indicators). Hampshire ranks 147 out of 153 PCTs in England. This picture of relative affluence is illustrated in Map 5 below. The predominance of white and pale blue areas represents the less deprived areas, whereas the darker blue areas are wards with higher levels of deprivation.

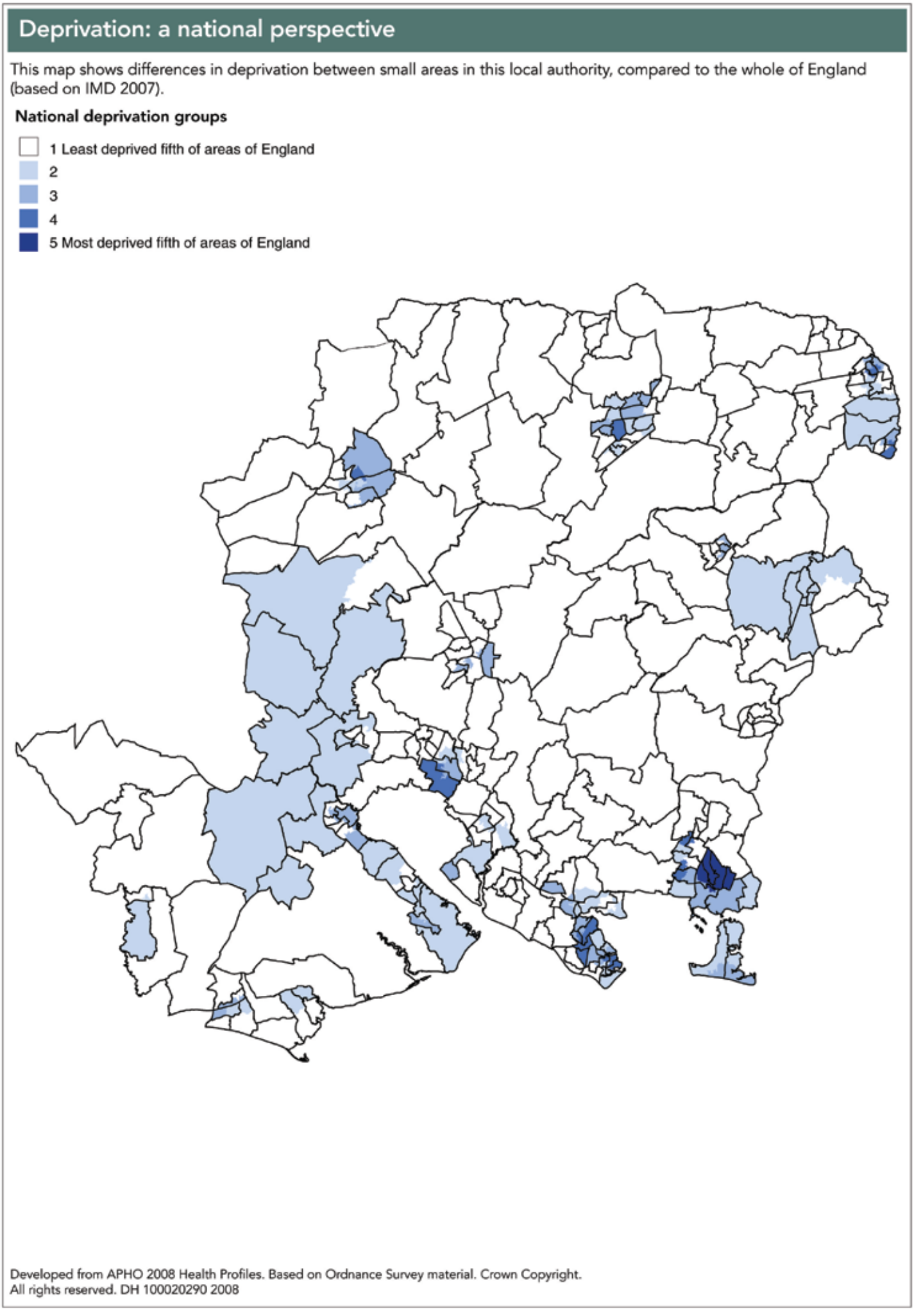
Despite relative overall affluence, there are notable pockets of deprivation visible as well. Figure 4 shows that wealth is unevenly distributed within the local authorities in NHS Hampshire. Hart is by far the least deprived local authority, with over 90% of residents living in the least deprived 20% of the population. Meanwhile, Havant and Gosport show the highest levels of deprivation. The distribution of deprivation in Havant mirrors the England averages. Most of the remaining local authorities have at least 50% of their population living in the least deprived 20%. This picture of deprivation at more of a local level is represented in Map 6, which compares deprivation at a local authority level rather than nationally.

Figure 4: Deprivation by local authority in NHS Hampshire (Crown Copyright, 2008)[5]



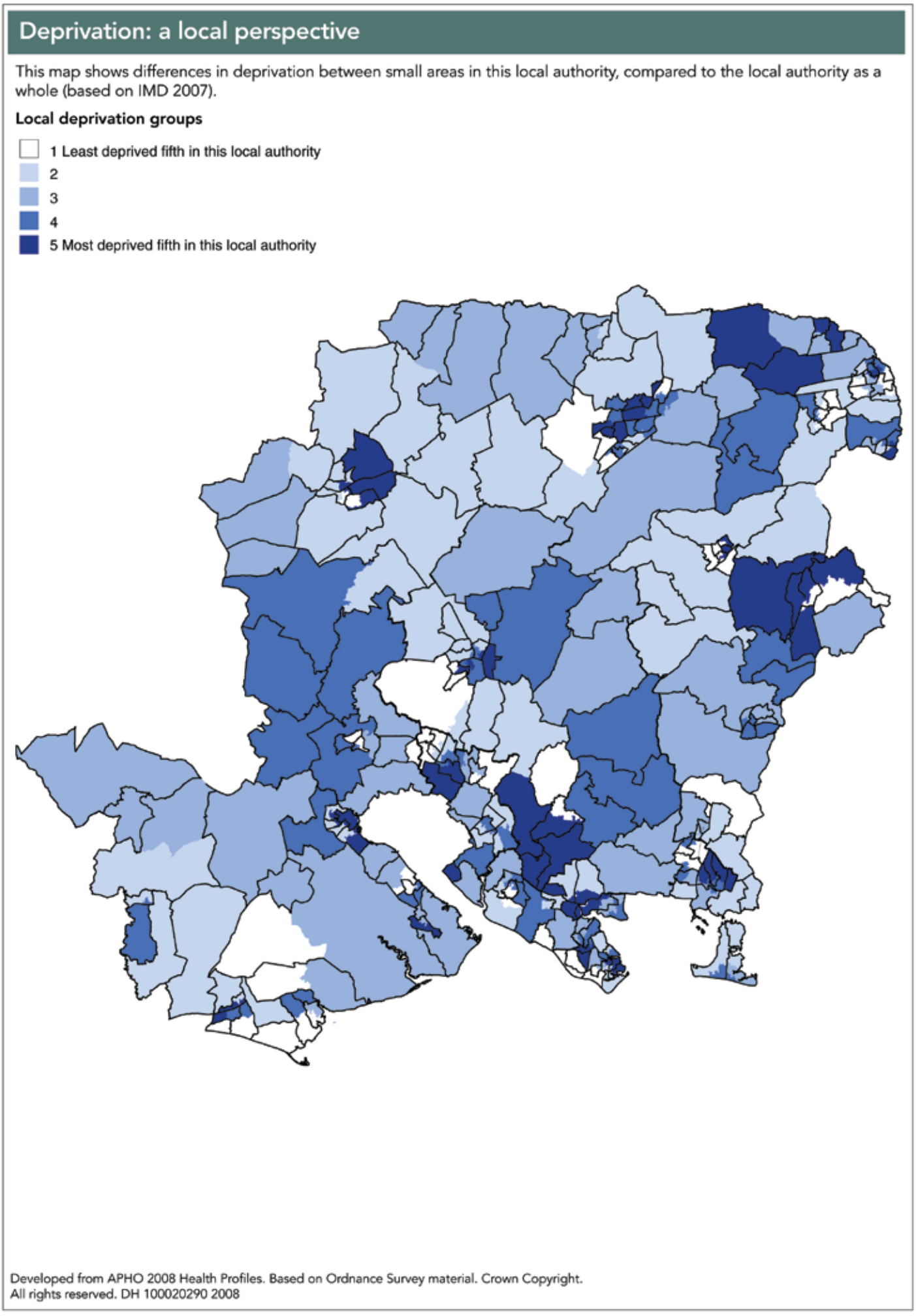
5. Hampshire Health Profile 2008. Crown Copyright, 2008 (www.healthprofiles.info)

Map 5: Hampshire Deprivation, a national comparison



Map 6: Deprivation in NHS Hampshire, a local comparison

*A labelled version of this map is provided in Appendix 2 (as three separate locality maps)



4.1.7 Other Notable Socio-Economic and Related Characteristics

NEET: National statistics on individuals Not in Education, Employment or Training (NEET) indicate that 6.3% of young people between 16 and 18 years of age in Hampshire were NEET in 2008. This figure is higher than that of the proportion of 16–18 year olds NEET in the South East, which is 5.7%, and is an increase on 2007 when there were 5.3% NEET. A particularly high proportion of 16–18 year olds current activity is unknown in Hampshire (17.2%), suggesting possible issues in local registration systems. The proportion in the South East is 5.9% unknown.

Looked after children (LAC): Nationally, have been identified as a higher risk group in terms of sexual health. There can be a higher prevalence of psychological disorders amongst this group, as well as behavioural problems that can lead to exclusion from school and social groups. The most recent report from the Department for Children, Schools and Family[6] reports that there were 720 children looked after in Hampshire during the twelve months preceding 30th September 2008. Of these, 79% were of school age and 18% missed at least 25 days at school during this period. The latter figure of 18% is significantly higher than regionally (13%) and Nationally (12%), indicating that attention should be paid to providing support and interventions for this group in Hampshire. More up-to-date data on LAC is due to be released on 13th October 2009.

Youth Offending: Youth offenders as a group often have behavioural problems that can increase risk of sexual health problems. In Hampshire there were 1,966 of first-time entrants to the criminal justice system aged 10-17 years in 2007-08[7]. Hampshire has seen a small gradual decrease in numbers of first time entrants in this age group since 2003-04 when there were 2115. This is in line with regional and national trends.

Drug and alcohol use: Local Alcohol Profiles for England[8] show Hampshire to rank significantly better than the England average for many of the indicators calculated to measure alcohol related harm. Hampshire generally falls near to the regional average, except in the case of alcohol-related recorded crimes and violent crimes, for which Hampshire is significantly better than the regional average.

Of note, Hampshire ranks 52 out of 152 PCTs in relation to alcohol specific hospital admission amongst under-18 year olds. A rank of 1 is the best primary care organisation in England and a rank of 152 is the worst.

Registered Sexual Offenders: A report published in 2008 states that there were 1155 registered sexual offenders in Hampshire in 2007-08. The majority of these offenders (79%) were managed at Level 1, 236 (20%) at level 2 and 9 (1%) were managed at level 3[9]. The higher risk cases tend to be managed at the higher levels.

Prisons: There are two prisons that lie within the borders of NHS Hampshire:

- HMIRC Haslar near Gosport is an Immigration Removal Centre that holds up to 160; it holds those detained by the UK Borders Agency while their eligibility to remain in the UK is considered and whilst removal or deportation processes are carried out.
- HMP Winchester has a current capacity of 707 and is for male prisoners only.

Military Bases: There are significant numbers of army personnel in Hampshire. Areas with the highest numbers are Aldershot, Fareham, Gosport, Hart, Rushmoor, Test Valley, and Winchester.

Naval Bases: The South-East of Hampshire hosts one of the three Royal Navy Bases in the UK. Approximately 17,200 people are employed at by the Navy, with up to 5 Naval establishments in the Portsmouth area.

6. DCSF: Statistical First Release (SFR) on Outcome Indicators for Children Looked After, Twelve months to 30 September 2008 – England. Available at http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000842/index.shtml

7. DCSF: First-time Entrants Aged 10-17 to the Criminal Justice System in England, 2000-01 to 2007-08. Available at http://www.dcsf.gov.uk/rsgateway/DB/STR/d000821/index.shtml

8. Northwest Public Health Observatory & DH: Local Alcohol Profiles for England available at: http://www.nwph.net/alcohol/lape/pctProfile.aspx?reg=q38

9. MAPPA Coordination Unit: Protecting the Public: Hampshire & Isle of Wight Annual Report 2007-08

4.2 Sexually Transmitted Infections (STIs)

This section aims to give an overview of trends in STIs across NHS Hampshire. Through analysing data collected by local sexual health services on diagnosis and treatment of STIs, and comparing it with national trends it is possible to build an understanding of current and projected activity around local sexual health services.

4.2.1 Data Sources Used in this Analysis and their Limitations

KC60 Statistical returns from GUM clinics

GUM clinics report data on new STI diagnoses quarterly to the Dept of Health via the Health Protection Agency (HPA). For the purposes of this SHNA we have analysed KC60 data for 2004–2008 for the five major STIs (chlamydia, HPV, HSV, gonorrhoea and syphilis) inclusive from the following GUM clinics:

- Royal Hampshire County Hospital & Andover War Memorial Hospital (analysed together)
- North Hampshire Hospital
- Frimley Park Hospital
- St Mary's Hospital, Portsmouth
- Royal South Hampshire Hospital, Southampton

The last three GUM clinics are not within NHS Hampshire boundaries; however, the services are commissioned by NHS Hampshire and many NHS Hampshire residents attend these clinics. Area of residence is not collected via KC60 returns. However, the geographical location of the GUM clinic is such that a sizeable proportion of users will be NHS Hampshire residents. These data do not represent prevalence of all STIs in the Hampshire population, but are a strong marker for trends across the area. The KC60 data in this case shows general trends and at-risk groups, rather than epidemiological rates.

NOTE: The KC60 system has been updated to include data on ethnicity, sexual orientation and country of birth, and will be reported quarterly through the HPA. The new KC60 (called GUMCAD: Genito-Urinary Medicine Clinic Activity Dataset) will include individual diagnosis (anonymised), which will enable a detailed breakdown to PCT level and below. Additionally, the new return will capture more detailed data on area of residence, and each individual will have a unique patient number allowing patients' records to be linked. All GUM clinics were expected to change to GUMCAD within six months of the Data Set Change implementation on 01/09/2008.

Data on diagnosed cases of HIV (SOPHID)

The primary source of data used in this needs assessment is SOPHID. This is the annual surveillance of HIV-infected individuals seen for HIV-related care in England, Wales and N. Ireland. It collates residence and limited epidemiological data on those seen for HIV-related care. These data only count people who have been diagnosed as HIV-positive AND are receiving HIV-related care. They will not reflect true prevalence of HIV in any area as it is currently estimated that approximately 28% of all HIV infections remain undiagnosed.

NOTE: New diagnoses and tests from non-GUM settings indicate incidence, while SOPHID reflect prevalence (noting the percentage not captured by SOPHID) as those counted may have been diagnosed many years ago while diagnosis in GUM and non-GUM count only new diagnoses (although not necessarily new infection).

On the assumption that the prevalence of HIV infections that have already been diagnosed is a good indicator of the prevalence of undiagnosed HIV infection in a particular place, the recent national guidelines for HIV testing state that consideration should be given to offering HIV testing to all men and women aged 15–59 registering at all general practice in areas where the prevalence of diagnosed HIV infections is greater than two in 1,000.

National Chlamydia Screening Programme

Data are collected on all individuals screened as part of the NCSP, including area of residence. As with any screening data, only cases that present or consent to screening are recorded, so figures underestimate population prevalence, and age and sex specific patterns of infection will be affected by selection biases. However, The NCSP has found that 2 in 25 under 25 year olds tested carry chlamydia[10].

Given that a significant amount of chlamydia screening and testing is occurring amongst young people in a variety of community settings that are not part of the NCSP, from April 2008 all chlamydia screens/tests undertaken outside of GUM on 15–24 year olds will count towards calculating screening coverage in residents of each PCT. This has been detailed in a letter sent to SHA Chief Executives in May 2008 by the Director of Performance at the DH. It is recommended that the trust refers to this letter for details of using non-NCSP activity towards the 2008/09 LDP target. The letter is available at www.dh.gov.uk/en/Publichealth/Healthimprovement/Sexualhealth/SexualHealthGeneralInformation/DH_4084098

For the purposes of this SHNA, national-level data will be complemented by data provided by the local Chlamydia Screening Programme in Hampshire.

10. National Chlamydia Screening Programme Website: http://www.chlamydiascreening.nhs.uk/ps/index.html

Notification of Infectious Diseases (NOIDs)

This is a national data set that is collected by the Health Protection Authority (HPA) which reports on a number of infections for which clinicians are responsible for notifying the HPA. These infections include hepatitis A, B and C. The HPA then collates and analyses the weekly returns in order to assess local and national trends.[11]

4.2.2 Overview of STI diagnoses in NHS Hampshire

Across the GUM clinics analysed there were 7,390 diagnoses of the five major STIs in 2008. This represents a 12.2% increase on the 2004 total figure (6,586). The increase in diagnoses nationally was 9% over the same period[12]. The 2008 total is however lower than the 2007 total which was 7,609 new diagnoses, showing a 3% decrease. Nationally, there was a 0.5% increase in STI diagnoses between 2007 and 2008.[13]

The 15–24 age group, accounting for 11.9% of the total population of Hampshire NHS, is carrying over half of the burden of disease in terms of STI diagnoses. 61% (4,480) of STI diagnoses in 2008 were amongst 15–24 year olds in Hampshire NHS, mirroring national trends of under-25s.[14]

Figure 5 shows the trends in diagnoses over the five years analysed. The most commonly reported STI through GUM clinics in 2008 was chlamydia, followed by HPV. Syphilis was the least commonly reported STI. This is in line with regional and national trends, and has remained constant over the years analysed.

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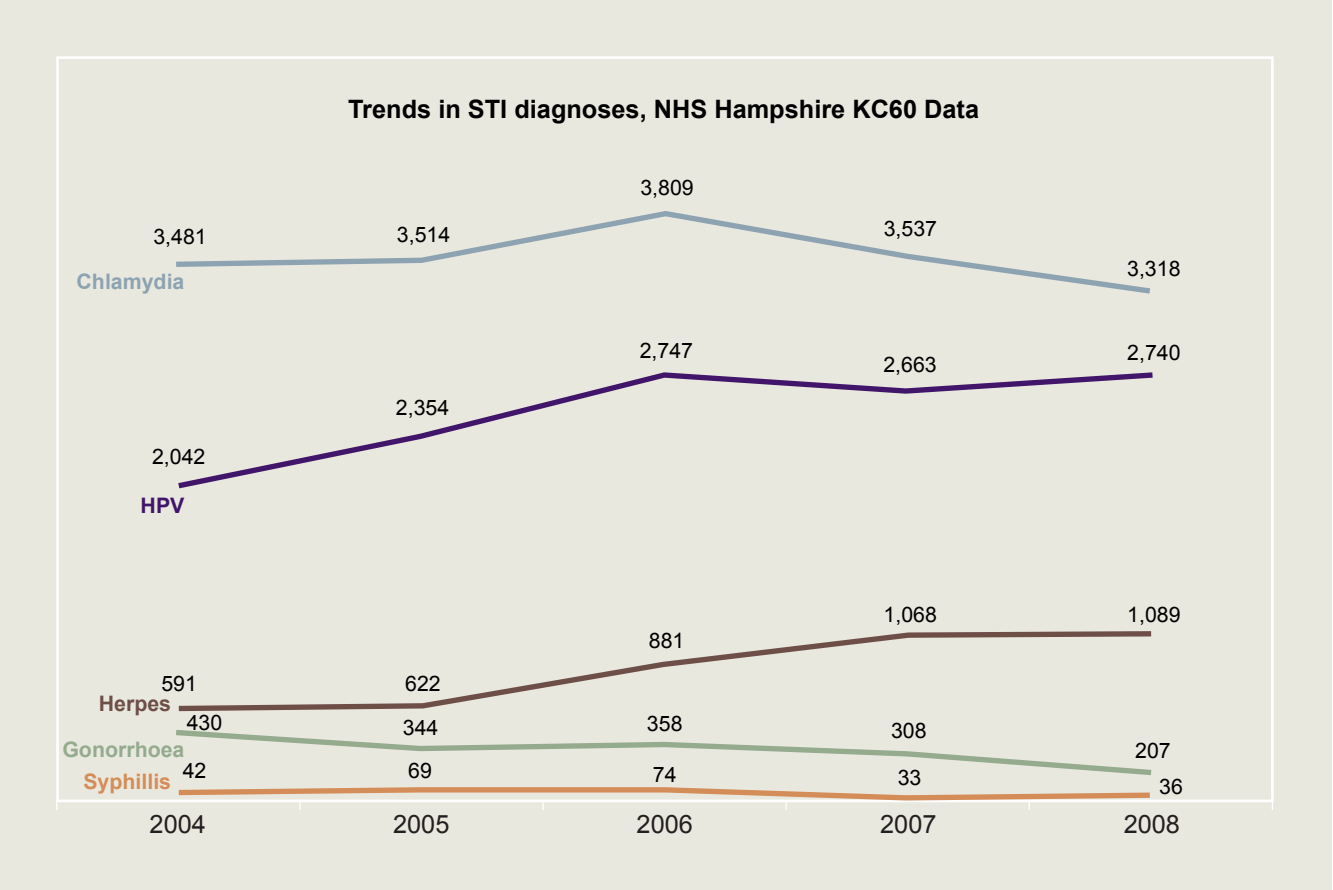
11. Health Protection Agency. 2009. Notifications of infectious diseases (NOIDs). London: HPA. Available at: http://www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListName/Page/1191942172947

12. Health Protection Authority. 2009. Number of new STI episodes seen at genitourinary medicine clinics by sex, 1999-2008. Available at: http://www.hpa.org.uk/webw/HPAweb&HPAwebPrinterFriendly/HPAweb_C/1247816582708?p=1231252394302

13. Health Protection Authority. 2009. Number of new STI episodes seen at genitourinary medicine clinics by sex, 1999-2008. Available at: http://www.hpa.org.uk/webw/HPAweb&HPAwebPrinterFriendly/HPAweb_C/1247816582708?p=1231252394302

14. Health Protection Authority. 2009. Number of new STI episodes seen at genitourinary medicine clinics by sex, 1999-2008. Available at: http://www.hpa.org.uk/webw/HPAweb&HPAwebPrinterFriendly/HPAweb_C/1247816582708?p=1231252394302

Figure 5: Trends in STI diagnoses, NHS Hampshire KC60 Data



4.2.3 Analysis by Clinic

STI diagnoses from five clinics providing services commissioned by NHS Hampshire were analysed in this SHNA.

4.2.3.1 Attendances

There were 79,523 attendances at GUM clinics commissioned by NHS Hampshire in 2008. This represents a 16% increase on attendance numbers for 2007 (68682). presents attendance data for Hampshire GUM clinics for 2007 and 2008. Analysis of Genito-Urinary Medicine Access Monthly Monitoring data (GUMAMM)data[15] (on Hampshire residents) and KC60 data on attendances (not disaggregated by PCT of residence) shows that in 2008, 87% of attendances at Winchester and Eastleigh Healthcare Trust GUM clinics (Royal Hampshire County GUM + Andover War Memorial GUM) were by NHS Hampshire residents. This is in contrast to only 32% of attendances being NHS Hampshire residents at Royal South Hampshire Hospital in Southampton.

As illustrated in Table 4, there is a significant difference in the caseload going through each clinic, with St Mary's GUM seeing the largest numbers of attendees annually (34% of all attendees across the GUM clinics in 2008). Of note, is the increase of 52% (2627) in attendees at Royal South Hampshire Hospital between 2007 and 2008.

15. GUMAMM is reported to the Dept of Health via UNIFY

Table 4: Attendances by NHS Hampshire residents by GUM Clinic, 2007 & 2008 (UNIFY / KC60 Data

GUM clinic	Total Attendances (Hampshire Residents)*		Total Attendances (Residents from all PCTs)**		Proportion of Attendances by Hampshire Residents	
	2007	2008	2007	2008	2007	2008
Frimley Park Hospital	4545	4767	8158	8403	56%	57%
Winchester and Eastleigh Healthcare NHS Trust	5504	6430	6014	7372	92%	87%
North Hampshire Hospital	3948	4401	6299	6998	63%	63%
Royal South Hampshire Hospital	5043	7670	19716	23859	26%	32%
St Marys Hospital, Portsmouth	10937	12194	28495	32891	38%	37%
Total	29977	35462	68682	79523	44%	45%
* UNIFY Data						
** KC60 data						

Of the 79,523 attendances at all NHS Hampshire commissioned GUM clinics in 2008, 64% (50859) were new attendees and 36% (28664) were follow-up appointments. This translates to a ratio of 1:0.56 of new to follow-up attendances overall in NHS Hampshire GUM clinics (i.e. 0.56 follow-up attendances to every 1 new attendance).

Disaggregation of new to follow-up ratios by gender highlights considerable variations across Hampshire clinics (see Table 4). Of particular note is that in 2008 across all clinics the ratios amongst MSM were above 1:1. This is most pronounced in St Mary's GUM clinic, for which the ratio was 2.79 follow-up attendances to every 1 new attendance; a figure considerably higher than the national guidelines recommend. It is suggested that further work be undertaken to understand the reasons for this high ratio.

Table 5: New to follow-up ratios by GUM clinic and sex, 2004-08 (KC60 data)

New:follow-up Ratios*	Sex	2004	2005	2006	2007	2008	Change '04-08
Frimley Park	M	0.93	0.81	0.51	0.41	0.37	-61%
	MSM	2.35	1.46	0.80	1.18	1.18	-50%
	F	1.06	0.88	0.65	0.49	0.43	-60%
	T	0.99	0.84	0.58	0.45	0.40	-60%
North Hampshire Hospital	M	0.47	0.54	0.48	0.41	0.36	-24%
	MSM	1.36	1.47	1.56	1.24	1.01	-26%
	F	0.50	0.44	0.43	0.39	0.37	-26%
	T	0.48	0.49	0.46	0.40	0.36	-25%
Royal Hampshire County Hospital (including Andover)	M	0.53	0.52	0.28	0.22	0.21	-61%
	MSM	0.30	0.76	0.82	1.00	1.53	410%
	F	0.93	1.01	0.35	0.27	0.25	-73%
	T	0.74	0.80	0.32	0.25	0.23	-69%
Royal South Hants Hospital, Southampton	M	1.30	1.24	1.18	0.89	0.76	-42%
	MSM	2.26	2.29	1.96	1.55	1.30	-42%
	F	1.28	1.18	1.12	0.70	0.70	-45%
	T	1.29	1.21	1.15	0.79	0.73	-43%
St Mary's Hospital Portsmouth**	M	0.96	0.85	0.88	0.70	0.71	-26%
	MSM	3.43	3.03	3.67	2.99	2.79	-18%
	F	1.08	0.88	0.85	0.67	0.60	-44%
	T	1.02	0.87	0.86	0.68	0.65	-36%
*To every new attendance there were X follow-up attendances (national average = 1:0.75)							
**NB: St Mary's completed only 3 quarterly KC60 returns for 2008							

STI diagnosis by clinic

In the context of this needs assessment, analyses have been carried out on diagnoses of the five major STIs (Chlamydia, HPV, HSV, Gonorrhoea and Syphilis) in each clinic. Data on attendances at GUM clinics provided in the KC60 dataset are not disaggregated by age, however it is possible to adjust analysis by the number of attendees at each clinic in order to get a rate of diagnosis by 1000 attendees. Analysis by clinic will therefore concentrate on gender differentials by STI and section 4.2.4, which presents composite data from all clinics by STI, will include an age break-down by STI.

The proportions of attendees not diagnosed with one of the five major STIs has been calculated by clinic, however caution must be employed here as attendees could have been to the clinic for another reason or been diagnosed with an sexual health condition apart from the five key STIs. In order to ascertain precisely the proportion of patients who do not require level 3 GUM services, one would have to conduct prospective analysis of the reason for attendance. Deeming those who are not diagnosed with an STI as 'worried well' is not appropriate, as a proportion of patients will attend services with possible signs and symptoms, but will not be diagnosed with a STI.

Table 6 presents rates of STI diagnosis per 1000 attendances at each clinic over a five year period. The overall rates in 2008 ranged from 142 diagnoses per 1000 attendances at St Mary's GUM to 209 diagnoses per 1000 attendances at Frimley Park GUM clinic. However, it is important to note here that St Mary's GUM only submitted 3 quarterly returns for 2008 so it is likely from previous trends that the actual figures for this clinic would be higher. This underlines the importance of timely data returns to the HPA. Of note, are the declines in rates over the years analysed. The declining rates either mean a real decrease in STI trends, or increasing proportions of asymptomatic screens; a reflection of heath promotion efforts to 'know your partner's status before stopping condom use'.

Table 6: STI diagnosis rates by clinic and sex, 2004-08 (KC60 data)

STI Diagnosis Rates per 1000 Attendees*		2004	2005	2006	2007	2008	Change '04-08
Frimley Park	M	216	186	198	204	206	-5%
	F	209	209	221	206	212	1%
	T	213	197	209	205	209	-2%
North Hampshire Hospital	M	196	194	211	198	183	-7%
	F	217	192	216	187	187	-14%
	T	206	193	213	193	185	-10%
Royal Hampshire County Hospital (including Andover)	M	228	185	198	162	172	-24%
	F	380	164	157	130	149	-61%
	T	308	173	175	144	159	-48%
Royal South Hants Hospital , Southampton	M	206	181	192	187	173	-16%
	F	212	192	187	169	156	-26%
	T	209	186	190	178	165	-21%
St Mary's Hospital Portsmouth**	M	319	358	365	252	146	-54%
	F	401	415	372	281	139	-65%
	T	357	385	369	267	142	-60%
* For the five major STIs (Chlamydia, HPV, HSV, Gonnorrhoea, Syphilis)							
** St Mary's completed only 3 quarterly KC60 returns for 2008							

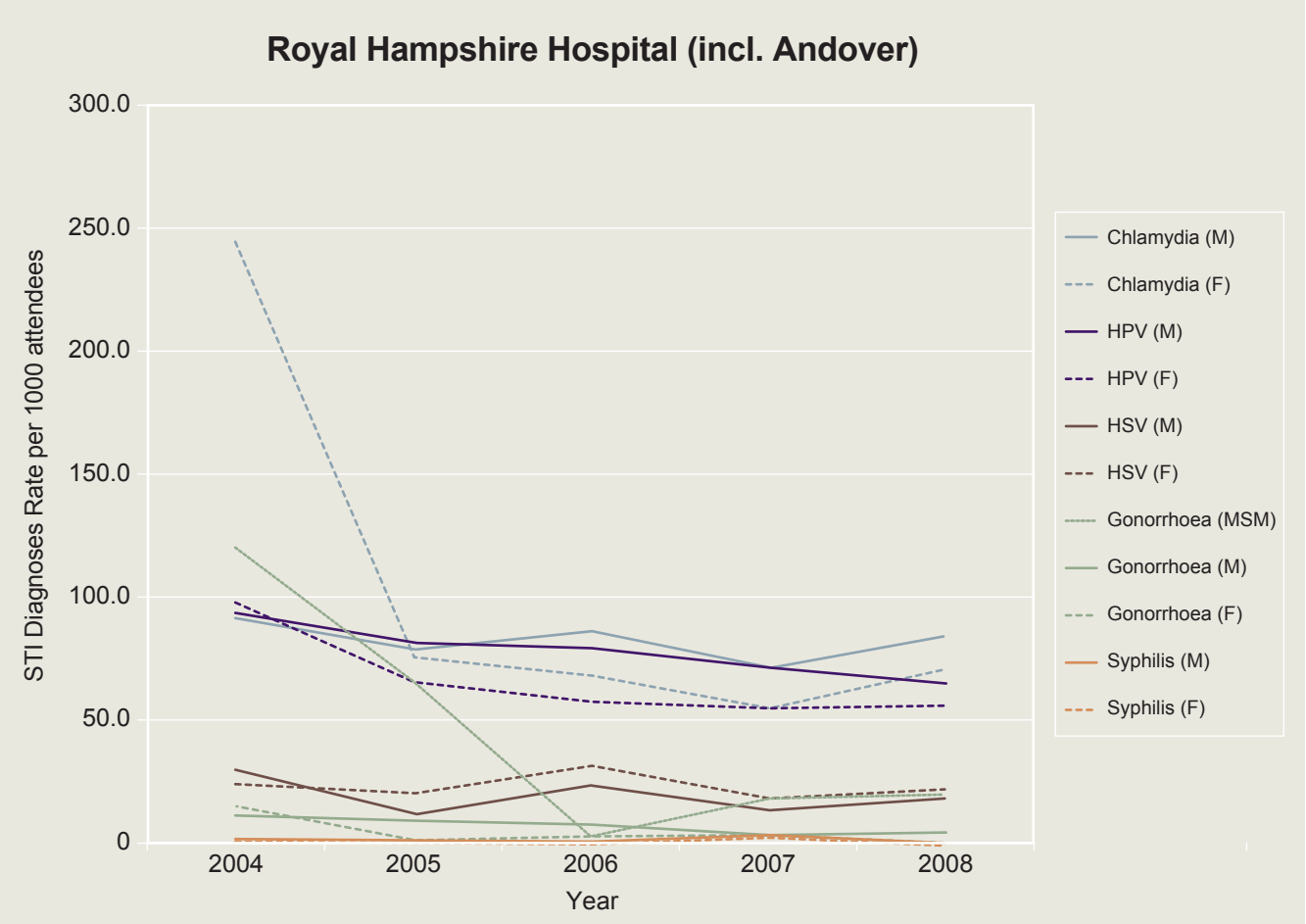
The following pages illustrate the trends in diagnoses rates by clinic for the five major STIs over the five year period analysed. Rates for each clinic will be presented in tables alongside the actual numbers of attendances and diagnoses which form the basis of the rates, as well as visually, in the form of graphs.

Royal Hampshire County Hospital GUM Clinic (Including Andover Hospital GUM Clinic)

Table 7: STI diagnoses at Royal Hampshire County Hospital (including Andover Hospital)

Royal Hampshire County Hospital (including Andover)		2004	2005	2006	2007	2008	Total	Change '04-08
First Attendances	M	1524	1804	1576	2158	2575	9637	69%
	F	1669	2499	1975	2670	3417	12230	105%
	T	3193	4303	3551	4828	5992	21867	88%
Total STI Diagnoses*	M	348	334	312	350	444	1788	28%
	F	634	411	311	346	509	2211	-20%
	T	982	745	623	696	953	3999	-3%
Proportion of Attendances not diagnosed with STI	M	77%	81%	80%	84%	83%	81%	7%
	F	62%	84%	84%	87%	85%	82%	37%
	T	69%	83%	82%	86%	84%	82%	21%
Rate of STI Diagnosis per 1000 Attendees	M	228.3	185.1	198.0	162.2	172.4	185.5	-24%
	F	379.9	164.5	157.5	129.6	149.0	180.8	-61%
	T	307.5	173.1	175.4	144.2	159.0	182.9	-48%

* for the five major STIs (Chlamydia, HPV, HSV, Gonnorrhoea, Syphilis)



Key trends:

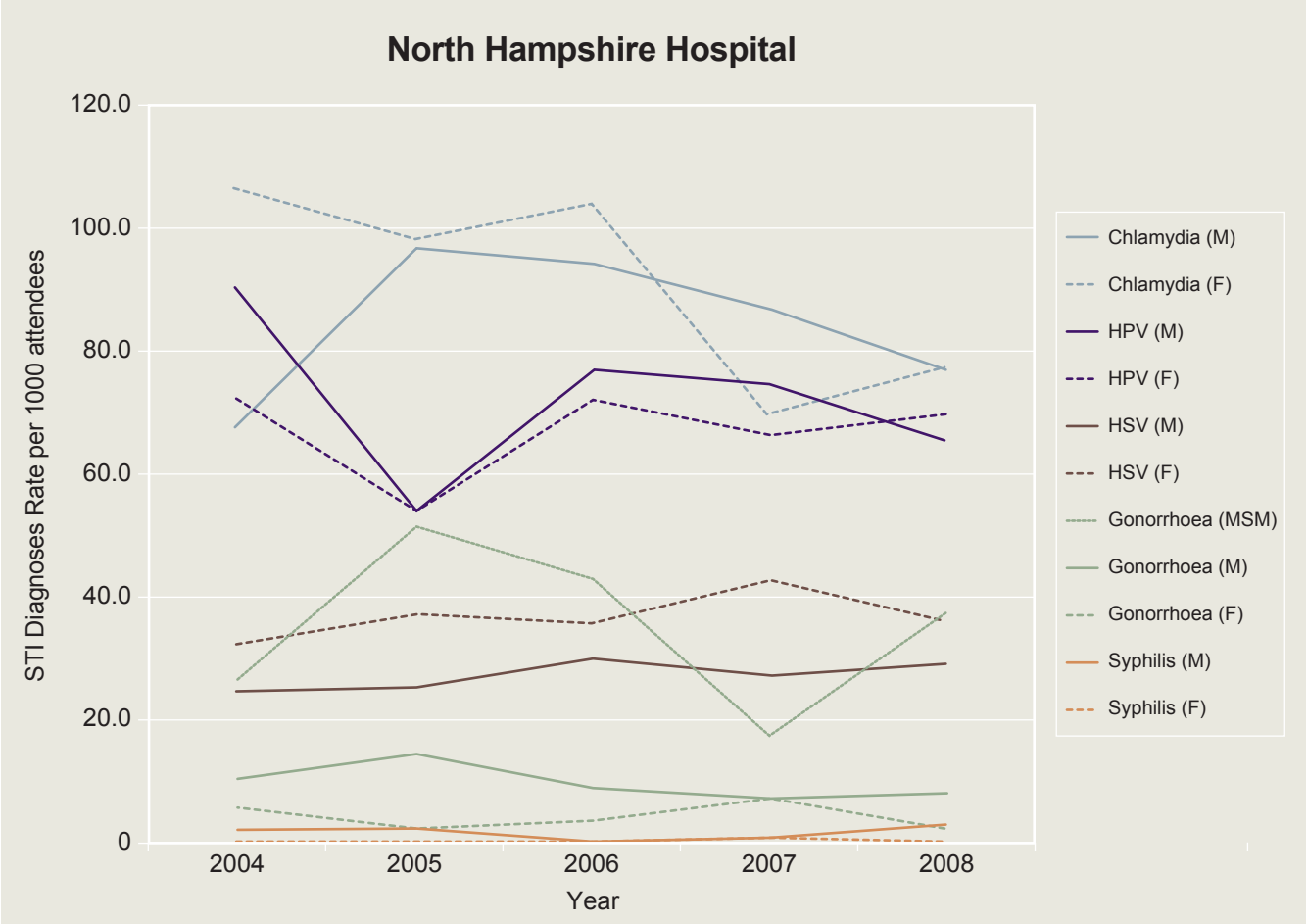
- Sharp reduction (-54%) in diagnoses of chlamydia amongst females between 2004 and 2005. The chlamydia diagnosis rate amongst females in 2004 was 243.9 diagnoses per 1000 attendees compared to 75.6 in 2005. Relatively stable rates since then.
- Decline in HPV diagnoses, particularly amongst female attendees (-42%).
- Sharp decline in diagnoses of gonorrhoea amongst MSM between 200-06, fall from 120.0 diagnoses per 1000 MSM attendees in 2004 to 0 diagnoses per 1000 MSM attendees in 2006, however there were small numbers of diagnoses so caution must employed in interpreting the rates for MSM.

North Hampshire Hospital GUM Clinic

Table 8: STI diagnoses at North Hampshire Hospital

North Hampshire Hospital		2004	2005	2006	2007	2008	Total	Change '04-08
First Attendances	M	2044	2221	2202	2313	2542	11322	69%
	F	1993	1902	2025	2188	2596	10704	150%
	T	4037	4123	4227	4501	5138	22026	27%
Total STI Diagnoses*	M	401	430	465	458	466	2220	28%
	F	432	366	437	409	485	2129	-20%
	T	833	796	902	867	951	4349	14%
Proportion of Attendances not diagnosed with STI	M	80%	81%	79%	80%	82%	80%	2%
	F	78%	81%	78%	81%	81%	80%	4%
	T	79%	81%	79%	81%	81%	80%	3%
Rate of STI Diagnosis per 1000 Attendees	M	196.2	193.6	211.2	198.0	183.3	196.1	-24%
	F	216.8	192.4	215.8	186.9	186.8	198.9	-61%
	T	206.3	193.1	213.4	192.6	185.1	197.4	-48%

* for the five major STIs (Chlamydia, HPV, HSV, Gonnorrhoea, Syphilis)



Key trends:

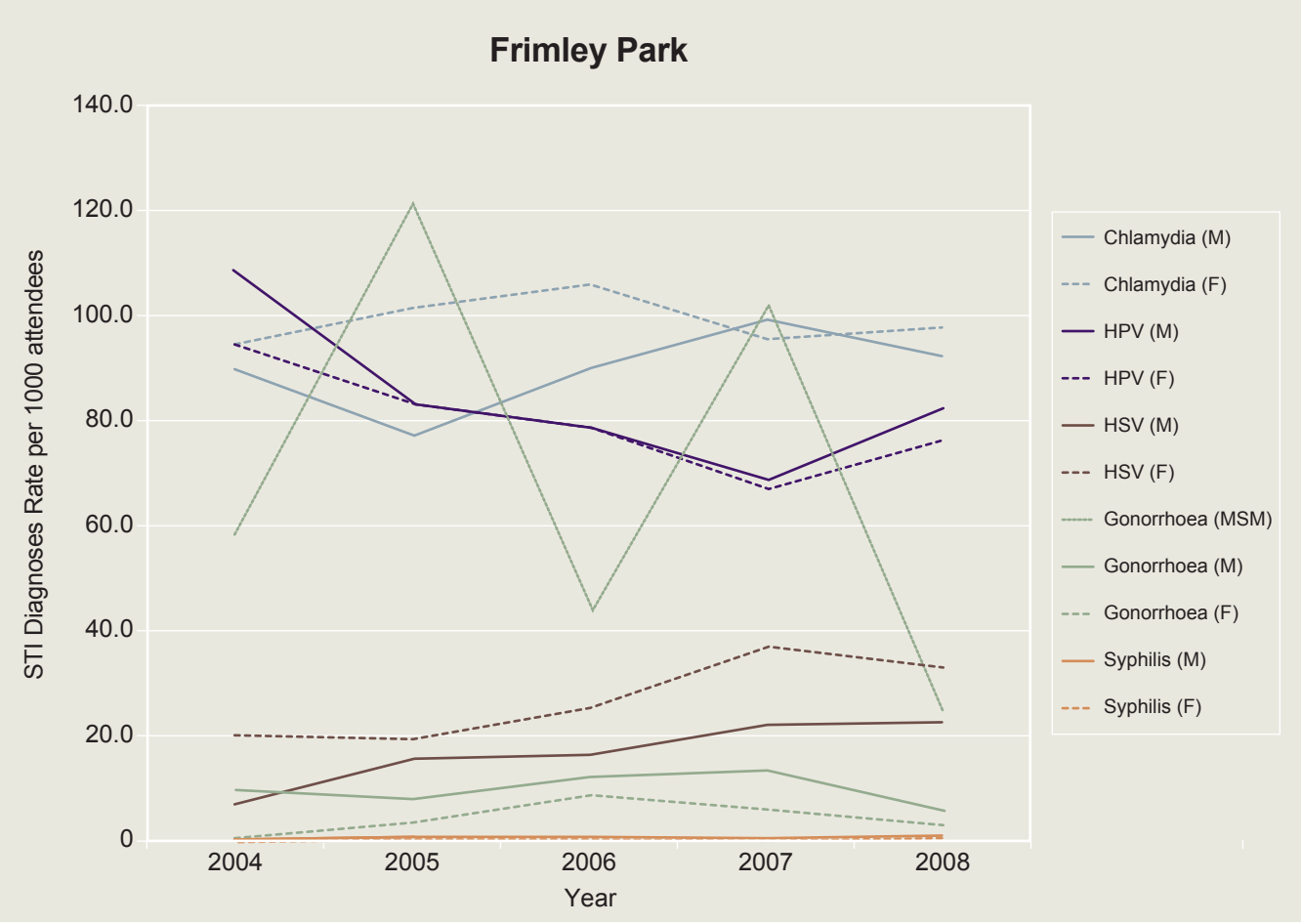
- Similar levels of female and male diagnoses of chlamydia in 2008 despite distinctly different trends. 42% increase in rate of male chlamydia diagnoses between 2004 and 2005 from 139 to 215 diagnoses, steady decline since. Female diagnoses peaked in 2006 (211 diagnoses), but troughed again in 2007.
- Similar trends in HPV amongst males and females, however rise in the rate of female diagnoses in 2008.
- Small peak in rate of gonorrhoea diagnoses amongst men in 2005 (32 diagnoses) and amongst women in 2007 (16 diagnoses). Higher rates of diagnoses amongst MSM attendees, however small numbers of diagnoses can skew rates.

Frimley Park Hospital, Surrey

Table 9: STI diagnoses at Frimley Park Hospital GUM Clinic

Frimley Park		2004	2005	2006	2007	2008	Total	Change '04-08
First Attendances	M	1447	1629	2167	2674	3095	11012	69%
	F	1223	1470	2108	2954	2921	10676	105%
	T	2670	3099	4275	5628	6016	21688	125%
Total STI Diagnoses*	M	313	303	430	545	638	2229	28%
	F	256	307	465	610	619	2257	-20%
	T	569	610	895	1155	1257	4486	121%
Proportion of Attendances not diagnosed with STI	M	78%	81%	80%	80%	79%	80%	1%
	F	79%	79%	78%	79%	79%	79%	0%
	T	79%	80%	79%	79%	79%	79%	1%
Rate of STI Diagnosis per 1000 Attendees	M	216.3	186.0	198.4	203.8	206.1	202.4	-24%
	F	209.3	208.8	220.6	206.5	211.9	211.4	-61%
	T	213.1	196.8	209.4	205.2	208.9	206.8	-48%

* for the five major STIs (Chlamydia, HPV, HSV, Gonnorrhoea, Syphilis)



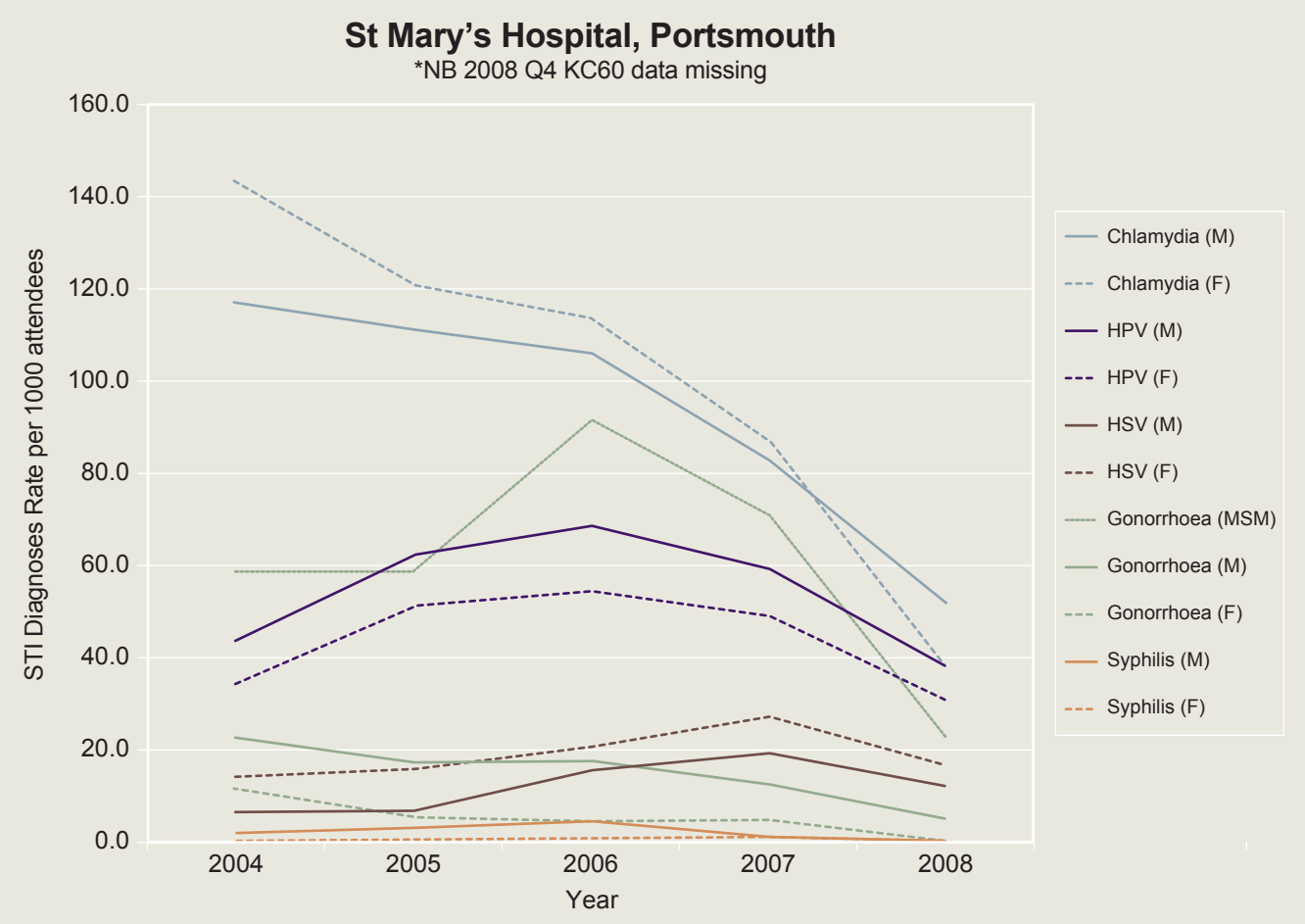
Key Trends:

- Relatively stable chlamydia diagnoses, with the rate of male diagnoses increasing between 2005-08.
- Similar patterns of increase in rates of HPV diagnoses amongst both sexes; 24% decrease in rate of male diagnoses between 2004-08, decrease of 18% amongst female attendees.
- Peak in rate of female diagnoses of HSV in 2007.
- Relatively stable rate diagnoses of gonorrhoea, with the exception of rates amongst MSM, however small numbers of

St Mary's Hospital GUM Clinic, Portsmouth

Table 10: STI diagnoses at St Mary's Hospital GUM Clinic

St Mary's Hospital Portsmouth**		2004	2005	2006	2007	2008	Total	Change '04-08
First Attendances	M	3965	4411	4936	5479	6870	25661	69%
	F	3460	3914	4821	5530	6911	24636	105%
	T	7425	8325	9757	11009	13781	50297	86%
Total STI Diagnoses*	M	1266	1577	1804	1378	1003	7028	28%
	F	1386	1624	1794	1556	958	7318	-20%
	T	2652	3201	3598	2934	1961	14346	-26%
Proportion of Attendances	M	68%	64%	63%	75%	85%	73%	25%
not diagnosed with STI	F	60%	59%	63%	72%	86%	70%	44%
	T	64%	62%	63%	73%	86%	71%	33%
Rate of STI Diagnosis per 1000 Attendees	M	319.3	357.5	365.5	251.5	146.0	273.9	-24%
	F	400.6	414.9	372.1	281.4	138.6	297.0	-61%
	T	357.2	384.5	368.8	266.5	142.3	285.2	-48%
* for the five major STIs (Chlamydia, HPV, HSV, Gonnorrhoea, Syphilis)								
**NB: only 3 quarterly returns completed for 2008								



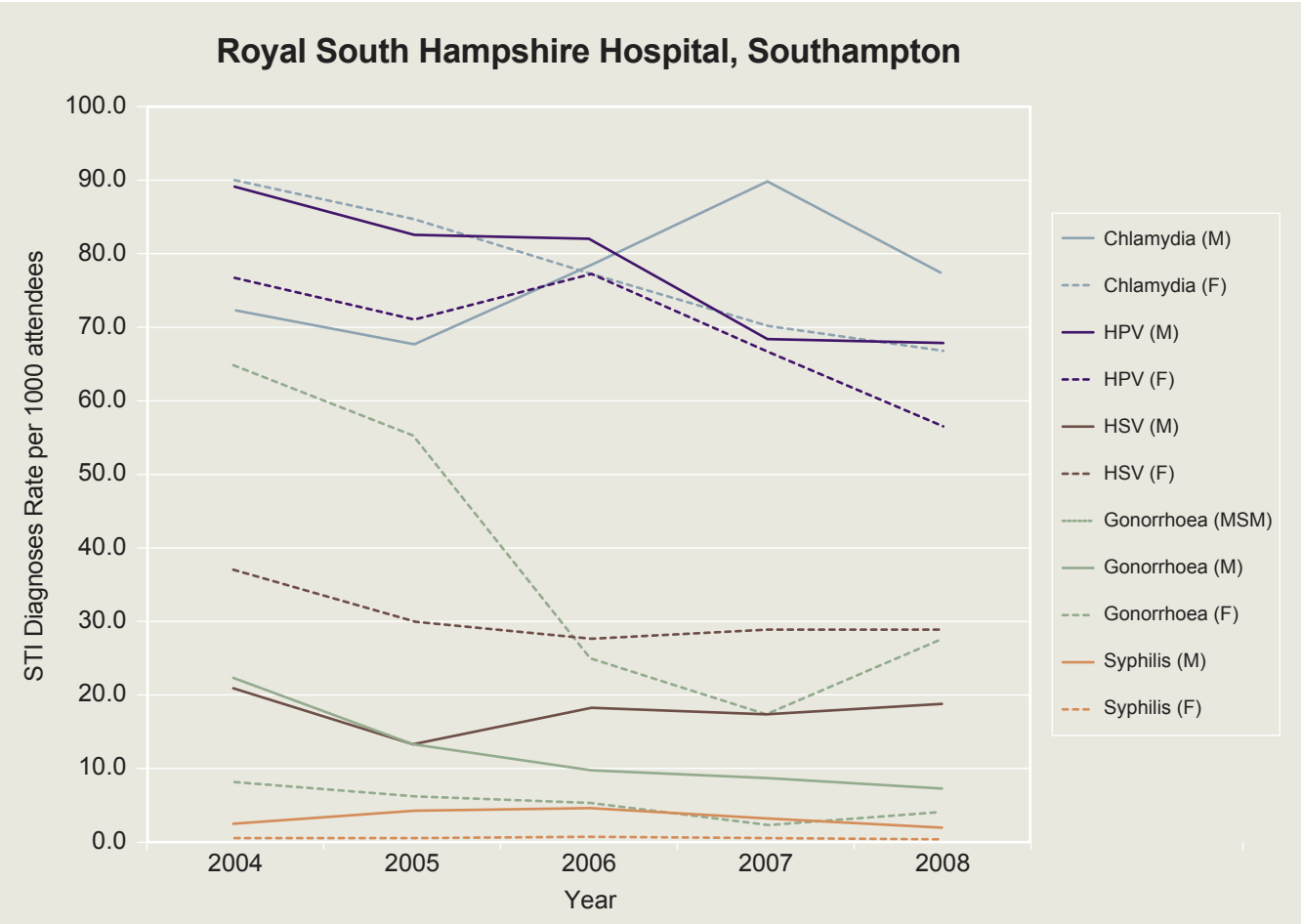
Key Trends:

- Incomplete KC60 return for 2008; caution should be used when analysing 2008 data.
- Decreases in rate of chlamydia diagnoses between 2004-07, most pronounced amongst females; decrease of 39% in comparison to 29% decrease amongst males.
- Peak in HPV diagnoses in 2006, slight decrease since then.
- Gradually rising rates of HSV diagnoses amongst both sexes.
- Relatively stable rate diagnoses of gonorrhoea, with the exception of rates amongst MSM, however small numbers of diagnoses in this group skew the rates.

Royal South Hampshire Hospital GUM Clinic, Southampton

Table 11: STI diagnoses at Royal South Hampshire Hospital GUM Clinic

Royal South Hants Hospital, Southampton		2004	2005	2006	2007	2008	Total	Change '04-08
First Attendances	M	3965	4411	4936	5479	6870	25661	69%
	F	3460	3914	4821	5530	6911	24636	105%
	T	7425	8325	9757	11009	13781	50297	86%
Total STI Diagnoses*	M	818	799	948	1024	1188	4777	28%
	F	732	752	903	933	1080	4400	-20%
	T	1550	1551	1851	1957	2268	9177	46%
Proportion of Attendances	M	79%	82%	81%	81%	83%	81%	4%
not diagnosed with STI	F	79%	81%	81%	83%	84%	82%	7%
	T	79%	81%	81%	82%	84%	82%	6%
Rate of STI Diagnosis per 1000 Attendees	M	206.3	181.1	192.1	186.9	172.9	186.2	-24%
	F	211.6	192.1	187.3	168.7	156.3	178.6	-61%
	T	208.8	186.3	189.7	177.8	164.6	182.5	-48%
* for the five major STIs (Chlamydia, HPV, HSV, Gonnorrhoea, Syphilis)								



Key trends:

- Higher diagnosis rate amongst males than females. Overall between 2004-08, 8% increase in diagnosis rates amongst males compared to a reduction of 26% in rate of diagnoses amongst females.
- Similarly rate of HPV diagnoses higher amongst males, however proportionally similar decreases in rates over the 5 years; -24% amongst males and -26% amongst females.
- Consistently higher levels of HSV amongst females.
- Relatively high levels of syphilis diagnoses amongst males, with a peak in 2006 of 22 diagnoses.

4.2.4 Analysis by STI

Analysis will be presented by STI using data from all of the clinics combined. Where available, a range of data sets will be used (i.e. KC60 and NCSP data for chlamydia) and comparisons at both the national and regional level will be included.

4.2.4.1 Chlamydia

KC60 Data

In line with national and regional trends, chlamydia was the most commonly diagnosed STI across the GUM clinics in NHS Hampshire. In 2008 there were 3,318 new diagnoses of chlamydia, with a diagnosis rate of 65.2 diagnoses per 1000 attendees at GUM clinics across NHS Hampshire. This represents a decrease of 5% over the five year period analysed. This decrease is largely due to decreases amongst female diagnoses, most notably in the 35–44 age group. Male diagnoses on the other hand increased by 17%, most notably in the 15–19 year age group.

Although the proportion of diagnoses attributable to males has increased steadily over the five year period, rising from 42% in 2004 to 51% in 2008, the rate of diagnosis amongst male attendees has in fact decreased from 94.1 to 70.5, indicating that the higher proportion of male diagnoses is due to increased numbers of male attendees.

Comparison at the regional (South Central SHA) level shows that NHS Hampshire saw a reduction in diagnoses amongst both males and females (-3% in males and -11% in females) over 2006–2007 and 2007–2008, whereas regionally in 2006–2007 there was an 18% increase in male diagnoses and a 4% increase in female diagnoses. Nationally 65% of chlamydia diagnoses were amongst young people aged 16–24 years in 2008, a figure slightly lower than that for Hampshire NHS which saw 69% amongst 15–24 year olds (please note the differing age categories).

National Chlamydia Screening Programme (NCSP) Data

Data from the National Chlamydia Screening Programme for the period 1st April 2008 to 31st March 2009 indicate that there were 17,867 chlamydia tests reported to the NCSP, 407 of which were partner/contact tests. Of the tests reported, 1,285 were positive (7.1%). Including lab tests done outside of GUM which were not reported directly to the NCSP there was a total of 23,013 tests done in NHS Hampshire over the period analysed. This represents 15.4% of young people aged 15–24 years, placing NHS Hampshire at 85 out of 152 PCTs in the national ranking tables. The proportion of young people tested in NHS Hampshire is higher than regional figures (12.5%) and similar to national figures (15.9%), indicating that although NHS Hampshire did not meet the 2007/08 vital signs target of 17% of the under-25 population tested, it is not too far behind. The target for 2009/10 is 25%, rising to 35% in 2011.

Table 12: Chlamydia diagnoses over five-year period by age and sex, KC60 data

Chlamydia	2004			2005			2006			2007			2008			Change 2004-2008		
Age	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	T
<15	0	9	**9**	0	<5	**4**	<5	17	**18**	<5	9	**10**	0	7	**7**	**0%**	**-22%**	**-22%**
15-19	212	748	**960**	248	743	**991**	292	727	**1,019**	305	636	**941**	294	618	**912**	39%	**-17%**	**-5%**
20-24	678	831	**1,509**	817	775	**1,592**	810	839	**1,649**	706	719	**1,425**	745	634	**1,379**	10%	**-24%**	**-9%**
25-34	429	328	**757**	459	271	**730**	522	322	**844**	565	330	**895**	492	291	**783**	15%	**-11%**	3%
35-44	103	83	**186**	99	56	**155**	130	64	**194**	149	65	**214**	129	45	**174**	25%	**-46%**	**-6%**
45+	39	21	**60**	27	15	**42**	64	21	**85**	38	14	**52**	48	15	**63**	23%	**-29%**	5%
Total	**1,461**	**2,020**	**3,481**	**1,650**	**1,864**	**3,514**	**1,819**	**1,990**	**3,809**	**1,764**	**1,773**	**3,537**	**1,708**	**1,610**	**3,318**	**17%**	**-20%**	**-5%**
Rate *	94.1	133.3	113.5	92.3	102.9	97.7	94.3	98.9	96.7	86.5	78.8	82.5	70.5	60.5	65.2	-25%	-55%	-43%

*Diagnosis rate per 1000 attendances

Table 13: Local NCSP Screening Data, by venue of screen (April 2008-March 2009)

North-East and West			South-East		
Venue	**Screens**	**Proportion**	**Venue**	**Screens**	**Proportion**
CaSH	1541	18%	CaSH	1899	35%
GPs	2455	28%	GPs	1362	25%
Military	1414	16%	Sex Sense	485	9%
Colleges	2189	25%	Outreach	354	6%
Maternity	135	2%	CSO	412	8%
TOP	225	3%	UPAC	331	6%
Prison	50	1%	YP Sexual Health Nurses	281	5%
Postal	529	6%	ANC/Maternity	140	3%
Pharmacy	81	1%	Other*	194	4%
Total	8619	100%	Total	5458	100%
* includes youth centres, school nurses, ARC, Haslar and Gynae - all small numbers					

Data collected from the local NCSP programme indicates similar figures to those reported nationally; however, a breakdown of the tests done by screening venue gives an additional insight into the principal actors working towards achieving the vital signs targets. North East and West Hampshire localities report together and South East Hampshire reports separately. Table 11 details screens by venue. In the North East and West localities GPs provide the highest proportion of screens, closely followed by colleges, whereas in South-East Hampshire it is CaSH services followed by GPs.

KC60 Data

HPV is the second most commonly diagnosed STI across NHS Hampshire. In line with national and regional trends, there has been a significant increase (34%) in HPV diagnoses since 2004, largely due to increases in numbers of diagnoses between 2004 and 2006. Rates of diagnoses however have seen a decrease of 19%, indicating that although numbers of diagnoses have increased, numbers of attendees have also grown. Over the last year (2007/08) there was a 3% increase in numbers of HPV diagnoses, a proportion identical to increases at a national level.[16]

Although there have been more pronounced increases in numbers of diagnoses amongst females than males, with increases of 45% and 26% respectively, rates of diagnosis show these differences to be largely due to differences in numbers of attendees. As with chlamydia, diagnoses amongst young people aged 15–24 years account for the highest proportion of diagnoses (59%), a figure slightly higher than national proportions. Male diagnoses outnumber female diagnoses amongst the elder age groups; however, for those under 20 years female diagnoses are more common.

Table 14: HPV diagnoses over five year period by age and sex, KC60 data

HPV (Warts)	2004			2005			2006			2007			2008			Change 2004-2008		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	T
<15	0	<5	**<5**	<5	5	**6**	<5	<5	**<5**	<5	<5	**5**	0	<5	**<5**	**0%**	**0%**	**0%**
15-19	118	261	**379**	121	357	**478**	170	423	**593**	135	435	**570**	158	415	**573**	34%	59%	51%
20-24	437	338	**775**	522	396	**918**	527	492	**1,019**	521	457	**978**	568	489	**1,057**	30%	45%	36%
25-34	356	183	**539**	406	216	**622**	494	249	**743**	439	275	**714**	430	289	**719**	21%	58%	33%
35-44	141	101	**242**	124	78	**202**	172	86	**258**	156	103	**259**	149	94	**243**	6%	**-7%**	**0%**
45+	71	34	**105**	81	47	**128**	83	47	**130**	96	41	**137**	107	39	**146**	51%	15%	39%
Total	**1,123**	**919**	**2,042**	**1,255**	**1,099**	**2,354**	**1,447**	**1,300**	**2,747**	**1,348**	**1,315**	**2,663**	**1,412**	**1,328**	**2,740**	**26%**	**45%**	**34%**
Rate*	72.3	60.7	66.6	70.2	60.7	65.4	75.0	64.6	69.7	66.1	58.5	62.1	58.3	49.9	53.9	**-19%**	**-18%**	**-19%**

*Diagnosis rate per 1000 attendances

16. Health Protection Authority. 2009. Number of new STI episodes seen at genitourinary medicine clinics by sex, 1999-2008. Available at: http://www.hpa.org.uk/webw/HPAweb&HPAwebPrinterFriendly/HPAweb_C/1247816582708?p=1231252394302

4.2.4.3 Herpes Simplex Virus (genital herpes)

KC60 Data

There were 1,089 diagnoses of herpes in 2008. This figure has increased year on year since 2004 (84% in all), with the largest increase being between 2005 and 2006 when diagnoses increased from 622 to 881. Regionally over 2006–2007 there was an overall 4% increase in diagnoses amongst males and a 11% increase amongst females. Increases over this period were higher in NHS Hampshire, seeing a 9% and 30% increase respectively. Between 2007 and 2008 in NHS Hampshire there was only a 2% increase overall in diagnoses, a figure significantly lower than nationally, where there was an increase of 11%.[17] Increases in diagnoses over the last few years could be due to the use of improved sensitivity in the testing process.[18] Despite these significant increases in numbers diagnosed, when adjusted for the number of attendees to NHS Hampshire GUM clinics, the figures show that although there has been an increase of 11% in the rates of diagnoses over the 5 year period, it is not as marked as the numbers would suggest. Although female diagnoses rates are consistently higher than male rates, the increase in male diagnoses has been more rapid.

