

LONDON
SCHOOL of
HYGIENE
& TROPICAL
MEDICINE



LSHTM Research Online

Kane, R; (2005) Providing sexual health services in England: meeting the needs of young people. PhD thesis, London School of Hygiene & Tropical Medicine. DOI: <https://doi.org/10.17037/PUBS.04652251>

Downloaded from: <https://researchonline.lshtm.ac.uk/id/eprint/4652251/>

DOI: <https://doi.org/10.17037/PUBS.04652251>

Usage Guidelines:

Please refer to usage guidelines at <https://researchonline.lshtm.ac.uk/policies.html> or alternatively contact researchonline@lshtm.ac.uk.

Available under license: <http://creativecommons.org/licenses/by-nc-nd/2.5/>

<https://researchonline.lshtm.ac.uk>

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.0 BACKGROUND TO THE STUDY

1.1 The policy context

1.1.1 Recent developments in sexual health service provision

The sexual and reproductive health of young people has been of concern to health professionals, policy makers and politicians in this country for some decades. Successive UK Governments have tried to address the issues of teenage pregnancy and sexual health, which have assumed a higher priority on the political agenda in recent years.

In 1992 the Conservative Government produced the Health of the Nation Strategy (HotN), for England and Wales¹, the first attempt by the government to provide a strategic approach to improving the overall health of the population^{1 2}. Sexual health was a HotN priority. Targets and objectives were set in the areas of sexually transmitted infections and under 16 conceptions, and were highlighted as key areas for priority action¹.

At the same time, awareness was increasing regarding the delivery of services. The NHS Management Executive guidelines for reviewing contraceptive services,³ emphasised the need for an appropriate balance between services provided by GPs and those provided by family planning clinics. Young people were identified as a group with relatively poor uptake of contraceptive services and their need for separate, less formal family planning arrangements was emphasised.

In 1999 the Labour Government, through its Social Exclusion Unit, produced a comprehensive action plan⁴. This has a new target to halve the rate of under 18 conceptions by 2010. The document contains considerable discussion about the possible reasons for the high rates. Unlike previous government publications it acknowledges the link with poverty. The report, which laid the foundations for the Teenage Pregnancy Strategy, also described the need for new NHS criteria for effective and accessible young people's contraception and advice services⁴. The importance of appropriate service delivery for young people, and the improved co-ordination between different aspects of sexual health care, were re-iterated in the National Strategy for Sexual Health and HIV, published in 2002⁵. More recently in 2004, the publication of 'Choosing Health', the new White Paper in Public Health, reinforced the need for the review and transformation of sexual health services⁶.

¹ The HotN document identified prevention of pregnancy in teenagers under 16 as a priority and set a target of reducing the rate from 9.6 per 1000 in 1989 to 4.8 per 1000 by 1999.

1.1.2 Provision of young² peoples' services

Until relatively recently, young people have been regarded as infrequent users of health services^{7 8 9} and less of a priority than older people in terms of health service delivery. However, attention to their needs has increased with current concerns for their sexual health¹⁰, in particular, high rates of teenage pregnancy⁴, a marked rise in STI incidence among 16-19 year olds^{11 12 13} and low levels of awareness about STIs.^{14 15 16}

The problem does not seem to be related to the number of services available. The 1990s witnessed a proliferation in sexual health services for young people¹⁷. According to one estimate, 85 per cent of Health Authorities set up young people's sexual health services as a direct result of the Health of the Nation¹⁸ and more recently the Teenage Pregnancy Strategy has provided further impetus to this trend¹⁹. A recent audit of contraceptive services showed that nearly a quarter of current contraceptive services had been developed since the Teenage Pregnancy Strategy (i.e. since 1999) and many of these are specifically dedicated to young people²⁰.

The problem seems to be one of under-use of existing services by young people^{21 22}. Several reports indicate dissatisfaction with current service provision^{23 24 25}. A growing body of research identifies obstacles faced by young people in their quest for sexual health advice and treatment¹⁰. These studies have prompted health professionals to think more deeply about how to provide services for young people^{26 27 28 29}. Policy discussions on how young people's sexual health needs might best be met have focussed on aspects of service organisation, on whether STI and contraceptive services should be integrated rather than provided separately; whether young people are best seen in dedicated young people's or all age services; and whether these services should be located in community or more formally medicalised settings. The optimal configuration of services is still unresolved.

²Definitions of what constitutes a 'young person' vary widely. A cut off point at age 25 is made by some, 21 by others, while others focus on teenagers. Here young person's services are classified as those which hold sessions specifically for young people regardless of the age specification. Most services do not have a lower age limit.

1.2 Aims and Objectives

1.2.1 Aims

The main aim of this study is to investigate the relationship between the satisfaction of young service users and key organisational features of sexual health service provision.

The key research questions are:

- How does young people's satisfaction with sexual health services vary with the age-dedication of the service; that is, whether it serves young people only, or all ages?
- How does young people's satisfaction with sexual health services vary with the integration of the service; that is, whether family planning and genito-urinary services are offered separately, or together?
- How does young people's satisfaction with sexual health services vary with the location of the service; that is, in community or hospital based services?

1.2.2 Objectives

- To document the history of the development of sexual health and youth services in England; to describe the impetus to change in the organisation of service delivery seen in recent years; and to outline the main models of contemporary service delivery now emerging
- To conduct in-depth qualitative interviews with service users probing their views on aspects of service delivery to inform the design of the questionnaire
- To conduct a survey amongst users of sexual health services to investigate variations in levels of client satisfaction with organisational features of service delivery
- To develop recommendations for improving the delivery of sexual health services to young people based on these findings

1.2.3 Rationale for the research

Despite the attention focussed on the provision of sexual health services to young people, the optimal mode of service delivery, from the client's perspective, remains to be established.

Neither is there consensus as yet among health professionals on the best way forward³. Pleas have been made by academics and practitioners alike for rigorous evaluation of the relative merits of dedicated youth and all-age sexual health services.^{30 31} The need for data on what constitutes 'best practice' in service delivery is pressing, given the current move towards the expansion of services for young people. Service development needs to be evidence-based in order that services meet the needs of potential clients and resources are allocated appropriately.

The focus to date, as indicated above, has been on several aspects of service organisation: notably on whether young people are best seen in dedicated young people's or all-age services³², on whether STI and contraceptive services should be integrated rather than provided separately^{33 34 35 36 37} and where these services should optimally be located. However, because services have developed in a somewhat piecemeal fashion, and because evaluations have tended to focus on services in their entirety rather than on their characterising features, it has been difficult to isolate and assess the effects of specific organisational characteristics. What seems to be missing is a study of the effects, not of specific individual services, but of the key organisational features that characterise them, and the effect of these features on client satisfaction. The key organisational features under investigation here are the degree of **dedication**, i.e. whether or not the service serves only the young, or people of all ages; **integration**, that is, whether contraception and infection control are combined in one service or provided separately and **location**, that is whether services are based in hospitals or in the community.

Services combine more than one of these characteristics, and this presents difficulties for evaluation in terms of attribution of effect³⁸. There is a lack of information on the relative effectiveness of different models of sexual health service provision for young people^{30 39 40}. Evaluations carried out to date have most commonly focussed on single services, using different methodologies. An important role for this study will be to focus on several services, using a common methodology, in order to assess which features of service organisation (ie. **integration, age-dedication** and **location**) appear to be linked with satisfaction with key components of quality of care. This study aims to help provide answers to the research questions identified above to inform future policy and service development.

³ Preparatory research for this study involved a round of qualitative interviews with service providers which resulted in the following two publications, included at Appendix 1:
Kane R & Wellings K. Integrating sexual health services: The views of medical professionals. *Culture Health and Sexuality* **1999** vol 1 (2) 131-145
Kane R, Wellings K. Staff Training in Integrated Sexual Health Services. *Sexually Transmitted Infections*. Editorial. **2003** vol 79(5) 354-6

1.3 Overview

Qualitative and quantitative research methods are used to investigate variations in client satisfaction with characteristics of the service and of the user⁴. The two main components of the study are:

- In-depth interviews exploring the views of young people accessing these services
- A user-satisfaction survey among young people attending sexual health services representing the various models of service delivery

The methodology is discussed more fully in Chapter 3.

⁴ The focus of this work is on satisfaction among users of services with different organisational features. The participants are therefore those currently attending a service.

CHAPTER 2: LITERATURE REVIEW (5928 words)

Since the aim of this research is to explore the influence of organisational features of sexual health service delivery on young people's satisfaction, two important tasks for the literature search are, firstly, to examine the relative merits of different configurative modes as currently documented, and secondly, to carry out a review of what qualities might ideally characterise a young people's services, from a lay and professional standpoint.

2.1 Aspects of service configuration

2.1.1 Dedication: Separate services for young people, or all age services?

Teenagers are often regarded as healthy people who have only minor illnesses and who are therefore infrequent users of services.^{7 8 9} However, within almost all countries there is a growing concern about the sexual and reproductive health of adolescents⁴¹ and their needs have recently received increased attention.^{42 43 44}

The sexual health of adolescents in the UK has been reported to be amongst the worst in Europe⁴⁵. The continuing concern over high rates of teenage pregnancy^{4 46}, a marked rise in the incidence of STIs among 16-19 year olds in recent years^{11 12 13} and the low levels of awareness about STIs, even among young people attending GUM^{14 15 16} and family planning clinics⁴⁷, have highlighted the need for better sexual health services for teenagers⁴².

In 1992 the NHS Management Executive published guidelines for reviewing family planning services. Young people were identified as a group with relatively poor uptake of contraceptive services and the need for separate, less formal family planning arrangements for teenagers was identified³. A year later, in 1993, the health of adolescents was highlighted as being particularly important in the Chief Medical Officer's report which argued that more health services and education should be targeted specifically at teenagers. More recently, the Teenage Pregnancy Strategy and the National Sexual Health and HIV Strategy have set further standards for young people's sexual health services.

A growing body of research identifies obstacles faced by young people in their quest for health advice and treatment.^{24 42} Many barriers have been identified through research with young people (and are described more fully below). Perhaps the most frequently cited barrier to accessing care is fear of a breach in confidentiality^{48 31}. According to one study, 25-50 percent of teenagers still believe that doctors are obliged to tell parents about requests for contraception⁴⁹. Other myths about accessing general practice persist among young people. A recent survey showed 54 per cent of 13-15 year olds believed patients had to be over 16 in order to access sexual health services⁴⁸.

These findings have led health professionals to think more deeply about how to provide more user friendly services for teenagers⁴². Service providers have been urged to be aware of the special difficulties young people face when accessing services²⁶ and that contraceptive and STI/HIV services, including those in primary care, should be made easily available to young people, irrespective of their age, marital status or financial situation.^{50 23 28 29} There is a growing consensus that young people need to be targeted as a separate group with information and services and that their views should be taken on board by those designing, planning and delivering health services.^{21 29 42 51 52 53}

The introduction of specialist sexual health clinics, accessible and acceptable to young people, is a relatively recent public health phenomenon. The 1990s witnessed a growth in dedicated youth clinics including advisory clinics for young people¹⁷. The number is increasing rapidly and there are now reports of teenage clinics increasingly being held in general practice.^{54 55 56} A recent audit of contraceptive services showed that nearly a quarter of current contraceptive services had been developed since the Teenage Pregnancy Strategy (i.e. since 1999) and many of these are specifically dedicated to young people²⁰.

Potential advantages of separate youth clinics

The case for separate services is made in terms of removing obstacles preventing young people from using services. Dissatisfaction with conventional health care is frequently reported by young people^{24 25 57 58} and has led to pleas for dedicated young people's sexual health services⁵². Documented problems include an unwelcoming atmosphere^{31 51}, judgemental or unfriendly staff^{30 51 59}, a lack of respect for young patients' concerns^{27 31}; fears relating to confidentiality issues²⁷; disapproval and stereotyping by adults^{27 60} and embarrassment about disclosing sexual activity^{24 31 61 62}. More practical barriers include inappropriate opening hours, apprehension about making appointments^{27 63}, and delay in obtaining them.^{31 64}

A good deal of work relating to the need for separate, youth-friendly services has focussed on the general practice setting. Many teenagers are unhappy with the care they receive^{23 25 58 64-66} and there is scope for improving the approach of GPs towards teenagers⁴⁸. The evidence is that young people underestimate their own importance and think GPs may not have the time to see them⁴⁸, particularly for contraceptive concerns. Despite preferring more time with the doctor²⁷, teenagers have shorter consultation times than older patients⁶⁵. Additionally, young people feel that GPs should know more about their age group in general⁵⁷. Offering a dedicated, preventive contraceptive service may be one way of overcoming this.

It is argued that GPs frequently fail to make the most of the opportunities afforded by routine consultations²³. GP attitude has been identified as adversely affecting decisions about obtaining contraceptives⁶³. There may still be problems within primary care in terms of attitudes towards sexuality. It has been argued that negative attitudes amongst some adults towards young people hinder the provision of sympathetic and appropriate health services⁴². For example, young people are often perceived as being difficult to communicate with and more likely than older people to take risks. This can lead to unsympathetic responses to some health problems⁴².

In general practice, the view has been expressed that traditional surgeries may not meet teenagers' needs and that they should therefore be seen in specially run teenage health clinics⁵⁴. Adolescents have a clear view regarding the nature of the service they would like to see provided^{63 67 68 69}. The desire for drop-in services among young people has been well documented⁶⁴. It is argued that the type of service teenagers have been shown to prefer – those which are accessible every day and in an emergency and are local – are more readily provided by general practice⁷⁰.

However, young people have stated a preference to see a teenage health specialist at a venue other than their local surgery⁶⁴ and have suggested the establishment of sexual health services for young people in the youth settings they frequent⁷¹. There is also evidence that teenagers prefer physically separate services set up especially for them in premises designed to meet their needs⁷².

The potential benefits of age-dedicated services have also been recognised at national level. The Teenage Pregnancy Unit recommends that *'services should encourage access by younger teenagers by setting an upper age limit of 25 and encouraging older people to access other appropriate services'*⁵². A review by the HEA, whilst recognising that service provision could be improved in traditional settings, also recommended expansion to include dedicated young peoples services⁷³.

Potential disadvantages of separate youth clinics

Despite the clear advantages of designated youth clinics, there remains a good deal of scepticism among some health professionals as to whether this is the most appropriate and efficient way forward. The evidence is not clear-cut. Some argue that the demand for dedicated services may have been over-stated, and that whilst professionals might favour separate premises, young people themselves would be satisfied with services which are more young-person-friendly^{27 51}, and that large financial savings might be made if staff in mainstream facilities were simply trained to be sensitive to the needs of young people.

There is also evidence that young people may not take full advantage of dedicated youth services. Some teen clinics are poorly attended^{58 70}. Research also points to some potentially adverse outcomes of age dedication. The very reasons young people give for not attending traditional services (limited opening hours; inappropriate opening times) are exacerbated by the provision of designated youth clinics, which will be likely to have more restricted opening than mainstream traditional services. Establishing a designated youth service from a traditional all-age service is seen by some as having the potential to result in duplication with the running of two parallel sessions (one for young people and one for older people) and would be an inefficient use of already limited resources³⁰.

Others have pointed out that taking youth clinics out of the mainstream might inadvertently convey the impression that young people are unwelcome at all-age clinics, thus perpetuating the notion that the sexual activity of young people should be concealed³⁰. This notion goes against the stance that openness about sex should be encouraged.

A frequent reason cited to advocate the development of youth services is that young people may feel intimidated by sharing clinic sessions with older people. However a recent study of views on service provision among 11-18 year olds showed that sharing a waiting room with older people was not something which concerned them¹¹². More important were the appropriate attitudes of staff, and confidentiality.

Moreover, the common practice in youth settings, of targeting young people under the age of 21, is seen by some to be inappropriate.³⁰ The highest rates of abortion and STIs occur in people aged 20-24⁵² and so designated services may exclude those most at risk of negative outcomes of sexual activity.^{30 70}

One of the fundamental reasons behind the promotion of designated youth clinics is that confidentiality and professionalism amongst staff can be guaranteed. However it has been argued that these conditions are pre-requisites for any sexual health service and are not exclusive to young people's clinics. There is evidence that these conditions are already being met in all-age mainstream services³⁰ and that mainstream services are as attractive to young people as designated youth services if they are of sufficient quality, if they are well advertised and known to be confidential and if they are welcoming to everyone.^{30 74}

The idea of prioritising the specific needs of young people based on assumptions of homogeneity of need has also been challenged. Some see this as inappropriate as young people are a heterogeneous group of people with multi-faceted needs which are likely to vary

greatly.^{2 4 7 8 28 68} Assumptions of common need may deflect attention away from the individual and may lead to a degree of stereotyping, itself making some teenagers resentful of comparison with others of the same age.²⁷

Thus the wisdom of setting up services specifically targeting young people has not gone without question, and this has prompted consideration of alternate models. An example of an alternative model has recently been piloted in Lewisham, South London and consists of an all age drop-in clinic which instead of running parallel sessions for young people, has extended its opening hours to include lunchtimes, evening and after school and is widely advertised to young people through outreach to youth clubs and schools as a friendly, welcoming and confidential service³⁰.

2.1.2 Integration: combining GUM and contraception services

Traditionally, infection and contraceptive services have not always been offered together on the same site. Infection services have most commonly been based within a hospital setting and contraceptive services in the community. They have typically been managed and funded separately and staff in the two services have often had little, if any, communication.⁷⁵ Offered separately, the two services are seen by some as being imperfect as neither deals with the broad spectrum of sexual health in an holistic way.⁷⁶ Moreover, an increasing body of literature now points to the similarities between the two types of service theoretically, practically and epidemiologically.

Recent years have thus seen a move towards the provision of generic sexual health services with a broader remit than that relating specifically to contraceptive or infection service provision. The move has been driven by the epidemiological evidence; the need to inhibit the transmission of HIV and other STIs has motivated efforts to improve sexual health provision and to improve cost effectiveness. It has also been guided by the need to rationalise resources available for infection and contraceptive service provision. Integration is occurring in both directions with family planning services branching out to provide screening and treatment of STIs and with GUM services broadening their remit to provide contraceptive advice and supplies⁷⁵ and a number of centres are now emerging in which the two specialities are completely integrated.^{25 77 78}

The evidence is that services in which screening and treatment for STIs and a full contraceptive service are offered under one roof have been well received by patients and by staff.^{78 79} Integrated services are thought to be of particular importance to young clients as there is evidence that consumers appreciate the advantages of a one-stop service providing co-

ordinated sexual health care.^{80 80 81 82} Indeed studies have shown that there is an expectation on behalf of consumers that staff will counsel them in all areas of sexual health³⁴.

Potential advantages of the integrated approach

The integrated approach to sexual health provision has a good deal of logical appeal. The control of fertility and the control of sexually transmitted infection are inextricably linked in a number of ways. The choice of contraceptive method, for example, has important consequences for transmission of infections. The protective effect of different barrier and spermicidal contraceptives against STIs is well documented.^{83 84 85 86 87} Condoms protect against sexually transmitted infections such as herpes simplex virus and chlamydia trachomatis⁸⁸, cytomegalovirus⁸⁹ and HIV⁹⁰ and gonorrhoea⁹¹. There is also evidence, though weaker and more equivocal, that the use of other contraceptives - the IUD and, more controversially, oral contraceptives - may assist transmission of sexually acquired organisms. The presence of infection in turn has consequences for fertility, particularly in cases where undiagnosed infection leads to infertility. STIs are more easily acquired by women from men than the reverse, they are frequently asymptomatic in women, and long term complications are more common and more serious⁹².

There is also considerable overlap between the two services in terms of client needs. Studies have shown high proportions of GUM attenders to be at risk of pregnancy.^{80 93 94 95 96 97} It has been argued that the installation of a family planning clinic in the same building as GUM services may contribute to an increase in contraceptive use and therefore to a reduction in the number of women at risk of unplanned pregnancy⁹⁶.

Similarly, reviews of those attending family planning clinics show sizeable proportions to be at risk of infection⁸⁰. Studies have shown over 50 per cent of female family planning clinic attenders to have reported one or more prior episodes of an STI⁹⁸. Contraceptive visits offer an opportunity to screen for asymptomatic lower genital tract infections that can be treated before they create complications. In the United States, more STI screening occurs during routine family planning visits than through any other type of health care⁹⁹.

STI control and pregnancy prevention have in common a concern with sexual behaviour, and a behavioural focus as opposed to an emphasis on disease outcome may serve to soften a preoccupation with pathological outcomes of sexual behaviour.

Co-ordination of family planning and GUM services then has the potential to boost the effectiveness of both, to broaden opportunities for screening and preventive health checks and to afford possibilities for raising a variety of sexual health problems.

Possible disadvantages of integration

Despite the clear advantages of combining services in one clinic, there may also be adverse consequences. It has been hypothesised that provision of infection services on the same site may have a negative impact on contraceptive services^{100 101}. The stigma attached to STIs¹⁰² may deter those simply seeking contraceptive advice and may thereby diminish acceptance of services¹⁰³.

A further possible deterrent to attendance at a combined service relates to the gender distribution in the two services, women traditionally being over represented in family planning services and men in STI services¹⁰⁴. Of interest is the extent to which this may affect willingness to attend on the part of young men and young women and an important question here relates to the trade off between the benefits of involving young men in contraception via a more generic service, and the possible costs in terms of young women lost to the service.^{105 106}

Calculation of the balance of risk is also different for contraception and infection. The proportion of individuals capable of transmitting an STI in any one month is relatively small in comparison with the proportion of women who are fertile. For each coital episode, the risk of either partner transmitting a bacterial lower genital tract infection is much higher than the risk of the woman becoming pregnant. Further, because pregnancy and infection occur through slightly different biological mechanisms, advice on risk reduction strategies relating to the prevention of each varies¹⁰⁷. No currently available method is effective in protecting simultaneously against pregnancy and infection. The risk of HIV and other STIs has focused on the 'belt and braces' approach, using a reliable method of contraception together with a means of avoiding infection¹⁰⁷. Relatively high success rates in motivating such a strategy have been reported in sexual health clinics⁸⁰.

An organisational issue relates to the fact that the two fields emphasise different aspects of health care. Those seeking contraceptive advice and treatment are healthy, and the provider's role is to support them in taking preventive rather than remedial action. Because family planning emphasises prevention, clinic staffing patterns can be determined in advance, allowing the best use of personnel, space and time¹⁰⁸. In contrast, STI care is relatively crisis-oriented. Most patients seek medical services either because they have symptoms or because screening has revealed an infection.

2.1.3 Location: where are young people's services best situated?

Contraceptive advice has been available on the NHS free of charge to everyone in the UK since 1974, emergency contraception since 1984. These and other sexual health services are available for teenagers at a number of different outlets. These include:

General Practitioners

General practice has been shown to be the most popular choice for women requiring contraception^{109 110} and it has been recommended that GPs should target their services to teenagers¹¹¹. The number of teenage clinics held in general practice has been increasing recently.^{54 55 56 112} A key advantage of establishing young people's clinics in GP surgeries is the fact that most teenagers are registered with a GP¹¹³. It is difficult however, to establish exactly how many teenagers consult their GPs for sexual health advice. Unlike Family Planning clinics, GPs do not keep records of attenders by age and the claim forms submitted by general practitioners for contraceptive work only differentiate between fitting of an intrauterine contraceptive device and all other forms of contraceptive advice. Research shows however, the GP to be the first port of call for the majority of young people seeking contraception^{114 115 116}. A survey of younger girls (aged 16-19)¹¹⁷ showed that the 58% had consulted their GP for contraceptive advice.

However, there is evidence suggesting widespread dissatisfaction on the part of teenagers with primary care^{23 31 51 58 64}. The most frequently cited concern relates to fear of a breach in confidentiality^{48 49 64 118 119} but there is evidence that this may have less influence on actual consultation behaviour than was previously supposed^{61 62}. A recent survey of GPs showed that 94 per cent agreed with the notion that the same duty of confidentiality applies to under-sixteens as to older patients¹²⁰. So, despite frequently reported anxieties relating to confidentiality and the possible loss of trust caused by the Gillick campaign in the early to mid 1980s, it is clear that young people do still make considerable use of their GP for sexual health services.

Misconceptions about age-related eligibility also deter attendance⁴⁸. Despite preferring more time with the doctor²⁷, teenagers have shorter consultation times than older patients⁶⁵, and feel that GPs often fail to make the most of opportunities afforded by routine consultations²³.

Attitudes of GPs have also been identified as a problem¹²¹; young people have complained of generalisations being made about their age group^{31 57}, failure to respect their viewpoint⁵⁹, and there may still be problems within primary care in terms of attitudes towards sexuality, particularly that of young people⁶³. Most GPs do not offer contraceptive services for men and not all practices have free condom schemes¹²².

Family Planning Clinics

It is a Department of Health requirement that contraceptive services, responsive to the needs of the local population, are provided³. Family planning clinics are seen by some as an essential component of effective contraceptive service provision for teenagers³². They have the advantage of open access, no appointment is needed and they are often based in a community setting which serves to increase anonymity as young people can often attend without being seen to be entering a hospital or medical setting. Evening opening times are convenient to those attending school or college. The majority, however, do not provide generic sexual health care.

Attendances by women aged under 20 to Family Planning Clinics in England have been increasing steadily in recent years (except for a brief period in the three years following the Gillick case in 1983), suggesting the increased importance of this setting as a source of contraceptive advice for young women. A survey of contraceptive services in London in the late 1990s showed that approximately 17 per cent of the total Family Planning clinic hours per week in London are designated specifically for young people's services¹²². Data were collected for the first time in 1994-95 disaggregating under 16s into those who were aged 15 and those aged under 15. Steady increases in attendances in both these age groups were seen during the 1990's¹²³.

Interestingly, the number of men attending family planning clinics has also been increasing in recent years although this information is not available by age group. The increase was steady throughout the 1970s and 1980s but more dramatic since 1990¹²³. These figures may also under-represent the numbers of men using this service as many more clinic contacts with men will be as part of a couple where the woman is registered as the first contact. Nevertheless it is encouraging that men are now beginning to use family planning services¹²².

Genito-urinary medicine (GUM) clinics

Young people also have access to sexual health services through traditional GUM clinics. Such clinics are based on self-referral and are usually operated on a walk-in basis and take several different forms, for example clinics, outreach services held at times thought to be more accessible to young people. Another method is a fast-track system to ensure that young people are seen immediately wherever possible. This is particularly important given the long waiting times people often face when accessing genitourinary medicine clinics^{124 125 38}.

What has not been adequately investigated is the impact on young people of the long waiting times faced when accessing genitourinary medicine clinics^{38 125}. There is concern also that the

stigma traditionally attached to STIs continues to contribute to low levels of acceptance of services and deters young people attending.^{102 103}

Despite their increasing youth-friendliness, few GUM clinics hold sessions specifically designated for young people¹²⁶, though the number is increasing¹⁷. Interestingly there is some evidence of changing patterns of clinic use by young people with increasing numbers of women using them^{38 93 127}. Two recent studies have shown that the majority of young attenders are female¹²⁶. In another study only 15 percent of users aged 16 and under were young men⁹³.

Young Person's Advice Centres (YPACs)

An increasing number of Young Persons' Advice Centres have been established recently, normally offering generic advice in a variety of areas. Research has shown great demand amongst young people for services which offer a range of facilities (such as services on relationship and family problems, counselling and other health risks including drugs and smoking information), and not just those which fall strictly within the remit of sexual health^{128 129}. Thus many services have now been developed in response to the recommendation that they need to be designed to meet users' needs in an environment which is acceptable to young people. It has been recommended, for example, that the environment in which services are provided should aim to avoid the 'clinical' atmosphere often associated with hospitals and hospital based care¹¹⁹. These centres have a diversity of service organisation, with many providing outreach services which are felt to be particularly appropriate for reaching young people who would otherwise be reluctant to access services themselves.

