Sexual Health Needs Assessment Refresher

Carried out on behalf of NHS Cambridgeshire

May 2009

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Introduction

DHIVERSE has delivered sexual health outreach services within Cambridgeshire since 1986. The last decade has seen an expansion and intensification of services delivered outside Cambridge City, with the addition of an office Huntingdon in 2003 and the extension of targeted services to East Cambridgeshire and Fenland from 2006.

We recognise the need to research the specific sexual health requirements of communities within Cambridgeshire and their particular experiences of local sexual health services, in addition to keeping abreast of national trends. Cambridgeshire exhibits considerable economic and social diversity, from regions which have seen high levels of economic growth and wealth to regions which show high levels of social inequality and deprivation, both precursors of poorer health outcomes (see the final report from the WHO Commission on the Social Determinants of Health for an overview at www.who.int/social_determinants/thecommission/finalreport/en/index.html). It is particularly important, therefore, that the sexual health needs of groups hard to reach by standardised methods are monitored and integrated into a continuing sexual health strategy.

As part of this process DHIVERSE conducted five focus groups during March and April 2009 on behalf of NHS Cambridgeshire.

Structure and Organisation of Focus Groups

In previous years we have carried out focus group research for NHS Cambridgeshire with the primary target groups for HIV infection, i.e. gay and bisexual men and African communities. For the refresher exercise we turned to predominantly younger people and migrant worker communities in order to capture feedback from groups that may face specific and multiple forms of discrimination and exclusion from mainstream services. By this means we sought to expand the diversity of feedback informing the development of future services.

We used the questionnaire framework from previous years' research to enable comparison with these earlier focus group responses. The only changes were the inclusion of specific reference to Chlamydia screening, the C-Card scheme and LARCs.

Each focus group was facilitated by a staff member or trained volunteer from DHIVERSE, with the kind support of staff and volunteers from the services involved. Participants were made aware that the focus groups were entirely confidential and that no information which might reveal the identity or views of

individual participants would be disclosed. Participants were offered the opportunity to reclaim any travel expenses incurred and groups were offered reimbursement for refreshments provided.

Demographics

The total number taking part in all five focus groups was 34.

The following tables show the combined and disaggregated demographic profile data.

Aggregated data

Age	Gender	Ethnicity	Occupation
14 – 45	Male: 10 Female: 24	▪ White UK: 7 ▪ White European: 8 ▪ English (no racial or ethnic origin specified): 5 ▪ US (no racial or ethnic origin specified): 1 ▪ Not specified: 14	▪ Administrator: 2 ▪ Agency worker: 1 ▪ Biologist: 1 ▪ Consultant: 1 ▪ Healthcare assistant: 1 ▪ Parent (full-time): 5 ▪ Photographer: 1 ▪ Project worker: 2 ▪ Retail worker: 2 ▪ Student: 9 ▪ Teacher: 1 ▪ Didn't say: 11 NB three people had two occupations.

Disaggregated data

Community Group	Age	Gender	Ethnicity	Occupation
Eastern European migrants, Rosmini Centre	24 – 32	Male: 2 Female: 6	White European	▪ Administrator: 1 ▪ Agency worker: 1 ▪ Biologist: 1 ▪ Healthcare assistant: 1 ▪ Parent (full-time): 2 ▪ Project worker: 1 ▪ Didn't say: 2

				NB one person had two occupations.
2BYou, LGBT youth group, Cambridge-based	17 – 23 NB one person didn't give their age	Male: 3 Female: 5	English: 5 USA: 1	▪ Administrator: 1 ▪ Student: 5 NB two people didn't give their occupation
Ripton Court, Huntingdon, housing project for homeless people aged 16 – 35	17 – 21	Male: 5 Female: 2	White UK: 7	No information on occupations given
Field's Children's Centre, Cambridge	25 – 45	Male: 0 Female: 7	No ethnicity data given	▪ Consultant: 1 ▪ Parent (full-time): 3 ▪ Photographer: 1 ▪ Project worker: 1 ▪ Retail worker: 2 ▪ Teacher: 1 NB two people had two occupations.
Huntingdon Youth Centre	14 – 18	Male: 0 Female: 4	No ethnicity data given	▪ Student: 4

Data and Analysis

The questions used for each session fell into three broad headings:

- Knowledge and understanding of sexual health services
- Rating of services accessed
- Awareness and impact of publicity resources.

