Evaluation of young people’s contraceptive and sexual health services in Knowsley

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Acknowledgements

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Executive Summary

Introduction
The Knowsley teenage pregnancy strategy group recognised a need to evaluate their current contraception and sexual health service provision for young people to inform future service planning. In line with the National Teenage Pregnancy Strategy (1), one of Knowsley’s floor targets is to reduce teenage pregnancy by half for young people aged under 18 years, including a reduction in the rates of teenage pregnancy for young people aged under 16 years. This evaluation set out to examine young people’s sexual health services in Knowsley. It includes views from service users and young people from schools and youth and community services who may currently use the service or who may use the services in the future.

Methods
For this evaluation questionnaires were distributed by personal, social and health education (PSHE) teachers in schools, and by youth workers in youth services. Service user questionnaires were also distributed to young people accessing clinic services by clinic staff. To assist with distribution a researcher from the Centre for Public Health (CPH) also attended sessions at a One Stop Shop in Kirkby, a young people’s drop-in clinic operating twice per week. In addition to the questionnaires two single sex focus groups were carried out at a youth and community service in Knowsley. Service providers were asked to complete a questionnaire regarding clinical services. Literature searches were carried out to explore national policy and guidance, contraceptive initiatives and evaluations, health promotion campaigns and evaluations, sexually transmitted infections (STIs) and contraception data, and information on sexual behaviour. All relevant literature was examined to inform and identify best practice.

Findings

School and youth and community service
- The findings show that there is a deficit in young people’s knowledge of STIs, including the names and symptoms of infections.
- Young people involved in the study stated that they would ask parents or friends for sexual health and contraceptive advice. However, very few stated that they would ask a Connexions PA, Learning Mentor or Teacher for advice.
- The majority of young people had not accessed any sources of sexual health information. However, those who had (n=126, 27%) were most likely to access youth services and Brook advisory centres.
- Young people stated that they were aware of their local services, however the majority had not accessed them.
- Young people questioned stated that increased awareness of services and more local services would encourage the use of clinics.
- Young people would prefer services to be located in health buildings or in schools and youth services.

Young people’s sexual health service users
- The age of first sexual episode of service users was between 13 and 15 years.
- Service users were happy with the services provided. However, they would prefer it if the clinics were more discreet and less busy.
- Service users stated that they liked the fact that the clinic staff were very friendly, helpful, easy going and provide a quick service; they liked the fact that they could access free condoms; that they can talk in private; that the service is confidential and that they can just turn up without an appointment.
Young people accessed clinics primarily for condoms, emergency contraception and advice about sexually transmitted infections.

Results show that young people believe there should be a choice to see a male or female doctor; that there ought to be special sessions for young people; and that contraceptive services ought to be provided alongside STI services.

Service users primarily found out about clinics through word of mouth from friends.

Focus groups

- Focus group participants lacked in depth knowledge of STIs, including the names and symptoms of infections.
- Young people in focus groups stated that clinic advertising ought to be more widespread and ought to include further information about the age at which young people can access clinics.
- Findings show that young people would like more choice of barrier method contraception, for example femidoms and dental dams.
- Young women were most likely to remember sexual health campaign information such as help-line phone numbers. Young men were more likely to access information via leaflets or the internet.
- Young people stated that there is insufficient sex education in schools and that peer education, personal stories, graphic images and reward schemes were the most effective ways to educate young people.

Recommendations

- One way of providing more local services would be via a c-card scheme. Knowsley could consider implementing a c-card distribution scheme, similar to those in operation in Leeds and Wirral. This service could be set up in conjunction with schools or youth and community services in order to improve joined up working. The main demand on young people’s clinics is for free condoms. Implementing a c-card distribution scheme could alleviate the pressure on services and allow more time for them to focus on other contraceptive services. It would also ensure that young people have more opportunity to access free condoms, have access to verbal and written sexual health information and have access to a service that aims to empower young people to make informed sexual health choices thus fewer reasons to take part in risky sexual behaviour (23). This service would also make it easier to monitor the demand for services in each area. If the scheme was set up, it could be evaluated using Neighbourhood Renewal Funding.

- Personal Social and Health Education (PSHE) classes in schools, including Catholic schools, ought to include comprehensive sex education, information on STIs and relationship negotiation skills for young people. They should aim to meet healthy schools targets and should work with parents to improve their communication skills and level of sexual health knowledge.

- Schools and youth services in Knowsley ought to consider implementing wide-spread peer education initiatives as part of a broad programme. Where these initiatives are implemented they should be evaluated accordingly.

- All young people’s clinics ought to have information available on long acting reversible contraceptives (LARC) such as intrauterine devices and systems (IUD/IUS). Clinics ought to encourage young people to consider LARC, clinics ought to supply LARC and staff ought to be trained to deliver this method of contraception.
• Clinics ought to provide more of a variety of barrier method contraception, such as different sizes and possibly different brands, e.g. Durex or Passante as opposed to just Condomania as well as femidoms. Clinics should also provide dental dams and lubricant.

• They should also consider providing flavoured condoms as an option on their own, separate from a mixture of condoms. This could save on wasted condoms for those young people only participating in oral sex.

• Clinic services, opening times, locations and age limits should be advertised more widely.

• Knowlsey should apply to use Neighbourhood Renewal Funding to fund sexual health services and sexual health campaigns in the area with the aim of meeting the floor target of reducing the number of under-18 conceptions by 50% by 2010.

• When sexual health promotion campaigns, such as ‘Be a Rubber Lover’ have been implemented in the area, Knowsely PCT should consider funding an evaluation of the campaign in order to inform future decisions regarding sexual health promotion in the area.

• Knowsley PCT should explore the internet as a method of promoting sexual health, particularly for young men. This should start with an assessment of currently available tools with a view to making them relevant for local young people and linking or advertising on web resources that are well used by local young people.

• All clinics need to update their policy and guidance on the reporting of under age sex in accordance with any new government guidance.
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1. Introduction

National Overview
The sexual health of the UK population continues to cause concern, the last five years having seen dramatic increases in sexually transmitted infections (STIs), including HIV (2,3). Although government policies have attempted to address the issue of STIs and HIV, and have initiated sexual health promotion campaigns, the rates of newly diagnosed STI and HIV infections continue to increase nationally. The total number of new HIV diagnoses in the United Kingdom, in 2004, was 7271 compared with 3850 in 2000, a percentage increase of 89% (3). STI data show that from 2000 to 2004 there was a 20% increase in the number of new STI diagnoses at genito-urinary medicine (GUM) clinics (from 623,545 in 2000 to 751,282 in 2004). Between 2000 and 2004:

- chlamydia increased by 52% (from 68,337 to 103,932)
- gonorrhoea increased by 2% (from 21,800 to 22,320)
- syphilis increased by 558% (from 342 to 2,252)
- herpes increased by 6% (from 17,823 to 18,923)
- warts increased by 12% (from 71,321 to 79,618) (4)

Although STIs affect all age groups, ethnicities, and sexual orientations, data show that young people under the age of 25 in the UK continue to be disproportionately affected by STIs (4). The highest rates for each of the STIs, except for syphilis, presented in the 20-24 and 16-19 age groups consistently each year (5). In 2004, young women aged 16-24 accounted for 74% of all chlamydia diagnoses in women, 70% of gonorrhoea, 62% of warts, and 48% of herpes in the United Kingdom. Young men aged 16-24 accounted for 56% of all chlamydia diagnoses in men, 46% of warts, 41% of gonorrhoea, and 29% of herpes. Re-infection with acute STIs is also a particular problem for young people aged 16-24, and evidence has shown that the risk reduces with increased age (4).

Alongside STIs other consequences of poor sexual health include:

- pelvic inflammatory disease (PID) that can cause ectopic pregnancies and infertility
- cervical and other genital cancers
- hepatitis, chronic liver disease, and liver cancer
- unintended pregnancies and abortions
- poor educational, social and economic opportunities for teenage mothers (6)

The NATSAL (National Survey of Sexual Attitudes and Lifestyles) survey 2000, carried out to explore young people’s attitudes to sexual health, showed that age of first sex has reduced in the last ten years, from a median of 17 years (in 20 – 44 year olds surveyed), to a median age of 16 years (for 16-19 year olds surveyed) (7). There was also an increase in the proportion of people with concurrent relationships, and although there has been evidence of increased condom use, this positive development has been offset by increased numbers of sexual partners reported, especially in young heterosexuals (8). In 2001, the Government published the national sexual health strategy, which aimed to:

- reduce the transmission of HIV and sexually transmitted infections (STIs)
- reduce the prevalence of undiagnosed HIV and STIs
- reduce the rates of unintended pregnancies
- improve health and social care for people living with HIV; and
- reduce the stigma associated with HIV and STIs

The government hoped to achieve this through, for example, the provision of clear information; ensuring there is a sound evidence base for effective local HIV/STI prevention; setting a target to reduce the number of newly acquired HIV infections; developing managed networks for HIV and sexual health services; evaluating the benefits of more integrated sexual health services,
including pilots of one-stop clinics; beginning a programme of chlamydia screening; stressing the importance of open access to GUM clinics and ensuring that a comprehensive range of contraceptive services are available to those who need them (6). The ‘Sex Lottery’ campaign was a key commitment of the national sexual health and HIV strategy. It was launched in 2002 and was aimed primarily at young (18-30 year old), heterosexual adults, from lower socio-demographic groups in England. The campaign promoted condom use through the slogan ‘Don’t play the Sex Lottery. Use a condom’ and was subtitled with additional sexual health messages such as, ‘some STIs have no symptoms, some cannot be cured’, ‘you can’t tell by looking at someone whether they have an STI’, and ‘STIs can have serious consequences’ (see appendix 1). The message was promoted using beer mats, scratch cards and washroom posters and ran alongside the ‘playing safely’ website and helpline phone number. Initial evaluation results of this campaign showed that the number of calls to the helpline increased by 32% when the campaign went live, with the majority of calls from the target audience of 18-30 year olds (9).

In 2004 the public health white paper, Choosing Health: making healthier choices easier (10), called for action to improve sexual health in the UK, through a £300 million investment over three years. The aims were:

- to implement a national and regional sexual health campaign aimed at young men and women to promote condom use and explain the risks of unprotected sex; using £50 million of the funding;
- to make a commitment to sexual health in England through additional funding to deliver multidisciplinary sexual health services in a range of settings;
- for the national chlamydia screening programme to cover the whole of England by March 2007 (with it an additional £80m to help achieve this goal);
- to carry out an audit of contraceptive services in 2005 in order to improve service provision;
- focus on modernising GUM clinics with an investment of £130 million over three years including upgraded prevention services with an additional £40 million provided for this purpose; and
- to ensure that every individual referred to a GUM clinic has an appointment within 48 hours by 2008.

Along with increasing rates of sexually transmitted infections (STIs) (2) and HIV (3) there are increasing rates of teenage conception and abortion (11,12). The Teenage Pregnancy strategy calls for:

- a reduction in the rate of teenage conceptions with the specific aim of halving the rate of conceptions among under 18s, and to set a firmly established downward trend in the rate of conceptions among those aged under 16, by 2010; and
- to increase the participation of teenage parents in education, training and employment to 60% by 2010, to reduce their risk of long-term social exclusion (1).

The UK has the highest rates of teenage births in Europe (Figure 1.1), which gives rise to public health concerns because of the links between teenage pregnancy and low socio-economic status. Research suggests that not only can teenage pregnancy have a negative impact on a young woman’s academic achievement, employment, earning potential, mental health and living conditions, it can also have a negative impact on the child. The child of a teenage mother is more likely to belong to a one-parent family, be a low academic achiever, experience abuse, be involved in crime, misuse drugs and alcohol and become a teenage parent, thereby perpetuating the cycle (13).
The Choosing Health White Paper has a focus upon young people which is consistent with the Every Child Matters (14) recommendations, and recognises that ‘emotional well-being underpins good physical health and reduces the likelihood that children and young people will take inappropriate risks’. To this end the White Paper states that:

- extended schools can also provide, for example, One Stop Shops and multi-agency health centres located on a school site, which will enable health professionals to work alongside education and social care professionals;
- personal health guides (PHG) will encourage young people to build health into the way they live their lives;
- general information, advice and support about health issues, as well as emotional well-being, puberty, sexual health and access to further help and advice will be provided, for example, through a confidential email service;
- learning about health choices and managing risk will be supported, for example, through incentive schemes using reward points.

To help achieve these aims, from 2006 school nurses will be placed in schools in the worst health and deprivation indicators. Healthy schools initiatives are beginning to have an effect upon health and well-being, especially in disadvantaged areas (15). Therefore, schools will be
encouraged to become health schools by 2006 with a focus upon childhood obesity and teenage pregnancy. In addition to this the White Paper supports the implementation of comprehensive personal, social, and health education (PSHE). As such, sexual health education in schools has also been the focus of recent change and the Secretary of State for Education and Employment has issued new guidance on sex and relationship education (SRE) to support schools and teachers. It is linked to the Personal, Social and Health Education Framework and the National Healthy School Standard. However, parents have the right to withdraw their child from all or part of the SRE. Also, it remains for each individual school to decide whether to provide more than the statutory SRE; one of these non-statutory elements includes units on sexual relationships, contraception and STIs. However, for those schools keen to incorporate these units into their PSHE classes comprehensive support is provided on the website (16).

It is estimated that 30% of pregnancies are unplanned and, in order to reduce the rate of unplanned and unwanted pregnancies, the National Institute for Health and Clinical Excellence (NICE) has released new guidelines to promote long acting contraception to women (17). The guidance promotes the use of long acting reversible contraceptives (LARC) such as the contraceptive injection, contraceptive implant and intra-uterine methods, which don’t need to be remembered daily and are less susceptible to incorrect usage. The most popular methods of contraception for women in 2003-04 were the pill and condoms (25% and 23% respectively), with only 8% of women, aged 16-49, using LARC (18). However, this may change in future. NICE aims to improve the deficit in guidance and training available to healthcare workers in order to enable women to make informed contraceptive choices (17). One negative effect of this approach of promoting hormonal contraception is that it may reduce the number of women using barrier method contraceptives and could thereby lead to an increase in the numbers of STIs.