The age group with the highest number of diagnoses is the 25–34 year olds; however, if disaggregated by sex, female diagnoses peak in the 20–24 year age group. Of note, are the marked increases amongst the 45+ age group over the five year period, especially amongst females. However, caution must be employed here as although proportionally the increases are large, the numbers are small in comparison to other age groups. The proportion of female diagnoses was consistently higher than males, rising as high as 64% in 2005 over the years analysed. In 2008 50% of diagnoses were amongst females. This proportion does, however, vary by age, being most pronounced amongst the younger ages.

Table 15: Herpes diagnoses over five year period by age and sex, KC60 dat

Herpes Simplex Virus	2004			2005			2006			2007			2008			Change 2004-2008		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	T
<15	0	<5	**<5**	0	<5	**<5**	<5	<5	**<5**	0	0	**0**	0	<5	**<5**	0%	0%	0%
15-19	15	85	**100**	22	88	**110**	15	98	**113**	24	155	**179**	29	127	**156**	93%	49%	56%
20-24	61	104	**165**	64	101	**165**	90	133	**223**	113	204	**317**	102	180	**282**	67%	73%	71%
25-34	80	95	**175**	63	106	**169**	114	173	**287**	131	145	**276**	143	176	**319**	79%	85%	82%
35-44	50	50	**100**	43	64	**107**	73	65	**138**	67	88	**155**	95	90	**185**	90%	80%	85%
45+	29	21	**50**	30	39	**69**	75	42	**117**	67	74	**141**	66	80	**146**	**128%**	**281%**	**192%**
Total	**235**	**356**	**591**	**222**	**400**	**622**	**368**	**513**	**881**	**402**	**666**	**1,068**	**435**	**654**	**1,089**	**85%**	**84%**	**84%**
Rate	15.1	23.5	19.3	12.4	22.1	17.3	19.1	25.5	22.4	19.7	29.6	24.9	18.0	24.6	21.4	19%	5%	11%

*Diagnosis rate per 1000 attendances

17. Health Protection Authority. 2009. Number of new STI episodes seen at genitourinary medicine clinics by sex, 1999-2008. Available at: http://www.hpa.org.uk/webw/HPAweb&HPAwebPrinterFriendly/HPAweb_C/1247816582708?p=1231252394302

18. Health Protection Authority. 2009. Number of new STI episodes seen at genitourinary medicine clinics by sex, 1999-2008. Available at: http://www.hpa.org.uk/webw/HPAweb&HPAwebPrinterFriendly/HPAweb_C/1247816582708?p=1231252394302

KC60 Data

Both numbers and rates of gonorrhoea have decreased in NHS Hampshire over the years analysed. Number have decreased by 52% overall whereas rates have decreased by 71%. Between 2007 and 2008 there was a 33% reduction in the number of diagnoses, a figure which is significantly higher than the national decline (-11%).[19] The reduction is more pronounced amongst females (-44%); however, the numbers of diagnoses of gonorrhoea amongst females are smaller. The changes in diagnoses rates show similar patterns to those of the numbers, however the decrease is more pronounced, with female diagnoses rates decreasing by 53% between 2007-08.

The burden of disease concentrated amongst the younger age population (15–24 years) is 55%, a figure slightly higher than national proportions (47%). Males accounted for 73% of diagnoses in 2008, of which MSM diagnoses made up 27%. The proportion of MSM diagnoses increases in the older ages, rising to 50% in the 45+ age bracket.

Table 16: Gonorrhoea diagnoses over five year period by age and sex, KC60 data

Gonorrhoea	2004				2005				2006				2007				2008				Change 2004-2008			
	M	MSM*	F	Total	M	MSM*	F	Total	M	MSM*	F	Total	M	MSM*	F	Total	M	MSM*	F	Total	M	MSM*	F	Total
<15	0	0	0	**0**	0	0	0	**0**	0	0	0	**0**	0	0	<5	**<5**	0	0	0	**0**	0%	0%	0%	0%
15-19	41	3	55	**96**	21	4	36	**57**	43	17	37	**80**	45	18	32	**77**	17	4	17	**34**	-59%	33%	-69%	-65%
20-24	95	11	43	**138**	90	27	32	**122**	92	23	36	**128**	56	14	27	**83**	56	11	23	**79**	-41%	0%	-47%	-43%
25-34	84	19	29	**113**	79	19	14	**93**	68	21	14	**82**	60	5	24	**84**	36	8	8	**44**	-57%	-58%	-72%	-61%
35-44	44	11	10	**54**	53	21	5	**58**	29	11	12	**41**	19	8	7	**26**	23	8	5	**28**	-48%	-27%	-50%	-48%
45+	25	5	<5	**29**	12	2	<5	**14**	24	4	<5	**27**	29	14	7	**36**	20	10	<5	**22**	-20%	100%	-50%	-24%
Total	**289**	**49**	**141**	**430**	**255**	**73**	**89**	**344**	**256**	**76**	**102**	**358**	**209**	**59**	**99**	**308**	**152**	**41**	**55**	**207**	-47%	-16%	-61%	-52%
Rate**	18.6	60.5	9.3	14.0	14.3	59.1	4.9	9.6	13.3	61.4	5.1	9.1	10.2	47.9	4.4	7.2	6.3	25.9	2.1	4.1	-66%	-57%	-78%	-71%

*Male diagnoses include MSM diagnoses

**Diagnosis rate per 1000 attendances

19. Health Protection Authority. 2009. Number of new STI episodes seen at genitourinary medicine clinics by sex, 1999-2008. Available at: http://www.hpa.org.uk/webw/HPAweb&HPAwebPrinterFriendly/HPAweb_C/1247816582708?p=1231252394302

4.2.4.5 Syphilis

KC60 Data

Syphilis diagnoses have been consistently low in NHS Hampshire, with the maximum number of diagnoses in a year being 74 diagnoses in 2006. Overall, since 2004 there has been a 14% decrease in diagnoses; there has been a similar decrease in diagnoses at a national level. When adjusted for attendances however, larger reductions can be seen (-48% overall).

The age group with the highest burden of disease is the 35–44 year olds, in 2008 accounting for 33% of all diagnoses. The sex profile of syphilis is distinctly male, with minimal numbers of women diagnosed each year.

Despite this Hampshire-wide profile highlighting elder males as the most-at-risk group, the nature of syphilis is that it generally occurs in localised outbreaks so trends do not tend to be uniform. NHS Hampshire has recently confirmed a local outbreak of Syphilis amongst young heterosexuals in the South East of the region. There have been approximately 20 new cases of Syphilis in young heterosexuals in Portsmouth & SE Hampshire between May 2007 and May 2009.

Table 17: Syphilis diagnoses over five year period by age and sex, KC60 data

Syphilis	2004			2005			2006			2007			2008			Change 2004-2008		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	T
<15	0	0	**0**	0	0	**0**	0	0	**0**	0	0	**0**	0	<5	**<5**	0%	100%	100%
15-19	<5	0	**<5**	<5	0	**<5**	<5	0	**<5**	0	<5	**<5**	<5	0	**<5**	-75%	0%	-75%
20-24	7	<5	**8**	6	<5	**10**	7	<5	**8**	<5	0	**<5**	5	<5	**7**	-29%	100%	-13%
25-34	9	<5	**11**	17	<5	**18**	13	<5	**14**	8	0	**8**	8	0	**8**	-11%	-100%	-27%
35-44	8	<5	**9**	25	<5	**28**	32	<5	**35**	13	0	**13**	12	0	**12**	50%	-100%	33%
45+	10	0	**10**	11	0	**11**	14	0	**14**	8	0	**8**	6	<5	**7**	-40%	100%	-30%
Total	**38**	**<5**	**42**	**61**	**8**	**69**	**69**	**5**	**74**	**32**	**<5**	**33**	**32**	**<5**	**36**	-16%	0%	-14%
Rate*	2.4	0.3	1.4	3.4	0.4	1.9	3.6	0.2	1.9	1.6	0.0	0.8	1.3	0.2	0.7	-46%	-43%	-48%

*Diagnosis rate per 1000 attendances

4.2.4.6 HIV (SOPHID Data)

BHIVA 2008 guidelines key issues:[20] HIV is now a treatable medical condition and the majority of those living with the virus remain fit and well on treatment. Despite this, a significant number of people in the United Kingdom are unaware of their HIV infection and remain at risk to their own health and of passing their virus unwittingly on to others. Late diagnosis is the most important factor associated with HIV-related morbidity and mortality in the UK. Patients should therefore be offered and encouraged to accept HIV testing in a wider range of settings than is currently the case. Patients with specific indicator conditions should be routinely recommended to have an HIV test. All doctors, nurses and midwives should be able to obtain informed consent for an HIV test in the same way that they currently do for any other medical investigation.

SOPHID data for 2007 shows Hampshire to have 553 residents (aged 15–59 years) diagnosed with HIV and accessing HIV-related care. This translates to a prevalence of 0.7 cases per 1,000 people. While the prevalence of diagnosed HIV-infected people utilising HIV-related care may be low, the number of individuals accessing care increased from 283 over 2003 to 553 at the end of 2007, representing a 195% increase in the number of cases over this five year period. Further when taking into account the number of undiagnosed cases it is likely that there are as many as 768 individuals living with HIV across Hampshire. The overall prevalence of HIV in Hampshire as reported by the HPA is 0.68 per 1,000 (population aged 15–59).

England comparisons (according to the HPA):

- An estimated 77,400 persons were living with HIV in the UK at the end of 2007, of whom over a quarter (28%) were unaware of their infection.
  - In the case of NHS Hampshire, there were 553 individuals accessing care for HIV in 2007. If 28% are assumed to be unaware of their infection, the total number of people living with HIV in NHS Hampshire could be close to 737 (184 of whom are unaware of their infection).

- During 2007 there were 7,734 new diagnoses of HIV, a similarly high figure to the diagnoses made in each of the previous four years.
  - Although data on new diagnoses of HIV in NHS Hampshire is not represented by SOPHID data, the number of individuals accessing care in the area increased 21% between 2006-07.

- New HIV diagnoses among men who have sex with men continue to increase and over four-fifths of these infections were probably acquired in the UK.
  - Although data on new diagnoses of HIV in NHS Hampshire is not represented by SOPHID data, the number of men who have sex with men accessing care in the area increased by 21% between 2006 and 2007.

- The estimated number of persons infected through heterosexual contact within the UK has increased from 540 new diagnoses in 2003 to 960 in 2007, and has doubled, from 11% to 23%, as a proportion of all heterosexual diagnoses during this period.
  - Although SOPHID data does not detail the country of transmission, the number of heterosexuals accessing care for HIV in NHS Hampshire increased from 158 in 2003 to 330 in 2007, an increase of 109%.

- Almost a third (31%) of persons newly diagnosed with HIV were diagnosed late, that is at a point after which therapy should have begun (CD4 cell count less than 200 per mm3).
  - SOPHID data does not detail CD4 cell count at time of diagnosis.

- Seventy per cent of the 56,556 persons seen for HIV care were receiving antiretroviral therapy. Almost one in five HIV-infected persons with severe immune-suppression were not on treatment.
  - 70% of the 553 individuals accessing care for HIV in NHS Hampshire were receiving antiretroviral therapy in 2007.

- Uptake of HIV testing in genito-urinary medicine and antenatal clinic settings Nationally reached 75% and 94%, respectively.
  - Uptake of HIV testing across NHS Hampshire GUM clinics in 2008 was 74% (KC60 data). Disaggregated by clinic these rates do vary however:
    - Frimley Park Hospital – 88%
    - Royal South Hampshire Hospital – 84%
    - St Mary's Hospital Portsmouth – 70%
    - North Hampshire Hospital – 68%
    - Royal Hampshire County Hospital (incl. Andover) – 50%

20. http://www.bhiva.org/cms1222621.asp

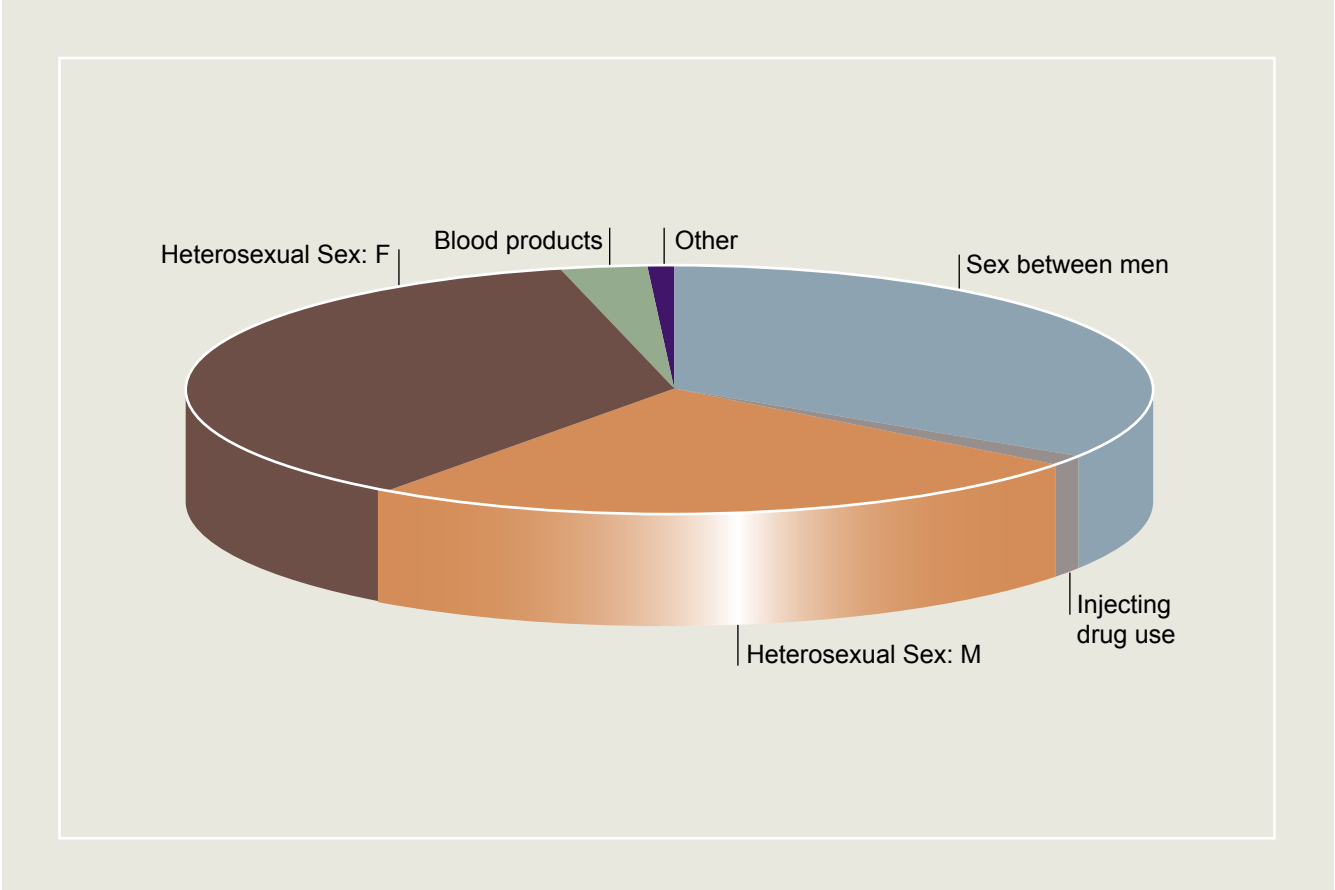
Route of transmission

Table 18: Numbers of diagnosed HIV-infected individuals by probable route of HIV-infection, sex and survey year

Transmission mode	Sex between men	Injecting drug use		Heterosexual		Blood/blood products recipient		Mother-to-child transmission		Other/Not known		Total
Survey Year	M	M	F	M	F	M	F	M	F	M	F	
2003	99	<5	<5	66	92	16	<5	<5	0	<5	<5	283
2004	129	6	<5	78	111	16	<5	<5	0	<5	<5	349
2005	141	5	<5	93	143	17	<5	<5	<5	<5	<5	409
2006	**153**	**7**	**<5**	**106**	**159**	**17**	**<5**	**<5**	**<5**	**<5**	**<5**	**456**
2007	185	7	<5	136	194	17	<5	<5	<5	5	<5	553

As Table 18 shows, heterosexual sex is the most common route of transmission of HIV for individuals living in Hampshire. Sex between men is the second most common. Though absolute numbers are small, there are still persons living in Hampshire who had contracted HIV through injecting drug use, blood products, and mother-to-child transmission (MTCT).

Figure 6: Mode of HIV transmission in NHS Hampshire, 2007



As Figure 6 illustrates, 34% of all individuals seeking HIV-related treatment contracted the virus through sex between men; 36% females contracted through heterosexual sex and 25% males through heterosexual sex. (NB: MTCT is not included as the percentage is less than 1).

To compare to the rest of the UK, according to the HPA report on HIV in the United Kingdom, 2008:

After adjusting for missing information, an estimated 55% (4,260) of persons diagnosed in 2007 acquired their infection through heterosexual contact (1,690 men and 2,570 women) and 41% (3,160) through sex between men. The number of HIV diagnoses among persons infected heterosexually has declined from a peak of approximately 4,850 in 2004, whereas new diagnoses among men who have sex with men (MSM) have continued to increase. The estimated numbers of diagnoses of HIV infection acquired through injecting drug use (180 in 2007) and mother-to-child transmission (110 in 2007) have remained low over the past five years.

Of the estimated 4,260 heterosexually acquired new diagnoses of HIV, 77% (3,300) were probably infected abroad. An estimated two thirds (2,850) were of black-African ethnicity, of whom the majority (90%) acquired their infection abroad, mainly in sub-Saharan Africa. In contrast, among HIV-infected MSM diagnosed in 2007, 82% (2,580) probably acquired their infection in the UK

Ethnicity and age of individuals seeking HIV-related treatment

From the HPA's "Sexually transmitted infections in black African and black Caribbean communities in the UK: 2008 report":

- The prevalence of diagnosed HIV in black African and black Caribbean communities in England is estimated to be 3.7% and 0.4% respectively, compared to 0.09% among the white population.
- In 2007 there were 2,691 new HIV diagnoses among black Africans, representing 40% of all new diagnoses in the UK. The majority had acquired their infection heterosexually and in Africa. The number of new diagnoses among black Caribbeans remained low (189 in 2007), representing 3% of new diagnoses in 2007.
- The percentage of late diagnoses, that is after a point when treatment should have begun, among new diagnoses of HIV in 2007 was highest among black Africans (42%). Twenty-seven per cent of HIV diagnoses among black Caribbeans were late.
- In 2007 black Caribbeans accounted for over a quarter (26%) of heterosexually acquired gonorrhoea diagnosed in a sample of genito-urinary medicine clinics in England and Wales.

Table 19: Total cases by ethnic group and year, SOPHID data (2007)

Ethnic Group	2003	2007	% change
White	173	317	83%
Black-Caribbean	< 5	< 5	-
Black-Africa	93	192	106%
Indian/Pakistani/ Bangladeshi	< 5	< 5	-
Other/not known	14	32	129%
TOTAL	283	553	95%

As Table 19 shows, White individuals carry the burden of HIV infection in terms of number of individuals seeking treatment. However, when we look at prevalence rates (Table 20) for NHS Hampshire, Black Africans carry a significant burden of disease – 22 per 1,000 for Black African men and 50 per 1,000 for Black African women. In comparison the prevalence in White males is 0.58 per 1,000 and White females is 0.12 per 1,000. Considering the small numbers of Black Africans living in Hampshire, the number of individuals living with HIV is quite high. Additionally, there has been a 106% increase in Black African individuals seeking HIV-related treatment over the past five years, over 20% more than the increase amongst White individuals.

Table 20: Total cases by ethnic group and year, SOPHID data (2006)

Ethnic Group	Sex	Individuals accessing care for HIV in 2006	% of all those accessing care	PCT population (women 15-49 yrs, men 15-64 yrs)	Individuals accessing care for HIV per 1000, 2006
White	M	224	49%	384700	0.58
	F	41	9%	348500	0.12
Black-Caribbean	M	6	1%	1300	4.62
	F	4	1%	1300	3.08
Black-African	M	44	10%	2000	22.00
	F	105	23%	2100	50.00
Indian/Pakistani/Bangladeshi	M	1	0%	6400	0.16
	F	1	0%	6100	0.16
Other (Black/Mixed/Asian Other)	M	14	3%	2500	5.60
	F	16	4%	2300	6.96
Total		**456**	**100%**		

Figure 7: Age of individuals seeking HIV-related care

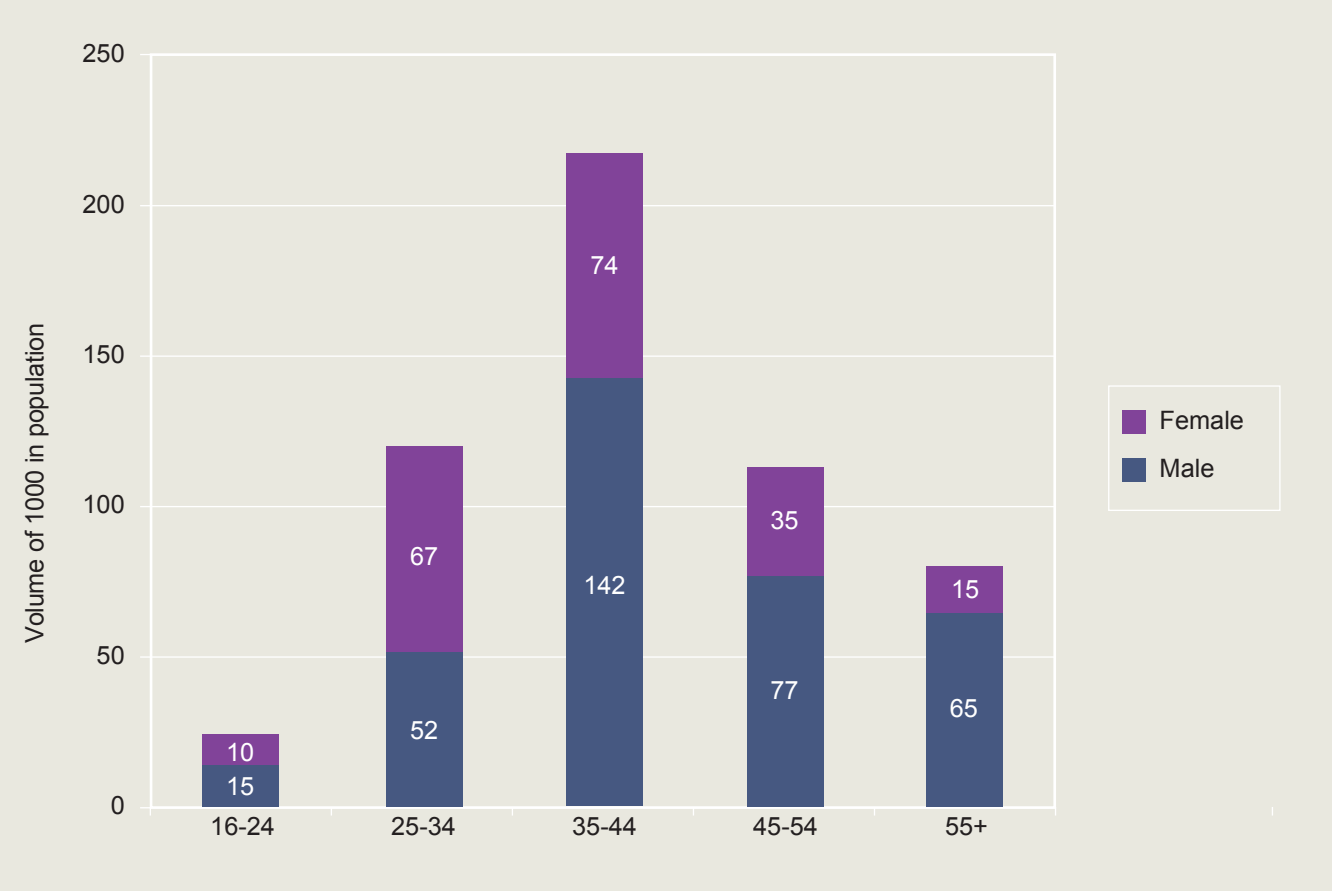


Figure 7 shows, the majority of HIV-infected individuals are between the ages of 35 and 44, accounting for 40% of all individuals living with HIV. Notably, there are more females than males in the 25–34 age category. Though we are limited by the SOPHID data collection system, we can infer that these are likely to be young Black African women, many of whom would have contracted HIV abroad. For the rest of the age categories, there are more males seeking treatment than females. This age stratification confirms that young Black African women and older MSM make up the majority of persons living with HIV in Hampshire.

Site of treatment

Hampshire residents seeking HIV-related treatment attend a number of different hospitals, with Portsmouth, Basingstoke, and Southampton seeing a combined total of 53.17%.

Table 21: Site of treatment with 2007 percentages (sites treating five individuals or less not listed)

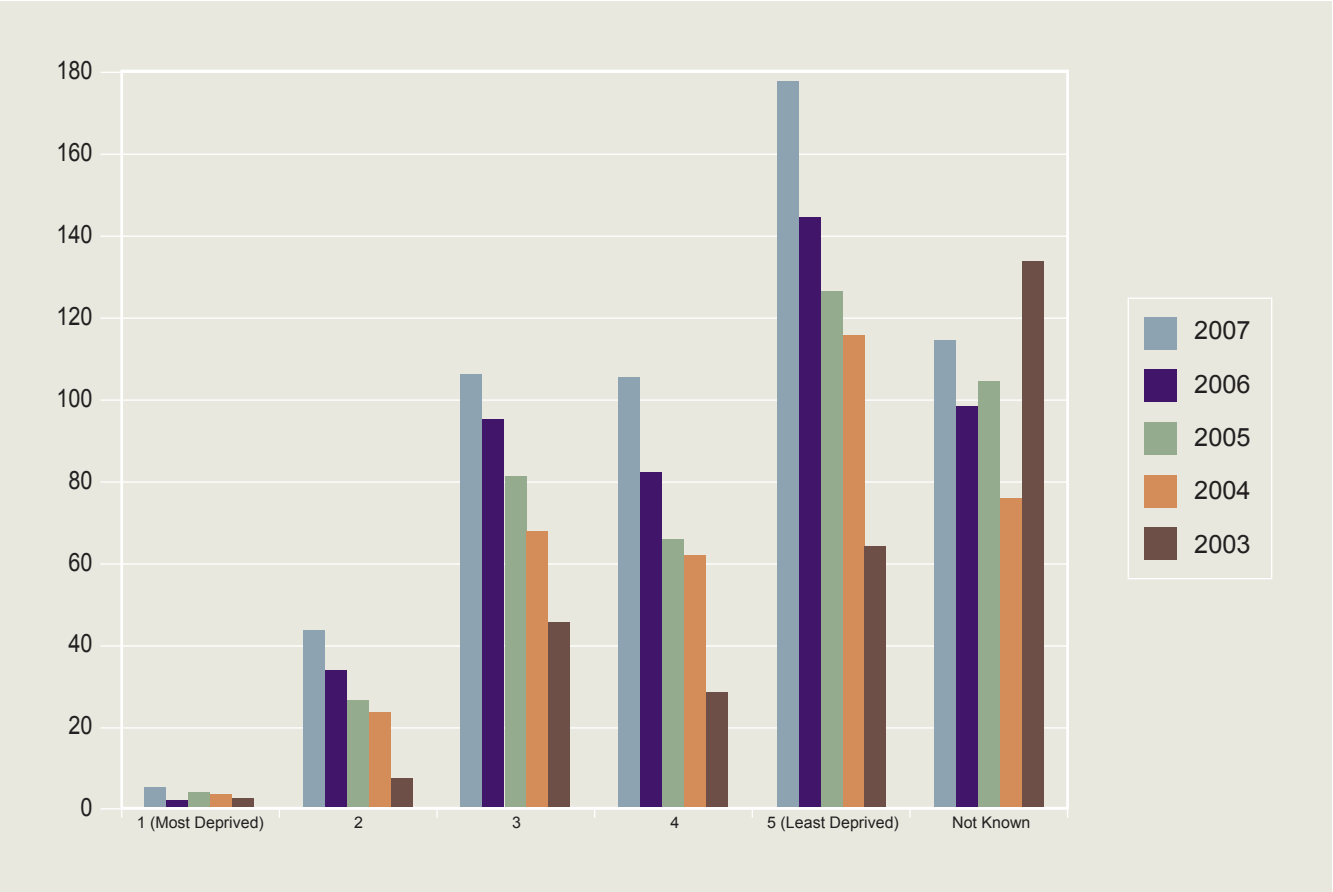
Site of treatment	Survey year					% (2007)
	2003	2004	2005	2006	2007	
Portsmouth - St Mary's Hospital	62	63	76	86	105	19.0%
Basingstoke - North Hampshire Hospital	36	54	66	74	95	17.2%
Southampton - Royal South Hants Hospital	51	59	68	78	94	17.0%
Frimley Park - Frimley Park Hospital	30	42	52	47	55	9.9%
Winchester - Royal Hampshire County Hospital	22	34	30	45	52	9.4%
Guildford - Farnham Road Hospital	23	26	28	30	34	6.1%
London - Chelsea & Westminster	19	18	22	20	23	4.2%
Bournemouth - Royal Bournemouth Hospital	<5	6	<5	11	19	3.4%
Reading - Royal Berkshire Hospital	<5	<5	5	5	9	1.6%
London - Royal Free Hospital	<5	6	8	6	8	1.4%
London - St George's Hospital	<5	5	<5	6	7	1.3%
London - Mortimer Market Centre	<5	5	<5	<5	6	1.1%

HIV and Deprivation

In 2007, SOPHID began reporting the numbers of diagnosed HIV-infected individuals by index of multiple deprivation and survey year. In NHS Hampshire there is an unusual relationship between deprivation and HIV prevalence. Across the UK, HIV prevalence tends to be concentrated in areas of higher deprivation; however, in Hampshire, the opposite is true. As Figure 8 illustrates, there are more HIV-positive individuals seeking treatment from the least deprived areas than the most deprived.

There are two possible explanations for this (again, limited by the depth of the data collected through SOPHID): 1) MSM tend to live in less deprived areas, and 2) there are a significant number of individuals for whom residence and thus deprivation ranking is not known in NHS Hampshire. It is possible that this data shows a combination of the prevalence among MSM living in the least deprived areas and a number of individuals who likely do live in the most deprived areas, but are not captured in these figures due to incomplete data collection.

Figure 8: Numbers of HIV-positive residents seeking treatment by area of deprivation (most > least deprived)



As Figure 8 shows, there is a clear relationship between area of deprivation and number of HIV-positive residents seeking treatment in NHS Hampshire. In 2007, 32% of the total number of HIV-positive individuals accessing care were residing in the most affluent areas in Hampshire whereas 1% were resident in the most deprived areas. The relationship illustrated in the graph could however be significantly altered if the unknown data was known. This highlights the need for accurate and comprehensive data collection.

HIV Testing in GUM

HIV testing should be offered as part of routine STI testing, regardless of presentation of symptoms.[21] Although KC60 returns tell us numbers of tests done, there is no information on the outcome of these tests and as a result only crude analysis has been carried out on the data supplied from GUM clinics in this respect.

21. BASHH guidelines

4.2.4.7 Hepatitis

Hepatitis B and C are blood-borne viruses. In general, hepatitis B in the UK is mainly spread through sexual contact and needle sharing and hepatitis C is primarily (to date) spread through blood transfusions (pre-1991) and needle sharing, but it can also be transmitted sexually.

BASHH screening guidelines for hepatitis B

Hepatitis B virus (HBV) infection can be transmitted vertically (mother to child), parenterally and sexually. There is a much lower risk to household contacts of acute cases and high infectivity carriers. Of those seen in GUM clinics, those at greatest risk of infection are MSM and injecting drug users. Acute HBV infection has an incubation period of 40–160 days with symptoms lasting up to 12 weeks. Fulminant hepatitis occurs in about 1% and may be fatal. A high proportion of infected adults are asymptomatic. About 5–10% of immunocompetent and up to 40% of immunocompromised patients develop chronic infection. Symptomatic acute infection very rarely leads to chronicity. Infectivity lasts from approximately two weeks before the onset of jaundice until the loss of infection markers. Cirrhosis or liver cancer may develop in up to 20% of chronic carriers over 10–50 years. Tests for HBV markers are indicated for diagnostic purposes and for screening. Screening serves the dual purpose of identifying those who are currently infected, and those who are immune by natural infection (and by elimination those who are still susceptible and should receive vaccine).

BASHH screening guidelines for hepatitis C

Hepatitis C virus (HCV) is transmitted parenterally, although there is a low rate of sexual and vertical transmission, which is more likely to occur within the setting of HIV/HCV co-infection. Acute icteric hepatitis is about 10% of infections. The majority (60–70%) develop chronic infection. As with HBV infection, cirrhosis and liver cancer ensue in 20% or more over the next 10–50 years.

KC60 Data on Hepatitis B Vaccinations

There were 568 Hepatitis B vaccinations (first dose only) administered in GUM clinics commissioned by NHS Hampshire in 2008, 73% of which were amongst males. Of these, 156 (38%) were amongst MSM.

Table 22 represents data collected as part of the KC60 data returns from GUM clinics on Hepatitis B Vaccinations (first dose only). The table represents rates of vaccination per 1000 clinic attendees and age for a 5 year period. In terms of dissecting this data, it is mostly relevant to look at the Department of Health target vaccination groups, although KC60 data is only able to identify the MSM target group. In 2008, the overall vaccination rate amongst MSM was 99 vaccinations per 1000 MSM attendances. The rates differ by clinic, with Royal Hampshire County Hospital highlighted as having the highest rate of vaccination amongst MSM attendees (333 vaccinations per 1000 MSM attendees in 2008), although numbers are small in this group so some caution must be employed here (51 attendances and 17 vaccinations). In general, it important to note that the core MSM target group are being prioritised in all clinics above the general population.

Table 22: Hepatitis B Vaccinations by GUM clinic and gender and sexual orientation, 2004-08 (KC60 data)

Rates of vaccination per 1000 attendees	Sex	2004	2005	2006	2007	2008
Total: ALL GUM	Male	20	21	22	20	17
	of which MSM	184	155	143	139	99
	Female	5	7	7	6	6
	Total	**13**	**14**	**14**	**13**	**11**
	Sex	**2004**	**2005**	**2006**	**2007**	**2008**
Frimley Park	Male	20	8	8	8	11
	of which MSM	412	73	133	163	185
	Female	7	5	4	5	7
	Total	**14**	**6**	**6**	**6**	**9**
	Sex	**2004**	**2005**	**2006**	**2007**	**2008**
North Hampshire Hospital	Male	32	34	25	28	24
	of which MSM	300	322	209	206	155
	Female	7	16	11	9	16
	Total	**20**	**26**	**18**	**19**	**20**
	Sex	**2004**	**2005**	**2006**	**2007**	**2008**
Royal Hampshire County Hospital (including Andover)	Male	18	13	21	27	30
	of which MSM	480	177	436	291	333
	Female	3	2	3	5	8
	Total	**10**	**7**	**11**	**15**	**18**
	Sex	**2004**	**2005**	**2006**	**2007**	**2008**
Royal South Hants Hospital , Southampton	Male	20	23	26	30	26
	of which MSM	117	165	120	149	103
	Female	4	6	9	9	5
	Total	**13**	**15**	**18**	**20**	**16**
	Sex	**2004**	**2005**	**2006**	**2007**	**2008**
**NB: only 3 quarterly returns for 2008						
St Mary's Hospital Portsmouth	Male	17	20	22	13	7
	of which MSM	137	92	122	99	56
	Female	4	7	7	4	3
	Total	**14**	**16**	**19**	**12**	**7**

HPA reporting of hepatitis

The HPA's 2007 final report on NOIDs (notification of infectious diseases) shows NHS Hampshire to have reported 46 cases of hepatitis B and 57 cases of hepatitis C over the year. The number of viral hepatitis infections reported for 2007 is slightly lower than for 2006, for which 22 cases were reported.

In the HPA's weekly report for the week ending 31/07/09 there were six reported cases of hepatitis (all types). Unfortunately, under-reporting of Hepatitis diagnoses to the HPA is common, meaning that the figures represented here may not be providing the complete picture of hepatitis in NHS Hampshire. Previous experience of Options UK has shown that direct data analysis from local laboratories provides a more complete picture of local infections, and, in many situations, there is a substantial difference between what is reported to the HPA and what has been diagnosed. Analysis of non-GUM data from the laboratory at Queen Alexandra Hospital in Portsmouth indicated that there were in fact 188 positive diagnoses of Hepatitis A, B and C over the period January – June 2009 (see Table 23) . Although not all of these will be attributable to NHS Hampshire residents, it indicates the possibility of under-reporting to the HPA.

Table 23: Hepatitis diagnoses in non-GUM settings, Queen Alexandra Hospital (January – June 2009)

	Negative	Positive	Grand Total
Hepatitis A	744	7	751
Hepatitis B	7596	63	7659
Hepatitis C	4082	118	4200
Grand Total	**12422**	**188**	**12610**

HM Prison Hepatitis B (HBV) Vaccination Programme

The Prison Infection Prevention Team (part of the HPA) was established in 2003 in order to monitor the hepatitis B vaccination programme being rolled out in prisons across the country. All new receptions to prisons are encouraged to be vaccinated against hepatitis B using the 'super accelerated schedule' which consists of a single dose of the HBV vaccine being administered on days 0, 7 and 21.[22] In order to assure optimum protection, the full three doses are required, as well as a blood test to check for antibody presence. Prisons are encouraged to join this vaccination programme in order to comply with the Key Performance Indicators for Prison Health.

Monitoring data from all prisons reporting on the programme is analysed using the most recently published monthly report (April 2009) in order to assess vaccination coverage in the prisons as well as the extent to which the full three doses of vaccine are administered.

An average of 80% of prisons in England and Wales reported data on the programme in 2008; however the South East Region (of which Hampshire is a part) had the highest proportion of prisons not reporting. Both of the two HM Prisons in NHS Hampshire (HMP Winchester and HMRC Haslar) failed to report on indicators for the programme monitoring. This highlights the need for an improved reporting system and communications between healthcare professionals, the prison service and commissioners in order to produce meaningful monitoring data.[23]

22. Health Protection Agency. 2008. Clinical Guidance on Prison Hepatitis B Vaccination: Frequently Asked Questions. London: HPA. Available at: http://www.hpa.org.uk/web/HPAweb-File/HPAweb_C/1205310735401

23. HPA Prison Infection Prevention Team. 2009. Infection inside: The prison infectious disease quarterly, 5 (2). London: HPA. Available at: http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1237192256416

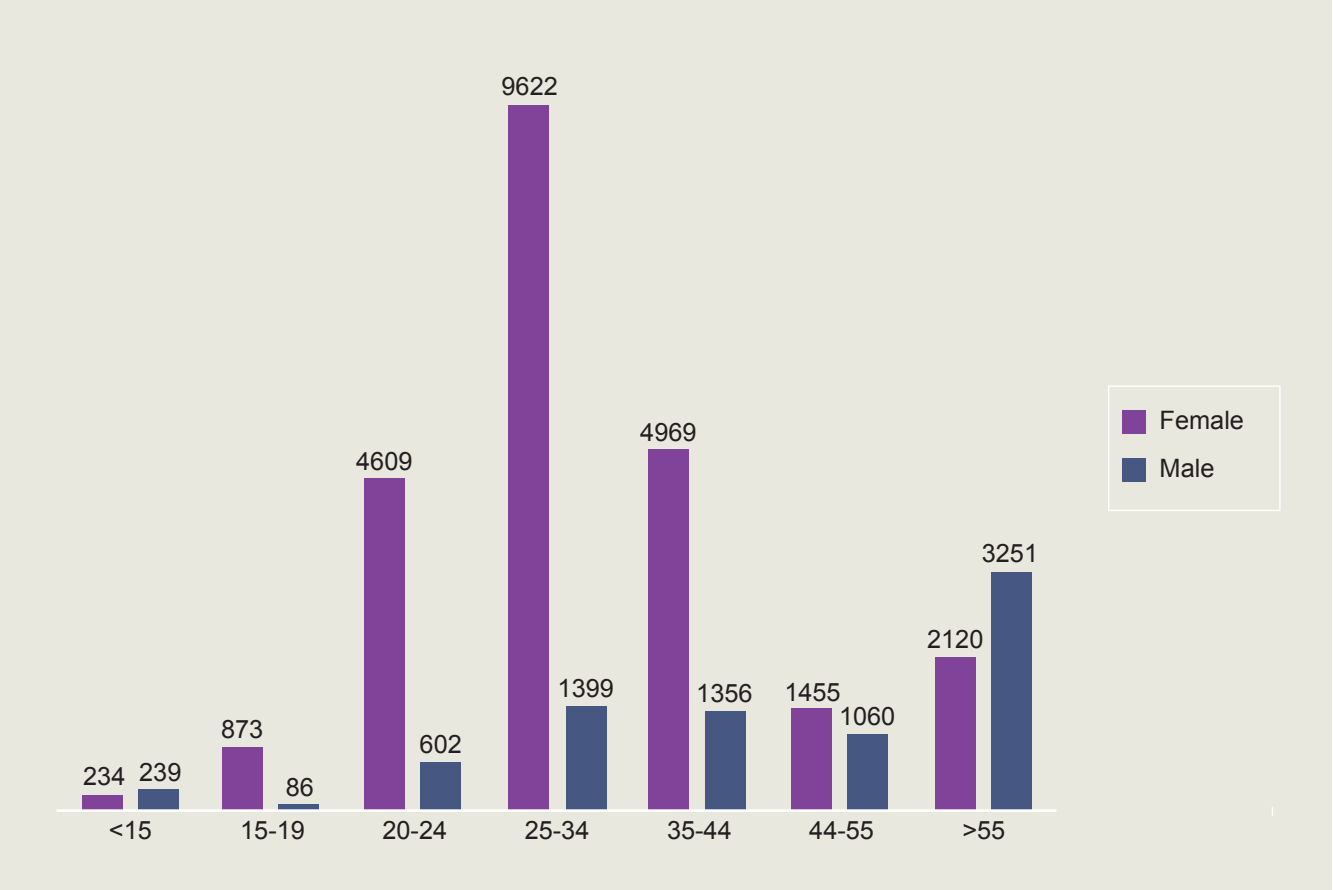
4.3 Non-GUM STI Data

STI data from non-GUM venues: Analysis has been carried out on data reports on the number of tests taken outside of GUM clinics in locations such as general practices and non-GUM hospital departments. One of the five pathology services commissioned by NHS Hampshire provided data for this analysis - The Department of Clinical Microbiology at Queen Alexandra Hospital in Portsmouth.

Comparing KC60 data to data from the local laboratories is usually a method for painting a more complete picture of STIs across the patch; however, caution should be exercised when interpreting analysis as KC60 data reports the number of positive test results only, whereas non-GUM data reports the total number of tests making comparisons difficult. Additionally, it is not possible to disaggregate the data by patient's PCT of residence, so particularly in the case of Portsmouth, caution must be employed in attributing findings to NHS Hampshire residents alone.

Analysis included tests done for the following eight STIs: chlamydia, gonorrhoea, Hepatitis A,B & C, genital herpes, syphilis, and HIV.
The dataset required a certain amount of cleaning, and in total 4048 records from Portsmouth were excluded from the analysis. These exclusions were made where incomplete information was provided (predominantly on gender or age) or test results were inconclusive.

Figure 9: Age and sex breakdown of total STIs tested at non-GUM locations, Queen Alexandra Hospital Microbiology, January – June 2009



4.3.1 Total Tests Done

Portsmouth
After data cleaning, we performed an analysis of 31,875 tests that were reported by the Department of Microbiology at Queen Alexandra Hospital between January and June 2009. The samples were from tests carried out at general practices, in hospital settings, and through the Military Services (Ministry of Defence and Prison Services).

4.3.2 Age & Gender Disaggregation

Portsmouth

Figure 9 illustrates the age and gender related to the tests performed. 75% of tests were taken from females (n=23,882) in comparison to males (n=7,993). This is most pronounced amongst the 25-34 year old age groups, although this trend is reversed in the older ages, with males above 55 years of age having more tests carried out than females of that age. Overall, the largest proportion (35%) of tests carried out were amongst the 35-44 year age group, although when disaggregated by sex, the proportion of tests carried out amongst females is considerably higher (40%) in the 25-34 year age group, and male tests fall relatively equally between these two age groups (17% and 18% respectively).

4.3.3 STI Disaggregation

Portsmouth

Of the 31,875 tests undertaken over the period analysed, a quarter (n=7,811) were testing for chlamydia and a similar proportion (n=7,659) for Hepatitis B. The STI that was tested for the least was genital herpes, for which only 237 tests were carried out.

Table 24 provides a breakdown of tests carried out for each STI, disaggregated by age and gender.

Table 24: STIs tested at non-GUM locations by age and gender, Queen Alexandra Hospital Microbiology, January – June 2009

		M	F	Total
Chlamydia	<15	32	8	40
	15-19	393	45	438
	20-24	1316	283	1599
	25-34	2594	381	2975
	35-44	1769	179	1948
	44-55	587	86	673
	>55	94	44	138
	Total	6785	1026	7811

		M	F	Total
Genital Herpes	<15	3		3
	15-19	12	1	13
	20-24	63	1	64
	25-34	67	1	68
	35-44	42	2	44
	44-55	25	4	29
	>55	16		16
	Total	228	9	237

		M	F	Total
Gonorrhoea	<15	129	150	279
	15-19	38	2	40
	20-24	217	12	229
	25-34	361	37	398
	35-44	258	40	298
	44-55	107	27	134
	>55	48	45	93
	Total	1158	313	1471

		M	F	Total
HIV	<15	8	10	18
	15-19	126	2	128
	20-24	946	46	992
	25-34	2061	185	2246
	35-44	828	233	1061
	44-55	131	151	282
	>55	256	458	714
	Total	4356	1085	5441

Total STI Tests	
Male	7993
Female	23882
Total	31875

		M	F	Total
Syphilis	<15	2	2	4
	15-19	124	3	127
	20-24	936	24	960
	25-34	2002	94	2096
	35-44	717	95	812
	44-55	41	54	95
	>55	93	118	211
	Total	3915	390	4305

		M	F	Total
Hepatitis A	<15	11	17	28
	15-19	10	4	14
	20-24	23	19	42
	25-34	46	65	111
	35-44	56	56	112
	44-55	42	60	102
	>55	153	189	342
	Total	341	410	751

		M	F	Total
Hepatitis B	<15	24	24	48
	15-19	139	13	152
	20-24	988	73	1061
	25-34	2168	268	2436
	35-44	940	354	1294
	44-55	249	337	586
	>55	782	1300	2082
	Total	5290	2369	7659

		M	F	Total
Hepatitis C	<15	25	28	53
	15-19	31	16	47
	20-24	120	144	264
	25-34	323	368	691
	35-44	359	397	756
	44-55	273	341	614
	>55	678	1097	1775
	Total	1809	2391	4200

Portsmouth
Of the 31,875 tests undertaken, 593 produced a positive result for the eight STIs analysed (chlamydia, gonorrhoea, Hepatitis A, B & C, genital herpes, syphilis, and HIV). This translates into an overall rate of 1.9 positive results for every 100 tests carried out.

Table 25 disaggregates these rates by STI and gender, highlighting the variations. Of note, are the particularly high rates of positive results of genital herpes, however this is largely due to the fact that testing for genital herpes is generally performed for diagnostic reasons (i.e. when signs and symptoms of genital herpes are present), whereas the other STI tests are often performed as a general screen (i.e. even when no signs and symptoms are present). Hepatitis B diagnoses (defined as HBsAg positive) are relatively high, particularly amongst males; however without additional information on sexual orientation and ethnic origin, it is difficult to draw further conclusions. Some of these diagnoses will include chronic carriers (without a complete clinical picture we were unable to differentiate), so this again is not a useful marker of acute infections in the local community. This highlights the importance of core dataset reporting in line with the national GUMCAD reporting system for GUM clinics.

Table 25: Positivity rates per 100 tests done by STI and gender, Queen Alexandra Hospital Microbiology, January – June 2009[24]

Sex	Female			Male		
STI	No. tested	No. positive	Positivity rate per 100 tests	No. tested	No. positive	Positivity rate per 100 tests
Chlamydia	6785	214	**3.2**	1026	84	**8.2**
Gonorrhoea	1158	0	**0.0**	313	0	**0.0**
Hepatitis A	341	5	**1.5**	410	2	**0.5**
Hepattis B	5290	28	**0.5**	2369	35	**1.5**
Hepatitis C	1809	35	**1.9**	2391	83	**3.5**
Genital Herpes	228	63	**27.6**	9	4	**44.4**
HIV	4356	15	**0.3**	1085	11	**1.0**
Syphilis	3915	9	**0.2**	390	5	**1.3**
Total	**23882**	**369**	**1.5**	**7993**	**224**	**2.8**

Further analysis of chlamydia tests carried out has been undertaken in order to provide a clearer picture of the age and gender differences in positive results (see Table 26). The high rates amongst both sexes fall in the 15-19 and the 20-24 year age groups, however the rates are consistently higher amongst tests done on males. This gender skew may be compounded by the fact that women are more likely to be screened when they are asymptomatic (often during cervical screening), whereas men may be more likely to get screened only when they present with symptoms.

24. There were 44 results labelled as 'low positive' which have been included as 'positive' for analysis purposes. The majority of these results were from HIV (14) and Hepatitis B (14) tests. These results have been considered by the lab as positive results, but it has been indicated to the requesting clinician that it is a weak result which may have some bearing on the management of the patient.

Table 26: Positivity rates by age and sex for Chlamydia tests done, Queen Alexandra Hospital Microbiology, January – June 2009

Age Group	Sex	Total tested	Positive	Rate per 100 tests done
<15	F	32	0	0.0
	M	8	0	0.0
15-19	F	393	32	8.1
	M	45	9	20.0
20-24	F	1316	92	7.0
	M	283	40	14.1
25-34	F	2594	75	2.9
	M	381	25	6.6
35-44	F	1769	11	0.6
	M	179	8	4.5
44-55	F	587	4	0.7
	M	86	1	1.2
>55	F	94	0	0.0
	M	44	1	2.3
Total		**7811**	**298**	**3.8**

4.3.5 Location Analysis

Portsmouth
Testing in hospital settings was the most common, with 25,186 tests carried out from January to June 2009. This represents 79% of all tests performed. General Practice carried out 6089 tests (19%) and Military Services 600 (2%).

Table 27 presents results from all tests done by STI and location. Rates of positive results per 100 tests done are significantly higher in the tests carried out by the Services (3.7 positive results per 100 tests done) compared to tests done in General Practice (2.8 positive results per 100 tests done) and in Hospital settings (1.6 positive results per 100 tests done).

Table 27: Test results by STI and location of test, Queen Alexandra Hospital Microbiology, January – June 2009

	General Practice		Hospital		Services	
	Negative	Positive	Negative	Positive	Negative	Positive
Chlamydia	2911	86	4419	199	183	13
Gonorrhoea	703	0	748	0	20	0
Hepatitis A	253	5	470	2	21	0
Hepattis B	797	24	6679	36	120	3
Hepatitis C	634	32	3346	83	102	3
Genital Herpes	29	11	141	55	0	1
HIV	376	7	4950	18	89	1
Syphilis	218	3	4030	10	43	1
Total	**5921**	**168**	**24783**	**403**	**578**	**22**

4.4 Teenage Pregnancy

National-level data:
NHS Hampshire reported a total of 763 under-18 conceptions in 2007, translating to a rate of 31.7 pregnancies per 1,000 female population aged 15–17 years. This rate is lower than regional (32.8) and national rates (41.7). In terms of the change in rates since the 1998 baseline, NHS Hampshire has seen a rate reduction of 12%, indicating that it has made higher than average progress in comparison to national reductions (-10.7%).

Data analysed as a rolling three-year average is represented in Table 28. It shows trends in conceptions since 1998 in NHS Hampshire, broken down to Local Authority level. The highest and lowest rates, proportions leading to abortion and changes in rates have been highlighted in red and green for the latest reporting period. The LA with the highest rate in 2005–2007 was Gosport, with a rate of 52.5 pregnancies per 1,000 female population aged 15–17 years. The rate has increased 3.9% since the baseline. There is also a low proportion leading to abortion in Gosport, suggesting potential barriers to accessing abortion services for this population group. Havant has a similarly high rate (41.7) and low percentage leading to abortion, but in contrast to Gosport, shows a rate reduction of 25.3%, the largest reduction of all the LAs.

Table 28: Under-18 conception rates, 1998–2007

	1998-00			2001-03			2004-06			2005-07			% change in rate
	Number	Rate	% leading to abortion	Number	Rate	% leading to abortion	Number	Rate	% leading to abortion	Number	Rate	% leading to abortion	98/00 - 05/07
ENGLAND	119,036	45.0	43.6	117,364	42.5	46.0	118,567	41.2	47.0	119,272	41.2	49.0	-8.5%
South East SHA	15,527	36.6	45.8	14,984	34.1	48.2	15,630	33.5	0.5	15,747	33.3	51.0	-9.0%
Hampshire County	**2,230**	**33.3**	**45.7**	**2,154**	**31.2**	**47.1**	**2253**	**31.2**	**0.5**	**2294**	**31.7**	**52.0**	**-4.9%**
Basingstoke and Deane	298	36.3	40.9	313	37.1	47.0	281	33.1	0.5	304	35.4	50.0	-2.4%
East Hampshire	143	22.9	44.8	135	20.6	36.3	162	23.3	0.6	168	24.2	57.0	5.9%
Eastleigh	181	27.9	53.6	174	26.1	58.6	196	27.2	0.5	204	28.4	54.0	1.8%
Fareham	163	29.9	54.6	155	25.0	54.8	157	25.0	0.6	176	28.2	63.0	-5.7%
Gosport	218	50.5	35.8	203	45.5	40.9	232	51.8	0.5	230	52.5	47.0	3.9%
Hart	100	21.0	62.0	75	16.3	57.3	83	17.0	0.5	89	17.7	62.0	-15.6%
Havant	380	55.8	37.4	336	47.1	36.6	300	42.2	0.4	291	41.7	46.0	-25.3%
New Forest	268	32.5	49.3	272	31.5	52.2	294	31.9	0.5	280	30.5	49.0	-6.0%
Rushmoor	184	39.6	41.8	194	40.1	50.0	209	43.1	0.5	191	39.0	47.0	-1.6%
Test Valley	172	29.7	48.8	167	28.6	41.9	203	30.6	0.5	219	32.5	53.0	9.4%
Winchester	123	20.8	59.3	130	22.7	56.2	136	21.8	0.6	142	22.5	61.0	8.1%

Local teenage pregnancy data:

Data supplied by NHS Hampshire detail the breakdown of the outcome of under-18 pregnancies in 2008 by local authority. Basingstoke and Deane had a total of 126 teenage conceptions, a figure much higher than other LAs. Out of the 627 pregnancies detailed in the data set, 329 (52%) of under-18 conceptions resulted in a delivery and 298 (48%) resulted in a termination. The proportion of the pregnancies carried to term varies by LA, ranging from 31% in Hart to 55% in the New Forest.

Important note: Data for terminations carried out by Portsmouth City PCT (Ella Gordon Unit) are only available at the aggregated Hampshire PCT level. There were 550 terminations in 2007/08 and 341 for April to November 2008/09. In order to carry out a comprehensive comparison of teenage conception data across LAs, data from the South East is needed.

Table 29: Outcome of under-18 pregnancy by LA, 2008

LA Name	Deliveries	Terminations	Proportion carried to term	Total
Basingstoke and Deane	57	69	45%	126
East Hampshire	22	28	44%	50
Eastleigh	29	34	46%	63
Fareham	19	-	-	-
Gosport	34	-	-	-
Hart	11	25	31%	36
Havant	39	-	-	-
New Forest	41	33	55%	74
Rushmoor	26	46	36%	72
Test Valley	36	33	52%	69
Winchester	15	26	37%	41
Total	**329**	**298**	**52%**	**627**

4.5 Abortion

Of the 3,195 abortions that took place in NHS Hampshire in 2008, 95% were NHS-funded. This proportion is higher than both the national (91.0%) and regional (93.4%) averages. The age groups with the highest rate are the 18–19 year olds and the 2—24 year olds, both with a rate of 25 abortions per 1000 female population. This figure is significantly lower than national rates for both age groups (34 and 32 respectively) but at similar levels to the regional averages (26 and 25 respectively).[25] 76.7% of these NHS-funded abortions were performed at under 10 weeks gestation, a figure slightly higher than both national and regional averages, indicating that access to abortion services in NHS Hampshire is good.

Table 30: Abortion rates per 1,000 female population (15-44 years) by age, 2008

	Age							
	Total no. of abortions	**Overall rate**	**<18**	**18-19**	**20-24**	**25-29**	**20-34**	**35+**
England	186,218	18.3	19	34	32	24	16	6.8
South Cental SHA	11,934	15	15	26	25	19	13	6
Hampshire	3,195	14	17	25	25	18	13	5
National difference	-	-4.30	-2.00	-8.50	-6.70	-6.00	-2.70	-1.80
Regional difference	-	-1.00	2.00	-1.00	0.00	-1.00	0.00	-1.00

It is possible to see from the table above that age-specific abortion rates for NHS Hampshire differ significantly from the national and regional rates. Rates in Hampshire are consistently lower than or equal to regional and national ones, except for in the under-18 year olds for whom Hampshire's rate is higher than the regional one. The difference with the national rate is most pronounced in the 18–19 year bracket where there is an 8.5% difference.

Data from 2008 shows 10.1% of women under 19 years of age undergoing abortions in NHS Hampshire had previously undergone one or more abortions in their lifetime. This figure indicates that there could be a gap in providing follow-up advice on contraceptives (especially LARCs) to these women after undergoing their first abortion. This figure is, however, lower than the national figure of 11.0%. There is a similar dynamic seen in repeat abortion data for women under 25 years, NHS Hampshire having a proportion of 20.4% if women under 25 years had previously undergone an abortion and the England average being 24.4%.

25. National Abortion Data, 2008.

4.6 Contraception

4.6.1 KT31 Data on Contraceptive Services

KT31 data collects information on contacts at community contraception services (CCS) and is currently under revision by DH as current data are flawed. KT31 collects the gender, age, first contact and total number of service contacts. The method of contraception chosen is recorded only at first visit, missing those women who switch methods – especially to the use of long-acting reversible contraception (LARC). Caution should therefore be exercised when interpreting the KT31 data, as data are recorded by first attendance data only and can give no account of the frequency of an individual's annual attendances or changes in contraceptive method at subsequent visits. The open access to CCS means that KT31 does not collect residence data and it is not possible to give a breakdown of clinic attendees by PCT of residence. It also does not adequately reflect the full range of work of CCS, including training, chlamydia screening, cervical cytology screening, abortion referrals, follow-up and complex contraception provision outside of first visits.

In 2007–2008, there were 6,000 first contacts made at contraception clinics located in NHS Hampshire,[26] 5,500 (92%) of which were by females. As with many contraception clinics, very few men attend. Data from

Table 31: KT31 First Contacts with women by age and method, 2007–2008

	Total first contacts with women	Age Breakdown			Method breakdown			
		women < 20 yrs	women 20-34 yrs	women 35+ yrs	LARCs	User dependent methods	Other methods	No Method provided/ contact for other reason
England	1,110,300	30%	48%	22%	16%	51%	4%	29%
South Central SHA	69,400	31%	51%	19%	14%	50%	3%	33%
Hampshire Community Healthcare	2,700	52%	35%	14%	11%	51%	2%	35%
Winchester & Eastleigh CT	2,800	35%	48%	17%	29%	56%	1%	14%
Southampton City PCT	8,600	28%	58%	15%	15%	39%	2%	44%
Portsmouth City PCT	21,300	32%	49%	19%	15%	57%	1%	27%

Hampshire Community Healthcare clinics shows that of these first contacts made by women, 52% were made by women under 20 years old (see Table 31), a figure that is significantly higher than national (30%) and regional figures (31%). This indicates excellent access to contraceptive services for young women in NHS Hampshire. As many NHS Hampshire residents access contraceptive clinics in Southampton and Portsmouth, data has been provided on these trusts as well. Of note, is the relatively high number of first contacts with women in Portsmouth City PCT (21,300), indicating the high uptake of contraceptive services in the area.

Provision of long-acting reversible contraception in clinics situated in NHS Hampshire (including Hampshire Community Healthcare and WEHCT) averages 20%, a figure notably higher than both regional and national averages. This is largely due to a particularly high proportion of LARC provision through WEHCT (29% LARCs). This is a positive indicator and it must be recognised as an example of good practice.

26. This figure includes data from NHS Hampshire as well as Winchester and Eastleigh Healthcare Trust (WEHCT).

LARC provision in Southampton City PCT and Portsmouth City PCT is roughly similar to national and regional figures. Many first visits may be primarily for information or in some circumstances women may need to return to clinics to commence contraceptive methods – therefore, the low level of LARCs supplied could be slightly underestimated – a limitation of current KT31 data.

Varying proportions of women did not receive any contraception at their first visit. There may be clinical reasons for this, but this may also represent missed opportunities for those who are then lost to follow-up. Of particular note here is the low proportion in WEHCT (14%) and the higher proportion in Southampton City PCT (44%).

4.6.2 Electronic Prescribing Analysis and Cost (ePACT)

It is estimated that, nationally, approximately three-quarters of all contraception provision is through general practice.[27] GP prescribing ePACT data gives a further level of intelligence of contraceptive supply. In practice, the majority of this prescribing data will represent prescribing for the resident population.

Table 32 contains analysis of GP prescribing behaviour over the financial year 2008/09 at National, SHA and local NHS level. The analysis demonstrates the high use of traditional user-dependent methods at all levels such as the pill (combined hormonal contraceptives represented 63.7% of all prescriptions for NHS Hampshire) compared to non-user-dependent methods, which are more cost-effective and have significantly lower failure rates. For example, the typical-use failure rates for the combined pill and the mini pill are 8 in 100 within the first year of use, whereas typical-use failure rates for IUDs are 2 in 100 within the first year of use for Progestasert and 0.8 in 100 within the first year of use for ParaGard.[28] NICE guidance (2005) encourages clinicians to shift to LARC methods. LARC prescriptions, highlighted in the table below make up 11.8% of all prescriptions for NHS Hampshire, a proportion slightly lower than both regional (12.5%) and national (13.0%) averages.

27. Department of Health. Available at: http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Sexualhealth/Sexualhealthgeneralinformation/DH_4001998

28. 'Long-acting reversible contraception – The effective and appropriate use of long-acting reversible contraception' National Collaborating Centre for Women's and Children's Health. Commissioned by the National Institute for Health and Clinical excellence. October 2005.