2.2 Aspects of client satisfaction

Aspects of care likely to impact on client satisfaction have been identified from the literature. Studies of health professionals^{27 42 52 130} and young people themselves^{8 24 63 68 69} have been included. These are categorised and summarised below:

2.2.1 Awareness

Clearly a pre-requisite of use of a service is knowledge of its existence and whereabouts. Emphasis is placed on the need for young people's sexual health services to be advertised as widely and as effectively as possible^{72 128 131-134}. The evidence on awareness of sexual health services among young people is equivocal; while some studies have shown it to be low¹³², others have shown high levels of information about where local services are¹³⁵. However, young clinic attenders have reported difficulty in finding clinics or finding any information about them^{128 136 137}. An important source of information has been shown to be the peer group and word of mouth is therefore an effective advertising strategy^{72 132 138-140}.

The evidence is that promotional materials should be located at places where young people spend their time and if possible, where material can be accessed discretely¹³², for example, in schools and colleges; cafes, pubs and clubs; shopping locations; leisure centres and the local press^{72 128 131 132 141-143}. Materials appear to be most effectively presented using a format and design targeted to young people^{132 141}. Outreach into schools is crucial in maximising awareness^{132 134 136 144 145}.

2.2.2 Inclusiveness

Uptake of health services by minority ethnic groups is often poor¹⁴⁶⁻¹⁴⁸ and accessibility to contraceptive services for minority ethnic groups varies markedly¹²². Trained interpreters are seen as the ideal^{146 148}, logistical difficulties relating to confidentiality and to the sessional basis of clinic organisation are recognised¹⁴⁷. Pleas have been made for leaflets to be translated into appropriate languages and to reflect the multi-racial composition of the population¹⁴⁸. Some concerns have also been expressed about the ethnic composition of staff^{147 148}.

2.2.3 Acceptability

An important criterion of acceptability relates to the personal characteristics of staff.^{72 149-153} Gender appears to be more important than age or ethnicity in this respect,^{151 153} higher satisfaction being achieved by female compared with male providers^{72 152}. General attitudes of the staff have also been shown to be important^{72 152}. Trustworthy and friendly staff make young people feel welcome and relaxed^{149 150} and a non-judgmental approach seems particularly important to younger girls⁷². The quality of staff interaction with clients is also crucial. Privacy, respect and responsiveness, time spent with client, and personal qualities of honesty, tact and sensitivity, have all been shown to be determinants of satisfaction^{30 74 154 155}.

The physical environment of the clinics also influences acceptability of a service.¹²⁸ Décor, general ambience and facilities offered (drinks machine; magazines, etc) have been shown to be second only to staff friendliness as factors determining user satisfaction¹⁵⁰.

2.2.4 Accessibility

Accessibility is a further key factor determining satisfaction¹⁵⁶ and proximity and opening times are crucial factors determining use^{128 131 157 158}. The more easily a service can be reached, the more likely a client is to make use of it^{128 157} and so the geographical location of the service is crucial, though the tension between the parallel needs for anonymity and access needs to be explored. Attention has been drawn in this context to the adequacy of

public transport, the need for parking facilities, facilities for disabled people¹⁵⁹ and waiting areas for accompanying persons¹⁵⁶.

Open access clinics have been recommended for young people¹⁶⁰. Since young people often have little control over their own time and transport, access to a drop-in service is seen as preferable to the appointment system^{128 150 157 158}. The evidence is that young people prefer clinics to be open in the evenings¹³⁴ and at weekends^{128 131 150 158}. Sessions held several times a week¹²⁸ maximise choice.

2.2.5 Adequacy of service provision

The range of health care on offer also influences client satisfaction.^{128 133} Access to the full range of contraceptive methods (including post coital contraception) has been shown to be important^{132-134 161} as has access to on the spot pregnancy testing, counselling and referral for termination of pregnancy¹³⁴. Marked variation between services, and within services to different clients, has been shown in this respect.¹⁵⁸ Adequacy of choice of method extends to the selection of contraceptive care most likely to continue without intolerable side effects¹⁶².

2.2.6 Confidentiality

Research has shown assurances about confidentiality to be pivotal in determining initial attendance, satisfaction with the visit and willingness to return^{72 128 141 144 156 158 161} especially among those aged under 16. The evidence is that if confidentiality is not guaranteed, young people may forego advice rather than risk their parents being told of their sexual activity¹⁶³.

Some justification for these fears is provided by research showing that, even among family planning clinic staff, 5% of doctors will not give post-coital contraception without parental consent¹⁶⁴. Young people need to be reassured about confidentiality immediately on entering the service^{134 144 165}. Receptionists play a crucial role as the first contact with clients; the evidence is that patients worry more about confidentiality of information given to clerical staff than to medical staff¹³¹.

2.2.7 Quality and quantity of information

The quality and type of information given to users at sexual health services has also been suggested as a proxy for the quality of care¹⁶⁶, both during and after the consultation. Young people are critical of the amount and quality of information they receive from providers^{128 133} and do not always find it easy to assimilate¹²⁸. Recommendations are that information should be appropriately targeted^{128 156}, conveyed by a combination of methods and easily obtained^{128 158}.

2.2.8 Continuity of care

Intention to return¹⁶⁷ is an important indicator of satisfaction with the services. Efforts to ensure the clients' return to the clinic have been documented¹²⁸ and include referral between centres¹⁴⁴, avoiding unnecessary repeat visits^{131 167}, allowing clients to make appointments in advance at their convenience,¹⁶⁷ reminder letters, and making follow-up appointments during the current visit¹³¹.

2.3 Summary

This section has presented a summary of the literature on key elements of service provision important in the delivery of appropriate sexual health services to young people. The literature was grouped into the following key areas and presented as such:

- Awareness (2.2.1)
- Inclusiveness (2.2.2)
- Acceptability (2.2.3)
- Accessibility (2.2.4)
- Adequacy of service provision (2.2.5)
- Degree of confidentiality (2.2.6)
- Quality/quantity of information (2.2.7)
- Continuity of care (2.2.8)

This list was used as the basis for the derivation of the main measurement variables. The next step was to operationalise these variables, full details of which are presented in chapter 5.

2.4 The importance of user satisfaction

Quality and efficiency have been said to be the cornerstones of appropriate service delivery and are meaningful and important indicators of achievement and of effectiveness¹⁶⁷. During recent years the nature of service delivery, quality of care and client satisfaction have assumed increasing importance^{168 169 170}, indeed one of the five key standards of the recent National Service Framework for children, young people and maternity services states that children and young people should receive high quality services which are co-ordinated around their individual and family needs and take account of their views¹⁷¹.

The degree to which service users are happy with the outcome of service delivery will impact on the extent to which advice and treatment is adhered to, on the decision to re-visit the service in the future,¹⁷² and, indirectly, on longer-term outcomes relating to prevention of

unplanned pregnancy and STIs. Non-use of health care services also has implications for cost-effectiveness so it is crucial that services for young people are delivered appropriately.

Satisfaction with services is particularly important among young people who, as has been documented, are often anxious and reluctant to attend sexual health clinics^{62 48 113}. A good deal of work has been done in England to try and ensure the delivery of health services is appropriate to meet the needs of young clients. Services are becoming more sensitive to these needs as teenagers report more dissatisfaction with health services than older people¹⁷³.

Recent advances in the NHS have shifted the focus towards patient-centred care. The white paper, *A First Class Service: Quality in the New NHS*, published in 1998¹⁷⁴, placed great emphasis on improving and maintaining quality and on clinical governance which it described as *'a framework through which NHS organisations are accountable for continuously improving the quality of their services and safe-guarding high standards of care by creating an environment in which excellence and clinical care will flourish'*.

The suggestion has been made that quality should be measured from three standpoints: its readiness to provide services (service perspective); delivery of the service (provider perspective) and receipt of the service received (client perspective).¹⁶⁷ This study concentrates on the last of these, that is, satisfaction with the **service received** from the **perspective of the client**.⁵

In relation to this goal, it is often debated whether client satisfaction constitutes process or outcome evaluation. Satisfaction with the service is certainly relevant to an assessment of the process by which the service is delivered. However it may also be argued that satisfaction in itself is an outcome of the service and so could equally be classified as outcome evaluation, albeit an interim outcome. The importance of satisfaction as an intermediary outcome of service delivery cannot be understated as it is likely to impact on a client's decision to re-visit the same service in the future and so will inevitably have an impact on longer term outcomes of contraceptive cover and avoidance of STIs.

Although it has been argued that the client perspective is an important factor in identifying and assessing quality, the client is not usually in a position to assess certain aspects of service delivery¹⁷⁵ and inevitably will have different priorities in terms of what is important. Health care services that are not used are, by that fact alone, ineffective and clients will not use services if

⁵ A larger research project from which this PhD developed involved the development of a toolkit to measure service delivery from the perspective of the provider. It also gave a list of potential data sources to be used in outcome evaluation.

they find them unwelcoming or inappropriate¹⁷². This is particularly the case among young people in contraceptive and sexual health services.

Underpinning all these debates is the concept of client satisfaction with the services. The importance of user satisfaction, particularly among young people who, as has been well documented, are often anxious and reluctant to attend clinics^{48 113}, is very important as it impacts on continuation rates. User satisfaction has not yet been compared in any rigorous way using consistent research instruments across different studies. This work therefore sets out to answer specific questions regarding the optimal model of the provision of sexual health services of young people.

3.1 Study design

As identified above, the research questions for this study relate to how levels of satisfaction of young men and women vary with aspects of service configuration, namely **age-dedication; integration** and **location**. In thinking about study design, one of the challenges faced was the need to be confident that outcomes in terms of aspects of client satisfaction could genuinely be attributed to features of service delivery and not to other extraneous variables. A prospective, quasi-experimental design, involving random allocation of users to different services would have had the best chance of providing this assurance. In practice, economic and ethical considerations ruled out such an approach. It was not possible to allocate young people in the community to different sexual health services when they themselves had not elected to do so, and random allocation at the point of presentation at a service, even if feasible, would be likely to delay provision of advice and treatment. Additionally, not all types of service are represented in each geographical area so clients would have been required to travel some distance before reaching the service to which they had been randomly allocated. A randomised controlled trial was therefore not considered appropriate for this study.

Even a retrospective study using intervention and matched comparison services would have been difficult, requiring as it does either the identification of services which differ from one another on no other variables than those under scrutiny, that is, relating to the organisational features of service delivery. In practice, staffing, resourcing and social and geographical location are inextricably linked with features of service organisation and the characteristics of clients vary between different outlets^{131 133}. A further difficulty inheres in the fact that, in the real world, all services share both similarities and differences. As a result, where there are differences in outcome between them, it would be difficult to assess to which of the three key characteristics, **dedication, integration** or **location**, it might be attributed.

An important question for this study was not which service works best, but which features might be replicated to advantage, with which populations and in which public health cultures. Although I was unable to describe conditions prior to, or in the absence of, the services, I was nevertheless eager to assess which of their features seem to be associated with key outcomes and with what strength of effect. Using the design described below, the aim was to exploit opportunities for comparisons which could be expected to show intervention-related variation. Adjusting for aspects of service configuration in the multi-variate analysis would, I anticipated, allow me to eliminate confounding between, for example, dedication and location, and dedication and integration. Where significant variation in the outcomes was

found with key characterising features of a service, and where no alternative explanation was obvious, I felt I would be able to make cautious claims relating to influence.

3.2 Seeking Ethics approval

Ethics approval was granted from the London School of Hygiene and Tropical Medicine Ethics Committee in March 1998 (for the initial study from which this work developed, including the development and piloting of the research instruments) and again in November 2003 (for the main study including the client satisfaction survey). Both approval letters are included at Appendix 2.

Ethics approval was also sought and granted in July 2003 from the Multi-Centre Ethics Committee (MREC). The original proposal was accepted provisionally, on the requirement that specific key questions were addressed and some minor points of clarification made. A copy of my reply to the MREC and the final MREC approval letter are included at Appendix 3.

Once MREC approval was received, the next stage was to identify the appropriate Local Research Ethics Committees (LRECs) for each of the study sites. This was done through the web site of the Central Office for Research Ethics Committees (COREC)⁶. A response had to be received from each LREC before data collection could begin.

Newly instituted LREC procedures led to some delays. From September 2003 each LREC required the study to be registered with the Research and Development department of the relevant NHS Trust and with the appropriate Data Protection manager in each area. This administrative task was undertaken during September and October, 2003. An additional new requirement was that the researcher responsible for data collection in each site should be appointed as a temporary honorary member of staff in each NHS Trust. This created a further delay as applications had to be processed and references provided for all researchers involved.

Further, one LREC and the Research and Development department at one NHS Trust insisted that specific changes to the patient information sheet be made prior to the study being approved.

After the first phase of data collection when it became apparent that modifications to the original study protocol needed to be made in order to recruit the GP practices, MREC were informed of these changes. Approval had to be received before the study could continue. Specifically the MREC was informed that the original data source – the Sexwise database –

was not available for this particular project and other options such as the use of the GPRF and of other local research consortiums was being explored along with the necessity of recruiting through professional contacts known to myself and the advisory group. Additionally the committee was informed that more than the original 4 practices would be needed to achieve the target sample of 800 completed questionnaires and that the help of general practitioners and practice nurses may be necessary for assistance with the data collection at some sites.

3.3 Qualitative study: exploring the views of young users on aspects of service provision

The aim of the qualitative study was to help inform the research with respect to key variables to be included in the research instruments, in relation to client satisfaction. Depth interviews have the advantage of encouraging the interviewee to talk about their perceptions and experiences, allowing the necessary time and space to develop their own ideas¹⁷⁶. In addition the participants are able to explore the issues that they feel to be important and which the interviewer may not have considered beforehand.

3.3.1 Research instruments for the qualitative component

A topic guide in unscheduled, semi-structured form was designed to elicit specific views on integrating contraceptive and infection services; integrating young people's sessions with those for people of all ages, and the optimal location of these services. The interview schedule was designed to explore a range of issues in relation to their experience of the service with a view to a) designing the questionnaire and b) providing insights into the associations found in previous published literature. A copy of the topic guide is to be found at Appendix 4.

3.3.2 Sampling strategy and fieldwork for the qualitative component

The in-depth interviews were conducted in 2000. A sample of sexual health services was purposively selected to meet specific criteria relating to the type of service provided. All of these services were in the South-East of England.

The sampling frame

Existing maps of sexual health services provided a ready made sampling frame. A useful starting point was the HEA's UK directory of clinics providing sexual health services which contained a list of GUM clinics in the United Kingdom with over 350 entries and provided contact details and some information about each service¹¹⁹. Another Health Education Authority publication, a compendium containing information on 66 different services,

⁶ <http://www.corec.org.uk>

produced to facilitate the exchange of information between professionals working with sexual health and young people, provided further information on family planning services for young people. In addition, a list of family planning clinics known to provide separate sessions for young people and containing details of 33 services, was obtained from the Family Planning Association. Further details of additional services were obtained through personal contacts.

Inclusion criteria

Given the diversity in the types of service provision it was decided that a sample of services which represent the different modes of service delivery should be selected. This was to ensure that the views of users of each of the different types of service could be represented. This provided the two most vital criteria determining inclusion of services in the sample, ie. firstly that they should offer at least some sessions specifically for young people and secondly, that they should provide both contraceptive and prophylactic advice. Further details of these services are included at Appendix 5.

From the lists of sexual health services described above, 11 services were initially contacted and invited to participate. Four were not able to do so, mainly for logistical reasons. One service, for example, (in Oxford) could only participate once ethical clearance had been obtained from the local Health Authority, despite the fact that assurances were given that the study had already cleared the LSHTM Ethics Committee. Another (in central London) had recently re-located and after the move, had lost a large proportion of its young clients. Although the staff at this service were optimistic that teenage client numbers would recover, they felt it would not be worth our while visiting that site at that particular time. The third service (in south London) which could not be included although potentially willing, would only allow us to visit once this had been agreed at a meeting with the senior management. As these meetings were only convened very infrequently (and one had just been held) approval could not be sought in time. The staff at the fourth clinic (in north London) just felt that they had recently been host to many different researchers and were concerned that the clients may suffer 'research fatigue'.

Once the remaining sites had been selected, staff were contacted and sent a brief description of, and explanation for, the research. This was followed up soon afterwards with a telephone conversation in which the details for the research and our reasons for wanting to visit the clinic, were re-iterated. Any specific questions from the staff were answered.

Once the staff had agreed, details were taken about the number and timing of their sessions for young people and visits were arranged.

Service users were approached as they waited for their consultation, and asked if they were interested in taking part in a study. An information sheet (Appendix 6) about the research was provided and they were given the opportunity to discuss it, or ask further questions about the study. 25 interviews were conducted in total.

The inclusion criteria for participants were that they should be:

- attending the service on their own behalf and not accompanying someone else
- under the age of 25
- have a reasonable grasp of English (adequate to be interviewed in English)⁷

Service users were asked their age to establish eligibility. After agreeing to participate, they were asked to sign a consent form (attached at Appendix 7) and arrangements were made for the interviews to be conducted in a private room in the clinic, following their consultation. Written consent was sought from all participants, including those under 18. The same conditions of consent apply to under 18s as to participants over 18. With regard to young women under the age of 16, the Gillick ruling was applied. For this we ensured that:

- They had been counselled and did not wish to involve their parents
- They had sufficient maturity to understand the nature and purpose of the study
- The health professionals responsible for the young person were happy for them to participate

The sample included both young men and young women, although higher attendance rates amongst young women led to over representation. Table 3.3.2 below shows the age and gender breakdown of the respondents along with the type of service from which they were selected.

⁷ The number of participants whose English was too poor for them to be included in the study was not expected to be high. The qualitative component requires only that participants understand spoken English as no writing is required on their part. Unfortunately funding did not allow for employment of translators. In principle, we anticipated making use of interpreters accompanying users to the clinic, though in practice this situation never arose.

Table 3.3.2 Distribution of participants for in-depth interviews across different service types

age	Integrated services		Separate services	
	boys	girls	boys	girls
13		1*		
14		1*		1*
15		4*#		1
16	1*	1*		
17		1*		
18		1		1*# 1
19	1*			1#
20		3*#		
21		1*	1#	1#
22				
23			1	2#
Total	2	13	2	8
	15		10	

*Recruited from services dedicated to young people

#Recruited from community (rather than hospital) based service

All the interviews were tape recorded and transcribed with the permission of the participant. A unique code was assigned to each interview and neither interviewee names nor personal details appeared on the tape. A proportion of the transcripts were checked to ensure accuracy of transcription.

3.3.3 Analysis of the qualitative data

Interviews were analysed using the 'Framework' method of qualitative data analysis which was developed by the then Social and Community Planning Research (now called the National Centre for Social Research) which involved the following five steps:

- Familiarisation with the material
- Identifying a thematic framework (and developing a coding frame)
- Indexing (applying codes to the data)
- Charting (on a spreadsheet to allow analysis within and between themes using data from all the interviews)
- Mapping and interpretation

Data from these interviews are reported in Chapter 5⁸.

⁸ Preliminary findings have been published: **Kane R**, Wellings K & Macdowall W. Providing information for young people in sexual health clinics: getting it right. *Journal of Family Planning and Reproductive Health Care* **2003**;29(3):141-145. This paper is included at Appendix 8.

4.1 Quantitative component: User satisfaction survey across 10 study sites

Design

As stated above, the key research question to be answered by the quantitative component was: how do satisfaction levels with key aspects of quality of care (identified at 2.2) vary with use of integrated services and non-integrated services; dedicated services and non-dedicated services and between those located in the community and those located in hospitals. The focus was therefore on variations in client satisfaction with these three key features of service delivery.

The services selected were characterised by the three key variables, that is:

- **integration**: that is, services offering GUM and contraceptive provision in combination or separately;
- **dedication**: that is, providing services specifically for young people or for all ages; and
- **location**, in hospital or community based services

Creating a matrix for every possible combination of these variables produces 10 services as set out at Table 4.1 (below). This stratification produced 10 groups from which the study sites were then randomly selected⁹.

⁹ In practice, not all services fit perfectly into the matrix as illustrated. For example, the first service (FP + GUM for YP) might include a YPAC, and the GP with sexual health services for young people, is likely to be represented by a GP with special sexual health sessions for young people, rather than a whole service.

Table 4.1 Matrix of services for sampling frame

	Integrated	Non-integrated
Dedicated YP	<p>Service type 1 FP + GUM for YP (n=43)</p> <p>Service type 2 GP with SH for YP</p>	<p>Service type 5 FP only; for YP (n=141)</p> <p>Service type 6 GUM only; for YP (n=9)</p> <p>Service type 7 GP FP only; for YP</p>
All age	<p>Service type 3 FP + GUM all ages (n=22)</p> <p>Service type 4 GP with SH all ages</p>	<p>Service type 8 FP only (n=253)</p> <p>Service type 9 GUM only (n=43)</p> <p>Service type 10 GP</p>

NB. Numbers in brackets refer to the global population of clinics in the database of services which fall into each of the categories

4.2 Sampling strategy for the quantitative component

Initially it was hoped that services would be drawn from England as a whole. However on considering the organisation of the fieldwork it became apparent that this would not be feasible within the constraints of a PhD dissertation. In discussion with the Advisory Group, the decision was therefore taken to concentrate the fieldwork to a specific region, making data collection more manageable. The geographical study area covers London and the South East. The decision to concentrate on London and the South East was guided by expediency, given the impracticality of co-ordinating the data collection over a large geographical area when so few researchers were involved. All Local Authority areas covered by London and the South East Government Office Regions are included.

Sampling frame for the sexual health services¹⁰

The 'Sexwise' database, a register compiled by the Central Office of Information for use in conjunction with the TPU's 'Sexwise' helpline, containing information on 2050 sexual health services in England, provided the sampling frame from which the study sites were drawn. The first task was to stratify the dataset by region to ensure that only services from London and the South East were included. This gave a total of 731 services, which then had to be categorized into service type, according to the tri-partite classification. Any services which

¹⁰ Note that a different sampling process had to be used for the GP practices – described in detail below

did not fit into the classification (for example those which were telephone help-lines or did not offer any clinical services) were removed from the sampling frame. This left a total of 511 services from which to draw the sample. The numbers in each classificatory group are illustrated in brackets in Table 4.1 above.

Each group of services was then taken separately and one service selected randomly from each, using the random selection facility in SPSS (version 12.01). Once selected the details of each service were checked to be sure that they conformed to the appropriate classification. Each service was then contacted by telephone to ascertain the name of the clinic manager or most appropriate person to whom correspondence about the research should be addressed. Details of the study and a letter of invitation were sent to each potential study site in August 2003. Supporting documents (a brief summary of the research and confirmation of MREC ethics approval) were also included.

Where no reply was received after two weeks, clinics were again contacted by telephone to ensure that the letter had been received. On most occasions delays in replying to the letter were explained either by annual leave of key staff or the necessity of bringing the prospect of being involved in the study up at managerial meetings, which in some services were held only infrequently.

In practice, all of the services had replied by October 2003. One (service type 9) declined to participate due to its departments undergoing re-refurbishment during the scheduled time for data collection. This service was replaced with another from group type 9, selected randomly using the process described above.

Selecting the GP practices

Because such a large part of sexual health care is delivered through general practice, I considered it important also to include GP practices in the study. These however are not included in the Sexwise database and so an alternative sampling frame had to be explored.

Initially I hoped to use as the sampling frame, a recent audit of all practices in England providing details of specific elements of service provision. My hope was that these data could also have been stratified by type of service provision and then individual services could then have been randomly selected in the same way as above. This would have provided the ideal sampling frame. However we were not allowed access to this resource as it had been developed on the understanding that it would be used for the initial purpose for which it was collected and would only be accessed by the Department of Health who co-ordinated the collection of data.

The second option explored was to use the General Practice Research Framework (GPRF) which lists over 1000 general practices throughout the UK involved in epidemiological, primary care and health services research. However, given that only 4 practices were required for selection, purchase of the dataset proved too expensive and therefore not cost-effective.

On making enquiries about the GPRF however, I was informed that the Royal College of General Practice (RCGP) holds a complete list of general practices for the country as a whole, which can be accessed through their web site¹¹. This allows searches for services by geographical area. In discussion with the Advisory Group, this was agreed to be the most appropriate sampling frame for the general practices. The first step was to ascertain all the Local Authority areas within the study area (London and the South East Government Office Region¹²) and then to search the database for services in each area. Addresses and details of 2599 services throughout London and the South East were copied into a word document. The next stage was to examine the list to ensure that each service did indeed fall within the geographical area covered by the study. (I discovered that the results of a search for 'Brighton' for example, would also include any practice with the word Brighton in its address, for example Brighton Road, Lincolnshire; once such services were deleted, each remaining service was assigned a unique identification number, which was to be used in the random selection process).

Unfortunately the database did not include details of what was actually delivered within each setting. For example, no details were available on whether a young people's service, i.e. a specific sexual health or contraception clinic or session, was provided. This could only be ascertained by contacting each service individually. The next stage was to randomly select a number of services from the full list and telephone each service individually to enquire about their arrangements for the delivery of sexual health service to young people.

The random selection was again carried out using SPSS (version 12.01) and was done in groups of the ten, i.e. a group of ten services was selected and they were contacted in the order which they emerged. The first round of brief telephone interviews with service staff revealed that one of this ten fitted the selection criteria for the study, i.e. provided an integrated sexual health clinic open to people of all ages (Service Type 4). The remaining 9 services were classified under service Type 10 (i.e. a normal GP practice with no special provision for young people or for sexual health care). This process was repeated until a service which could be classified as Type 2 (GP with an integrated SH service dedicated to

¹¹ <http://www.rcgp.org.uk/extensionfr.asp?ext=externallinks/index.asp>

YP) and service which could be classified as Type 7 (GP with a contraception only, [i.e. not STIs] clinic, dedicated to young people) could be identified.

In practice, the fourth service contacted provided a practice which met the criteria for service Type 4, the 11th service met the criteria for service Type 2 and the 17th service contacted met the criteria for service Type 7. The remaining practices contacted all met the criteria for service Type 10 (i.e. no special sessions whether for young people, or for sexual health, or contraception) and so the first one of these was selected for inclusion in the study.

Once the practice was selected and the appropriate contact person within each practice had been identified, the practices were contacted by letter and invited to take part in the study, in the same way as described above.

Disappointingly, this whole process yielded not a single participating practice. A further two were invited, following the same process described above – but again no response was received.

Once again further options had to be explored. On further discussions with staff at the GPRF, I was informed of a research organisation operating in the South East which was responsible for recruiting general practices into research studies. The North Central London Research Consortium (NoCLoR)¹³ is a partnership between Camden PCT, Barnet PCT, Enfield PCT, Haringey TPCT, Islington PCT, Barnet Enfield & Haringey Mental Health Trust and Camden & Islington Mental Health and Social Care Trust. The Consortium also encompasses the former North Central Thames Primary Care Research Network (NoCTeN). One of their main aims is to support the development of new research in primary care, including assistance with recruiting practices into studies such as this one.

After lengthy discussions with the research administrator, a full application was submitted for consideration to carry out the study with their assistance. This was done in February 2004. Once again the protocol had to be sent out for review by the ethics board of NoCLoR. In April 2004 confirmation was received that the study had been approved by NoCLoR and was given permission to go ahead. Some financial assistance was also granted to support the data collection process. The process of selecting and approaching GP practices then took place.

Further problems were encountered in the recruitment process. Of the GPs approached, it proved very difficult to find any who agreed to participate in the research. The variety of

¹² The list of Local Authorities which come under London and the South East Government Office Region is included at Appendix 9.

reasons included 'research overload' whereby the practice manager explained that another research project had recently been conducted in the practice, staff shortages, relocation or refurbishment of premises or poor attendance by young people for sexual health concerns and simply too many demands on staff time as a result of NHS re-organisation.

Where practices did agree to participate, numerous problems were encountered in seeking ethics approval from local PCTs and Research and Development departments. This added several months onto the research process and unfortunately resulted in my being unable to include them in the PhD study. An important consideration relating to data collection was that it should occur simultaneously across all the research sites. Given the much later inclusion of the general practices a serious time lag would have occurred were they to be included.