The full questionnaire framework can be found at Appendix 1.

Knowledge and understanding of sexual health services

When asked about the services available from sexual health clinics, all groups mentioned:

- Provision of information
- Testing and screening for specific STIs
- Treatment of STIs.

The groups for young people also discussed access to free condoms and sexual health supplies for STI prevention, as well as contraceptive advice and pregnancy testing, through clinical, school-based and voluntary sector services. A small number knew about LARCs when prompted, citing the contraceptive pill for women as the only example; only one young woman volunteered the information that she had used the contraceptive injection.

The groups with older people mentioned the role of services, particularly GP-based services, in referring on to other health professionals for more complicated needs ('bigger problems').

Hepatitis, HIV and Chlamydia were the only specific STIs mentioned. Most of the young people knew about the Chlamydia screening programme; one group of older women was aware of the availability of cervical cancer screening ('smear tests'). None mentioned PEPSE. One of the three groups of young people knew of the C-Card scheme, one had no knowledge of it but expressed interest in establishing it at their project and the third made no mention of it. It is possible that the association of the scheme with pregnancy reduction makes it of no consequence to LGBT individuals. As one young man noted, 'I don't need any contraception; my boyfriend can't get pregnant.'

With the exception of the Polish group, participants were largely aware of the location and purpose of GUM clinics in their locality. The Polish group was more focused on services around family planning, which they accessed through GP surgeries. Midwives were another source of contraceptive advice cited, though it was felt that information provided in appropriate languages might help prevent some unplanned pregnancies.

Some groups stressed the importance of voluntary and community sector organisations in finding out about sexual health issues and onward referral to clinical services when needed, as well as signposting to other community-based support services for non-clinical needs.

Rating and evaluation of services

Overall there was a contrast between the younger people, who were well informed about the services of local GUM clinics and said that they would feel comfortable about approaching them, albeit with support from the voluntary sector, and those over 25 or from Eastern Europe. The latter, though aware of issues around sexual health, focused rather on access to contraception,

ante- and post-natal care, as well as early years child care, through general health services.

There was a general emphasis on the importance of friendly, non-judgmental behaviour by service staff from all sectors. Positive examples included that of Centre 33, where it was felt by one group that a lot of effort was put into making service users feel comfortable; and of a health visitor, who, realising that her client felt embarrassed at openly discussing sexual health issues, left her some leaflets to read at her leisure. The young woman felt able to speak to the health visitor the following week to talk through her concerns and deal with them appropriately.

By contrast, the majority of participants from the Polish community felt their health problems were often not taken seriously by their GP. Accounts were given of prescriptions issued without examination and long waiting times for test results. Five of the eight participants said that they went to friends and family for advice on health issues following these experiences. Difficulties faced by non-English speakers in communicating health needs was felt to be ignored. Since many from this community works shifts, it was felt that evening opening for GP surgeries would be helpful in facilitating access. The Polish community would also like to see greater interest in natural family planning, a service available in Poland and in keeping with their religious beliefs. They would also like to see more gynaecology services at GP surgeries as well as health checks for children. The community felt that more information in their own language would raise awareness of sexual health issues and services.

One group of young people found that health professionals often displayed negative assumptions about their sexual behaviour and sexual health needs. One young person from this group noted that a nurse had recommended a course of antibiotics after a sexual health test had proved negative 'just in case.' No further explanation was offered, prompting the young person to note, 'my results were clear so what was that, "just in case" for?' Another related that waiting times for appointments were too long, increasing anxiety that, 'everyone knows what you're there for, giving you dirty looks.'

The importance of accurate information relating to the limitations of contraceptive and other interventions was raised. No information was given, for instance, recommending the use of condoms alongside LARCs to prevent contraction of STIs. One young woman also recounted that she had become pregnant while on the contraceptive injection and thought that she would have benefited from knowing that this method isn't 100% effective.