Table 32: Contraceptives Prescribed by GPs in NHS Hampshire, Financial year 2008/09

	England			SHA			NHS Hampshire		
Contraceptives Prescribed	**Items**	**%**	**Cost**	**Items**	**%**	**Cost**	**Items**	**%**	**Cost**
Combined Hormonal Contraceptives	5692992	64.2%	£44,250,717.88	474175	63.6%	£3,867,904.56	133065	63.7%	£1,068,354.64
Contraceptive Devices*	4504	0.1%	£29,226.48	475	0.1%	£3,047.16	127	0.1%	£804.14
Emergency Contraception	262854	3.0%	£1,569,262.26	19668	2.6%	£117,108.61	4891	2.3%	£30,383.11
Progesterone-only contraceptives**	1744933	19.7%	£13,400,811.32	156898	21.1%	£1,239,694.69	45797	21.9%	£362,367.11
Spermicidals	9948	0.1%	£71,884.91	1149	0.2%	£8,376.80	271	0.1%	£1,989.02
LARCs	1148215	13.0%	£19,405,054.12	92862	12.5%	£1,796,686.70	24648	11.8%	£545,953.50
Total	**8863446**	**100.0%**	**£78,726,956.97**	**745227**	**100.0%**	**£7,032,818.52**	**208799**	**100%**	**£2,009,851.52**
LARC Breakdown									
IUCDs	41314	3.6%	£451,819.12	3600	3.9%	£38,602.23	807	3.3%	£8,743.58
IUD Progestogen-only	105130	9.2%	£8,140,112.50	11428	12.3%	£882,765.55	3658	14.8%	£281,384.21
Parenteral Progestogen-only	1001771	87.2%	£10,813,122.50	77834	83.8%	£875,318.92	20183	81.9%	£255,825.71
LARC Total	**1148215**	**100.0%**	**£19,405,054.12**	**92862**	**100.0%**	**£1,796,686.70**	**24648**	**11.8%**	**£545,953.50**
* includes contraceptive caps, diaphragms, fertility thermometers									
** excludes LARCS									

Figure 10: GP Prescribing of Contraceptives by GPs in NHS Hampshire, Financial year 2008/09

Further analysis of this data shows the average LARC prescription rate to be 167 LARC prescriptions per 1,000 women aged 15–49. There is, however, significant variation in rates between the practices, ranging from 4 to 258 prescriptions per 1,000 women aged 15–49 (see Table 33).

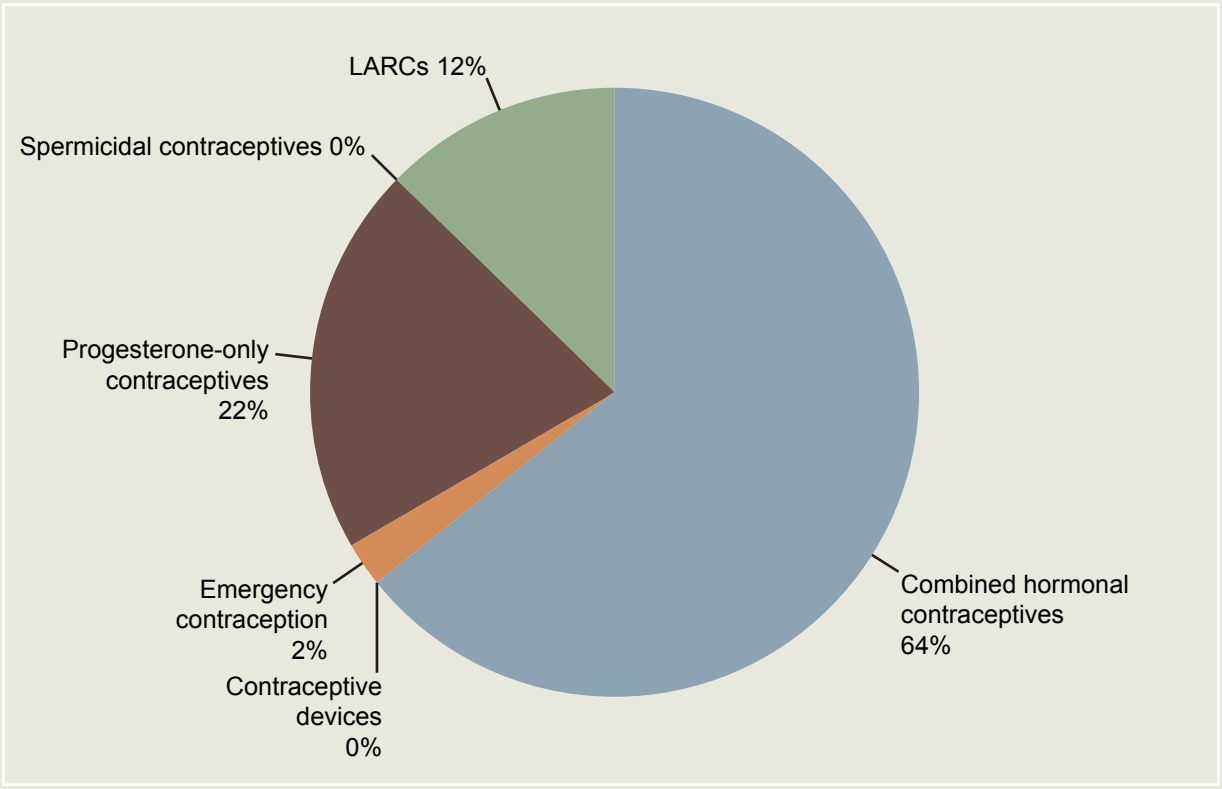


Table 33: Selected anonymised prescribing indicators for the lowest and highest LARC prescribing practices, NHS Hampshire

GP Contraceptive Prescribing Data		Proportion of prescriptions LARCs		Rate of Prescribing (all contraceptives)	Prescription rate (LARCs)	Spend on contraceptives
		ID	%	Rate per 1000 women (15-49 yrs)	Rate per 1000 women (15-49 yrs)	Spend per woman (15-49 yrs)
5 lowest practices* (1 being lowest)	1	7	0.6%	722	4	£ 5.49
	2	2	1.6%	721	11	£ 4.11
	3	20	3.7%	546	20	£ 4.88
	4	5	4.4%	599	26	£ 4.66
	5	6	4.7%	696	33	£ 7.35
5 highest practices* (5 being highest)	1	11	22%	661	146	£ 3.18
	2	130	23%	698	157	£ 7.29
	3	55	23%	631	144	£ 6.73
	4	147	24%	529	128	£ 9.21
	5	19	37%	696	258	£ 4.38
Average			12.1%	706	167	£ 6.58
Minimum			0.6%	430	4	£ 3.18
Maximum			37%	1203	258	£ 10.37

The average spend on contraceptive prescriptions across the GP surgeries was significantly lower than across PCTs nationally, being £6.58 per female aged 15–49 registered with NHS Hampshire GPs and £11.67 per female aged 15–49[29] nationally. Please note, however, that this national figure refers to all community contraceptive services, including primary care prescriptions and emergency contraception. Table 34 breaks down these same indicators by locality. It is evident that of all contraceptives prescribed by General Practitioners, higher proportions of LARCs are being prescribed by practitioners in the South East Locality.

29. Department of Health – 'Findings of the baseline review of Contraceptive Services' 2007.

Table 34: Selected anonymised prescribing indicators by locality, NHS Hampshire

GP Contraceptive Prescribing Data		Proportion of prescriptions LARCs	Rate of Prescribing (all contraceptives)	Prescription rate (LARCs)
		%	Rate per 1000 women (15-49 yrs)	Rate per 1000 women (15-49 yrs)
West Locality	Average	11.5	711.2	81.3
	Minimum	3.7	429.8	20.4
	Maximum	22.7	991.3	143.5
North & East Locality	Average	11.9	702.9	82.8
	Minimum	0.6	513.4	4.4
	Maximum	24.2	1203.1	185.7
South East Locality	Average	12.8	704.1	88.5
	Minimum	4.7	446.1	32.5
	Maximum	37.0	1168.0	257.6

4.6.3 Pharmacy Prescribing of EHC

Data on consultations at pharmacies in NHS Hampshire providing free EHC is presented in Table 33. EHC is available free for women of any age at 140 of the 218 pharmacies across NHS Hampshire[30]. Data is collected on every consultation for EHC that the pharmacist undertakes, including when no contraception is prescribed, although over the period analysed 96% of consultations resulted in EHC being prescribed.

Over the year April 2008-March 2009 the majority (54%) of consultations occurred 12 - 24 hours after intercourse, with a sizeable proportion (22%) also occurring between 24-48 hours after. EHC is more effective the sooner it is taken after intercourse, therefore quick and easy access to EHC is important. Mondays and Saturdays were the most common days of the week for EHC consultations in pharmacies. This highlights the need for weekend access to EHC. The age group most commonly accessing EHC via pharmacies during the year analysed was 17-19 year olds, followed by 14-16 year olds. This suggests that there is relatively high awareness of EHC amongst young people across Hampshire.

Table 35: Pharmacy EHC prescriptions in NHS Hampshire, March 2008-April 2009

Time to Consultation (*2 unknown values excluded)						
EHC given	**<12hrs**	**12-24hrs**	**24-48hrs**	**48-72hrs**	**72hrs+**	**Total**
Yes	1028	3456	1391	499	10	6384
No	70	122	57	32	11	292
Total	1098	3578	1448	531	21	6676
% of total	16.4%	53.6%	21.7%	8.0%	0.3%	

Weekday								
EHC given	**Monday**	**Tuesday**	**Weds**	**Thurs**	**Friday**	**Saturday**	**Sunday**	**Total**
Yes	1549	958	681	698	905	1055	538	6384
No	88	58	25	39	23	45	16	294
Total	1637	1016	706	737	928	1100	554	6678
% of total	24.5%	15.2%	10.6%	11.0%	13.9%	16.5%	8.3%	

Age (*10 unknown values excluded)											
EHC given	**10-13**	**14-16**	**17-19**	**20-22**	**23-25**	**26-29**	**30-34**	**35-39**	**40-44**	**45+**	**Total**
Yes	35	1483	2248	860	494	434	352	250	140	78	6374
No	3	87	117	35	22	11	12	5	1	1	294
Total	38	1570	2365	895	516	445	364	255	141	79	6668
% of total	0.6%	23.5%	35.5%	13.4%	7.7%	6.7%	5.5%	3.8%	2.1%	1.2%	

30. Data provided by NHS Hampshire in May 2009.

2
Service Reviews

5.1 Introduction

This section focuses on the design of contraception and sexual health services in NHS Hampshire from a service user perspective; it does not assess clinical aspects of care. The section is divided into four parts: Service Mapping, Service Overviews, Service User Knowledge and Awareness and Future Models of Care for Contraception and Sexual Health Services.

- The **Service Mapping** section is comprised of a series of maps and timetables that seek to demonstrate visually the distribution and accessibility of contraception, sexual health and related services in NHS Hampshire, highlighting areas in potential need of service development
- The **Service Overview** section focuses on the contraception and sexual health services visited by Options UK's service design team as part of this SHNA. Key recommendations are made for each service based on interviews with service providers, service users and the observations of the service design team.
- The **Service User Knowledge and Awareness** section details service users' knowledge and awareness of other existing services and issues including contraceptive methods, STIs and access to abortion services.
- **Future Models of Care for Contraception and Sexual Health Services** details the preferences expressed by service users and ideas put forward by service providers for the future of contraception and sexual health services in NHS Hampshire.

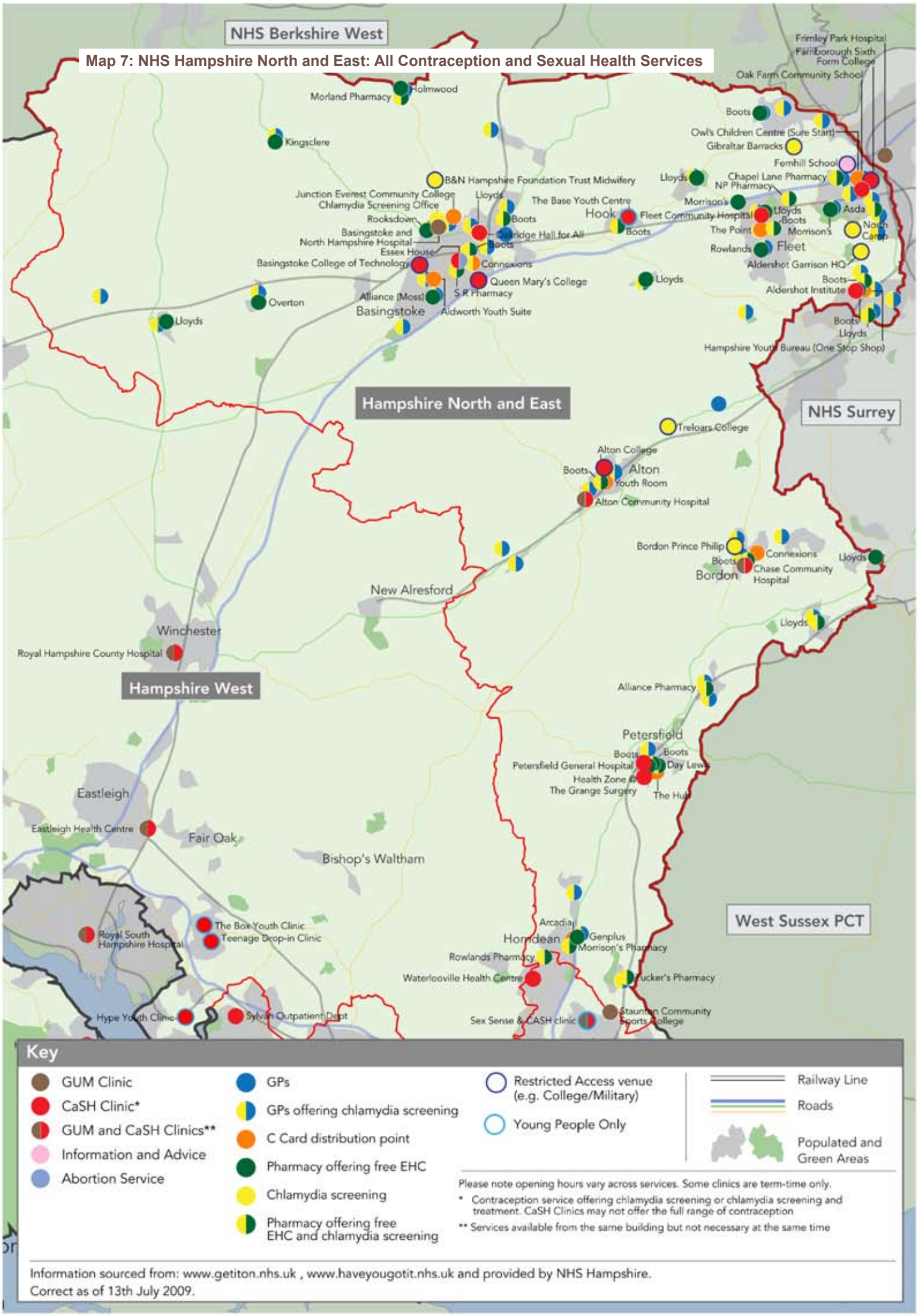
5.2 Service Mapping

The maps included in this section give an overview of service coverage. They show where services are, what they provide and how they relate to each other in terms of the geography and demographics of the area. The maps included in this report are intended to be used as guides only and may not be accurate to a street level.

To give a fuller impression of the services available, timetables have been created to complement the maps. Together the maps and timetables show service coverage and availability across NHS Hampshire.

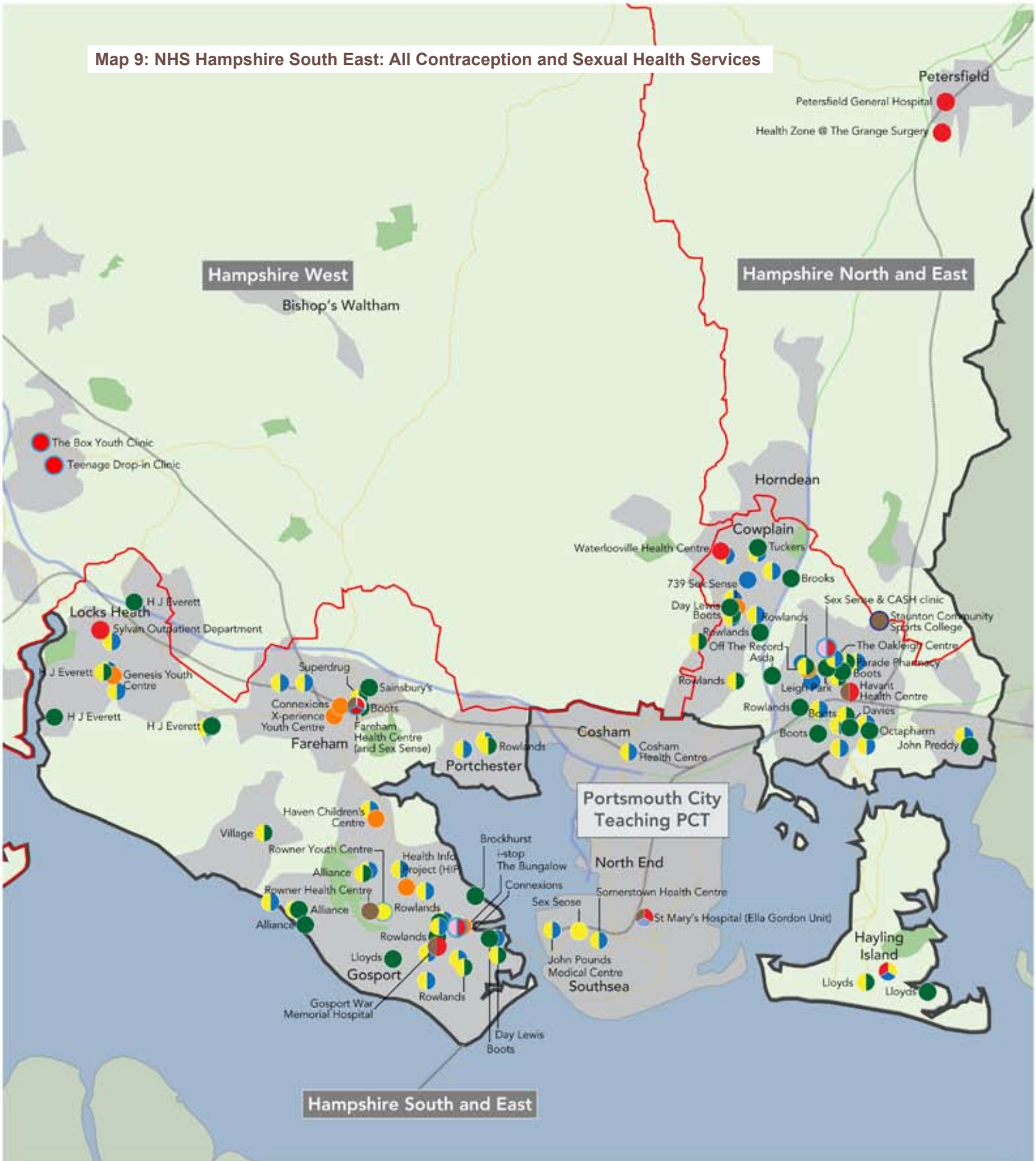
NHS Hampshire is divided into three areas: NHS Hampshire North and East, NHS Hampshire West and NHS Hampshire South East. Options UK have mapped services according to the boundaries of these areas.[31]

31. Area boundaries provided by NHS Hampshire, originally plotted by Dotted Eyes Digital Mapping Solutions: http://www.dottedeyes.com/


NHS Berkshire West
Map 7: NHS Hampshire North and East: All Contraception and Sexual Health Services
Frimley Park Hospital
Farnborough Sixth Form College
Oak Farm Community School
Holmwood
Morland Pharmacy
Kingsclere
Boots
Owl's Children Centre (Sure Start)
Gibraltar Barracks
Fernhill School
B&N Hampshire Foundation Trust Midwifery
Lloyds
Chapel Lane Pharmacy
NP Pharmacy
Junction Everest Community College
Chlamydia Screening Office
Lloyds
The Base Youth Centre
Morrison's
Hook
Fleet Community Hospital
Lloyds
Asda
Rooksdown
Boots
Boots
Boots
Basingstoke and North Hampshire Hospital
Basingstoke Hall for All
The Point
Morrison's
North Camp
Essex House
Boots
Rowlands
Fleet
Basingstoke College of Technology
Connexions
Aldershot Garrison HQ
Queen Mary's College
Lloyds
Boots
Aldershot Institute
Overton
Alliance (Moss)
S R Pharmacy
Basingstoke
Aldworth Youth Suite
Lloyds
Boots
Lloyds
Hampshire Youth Bureau (One Stop Shop)
Hampshire North and East
NHS Surrey
Treloars College
Alton College
Boots
Alton
Youth Room
Alton Community Hospital
Bordon Prince Philip
Connexions
Boots
Lloyds
Bordon
Chase Community Hospital
New Alresford
Lloyds
Winchester
Royal Hampshire County Hospital
Hampshire West
Alliance Pharmacy
Petersfield
Boots
Boots
Petersfield General Hospital
Day Lewis
Health Zone &
The Grange Surgery
The Hub
Eastleigh
Eastleigh Health Centre
Fair Oak
Bishop's Waltham
West Sussex PCT
The Box Youth Clinic
Teenage Drop-in Clinic
Royal South Hampshire Hospital
Arcadia
Horndean
Genplus
Morrison's Pharmacy
Rowlands Pharmacy
Waterlooville Health Centre
Tucker's Pharmacy
Hype Youth Clinic
Sylvan Outpatient Dept
Sex Sense & CASH clinic
Staunton Community Sports College
Key
GUM Clinic
CaSH Clinic*
GUM and CaSH Clinics**
Information and Advice
Abortion Service
GPs
GPs offering chlamydia screening
C Card distribution point
Pharmacy offering free EHC
Chlamydia screening
Pharmacy offering free EHC and chlamydia screening
Restricted Access venue (e.g. College/Military)
Young People Only
Railway Line
Roads
Populated and Green Areas
Please note opening hours vary across services. Some clinics are term-time only.
* Contraception service offering chlamydia screening or chlamydia screening and treatment. CaSH Clinics may not offer the full range of contraception
** Services available from the same building but not necessary at the same time
Information sourced from: www.getiton.nhs.uk , www.haveyougotit.nhs.uk and provided by NHS Hampshire.
Correct as of 13th July 2009.


Map 8: NHS Hampshire West:
All Contraception and Sexual Health Services
Hampshire North and East
Hampshire West
NHS Wiltshire
NHS Dorset
Hampshire South and East
Oakridge Hall for All
Basingstoke and North Hampshire Hospital
Basingstoke College of Technology
Essex House
Queen Marys College
Basingstoke
The Andover Health Centre
Askalot
Andover Family Learning
Andover Crisis Centre
Andover College
The Wedge Youth Centre
Boots
Two Saints
Alliance Pharmacy
Teenage Parents Support Group
Army Air Corp, Middle Wallop
Stockbridge
Worthy Down
Army Training Regiment
Springvale
Twenty 5
Sparsholt College
Alliance
Lloyds
Street Reach
Trinity Centre
Royal Hampshire County Hospital
Boots
Lloyds
RHCH Midwifery
Lloyds
The Carroll Youth Centre
Lloyds
Sainsbury's
University of Winchester
New Alresford
Wessex Pharmacy
Alresford Pharmacy
Romsey
Youth in Romsey
Alliance
Boots
Superdrug
Lloyds
Pharmacy Direct
Youth In Romsey (Children's Services)
Eastleigh
Day Lewis
Connexions
Boots
Boyatt
Fleming Park Leisure Centre
Eastleigh Health Centre
Boots
Asda
Eastleigh College
Barton Peveril College
Bishop's Waltham
Alliance Pharmacy
Totton Health Centre
It's Your Choice
New Forest Youth Team
Lloyds
Forest
Totton
Lloyds
Fordingbridge
Lloyds
Royal South Hampshire Hospital
St Lukes
The Box Youth Clinic
Teenage Drop-in Clinic
David Pigg
Rowlands
H J Everett
Alliance
Waterlooville Health Centre
Day Lewis
Lyndhurst
Marchwood Military Port
New Forest
The Handy Trust
Tesco
Sylvan Outpatient Dept
Asda
Tuckers
Connexions
Hythe Medical Centre
Boots
Hythe Youth Centre
Fareham Health Centre
The Annexe
Lloyds
Ringwood
Ringwood Health Centre
Boots
Brockenhurst College
Martins of Brokenhurst
Brockenhurst
Lloyds
Rowner Health Centre
i-stop
St Mary's Hospital
Gosport War Memorial Hospital
Lymington Clinic at Options
Boots
Lloyds
Hordle
Alliance
Lymington Hospital
Alliance Pharmacy (within Waitrose)
New Milton Young People's Clinic
New Milton Health Centre
Key
GUM Clinic
CaSH Clinic*
GUM and CaSH Clinics**
Information and Advice
Abortion Service
GPs
GPs offering chlamydia screening
C Card distribution point
Pharmacy offering free EHC
Chlamydia screening
Pharmacy offering free EHC and chlamydia screening
Restricted Access venue (e.g. College/Military)
Young People Only
Railway Line
Roads
Populated and Green Areas
Please note opening hours vary across services. Some clinics are term-time only.
* Contraception service offering chlamydia screening or chlamydia screening and treatment. CaSH Clinics may not offer the full range of contraception
** Services available from the same building but not necessary at the same time
Information sourced from: www.getiton.nhs.uk , www.haveyougotit.nhs.uk and provided by NHS Hampshire.
Correct as of 13th July 2009.

Map 9: NHS Hampshire South East: All Contraception and Sexual Health Services



Key

- GUM Clinic
- CaSH Clinic*
- GUM and CaSH Clinics**
- Information and Advice
- Abortion Service
- GPs
- GPs offering chlamydia screening
- C Card distribution point
- Pharmacy offering free EHC
- Chlamydia screening
- Pharmacy offering free EHC and chlamydia screening
- Restricted Access venue (e.g. College/Military)
- Young People Only
- Railway Line
- Roads
- Populated and Green Areas

Please note opening hours vary across services. Some clinics are term-time only.

* Contraception service offering chlamydia screening or chlamydia screening and treatment. CaSH Clinics may not offer the full range of contraception

** Services available from the same building but not necessary at the same time

Information sourced from: www.getiton.nhs.uk , www.haveyougotit.nhs.uk and provided by NHS Hampshire.
Correct as of 13th July 2009.

5.2.1 Key Points Relating to All Contraception and Sexual Health Services (Map 7, Map 8, Map 9)

- Overall service coverage across NHS Hampshire is good.
- There are no sexual health services based in the following small towns or villages, the majority of these places are close to major towns or cities and therefore may not require additional services:

NHS Hampshire North and East

- East Oakley (no services)
- Grayshott (one pharmacy providing EHC only

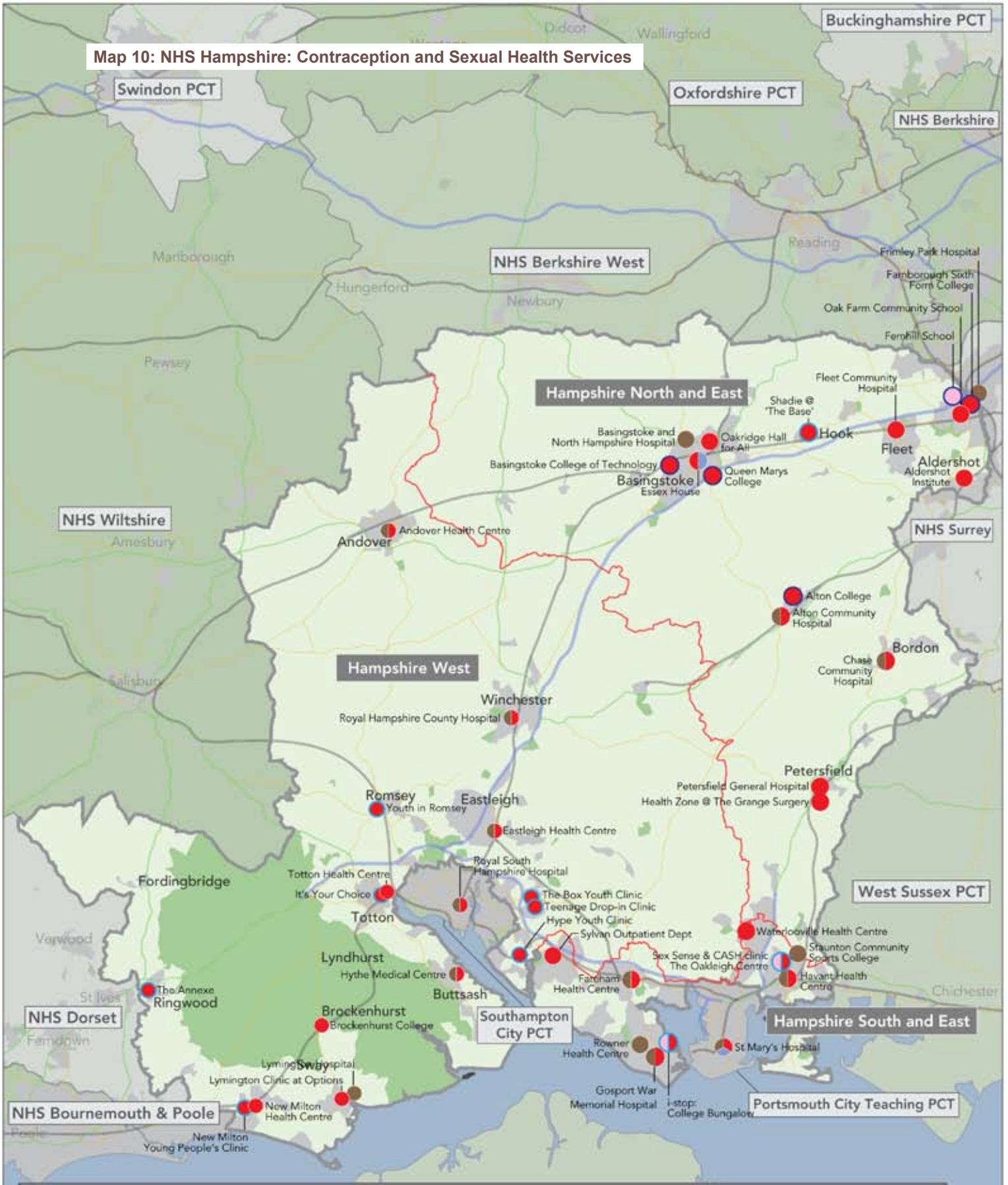
NHS Hampshire West

- South Wonston (no services)
- Colden Common (no services)
- Twyford (no services)
- Milford-on-Sea (no services)
- Rownhams (no services)

NHS Hampshire South East

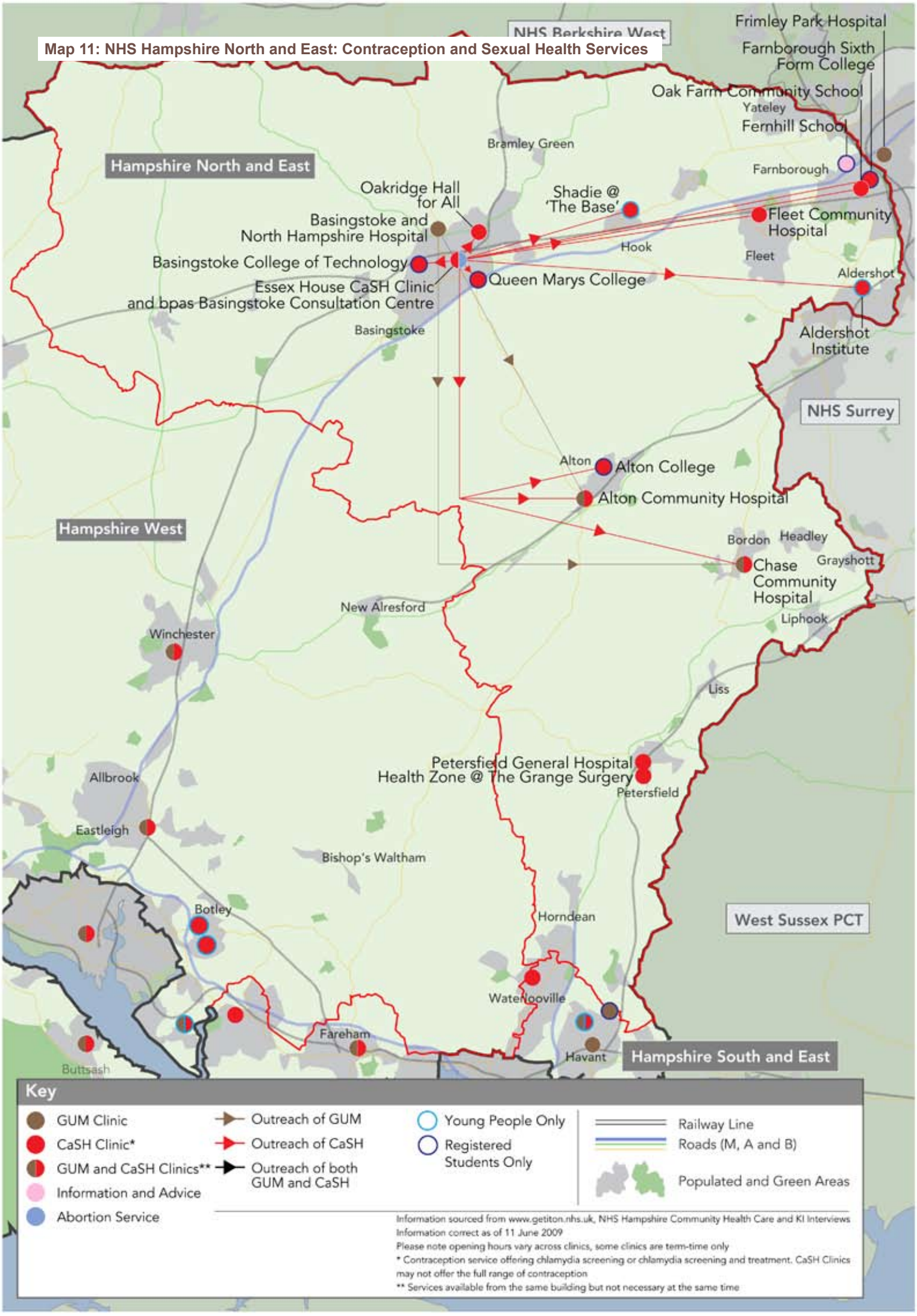
- Portchester (two pharmacies and one GP only)
- Hayling Island (two pharmacies and one GP only)
- Hill Head and Stubbington (one pharmacy only)
- Emsworth (one GP and one pharmacy only)
- Westbourne (no services)

Map 10: NHS Hampshire: Contraception and Sexual Health Services

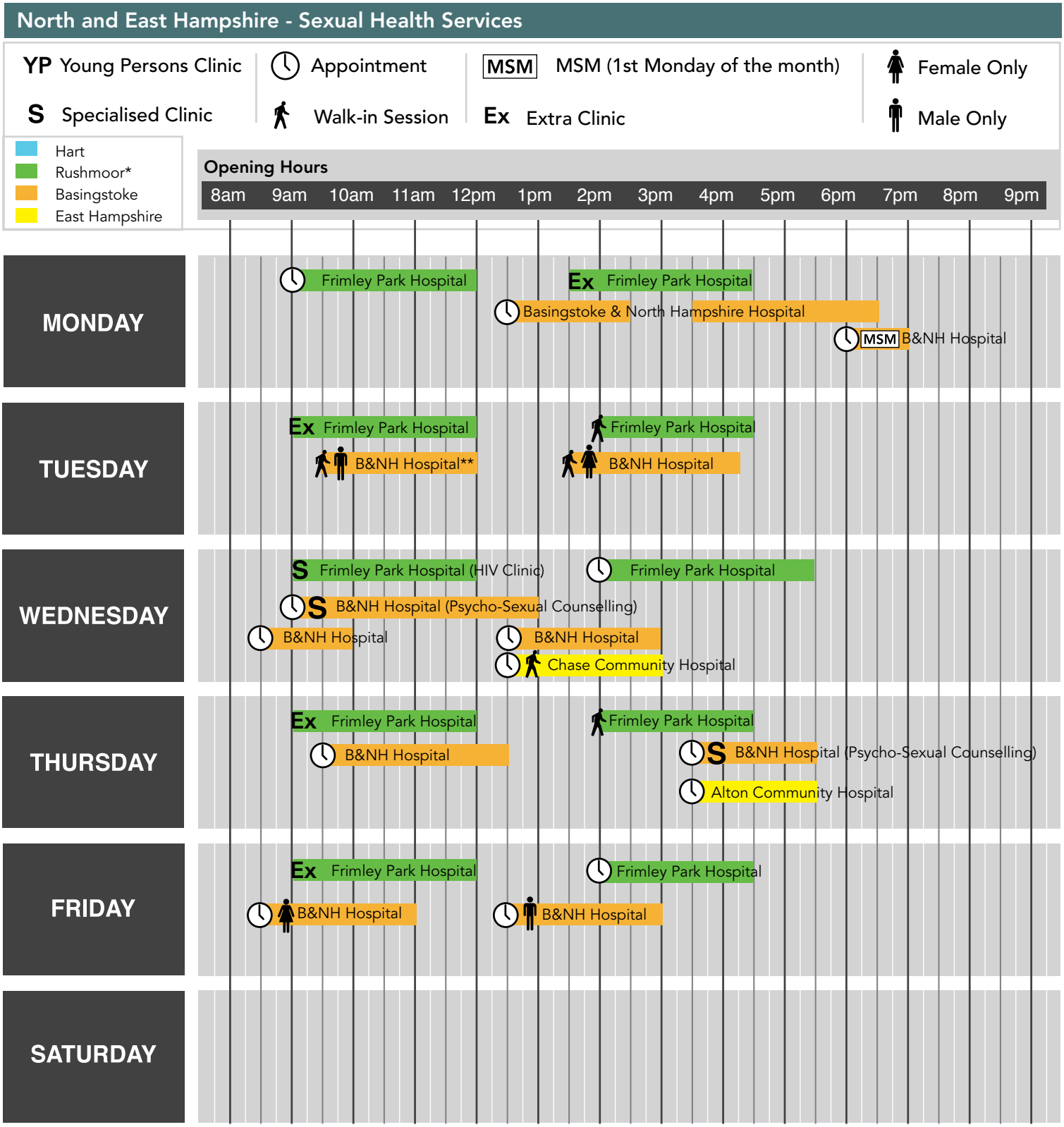


Information sourced from www.getiton.nhs.uk, NHS Hampshire Community Health Care and KI Interviews
Information correct as of 11 June 2009
Please note opening hours vary across clinics, some clinics are term-time only
* Contraception service offering chlamydia screening or chlamydia screening and treatment. CaSH Clinics may not offer the full range of contraception
** Services available from the same building but not necessary at the same time

Map 11: NHS Hampshire North and East: Contraception and Sexual Health Services



Timetable 1: NHS Hampshire North and East: Sexual Health Services



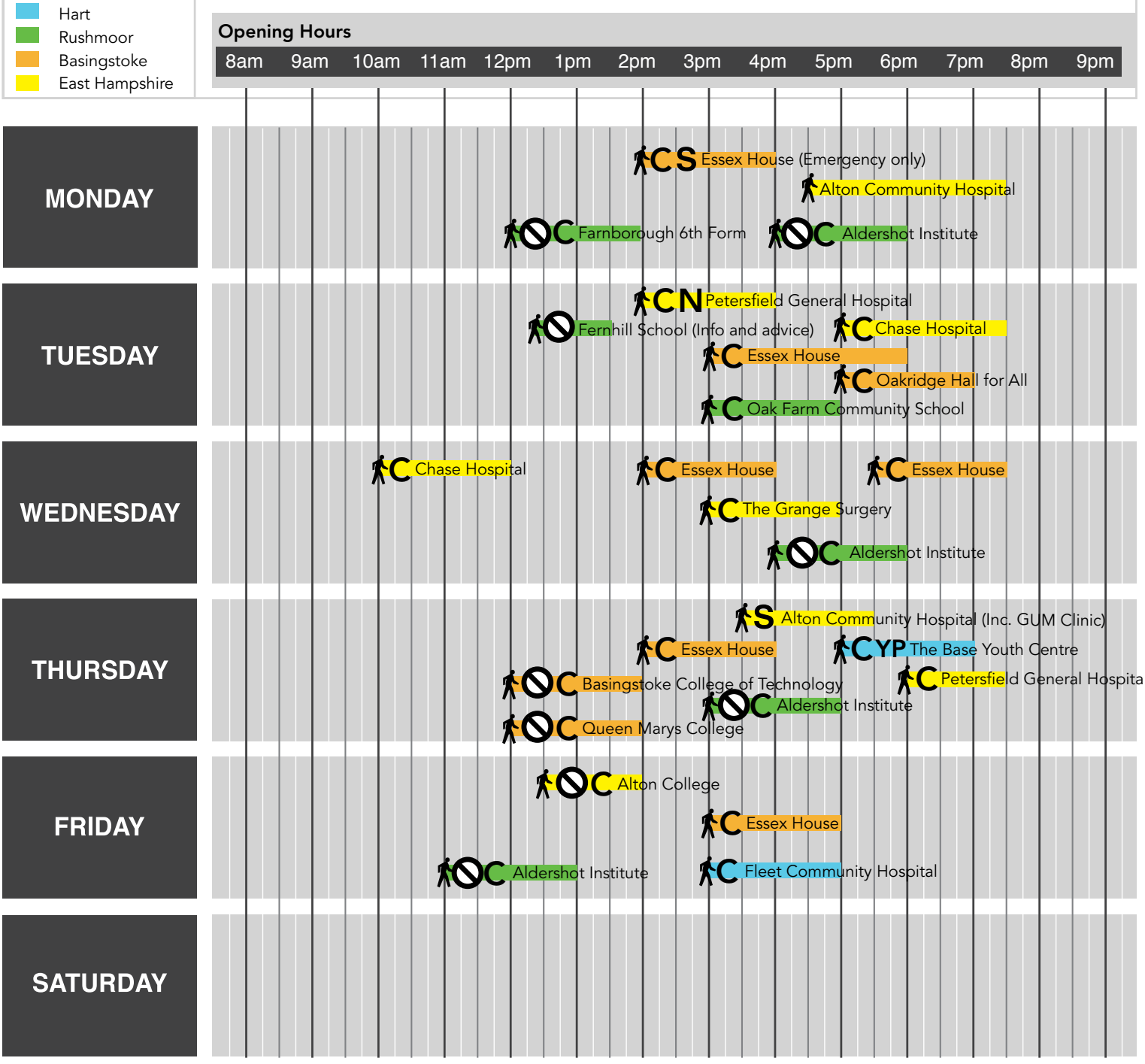
* The Frimley Park Hospital is outside of the boundaries of Rushmoor and is included for reference.
** Basingstoke and North Hampshire Hospital

No clinics will be held on bank holidays
Information taken from http://www.getiton.nhs.uk/. Accessed 3.7.09.

North and East Hampshire - Contraception Services

YP Young Persons Clinic
Appointment
Restricted Access
N Nurse led Service
S Specialised Clinic
Walk-in session
C Chlamydia Screening Offered

Hart
Rushmoor
Basingstoke
East Hampshire



Nurse led services may not offer IUD / IUS insertion.
Information taken from http://www.getiton.nhs.uk/. Accessed 3.7.09.

5.2.2 Key Points Relating to NHS Hampshire North and East: Contraception and Sexual Health Services (Map 11, Timetable 1, Timetable 2)

Overview

- No contraception or sexual health services are open at the weekend.
- There are no dedicated services for young people outside those available through schools or colleges. Exit interview (EI) participant analysis suggests that the majority of young people are comfortable with attending open access services, so this should not be problematic for most young people.

Sexual Health Services

- There is good daytime coverage of GUM services across the working week.
- Access to GUM services in the evening is comparatively poor with only one clinic opening until 6.30pm one day a week.
- Basingstoke and North Hampshire Hospital is the only GUM service in the PCT with separate clinics for men and women. EI participant analysis from other clinics engaged with as part of this SHNA strongly suggests that clinics divided by gender are not considered to be necessary by service users.
- There is limited access to GUM services in the south of Hampshire North and East, with just 4.5 hours per week being offered between Alton and Bordon.

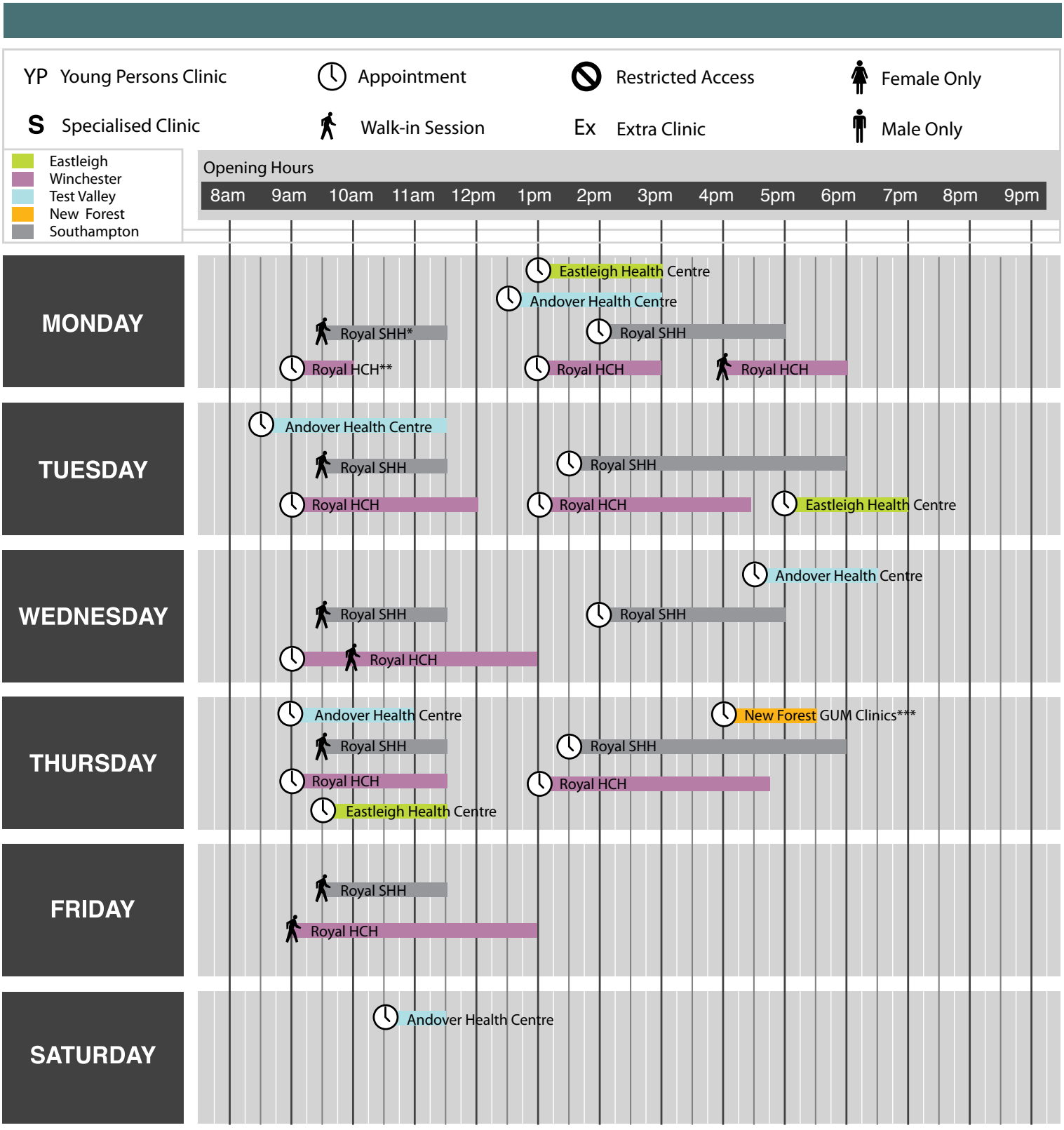
CaSH Services

- Service providers have commented that Farnborough may benefit from an additional CaSH clinic. The CaSH service in Farnborough is school based and this may alienate older potential service users.
- All CaSH clinics are walk-in format; it may benefit some users if a limited number of appointments were available.
- Bordon is the only area of the North and East offering a morning CaSH clinic (Wednesdays, 10.00am-12.00pm). EI participant analysis shows a lower demand for morning clinics than evening or weekend clinics.

Map 12: NHS Hampshire West: Contraception and Sexual Health Services


NHS Berkshire West
Hampshire North and East
NHS Wiltshire
Basingstoke
The Andover Health Centre
Andover
Hampshire West
New Alresford
Winchester
Royal Hampshire County Hospital
Youth in Romsey
Eastleigh
Eastleigh Health Centre
Royal South Hampshire Hospital
Bishop's Waltham
Fordingbridge
Totton Health Centre
It's Your Choice
The Box Youth Clinic
Teenage Drop-in Clinic
Hype Youth Clinic
NHS Dorset
Hythe Medical Centre
The Annexe
St Leonards
Buttsash
Hampshire South and East
Brockenhurst
Brokenhurst College
Gosport
Lymington Hospital
Lymington Clinic at Options
New Milton
New Milton Health Centre
NHS Bournemouth and Poole
Milford on Sea
New Milton Young People's Clinic
Key
GUM Clinic
CaSH Clinic*
GUM and CaSH Clinics**
Information and Advice
Outreach of GUM
Outreach of CaSH
Outreach of both GUM and CaSH
Young People Only
Registered Students Only
Railway Line
Roads (M, A and B)
Populated and Green Areas
Information sourced from www.getiton.nhs.uk, NHS Hampshire Community Health Care and KI Interviews
Information correct as of 11 June 2009
Please note opening hours vary across clinics, some clinics are term-time only
* Contraception service offering chlamydia screening or chlamydia screening and treatment. CaSH Clinics may not offer the full range of contraception
** Services available from the same building but not necessary at the same time

Timetable 3: NHS Hampshire West: Sexual Health Services



* Royal South Hants Hospital. Included for reference.
** Royal Hampshire County Hospital
***New Forest GUM hosted at Lymington Hospital on the 1st and 2nd Thursday of the month and at Hythe Medical Centre on the 3rd and 4th Thursday of the month.

Information taken from http://www.getiton.nhs.uk/. Accessed 3.7.09.

Timetable 4: NHS Hampshire West: Contraception Services

West Hampshire - Contraception Services

YP Young Persons Clinic
Appointment
Restricted Access
N Nurse led Service
S Specialised Clinic
Walk-in session
C Chlamydia Screening Offered

Eastleigh
Winchester
Test Valley
New Forest
Southampton

Opening Hours

8am 9am 10am 11am 12pm 1pm 2pm 3pm 4pm 5pm 6pm 7pm 8pm 9pm

MONDAY
- NYP New Milton Health Centre
- It's Your Choice
- Royal HCH*
- Royal HCH
- Royal HCH
- Eastleigh HC
- Eastleigh HC
- CYP The Box Youth Clinic
- Andover Health Centre
- Andover Health Centre
- Royal SHH**
- S (Implant clinic)
- Royal SHH

TUESDAY
- Royal HCH
- Royal HCH
- Eastleigh HC
- Royal SHH
- Royal SHH
- YP Youth In Romsey
- Lymington Clinic at Options

WEDNESDAY
- Royal HCH
- CYP Teenage Drop-in Clinic
- Totton Health Centre
- Hythe Medical Centre
- Hythe Medical Centre
- Andover Health Centre
- Ringwood

THURSDAY
- Royal HCH
- Royal HCH
- Royal HCH
- Royal SHH
- New Milton Health Centre
- Eastleigh HC

FRIDAY
- Royal HCH
- S Royal SHH (IUD Clinic)

SATURDAY
- Andover Health Centre

* Royal Hampshire County Hospital
** Royal South Hants Hospital. Included for reference.

Nurse led services may not offer IUD / IUS insertion.
Information taken from http://www.getiton.nhs.uk/. Accessed 3.7.09.

5.2.3 Key Points Relating to NHS Hampshire West: Contraception and Sexual Health Services (Map 12, Timetable 3 and Timetable 4)

Overview

- There are no GUM or CaSH services available to the older population of Romsey.
- Service providers have highlighted the lack of GUM and CaSH services in New Alresford and Bishops Waltham. Further work may be necessary to determine how these populations are accessing services and if they are adequately catered for.
- Residents of the New Forest may experience difficulties in trying to access GUM and CaSH services. The two clinics based in the New Forest alternate weekly for one hour and thirty minutes between Hythe Medical Centre and Lymington Hospital. Residents in parts of the New Forest (particularly in the South West) may be more likely to access services in Salisbury or Dorset.
- Andover is considered to be particularly in need of increased services by service providers.

Sexual Health Services

- The majority of GUM outreach is delivered by Royal South Hampshire Hospital (RSHH).
- Coverage across the week is good. Friday afternoons and Saturdays have the least clinical sessions.
- More satellite services may increase access to young people living in outlying small towns and villages.

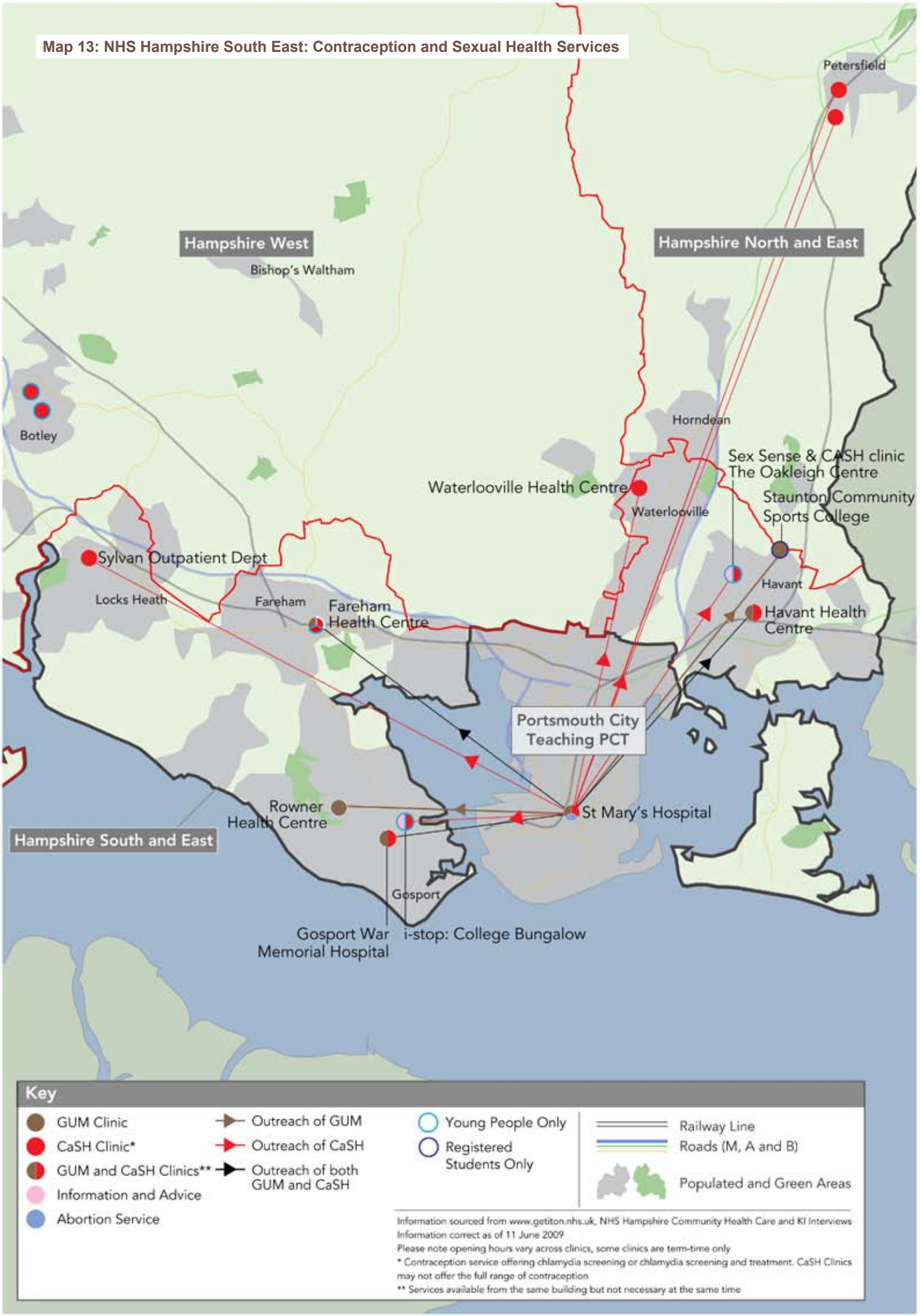
"I think offering more satellite services, because I think we are a very huge geographical patch, and especially in relation to the [New] Forest, and even in the rest of Hampshire, there are lots of villages around and there are quite a lot of young people around here. It's difficult to access services because of bus routes and times of services running, so I think, actually, taking the services out to them is something we really do need to have a close look at."

Service provider, RSHH

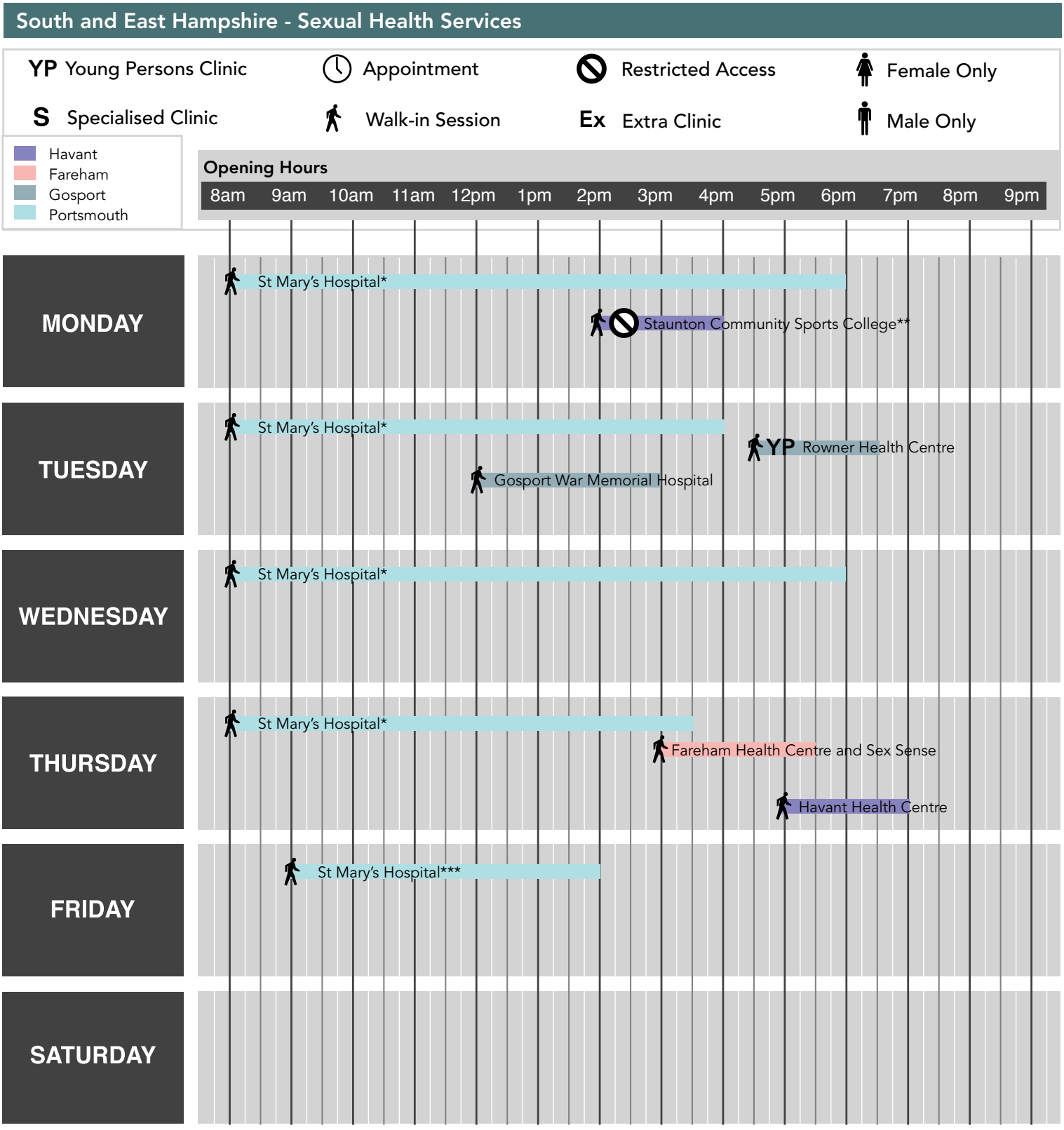
CaSH Services

- Monday has the most concurrently running clinics with seven clinics open at different locations simultaneously in the evening. Although these clinics may all be well attended and important to local communities it should be noted that gaps exist in the mornings and on Fridays and Saturdays, some reallocations of clinical time may benefit NHS Hampshire West as a whole.
- Morning clinics are only available in Winchester and Southampton.
- NHS Hampshire West has the most non-school based young people's clinics in NHS Hampshire.
- NHS Hampshire West is the only part of NHS Hampshire to offer a clinic on a Saturday, Options UK understand this is well attended and populations in the North and East and South East may benefit from Saturday clinics as well.

Map 13: NHS Hampshire South East: Contraception and Sexual Health Services



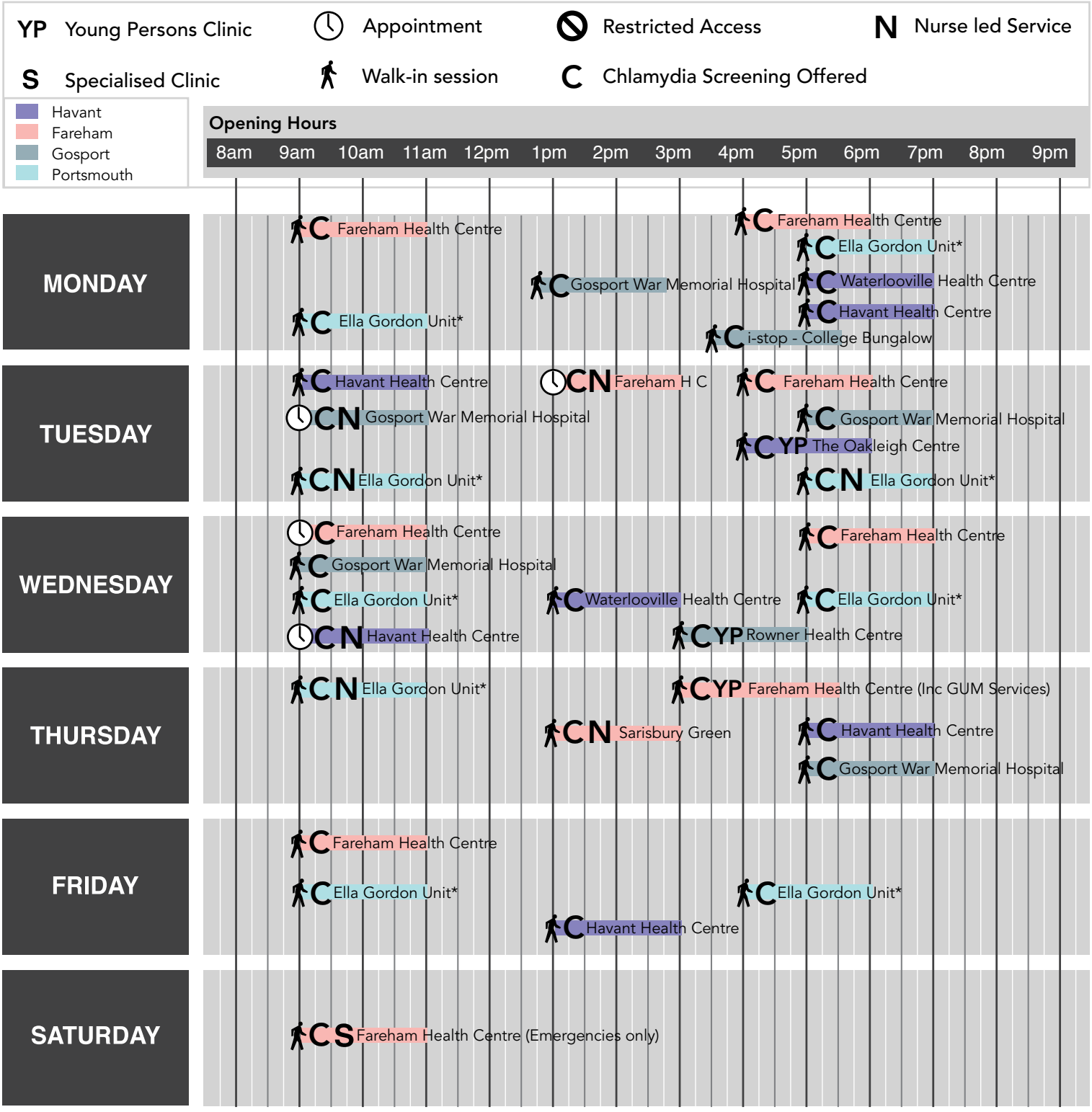
Timetable 5: NHS Hampshire South East: Sexual Health Services



* St Mary's Hospital included for reference.
** Clinic runs on the 1st Monday of each month
*** Clinic may close early due to staffing levels & demand

Information taken from http://www.getiton.nhs.uk/. Accessed 3.7.09.

South and East Hampshire - Contraception Services



* The Ella Gordon Unit. Included for reference.

Nurse led services may not offer IUD / IUS insertion.
Information taken from http://www.getiton.nhs.uk/. Accessed 3.7.09.