The unanticipated delays were largely due to the Research Governance Framework introduced in 2001 and updated in 2003 which means that anyone intending to conduct research in primary care must now obtain permission individually from each PCT despite studies already having been granted MREC approval. Because procedures and application forms are not standardized across PCTs this adds considerably to the time needed to initiate data collection.

Sample size

Sample size was based on a cluster randomisation. As the unit of randomisation was the service, rather than the individual client, it was necessary to apply an inflation factor to account for the loss of power to detect a real intervention effect^{177 178}. The sample size was calculated with the assistance of a key member of the Advisory Group (Dr. Paul Wilkinson). A sample size was chosen that would provide reasonable precision in estimating the various outcomes of satisfaction and the differences in them by service type. For example, for the key classifying variables, **dedication**, **integration** and **location**, we would have 90% power to detect differences of 5% to 6% in binary outcome variables such as the proportion of young people already sexually active when they first access a service¹⁰³. For comparisons between individual services with other areas it was estimated that there would be 90% power to detect differences of 7% to 10% in binary outcome measures.

The ten services, it was estimated, would be likely to yield a total sample of 2,000 young people, of whom 800 would be attending an integrated, and 1200 a non-integrated service; 1000 would be in dedicated young people's services and 1000 in all age services; and 800 in primary care and 1,200 in other settings. It was initially estimated, on the evidence of numbers

¹³ <http://www.ucl.ac.uk/primcare-popsi/nocten/>

attending existing service services (Appendix 10), that it would be necessary to gather data during 10 sessions in each of the services to achieve the sample size specified.

Later, on realising that the GPs would have to be omitted, I considered returning to the other services to continue recruiting further participants, in order still to achieve the initial target of 2000. However, data collection had by this time actually been completed at some sites and returning would have necessitated my applying again for honorary contracts and re-establishing arrangements for another round of visits to each site. On consultation with my supervisor and advisory group, I took the decision to forfeit these additional respondents, even though it meant compromising my sample size slightly.

Since the services were selected randomly, they represented a mix of populations in terms of for example, population density, deprivation levels and teenage conception rates. Full details of all the study sites are given below (Chapter 6).

4.3 Data Collection

Three stages of work aimed at collecting data are described in detail below: *Operationalising the variables and drafting the questionnaire, piloting the questionnaire and fieldwork*

4.3.1 Operationalising the variables and questionnaire design

The questionnaire was developed in four stages:

i) First, an extensive *examination of the relevant literature* on the provision and evaluation of sexual health services was conducted to identify characteristics of service provision which had been shown to be important in influencing uptake, continuation of use and satisfaction of young users (Chapter 2).

ii) Second, to ensure that the questionnaire would be patient-derived, in-depth interviews were carried out with 25 service users from the sample of 7 services described in Appendix 5¹⁴. The young people were approached whilst in the waiting room, and interviewed directly after their clinic appointment. They were asked, using open-ended questions, about their experience of attending the service, including which aspects of their visit had pleased and displeased them.

iii) Third, to ensure that indicators would be consensus as well as evidence based, questionnaires which had already been used in the evaluation of services for young people

were collected and the questions relating to the variables identified as important to young people, where available, were collated and existing measures incorporated into the instrument, wherever possible¹⁵.

iv) In the final stage, and based on stages i) to iii), a questionnaire was developed which was evidence-based, patient-derived and supported by expert opinion.

In terms of the independent variables, that is, the organisational features of service delivery, services were characterised according to the degree of **dedication**, i.e. whether or not they were separate young people's service or served all ages; **integration**, that is, whether contraception and infection control were combined in one service or provided separately, and **location**, that is whether they were situated within a hospital or in the community.

For the attributes of young people using the services, I was interested in their demographic profile (for example, age, deprivation level, ethnicity) and risk behaviour (for example, onset of sexual activity, and risk reduction practices, e.g. condom use), so as to be able to describe their level of risk in the context of the inclusiveness of the services.

In addition, I was interested in collecting data relating to the user satisfaction themes generated by the existing literature (Chapter 2):

- Awareness (2.2.1)
- Inclusiveness (2.2.2)
- Acceptability (2.2.3)
- Accessibility (2.2.4)
- Adequacy of service provision (2.2.5)
- Degree of confidentiality (2.2.6)
- Quality/quantity of information (2.2.7)

¹⁴ Full details of the way in which these services were selected for inclusion into the study can also be found at Section 3.3.2.

¹⁵ Initially, questionnaires were collected from around 60 sexual health services. The purpose of this exercise was to determine what is currently being measured in existing service evaluation, and how this information is being collected. This was felt to be an important aspect of the project in terms of proven feasibility, i.e. to ensure that it was possible to collect data relating to the key variables being developed. Questionnaires from a core sample of 8 services were searched for the key variables identified as important in the literature search. Where variables emerged from the literature as important, for which no measures were developed by the core sample of services, the instruments from the subsidiary sample of services were systematically examined to identify services which managed to collect such information. Where shown to be feasible, the variables were retained and included in the final questionnaire. Where a measure could not be found in any of the existing research instruments, I devised questions from scratch in conjunction with my supervisor and Advisory Group.

- Continuity of care (2.2.8)

I have described in detail below the procedures followed for operationalising one of the themes, that is, acceptability, to serve as an illustrative example. For reasons of space, the details of the remaining seven groups are detailed in Appendix 11.

Acceptability

The review of the published literature around the issue of acceptability of sexual health services to young people, led to the development of a number of recommendations for service provision and therefore, measurement objectives for evaluation of the services.

Recommendations

- Services should be acceptable and appropriate to clients
- Service staff should have an appropriate age and gender-mix
- Staff should be non-judgmental, trustworthy and welcoming
- The physical environment of the clinic should create a relaxed atmosphere

These recommendations provided a list of variables which must be measured when assessing the acceptability of a service in the clients' view.

Measurement Objectives

- To ensure that female doctors and nurses should be available on request
- To ensure that male doctors and nurses should be available on request
- To ensure that staff have a special interest in working with young people
- To ensure that the atmosphere is friendly, relaxed and informal
- To ensure that privacy should be provided during all consultations
- To ensure staff are responsive to client requests and behaviour
- To ensure clients are given every opportunity to make informed choice

The next task was to operationalise these variables. For each theme, I listed all the possible indicators that might be obtained from the client. Clearly, in the case of acceptability, some dimensions were more easily measured than others. Young people could not be relied upon to accurately describe the age of providers for example. Table 4.3.1, below, illustrates the indicator and operational variables, identified from the literature as being important in measuring the acceptability of sexual health services to young people. The next stage of this work was to examine the research instruments obtained from the sample clinics to determine the means by which these variables have been measured in practice.

Table 4.3.1 Acceptability of service:

Indicator variable		data sought from client
Satisfaction with:	Physical environment	Cleanliness Orderliness Comfort Layout Décor Equipment/facilities
	Atmosphere	Acceptability of accompanying friends Social ambience Adequacy of personal space Welcome/ friendliness
Interaction between clients and providers	Staff attitudes	Possibilities for patient choice/ decision making Neutrality of staff Opportunity for clients to express views, concerns and questions Privacy: anonymity confidentiality Concern/ empathy / tact / sensitivity
	perceptions of characteristics of staff	age gender
	Treatment	Satisfaction with: nature of any physical examination medical history taking information provision help given counselling received information received prior to treatment

Examination of the questionnaires derived from the pilot services¹⁶, revealed the following examples of question items and wording from existing questionnaires, designed with the aim of measuring client satisfaction with acceptability:

Satisfaction with:

Physical environment

Were the rooms:

Comfortable? Yes • No • Don't know •
Private enough? Yes • No • Don't know •

GP Sample A

Arrangement of space

On a scale of 1 to 4 could you say how satisfied you are with each of these. One would mean you were not satisfied, 4 would mean you were totally satisfied. **Please circle the number you want.**

The waiting room 1 2 3 4
The refreshments available 1 2 3 4
Lighting/heating 1 2 3 4
Any other comments about the amenities? _____

Streetwise Sample A

¹⁶ Copies of the questionnaires used are included at Appendix 12.

Atmosphere

What did you find the clinic to be like?

- i) *Friendly/Nice*
- ii) *Sympathetic*
- iii) *Approachable*
- iv) *Relaxed*
- v) *Informal*
- vi) *Well equipped*
- vii) *Badly equipped*
- viii) *Hospital-like*
- ix) *Other* _____

Salisbury Sample A

How welcome did you feel when you first arrived at the lodge, tick the box that best describes the way you felt

- | | | | | |
|----------------|----------------|-----------|-----------------|-------------------|
| • | • | • | • | • |
| <i>Very</i> | <i>Quite</i> | <i>OK</i> | <i>Not very</i> | <i>Not at all</i> |
| <i>welcome</i> | <i>welcome</i> | | <i>welcome</i> | <i>welcome</i> |

Slough - Sample A

Can you give us your ideas on how to make it more welcoming for you.

.....

Slough - Sample A

Attitudes of staff

Did you find the staff:

- | | | | |
|---------------------------------|-------|------|--------------|
| Friendly and welcoming? | Yes • | No • | Don't know • |
| Treated you as an adult? | Yes • | No • | Don't know • |
| Respected your confidentiality? | Yes • | No • | Don't know • |

GP Sample A

Were the staff at the centre

- | | | |
|-------------|-----|----|
| | Yes | No |
| Helpful | • | • |
| Sympathetic | • | • |
| Friendly | • | • |
| Informative | • | • |

Salisbury Sample A

What did you find the doctor to be like?

- i) *Friendly/Nice*
- ii) *Sympathetic*
- iii) *Approachable*
- iv) *Non-Judgmental*
- v) *Easy to talk to*
- vi) *Intimidating*
- vii) *Poor attitude*
- viii) *Other* _____

Salisbury Sample A

What did you find the nurse to be like?

- i) *Friendly/Nice*
- ii) *Sympathetic*
- iii) *Approachable*
- iv) *Non-judgmental*
- v) *Easy to talk to*
- vi) *Intimidating*
- vii) *Poor attitude*
- viii) *Other* _____

Salisbury Sample A

What did you find the receptionist to be like?

- i) *Friendly/Nice*
- ii) *Sympathetic*
- iii) *Approachable*
- iv) *Non-judgmental*
- v) *Easy to talk to*
- vi) *Intimidating*
- vii) *Poor attitude*
- viii) *Other* _____

Salisbury Sample A

Are there any bad things about the clinic that need changing?

- i) *Too long a wait*
- ii) *Unhelpful staff attitude*
- iii) *Yes, other* _____
- iv) *No*

Salisbury Sample A

On a scale of 1 to 4, please say how satisfied you were with each of these. One would mean you were not satisfied, and 4 would mean you were totally satisfied. Please ring the answer you want.

<i>The welcome from the clerk/receptionist</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>
<i>The Doctor's attitude and manner</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>
<i>The Nurse's attitude and manner</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>
<i>The usefulness of the service you received</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>

Streetwise Sample A

Perceptions of characteristics of staff

Do you prefer to see male or female staff or either? (Please ring answer)

Male *Female* *Either*

Streetwise Sample A

Treatment

If you had a choice which would you prefer?

See Nurse only

See Nurse & Doctor

See Doctor only

Does not matter to me

Brook Sample A

Today's Experience:

Did you feel comfortable seeing the nurse?	YES	NO
Did you get what you needed from the nurse?	YES	NO
Did you receive the information you needed from the nurse?	YES	NO
Did you feel you could ask the nurse all the questions you needed to ask?	YES	NO
Did you feel confident that the nurse was capable of giving you contraceptive supplies if needed?	YES	NO
Were you given the choice to see the doctor as well?	YES	NO

What do you think the visit should be like?
(circle those that apply to you.)

EXPLAIN MORE THAN ONCE SEE DOCTOR ON EACH VISIT QUICK VISIT
LONG COMPLETE CHECK-UP SEE NURSE ONLY EXPLAIN ONCE

On future visits, would you prefer to see:

Nurse Only Nurse & Doctor Doctor Only Does Not Matter

It Depends (list depending factor)

COMMENTS: Is there anything you would like to say on this matter?

Brook Sample A

DID YOU FIND THE ADVICE / HELP / INFORMATION?

NOT HELPFUL HELPFUL VERY HELPFUL

OTHER, (please specify)

GP Sample A

The nurse

Did you feel able to say what you wanted to say to the NURSE

Yes completely • Almost all I wanted • Not at all •

Slough - Sample A

Do you feel the nurse understood you and your needs?

Yes • Quite a lot • No •

Slough - Sample A

Did you understand what the nurse was saying to you?

Yes all of it • Almost all of it • Not at all •

Slough - Sample A

The Doctor

Did you feel able to say what you wanted to say to the DOCTOR

Yes completely • Almost all I wanted • Not at all •

Slough - Sample A

Do you feel the doctor understood you and your needs?

Yes • Quite a lot • No •

Slough - Sample A

Did you understand what the doctor was saying to you?

Yes all of it • Almost all of it • Not at all •

Slough - Sample A

Did you feel you got what you wanted from the clinic?

Yes completely • Almost all I wanted • Not at all •

Slough - Sample A

Did anything happen that made you feel embarrassed, frightened or upset? If so please give brief details.

.....**Slough - Sample A**

Would you come again? Yes • No •

Slough - Sample A

Would you recommend a friend to come?

Yes •

No •

Slough - Sample A

Please tell us what we could do to make the service better?
.....

Slough - Sample A

4.3.2 Piloting the questionnaire

The questionnaire was piloted across 7 services in 2001. A sample of 30 young men and women were asked to self-complete the standardized and scheduled questionnaire. The questionnaires were distributed in the waiting room, prior to their being seen by staff, but participants were asked to complete them following their clinical consultation so that they were able to comment on their entire experience of attending the service.

Following completion of the questionnaire, all the young people were taken to one side for an in-depth interview to ascertain any difficulties experienced whilst completing the questionnaire and to probe the extent to which it was comprehensive, intelligible and appropriate. The purpose of these interviews was to 'talk participants through' their responses in the quantitative questionnaire to seek ways in which the design of the questionnaire might be improved.

Modification to the instruments on the basis of pilot

The questionnaire was modified following the piloting. The first draft of the questionnaire is included as Appendix 13. Also included is the feedback from the piloting and rationale for the decisions relating to the design and structure of the final version. The final questionnaire is included at Appendix 14.

On reviewing the questionnaire prior to the start of data collection, staff at one of the study sites (Service Type 6a/6b) made a special request for some additional questions to be included in order that the results from this study be more comparable with an earlier study they had conducted. After negotiation with the staff and consultation with my supervisor the decision was taken to modify the questionnaire slightly for this site alone. All the original questions remained, but two completely new questions were inserted. This was carried out as a courtesy to the staff at the study site. Analysis of the additional questions was included in the summary of results provided to the clinic, but not in the analysis for the study as a whole.

4.3.3 Fieldwork: quantitative component

Visiting the services

Once the services had agreed to participate, the next stage was for me to visit the service to meet with the key staff and explain the research in more detail. These meetings were held

between September and November 2003. In each of the meetings I was introduced to the consultant in charge and all the medical, nursing and support staff. This process allowed me to become familiar with the workings of the service and to be able to verify exactly what services were provided. Getting to know the staff and the layout of the clinics was extremely useful when the data collection process began.

On meeting the manager of service Type 6 it transpired that she was equally responsible for two services within the same NHS Trust. Both were similar in terms of the service provided but differed in the population group they attracted. The first, for example, was a female-only clinic located in a central location close to a university. As such, the majority of the client base was young female students in their late teens or early twenties. By contrast the second service was located in a much more mixed area and attracted a younger population from more diverse ethnic and educational backgrounds. It was also a mixed sex service. On discussion with the Advisory Group the decision was taken to retain both of these services in the study, aiming to achieve 100 completed questionnaires from each.

During the visit and discussion with the consultant in another service (originally classified as Type 7), it emerged that this service was actually more appropriately classified as Type 5. I was told that it was not run by general practice, rather by the community trust and was in fact a family planning service specifically for young people.

Again, after discussion with the Advisory Group, a decision was taken to continue to include this service but to have two Type 5 services (i.e. dedicated but not integrated) and aim for a response of 100 questionnaires from each.

This was possible due to the nature of the study design in that the investigative focus was on service characteristics (i.e. **dedication**, **integration** and **location**), rather than the specific services themselves. This reorganisation still resulted in the same number of responses from each type of service. The modification turned out to be fortuitous as neither service classified as Type 5 was especially busy and the original target of 200 questionnaires from each would not have been achievable in the data collection period.

To avoid a seasonal effect, the initial aim was for data collection at each service to be carried out simultaneously over a two-month period (October – November 2003). In fact this period was extended to March 2004. The questionnaire was fully structured and scheduled except for two open-ended questions probing what the user liked most and least about the service and what they might change. Piloting showed the questionnaire to be quick and easy to self-complete.

Selecting the participants

The fieldwork was carried out by myself with the help of two research assistants, Emily Mabonga and Posy Bidwell. All young people attending the participating services for any reason during the fieldwork period were asked to complete a questionnaire. Men and women, and different ethnic¹⁷ and socio-economic groups, were represented in the sample in the proportions in which they attended.

The inclusion criteria for participants were that they should be:

- attending the service on their own behalf and not accompanying someone else
- under the age of 25
- have a reasonable grasp of English (adequate to be interviewed)¹⁸

In the dedicated young peoples' services, recruitment of participants involved approaching all young people who entered the clinic for treatment (as opposed to accompanying a friend). Given that the target age of the services was under 25, clients automatically qualified and could be approached directly. In all-age services the process was a little more complicated in that those over the age of inclusion (25) had to be identified and excluded. This was generally done with the help of the receptionists in each service who were asked discreetly to check the patient's date of birth from the notes, and point the researcher in the direction only of those who met the inclusion criteria.

Once the eligible potential participants were identified, they were approached whilst in the waiting room, prior to being seen by the nurse or doctor. A brief explanation of the research was given along with a written information sheet (attached at Appendix 15). The clients were then given a few minutes to decide whether they wanted to become involved in the study. Those who agreed were handed the questionnaire, which they were asked to complete after they had been seen by all the appropriate medical staff. Once completed, they were asked to seal it into an envelope provided and to leave it on the receptionists desk on their way out. The selected services and the actual data collection periods are shown on Table 4.3.3 below:

¹⁷ Although I recognised that there are significant variations in sexual health risk factors with ethnicity, and over-sampling of some groups may have allowed further investigation of this, I took the decision not to over-sample, but just to invite people into the study in the proportions in which they attended. Ethnic group was however included in the questionnaire, so some comparison of outcome by ethnicity was possible.

¹⁸ It was expected that a very small number of participants would have English which was too poor to be included in the study. During the piloting of the research instruments, none of the participants understood too little to take part.

Table 4.3.3 Details of sample services for quantitative component

	Dedicated	Integrated	Located	Data collection period	Number participants recruited
Type 1	Yes	Yes	Hospital GUM department	4 th November 2003 – 4 th May 2004	173
Type 2	N/A				
Type 3	No	Yes*	Hospital GUM department	24 th November 2003 – 27 th January 2004	182
Type 4	N/A				
Type 5	5a Yes	5a No	5a Community centre on school grounds	12 th November 2003 – 7 th January 2004	105
	5b Yes	5b No	5b Community centre on high street	5b 12 th November 2003 – 24 th March 2004	108
Type 6	Yes (6a for young women only)	Yes***	6a Community based GU dept	1 st March 2004 – 29 th March 2004	85
	Yes (6b for under 20s men and women)	Yes	6b Community based GUM department	24 th February 2004 – 16 th March 2004	91
Type 7	N/A				
Type 8	No	No	Community based FP clinic	10 th October 2003 – 18 th November 2003	192
Type 9	No	No**	Hospital GUM department	3 rd November 2003 – 20 th November 2003	230
Type 10	N/A				

*This service can be described as integrated on some occasions and not others. On some days a contraceptive specialist was on site and on other days no contraceptive expert was available. The researchers collecting the data took note of the situation on each clinic visit to allow the data to be analysed accordingly.

**This service was originally GU but has now introduced some FP. However the decision was taken to classify it as not integrated since people attend primarily for GU concerns and rarely solely for FP.

*** This service although originally GU, now provides a comprehensive FP service to all clients and people often attend solely for contraception.

4.4 Analysis

The statistical analysis was carried out using SPSS (version 12.01). A crucial first task was the calculation of the response rate. In order to be able to assess this accurately three observations had to be made in the data collection process:

- The number of people asked to complete the questionnaire
- The number of people who agreed to do so
- The number of questionnaires actually returned

Denominators for calculating the response rate included every person asked to complete a questionnaire and the numerator was the number actually returned. Some people did initially agree to take part but then failed to return their questionnaire or returned incomplete questionnaires. Where questionnaires remain partially completed they are included in the calculation of the response rate but specific item non-response were accounted for in the analysis.

Next, the relationship between organisational features of service provision and key aspects of client satisfaction with key aspects of care was examined. The key to the analysis was not to compare satisfaction between attenders at one individual service with those at another, but to examine variation in variables relating to satisfaction with key features of service configuration: which were represented across the whole sample of services. Thus the data were analysed specifically to examine the influence of these three core variables of interest: **integration**, **dedication** and **location**, on satisfaction levels amongst users.

Bi-variate and multi-variate analyses were carried out and results are presented in chapters 6 and 7. Odds ratios were calculated for each of the outcomes in terms of aspects of client satisfaction, adjusted for organizational features of service delivery. In all the comparisons, results are reported with and without adjustment for as many other confounding variables as possible, including age and area-related deprivation level.

CHAPTER 5: REPORT ON THE QUALITATIVE INTERVIEWS

This chapter presents data from the round of 25 qualitative interviews conducted in 2000 with the purpose of informing the development of the questionnaire for the quantitative component of the study and to shed light on young people's spontaneous views of the services. Further details of this methodology, along with a demographic breakdown of the participants is presented in Chapter 3.

The topic guide was developed around the eight key areas of service quality, described in Chapter 2. The interviews confirmed the importance of these eight areas and fed directly into the development of the questionnaire. The qualitative data were also analysed using a thematic approach to explore the significance of the three key research questions in the study:

- How does young people's satisfaction with sexual health services vary with the age- dedication of the service; that is, whether it serves young people only, or all ages?
- How does young people's satisfaction with sexual health services vary with the integration of the service; that is, whether family planning and genito-urinary services are offered separately, or together?
- How does young people's satisfaction with sexual health services vary with the location of the service; that is, in community or hospital based services?

5.1 Integration

Infection and contraception services: separate or combined?

The provision of both infection and contraception services together in the same service was welcomed by the participants. Many felt confident that the staff in specialised sexual health clinics would be expert in dealing with a range of sexual health issues as they: '*deal with that kind of thing all of the time. They are specialised in it*'. This seemed to result in increased confidence in the knowledge and ability of the staff. They were felt to have a less judgemental attitude than staff who deal with sensitive issues less frequently. This in turn was felt to reduce the level of embarrassment experienced during consultations.

Res: It's not like you should feel shy to talk to them [the doctors] about anything.....there are many people before you who have come to them with problems so it's like .. I don't feel like afraid to say anything, because they've come across this many times.

Female, 18yrs, Integrated service

There was a feeling among the participants that a further benefit of integrated services was the increased efficiency which was likely to result from this mode of delivery. Several reported that the single best thing about the service was that they were able to have all their needs met in one visit. This even included sexual health concerns additional to those for which they had originally attended. Many, for example, who had initially attended for contraception were also offered opportunistic screening for sexually transmitted infection. Despite reported concerns in the published literature that this may deter people from attending integrated services^{102 103}, no one in this study, even those who had only had sex with one partner, reported being offended by the offer of tests for infection. Even those young women who declined the offer of screening reported that they would go away to think about it and perhaps take up the offer on their next visit to the clinic. This seems to demonstrate the usefulness of introducing screening as a vehicle for discussing sexually transmitted infections and thus provides an opportunity for health education and promotion.

Integrated services also provided the opportunity for young people to be regularly tested for infection when they might primarily be attending for contraception. This allowed testing where they wouldn't think to visit an STI clinic simply for routine check ups. Some young women reported regularly taking up the opportunity for STI testing despite being asymptomatic.

One young woman described the way in which having the opportunity to have all needs met in the same place removed the need for young people to visit their GP:

Int: So how do you feel about the fact you can get infections treated and you can get the pill and everything all in the same clinic session?

R: I think it's good because then you don't have to go to the doctor or nothing 'cus quite a lot of people don't want to, do they?

Int: So you don't mind that people are here for infections as well as contraception?

R: No, I think its good.

Female, 13yrs, Integrated service

The participants were asked whether they could name some of the services on offer at the clinic. This was to explore whether those coming for contraception were also aware that infection services were offered on the same site and to probe their feelings on this. One young woman described the way in which staff introduced the subject of infection opportunistically during her contraception consultation and went on to describe the importance of staff taking this opportunity:

Int: So you said you came here to get the pill, can you tell me, do you know of any other sort of things that you can treatment or advice about?

R: Well they give you condoms if you need them, they do smears, I know that, um... but I don't really know anything ...they do all, they told me that when I came, they gave me some leaflets about the pill, and they also gave me leaflets about irritants and viruses that you can get and that.

Int: Sexually transmitted viruses? Right so they gave you information about infection? How did you find that information?

R: It was good, it was useful.

Int: So they gave you it in leaflet form and also talked to you about it during the consultation.

R: Yeah.

Int: So how did you feel about them bringing up the issue of infection?

R: I think it was good, it was alright, yeah ...

Female, 15yrs, Integrated service

There was evidence among those attending non-integrated services of receiving fragmented care. The following excerpt describes the request made of one young woman, aged 16, to come back to the same clinic a week later for a repeat pregnancy test before being given contraception, and being told she had to visit her GP for her symptoms of urinary tract infection.

R: They said that next week I have to come back and then we might be able to discuss, to start thinking about using contraception pills.

Int: So you are coming back next week?

R: Yeah

Int: Why do you have to come back next week? Why can't everything be done now? Do you know?

R: Yeah. Because I missed a period and there could be a fair chance that I am pregnant. But the test that I had done today was negative. But you really cannot be too sure so that is why I have to take another test.

Int: OK, you said you came here mainly because you had trouble passing urine.

R: Yeah, when I was passing urine they told me it had blood in it and it was an infection. But they didn't tell me the cause of it. I asked her the cause and she said it is like a sore throat – that anyone can catch it. They just told me it was a bladder infection and that I should drink cranberry juice and that I should talk to my GP and that he should give me some antibiotics.

Int: So they weren't able to give you antibiotics here? Or a prescription?

R: No

Int: Oh I see. So you have to go back to make another appointment with your GP?

R: Yeah, I have to talk about it to my GP and I have to give my GP a urine sample.

Int: OK For a pregnancy test?

R: Well for a bladder test and – for both.

Int: So now you have to make another appointment?

R: Yeah. She asked me to do it tomorrow. And I have to take another urine test for the clinic at 7 in the morning and bring it back here for a pregnancy test on Thursday.

Int: So how do you feel about the fact that everything wasn't sorted out in one go?

R: I was sort of hoping that everything would be sorted out in one go, cos I would quite like to get everything over and done with. But if I have got to do it I have got to do it but I would have preferred it to have been all done at one time.

Female, 16yrs, Separate FP service

This excerpt demonstrates the difficulties young people face in accessing comprehensive services. The reluctance of young people in accessing their family GP has been well documented and in this case could have been avoided had the clinic been equipped to test for and treat infections.

Irritation about the limited services available at some non-integrated clinics appeared repeatedly in the transcripts.

There was evidence that integrated services encourage young people to be proactive in taking responsibility for their health. One young woman reported how she frequently visited a clinic and specifically requested infection testing despite having no symptoms. She wanted to be sure that after each occasion of sexual intercourse, she remained free from infection:

Int: So how many times have you been roughly?

R: About 12 times.