Overview of socio-demographics in Knowsley
Poor sexual health has been linked to deprivation, low socio-economic status and low educational achievement. In 2001, Knowsley scored 3 on the Indices of Multiple Deprivation for Local Authorities (LA) (where 1 is the most deprived LA, and 354 the least deprived LA), which makes it one of England’s 88 most deprived Local Authorities \(^1\). In 2003, 42% of Knowsley’s population was living on low incomes \(^2\). Knowsley has a higher than regional average number of 16-74 year olds with no qualifications (43% in Knowsley, compared to 32% in the North West), and a lower than regional average of people aged 16-74 years reaching the highest qualification level 4/5 \(^3\) (10% in Knowsley, compared to 17% in the North West). There is also a slightly younger population in Knowsley compared with the England and Wales average (36 years, compared to 39 years), and the total fertility rate (TFR) \(^4\) in 2003 was 1.73, which was higher than the UK TFR of 1.64. Knowsley’s standardised mortality ratio \(^5\) is also higher than the UK average at 130 (20).

\(^2\) As measured by receipt of Income Support and Job Seekers Allowance, and based upon 2001 census population data.
\(^3\) Level 4/5 includes First degree; Higher degree; NVQ levels 4 and 5; HNC; HND; Qualified Teacher Status; Qualified Medical Doctor; Qualified Dentist; Qualified Nurse; Midwife; Health Visitor.
\(^4\) Which is the average number of children borne to a woman if she experiences the current age-specific fertility rates throughout her childbearing years.
\(^5\) Standardised mortality ratio (SMR) is the ratio of the actual number of deaths in a population to the number of deaths one would expect if the population had the same death rate as the standard population. The national SMR for all the UK that is used as a standard is 100. A figure over 100 is worse than the national average and a figure less than a 100 is better.
Sexually transmitted infections in Knowsley

The current system of surveillance for sexually transmitted infections does not allow data to be broken down by primary care trust (PCT), as residency data are not collected. However, a pilot STI surveillance project has recently taken place in Cheshire and Merseyside that provided an estimate of numbers and rates of STIs by PCT (21). Data (tables 1.1 and 1.2) have been gathered over a two year period from three GUM clinics, Royal Liverpool, Arrowe Park, and the Countess of Chester. These data may be an underestimate of the actual numbers of STIs diagnosed in people resident in Knowsley PCT, as they do not account for residents who are diagnosed in clinics not participating in the pilot, for example St Helens and Knowsley GUM clinic. They also, in common with the national KC60 system of reporting new diagnoses of STIs, do not count diagnoses in general practice or family planning clinic settings.

Table 1.1 shows STI pilot data for 2003 and 2004 for Knowsley. Compared to the rate for Cheshire and Merseyside strategic health authority (SHA) 2004 STI data, these data reveal Knowsley had slightly lower rates of chlamydia (165.8 compared to 174.5) and warts (127.2 compared to 133.7) syphilis (0.7 compared to 3.8) and herpes (6.7 compared to 31.8), but higher rates of gonorrhoea (41.9 compared to 37.5) (5).

Table 1.2 shows the total number and rate of STIs in Knowsley PCT by sex and age group for 2003 and 2004. Although it is clear that the 20-29 age group have the greatest number and rate of STIs, it is also clear that those aged less than 20 years are greatly affected by STIs with infections affecting more females than males, with the number of infections in females aged less than 20 outnumbering all other female age groups in 2004. This table also shows that infections increased for both sexes from 2003 to 2004.

Table 1.3 shows the total number of people accessing treatment for HIV in Knowsley PCT by sex and age group in 2004. There were 14 cases of HIV in Knowsley with one new case since 2003. Currently, there are no individuals below the age of 20 years diagnosed with HIV in Knowsley. However, this may be an under estimate of the prevalence of HIV in this population, as a diagnosis of HIV may occur many years after infection. Increasing rates of STIs indicate an increase in risk behaviour, and the presence of an ulcerative STI in itself also increases the risk of HIV transmission.

Table 1.1: Sexually transmitted infection data by number and rate* from the STI pilot for Knowsley PCT. Rates are per 100,000 population recorded for 2003 and 2004. Source: analysis by M. Ashton using STI data held at Centre for Public Health, Liverpool John Moores University.
Table 1.2: Total number and rate* of sexually transmitted infections in Knowsley by age group and sex from the STI pilot for Knowsley PCT. Rates are per 100,000 population recorded for 2003 and 2004. Source: analysis by M. Ashton using STI data held at Centre for Public Health, Liverpool John Moores University.

<table>
<thead>
<tr>
<th>Age group</th>
<th>2003 Male</th>
<th>2003 Female</th>
<th>2004 Male</th>
<th>2004 Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Rate</td>
<td>Number</td>
<td>Rate</td>
</tr>
<tr>
<td>&lt;20</td>
<td>35</td>
<td>162</td>
<td>71</td>
<td>339.7</td>
</tr>
<tr>
<td>20-29</td>
<td>125</td>
<td>1582.3</td>
<td>92</td>
<td>1069.8</td>
</tr>
<tr>
<td>&gt;=30</td>
<td>46</td>
<td>110</td>
<td>27</td>
<td>54.5</td>
</tr>
<tr>
<td>All</td>
<td>206</td>
<td>288.9</td>
<td>190</td>
<td>240.8</td>
</tr>
</tbody>
</table>

*Rates could include double counting of people with more than one infection.

Table 1.3: Number of HIV positive people in treatment and care resident in Knowsley in 2004 by sex and age group. Source: Cook PA, et. al. (2005) HIV & AIDS in the North West of England 2004, Centre for Public Health, Liverpool John Moores University.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>30-34</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>35-39</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>45-49</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>55-59</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>60+</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>4</td>
<td>14</td>
</tr>
</tbody>
</table>

Local Genito-urinary Medicine clinics

The pilot STI survey made estimates for Knowsley assuming that people from Knowsley will go to the Royal Liverpool Hospital GUM. Data in Figure 1.2 show that chlamydia and warts are the most common STIs recorded at the Royal Liverpool Hospital GUM. St Helens and Knowsley GUM was not included in the STI pilot study, however Knowsley residents may also attend for services there. Figure 1.3 shows that St Helens and Knowsley GUM has recorded a greater than two fold increase in the number of cases of chlamydia, gonorrhoea and herpes virus since 1995 (chlamydia: 258% increase; gonorrhoea: 590%; herpes virus: 418%) (2).
Figure 1.2: Numbers of Sexually Transmitted infections presenting to Royal Liverpool Hospital GUM 1995-2004.  

Figure 1.3: Numbers of Sexually Transmitted infections presenting to St Helens and Knowsley GUM 1995-2004.  

Herpes – Anogenital herpes simplex – first attack  
Gonorrhoea – Uncomplicated  
Syphilis – Primary and secondary infectious syphilis

Chlamydia – Uncomplicated chlamydial infection  
Gonorrhoea Warts – Anogenital warts – first attack

Herpes – Anogenital herpes simplex – first attack  
Gonorrhoea – Uncomplicated  
Syphilis – Primary and secondary infectious syphilis

Chlamydia – Uncomplicated chlamydial infection  
Gonorrhoea Warts – Anogenital warts – first attack
Conceptions and abortions in Knowsley

In Cheshire and Merseyside the number of conceptions in those aged under 16 years has shown a reduction of 10% from 98/00 to 01/03, compared with a 5% reduction for the whole North West (table 1.4). In Knowsley the conception rate of young people under the age of 18 years is lower than the national average, at 38.8 per 1000 compared to 42.3 per 1000 (table 1.5).

Table 1.4: Under 16 conceptions by region and SHA. Rates are per 1000 female population aged 13-15. Source: Office for National Statistics and Teenage Pregnancy Unit.

<table>
<thead>
<tr>
<th>Region and SHA</th>
<th>1998-00</th>
<th>2001-03</th>
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<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Rate</td>
</tr>
<tr>
<td>England and Wales</td>
<td>24,512</td>
<td>8.5</td>
</tr>
<tr>
<td>North West</td>
<td>3,512</td>
<td>8.8</td>
</tr>
<tr>
<td>Cheshire &amp; Merseyside</td>
<td>1,097</td>
<td>7.8</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Area of Residence</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Rate</td>
<td>%</td>
<td>No.</td>
<td>Rate</td>
<td>%</td>
</tr>
<tr>
<td>England and Wales</td>
<td>44,119</td>
<td>47.1</td>
<td>42.0</td>
<td>42,028</td>
<td>45.1</td>
<td>43.1</td>
</tr>
<tr>
<td>North West</td>
<td>6,457</td>
<td>50.3</td>
<td>38.5</td>
<td>6,283</td>
<td>48.8</td>
<td>39.9</td>
</tr>
<tr>
<td>Merseyside</td>
<td>1,358</td>
<td>50.6</td>
<td>42.0</td>
<td>1,333</td>
<td>49.1</td>
<td>43.3</td>
</tr>
<tr>
<td>Knowsley MCD</td>
<td>184</td>
<td>54.8</td>
<td>38.6</td>
<td>156</td>
<td>46.9</td>
<td>40.4</td>
</tr>
</tbody>
</table>

Health Promotion initiatives in the Merseyside area

Young people in Knowsley have been exposed to recent national and local sexual health promotion campaigns aimed at young people that have taken place throughout the whole of Merseyside (see appendix 1). The evaluations of these campaigns were commissioned by Wirral PCTs, and as such they were undertaken outside Liverpool. However, the evaluations did not take into account the fact that people were likely to have been influenced by the campaign coverage in Liverpool as many young Wirral residents socialise in Liverpool city centre and thus findings may also be relevant to young people in Knowsley, who also tend to socialise in the area. The local campaigns ‘Be a Rubber Lover and ‘on the Town' campaigns were jointly funded across Wirral and Liverpool. 2004 saw the implementation of the ‘Be A Rubber Lover’ campaign, developed by HILT, a Liverpool based organisation. Aimed at 16-25 year olds, the campaigns attempted to influence young people’s sexual behaviour to encourage good sexual health and the promotion of condom use, through the use of billboards,
customised condom packs, t-shirts, promotional launch nights, taxi promotions, magazine advertising, and local press as well as a website. The ‘Be a Rubber Lover’ campaign evaluation showed that the campaign was successful in its aim to promote important sexual health messages, as a contribution to the long-term aims of lowering the rates of teenage pregnancy and STIs in the area. The greatest impact was on those aged 16-18 years (22). Another recent study evaluated access to sexual health information in Wirral in 2004 (23). This study used examples of sexual health promotion images from the ‘Sex Lottery’, ‘Sex: Are you thinking about it enough?’ and ‘Out-Reach Service: Sexual health promotion for the diverse gay community’ campaigns. The results showed that, of those aged under 16 – 24 years, 70% felt that sexual health campaigns were aimed at them, and of these campaigns, those aged 16 – 34 years recognised the ‘Sex Lottery’ campaign more than any other campaigns. Those aged under 16 years were more likely to recognise the ‘chlamydia’ campaign with the slogan ‘How do I know if I’ve got it?’.

**Background to sexual health services in Knowsley**

At present St Helens Family Planning Service provides a specialist young people’s contraceptive service on behalf of Knowsley Primary Care Trust. The service is offered from a range of venues throughout the borough and works with Knowsley’s Metropolitan Borough Council’s Community and Youth Service to provide a comprehensive service that offers contraception, advice, education and referrals. This service aims to provide a more informal approach with appropriately trained staff in venues that young people, particularly those under 16 years, can confidently access (see appendix 2). There are currently four young people’s clinics available across the three boroughs, and two GUM departments that can be accessed as well as walk-in clinics in case of emergency.

**Aim**

The high rates of teenage pregnancy and sexually transmitted infections highlight the need to provide better sexual health services for young people. Knowsley teenage pregnancy strategy group wished to undertake an evaluation of the current contraception and sexual health service provision for young people to inform future service planning. One of the floor targets Knowsley PCT needs to meet is a reduction in the teenage pregnancy rates for young people aged under 18 years, and to demonstrate a downward trend for the teenage pregnancy rates for young people aged under 16 years, in line with the National Teenage Pregnancy Strategy. Since baseline statistics of 1998, the rate of teenage pregnancy has reduced. However, this positive trend has slowed down and is in danger of reversing.

This evaluation will be used to:

- assess how well the services are working;
- determine whether services are effective;
- make recommendations for the design of services.

**Methodology**

This evaluation makes use of the previously validated Evaluation Kit: Sexual Health Services for Young People, developed by the London School of Hygiene and Tropical Medicine (LSHTM) (25), referred to as the LSHTM toolkit, as well as additional tools that were developed by the Centre for Public Health (CPH). Prior to any focus groups taking place or questionnaires distributed, approval was sought from Liverpool John Moores and the St Helens and Knowsley Local Research Ethics Committee.
Questionnaire work
Survey of service providers
The LSHTM toolkit contained a self-completion questionnaire for the service provider. Provided the respondent had adequate knowledge, only one submission per service was required. The CPH distributed questionnaires to clinics that had agreed to take part.

Survey of clinic users
The LSHTM toolkit contained a self-completion questionnaire for the service user. The CPH distributed the questionnaires to the clinics and the clinics distributed them to the attendees. Each questionnaire was coded to identify the clinic of origin. Participants were assured of confidentiality and anonymity. Clinic employees were asked to encourage a high response rate by approaching all young people and asking them to complete a questionnaire and to record the number of completed questionnaires. A researcher from CPH visited clinics on two occasions to assist service users with the completion of the questionnaires. Two clinics, out of the four in Knowsley, participated in the clinic evaluation element of the study.

Questionnaires for young men and women in schools and youth and community services
As there was no tool in the LSHTM toolkit for this aspect of the research, the CPH developed a questionnaire for young men and women, many of whom may not access the clinics. The questionnaire ascertained aspects such as: whether the young people used services; what would encourage attendance at a service; and specific characteristics of good services. The questionnaire was disseminated within classrooms (by PHSE teachers) and in participating Youth and Community Services to encourage a high response rate. Parental/guardian consent letters were sent out prior to the questionnaires being disseminated in schools. This gave parents/guardians the opportunity to withhold their permission if they wished. However, if parents did not return their forms or contact the school their consent was inferred. Informed consent was also sought from each participant and was witnessed by the PSHE teacher holding the session. This method of consent resulted in a good response rate and a large number of completed questionnaires generated for the study. Questionnaires were returned from one youth and community service and four schools.