5.2.4 Key Points Relating to NHS Hampshire South East: Contraception and Sexual Health Services (Map 13, Timetable 5 and Timetable 6)

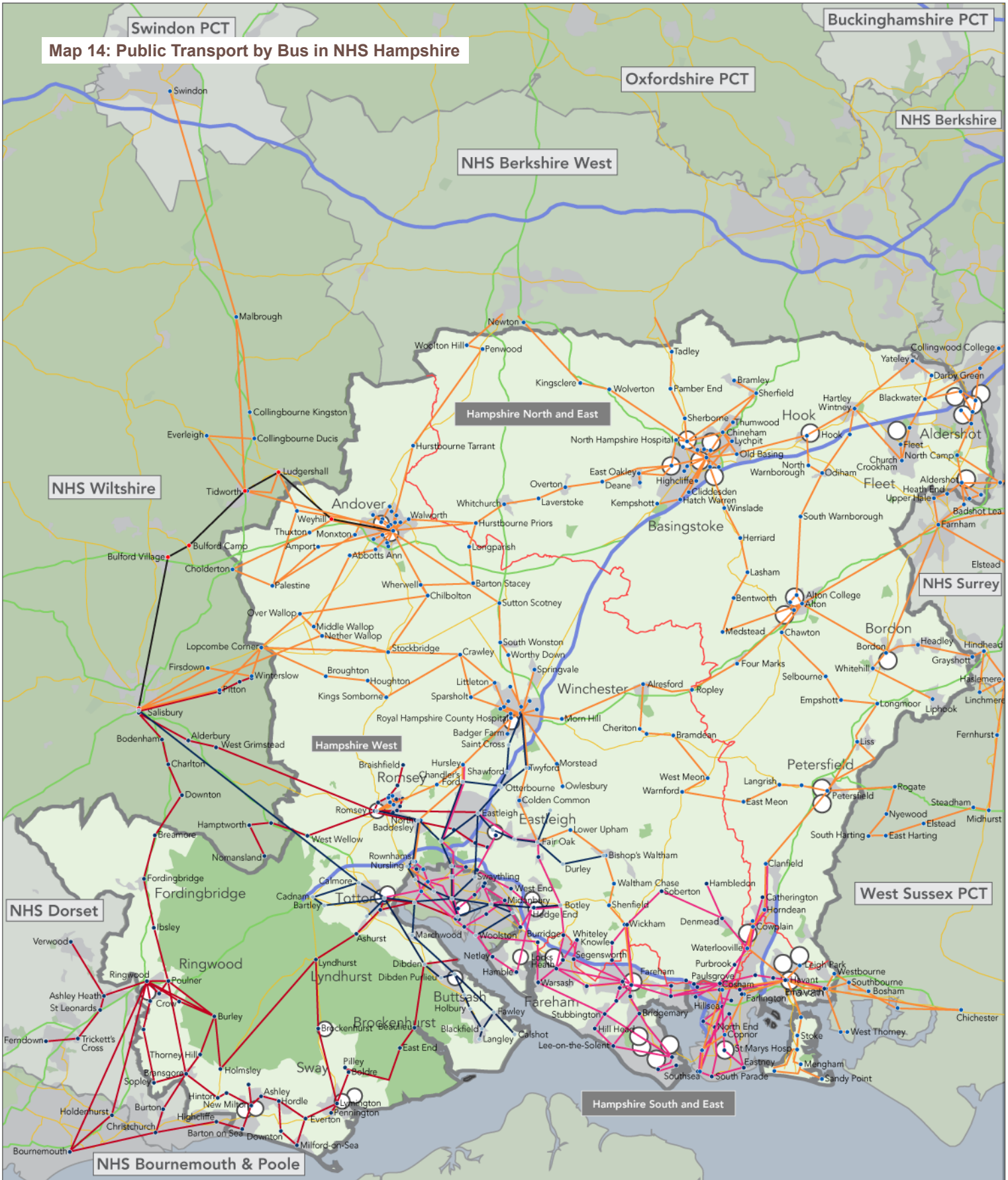
Sexual Health Services

- Availability of sexual health services is good in Hampshire South East, although service providers believe there is a need for increased services in the evenings and weekends, this was corroborated by EI participants.
- All sexual health services are walk-in only, with no general appointments available.

CaSH Services

- There is good availability of CaSH services across Hampshire South East. The main gap exists between 11.00am and 4.00pm.
- Appointment clinics are mainly available during the mornings and at present there are no evening appointment clinics.
- There is no CASH provision in Gosport on a Friday or Saturday. In addition, Gosport has the highest rate of teenage conception in Hampshire South East.

Map 14: Public Transport by Bus in NHS Hampshire

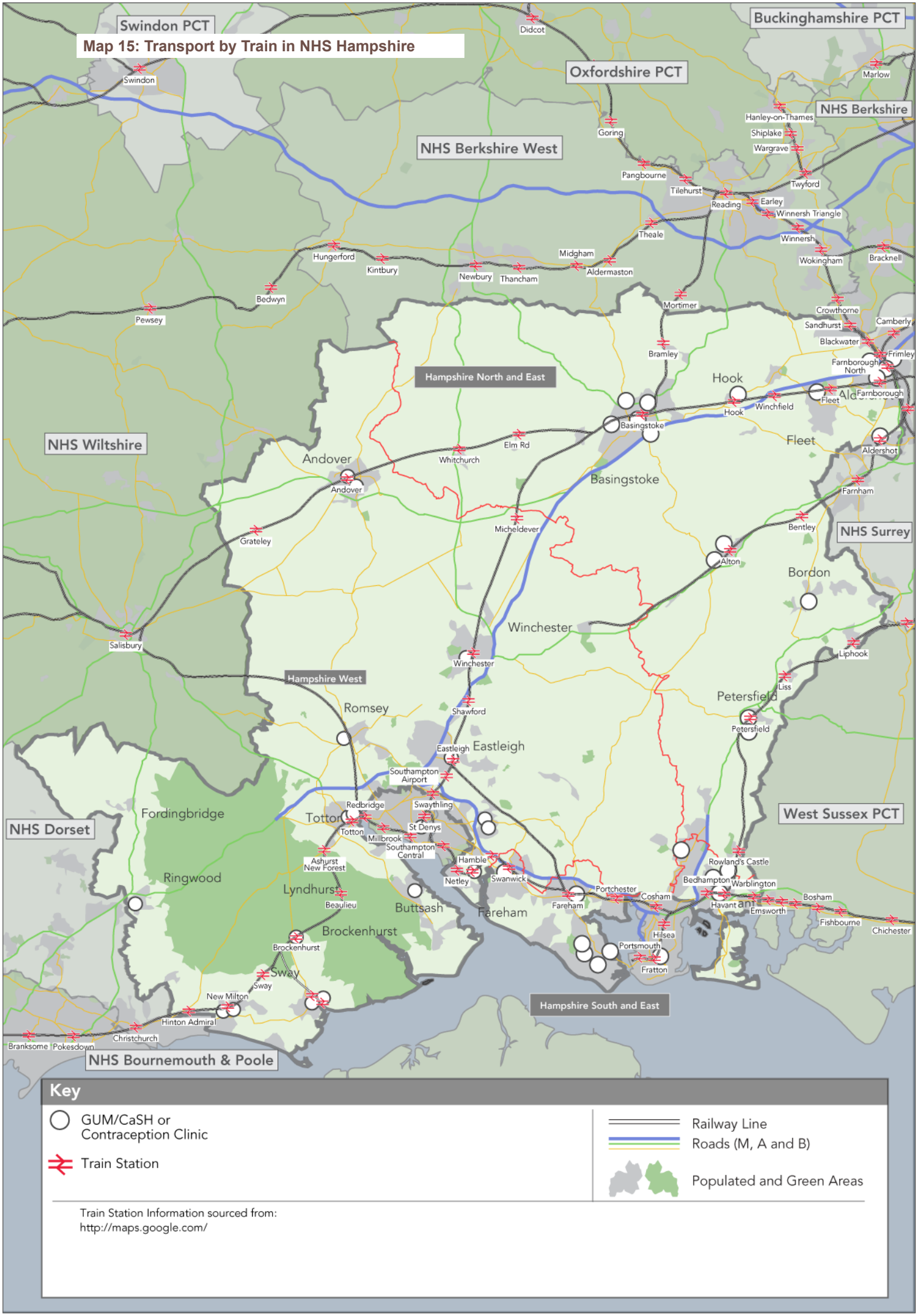


Key

- GUM/CaSH or Contraception Clinic
- Blue Star
- First
- Stagecoach South
- Activ8
- Wilts&Dorset*
- Railway Line
- Roads (M, A and B)
- Populated and Green Areas

Bus route information sourced from (Correct as of 25th June 2009):
www.bluestarbus.co.uk
www.firstgroup.com/ukbus/southwest/hampshire/home
www.stagecoachbus.com/south
www.stagecoachbus.com/timetables/ANActiv8timetable261008.pdf
www.wdbus.co.uk

* Please note many Wilts&Dorset buses are infrequent


Map 15: Transport by Train in NHS Hampshire
Swindon PCT
Buckinghamshire PCT
Oxfordshire PCT
NHS Berkshire
NHS Berkshire West
NHS Wiltshire
Hampshire North and East
Hampshire West
Hampshire South and East
NHS Surrey
West Sussex PCT
NHS Dorset
NHS Bournemouth & Poole
Swindon
Didcot
Marlow
Hanley-on-Thames
Shiplake
Wargrave
Goring
Pangbourne
Tilehurst
Reading
Earley
Twyford
Winnersh Triangle
Winnersh
Wokingham
Bracknell
Theale
Midgham
Aldermaston
Newbury
Thatcham
Hungerford
Kintbury
Bedwyn
Pewsey
Mortimer
Crowthorne
Sandhurst
Camberley
Blackwater
Frimley
Farnborough North
Farnborough
Bramley
Hook
Winchfield
Fleet
Aldershot
Basingstoke
Elm Rd
Whitchurch
Andover
Grateley
Micheldever
Farnham
Bentley
Alton
Bordon
Liphook
Liss
Petersfield
Salisbury
Winchester
Shawford
Eastleigh
Romsey
Southampton Airport
Swaythling
Redbridge
Totton
St Denys
Millbrook
Southampton Central
Ashurst New Forest
Hamble
Netley
Swanwick
Fordingbridge
Ringwood
Lyndhurst
Beaulieu
Buttsash
Fareham
Portchester
Cosham
Rowland's Castle
Bedhampton
Warblington
Havant
Emsworth
Bosham
Fishbourne
Chichester
Brockenhurst
Sway
New Milton
Hinton Admiral
Christchurch
Branksome
Pokesdown
Hilsea
Portsmouth
Fratton
Key
GUM/CaSH or Contraception Clinic
Train Station
Railway Line
Roads (M, A and B)
Populated and Green Areas
Train Station Information sourced from:
http://maps.google.com/

5.2.5 Key Points Relating to Public Transport in NHS Hampshire (Map 14 and Map 15)

Please see 'Future Models of Care for Contraception and Sexual Health Services' (5.4), and 'Travel to services' (5.3.3) for analysis of EI participant responses relating to travel to services in NHS Hampshire.

NHS Hampshire North and East

- Public transport from Alton, Bordon, Headley, Grayshott and Liphook to Basingstoke has been highlighted as particularly restricted:

"Bordon doesn't have a rail service. It has a very poor bus service… The earliest, by public transport, that somebody can get to Basingstoke is eleven o'clock, and the latest they can leave Basingstoke to get back to Bordon is two o'clock in the afternoon".
Service provider, Essex House

- Some areas are particularly disconnected to Basingstoke and North Hampshire Hospital in terms of public transport,[32] these are:
    - Bordon (Headley, Grayshott and Liphook)
    - Petersfield

NHS Hampshire West

- The New Forest has limited bus routes in comparison to the rest of Hampshire and only some areas are connected to the rest of NHS Hampshire by train.

"They're quite close to the city [Southampton], but they're very rural, and transport is very difficult."
Service provider, RSHH

- Romsey is poorly connected in terms of the road system and public transport, and the population may benefit from outreach services.
- In some areas to the west of the New Forest, residents are required to travel over 20 miles[33] (40 mile round journey) to access the nearest sexual health service.
- Some areas are particularly disconnected to RSHH and RHH in terms of public transport,[34] these are:
    - The New Forest
    - Andover
    - Bramdean
    - Andover
    - Bishops Waltham

NHS Hampshire South East

- The transportation network across the South East is comparatively good.
- Rowner has been highlighted by service providers as being particularly isolated in terms of the road network and public transport.
- There is poor access by bus from Havant and Portsmouth to the North NHS Hampshire.
- There is no rail network in Gosport, although a ferry service does operate between Gosport and Portsmouth. The service runs daily every 7.5 to 15 minutes, between the hours of 5:30am and midnight, weather permitting. The crossing time is approximately 4 minutes each way. A daily adult return costs £2.30, seasonal tickets are also available which reduce costs per journey.[35]
- Hayling Island has one bus route; this is likely to restrict travel from the island to services for some of the population.

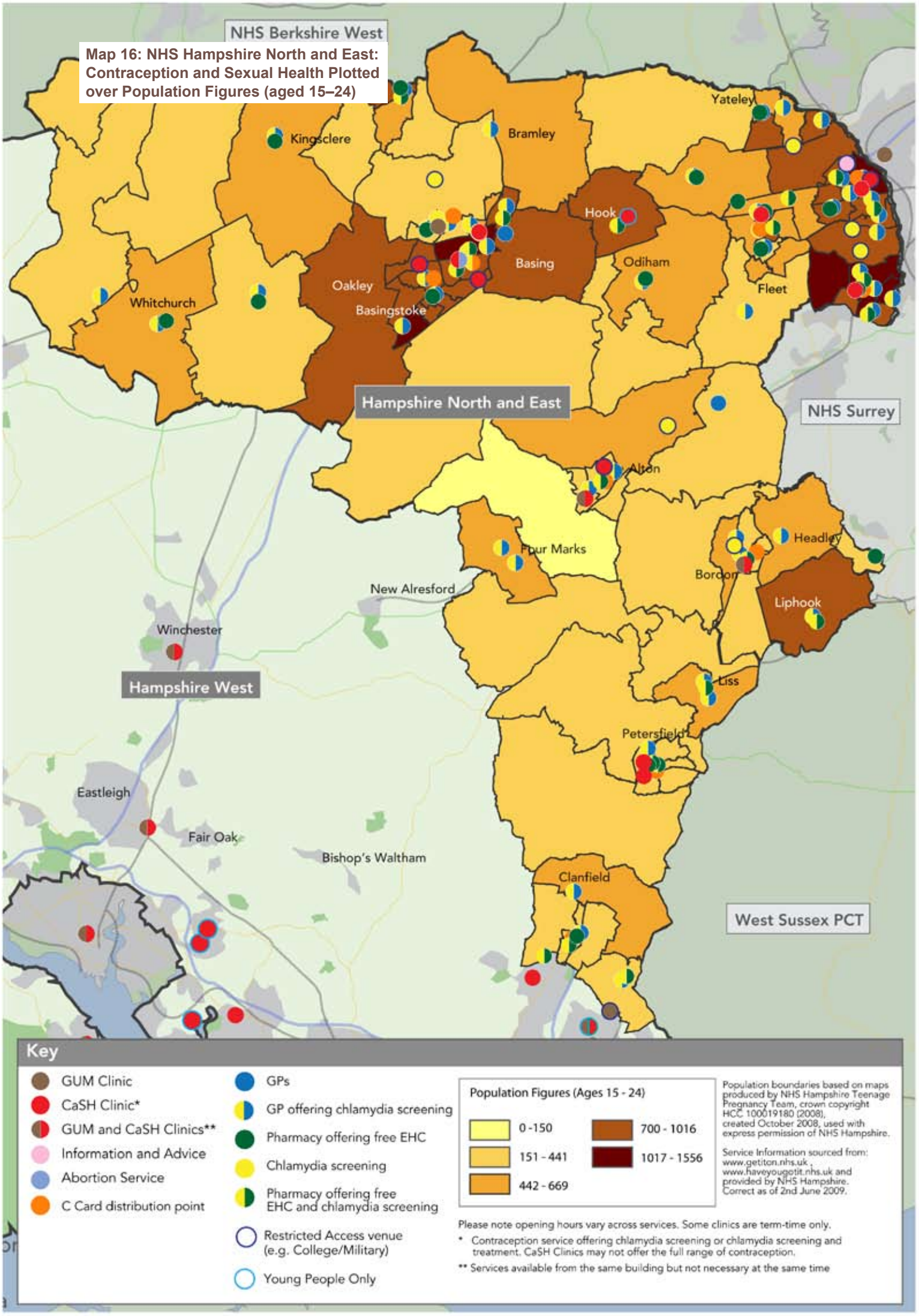
32. Areas selected on the basis of not being directly connected to their corresponding hub service and requiring one or more changes to make the journey.

33. Measurements taken from Ashford (Fordingbridge) to Hythe and Lymington using http://maps.google.com/

34. Areas selected on the basis of not being directly connected to their corresponding hub service and requiring one or more changes to make the journey.

35. Gosport Ferry Ltd. [online] Available from: http://www.gosportferry.co.uk/ferryservices.php [Accessed on the 16th of November 2009]

Map 16: NHS Hampshire North and East: Contraception and Sexual Health Plotted over Population Figures (aged 15–24)



Key

- GUM Clinic
- CaSH Clinic*
- GUM and CaSH Clinics**
- Information and Advice
- Abortion Service
- C Card distribution point
- GPs
- GP offering chlamydia screening
- Pharmacy offering free EHC
- Chlamydia screening
- Pharmacy offering free EHC and chlamydia screening
- Restricted Access venue (e.g. College/Military)
- Young People Only

Population Figures (Ages 15 - 24)

0 - 150	700 - 1016
151 - 441	1017 - 1556
442 - 669	

Population boundaries based on maps produced by NHS Hampshire Teenage Pregnancy Team, crown copyright HCC 100019180 (2008), created October 2008, used with express permission of NHS Hampshire.

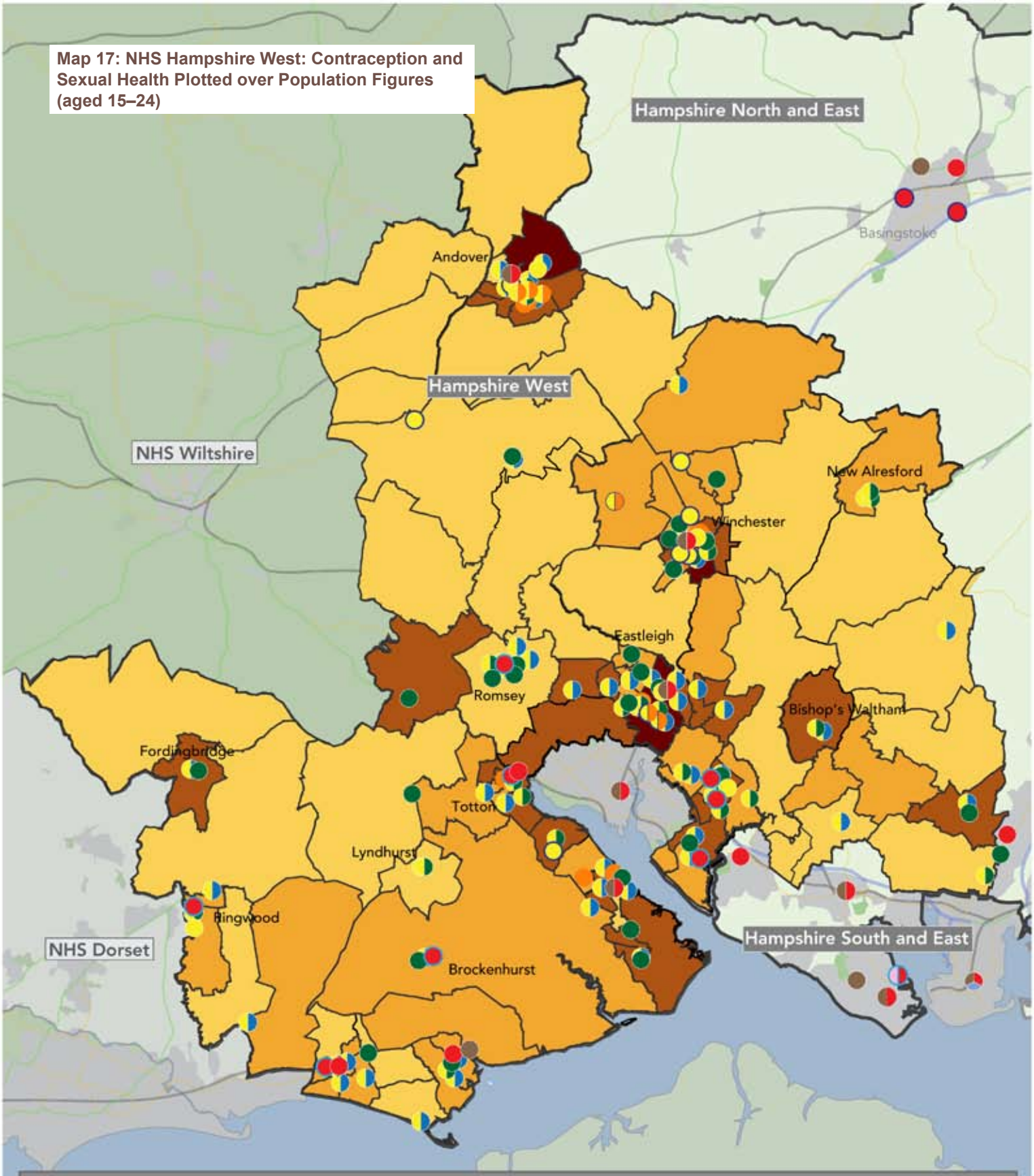
Service Information sourced from: www.getiton.nhs.uk , www.haveyougotit.nhs.uk and provided by NHS Hampshire. Correct as of 2nd June 2009.

Please note opening hours vary across services. Some clinics are term-time only.

* Contraception service offering chlamydia screening or chlamydia screening and treatment. CaSH Clinics may not offer the full range of contraception.

** Services available from the same building but not necessary at the same time

Map 17: NHS Hampshire West: Contraception and Sexual Health Plotted over Population Figures (aged 15–24)



Key

- GUM Clinic
- CaSH Clinic*
- GUM and CaSH Clinics**
- Information and Advice
- Abortion Service
- GPs
- Pharmacy offering free EHC
- Chlamydia screening
- Pharmacy offering free EHC and chlamydia screening
- Restricted Access venue (e.g. College/Military)
- Young People Only

Population Figures (Ages 15 - 24)

0 - 150	700 - 1016
151 - 441	1017 - 1556
442 - 669	

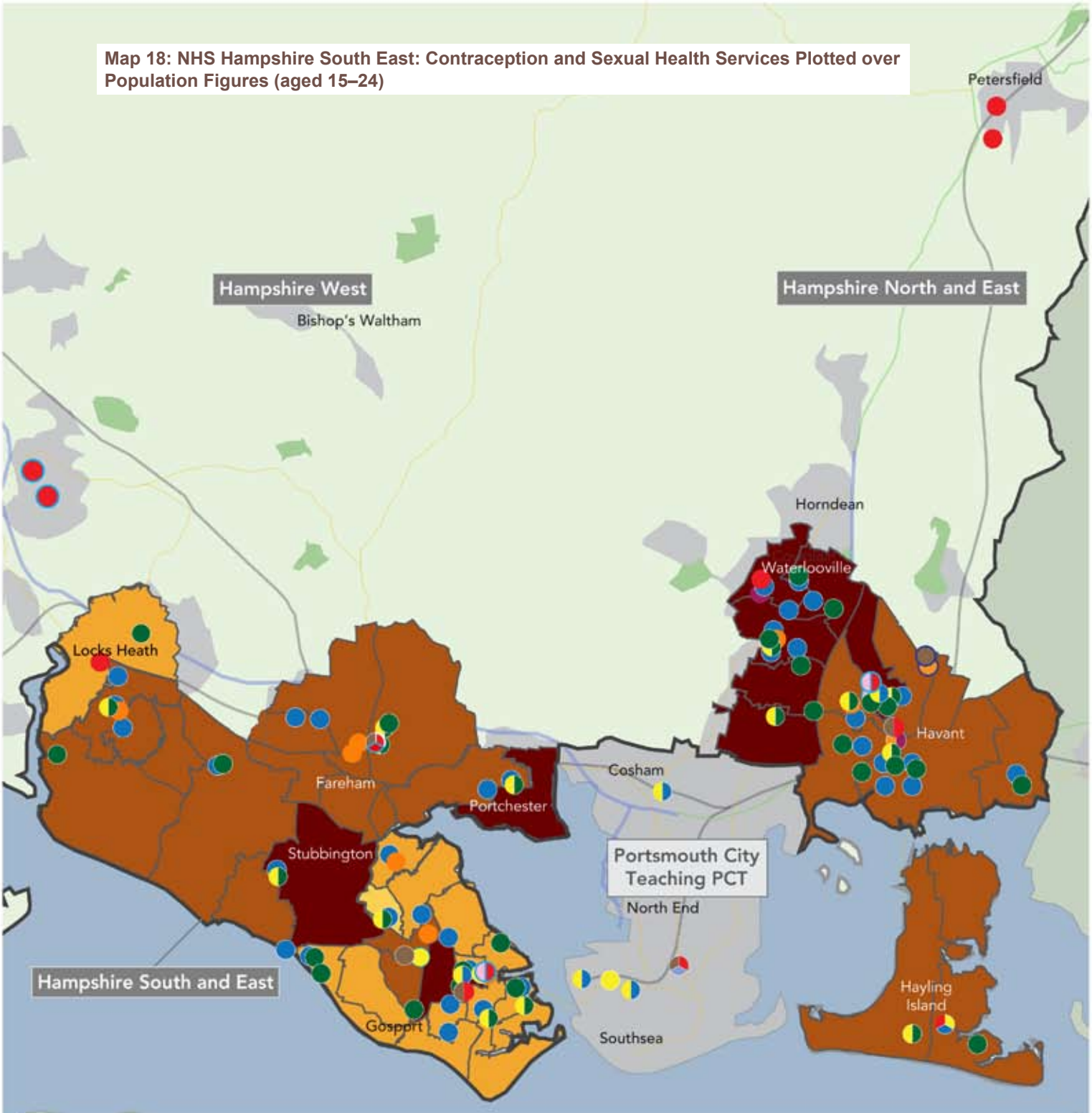
Service Information sourced from: www.getiton.nhs.uk , www.haveyougotit.nhs.uk and provided by NHS Hampshire. Correct as of 2nd June 2009.

Please note opening hours vary across services. Some clinics are term-time only.

* Contraception service offering chlamydia screening or chlamydia screening and treatment. CaSH Clinics may not offer the full range of contraception

** Services available from the same building but not necessary at the same time

Map 18: NHS Hampshire South East: Contraception and Sexual Health Services Plotted over Population Figures (aged 15–24)



Key

- GUM Clinic
- CaSH Clinic*
- GUM and CaSH Clinics**
- Information and Advice
- Abortion Service
- C Card distribution point
- GPs
- GPs offering chlamydia screening
- Pharmacy offering free EHC
- Chlamydia screening
- Pharmacy offering free EHC and chlamydia screening
- Restricted Access venue (e.g. College/Military)
- Young People Only

Population Figures (Ages 15 - 24)

- 0 - 150
- 151 - 441
- 442 - 669
- 700 - 1016
- 1017 - 1556

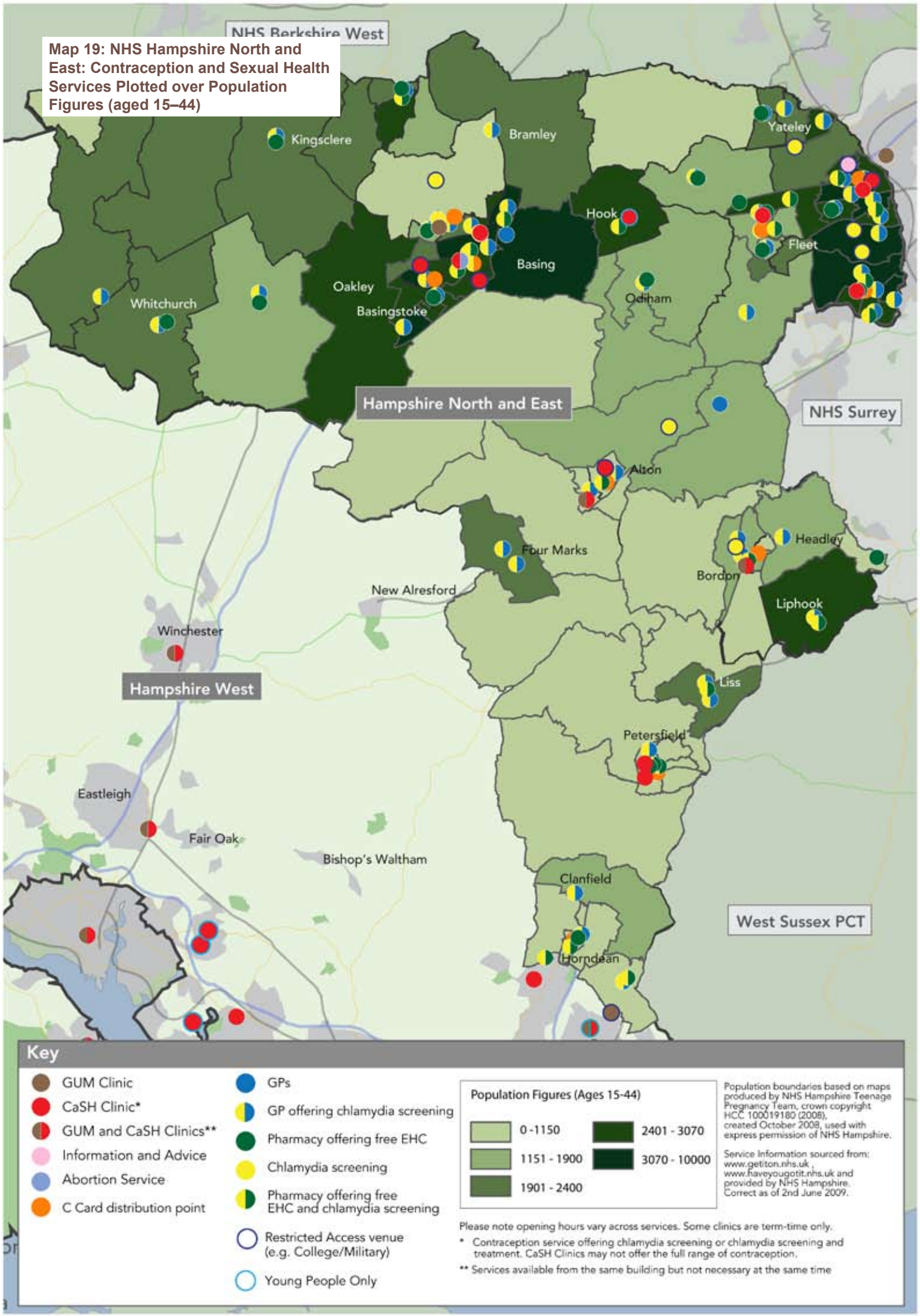
Please note opening hours vary across services. Some clinics are term-time only.

* Contraception service offering chlamydia screening or chlamydia screening and treatment. CaSH Clinics may not offer the full range of contraception

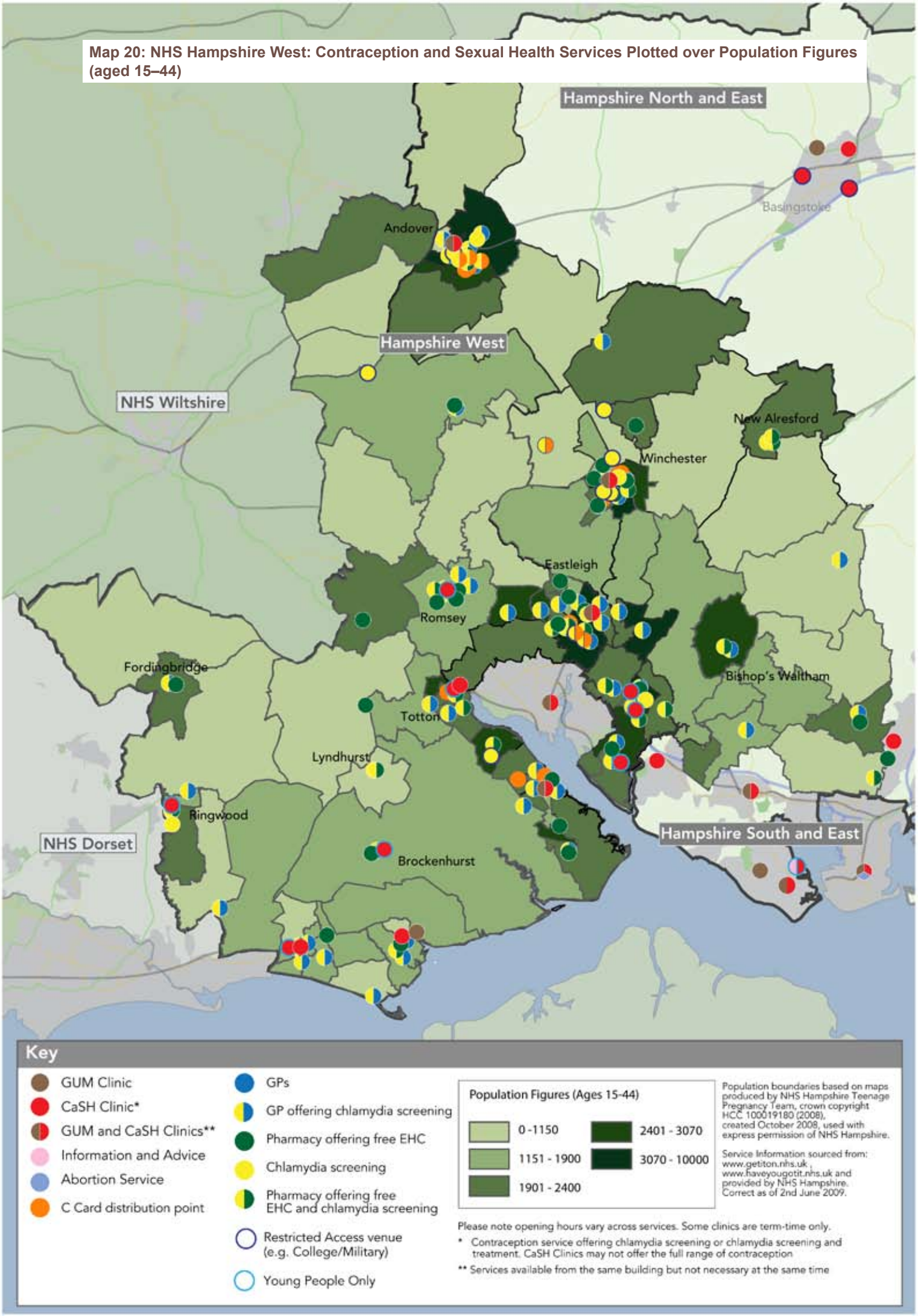
** Services available from the same building but not necessary at the same time

Service Information sourced from: www.getiton.nhs.uk , www.haveyougotit.nhs.uk and provided by NHS Hampshire.
Correct as of 2nd June 2009.

Map 19: NHS Hampshire North and East: Contraception and Sexual Health Services Plotted over Population Figures (aged 15–44)



Map 20: NHS Hampshire West: Contraception and Sexual Health Services Plotted over Population Figures (aged 15–44)



Population boundaries based on maps produced by NHS Hampshire Teenage Pregnancy Team, crown copyright HCC 100019180 (2008), created October 2008, used with express permission of NHS Hampshire.

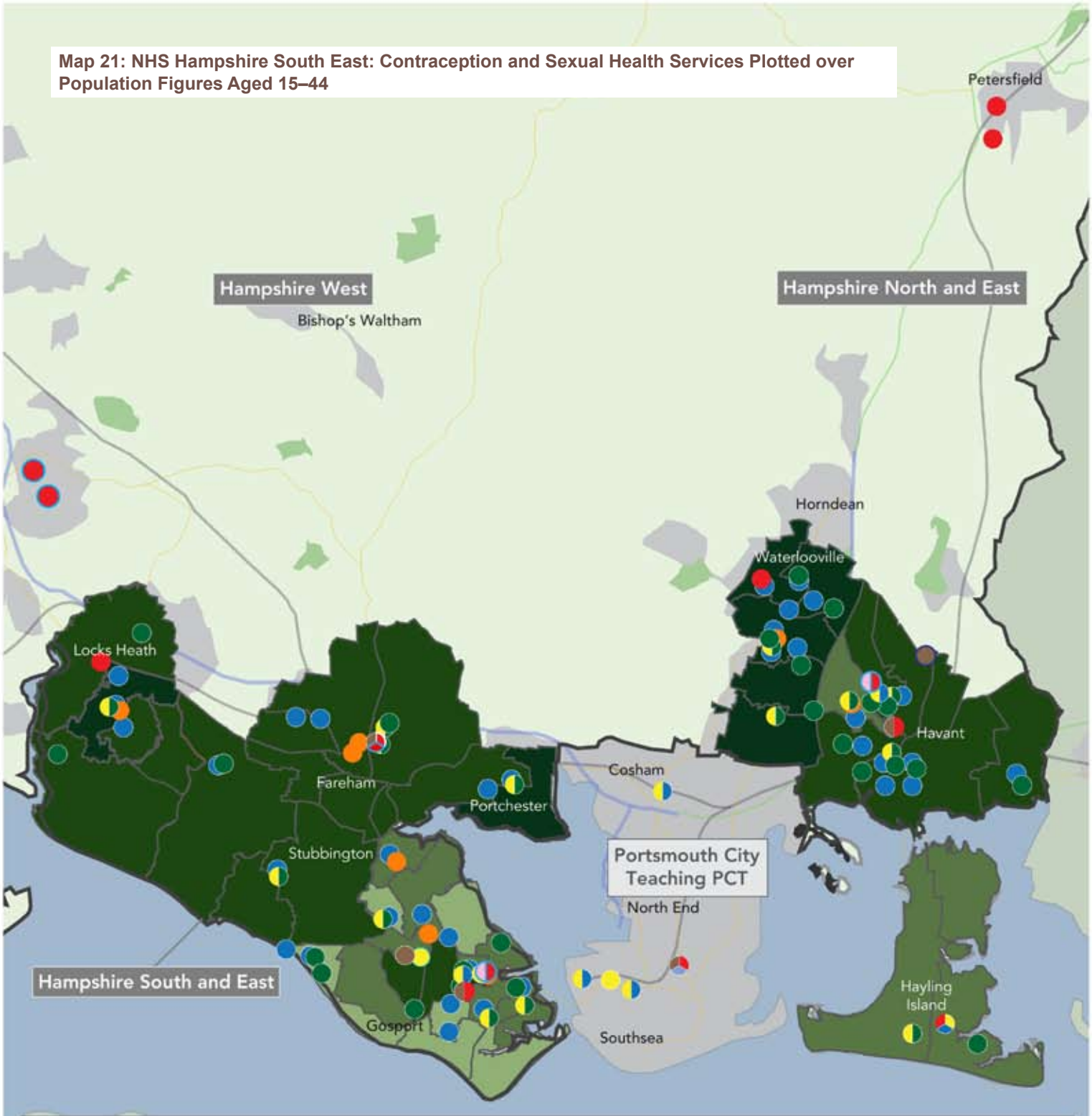
Service Information sourced from: www.getiton.nhs.uk , www.haveyougotit.nhs.uk and provided by NHS Hampshire. Correct as of 2nd June 2009.

Please note opening hours vary across services. Some clinics are term-time only.

* Contraception service offering chlamydia screening or chlamydia screening and treatment. CaSH Clinics may not offer the full range of contraception

** Services available from the same building but not necessary at the same time

Map 21: NHS Hampshire South East: Contraception and Sexual Health Services Plotted over Population Figures Aged 15–44



Key

- GUM Clinic
- CaSH Clinic*
- GUM and CaSH Clinics**
- Information and Advice
- Abortion Service
- C Card distribution point
- GPs
- GPs offering chlamydia screening
- Pharmacy offering free EHC
- Chlamydia screening
- Pharmacy offering free EHC and chlamydia screening
- Restricted Access venue (e.g. College/Military)
- Young People Only

Population Figures (Ages 15-44)

- 0 -1150
- 1151 - 1900
- 1901 - 2400
- 2401 - 3070
- 3070 - 10000

Please note opening hours vary across services. Some clinics are term-time only.

* Contraception service offering chlamydia screening or chlamydia screening and treatment. CaSH Clinics may not offer the full range of contraception

** Services available from the same building but not necessary at the same time

Service Information sourced from: www.getiton.nhs.uk , www.haveyougotit.nhs.uk and provided by NHS Hampshire.
Correct as of 2nd June 2009.

5.2.6 Key Points Relating to Contraception and Sexual Health Service Distribution in Terms of Population Figures (aged 15–24 and 15–44 population)

(Map 16, Map 17, Map 18, Map 19, Map 20, Map 21)

NHS Hampshire South East has more areas falling into the highest population figures for both age groups than Hampshire North and East or West.
The highest populations of 15–24 year olds and 15–44 year olds tend to be found in the cities and major towns of NHS Hampshire. In particular, these are:

NHS Hampshire North and East

- Basingstoke
- Hook
- Oakley and North Waltham
- Aldershot
- Liphook

NHS Hampshire West

- Andover
- Winchester
- Eastleigh
- Blackwater
- Bishops Waltham
- Totton
- Hythe
- Fawley
- Fordingbridge

NHS Hampshire South East

- Portchester
- Stubbington
- Waterlooville
- Purbrook

Some wards, with the highest population figures of between 700 and 1,556 15–24 year olds or between 2,401 and 10,000 15–44 year olds appear to have less access to community-based services such as free EHC, chlamydia screening and the C-Card scheme.
In particular, these are:

NHS Hampshire North and East

- In Basingstoke; Hatch Warren and Beggarwood, Kempshott and Brighton South Hill (no C-Card access point, chlamydia screening or free EHC)
- Blackwater and Hawley (no C-Card access point or free EHC)
- Oakley and North Waltham (no C-Card access point, chlamydia screening or free EHC)
- Basingstoke (700–1,016 15–24 year olds) no C-Card access point, chlamydia screening or free EHC
- Liphook, (700–1,016 15–24 year olds) no C-Card scheme

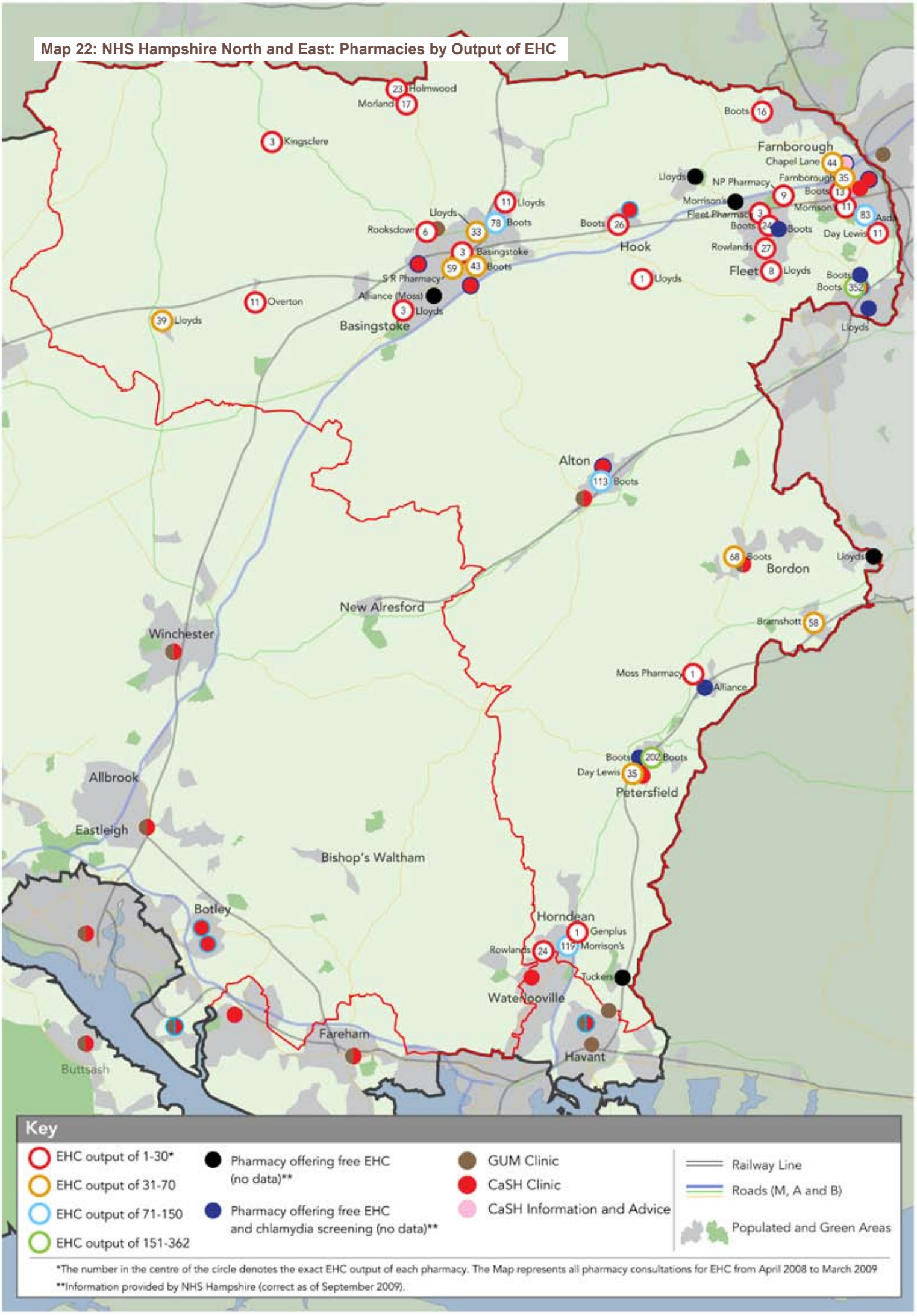
NHS Hampshire West

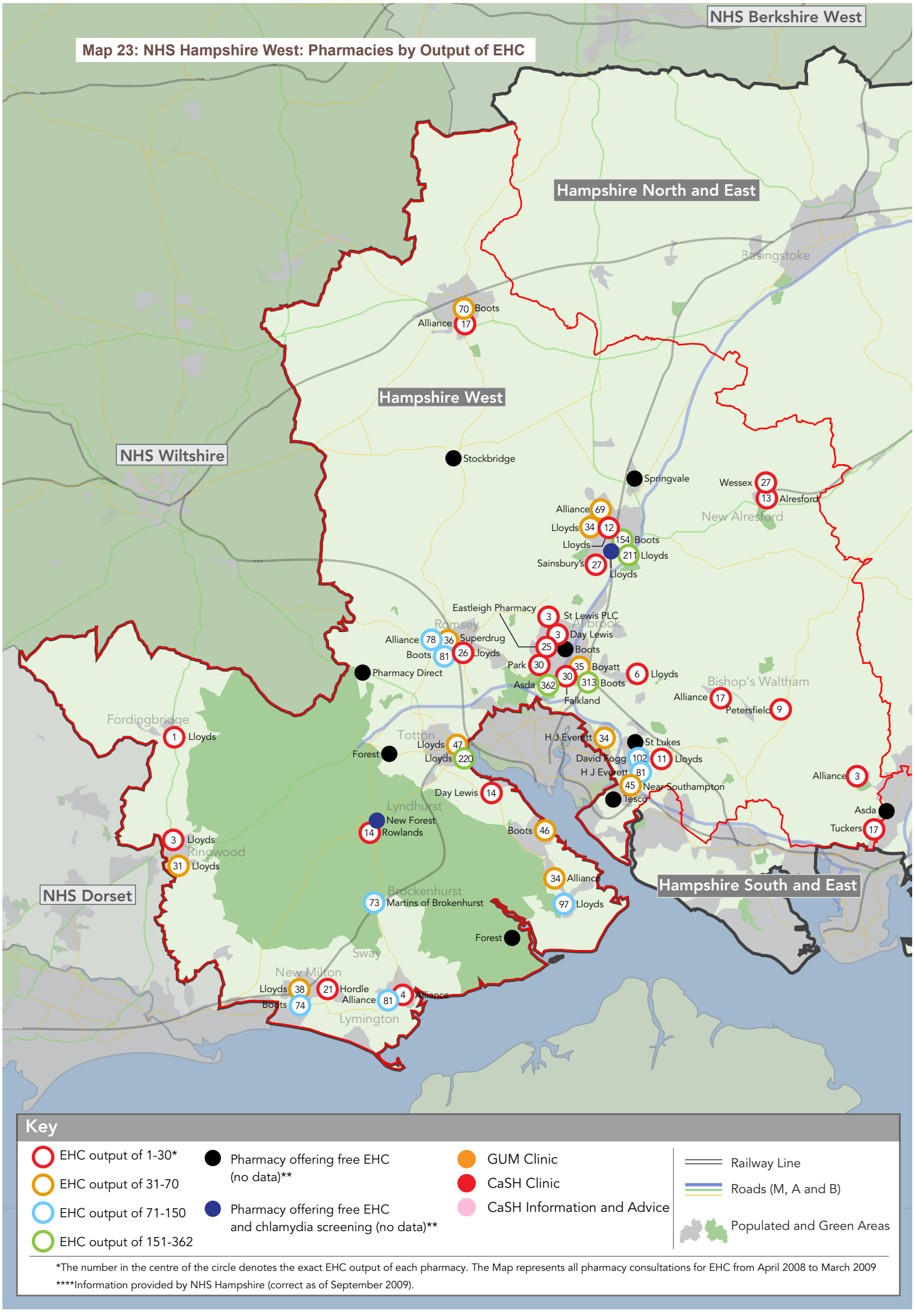
- Fordingbridge (no C-Card access point, chlamydia screening or free EHC)
- Fawley Blackfield & Pennington, Holbury and North Blackfield (no C-Card access point, chlamydia screening or free EHC)
- Blackwater (no C-Card access point, chlamydia screening or free EHC)
- Chilworth, Nursling and Rownhams, North Baddesley and Olivers Battery and Badger farm (no C-Card access point, chlamydia screening or free EHC)
- Burlesdon and Old Netley (no C-Card access point, chlamydia screening or free EHC)
- Denmead (no C-Card access point, chlamydia screening or free EHC)
- Alamein (no C-Card access point or free EHC)

NHS Hampshire South East

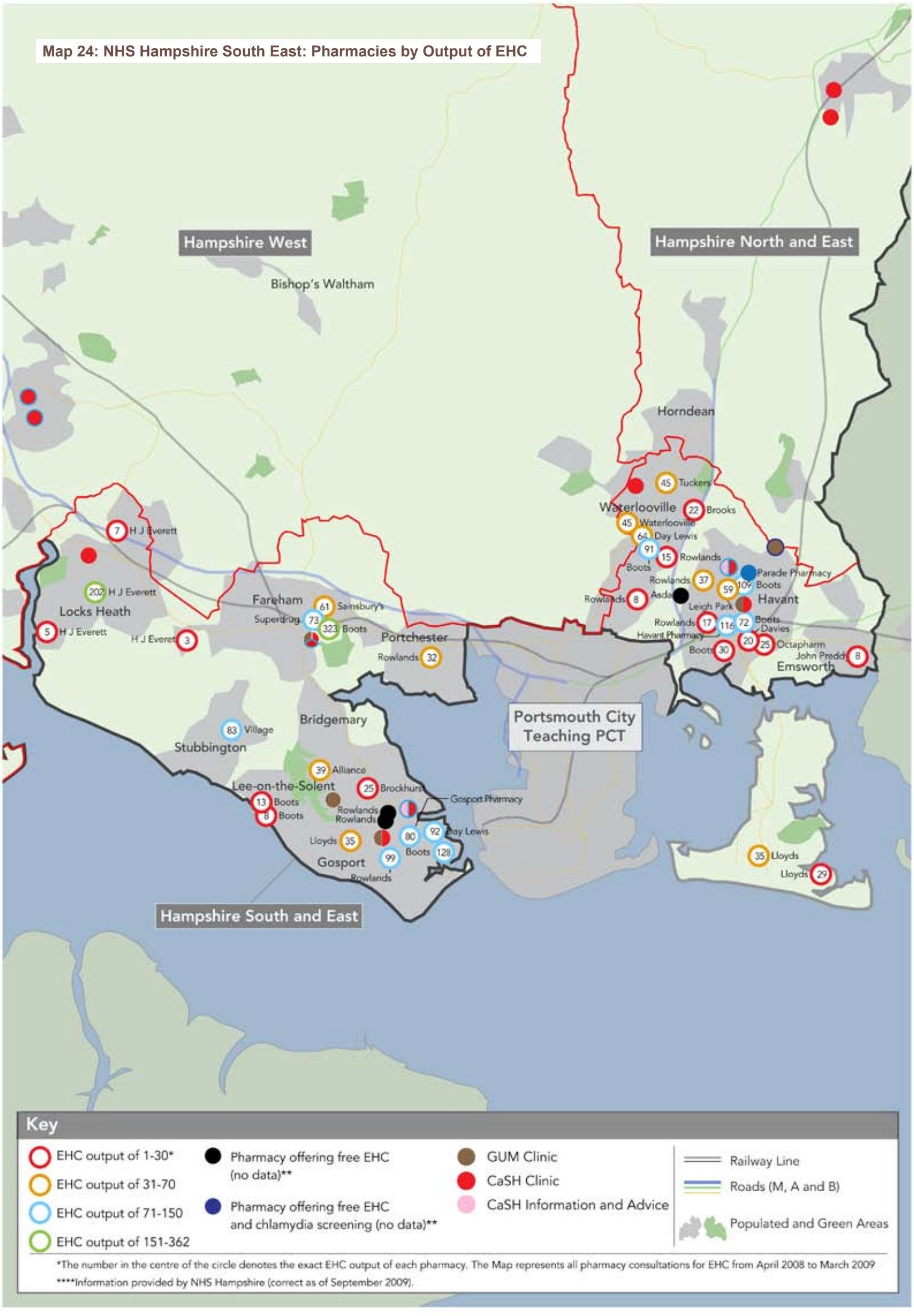
- Portchester (no C-Card access point, chlamydia screening or free EHC)
- Titchfield and Titchfield Common (no C-Card access point or free EHC)
- Warsash (no C-Card access point, chlamydia screening or free EHC)
- Fareham East (no C-Card scheme)
- Fareham North West, Fareham West, Fareham South and Portchester West (no C-Card access point, chlamydia screening or free EHC)
- Hill Head and Stubbington (no C-Card access point, only one pharmacy between both wards offering chlamydia screening and free EHC)
- Hayling Island (no C-Card Scheme)
- Purbrook and Stakes (no C-Card scheme)
- Emsworth, Bondfields, Warren Park, Cowplain and St Faiths (no C-Card scheme)
- Bedhampton (no C-Card scheme or chlamydia screening)

Map 22: NHS Hampshire North and East: Pharmacies by Output of EHC




Map 23: NHS Hampshire West: Pharmacies by Output of EHC
NHS Berkshire West
Hampshire North and East
Basingstoke
70 Boots
Alliance 17
Hampshire West
NHS Wiltshire
Stockbridge
Springvale
Wessex 27
13 Alresford
New Alresford
Alliance 69
Lloyds 34 12
Lloyds 154 Boots
211 Lloyds
Sainsbury's 27
Lloyds
Eastleigh Pharmacy
3 St Lewis PLC
Romsey
Allbrook
3 Day Lewis
Alliance 78 36 Superdrug
25 Boots
Boots 81 26 Lloyds
Park 30
35 Boyatt
6 Lloyds
Pharmacy Direct
Asda 362
30 313 Boots
Falkland
Bishop's Waltham
Alliance 17
Petersfield 9
Fordingbridge
1 Lloyds
Totton
H J Everett 34
St Lukes
Lloyds 47
Forest
Lloyds 220
David Fogg 102 11 Lloyds
H J Everett 81
45 Near Southampton
Tesco
Alliance 3
Day Lewis 14
Lyndhurst
New Forest
14 Rowlands
Asda
Tuckers 17
Boots 46
3 Lloyds
Ringwood
31 Lloyds
34 Alliance
NHS Dorset
Hampshire South and East
Brockenhurst
73 Martins of Brokenhurst
97 Lloyds
Forest
Sway
New Milton
Lloyds 38
21 Hordle
Alliance
4 Alliance
Boots 74
81
Lymington
Key
EHC output of 1-30*
EHC output of 31-70
EHC output of 71-150
EHC output of 151-362
Pharmacy offering free EHC (no data)**
Pharmacy offering free EHC and chlamydia screening (no data)**
GUM Clinic
CaSH Clinic
CaSH Information and Advice
Railway Line
Roads (M, A and B)
Populated and Green Areas
*The number in the centre of the circle denotes the exact EHC output of each pharmacy. The Map represents all pharmacy consultations for EHC from April 2008 to March 2009
****Information provided by NHS Hampshire (correct as of September 2009).

Map 24: NHS Hampshire South East: Pharmacies by Output of EHC



Key

- EHC output of 1-30*
- EHC output of 31-70
- EHC output of 71-150
- EHC output of 151-362
- Pharmacy offering free EHC (no data)**
- Pharmacy offering free EHC and chlamydia screening (no data)**
- GUM Clinic
- CaSH Clinic
- CaSH Information and Advice
- Railway Line
- Roads (M, A and B)
- Populated and Green Areas

*The number in the centre of the circle denotes the exact EHC output of each pharmacy. The Map represents all pharmacy consultations for EHC from April 2008 to March 2009

**Information provided by NHS Hampshire (correct as of September 2009).

5.2.7 Key Points Relating to the EHC Output of Pharmacies (Map 22, Map 23, and Map 24)

- EHC output is generally higher in areas where the 15–24 population is 700 or higher.
- EHC uptake is particularly high in Hampshire South East.
- Boots the Chemist commonly has the highest outputs of EHC across NHS Hampshire.
- Although Basingstoke has a higher 15–24 population than Winchester; its EHC uptake is considerably lower (89 in total) than Winchester (188).
- Andover, North Farnborough, Bordon, Alton and Hook also have low EHC uptake when compared to their 15–24 population figures.

Map 25: NHS Hampshire North and East: Chlamydia Screening Programme Access Points

Key

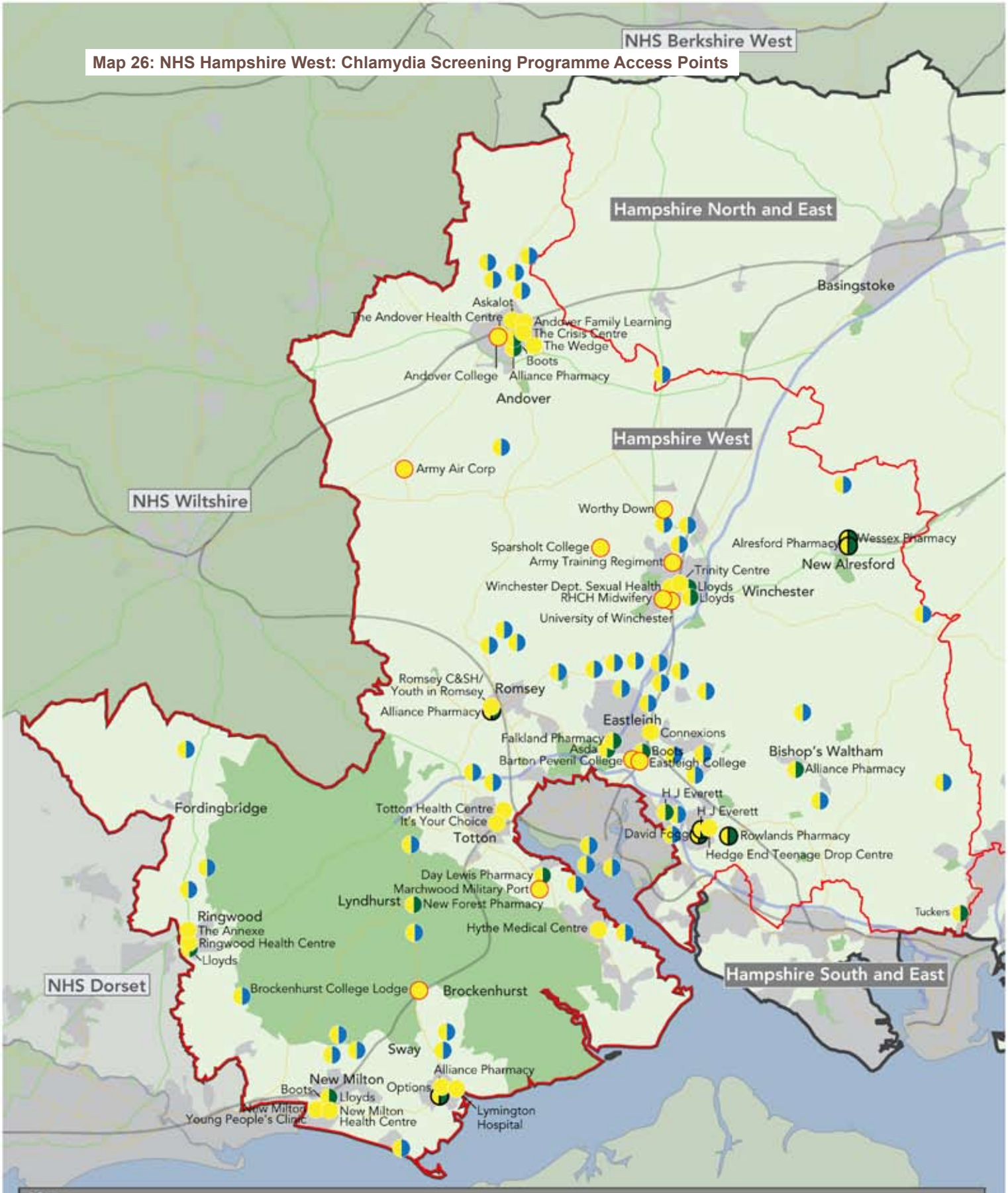
- Chlamydia screening from pharmacies
- Chlamydia accredited pharmacies
- Chlamydia screening from other venues
- Restricted access venue (e.g. College/Military)
- GP offering chlamydia screening*
- GP not offering chlamydia screening

- Railway Line
- Roads (M, A and B)
- Populated and Green Areas

* Chlamydia screening from GPs only available to registered patients

Information sourced from: www.getiton.nhs.uk , www.haveyougotit.nhs.uk and provided by NHS Hampshire. Correct as of 8/7/09

Map 26: NHS Hampshire West: Chlamydia Screening Programme Access Points



Key

- Chlamydia screening from pharmacies
- Chlamydia accredited pharmacies
- Chlamydia screening from other venues
- Restricted access venue (e.g. College/Military)
- GP offering chlamydia screening*
- GP not offering chlamydia screening

- Railway Line
- Roads (M, A and B)
- Populated and Green Areas

* Chlamydia screening from GPs only available to registered patients

Information sourced from: www.getiton.nhs.uk , www.haveyougotit.nhs.uk and provided by NHS Hampshire. Correct as of 8/7/09

Map 27: NHS Hampshire South East: Chlamydia Screening Programme Access Points

Key

- Chlamydia screening from pharmacies
- Chlamydia accredited pharmacies
- Chlamydia screening from other venues
- Restricted access venue (e.g. College/Military)
- GP offering chlamydia screening*
- GP not offering chlamydia screening

- Railway Line
- Roads (M, A and B)
- Populated and Green Areas

* Chlamydia screening from GPs only available to registered patients

Information sourced from: www.getiton.nhs.uk , www.haveyougotit.nhs.uk and provided by NHS Hampshire. Correct as of 8/7/09

- There are only four GPs in NHS Hampshire that have not signed up to provide the PCTs Local Enhanced Service (LES) agreement for Chlamydia Screening, these are:

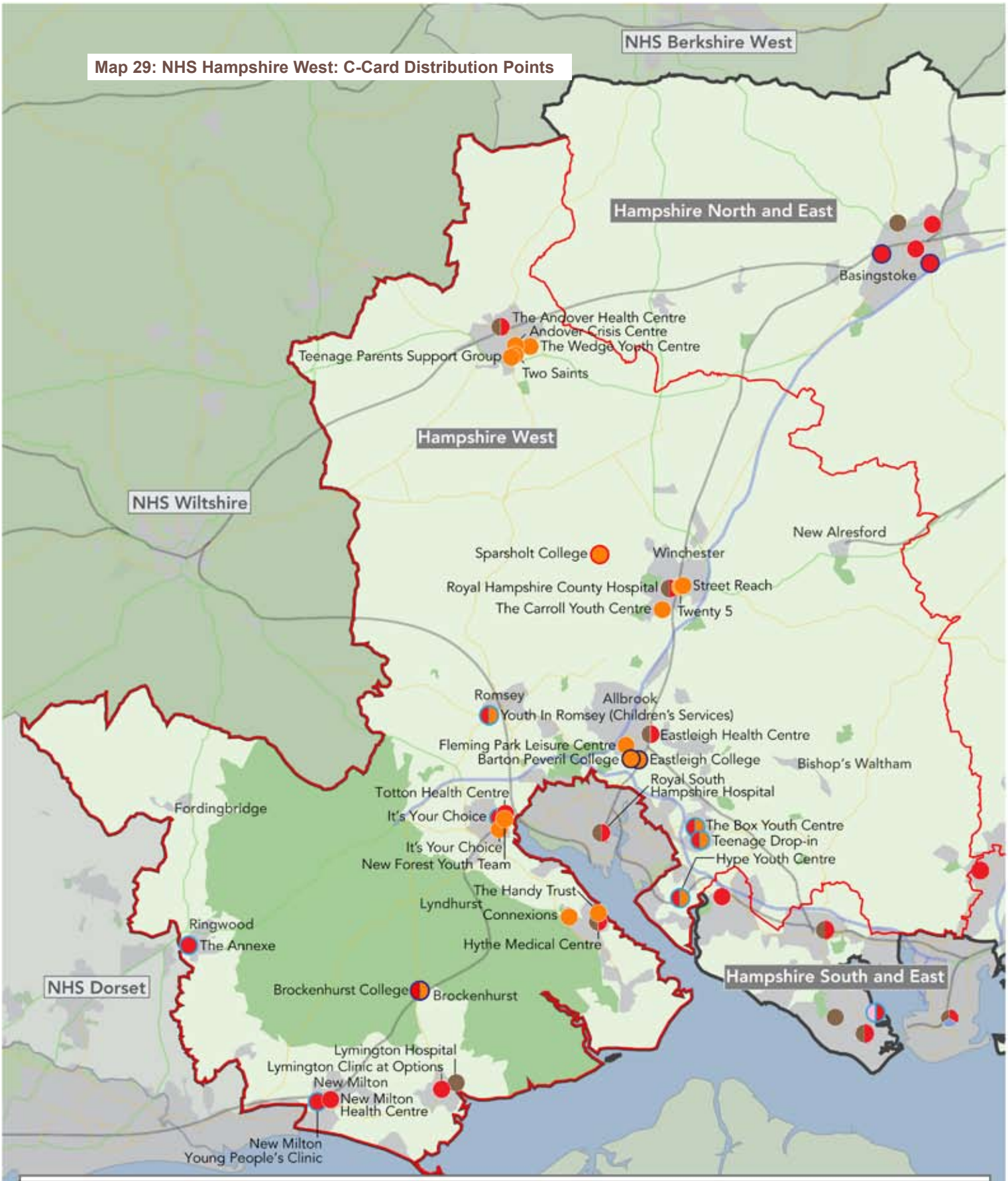
    - Bentley Village Surgery (Hampshire North and East)
    - East Barn Surgery (Hampshire North and East)
    - Park Lane Medical Centre (Hampshire South East)
    - Dr Daniel RJE (Hampshire South East)

These GPs are not based in areas where this is likely to have a significant impact on the local populations.