Int: So you've been here 12 times in a year?

R: Yeah.

Int: And is it always for the same thing?

R: Yeah just for pregnancy test, or if I want to take any tests for infections or basically that.

Int: So they offer screening for infection then?

R: Yeah.

Int: So you don't come because you've got symptoms?

R: I just come out of interest.

Int: Right.

R: Because I heard about this chlamydia, the lady and the doctor about this new illness called chlamydia, and said if I came straight away, she could cure it straight away if there was anything wrong with me, so I get that tested regularly.

Int: Right so you get a test to make sure you haven't got it then as opposed to having symptoms.

R: Yeah.

Female, 14yrs, Integrated service

Integrated services appear to remove the need for young people to attend on numerous occasions for the same health concern. Participants appeared to greatly appreciate not being asked to come back at a later date for test results – something which is likely only to be possible at a well-equipped centre where diagnoses can be made on-the-spot. This was particularly important for pregnancy tests *'They always tell me when my pregnancy test is positive or negative like straight away they will tell me'* but also included getting results of swabs.

Integration therefore appears to reduce the risk of care being fragmented. It avoids people being asked to come back on different days or being sent to different clinics which in turn runs the risk of people being lost to follow-up. There were reports of people being frustrated by being asked to return to the clinic at a later date because not everything could be dealt with there and then. Such complaints are likely to be more frequently seen in non-integrated services.

Another reported benefit of integrated services is that they may be less embarrassing for people to attend. People are afforded anonymity in contrast to separate clinics in which the reason for their attending where it may be obvious to other people in the waiting room, or to people observing others entering or leaving the service, (eg a traditional separate GUM service) those attending integrated services can attend under the auspices of several alternative reasons.

Int: ... you said that you know you can get sexual transmitted infectious treated here and you can get contraception and all that so it's quite a broad spectrum kind of clinic. Can you tell me what your feelings are about that sort of service?

R: I think its [integrated services] less embarrassing for people as well. To have separate clinics and so people know I am going so I could have a sexually transmitted disease is embarrassing

Int: So if the clinic was just for an infection you'd think that then, like it would be like people would know? But here its better?

R: Yes.

Female, 20yrs, Integrated service

Unexpected benefits of integrated services also emerged. For example, one participant suggested that integrated services may make boys more responsible about contraception. The feeling was that traditional contraceptive services would have difficulty attracting boys as the convention has been that these are attended mainly by women wanting contraception. The feeling was that as the image of the clinic changed to be more all-encompassing in terms of sexual health, boys may be more likely to attend as they identified it as somewhere they may be welcome. This may in turn have an impact on their interest in contraception, shifting the responsibility away from solely being that of the woman.

Generally speaking there were no negative reports about the issue of integration. The following response was quite typical.

Int: How do you feel about the fact, all in the same place, infections are treated as well as contraception?

R: I think that's good because you don't have to .. if you came and told them you had a problem say, then they can sort it out straight away, they can give you a test or something straight away, rather than sending you away to somewhere else.

Int: You think it's better that it's all in one session?

R: Yes.

Int: Ok, so would you think there would be a problem, with people being put off coming or anything, because it's an infection clinic as well?

R: I wouldn't, no.

Female, 15yrs, Integrated Service

There was no evidence from the interviews with young people in integrated services of concern about infection and contraceptive services being offered together. For most, it was seen as only beneficial and the concerns which have previously been expressed in the published literature were not apparent in the in depth interviews.

On the down side, there was a perception on the part of some that offering a walk-in integrated service could have an impact on health-seeking behaviour with people becoming less cautious in terms of prevention, knowing that, should they become pregnant with an unwanted pregnancy or infected with an STI, with regular attendance they might be detected and treated early thus lessening the need for safe-sex practiced initially.

5.2 Dedication

Sexual health services for young people: separate or combined?

These interviews revealed mixed views on the potential benefits of offering young people separate clinical services. Some participants felt that youth-dedicated services were very important whilst others were indifferent. For many it was an issue that had never been considered and for these young people, age exclusiveness of a service was not of prime importance to them in deciding which clinic to attend.

For those clinics which do provide youth services, an important question appears to be the appropriate age group to which to offer the service. There is evidence here that age dedicated services could result in exclusion of some potential users. This could occur either through certain people not being permitted to attend the specific session (due to being in the wrong age group) or because the young persons' services are necessarily restricted to a limited number of hours per week, thus inevitably resulting in limited access. The following young woman reports being almost turned away:

R: Well she [the receptionist] asked me how old I was and I said I was 21, well she said are you under 21, and I said no, she said you will have to come back at the end then, and I said, well I am 21 so can I squeeze in, and she said that would be ok.... I might have been a bit annoyed if I'd had to come back.

Female, 21yrs, Integrated service

Promoting young peoples' sessions may also result in limited awareness of the timing of alternative clinical sessions to which young people are also welcome to attend. One young woman was aware only of the weekly session which was dedicated to young people, despite the clinic being open on several other evenings during the week:

Int: Are the opening times convenient for you then?

R: It just so happens I have Mondays off anyway, and Mondays is when the young people's bit is between 3 and 5 so if I didn't have Mondays off I'd probably get a bit stuck.

Int: Right, do you know if they do evening sessions here, the young people's is just once a week on a Monday ...?

R: *Yes, just on a Monday so...*

Female, 16yrs, Integrated service

Practitioners are therefore faced with the difficult task of achieving the fine balance between offering separate services and compromising on clinic hours such that the service does not become less accessible to other young people, in their late teens or early twenties, who may not fall within the target age group.

There was a general view among the participants in this study that the age exclusiveness is more important to younger clients, whilst the older participants attached more importance to longer opening hours to ensure they have greater opportunity to attend.

Int: *So this session is specifically ... it's just two hours isn't it Do you think that's a good thing to have? Dedicated hours like that?*

R: *Um ... yeah I think it is for the younger people, 'cos they will come in and there will be other young people there and there won't be old people, like what are they thinking about me, sort of thing.....'*

Male, 19yrs, Integrated service

It was generally reported that a young people's service was more important to younger users and was largely irrelevant to those in their older teens. The following was a typical response from the older participants:

R: *I don't think ... well me personally it wouldn't bother me like if there was older people here, but I'm not too sure about other kids but it wouldn't ... I suppose some kids would think 'oh no'. They'd feel intimidated and they'd feel a bit funny ...*

Female, 18yrs, Integrated service

Younger participants appeared more age-sensitive:

Int: *What about if... tonight is just under 21s, how do you feel the age group*

R: *I dunno, 'cus I'd rather just come when its young people, because old people probably would make me paranoid, looking at me saying she's too young, things like that. Yeah I'd rather come when it's just under 21s.*

Female, 15yrs, Integrated service

There were reports also of older teenagers being put off entering service in which crowds of younger people could be seen waiting around the entrance or in the clinic itself:

R: *I mean there were a couple of school girls in as well and I was like... felt really old .. that kind of thing, looking at them*

Female, 20yrs, Integrated service

There was some concern that it would be the adults rather than the teenagers who would feel uncomfortable in mixed age services:

R: And they would feel funny just sitting around you know a group of grown ups just sitting there and you are about 16 or 15 and still at school, but it really doesn't bother me that much.

Female, 18yrs, Integrated service

Contrary to a common concern among health professionals, many young people in this study didn't feel uncomfortable at the thought that they might recognise people in the waiting room. The general feeling was that, whilst attending their local service, the likelihood of bumping into a school friend or someone else known to them, was quite high. This only seemed to cause concern if the person they recognised was older than the participant.

Int: Ok, how would feel if you saw other people who were here that knew you, like older people? Would that be worse or better?

R: Worse Well it depends if ... some people are a bit, well they might say something about it and that but I wouldn't, but some people wouldn't, most, it was like people I knew really well I wouldn't be bothered.....No I think ... if it was older people like your mum like that or your teachers or something that would be embarrassing

Female, 13yrs, Integrated service

Fear of being seen by someone familiar does not necessarily appear to act as a deterrent to attendance. This young woman speaks positively about recognising people:

Int: So did you find it quite comfortable being here then?

R: Yeah, like there's loads of people, there are loads of people who I knew here and that...

Female, 13yrs, Integrated service

Young people generally seemed to soon recover from the initial embarrassment felt on seeing someone they knew in the waiting room, recognising that everyone was there for the same reason so there was therefore little point in making reference to it in the future.

For some, it was actually the presence of familiar faces in the waiting room which helped them to feel more relaxed. One participant summed up her lack of concern about the other people in the waiting room:

R: No it's not because it doesn't bother me 'cus it's not like I come in here to socialise, I'm just coming here to ...

Female, 18yrs, Separate FP service

So in support of age-dedicated services, there was a feeling that these would safe-guard young people from being seen by older family members or other people known to them. However there were some reports that the older people in this study may be uncomfortable with age-dedicated services due to their discomfort sharing facilities with teenagers. This again highlights the challenge to health professionals in getting the age targeting right so as to be as inclusive as possible. For example there was a feeling among some that the age limit for some sessions was too broad. There were reports of people in their early 20s feeling uneasy in the presence of school girls.

It seems the younger users, those most likely to need reassurance about attending the clinic do get some comfort out of separate age-specific services possibly because they identify with the others in the waiting room:

Int: Do you think there is anything that can be done to make clinics like this less scary to come to? For the first time?

R: I'm not sure really, I don't know, there are a lot of young people here like, when I actually came in there were already a lot of people in school uniform and that, and that sort of made me feel a lot more comfortable that I wasn't the only person so, I don't know, I'm not too sure.

Female, 15yrs, Integrated service

Int: And how would you feel if it wasn't, say this was just for anyone and anybody of any age, male or female could come in, how would you feel about sharing a waiting room with all

R: Yeah, if there were like loads of older people there I might feel that they were like looking down on me and going 'she is only young, what's she doing here'

Int: Right, so do you think it is better then that it's just young people sessions

R: Yeah, yeah, I feel more comfortable sitting here when there's more people my age

Female, 16yrs, Integrated service

Despite some reporting feelings of embarrassment, no one felt particularly strongly about the issue. There was no strong sense that people attended specifically because the services were for young people. What appeared to attract them into dedicated young people's services was their perception that this is when they were supposed to attend. No one reported that the age segregation would put them off attending again in the future. Generally it was not something which was high on users' agendas. More important were the other factors reported elsewhere - that the attitude and approach of the staff is the single most important thing.

The existence of a youth clinic may be enough in itself to ensure that news of the clinic spreads by word of mouth. Alternatively the characteristics that come along with having a youth friendly service – such as the relaxed atmosphere, perhaps music and other comforting accessories contributing to making it welcoming – rather than the age issue *per se*.

R: and also seeing that it's under 21s today they have the radio on and magazines, and people just seemed really, really relaxed.....I mean the reception area is quite free to go in and out of, it's nice and relaxed.

Female, 20yrs, Integrated service

It could be argued that these conditions may quite easily be present in an all age service. For example, when probed about the benefits of the service many participants felt that the best thing about the young person's sessions were not that they were dedicated exclusively to young people, but that they were walk-in where no appointment was necessary. This was felt to be suitable as many young people tend to be spontaneous and bad at planning and keeping appointments. This element of the service is sometimes found at all age services and is not exclusive to young peoples' clinics.

5.3 Location

The setting of a sexual health service appears from these interviews to be instrumental in determining the likelihood of young service users being seen entering or leaving the clinic. A key concern amongst the participants was that they may be recognised approaching or leaving the entrance to the clinic. Location appears to have the potential to reduce embarrassment and help to maintain anonymity.

The participants generally appreciated the entrances to clinics being hidden around the back of buildings where they could enter or exit discreetly. Preference was also expressed for services located within a larger health centre or hospital as, as one participant reported: '*you can lie about where you are going*'. The importance of balancing discreet location with adequate sign-posting was also mentioned. If services are too well hidden and inadequately sign-posted, having to ask directions could also create embarrassment and so could constitute a significant barrier to attendance.

Although they valued proximity to a service, some participants reported that they would be willing to travel to a more distant clinic to avoid being seen by someone known to them, or to avoid going to their own GP: '*I didn't want to go to my GP..... he's known me all my life*' was a typical response. For others, however, the desire to remain unrecognised was not significant enough to make them travel to a more remote service. Generally the willingness to travel further and the desire not to be seen were more significant factors for younger

participants. One young woman reported actually changing clinics because of seeing too many people on a previous visit elsewhere. Suggestions as to ways of maximising anonymity were made, including rearrangement of the waiting area to provide *'more places to hide'*.

On the other hand, benefits of more conspicuous services were pointed out, particularly the increased likelihood of potential service users becoming aware of it by simply walking past the entrance, and taking note for future reference. Given the difficulties reported in the published literature of raising awareness of the existence of sexual health services to young people, there may be some positive aspects of less discreet locations. These interviews, in common those carried out by others^{72 132 138 139 141}, show that a frequent source of information about service provision and location is by word of mouth.

Although possibly of interest to the planning of additional services, this information is of limited value to services which are already established as they can do little to change their geographical location.

The strongest opinions to emerge among the participants, when asked about their choice of service were those relating to the relative benefits of General Practice over sexual health services in alternative locations. Comparisons were made between community clinics and General Practice settings. Many participants described confidentiality and anonymity as crucial in their choice of service, which, in addition to the location of a service, appear to be important when recommending a particular clinic.

There appeared to be a great deal of confidence among the participants that contraceptive and sexual health services are confidential. This, however did not extend to General Practice. The problem related more to lack of anonymity, than lack of trust in the doctors themselves. There is still concern about being recognised, particularly by a relative, which is perceived to be more likely to happen in General Practice than a specialist sexual health service. On explaining her choice of a community clinic over General Practice, one participant explained: *'I was just a bit nervous that my mum would find out that I had been down to the GP so I thought this would be more ... like ... private ...and she wouldn't find out about it.....I know it's [the GP] confidential its just more .. like .. I felt more comfortable coming here where people didn't know my family'*

Female, 17yrs, Integrated service

A common concern was that parents would either be informed of the visit or find out accidentally. There was some anxiety, particularly among the younger participants, that the GP would actively inform the parents of their visit:

R: *Well I'm scared that my GP will tell my mum because it's like a family ... like we go there together, me and my mum.*

Female, 14yrs Integrated service

Others, although perhaps having more trust in their GP, were still concerned that their parents may be informed inadvertently:

R: *Yeah, in the doctor's, I thought uh.... the doctor knows my mum, he might let it slip out*

Female, 18yrs, Integrated service

As recommended⁵⁹ and as is already happening in many services²⁰ assurances of confidentiality were on display in many reception areas, or were frequently reported on display. Many participants were also given additional assurance verbally by the staff that the service was confidential. Even those young people who were in no doubt that both General Practice and sexual health services were confidential, or those whose parents were aware of their attendance at the clinic, still reported their increased willingness to attend a clinic in preference over their own GP:

R: *Well ... I know it's all confidential and that at the GP's and everything but I just ... I just don't know, don't know, why I just feel more comfortable coming here. My parents know and everything I come here, my mum dropped me off here earlier, but I just don't know*

Female, 16yrs, Integrated service

Many simply reported that the atmosphere was more relaxed and informal at clinics than at their GP, demonstrating a preference for a less medicalised setting:

R: *It's more, it was more... I felt more comfortable here. It's a nicer atmosphere rather than going to the doctor's surgeryIt just seems like ... like more friendly like, I don't know..... like in your GP's it's just I don't know, you just feel really weird, and ... like you're in hospital and you've done something wrong.*

Female, 17yrs, Integrated service

Some explained that although they were initially very anxious that staff would contact their parents they soon were reassured that this would not happen and went away with complete trust in the staff. One participant however, did have a negative experience to report. She

chose a community clinic in preference to her GP because of fear of a breach in confidentiality, yet this happened anyway, despite assurances to the contrary:

R: *I think the first time I went to one [FP clinic], I was about fifteen, and I was terrified and the woman that had me was actually the mother of a boy I'd been to primary school with and she knew my mum and everybody, and I was really, really frightened that my mum would find out, and I was only fifteen. That's why I didn't go to my GP, I went to a family planning clinic, but she assured me that she wouldn't say anything and that she wasn't allowed. But then a couple of years later, this boy that I'd been to school with somehow knew about it.*

Int: *Really?*

R: *Yeah and that really, really made me angry actually, because there is no way that he would have found out unless she had a conversation with him about it. But I never said anything about it. My mum never found out obviously but she'd obviously told someone else which was really... I don't know, I felt a bit vulnerable in a way.*

Int: *Do you think that's affected your trust in clinics?*

R *Well I haven't been back to that one (laughs).*

Female, 21yrs, Separate FP service

Even this participant however, insisted that she now had confidence in the service and that young people today generally trust staff in sexual health clinics.

Many reported also that the staff in clinics were easier to talk to than their GP. When probed on this subject, the general feeling was that there was no need to feel intimidated as the staff were all professionals, and trained doctors and nurses. However, there was a feeling that GPs see patients about all types of health concern, rather than exclusively about sexual health concerns, and so were more likely to feel uncomfortable talking about sexual health.

What came through from the transcripts, was the importance of both the age and the gender of health professionals. There were mixed views and for some neither was an issue. However there was some feeling that female doctors may be more likely to empathise more with young women. The general perception was that clients would be more likely to be seen by a female doctor in a sexual health clinic than they would at their General Practice. There was a strong feeling, regardless of the setting, that a choice of male or female doctor should be offered.

For one young male participant, the issue of gender was very important. He reported that, on finding out his GP was a woman, he was very reluctant to make an appointment to see her about a sexual health concern. It took him several months to gather the confidence to see her, despite knowing that he had a sexually transmitted infection.

With regard to the age of health professionals, there was a widespread feeling that younger doctors would be less judgemental, better equipped to offer understanding and empathy and would just be *'more clued up about contraception'*.

In conclusion, these interviews re-affirmed the importance of specific service characteristics to young people. Respondents appreciated the benefits of relaxed and open staff attitudes, efficient, confidential, comprehensive services and the opportunity to receive test results quickly. All of these were felt to be more likely to be found in integrated as opposed to more traditional separate services. The further benefits of integrated services were felt by the respondents, to be greater levels of staff expertise, greater opportunity for opportunistic screening for STIs – the introduction of which was not offensive to any of the participants – and the increased likelihood of young men feeling welcome to attend. On the downside however, there was some concern that offering a walk-in integrated service could have an impact on health-seeking behaviour with people becoming less cautious in terms of prevention.

Views amongst service users on age-dedicated services were more ambivalent. Few participants felt strongly that sessions specifically for young people would influence their decision to attend one service over an alternative one. In fact there was some anxiety that dedicated services could inadvertently lead to accessibility becoming more restricted. The benefits of age-dedicated services were thought to be felt more by younger teenagers, whilst the older participants placed more value on longer opening hours.

Respondents stated the need for services to be anonymous in terms of not being seen on entering or leaving by someone known to them. This was felt to be most likely achieved in a community based setting. However services located within large hospitals also offered the possibility of anonymity as being seen on site didn't necessarily mean sexual health services were being attended. Participants explained the need to get a balance between discreet location and adequate sign-posting and similarly between proximity to home and the risk of being seen by a family member or neighbour. These issues seem to be most important to the youngest respondents. The issue of anonymity doesn't seem as important in this study as has been reported elsewhere. It seemed instead that it was the characteristics of age-dedicated

sessions, such as the relaxed friendly atmosphere and particularly the drop-in arrangements, which make them attractive rather than the age issue per se. These however are not necessarily exclusive to young people's services. Indeed some respondents found comfort and reassurance by seeing familiar faces in the waiting area. The other side of the coin in terms of not being seen by those who might be unsympathetic, it seems, was peer support and solidarity – a feeling that going to a clinic was normal.

Once within a service however, confidence that a service is completely confidential remains paramount to young people and there was a perception amongst the participants that this is more likely to be achieved in sexual health services (as opposed to in General Practice). Gender of staff was also an issue for some respondents and there was a perception that female doctors were more likely to be available in clinics than in General Practice.

For many respondents, the issue of confidentiality may be becoming less significant than previously reported. Several reported that their mothers were aware of their attendance at the service – indeed some actually had their mother drop them off at the door. There now seems to be a good deal of confidence that health professionals will maintain confidentiality – even among the very young people. The concern is more that information about their attendance at the service or GP might slip out inadvertently to parents.

The issue of potential embarrassment was quite strong – with young people reluctant to attend their GP with whom they may have been registered all their lives. The concern however seemed to be related to embarrassment at the thought that the family doctor would become aware of their sexual activity.

In this chapter I report the results from the survey of young people accessing sexual health services. A total sample of 1166 was achieved. Of these, 415 (35.6%) were attending an integrated service and 751 (64.4%) were attending a more traditional 'separate' service. 562 (48.2%) attended a service dedicated to young people and 604 (51.8%) an all-age service. 585 (50.2%) attended a hospital-based service and 581 (49.8%) a service located in the community. Of the total sample, 260 (22.4%) were male and 899 (77.6%) female.

Table 6.0: Number of respondents by type of service.

		Integrated	Not integrated	Total
Dedicated to young people	Hospital-based	173	0	173
	Community-based	176	213	389
	Sub total	349	213	562
Not dedicated to young people	Hospital-based	66	346	412
	Community-based	0	192	192
	Sub total	66	538	604
	Total	415	751	1166

6.1 Response rates

A total response rate of 83% was achieved. This is broken down below:

1.	Number of people approached	1407
2.	Number refused	131
3.	Number of questionnaires given out	1178
4.	Number returned	1166
	Refusal rate (2/1*100)	9.31%
	Return rate (4/3*100)	98.98%
	Response rate (4/1*100)	82.87%

Details of the samples achieved for each service are shown below (Table 6.1)

¹⁹ Data from all the services were analysed together by characteristics of service. However as a courtesy to each of the sample sites, a full report of their individual results was provided. One sample report is included at Appendix 16.

Table 6.1 Details of samples achieved for each service

	Dedicated	Integrated	Hospital based	Number of people approached to take part (x)	Number refused	Number of questionnaires distributed	Number of questionnaires returned (y)	Response rate (y/x*100)
Type 1	Yes	Yes	Yes	183	3	180	173	95%
Type 2	N/A							
Type 3	No	Yes*	Yes	212	10	202	182	86%
Type 4	N/A							
Type 5	5a Yes	5a No	No 5a Community centre on school grounds	123	14	109	105	85%
	5b Yes	5b No	5b Community centre on high street	120	8	114	108	90%
Type 6	Yes (6a for young women only)	Yes***	No 6a Community based GUM dept	104	4	100	85	82%
	Yes (6b for under 20s men and women)	Yes	6b Community based GUM department	101	3	98	91	90%
Type 7	N/A							
Type 8	No	No	No Community based FP clinic	220	20	200	192	87%
Type 9	No	No**	Yes Hospital GUM department	344	69	275	230	67%
Type 10	N/A							

*This service can be described as integrated on some occasions and not others. On some days a contraceptive specialist was on site and on other days no contraceptive expert was available. The researchers collecting the data took note of the situation on each clinic visit to allow the data to be analysed accordingly.

**This service was originally GU but has now introduced some FP. However the decision was taken not to classify it as integrated and people attend primarily for GU concerns and rarely solely for FP.

*** This service although originally GU, now provides a comprehensive FP service to all clients and people often attend solely for contraception.

6.2 Results

Bi-variate findings are organised by the extent to which services appear to meet service users' requirements in terms of the themes identified in the literature and listed earlier (Chapter 2). Comparisons are made on these variables for each of the three characterising features of service organisation, ie: **Integration, dedication** and **location**. The data have been analysed separately for each sex. Full tables are presented Appendix 17.

6.2.1 Awareness

Respondents were asked one key question to assess awareness: Q10: How did you find out about this service? A long list of response options was offered and the most popular are presented below.

Among both men and women and across all service types, word of mouth was the most common way in which people became aware of services (55%). The difference was most marked between men attending hospital-based services compared with those attending community-based services (54% and 82% respectively reported friends as their main source).

The GP was the next most commonly reported source of awareness (19% in the whole sample). The GP was a source of information for a higher proportion of women attending separate FP and GUM services than it was for those attending integrated services (26% cf 16%). and the same was true of those at hospital-based services compared with community-based services (26% and 19%) and at all-age services compared with dedicated services through their GP surgery (27% cf 17%) than at community-based services. For men, significant differences were only seen with location, men attending hospital based services having more commonly found out about the service from their GP.

Hearing of the service from school or college was comparatively less commonly reported (16% in the sample as a whole). Men at community based services had much more commonly heard about the service from school or college (22%) than had those at hospital based services (5%). Unsurprisingly school or college was more commonly reported as the source on information about the service from those attending dedicated services, but this is likely to be confounded by age.

Table 6.2.1 Awareness by service characteristics

	DEDICATION				INTEGRATION				LOCATION			
	YP service		All age service		Integrated sexual health service		Separate GUM or FP service		Community-based service		Hospital based service	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Total	449	108	450	152	334	77	565	183	496	81	403	179
How found about service?												
Friend	<i>p=0.029 (women); p=0.001 (men)</i>				<i>p=0.283 (women); p=0.088 (men)</i>				<i>p=0.006 (women); p<0.001 (men)</i>			
Yes	244 (56.2)	74 (74.7)	216 (48.9)	80 (54.4)	163 (50.2)	41 (54.7)	297 (53.9)	113 (66.1)	274 (56.7)	60 (82.2)	186 (47.3)	94 (54.3)
No	190 (43.8)	25 (25.3)	226 (51.1)	67 (45.6)	162 (49.8)	34 (45.3)	254 (46.1)	58 (33.9)	209 (43.3)	13 (17.8)	207 (52.7)	97 (45.7)
GP?	<i>p<0.001 (women); p=0.958 (men)</i>				<i>p=0.001 (women); p=0.269 (men)</i>				<i>p=0.012 (women); p=0.003(men)</i>			
Yes	73 (16.7)	10 (10.0)	120 (27.0)	15 (10.2)	52 (15.9)	10 (13.3)	141 (25.5)	15 (8.7)	91 (18.8)	1 (1.4)	102 (25.8)	24 (13.9)
No	363 (83.3)	90 (90.0)	324 (73.0)	132 (89.8)	275 (84.1)	65 (86.7)	412 (74.5)	157 (91.3)	394 (81.2)	73 (98.6)	293 (74.2)	149 (86.1)
School/college?	<i>p<0.001 (women); p=0.003 (men)</i>				<i>p=0.910 (women); p=0.010 (men)</i>				<i>p<0.001 (women); p<0.001 (men)</i>			
Yes	108 (24.9)	17 (17.2)	50 (11.3)	8 (5.4)	58 (17.8)	2 (2.7)	100 (18.1)	23 (13.5)	108 (22.4)	16 (21.9)	50 (12.7)	9 (5.2)
No	326 (75.1)	82 (82.8)	392 (88.7)	139 (94.6)	267 (82.2)	73 (97.3)	451 (81.9)	148 (86.5)	375 (77.6)	57 (78.1)	343 (87.3)	164 (94.8)
Internet?	<i>p=0.073 (women); p=0.027 (men)</i>				<i>p=0.137 (women); p=0.887 (men)</i>				<i>p=0.031 (women); p=0.027 (men)</i>			
Yes	13 (3.0)	4 (4.0)	24 (5.4)	18 (12.2)	18 (5.5)	7 (9.3)	19 (3.4)	15 (8.8)	14 (2.9)	2 (2.7)	23 (5.9)	20 (11.6)
No	421 (97.0)	95 (96.0)	418 (94.6)	129 (87.8)	307 (94.5)	68 (90.7)	532 (96.6)	156 (91.2)	496 (97.1)	71 (97.3)	370 (94.1)	153 (88.4)

The internet was not a common source of information about services according to these data, though in general it was more common amongst men than women. The low proportion reporting this source varied little between service type. Only amongst men in hospital-based services did it reach double figures.