Focus groups with young men and women in youth services
As there was no focus group schedule in the toolkit for this aspect of the research, the CPH developed a tool for focus groups (appendix 3). The focus groups explored the reasons why individuals do not use services and what could be done to attract them to the services. The participants were recruited by youth and community workers on behalf of CPH. The young people who agreed to participate were regular attendees of the youth and community centre. The focus groups took place in Huyton (Knowsley) and consisted of eight young men and seven young women.
2. School and Youth & Community service questionnaire results

A total of 483 questionnaires were returned from three schools and two youth and community services in Knowsley. Young people completing the questionnaire did not have to be sexually active or have attended contraceptive or sexual health clinics in order to give their views. We received more valid questionnaires from females (52%) than males (48%). To our knowledge this is a reflection of the young people present in class on the day of the survey (none of the teachers notified us of any young people declining to participate). Fewer than ten questionnaires were spoilt (it is not clear whether these were from young men or women). Also, all youth and community questionnaires received were from females (21 questionnaires). The majority of respondents were aged 15 (65%), the most common age of young people’s clinic attendees (see chapter 3), with 26% aged 14 or under. The vast majority of respondents were self-defined as white (n=463, 96%). As only 3% of questionnaire respondents were self-defined as either black, Asian or other, no breakdowns by ethnicity have been provided. This profile of ethnicity corresponds with the ethnic profile of Knowsley (20). Tables and figures are presented at the end of the chapter.

Awareness and use of sexual health and contraceptive services

The majority of respondents stated that they were aware of the local contraceptive clinics (n=370, 77%) (table 2.1). Of those who had used a local contraceptive service (n=112, 23%), 46 (41% of service users) had used the service during 2005.

The vast majority of young people had never attended a local contraceptive clinic (364, 75%). However, a large proportion of 14 year old males stated that they were not aware of local contraceptive services (n=24, 38%) and, overall, males were less likely to be aware of local services (153, 70%) than females (217, 85%: chi square=15.8, P<0.001). Even though 59% of respondents stated that they did not currently use a specialist service, and a proportion omitted to answer the question (10%), 20% of respondents said that they used their GP or nurse. School children stated that awareness of clinic services and more local services would encourage them to use the clinics (37% and 31% respectively) (table 2.2). Even out of those young people who said they were already aware of services, 28% stated that awareness would encourage them to attend, perhaps suggesting that simply knowing that a service exists is not sufficient.

Views on sexual health and contraceptive services

School children were asked their views on where they thought clinics should be located, what the clinic environment ought to be like, and what services should be provided. Table 2.3 shows that young people would prefer clinics to be located in a health building, school, youth centre or community centre (60%, 33%, 24% and 19% respectively) and male and female respondents were in agreement over these locations. When asked how far they would be willing to travel to services the majority said that they would be willing to travel to Huyton, Halewood and Liverpool for services. The majority of those willing to travel to Huyton were resident in the Huyton/Prescot/Kirkby and other areas. The majority willing to travel to Halewood lived in the Halewood/other areas. Liverpool was the only other main location that people resident elsewhere would travel to. The fact that some young people reported being willing to attend a clinic outside the area in which they live may be due to the fact that they go to school outside the area they live in.

The results show that people thought the most important aspect of a clinic is that it is able to provide privacy (71%) and a relaxed environment (58%) (table 2.4). However, females were significantly more likely to rate privacy as more important (77% compared to 62%: chi=14.8, P<0.001). When asked their views on what other features are important in a contraceptive
clinic, privacy, confidentiality, and a relaxed environment were supported by statements such as: ‘to make sure you don’t have to give your name’; and ‘to be able to take a person you trust with you e.g. a friend’. As well as these main points, advice on sex, contraception and access to information, counselling and free condoms were also given as important aspects of a clinic, for example, ‘advice on which contraception to use and how to use it’. In addition to this, young school people thought it was important to have the choice to see either a male or a female doctor, that there were special sessions for young people, and that both contraception and infections are dealt with in one place. A majority of young people felt that it was also beneficial that men and women attended the clinic at the same time. However, 100 respondents also thought that this was a negative point, and over 150 stated that it did not matter as much (figure 2.1). When asked about what areas of advice or treatment should be available from a clinic (table 2.5), young people from all areas rated contraception (88%) and pregnancy testing (80%) as the most important, followed by advice about STIs (67%), treatment of STIs (65%), emergency contraception (65%) and routine check-ups (63%).

Current sources of sexual health information and knowledge of sexually transmitted infections

The questionnaire aimed to elicit information about who or what young people access for sexual health and contraceptive information. When asked who they would talk to for help and advice the results show that the majority of school respondents would talk to a friend, parent, or a GP/Practice nurse, with many more females likely to talk to a friend than males (figure 2.2). When asked what people or services young people have used in the past the most frequent response was Youth/Brook advisory centre (34%), Sexwise helpline (26%) and teacher/school nurse (23%), (table 2.6). Of note, the majority of respondents (n=357, 74%) either left the question unanswered or had not contacted any of the people or services listed for help or advice with contraceptive and sexual health information.

Table 2.7 shows that high proportions of young people have heard of the most common sexually transmitted infections. HIV and chlamydia (98% and 83% respectively) are the most commonly known STIs with syphilis and gonorrhoea (49% and 56% respectively) the least well known. Females were more likely to have heard of chlamydia (89% compared to 76% of males: chi square=14.0, P=0.001). Although young people’s knowledge of the names of STIs was questioned in the survey, the most revealing information involves the level of knowledge school children have regarding STIs. Figure 2.3 shows the results of young people’s awareness and side effects of STIs. School respondents were asked to rate statements as ‘true’, ‘false’, or ‘don’t know’, the table clearly shows that the majority did not know whether the statements were true or false, and in some cases young people gave an incorrect answer. Table 2.8 shows sub group analyses of the data from both table 2.7 and figure 2.3. The results show that young people who stated that they were aware of the particular infection were significantly more likely to be aware of the corresponding symptoms, long-term consequences and/or treatment.

Table 2.9 shows school children’s knowledge and views regarding the emergency contraceptive pill. Almost all those that answered stated that they had heard of the emergency contraceptive pill (96%), however, fewer were aware that the emergency contraceptive pill could be accessed free of charge at some pharmacies (67%), and almost three quarters of respondents stated that they would use this service (68%).
## Table 2.1: Awareness and use of clinic services by age group and sex (school survey)

<table>
<thead>
<tr>
<th>Age group and sex</th>
<th>Not Answered</th>
<th>14 or under</th>
<th>15</th>
<th>16 - 17</th>
<th>18-19</th>
<th>Total (n=483)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male (n=1)</td>
<td>1 (100%)</td>
<td>40 (63%)</td>
<td>104 (70%)</td>
<td>142 (85%)</td>
<td>8 (80%)</td>
<td>370 (77%)</td>
</tr>
<tr>
<td>Female (n=1)</td>
<td>1 (100%)</td>
<td>47 (77%)</td>
<td>122 (81%)</td>
<td>150 (86%)</td>
<td>7 (88%)</td>
<td>370 (77%)</td>
</tr>
<tr>
<td>Male (n=64)</td>
<td>1 (2%)</td>
<td>2 (1%)</td>
<td>3 (2%)</td>
<td>1 (1%)</td>
<td>1 (5%)</td>
<td>7 (1%)</td>
</tr>
<tr>
<td>Female (n=61)</td>
<td>2 (3%)</td>
<td>4 (7%)</td>
<td>15 (10%)</td>
<td>19 (11%)</td>
<td>1 (10%)</td>
<td>42 (8%)</td>
</tr>
<tr>
<td>Male (n=148)</td>
<td>1 (100%)</td>
<td>1 (100%)</td>
<td>1 (1%)</td>
<td>1 (1%)</td>
<td>1 (5%)</td>
<td>7 (1%)</td>
</tr>
<tr>
<td>Female (n=168)</td>
<td>1 (100%)</td>
<td>2 (1%)</td>
<td>3 (2%)</td>
<td>1 (1%)</td>
<td>1 (5%)</td>
<td>7 (1%)</td>
</tr>
<tr>
<td>Male (n=10)</td>
<td>1 (100%)</td>
<td>1 (100%)</td>
<td>1 (1%)</td>
<td>1 (1%)</td>
<td>1 (5%)</td>
<td>7 (1%)</td>
</tr>
<tr>
<td>Female (n=22)</td>
<td>2 (10%)</td>
<td>1 (5%)</td>
<td>1 (2%)</td>
<td>1 (1%)</td>
<td>1 (5%)</td>
<td>7 (1%)</td>
</tr>
</tbody>
</table>

### Are you aware of local clinics?

<table>
<thead>
<tr>
<th>Sex</th>
<th>Total (n=483)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Answered</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>Yes</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>No</td>
<td>7 (1%)</td>
</tr>
</tbody>
</table>

### Have you ever been to a clinic?

<table>
<thead>
<tr>
<th>Sex</th>
<th>Total (n=483)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Answered</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>Yes</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>No</td>
<td>106 (22%)</td>
</tr>
</tbody>
</table>

### What service do you currently use?

<table>
<thead>
<tr>
<th>Service</th>
<th>Total (n=483)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Answered</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>1 (0%)</td>
</tr>
<tr>
<td>Family Planning Clinic</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Brook/youth advisory</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>GP/nurse</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>One Stop Shop</td>
<td>1 (1%)</td>
</tr>
</tbody>
</table>

Columns cannot be totalled as they contain multiple responses.

## Table 2.2: Factors that would encourage service use by sex (school survey)

<table>
<thead>
<tr>
<th>Sex</th>
<th>Total (n=483)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Answered</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>Not Applicable</td>
<td>1 (0%)</td>
</tr>
<tr>
<td>More frequent service</td>
<td>2 (3%)</td>
</tr>
<tr>
<td>More local services</td>
<td>22 (10%)</td>
</tr>
<tr>
<td>Less local services</td>
<td>5 (2%)</td>
</tr>
<tr>
<td>Awareness of services</td>
<td>86 (39%)</td>
</tr>
<tr>
<td>Other</td>
<td>51 (23%)</td>
</tr>
</tbody>
</table>

Columns cannot be totalled as they contain multiple responses.

## Table 2.3: Preferred locations of clinics by sex (school survey)

<table>
<thead>
<tr>
<th>Location</th>
<th>Total (n=465)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Building</td>
<td>103 (49%)</td>
</tr>
<tr>
<td>School</td>
<td>76 (36%)</td>
</tr>
<tr>
<td>College</td>
<td>34 (16%)</td>
</tr>
<tr>
<td>Shop front</td>
<td>17 (8%)</td>
</tr>
<tr>
<td>Mobile unit</td>
<td>33 (16%)</td>
</tr>
<tr>
<td>Community setting (e.g. sure start)</td>
<td>10 (5%)</td>
</tr>
<tr>
<td>Community centres</td>
<td>42 (20%)</td>
</tr>
<tr>
<td>Youth centres</td>
<td>45 (21%)</td>
</tr>
</tbody>
</table>

Columns cannot be totalled as they contain multiple responses.
Table 2.4: Opinions on important factors in a clinic by sex (school survey)

<table>
<thead>
<tr>
<th></th>
<th>Male (n=212)</th>
<th>Female (n=257)</th>
<th>Total (n=469)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relaxed</td>
<td>119 (56%)</td>
<td>152 (59%)</td>
<td>271 (58%)</td>
</tr>
<tr>
<td>Cheerful</td>
<td>51 (24%)</td>
<td>68 (26%)</td>
<td>119 (25%)</td>
</tr>
<tr>
<td>Comfy</td>
<td>70 (33%)</td>
<td>86 (33%)</td>
<td>156 (33%)</td>
</tr>
<tr>
<td>Well equipped</td>
<td>64 (30%)</td>
<td>62 (24%)</td>
<td>126 (27%)</td>
</tr>
<tr>
<td>Able to offer privacy</td>
<td>132 (62%)</td>
<td>199 (77%)</td>
<td>331 (71%)</td>
</tr>
</tbody>
</table>

Figure 2.1: Opinions on features of the clinic service (school survey)
Table 2.5: Opinions on areas of advice/treatment in a clinic by area of residence (school survey)

<table>
<thead>
<tr>
<th>Advice/treatment</th>
<th>Area of residence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Kirkby (n=104)</td>
</tr>
<tr>
<td>Contraception</td>
<td>92 (88%)</td>
</tr>
<tr>
<td>Smear testing</td>
<td>43 (41%)</td>
</tr>
<tr>
<td>Routine check-ups</td>
<td>62 (60%)</td>
</tr>
<tr>
<td>Emergency contraception</td>
<td>63 (61%)</td>
</tr>
<tr>
<td>Pregnancy testing</td>
<td>83 (80%)</td>
</tr>
<tr>
<td>Help with personal relationships</td>
<td>46 (44%)</td>
</tr>
<tr>
<td>Advice about STIs</td>
<td>59 (57%)</td>
</tr>
<tr>
<td>Treatment of STIs</td>
<td>61 (59%)</td>
</tr>
<tr>
<td>Access to abortion</td>
<td>49 (47%)</td>
</tr>
<tr>
<td>On-site counselling</td>
<td>51 (49%)</td>
</tr>
<tr>
<td>Referral to counselling</td>
<td>28 (27%)</td>
</tr>
</tbody>
</table>

Columns cannot be totalled as they contain multiple responses.