- There is good coverage of chlamydia screening services across NHS Hampshire, although some wards may need increased outlets (please see 5.2.6 for suggested wards).

Map 28: NHS Hampshire North and East: C-Card Distribution Points

Map 29: NHS Hampshire West: C-Card Distribution Points

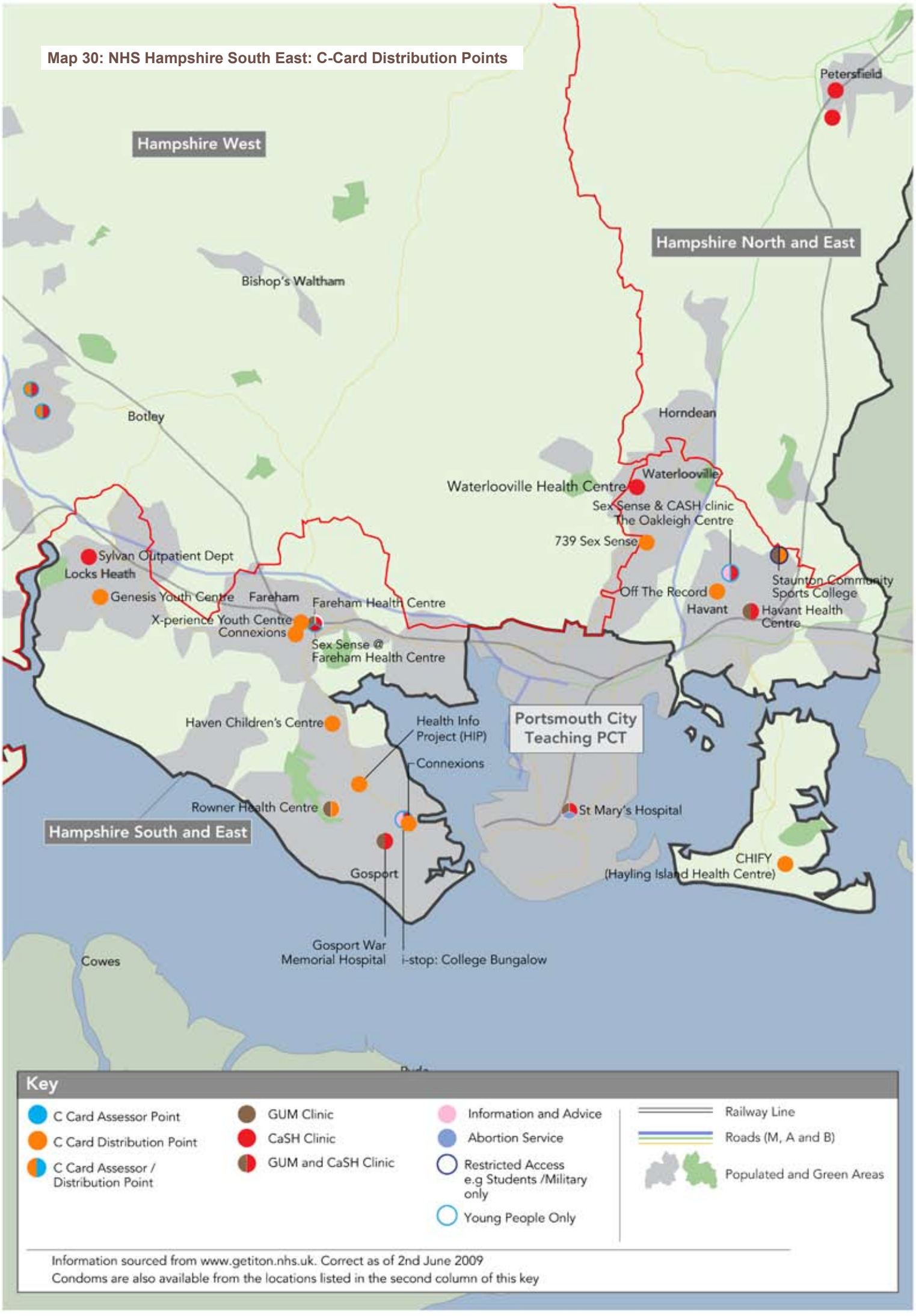


Key

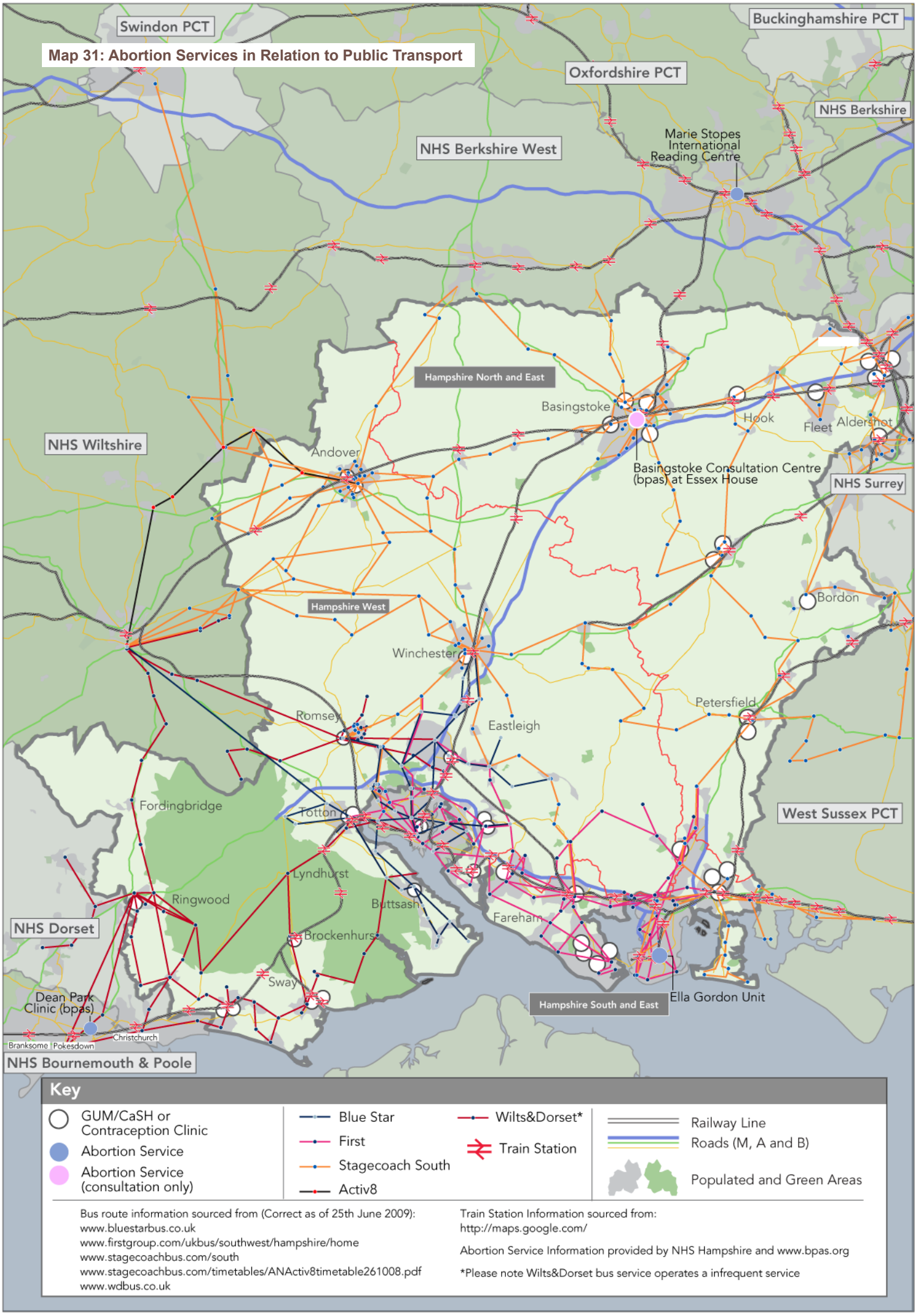
- C Card Assessor Point
- C Card Distribution Point
- C Card Assessor / Distribution Point
- GUM Clinic
- CaSH Clinic
- GUM and CaSH Clinic
- Information and Advice
- Abortion Service
- Restricted Access e.g Students /Military only
- Young People Only
- Railway Line
- Roads (M, A and B)
- Populated and Green Areas

Information sourced from www.getiton.nhs.uk. Correct as of 2nd June 2009
Condoms are also available from the locations listed in the second column of this key

Map 30: NHS Hampshire South East: C-Card Distribution Points



- Generally, there is at least one C-Card access point in all cities and major towns across NHS Hampshire.
- A list of areas in potential need of increased access can be found in 5.2.6.


Map 31: Abortion Services in Relation to Public Transport
Swindon PCT
Buckinghamshire PCT
Oxfordshire PCT
NHS Berkshire
NHS Berkshire West
Marie Stopes International Reading Centre
Hampshire North and East
Basingstoke
Hook
Fleet
Aldershot
NHS Wiltshire
Andover
Basingstoke Consultation Centre (bpas) at Essex House
NHS Surrey
Bordon
Hampshire West
Winchester
Petersfield
Romsey
Eastleigh
Fordingbridge
Totton
West Sussex PCT
Lyndhurst
Ringwood
Buttsash
Fareham
NHS Dorset
Brockenhurst
Sway
Dean Park Clinic (bpas)
Hampshire South and East
Ella Gordon Unit
Branksome
Pokesdown
Christchurch
NHS Bournemouth & Poole
Key
GUM/CaSH or Contraception Clinic
Abortion Service
Abortion Service (consultation only)
Blue Star
First
Stagecoach South
Activ8
Wilts&Dorset*
Train Station
Railway Line
Roads (M, A and B)
Populated and Green Areas
Bus route information sourced from (Correct as of 25th June 2009):
www.bluestarbus.co.uk
www.firstgroup.com/ukbus/southwest/hampshire/home
www.stagecoachbus.com/south
www.stagecoachbus.com/timetables/ANActiv8timetable261008.pdf
www.wdbus.co.uk
Train Station Information sourced from:
http://maps.google.com/
Abortion Service Information provided by NHS Hampshire and www.bpas.org
*Please note Wilts&Dorset bus service operates a infrequent service

5.2.10 Key Points Relating to Abortion Services in Relation to Public Transport (Map 31)

Three services provide abortion services for NHS Hampshire residents, all are located outside of NHS Hampshire and are as follows:

- Marie Stopes (Reading)
- The Ella Gordon Unit (Portsmouth) - only available to those resident in Hampshire South East
- bpas (Bournemouth)
- bpas consultation-only centre (Basingstoke)

bpas are currently applying for a licence to provide EMA at their Basingstoke centre. If an EMA service were offered from Basingstoke, this would greatly increase the accessibility of abortion services across NHS Hampshire.

Access to the nearest abortion services (by car) from major towns and cities is as follows:[36]

Marie Stopes (Reading)

- Andover: 39 miles, 57 minutes
- Farnborough: 22 miles, 38 minutes
- Aldershot: 20 miles, 45 minutes
- Basingstoke: 18 miles, 34 minutes
- Fleet: 16 miles, 32 minutes

bpas (Bournemouth)

- Andover: 45 miles, 1 hour, 5 minutes
- Winchester: 38 miles, 48 minutes
- Eastleigh: 33 miles, 43 minutes
- Romsey: 28 miles, 35 minutes
- Totton: 27 miles, 37 minutes
- Lymington: 17 miles, 37 minutes
- Fordingbridge: 17 miles, 25 minutes

The Ella Gordon Unit (Portsmouth)

- Gosport: 14 miles, 30 minutes
- Fareham: 9 miles, 17 minutes

36. Calculations are all approximations based on http://maps.google.com/ 'directions' application.

Average travel times (by car from all areas with young people populations (15 – 24) over 1017 to abortion services[37]

Marie Stopes (Reading)

Hampshire South and East

- Gosport: 64.4 miles, 1 hour and 28 minutes
- Portchester: 60.9 miles, 1 hour and 21 minutes
- Fareham: 59.3 miles, 1 hour and 15 minutes
- Stubbington: 58.5 miles, 1 hour and 21 minutes
- Waterlooville: 52 miles, 1 hour and 24 minutes

Hampshire North and East

- Farnborough: 22 miles, 38 minutes
- Aldershot: 20 miles, 45 minutes
- Basingstoke: 18 miles, 34 minutes
- Fleet: 16 miles, 32 minutes

Hampshire West

- Lymington: 65.2 miles, 1 hour and 31 minutes
- Fordingbridge: 63 miles, 1 hour and 24 minutes
- Romsey: 50.9 miles, 1 hour and 10 minutes
- Totton: 49.9 miles, 1 hour and 7 minutes
- Eastleigh: 41.8 miles, 59 minutes
- Andover: 39 miles, 57 minutes
- Winchester: 35.6 miles, 55 minutes
- BPAS (Bournemouth)
- Hampshire South and East
- Waterlooville: 55.3 miles, 1 hour and 5 minutes
- Gosport: 50.9 miles, 1 hour and 6 minutes
- Portchester: 47.4 miles, 58 minutes
- Fareham: 45.8 miles, 53 minutes
- Stubbington: 45 miles, 58 minutes

Hampshire North and East

- Farnborough: 73 miles, 1 hour and 21 minutes
- Aldershot: 71.5 miles, 1 hour and 26 minutes
- Fleet: 68.9 miles, 1 hour and 22 minutes
- Basingstoke: 58.6 miles, 1 hour and 7 minutes

Hampshire West

- Andover: 45 miles, 1 hour and 5 minutes
- Winchester: 38 miles, 48 minutes
- Eastleigh: 33 miles, 43 minutes
- Romsey: 28 miles, 35 minutes
- Totton: 27 miles, 37 minutes
- Lymington: 17 miles, 37 minutes
- Fordingbridge: 17 miles, 25 minutes

37. Calculations are all approximations based on http://maps.google.com/ 'directions' application. These calculations do not take into account construction projects, traffic, weather, or other events which may increase or reduce travelling distances and times.

The Ella Gordon Unit (Portsmouth)

Hampshire North and East

- Rushmoor, Grange: 43 miles, 1 hour and 7 minutes
- Rushmoor, Mayfield: 44 miles, 1 hour and 9 minutes
- Rushmoor, North Town: 41 miles, 1 hour 7 minutes
- Rushmoor, Manor Town: 42 miles, 1 hour 8 minutes
- Rushmoor, Wellington: 40 miles, 1 hour, 1 minute
- Basingstoke & Deane, Norden: 41 miles, 58 minutes
- Basingstoke & Deane, Hatch Warren and Beggarwood: 45 miles, 52 minutes

Hampshire West

- Eastleigh South, Central and North: 26 miles, 34 minutes
- Winchester St Michael and St Paul: 32 miles, 41 minutes
- Test Valley Alamein: 49 miles, 1 hour 3 minutes

Hampshire South and East

- Gosport: 14 miles, 30 minutes
- Stubbington: 12.2 miles, 27 minutes
- Fareham: 9 miles, 17 minutes
- Waterlooville: 6.5 miles, 19 minutes
- Portchester: 6.3 miles, 19 minutes

Average travel times (by public transport) from all areas with young people populations (15 – 24) over 1017 to abortion services[38]

BPAS (Bournemouth)

Hampshire North and East

- Aldershot: 2 hours and 30 minutes / 1 hour and 56 minutes with 1 change (Train only)
- Fleet: 1 hour and 47 minutes/ 1 hour and 51 minutes with 1 change (Train only)
- Farnborough: 1 hour and 40 minutes/ 1 hour and 57 minutes with 1 change (Train only)
- Basingstoke: 1 hour and 15 minutes with 0 changes (Train only)

Hampshire West

- Andover: 2 hours and 4 minutes/ 2 hours and 8 minutes with 1/3 changes (Bus and Train) or 1 hour and 48 minutes with 1 change (Train only)
- Romsey: 1 hour 20 minutes/ 1 hour 14 minutes with 1 change (Train only)
- Totton: 1 hour and 14 minutes with 1 change (Bus and Train) or 50 minutes with 1 change (Train only)
- Eastleigh: 1 hour and 7 minutes / 1 hour and 4 minutes with 1 change (Train only)
- Winchester: 1 hour and 4 minutes/ 1 hour /57 minutes with 0 changes (Train only)
- Fordingbridge: 1 hour and 2 minutes with 1 change (Train only)
  Lymington: 39 minutes / 54 minutes with 1 change (Train only)

Hampshire South and East

- Stubbington: 3 hours and 15 minutes/ 3 hours and 21 minutes with 3/4 changes (Bus and Train)
- Waterlooville: 2 hours and 6 minutes /2 hours and 13 minutes with 2/3 changes (Bus and Train)
- Gosport: 1 hour and 57 minutes with 1 change (Bus and Train)
- Portchester: 1 hour and 28 minutes/ 1 hour and 38 minutes with 1 change (Train only)
- Fareham: 1 hour and 22 minutes/ 1 hour and 16 minutes with 1 change (Train only)

Marie Stopes (Reading)

Hampshire North and East

- Aldershot: 1 hour and 27 minutes with 0 changes (Bus only) or 1 hour and 16 minutes / 1 hour and 22 minutes with 2/3 changes (Bus and Train)
  Farnborough: 1 hour and 7 minutes/ 1 hour and 11 minutes/ 1 hour and 14 minutes with 1/2 changes (Bus and Train)
- Fleet: 57 minutes with 0 changes (Bus only) or 1 hour and 5 minutes with 2 changes (Bus and Train)
- Basingstoke: 45 minutes / 37 minutes with 1 change (Bus and Train)

Hampshire West

- Fordingbridge: 2 hours and 29 minutes/ 2 hours and 27 minutes with 3 changes (Bus and Train)
- Romsey: 2 hours / 1 hour and 34 minutes/ 1 hour and 58 minutes with 2/3 changes (Bus and Train)
- Andover: 1 hour and 20 minutes/ 1 hour and 15 minutes with 2 changes (Bus and Train)
- Totton: 1 hour and 39 minutes/ 1 hour and 34 minutes with 2 changes (Bus and Train)
- Lymington: 1 hour and 38 minutes with 2 changes (Bus and Train)
- Eastleigh: 1 hour and 13 minutes with 2 changes (Bus and Train)
- Winchester: 53 minutes with 1 change (Bus and Train)

Hampshire South and East

- Stubbington: 2 hours and 16 minutes with 3 changes (Train only)
- Gosport: 2 hours and 11 minutes with 2/3 changes (Bus and Train)
- Waterlooville: 2 hours and 9 minutes with 3 changes (Bus and Train)
- Portchester: 2 hours and 1 minutes / 1 hour and 52 minutes/ 1 hour and 54 minutes with 2/3 changes

38. Calculations are all approximations based on http://maps.google.com/ 'directions' application. These calculations do not take into account construction projects, traffic, weather, or other events which may increase or reduce travelling distances and times.

(Train only)
- Fareham: 1 hour and 37 minutes with 2 changes (Bus and Train)

The Ella Gordon Unit (Portsmouth)

Hampshire North and East

- Rushmoor, Grange: 2 hours 12 minutes to 2 hours 32 minutes with 2-3 changes, (Train and Bus)
- Rushmoor, Mayfield: 2 hours 7 minutes with 2 changes (Train and Bus)
- Rushmoor, North Town: Journeys between 1 hour 58 minutes and 2 hours 19 minutes with 1-3 changes (Train and Bus)
- Rushmoor, Manor Town: Journeys between 1 hour 56 minutes and 2 hours 31 minutes with 2 changes (Train and Bus)
- Rushmoor, Wellington: Journeys between 1 hour 58 minutes and 2 hours 20 minutes with 2 changes (Train and Bus)
- Basingstoke & Deane, Norden: Journeys between 1 hours 43 minutes and 2 hours 17 minutes with 1-2 changes (Bus and Train)
- Basingstoke & Deane, Hatch Warren and Beggarwood: 1 hour 43 minutes to 2 hours 17 minutes with 1-2 changes (Bus and Train)

Hampshire West

- Eastleigh South, Central and North: Journeys between 54 minutes and 1 hour 21 minutes with 1-2 changes (Train and Bus)
- Winchester St Michael and St Paul: Journeys between 1 hour 33 minutes and 2 hours 4 minutes with 1-3 changes (Bus and Train)
- Test Valley Alamein: Journeys between 2 hours 1 minute and 2 hours 22 minutes with 2 changes (Bus and Train)

Hampshire South and East

Please note; people travelling from the South and East to Portsmouth may travel by the Gosport-Portsmouth ferry. The ferry departs from Gosport every 7.5 to 15 minutes. The crossing time is approximately 4 minutes.

- Stubbington: 2 hours and 16 minutes with 3 changes (Bus and Train)
- Gosport: 2 hours and 11 minutes with 2/3 changes (Bus and Train)
- Waterlooville: 2 hours and 9 minutes with 3 changes (Bus and Train)
- Portchester: 2 hours and 1 minute /1 hour and 52 minutes/ 1 hour and 54 minutes with 2/3 changes (Bus and Train)
  Fareham: 1 hour and 37 minutes with 2 changes (Bus and Train)

Service providers have expressed concerns over the distances people are required to travel to access services:

"Certainly, with unplanned pregnancy it is a long way to travel, especially if you're a young person and you need someone to come with you. It's a long way to go and a long way to come back. I think the concern is that people are going for these appointments on their own and have to travel quite large distances."
Service provider, RSHH

Andover has been highlighted as having particularly poor access to abortion services, particularly in light of Andover's high teenage pregnancy and high population of young people.

5.3 Service Overviews

During the course of the SHNA, Options UK's service design team visited five key contraception and sexual health services used by people living in NHS Hampshire. Service providers and users were engaged with at all services and interviewed. The services visited were as follows:

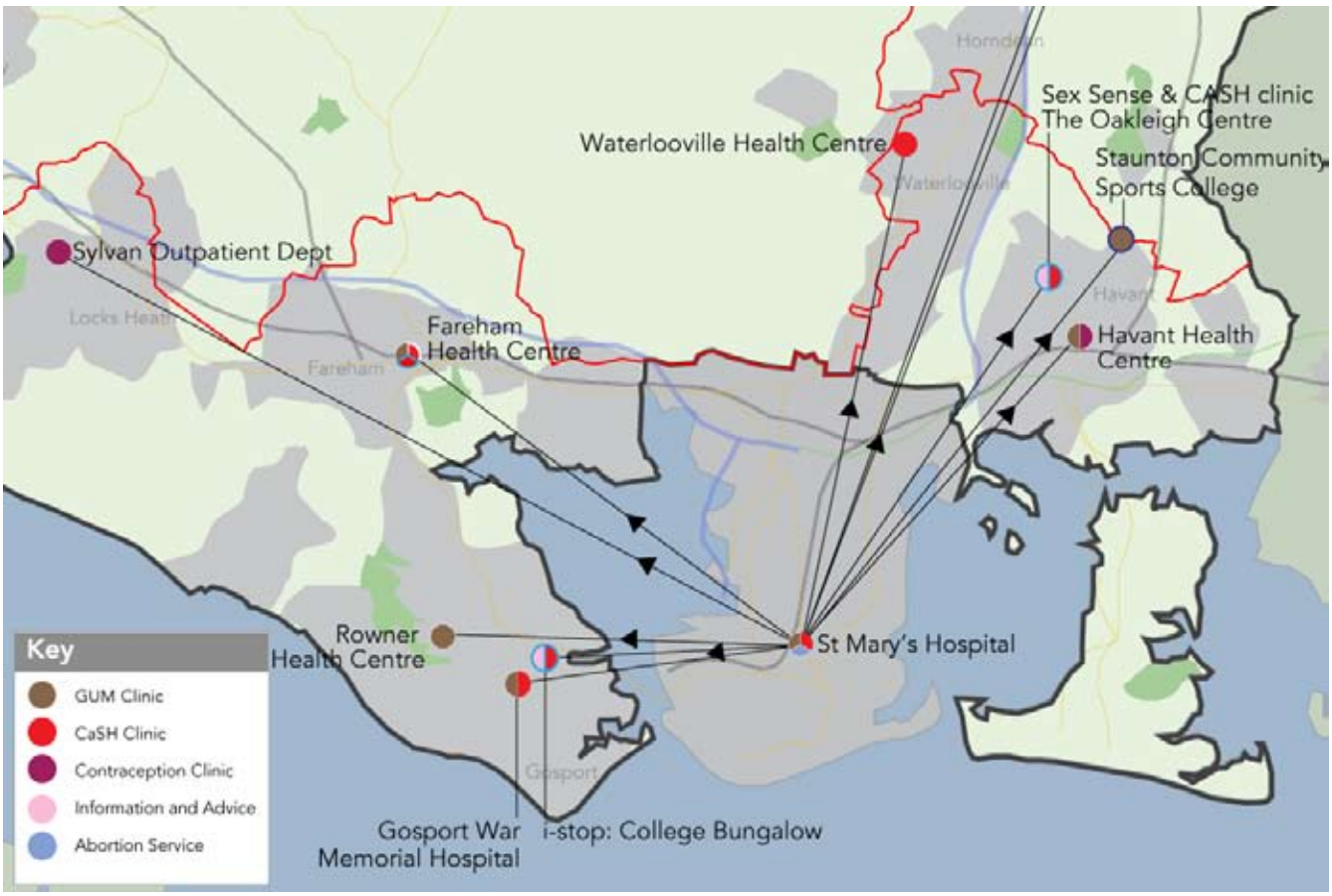
- Royal Hampshire County Hospital GUM Service (9 exit interviews, 6 females aged 17 to 35, 3 males aged 32 to 44)
- Royal South Hants Hospital GUM Department (10 exit interviews, 2 females aged 21, 8 males aged 18 to 53)
- Essex House (Basingstoke) (9 exit interviews, females aged 16 to 36)
- The Ella Gordon Unit (St Mary's Hospital) (2 exit interviews, females aged 19 to 23)
- Waterlooville Health Centre (outreach service from The Ella Gordon Unit) (1 exit interview, female aged 16)

Exit interview participants (EI participants) were asked about all stages of their care pathway and given the opportunity to suggest service improvements both for existing services and for the future of contraception services in NHS Hampshire (comments relating to the future of services can be found in Section 5.4).

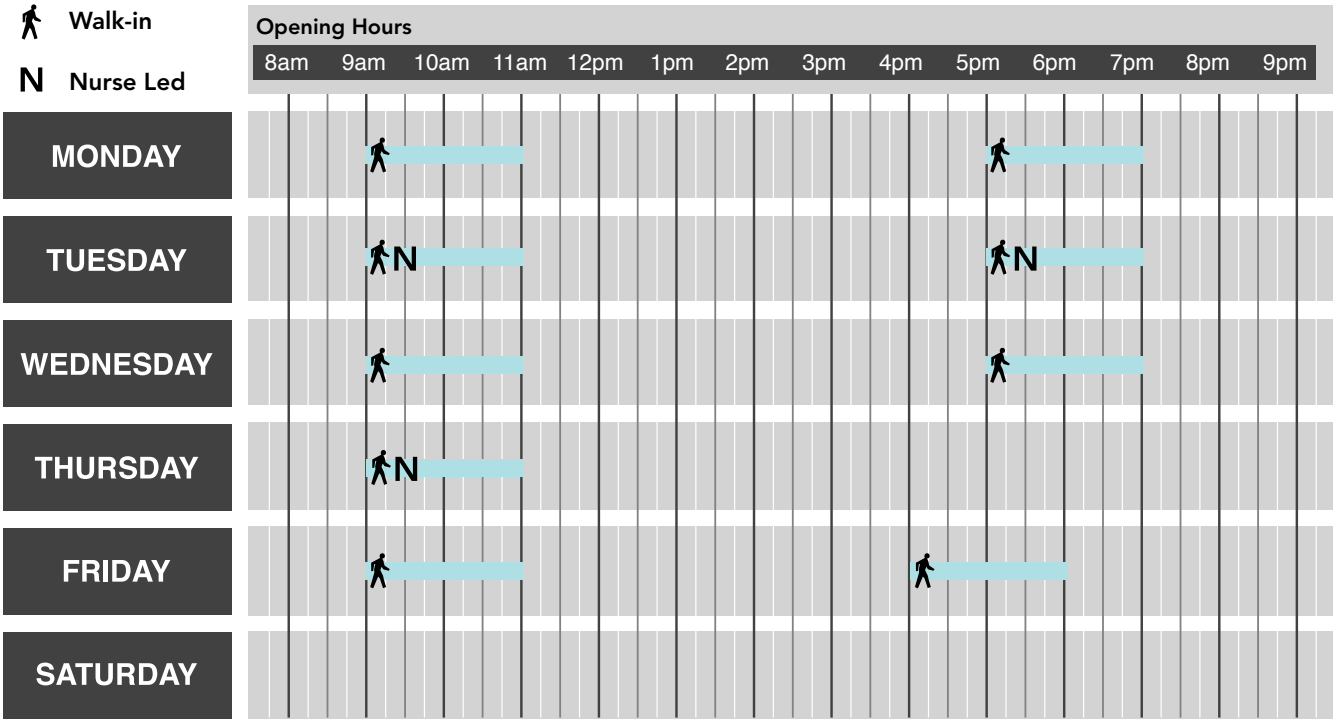
Table 36: Services Available at the Services visited by Options UK

	Royal Hampshire County Hospital GUM Clinic	Royal South Hants Hospital GUM Department	Essex House	The Ella Gordon Unit (and its outreach clinics)
Level One				
Sexual history and risk assessment	√	√	√	√
Contraceptive information and services	√	X	√	√
Free condoms (with information and guidance on correct use)	√	√	√	√
Emergency hormonal contraception	√	√	√	√
STI testing for women	√	√	√	√
Assessment and referral of men with STI symptoms	√	√	X	√
HIV testing and counselling	√	√	X	X
Cervical cytology screening and referral*	√	√	√	√
Pregnancy testing and referral	√	√	√	√
Hepatitis B immunisation	√	√	X	X
Level Two				
Intrauterine device insertion (IUD)	√	√*	√	√
Contraceptive implant insertion	√	X	√	√
Testing and treating sexually transmitted infections	√	√	X	√
Vasectomy	X	X	X	√
Invasive sexually transmitted infection testing for men	√	√	X	X
Level Three				
Outreach for sexually transmitted infection prevention	√	√	X	√
Outreach contraception services	X	X	√	√
Specialised infections management	√	√	X	X
Co-ordination of partner notification	√	√	X	X
Specialised contraception	√	√	√	√
Specialised HIV treatment and care	√	√	X	X
*For HIV-positive women only				

The Ella Gordon Unit and its Outreach Clinics: Overview



Opening Hours



Key Points and Opportunities Relating to The Ella Gordon Unit and its Outreach Clinics

- Fridays have been highlighted as in need of increased clinics.

- Waiting times were understood to be one of the poorer aspects of the service and although rare a service user may wait up to one and a half hours to be seen, particularly during evening clinics.

- Service providers feel that GUM services would be welcome in existing contraception and CaSH outreach clinics, particularly in Waterlooville, Locks Heath and Gosport.

- The EGU provides a referral-based domiciliary contraception services for people unable to access a clinic. This model of care may benefit people living in other parts of Hampshire.

- Service providers highlighted the following areas as in potential need of increased services:
    - Gosport (Rowner in particular)
    - Havant
    - Leigh Park
    - Fareham

- These communities were highlighted as they fall into the most deprived in the South and East. People living in these areas may not be equipped or inclined to travel to hub services and may benefit from increased services in their communities. A full-time Band 6 nurse will soon begin working exclusively in Gosport and Havant offering a 'clinic in a box' service

"We find that a lot of people that don't come are from the deprived areas because they can't afford to get to any of the clinics, or they just don't know, or they do but they're scared to come."
Service Provider

"Rowner, that's particularly poorly, very large estates, and very poor people, and a big area of deprivation and big problems with them accessing healthcare."
Service Provider

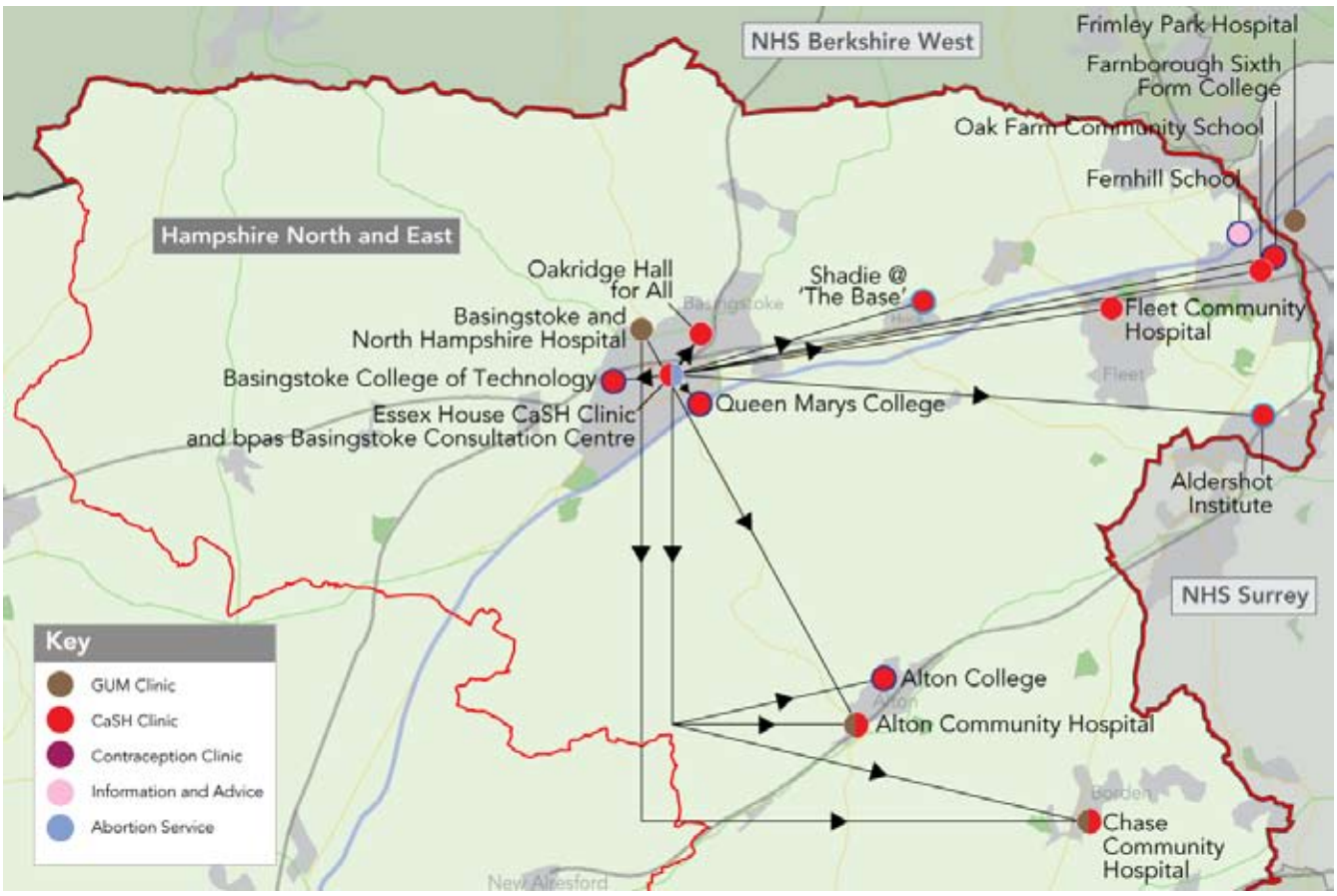
- Although the 'clinic in a box' service is likely to improve access to services a future model of care may look at developing full-time dedicated clinics in these areas.

"***I think we should have a Centre of Excellence that's open six days a week, eight till eight; one in Gosport, one in Fareham, one in Havant, that is GU, CaSH and Young People. People walk through one door and they get everything.***"
Service Provider

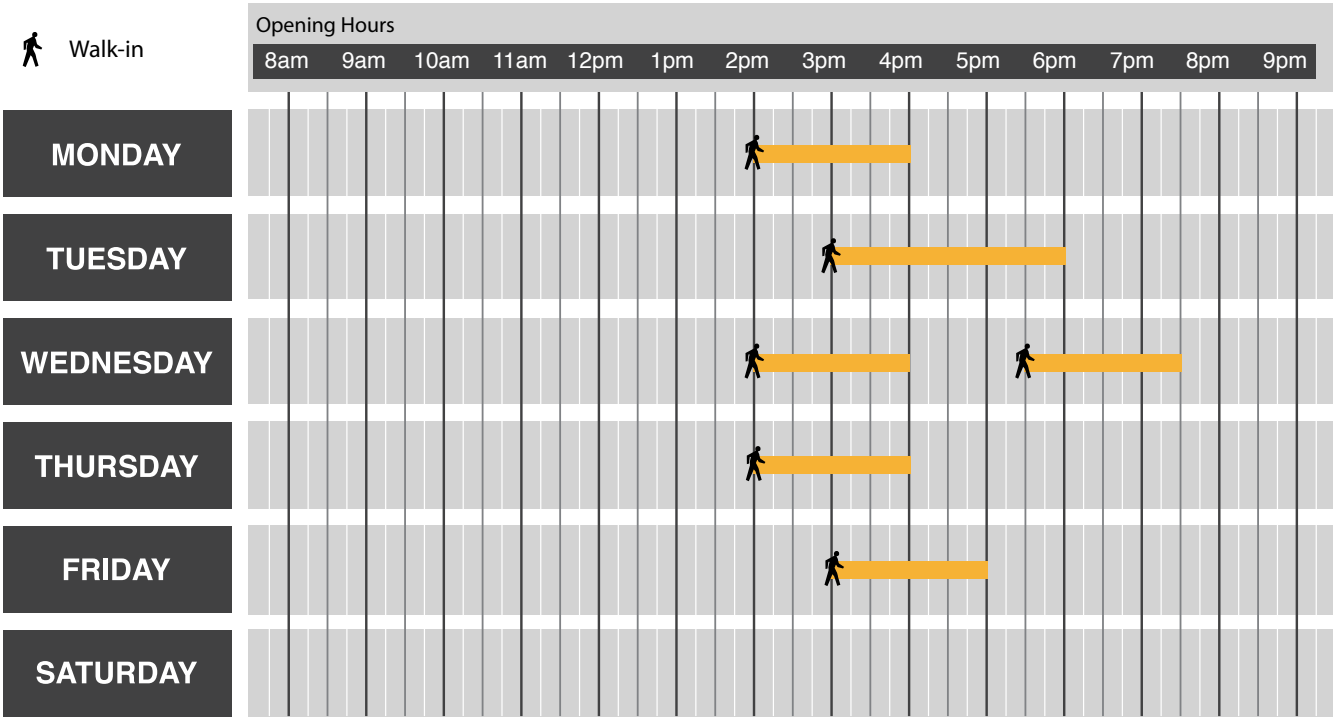
- IUD/IUS can only be fitted in the outreach clinics if a doctor is present. Service providers have reported users requiring IUD/IUS services being turned away either because a doctor is not present or busy. If nurses were trained to fit IUD/IUS the efficiency of clinics could be improved, resulting in fewer service users being redirected.

- Service providers suggested that supplying contraceptive clinics in schools would be an effective and accessible way to target young people and increase the number of young people's clinics.

Essex House and its Outreach Clinics: Overview



Opening Hours



Key Points and Opportunities Relating to Essex House and its Outreach Clinics

- The lack of clinical and administrative space is a key difficulty for service providers at Essex House.
- Essex House presently does not offer morning clinics. It is felt that a Monday morning clinic would be beneficial for services users, particularly for those requiring EHC.
- Service providers are considering implementing Saturday clinics, as it is felt there is a need, although some staff resistance is expected.

"I would like to see, in the future, say, within the next five years, that we'd be running three Saturday services, one from Basingstoke, one from Aldershot, and one from Alton but staffing that is going to be a real nightmare."
Service Provider

- It is thought that an integrated IT system (possibly Hampshire wide) would improve the efficiency of clinics and confidentiality for service users, especially for those who use more than one clinic.
- Equipping clinical staff with laptops would allow them to utilise their time during quiet periods in outreach clinics.
- Soundproofing has been highlighted as a particular issue at the Chase Community Hospital outreach clinic.

"At the Bordon clinic you can hear between the rooms, far too much; a really big issue, I think."
Service Provider

- The positioning of the examination beds in Alton Community Hospital is thought to be inappropriate for cervical cytology or IUD/IUS services.

"The couches face the door. So if you've got a girl on a couch and the curtains don't go around the couch, you have to lock the door for security, which is against all health and safety, otherwise someone could open the door and the girl's there, legs akimbo, you know?"
Service Provider

- Alton Community Hospital is located on the outskirts of Alton, and as such may not be attracting as many service users as a central location would. At present no alternative location can be determined.

"It's not ideal by any stretch of the imagination, but the question is where else could we be?"
Service Provider

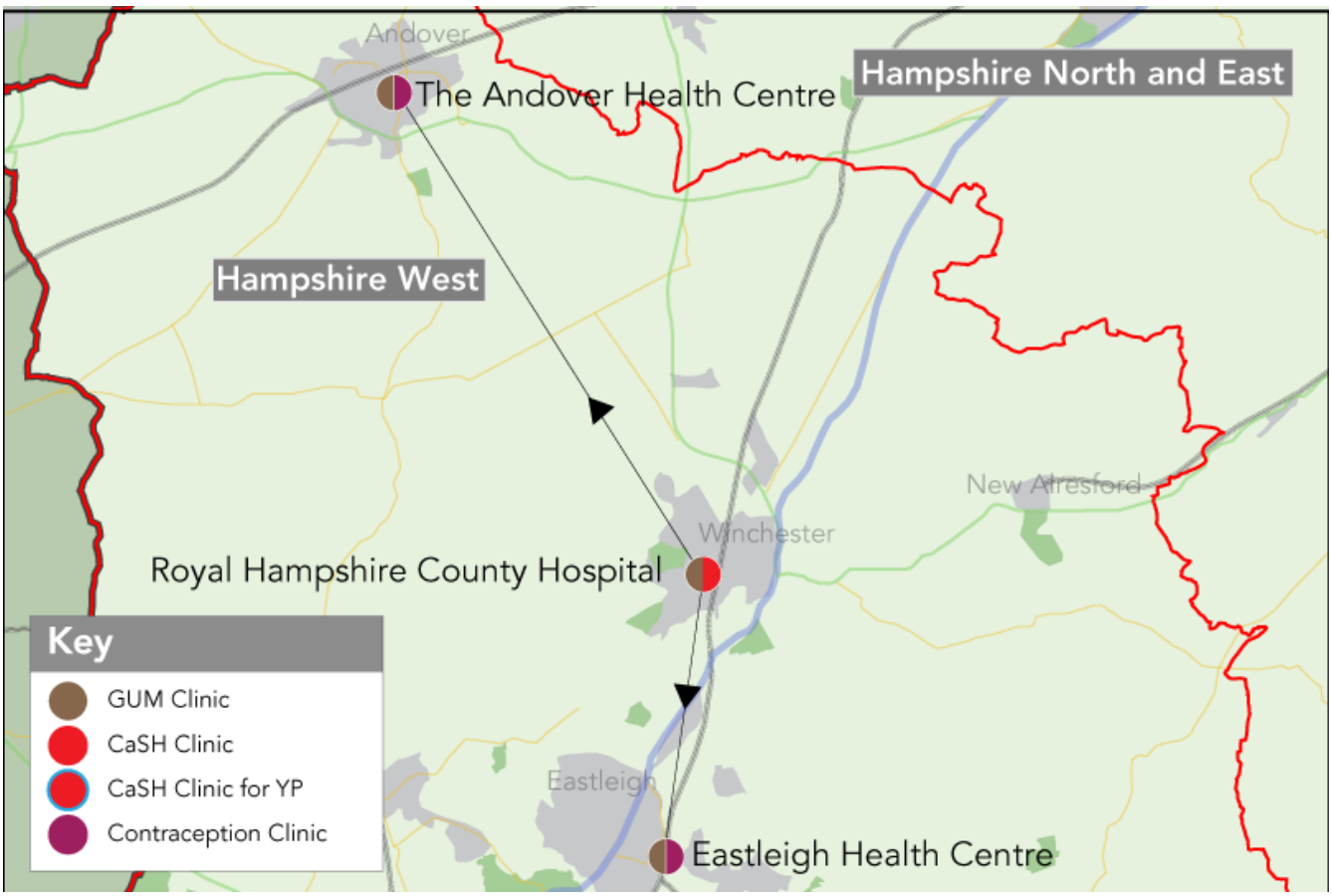
- GUM and CaSH service providers work concurrently, together in two outreach clinics. EI participants welcomed the suggestion of fully integrated clinics and this model is likely to prove popular in other outreach services.

"We would like to work much more closely with GU, and bring the two together"
Service Provider

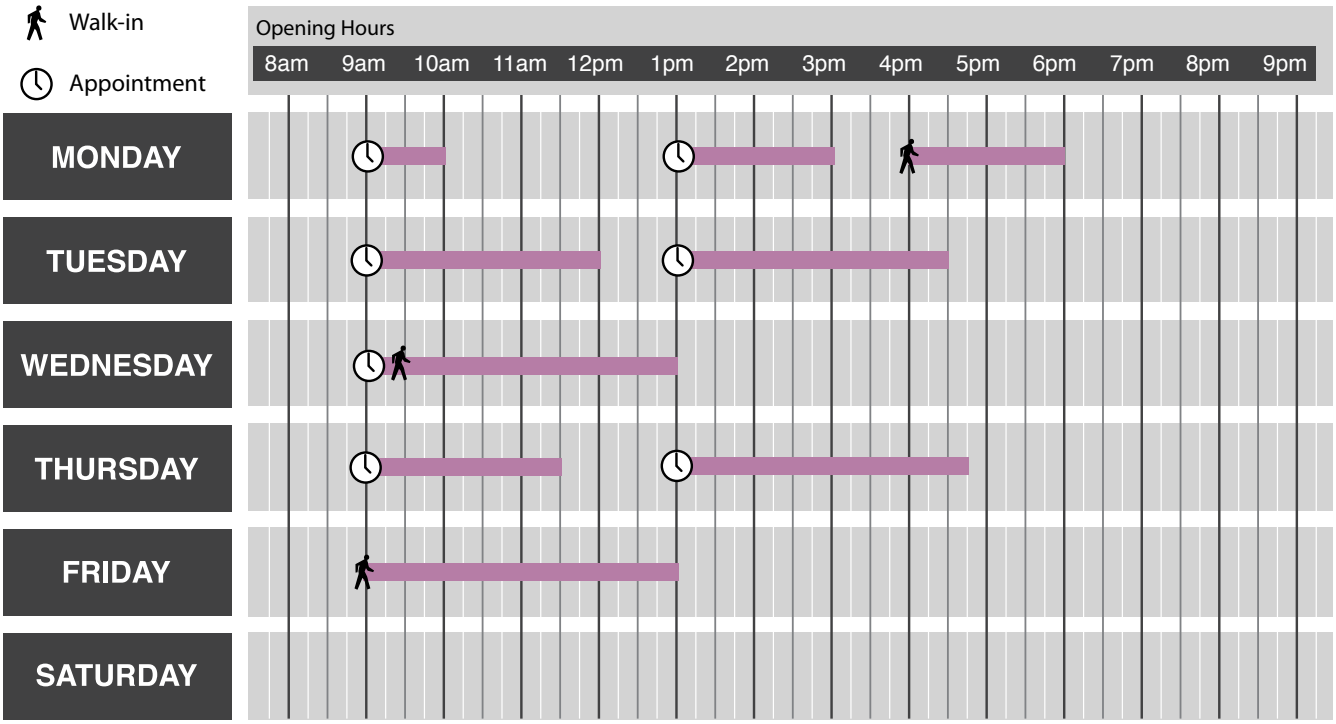
- Some issues have been highlighted regarding the shared clinics between GUM and CaSH, in relation to different methods of working, ideally one method should be adopted for shared clinics and conformed to by all, this would improve accessibility for service users

"We're having major issues with appointments. People are booking into [contraception] clinic when they should be in the GU clinic, and the GU clinic will only see people with appointments, whilst we will see walk-ins."
Service Provider

Royal Hampshire Hospital GUM and its Outreach Clinics: Overview



Opening Hours



- It is felt that better relationships with schools need to be built and that SRE should be delivered exclusively by trained nurses rather than school teachers;

"I think we need much stronger links with schools, in terms of the education. I think you get teachers doing it, and they don't know what they're taking about often, they don't know the full depth of knowledge. "
Service Provider

- Some EI participants reported difficulties finding the RHH GUM clinic building, as it is part of a terrace it is not visually prominent. In addition its residential appearance may not visually resonate with a medical institution, potentially disorientating services users and potential users. It may benefit service users and local awareness of the service if clearer signage was put in place to the front and rear of the building. Guidance on an effective wayfinding system can be found in the NHS Estates guide on wayfinding.[39]

"The first time I came here... it wasn't easy to find. Even the second time that I came back I went into the wrong building. There are lots of little blue doors, so I wasn't sure."
Service User at Royal Hampshire Hospital GUM, female, 35

- Funding for psychosexual services was withdrawn in 2008. Psychosexual services are now delivered on an individual 'case-by-case' basis. It is felt that if commissioning for the service was restored it would be fully utilised.

- In 2008 the service's funding was changed from a PBR tariff to a block contract. Service providers feel that with their current access targets they are unable to develop the service's activity. Something they feel would be possible if the service was returned to a PBR tariff.

- The outreach clinics in Andover see a significant number of Salisbury residents. This is thought to be because there is not a GUM consultant working in Salisbury. It is felt that under a PBR tariff the Salisbury residents accessing clinics in Andover could be an extra source of income for the service.

- Current staffing levels are preventing additional clinics being instigated in either Andover or Eastleigh. These areas are comparatively deprived and it is felt that increased clinics would be welcomed and filled to capacity.

- There may be a need to introduce new clinics or reallocate existing clinics at RHH GUM to the evening. A recent in-house survey looked at why uptake of 48 hour access was low. 90% of respondents stated that they had to arrange appointments around work and 48-hours was not a permissible notice period. It is likely that evening clinics would cater for the needs of those working traditional office hours.

"I would say Fridays is a bit short. If anything, it should be later opening times for the appointments, and later closing."
Service User at Royal Hampshire Hospital GUM, male, 44

- It is felt that access to GUM services for the prisoners in Winchester Prison is poor. A service used to be offered in the prison, this was withdrawn due to high numbers of DNAs. It is thought the best solution may be to train prison staff to offer level one and two services.

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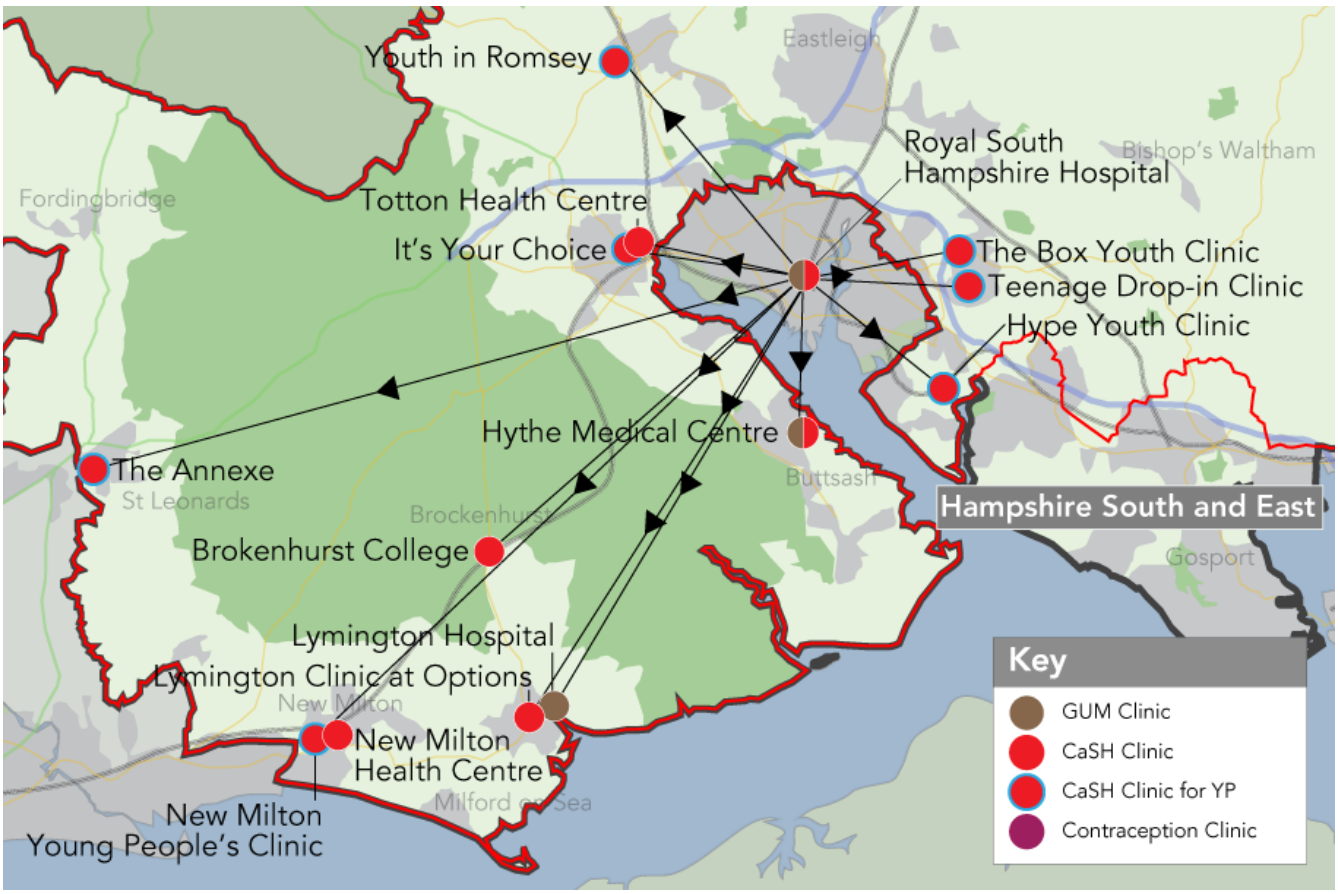
39 Miller, C. and Lewis, D. (1999) Wayfinding - Effective wayfinding and signing systems, Guidance for healthcare facilities

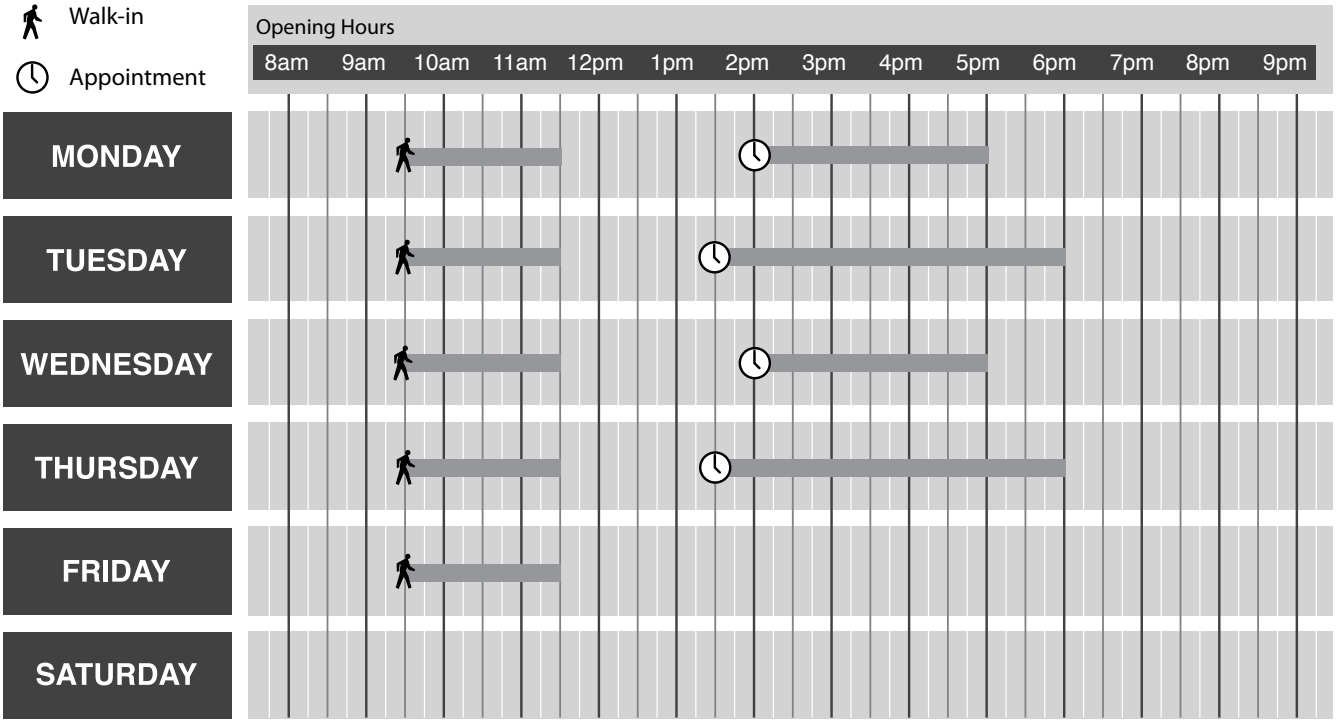
Royal South Hants Hospital GUM and its Outreach Clinics: Overview



Opening Hours

Walk-in

Appointment



- An electronic remote booking system may be instigated as part of the Southampton GUM website, a model similar to this may benefit service users across NHS Hampshire.
- RSHH GUM currently operates 2 outreach clinics for GUM and 15 for CaSH, the long-term aim is to reduce the number of outreach clinics but to increase clinical outreach hours across the remaining sites.
- RSHH GUM's long-term aim is to increase clinical hours to offer an "eight to late, at least Monday to Friday" service offering GUM contraception and abortion services from the same site.
- Although it is acknowledged that later opening hours would benefit service users of RSHH GUM the clinic cannot open later than 6pm for security reasons as it is situated in an outpatients department.
- Service providers are working towards bringing sexual health services into local schools and colleges

"Clearly we'd like a dedicated young persons' clinic… We're looking at setting in our sexual health drop-ins in all our secondary schools and colleges."
Service Provider

- This is seen as a way of targeting young people effectively and introducing sexual health services as part of a normal healthy lifestyle from a young age. Service providers are aware that they will have to overcome some resistance from some schools before services can be implemented.

"[A service] that helps young people start to identify, from an early age, this is the face of our clinic, this is how it works, we're here, we're approachable, and we will take you through the rest of your sexual health life."
Service Provider

- Service providers are aware that young people have a smaller window of opportunity to access sexual health services, particularly if they wish to keep their access from their parents. The service may consider implementing a young people's 'One-stop shop' walk-in between 3 and 6pm weekdays. There will be space and capacity considerations to make before this service can commence.
- Soundproofing in some consultation / examination rooms has been identified as an issue. Radios are placed in these rooms, but this is not an ideal circumstance and ideally measures should be taken to improve the quality of soundproofing.
- Clinical space in RSHH GUM is felt to be insufficient. Service providers feel that two more consultation / examination rooms would allow them to increase their capacity and provide a better quality service.
- One EI participant expressed concerns about her privacy and dignity during an examination:

"I don't know about you, but I always worry... Nurses are flying in and out all the time, and I genuinely sometimes get a bit worried, because they fly in, and it's, hello."
Service User, RSHH, female, 21

Care should be taken to give the service user control of who enters consultation/examination rooms, particularly when they are in a vulnerable position.

- In the long-term service providers would like to see an integrated CaSH and GUM service and are currently working towards bringing the CaSH service closer to GUM.

"The long term aim is that we will actually have the sexual health and contraception services, with ultimately the one reception desk running the clinics, at the same times."

Service Provider

- In the future service providers would like the GUM and CaSH services to become fully integrated:

"Having a bespoke building, just being allowed to build something that was a sexual health service, which covered both options [CaSH and GUM], so you could go left to one centre, right to another and being able to have as much space and flexibility with clinics would be lovely."

Service Provider

5.3.1 Marketing and Advertising of Contraception Services

5.3.1.1. Pathways into Services

The majority of EI participants reported being referred into services via a 'word of mouth' recommendation, usually from a friend who had previously accessed services. The second most highly reported route into services was a referral from a GP.

Some younger participants had learnt about services in school.

Three EI participants at RSHH identified themselves as being in the army. They had been referred to the service by medical services in their army camps.
A smaller group of participants had searched for information on clinics using the internet, but had not always been successful and felt improvements were necessary (it is assumed these participants had not accessed 'Get It On').

"It wasn't very good at all, for starters, the number one result that comes in on Google, if you put in quite a specific search isn't this [RHH], it's something else, and then you've got to go through a bit of searching to actually get what you want. The opening hours on the web bear no resemblance to what's here, so I've actually been trying to come up for a walk-in appointment for a while, but it's on different days and so that could actually be quite a lot better."

Service User at RHH GUM, male, 32

5.3.1.2. Marketing Campaigns and Websites

Knowledge and Awareness of the 'Get It On' and 'Have You Got It?' Brands and Websites

The majority of EI participants did not recognise either brand. The minority of EI participants who did had generally only seen the brands inside clinics and had not accessed either website.

A minority of younger EI participants had heard of the 'Get It On' condom distribution scheme. They felt they would use the scheme, but some stigma was attached to being seen on the scheme's website especially when accessing it in public environments.

"Well, my friend has a 'Get It On' card and I went on it [The 'Get It On' website] just to check it out. I didn't stay on it long… I thought it more comfortable just to talk to my friend about it because he already had one"

Service User at Waterlooville Health Centre, female, 16

The EI participants that had seen either of the brands were asked to explain what they represented, no participants had a strong or familiar knowledge of the brands' meanings.

"It's all about wearing condoms."

Service User at The Ella Gordon Unit, female, 23

Two participants reported using 'Get It On' to access information on services. Both stated that the website contained all the information they had required and was simple to use:

"I went to it last night actually. I needed to find out times and stuff for yesterday. I thought it was quite good actually, pretty good."

Service User at RHH GUM, female, 17

It should be noted that no EI participants reported owning or ever using a C-Card, despite the fact that almost all

participants reported accessing contraception or sexual health services on more than one occasion.