6.2.2 Inclusiveness

a) Demographic profile of service users

Young people who are vulnerable and deprived are deemed priority clients at sexual health services. Of considerable interest then, was whether patterns of service delivery appeared to be associated with the extent to which young people at greater risk on the basis of demographic criteria (such as age and deprivation) were included in the service population.

Age profiles of the different services varied markedly and significantly with type of service, (Table 6.2.2a). Predictably, the greatest differences in this respect are seen between services dedicated to young people and those serving all-ages. More than half (58%) of young women using dedicated young people's services were aged under 18 years, compared with 17% in all-age services. Among young men, the difference was more striking; four out of five (79%) of all under 25 year old male attenders at dedicated young people's services were aged under 18, compared with only 6% in all-age services. The pattern is similar for under 16 year old users. 17% of under 25 year old women, and 39% of under 25 year old men attending services dedicated to young people were aged 15 or younger, compared with fewer than 5% and 3% respectively in all age services.

Age differences between users of integrated and non-integrated services, and between users of hospital and community based services, were also in evidence, though they were not of the same magnitude and were more pronounced among men, especially at the younger ages. The proportions of young women users of integrated and non-integrated services who were aged under 16 was roughly the same (10% cf 12%) but a greater disparity was seen for men. More than one in five young men attending separate services were aged 15 or younger, compared with one in 15 at integrated services.

With respect to community and hospital based services, there was little difference in the proportion of young women attending who were aged under 18 (37% cf 36% respectively). (Table 6.2.2a). However, nearly twice as many young men attending community based services (37% cf 20%) were aged under 18, compared with hospital based services, though these results are likely to be confounded by age-dedication. Very young, ie. under 16 year old, men and women made up a considerably higher proportion of young people attending community based services, and again the difference was more marked for men (14% of

young women, and 17% of young men, in community based services were aged 15 or younger, compared with 8% and 3% respectively, in hospital-based services).

Employment status was significantly different between those attending dedicated compared with all-age services, 15% of women were in full-time work, 56% were at school or college and 12% at university, compared with 32%, 25% and 56% respectively. A similar pattern was found among men. This is unsurprising however, as for both men and women, employment status is likely to be strongly confounded by age so that, in the bi-variate analysis, we see school attenders featuring most prominently amongst attenders of services with a younger profile, ie. dedicated, integrated and community based, whilst the reverse is true for those who are in work or training.

The differences between service populations were less marked with respect to ethnic group and nationality, and were not statistically significant, though this may be partly a function of the small numbers involved. There were certainly some sizeable differences between services in the proportions of some ethnic groups attending. For example, among men, white service users made up a higher proportion of the under 25 year old clientele at dedicated young people's services than they did of those in all age services (61% cf 47%) and the reverse was true for Asian service users (making up 2% of the clientele in dedicated services compared with 5% in non-dedicated services). Higher proportions of women at integrated services were of white ethnic group than those at non-integrated services (68% cf 60%) and the difference was statistically significant. Similarly, black African service users featured more prominently amongst attenders at separate services than they did amongst those at integrated services, whilst for Afro-Caribbean men and women the reverse was true, though these differences were not statistically significant.

With respect to deprivation, those from lower socio-economic groups were significantly more likely to be among the users of all-age, non-integrated and community based services. The difference was most marked among the profile of men at dedicated services, of whom 16% were from the most deprived group and 52% from the least deprived, compared with 61% and 2% at all age services. For women, the big differences were seen with respect to the integration of the service; the proportion of attenders living in an area in the upper quartile of deprivation was twice as high in separate services compared with those which were integrated (Table 6.2.2a).

Table 6.2.2a Demographic profile of users by service characteristics

	DEDICATION				INTEGRATION				LOCATION			
	YP service		All age service		Integrated sexual health service		Separate GUM or FP service		Community-based service		Hospital based service	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Total	449	108	450	152	334	77	565	183	496	81	403	179
Age	p<0.001 (women); p<0.001 (men)				p<0.001 (women); p<0.001 (men)				p<0.001 (women); p<0.001 (men)			
15 or under	77 (17.2)	42 (38.9)	20 (4.5)	2 (1.3)	32 (9.6)	5 (6.5)	65 (11.5)	39 (21.5)	67 (13.5)	44 (17.1)	34 (7.5)	5(2.8)
16-17	174 (38.8)	43 (39.8)	54 (12.0)	7 (4.9)	116 (34.7)	13 (39.0)	112 (19.9)	20 (11.0)	114 (23.0)	50 (19.4)	114 (28.4)	30 (16.9)
18-19	92 (20.5)	17(15.7)	91 (20.3)	14 (9.3)	70 (21.0)	16 (20.8)	113 (20.1)	15 (8.3)	108 (21.8)	31 (12.0)	75 (18.7)	15 (8.5)
20 or over	105 (23.4)	6 (5.6)	284 (63.3)	127 (84.7)	116 (34.7)	26 (33.8)	273 (48.5)	107 (59.1)	206 (41.6)	133 (51.6)	183 (45.5)	127 (71.8)
Employment status*	p<0.001 (women); p<0.001 (men)				p=0.035 (women); p=0.533 (men)				p=0.015 (women); p<0.001 (men)			
Working (inc training scheme and PT)	104 (23.2)	22 (20.4)	192 (42.7)	71(46.7)	100 (29.9)	27 (35.1)	196 (34.8)	66 (36.1)	143 (28.9)	15 (18.5)	153 (38.0)	78 (43.6)
Unemployed	40 (8.9)	5 (4.6)	50 (11.1)	27(17.8)	26 (7.8)	7 (9.1)	64 (11.3)	25 (13.7)	54 (10.9)	3 (3.7)	35 (8.9)	29 (16.2)
At school/college/uni	304 (67.9)	81 (75.0)	208 (46.2)	54 (35.5)	208 (62.3)	43 (55.8)	304 (53.9)	92 (50.3)	298 (60.2)	63 (77.8)	214 (53.1)	72 (40.2)
Ethnic group	p=0.802 (women); p=0.147 (men)				p=0.009 (women); p=0.536 (men)				p=0.004 (women); p=0.236 (men)			
Black African	34 (7.6)	12 (11.1)	41 (9.3)	20 (13.5)	18 (5.4)	7 (9.1)	57 (10.3)	25 (14.0)	38 (7.7)	32 (12.5)	37 (9.4)	21 (12.0)
Black Caribbean	58 (13.0)	24 (22.2)	65 (14.7)	38 (25.7)	35 (10.5)	16 (20.8)	88 (15.7)	46 (25.7)	52 (10.5)	62 (24.2)	71 (18.0)	40 (22.9)
White	286 (64.0)	66 (61.1)	272 (61.7)	70 (47.3)	227 (68.2)	46 (59.7)	331 (59.6)	90 (50.3)	332 (67.2)	136 (53.1)	226 (57.4)	91 (52.0)
Asian	22 (4.9)	2 (1.9)	20 (4.5)	8 (5.4)	19 (5.7)	4 (5.2)	23 (4.1)	6 (3.4)	27 (5.5)	10 (3.9)	15 (3.8)	9 (5.1)
Mixed Race	47 (10.5)	4 (3.7)	43 (9.8)	12 (8.1)	34 (10.2)	4 (5.2)	56 (10.0)	12 (6.7)	45 (9.1)	16 (6.3)	45 (11.4)	14 (8.0)
Deprivation level**	p<0.001 (women); p=0.012 (men)				p<0.001 (women); p<0.001 (men)				p<0.001 (women); p=0.004 (men)			
Upper quartile (most deprived)	87 (36.0)	5 (16.1)	100 (40.8)	52 (61.2)	44 (25.1)	28 (46.7)	143 (45.8)	29 (51.8)	111 (40.8)	28 (70.0)	76 (35.3)	29 (38.2)
2 nd quartile	54 (22.3)	4 (12.9)	75 (30.6)	27 (31.8)	34 (19.4)	11 (18.3)	95 (30.4)	20 (35.7)	91 (33.5)	9 (22.5)	38 (17.7)	22 (28.9)
3 rd quartile	32 (13.2)	6 (19.4)	43 (17.6)	4 (4.7)	27 (15.4)	6 (10.0)	48 (15.4)	4 (7.1)	45 (16.5)	2 (5.0)	30 (14.0)	8 (10.5)
4 th quartile (least deprived)	699 (28.5)	16 (51.6)	27 (11.0)	2 (2.4)	70 (40.0)	15 (25.0)	26 (8.3)	3 (5.4)	25 (9.2)	1 (2.5)	71 (33.0)	17 (22.4)

*Groups conflated due to small numbers among men ** Refers to Multiple Index of Deprivation, calculated from respondents' postcode

b) Sexual health status of service users

In addition to demographic profile, the sexual health status of service users is of interest in assessing the extent to which different features of service organisation appear to influence use of the service by those in need. In this context I was interested in age at onset of sexual activity, current relationship status, sexual orientation and risk reduction practice (condom use). I was also interested in young people's use of services before becoming sexually active.

Age at first sexual intercourse varied significantly by integration and dedication, but not location of the service for women, while for men, the significant associations were with dedication and location (Table 6.2.2b). The proportions of women reporting intercourse before age 16 were higher among users of integrated sexual health services and dedicated young people's services. Young men reporting lower ages of first sexual intercourse were more commonly users of dedicated than all age services, and at community-based compared with hospital-based services. For men, relationship status did not vary significantly with service configuration. For women, it varied significantly only with dedication, with higher proportions at young people's services reporting that they were either in casual relationships (20% cf 16%) or not in a relationship (25% cf 20%).

Sexual orientation varied with location and integration of service for women, and with dedication for men (Table 6.2.2b). Women attracted mainly to women were more common attenders of hospital than community-based services (12% and 5% respectively). The numbers are small for men, but higher proportions of those attracted to other men were seen among users of all age services compared with those dedicated to young people (14% cf 4%) and in hospital compared with community-based services (12% cf 4%).

Respondents were asked if they were sexually active at the time of interview and so it was possible to assess whether their current visit to the service was an anticipatory one. 88% of men and 95% of women across the whole sample reported having previously had sexual intercourse. Significant differences in the proportions who had not were reported by women at dedicated young people's services compared with all-age services (8% cf 3%); and between those attending hospital compared with community-based services (7% cf 3%). For men differences between attenders at dedicated young people's services and all-age services were of a greater magnitude (23% cf 4%) as were those between attenders at hospital-based services compared with those in the community (28% cf 5%).

They were also asked whether they had visited any sexual health service before first having sex and again the vast majority (84% overall) replied that they had not. Use of any sexual health service before becoming sexually active varied significantly for men and women with

Table 6.2.2b Sexual health profile of users by service characteristics

	DEDICATION				INTEGRATION				LOCATION			
	YP service		All age service		Integrated sexual health service		Separate GUM or FP service		Community-based service		Hospital based service	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Total	449	108	450	152	334	77	565	183	496	81	403	179
Age at first sexual intercourse	p<0.001 (women); p<0.001 (men)				P<0.001 (women); p=0.846 (men)				p=0.796 (women); p<0.001 (men)			
Under 16	237 (61.0)	60 (82.2)	146 (35.4)	53 (41.1)	173 (56.2)	37 (56.9)	210 (42.6)	76 (55.5)	204 (47.4)	40 (83.3)	179 (48.3)	73 (47.3)
16+	152 (39.0)	13 (17.8)	267 (64.6)	76 (58.9)	135 (43.9)	28 (43.1)	284 (57.5)	61 (44.6)	227 (52.8)	8 (16.7)	192 (51.7)	81 (52.6)
Had sex before this service visit	p=0.001 (women); p<0.001 (men)				p=0.092 (women); p=0.206 (men)				p=0.006 (women); p<0.001 (men)			
Yes	405 (92.5)	81 (77.1)	436 (97.5)	143 (96.0)	316 (96.6)	70 (92.1)	525 (94.1)	154 (86.5)	453 (93.2)	56 (71.8)	388 (97.2)	168 (95.5)
No	33 (7.5)	24 (22.9)	11 (2.5)	6 (4.0)	11 (3.4)	6 (7.9)	33 (5.9)	24 (13.5)	33 (6.8)	22 (28.2)	11 (2.8)	8 (4.5)
Had sex before first service visit	p=0.051 (women); p<0.001 (men)				p<0.001 (women); p=0.001 (men)				p<0.001 (women); p<0.001 (men)			
Yes	335 (82.5)	54 (64.3)	373 (87.4)	121 (93.8)	280 (91.5)	58 (96.7)	428 (81.2)	117 (76.5)	360 (80.0)	32 (51.6)	348 (90.9)	143 (94.7)
No	71 (17.5)	30 (35.7)	54 (12.6)	8 (6.2)	26 (8.5)	2 (3.3)	99 (18.8)	36 (23.5)	90 (20.0)	30 (48.4)	35 (9.1)	8 (5.3)
Relationship status	p=0.025 (women); p=0.617 (men)				p=0.079 (women); p=0.736 (men)				p=0.327 (women); p=0.538 (men)			
Steady	243 (55.2)	43 (42.6)	282 (64.2)	57 (38.8)	183 (55.6)	31 (40.8)	342 (62.2)	69 (40.1)	300 (61.7)	33 (44.6)	225 (57.3)	67 (38.5)
More casual	87 (19.8)	22 (21.8)	69 (15.7)	40 (27.2)	59 (17.9)	21 (27.6)	97 (17.6)	41 (23.8)	85 (17.5)	19 (25.7)	71 (18.1)	43 (24.7)
Not in one	110 (25.0)	46 (35.6)	88 (20.0)	50 (34.0)	57 (26.4)	24 (31.6)	111 (20.2)	62 (36.0)	101 (20.8)	22 (29.7)	97 (24.7)	64 (36.8)
Mainly sexually attracted to...	p=0.084 (women); p=0.020 (men)				p=0.060 (women); p=0.787 (men)				p=0.001 (women); p=0.086 (men)			
Same sex	28 (6.4)	4 (3.8)	47 (10.5)	21 (13.8)	19 (5.8)	8 (10.4)	56 (10.0)	17 (9.4)	26 (5.3)	3 (3.8)	49 (12.3)	22 (12.3)
Opposite sex	401 (91.1)	101 (96.2)	390 (87.2)	130 (85.5)	299 (91.2)	69 (89.6)	492 (88.0)	162 (90.0)	454 (92.7)	75 (96.2)	337 (84.9)	156 (87.2)
Both	111 (2.5)	0 (0)	10 (2.2)	1 (0.7)	10 (3.0)	0 (0)	11 (2.0)	1 (0.6)	10 (2.0)	0 (0)	11 (2.8)	1 (0.6)
Ever used a condom	p=0.001 (women); p<0.001 (men)				p=0.702 (women); p=0.122 (men)				p=0.122 (women); p<0.001 (men)			
No	38 (9.5)	20 (21.5)	16 (3.7)	3 (2.2)	19 (6.1)	4 (5.5)	35 (6.7)	19 (12.0)	35 (7.7)	19 (28.4)	19 (5.0)	4 (2.4)
Yes	362 (90.5)	73 (78.5)	416 (96.3)	135 (97.8)	294 (93.9)	69 (94.5)	484 (93.3)	139 (88.0)	420 (92.3)	48 (71.6)	358 (95.0)	160 (97.6)

where the service currently attended was located and whether it was an integrated sexual health service and, for men but not for women, with whether it was a young people's service. For young men, the difference was striking; more than a third (36%) of those currently attending a service for young people reported having first used a service before becoming sexually active, compared with only 6% currently attending an all age service ($p < 0.001$), though of course we cannot know whether the first service attended was the current one.

Differences of a similar magnitude are seen for young men in terms of integration and location. Nearly a quarter of men (24%) attending non-integrated services had made their first visit to a sexual health service before becoming sexually active compared with only 3% of those attending integrated services, and nearly half (48%) of those attending community-based services had done so compared with 5% at hospital-based services. Differences on this scale were not seen for women, though the associations between all three service types were significant. The proportion who had used a service before having sex was higher among dedicated service users than among users of all age services (18% cf 13%); higher among users of separate services compared with integrated services (19% cf 9%); and higher among community-based services compared with hospital-based services (20% cf 9%).

6.2.3 Acceptability

Many of the questions in the questionnaire could be considered measures of levels of acceptability to the young service user. However, the published literature refers repeatedly to a number of themes identified as being particularly important. These are represented by the following questions:

Q11: How did the service feel to you:

- Relaxed?
- Cheerful?
- Comfy?
- Well equipped?

Q12: In general would you say staff were:

- Friendly?
- Helpful?
- Welcoming?
- Approachable?

In general, more positive appraisals were made by attenders at services which were dedicated to young people (as opposed to all age) and community-based (as opposed to

hospital based) and, for women but not men, separate (as opposed to integrated) (Table 6.2.3).

In terms of the physical qualities of the service provision, that is comfort and level of equipment, young people's services were rated more highly than all age clinics, and community based services were rated more highly than hospital-based services, by larger proportions of both men and women, but especially men. Differences by integration were only seen for women, with higher proportions at separate FP and GUM services feeling 'comfy'. Significant differences by type of service in terms of adequacy of equipment are seen only for location, and only among women, those attending community based services more commonly deeming them as well equipped.

For the general ambience, that is, whether the service was relaxed and cheerful, there were no significant differences by age-dedication but higher proportions of women in separate services rated them as relaxed. Significantly higher proportions of both men and women attending young people's services found them to be cheerful, compared with all age services. There were no significant differences on either any of the dimensions of ambience by location or integration for men, but separate GUM and FP (as opposed to integrated) services, and community based (as opposed to hospital based) services, scored more highly on both dimensions of ambience for women.

A similar pattern was found regarding staff characteristics, but across all types of service the proportion of men and women rating staff as friendly was generally high. Significantly higher proportions of men and women attending services which were dedicated for young people and which were community-based, and higher proportions of women attending separate GUM/FP reported staff being friendly (there were no differences for men). Significantly higher proportions of both men and women attending young people's services, and significantly higher proportions of women attending separate services found the staff welcoming. Fewer differences by service configuration were seen for other staff attributes. Men attending young people's services more commonly reported staff as helpful, as did both men and women attending community based services. Significant differences in the approachability of staff were seen only by location, and only for women; staff at community services being more commonly considered approachable by female attenders.

Table 6.2.3 Acceptability by service characteristics

	DEDICATION				INTEGRATION				LOCATION			
	YP service		All age service		Integrated sexual health service		Separate GUM or FP service		Community-based service		Hospital based service	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Total	449	108	450	152	334	77	565	183	496	81	403	179
How did the service feel to you: relaxed?	p=0.749 (women); p=0.286 (men)				p=0.020 (women); p=0.459 (men)				p<0.001 (women); p=0.383 (men)			
Very	189 (47.4)	42 (47.7)	206 (49.2)	52 (39.4)	127 (42.2)	26 (37.7)	268 (51.8)	68 (45.0)	253 (55.8)	32 (49.2)	142 (38.9)	62 (40.0)
Quite	188 (47.1)	40 (45.5)	187 (44.6)	74 (56.1)	157 (52.2)	40 (58.0)	218 (42.2)	74 (49.0)	185 (40.8)	29 (44.6)	190 (52.1)	85 (54.8)
Not at all	22 (5.5)	6 (6.8)	26 (6.2)	6 (4.5)	17 (5.6)	3 (4.3)	31 (6.0)	9 (6.0)	15 (3.3)	4 (6.2)	33 (9.0)	8 (5.2)
cheerful?	p=0.003 (women); p=0.002 (men)				p=0.047 (women); p=0.199 (men)				p<0.001 (women); p=0.056 (men)			
Very	124 (33.8)	34 (45.3)	100 (26.5)	24 (20.9)	72 (25.5)	24 (38.1)	152 (31.9)	34 (26.8)	154 (37.6)	23 (43.4)	70 (20.1)	35 (25.5)
Quite	196 (53.4)	30 (40.0)	209 (53.5)	68 (59.1)	167 (59.2)	27 (42.9)	238 (50.0)	71 (55.9)	214 (52.2)	22 (41.5)	191 (54.9)	76 (55.5)
Not at all	47 (12.8)	11 (14.7)	82 (21.0)	23 (20.0)	43 (15.2)	12 (19.0)	86 (18.1)	22 (17.3)	42 (10.2)	8 (15.1)	87 (25.0)	26 (19.0)
comfy?	p=0.024 (women); p=0.038 (men)				p=0.031 (women); p=0.729 (men)				p<0.001 (women); p=0.001 (men)			
Very	126 (33.9)	29 (39.7)	110 (27.7)	26 (22.4)	72 (25.4)	16 (25.4)	164 (33.8)	39 (31.0)	157 (37.0)	25 (47.2)	79 (22.9)	30 (22.1)
Quite	214 (57.5)	35 (47.9)	231 (58.2)	73 (62.9)	181 (63.7)	38 (60.3)	264 (54.4)	70 (55.6)	238 (56.1)	20 (37.7)	207 (60.0)	88 (64.7)
Not at all	32 (14.1)	9 (12.3)	56 (14.1)	17 (14.7)	31 (10.9)	9 (14.3)	57 (11.8)	17 (13.5)	29 (6.8)	8 (15.1)	59 (17.1)	18 (13.2)
well equipped?	p=0.221 (women); p=0.363 (men)				p=0.145 (women); p=0.055 (men)				p=0.018 (women); p=0.267 (men)			
Very	203 (56.1)	41 (55.4)	194 (50.4)	50 (45.0)	141 (50.7)	25 (41.7)	256 (54.6)	66 (52.8)	325 (57.5)	32 (58.2)	162 (47.9)	59 (45.4)
Quite	119 (31.6)	30 (40.5)	179 (46.5)	54 (48.6)	133 (47.8)	34 (56.7)	198 (42.2)	50 (40.0)	167 (40.8)	21 (38.2)	164 (48.5)	63 (48.5)
Not at all	17 (4.8)	3 (4.1)	12 (3.1)	7 (6.3)	4 (1.4)	1 (1.7)	15 (3.2)	9 (7.2)	7 (1.7)	2 (3.6)	12 (3.6)	8 (6.2)
In general would you say staff were: Friendly	p=0.009 (women); p<0.001 (men)				p=0.050 (women); p=0.302 (men)				p<0.001 (women); p=0.004 (men)			
Very	302 (72.6)	79 (83.2)	269 (64.8)	75 (57.3)	205 (65.3)	50 (69.4)	366 (70.8)	104 (67.5)	348 (74.8)	58 (82.9)	223 (60.9)	96 (61.5)
Mostly	111 (26.7)	16 (16.8)	134 (32.3)	51 (38.9)	106 (33.8)	22 (30.6)	139 (26.9)	45 (29.2)	115 (24.7)	12 (17.1)	130 (35.5)	55 (35.3)
Not at all	3 (0.7)	0 (0)	12 (2.9)	5 (3.8)	3 (1.0)	0 (0)	12 (2.3)	6 (3.2)	2 (0.4)	0 (0)	13 (3.6)	5 (3.2)

helpful?	p=0.116 (women); p=0.024 (men)				p=0.251 (women); p=0.254 (men)				p<0.001 (women); p=0.046 (men)			
Very	306 (75.7)	65 (79.3)	292 (71.0)	82 (63.1)	220 (71.2)	43 (66.2)	378 (74.7)	104 (70.7)	355 (78.9)	48 (81.4)	243 (66.6)	99 (64.7)
Mostly	97 (24.0)	17 (20.7)	114 (27.7)	44 (33.8)	88 (28.5)	22 (33.8)	123 (24.3)	39 (26.5)	93 (20.7)	11 (18.6)	118 (32.3)	50 (32.7)
Not at all	1 (0.2)	0 (0)	5 (1.2)	4 (3.1)	1 (0.3)	0 (0)	5 (1.0)	4 (2.7)	2 (0.4)	0 (0)	4 (1.1)	4 (2.6)
welcoming?	p=0.011 (women); p=0.021 (men)				p=0.005 (women); p=0.673 (men)				p<0.001 (women); p=0.204 (men)			
Very	263 (66.9)	57 (72.2)	247 (61.6)	65 (52.8)	178 (59.9)	40 (63.5)	332 (66.8)	82 (59.0)	312 (71.7)	40 (70.2)	198 (55.2)	82 (56.6)
Mostly	124 (31.6)	19 (24.1)	133 (33.2)	47 (38.2)	114 (38.4)	20 (31.7)	143 (28.8)	46 (33.1)	118 (27.1)	14 (24.6)	139 (38.7)	52 (35.9)
Not at all	6 (1.5)	3 (3.8)	21 (5.2)	11 (8.9)	5 (1.7)	3 (4.8)	22 (4.4)	11 (7.9)	5 (1.1)	3 (5.3)	22 (6.1)	11 (7.6)
approachable?	p=0.904 (women); p=0.386 (men)				p=0.070 (women); p=0.717 (men)				p=0.001 (women); p=0.275 (men)			
Very	238 (60.9)	47 (63.5)	240 (59.9)	67 (54.5)	165 (55.4)	35 (55.6)	313 (63.4)	79 (59.0)	289 (66.3)	35 (67.3)	189 (53.1)	79 (54.5)
Mostly	140 (35.8)	26 (35.1)	149 (37.2)	52 (42.3)	121 (40.6)	27 (42.9)	168 (34.0)	51 (38.1)	137 (31.4)	16 (30.8)	152 (42.7)	62 (42.8)
Not at all	13 (3.3)	1 (1.4)	12 (3.0)	4 (3.3)	12 (4.0)	1 (1.6)	13 (2.6)	4 (3.0)	10 (2.3)	1 (1.9)	15 (4.2)	4 (2.8)

6.2.4 Accessibility

Several questions were asked in an attempt to assess the accessibility of the service:

- Q5: Did you find it convenient to attend at the time you came here?
- Q6: How long did you have to wait to get an appointment?
- Q6a: How long before being seen by doctor/nurse
- Q7: How did you get here today?
- Q8: How long did it take to get here?
- Q9: Nearest to where you live?
- Q9a: Close to school/college/work

Most respondents found it convenient to attend the services on the day in which they took part in the survey. Differences were only significant among women for community services (90%) compared to hospital-based services (80%) and these were not marked.

Drop-in facilities were more commonly found at dedicated and in community-based services than at all-age services, or those located within a hospital. Once at the services, shorter waiting times were generally reported in non-integrated and at dedicated services and these differences were statistically significant. Waiting times were also much shorter at community services, where for example, 53% of men reported having to wait only 10 minutes to be seen by a doctor or nurse, compared to 10% at hospital-based services.

Dedicated and community services appear to be more conveniently located than non-dedicated and hospital-based services. Significantly higher proportions reported travelling to them on foot. The difference was most marked among men 53% of whom reported walking to community services compared with 23% to hospital services. Similarly, time taken to travel to the service was significantly shorter for both dedicated and community based services. Again, the difference was particularly marked for young men at community services, 68% percent of whom reported travel times of less than 15 minutes compared with 36% at hospital-based services. There were no significant differences between integrated and non-integrated services.

Additionally, 64% of men reported that the dedicated young people's service they were attending was the closest to home, compared to 55% attending a non-dedicated services. Dedicated services were also significantly more likely to be located close to school, but less likely to be close to college/university or work, while the reverse was true of users of hospital-based services, but these findings are again likely to be confounded by age.

There was some evidence that women were willing to travel a little further for a more comprehensive service. High proportions reported that the integrated service they were

attending was not the closest service to their home and this difference was significantly different for separate GUM and FP services (30% cf 23%). There was no difference amongst men.

The proportion of men and women taking more than half an hour to get to the service was twice as high among those attending hospital-based services as it was among those who had travelled to community-based services.

In the open-ended questions, a variety of reasons were given for changing to the current service and these included closer vicinity to home or work and more convenient opening hours than service previously attended. Problems of other services being too busy and other restrictions such as designated age limits or long waiting times were also documented. Walk-in arrangements were generally preferred as were *'getting results the same day'* and receiving *'on the spot help'*.