Figure 2.2: Sources of help/advice that respondents would use for sexual health/contraception issues (school survey)
Table 2.6: Visits or contacts for sexual health advice by area of residence (school survey)

<table>
<thead>
<tr>
<th>Area of residence</th>
<th>Halewood (n=27)</th>
<th>Kirkby (n=19)</th>
<th>Prescot (n=27)</th>
<th>Huyton (n=6)</th>
<th>Other (n=13)</th>
<th>Unknown (n=34)</th>
<th>Total (n=126)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher/school nurse</td>
<td>4 (15%)</td>
<td>4 (21%)</td>
<td>12 (44%)</td>
<td>1 (17%)</td>
<td>2 (15%)</td>
<td>6 (18%)</td>
<td>29 (23%)</td>
</tr>
<tr>
<td>Family planning clinic</td>
<td>1 (4%)</td>
<td>6 (32%)</td>
<td>1 (4%)</td>
<td>1 (17%)</td>
<td>1 (8%)</td>
<td>4 (12%)</td>
<td>14 (11%)</td>
</tr>
<tr>
<td>GP/Practice nurse</td>
<td>4 (15%)</td>
<td>4 (21%)</td>
<td>3 (11%)</td>
<td>3 (50%)</td>
<td>2 (15%)</td>
<td>7 (21%)</td>
<td>23 (18%)</td>
</tr>
<tr>
<td>Pharmacy/chemist</td>
<td>2 (7%)</td>
<td>2 (11%)</td>
<td>4 (15%)</td>
<td>1 (8%)</td>
<td>6 (18%)</td>
<td>15 (12%)</td>
<td></td>
</tr>
<tr>
<td>Youth/Brook advisory centre</td>
<td>13 (48%)</td>
<td>4 (21%)</td>
<td>4 (15%)</td>
<td>6 (46%)</td>
<td>13 (38%)</td>
<td>43 (34%)</td>
<td></td>
</tr>
<tr>
<td>Sexwise helpline</td>
<td>11 (41%)</td>
<td>4 (21%)</td>
<td>7 (26%)</td>
<td>6 (46%)</td>
<td>5 (15%)</td>
<td>33 (26%)</td>
<td></td>
</tr>
<tr>
<td>Contraceptive Education Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ruthinking website</td>
<td>1 (4%)</td>
<td></td>
<td></td>
<td></td>
<td>1 (17%)</td>
<td></td>
<td>2 (2%)</td>
</tr>
<tr>
<td>NHS Direct phone line</td>
<td>1 (5%)</td>
<td>1 (4%)</td>
<td></td>
<td>1 (8%)</td>
<td></td>
<td>3 (2%)</td>
<td></td>
</tr>
<tr>
<td>NHS website</td>
<td>1 (4%)</td>
<td>2 (11%)</td>
<td>3 (11%)</td>
<td></td>
<td>1 (8%)</td>
<td></td>
<td>7 (6%)</td>
</tr>
<tr>
<td>NHS walk in centre</td>
<td>4 (15%)</td>
<td>1 (5%)</td>
<td>7 (26%)</td>
<td>2 (33%)</td>
<td>3 (23%)</td>
<td>8 (24%)</td>
<td>25 (20%)</td>
</tr>
</tbody>
</table>

Columns cannot be totalled as they contain multiple responses.

Table 2.7: Awareness of sexually transmitted infections by sex (school survey)

<table>
<thead>
<tr>
<th>Sexually transmitted infection</th>
<th>Aware</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (n=213)</td>
<td>Female (n=253)</td>
<td>Total (n=466)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genital Herpes Yes</td>
<td>147 (69%)</td>
<td>171 (68%)</td>
<td>318 (68%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>51 (24%)</td>
<td>76 (30%)</td>
<td>127 (27%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Answered</td>
<td>15 (7%)</td>
<td>6 (2%)</td>
<td>21 (5%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gonorrhoea Yes</td>
<td>120 (56%)</td>
<td>142 (56%)</td>
<td>262 (56%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>74 (35%)</td>
<td>105 (42%)</td>
<td>179 (38%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not answered</td>
<td>19 (9%)</td>
<td>6 (2%)</td>
<td>25 (5%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis Yes</td>
<td>111 (52%)</td>
<td>118 (47%)</td>
<td>229 (49%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>77 (36%)</td>
<td>122 (48%)</td>
<td>199 (43%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Answered</td>
<td>25 (12%)</td>
<td>13 (5%)</td>
<td>38 (8%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlamydia Yes</td>
<td>162 (76%)</td>
<td>224 (89%)</td>
<td>386 (83%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>42 (20%)</td>
<td>27 (11%)</td>
<td>69 (15%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Answered</td>
<td>9 (4%)</td>
<td>2 (1%)</td>
<td>11 (2%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Yes</td>
<td>207 (97%)</td>
<td>248 (98%)</td>
<td>455 (98%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>5 (2%)</td>
<td>4 (2%)</td>
<td>9 (2%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Answered</td>
<td>1 (0%)</td>
<td>1 (0%)</td>
<td>2 (0%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B Yes</td>
<td>137 (64%)</td>
<td>180 (71%)</td>
<td>317 (68%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>60 (28%)</td>
<td>64 (25%)</td>
<td>124 (27%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Answered</td>
<td>16 (8%)</td>
<td>9 (4%)</td>
<td>25 (5%)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 2.3: Are the following statements about sexually transmitted infections true or false?

Table 2.8: Knowledge about infections by awareness of that infection (school survey)

<table>
<thead>
<tr>
<th>Question</th>
<th>Awareness of infection</th>
<th>Answer to question</th>
<th>Total</th>
<th>Chi</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Untreated chlamydia can cause female infertility</td>
<td>Aware of chlamydia</td>
<td>206 (56.9%)</td>
<td>13 (3.6%)</td>
<td>143 (39.5%)</td>
<td>362</td>
</tr>
<tr>
<td></td>
<td>Not aware of chlamydia</td>
<td>16 (25%)</td>
<td>4 (6.3%)</td>
<td>44 (68.8%)</td>
<td>64</td>
</tr>
<tr>
<td>Chlamydia can be treated with antibiotics</td>
<td>Aware of chlamydia</td>
<td>156 (43.3%)</td>
<td>35 (9.7%)</td>
<td>169 (46.9%)</td>
<td>360</td>
</tr>
<tr>
<td></td>
<td>Not aware of chlamydia</td>
<td>11 (17.2%)</td>
<td>6 (9.4%)</td>
<td>47 (73.4%)</td>
<td>64</td>
</tr>
<tr>
<td>Symptoms of gonorrhoea include discharge</td>
<td>Aware of gonorrhoea</td>
<td>61 (24.8%)</td>
<td>4 (1.6%)</td>
<td>181 (73.6%)</td>
<td>246</td>
</tr>
<tr>
<td></td>
<td>Not aware of gonorrhoea</td>
<td>19 (11.2%)</td>
<td>3 (1.8%)</td>
<td>147 (87%)</td>
<td>169</td>
</tr>
<tr>
<td>Painful urination is not a symptom of gonorrhoea</td>
<td>Aware of gonorrhoea</td>
<td>28 (11.5%)</td>
<td>47 (19.3%)</td>
<td>169 (69.3%)</td>
<td>244</td>
</tr>
<tr>
<td></td>
<td>Not aware of gonorrhoea</td>
<td>16 (9.6%)</td>
<td>11 (6.6%)</td>
<td>139 (83.7%)</td>
<td>166</td>
</tr>
</tbody>
</table>
### Table 2.9: Awareness of the emergency contraceptive pill by area of residence (school survey)

<table>
<thead>
<tr>
<th>Emergency Contraceptive Pill (ECP)</th>
<th>Area of residence</th>
<th>Total (n=459)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Halewood (n=92)</td>
<td>Kirkby (n=100)</td>
</tr>
<tr>
<td>Heard of the ECP?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>87 (95%)</td>
<td>98 (98%)</td>
</tr>
<tr>
<td>No</td>
<td>5 (5%)</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>Aware that you can get ECP free from some pharmacies?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>62 (67%)</td>
<td>73 (73%)</td>
</tr>
<tr>
<td>No</td>
<td>29 (32%)</td>
<td>26 (26%)</td>
</tr>
<tr>
<td>Not Answered</td>
<td>1 (1%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Would you use this service?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>70 (76%)</td>
<td>65 (65%)</td>
</tr>
<tr>
<td>No</td>
<td>20 (22%)</td>
<td>30 (30%)</td>
</tr>
<tr>
<td>Don't know</td>
<td>1 (1%)</td>
<td></td>
</tr>
<tr>
<td>Not Answered</td>
<td>2 (2%)</td>
<td>4 (4%)</td>
</tr>
</tbody>
</table>
3. Young People’s Sexual Health Clinic service user questionnaire results

A total of 58 questionnaires were completed from two young people's sexual health clinics in Knowsley: one based in Kirkby and one in Huyton. The majority of service users were aged 15-16 with 14 year olds or under representing the next largest service user group. Whereas the majority of school and youth and community service respondents were female (58%), clinic respondents were divided more evenly, with males representing 48% of respondents. All those who participated in the survey were self-classified as white therefore no breakdowns by ethnicity have been provided. Both clinics were One Stop Shops operating in the evening time on differing days.

Table 3.1 shows that the majority of service users (78%) attended either school or college. Although most service users stated that they were in a steady relationship (55%), 31% were either not in a relationship, or in a casual relationship (14%). When asked who they were attracted to, all but one responded that they were attracted to members of the opposite sex. Table 3.1 also shows service user responses to whether or not they had sexual intercourse. The majority of service users had had sexual intercourse and of the 15 individuals (26%) who stated that they had not had sex 60% were aged 14 years or less. Thus, although 29% of service users participating in this study were in the 14 or under age group 53% of these young people had not had sex. Anecdotal evidence gathered from clinic staff suggests that many young people in this age group attend the clinic to access free condoms (including flavoured condoms). Therefore, it is likely that they are practising oral sex but are not participating in full sexual intercourse yet. Table 3.1 also shows that fewer male than female service users had had sex, and that the majority of females in the 15-16 year age group had had sex (89% of females aged 15-16 and 83% of total females).

Service users were asked their age at first sex, 12% of respondents chose to leave this question unanswered and it was not applicable to 24%, however, for those to whom it was applicable the most common ages at first sex were 15, 14 and 13 years (19%, 16% and 10% respectively). Twenty six percent (n=15) stated that they had visited a clinic prior to having first sex, with most (33%, n=5) visiting less than six months prior to first sex. Thirty eight percent (n=22) stated that they visited a clinic after first sex with 32% (n=7) visiting less than six months after first sex.

Service user views and use of clinics

Table 3.2 shows service user responses by area of residence. It is clear that the majority of service users from the two clinics surveyed resided in Kirkby. Twenty two percent of service users questioned were accessing services for the first time, however, the majority of those repeat service users last attended the clinic less than one month or 1-3 months prior to this attendance (n=15). This table also shows that the majority of service users had not used any clinic other than the one they were currently accessing (85%). Almost all (98%) said that they found it easy to attend at the times the clinics currently operate (see appendix 2), and when asked what specific times and days they would like the clinics to operate the most common response was between 3-6 pm (n=26), which fits in with existing clinic times and is convenient for people to attend after school, college or work. When asked what days of the week service users would prefer the clinic to operate the most common response was any day (n=20) and the most common days that were specified were Mondays and Tuesdays with the weekend being the least desired time for service users to want a clinic to be open.

Table 3.2 also shows that most service users access clinics closest to where they live (80%) and the majority of service users travel to services on foot (57%) and travel for less than 15 minutes to access clinic services (n=44). Both the clinics that participated in this study were drop in clinics where no appointment was necessary and service users stated that they waited
either under five minutes or 5-10 minutes before seeing a doctor or nurse (50% and 29% respectively).

The vast majority of service users attended the clinic to access free condoms, the contraceptive injection, the contraceptive pill or emergency contraceptive pill. When asked about additional advice they had received, other than that which they had attended for, figure 3.1 shows that they were given advice primarily on contraceptives, emergency contraception and sexually transmitted infections. However, none of the service users were given information on smear tests and very few were given information on routine check-ups.

Figure 3.2 shows service user views of clinic features, and shows that the majority of clinic users thought that it would be a plus point if they had the choice to see a male or female doctor; to have special sessions for young people; that couples could attend at the same time; and that both contraception and infections are dealt with in the one place. Table 3.3 shows that in the most part clinic users received all the advice and information they wanted, found it easy to ask questions, and found it easy to understand the clinician’s answers. Table 3.4 shows that although the majority of respondents stated that they received advice on methods of contraception, how effective they are, how to use them and potential side effects, a significant proportion of service users did not.