5.3.2 Accessibility and Usability of Sexual Health and Contraception Websites

When 'Hampshire contraception' is searched in Google[40], the top hit directs the user to http://www.hampshirecash.org.uk/ a dedicated website for those resident in Hampshire North and East. The site displays detailed and comprehensive information about all aspects of contraception and sexual health. The 'Hampshire CaSH' site is easy to navigate, with an aesthetic that suggests its inclusivity and accessibility to all. It may be beneficial however, if the site integrated service information for the whole of NHS Hampshire, serving as an age-inclusive alternative to the young peoples' dedicated, 'Get it on' website.

When searching 'Hampshire sexual health' in Google, the top hit directs the user to the young persons' website 'Get it on' http://www.getiton.nhs.uk/ .The website has a strong brand targeted at young people and has an accessible and unisex aesthetic quality. Navigation and layout is straightforward with the use of a simple menu system and the addition of an interactive map allows users to find appropriate services locally. The information provided is coherent and jargon-free with numerous links directing the user to more detailed sources of information.

When 'Hampshire chlamydia' in searched in Google, the top hit directs the user to the young persons' website 'Chlamydia ...have you got it?' found at; http://www.haveyougotit.nhs.uk/ . The website is aimed at young NHS Hampshire and Portsmouth residents and has a strong, distinctive brand and unisex aesthetic. It is easy to navigate and includes all chlamydia screening sites, the site also allows the user to order a free postal screening kit online.
The Royal South Hants Hospital has a dedicated CaSH website which can be found at; http://www.cashsouthampton.nhs.uk/ .The website is effectively stylised in an accessible, inclusive and engaging way. The site features an interactive menu system, a step-by-step clinic guide and a 'hide button' allowing the user to discreetly browse the site. In order to improve access to the site, translation services, virtual clinic tours[41] and audio options[42] could be added to these websites where appropriate.

This independently stylised model of website may be a useful precedent for other neighbouring GUM services as most are stylised as a branch of the main hospital website, with minimal information with regards to prevention, education and other related issues.

The points to remember section includes a guidance note detailing "if you have had a specific recent infection risk, want testing and have no symptoms, wait at least a week before you attend for screening"[43]. Whilst this may be the appropriate action for most service users, it may be advisable to encourage potential service users to present at the service in order to screen those who may already have a pre-existing STI and to prevent those at risk of HIV from waiting longer than necessary for a consultation, particularly with regard to the offering of PEP[44].

Presenting post-sex also enables clinical staff to assess for risk of pregnancy, a subsequent offer of emergency contraception should this be required. Those at risk of other infections may be encouraged to undergo screening and then advised to return after the appropriate incubation period for further screening.

Hampshire Contraception and Sexual Health Helplines

Although NHS Hampshire does not appear to have a dedicated sexual health helpline, links to relevant national websites with established helplines are prominently situated on the 'Get it on' website. Links include the Brook and the 'r u thinking' website, both with free contraception and sexual health helplines. Links from the 'Get it on' website also include other national bodies with helplines dealing with other related issues such as careers guidance, substance misuse, and

40. An internet based search engine, which can be found at; www.google.co.uk

41. For an example of this please visit http://www.sexfaqs.org/gaolstreet.asp

42. For more information on audio options see the browsealoud enabled NHS website browsealoud http://www.nhs.uk/accessibility/Pages/Accessibility.aspx

43. It is recommended that patients are encouraged to undergo testing for chlamydia with NAAT when they first present and, if they are concerned about exposure which has occurred within the last two weeks, that they are also advised to return for a repeat NAAT two weeks after the last exposure. For further information please visit: http://www.bashh.org/documents/1743/1743.pdf

44. The evidence base for specific recommendations on how long to wait before testing for different STIs is limited. In general: for serological testing (e.g. HIV, syphilis, hepatitis), an interval of 3-6 months is required with the interval reflecting the timing of potential exposure to infection (level IIb). For bacterial STIs, many clinicians would wait 3-7 days before testing (level IV). For further information please visit: http://www.bashh.org/documents/59/59.pdf

unplanned pregnancy.

Other NHS Hampshire contraception and sexual health websites including 'Hampshire CaSH' and the various NHS Hampshire hospital websites do include contact telephone numbers, but do not specify what type of service is offered. Information detailing whether the service offers an appointment-only or an information and advice service may serve to reassure prospective callers. Other CaSH services, such as the St Mary's Hospital CaSH clinic do include a telephone helpline number in their information and promotional literature, although the opening hours are specified as 12.00 – 2.00pm weekdays, which may not be a convenient time for some younger prospective callers.

5.3.2.1 Leaflets and Posters

Two EI participants from Southampton University commented that they had seen service advertisements on campus.

"I found out through my university. I'm at Southampton University… there's lots of posters and that, I think it was in Fresher's Week. I think there was a little store, but there was definitely posters and stuff."

Service User at RSHH, male, 18

5.3.3. Travel to Services

The majority of EI participants were reluctant to travel further than the city or town they lived in to access contraception or sexual health services, particularly if they felt their need was low priority or routine. However, in acute situations or if the need was felt to be urgent then distances they would be prepared to travel would increase dramatically.

"I probably wouldn't go out of Basingstoke. It's hard enough as it is to get round Basingstoke let alone go out of it."

Service User at Essex House, female, 23

Older EI participants and those with personal transport felt less restricted in terms of the distance they would be prepared to travel to access services.

Younger EI participants perceived greater geographical barriers to accessing services as they were likely to travel by foot, this would restrict how far they were able to go.
Travel costs were not a big issue to most EI participants, most were prepared to spend between £5 and £10 to access services. Younger EI participants aged 16 were only prepared to spend up to £2 to travel to services.

5.3.4. Stigmatisation Associated with Accessing Contraception or Sexual Health Services

Most EI participants acknowledged that there was some level of stigmatisation associated with accessing services (particularly sexual health services) and did not see scope for perceptions to change in the near future. A minority expressed desires for services to become more mainstream and felt that this could be achieved though better education for young people.

"It needs to be more normal because it is the walk of life really, isn't it? I think, the NHS, if they were able to get into the education system better, and you kind of grew up with it, then it's not so much of a big deal."

Service User at RHH GUM Female, 21

Some younger EI participants felt the need to keep their use of services secret from authority figures, in particular, their parents, and felt they could only access services at times when their absence would not be noted.

5.3.5 Opening Hours

5.3.5.1 Service User Preferences for Service Opening Times

EI participants of all ages suggested that evening clinics would be beneficial to them.

"The weekends and evenings – because I finish college in a week – so the evenings and weekends is probably the best time that I'd be up to get in."

Service User at RHH GUM, female, 17

Saturday clinics were particularly welcomed by older EI participants that worked traditional office hours and younger EI participants as a source of EHC.

"They still should do it on a Saturday because, say you go out Friday night and then you could come in on Saturday morning."

Service User at Essex House, female, 16

"Probably, say, a Saturday morning or something, because that said, if you are busy working Monday-Friday, you might miss all these chances to get here."

Service User at RSHH, male, 23

A smaller number of EI participants felt that clinics should remain open during lunchtimes.

EI participants who identified themselves as university students at RHH and RSHH GUM departments were more flexible in terms of the times they could access clinics and preferred to walk-in.
"I would probably only ever come in for walk in, but there's enough time on there to work around a university timetable to be able to come in"

Service User at RHH GUM, female, 21

Some EI participants suggested that consistent opening hours would help them remember when the clinic was open.

"It's on a Monday in the afternoon and Wednesday in the morning… it would be good if the pattern was the

same throughout the week."

Service User at RHH GUM, male, 32

The vast majority of EI participants were comfortable that clinics were open access to all. As all clinics visited were open access services, these responses are unsurprising and may not represent the needs of the wider population of NHS Hampshire.

A small minority of younger EI participants would like clinics to be split for males, females and young people, feeling this would be less stigmatising.

5.3.6 Appointment Booking

5.3.6.1 Service User Preferences for Appointment or Walk-in Services

Participants generally preferred to access walk-in clinics. Providers tended to support walk-in access, feeling it provided consistent, convenient access for their service users as well as preventing DNAs.

"Appointments are a pain in the ass, do you know what I mean? It takes you ages to get one, and then sometimes it gets cancelled and stuff like that, I don't really like appointments. And you have to wait days and days and days to get one. You just walk in and you know you are there."

Service User at RSHH GUM, male, 18

Most younger EI participants preferred walk-in services as they felt that this simplified the process of accessing services, concerns were also raised that parents may overhear if an appointment was booked over the phone.

"A lot of my friends can't call up and make an appointment because of people hearing, like their Mum and Dad or something. So just walk-in's easier."

Service User at Essex House, female, 16

Many EI participants felt that the best accessibility for all could be achieved by providing a mixture of walk-in and appointment clinics.

Older EI participants in particular expressed desires for appointment-based clinics, which could be booked at least a week in advance. This was particularly so routine visits could be planned around other aspects of their lives, in particular, work.

"I would say appointments should be able to be made within a week of you phoning, really."

Service User at RHH GUM, female, 35

5.3.6.2 Appointment Booking Methods

EI participants who selected appointment-based clinics as their preferred method of access were asked how they would like to make an appointment. The most common response was to call the clinic, a minority of service users preferred to make bookings over the internet.

"Ideally it should be on the web. You go on the web, get the website for here, and you say I want an appointment or fill in a web form and then it texts to you, your appointment is such and such, that would be good."

Service User at RHH GUM, male, 32

5.3.7 Service User Knowledge and Awareness

5.3.7.1 Service Users' Knowledge and Experience of Contraception

During the exit interviews participants were shown the full range of contraceptive methods and were asked to explain which methods they felt were suitable for them and which methods they would and would not consider using.

Generally

Some EI participants dismissed the suggestion of using a LARC method as they were felt to be too permanent. Three male army personnel were interviewed, their knowledge of contraceptive methods was poor in comparison with other (non-army) EI participants.

Depo-Provera and Implanon

Some service users felt that Implanon and Depo-Provera were too invasive:

"I don't like the idea of anything inserted… and I don't really like injections"

Service User at RHH GUM, female, 21

"The injection: I do not like. For some reason, the idea of injecting something like that into your body – it's not that I've got things about needles or anything – it just doesn't seem right."

Service User at Royal Hampshire Hospital GUM, female, 35

There were also some misconceptions about the length of time that these methods are effective for:

"The implant I know is put into your arm and I think it's there for ten years."

Service User at Essex House, female, 36

"[Depo-Provera] I know you have it done every six months, again I don't really know how it works."

Service User at RHH GUM, female, 19

The negative anecdotal evidence of peers who had used Implanon was frequently cited as a reason for not considering Implanon:

"I had a friend who had an implant and it went horribly wrong. No, and after seeing what happened to her, no way."

Service User at RHH GUM, female, 35

IUD/IUS

EI participants over 35 were more likely to have used an IUD/IUS method or were more open to considering it. Younger EI participants commonly felt IUD/IUS were most suitable for older women. Some younger participants felt IUD/IUS were less modern (and, therefore, less attractive) forms of contraception:

"My mum uses it. I think it's a bit old school… And nowadays, I think it's quite impractical, and uncomfortable… Not horror stories, but it's not very attractive at all."

Service User at RSHH GUM, female, 21

Diaphragm and Spermicide

No EI participants had experience of the diaphragm or would consider using one. The diaphragm was perceived to be less convenient and practical than other methods. The reusable aspect of the diaphragm was thought to be less hygienic in comparison with other methods.

Contraceptive Patch

The majority of EI participants had never heard of the contraceptive patch. Those that did had basic knowledge of the method, no participants felt they would consider this method.

Contraceptive Pill

The contraceptive pill was seen as the most common method of contraception, particularly for younger people. The positive experiences of peers had encouraged many younger EI participants to use the contraceptive pill.

"The contraceptive pill is very popular so, as I said, I'd go on that."

Service User at Waterlooville Health Centre, female, 16

EHC

Awareness of EHC was particularly good. Most participants were aware that the circumstances in which it should be taken and how long after unprotected sex it is effective for.

"Morning after pill, that's taken at once, but you can take it in the next 72 hours after the accident. But the quicker you take it obviously the faster it works, or more effective it is."

Service User at The Ella Gordon Unit, female, 19

Condoms

EI participants were generally aware that the use of condoms prevent pregnancy and the spread of STIs.

A minority of female EI participants believed that it is a male's responsibility to provide condoms.

"Yeah, it's a male thing; not a female… The boys usually have them."

Service User at Essex House, female, 16

Some respondents preferred not to use condoms as they were felt to be unreliable (splitting easily), tactilely unpleasant or a barrier to intimacy:

"A bit of a mood-killer, aren't they?"

Service User at RSHH GUM, male, 23

Female Condom

Awareness of the female condom was low amongst respondents. No participants would consider using the female condom.

Male EI Participants' Perceptions of Female Contraception

Male EI participants had little knowledge of contraceptive methods beyond the condom. Some male participants particularly disapproved of LARC methods as they were seen as too invasive:

"One of my friends had it in the arm, or something like that… very weird, like an alien put something into your body."

Service User at RSHH GUM, male, 26

Some male participants felt it was the responsibility of the female to ensure that she was protected from pregnancy and that female methods were more convenient to use than condoms:

"The pressure's on the woman to make sure that she doesn't get pregnant, more than the bloke, which isn't right but I just think that's the way it is at the moment because you'd expect a girl to be on the pill, in a relationship or not, because obviously it's a lot easier to do it that way, rather than use a condom every time you have sex."

Service User at RSHH GUM, male, 23

5.3.7.2 Service Users' Knowledge and Awareness of STIs

First Action

The majority of EI participants felt they would visit their GP if they had symptoms or suspected they had an STI, they would then expect to be referred by their GP into GUM or contraceptive services for full diagnosis and treatment.

"If I suspected I had any of them.... I would go to the doctor's first and then presumably they would send me here if I needed to."

Service User at RHH GUM, female, 35

General Awareness of STIs

Most participants had some knowledge of at least one STI (most commonly HIV or chlamydia) a minority of participants had no knowledge of any STIs or their symptoms.

EI participants who identified themselves as army personnel (three in total) had comparatively poorer knowledge of STIs and contraception than other participants. They were more likely to have misconceptions in relation to routes of transmission and exaggerated perceptions of symptoms. Misconceptions included the belief that climate change could cause chlamydia and that some STIs only affect females.

"Lumps on you. Yes, you get lumps, great lumps"
Service User at RSHH GUM, male, 21

"I think maybe chlamydia, I think for guys, being in a hot climate"
Service User at RSHH GUM, male, 21

Chlamydia

EI participants considered chlamydia to be the most common STI as well as the most contagious.

EI participants knew the most about the symptoms and treatment of chlamydia compared to the other STIs. The majority of EI participants knew chlamydia could be asymptomatic. A smaller number of participants would expect to experience a symptom if they had a chlamydia infection, which would be their prompt to access services.

"Chlamydia, that's not very noticeable: you don't get any symptoms with that, but it can stop you having kids, i.e. for boys, and I think girls as well, to be honest."
Service User at RSHH Hospital GUM, male, 18

Gonorrhoea

EI participants had relatively poor knowledge of the symptoms or route of transmission of gonorrhoea:

"I couldn't tell you what gonorrhoea was or any symptoms for it at all"
Service User at RSHH, male, 23

A minority of male participants felt that gonorrhoea would only affect women.

HIV/AIDS

EI participants firmly associated the transmission of HIV with bodily fluids (in particular blood and salvia) and needle sharing. A minority of participants stated sexual contact as a route of transmission:

"You can catch AIDS through blood and saliva, as far as I know"
Service User at Essex House, female, 23

HIV/AIDS was the most feared STI, although EI participants could not express specific reasons why and symptoms were not known. The majority of EI participants strongly felt HIV/AIDS would be terminal and timescales between transmission and death would be short.

Participants did not separate HIV and AIDS, using the terms interchangeably, feeling AIDS could be caught after a first contact:

"HIV and AIDS are pretty dangerous. Don't get them."
Service User at The Ella Gordon Unit, female, 19

"[You] don't really have any symptoms of HIV until it turns to AIDS, and AIDS is the stage where basically, you've had it."
Service User at RHH GUM, male, 32

"AIDS; stay clear from AIDS"
Service User at RSHH GUM, male, 23

One participant may have heard of PEP, but did not exhibit a clear understanding of why, when and where PEP should be accessed:

" I think if you've got HIV really quickly they can do something about it, but if not then it turns into AIDS"
Service User at RHH GUM, female, 19

Based on the comments of EI participants there may be a need for further awareness raising programmes for HIV in NHS Hampshire, it may be particularly beneficial to instigate campaigns in schools/colleges and universities.

Herpes and Genital Warts

EI participants had basic knowledge of the symptoms of warts and herpes, but were less likely to comment on routes of transmission. Herpes in particular was thought to be unpleasant although specific reasons why could not be given.

"I think herpes, it's quite nasty, I don't really know much about it, and what you do about it."
Service User at RHH GUM, female, 19

A minority of participants felt that herpes only affects females:

"Herpes, don't really know the symptoms. All I know is that it's mainly for girls who get that, apparently"
Service User at RSHH GUM, male, 18

A minority of younger participants thought that genital warts were a result of unhygienic living.

"Warts is basically hygiene, isn't it?"
Service User at Essex House, female, 16

5.3.8 Abortion

5.3.8.1 Knowledge and Awareness of Abortions Services

Presently abortion services are delivered by bpas in NHS Bournemouth and Poole, Marie Stopes International (MSI) in NHS Reading and by The Ella Gordon Unit in Portsmouth City PCT. A new service offering EMA (up to 10 weeks) may soon be provided by bpas in Basingstoke and MSI in Winchester.

EI participants were asked where they would go to seek advice or information on abortion. The majority of EI respondents stated that they would visit a contraception or sexual health clinic as their primary contact point for advice, feeling that the environment was more appropriate and confidential than a visiting their GP. These participants felt that GPs would not be able to offer the same level of support or information as family planning or GUM clinics. A smaller group of older EI participants would visit their GP as the first point of call.

5.4 Future Models of Care for Contraception and Sexual Health Services

5.4.1 Integration of Contraception and Sexual Health Services

The majority of EI participants felt that contraception and sexual health services should be made available from the same building at the same times. Participants believed that both services were a necessary part of a sexually active lifestyle and as such should not be independent of each other.

"People are busy, and they haven't really got time to travel to one place and then go to another, or go to one place, have to wait a couple of hours and go back. It's just easier to get your implant or whatever, and then to get screened at the same time."

Service User at The Ella Gordon Unit, female, 19

A smaller number of participants (particularly younger participants requiring contraception services) felt that contraception and sexual health services should be based in the same building, but not be held at the same time. They felt a clear definition between the two was important, so that they could be sure they were accessing the appropriate service for their needs (contraception) and avoid feeling any of the stigmatisation they associated with sexual health services.

"Probably the same building but just at different times. Maybe if it's only a half hour between or something, make it shorter services but apart…so that you can see you're not going into the wrong services; and you know what you're going in there for and that only people that are in your position will be in there."

Service User at Waterlooville health Centre, female, 16

5.4.2 Service User Preferences for Advertising Locations

EI participants were shown the following options and asked to select the places advertising campaigns could be placed to target themselves and their peers.

- The internet
- On television
- In magazines
- Buses, bus stops and on the tube
- In schools/colleges and universities
- In community centres or youth clubs
- In GPs and pharmacies
- In nightclubs and pubs
- On the high street

'Schools colleges and universities' was the most commonly selected option followed by 'community centres and youth clubs' and 'buses, bus stops and on the tube'.

EI participants were divided over whether services should be advertised in nightclubs and pubs:

"I wouldn't really say nightclubs and pubs, because no-one actually stands there and goes, oh, what's this about then? They're busy drinking."

Service User at The Ella Gordon Unit, female, 19

"Clubs and pubs definitely, as people are more likely to have unprotected sex there so, have a think about it."

Service User at RHH GUM, female, 17

When prompted, the majority of participants agreed that primary care settings would be good venues in which to advertise, although no participants selected this option as a first choice. It may be that GPs and pharmacies are seen as pre-existing places for advertisements or that participants are less engaged with these services. Younger EI participants rejected the suggestion of advertising in primary care settings they would not commonly access these environments:

"Most teenagers and young people don't really go into pharmacies."

Service User at Essex House, female, 16

Some older participants keenly felt that although services should be widely advertised this should be done discretely so as not to cause offence.

"I suppose, you don't want to make it so graphic, some kids just don't understand; you have to be careful how you advertise it, not so in your face, maybe a little bit more discrete."

Service User at Essex House, female, 34

5.4.3 Preferences for Venues to Access Contraception and Sexual Health Services from

During Exit Interviews participants were asked to choose which types of venues they would like to access contraception or sexual health services from, the options given were:

- GPs
- Pharmacies
- In schools/colleges and universities
- In community centres or youth clubs
- In hospitals
- On the high street

5.4.3.1 Sexual Health Services (EI participants from RSHH and RHH)

The majority of EI participants felt that sexual health services should be offered from acute settings or close to acute settings in stand-alone clinics.

"It's really better here, you don't feel like everyone else is looking at you, thinking, they're going to that section sort of thing, here you don't really take much notice of each other, it probably is better like this.

Service User at RHH GUM, female, 19

A smaller group of EI participants felt that services should be based in schools, colleges and universities.

"Definitely at schools and university. We used to have one in my university, which was very good for students."

Service User at RSHH GUM, male, 26

Primary care settings (GPs and pharmacies) were felt to be less well equipped for sexual health clinics, some felt they might use them to access basic information and advice.

5.4.3.2 Contraception Services (EI participants from The Ella Gordon Unit, Waterlooville Health Centre and Essex House

EI participants felt contraception services should be delivered from bespoke clinics or health centres. Hospitals and pharmacies were selected to a lesser extent.

Access to Free Condoms

During exit interviews, participants were asked to choose where they would like to get free condoms from, the options for each category were:

- At your GP
- From pharmacies
- From free vending machines in places like this
- By ordering them free from the internet
- In schools/colleges and universities
- In community centres or youth clubs
- In nightclub and pubs
- On the high street (shopping locations)

Many EI participants expressed concerns over the quality of free condoms, particularly if they were available from nightclubs/pubs, vending machines or from the internet and stated they would prefer to buy condoms as quality assurance was perceived to be higher. The brand of the condom would be an important factor in judging whether it was 'safe' to use or not.

From GPs and Pharmacies

GPs and pharmacies were less likely to be selected as a first choice to access free condoms from, when prompted on these settings most EI participants said they would access free condoms from GPs or pharmacies; however, this may not be a good indication of actual behaviours as the venues were only selected when specifically prompted.

The majority of younger EI participants felt they would not access free condoms from GPs or pharmacies for fear of being seen by an authority figure or relative. Younger people were more likely to choose to access free condoms in environments they were familiar with and confident in, such as school, college or a youth club.

"I don't know how I feel about pharmacies because I feel – when I'm this age – it feels like everyone's looking at you when you're like, oh can I have a pack of condoms please? And they're like, what? And then you need to say it again and you have to say it louder and you're like, ugh. So I don't think pharmacies."

Service User at Waterlooville Health Centre, female, 16

Older EI participants tended to have more confidence accessing primary care venues for free condoms as they felt these environments offer a level of quality assurance:

"Probably, maybe the health centres and pharmacies, I think. I'm not sure if I'd feel quite good to get them from other places."

Service User at The Ella Gordon Unit, female, 23

By ordering them free from the internet

Some EI participants were in favour of being able to order free condoms from the internet, but felt quality assurance and confidentiality would be a particularly important issue.

"Provided they were coming from somebody like the Health Service, then absolutely, but if it's from some dodgy website, then you would have concerns about that"

Service User at RSHH GUM, male, 32

"You don't know where your details are going as well, and you don't know if they're going to be pinpricked when you get them."

Service User at Essex House, female, 16

Some EI participants (particularly younger participants) were not in favour of ordering free condoms from the internet, feeling it would not always be a viable option as they were generally less likely to be able to plan for their contraceptive needs and would need instant access.

"They'd have to get sent out and everything. You wouldn't get them straight away; you'd have to plan in advance. I'm not really a planning person."

Service User at The Ella Gordon Unit, female, 19

In schools/colleges and universities

Young people were divided over whether condoms should be made available from schools and colleges, particular concerns were expressed over the system being abused.

"I wouldn't think schools because boys would just get them, mess about"

Service User at Essex House, female, 16

In nightclubs and pubs

EI participants were divided over whether free condoms should be made available from nightclubs and pubs. Younger EI participants (particularly those of college/ university age) felt that nightclubs and pubs were a sensible and practical location to provide free condoms from:

"I think it would be definitely nightclubs and pubs without a shadow of a doubt. It's the worst thing when you've got no money, and you want to…you know what I mean? You've got no money at all and it's costing you £3, or £4 just to get one condom, it's a nightmare."

Service User at RSHH GUM, male, 18

A smaller number of participants felt that condoms from this setting would be less reliable or of an inferior quality:

"I wouldn't think nightclubs and pubs would be, unless they were in a controlled area, because I wouldn't trust them if they were from there…. In case someone's tampered with them; I'm a bit funny about it."

Service User at RHH GUM, female, 19

Some older EI participants felt that providing free condoms from nightclubs and pubs would encourage casual sex, which they saw as an irresponsible action on behalf of the NHS.

On the high street (shopping locations)

All EI participants dismissed the suggestion of providing free condoms from high street shops, feeling the environment was too public and therefore stigmatising.

5.4.3.3 Branding of Contraception Services

Service users were presented with a range of options for naming services and were asked to select their favourite and least favourite.

Opinions on service branding are as follows:

Family Planning

EI participants were divided over the name 'family planning clinic' some felt it was welcoming whilst others felt was unclear and misleading.

Genito-Urinary Medicine Clinic (GUM Clinic)

The term 'GUM Clinic' was the most popular name for a sexual health service. Some EI participants felt that the name 'GUM Clinic' held a welcome level of ambiguity. They felt the term had no relation to sexual health and therefore wouldn't expose their needs to others if they spoke of going to the 'GUM Clinic'.

"Yes, it works for me, because everybody knows what it is, but they don't really know what the actual words mean, if that makes sense. So the GUM clinic, I think it's fine as it is."

Service User RSHH GUM, male, 23

Sexual Health Clinic

'Sexual Health Clinic' was a popular term, it was felt to be direct and self-explanatory in a positive way.

"Well, everyone wants to keep an eye on their Sexual Health. They don't want to be going out and getting diseases, do they? So Sexual Health Clinic, if it's called that, then it is pretty much just there, the name, and you know what it's there for."

Service User RSHH GUM, female, 19

Contraception and Sexual Health Service (which might be shortened to CaSH service)

Both of these terms were popular choices amongst EI participants. It was felt that the name Contraception and Sexual Health Service was useful to potential users as it was clear and apparent.

"I think it's fine to call it what it is, call a spade a spade"

Service User at RHH GUM, male, 32

Whereas the abbreviation 'CaSH' would offer discretion to those who needed it:

"I quite like the name it's already got, the CaSH Clinic, because you can say that to someone, and if they don't really know then they're not going to know what you're doing."

Service User at Essex House, female, 16

6
Potential and Current Service User Engagement for NHS Hampshire

6.1 Men who have Sex with Men (MSM)

6.1.1 Methodology

Men who have sex with men were engaged with through two focus group discussions, with an older and younger group of men, in North Hampshire. A total of 19 men (12 younger, and 7 older) were engaged with. They were recruited through local LGBT projects, and men in both groups appeared to know each other well and feel comfortable talking about issues related to sexual health. The research methodology used was qualitative and semi-structured.

6.1.2 Background

Participants described Hampshire as having generally low levels of homophobia. Older men described a generally supportive political establishment, which had supported the development of several innovative projects involving MSM. Younger gay men described

general acceptance of sexual orientation in urban town centres, with pockets of homophobia in more rural areas, ***"(Andover) is probably one of them; people aren't that nice in general, you don't have to know them, you can just be walking around town and they shout at you for anything if you're not one of them."*** Environments such as schools, while acknowledged to be mainly focused on 'straight' sexual health, were also said to be broadly accepting of sexual orientation: ***"generally most people I know around here have found it okay to come out and say who they are; they've generally been accepted"*** **(Young Gay Man).**

Participants described a relatively low-key gay social scene, with relatively few social venues. Both older and younger gay men said that they were likely to access gay entertainment areas in places such as Southampton and Reading, and more infrequently (especially for younger men), London: ***"but you don't do it that often because it's so much hassle".*** The expense and difficulty of travelling to these other areas meant that younger gay men described themselves as being relatively cut off from the 'gay scene', and reliant on local social networks.

Participants described several cruising/cottaging areas (Public Sex Environments – (PSEs)), but said that despite historically good cross-working with local authorities (such as the police), these had successively been obstructed from use – ***"there's not really any cruising grounds around here anymore".*** Several men in the FGDs asserted that this had pushed sex in PSEs into different locations, where men were harder to target by sexual health outreach teams. One participant asserted that men in these areas may be taking sexual risks:

"I have actually met a man outside that cottage…one of the questions he asked was, I have unprotected sex because I don't know where to get condoms… But he said there were lots of guys that go to that particular place that are married men who just go there to have sex with men and will take risks, which frightened me."

Participants across several different groups asserted that there was a general lack of awareness of HIV in Hampshire, and a growing generational gap between younger and older men in terms of their perception of personal risk of contracting HIV: ***"I knew people when I first came out that were sick and subsequently died…but the younger people that we work with don't have that"*** **(Older Gay Man)**. Participants felt that HIV has become less 'visible', as people accessing ART are living a lot longer, and appearing to be healthier. In addition, they asserted that some men may perceive 'sexual risk' as being negligible in Hampshire, compared to other more notorious areas with a thriving gay 'scene': ***"older men in Basingstoke, particularly, people don't think it happened here or that it is happening here or that there are many people in Basingstoke who are HIV-positive. And someone that I met in Basingstoke outside a cottage was saying there's a lot of men that will take risks because everyone looks really well and it's Basingstoke, isn't it? It's not Manchester."*** A younger gay man also explained that many people in his peer group felt that HIV was not a risk that they considered: ***"I think that there's a certain amount of, well it's a weird analogy, but the tsunami, you wouldn't think it would happen to you."***

This finding was echoed across several different groups when discussing perception of risk of HIV, for instance, BME groups.

6.1.3 Current Access to Services

Access to Sexual Health Information

For young gay men had had varying access to SRE/ PSHE in schools. However, many of the respondents described SRE as having limited explanatory value for them. A few felt that the key messages included in SRE/ PSHE had been targeted at a 'general' audience, and thus of some use to be able to generally understand about protecting their sexual health: ***"at school; it was never said, if you're having straight sex use a condom, it was all, if you're having sex, so that's universal and does not discriminate."*** Some respondents felt that there should be more access to information about sexual health for people of different sexual orientations included in schools-based information: ***"It's not really fair, because technically we are a minority group and we have to learn about straight sex, which we're not going to use, so when I was in school I just got very bored very quickly and started pratting around! I got shouted at for it, but I made the point, why aren't we learning what we want to know as well?"*** However, others felt that it would be difficult to fully engage with sexual health information in the schools environment in front of their peers, especially if they had not yet socially acknowledged their sexual orientation.

Most respondents, however, felt that schools-based health information had little relevance for them as young gay men, and will offer little support for finding out relevant sources of further information about their sexual orientation: ***"obviously the teaching in schools is all about straight sexual health and I went home and went on the internet because I want to know what I'm going to be doing and what that involves."*** Many of the young gay men said that their initial interest had been in both what gay sex involved, as well as sexual health, and that they had mostly accessed the internet as a first point of reference. Some had accessed chat forums on gay 'cruising' sites such as 'Gaydar', and had been able to ask questions online and in an interactive way with other members: ***"It's very useful, especially forums where you've got people, it's not like an article that you just read through."*** Some respondents also acknowledged that they would mostly be seeking knowledge about gay sexual experience, rather than

health questions: ***"I would say that a lot of it through chat rooms – it wasn't the sexual health side, it was more how to do it and what's it like, there wasn't, be careful because you might catch that…unless you specifically asked those questions."*** Young men in an LGBT forum included in the user engagement felt that this was not always the 'best way' for young men who have sex with men to learn about their sexual health.

Young gay men in the user engagement had also accessed health information given through an LGBT young people's social group. Young men seemed to feel that health messages given in this format were more informative, as they were given in an interactive way in which open discussion about gay sex in general was encouraged. They also felt that these health messages were more targeted at them and their maturity levels: ***"they're sharing it rather than showing childish videos like Johnny Condom; this is more hard hitting – it's the facts as they apply to you."*** LGBT youth workers could give more personalised messages, linking messages about safe sex to the enjoyment of sex, which respondents found more believable than schools-based messages, which had focused on negative aspects of sexual life. Young men also felt that sexual health information given in a group was more 'normalising', and contrasted this to the school environment, where young people in general were afraid to ask questions. This suggests that mainstreaming messages about men having sex with men into schools-based health information would not be as accessible for young LGBT people as those given in an exclusive LGBT forum.

Young men felt that they had good access to health information through this LGBT youth forum. However, they highlighted young men having sex with men as being at 'risk' if they lived in remote areas where they could not easily access health interventions through LGBT groups, and might rely on other less informative sources: ***"I think in the outlying areas and villages around Basingstoke there are a lot of smaller communities who might not have the same standard of information that we are getting", "they might try and find their own things (on the internet) which may not be the best method of learning it."***

Most of the young men had been referred to the LGBT group through personal social networks. For some, it had taken up to eight months to be able to access the group, once they had started searching for one. However, young men said that they preferred this method of recruitment of the group, as widespread advertising brought the risk of homophobic incidents.

Older gay men had had access to a variety of mainstream websites, many of which focused specifically on sexual health. These respondents felt that they were very able to access sexual health information should they need it. However, they did highlight the need to target and include men having sex with men, particularly those who may not be socially acknowledging their sexual orientation, and accessing PSEs. Several respondents felt that more could be done to better signpost these men into mainstream services, or to improve condom distribution in these areas.

Lastly, in discussions about accessing information and advice through different care providers, it was clear that younger gay men felt less inclined to access integrated services, which they perceived as being more likely to be homophobic. One young man, discussing the idea of a 'One-Stop Shop', said: ***"I just don't like the idea of going there, especially around my area because they are not exactly keen on gay and lesbian people".*** Young gay men felt similarly reticent to talk about gay sexual health with their GPs, ***"I'm not really going to go and see my doctor because I don't even like her".*** This was echoed by a few respondents in the older age group.

Access to sexual health services

For both younger and older men, the first line of care-seeking appeared to be the GUM clinic. Young gay men had been signposted in services both through mainstream schools-based health education, as well as through LGBT youth forums.

Younger and older gay men felt that the services were in many respects very accessible for people, and that the supportive attitude of the staff had encouraged access through 'word of mouth' to a wider audience. Key stakeholders also felt that the service had been flexible to accommodate a need for discreetness among younger men: ***"It's all very friendly and very professional now, and they try and put you at ease as best they can", "when you first come down here they emphasise the positive sides."*** Respondents felt that the 'Men only' clinic had encouraged MSM access to services, and that opening hours (in the evening) facilitated access for married men, who could go there on the way home from work: ***"So, it would be fairly discreet for them. I know a couple of dads that have used the one hour once a month service."*** However, many of the respondents felt that opening hours overall were too limited for MSM access, and reported that they had had problems accessing GUM without impacting their work hours: ***"It took about three months for me to get an appointment in the evening and in the end I just took one during the day and just took time off work", "It's crazy because it's mainly in the day; Tuesdays and Fridays".*** One respondent also reported that walk-in fee paying clinics had started in a GP's surgery, and had been popular due to poor access to the GUM clinic. Younger men also felt that GUM services could be difficult to access and that services would be more

accessible if located closer to the centre of town.

A few of the older men included in the user engagement felt that their local GP surgeries, who had made service provision for giving general sexual health information, as well as care and treatment: ***"you can go in and ask questions, speak to a GP or the nurse, if you don't have time to go to the GP. So, they're quite proactive, the surgery that I go to."*** While this may suggest that GPs' surgeries are becoming more accessible for sexual health than local GUM clinics, it was widely felt that younger gay men would be very unlikely to disclose their sexual orientation to a GP, or to regularly access GP surgeries in general. Even some of the older men said that they would never access their GPs for sexual healthcare: ***"I avoid mine like the plague. Not that I don't like them. I just have no reason to go there."***

Many of the older respondents also had accessed sexual healthcare and advice through their local pharmacies: ***"Superdrug…she's fantastic there. She's helped me with lots of different things to the point where she's almost my second GP."*** Respondents on the whole supported increasing access to sexual health services through pharmacies. However, many respondents (both young and old) mentioned several key barriers to service provision. There was general anxiety about how to discuss sexual health issues, or request sexual health products in the public area at the counter: ***"Superdrug… they have a little consultation (room)…It's right there in the front so everyone sees you and everyone tries to stand there and listen because I know I do it… And you try to walk out of there like there's nothing wrong with me", "it's more the people in the queue behind you!"*** Younger respondents especially felt that they would feel embarrassed to ask for products in pharmacies, and that in smaller areas there was a perceived risk that pharmacists would be known to people's personal network: ***"you haven't got the pharmacist who might be best friends with your Grandad."*** Key stakeholders also felt that individual pharmacies were not following the 'You're Welcome' criteria, mainly due to their perceived faith-based objections.

Young men in the user engagement had been aware of the availability of chlamydia testing through a variety of sources. However, many felt that they had preferred to access testing through their local LGBT forums than through other 'public' outlets. Echoing other groups in the user engagement, they highlighted how chlamydia testing had played an important role in 'normalising' access to sexual health testing, even if some young people had not followed this up by accessing mainstream GUM services at a later stage for a wider range of STI testing. For some respondents, accessing chlamydia testing through groups had reduced embarrassment at talking about potentially contracting STIs: ***"Most people do it here so it's not like, oh yes I might have chlamydia, it's just like checking", "It feels more comfortable; you're with your friends and they might be doing it at the same time."*** However, younger gay men also felt that they regularly accessed STI screening (with the support and encouragement of LGBT youth workers) and that more could be done to encourage more regular access to a range of STI testing for young people in general.

Access to PEP was also discussed with both older and younger men. Older groups felt that they could be less likely to know about PEP: ***"I was quite like, oh, that's quite good; it exists. But I didn't know about it. It took me such a long time."*** Similarly to other national-level data,[45] awareness and knowledge of PEP appeared to be very low among younger men. However, some respondents felt concern that more knowledge about the availability of PEP would in turn encourage carelessness about using protection, and that messaging about PEP should include full information about the negative side effects of accessing it. Some of the younger men reported that they knew of one of their peers who had accessed PEP with the support of LGBT youth workers. Key stakeholders felt that PEP had initially been difficult to access, ***"You need to ask for it (PEP) and be quite firm with them (A&E staff)."***

While participants said that there was good access to condoms in some ways, such as some (but not all) schools, LGBT youth clubs and in some gay entertainment areas, access for some groups, such as married men having sex with men in PSEs, was said to be difficult. General access through shops and vending machines in most areas was said to be especially difficult for young men: ***"I know people who are embarrassed to go and buy them in a shop", "I think sometimes they're overpriced, as well, which puts people off."***

6.1.4 Future Service Preferences

Echoing many of the other people who were involved in the user engagement, there was a widespread perceived need for a national campaign to raise awareness about HIV, and for local campaigns to combat the perception that HIV was 'not an issue' in Hampshire. However, older men felt that their awareness of HIV was based on earlier campaigns (during the 1980s) and personal experience, and that given improved health outcomes for HIV patients, the 'scare tactics' of earlier HIV awareness campaigns would not resonate as 'being true' for younger gay men.

As will be explored, along with other groups, younger and older gay men broadly supported and saw an opportunity for 'normalising' access to testing for HIV and

45. Sigma Research (2006) 'PEP Talk: Awareness of, and access to, post-exposure prophylaxis among gay and bisexual men in the UK'.

other STIs and making it more widely available outside of GUM and GP services. Younger gay men particularly talked about interventions that targeted mass audiences as having been important to reduce embarrassment about accessing STI testing: "***Also to reduce the embarrassment…you go and have this sex check and then people see you there and say, oh what are you doing here, and you say, well I've got to have it because everyone does, and they say, I had mine last week."*** Other respondents felt that the marketing and 'freebies' associated with mass targeting for STI tests encouraged 'normalisation', and needed to be developed for a wider range of tests, ***"and the T-shirt and the pens, and making it known that everyone goes for one and there's no trouble around chlamydia testing, which needs to be done for the rest of the tests."***

In terms of increasing access to GUM, respondents felt very confident in the quality of the service. However, there was a felt need for longer and more accessible opening hours: ***"the clinic in Reading is seven to seven, which is ideal really".***

In discussions about devolving STI testing to locations other than GUM, younger gay men highlighted the difficulties of accessing GUM for some of their counterparts, and the need for services that were centrally located and easy to access through public transport: ***"ours is out at the hospital and there is a good bus service, but as we've said bus services can be a bit pants and so it's quite hard to get to unless you've got transport or someone is willing to take you but then you've got the GP, why do you need to go there?"*** Most of the participants broadly supported integrating HIV and other STI testing into general 'MOTs' for sexual health: ***"I think that's a good idea, it's a great idea to integrate it with other things so that people don't know, it's not telling someone what you're doing".*** Younger gay men especially felt that their peers would feel less embarrassment about accessing pharmacies than other areas: ***"Most of the things that we see in the pharmacy, they don't really shock you after a while, so it's normally alright and there's no embarrassment."***

However, both older and younger respondents felt that 'MOT' testing through pharmacies would be most successful if it included;

- Training for pharmacy staff on discreet and confidential service provision
- Trained health advisers available
- Most participants preferred to have female health staff, (for younger men) some preferred staff who were closer in age to themselves
- Range of STI testing available, especially for 'symptomless' STIs
- Integrated with other kinds of tests, such as for BMI and cholesterol
- Regular reminders for screenings
- Touch screens with different options, ***"then you haven't got the issue of someone behind you in the queue and things like that"***
- Options given for receiving results (text, face-to-face or letter)
- Relatively rapid testing available

Younger men also felt that integrated screenings could allow for regular reminders to be sent, in a similar way to other screening programmes: ***"I think you could offer it regularly like smear tests for women, because if you got a letter through your door saying that you're due an HIV test people might be more willing to go."*** This demonstrates strong support for a more active testing strategy than is currently available to them, at least on an 'opt-out' rather than 'opt-in' basis.

At the local level, there was a perceived need for better signposting to local MSM health outreach projects, such as through local PSEs, so that hard to reach 'high risk' groups (such as married men having sex with men) would be able to access information and support. Many respondents felt that MSM needed to have access to these projects, as they were getting key messages but not in-depth information about sexual health from other more mainstream sources, and there was a need for more detailed and discreet access to sexual health information. It was felt that national campaigns on STIs could signpost to local numbers, or be advertised through the local press, to raise awareness of local MSM services: ***"I think having more of that in a local sense would help a lot for a lot of people in the area."***

There was also some support for increasing condom distribution through vending machines, especially among younger men. However, older men reported that outreach workers do regularly provide condoms through LGBT youth forums, and gay bars/clubs. However, condoms in general were felt to be too expensive for young men to be able to easily access. Respondents strongly supported being able to have a swipe card with a weekly allocated condom allowance, accessible through vending machines in key areas, ***"maybe if they had a chip and pin, as well, you wouldn't have to have two pound coins – the 21st century!"***

Lastly, there was a perceived need for more promotion and 'responsible' awareness raising about PEP – ***"I think they should let them know on condom packets", "It should be advertised but they should let it be known that it's not like you can have sex and then go and sort out afterwards, you should still use condoms."***

6.2 Black and Minority Ethnic Groups

6.2.1 Methodology

People from BME groups were engaged with through three FGDs, with a total of 15 participants (7 men and 8 women). In terms of age groupings, two of the FGDs were with older participants (25 years and above), and one mixed group with younger participants (under 25 years).

6.2.2 Background

Both older and younger participants described the BME community as non-cohesive, though with some strong groupings around faith-based communities. In discussing their community, participants said:

"I don't think it's tightly knit. That's my opinion, I think it's very loosely knit."

"Communities that gather around the church are much more closely knit. If you're not in the church or part of the congregation then I think it is quite fragmented and difficult for the community to come together."

This appeared to have strong implications for both sexual decision making, and for some aspects of the care pathway that were reported by some of the younger participants.

Older participants raised concerns about wide-ranging issues to do with sexual health, and most especially high rates of single parenthood among the BME community, which they felt had strong implications for the social progression of their community, resulting in low attainment, deprivation and 'male irresponsibility'. For both male and female participants, this concern seemed to be framed within a feeling of erosion of responsibility in sexual relationships, especially amongst young men. More widely, this was perceived to have resulted from an erosion of family structure, and both younger and older participants talked about a 'lack of discipline'.

"As it's got on, the parents have become more lenient with the kids and now they can just do whatever they want. So it has just broken down the communication".

Young Woman

Conversely, many of the participants raised the theme of lack of communication between the generations about sexuality and relationships. Older participants especially felt that people in their community would find talking about issues to do with sexuality difficult:

"I think for my age group, anyway, sex wasn't something that was talked about. It was just something that you never talked about. I think that a

lot of the younger people today, parents might find it hard to talk to them about sexual issues and things like that."

Older Woman

Both younger and older participants felt that myths about Black male virility had a continued effect on current day sexual decision-making and relationships. Older female participants, for instance, talked about how this myth of male virility continued, for some, to be an important part of men's socially constructed identities,

"It's a man thing…They put a great store by sex. There is no two ways about it."

BME Woman

Younger women asserted that young BME men were also having a lot more mixed race sexual relationships, partly due to ongoing social myths about Black male virility, and that this appeared to have resulted in more casual relationships among their peers,

"(they say Black men are) bigger than a white guy, and plus they want a mixed race baby…It's like a little fashion accessory".

Both younger and older participants asserted that men were less likely to use condoms, but it was also clear that there were strong gender divides in terms of responsibility for getting condoms, whereas younger women asserted that they would be responsible for other forms of birth control. In their narratives, it was clear that in cases of unplanned pregnancy, the male would be expected to have little responsibility:

"Obviously he is just there doing his thing and you are the one carrying the baby, so the girl would have to be responsible".

Young Woman

For older (especially female) participants, these social patterns translated into a concern that sexual health programmes should be more firmly integrated into interventions that talked about gender issues, and were more targeted at men.

It was also clear that for younger participants, there was an ongoing gap in expectations between the values of their parents' generation (which young people themselves also embraced to a certain extent), and the pressures towards sexual activity and early sexual debut that they experienced among their peers.

"I remember by the time they did it (SRE), most people were having sex, so no one really listened. It was like what can you tell me about sex?"

Young Woman

Young women especially highlighted that teenage pregnancy had become normal, and an expected outcome in cases of unplanned pregnancy, though they themselves strongly felt that this was misguided:

"All my other friends have left school and there are at least 15 of them that all have kids or are pregnant and they are excited. I'm like why are you excited?"

Young Woman

It was clear that among both younger and older generations, the issue of unplanned pregnancy was a difficult one. There was consensus that unplanned, extra-marital pregnancy would be strongly frowned upon by the older generation: ***"I think with some West Indian parents, if the daughter gets pregnant, when the parents find out, that's World War Three, Two and One and all the wars you can think of"*** **(Older Woman)**. Though none of the participants directly linked this to a faith basis, it was clear that terminations of pregnancy were a contentious issue. Older participants asserted that parents would probably want to keep the child, but younger women felt that some 'stricter' parents may be unsupportive if a young woman had an extra-marital pregnancy. Some of the younger participants felt that unplanned pregnancy would be concealed from parents, while trying to find their own 'solutions', as one (male) participant related:

"(I would) just try and do something that I'm not going to be involved at all, because if the parents find out, it would be big trouble".

Lastly, echoing findings from BME participants in user engagement with people living with HIV (PLHIV), it was generally felt that there was low awareness and low perception of risk of HIV.

"In England I don't think people actually think about HIV as much as other countries, because HIV is not a major issue in this country compared to some other countries and so some people don't really think about HIV".

Young Woman

Participants still felt that HIV was perceived to be a 'gay man's disease', and that people in the community would find talking about HIV difficult, due to the fear of social stigma. One female participant asserted that men did not perceive themselves to be at risk of contracting HIV, and used this to negotiate themselves out of condom use:

"They actually think they won't get anything. I've heard some men say it'd be harder for a man to get AIDS than it is for a woman because of… do you know what I mean? I've heard them say it. Especially Caribbean men I've heard say that. There's a theory that because of how the penis is and loads of different stuff, they think it's harder for them to get it".

Older Woman

There was little evidence, especially among the younger participants, that they were aware of the greater risk of contracting HIV, especially for women, but some

respondents wanted this to be included in information and education in schools. However, this had huge implications for targeting health messages about sexual health at BME communities, with both young and older participants feeling that this would increase stigma and even carry the risk of increasing public resentment towards some immigrant (Black African) groups.

"I think that would be an issue because I would feel offended on behalf of young Black people, nieces and nephews and things…because they're assuming this group knows less than another group in society."

Older Woman

6.2.3 Current Access to Services

Condoms

As discussed above, it was clear from female participants (young and old) that strong gender norms had influenced patterns of condom use, and that they perceived Black men as being less likely to use condoms. However, younger participants talked about the influence of a prevailing youth culture, and asserted that access to condoms was unproblematic, but that unprotected sex was widely practiced.

"A lot of people don't like using condoms. So I know a lot of people use it (EHC) just because they don't want to have to use condoms".

Young Woman

"No one uses them anymore…it isn't fun to use them…Most guys don't like using them. They tell you they don't work well with it, so if they want more pleasure, some guys say they don't work well with them".

Young Woman

While presenting this as a male pattern of behaviour, young woman also seemed to agree that both male and female partners would prefer to not use condoms, and that their responsibility would lie in accessing reliable contraception.

"We have the pill so why do we need to carry a condom?"

Young BME woman

"I think it's both, but it's more the boys are saying oh come on babe, it's cool, you won't get pregnant."

Young BME Woman

Unplanned Pregnancy – Care Pathway

As explored above, extra-marital unplanned pregnancy might be frowned among some families. However, younger participants explained that this was a common occurrence among their peers, and some of them had been involved in supporting their friends in finding solutions to an unplanned pregnancy. As will be explored below access to EHC appeared to be variable, and in some cases was classified with abortions.

Several factors seemed to delay access to termination of pregnancy (TOP) for young women from BME communities. Firstly, younger participants reported that it might be difficult to access free pregnancy testing kits, which they had found were not available from their local GP surgeries.

Secondly, young women may face issues to do with family pressure, social stigma at premarital pregnancy, or a lack of support, which may result in a delay in seeking care. It was also apparent that they may be being signposted into organisations which actively seek to delay their access to TOPs. One respondent talked about accompanying her friend who had gone for a pregnancy test (after not being able to get one in her local GP's surgery) and advice while considering a TOP, and had clearly felt that she had received a biased view:

"Then the lady was showing her pictures, your baby will look like this at this time, and it just made it harder for her to abort, because that's the way she was leaning. But then afterwards she was thinking oh, I don't know because I saw the picture and it actually looks like something, I feel worse now. So I didn't really like the way she presented it."

Young Woman

Lastly, while many participants said that they would like to be able to access more reproductive health services through their GPs, in some cases it was also clear that they felt some GPs were racist. This especially seemed to be felt among the young people's group, when they were trying to access contraception, and might make them less likely to seek advice from primary care.

Sexual health testing

Among the young people talked to, there appeared to be good signposting into mainstream sexual health testing services. Some respondents especially felt that they liked the range of services that they could access through sexual health clinics, and the encouragement to do a range of testing.

"They will ask you if you want to get tested for AIDS and gonorrhoea, let's be on the same safe side, let's do it now so that you don't have to come back later and find out something else. So I think that's really good."

Some of the participants also appreciated this approach, against a background of feeling that mass STI testing campaigns, especially for chlamydia, had given them an

awareness but not much depth of knowledge about STIs:

"I don't even know what chlamydia is. That's the thing. I have heard about it from secondary school, people talk about it, but I don't really know what it is [laughs]. That's the thing, I don't really know what it is".

Young Man

There were extensive discussions about current access to HIV testing. Many of the participants strongly felt that people were unlikely to access HIV testing through GUM and other sexual health services, as the stigma of being seen accessing services was of high concern. Older participants were more likely to feel this than their younger counterparts, who had already experienced and advocated strong messaging around sexual health 'MOTs':

"I think what I've always struggled with, with the concept of having an HIV test, is that the onus is on you to go to a place that's separate from the doctor's and clinic and put yourself forward for a test. I always thought, why is it that you can't have a blood test at your doctors and one of the things they look for is HIV/AIDS, and then you might actually detect it."

Older Woman

"I think it still boils down to seeing people go in."

Older Woman

Younger participants also said that they were unlikely to access sexual health testing services through college, which had been placed in a very public location,

"I wouldn't go to college. There are too many people there watching. The room that the sexual clinic is in, everyone can see it…"

Young Woman

Access to Contraception

EHC

For many participants, it was clear that EHC was seen as a form of abortion, and that consequently increased access to EHC was not advocated by all of the participants. For both older and younger women, however, it was seen as a preferable option to abortion, which would present deeper ethical dilemmas.

Younger women seemed unaware of the branding around EHC, and of how to access information on where it was available (principally through the 'Get It On' website). Access to EHC principally seemed to revolve around being aware of free distribution points,

"Yes, if you don't know then it's difficult, but if you know or someone knows, then basically it's easy".

Young BME woman

Another participant also asserted that many of her peers would not think about accessing EHC, preferring to wait until later:

"I don't think people think about the morning after pill. I think oh, I need a pregnancy test and I wait like two weeks, and then I think oh, I could have taken the morning after pill then. It's not the first thing you think of".

Young BME Woman

LARCs

Younger women seemed to be very aware that they and their peers would often find themselves being prescribed 'the most popular' form of contraception, namely the pill, through their GPs. Older women, when prompted with service maps of their local area, were very unaware of contraception/family planning services available to them. They also strongly felt that they would prefer to access a family planning clinic than their local GP, principally so that they could get good advice and information. In some cases, participants said that this had affected their access to LARCs:

"I think there should be more information that you don't have to go in there. Do you see what I mean? Because I want to get the coil but I don't know who to talk to so that's why I haven't even done it yet. I feel like, oh then I'm just going to see the GP. I'd rather just speak to someone about it".

BME Woman

6.2.4 Future Service Preferences

In the overall discussions, it was clear that there was a perception that Hampshire NHS was 'behind the times' in terms of engaging with BME communities around broad health issues. In terms of sexual health, participants wanted to see a more community-based approach, engaging with a range of participants but including young men, and tackling gender roles and expectations.

Increasing Access to Signposting

Many of the gaps and problem areas for signposting, for instance, increasing access to EHC, would have been addressed had participants known about the 'Get It On' Website. Participants also felt quite disturbed that they did not know about it:

"You see, even at our age, if we don't know about this, this is quite bad. Like this is not good if we don't know about this site. It's in Hampshire as well, so young kids aren't going to know anything, they're going to ask other people".

Young Woman

Younger participants especially felt that signposting should be aimed at a 'younger' age group, so that they would know where to go and not have to rely on

unreliable means of getting information (principally word of mouth).

Older women also felt that there was a lack of signposting to contraception services, and that they were unaware of how to access this information in their local area.

More feedback from users on their knowledge and awareness of the 'Get It On' website and the 'Have You Got It?' website is discussed in Section 5.3.1.2.

Increasing Access to Sexual Health Information and Knowledge

Younger participants felt that health messaging in schools was targeted at an older age group who were less likely to pay attention, and would be more effectively targeted at younger age groups.

"I think 11 or 12 onwards would be the right point to say you need to use a condom, and then they can elaborate on whatever else at 12 or 13."

Younger Woman

Increasing Access to Testing Services

Participants saw two main ways of increasing access to sexual health testing, which they felt carried more likelihood of involving both men and women (rather than through more 'female' centred services, such as Family Planning). They also felt that fear of being seen by someone in the community was the main factor that dissuaded people from going for tests.

Some participants wanted to have extended STI testing through local GP surgeries, especially for HIV.

"GP, because if you are walking into your GP, the one I go to, they have a separate health clinic on certain days or whatever. But if you are walking in there and if people see you, it's not like oh my god, she's there because of this, that and the other. You could be going to the GP for a number of reasons."

Older Woman

However, many participants felt that men were unlikely to access testing through GPs, and that this would be inherently unattractive to them.

"Men hate that word: GP. They do".

BME Woman

Female participants also felt that the 'MOT' approach to sexual health testing could be promoted through pharmacies. An 'MOT' would include testing for 'non-stigmatised' general health, including potentially BMI, cholesterol, blood pressure, and offer HIV testing as an opt-out. It could also include screening for certain diseases, such as sickle cell anaemia, which are particularly high among Black Caribbean groups. This option appealed principally as it was likely to capture both men and women.

"It's also not geared specifically for women. You see men at the counter buying various different … you might capture males and females of different ages."

BME Woman

In discussions about how such a service would be promoted, respondents raised strong concerns about how people from BME communities could be targeted in promotional materials and encouraged to go and get tested. This raised the possibility that stigmatisation of certain groups (such as Black Africans) could increase:

"I don't think that they are saying Black people go and get tested, I just think they are using us as bad… they are just doing it to degrade us, that is what I am saying."

Young BME Woman

In terms of staffing, participants also felt that staff should not include people from the BME community, or that potential users of the service could be given the option of different staff members to reduce the fear of gossip among the community.

6.3 Young People

6.3.1 Methodology

Two same sex FGDs were conducted through a youth centre in an area with high deprivation and teenage pregnancy. A total of 12 people were engaged with (6 men and 6 women). All of the young people were under 25, with most around 15–17 years old. The young people were accessing sexual health services through the 'Sex Sense' sexual health outreach workers.

6.3.2 Background

In discussing their main concerns in relationships, young women said that they were mostly concerned about unplanned pregnancies, though as a group they were highly knowledgeable and aware of the risk of contracting STIs:

"I don't think that anyone has worries unless they think that they are pregnant"

Young Woman

Common to their age group, they also reported that relationships were highly unstable, and unlikely to be monogamous:

"Most boys just have sex and then leave you."

Young Woman

6.3.3 Current Service Access

Sexual Health Information and Signposting

The participants in the FGDs were currently accessing sexual health education signposting through both schools-based and youth centre-based programmes, and could compare and contrast the two approaches. These two settings would also comprise different social networks – in schools, a wide and diverse peer group would be present, and in youth centres, a close and more trusting peer network. This was found to strongly affect service preferences among both male and female participants.

It was clear that access to SRE in school varied widely, with some participants saying that they had had no access. Male participants also self reported that they were unlikely to pay attention to health messages in that environment:

"I don't think in secondary school we had any."

Young Man

"If I did, I probably didn't listen."

Young Man

Both male and female participants found the sexual health messaging in schools to be limited, and spoke about the awkwardness of talking to teachers about sexual health issues: ***"It's just factual. It's like, easier to learn more when you're talking about it with someone...you don't want to be talking about sex with your teacher"*** **(Young Woman).** Messages

that do not address the enjoyment of sex, as well as the need for protection, were seen as unrealistic and overly pessimistic in the female group. One female respondent summed up her understanding of key messages as ***"don't have sex, don't have anything"*** **(Young Woman).** Female respondents also highlighted a recurring issue, which was their perception that school authorities would adopt a moralistic attitude towards unplanned pregnancies:

"At my school there was this girl that was pregnant and she got kicked out because she was pregnant. Everyone found out because she was discussing it with a teacher at school, so she got kicked out and then she had to move to a different school."

Young Woman

There was a strong perception that in cases of underage sex, the school authorities would be legally bound by child protection concerns to report these cases, and, as such, were not a trusted point of contact for young people. Other service providers, such as pharmacies, were perceived to be less bound by these regulations, and more accessible for people under the age of 16 years.

Sexual health service provision through the youth centres was preferred by young people for a variety of reasons. First and foremost was the depth of information that they could receive their about sexual health, for instance, 'proper' condom use:

"Like you knew, but you didn't know how to like, properly."

Young Woman

Health advice was also said to be wide ranging, encompassing other reproductive health issues, and also included wider advice for young people for their life circumstances.

The mixture of messaging through group work and also being available through confidential face-to-face advice was found to be especially important for all respondents, who felt able to discuss their concerns with staff members, and trust that these discussions would be confidential (which they contrasted to service provision through schools):

"Say like, I would come in for a pregnancy test. It would all be confidential. No one would know about it."

Young Woman

This was found to be especially important with young men, who despite high levels of bravado, seemed to be especially sensitive to being seen accessing services by their wider male peer group, and the effect that this might have on their social reputation.

"If you walk in there, and your mate from school sees you walking straight in there, you're going to be hammered when you get back to school or college" **(Young Man).**

It was also apparent that this was not the case with their immediate peer group, whose presence and input they valued during group discussions about sexual health issues in the youth centre: ***"I don't care about this lot, though."*** They clearly preferred accessing services through a trusted youth worker: ***"I could trust them up here", "Yeah. Nowhere else".***

Both male and female respondents valued the consistent signposting through the youth centre into other mainstream services, such as local GUM clinics: ***"This lets me know about everything else"*** **(Young Woman).** However, female respondents felt strongly that signposting in itself was not sufficient, and that they had gained the confidence to access services from the encouragement and open discussions at their youth centre. It was also clear that 'youth friendly' service provision had encouraged word of mouth referrals – several respondents in the female group had referred their peers into the service in cases where they had identified a need.

This group was more aware than others about local health campaigns, such as the 'Get It On' website, and branding around access to EHC and chlamydia testing. However, in both male and female groups just under half of respondents had not heard of the website and local health campaigns.

Access to Sexual Health Services

Sexual health services were mainly accessed through local youth centres. Respondents talked about the 'normalising' effects of accessing these tests with their peers in local youth centres: ***"Because we are not really shy about those tests…we're not really bothered. We can talk about anything"*** **(Young Woman).**

Several key issues emerged when discussing accessing sexual health services in other areas. When reviewing services that were locally available to them, it seemed that respondents would be very unlikely to travel, principally because of the time needed to do so (female respondents said it would take 45 minutes to travel to local sexual health services currently being provided through a local GP surgery), and because this would necessitate asking their parents for a lift to these places. Services that did not involve disclosure about their sexual life to their parents were perceived to be the most accessible: ***"we don't have to go all the way to St Mary's with our parents or whatever. We can just come here and do it", "It would be like, why do you want to go up there? There would be like, questions"*** **(Young Woman).**

In response to an open question about what would prompt them to access services, female respondents also said that triggers for testing would include

unprotected sex with a partner that they did not know, and that they had been encouraged and advised to go and get access to testing in cases of unprotected sex.

Young men seemed particularly averse to accessing sexual health services through other service providers, especially when they did not personally know or feel that they could trust a local service provider. For instance, in discussing accessing services through GPs, young men said: ***"I wouldn't ask if it's a woman", "I get a different GP every time I go", "I would speak to my own GP, but other ones I wouldn't"*** **(Young Man).** Young men felt unsure that they would be able to access their own GPs, and this dissuaded them from accessing these service providers.

When discussing increasing uptake of HIV testing, respondents also felt that they wanted to have access through trusted providers in their youth centre, and were very averse to accessing this through providers that were not known to them: ***"I'd rather do it with someone I'm closer to and like, I know. I could talk more"*** **(Young Woman).**

Access to Contraception and LARCs

Uptake of contraception mainly seemed reflective of what was available through sexual health outreach workers. However, several respondents said that they had accessed mainstream services further afield, for instance, for implant insertion. They had only done so once they were clear about their specific service need through discussions with sexual health outreach workers, and said that they would not have accessed mainstream services with a more generalised need: ***"I wouldn't go. I wouldn't like, get there just to go there. If I was near there, I'd go there"*** **(Young Woman).** In this case, first contact and contraception counselling seemed pivotal to promoting access to second level services.

There appeared to be a good uptake of some LARCs among young people, especially the implant, though with some remaining aversion and misinformation about some methods such as the coil. Young women preferred accessing information about contraception through face-to-face education, and felt that printed materials they had been given were too 'wordy' for them to access: ***"Yeah, it was just like words that people would be able to like, explain clearer to me than reading it"*** **(Young Woman).**

Young women seemed to feel that the implant was the most appropriate method for them to prevent contraceptive failure, and young men seemed very aware of its popularity: ***"everyone's been going for this one recently", "It's sort of squeamish. But anyone else, it's the best choice, apparently"*** **(Young Man).**

Condoms

There appeared to be relatively little gender discrimination in terms of social expectations over accessing condoms. Male and female respondents said that both young men and women could access and carry condoms, though conceded that this was most often done by young men. However, all of the female respondents also had a personal supply of condoms at home. Female respondents attributed their confidence in accessing condoms to being able to talk openly about sex during group work in the youth centres, ***"it's only because we're all open about everything, not like how funny it was"*** **(Young Woman).**

This also appeared to translate into confidence around condom negotiation skills for female participants: ***"Would the boys rather have a baby or have sex with a johnny? I'd rather have a johnny"*** **(Young Woman).**

All respondents were highly aware of local free condom distribution points in their local area, which had been pointed out to them by their youth workers. They also felt that access and awareness of condom distribution was high amongst their peers, and that there were no groups of people who would not be accessing condoms: ***"I think that everyone's aware where you can get them from"*** **(Young Woman).**

EHC

Female respondents also had a high awareness of distribution points for EHC and where they could get it for free.