Table 6.2.4 Accessibility by service characteristics

	DEDICATION				INTEGRATION				LOCATION			
	YP service		All age service		Integrated sexual health service		Separate GUM or FP service		Community-based service		Hospital based service	
	Women n (%)	Men n (%)	Women n (%)	Men n (%)	Women n (%)	Men n (%)	Women n (%)	Men n (%)	Women n (%)	Men n (%)	Women n (%)	Men n (%)
Total	449	108	450	152	334	77	565	183	496	81	403	179
Convenient to attend today?	p=0.890 (women); p=0.112 (men)				p=0.392 (women); p=0.558 (men)				p<0.001 (women); p=0.112 (men)			
Yes	359 (84.5)	84 (87.5)	355 (84.1)	113 (79.6)	262 (82.9)	62 (84.9)	452 (85.1)	135 (81.8)	421 (89.8)	63 (88.7)	293 (77.5)	134 (80.2)
No	66 (15.5)	12 (12.2)	67 (15.9)	29 (20.4)	54 (17.1)	11 (15.1)	79 (14.9)	30 (18.2)	48 (10.2)	8 (11.3)	85 (22.5)	33 (19.8)
Time waited for appointment?	p=0.001 (women); p<0.001 (men)				p=0.062 (women); p=0.496 (men)				p<0.001 (women); p=0.035 (men)			
Less than a day	49 (11.4)	10 (10.1)	76 (17.3)	29 (20.3)	39 (12.2)	9 (12.3)	86 (15.6)	30 (17.8)	49 (10.1)	9 (12.5)	76 (19.5)	30 (17.6)
A few days	18 (4.2)	2 (2.0)	14 (3.2)	13 (9.1)	15 (4.7)	4 (5.5)	17 (3.1)	11 (6.5)	7 (1.4)	2 (2.8)	25 (6.4)	13 (7.6)
A week or more	8 (1.9)	2 (2.0)	26 (5.9)	13 (9.1)	7 (2.2)	3 (4.1)	27 (4.9)	12 (7.1)	7 (1.4)	1 (1.4)	27 (6.9)	4 (8.2)
No appt needed	355 (82.6)	85 (85.9)	327 (73.8)	88 (61.5)	259 (80.9)	57 (78.1)	423 (76.5)	116 (68.6)	420 (87.0)	60 (83.3)	262 (67.2)	113 (66.5)
Time before being seen?	p<0.001 (women); p<0.001 (men)				p=0.029 (women); p=0.015 (men)				p<0.001 (women); p<0.001 (men)			
Under 10 minutes	136 (41.1)	37 (49.3)	66 (21.1)	7 (6.4)	60 (24.9)	9 (16.1)	142 (35.3)	35 (27.4)	140 (38.3)	31 (53.4)	62 (22.3)	13 (10.3)
10 – 30 minutes	100 (30.2)	22 (29.3)	115 (36.7)	29 (26.6)	83 (34.4)	22 (39.3)	132 (32.8)	29 (22.7)	135 (39.6)	13 (22.4)	80 (28.8)	38 (30.2)
Over half an hour	95 (28.7)	16 (21.3)	132 (42.2)	73 (67.0)	98 (40.7)	25 (44.6)	129 (32.0)	64 (50.0)	91 (24.9)	14 (24.1)	136 (48.9)	75 (59.5)
How did you get here today?	p<0.001 (women); p<0.001 (men)				p=0.208 (women); p=0.372 (men)				p=0.005 (women); p<0.001 (men)			
Own transport/ lift	67 (15.6)	24 (24.7)	110 (24.9)	28 (19.2)	59 (18.3)	19 (25.7)	118 (21.5)	33 (19.5)	98 (20.5)	11 (15.7)	79 (20.2)	41 (23.7)
Public transport	209 (48.7)	29 (29.9)	236 (53.4)	85 (58.2)	177 (55.0)	30 (40.5)	268 (48.8)	84 (49.7)	224 (46.8)	22 (31.4)	221 (56.4)	92 (53.2)
Walked	153 (35.7)	44 (45.4)	96 (21.7)	33 (22.6)	86 (26.7)	25 (33.8)	163 (29.7)	52 (30.8)	157 (32.8)	37 (52.9)	92 (23.5)	40 (23.1)
How long did it take to get here?	p<0.001 (women); p<0.001 (men)				p=0.258 (women); p=0.054 (men)				p<0.001 (women); p<0.001 (men)			
Under 15 minutes	237 (54.9)	62 (60.2)	188 (42.2)	52 (35.6)	145 (44.8)	34 (44.2)	280 (50.6)	80 (46.5)	274 (57.0)	52 (68.4)	151 (38.1)	62 (35.8)
15 – 30 minutes	119 (27.5)	26 (25.2)	137 (30.8)	42 (28.8)	101 (31.2)	29 (37.7)	155 (28.0)	39 (22.7)	133 (27.7)	13 (17.1)	123 (31.1)	55 (31.8)
30 – 60 minutes	69 (16.0)	11 (10.7)	95 (21.3)	43 (29.5)	68 (21.0)	11 (14.3)	96 (17.4)	43 (25.0)	66 (13.7)	7 (9.2)	98 (24.7)	47 (27.2)
More than an hour	7 (1.6)	4 (3.9)	25 (5.6)	9 (6.2)	10 (3.1)	3 (3.9)	22 (4.0)	10 (5.8)	8 (1.7)	4 (5.3)	24 (6.1)	9 (5.2)

Is this the nearest clinic to home?	p=0.822 (women); p=0.016 (men)				p=0.011 (women); p=0.836 (men)				p<0.001 (women); p=0.327 (men)			
Yes	269 (62.1)	65 (63.7)	267 (60.1)	67 (45.6)	177 (54.6)	43 (55.8)	259 (64.9)	89 (51.7)	304 (62.8)	45 (60.0)	323 (59.0)	87 (50.0)
No	107 (24.7)	18 (17.6)	117 (26.4)	44 (29.9)	97 (29.9)	18 (23.4)	127 (23.0)	44 (25.6)	119 (24.6)	15 (20.0)	105 (26.7)	47 (27.0)
Don't know	57 (13.2)	19 (18.6)	60 (13.5)	36 (24.5)	50 (15.1)	16 (20.8)	67 (12.1)	39 (22.7)	61 (12.6)	15 (20.0)	56 (12.6)	40 (23.0)
Is it close to: School?	p<0.001 (women); p<0.001 (men)				p=0.057 (women); p=0.060 (men)				p=0.960 (women); p<0.001 (men)			
Yes	128 (33.9)	42 (48.8)	23 (7.5)	2 (2.2)	73 (25.6)	11 (16.7)	78 (19.5)	33 (29.2)	88 (22.1)	32 (51.6)	63 (22.0)	12 (10.3)
College?	p=0.001 (women); p<0.001 (men)				p=0.088 (women); p=0.077 (men)				p=0.003 (women); p=0.067 (men)			
Yes	97 (25.7)	9 (10.5)	115 (37.6)	31 (33.3)	78 (27.5)	10 (15.2)	134 (33.6)	30 (26.5)	141 (35.5)	9 (14.5)	71 (24.8)	31 (26.5)
Work?	p<0.001 (women); p<0.001 (men)				p=0.838 (women); p=0.376 (men)				p<0.001 (women); p<0.001 (men)			
Yes	70 (18.6)	8 (9.3)	118 (38.6)	48 (51.6)	77 (27.1)	18 (27.3)	111 (27.8)	38 (33.6)	88 (22.2)	4 (6.5)	100 (35.0)	52 (44.4)

6.2.5 Adequacy of service provision

Respondents were asked an open-ended question about their reason for attending the service. This was then back coded and full results are shown at Appendix 18.

Higher proportions of women at integrated services attended for STI tests or a routine check up at than at non-integrated services, yet higher proportions attended for contraception (including all main methods) at non-integrated services.

At dedicated services higher proportions attended for STI tests, condoms and information or advice alone, than at non-dedicated services, while they attended more commonly for other contraception (including injectables and EC), or for results/follow-up or treatment at non-dedicated services.

Hospital-based services were more commonly visited for STI tests, routine check ups and results/follow-up or treatment than community-based services, where higher proportions reported attending for contraception (all main methods), pregnancy tests or information/advice alone.

Of key importance here though was the breadth of the service provided. Participants were asked an additional question: *In addition to what you came here about, what other services were you offered?* Responses were coded to discriminate between those who received only what they came about and those who were offered something extra. Comparisons were made of the differences between service type in proportions offered a broader service are shown in Table 6.2.5 below.

Overall, most people were offered an additional service to the one for which they attended (94% across the sample as a whole). Significant differences were found between women in integrated and non-integrated services, with higher proportions of those at the latter being offered an additional service (92% cf 97%); at young people's and all-age services with higher proportions at the latter being offered an additional service (91% cf 97%) and at community compared with hospital services (93% cf 97%). No significant differences were found among the men.

In the open-ended question, several reported choosing the current service because of the range of services on offer, which were unavailable at alternative clinics. Previous services were reported not to *'offer the same things'* and the current clinic was reported to have: *'offered a different service to the previous place'*.

Table 6.2.5 Adequacy of provision by service characteristics

	DEDICATION				INTEGRATION				LOCATION			
	YP service		All age service		Integrated sexual health service		Separate GUM or FP service		Community-based service		Hospital based service	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Total	449	108	450	152	334	77	565	183	496	81	403	179
In addition to what you came for, were you offered any other services?	p=0.007 (women); p=0.115 (men)				p=0.001 (women); p=0.499 (men)				p=0.033 (women); p=0.194 (men)			
Yes	330 (91.9)	62 (89.9)	341 (96.6)	112 (95.7)	256 (90.8)	56 (91.8)	415 (96.5)	118 (94.4)	377 (92.6)	43 (89.6)	294 (96.4)	131 (94.9)
No	29 (8.1)	7 (10.1)	12 (3.4)	5 (4.3)	26 (9.2)	5 (8.2)	15 (3.5)	7 (5.6)	30 (7.4)	5 (10.4)	11 (3.6)	7 (5.1)

Others reported that they *'go to both for different reasons'*, suggesting that all needs were not being met in either setting.

6.2.6 Degree of confidentiality

Participants were asked a number of questions to assess the perceived level of confidentiality of the service:

Q11: how did the service feel to you – private

Q12: would you say the staff were: discreet
to be trusted with private info

Q12a: confident that it was confidential

On all the dimensions of confidentiality that I included in the questionnaire, privacy, discretion, trust and confidentiality, there were high levels of confidence expressed across all services. This was especially the case with respect to the question specifically eliciting levels of user confidence in the confidentiality of the service young men and women were currently attending. Across the whole sample, 97% of respondents reported feeling that the service was confidential, and this varied little with service type or the gender of attendees. Proportions of men and women assessing their service as feeling private, staffed by discreet practitioners and to be trusted with private information were lower, but they still comprised the majority view.

Only in terms of the location of the service were differences seen in terms of the indicators of perceived confidentiality. Hospital-based services fared slightly less well. Significant differences were seen by service location, for women, fewer of whom reported feeling that the staff were discreet (60% compared with 70%), could be trusted with private information (69% compared to 78%) and that the service was confidential (95% compared to 98%) than those at community-based services.

Those who expressed concern about levels of confidentiality, were asked to elaborate. Explanations related to the amount of information needed by the staff and the number of staff members who have access to private information whilst others related to the way in which information was communicated.

Table 6.2.6 Confidentiality by service characteristics

	DEDICATION				INTEGRATION				LOCATION			
	YP service		All age service		Integrated sexual health service		Separate GUM or FP service		Community-based service		Hospital based service	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Total	449	108	450	152	334	77	565	183	496	81	403	179
How did the service feel to you: private?	p=0.704 (women); p=0.352 (men)				p=0.399 (women); p=0.086 (men)				p<0.001 (women); p=0.132 (men)			
Very	240 (63.7)	52 (71.2)	244 (62.2)	75 (63.6)	170 (59.9)	39 (62.9)	314 (64.7)	88 (68.2)	300 (70.6)	39 (75.0)	184 (53.5)	88 (63.3)
Quite	119 (31.6)	16 (21.9)	124 (31.6)	37 (31.4)	97 (34.2)	22 (35.5)	146 (30.1)	31 (24.0)	110 (25.9)	9 (17.3)	133 (38.7)	44 (31.7)
Not at all	17 (4.8)	5 (6.8)	24 (5.5)	6 (5.1)	17 (6.0)	1 (1.6)	25 (5.2)	10 (7.8)	15 (3.5)	4 (7.7)	27 (7.8)	7 (5.0)
Would you say the staff were... discreet?	p=0.161 (women); p=0.705 (men)				p=0.095 (women); p=0.022 (men)				p=0.018 (women); p=0.428 (men)			
Very	241 (62.9)	48 (63.2)	268 (67.7)	67 (58.3)	179 (60.7)	38 (60.3)	330 (68.2)	77 (60.2)	299 (69.7)	36 (66.7)	210 (60.0)	79 (57.7)
Mostly	124 (32.4)	24 (31.6)	118 (29.8)	39 (33.9)	103 (34.9)	25 (39.7)	139 (28.7)	38 (29.7)	116 (27.0)	14 (25.9)	126 (36.0)	49 (35.8)
Not at all	18 (4.7)	4 (5.3)	10 (2.5)	9 (7.8)	13 (4.4)	0 (0)	15 (3.1)	13 (10.2)	14 (3.3)	4 (7.4)	14 (4.0)	9 (6.6)
...to be trusted with private information?	p=0.843 (women); p=0.273 (men)				p=0.418 (women); p=0.383 (men)				p=0.008 (women); p=0.748 (men)			
Very	283 (73.9)	55 (74.3)	294 (73.9)	74 (63.2)	214 (73.0)	42 (68.9)	363 (74.4)	87 (66.9)	334 (78.0)	38 (71.7)	243 (68.8)	91 (65.9)
Mostly	96 (25.1)	18 (24.3)	98 (24.6)	40 (34.2)	77 (26.3)	19 (31.1)	117 (24.0)	39 (30.0)	91 (21.3)	14 (26.4)	103 (29.2)	44 (31.9)
Not at all	4 (1.0)	1 (1.4)	6 (1.5)	3 (2.6)	2 (0.7)	0 (0)	8 (1.6)	4 (3.1)	3 (0.7)	1 (1.9)	7 (2.0)	3 (2.2)
Confident that service was confidential?	p=0.138 (women); p=0.376 (men)				p=0.501 (women); p=0.485 (men)				p=0.050 (women); p=0.552 (men)			
Yes	391 (95.6)	85 (100)	414 (97.0)	129 (97.7)	302 (96.2)	70 (100)	603 (96.4)	144 (98.0)	448 (97.6)	61 (100)	357 (94.7)	153 (98.1)
No	18 (4.4)	0 (0)	11 (2.6)	2 (1.5)	12 (3.8)	0 (0)	17 (3.3)	2 (1.4)	11 (2.4)	0 (0)	18 (4.8)	2 (1.3)
Not sure	0 (0)	0 (0)	2 (0.5)	1 (0.8)	0 (0)	0 (0)	2 (0.4)	1 (0.7)	0 (0)	0 (0)	2 (0.5)	1 (0.6)

Some reasons though fell beyond the control of the service staff, largely due to the size or lay-out of the clinic: *'although waiting room very small'*; *'because a girl from my school works here'*; *'the reception was in the waiting room so when you say what you are here for people can hear'*. Others just reported feeling generally untrusting of people not known to them: *'cant trust people I don't know medical or not'* (service 3); *'I don't trust anyone who I don't know'*.

These comments were not numerous though and so it is difficult to generalise about the type of service in which each of these concerns might arise.

In addition, many respondents reported in the open-ended questions that the best thing about the service for them was the level of confidentiality. Furthermore, reasons for changing to the current service included reports that respondents ran the risk of seeing fewer people from their area, suggesting they prioritised anonymity over accessibility. Others reported the current service to be: *'more discreet and confidential'* while others simply felt that *'it's more confidential and private here'*.

6.2.7 Continuity of care

As a measure of continuity of care, respondents were asked whether they had visited the service previously:

Q3: Is this your first visit here?

Q3a: If no, when was the last time you came?

The thinking here was that services with higher proportions of users on return visits, may be achieving better continuity of care through time.

At both integrated and hospital based services, significantly higher proportions of men and women reported that the current visit was their first to that particular service, compared to non-integrated and community based services. The most notable difference was among men at hospital services, 50% of whom were attending for the first time, compared with only 31% at community services. There were no significant differences between dedicated and non-dedicated services.

For those who had visited the service on a previous occasion, the difference in time prior to the current visit was significant for both men and women at hospital and community based services, with those at hospitals being more likely to have attended within the last month. A similar pattern was seen for men attending dedicated compared with non-dedicated services.

Table 6.2.7 Continuity of service use

	DEDICATION				INTEGRATION				LOCATION			
	YP service		All age service		Integrated sexual health service		Separate GUM or FP service		Community-based service		Hospital based service	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Total	449	108	450	152	334	77	565	183	496	81	403	179
Is this your first visit here?	p=0.053 (women); p=0.526 (men)				p<0.001 (women); p=0.005 (men)				p=0.043 (women); p=0.005 (men)			
Yes	167 (37.9)	42 (41.6)	142 (31.7)	68 (45.6)	147 (45.0)	43 (58.1)	168 (29.9)	68 (38.6)	156 (31.8)	23 (30.7)	153 (38.3)	87 (49.7)
No	274 (62.1)	59 (58.4)	306 (68.3)	81 (54.4)	180 (55.0)	31 (41.9)	394 (70.1)	108 (61.4)	334 (68.2)	52 (69.3)	246 (61.7)	88 (50.3)
If no when was the last time you came?	p=0.161 (women); p=0.015 (men)				p=0.090 (women); p=0.311 (men)				p=0.023 (women); p=0.012 (men)			
Under a month ago	61 (23.0)	30 (51.7)	76 (25.3)	23 (29.1)	34 (19.4)	9 (29.0)	101 (26.4)	44 (41.5)	71 (22.1)	27 (52.9)	66 (27.0)	26 (30.2)
1-3 months ago	93 (35.1)	13 (22.4)	83 (27.7)	22 (27.8)	49 (28.0)	12 (38.7)	125 (32.6)	23 (21.7)	111 (34.6)	11 (21.6)	65 (26.6)	24 (27.9)
4-6 months ago	47 (17.7)	11 (19.0)	61 (20.3)	13 (16.5)	37 (21.1)	5 (16.1)	70 (18.3)	19 (17.9)	69 (21.5)	10 (19.6)	39 (16.0)	14 (16.3)
7-12 months ago	38 (14.3)	3 (5.2)	36 (12.0)	12 (15.2)	31 (17.7)	2 (6.5)	43 (11.2)	13 (12.3)	33 (10.3)	3 (5.9)	41 (16.8)	12 (14.0)
Over a year ago	26 (9.8)	1 (1.7)	44 (14.7)	9 (11.4)	24 (13.7)	3 (9.7)	44 (11.5)	7 (6.6)	37 (11.5)	0 (0)	33 (13.5)	10 (11.6)

The difference in proportions who had visited similar services previously was only significantly different amongst men attending dedicated and non-dedicated services (20% and 31% respectively).

Only 10% across the whole sample reported being referred on to a further service and there were no statistical differences amongst men or women at any service type.

6.2.8 Quality/quantity of information

Several questions were asked to assess the extent to which users were happy with the amount and type of information received during their visit to the clinic:

- Q16: What about information
- a did you get all you wanted
 - b easy to ask questions?
 - c answers clear?
- Q17 If you came here for contraception, did you talk about:
- Choice of method
 - How effective it is?
 - Side effects?
 - How to use them?
 - Using the pill and condoms together?
 - What to do if something goes wrong?

Generally respondents were happy with the amount of information offered with 84% in total reporting that they received all they wanted. However significantly higher proportions of women than men were happy with the amount of information received (87% compared to 75%). A higher proportion of women reported receiving all the information they wanted from staff at community-based services over hospital-based services (89% and 83% respectively).

With regard to communication with staff, 83% reported receiving clear answers to their questions while 84% reported that it was easy to ask questions, and proportions were significantly higher among men at hospital services than in community settings (88% compared to 74%).

Those who were given contraceptive advice or supplies were asked whether they received further information on a number of related issues. Significant differences were reported between integrated and non-integrated services, with women at integrated services being less likely to be given information about contraceptive method side effects than those at non-integrated services (59% and 69%).

At dedicated services higher proportions of women reported receiving information about effectiveness of contraception (74%), using the pill and condoms together (67%) and what

to do if something goes wrong (67%), than those at non-dedicated services (65%, 56% and 58%).

Table 6.2.8 Amount and quality of information by service characteristics

	DEDICATION				INTEGRATION				LOCATION			
	YP service		All age service		Integrated sexual health service		Separate GUM or FP service		Community-based service		Hospital based service	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Total	449	108	450	152	334	77	565	183	496	81	403	179
Did you get all the information you wanted?	p=0.144 (women); p=0.854 (men)				p=0.126; p=0.508 (men)				p=0.003(women); p=0.313 (men)			
Yes	331 (87.3)	65 (71.4)	345 (84.4)	97 (72.4)	245 (86.0)	49 (72.1)	431 (85.7)	113 (72.0)	387 (89.2)	44 (66.7)	289 (81.6)	118 (74.2)
Mostly	47 (12.4)	22 (24.2)	58 (14.2)	33 (24.6)	40 (14.0)	18 (26.5)	65 (12.9)	37 (23.6)	46 (10.6)	18 (27.3)	59 (16.7)	37 (23.3)
No	1 (0.3)	4 (4.4)	6 (1.5)	4 (3.0)	0 (0)	1 (1.5)	7 (1.4)	7 (4.5)	1 (0.2)	4 (6.1)	6 (1.7)	4 (2.5)
Was it easy to ask questions?	p=0.253 (women); p=0.097 (men)				p=0.860 (women); p=0.432 (men)				p=0.514 (women); p=0.013 (men)			
Yes	292 (82.0)	55 (73.3)	326 (86.5)	107 (85.6)	231 (84.0)	54 (85.7)	387 (84.5)	108 (78.8)	346 (85.6)	36 (67.9)	272 (84.7)	126 (85.7)
Mostly	58 (16.3)	16 (21.3)	46 (12.2)	15 (12.0)	39 (14.2)	8 (12.7)	65 (14.2)	23 (16.8)	53 (13.1)	13 (24.5)	51 (15.5)	18 (12.2)
No	6 (1.7)	4 (5.3)	5 (1.3)	3 (2.4)	5 (1.8)	1 (1.6)	6 (1.3)	6 (4.4)	5 (1.2)	4 (7.5)	6 (1.8)	3 (2.0)
Were the answers clear?	p=0.186 (women); p=0.226 (men)				p=0.412; p=0.964 (men)				p=0.043 (women); p=0.318 (men)			
Yes	295 (83.8)	50 (68.5)	306 (84.1)	97 (78.9)	228 (84.4)	45 (73.8)	373 (82.5)	102 (75.6)	342 (85.3)	35 (68.6)	259 (80.7)	112 (77.2)
Mostly	56 (15.9)	18 (24.7)	58 (15.9)	22 (17.9)	41 (15.2)	13 (21.3)	73 (16.2)	27 (20.0)	58 (14.5)	12 (23.5)	56 (17.4)	28 (19.3)
No	1 (0.3)	5 (6.8)	6 (1.6)	4 (3.3)	1 (0.4)	3 (4.9)	6 (1.3)	6 (4.4)	1 (0.2)	4 (7.8)	6 (1.9)	5 (3.4)
Did you talk about: Choice of method	p=0.680 (women); p=0.071 (men)				p=0.545(women); p=0.791 (men)				p=0.071 (women); p=0.251 (men)			
Yes	169 (71.9)	33 (55.0)	160 (70.2)	21 (38.2)	101 (69.2)	13 (44.8)	228 (71.9)	41 (47.7)	223 (73.8)	27 (52.9)	106 (65.8)	27 (42.2)
No	66 (28.1)	27 (45.0)	68 (29.8)	34 (61.8)	45 (30.8)	16 (55.2)	89 (28.1)	45 (52.3)	79 (26.2)	24 (47.1)	55 (34.2)	37 (57.8)
How effective?	p=0.035 (women); p=0.220 (men)				p=0.636 (women); p=0.624 (men)				p=0.213 (women); p=0.764 (men)			
Yes	168 (74.0)	32 (55.2)	146 (64.9)	24 (43.6)	98 (71.0)	15 (53.6)	216 (68.8)	41 (48.2)	208 (71.5)	23 (47.9)	106 (65.8)	33 (50.8)
No	59 (26.0)	26 (44.8)	79 (35.1)	31 (56.4)	40 (29.0)	13 (46.4)	98 (31.2)	44 (51.8)	83 (28.5)	25 (52.1)	55 (34.2)	32 (49.2)
Side effects?	p=0.669 (women); p=0.390 (men)				p=0.048 (women); p=0.723 (men)				p=0.032 (women); p=0.358 (men)			
Yes	146 (64.6)	22 (38.6)	149 (66.5)	15 (30.6)	80 (58.8)	9 (32.1)	215 (68.5)	28 (35.9)	203 (69.0)	19 (39.6)	92 (59.0)	18 (31.0)
No	80 (35.4)	35 (61.4)	75 (33.5)	34 (69.4)	56 (41.2)	19 (67.9)	99 (31.5)	50 (64.1)	91 (31.0)	29 (60.4)	64 (41.0)	40 (69.0)

How to use them?	p=0.283 (women); p=0.338 (men)				P=0.602 (women); p=0.058 (men)				p=0.435 (women); p=0.461 (men)			
Yes	160 (70.5)	26 (47.3)	146 (65.8)	19 (38.0)	91 (66.4)	7 (26.9)	215 (68.9)	38 (48.1)	202 (69.4)	22 (46.8)	104 (65.8)	23 (39.7)
No	67 (29.5)	29 (52.7)	76 (34.2)	31 (62.0)	46 (33.6)	19 (73.1)	97 (31.1)	41 (51.9)	89 (30.6)	25 (53.2)	54 (34.2)	35 (60.3)
Using pill & condoms together?	p=0.016 (women); p<0.001 (men)				p=0.935 (women); p=0.852 (men)				p=0.239 (women); p=0.015 (men)			
Yes	150 (67.3)	28 (49.1)	123 (56.2)	8 (16.7)	83 (61.5)	10 (35.7)	190 (61.9)	26 (33.8)	183 (63.8)	22 (46.8)	90 (58.1)	14 (24.1)
No	73 (32.7)	29 (50.9)	96 (43.8)	40 (83.3)	52 (38.5)	18 (64.3)	117 (38.1)	51 (66.2)	104 (36.2)	25 (53.2)	65 (41.9)	44 (75.9)
What to do if something goes wrong?	p=0.046 (women); p=0.007 (men)				p=0.763 (women); p=0.859 (men)				p=0.154 (women); p=0.036 (men)			
Yes	149 (67.1)	28 (50.0)	128 (57.9)	12 (24.5)	83 (61.5)	10 (37.0)	194 (63.0)	30 (38.5)	187 (64.9)	23 (48.9)	90 (58.1)	17 (29.3)
No	73 (32.9)	28 (50.0)	93 (42.1)	37 (75.5)	52 (38.5)	17 (63.0)	114 (37.0)	48 (61.5)	101 (35.1)	24 (51.1)	65 (48.9)	41 (70.7)

6.2.9 General questions relating to satisfaction

Respondents were asked at the end of the questionnaire whether they would make any changes to the service and whether they would recommend it to friends – two key indications of satisfaction.

These questions were not very discriminating, with very high proportions stating that they would recommend the service to a friend (98% across the whole sample). Significant differences were found however with location of service with only 1.5% of women saying they would not recommend community-based services compared to 2.7% at hospital services. For men the results were reversed with 7.4% saying they would not recommend the community service, compared with just 1.8% at hospital-based services.

Women more commonly reported that they would make changes to the service in non-dedicated than at dedicated young people's services (39% compared to 31%, $p=0.026$). Much bigger differences were found among men: 45% compared with 21%, ($p<0.001$).

Both women and men more commonly reported that they would make changes at hospital compared to community-based services (43% and 28% among women, and 41% compared to 22% in men).