Figure 3.3 shows that the vast majority of service users thought that the clinics felt private, relaxed, cheerful, comfy and well equipped. It is also clear from Figure 3.4 that service users also have very positive views of clinic staff, with only slight concerns over the discretion displayed within clinics. Service users reported no negative views of clinics doctors and nurses (Figure 3.5). Figure 3.6 shows the various sources of information where service users found out about the young people’s sexual health clinic they currently access. From this chart it is clear that the vast majority of service users found out about the clinic via word of mouth through friends, none found out about the clinic through a newspaper, and one person found out about it through Connexions. Service users were asked if they would change anything about the clinic and almost all respondents stated that they would not. One service user said that they wanted the clinic to be more discreet and two service users stated that they would prefer it to be less busy. When asked what they liked best about the clinic there was a variety of responses. Service users stated that they liked the fact that the clinic staff were very friendly, helpful, easy going and provide a quick service; they liked the fact that they could access free condoms; that they could talk in private; that the service was confidential; and that they could just turn up without an appointment.
Table 3.1: Occupation, relationship status, sexual experience and sexuality by age and sex (service user survey)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Not Answered</th>
<th>14 or under</th>
<th>15-16</th>
<th>17-19</th>
<th>20 or over</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male (n=1)</td>
<td>Male (n=14)</td>
<td>Female (n=3)</td>
<td>Male (n=7)</td>
<td>Female (n=18)</td>
<td>Male (n=6)</td>
<td>Female (n=8)</td>
</tr>
<tr>
<td>Are you…</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working full-time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working part-time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At school or college</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is your relationship….</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steady</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Casual</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not in a relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you mainly attracted to…</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not answered</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men and women</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever had sexual intercourse?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not answered</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Working full-time: 2 (33%) male, 2 (7%) female
- Working part-time: 2 (14%) male, 2 (6%) female
- Unemployed: 1 (14%) male, 1 (14%) female
- At school or college: 1 (100%) male, 12 (100%) female
- Steady: 5 (36%) male, 4 (57%) female
- Casual: 3 (21%) male, 2 (67%) female
- Not in a relationship: 1 (100%) male, 6 (43%) female
- Men: 3 (100%) male, 18 (100%) female
- Women: 1 (100%) male, 7 (100%) female
- Men and women: 1 (100%) male, 1 (100%) female
- Yes: 1 (100%) male, 6 (43%) female
- No: 8 (57%) male, 1 (33%) female
Table 3.2: Clinic use and access by area of residence and sex (service user survey)

<table>
<thead>
<tr>
<th>Area</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Kirkby</td>
</tr>
<tr>
<td></td>
<td>Male  (n=9)</td>
</tr>
<tr>
<td>Is this your first visit to the clinic?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2 (22%)</td>
</tr>
<tr>
<td>No</td>
<td>7 (78%)</td>
</tr>
<tr>
<td>Have you been to any other clinics like this one?</td>
<td></td>
</tr>
<tr>
<td>Not answered</td>
<td>1 (13%)</td>
</tr>
<tr>
<td>Yes</td>
<td>8 (89%)</td>
</tr>
<tr>
<td>No</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>Did you find it easy to attend at the time you came here today?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9 (100%)</td>
</tr>
<tr>
<td>No</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Is this the nearest clinic to where you live?</td>
<td></td>
</tr>
<tr>
<td>Not answered</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>Yes</td>
<td>7 (78%)</td>
</tr>
<tr>
<td>No</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>Don't know</td>
<td>1 (11%)</td>
</tr>
</tbody>
</table>

Figure 3.1: Additional advice offered (service user survey)

- Abortion
- Advice about sexually transmitted infections
- Help with personal relationships
- Pregnancy test
- Emergency contraception
- Routine check-up
- Contraception advice or services
Figure 3.2: Opinions on features of the clinic service (service user survey)

Table 3.3: Availability of clear advice and information (service user survey)

<table>
<thead>
<tr>
<th>Sex</th>
<th>Male (n=27)</th>
<th>Female (n=24)</th>
<th>Total (n=51)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you get all the advice and information you wanted?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Answered</td>
<td>1 (4%)</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Yes</td>
<td>21 (78%)</td>
<td>19 (79%)</td>
<td>40 (78%)</td>
</tr>
<tr>
<td>Mostly</td>
<td>5 (19%)</td>
<td>5 (21%)</td>
<td>10 (20%)</td>
</tr>
<tr>
<td>Was it easy to ask questions?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Answered</td>
<td>2 (7%)</td>
<td>2 (8%)</td>
<td>4 (8%)</td>
</tr>
<tr>
<td>Yes</td>
<td>21 (78%)</td>
<td>17 (71%)</td>
<td>38 (75%)</td>
</tr>
<tr>
<td>Mostly</td>
<td>4 (15%)</td>
<td>5 (21%)</td>
<td>9 (18%)</td>
</tr>
<tr>
<td>Were the answers clear?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Answered</td>
<td>3 (11%)</td>
<td>2 (8%)</td>
<td>5 (10%)</td>
</tr>
<tr>
<td>Yes</td>
<td>21 (78%)</td>
<td>17 (71%)</td>
<td>38 (75%)</td>
</tr>
<tr>
<td>Mostly</td>
<td>2 (7%)</td>
<td>5 (21%)</td>
<td>7 (14%)</td>
</tr>
<tr>
<td>No</td>
<td>1 (4%)</td>
<td>1 (2%)</td>
<td>2 (4%)</td>
</tr>
</tbody>
</table>
Table 3.4: Advice received regarding contraception (service user survey)

<table>
<thead>
<tr>
<th></th>
<th>Male (n=23)</th>
<th>Female (n=22)</th>
<th>Total (n=45)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Choice of method?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Answered</td>
<td>1 (4%)</td>
<td>1 (2%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Yes</td>
<td>15 (65%)</td>
<td>14 (64%)</td>
<td>29 (64%)</td>
</tr>
<tr>
<td>No</td>
<td>7 (30%)</td>
<td>8 (36%)</td>
<td>15 (33%)</td>
</tr>
<tr>
<td><strong>How effective they are?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Answered</td>
<td>2 (9%)</td>
<td>2 (4%)</td>
<td>4 (8%)</td>
</tr>
<tr>
<td>Yes</td>
<td>15 (65%)</td>
<td>13 (59%)</td>
<td>28 (62%)</td>
</tr>
<tr>
<td>No</td>
<td>6 (26%)</td>
<td>9 (41%)</td>
<td>15 (33%)</td>
</tr>
<tr>
<td><strong>Any side-effects?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Answered</td>
<td>1 (4%)</td>
<td>1 (2%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Yes</td>
<td>14 (61%)</td>
<td>10 (45%)</td>
<td>24 (53%)</td>
</tr>
<tr>
<td>No</td>
<td>8 (35%)</td>
<td>9 (41%)</td>
<td>17 (38%)</td>
</tr>
<tr>
<td><strong>How to use them?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Answered</td>
<td>2 (9%)</td>
<td>2 (4%)</td>
<td>4 (8%)</td>
</tr>
<tr>
<td>Yes</td>
<td>17 (74%)</td>
<td>12 (55%)</td>
<td>29 (64%)</td>
</tr>
<tr>
<td>No</td>
<td>4 (17%)</td>
<td>10 (45%)</td>
<td>14 (31%)</td>
</tr>
</tbody>
</table>

Figure 3.3: Service users’ opinions of the clinics
Figure 3.4: Service users’ opinions on reception staff

- Can be trusted with private information
- Discreet
- Approachable
- Welcoming
- Helpful
- Friendly

Number of responses

- Can be trusted with private information
- Discreet
- Approachable
- Welcoming
- Helpful
- Friendly

- very
- mostly
- not at all
Figure 3.5: Service users’ opinions on doctors and nurses

- Can be trusted with private information
- Discreet
- Approachable
- Welcoming
- Helpful
- Friendly

Number of responses

- Can be trusted with private information: 33 responses mostly, 5 responses very
- Discreet: 10 responses mostly, 5 responses very
- Approachable: 35 responses mostly, 5 responses very
- Welcoming: 35 responses mostly, 5 responses very
- Helpful: 35 responses mostly, 5 responses very
- Friendly: 40 responses mostly, 5 responses very
Figure 3.6: Sources of information about the clinic (service user survey).
4. Service provider questionnaire results

One service provider questionnaire was completed for this study by a health care professional working across all three of the community based, young people's sexual health clinics in Knowlsey.

Clinic promotion
The clinics are advertised in schools and colleges as well as in shops, general practitioners and pubs and clubs however, they are not advertised in local papers or on any local TV or radio stations. The clinic advertisements include information on the location of the clinic, the services available, the number and times of the clinics and a helpline number. However, they don’t include information on how to get to the clinic or the clinic appointment system.

Services provided at the clinics
Overall there are five young people’s sexual health clinics per week throughout Knowsley, based in the Kirkby, Huyton and Halewood areas (see appendix 2).

The clinics in Knowlsey provide facilities for parking cars, storing pushchairs, and people accompanying clients. They also provide access for wheelchair users and information ‘out of hours’. Although the clinics do not provide outreach work as such, they operate in association with youth and community services.

The clinics in Knowlsey do not provide information leaflets in any other language other than English however this may be due to a lack of demand for this service.

All clinics inform clients that their visit is confidential and they operate a drop-in system where no appointment is needed. Service users are called using either their first name or a number and the average length of a consultation lasts between 10 – 30 minutes.

The young people’s sexual health clinics focus primarily upon contraceptive services and offer a full range of information on the use, type, effectiveness and side-effects of contraceptives. The clinics specifically provide services such as pregnancy tests, postcoital contraception, oral contraception, injectable contraception and condoms. The clinics also refer service users to other services if necessary such as, genito-urinary medicine clinics, family planning clinics, termination of pregnancy services, counselling and connexions. They do not offer services such as cervical smears, STI screening or treatment, or counselling, however, it was stated that these other services are provided locally. They also do not arrange follow-up visits after a client’s initial visit.

Clinic staff and protocols
The clinics employ doctors, nurses, youth workers and receptionists. Employees are offered training courses on contraception as well as anything else available through PCT ‘learning at work’.

The clinics have protocols in place for equal opportunities among staff, advice relating to client confidentiality and advice on legal issues relating to sexually active under-16s.
5. Focus Group Results

Focus groups were carried out on November 1st 2005 with youth and community service users in Huyton. Two single sex focus groups were carried out and they consisted of seven young women (labelled a. to g.) and eight young men (labelled a. to h.). Each focus group had a youth worker present and each group discussion was based around the same nine questions (appendix 3). The results of the focus groups are presented by theme and sex.

Knowledge of sexually transmitted infections

The majority of the young men involved in the focus group were also members of a peer education group that had previously covered sexual health issues. Although the young men offered more information on the names of STIs than the young women they did not offer many of the symptoms. However, they were more aware of the treatments and route of infections than the young women (box 1). The young men focused more around the subject of HIV/AIDS while the young women concentrated on chlamydia. The female focus group made it clear that they were aware of their lack of STI knowledge, especially of the symptoms, and would like to be involved with peer education scheme similar to the one the young men were involved with.

Both focus groups talked about long acting reversible contraception (LARC) in terms of it having a potential increase in STIs, however the young women’s group were hesitant about the idea. They did not like the idea of using coils and preferred the idea of using the contraceptive pill in conjunction with condoms. Although the majority of the young men in the focus group said that they would still use condoms to protect themselves from STIs even if their girlfriend was using LARC, a couple of young men stated that they would not.

Box 1 – Sexually Transmitted Infections

Young women

a. Can I ask you, what is chlamydia?
   b. It burns, I don’t know.
   c. Gonorrhea can kill you, can’t it?
      a. And what’s the other one, herpes, what’s that?
      b. That’s the one that’s like big cold sores all over your erm….
      b. and c. You know the names of them but you’re not sure what they all are.

-------

(multiple) by having sex without protection….condoms….through blood….putting your mouth on a penis….kiss….oral sex

Young men

b. They can all be treated….apart from AIDS which can’t be treated….yes that’s the only one that can’t be treated all the others can…..antibiotics, some special sort of antibiotics

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(multiple) through sex…yes through sexual intercourse…..through bodily fluids….no through the blood as well can’t you?…yes..yes, through open cuts or injected….sharing needles [referring to HIV].

Sexual health information

Both groups stated that they could access sexual health information through clinics, such as GUMs, walk-in centres, family planning clinics and GP practices. There were mixed views in
both groups about whether or not young people could talk to a parent about sexual health
issues, in some cases young people were more likely to talk to another relative or friend.

Both groups also gave a variety of different options about where they would access sexual
health information, for example, GP practices, clinics, leaflets, the internet, and youth workers.
However, young women were more likely to be aware of the phone numbers available to ring
for advice. The groups differed in their awareness of sexual health promotion campaigns (box 2).
When asked what campaign tactics would work on young people the groups suggested real
life stories, graphic images and reward schemes.

Both groups clearly stated that they thought that there was not enough sexual health education
in schools, with comments such as

b. ‘I haven’t done it up to now [sex education] in year 11 but in our school you only do it in year
7 and 11, you don’t do it in any other year, and every year the girls get the packs with the
towels in, and the thong things and tampons…you name it, it’s got it in’.

Young woman b also suggested that young people were shown around clinics and told where
they were located. This method had been used with the young men in their peer education
group and had helped to make them aware of the services. Other examples were poster
advertisements and leaflets through the door. The young men’s groups said that having a
sibling become a parent at a young age impacted upon their sexual health decision-making
because they didn’t want the same thing to happen to them.

<table>
<thead>
<tr>
<th>Box 2 – Sexual Health Information</th>
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<tbody>
<tr>
<td><strong>Young women</strong></td>
</tr>
<tr>
<td>(researcher) have you heard any adverts on the radio recently?</td>
</tr>
<tr>
<td>a. Ages ago</td>
</tr>
<tr>
<td>b. And there was posters as well like er…they done it like a jokey one….have you seen the one where the girl’s looking between her legs for chlamydia….have you seen it where she goes [attempts to copy advert]…in magazines as well….have you heard the one on the radio?</td>
</tr>
<tr>
<td>a. I have but I can’t remember what its about.</td>
</tr>
<tr>
<td>b. STI lottery or something like that</td>
</tr>
<tr>
<td>c. and the one about the school register</td>
</tr>
<tr>
<td>b. She goes to him any food? And he goes no, any condoms? Yes, got strawberry, vanilla, goes through all of them and says…..ribbed and goes through every single condom there is….and says I’ve got one femidom [laughs].</td>
</tr>
</tbody>
</table>

| **Young men**                     |
| (researcher) do you ever hear any sexual health campaigns? |
| b. There has been some but there’s not many. |
| c. No I haven’t really heard any. |
| a. No I haven’t really heard any but you know that there is some there but nobody hears them… |
| b. [interrupts] you feel ashamed. |
| a. yes, you feel …but you can go on the internet anywhere can’t you and just look up and then people won’t know what you’re looking for and stuff. |
The issue of mixed messages was raised in both focus groups. In some cases, these comments were with regard to messages given in Catholic schools linked to religious beliefs regarding the use of condoms resulting in ‘killing babies’. The young women referred to mobile phone text messages, which had been circulating among young people, saying ‘if you have sex you will die’ and ‘if you get pregnant you will die’. The young women had also heard that there is a risk of long acting reversible contraception causing infertility. As such it is important that young people can access sexual health information via safe and trustworthy means. Both focus groups stated that they were happy and comfortable to talk in confidence to the youth workers in the community centre.

Clinic services

Young people were asked their views on clinics, the services they provide, and the environment they should encourage. The young people participating in the study stated that the barriers to seeking help and advice were primarily embarrassment or shame. However, the young people stated that it was important for clinics to provide free contraception, including emergency contraception. The male focus group also suggested that there should be more choice in the sizes and types of condoms provided at the clinics, including femidoms. They also suggested that dental dams be provided at clinics. Young men agreed that long acting reversible contraceptives were a good idea and ought to be available from clinics, and that demonstrations ought to be provided. In contrast, the female focus group suggested that pregnancy tests were the main service that should be provided by clinics (box 3.).