However, in discussions about expanding provision, or making it more accessible, they clearly felt that this would have to be done through providers that were open to all age groups. In considering distribution through schools, for instance, which had been suggested in other groups, young women felt that their schools could not assure confidentiality due to their child protection mandate: ***"They've got to report it. Say I was talking in class and said something about me being sexually active and the teacher hears, they've got to go and tell people. They've got to report it and then everyone knows that you've had sex"*** **(Young Woman).** In contrast, pharmacies were seen as more accessible: ***"They don't ask you anything. They just give you it and then you go."*** It is also worth noting that during discussions female respondents raised issues to do with a case among their peers that required intervention by youth workers because of child protection, and that respondents clearly supported the need for intervention.

6.3.4 Future Service Preferences

It was clear that for this group of young people, successful service provision for them relied on them being in their local area, encompassing their immediate peer group, confidential and not involving disclosure to their parents. The model of service provision delivered through 'Sex Sense' appeared to reach young people who would have been unlikely to travel to access mainstream services. It also more successfully signposted them into other sexual health interventions, such as EHC distribution points.

- Most of the respondents' preferences revolved around expanding this model. They advocated:
- Better links for 'Sex Sense' into schools, to broaden awareness of the service among their peers
- More testing being available through the current model, for instance, for HIV
- Free pregnancy tests available through pharmacies
- More availability to get the implant (difficult to access)

6.4 Young Parents

6.4.1 Methodology

Two focus group discussions were held with groups of women who had either been teenage mothers at the birth of their first child, or who were currently under 25 years old. A total of 15 took part in group discussions. The age ranged from 15 to 28 years old, and took place in local community and children's centres.

While both groups took place in areas with high rates of teenage pregnancy, there appeared to be a significant difference between the two groups. The first group comprised younger women (around 15–18 years old), who were less likely to have access to better transport, such as cars. The second group included 'older' women, ranging from 18 to 28 years old, but who faced fewer transportation barriers.

6.4.2 Background

While research and policy[46] identified a range of factors as contributing to young parenthood, this may be at odds with explanations from young women themselves. Young women engaged with mainly attributed high teenage pregnancy rates to perceived benefits, lack of access to contraception, and/or contraceptive failure.

In the second group, there was a wide consensus that among younger people there was a perception of strong benefits and incentives for young parenthood: ***"years ago, you used to get pregnant and you would have a council house. But it is so much harder now to get a council house. I think they need to know that because a lot of them think that they can leave school, get pregnant and get a house".***

Several of the respondents attributed their early conceptions to contraceptive failure, as well as lack of access to EHC:

"Contraception is shit. Two of my kids were conceived with the contraception (pill)".

Young Woman

Of note, young women in the groups did not appear to see themselves at high risk of STIs. To a certain extent, they also are 'destigmatised' about accessing sexual and reproductive health services, stating that members of their peer group may well feel embarrassed about

46. Social Exclusion Unit (1999) 'Teenage Pregnancy', London: Stationary Office.

accessing services, but they themselves do not face such barriers to access: ***"If I didn't have a kid I would be embarrassed".*** Some of the older respondents also appeared to perceive themselves to be at low risk of STI transmission: ***"I've got too old now. I've got to a point where I've probably had it for years so I'm not going to bother".***

The younger women in the first group appeared to be more disengaged from health services: ***"I don't even go when I'm ill, unless I have to".*** Some of them felt that they had noticed 'negative' attitudes from some healthcare providers, and tended to rely on ones that were already known to them. Most of their health needs being currently met through local GP surgeries and service provision through the young parents' group.

Some of the respondents in the 'older' women in the second group were no longer eligible for some young people's service provision, and as will be explored, consequently faced difficulties accessing services. They strongly felt that they should be considered for some of the free service provision, as they often continued to face hardships in their daily lives, meeting their own needs and those of their family, sometimes as single parents living on meagre incomes.

6.4.3 Current Service Access

Sexual Health Information and Signposting

"If it helped us then why are we sitting here now?"

Only a few respondents were currently still accessing schools-based sexual health information. For those who had accessed SRE in schools, it was commonly felt to be limited, containing basic messaging about protection, and little elucidating details: ***"Just condoms, I remember, it was just condoms…really basic".*** SRE delivered by teachers was felt to be embarrassing, and limited participation in the lessons: ***"I don't think anyone wanted to because it's your teacher who you saw every day".*** Some respondents particularly felt that it did not contain enough information about contraception: ***"When I was 16, I just assumed there was the pill or condoms, you didn't know about anything else"*** **(Young Woman).** A few respondents said that they had not had any access to SRE, due to being 'transferred' (possibly excluded) from schools. Women in the younger group felt that SRE had been adequate but that their peers were 'not interested' in listening to the messages: ***"I don't think anyone listens though, everyone just thinks it's funny", "it was good but I wasn't interested"*** **(Young Woman).**

Women from the older group said that knowledge about local family planning services was not until 'later on in school', and they found out about services through friends and word of mouth, in order to access condoms and EHC. Some respondents said that younger people would access condoms through peer networks: ***"a couple of my friends used to lay the condoms out for the boys"*** **(Young Woman).** Women in the younger age group had a wider range of service providers that they could avail themselves of, but as will be explored below, may also have faced barriers accessing these.
Some of the respondents were aware of local health campaigns about STI testing, and felt that there were rising levels of awareness among their peer group about the importance of testing: ***"There are leaflets about the clinic and a lot of people go up there", "That's started on the radio as well…they're on about where you can go, open till late, just drop-in, walk in. So it's more talked about now, which I think it needs to be because of all the diseases"*** **(Older Woman).**

In terms of current access, many of the respondents felt that they had enough access to information, or could get it if they wanted. ***"I think that if we haven't got enough information, we know where to go and get it", "you get plenty off the internet anyway, I think".*** However, women in the older group especially seemed to be unclear about some service availability, for instance, EHC.

Websites

A few respondents in the first group (younger women) said that they had heard of the 'Get It On' website, but had not been interested enough to access it. Respondents in the second group (older women) had not heard of the website.

Sexual Health Testing

Respondents had accessed sexual health testing through chlamydia mass screening campaigns, and through antenatal services.

Respondents had found access to chlamydia tests useful because of the discreet service: ***"you can post it off. No one knows your results. No one knows what's going on"*** **(Older Woman).** Other respondents felt that access to STI testing through antenatal screenings had given them wider access to testing: ***"I mean, you are always tested for stuff like HIV. They always test you when you are pregnant for hepatitis, HIV, which is brilliant. It's a simple blood test"*** **(Older Woman).**

While respondents felt that this had 'normalised' STI testing, they also appeared to view themselves as low risk, and not very likely to go and get sexual health testing: ***"It's just one of those things where you say, oh, it won't ever happen to me so there's no point in going for a test".*** Some respondents felt that testing should be made opt-out, with regular screenings and reminders, and felt that they would otherwise be unlikely to go and get a sexual health screen: ***"I think that you should be made, well, not made to do it, but if you're having sex, then you should be called up to do it because if you don't get offered it, you don't just go and do it, do you, really? It's not something you do."***

Some respondents linked this low motivation to a lack

of awareness and national campaigns around sexual health, which they felt had previously motivated people to get tested: ***"Most of them went to do it because it was national news. It's in your face".***

Contraception

Respondents had varied access to local contraceptive services. Younger women had accessed implants through their young mother's support group, with the support of the project worker. Further services were available through their GP's surgery and a local family planning clinic. However, several younger women said that they had felt that staff in the local family planning clinic were 'negative', and that this service had been hard to access due to the difficulty of going there with their young children. They perceived local GP surgeries as being easier to travel to, and more child friendly, as they had allocated sessions for people with children. Lastly, they clearly also preferred service providers who were known to them: ***"most of (my friends) can't be bothered to go up to the clinics and stuff like that, because they don't know what to expect".***

In reviewing local services, the second group only would have been able to access services in their local family planning clinic on one day per week, on a Wednesday during the day, and otherwise would have to access services through their GPs. Several respondents felt that they would be unable to access family planning services, as they were now 'too old': ***"family planning is for under 25 years so I have a doctor's appointment because I'm too old now"*** **(Older Woman).** Older women (over 25 years old) felt that service provision had worsened for them since they had reached the 'young person's' age limit:

"Actually I think it's harder at 26, 27, 28 to get these services than what it is at 16. Because I've hit the age now where I just have to get everything done at my GP".

Service provision through their local family planning was difficult to access due to infrequent opening hours, or opening hours that older women found it difficult to fit in with their working lives and childcare responsibilities, ***"I don't think there's enough. It's only once a week, it should be more days I think", "I'm not being funny, but some people, some of us, actually work, believe it or not. If we are working on a Wednesday…"*** **(Older Woman).**

LARCs

LARCs were cited as the preferred contraception for many of the respondents. Among the younger women, implants and condom appeared to be most likely to be chosen. Older women also cited coils and injections as a preferred method: ***"you can't forget to take it and you can't forget to put it on, can you?"*** For the younger age group, respondents were less able to travel and had accessed services that were made very accessible to them through their young parent's support group, ***"well, as I say, I just turned up somewhere and had it done there".*** However, older women reported extensive difficulties accessing LARCs, especially the coil, through their local GPs: ***"Eight months it took to get my coil out from my GP and in the end I had to go to family planning".*** For this woman, it had been difficult to get an appointment with a female doctor, in a smaller area with a smaller GP's surgery.

EHC

Some of the respondents had been able to access EHC through school nurses, but this reportedly varied significantly from school to school. Several respondents stated that they had supported friends to access EHC, but that they had been required to pay for it. There seemed to be a low awareness of the branding in pharmacies around free access to EHC, and some of the older respondents were not aware of EHC availability, even though they felt that their peer group (especially single mothers, rather than teenage mothers) might have a strong need for accessing EHC, and for addressing unplanned pregnancies: ***"she could be single, only on benefits, can't really afford much, struggling to live and then she's got to pay 12 quid for a pregnancy test".***

In the second group, it was a widely held perception that EHC would have to be paid for, and thus that access was difficult for some young people. One respondent had been told by the pharmacist that she would only be allowed free access once, suggesting that some pharmacists are not following the 'You're Welcome' criteria.

In terms of choice of provider, GPs were the first line for younger respondents.

Respondents felt that pregnancy test kits were difficult to access in some places, and very expensive to buy. Many of them mentioned family planning as a provider of free pregnancy tests, but women in both groups talked about the embarrassment of testing there: ***"but family planning, you have to walk through there with a piss pot in your hand…and as soon as you've got a sample, hey, you're pregnant", "when I was 16 and found out I was pregnant, the whole waiting room knew I was pregnant".*** This may be especially difficult in more rural areas, where the fear of being recognised accessing the clinic is greater.

Condoms

Most of the older respondents felt that they did not need access to condoms, as they were either single, or in stable relationships.

However, in discussing condom use with younger women, it was clear that they had often faced significant difficulties in getting their partners to use condoms, stating that male partners would refuse to use them: ***"most boys go I'm allergic to it, don't they?", "they're***

not going to (use condoms)". Some of the respondents also felt that their male partners were unreliable, and likely to leave their partnerships: ***"they just leave you anyway, don't they?".*** Younger women may thus face more difficulties in maintaining safe sex practices.

Younger women knew of condom distribution points through several venues, including the young mother's support group, local 'Get It On' distribution points, and through 'Sex Sense' walk-in clinics. Despite feeling that they were less embarrassed than their peers in accessing reproductive health services, a few respondents did still feel too embarrassed to access condoms through 'normal' routes: ***"I would be too embarrassed to go into a shop and say, excuse me, can I have some condoms please? I would. I wouldn't go and get them"*** **(Young Woman).** Current service provision through 'young people' friendly routes still appeared to be important for this group, as it was widely felt that commercially sold condoms were too expensive for young people to afford (see 6.3.3).

Condoms had been available in some of the schools that the respondents had been attending, but echoing findings from the young people's group, younger respondents felt that there was a risk of lack of confidentiality in approaching school nurses. In one case, this was based on personal experience, when a school nurse had divulged the result of a pregnancy test to the respondent's mother without her consent. Nonetheless, respondents did support more condom provision in school.

Reproductive Health

Some of the older respondents stated that they had had problems accessing smear tests, as they were under the age of 25. Many of them strongly felt that their reproductive health had suffered because of this: ***"I was called by the doctor to have one, but then when I rang up the doctors, they said I was too young".*** One respondent reported that these difficulties had persisted, even in cases where there were clear signs for concern: ***"I have a friend who's 24 and she's had the same problems I had, like pain during sex and irregular bleeding, and she thinks that maybe she's got something wrong. And they still won't do a smear test on her, not until she hits 25".***

6.4.4 Future Service Preferences

Both younger and older respondents particularly prioritised services that were in their local area, and said that they would have difficulties travelling to access services: ***"If it's quite far away it's harder to get there, if you haven't got a car or something, it takes ages to get there", "I'm a bit lazy, aren't I? If it's not on my doorstep I'm not going to do it".***

Respondents prioritised an integrated service, with both sexual and reproductive health services, including pregnancy tests, available through local GP surgeries: ***"I feel more comfortable going to my GP because I know them…and it's not strange, not being scared to talk to them".*** Younger respondents said that their local GPs surgeries were also more child friendly, and stated that they wanted to access services where their children would be welcome.

Preferred choices of working hours also varied among participants, some of whom were working or still attending school, whereas others found access easier during the day. Assumptions that young mothers would prefer daytime for access were found not to be verified.

SRE

In terms of sexual health information, respondents felt that they were relatively well informed and did not need further interventions. However, they prioritised younger school age people as needing more access to sexual health information, mainly based on their own experiences of having incomplete access before they became young parents.

Young mothers wanted to see SRE that was:

- Given in smaller groups
- Separate sessions for male and female students
- Developed links between staff from local services and schools, so that service providers would be known to them
- Regular on-site sessions, with face-to-face education available
- Included full information about the range of contraception available to them at a younger age
- Delivered by people from outside the school, and not by teachers
- Included information about young parenthood – ***"Show them, on a day-to-day basis, what it's like to have kids", "I think every kid from school should get a baby and learn about motherhood and fatherhood at the age of about 13, 14; the sleepless nights, you can't go out…"***

Access to Condoms

Current access to condoms was felt to be good; however, respondents advocated for continued provision through venues that were 'youth-friendly', such as youth centres.

Increasing Access to Contraception

Respondents felt that there was a need to increase access to contraception, particularly to LARCs (such as the implant), as well as EHC, through both youth centres and school nurses: ***"I think if they can have condoms in the youth club, why can't you have the implant?"***

Both older and younger respondents felt that school nurses could play a wider role in both providing services and linking younger women into service provision, for instance, making appointments for young women to

access contraception, especially for LARCs: ***"and you know, call them down individually and just discuss it individually with them and ask them whether they are using contraception or whether they want to start on any", "if they are being asked, they might actually say, yeah, I actually do want to go on the pill, rather than them actually going to find someone and saying I want to go on the pill".*** Many respondents also felt that school nurses should provide EHC on site in schools, with the caveat that they should be bound by rules of confidentiality.

Older women felt that more could be done to increase access to LARCs through local GPs surgeries, for instance, through providing integrated contraception and sexual health sessions, including coil fittings and removals.

Increasing Access to Sexual Health Testing

The preferred service provider for sexual health testing for young mothers was GPs, especially for HIV tests. A few respondents felt that this could be done through pharmacies.

Some respondents also felt that more promotion of sexual health testing could be done through online programmes, especially for self-checking applications:

"Everyone is on Facebook, either Facebook or Twitter", "I would do it just because I was bored".

6.5 Military

6.5.1 Methodology

Data was collected during four FGDs, which were conducted with a total of 22 people (6 women, and 16 men), in small groups and in two separate bases. Respondents were interviewed in same sex groups.

Military personnel were recruited by local army personnel on each base, who were asked to find volunteers willing to take part in a review of access to health services. Consent was re-established by researchers at the beginning of each group.

Service provision while posted abroad was explored to a limited extent. This report, however, focuses on needs for sexual health service provision in the Hampshire NHS area.

6.5.2 Background

The two bases included in the service user engagement varied in terms of their access to GUM services and general population. The first base had a higher ratio of male to female serving soldiers, with some sexual health service provision on site. Despite high levels of casual sex, many sexual relations appeared to happen within the military, with low levels of mixing with adjoining populations. The second base had a higher proportion of male soldiers, with signposting but not sexual health service provision on site, and reported high levels of sexual mixing with local populations.

Respondents described very high levels of casual sex among most of their peers: ***"There's nothing to do here, social-wise, so all you do is get pissed and that's it. Casual sex is something to do"*** **(Male Soldier).** Most of the casual sex was said to be linked to high alcohol intake during free time, when unprotected sex was likely to happen. It was evident that many of the relationships with women outside of the military were often low commitment, based on little trust or partner communication, ***"And you go out every night, pick her up, bring her back, fuck her off, get another one the next night"*** **(Male Soldier).** Casual sex was said to be widespread, even among people with long-term partners.

Sexual relations were clearly influenced by a (mostly male) culture of bonding and bravado, which might also include sharing female sexual partners for male soldiers. The women who engaged in group sex were described as regular participants in group sex: ***"Yeah with the same collection of girls that seem to go from one place to another…we still know the same girls. And a lot of it is unprotected"*** **(Male Soldier).** Rates of unprotected group sex were said to be higher among younger male soldiers, as 'older' male soldiers were

said to be more concerned about onwards transmission to their long-term partners. Group sex also seemed to allay the fears of establishing paternity in cases where group sex had resulted in a pregnancy: ***"No, because there's like quite a few of them in one night, so it's one girl but she's slept with four guys".*** Some respondents said that they were concerned about HIV in these situations, which they said was high risk due to mixing with soldiers of other nationalities from high HIV prevalence areas. It was not clear how widespread these practices are, but respondents talked about them in both bases.

In terms of their conceptions of risk, many respondents felt that there was a higher risk of contracting HIV on postings abroad, where there might also be a higher use of commercial sex workers: ***"(prostitutes abroad) – that's the only people you'd probably sleep with abroad; foreigners don't like us".*** Visits to sex workers in the UK were also talked about in the second base, in the South of Hampshire. Partner reduction messages included in military sexual health briefings often seemed to have been interpreted as not having sexual relations with the 'wrong' women, though respondents were highly aware that many STIs would be symptomless.

Male respondents felt that there was a strong perception of benefits within local female populations to get pregnant by a soldier. Respondents claimed that in cases where paternity could be established, women could claim free housing, and financial support if they managed to prove paternity. For some male respondents, this seemed to entail trying to avoid claims of paternity, and an assumption that sexual relationships would be inherently untrustworthy: ***"Some lie as well to tie you down", "There is a saying in the army – 'trapped' – where sometimes the local girls are trying to trap you because you've got a decent job", "unplanned pregnancy is more of a worry than STIs, to myself".***

Respondents also felt that different sexual orientations would be accepted in military units. Some respondents specified that lesbians were widely accepted, but that gay men would be to a lesser extent. Female respondents felt that homosexuality would be bantered about but eventually accepted***: "We'd laugh about it for the first three days and that would be about it. But it's not to the point where it's upsetting, it's just like blah, blah, blah"*** **(Female Soldier).**

Generally, respondents seemed to be resistant to the idea of increasing the uptake of condom use, particularly due to high levels of drug and alcohol intake: ***"Even he's been shown all these pictures, when he's absolutely fucked off his face, he's not going to turn around and go, oh, wait, I need a condom".*** However, respondents identified themselves as being highly motivated to access regular sexual health screens. In part, this seemed to be due to practices of sharing sexual partners (in succession), and a duty to their colleagues to protect them from onward transmission: ***"if you don't go (for a sexual health test), and you've got something, you just end up spreading it around".*** Sex, sexuality and sexual health were felt to be openly discussed among peers, with perceived variation in support for sexual health among the upper echelons of the military hierarchy. Sexual health planning would not necessarily need to be discreet: ***"I don't think any of us care"*** (though with certain caveats – see Section 6.5.4 below). Most of the respondents were highly aware of the higher levels of STIs regularly found among army personnel.

Lastly, as will be explored below, access to HIV seemed to be a particularly problematic issue. Many respondents felt that being HIV-positive would entail being dismissed from their jobs, and removed from front-line duties. Many other respondents were simply unclear as to what would happen in these cases. Much of the discussion around HIV involved talking about the perceived risk of being in combat with an HIV-positive colleague. The low rates of testing for HIV are broadly reflective of these broad concerns.

6.5.3 Current Service Access

Sexual Health Information and Signposting

Many respondents included in the FGDs had joined the army at a very young age (16 years and above), and said that they had accessed relatively little sexual health information before then.

Respondents said that they would regularly (once a year) access briefings about sexual health, which would include messages about signs and symptoms of STIs, and partner reduction. Several respondents had accessed these briefings intermittently, due to being transferred to other bases. Most respondents felt that briefings were not engaging or interesting, and failed to grab their attention: ***"It's just one of those briefs that you go on before you leave, and nobody really listens anyway", "you get a brief, there are some leaflets on a board and that's it".***

However, male respondents also felt that they were relatively well informed about sexual health, and the lack of engagement in sexual health briefings could also be attributed to being perceived as a 'work-based' and required activity. For instance, when asked about desired content of sexual health information, respondents broadly identified areas that had been identified in the briefings. There also appeared to be quite a big difference in terms of other sexual health information available in different bases – in the first base, sexual health promotional literature was spread throughout communal areas, whereas in the second base, it was mainly accessible through the Medical Centre, which respondents said they rarely accessed.

Nonetheless, as a group it was clear that some messages and channels would be better received than others. Some respondents appeared to be disengaged and have message 'fatigue', particularly over condom use messaging: ***"It bores you. It's like when…Do***

you know that thing on the media…Did you use a condom and all that shit? And I'm like, fucking, just turn the channel over".

Others felt that printed 'wordy' materials, such as leaflets, would be generally ignored: ***"most people chuck leaflets away", "I tried reading one, had it for over a week before I looked at it; just so boring. If it had little pictures, I might actually read it".***

It was also apparent that some key messages, such as those about partner reduction, were felt to be unrealistic, particularly in a sexual culture where monogamy for some was equated with 'entrapment',: ***"Yes, but when you think about that at our age, I mean 19, 18 years olds, you don't want to settle down at this age do you?", "you are never going to stop casual sex in the army. It's never going to happen. The information's there, there's plenty of it, it's easily accessed, but you're still never going to stop it".*** Other types of interventions, such as integrating sexual health and alcohol messaging, were also felt to be unrealistic.

Many of the respondents in the FGDs felt that they mainly relied on their friends and army colleagues for advice and support in maintaining their sexual health, again partly due to widespread sharing of sexual partners: ***"Your mates help you as well. Your mates are probably the reason you've got it".*** There appeared to be few barriers to open discussion about sexual health issues.

Lastly, there was a significant difference among the two bases in terms of readily accessible sources of health information and advice. Respondents (particularly female ones) on the first base felt that there were people that they could approach, and who would support their access to sexual health services: ***"You've always got someone higher up in the chain of command that you do feel you can turn to. If you're desperate you can always go to her. She's a nurse as well"*** **(Female Soldier).** Respondents on the second base, however, did not have these informal sources of advice.

Website

Respondents were asked about their access to the internet, and the 'Get It On' website. There was low to little awareness of the 'Get It On' brand and website, with low levels of access to the internet, making it unlikely that respondents would access information in this way.

6.5.4 Access to Sexual Health Services

Overall, respondents felt that people in the army were highly motivated to access sexual health screens, despite high levels of unprotected sex: ***"I joined the army with an STD and I didn't know…I think it's a lot better in the forces for keeping yourself tested".*** Consequently, respondents felt that there was little need for signposting to services: ***"they would go off their own backs".***

Female respondents, and male respondents acknowledged, that women who had been diagnosed with STIs would be more likely to be labelled than men: ***"if a chick goes down and she's got something, skank".*** However, this did not seem to affect their likelihood of accessing sexual health services, and self-reported rates of accessing STI screens were high. Other KIs said that women would often go to access GUM services together, and that sexual health issues were openly talked about with their peers (similar to the men).

However, there were significant disparities in ease of access to sexual health services across the two bases. Participants on the first base could access services on site, and were supported to do this in their time (without having to disclose too much information about what health checks they were conducting). Being allowed to go for STI screenings during work seemed to encourage access: ***"most people like it because you can get out of work"*** **(Male Soldier).** It was felt that despite high levels of motivation, military personnel would be unlikely to seek STI healthcare if it was required to do so during their 'free time', ***"never do it in your own time"*** **(Female Soldier).**

Whereas self-reported rates of access were high in the first base, they appeared very low in the second base, with several respondents having accessed their screens over a year ago. The most accessible sexual health services were available off-site, with walk-in appointments mainly available during the daytime. Respondents said that it was difficult to get appointments, as it was hard to get permission for time off from their superiors: ***"You get the basic; it's your fault, you caused it, you do it on your time".*** Soldiers also found it hard to get appointments once they got there, and reported long waiting times of up to three hours, which made it impossible for them to juggle with their work requirements: ***"if we get any time off to go, it would be on a Wednesday afternoon and by the time we get there, there are already 300 people waiting. So it's pretty hard for us to get there", "Everyone knows that they need to get tested but no one can get tested."*** **(Male soldiers).**

Some respondents had accessed chlamydia screens through their health centres, but some respondents in the base with on-site services seemed unaware that they were available. There was an overall low awareness of local health campaigns, such as the Hampshire NHS 'Have You Got It?' campaign, even though most of the respondents in the FGDs were under 25 years old.

Lastly, as explored above in Section 6.5.2, there appeared to be a great reticence to test for HIV, though some respondents acknowledged that their sexual practices did put them at risk. Some respondents felt that HIV posed a negligible risk to them in Hampshire, ***"it's rare as shit now"*** **(Male Soldier).** Some respondents also asserted that they had been screened for HIV when they had joined the army, but that medical staff were

"not allowed to tell them the result", again reinforcing a culture of secrecy around HIV, ***"I think it's very hush-hush about it"*** **(Female Soldier).** Even where there was good and regular access to GUM services, HIV testing was 'opt-in', and the self-reported uptake appeared low. Many respondents felt that HIV testing should be mandatory, especially before being posted to combat zones.

Lastly, service delivery through local GPs was said to not be an option for most respondents. Army personnel were said to be actively encouraged not to access local GP services, and had been told that this might result in duplication of records.

Access to Contraception and LARCs

There appeared to be a good awareness of LARCs among female personnel, who seemed to prefer them as it fitted in with their work requirements: ***"I think it's easier because some people are quite forgetful and when they're on exercise you don't want to be carrying pills"*** **(Female Respondent).**

Among the men, while there was strong involvement in contraceptive decision-making with long-term partners when considering starting families, most male respondents felt that they would not be involved in decision-making about contraception. Men seemed to value male-controlled methods (condoms), often due to an apparent lack of trust of their short-term sexual partners: ***"The pill would be a bit dangerous, just in case she's forgetting to take it", "They could say they're going to take the morning after pill; whether they take it or not, that's a different question. It's just you know with a condom"*** **(Male Soldier).**

EHC

Use of EHC was said to be widespread among both female soldiers and women from adjoining populations, ***"I know a lot of girls who take the morning after"*** **(Male Solider).**

In the women's FGD, some respondents had accessed EHC through local pharmacies but had had to pay for it, with concomitant low awareness of local free EHC distribution schemes: ***"I think you should let that be something that they're aware they wouldn't pay for".*** A few respondents said that EHC had sometimes been difficult for them to access on weekends through local pharmacies, and that this had caused a delay in care-seeking.

Condoms

While apparently highly motivated to use condoms, both male and female soldiers reported high levels of unprotected sex, particularly linked to alcohol/drug-based socialising.

Condom distribution seemed to vary among the two bases. Respondents at the first base identified several distribution points across the base where they could easily access condoms. Those in the second base, however, said that condoms were only accessible through the Medical Centre (which they rarely visited). Some respondents mentioned 'special' camouflage tins with condoms, but condoms provided were not deemed sufficient. Condom distribution schemes thus varied enormously from base to base, and respondents seemed to feel little confidence in their own ability to advocate for increased service provision: ***"it will go from person to person and then it won't be carried forward"*** **(Male Soldier).**

There was a low awareness of local condom distribution schemes. One respondent mentioned accessing free condoms from a local chemist, but had had to subsequently pay for them, and thus was clearly not well signposted signing up for the scheme. Some respondents felt that they were most likely to access condoms through vending machines in local entertainment venues, but similarly to other respondents across Hampshire, felt that this kind of condom provision was expensive: ***"you go in (to the pharmacy), they're about seven quid for about six, or something stupid"*** **(Male Soldier).**

6.5.5 Future Service Preferences

Increasing Awareness and Knowledge

Some respondents said that there was a need for more briefings around sexual health, though using more innovative methods: ***"I actually would bring a woman into it, I would; for the males I'd bring a woman into it; and for the females I'd bring a male into it".*** A few respondents felt that male soldiers would be less likely to listen to a man, and others wanted a less dry, more interactive style, such as question and answer sessions.

However, other respondents also felt that messages should be given in the style and language of their work peer group, who communicated in a way that they understood. For instance, some respondents felt that a DVD, developed along participatory lines, would engage soldiers more in their sexual health. Messages needed to be more hard-hitting, given the combat background of the target audience: ***"I've got to see the gore; I've got to see people getting shot", "Yes, it has to start off horrible and then bring it down to having sex; I reckon that's how I would make my video"*** **(Male Soldier).**

Some respondents felt that health information should include messages about self care: ***"I think to make it as if it's a normal thing to go and get yourself checked out instead of going, oh, they've got a disease. I don't think you'll ever change people's opinion on it",*** and build on current feelings collective duty to maintain individual and group health.

Increasing Access to STI (including chlamydia) tests

Respondents with low access to GUM services and STI testing conceived of barriers to care mostly being logistical, and strongly felt that services should be provided on-site, through a mobile STI testing unit: ***"I think more people would go, especially if it's a young camp, because you'd all talk about it, wouldn't you?", "If we could get one on an army camp…that would be good"*** **(Male Soldier).** There was a clear preference for army service provision for sexual health, as staff 'speak the same language'.

A few respondents felt that peer encouragement could build on current social networks to encourage access, if logistical barriers were no longer in place: ***"you need to talk about it with a friend"*** **(Female Soldier).**

There was some support for accessing tests through local pharmacies, particularly if these were already being accessed for free condoms and/or EHC. However, respondents particularly prioritised this for local female sexual partners, who they felt were often taking sexual risks. A few respondents felt that men were unlikely to visit a pharmacy: ***"Say if a girl goes in to get the morning after pill or some condoms, the pharmacist could say there and then, would you like me to conduct a test for you, just in case?...I would say the majority could turn around and say, yes…but if you go, oh, yes, you have to go here, here and here, that's kind of like just…"*** **(Male Soldier).**

EHC

Male respondents felt that more could be done to Increase access to EHC, especially for female soldiers, and suggested distribution through the military units, given out by peer distributors.

Condom Distribution

While clearly weary of messaging around increasing condom use, most respondents, especially on the second base, felt that more could be done to increase access to condoms, especially through distribution across the base, through points that were easy to access without going to the Medical Centre, and easily available before free time, such as through the battery office, gate houses, and gym: ***"they should have a little box, saying, help yourself"*** **(Male Soldier).** Several respondents advocated active distribution to army personnel before weekends.

Some respondents also felt that condoms were better distributed through local venues where soldiers were likely to be socialising and finding prospective sexual partners: ***"I think we should put just put them all in a bar, because that's when you're more likely to pull, and the girls will know as well"*** **(Male Soldier).** Some felt that vending machines, with subsidised and more affordable condoms, were 'ideal'. Soldiers' descriptions of their social life identified some easily targeted venues where vending machines could easily increase condom use.

Lastly, one respondent felt that current condom distribution schemes were not well signposted, and that advertising could increase uptake: ***"Advertise where you can get them from, because quite a lot of people don't know where. It's just word of mouth. You might as well advertise it"*** **(Male Soldier).**

6.6 People with Physical and Learning Disabilities

6.6.1 Methodology

A total of 11 people with learning disabilities took part in the user engagement (six women and five men), through two focus group discussions. A further four (two women and two men) of the participants in the FGDs took part in in-depth interviews to discuss more sensitive issues in depth. A group discussion was also conducted with staff in a residential home for people with learning disabilities.

Three women with physical disabilities took part in in-depth interviews with researchers, and were recruited by staff in a local residential home for people with physical disabilities (PDs).

6.6.2 Background

As many of the issues facing these two groups were broadly similar, these findings are presented together.

Recent research into sexuality and people with learning and/or physical disabilities has highlighted persistent needs that were echoed throughout the user engagement. People with learning disabilities may have restricted access to areas that would allow socialising, meeting potential partners and developing a healthy sexuality, and may be prevented from having sexual relationships due to an 'infantalisation' of their identities and needs. People with LDs/PDs have also been shown to be at higher risk of sexual exploitation and abuse, particularly within residential settings, principally due to a lack of knowledge and information about sex, and a consequent lack of understanding of consent. People with disabilities may face restricted mobility and limited opportunities to meet potential partners, but appear to face a similar lack of access to advice and information about sex and relationships.

Physical Disabilities: The women with physical disabilities who were included in the user engagement lived in a residential home. One woman had developed a strong and fully sexual relationship with her partner. However, for the other two interviewees, opportunities to meet partners and form relationships appeared limited, which two respondents clearly felt a deep need for:

"I think it's very hard for me, but I think I know I like boys, but I haven't found anyone. And I don't know, but maybe I'm looking too hard, but I'm really desperate to find someone" **(Woman with PDs).**

Several of the respondents had heard of 'companies' that could provide information and 'assistance' to people with physical disabilities to be able to become sexual, but knowledge about them, or how to contact them, did not seem clear to the interviewees. Yet, for one respondent,

whether she would have the physical ability to have a sexual relationship, and whether she was 'ready' to be sexual, troubled her, and she felt strongly that she did not want to have these discussions with her care staff/ key workers: ***"it takes up all of my thinking. All the time I am thinking about these issues, and it is really upsetting me".***

For the respondent who was sexually active, it was clear that she was given space by care staff, and supported to develop her relationship: ***"a lot of the staff are very good about all of that…I've got a sign I can turn on my door, to say, please do not disturb, and a lot of the staff here actually know and accept that me and my partner have got a sexually active relationship".***

As will be explored below (see Section 6.6.4), one respondent also stated that she had been sexually exploited. It appeared that lack of information, especially around issues of consent, and a lack of confidence to negotiate sex, had partly contributed to this situation.

In general, there appeared to be poor access to current or potential sources of information and advice. For instance, the internet was said to be only accessible in public, and respondents felt that their only other source of advice and information could be the local doctor.

Learning Disabilities: Care staff in the residential home that was visited reported that they were moving clients towards supported assisted housing, and thus to more independent living. Staff felt that this was reflective of a general move across the Hampshire area, to reduce reliance on care through institutionalisation. Several of the people with learning disabilities in the user engagement had developed relationships, the younger ones often meeting through college and/or day centres, which clearly provided a valuable space for developing relationships.

Some of the care staff felt that the move to more independent living was to be supported, as it gave people with LDs more opportunities to have relationships, but that this 'empowerment' approach could conflict with their duty of care for clients. This especially seemed to be the case where people with LDs had had a lack of access to any kind of SRE, which was more likely among the older age groups engaged with. There was a strong concern among staff that people with LDs were not fully informed about the choices that they were making, when having sexual relationships: ***"I don't know if she's got the ability to understand what she's consenting to".*** For staff, this led to a need for SRE/PSHE to include issues to do with relationships: ***"I don't think that they necessarily understand about relationships. Not just about sexual relationships, about the whole relationship thing: girlfriend, boyfriend"*** **(Care Staff working with People with LDs).**

There was very little guidance for care staff, either in terms of local policy, or through clear referral pathways, on how to address their client's needs for more knowledge and sexual health information, which was consistently found across several care settings. Training for staff in this case had focused exclusively on adult protection issues, and did not include supporting the development of healthy sexuality: ***"I've had training in rape crisis, but it doesn't really deal with relationships, it deals more with abuse, sexual abuse, and that".*** Staff were clearly aware that not all of their client's sexual health needs were being met, and did not seem clear about where they could find resources to give their clients more information, and do not feel that they have had the right training to address these issues.

Some of the care staff also felt that older people with LDs were more likely to be assumed to be sexually inactive, and their sexual/reproductive health needs ignored, ***"because the ladies are older, that they (service providers) probably think, I don't have to do this, but there's a lot of people in their '50's who are very sexual. I think that they are dismissed because they are older"*** **(Care Staff working with People with LDs).**

6.6.3 Current Service Access

Sexual Health Information and Signposting

Physical Disabilities: All three of the women with physical disabilities who were interviewed had accessed SRE through schools and colleges. However, several of the respondents, when asked, felt that they "***don't know much".*** People with LDs also said that they wanted to be able to access more information, and advice,

"My main question is whether I would be able to do it or not" **(Woman with PDs).**

Respondents appeared to have few available sources of information or advice, in an interactive format. Available sources of information cited by respondents included local GPs, but as both were male, female respondents did not feel that they could freely ask questions. Changing GP was also not a viable option as transport to other surgeries would be difficult.

One respondent with PDs said that she and her boyfriend were both questioning their sexuality, and were not sure which label to use to describe themselves. As they had no one to seek advice from, they relied on each other to talk about their sexuality issues, with questions remaining. The difficulty of raising these issues meant that this respondent had not talked with anyone else about these issues.

Respondents felt that they clearly lacked access to information and basic knowledge. For instance, when asked about STIs, one respondent said the television was her main source of information. Another respondent clearly felt frustrated about her lack of information about contraception and the different methods available to her. There was a clear lack of knowledge about reproductive health, such as smear tests. Knowledge about different methods of contraception also seemed quite low (See

Section 6.6.4 below).

Learning Disabilities: There was a clear discrepancy between older and younger people with LDs, and their access to sexual health information and knowledge. People in one daycentre had access to SRE/PSHE through college, and had furthermore attended a one-day course organised by local care managers, about sexual health, which they had clearly valued: ***"It got me quite a lot of information because I've got a boyfriend anyway and it got me more confident on what to use in our relationship"*** **(Female respondent).**

However, access to sexual health information and advice outside of schools/colleges seemed intermittent and ad-hoc, often dependent on the care manager's initiative. Access to other sources of information also seemed difficult. For instance, people with LDs could name several sites for using computers with an internet connection, including the library, but for both people with LDs and PDs, accessing the internet in a confidential manner was problematic or unavailable.

In some cases, it was clear that access to further sources of information and advice was reactive, rather than proactive, occurring when people with LDs became 'problem' cases. Issues often arise due to a lack of access to adequate sexual health information. For instance, one respondent had had access to a community nurse, seemingly after inappropriately sexual behaviour in public. He stated that he had had little to no access to SRE before this. In another case, a care manager was unclear of the referral pathway when her client started touching women inappropriately in public.

For both people with learning disabilities and physical disabilities, it was also clear that their lack of access to information and advice was partly due to a strong preference for talking to well known and trusted staff. One respondent articulated how people with learning disabilities may find talking to unfamiliar people difficult: ***"It puts you off: people don't understand you; that's one thing. They don't want to know you: that's another, too"*** **(Male Respondent).**

6.6.4 Access to Sexual Health Services

For both people with physical and learning disabilities, accessing mainstream sexual health services seemed problematic. One respondent (with learning disabilities) appeared well signposted and linked to local sexual health services, as she had been supported to do so in college.

"It's okay now…the first time was nerve wracking, but I'm a bit more comfortable now. I can just go straight in and say, ask her, at the desk" **(Woman with LDs).**

This respondent was the exception. Overall, access and use seemed low. Given the difficulties with transportation and access to information that people with LDs face, unless they have been actively supported to access services, they are unlikely to have used them: ***"I would ask someone to come with me because I don't know where that hospital is… Not my mum and dad. I'd take a support worker"*** **(Woman with LDs).**

In one residential setting, several women with LDs had been removed from cervical screening programmes, as they were assumed to be sexually inactive. Other respondents said that uptake may also be low, as women with LDs may be fearful of having a PAP smear. This is largely reflective of a lack of access to clear education for people with LDs about accessing reproductive health services, as well as provider bias.

People with LDs/PDs may also face a range of logistical problems in accessing services in a confidential way. For instance, women with physical disabilities would have had to request staff in their residential home for special transportation to access outside services. Respondents clearly favoured being able to access services in their local area. Several respondents also worked, and preferred services that they could access in the evenings, or at weekends. Finally, both male and female respondents wanted to see staff of the same sex as them, and this had acted as a barrier to services in several instances.

Access to Contraception and LARCs

Physical disabilities: There was a clear overall lack of information about contraception. Respondents may be using contraception for different reasons, the most common among physical disabilities was to control periods. It was not clear if this was a decision that they had made alone, or which their carers felt was appropriate. However, there was consistent evidence that they were not being given full information, as one respondent did not realise that the Depo-Provera that she was using was actually a contraceptive.

One respondent who was sexually active had preferred to access LARCs, and was very concerned about preventing pregnancy (though she was aware that she could have children, should she want to). LARCs was her most favoured option: ***"Because I'd forget the pill every morning, that's why I have the injection. That's why I don't forget to do that, I just go to the doctor's and have that done"*** **(Woman with PDs).**

Learning Disabilities: Care staff raised serious concerns about the access of women to contraception. Again, it seems that this was most often due to a desire to control periods than to regulate fertility, ***"they've just been put on it, and left on it, like so many other medications they're just put on, and you try and get it reviewed, and same story…they could have been on it for years and years…I don't know whether they've ever been offered the education on different forms of contraception, or even if they know why***

***they're on it or what it actually does"* (Care Staff working with People with LDs).**

For both groups, there was no clear signposting into mainstream services, and a common assumption that they will access services through local GPs, though they would get a wider range of services through CaSH/family planning clinics.

EHC

Many of the respondents were very unclear about what EHC was, how to access it, and where it could be accessed for free.

However, two respondents appeared to have needed and accessed EHC through college nurses, principally due to a lack of preparedness for being sexually active at the beginning of their sexual lives, and 'grabbing the moment sex', ***"We didn't really have the chance, because we had intimate sessions and we just decided to go for it, and it just happened so quick"*** **(Woman with PDs)**. These respondents were also very concerned with preventing pregnancies and were clearly distressed by the uncertainty of whether the EHC had 'worked'.

Condoms

Most of the respondents who had accessed condoms appeared to know of several sources, including local GPs and buying them from chemists. People with LDs could name several free sources, but several respondents appeared to favour venues (such as vending machines in pub toilets) that could be accessed alone and without embarrassment.

In one respondent's narrative, it was clear that he was questioned by service providers as to his need for them. Clearly, this could increase embarrassment for service users.

Some respondents felt that condoms were too expensive for them, and that could make access difficult: "***Make it more flexible, make it free most of the time instead of spending money because they can be expensive"* (Man with LDs).** Many of the respondents would not be eligible for the 'Get It On' condom distribution (being over 25 years old).

One female respondent felt that she could easily access condoms, as she had pushed her local shop to provide the ones that she and her partner preferred. Nonetheless, her case highlighted that access to condoms would be intermittent for many people with physical disabilities, relying on transportation into urban centres once a week.

Sexual Exploitation

People with LDs can face deep and complex issues to do with sexual exploitation, and are more likely to occur in situations where they have not been empowered with access to sexual health information, and are less clear about consent.

Though the sample size was small, issues to do with sexual exploitation came up in several instances. One respondent stated that she had been sexually abused by another member of her residential home. Adult protection measures had been followed, but it was also clear that this case had partly arisen due to this respondent's confusion over consent, and her right to refuse sexual advances. There also appeared to be little follow-up in counselling for her, despite the evident distress that she felt in relating the disbelief of her family. As she said when talking about her mother's reaction: ***"I'm not making it up, she just doesn't believe my story. When I told other people they were like, no…he's a lovely guy"* (Woman with PDs).** A second respondent had clearly come to be viewed as a risk of being an abuser, but had had little to no access to SRE. His case highlights the deep need that people with LDs often have for in-depth SRE, including issues of consent and what is or is not appropriate in public.

6.6.5 Future Service Preferences

In terms of future service preferences, it must be borne in mind that people with LDs/PDs have had limited contact with sexual health services, and discussions about future health service access are reflective of this.

Physical Disabilities: Respondents advocated having access to interactive and personal sexual health advice, preferably a sexual health nurse to come and speak in the residential homes.

Respondents also preferred to have sexual health tests done through their GP, with female doctors for female patients. It was clear that they mainly prioritised GPs due to severe logistical problems getting to services further afield. However, in discussing models of care that appealed, respondents also prioritised pharmacies, as these were often available either in their local area, or in places that they regularly travel to.

Learning Disabilities: People with learning disabilities themselves had clearly enjoyed and participated in SRE. They advocated more SRE, provided in smaller groups, with more interaction and participation, to be able to safeguard their own sexual health, and provided at an earlier age (from 17 upwards): ***"because you understand it, people explain it to you, you understand; and you just have it now, too late"* (Man with LDs).**

Care staff highlighted the clear need for guidelines and local level policies to clarify roles and responsibilities in facilitating and empowering people with LDs to safeguard their own sexual health.

Clear policies and guidelines would lead to greater access to reproductive health interventions (breast screenings, PAP smears (even if they are not sexually active), and how they can support their clients to be able to protect their own sexual health. Staff also felt a need for concerted training, clarifying their role: ***"I think we should have training as well. I think we need to know where our cut-off point is. If she goes in, and we say, yeah, you've made that decision, in you go, and then she comes out and says, he's raped me. Where does that leave you?"***

6.7 People Living with HIV

6.7.1 Methodology

Two separate FGDs were conducted with 11 people living with HIV (2 men, 9 women). The majority came from BME groups. Both groups were arranged through local HIV social support organisations.

Efforts were made to recruit more participants using a variety of methods, but there was a high refusal rate, which KIs attributed to concerns about disclosure, and were arguably reflective of a continuing high rate of stigma and discrimination.

6.7.2 Background

SOPHID data from Hampshire highlighted that there are a significant group of PLHIV who come from the wealthier segments of the population. It is likely that those accessing support groups are those who are in greater need of emotional, financial and other forms of support, and thus that the needs of this wealthier group have not yet been fully explored.

Many of the people contacted through the user engagement came from BME communities, and were often recent migrants into emerging BME communities in the Hampshire area. While levels of stigma and discrimination were felt to be high for PLHIV in general, people from BME communities felt that this was especially the case among certain Black African communities. This continued to act as a barrier to community mobilisation around HIV issues, and overall awareness of high levels of HIV in Hampshire were low: ***"They don't want to come and join us, because they think if they come to us, it's like a label"*** **(Woman from BME group).** Among Black African communities, HIV was still said to be predominantly associated with transgression of strict sexual moral codes, and associated exclusively with certain groups ('prostitutes', or 'gay men').

KIs also highlighted emerging BME communities, particularly from Asia, where levels of discrimination were seemingly as high as that among Black African communities.

A few respondents had unresolved immigration status, and the consequent fear that people have of 'being caught' continue to make efforts at social mobilisation and social support difficult, especially among Black African groups. It was felt that people whose immigration status was unresolved would feel reticent about accessing health services in general, and sexual health services in particular (due to stigma).

6.7.3 Current Service Access

The principal site of HIV-related care in NHS Hampshire is Southampton GUM, although the other GUM clinics do provide HIV testing services. In addition, it has several HIV CBOs running support groups across the patch. At the time of the user engagement, there were reduced roles for HIV specialist social workers (who were allocated to PLHIV whose condition was more progressed), and medical support was exclusively provided through GUM. Nurse clinical specialists were not available outside of GUM, and sexual health outreach workers were conducting information and advice sessions through local CBOs.

GPs

Many of the respondents included in the user engagement had chosen to disclose their status to their GPs. However, use of GPs for advice and information related to their HIV or other healthcare varied tremendously, and appeared very patchy. Where PLHIV had managed to identify a knowledgeable and sympathetic GP, they seemed to rely on them extensively, and could be a valuable and trusted source of care, often more locally based than most GUM services: ***"He treats me very good. Anytime I can call him, and he's always there"*** **(Woman from BME group).**

A few respondents felt that their GPs were simply unwilling to 'deal with' them as an HIV patient: "***If I go there with any other illness, (he tells me to) go to the GUM clinic. They exclude me, like go and use your consultant"*** **(Woman from BME group).** In one case, a GP had refused to register a woman whose immigration status was in process but not resolved. She was consequently relying on GUM for all of her healthcare. Other respondents had managed to find engaged GPs, despite initial aversion from the GP they were registered with. Access to GPs thus seemed to rely on the inclination of the GP to 'take on' an HIV patient. In cases where respondents had felt that GP care was not accessible, they seemed unclear about how they could change their GP registration.

A few respondents felt that the difference in GP attitudes was reflective of a generational difference, and concomitantly different levels of training around care and treatment of HIV: ***"So I saw another GP who was a bit younger, and she was a bit more knowledgeable about HIV and what to do with it, and at the time I was also going into depression, so she was quick to give me anti-depressants, and quick to tell me what to do"*** **(Woman PLHIV).**

For several respondents, GP surgeries had become problematic, as they had been forced to disclose their HIV status in discussions with nurses and receptionists. Respondents cited cases of having their medical records marked inappropriately with 'HIV', which made them reticent and fearful of reactions among other staff. In discussions about devolving more HIV-related care to GPs, a principal stumbling block appeared to be communication between GPs and GUs, which would need to be improved, ***"so that they know what's going on"*** **(Man PLHIV).** Communication among different healthcare providers was said to be especially bad in patients with complex needs, or those who had constrained resources, such as HIV consultants.

Social Support Groups

A variety of social support groups were running across Hampshire NHS area for PLHIV, with other support organisations targeting their support through the CBOs. Other services that could be accessed through these groups included (but were not limited to) Citizens' Advice Bureau (CAB), clinical nurse specialists, social workers, sexual health outreach workers, and health advocates.

Respondents still agreed with findings from the HIV Needs Assessment (2006) that most people get their information on dealing with HIV from other PLHIV. Social support groups are still the most valuable source of emotional and informational support for PLHIV included in the user engagement, ***"We're all different, but when we get here, it becomes like one family"*** **(Woman PLHIV).**

However, referral pathways between GUM services and CBOs were still felt to be shaky, and other respondents felt that they were initially put off by the perception that some groups were 'for' certain groups: ***"I must admit, when I was diagnosed and I was looking around for some…there were a lot of groups for Black African people, there were a lot of groups for gay men. What I would want is one for straight white men"*** **(Man PLHIV).** Respondents in one support group felt that they had successfully overcome this initial reticence, and represented a mix of PLHIV. However, others felt that there was more need for a focus on certain groups, for instance, Black African groups.

Sexual Health Information and Signposting

Respondents firstly identified signposting at time of diagnosis as being of crucial importance. Means of diagnosis was not explored extensively; however, a few respondents felt strongly that they had not been treated well by medical staff at the time of diagnosis, and had been left with little follow-up: ***"Boom, you are HIV, in front of all the nurses and everyone, and to my ex-husband, you are not…and I was just shocked, because you know?"***

People diagnosed through GPs seemed to be less likely to be linked into social support services, and perceived GPs to be less well informed about local resources: ***"I don't think from the GP there's any information in***

there about HIV, quite honestly. I haven't seen it, and the relationship I have with my GP as well is not very good, but with my consultant, it's really good" **(Woman from BME group).**
However, a significant minority of respondents felt that signposting into services had improved recently. Both CBOs who were part of the user engagement had been able to provide information through GUs: ***"I think it's changed from the time when we were diagnosed. I think it's improved"*** **(Woman from BME group).**
Respondents from BME groups felt that there was now a higher awareness of where information and support was available from, partly due to better signposting, and more informed social networks.

Most of the respondents said that they relied extensively on clinical nurse specialists, especially during the time post-diagnosis. However, they were also highly aware that these nurses come from Surrey PCT, and that there is no similar service in Hampshire NHS area: ***"I used to have one as well…who used to help us, come even to our homes and you can feel comfortable to talk about this personal stuff with the clinical nurse. That was a good service provision then, but now it's kind of vanished".***

Several respondents felt that more could be done to link people into support groups, as the time post-diagnosis was often frantic, and it had taken several years before they had approached social support groups, and had been able to avail themselves of their information and guidance. Respondents still expressed strong concern for PLHIV who were not attending social support groups, and felt strongly that more could be done to link newly diagnosed PLHIV into internet-based information.

Prevention of Onwards Transmission

Respondents from Black African communities said that there was still a wide perception among their community that there was a low risk of contracting HIV in Hampshire, compared to their countries of origin: ***"they feel it's not the same here, it's somebody else. That's their way of thinking"*** **(Woman from BME group),** and were similarly unaware of high rates of HIV among BME groups in the UK. Advocates from BME groups (specifically Black African groups) felt that not enough was being done to address this perception, and there was therefore a high risk of onwards transmission.

Respondents in general said that advice and information about prevention of onwards transmission was accessed through local support groups; however, there was little to none available through local GUs: ***"The first time you go there, they test you for everything under the sun, but after that, they don't bother"*** **(Woman PLHIV).** Some felt that this was again due to resource over-stretch through GUM: ***"I think that the [medical staff] don't have time to spend with each person giving that information"*** **(Male KI).** As key stakeholders pointed out, however, not all PLHIV will be accessing social support groups, and may not be accessing sexual health screens or safe sex information: ***"they think people have understood, but I think it needs to be…everything needs to be refreshed, reminded"*** **(Woman PLHIV).**

Condoms

Respondents said that they could access free condoms through local CBOs. Local CBOs (from BME groups) have been arranging distribution of condoms to pubs attended by people from Black African communities, with the support of local health promotion teams.

However, echoing perceptions across different groups, it was felt that there was a general lack of availability of free condoms in areas where transmission was likely to take place. People from BME communities especially felt that people would often feel that commercially provided condoms were too expensive: ***"if they need the money, they get stuck and they have to do it, and then that's when they catch the AIDS"*** **(Woman from BME group).**

Access to HIV specialist services

Most of the respondents interviewed said that they accessed care through GUM services in their local area. A few respondents had chosen to go and access GUM services further afield, one due to being unable to access the medications that he felt he needed, and another for mixed care due to complex health presentations. The extent to which respondents relied on their GUM services seemed to vary, mainly due to the relationship that they had with their GP (a few respondents had been refused access to GP services, see above), or their perception of levels of ability in self-management.

Several respondents had attended Expert Patient Programmes (EPP), which they felt had reduced their reliance on GUM services, making them more confident in self-management, improving drug compliance and eventually leading to better healthcare outcomes for them: ***"when I go to GU, I know what to tell my doctors because I have read about it…I did EPP, which actually tells you about relying on yourself with the HIV. So…you are really pushing the boundaries with the doctor sometimes", "honestly, if you haven't done those courses, you find yourself just calling for something as simple as a slight headache"*** **(Woman PLHIV).**

In terms of empowering patients to be better able to manage and live with their condition, many respondents advocated for more PLHIV-led interventions, including better links with GUM for the newly diagnosed: ***"some who is HIV would be probably a good person to tell the newly diagnosed person, or someone who is in***

***denial, to tell them, look at me, I have lived it", "like they've had it for five or ten years and somebody's been diagnosed, they can say, well, this is how it works"* (Woman PLHIV).**

Most of the respondents felt that they received good quality of care through HIV treatment services: ***"it's fantastic", "it's very good", "I come back smiling each time I go".*** There was a widespread feeling that care was, however, constrained due to lack of resources and shortages of staff, which impeded on their ability to easily contact HIV consultants: ***"if you want to see a consultant you are not assigned to, you have to come up with something very serious so they can make an exception"* (Woman PLHIV).** It was also felt that the facilities were similarly constrained: ***"to be honest, the GU at Frimley Park is…basically a shed round the back of the hospital"* (Man PLHIV).**

A significant minority of respondents also felt that care was inefficient and lengthy, especially compared to London HIV services that provide rapid results for blood monitoring, ***"If I needed that to be done at Farnham Road, it would take about two or three trips".*** Respondents said that blood tests are not done on site, resulting in a cumbersome process and repeat visits. It was widely felt that local GP services could play a more active role in blood monitoring, leaving the HIV services to focus on treatment.

Social Care

Most of the social care interventions available to PLHIV is channelled through social groups. This included advocacy, financial advice and support to access benefits. There was a wide consensus that HIV social workers were unavailable, and not proactive: ***"I don't think social care is very good…they are not very sensitive"* (Woman from BME group).**

Respondents in the user engagement stated that they had had little or no contact with their social workers. Consequent gaps in service provision included accessing respite care: ***"I would like some respite holiday. I know people do take the offer. I've never been offered it. I suppose I could ask, but I don't really know where to ask".*** A few respondents also said that it was difficult to maintain good health (for instance, through good nutrition) on benefits, and that accessing other forms of benefits could be difficult, ***"they don't seem to give people with HIV a priority in terms of housing"* (Male PLHIV).**

This issue was particularly complex with PLHIV with unresolved immigration status, who often met with confusion and resistance from service providers in accessing a wide range of social benefits. Respondents from BME groups felt that this meant needs were left unmet: ***"Because some people who are HIV are elderly, they need social help and they are excluded because of their legal status, it all comes back to legal status"* (Woman from BME group).** CBOs then play a vital role as advocates for these PLHIV to access services.

Some respondents had previously taken part in a PLHIV-led 'Buddying' system, and felt that this would work for the Black African community as well, to overcome the severe social isolation that PLHIV may face: ***"I find it helpful and there are still people in that situation as well", "the people are very stressed and very depressed and we are short of people. To talk to someone, we don't have that"* (Woman from BME group).**

Stigma and Discrimination

Self-reported levels of discrimination were said to be high, especially among certain BME groups, including Black Africans and emerging Asian groups. Echoing other groups, there was a widespread feeling (especially among the long-term diagnosed) that levels of stigma and discrimination had altered little. This was principally because HIV had become less 'visible' publicly. One respondent also felt that the Expert Patient Programme (EPP) had helped her to overcome deeply felt stigma, ***"The stigma, it takes away a bit of that stigma to make you actually talk about it, because I couldn't speak about it. It was like taboo where I come from. But when you do the programme, you actually feel you can open up and talk about it"* (Female PLHIV).**

6.7.4 Future Service Preferences

In group discussions, respondents considered the needs that had been highlighted, and how they felt these could best be addressed.

Increasing Social Support, Information and Advice

It was felt that there was a need for more PLHIV initiatives, including a 'Buddy' system, which links long-term diagnosed with the newly diagnosed: ***"some don't even feel like they want to start the medication, because they feel that the after effects is worse than living with HIV…but when they see someone who has gone through it….nobody would tell she's HIV. So that is something that would help HIV people" (Woman PLHIV).***

Respondents felt that more could be done immediately post-diagnosis, as people might not access support groups. There was a perceived need for better links between GUM services and CBOs, including allowing CBOs to be present in the GUs to directly accept referrals on-site, ***"you'd say, this is your result; by the way, this support group exists, here they are"* (Male PLHIV).**[47] Advice could also be accessed confidentially, in an interactive format, through either through a freephone

47. KIs reported that some CBOs, such as Positive Action, do have staff on-site in some GUM departments, but their presence is limited.

number, or through an internet group.

Quality of Care

GPs in HIV care – PLHIV were generally supportive of more involvement of GPs in HIV-related care, provided that training and refresher courses were made available for GPs of all ages on care for HIV patients. This could lead to GPs being more involved in blood monitoring, for instance, reducing travel and waiting times for PLHIV, and reliance on HIV specialist services. There was a concomitant need for better communication between GPs and HIV specialist services, which respondents felt depended on reducing overstretch in GUM services.

There was also a perceived need for training for all staff in the GP environment to reduce forced disclosure of HIV status, and make it more sensitive to the needs of PLHIV. This included more sensitive handling of medical records (recording patients as 'immuno-suppressed' rather than HIV-positive).

Prevention of Onwards transmission

There was a need for better integration of sexual health screens and advice into GUM services, to support the prevention of onwards transmission.

Among people from BME groups, there was a perceived need for a free condom distribution scheme, given the precarious financial status of those with unresolved immigration status: ***"I don't think people should buy condoms, they should be free"*** **(Woman PLHIV).**

Increasing Access to Testing

There was a clear preference for testing through GPs among BME groups: ***"If they can go to their GP for a test, they can just see. If they go to the GUM clinic, it's like you know…But the GP you can go for anything"*** **(Woman from BME group).** Testing through community-based interventions would not work, but community-based interventions would be needed to promote the service to a wider audience. Women of Black African descent felt that GPs would generally be trusted to be confidential by the community.

Women from BME groups also discussed increasing access to testing in integrated tests through pharmacies, which they felt could be more easily promoted than community based testing: ***"everyone uses Boots. And, if somebody knows that, they can encourage another one in their own language, once they find out"*** **(Woman from BME group).**

Reducing Stigma and Discrimination

Respondents were highly aware of increasing rates of HIV across Hampshire, and felt that more needed to be done to reduce stigma and discrimination, and increase uptake of testing. Specific groups that they felt were being missed in awareness raising included older groups (who are now showing higher prevalence of HIV), and those from a range of BME groups (African and Asian).

Some respondents said that reduction of stigma would work well through collaborative working with faith-based organisations.

PLHIV also advocated more general HIV-related education in schools, led and delivered by PLHIV, to raise awareness about HIV in Hampshire.

6.8 Gypsies and Travellers

6.8.1 Introduction

A total of 16 English Romany Gypsies were interviewed covering an age range of 14–51 years. The gender balance was 4 males (3 were 18 years or under, one 40 years) to 12 females (1 under 18 years, 3 in their 20s, 3 in their 30s, 3 in their 40s, and 2 in their 50s). Six of the women had children.

One focus group discussion was conducted with five women, and the remaining respondents were engaged with in eleven one-to-one interviews. All the people interviewed, except one, lived on a permanent site in Totton. The non-resident lived on a permanent site out of area.

6.8.2 Sexual Health Services

All the respondents were registered with a local GP surgery and reported that they received a good, if somewhat rushed, service from the doctors there. This surgery was where all the women using contraception obtained their information and supplies. There was only one report of a community member having had an STI and for this they were taken to the GP, although it was not clear if they had been referred to GUM services afterwards.

No respondents reported having had any difficulties obtaining health treatment because of their being a Gypsy or Traveller and even those who had lived roadside said they had been able to access health services across the area. This is unusual for this community and may reflect the large Gypsy population locally and the higher profile they have here than in other parts of the country.

Apart from the Queen Elizabeth and hospitals in Southampton the only reference made to another health service was a single report of use of a walk-in clinic in Totton and several mentions linked to treatment of mental health problems via Ashmore House.

6.8.3 Age of first child

Applied to women only, 17–23 years. All the women stated that they had had their children in local hospitals with one saying she accessed a hospital whilst roadside. The women all reported a good experience of their

children's births with regard to the health services they received. None of the women had attended antenatal classes.

6.8.4 Age when you 'entered into womanhood' (menarche)?

Applied to women only. One was 10 years, six were 11 years, two were 12 years, three were 13 years. The relatively young age of menarche for the majority of the women is in keeping with Options UK findings from work with Gypsy and Traveller women in Kent.
Three respondents reported not knowing what was happening when their periods started and consequently reported being frightened: ***'I thought I was dying'***, others mentioned that they had a bit of an idea about periods because they had older sisters or their friends had spoken about them.

All of the women said that it was at this time that they were told about sex and reproduction and half of the respondents were pulled from school at this stage due to cultural concerns about them mixing with boys and men once their periods had started.

6.8.5 Who told you about sex and sexual health and what were you told?

Applied to both men and women. Most female respondents said that it was their mothers who told them about 'entering into womanhood', with others saying it was a grandmother or auntie who explained.

None of the female respondents were told about reproduction or sex in any specific detail with the overwhelming information they recalled receiving being about the practicalities of dealing with their periods and the instruction 'to keep away from boys now and keep decent'. It was for this reason too that respondents had been taken out of school or had taken their own daughters out of school.

Respondents all reported that they had learned about reproduction from older friends or married family members but that this was not in any way a formal imparting of information or education.
All respondents except four were pulled out of formal sex education at school when it occurred. Two older women said they had had some sex education due to parents not being notified of these lessons when they were at school. Another said that as their parents could not read they did not realise the lessons were happening. One younger woman said that she excused herself from the lesson once she was aware of what it was about and 'when they showed filthy pictures'.

Discussions and advice about contraception typically occurred once a woman had a boyfriend and was expected to marry them. All the women stated that they were expected to keep themselves 'decent' and so advice about contraception was aimed at delaying pregnancy only after they were married. Mothers, aunties or sisters 'passed on what they knew'.