Interestingly across the sample as a whole, key elements of service delivery (those variables relating to staff and service characteristics) were all found to be significantly associated with both the proportions stating that they would not make changes to the service and those reporting that they would recommend it to friends. For example those respondents who felt the service to be very relaxed were significantly more likely to say they would make no changes and would recommend it (Table 6.2.9b). Findings were significant with all the measures of service acceptability.

Table 6.2.9a General measures of satisfaction by service characteristics

	DEDICATION				INTEGRATION				LOCATION			
	YP service		All age service		Integrated sexual health service		Separate GUM or FP service		Community-based service		Hospital based service	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Total	449	108	450	152	334	77	565	183	496	81	403	179
Is there anything you would change?	p=0.026 (women); p<0.001 (men)				p=0.072 (women); p=0.369 (men)				p<0.001 (women); p=0.007 (men)			
Yes	115 (30.9)	18 (21.4)	156 (38.5)	61 (44.9)	112 (38.9)	27 (40.3)	159 (32.5)	52 (34.0)	119 (27.9)	13 (21.7)	152 (43.3)	66 (41.3)
No	257 (69.1)	66 (78.6)	249 (61.5)	75 (55.1)	176 (61.6)	40 (59.7)	330 (67.5)	101 (66.0)	307 (72.1)	47 (78.3)	199 (56.7)	94 (58.8)
Would you recommend this service to friends?	p=0.552 (women); 0.571 (men)				p=0.523 (women); p=0.352 (men)				p=0.004 (women); p=0.035 (men)			
Yes	396 (97.5)	90 (95.7)	421 (98.1)	135 (97.1)	303 (97.4)	71 (97.3)	514 (98.1)	154 (96.3)	453 (98.5)	63 (92.6)	364 (97.1)	162 (98.2)
No	10 (2.5)	4 (4.3)	8 (1.9)	4 (2.9)	8 (2.6)	2 (2.7)	10 (1.9)	6 (3.8)	7 (1.5)	5 (7.4)	11 (2.7)	3 (1.8)

Table 6.2.9b Service characteristics and satisfaction with service

	Would make changes to the service		Would recommend service to friends	
	Yes n (%)	No n (%)	Yes n (%)	No n (%)
How did the service feel to you. Was it...				
Relaxed?	p<0.001		p<0.001	
Very	131 (28.9)	323 (71.1)	457 (99.4)	3 (0.6)
Quite	175 (40.5)	257 (59.5)	451 (97.0)	14 (3.0)
Not at all	27 (55.1)	22 (44.9)	43 (84.3)	8 (15.7)
Cheerful?	p<0.001		p<0.001	
Very	58 (22.9)	195 (77.1)	275 (100.0)	0 (0)
Quite	179 (38.7)	284 (61.3)	467 (97.7)	11 (2.3)
Not at all	97 (56.4)	61 (43.6)	144 (92.9)	11 (7.1)
Comfy?	p<0.001		p<0.001	
Very	68 (25.8)	196 (74.2)	280 (99.3)	2 (0.7)
Quite	194 (38.6)	308 (61.4)	520 (97.7)	12 (2.3)
Not at all	58 (57.4)	43 (42.6)	95 (90.5)	10 (9.5)
Well equipped?	p=0.002		p<0.001	
Very	141 (31.5)	307 (68.5)	473 (99.2)	4 (0.8)
Quite	158 (42.2)	216 (57.8)	380 (96.7)	13 (3.3)
Not at all	13 (52.0)	12 (48.0)	22 (81.5)	5 (18.5)
Able to offer privacy?	p<0.001		p<0.001	
Very	180 (31.2)	380 (67.9)	585 (98.8)	7 (1.2)
Quite	113 (40.3)	150 (57.0)	273 (96.8)	9 (3.2)
Not at all	26 (56.5)	20 (43.5)	42 (87.5)	6 (12.5)
Would you say the staff were...				
Friendly?	p<0.001		p<0.001	
Very	196 (30.0)	458 (70.0)	684 (98.3)	12 (1.7)
Mostly	127 (46.0)	149 (54.0)	290 (97.6)	7 (2.4)
Not at all	12 (70.6)	5 (29.4)	15 (78.9)	4 (21.1)
Helpful?	p<0.001		p<0.001	
Very	197 (29.1)	497 (70.9)	714 (98.6)	10 (1.4)
Mostly	120 (50.8)	116 (49.2)	241 (96.4)	9 (3.6)
Not at all	8 (80.0)	2 (20.0)	7 (70.0)	3 (30.0)
Welcoming	p<0.001		p<0.001	
Very	168 (29.2)	407 (70.8)	603 (98.7)	8 (1.3)
Mostly	132 (46.2)	154 (53.8)	297 (97.1)	9 (2.9)
Not at all	22 (61.1)	14 (38.9)	34 (87.2)	5 (12.8)
Approachable?	p<0.001		p<0.001	
Very	169 (31.1)	375 (68.9)	567 (98.8)	7 (1.2)
Mostly	140 (43.9)	179 (56.1)	336 (97.4)	9 (2.6)
Not at all	16 (57.1)	12 (42.9)	24 (82.8)	5 (17.2)
Discreet?	p<0.001		p<0.001	
Very	180 (31.0)	400 (69.0)	603 (99.0)	6 (1.0)
Mostly	121 (45.5)	145 (54.5)	275 (96.5)	10 (3.5)
Not at all	17 (53.1)	15 (46.9)	31 (86.1)	5 (13.9)
To be trusted with private information?	p<0.001		p<0.001	
Very	211 (32.7)	434 (67.3)	680 (98.8)	8 (1.2)
Mostly	100 (45.0)	122 (55.0)	222 (94.9)	12 (5.1)
Not at all	8 (66.7)	4 (33.3)	11 (84.6)	2 (15.4)
Did you feel the service was confidential?	p=0.012		p<0.001	
Yes	316 (34.2)	608 (65.8)	966 (98.4)	16 (1.6)
No/not sure	16 (57.1)	12 (42.9)	23 (74.2)	8 (25.8)

CHAPTER 7: REPORT ON THE QUANTITATIVE COMPONENT: Multi-variate analysis

This chapter is arranged into 3 sections, each addressing a specific research question. The results from chapter 6 (bi-variate analysis) are built upon and data analysed using multi-variate methods, controlling for potential confounding factors²⁰.

The three key questions examined are:

- Which aspects of service configuration (**dedication, location, integration**) appear to be the strongest determinants in terms of including young people at greatest demographic risk?
- Which aspects of service configuration appear to be the strongest determinants in terms of including young people at greatest sexual health risk?
- Which aspects of service configuration show the strongest association with satisfaction?

Research question 1: Which aspects of service configuration appear to be the strongest determinants in terms of including young people at greatest demographic risk?

Table 7.1 Exploring the differences in the demographic profile of users at age dedicated services, compared with non-dedicated services: unadjusted and adjusted odds ratios for selected variables

Dependent variable	Attending a dedicated service ¹			
	Unadjusted Odds Ratio (95% CI)	p value	Adjusted Odds Ratio ² (95% CI)	p value
Demographic variables				
Men				
Age <16	47.091 (11.07 to 200.33)	<0.001	180.6 (16.67 to 1955.33)	<0.001
Age <18	57.899 (25.6 to 130.97)	<0.001	3143.5 (429.5 to 23005)	<0.001
Employed	0.292 (0.166 to 0.514)	<0.001	3.311 (0.71 to 15.437) ³	0.127
Most deprived	0.815 (0.393 to 1.689)	0.582	⁴	
Women				
Age <16	4.452 (2.670 to 7.422)	<0.001	9.850 (5.12 to 18.99)	<0.001
Age <18	6.457 (4.729 to 8.815)	<0.001	18.93 (11.87 to 30.2)	<0.001
Employed	0.406 (0.305 to 0.542)	<0.001	0.749 (0.463 to 1.21) ³	0.237
Most deprived	0.814 (0.565 to 1.173)	0.270	2.095 (1.238 to 3.55)	0.006

¹ Any OR>1 indicates greater likelihood in dedicated services

² Adjusting for integration and location of service

³ Adjusted additionally for age

⁴ Numbers too small to do tests

This section explores the extent to which each service type is reaching the local population of young people. Three key variables under investigation are: age < 16, age <18, employment status and deprivation. Data from men and women are analysed separately. Table 7.1 shows

²⁰ Tables listing all the variables found to be statistically significant in the bi-variate analysis are included at Appendix 19

the unadjusted odds ratios (ORs) for each of the key variables in dedicated compared with all-age services. Each was then adjusted for the effect of integration and location.

Unsurprisingly both men and women are more likely to be from young age groups at dedicated compared to all-age services, and differences remain significant after adjusting of the other service types. Women for example are 19 times more likely to be aged under 18 at dedicated youth services.

The employment and deprivation profiles are less clear-cut however. For both men and women employment status remained statistically significant after initially adjusting for service type ($p=0.015$ and <0.001 respectively) but lost statistical significance once age was entered into the model, illustrating its importance as a confounding factor. After adjusting for location and integration of the service, women attending dedicated young people's services were twice as likely as those at all-age services to live in an area in the highest quartile of deprivation (the least well-off) and this result was significant.

Table 7.2 Exploring the differences in the demographic profile of users at integrated services, compared with non-integrated services: unadjusted and adjusted odds ratios for selected variables

Dependent variable	Attending integrated services ¹			
	Unadjusted Odds Ratio (95% CI)	p value	Adjusted Odds Ratio ² (95% CI)	p value
Demographic variables				
Men				
Age <16	0.253 (0.096 to 0.669)	0.006	0.042 (0.009 to 0.196)	<0.001
Age <18	1.723 (0.998 to 2.974)	0.051	0.054 (0.016 to 0.182)	<0.001
Employed	0.957 (0.548 to 1.671)	0.878	0.954 (0.452 to 2.013) ³	0.902
Most deprived	0.122 (0.043 to 0.349)	<0.001	0.498 (0.137 to 1.815)	0.291
Women				
Age <16	0.812 (0.519 to 1.269)	0.360	0.248 (0.137 to 0.447)	<0.001
Age <18	1.735 (1.312 to 2.295)	<0.001	0.278 (0.182 to 0.425)	<0.001
Employed	0.802 (0.600 to 1.074)	0.139	1.143 (0.738 to 1.770) ³	0.550
Most deprived	0.397 (0.264 to 0.597)	<0.001	0.212 (0.115 to 0.392)	<0.001

¹Any OR >1 indicates greater likelihood in integrated services

²Adjusting for dedication and location of service

³Adjusting additionally for age

Separately run services appear to be more successful than integrated services in attracting very young people. Young men attending separately-run services were more likely to be aged under 16 than at integrated services and this remained true after controlling for the other two types of service configuration (dedication and location) and the magnitude of the greater likelihood was greatly increased .

Among those aged <18, unadjusted odds ratios show young men and young women to be nearly twice as likely to be found among clients in integrated services, compared with those which are separately run, but this effect is reversed after adjusting for dedication and location, and dramatically so for men.

Young women in integrated services were five times less likely to be living in an area in the highest quartile of deprivation, compared with those in separate services. There were no significant differences by deprivation for men and no statistically significant differences were found for employment status for of either men or women.

Table 7.3 Exploring the differences in the demographic profile of users at hospital services, compared with community based services: unadjusted and adjusted odds ratios for selected variables

Dependent variable	Attendance at hospital services ¹			
	Unadjusted Odds Ratio (95% CI)	p value	Adjusted Odds Ratio ² (95% CI)	p value
Demographic variables				
Men				
Age <16	0.031 (0.012 to 0.084)	<0.001	1.407 (0.217 to 9.110)	0.720
Age <18	0.092 (0.050 to 0.170)	<0.001	23.57 (4.52 to 122.8)	<0.001
Employed	3.398 (1.803 to 6.404)	<0.001	1.833 (0.59 to 5.677) ³	0.294
Most deprived	0.264 (0.117 to 0.600)	0.001	⁴	
Women				
Age <16	0.515 (0.328 to 0.810)	0.004	1.369 (0.765 to 2.450)	0.289
Age <18	0.968 (0.736 to 1.273)	0.817	2.750 (1.914 to 3.950)	<0.001
Employed	1.506 (1.139 to 1.993)	0.004	1.338 (0.96 to 1.875) ³	0.091
Most deprived	0.793 (0.548 to 1.148)	0.219	1.344 (0.872 to 2.071)	0.181

¹ Any OR >1 indicated greater likelihood at hospital services

² Adjusting for integration and dedication of service

³ Adjusted additionally for age

⁴ Numbers too small to do tests

After controlling for service type, fewer significant differences in the demographic profile of young people using hospital and community-based services are seen. However, the apparent effect on attendance by men and women of younger age (<18) is massively reversed after controlling for integration and dedication, particularly for men. Whilst the unadjusted odds ratios show men aged under 18 to be 10 times less likely to be attending hospital services compared with services based in the community, after adjusting for dedication and integration, they are more than 20 times more likely to be attending hospital based services, though the confidence intervals are wide because of the small sample size. Among those under 16, the age difference between hospital and community services is not significant in the adjusted model.

Research question 2: Which aspects of service configuration appear to be the strongest determinants in terms of including young people at greatest sexual health risk?

Of interest here was the extent to which each service type was reaching the local population of young people at greatest sexual health risk. Key variables under investigation were: relationship status: not in a steady relationship; sexual orientation; whether had sexual intercourse; age at first SI <16; timing of first visit to a sexual health service (before or after first SI); and unsafe sex practice (never used a condom). After controlling for the other two aspects of service configuration, other potential confounding factors were entered into the model. Each aspect of service configuration is examined in turn below.

Table 7.4 Exploring the differences in the sexual health risk profile of users at age-dedicated services compared with non-dedicated services: unadjusted and adjusted odds ratios for selected variables

Dependent variable	Attendance at dedicated service			
	Unadjusted Odds Ratio (95% CI)	p value	Adjusted Odds Ratio ¹ (95% CI)	p value
Measures of sexual risk				
Men				
Not in steady relationship	0.879 (0.527 to 1.466)	0.621	0.636 (0.164 to 2.462) ²	0.513
Attracted to same sex	0.247 (0.082 to 0.742)	0.013	0.139 (0.010 to 2.005) ⁵	0.147
Had SI: yes	0.142 (0.056 to 0.361)	<0.001	4.480 (0.137 to 146.9) ⁴	0.400
Age at first SI <16 ⁶	4.911 (2.397 to 10.060)	<0.001	⁷	
Had sex before first service visit	0.119 (0.051 to 0.277)	<0.001	3.578 (0.159 to 80.302) ²	0.422
Never used a condom	12.329 (3.545 to 42.879)	<0.001	7.194 (0.615 to 84.271)	0.116
Women				
Not in steady relationship	1.440 (1.100 to 1.884)	0.008	1.395 (0.917 to 2.123) ²	0.120
Attracted to same sex	0.578 (0.355 to 0.942)	0.028	1.283 (0.566 to 2.908) ⁵	0.550
Had SI: yes	0.310 (0.154 to 0.621)	0.001	0.291 (0.095 to 0.890) ⁴	0.030
Age at first SI <16 ⁶	2.465 (1.824 to 3.331)	<0.001	2.305 (1.253 to 4.238) ³	0.007
Had sex before first service visit	0.683 (0.466 to 1.002)	0.051	0.555 (0.320 to 0.963) ²	0.036
Never used a condom	2.732 (1.497 to 4.975)	0.001	4.951 (2.271 to 10.831)	<0.001

^{NB} Any OR >1 indicated greater likelihood at dedicated services

¹ Adjusting for integration and location of service

² Adjusting additionally for age

³ Adjusting additionally for deprivation

⁴ Adjusting additionally for both age and deprivation

⁵ Adjusting additionally for age and whether service was in London

⁶ Includes only those currently aged >15

⁷ Numbers too small to do tests

After controlling for location and integration of service, the only differences in the sexual health profile between users of dedicated and all-age services were found amongst women. Women were less likely to have had sex at young people's services even after controlling for age and deprivation. Women were also more likely to report low age at first sexual intercourse in dedicated services and statistical differences remained after controlling for integration and location of the service and level of deprivation.

Women at dedicated young people's services were more likely to have first visited a service before first having sexual intercourse than those at all-age services and this difference remained after adjusting for integration, location and age. They were more likely however to report unsafe sex (never used a condom) at dedicated than at all-age services, even after controlling for integration and dedication. This is difficult to interpret however. If for example someone was attending the service for the contraceptive pill and was in their first and steady monogamous relationship, then condom use may not be expected and thus alone is not a strong indicator of safe sex practice.

Table 7.5 Exploring the differences in the sexual health risk profile of users at integrated services compared with non-integrated services: unadjusted and adjusted odds ratios for selected variables

Dependent variable	Attendance at an integrated service			
	Unadjusted Odds Ratio (95% CI)	p value	Adjusted Odds Ratio ¹ (95% CI)	p value
Measures of sexual risk				
Men				
Not in steady relationship	0.957 (0.554 to 1.653)	0.874	1.078 (0.531 to 2.191) ²	0.835
Attracted to same sex	1.112 (0.458 to 2.697)	0.815	1.380 (0.543 to 3.508) ³	0.499
Had SI: yes	1.818 (0.712 to 4.646)	0.212	0.565 (0.048 to 6.702) ⁴	0.651
Age at first SI <16 ⁶	1.277 (0.690 to 2.364)	0.436	⁷	
Had SI before first service visit	8.923 (2.076 to 38.36)	0.003	5.261 (0.919 to 30.13) ²	0.062
Never used a condom	0.424 (0.139 to 1.295)	0.132	0.230 (0.060 to 0.880)	0.032
Women				
Not in steady relationship	1.286 (0.976 to 1.695)	0.073	0.978 (0.666 to 1.434) ²	0.908
Attracted to same sex	0.552 (0.322 to 0.947)	0.031	0.419 (0.20 to 0.89) ³	0.024
Had SI: yes	1.806 (0.900 to 3.624)	0.096	3.226 (0.940 to 11.072) ⁴	0.063
Age at first SI <16 ⁶	1.849 (1.366 to 2.503)	<0.001	1.429 (0.729 to 2.802) ⁵	0.299
Had SI before first service visit	2.491 (1.577 to 3.936)	<0.001	3.298 (1.840 to 5.912) ²	<0.001
Never used a condom	0.894 (0.502 to 1.592)	0.703	0.360 (0.171 to 0.757)	0.007

¹ Adjusting for dedication and location of service

² Adjusting additionally for age

³ Adjusting additionally for age and whether service was in London

⁴ Adjusting additionally for deprivation

⁵ Adjusting additionally for both age and deprivation

⁶ Includes only those currently aged >15

⁷ Numbers too small

No simple pattern is seen in the sexual health risk profile of users of integrated and non-integrated services. Sexual orientation is not significantly different for men between integrated and non-integrated services. Women at non-integrated services are significantly more likely to be attracted to other women than those at integrated services and this significance remains after controlling for the other two service types and for age and whether the service is located in London.

Difference between those who had already had sexual intercourse was not significant between integrated and non-integrated services. Similarly, there was no difference in age at first sexual intercourse although women attending integrated services did initially appear to be more likely to have had sex under 16 but the effect was lost when controlling for deprivation.

Table 7.6 Exploring the differences in the sexual health risk profile of users at hospital based services compared with community based services: unadjusted and adjusted odds ratios for selected variables

Dependent variable	Attendance at a hospital service			
	Unadjusted Odds Ratio (95% CI)	p value	Adjusted Odds Ratio ¹ (95% CI)	p value
Measures of sexual risk				
Men				
Not in steady relationship	1.220 (0.708 to 2.103)	0.474	1.245 (0.470 to 3.296) ²	0.660
Attracted to same sex	3.503 (1.017 to 12.072)	0.047	0.561 (0.076 to 4.116) ⁵	0.569
Had SI: yes	8.250 (3.478 to 19.572)	<0.001	2.096 (0.122 to 35.952) ⁴	0.610
Age at first SI <16 ⁶	0.280 (0.118 to 0.663)	0.004	1.195 (0.082 to 17.323) ³	0.896
Had sex before first service visit	16.758 (7.028 to 39.96)	<0.001	10.91 (0.722 to 164.88) ²	0.084
Never used a condom	0.063 (0.020 to 0.195)	<0.001	0.301 (0.034 to 2.674)	0.281
Women				
Not in steady relationship	1.201 (0.918 to 1.571)	0.183	1.336 (0.979 to 1.824) ²	0.068
Attracted to same sex	2.513 (1.531 to 4.124)	<0.001	2.867 (1.511 to 5.440) ⁵	0.001
Had SI: yes	2.570 (1.281 to 5.152)	0.008	1.167 (0.410 to 3.322) ⁴	0.772
Age at first SI <16 ⁶	1.137 (0.848 to 1.526)	0.391	1.683 (1.051 to 2.693) ³	0.030
Had sex before first service visit	2.486 (1.638 to 3.773)	<0.001	1.636 (1.006 to 2.661) ²	0.047
Never used a condom	0.637 (0.358 to 1.133)	0.125	1.205 (0.600 to 2.421)	0.601

¹ Adjusting for integration and dedication of service

² Adjusting additionally for age

³ Adjusting additionally for deprivation

⁴ Adjusting additionally for both age and deprivation

⁵ Adjusting additionally for age and whether service was in London

⁶ Includes only those currently aged >15

Women at integrated services were more likely to have had sexual intercourse before first visiting a sexual health service and this remained significant after controlling for dedication and location of the service and age. For men it was still significant after controlling for

dedication and location (not shown here) but when controlling also for age, became only of borderline significance ($p=0.062$).

Both men and women at integrated services were less likely to report unsafe sex (never used a condom) than those at non-integrated services and the differences remained significant after controlling for dedication and location.

The most interesting differences between hospital and community-based services is that women at hospitals are more likely to be attracted to women than at community settings even after controlling for integration, dedication, age and whether located in London. For men the effect was lost just after adjusting for potential confounding variables ($p=0.569$).

Women at hospital services were also more likely to report young age at first sexual intercourse than those in community settings, even after controlling for integration, dedication and deprivation.

Women at hospital based services were more likely to report having had sexual intercourse before visiting a sexual health service than those at community services, even after controlling for age. In men the effect was lost on controlling for integration, dedication and age.

Research question 3: Which aspects of service configuration (*dedication, location, integration*) show the strongest association with satisfaction?

Of interest here was the extent to which each service type achieved the highest levels of client satisfaction. Two key measures of satisfaction were explored: whether the user would recommend the service to a friend and whether they would make any changes to the service. These two measures were not always statistically significantly different in the bi-variate analysis (unadjusted odds ratios are shown in the table below for each type of service). Where significant however, the other types of service configuration were added to the model to examine their confounding effect.

Dedicated services

Men and women at both dedicated and all-age services reported almost universally that they would recommend the service to friends (women: 98% at both service types; men 96% at dedicated and 97% at all-age services). There were however statistically significant differences in the likelihood of wanting to make no changes to the service with its age-

dedication. After adjusting for the other aspects of service configuration, women in dedicated young people's services were nearly twice as likely to claim that they would make no changes to the service, but for men there was nearly a 7 times increased likelihood.

Integrated services

Very small differences were found in the bi-variate analysis between users of integrated and non-integrated services reporting that they would recommend the service to a friend (women: 97% and 98% respectively and men: 97% and 96%) and those reporting that they would make changes to the service (women: 39% and 33% respectively and men: 40% and 34%). The higher proportion of women reporting that they would make changes at integrated services remained significant after controlling for the other two service types. Men at integrated services were also more likely to want to make changes to the service than those at non-integrated services and this held after controlling for the other two service types.

Table 7.7 Unadjusted and adjusted odds ratios for selected variables

Dependent variable	Unadjusted Odds Ratio (95% CI)	p value	Adjusted Odds Ratio* (95% CI)	p value
Measure of satisfaction				
Dedication: ORs for attendance at dedicated young people's services				
Men				
Would not make changes to service	2.982 (1.602 to 5.550)	0.001	6.693 (2.113 to 21.21)	0.001
Women				
Would not make changes to service	1.400 (1.040 to 1.885)	0.027	1.816 (1.174 to 2.809)	0.007
Integration: ORs for attendance at integrated services				
Men				
Would not make changes to service	0.763 (0.422 to 1.378)	0.370	0.357 (0.167 to 0.760)	0.008
Women				
Would not make changes to service	0.757 (0.559 to 1.025)	0.072	0.558 (0.359 to 0.868)	0.010
Location: ORs for attending hospital services				
Men				
Would not make changes to service	0.394 (0.198 to 0.786)	0.008	1.766 (0.552 to 5.654)	0.338
Women				
Would not make changes to service	0.507 (0.376 to 0.684)	<0.001	0.631 (0.453 to 0.878)	0.006

*Controlling for the other two aspects of service configuration

Location of service

After adjusting for the other aspects of service configuration, there was no significant difference for men, by location of the service in whether or not they would make changes to it. However for women, the decreased likelihood of wanting to make changes to the service

among users at hospital-based services was slightly attenuated after adjusting for integration and age-dedication, but remained significant.

CHAPTER 8: CONCLUSIONS AND RECOMMENDATIONS

In carrying out this study, I have sought to provide insights into what might be the optimal patterns of organisation and configuration of sexual health services for young people. Prior to embarking on the study, I personally felt, intuitively, that integrated services, dedicated to young people and located in the community were most likely to be the best option and probably the future direction for policy development. On further investigation however, it became apparent that this was not a clear cut issue and now, on completion of the research, there remains no simple solution to the question of the optimal mode of service delivery. Each type of service configuration has strengths and weaknesses and meets different needs in different ways and to different people. What is clear however, is that a one-size-fits-all approach is unlikely to be the answer and crucial to service development is a close examination of the local population in terms of both its demographic and sexual health risk profile.

This study has focussed, not on a comparison of services in their entirety, but on a comparison of key features of their organisation, that is, whether they are provided separately as contraceptive and STI services or whether these aspects of sexual health provision are integrated in services (**integration**); on whether they are run exclusively for young people or for all ages (**dedication**); and on whether they are located in the community or in a hospital setting (**location**).

Using in-depth interviews with young people exploring their views and experience in accessing sexual health services, and a user-satisfaction survey among young people attending sexual health services representing the various models of service delivery, I explored the following three broad research questions: 1) *How does young people's satisfaction with sexual health services vary with the age-dedication of the service; that is, whether it serves young people only, or all ages?*; 2) *How does young people's satisfaction with sexual health services vary with the integration of the service; that is, whether family planning and genito-urinary services are offered separately, or together?* and 3) *How does young people's satisfaction with sexual health services vary with the location of the service; that is, in community or hospital based services?*

Specifically, I have attempted to answer the following:

- A. Which aspects of service configuration appear to be the strongest determinants in terms of including young people at greatest demographic risk?

- B. Which aspects of service configuration appear to be the strongest determinants in terms of including young people at greatest sexual health risk?
- C. Which, if any, of the qualities of a service (confidentiality, access, information, acceptability, etc) show the strongest association with satisfaction?
- D. Which aspects of service configuration (*dedication, integration, location*) show the strongest association with satisfaction?

8.1 Limitations of the study

A major limitation to this study was the failure to include General Practices in the sample. The stumbling blocks encountered were described fully in chapter 4. The problems included difficulties experienced in making initial contact with the practices. Where practices did show an interest, further problems were experienced with applications to PCTs and LRECs which added several months to the research process and unfortunately resulted in my being unable to include them within the time schedule for the PhD. This was largely due to the Research Governance Framework introduced in 2001 and updated in 2003 which means that anyone intending to conduct research in primary care must now obtain permission individually from each PCT despite studies already having been granted MREC approval. Because procedures and application forms are not standardized across PCTs this adds considerably to the time needed to initiate data collection. A BMJ article recently suggested that 150 working days should be added to a study protocol for ethics and governance in a multi-centre study such as this.¹⁷⁹

An important aim of the data collection was that it should occur simultaneously across all the research sites. Given the much later inclusion of the general practices, a serious time lag would have occurred were they to have been included, allowing for engaging the staff in the research and getting them to commit to becoming a study site. This was largely attributable to the workload already experienced in the practices, or in some cases to another research project currently or recently having taken place there. Where practices did show an interest, further problems were experienced with applications to PCTs and LRECs which added several months onto the research process and unfortunately resulted in my being unable to include them.