Both focus groups stressed the importance of clinic staff appearing welcoming, friendly and non-judgemental (box 3), as well as the clinic environment being relaxed and comfortable. Suggestions were made for relaxing wall colours, background music and lots of space between seats so that others cannot overhear conversations. It was also suggested that services should be provided locally.

There were mixed views on clinics being either single sex or young people only in the young men’s focus group, however the young women’s group thought that there should be sessions specifically for young people. Young people were primarily concerned with confidentiality and privacy within clinics. They expressed concerns about people in the waiting room being able to overhear the reasons for their visit and suggested that quiet rooms should be provided to go to in case they were upset, or that there should be a separate exit so that they don’t have to walk back out through the waiting room.

Both groups primarily agreed that it was important for the doctor they saw to be of the same sex; that clinics should provide information and tests for STIs; and that nurses/doctors take the time to talk to young people about their relationship and contraceptive choices; that they should be able to access services 24 a day, or at the very least after school until quite late at night.

<table>
<thead>
<tr>
<th>Box 3 – clinic Services</th>
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<tbody>
<tr>
<td><strong>Young women</strong></td>
</tr>
<tr>
<td>a. that they give pregnancy tests (multiple) that they’re welcoming</td>
</tr>
<tr>
<td>b. Like when you go in that they’re like ‘hello love’ and they’re not…they don’t look down their noses because you’re going for like a test or something.</td>
</tr>
<tr>
<td>c. they give you leaflets</td>
</tr>
<tr>
<td><strong>Young men</strong></td>
</tr>
<tr>
<td>e. I want it on my doorstep, the services</td>
</tr>
<tr>
<td>b. free demonstrations</td>
</tr>
</tbody>
</table>
Alternative sexual health care services/information

Alternative places for accessing sexual health care services and information were discussed and services attached to schools were one possible option, as long as there were multiple reasons for visiting the area so that it would not be obvious that young people were going specifically for sexual health information or services.

Both focus groups stated clearly that they were very comfortable discussing sexual health issues with the youth workers in the youth and community centre. The young women’s focus group requested that they put on weekly sessions for young people there, whilst the young men’s group stated that the youth workers had been useful in the past and brought in additional leaflet information about specific topics when requested to do so by members of the group.

The majority of the young women’s focus group agreed that they would pay more attention to sexual health advice if it came from parents as opposed to teachers and they suggested that parents ought to be educated in sexual health. Those in the young men’s focus group who felt they could not talk to their parents said that they were more comfortable speaking to their peer educator or youth workers.

Sexual activity

Oral sex was raised in discussion with the focus groups. Young people talked about their use of condoms and flavoured condoms, the young women talked about their favourite flavours and confirmed that ‘tutti fruity’ was the one they all liked. When young men were asked whether young people would request only flavoured condoms from clinics if they were available, they said that they would, as young people often practice oral sex prior to becoming fully sexually active.
6. Discussion

Overview
Young people participating in all three parts of this study (schools, clinics and focus groups) were primarily in the 14 to 17 year age group, with age 15 years being the most common age of participants. This age group was targeted as it is the main age of people accessing young people’s sexual health clinics and the target age for preventing conceptions among those under 16 years and under 18 years. All groups participating in the study consisted primarily of white individuals (>96%), which is representative of the ethnic distribution in Knowsley. Clinic users and focus groups comprised equal numbers of males and females. We received more valid questionnaires from females (52%) than males (48%). To our knowledge this is a reflection of the young people present in class on the day of the survey (none of the teachers notified us of any young people declining to participate). Fewer than ten questionnaires were spoilt (it is not clear whether these were from males or females). However, it may also be due to youth and community service questionnaires being completed by only females (21 questionnaires).

The majority of service users surveyed stated that they experienced first sex between the ages of 13-15 years. This differs greatly from the results of NATSAL survey which stated that the national average age of first sexual intercourse was 16 (7). However, those attending sexual health clinics are a subset of the population that is more likely to be engaging in sexual behaviour.

All of the schools involved with this study were comprehensive schools and this may affect the views provided by young people. Catholic schools in Knowsley were approached and asked to participate and they refused. However young people from Catholic schools were represented in the focus groups and it is likely that young people from Catholic schools are also represented in the service user aspect of this study.

Knowledge of sexual health and STIs
The questionnaires and focus groups revealed that there was a deficit in young people’s awareness and knowledge of STIs. Young people were much more aware of pregnancy as a result of unprotected sex and, although they were aware that unprotected sex can lead to infections, they were less aware of the symptoms and consequences of STIs. HIV was the most commonly known STI and also the one that young people are least likely to be affected by. Their awareness of HIV may stem from the publicity that HIV/AIDS receives through the media, World AIDS Day and ‘Make Poverty History’ as well as the poster campaigns that have been displayed in recent years. It may also stem from the fact that it is one of the few STIs for which there is no cure and this aspect may raise young people’s interest and awareness. School and youth service respondents were also aware of chlamydia and this may be due to the recent awareness campaigns targeting young people regarding chlamydia, as well as the increase in chlamydia testing with the advent of nucleic acid amplification test (NAAT) and the Government’s initiative to roll out chlamydia screening nationally.

The results of the survey show that young people were aware of the fact that they lacked knowledge of names and symptoms of STIs. However, the results of the analyses also showed that those who stated that they were aware of specific infections were also more likely know about the corresponding symptoms, long-term consequences and treatment (table 2.8). Although the STI names and questions in the questionnaire did not list a fake STI to control for those young people who may answer ‘yes/true’ for all questions, the questions listed in figure 2.3 did have one false question, and those correctly stating ‘false’ to ‘painful urination is not a
symptom of gonorrhoea’ were more likely to be those who stated they had heard of gonorrhoea.

STI advice and services need to be more comprehensive as it is important that young people know where to look for information and who to ask. However, recent campaigns have been supported by helplines and websites; the Sexwise helpline appeared as one of the most frequently accessed information services in the survey conducted in schools and youth services. The questionnaire only asked young people if they had accessed specific websites, for example, ‘RUTHinking’, but did not ask young people if they used the internet generally to find out about services and sexual health information. However, the young men’s focus group raised this as one of their main sources of sexual health information. As young men are one of the most hard to reach groups for sexual health promotion, this finding should be explored further. The fact that many young men, and women, have WAP [wireless access protocol] enabled phones and can access the internet anywhere at any time ought to be exploited to promote sexual health and services.

**Awareness of sexual health advice and services**

Young people surveyed stated that they would ask for sexual health information and advice from sources such as parents, friends, GPs or practice nurses. However, when asked what sources they had actually accessed previously, the results showed that the majority had not accessed many of the sources listed (this list did not include parents or friends as an option), and those that had accessed sources of sexual health information and care were most likely to have accessed youth services and Brook advisory centres, the Sexwise helpline and teachers or school nurses above all other services. These were also the services most highlighted by the focus group in addition to the one stop shop that they termed the ‘Johnny club’.

Most (77%) of the young people from schools and youth services stated that they were aware of the local clinics, although most (75%) had not been to one. This could be either because they were not currently sexually active or because the available clinic services do not currently appeal to young people. It is clear from the survey of schools and youth services and the focus groups that young people were not aware of all the services available and believe that increased awareness and increased local services would encourage them to use services. Awareness could be raised through, for example, improved advertising and education about services. Clinic services are currently advertised in schools and colleges as well as in shops, general practitioners and pubs and clubs. Service user results showed that the vast majority of young people accessing clinics found out about the service from friends, which suggests that the clinic services are not advertised as well as they could be. Young people interviewed suggested that clinics should be advertised on leaflets, posters, TV and on the sides of buses. Young people also cited schools and colleges as a source of information regarding clinics, and this could also be exploited further. Although there are provisions for sexual health care across the borough, our finding show that young people often feel embarrassed or ashamed to go to sexual health services, even when they are aimed specifically at young people. Young people stated that as well as locating sexual health services in health buildings they would like services to also be located in schools or youth and community centres. The focus groups also revealed confusion about the age at which a young person is able to access services, with participants unsure of whether or not services can be accessed at age 12 years, 13 years, 15 years or 16 years and over. This could be clarified on advertisements for the clinics.

The majority (n=95; 20%) of young people from schools and youth services stated that their main service was their GP practice. However this was in the form of a general question and may not have been answered specifically with reference to sexual health services. It is likely that young people, especially young women, will discuss issues such as the contraceptive pill with their GP before accessing other services. Although clinic services are advertised at GP
practices, it may be more useful to provide leaflets to be given out at GP practices. GPs are often the first port of call and are well placed to give out information to young people regarding local sexual health services.

Although peer education was not a choice that could be selected as a source of information on the school and youth service questionnaire, the focus group carried out with young men, a number of whom were involved in a peer education programme, showed that this method of education had had a positive impact on their sexual health awareness and was a valuable resource for advice and education. This approach needs to be developed throughout Knowsley as they currently focus upon young men only.

**Clinic services**

Almost all of the young service users surveyed stated that they were very happy with the service they received and would change nothing about it. The majority of service users accessed clinics closest to where they live. The majority wanted clinics to operate at the times they already operated. Most service users reported short waiting times with the majority stating that they were seen by a doctor or nurse within either five minutes or 5-10 minutes. This shows that young people had access to convenient local and timely services. Young people suggested that the level of privacy and space in clinics could be improved. Overall results showed that young people believe that contraception services should be provided alongside STI services and that they should be able to see a doctor of the same sex. Young people also stated that the most important services provided at clinics were contraceptives, pregnancy testing and emergency contraceptives. Knowsley’s young people’s clinic services operate a drop-in service for young men and women and provide pregnancy testing, emergency contraception and a wide variety of contraceptives, including injectable contraception. They do not provide contraceptive implants although they do supply information about this form of contraception.

STI advice and services need to be more comprehensive; our findings show that young people are taught only limited sexual health and STI information in schools, and young people’s clinics only provide limited contraceptive choices. Young people were of the opinion that STI information, tests and treatments, ought to be available at young people’s clinics. Young people were aware of their local clinics and some were aware that they can access advice, information and care at GUM departments, however young people saw these services as specifically for people with STIs and were concerned about others knowing the reason they were attending the clinic. Since young people may feel embarrassed to go to GUM clinics providing sexual health information and STI testing in young people’s clinics could increase the diagnosis of STIs in young people dramatically. One young woman stated that STI testing should be available at young people’s clinics because:

‘if you go to, like, the hospital and they’ve got to do tests and that on you, and then obviously you’re sitting in the room and everybody knows around you you’re sitting because you’re going for tests, if you go to the clinic and if its all the same they don’t know you’re going for tests, condoms, whatever’.

The service user results showed that most young people accessed clinics closest to where they lived (80%) and the majority of service users travelled to services on foot (57%) and travelled for less than 15 minutes to access clinic services. As such, it is important that services are provided locally for young people. This view was also reiterated by one of the focus group participants who stated that he wanted services ‘on my doorstep’. Many young people thought that clinics should be located either in a health building, school or youth and community service. It was suggested that a unit connected to a school or youth and community service that was used for other purposes as well as sexual health care would allay young
people’s concerns about other people knowing they were accessing the building for sexual health services.

The majority of clinic service users who completed questionnaires had experienced sexual intercourse (n=25; 83%). Fifteen (26%) stated that they had not had sex, 60% of whom fell into the 14 or under age group. Anecdotal evidence gathered from clinic staff suggests that many young people in this age group attend the clinic to access free condoms (including flavoured condoms). Therefore, it is likely that some service users were practising oral sex but were not participating in penetrative intercourse yet. This perspective on oral sex was confirmed within the focus group:

‘Some people don’t do, have sex, they have like oral sex before they have sex like don’t they?’

An evaluation of a c-card distribution scheme in Leeds found that the most commonly requested condoms were flavoured condoms. Although many young people stated that they were not sexually active, they were in fact participating in oral sex but did not consider this to mean that they were sexually active (24). The current method of condom distribution in Knowsley’s clinics means that it is difficult to monitor the types of condoms given to young people because at present flavoured condoms are only provided in mixed bags of condoms. However, it is possible that young people would request only flavoured condoms if this option was available.

The results of the clinic questionnaires show that young people access clinics most frequently for free condoms. This study has not evaluated the types of contraception that young people would like to access in young people’s sexual health clinics, however the focus groups carried out with young men and women stated that the range of condom choices were limited for young people. They suggested that clinics should provide more comprehensive choices of barrier method contraception such as different sizes of condoms (both smaller and larger), femidoms, and also expressed interest in dental dams. These findings reflect those of the c-card evaluation in Leeds, where young people also requested additional lubricants and condoms with bumps and studs. The service provisions in Leeds also consisted of ribbed, flavoured, extra-strong, and different brands of condoms as well as water-based lubricant (26).

Young people stated that emergency contraception was one of the main services that clinics should provide. When surveyed, most young people were unaware of the community pharmacy provision of emergency contraceptives and the school and youth service questionnaire revealed that 68% of young people would access free emergency contraception at a pharmacy if they could. Focus group data suggested that some young women currently try to ‘stock up’ on emergency contraception; as one of the young women in the focus group said, when asked if she would visit the sexual health clinic prior to having sex with her partner, she would ‘go and get a spare morning after pill’. An alternative approach to getting emergency contraception to target groups was implemented in Lothian, Edinburgh (27). The Lothian Emergency Contraceptive Project was a primary care based intervention to offer advance supplies of emergency contraception to women in the community in order to reduce unwanted pregnancy and abortion rates. However, due to health care professional reticence at offering supplies and promoting mixed sexual health messages the intervention was not associated with a reduction in abortion rates. An intervention that supplied young women with an advanced supply of emergency contraception could be used more effectively in Knowsley where there is

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8 A card scheme typically aimed at those under 25 years which allows easy access to free condoms and sexual health information.
a high rate of teenage conception and may be received better than in Lothian where the intervention was targeted at women in their late 20s attending GP practices.