The LGBT youth group participants expressed a lack of comfort in accessing clinical services. They related experiences of heterosexism, even when the health professional's approach otherwise puts them at ease. The general response to disclosures of being sexually active is to offer contraceptive advice, which is clearly not a concern for this group. The preferred approach is for health professionals to make no assumptions and ask open questions, enabling the person to discuss any concerns freely without needing to take the first step of 'outing' him- or her-self to a possibly homophobic clinician.

One young woman related two overtly homophobic incidents when a nurse at a GUM clinic refused her STI tests. The nurse told her that, as a lesbian, she couldn't have contracted any STIs. When she presented for a second time to request the tests, she was given all but an HIV test. This time she was told that, 'we don't get many of your sort in here.' The young woman noted that this might put off some gay or lesbian people from using the service. During discussion it was noted that, 'there are assumptions that lesbians don't get STIs and gay men get them all the time' and that homophobia isn't challenged during doctors' training. [NB thanks to the involvement of DHIVERSE in advocating with a client of an extended period, awareness of homophobia is included in the regular training of all clinical staff at a major hospital in Cambridgeshire.]

Opinion was divided on providing separate sexual health services for LGBT and younger people and on processes for disclosing sexual orientation, through face-to-face, non-judgmental conversation or by filling in a form beforehand.

The majority of the participants in all focus groups felt that accessing a service in their own locality was helpful. Some appreciated the familiarity of the staff whom they met at their local services. Other, however, noted that they feared meeting someone they knew there, both among the other service users and staff. The approach taken to Chlamydia screening at ARU was praised: because all are encouraged to test, it was felt that the stigma of doing so was broken down. Some young people expressed greater comfort in Chlamydia and pregnancy testing at school.

Although most participants felt fairly well informed on local GUM and family planning services, participants felt that there could be better signposting from GP practices and places of education or employment, emphasising the importance of 'multiple routes' to specialist services from a variety of starting points.

Publicity

Participants generally felt that there was, 'a lot of sexual health information out there,' but there were sometimes failures in language or tone, or that assumptions were made about the groups addressed.

It was felt that leaflets and fliers tend to be strong on information about infections, symptoms and treatments but generally poor on directing people to local services. The C-Card scheme was named as an exception.

Participants showed a keen awareness of the importance of language and presentation in delivering sexual health messages. Some felt that the language used was too complicated to convey information clearly and the cartoon style of some publicity was patronising. There was a general agreement that the bulk of sexual health information was targeted at young

people. Participants from the Polish community wanted to see more information in their own language and the young lesbian and gay people wanted more publicity directed to their specific needs and without characterising them as either at high risk or none solely because of their sexual orientation.

Much of the high profile advertising was felt to convey the wrong message. The national TV campaign showing underwear with the names of STIs on them, for example, was not felt to have had the right impact. Rather, it was felt that these ads suggested that it was fashionable to have, say, Chlamydia. Photographic images of what different infections looked like might have a more salutary effect.

One group believed it was the role of the NHS and schools to take ultimate responsibility for teaching young people, from primary school onwards, about sex and sexual health. The role of parents was to reinforce and not lead in this regard. Youth services, such as Connexions and the voluntary sector were also mentioned as playing a key role. Promoting messages in places where young people are most likely to go, including the rear seats on buses, was felt to be important.

Recommendations

When asked what improvements might be made to facilitate access to services, participants mentioned:

- Maintaining a friendly, non-judgmental environment
- Better signposting through voluntary sector, GP surgeries and educational institutions
- Making sure that information was available in relevant languages
- Strengthening the link between family planning and sexual health services
- Evening opening hours for GP practices.

More resources were called for to strengthen the referral pathways which already link diverse aspects of the statutory sector (e.g. GP surgeries, GUM and family planning clinics) and to extend and develop links with the voluntary sector, community health and educational settings.

Greater emphasis on up-to-date information about local services was called for in publicity media.

Attempts should be made to avoid heterosexist assumptions when communicating with service users and in promotional literature, with more research on the sexual health needs of women who identify as lesbian.