For women, pregnancy was also a time when they received information formally about sexual health if they attended for antenatal appointments and received screening for STIs. Respondents said that this meant they then felt better equipped to talk about STIs with other younger females. Some women said that they had felt 'ignorant' and also referred to some women from their community as being 'very backward' when it came to knowledge about sexual health. It was important therefore that professionals dealing with women during pregnancy or when any sexual health problems arose were aware of this and took time to explain: 'without making us feel ignorant'.

All the men and boys interviewed said that their fathers had spoken to them when they were 11 or 12 about sex although all three of the younger respondents had also attended SRE at school. The talks that fathers gave their sons consisted of discussions about hygiene and personal cleanliness as well as the basics of reproduction and the undesirability of getting a woman pregnant until they were married. Contraception and the use of condoms was mentioned by all the male respondents as something their fathers had talked to them about, or they spoke to their boys about, and all the males interviewed said it was impressed on them that it was their responsibility not to get girls pregnant.

As the men and boys interviewed were young they had all been told something about 'diseases' but the information they got was patchy and they were made aware of its incompleteness when they had SRE in school.

'stuff at school taught me a lot I didn't know'
Young Male

Some respondents reported seeing adverts and seeing articles in newspapers that had provided them with more information. Television and radio adverts were also mentioned and there was a mixed response about how appropriate these adverts were with some respondents saying they were switched off and others saying they were acceptable.

6.8.6 What do you think is the best way for Gypsy and Traveller children to learn about sex and sexual health? Applied to women and men:

- All respondents said that it was the parent's, or other trusted elder family member's, job to speak to their children on these matters. There was acknowledgement, however, that STIs had increased and that sometimes parents' knowledge was not sufficient.
- There was a consensus that formalised SRE was acceptable for boys and several female respondents said that SRE at school would be more acceptable if it was delivered to girls separately and if it was less graphic.

- Media messages and information were increasingly important for younger respondents as they filled the gaps in knowledge that some respondents reported.
- Bespoke and culturally appropriate material, such as a DVD, was also something that respondents felt would be useful as it could be viewed in private or as part of SRE at home or school.
- The women's focus group all said that they found the process of talking together, with a professional, 'someone who can answer our questions and who we trust', a comfortable and informative way to learn.

6.8.7 Contraception (men and women)

Within the Gypsy and Traveller community there is a clear difference in community and personal expectations about boys' and girls' behaviour. Boys are not discouraged from sexual activity 'spreading their wild oats' before they settle down to marry. Girls, however, are expected to be virgins when they marry and any sexual activity is frowned upon. Comments such as ***'I'll stay decent until I meet the right man'*** and ***'staying a 'V' is valuable, you don't want a reputation as a dirty girl'*** were typical of the view held by the women interviewed. All the women spoken to were under no illusions though that the rules were different for boys and that boys had a freedom that they did not have and which they did not appear to want. Many respondents said that this means that young men often have sexual relationships outside of the Gypsy and Traveller community with 'Gorgars', i.e. non-Gypsies. Several respondents, male and female, stated, however, that this freedom for men came with a responsibility not to bring 'shame' back to the community. Because of this, all the young men interviewed said their fathers had impressed upon them the importance of using condoms.

- All the male respondents knew where they, or their sons, could obtain free condoms (Connexions).
- All the male respondents said there should be more places where free condoms were available.
- Two male respondents suggested that free condoms should be available through the site office or through workers for Forest Bus.
- Women respondents demonstrated high expectations that their sons and other young men would use condoms if in sexual relationships (outside of the community) prior to marriage.

Of the women who had had children or married, all reported use of the contraceptive pill, although experiences of it varied. One interviewee said she had become pregnant whilst on the pill and three others reported bad headaches.

- A typical trend was for women to change to the coil after they had completed their families and mixed experiences were reported about the satisfaction of this form of contraception.
- Five of the women interviewed had been sterilised and of these four were reporting early menopausal symptoms

All the women interviewed who used contraception obtained it through their local GP surgery.

6.8.8 Related Health Issues

6.8.8.1 Women

During the focus group and interviews with women, six of the interviewees reported treatment for polycystic fibrosis and ovarian cysts. In some cases this was reported as the reason they had been 'sterilised'. There was a family link with these conditions as three of the women reporting them were cousins.

Two young women with polycystic fibrosis explained how they would not use the contraceptive pill to tackle related bleeding problems as they were still 'decent' and people might think they were taking the pill because they were sexually active. Both young women also reported that they had declined internal examinations for their conditions: ***'I won't ever have that type of exam, or a smear test, until I've been popped' .***

Smear Tests

Women who had had children all said that they attended for smear tests. Without exception those who had not had children, irrespective of their age, did not and said they would not have smear tests. During the focus group there was some discussion between the women about this, with some women urging the others to have smears and asking them what would encourage them to have them. Responses were either as described above or related to simply preferring not to know if there was anything wrong. This latter view was explained by several respondents as something that was prevalent in the community along with a tendency to believe any health issue was likely to be serious or terminal, hence the 'I'd rather not know' attitude.

Breast Examination

Views were less polarised on this subject and all women reported having either examined themselves or that they had been examined by a doctor. Several women said they were not sure how to examine properly and that they would value learning this either in a one-to-one setting or in a relaxed and informal group with a health professional or adviser they trusted.

6.8.8.2 Men

Testicular Examination

All four males said that they were aware of the need to examine their testicles and the father interviewed said he had told his sons that they must do so regularly. The younger men reported, however, that it was their mothers who had mentioned it to them and one young man reported that he had gone to his mother when he had concerns on this issue. She had referred him to the GP.

During the interviews it became clear that with the exception of the initial talk about sex that young men had with their fathers, it was often mothers who were the first point of contact for young men and it was also mothers that continued to impress on their sons the need for them to use protection if they were in sexual relationships before marriage. The women in the community are often a source of advice and information for all young people.

6.8.9 Understanding the Risks of STIs

During the focus group and interviews with women it emerged that (and this was also the case with other Gypsy women interviewed by Options UK in Kent) women sometimes did not understand that even though they had 'kept themselves decent' they could still be exposed to STIs if, once they married, their men had not always practiced safe sex.

The women discussed how this dilemma could be dealt with. The consensus was that it was not something young women could be expected to raise with their new husbands, but two mothers interviewed recounted how they had spoken to their sons, once they had become engaged, and had made their sons be tested for STIs prior to their marriage. Respondents were asked whether this was a good way to protect young women or whether fathers should take responsibility for advising their sons on this before they married. The overwhelming view was that mothers were best placed to do this, but that they needed to understand what they were talking about and understand themselves what the risks were.

There was patchy understanding, and also considerable curiosity and willingness to learn, among interviewees about STIs. Comments such as: ***'but only girls can get chlamydia'*** **Young Man** or ***'you can only get that [cervical cancer] if you've had a child'*** **Young Woman**, illustrate the gaps in understanding.

6.8.10 Health Service Needs

Although the focus of the community engagement was on sexual health issues many respondents wanted to talk about mental health issues. In some cases this was linked to coping with symptoms of the menopause, or the onset of menopause, causing worsening of existing depression and anxiety.

During the course of interviews and in focus groups, five people talked personally about their or their children's needs for mental health support and services. 'Suffering with nerves' or depression were specifically mentioned. In all cases, respondents were or had been in receipt of medical treatment via their GP, but all felt that they needed counselling or talking therapies and support.

All respondents expressed satisfaction with the GP services they accessed, although some felt they did not want to 'take up their time' when it came to mental health issues.

Several respondents said that they valued the opportunity that the community engagement had given them to ask questions and talk openly about their health and sexual health issues and that they thought a future way to help them learn about health would be to have 'a professional, or someone like you who can talk with us' come onto site with a community intermediary to hold group sessions.

Some respondents reported that there had been plans for a well woman clinic or session on site, but they had not heard anymore about the idea. All women respondents said they thought this would be a good service and one they would feel comfortable accessing. Respondents were asked whether they would use a family planning or sexual health clinic off site but all said they would not use such a facility.

Many respondents said that they had no dentist and could not register locally as there were no NHS dentists available.

6.8.11 Community Recommendations

- Culturally appropriate material or information sessions to educate and inform mothers and fathers and older community members about sexual health to empower them in their roles as educators and advisers
- Similar material or single sex sessions for the young people with material approved by the community
- For schools to deliver SRE in single sex classes and to have material that is culturally sensitive
- Outreach visits to site on different health topics, to include sexual health, delivered in partnership with a community member 'facilitator' or intermediary. This would help in cases where the 'professional' was not known by the community

- On-site well woman or drop-in clinic with time slots to enable people to talk about their issues and not feel rushed
- Expansion of free condom availability and consideration of supply through the site office
- Information or training on breast examination
- Outreach dental provision or access to local NHS dentistry

The following pages present findings from additional engagement with Gypsy and Traveller men which was funded by NHS Hampshire and The New Forest District

Council as a follow-on to the engagement above.

6.8.12 Introduction – Additional engagement with Gypsy and Traveller Men

A total of 10 English Romany Gypsy men were interviewed covering an age range of 14–69 years. Two focus group discussions were conducted with three male participants in each, and the remaining respondents were engaged with in four one-to-one interviews.

All the men interviewed spoke openly and appeared unembarrassed about the research subject. In response to the interviewer commenting on this, explanations included:

'Times are changing and things are worse now with diseases so there's no point not talking about it. It's on the telly and in the papers anyway. Years ago the

telly would be turned off if anything sexual came on and women were present, some still do but lots don't'

'I wouldn't talk to my wife about this but you're here to help so it's ok'

'I'm open and don't care what people know. I think it's not the same for the women though'

The men were also encouraged to take part by their female family and they were told that the content of the interviews or discussions was not 'dirty stuff' so seemed reassured.

6.8.13 General observations

The overall impression given by the men interviewed was that, in contrast to the women's views, wider society was having an impact on their beliefs and attitudes and that the community was not doing its young people favours by sticking to 'taboos'. Several men commented that they 'got out and about more than the women' and mixed through work and also through having sexual relations with 'Gorga/Gorgie' girls. Three of the respondents had non-community wives or partners. Nonetheless, all of the men interviewed thought that sex education, either in school or through the community, was best delivered in single sex lessons or informal talks and that girls should be taught by a woman. This was both a cultural preference, as the men felt it was not appropriate for an adult man to talk to young girls about sexual and reproductive health, and also a pragmatic thing to enable people to ask questions without embarrassment.

6.8.14 Health Service Use

All the respondents were registered with one of two local GP surgeries. They all reported a good service and all stated that they had no issue with seeing female doctors: ***'It's your health and they're there to help you so I don't care if they're man or woman, makes no difference to me'.***

This view also extended to their wives with men saying they did not mind if their wives saw a male doctor but that they were not so keen on their young daughters seeing male doctors for 'women's things'. In common with the women interviewed, the men reported no difficulties obtaining health treatment. Those with roadside experience reported use of A&E and also temporary registration with GPs when needed. Some of the older men said that they thought local GPs were used to having a relatively large Gypsy and Traveller population and historically had made services accessible to them.

A Walk-in centre at Millbrook/Shirley received negative comments from two men but these comments were tempered with an understanding that the service ***'didn't know me or my health issues so it felt a bit patch me up and get me out, but they weren't my doctor so there's a limit to what they can do'***

The only health service gap that was reported was dentistry. Respondents said that there had been a much valued outreach dentist that came onto site but the service had been stopped. Registration as an NHS patient locally was difficult and only one man was registered with a dentist.

6.8.15 Sexual Health Services

One man had used the sexual health clinic at St Mary's and reported a good service and said he would advise anyone with concerns about a sexual health issue or having had unprotected sex to go there. This same man had had several sexual health checks because, he reported, he had served time in prison and ***'had been sleeping around a bit before so I got tested in prison. I wasn't embarrassed about getting help'.***

Another man in the same discussion group said that he was worried about his sexual health because he had found out a girlfriend had slept with someone else and he had unprotected sex with her. He had not so far sought help but his friend's admittance about his own sexual health tests and knowledge about services prompted him to ask where he should go and what the tests would consist of. Two older respondents (69 and 53) referred to

the 'VD clinic' but stated that they did not know where the local one was and although they had no need for such checks they both said they would go to their GP if they did.

Another respondent, who was in a new relationship with a non-Gypsy woman after his marriage had broken down, said that he and his new partner had both had full sexual health tests before having unprotected sex with each other. This respondent said he advised his brothers and friends to do the same when starting new sexual relationships.

6.8.16 Age of first child and entering into 'manhood'

The men with children, 7 in total, had their first child between the ages of 21 and 28 with most saying they were 25. None of the men reported having more than 5 children and two men commented on how family size in the community had decreased over the years.

Some of the men were keen that their daughters did not start families too young, as was traditional. They said that they wanted their daughters to take their time before settling down or before having children when married. In one discussion the comparison was made with 'teenage mums doing it to get flats' from the Gorga community and how they did not want their daughters to be perceived in the same way.

A couple of men reported early sexual experience with one 22 year old saying ***'I first went with a woman when I was 13, nature just took over'***

All the men interviewed were open about the different standards and expectations their community had for men and women about sexual relations before settling down. All the men indicated that they had 'sowed their oats' or were doing so before they settled with a partner and started a family. One older respondent explained that the idea was, so his father had told him, that when the time came boys would be more ready to support and stay with a wife without wandering. All the sexual relationships the men had before marriage were with non-community women and this was reported as normal and accepted.

6.8.17 Learning on sexual health and relationships

In contrast to the women interviewed, who all reported being told about periods and reproduction typically by a close female family member, some males (4 of mixed ages) said that they had received no information at all from family members about sex. One respondent said that his father had told him nothing and he felt this was wrong and had disadvantaged him. He felt some older community members were 'closed in and unaware'. For him this made him feel ***'I was blind, I wish my parents had of told me. I think the old way is wrong'***

Of those that had been spoken to by their fathers, or in one case Grandfather and Grandmother together, they had been aged 11 or 12. The information given was about reproduction, personal hygiene and the need for them to prevent pregnancies until they married. Four respondents also reported that during these discussions their fathers had told them that they must never force a women into having sex. Discussion about sexual infections had been vague but all the men said that it had been impressed upon them that they should always use condoms until they were with the woman they were going to start a family with.

The male respondents reported 'peer education' more widely than the females as their first and most frequent source of information. Several spoke of how 'mates' and brothers had told them about sex and that conversations about women and sexual encounters were discussed when men were together and the young men just overheard things. In contrast to female Gypsies and Travellers, boys who were in school were not pulled out from SRE and the majority of the men interviewed had received school based sex education. For some this was where they had learned more about STIs. Views about school delivered sex education varied. Some respondents said they were too young when they received it, some said that it had been too biological and had not talked about emotions. All said they thought sex education should be delivered in small, single sex groups.

6.8.18 Preferences for sex and relationships education

As mentioned above, despite some of the male respondents believing that children and young people needed to know about sex and sexual health, all the men did not think this was best done in mixed sex classes. One commented that he did not think any children benefited from mixed classes for sex education delivered by schools.

The respondents all said however that they had been, or would be, responsible for telling their own boys about sex although there was a general perception that their sons were picking up information all the time, as they had done, from older friends and brothers.

'They know it all already. He probably knows more than me'

The men were also clear that it was not their role to speak to their daughters about sex and that this was the responsibility of mothers. One respondent also said that this was true in respect of school SRE.

'It is up to the mum to decide when they learn and then it's mum that should tell them'

Two men were critical about how they had not been spoken to by their fathers and that the 'strictness' and 'being too serious' approach that their fathers had taken with them was now outdated. One respondent said how boys and girls needed to be aware and that the community needed to speak more openly about sexual

health and the risks that people might encounter.

'In life everything is changing and there are risks so they need to be aware and equipped. It's 2009 and we need to protect youngsters from harm and talk openly about things'

Some respondents felt that an element of peer education would be useful, perhaps in small single sex groups with an elder community member who had been given the most up to date information to pass on. If non-community members were to come and speak about sex in these settings then the consensus was that a community member should be present to help. Another caveat was that the community could be sensitive about other adults talking to children who were not theirs and so parents should give their permission first.

6.8.19 Safe Sex

Because the men were open about sex before marriage and sex outside of the community they were also willing to talk about the problem of men and boys bringing STIs back to the community. All the respondents were clear about the need for safe sex and all said they would impress this on their sons but some of the men spoke about having had unprotected sex. Three of these men said it was the result of drinking and that they knew that type of scenario was not uncommon. Because of this there was a general consensus among the younger men that if in future their own daughters were to marry a man who they knew had been sexually active it was up to them to raise the subject of STI testing with any future 'son in law'. The older respondents were more likely to say they would stop the relationship but discussed how this, although possible in the past, was less of an option nowadays as girls were more likely to ignore family wishes.

All the men said that young men should have access to free condoms and they were positive about condom distribution through GPs, pubs and chemists. Five of the men felt that free condoms should extend to all men to make it easier for those who had little money to be safe too.

'Maybe because of how men can slip up when they've had a drink or two there should be free condoms in pubs'

The men also thought that there should be a range of materials including DVDs and leaflets that people could look at in their own time and in privacy as not everyone wanted to learn in a group setting.

6.8.20 Promoting Safe Sex

All the men had from a young age been exposed to the safe sex message both as the way to avoid diseases but more often to avoid unwanted pregnancies and any claims of fatherhood. They therefore agreed that these messages needed to be enforced on young men and were in support of open advertising about the diseases and their consequences. Some said any advertising should be blatant and show the effects of diseases or the effects of ending up with a child with a woman 'you didn't love or want to stay with'.

6.8.21 Self Examination and Health

Two of the older men were not aware of testicular cancer and the need for self examination or were confused about prostate cancer and testicular cancer. All the younger respondents said they knew about self examination and that they would tell their sons about the need for it too. Most of the men, when asked about their wives health and whether they had smear tests, said that they did not know and that they felt it was not their place to ask or discuss these matters with females in their families. One younger man did say that after the Jade Goody situation he did try and raise the subject with his wife but admitted it was in couched terms and that he and she had found this difficult. Another respondent who was seeing a non-Gypsy woman and who had also ensured both he and his partner had STI testing before unprotected sex, was unusually open and said that he would and did discuss these things with his partner and that he thought women from the Gypsy and Traveller community were responsible for the way these things were kept hidden and not discussed.

'the women use to be really bad, they'd turn the TV off if adverts came on for women's things, that happens less now though'

6.8.22 Homosexuality

In discussions with younger men the subject of homosexuality within the Gypsy and Traveller community came up. Respondents said that ***'there are lots of Gays in the community, I know of loads. Not Lesbians though, I don't know of any'.***

The men said that once it became known someone was gay there would be ***'five minutes of name calling then they're left to be'.***

Gay men would not join the other men in going out to work and tended to stay at home with the women or get 'regular jobs' as this, it was explained, was seen as more effeminate and something that girls were more likely to do before they had families.

Of the respondents who spoke about this the consensus was one of tolerance but disapproval with a pragmatic view that free condoms would protect these men from HIV and AIDs.

6.8.23 Community Recommendations

The men interviewed appeared to have few needs around sexual health and were fairly accepting that times were changing and the young of the community needed to be equipped to cope. Most opinions were expressed about sex education and the promotion of safe sex.

- That girls and boys receive sex education at school separately and that girls are taught by female staff
- That peer led or assisted sex education be available, with parents consent, in small single sex groups
- Sexual health promotion should include adverts with graphic images and clear messages about the dangers of unprotected sex and the increased risk of having unprotected sex when drunk or drinking alcohol
- That a range of materials be available for parents to keep up to date so that they can be confident they inform their children correctly
- That free condoms be widely available primarily for the young but also for older men and that pubs and bars should provide them.

7 Strategic and Operational Themes

7.1 Introduction

The following section outlines and synthesises comments from key participants (service providers and stakeholders) in interviews for NHS Hampshire's sexual health needs assessment. For the purpose of the SHNA, the Options UK team interviewed some 46 key informants across a range of disciplines and sectors. Their comments have been organised into a framework that includes key elements to be considered by organisations and partnerships in planning, delivering and monitoring programmes. The categories reflect the public health planning cycle and aim to be broadly in line with expectations of a number of performance managers and regulators such as the Health Care Commission.

Themes include:

- Strategy and leadership
- Partnerships
- Surveillance, monitoring and evaluation
- Service delivery
- Prevention and behaviour change
- User engagement
- Workforce
- Communications
- Commissioning

7.2 Strategy and Leadership

7.2.1 Strategy

A local sexual health strategy and sexual health needs assessment should drive the work of practitioners and providers of sexual health and related services. It is critical that plans for sexual health are needs driven and contribute to a reduction in health and well-being inequalities. It is also critical to ensure the wide involvement of planners, commissioners, service providers and users (and where possible, non-users) of services in the development, implementation and review of the plans and overriding strategy.

During its Rapid Assessment, the NST for Sexual Health noted NHS Hampshire's "excellent action plans" but observed that there was not a coherent vision or a formal sexual health strategy currently in place. It is anticipated that following the completion of this SHNA by Options UK in conjunction with the findings of the NST, NHS Hampshire will begin to develop both a shared vision for sexual health and a formal strategy.

KIs were keen to see the development of both a sexual health strategy and a sexual health network for NHS Hampshire:

"I think probably there's a lot of duplicated effort because there's not really an effective network. We need to drive that"

"We have an HIV strategy, a sexual health one, a chlamydia one and in some ways that's not helpful because I think people see them separately. So, sometimes the effort of us trying to work together isn't helped by the fact they're all separate strategies"

"The thing that would really crystallise things for me is the strategy and the process of identifying what the priorities are through that, and that would give us the framework for the next five years"

"We have our sexual health policy (Hampshire County Council) for adult services, which is quite unusual"

"I think there's been a real, sort of driving force behind keeping it high on the agenda and the right people being involved at the right level in developing the sexual health agenda"

There was felt to be good leadership and buy-in from both commissioners and the Director of Public Health:

"Rob Carroll is very strong. He keeps it on the agenda and I think he's got an eye on the wider public health view rather than just hitting targets, which is fantastic and to be applauded"

"Certainly the commissioners, Rob Carroll and Kate Donahoe, are working very hard I think to help raise its profile"

"In terms of priority I think it has been driven by our Director of Public Health taking it to the board and making sure that teenage pregnancy and chlamydia screening were given a fair hearing and seen as things that we could actually improve on"

There was some irritation expressed by KIs about the target-driven environments they now find themselves working in:

"It's extremely target driven. The target is sacrosanct"

7.3 Partnerships

Partnerships and working arrangements are critical to ensuring joined-up working across sectors to contribute to sexual health improvement. Good effective partnership working was evident across sexual health and allied services in NHS Hampshire, but there were some allegations of territorialism and a reluctance to share.

"I feel working in the South East, we have terrific partnership working"

"I feel like I'm in a bubble"

"What we tend to get in Hampshire is we get a little project, really good practices developing in an area, but actually sharing that across an area where you've got competing providers can be very difficult because, obviously, they're not always open to that if you're in competition with someone else. People are very protective over what they do"

"I'm very confident that the relationship between the Local Authority and Public Health is very good. The changes in Hampshire around the Commissioner/ Provider split of the PCT did cause a lot of tensions"

"I think the partnership between Health and the Hampshire County Council is really good, really strong and we've done a lot of really good work to get there"

7.4 Surveillance, Monitoring and Evaluation

Accurate data and intelligence is essential for effectively targeted programmes, performance management and regulation. Data issues were raised infrequently during KI interviews suggesting that this is not a significant problem for NHS Hampshire.

"Give us the data that we ask for. Some services are better than others"

"How sophisticated does counting have to be?"

"Computers are one thing, new systems, new phone systems, new developments in transmission of data from the laboratory into our systems - that's one of the key things"

"So the North and East service, I believe they don't do an annual review, but that's something new that will be written into all service specs this year"

7.5 Service Delivery

7.5.1 GUM

GUM services in NHS Hampshire are commissioned from five different providers across the patch. These are: Basingstoke and North Hampshire NHS Foundation Trust, Portsmouth Hospitals NHS Trust, Southampton City PCT, Frimley Park Hospital NHS Foundation Trust and Winchester and Eastleigh Healthcare Trust.

The NST recommended that GUM commissioning should be reviewed and streamlining of services with fewer providers should be considered. It also recommended that a lead organisation be appointed to:

"provide clinical leadership, facilitate cohesive service development, ensure equitable standards and robust governance arrangements across all GUM services".

Through key informant interviews, the Options UK team found that the smaller providers seemed to be, and some felt like they actually were, in the shadow of The Ella Gordon Unit and the GUM services at St. Mary's Hospital, Portsmouth, as they are well established and

enjoy a national reputation through their work with DH around chlamydia screening (they were a pilot site in 1999) and through their nurse-led services.

Geographical inequity in access to services was also identified by KIs, with provision in the South East being described as "excellent" and provision in the North East being described as "poor".

"I think we're very privileged in the South East with regards to sexual healthcare because we've got The Ella Gordon Unit, the contraceptive and sexual health service, which provides an excellent service, particularly for young people across the South East. I think that's quite different to the north and west. We have a lot more services that are far more flexible to the needs of young people, particularly, and lots of clinics in satellite areas with a full range of services, which include termination services, etc"

"They're not bad, they're not perfect. They can certainly do better in access and timeliness of access"

"I think the GU clinic in Southampton has improved vastly over the years"

"GUM is so overloaded. They cannot cope with the workload they're doing"

"They're so geographically dispersed. But it's not that they're working together. It would be nice if they did, but they're not going to. And that's universal for us as a county. We've got five major provider trusts and with the size we are, it's inevitable that's going to happen"

"I think, that's the biggest loss, if you don't have an integrated service"

"The NST has recommended that we need to look at the number of providers we have, both in GUM and also in contraception to see if actually there's a better way of modelling our services. So, for some, that's a threat"

The Options UK team were told that a number of escort sex workers who live in the Portsmouth area have reportedly been unhappy with the service they received from the local GUM service feeling they were treated like "dirt" and that staff were unfriendly and unhelpful. There was felt to be an attitude problem on the part of staff. As a result of these negative experiences, these workers were travelling to Southampton to access sexual health services there. It would appear there is a staff training issue here, which needs to be explored and addressed.

7.5.2 Contraception

Contraceptive services are provided by Hampshire Community Health Care (Hampshire PCT), Winchester and Eastleigh Healthcare NHS Trust, Portsmouth City Teaching PCT and Southampton City PCT.

As identified by the NST, service providers were very willing to deliver services appropriate to the needs of the local population, and the multitude of CASH locations across Hampshire bears witness to this.

"We've got CaSH services in 34 locations, so access to CaSH services is currently better than access to GU services"

"We currently have 54 out of 148 practices signed up to offer implants, which is a third, which I don't think is good enough"

In terms of staff training to provides LARCs:

"I would say our services in terms of staff training are on board. Where we could improve as an organisation is in primary care"

"There is a desire in primary care to do more around LARCs"

7.5.3 Abortion

A recent draft national service specification for termination of pregnancy from the Department of Health (July 2009 – final specification yet to be published) states that: *"The purpose of a termination of pregnancy is to provide abortions which are speedy and safe depending on the personal health and circumstances of the individual service user, to reduce repeat abortions and unintended pregnancies, and to promote better sexual health among service users"*. Key to this is the provision of a consistent, comprehensive, effective, accessible, legal and appropriate abortion service to women.

The Royal College of Obstetricians and Gynaecologists produced guidance on abortion services (The Care of Women Requesting Induced Abortion, RCOG, 2004) and this sets out best practice in delivering abortion services: http://www.rcog.org.uk/womens-health/clinical-guidance/care-women-requesting-induced-abortion

The Independent Advisory Group on Sexual Health and HIV's Contraception and Abortion Working Group published its report 'The Time is Now – Achieving World Class Contraceptive and Abortion Services' in June 2009. This report clearly states that there should be an integrated care pathway for pre- and post-abortion care within which contraception and sexual health is integral and tailored to the individual's specific needs. NHS Hampshire needs to be mindful of this, when reviewing its abortion care pathway.

Abortion provision in NHS Hampshire is via bpas in Basingstoke and Bournemouth, Marie Stopes (MSI) in Reading and the Ella Gordon Unit at Portsmouth City Teaching PCT.

Key informants described various inequalities within the NHS Hampshire abortion care pathway. Again, this was dependent on geographical location of the service user, versus the geographical location of the service. Issues

identified varied between no pre-termination counselling being offered, to no aftercare being accessed.

"The good is, it's easy and quick to refer into, but the horrifically bad is that there's no pre-termination counselling of any sort. They now have post-termination counselling, so once you've had your termination and you're regretting it, then you can get some counselling. But there's no counselling beforehand to actually decide if you want to have the termination"

"The issue is when it actually comes down to the abortion and the aftercare is that the young people are stuck really because they have to go all the way down to Bournemouth"

"And so basically they don't get any aftercare. They're not going all the way down there again and they don't get chased up locally. Often they aren't telling their families what's going on"

"We are close to running an Early Medical Abortion service in Basingstoke with bpas and a local provider"

"Across the patch, our termination services (Portsmouth), I know are one of the best in the country and certainly better than the rest of Hampshire, because they use mostly private providers"

"Ideally, we'd want to get to a stage where we maybe have centralised booking services for TOPs so that patients just need to phone one number and can be advised of the free services that are available, the locations and can book whichever one is the most convenient to them"

Finally, an issue was brought to the Options UK team's attention about a minority of GPs who have a conscientious objection to abortion, employing tactics to delay the process of abortion for women:

"They've got a conscientious objection to abortion, but what they should just do is not to see the woman in the first place. They should just signpost them to another GP in their practice", rather than:

"Insist that they see somebody else, so they'll send them on to a private provider for counselling, then get them to come back to them, then refer them on"

7.5.4 HIV Services

A key recommendation of the Hampshire and Isle of Wight HIV Needs Assessment completed in 2006, was the creation of a structured Network for HIV Care and Support. Unfortunately, such a network has not yet come to fruition, but KIs identified a clear need for it:

"My concern would be that our services are not part of a formal network of HIV. I'd like to see a bit more referral between services, recognising levels of expertise in different services in dealing with some of the more complex types of patients"

"I think HIV has fallen off the agenda"

Voluntary services for PLHIV were well thought of and well utilised:

"We have a really good voluntary sector provision in the area and Positive Action have offices in Aldershot, Portsmouth and Southampton that seem to be very well used by people locally"

"Groundswell is a Christian organisation and they do a lot of outreach work, they're a phenomenal organisation. Absolutely brilliant. They really fill a gap"

"Over the past six years, the voluntary sector within Hampshire has got very skilled, so they're picking up a lot more of the low key social care stuff"

Generally KIs thought HIV services in Hampshire were good:

"I think in terms of service provision, there's a good choice of clinics available. Feedback that we get from our client group says there is confidence in the service"

"Hampshire, I think, are better than many other areas in the country and we do have a team whose role is invested in preventing HIV, but it's a small team with a huge area to cover"

But one particular gap in service provision was identified:

"Mental health needs is certainly the most emerging need that we're seeing in recent years and that's really where the gap is"

7.5.5 National Chlamydia Screening Programme

As acknowledged by the NST, chlamydia screening coverage has increased in 2008/2009 in Hampshire and there are specific plans in place to improve uptake. These include rolling out Chlamydia screening for young people into pharmacies whereby:

"young people can go to a pharmacy, pick up a home testing kit, take it home and then post it back to the lab, then get their result from the chlamydia screening office"

Generally, KIs thought the NCSP in Hampshire was doing well with around 15% coverage this year. There was awareness that this was below the national target of 17%, but still thought to be a significant achievement.

"The team in the North, as far as the teenage pregnancy agenda goes, I think they're fantastic at working with us and we very rarely do an initiative without involving the other one because of that shared agenda"

"I think we are doing really well with chlamydia screening and it looks like our turnaround will be 15% this year. General practice probably provide about 40% of all screens"

"The current CaSH services are delivering quite well for Hampshire, but it needs to be absolutely embedded, it needs to be the question you ask every young person every time they go in, and I'm not convinced they have a 100% offer rate"

One team of NHS providers were very upset at losing their well established chlamydia screening contract which had gone out to tender, especially as they claimed they had been meeting the DH NCSP targets and were screening the highest volume of patients across Hampshire. They felt this was something they have been doing well and so are very disappointed to lose the contract.

7.5.6 Teenage Pregnancy

NHS Hampshire has very recently been visited by the NST for Teenage Pregnancy (during the process of this SHNA) to assess the situation in Hampshire. The KIs Options UK spoke with were all well aware that a further reduction in the numbers of teenage pregnancies was something that NHS Hampshire needed to work towards.

"Although we had a decrease in Hampshire, we are traffic lighted amber/red for our 2010 target. We are way off trajectory at the moment. We know there is some good work but it's probably not consistent and we're trying very hard to look at what we need to do to get back on track"

"We have seen quite a rise in school age pregnancies this year"

7.5.7 Condom Distribution Scheme

NHS Hampshire's condom distribution scheme is targeted at young people and is part of the 'Get It On' branded initiative. Distribution points are geographically well spread and include a variety of venues.

"We've certainly tried to open up our community condom scheme to include GP practices and we have had some take-up"

"Although they don't get paid for doing the condoms, they do for chlamydia. So if they're getting them through the door for condoms they can offer them a check. So I think there is buy-in with pharmacies"

"The positive thing is that I'm really surprised and really pleased that the pharmacies are coming on board with the condoms. A young person will go into the CaSH service first to get registered for the condom cards and then they'll be able to use cards at the pharmacies"

"One of the things that I would like to do is actually maybe looking at condoms by post, but I'm not sure how that will go down"

7.5.8 GPs

As identified by the Independent Advisory Group for Sexual Health and HIV in their recent review of the National Strategy for Sexual Health and HIV (see reference below):

"As the first port of call for large numbers of people with all types of health need, general practice has a unique opportunity and responsibility to identify and respond appropriately to sexual health needs which may otherwise be invisible"

NHS Hampshire published the results of their own surveys on contraception and sexual health service in general practice, covering all the localities, in April 2009.

Generally the KIs the Options UK team spoke to acknowledged the role that GPs can and do play in delivering sexual health and contraception services, although a variety of concerns were expressed.

"GPs have to make a decision about what they want to deliver to maintain their income, and I think they're very keen to deliver a service, but life is such in GP land at the moment that if you don't necessarily need to do it and it's going to cost you money to do so, you've got to make some decisions"

"I worry about the expertise if sexual health went into GP-based services. It's easy for things to get missed in the GP setting"

"People don't want their GP to know that they're married but they're having an affair and their husband is doing this"

"In the South East it's worked very well but in other areas there's been little take up of GPs willing to consider, particularly young peoples' needs around sexual health"

"Certain GPs do seem to be doing a lot more HIV testing as well because quite a number of our new positive diagnoses are initially being made in GP land and they're being referred to us for their ongoing management"

7.5.9 Psychosexual Services

In July 2008, The Independent Advisory Group on Sexual Health and HIV published a review of the National Strategy for Sexual Health and HIV 'Progress and priorities – working together for high quality sexual health'. This report states that although the need to address psychological and sexual problems was recognised within the strategy, this area of sexual health was not further developed in either the implementation action plan or commissioning toolkit. Therefore, nationally, psychosexual services have somewhat fallen by the wayside and have not been prioritised, resulting in inequities in service provision and access. This was certainly found to be the case in NHS Hampshire.

"Psychosexual services provision is certainly not uniform across the patch"

"We are very aware of the inequity and we need to look at reviewing the availability of psychosexual services across the area this year"

"Ultimately we need to make a decision as to whether we should be investing in psychosexual services, and if so, who should they be available for, or we decide that the services shouldn't be available on the NHS, or are low priority and therefore we wouldn't be funding them"

7.5.10 Young People's Services

The 'Sex Sense' young people's sexual health service and outreach walk-in clinics were well known and well thought of by KIs. There was also felt to be excellent partnership working between youth workers and other providers of young people's services in NHS Hampshire. The majority of KIs were unaware that although they as professionals had a good knowledge of the 'Get It On' young people's sexual health website, as the Options UK team discovered through its user engagement activities, young people in Hampshire had little knowledge of the brand or the website. Clearly this knowledge gap needs to be closed and apparently work has already begun to address this.

"We've always had lots of youth workers and Connexions workers that have been doing condom distribution, pregnancy testing and chlamydia screening, which I think has been really good"

"There are young people's family planning sessions, contraception sessions, but they don't really cover much of the STI and sexual health side of things, which is vital I think"

"I'd like to see, in every single village, somewhere where a healthcare professional or a youth trainer is trained in giving very basic sexual health advice to young people or knows where to signpost them"

"I'd like to see some sort of branding across the whole of young people's services"

"Young people, young people, young people, yeah! I mean if you're not under 16 or under 20, you're just not a priority"

"I would like to see far more school nurses being able to be involved in sexual health on a one-to-one basis, with young people, as well as supporting the school's syllabus of SRE"

"So we're trying to think about how we continue to provide and work with, what used to be the Youth Service within education to work with vulnerable young children and to work with the local authorities in the local Children and Young People's Partnership to work together, but also to try to find a way of using Health and Well-being Drop Ins and school premises as a way of giving young people somewhere to go and get advice and support, and sexual health would be part of that"

7.5.11 'Older People'

During the course of the SHNA, the issue of the sexual healthcare needs of 'older' people (thought to be 40 plus) was raised by both users and providers of services, as needing attention. There was perceived to be a genuine gap in targeted bespoke services for this group as services tend to be more geared towards young people.

"When you're in your 40s, 50s and 60s you want something that's accessible and comfortable, and I think that is a real gap"

"I think we need to be working with Age Concern and Saga and really targeting that group. They're extremely vulnerable"

7.6 Prevention and Behaviour Change

It is important to get the balance right between prevention and treatment, particularly in an area like sexual health. It is also important to ensure clients know how to protect themselves and their partners in the future. Currently investment in sexual health is heavily weighted towards treatment and care with relatively little investment in prevention and behaviour change outside of those activities focused towards young people. Evidence suggests that a targeted approach to prevention is needed if it is to reach those most at risk successfully. Several KIs had rather negative views about the lack of priority given to prevention activities:

"When you're talking about doing things that are prevention, like condoms and things like that, it's never high priority"

"There is less of an emphasis on prevention now because people think there is treatment for everything"

"Preparing young people to have sex is so important and we don't have a strong enough education system for that to happen. For me it would be about all schools across Hampshire having a team that can go in to deal with every year group and do a consistent message across the school. It would be a sexual health education team really for all schools, every year group, consistent approach and continuous"

"We've still got the same numbers of Health Promotion Specialists as such in Sexual Health, but they're now covering a much bigger geography than they did before, which usually means that they have to be more strategic than operational"

A shining example of prevention-focused work in Hampshire is the Southampton Working Women's Project:

"All our work is around prevention, it's about preventing women being murdered, preventing women being raped, preventing women getting infections and preventing women killing themselves" However, proving the impact of such prevention work was felt to be challenging – ***"How do I demonstrate that my interaction with that woman, me meeting her for an hour every week for six months, actually stopped her from topping herself?"***

An inequity in the provision of condoms to commercial sex workers was also identified during key informant interviews:

"They complain about things like 'I asked them for condoms and they only gave me 12' – here I give people great big bags of condoms of 60 or 70 because they're going to get through that in two weeks maybe"

7.7 User Engagement

User engagement in sexual health can be difficult and it is often only from regular service users that responses can be gained, e.g. from HIV service users. However, feedback from users of the service provides an essential measure of whether the service is meeting the needs of those who are using it.

It is important to try and gain the views of people who are unable or unwilling to attend local sexual health services as this can uncover issues about service access. In NHS Hampshire such data was lacking (excluding the Hampshire and Isle of Wight HIV/AIDS needs assessment carried out in 2005–2006).Some patient satisfaction surveys had been undertaken in some services in the past.

User engagement was mentioned by very few interviewees as a critical area. It is important to ensure that providers and commissioners of sexual health services value the input of users in building effective sustainable services.

The World Class Commissioning 11 competencies include: *"proactively seek and build continuous and meaningful engagement with the public and patients to shape services and improve health"*, and *"work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities".*

Some KIs did show an awareness of the importance of user engagement and feedback, but this needs to be much more firmly embedded within service specifications, so that all service providers understand its importance in terms of patient and public involvement and the development of future services.

"We need to be asking our services to do user feedback or customer surveys. Do it, but implement the findings as well, or at least have a reason why the findings are not being implemented"

"All our CaSH services will have to undertake an annual user survey"

"For example, last year [2008] in Portsmouth, women of all ages were overwhelmingly asking for services to open at eight o'clock in the morning, but as far as I'm aware they haven't done that"

"We've young people telling us they'd like to go to a GP, so we need to do something about it, but it's quite difficult"

The Southampton Working Women's Project has actively involved users of their service in developing two information booklets, one aimed at safety for street workers and one aimed at safety for escorting or indoor workers:

"I'm terrifically proud of those things because they had so much client involvement really. Now, when I give them out to women I say all of these ideas have either been approved or suggested by women in your situation. It's not just some abstract nonsense that I've dreamt up, it's actual real stuff"

7.8 Workforce and Training

A strong sense of genuine interest and commitment to their field of work was evident from the KIs that the Options UK team interviewed and several KIs felt compelled to express this verbally.

"I'm very passionate about this!"

"I'm passionately committed to this work. It's the best job in the world"

"I think sexual health at the moment is a very exciting place to be really, because you can see it grow and make changes and differences, but we've got a long way to go yet because there's so few of us"

There was some concern about the lack of importance and emphasis now given to the teaching and education of staff generally, in the new NHS market economy.

"I think units have been sold off with no teaching and education in there and all they're interested in is bums on seats – the number of people seen in clinics – which is very short-sighted really"

"The challenge of Payment By Results makes it very difficult to quantify the value of teaching against seeing patients when you're looking in monetary terms"

There was evidence of new roles being developed in response to particular groups needs, such as young people:

"***We've appointed more nurses dealing with young people, Young Persons Nurse type roles, who can go out and run assemblies and do teaching in schools and go out to vulnerable groups"***

"I think our outreach and our outreach team have developed really well. I think generally the standard that we expect from our staff and that they deliver is extremely high"

7.9 Communications

Overcoming gaps in communication with partners (e.g. about data and information), the media (e.g. to highlight new services or celebrate successes) and to ensure behaviour change and access to services, is critical to a successful sexual health programme.

Overall communications between partners in NHS Hampshire seemed to be quite effective, according to KIs. Particular strengths were identified in communications from commissioners and from public health who were well engaged with the sexual health agenda.

As part of the KI schedule of questions for the SHNA, Options UK asked if stakeholders had heard about the 'Get It On' young people's sexual health website for Hampshire.

Most KIs were aware of the website, this being in contrast to the exit interview participants (see Service Review section) who are service users, the majority of whom had not heard of the website.

"The 'Get It On' website itself is excellent and it allows professionals as well as young people wherever they are in Hampshire, to be able to access times and provision of sexual health services"

"I've never seen it"

"I think it would be nice to have something like a brand. We all know what McDonalds looks like and what KFC looks like"

Communications developed by individual providers, without knowledge about or coordination with, other related services, results in overlapping and uncoordinated service signposting, which is confusing to users and potential users.

Service signposting could be expanded and improved and more innovative methods for communicating and publicising services could be explored such as at bus stops and on the sides of buses, on billboards and the use of local radio and internet.

There is no one sexual health communications strategy budget to support sexual health across the board. Finding out about and negotiating the way around existing services is currently a little complicated and may present a significant barrier to access for a range of potential users. A centrally coordinated and designed sexual health communications strategy designed from the user's perspective is needed.

7.10 Commissioning

World Class Commissioning identified 11 competencies which PCTs and NHS providers should be striving to achieve. These include:

Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements.

Proactively seek and build continuous and meaningful engagement with the public and patients to shape services and improve health.

Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities.

The commissioning of this assessment is evidence that NHS Hampshire is working to achieve the first of the above. This assessment identifies a number of gaps in relation to the achievement of the second of the above and highlights the potential to strengthen collaboration with community partners.

Flexibility around commissioning arrangements can support innovation and there is potential for more flexibility in commissioning arrangements.

The development and performance management of more robust service specifications would strengthen areas highlighted in this assessment as needing attention – such as the engagement of users and potential users which could be included as a requirement of all services commissioned; the improvement of data collection, analysis and reporting again could be specified more clearly via this contracting process as could the commitment to collaborate, and to work within a patch-wide communications strategy, for example. The contracting process is the critical opportunity for addressing a number of aspects identified here as requiring some attention.

Meaningful and useful information and data to inform commissioning decisions is needed, although the NHS Hampshire commissioners seem to be doing well as comments from KIs show.

"I think the commissioning issue in all honesty has been very good"

"The only dealings I have with (named commissioner) are always positive. Obviously, they're trying to get the best value out of us they can and we're trying to get them to invest in more services"

And KIs had some suggestions for commissioners:

"Commissioning without too many barriers. Letting the service provider have independence and a say in how a service should develop, rather than taking it forward because this is what is said nationally is good"

"The PCT commissioners are creating unhealthy competition"

7.11 Three Wishes

All key informants were asked by the Options UK team ***"If you had a magic wand and could make three wishes for improving sexual health in Hampshire over the next five years, what would you wish for?"*** These are some of the responses:

"We can go and get haircuts at eight o'clock in the evening, but we can't get a smear test at eight o'clock in the evening"

"I'd have clinics running on Saturdays, definitely. There's no GU service running in Southampton on a Saturday and I think that's appalling"

"I would love to see more clinics open at the weekend"

"The government should stop putting out stupid targets"

"Every single GP practice in Hampshire would offer all four methods of LARC, and all practice nurses and doctors would be trained. And resource around LARC would not be an issue"

"I think there should be written in the school curriculum that there is a safer sex message by year nine, because I'm still getting 12 year olds having a score or getting pregnant"

"I would like for all the schools and colleges to have some sort of sexual health and relationship drop-in where condoms can be given out etc, because at the moment some governors put the kibosh on it, saying it doesn't give the look to the public school that we're aiming for and people don't do that sort of thing"

"My biggest plea would be to get either another half-time post or another full-time post for the Southampton Working Women's Project, which would enable us to have much wider impact with the women that we work with"

"I think just the reduction of stigma. We've got to stop making this a big problem that people snigger about behind their hands"

"We should have a single sort of place like 'last minute sexual health.com' or a website or an online service, and there would be an online booking service so you could actually book into any clinic across Hampshire"

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated

* relates to National Indicator 2007

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	**1** Deprivation	39424	3.1	19.9	89.2		0.0
	2 Children in poverty *	30311	12.4	22.4	66.5		6.0
	3 Statutory homelessness	924	2.1	4.4	14.4		0.0
	4 GCSE achievement (5 A*-C) *	8994	62.7	60.1	35.8		82.7
	5 Violent crime	22825	18.1	19.3	38.9		4.5
	6 Carbon emissions *	9127	7.4	7.6	20.6		4.6
Children's and young people's health	**7** Smoking in pregnancy	2022	14.8	16.1	38.8		4.4
	8 Breast feeding initiation *	10516	77.1	69.2	33.2		90.9
	9 Physically active children *	135617	87.8	85.7	63.3		99.2
	10 Obese children *	900	8.9	9.9	16.1		4.9
	11 Children's tooth decay (at age 5)	n/a	1.1	1.5	3.2		0.4
	12 Teenage pregnancy (under 18) *	750	31.1	41.1	83.1		12.5
Adults' health and lifestyle	**13** Adults who smoke *	n/a	15.7	24.1	40.9		13.7
	14 Binge drinking adults	n/a	12.2	18.0	28.9		9.7
	15 Healthy eating adults	n/a	31.9	26.3	14.2		45.8
	16 Physically active adults	n/a	13.1	11.6	7.5		17.2
	17 Obese adults	n/a	19.4	23.6	31.2		11.9
Disease and poor health	**18** Under-15s 'not in good health'	2213	9.8	11.6	20.8		6.4
	19 Incapacity benefits for mental illness *	12420	16.2	27.5	68.6		8.4
	20 Hospital stays related to alcohol *	2163	166.7	260.3	741.1		87.6
	21 Drug misuse	3524	4.3	9.9	34.9		1.3
	22 People diagnosed with diabetes	42361	3.4	3.7	5.9		2.1
	23 Sexually transmitted infections						
	24 New cases of tuberculosis	50	3.0	15.0	102.0		0.0
	25 Hip fracture in over-65s	1334	466.8	479.8	699.8		219.0
Life expectancy and causes of death	**26** Life expectancy - male *	n/a	79.4	77.3	73.0		83.1
	27 Life expectancy - female *	n/a	82.9	81.6	78.3		87.2
	28 Infant deaths	43	3.1	5.0	10.3		0.0
	29 Deaths from smoking	1874	181.4	225.4	355.0		139.4
	30 Early deaths: heart disease & stroke *	896	62.4	84.2	142.4		39.7
	31 Early deaths: cancer *	1481	105.0	117.1	167.8		76.7
	32 Road injuries and deaths *	634	50.3	56.3	194.6		20.8

Note (numbers in bold refer to the above indicators)

1 % of people in this area living in 20% most deprived areas of England 2005 **2** % of children living in families receiving means-tested benefits 2005 **3** Crude rate per 1,000 households 2005-2006 **4** % at Key Stage 4 2006-2007 **5** Recorded violence against the person crimes (crude rate per 1,000 population) 2006-2007 **6** Total end user CO2 emissions per capita (tonnes CO2 per resident) 2005 **7** % of mothers smoking in pregnancy where status is known 2006-2007 **8** % of mothers initiating breast feeding where status known 2006-2007 **9** % 5-16 year olds who spend at least 2 hrs/wk on high quality PE and school sport 2006-2007 **10** %. Schoolchildren in Reception year. 2006-2007 **11** Average (mean) number of teeth per child which were actively decayed, filled, or had been extracted (age 5) 2005-2006 **12** Under-18 conception rate per 1,000 females (crude rate) 2004-2006 (provisional) **13** %. Direct estimate from Health Survey for England. 2003-2005 **14** %. Direct estimate from Health Survey for England. 2003-2005 **15** %. Direct estimate from Health Survey for England. 2003-2005 **16** % aged 16+ 2005/06 **17** %. Direct estimate from Health Survey for England. 2003-2005 **18** % who self assessed general health as 'not good' (directly age standardised) 2001 **19** Crude rate per 1,000 working age population. 2006 **20** Directly age and sex standardised rate per 100,000 pop. 2006-2007 **21** Crude rate per 1000 population aged 15-64. No significance calculated for lower tier authorities. 2004-2005 **22** % of people on GP registers with a recorded diagnosis of diabetes. 2005-2006 **23** Indicator blank as data not yet available for local authorities. **24** Per 100,000 population (3-year average crude rate) 2004-2006 **25** Directly age-standardised rate for emergency admission 2006/07 **26** At birth, years 2004-2006 **27** At birth, years 2004-2006 **28** Rate /1,000 live births 2004-06 **29** Per 100,000 population age 35+, directly age standardised rate. 2004-2006 **30** Directly age standardised rate/100,000 pop. under 75 2004-2006 **31** Directly age standardised rate/100,000 pop. under 75 2004-2006 **32** Per 100,000 population (3-year average crude rate) 2004-2006

9 Appendix 2: Labelled Deprivation Maps

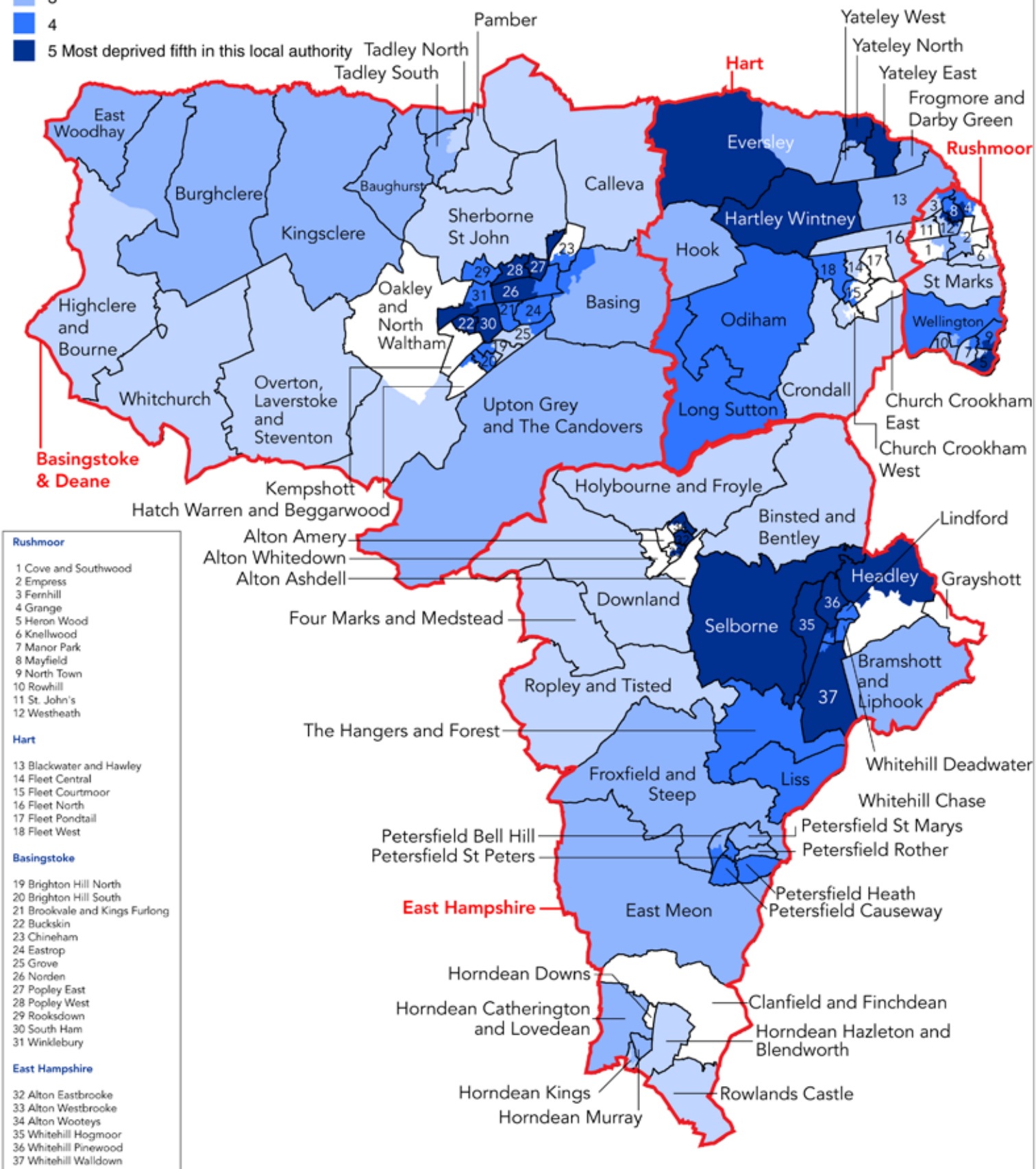
The following labelled maps are of a local comparison of deprivation levels in the three localities.

Hampshire North and East Deprivation: a local perspective

This map shows differences in deprivation between small areas in this local authority, compared to the local authority as a whole (based on IMD 2007).

Local deprivation groups

1 Least deprived fifth in this local authority
2
3
4
5 Most deprived fifth in this local authority



Rushmoor

1 Cove and Southwood
2 Empress
3 Fernhill
4 Grange
5 Heron Wood
6 Knellwood
7 Manor Park
8 Mayfield
9 North Town
10 Rowhill
11 St. John's
12 Westheath

Hart

13 Blackwater and Hawley
14 Fleet Central
15 Fleet Courtmoor
16 Fleet North
17 Fleet Pondtail
18 Fleet West

Basingstoke

19 Brighton Hill North
20 Brighton Hill South
21 Brookvale and Kings Furlong
22 Buckskin
23 Chineham
24 Eastrop
25 Grove
26 Norden
27 Popley East
28 Popley West
29 Rooksdown
30 South Ham
31 Winklebury

East Hampshire

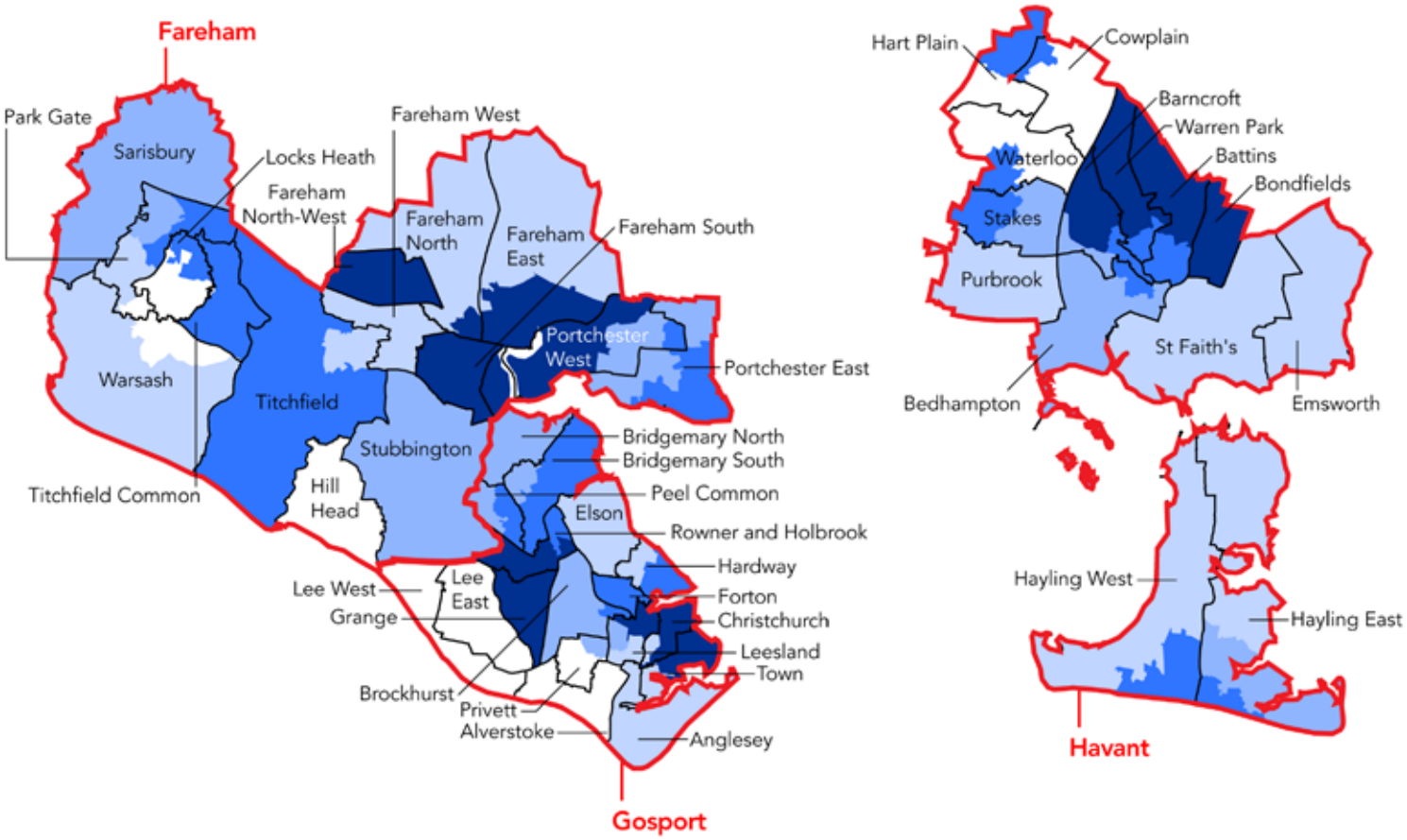
32 Alton Eastbrooke
33 Alton Westbrooke
34 Alton Wooteys
35 Whitehill Hogmoor
36 Whitehill Pinewood
37 Whitehill Walldown

Hampshire South and East Deprivation: a local perspective

This map shows differences in deprivation between small areas in this local authority, compared to the local authority as a whole (based on IMD 2007).

Local deprivation groups

- 1 Least deprived fifth in this local authority
- 2
- 3
- 4
- 5 Most deprived fifth in this local authority



Hampshire West Deprivation: a local perspective

This map shows differences in deprivation between small areas in this local authority, compared to the local authority as a whole (based on IMD 2007).

Local deprivation groups

- 1 Least deprived fifth in this local authority
- 2
- 3
- 4
- 5 Most deprived fifth in this local authority

Eastleigh

1 Bishopstoke East
2 Bishopstoke West
3 Botley
4 Bursledon and Old Netley
5 Chandler's Ford East
6 Chandler's Ford West
7 Eastleigh Central
8 Eastleigh North
9 Eastleigh South
10 Fair Oak and Horton Heath
11 Hamble-le-Rice and Butlocks Heath
12 Hedge End Grange Park
13 Hedge End St John's
14 Hedge End Wildern
15 Hiltingbury East
16 Hiltingbury West
17 Netley Abbey
18 West End North
19 West End South

Test Valley

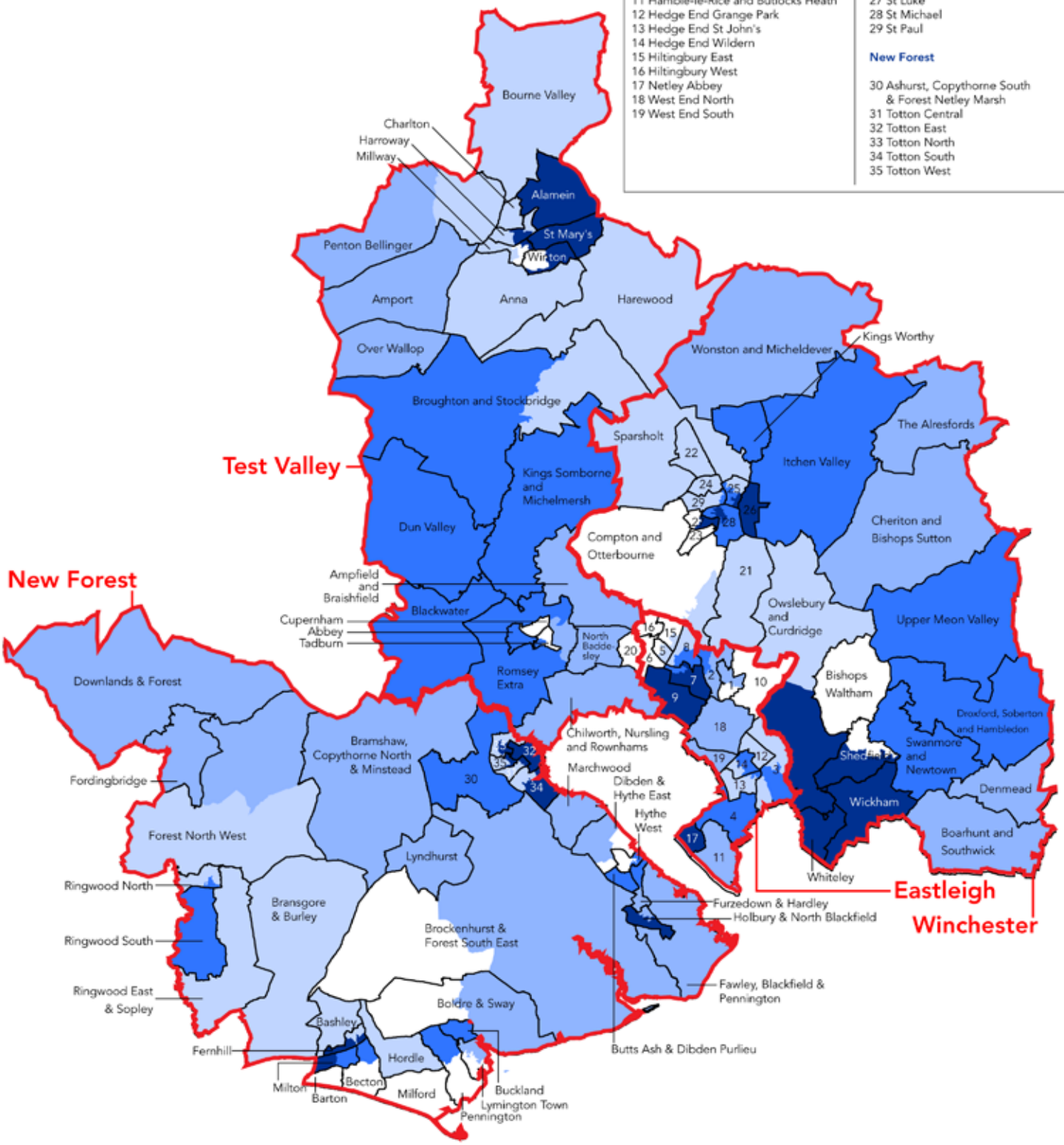
20 Valley Park

Winchester

21 Colden Common and Twyford
22 Littleton and Harestock
23 Olivers Battery and Badger Farm
24 St Barnabas
25 St Bartholomew
26 St John and All Saints
27 St Luke
28 St Michael
29 St Paul

New Forest

30 Ashurst, Copythorne South & Forest Netley Marsh
31 Totton Central
32 Totton East
33 Totton North
34 Totton South
35 Totton West



Options UK

20-23 Greville Street

London

EC1N 8SS

Tel: +44 (0)20 7430 1900

xxxx@xxxxxxx.xx.xx

www.options.co.u/uk