Young people’s clinics, in line with new NICE guidance, ought to inform, encourage and provide long acting reversible contraceptives (LARC) to young people (18). This aspect of contraception was not included in the questionnaire and, with hindsight this could have provided valuable information. However, the subject of LARC was raised during the focus group sessions and revealed that although young men think that it would be a good idea most young women stated that they would prefer to use condoms and the pill. Young girls involved in the focus group stated that they had heard that LARC could risk their fertility and this was one of the main reasons for their reticence to use it. A previous comprehensive qualitative study on contraception and contraceptive advice (28) also revealed similar reticence to the issue of LARC.

Along with contraception and pregnancy testing young people generally thought that clinics ought to provide counselling services. Young people’s clinics could consider providing counselling services on call as it would not be a service that would be needed for every clinic session. Also, clinics ought to develop further opportunities to talk to young people about their sexual activity, their choices of contraception, provide demonstrations and provide information and advice on sexually transmitted infections. Service provider information shows that young people’s services currently lack provisions such as counselling, however, support agencies such as these are provided locally and should work to improve multiagency working.

It is important to note that only two out of a potential four sexual health clinics in Knowsley participated in this study. Both of the services that participated were One Stop Shops. Of those that did not participate, one was a GP practice and another was a medical centre, which, although it had limited young people’s sessions, was the only one to provide weekend sessions. Therefore, the clinic users views are based upon their satisfaction with the One Stop Shop provision only.

**Sexual health education**

The results of the study show that young people access teachers and school nurses for sexual health advice and information. However the focus group revealed a deficit in school provision of sexual health education. For Catholic schools the situation appeared to be worse, with young people attending them confused by the dichotomy between scientific and religious views of life, thus receiving conflicting information regarding contraception. The Government has proposed a comprehensive schedule of PSHE in schools in line with ‘Every Child Matters’ (14), which will contain material on relationships, drugs, and alcohol as well as issues such as emotional difficulties. Research shows that sex education in schools does not lead to increased promiscuity and when joined up with contraceptive services can lead to a delay in first sex (29). This initiative is supported by ‘Choosing Health’, which states that ‘One Stop Shops and multi-agency health centres located on a school site enable health professionals to work alongside education and social care professionals’ (10).

Different approaches to tackling the issue of sex in schools and youth services, for example through peer education, were raised. As discussed, the focus group revealed that peer education through youth services has influenced young people’s sexual health awareness and knowledge of services. Peer education can also be carried out within schools within, for example PSHE classes as a teaching method. One example that has been used is RIPPLE (peer-led sex education) methods, where peer educators aged 16-17 years deliver sex education to those aged 13-14 years. Findings from one study showed that by age 16 years, of the young women involved in the peer-led study, fewer had experienced sexual intercourse and unintended pregnancies (30). However, there was no difference reported in rates of
unprotected first sex. Girls in the intervention arm of the study reported more unintended pregnancies. This method had greater effects on young women than young men. The peer-led sessions were delivered in mixed groups and although those involved were more satisfied with peer-led than teacher-led sex education, one the conclusions of the study was that single sex peer-led sessions ought to be investigated (30).

Theatre in education is also a new and innovative method of delivering sex education to young people in schools and youth and community services. This method of sex education is also a form of peer education and is specifically supported by the Department for Education and Employment, by Ofsted and by the Sex Education Forum. It is held up as good practice and aims to tackle young people’s ignorance in a creative way to support the national aims to reduce teenage conception (31).

Many young people stated that they would talk to their parents about sex if they needed to, however a large proportion of the young people involved in the focus group did not feel that they could talk to their parents. Parents could be a valuable source of information for young people given the correct information and ought to be helped to discuss sexual health with their children; as one young woman said ‘They [parents] just need educating’. Choosing Health also states that new ways to support parents need to be developed (10).

Young people also felt comfortable and secure talking to youth and community workers about sexual health. With the confusion surrounding sexual health messages for young people, especially mixed messages relating to religious teachings, it is important that young people can access sexual health information via safe and trustworthy means.

**Policy Development**

Knowsley’s young people’s clinic services currently have protocols in place relating to the legal issues of sexually active young people under 16 years. The Government is currently developing a new version of its *Working Together to Safeguard Children* guidance (32), which may require the mandatory reporting of sexual activity of those under 13 years to police and social services and the collection of data on sexually active young people under 16 years. There are concerns that this will undermine the privacy and confidentiality that young people seek in sexual health clinics (33). Clinics will need to update their policies to provide clear guidance to clinic staff regarding the reporting of sexual activity.

**Further work**

The potential use of the internet as a tool for providing information to young people ought to be explored. Possible further work could entail a mapping exercise to reveal existing information and gaps in information accessible to young people on the internet.

In order to tackle the rates of STIs and teenage pregnancy it is necessary to move beyond the provision of information. Areas not covered by this study are the investigation of factors affecting young people’s sexual decision-making such as the role of drugs and alcohol, as well as the issues around relationships, confidence, assertiveness and aspirations. A study investigating these factors has recently been carried out in Rochdale (34). The results of this study revealed that alcohol use, including ‘binge drinking’, was widely associated with having fun but also impaired sexual decision-making; pornography influences young people’s ideas about sex and can result in feelings of sexual disappointment; and young people can often lack the confidence to access sexual health services. Results from studies such as this can inform policies and services how to focus on challenging risk-taking behaviour in an effort to affect social change to empower young people and raise their expectations of relationships.
A formal evaluation of peer education and theatre in education in Knowsley could also provide information to inform future decision-making on sexual health education provision.
7. Conclusion

The results of this study show that clinic staff and youth services are working together to provide quite comprehensive contraceptive services for young people in Knowsley. However, these services are limited in their days of operation, advertising, variety of contraception and STI advice and care. The young people sampled who accessed One Stop Shops are very satisfied with the services they currently receive however they are of the opinion that it would be beneficial for the clinics to provide advice and testing for sexually transmitted infections.

A c-card distribution scheme would provide more local services, and connected to schools, colleges, and youth services, would raise awareness of the services available to young people in Knowsley. This would increase access to condoms, which is what young people want and which protect against STIs and pregnancy.

Young people surveyed accessed only limited sources of sexual health information, and most people accessed clinics via word of mouth. Since some young people may be misinformed or may not discuss sex and relationships with their peers, services need to be advertised more clearly and young people need to be directed towards sexual health care services more effectively.

Those surveyed showed a lack of knowledge and understanding of sexually transmitted infections and their symptoms. However, young people’s ignorance could be tackled more effectively through schools, clinics, and youth and community services improving their joint working, alongside more comprehensive PSHE classes.

Peer education is an innovative approach to improving sexual health knowledge and there are a variety of different formats to use in either schools or youth services. As this is a relatively new approach it would be necessary to ensure that these teaching methods were evaluated in order to gauge effectiveness and to inform future service planning and delivery.
8. Recommendations

- One way of providing more local services would be via a c-card scheme. Knowsley could consider implementing a c-card distribution scheme, similar to those in operation in Leeds and Wirral. This service could be set up in conjunction with schools or youth and community services in order to improve joined up working. The main demand on young people’s clinics is for free condoms. Implementing a c-card distribution scheme could alleviate the pressure on services and allow more time for them to focus on other contraceptive services. It would also ensure that young people have more opportunity to access free condoms, have access to verbal and written sexual health information and have access to a service that aims to empower young people to make informed sexual health choices thus fewer reasons to take part in risky sexual behaviour (23). This service would also make it easier to monitor the demand for services in each area. If the scheme was set up, it could be evaluated using Neighbourhood Renewal Funding.

- Personal Social and Health Education (PSHE) classes in schools, including Catholic schools, ought to include comprehensive sex education, information on STIs and relationship negotiation skills for young people. They should aim to meet healthy schools targets and should work with parents to improve their communication skills and level of sexual health knowledge.

- Schools and youth services in Knowsley ought to consider implementing wide-spread peer education initiatives as part of a broad programme. Where these initiatives are implemented they should be evaluated accordingly.

- All young people’s clinics ought to have information available on long acting reversible contraceptives (LARC) such as intrauterine devices and systems (IUD/IUS). Clinics ought to encourage young people to consider LARC, clinics ought to supply LARC and staff ought to be trained to deliver this method of contraception.

- Clinics ought to provide more of a variety of barrier method contraception, such as different sizes and possibly different brands, e.g. Durex or Passante as opposed to just Condomania as well as femidoms. Clinics should also provide dental dams and lubricant.

- They should also consider providing flavoured condoms as an option on their own, separate from a mixture of condoms. This could save on wasted condoms for those young people only participating in oral sex.

- Clinic services, opening times, locations and age limits should be advertised more widely.

- Knowsley should apply to use Neighbourhood Renewal Funding to fund sexual health services and sexual health campaigns in the area with the aim of meeting the floor target of reducing the number of under-18 conceptions by 50% by 2010.

- When sexual health promotion campaigns, such as ‘Be a Rubber Lover’ have been implemented in the area, Knowsely PCT should consider funding an evaluation of the campaign in order to inform future decisions regarding sexual health promotion in the area.
Knowsley PCT should explore the internet as a method of promoting sexual health, particularly for young men. This should start with an assessment of currently available tools with a view to making them relevant for local young people and linking or advertising on web resources that are well used by local young people.

All clinics need to update their policy and guidance on the reporting of under age sex in accordance with any new government guidance.
Appendix 1.

Images of campaigns
### Appendix 2.

#### Teenage services in Knowsley

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Location</th>
</tr>
</thead>
</table>
| Monday & Thursday  | 3pm – 5.15pm | Kirkby Health Suite  
                        | Cherryfield Drive  
                        | Kirkby  
                        | L32 8UR  
                        | Tel: 0151 545 0170 |
| Tuesday            | 3pm – 5.15pm | Page Moss  
                        | One Stop Shop  
                        | Huyton  
                        | L14 9ND |
| Wednesday          | 3pm – 5pm  | Dr Health’s surgery  
                        | Leather’s Lane  
                        | Halewood  
                        | L26 1XG |
| Saturday           | 12 noon – 2pm | Manor Farm Medical Centre  
                        | Huyton  
                        | L36 0UB |
Appendix 3.

Focus group schedule

Topic areas for discussion in focus groups
Main headings are questions, the text underneath is used to prompt/probe.

How much do young people know about sexually transmitted infections?
Have you heard about chlamydia, gonorrhoea, syphilis, genital warts and herpes?
How are they transmitted?
Can you tell if someone has an STI?
How is HIV transmitted?
What is it like to live with HIV?

Where/how do young people find out about sexual health information?
T.V
Radio
School
Clinic
Family
Friends

What would encourage young people to take care of their sexual health?
More information on how to avoid infections?
More graphic representation of consequences?
More openness about sexual health in general?

The role of parents/carers in influencing decisions over sexual health
Can you talk to your parents? For those who can, what has encouraged this? For those who can’t, why?
What effect does this have on the way you feel?

How do young people find out about a clinic?
How important is word of mouth? What else might attract them?
How likely are young people to approach a GP?
To what extent do young people talk to each other about sexual health issues?

What are most important about the services a clinic might offer?
Contraceptions and infections dealt with in one place
Men and women can come at the same time
Choice to see a male or female doctor
Special sessions for young people
What do you like best? What would you change to make it better?
What are the main services you think should be available at a clinic?
STI testing
Emergency contraception
Contraceptive services

How should a clinic feel?
Comfy
Relaxed
Cheerful
Well equipped
Able to offer privacy

Where else/ how else would you like to receive sexual health care?
G.P.
GUM clinic
Clinic attached to a school/ youth service
Self-testing kits (for chlamydia etc.) from the pharmacy
Appendix 4  Questionnaires
Evaluation kit: sexual health services for young people
Questionnaire for Schools

The information you provide will help us give you and others the best service we can. It will take you about 15 minutes to fill in this questionnaire. We don’t need your name; the questionnaire is anonymous and we value your opinion whether you are sexually active at the moment or not. Please answer by ticking the boxes or writing in the space provided.

1  First some general information, to help us find out who is using the service:

a) Postcode (First part e.g. L32)

…………………………………………………………………………………………………………………………

b) Are you……

□ Male?  □ Female?

c) How old are you?

□ 14
□ 15
□ 16 - 17
□ 18 - 19

d) How would you describe yourself?

□ Black
□ White
□ Asian
□ Other (Please specify)

…………………………………………………………………………………………………………………………

3) Are you aware of local contraception clinics?

□ Yes  □ No

4) Have you ever been to a local contraception clinic?

□ Yes  □ No

If yes, when did you last visit?

…………………………………………………………………………………………………………………………

What service do you use now?
(e.g. Brook, GP, none etc)

…………………………………………………………………………………………………………………………
5) What would encourage you to use a clinic?
- [ ] more frequent service
- [ ] more local service
- [ ] less local service
- [ ] awareness of service
- [ ] other

6) Where do you think clinics should be?
- [ ] health building
- [ ] school
- [ ] college
- [ ] shop front
- [ ] mobile unit
- [ ] community setting e.g. sure start
- [ ] community centres
- [ ] youth centres
- [ ] other (specify)

7) How far would you be willing to travel to a clinic?
- [ ] Huyton
- [ ] Halewood
- [ ] Kirkby
- [ ] Liverpool
- [ ] St Helens
- [ ] Warrington

8) Who would you ask for help/advice from for sexual health/contraception issues?
- [ ] brother or sister
- [ ] friend
- [ ] GP/Practice Nurse
- [ ] Youth Worker
- [ ] Teacher
- [ ] Learning Mentor
- [ ] Connexions PA
- [ ] Parent

9) What is important to you in a mobile unit clinic?
- [ ] relaxed
- [ ] cheerful
- [ ] comfy
- [ ] well equipped
- [ ] able to offer privacy
10) What areas of advice/treatment do you think should be available in a clinic?

- [ ] Contraception
- [ ] Smear testing
- [ ] Routine check-ups
- [ ] Emergency contraception
- [ ] Pregnancy testing
- [ ] Help with personal relationships
- [ ] Advice about STIs
- [ ] Treatment of STIs
- [ ] Access to abortion
- [ ] On-site counselling
- [ ] Referral to counselling

11) Have you ever been to or contacted any of the following for sexual health advice?