More generally, health practitioners should avoid the assumption that certain individuals will present a specific series of sexual health needs simply by belonging to a particular group. More training in diversity and equality issues

as they apply to clinical settings would be of value here and effective feedback and consultation mechanisms to measure performance and improvement against these indicators. Where good practice exists, straightforward and transparent mechanisms to make this known among different communities would generate greater confidence in accessing services for these groups.

As communication is particularly crucial in sexual health where 'taking the first step' to access services can easily be inhibited, it is important to identify and break down language barriers and to provide at least basic sexual health promotional materials in appropriate and non-English languages.

Postscript

DHIVERSE has planned follow-up work with a number of the groups visited with delivery to begin in condom week (May 18 – 25). Follow-up work with the remaining groups is scheduled for the coming weeks.

Funds are being sought to expand the focus group needs assessment among other key groups and geographical areas not reached during this phase. A number of groups showed interest in holding a focus group but could not facilitate this during the time allocated. We remain in touch with these groups and will prioritise them once the necessary funds are granted.

Key recommendations, particularly on the efficacy of publicity material, will form the basis for further funding bids in order to meet the needs expressed in each location.

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Huntingdon Youth Centre
Rosmini Centre, Wisbech
2BYou, Cambridge
Fields Children's Centre, Cambridge.

Julie Cartwright-Finch
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Appendix 1

Questions and prompts used in the focus groups.

- Introduction to the aims of the focus group covering the main questions of the research and confidentiality of the research.

- Include emphasis on how people feel services/other can encourage/support uptake of condom use. (Participants in a previous focus group felt it necessary to stress prevention rather than just treatment).

- Ideas about how participants think messages around safe sex could be communicated are also of interest to the PCT.

Knowledge and understanding of service provision

1. What do you consider the role of sexual health services (that is, clinical services) to be?
    a. What would you expect to receive in terms of service?
    b. Would you feel comfortable using any sexual health services?
    c. Would you feel comfortable using sexual health services in your area?

2. Would you know where to find sexual health services?
    a. Who provides these services in your area?
    b. How did you find out about them?

3. Have you ever used any sexual health promotion services (that is, preventative, information services, proactive rather than reactive)?
    a. If so, why? Can you say what made you choose that service in preference to another?
    b. If not, why not, any specific reasons?
    c. What discourages you from going?
    d. What might make you more likely to attend?
    e. Would you go for a check up or only if something was wrong?

Service rating

[For both clinical and promotion services. Focus group leader/note taker: please be careful to distinguish between the two sets of answers.]

4. Overall, what were your impressions of the service that you received?
    a. What perceptions did you have of the kind of service you might receive? Were these correct?
    b. What experiences/stories informed your view?

c. How would you rate the service you experienced – very good/good/uncertain/poor/very poor?

5. What did you find good/bad about the service you received?
    a. Did you receive the support that you felt you required?
    b. What were the staff like towards you? What might they have done differently?
    c. Do you think they could have done anything further?

6. Did you understand all that was said to you?
    a. What did you find difficult to understand, e.g. treatment, diagnosis, resources?
    b. Were you asked if you fully understood?
    c. What might have made it easier to understand?
    d. Were you asked any questions that you found inappropriate?
    e. Do you feel that any concerns you might have had were listened to?

7. Have you changed in any way decisions about your health based on your experience of these services?

8. Are there any services that you would like but that you cannot find or are unavailable to you?
    a. What services?
    b. Where might they be best provided for you to use them?

Publicity materials

9. Have you ever picked up or been given any written information about sexual health?
    a. What information have you read or been provided with?
    b. Did you fully understand the information?
    c. Did it provide you with the information you required?
    d. Did you find the format helpful?
    e. If not, how could it be made more suitable?

10. Have you seen any campaign materials promoting sexual health or promoting safer sex?
    a. Where did you see them?
    b. Did they use the right imagery for you?
    c. Was the message clear from the poster?
    d. What do you think of the materials we have here?
    e. Do they use the right imagery?
    f. Do they use the right language?

11. Have any resources or campaigns made you stop to think about your actions or behaviour?
    a. Have any resources or campaigns made you change your behaviour?