- [ ] Teacher/school nurse
- [ ] Family planning clinic
- [ ] GP/Practice Nurse
- [ ] Pharmacy/chemist
- [ ] Youth/Brook advisory centre
- [ ] Sexwise helpline
- [ ] Contraceptive Education Service
- [ ] RUThinking website
- [ ] NHS Direct phone line
- [ ] NHS website
- [ ] NHS walk in centre

12) Please say what you feel about these features of the clinic service.

<table>
<thead>
<tr>
<th>Feature of Clinic Service</th>
<th>A plus point</th>
<th>A minus point</th>
<th>Doesn't matter</th>
</tr>
</thead>
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<tr>
<td>a) Both contraception and infections are dealt with in one place.</td>
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</tr>
<tr>
<td>d) Having the choice to see a man or a woman doctor.</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

13) What other features are important in a contraception clinic?

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--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------
14) Have you heard of any of the following sexually transmitted infections?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genital Herpes</td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
</tr>
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</tr>
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<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
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</tbody>
</table>

15) Which of the following statements about sexually transmitted infections are true or false?

<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>False</th>
<th>Don’t Know</th>
</tr>
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<td>Chlamydia can be treated using antibiotics</td>
<td></td>
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16) Have you heard of the emergency contraceptive pill? (also known as the morning after pill)  
☐ Yes  ☐ No

17) Are you aware that you can get the emergency contraceptive pill free from some pharmacies?  
☐ Yes  ☐ No

18) Would you use this service? (This service is free and confidential and available to under 16’s)  
☐ Yes  ☐ No

Thank you.
The information you provide will help us give you and others the best service we can. It will take you about 15 minutes to fill in this questionnaire. We don't need your name; the questionnaire is anonymous and we value your opinion whether you are sexually active at the moment or not. Please answer by ticking the boxes or writing in the space provided.

1 First some general information, to help us find out who is using the service:

a) Postcode (First part e.g. L32)

b) Are you……

[ ] Male? [ ] Female?

c) How old are you?

[ ] 16
[ ] 17
[ ] 18 - 19

D) Are you….

[ ] working full-time?
[ ] working part-time?
[ ] unemployed?
[ ] at school or college?
[ ] at university?
[ ] in training or work scheme?

2) Have you ever had sexual intercourse?

[ ] Yes [ ] No

if yes, what age were you when you first had sexual intercourse?

[ ] years [ ] months

3) Did you first visit a sexual health clinic

[ ] before then? [ ] after then?

How long before or after?

[ ] years [ ] months
4) Are you aware of local contraception clinics?

☐ Yes  ☐ No

5) Have you ever been to a local contraception clinic?

☐ Yes  ☐ No

If yes, when did you last visit?

………………………………………………

What service do you use now?
(e.g. Brook, GP, none etc)

………………………………………………

6) What would encourage you to use a clinic?

☐ more frequent service  ☐ more local service  ☐ less local service

☐ awareness of service  ☐ other (specify)

………………………………………………

7) Where do you think clinics should be?

☐ health building  ☐ school  ☐ college

☐ shop front  ☐ mobile unit

☐ community setting e.g. sure start  ☐ community centres

☐ youth centres  ☐ other (specify)

………………………………………………

8) How far would you be able to travel to a clinic?

☐ Huyton  ☐ Halewood  ☐ Kirkby

☐ Liverpool  ☐ St Helens  ☐ Warrington

9) Who would you ask for help/advice from for sexual health/contraception issues?

☐ brother or sister  ☐ friend

☐ GP/ Practice Nurse  ☐ Youth Worker

☐ Teacher  ☐ Learning Mentor

☐ Connexions PA  ☐ Parent

………………………………………………

10) What is important to you in a clinic?

☐ relaxed  ☐ cheerful  ☐ comfy

☐ well equipped  ☐ able to offer privacy
11) what areas of advice/treatment do you think should be available in a clinic?

- [ ] contraception
- [ ] smear testing
- [ ] routine check-ups
- [ ] emergency contraception
- [ ] pregnancy testing
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- [ ] RUThinking website
- [ ] NHS Direct phone line
- [ ] NHS website
- [ ] NHS walk in centre

13) Please say what you feel about these features of the clinic service.

- A plus point
- A minus point
- Doesn't matter

a) Both contraception and infections are dealt with in one place.

b) Men and women can come here at the same time.

c) There are special sessions for young people.

d) Having the choice to see a man or a woman doctor.

14) What other features are important in a contraception clinic?

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Yes [ ]
No [ ]

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Yes [ ]
No [ ]

19) Would you use this service?
(This service is free and confidential and available to under 16’s)

Yes [ ]
No [ ]

Thank you.
questionnaire for service users

The information you provide will help us give you and others the best service we can. It will take you about 15 minutes to fill in this questionnaire. We don’t need your name; the questionnaire is anonymous. Please answer by ticking the boxes or writing in the spaces provided.

about you

1 First, some general information, to help us find out who is using the service:

a) Postcode (Do not give your full address.)

b) Are you ...
   ☐ male? ☐ female?

c) How old are you?
   ☐ 14 or under
   ☐ 15–16
   ☐ 17–19
   ☐ 20 or over

d) Are you ...
   ☐ working full time?
   ☐ working part time?
   ☐ unemployed?
   ☐ at school or college?
   ☐ at university?
   ☐ in a training or work scheme?

e) Are you ...
   ☐ in a steady relationship?
   ☐ in a more casual relationship?
   ☐ not in a relationship?
   ☐ other? (Please specify.)

f) How would you describe yourself?
   ☐ Black
   ☐ White
   ☐ Asian
   ☐ Other (Please specify.)

 g) Are you mainly sexually attracted to ...
   ☐ men?
   ☐ women?
   ☐ men and women?

2 Have you ever had sexual intercourse?
   ☐ Yes ☐ No

If yes, what age were you when you first had sexual intercourse?
   _______ years _______ months

3 Did you first visit a sexual health clinic ...
   ☐ before then?
   ☐ after then?

How long before or after?
   _______ years _______ months
4  Is this your first visit to this clinic?
   ☐ Yes       ☐ No

   If no, when was the last time you came?
   ☐ Under a month ago
   ☐ 1–3 months ago
   ☐ 3–6 months ago
   ☐ 6 months to 1 year ago
   ☐ More than 1 year ago

5  Have you ever been to any other clinics like this one?
   ☐ Yes       ☐ No

   If yes, why did you change to this one?

6  Did you find it easy to attend at the time you came here today?
   ☐ Yes       ☐ No

   a) What time of day is best for you?

   b) Which days of the week are best for you?

7a) How long did you have to wait for an appointment?
   ☐ Less than a day
   ☐ A few days
   ☐ A week or more
   ☐ No appointment needed

   b) How long did you have to wait today before you were seen by the doctor or nurse?
   ☐ Under 5 minutes
   ☐ 5–10 minutes
   ☐ 10–30 minutes
   ☐ More than 30 minutes

8  How did you get to the clinic today?
   ☐ Own transport (or a lift)
   ☐ Public transport

   ☐ Walked
   ☐ Other (Please specify.)

9  How long did it take you to get here today?
   ☐ Under 15 minutes
   ☐ 15 minutes to half an hour
   ☐ Half an hour to an hour
   ☐ More than an hour

10 Is this the nearest clinic to where you live?
    ☐ Yes       ☐ No       ☐ Don't know

11 How did you find out about the clinic? (Please tick all the ways you found out.)
   ☐ Brother or sister
   ☐ Advert in a public place
   ☐ Friend
   ☐ Doctor's surgery or other clinic
   ☐ Newspaper
   ☐ School or college
   ☐ Other (Please write in how else you found out about the service.)

12 How did the clinic feel to you? Was it ...
   (Tick one box along each line.)

   relaxed?  Very  Quite  Not at all
   cheerful?  ☐  ☐  ☐
   comfy?    ☐  ☐  ☐
   well equipped?  ☐  ☐  ☐
   able to offer privacy?  ☐  ☐  ☐

13 In general, would you say that today the staff at reception were ...
   (Tick one box along each line.)

   friendly?  Very  Mostly  Not at all
   helpful?  ☐  ☐  ☐
   welcoming?  ☐  ☐  ☐
   approachable?  ☐  ☐  ☐
   discreet?  ☐  ☐  ☐
   to be trusted with private information?  ☐  ☐  ☐
14 In general, would you say that today the doctors and nurses were ...
(Tick one box along each line)

<table>
<thead>
<tr>
<th>friendly?</th>
<th>Very</th>
<th>Mostly</th>
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</tr>
<tr>
<td>to be trusted with private information?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15 What did you come to this clinic for today?

16 What other advice were you offered apart from what you came about?
(Tick any number of boxes.)
- Contraception advice or services
- Smear test
- Routine check-up
- Emergency contraception
- Pregnancy test
- Help with personal relationships
- Advice about sexually transmitted infections
- Abortion
- Other (Please specify)

17 Were you referred to any other services?
- Yes 
- No
(Please specify.)

18 What about information?

a) Did you get all the advice and information you wanted?
- Yes
- Mostly
- No

b) Was it easy to ask questions?
- Yes
- Mostly
- No

c) Were the answers clear?
- Yes
- Mostly
- No

19 If you were given contraceptive advice or supplies today, did you talk about ...

<table>
<thead>
<tr>
<th>choice of method?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>how effective they are?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>any side-effects?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>how to use them?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

about the service the clinic offers

20 Please say what you feel about these features of the clinic service:

<table>
<thead>
<tr>
<th>A plus point</th>
<th>A minus point</th>
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</tr>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

21 What did you like best about the service?

22 Is there anything you would change?
- Yes
- No
If yes, please say what.

Please post your form in the box provided.

thank you!
questionnaire for
Service Providers

1 Are you located...
in a hospital? □
in the community? □
elsewhere? (Please specify.) .............................................

2 Do you advertise your service...
in local papers? Yes □ No □
through letters sent in the post? □ □
in schools and colleges? □ □
in shops? □ □
in GP’s surgeries? □ □
in pubs and clubs? □ □
in radio/TV? □ □
other? (Please specify.) .............................................

3 In your advertising, do you include information on ....
the location of the clinic? Yes □ No □
how to get to the clinic? □ □
the services available? □ □
number and times of sessions? □ □
helpline number? □ □
appointment system? □ □
information on other services? □ □
other? (Please specify.) .............................................

4 Do you provide information leaflets in any language other than English?
Yes □ No □

5 How many sexual health sessions are held per week?
............................................................................................

6 Is your service... drop-in? □ □
appointment only? □ □
both? □ □

7 On average, how long do people have to wait for an appointment?
less than a day □ □
a few days □ □
a week or more □ □
no appointment needed □ □

8 What is the average length of consultation?
under 5 minutes □ □
5-10 minutes □ □
10-30 minutes □ □
more than 30 minutes □ □

9 Do you have facilities for...
parking cars? □ □
locking bikes? □ □
storage pushchairs? □ □
children to play? □ □
clients' companions? □ □
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Does your building have access for wheelchair users?</td>
<td></td>
<td></td>
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<tr>
<td>11 Do you provide any information out of hours?</td>
<td></td>
<td></td>
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<tr>
<td>12 Do you provide any outreach work?</td>
<td></td>
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<tr>
<td>13 Are clients called in from the waiting room using……</td>
<td></td>
<td></td>
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<tr>
<td>their first name?</td>
<td></td>
<td></td>
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<tr>
<td>their surname?</td>
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<td></td>
</tr>
<tr>
<td>a number?</td>
<td></td>
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<tr>
<td>other? (Please specify)</td>
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<tr>
<td>14 Which of the following services do you provide?</td>
<td></td>
<td></td>
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<tr>
<td>Pregnancy tests</td>
<td></td>
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<tr>
<td>Cervical smears</td>
<td></td>
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<tr>
<td>STI screening</td>
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<td></td>
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<tr>
<td>STI treatment</td>
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<tr>
<td>IUCD fitting</td>
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<tr>
<td>Postcoital contraception</td>
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<tr>
<td>Oral contraception</td>
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<tr>
<td>Injectable contraception</td>
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<tr>
<td>Condoms</td>
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<tr>
<td>Counselling</td>
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<tr>
<td>Contact tracing</td>
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<tr>
<td>24-hour helpline</td>
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<tr>
<td>Other (Please specify.)</td>
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<tr>
<td>15 Do you provide information on…</td>
<td></td>
<td></td>
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<tr>
<td>the full range of contraceptives?</td>
<td></td>
<td></td>
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<tr>
<td>the effectiveness of each method?</td>
<td></td>
<td></td>
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<tr>
<td>the side-effectss of each method?</td>
<td></td>
<td></td>
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<tr>
<td>how to use each method?</td>
<td></td>
<td></td>
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<tr>
<td>16 Are clients informed that their visit is confidential?</td>
<td></td>
<td></td>
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<tr>
<td>17 Do you ever refer clients to other services?</td>
<td></td>
<td></td>
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<tr>
<td>(If yes, please specify.)</td>
<td></td>
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<tr>
<td>18 After a client’s initial visit, is a follow-up appointment arranged?</td>
<td></td>
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<tr>
<td>19 Who is employed here?</td>
<td></td>
<td></td>
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<tr>
<td>Doctors</td>
<td></td>
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<tr>
<td>Nurses</td>
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<tr>
<td>Health Advisors</td>
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<tr>
<td>Counsellors</td>
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<tr>
<td>Receptionists</td>
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<tr>
<td>Other (Please specify)</td>
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<tr>
<td>20 What type of training courses are available to clinic staff?</td>
<td></td>
<td></td>
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<tr>
<td>Contraception</td>
<td></td>
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<tr>
<td>Counselling</td>
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<tr>
<td>Communication skills</td>
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<tr>
<td>Working with young people</td>
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<tr>
<td>Computer skills</td>
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<tr>
<td>Presentation skills</td>
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<tr>
<td>Other (Please specify.)</td>
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<tr>
<td>21 Do you have a protocol on…</td>
<td></td>
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<tr>
<td>equal opportunities for staff?</td>
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<tr>
<td>advice relating to client confidentiality?</td>
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<tr>
<td>advice on legal issues relating to sexually active under-16s?</td>
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</tr>
</tbody>
</table>
References


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   Accessed 2nd November 2005


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