Otherwise, every effort was made to include services which represented every possible permutation of the three axes: dedication; integration and location, but no hospital-based

service was found which offered STI treatment and family planning separately and was also dedicated to young people, and no community-based service was found which combined STI treatment and family planning in an integrated service which was not dedicated to young people.

A further, though less significant, limitation was a slight difference in the content of the questionnaire between some of the study sites. As discussed in section 4.3.2, services 6a and 6b requested additional questions and response options. Although the additional data from these questionnaires were analysed separately and reported back individually to the services in question (as opposed to being incorporated into the combined analysis), there was still the small risk that data quality may have been compromised by use of the slightly longer questionnaire, as respondents would have needed to commit slightly more time to completing it. Ideally, the research instruments should be identical across all study sites to maximise comparability of data. However, a balance needed to be struck between standardisation and meeting the requests of the study sites in order to avoid losing them from the sample.

A further problem encountered was the difference between the service actually provided and that described in the Sexwise database, which was used as the basis for the initial sampling frame. Often, on making contact with the service, a more comprehensive service was being provided than was initially assumed from the information available at the time of selection. This serves to highlight the fact that service provision does not fit neatly into preconceived categories, but is fluid both between and within services. A problem which therefore arose from this, was the difficulty in classifying services into type. For example, service 3 could be more appropriately classified as integrated on some days and not on others (depending on whether a family planning practitioner was on site). The definition of integration remained therefore a relatively personal one throughout the study, though agreement with my supervisor on the definition was sought, and secured, in all instances of ambiguity.

Finally, achieving the target number of participants in each site proved difficult in some instances, particularly in dedicated services where attendance was much lower than in all-age services. At service number 7 for example, as few as three people attended some services. Given that this service was providing help only once a week, the time needed to collect 200 questionnaires would have been unreasonably long. As a consequence, the actual sample consisted of a smaller number of questionnaires across a larger number of services, than was first anticipated.

8.2 Summary and interpretation of key findings

A. Which aspects of service configuration appear to be the strongest determinants in terms of including young people at greatest demographic risk?

User profile of services

The qualitative and quantitative data generated by this study have provided opportunities to create a profile of users associated with the different configuration of services. This is clearly of importance in relation to setting priorities with regard to the delivery of services to particular target groups, noted above (page 1), and in particular to the question relating to whether problems of use stem, not from provision of an insufficient number of services, but from under-use of those currently existing (page 2).

These data, after adjusting for all three aspects of service configuration, have shown dedicated young people's services, not surprisingly perhaps, to be more successful in attracting young people than all-age services. Further, in the case of both young men and women, dedicated young people's services are more likely than all age services to attract the very young, that is, those under the age of 16. The success of dedicated services in attracting young men is particularly noteworthy, and perhaps less easily predicted. Similarly, young women (though not young men) living in the most deprived areas are also more likely to attend dedicated young people's services than they are to attend those catering for all ages.

The evidence from these data is that there are fewer differences by location or integration of service with regard to the demographic profile of users, significant ones bearing only on age of the user. Here, the finding that young men and women aged under the age of 18 are more likely to be represented among attenders at hospital-based and separately run, than community-based and integrated services, is perhaps counter-intuitive. It does, however, caution against drawing conclusions about where young people go for sexual health services from simple comparisons between services characterised by only one organisational criterion, since the different aspects of service configuration are clearly confounded. We cannot tell, from these data, what the explanation is for the greater popularity of hospital based and separately run sexual health services, but the fact that other studies have shown that specialist services provide a wider range of services, and offer more frequent sessions, may contribute to their popularity.

B. Which aspects of service configuration appear to be the strongest determinants in terms of including young people at greatest sexual health risk?

With respect to sexual health risk, the finding that dedicated services are more likely to attract young women who become sexually active early in life is further evidence that services specially set up for young people are more likely to reach those at risk of adverse sexual health outcomes. Moreover, dedicated young people's services, it seems, were significantly more likely to be attended by young women who had made their first visit to a service in an anticipatory way, that is, before they had embarked on sexual activity, though it should be noted that we cannot tell from these data whether that first visit was to the service currently attended. Young women appearing to have made their first visit to a sexual health service before becoming sexually active were also significantly more likely to be represented in separately provided FP and GUM services, compared with integrated services; and in community-based services, compared with hospital-based services. Thus if the ideal is that sexual health services should be concerned with more than harm limitation, and should be truly preventive in focus, then dedicated young people's services, community based services and separately run services all seem to be achieving more in this respect.

A finding which is difficult to explain and which may give cause for concern, and which is relevant in a preventive health context, is that young men and women who had never used a condom were significantly over-represented at separately run services compared with integrated services and, for women but not men, at dedicated young people's services compared with all age services.

C. Which, if any, of the qualities of a service (confidentiality, access, information, acceptability, etc) show the strongest association with satisfaction?

Overall satisfaction, as measured by my two indicators of willingness to recommend the service currently attended to a friend, and not wanting to change any aspects of the service, was high. As an indicator of general satisfaction, willingness to recommend it to a friend proved not to be very discriminating, since the proportion of young men and women who said they would do so was unexpectedly high at, at 98% across the whole sample. However, the overall proportion who felt they would like to make changes (35%) allowed more scope for assessing which factors seemed to make for satisfaction.

These data suggest that ambience is a high priority for young people and, moreover, that the features of the service setting which contribute most to this are a cheerful and comfortable environment.

D. Which aspects of service configuration (dedication, location integration) show the strongest association with satisfaction?

Dedication

One of the hypotheses to be tested in this thesis was whether young people need to be targeted as a discrete group. Despite the increasing general acceptance of this view, the existing literature identified some uncertainty. As noted in Chapter 1, much of the evidence on this issue stems from research in general practice, which I was unable to include as a research setting. The existing evidence is that young people generally prefer services set up especially for them in premises designed to meet their needs, but it is equivocal. This may be partly explained by the fact that study designs to date have been such that confounding of age-dedication with other aspects of service configuration such as location and integration was inevitable. In this study, I have been able to examine the possible effect of age-dedication by adjusting for variables relating to location and integration, examining satisfaction with young people's services irrespective of where they are provided, that is, in hospitals or in the community, and whether they are provided together in combination or separately as family planning and GUM.

The depth interviews with young men and women confirmed that, for most of those interviewed, being seen alongside age peers, rather than men and women older than themselves, and who moreover might recognise them, was a desirable feature of a sexual health service. However, the depth interviews also suggested that age-exclusiveness was not of prime importance to young people in deciding which clinic to attend; some preferred to be with other young people, others didn't mind.

An important policy question relates to the possible tension between offering a dedicated service and a frequent, easily accessed service. A concern documented in the literature stems from the problem of providing age-dedicated services with as great a frequency and in as large a number as more conventional services, such that the advantages of young people-friendliness has to be weighed against the potential for reduced accessibility. The bi-variate analysis showed that, for both men and women, attending an age-dedicated service took generally longer than attending an all-age service. Dedicated services however performed better on speed of being seen, compared with all age services. Young people attending age-

dedicated services were less likely to need an appointment, and this reflected the fact that they were more likely to be drop-in clinics.

The bi-variate analysis of the survey data supports the view that many aspects of dedicated young people's services appear to gain more favour among young people. Dedicated services were rated as more cheerful, comfortable and friendly than were all age services, though the differences were not always great. In the multi-variate analysis, where I was able to adjust for location and integration in relation to the two overall measures of satisfaction, both young men and young women are less inclined to change features of dedicated young people's services than they are those of other services. However, the strength of the effect for young men (a sevenfold increased likelihood of not being inclined to change the service, compared with only a twofold increased likelihood for young women) is particularly important from a policy perspective, and should be noted in the context of goals to increase the numbers of young men attending sexual health services.

Integration

The bi-variate analysis of the survey findings broadly confirmed the impression from the depth interviews, that young men and women welcomed having all their needs met in one place, including those they had not been aware of, and considered the avoidance of fragmented care to be an important aim in their choice of service. Concerns which have surfaced in other studies about prevention of infection and pregnancy being offered together were not apparent in the depth interviews. The qualitative study suggested that they were not offended by the offer of tests for infection. This finding goes some way towards refuting the suggestion, in some of the literature, of a stigma attached to STIs being addressed in the same service as family planning. It may be that, as the profile of the problem of STIs in the country has been raised, with publicity given to increasing rates, young people are less averse, than they might have been earlier, to having this issue raised. Moreover, the depth interviews suggested that young people appreciate the expertise within integrated sexual health services in dealing with sexual matters.

In general, this study confirms the value in combining qualitative and quantitative methods and data. However, despite the generally favourable stance taken towards integrated services in the depth interviews, the survey data revealed that there might be some reservations about integration, particularly among women, which emerged only in a comparison between integrated and separately run services. A higher proportion of women attending separately run family planning and STI services, for example, reported the staff being friendly and the service being very cheerful, comfortable and relaxed. Though not significant, the differences

for men were reversed in some cases, as for example in the case of the service being cheerful and welcoming, descriptions marginally more likely to be applied by male attenders in integrated than separate services. This may reflect the legendary hostility to men in family planning services.

An assumption on which the current growth in integrated services is predicated, and a hypothesis for this study, is that clients at such services will be offered broader based sexual health treatment. An important question to be asked therefore is whether in fact men and women are offered tests and treatments which they may need but did not necessarily attend for. Responses to the open-ended question about reasons for attendance gave clues to the answer. The bi-variate analysis showed that the proportion of women at integrated services who attended for STI tests and the higher proportion attending for contraception at separate services would tend to confirm the benefits of integrated services in this respect. However, these data also suggest that separate services offer women more advice on side effects of contraception and that the advice and information received in such services is clearer and more likely to be considered adequate.

Men attending integrated services were three times less likely, and women twice less likely, to say they would not make changes to service after adjusting for dedication and location. This finding is perhaps counter-intuitive and alerts us to the possibility that establishment of more integrated services may not be the policy solution to all sexual health problems.

Location

The high levels of confidence in the confidentiality of the services across the board are gratifying. However, bi-variate analysis of the survey data suggests that in respect of confidentiality and anonymity, location was the aspect of service configuration which appeared to have a greater influence. The depth interviews had suggested that hospitals had an advantage in this respect since the possibility of being treated on a hospital site, where other health services were offered, meant that the reason for attending could not be detected by simply approaching the building. Bi-variate analysis of the survey data, however, showed that hospital-based services got significantly lower ratings on confidentiality and privacy than others. Significantly fewer women attending hospital-based services reported that the service felt private, that the staff were discreet, and could be trusted with private information. This seems to be an area in which hospital-based services may learn from community-based services.

With regard to continuity, as measured by my two questions relating to whether the current visit was the first ever visit, and how recently they had attended previously, the location of

the service showed greater variation in response. A significantly higher proportion of young men and women attending community-based services had attended within the past six months, compared with those attending hospital-based services, though this may reflect the more acute nature of hospital attendance.

Bi-variate analysis of the survey data showed community-based services to be rated more highly than hospital-based services on the ambience and staff attitudes, and the differences here were large and significant for women on all the criteria, and for men on most. Community based services were more convenient: users were less likely to need an appointment and were seen quicker than in hospital services, and travel times to hospital services were longer. On all round satisfaction, as measured by willingness to recommend to others, and unwillingness to make changes, multi-variate analysis showed women, but not men, to be significantly more likely to want to make changes at hospital-based, after adjusting for dedication and location.

8.3 Recommendations and implications for policy

A. Which aspects of service configuration appear to be the strongest determinants in terms of including young people at greatest demographic risk?

Dedicated services for young people are significantly more likely to reach those groups in need (in demographic terms). This is particularly important in areas of deprivation and ethnic variation where risk factors for poor sexual health are more prevalent. There remains however, room for improvement in both age-dedicated and in all age services. Services need to continue their efforts to attract young people, particularly young men and those from areas of higher deprivation.

Recommendations:

Monitoring, communication and advertising strategies should be re-visited.

Better monitoring

- Services should be aware of the ethnic, socio-economic and age make-up of the local population and should target their services accordingly. This may be helped by monitoring the profile of users and making comparisons with local routinely available demographic data to identify groups not being reached.

- To improve the targeting of high-risk behaviours/groups, service providers should explore ways of establishing the pattern of sexual behaviour among their local population. Opportunities for analysing national data sets (such as NATSAL) or commissioning local studies need to be identified.

Better communication

- As discussed elsewhere,^{180 144} communication between different professionals should be encouraged to maximise awareness of services and to dispel fears and myths about attending them. Professionals in the education and health sectors should be made aware of the range of services available in their local area and be kept informed of service details opening times, age groups targeted etc.

- Service providers need to be aware of the importance of word of mouth in communicating information about their service to young people. This has the potential as a positive marketing strategy and could be taken advantage of but providers need to be aware that the reverse is also true and a clinic with a poor reputation will also soon become well known among the local community.

Better advertising

- Service providers should be encouraged to promote the use of all services available, rather than just the more traditional services with which they are familiar. Schools have the potential as a very useful source of information but they appear to be currently under utilised, with only 16% of young people in this study, having first heard of the service through school. Ways in which schools can most effectively communicate information to young people about local services available needs to be further explored.
- The Internet remains as yet an untapped resource for promoting services and the best ways to improve upon its use need further investigation.

B. Which aspects of service configuration appear to be the strongest determinants in terms of including young people at greatest sexual health risk?

Dedicated services for young people are significantly more likely to reach those in need in terms of their sexual health. However, services need to continue their efforts to attract young people, where possible before the onset of sexual activity. This is particularly true of services, which are not age-dedicated. There are two arguments for the provision of general advice and information to those not yet sexually active in all services. Firstly, as has been shown elsewhere¹¹⁸ contraceptive services have the potential to be very cost effective and so interventions introduced prior to sexual debut are likely to be more effective in reducing negative consequences of sexual activity. Secondly, in the case of young people early interaction with health services should be encouraged not least because of the benefits of simply familiarising themselves with the process of accessing a service and communicating with a health professional.

Contrary to the previous research this study shows that confidence in confidentiality is high, although hospital-based services did fare slightly lower in this respect. This is not to say that confidentiality is of diminishing importance to young people; many stated it as the single best thing about the service for them. What is shown here, however, is that trust of staff and a belief that services are confidential seems to have been achieved almost universally.

Recommendations:

- Services should explore ways of accessing very young people and those who are not yet sexually active. One option may be through forging stronger links with schools and youth groups.

- Services should make explicit in their advertising materials that they are open and welcoming to people wanting simply advice and information – and not exclusive to those already sexually active.
- Services should re-iterate their commitment to maintaining confidentiality to everyone – including those under the age of 16.
- The potential for informal, drop-in arrangements should be explored at all services.
- Services should be proactive in attracting people through appropriate advertising and offering a wide range of facilities to enhance continuity of care within a given visit. Continuity between visits should also be encouraged with active appointment making between visits.
- Services should continue to provide information in a variety of formats (written; verbal) and using a range of media (posters; leaflets) in a style that is accessible to young people.
- Condoms should be made readily available and free of charge.
- Services need to continue to reinforce the issue of confidentiality. Although services in this study do seem to have achieved high levels of trust among young people, there is no room for complacency. It may only take a single negative experience - remembering the significant influence of word of mouth - for a service to lose its good reputation.
- Hospital-based services might look to those in the community for tips on how to increase levels of perceived confidentiality.

C. Which, if any, of the qualities of a service (confidentiality, access, information, acceptability, etc) show the strongest association with satisfaction?

Ambience is a high priority for young people in particular, how cheerful and comfortable the service is felt to be. This has implications for client satisfaction and in turn the likelihood that a young person will recommend a service to friends.

- Service providers should, where possible, consult with young people in the design and decoration of their service.
- Staff should make a conscious effort to achieve a comfortable environment with the provision of appropriate magazines, radio/TV, etc, to encourage use.

D. Which aspects of service configuration (*dedication, integration, location*) show the strongest association with satisfaction?

The qualitative component of this study showed that most of the young men and women interviewed preferred being seen alongside age peers, rather than men and women older than themselves. However, it was also suggested that age-exclusiveness was not of prime importance to young people in deciding which clinic to attend; some preferred to be with other young people, others didn't mind. The quantitative component showed however that age-dedicated services were much more successful in attracting young people, particularly men.

There does appear to be a preference for comprehensive services where all sexual health needs can be met in one place and at one time. Concerns about prevention of infection and pregnancy being offered together were not in evidence here. However, separate services did score higher on some measures of satisfaction, particularly among women. These findings highlight the difficulties with taking a 'one-size-fits-all' approach to the design and delivery of sexual health services for young people.

Recommendations:

- Service providers need to carefully balance the advantages of age-dedicated young peoples services against the potential of restricting accessibility. This should be done taking into account the specific demographic profile of the local population.
- Service providers should be encouraged to offer a wide range of services and be aware of the broader sexual health needs than those with which a client first presents. This is possible even where services are not fully equipped to offer a comprehensive integrated service as additional services may simply mean information giving or signposting to an alternative clinic. Sexual health needs to be regarded in an holistic way rather than being compartmentalised.

- Staff at separate contraceptive services should be especially aware of the continued efforts needed to attract young men into the service.
- Integrated services need to improve the amount and quality of information they give to women attending for contraception.
- Staff at all service types need to be aware of the high value young people attach to the personal characteristics of staff and the ease with which perceived unfriendliness or and unwelcome environment may deter attendance.
- A range of different service types, which reflect the need of the local population, should continue to be provided.

References

1. DoH. *Health of the Nation: A strategy for health in England*. London: Department of Health HMSO, 1992.
2. DoH. *The Health of the Nation - a policy assessed*. Two reports commissioned for the Department of Health from the Universities of Leeds and Glamorgan and the London School of Hygiene and Tropical Medicine. 1992.
3. NHS Management Executive. *Guidelines for reviewing Family Planning services: guidance for regions*. Leeds: NHS Management Executive, 1992.
4. SEU. *Teenage Pregnancy*. Report by the Social Exclusion Unit. Published by the Stationery Office. 1999.
5. DoH. *National Strategy for Sexual Health and HIV. Better Prevention, Better services, Better sexual health*. Department of Health 2001.
6. DoH. *Choosing Health. Making healthy choices easier*. Department of Health, 2004.
7. Bewley BR, Higgs RH, Jones A. Adolescent patients in an Inner London general practice: their attitudes to illness and health care. *J R Coll Gen Pract* 1984;34(267):543-6.
8. Macfarlane A, McPherson A, McPherson K, Ahmed L. Teenagers and their health. *Arch Dis Child* 1987;62(11):1125-9.
9. Jacobson LD, Owen PA. Study of teenage care in one general practice. *Br J Gen Pract* 1993;43(373):349.
10. Coleman J. Meeting the health needs of young people. *J-Epidemiol-Community-Health*. 2001;55(8):532-3.
11. PHLS. Public Health Laboratory Service, Sexually transmitted infections in the UK. New episodes seen at GUM clinics 1995-2000. www.phls.co.uk
12. CDR, Weekly. Sexually transmitted infections quarterly report: an update on genital chlamydial infections in the United Kingdom, and efforts to improve screening services. 2004;14(5). www.phls.co.uk
13. CDR, Weekly. Gonorrhoea in England, Wales, and Northern Ireland. 2004;14(18). www.phls.co.uk
14. Devonshire P, Hillman R, Capewell S, Clark BJ. Knowledge of Chlamydia trachomatis genital infection and its consequences in people attending a genitourinary medicine clinic. *Sex Transm Infect* 1999;75(6):409-11.
15. Kellock DJ, Piercy H, Rogstad KE. Knowledge of Chlamydia trachomatis infection in genitourinary medicine clinic attenders. *Sex Transm Infect* 1999;75(1):36-40.
16. Macmillan S, Walker R, Oloto E, Fitzmaurice A, Templeton A. Ignorance about Chlamydia among sexually active women--a two centre study. *Hum Reprod* 1999;14(4):1131-5.
17. Bloxham S, Capstick S, Greenwood A. Combining GUM and contraceptive services for young people: profile of an innovative clinic.(GUM = genitourinary medicine). *Br J Fam Plann* 1999;25(1):18-21.
18. Margaret Jones. *Brook Advisory Centre, personal communication*, 1995.

19. TPSE Team. *An Audit of Contraceptive Service Provision in England, with special reference to service provision for young people*. TPU, 2002.
20. TPSE Team. *An Audit of Contraceptive Service Provision in England, with special reference to service provision for young people*. TPU, 2002.
21. Milne AC Chesson R. Health services can be cool: partnerships with adolescent in primary care. *Fam Pract* 2000; 17(4):305-8.
22. Milne AC Chesson R. Health services can be cool: partnership with adolescents in primary care. *Fam-Pract* 2000;17(4):305-8.
23. Jacobson LD, Wilkinson CE. Review of teenage health: time for a new direction. *Br J Gen Pract* 1994;44(386):420-4.
24. Kari J, Donovan C, Li J, Taylor B. Adolescents' attitudes to general practice in north London. *Br J Gen Pract* 1997;47(415):109-10.
25. Jones R, Finlay F, Simpson N, Kreitman T. How can adolescents' health needs and concerns best be met? *Br J Gen Pract* 1997;47(423):631-4.
26. International Planned Parenthood Federation. *Statement of contraception and STI/HIV protection services for adolescents*. International Planned Parenthood Federation. 2000. www.ippf.org
27. Jacobson L, Richardson G, Parry-Langdon N, Donovan C. How do teenagers and primary healthcare providers view each other? An overview of key themes. *Br J Gen Pract* 2001;51(471):811-6.
28. Macfarlane A, McPherson A. Primary health care and adolescence. *BMJ* 1995;311(7009):825-6.
29. Walker Z, Townsend J. The role of general practice in promoting teenage health: a review of the literature. *Family Pract* 1999;16:164-72.
30. Baraitser P, Fettiplace R, Dolan F, Massil H, Cowley S. Quality, mainstream services with proactive and targeted outreach: a model of contraceptive service provision for young people. *J Fam Plann Reprod Health Care* 2002;28(2):90-4.
31. Jacobson L, Kinnersley P. Teenagers in primary care--continuing the new direction. *Br J Gen Pract* 2000;50(461):947-8.
32. Allaby MA. Contraceptive services for teenagers: do we need family planning clinics? *BMJ* 1995;310(6995):1641-3.
33. Hardee K, Yount K.M. From rhetoric to reality: delivering reproductive health promises through integrated services. *Family Health International* 1995;5(39).
34. Tobin JM, Roy RB. Are we failing our teenagers? Value of a family planning service for teenagers within the sexually transmitted disease clinic. *Br Med J (Clin Res Ed)* 1985;290(6465):376-8.
35. Elias CJ, Leonard A. Family planning and sexually transmitted diseases: the need to enhance contraceptive choice. *Curr Issues Public Health* 1995;1(5):191-7.
36. Greenhouse P. Rethinking sexual health clinics. Primary and secondary sexual health services need a consistent philosophy. *BMJ* 1995;310(6988):1193.

37. Ward H, Kubba A., Bradbeer C, Pillaya J and Randall S. Health Medicine, 1995 MSSVD. Consensus workshop on sexually transmitted diseases and contraception: sexual health promotion and service delivery.: Faculty of Family Planning and Reproductive Health care; Faculty of Public, 1995.
38. Harry TC. Quality and resource management in genitourinary medicine service delivery. *Int J STD AIDS* 1999;10(11):751-4.
39. Peckham S. Preventing unintended teenage pregnancies. *Public Health* 1993;107(2):125-33.
40. Centre for Reviews and Dissemination. *Preventing and reducing the adverse effects of unintended teenage pregnancies*. University of York 1997.
41. UNFPA. *A Time Between. Health, sexuality and reproductive health rights of young people*. United Nations Population Fund, 1999. UNFPA. ISBN: 0-89714-550-X. www.unfpa.org
42. Coleman J. Meeting the health needs of young people. *J Epidemiology & Community Health. Editorial.* 2001;55:532-533.
43. UNFPA. *Reproductive health and education for young people. Enabling choices. Promoting empowerment*. United Nations Population Fund, 2003.
44. UNFPA. *Investing in people - A summary*. National Progress in Implementing the ICPD Programme of Action 1994-2004: United Nations Population Fund. International Conference on Population and Development, 2004.
45. Nicol A, Catchpole M, Cliffe S, Hughes G, Simms I, Thomas D. Sexual health of teenagers in England and Wales: analysis of national data. *BMJ* 1999;318:1321-22.
46. Kane R, Wellings K. Integrated sexual health services: the views of medical professionals. *Cult Health Sex* 1999;1(2):131-45.
47. Piercy H, Kellock D, Rogstad K, Searle ES. Knowledge of genital Chlamydia trachomatis infection in family planning clinic attenders. *Br J Fam Plann* 2000;26(4):195-8.
48. Burack R. Young teenagers' attitudes towards general practitioners and their provision of sexual health care. *Br J Gen Pract* 2000;50(456):550-4.
49. Hadley A. Do teenagers know you don't have to tell? *Pract Nurse* 1999;17:395-398.
50. Jacobson LD, Mellanby AR, Donovan C, Taylor B, Tripp JH. Teenagers' views on general practice consultations and other medical advice. The Adolescent Working Group, RCGP. *Fam Pract* 2000;17(2):156-8.
51. Chambers RB, Chambers S. Young people's and professionals' views about ways to reduce teenage pregnancy rates: to agree or not agree. *J-Fam-Plann-Reprod-Health-Care* 2002;28(2):85-90.
52. TPU. *Best Practice Guidance on the Provision of effective contraception and advice services for young people*. TPU, Department of Health, 2000.
53. Donaldson L. *On the state of the public health: Annual report of the Chief Medical Officer 2003*: Department of Health, London. 2003.
54. Donovan C, McCarthy S. Is there a place for adolescent health screening in general practice? *Health Trends* 1988;20:64-65.

55. Hibble A, Elwood J. Health promotion for young people. *Practitioner* 1992;236(1521):1140, 1142-3.
56. Campbell A, Edgar S. Teenage screening in a general practice setting. *Health Visit* 1993;66(10):365-6.
57. Jacobson L, Wilkinson C, Pill R, Hackett P. Communication between teenagers and British general practitioners: a preliminary study of the teenage perspective. *Ambul Child Health* 1996;1:291-301.
58. Davies L, S. The adolescent view of accessing health services. *Br-J-Gen-Pract.* 1999;49(443):486-7.
59. Jacobson L, Kinnersley P. Teenagers in primary care--continuing the new direction. *Br-J-Gen-Pract* 2000;50(467):947-8.
60. Williams EC, Kirkman RJ, Elstein M. Profile of young people's advice clinic in reproductive health, 1988-93. *BMJ* 1994;309(6957):786-8.
61. Churchill D, Allen J, Pringle M, Hippisley-Cox J, Ebdon D, Macpherson M, et al. Consultation patterns and provision of contraception in general practice before teenage pregnancy: case-control study. *BMJ* 2000;321(7259):486-9.
62. Churchill R, Allen J, Denman S, Williams D, Fielding K, von Fragstein M. Do the attitudes and beliefs of young teenagers towards general practice influence actual consultation behaviour? *Br J Gen Pract* 2000;50(461):953-7.
63. McPherson A, Macfarlane A, Allen J. What do young people want from their GP? *Br J Gen Pract* 1996;46(411):627.
64. Donovan C, Mellanby AR, Jacobson LD, Taylor B, Tripp JH. Teenagers' views on the general practice consultation and provision of contraception. The Adolescent Working Group. *Br J Gen Pract* 1997;47(424):715-8.
65. Jacobson LD, Wilkinson C, Owen PA. Is the potential of teenage consultations being missed?: a study of consultation times in primary care. *Fam Pract* 1994;11(3):296-9.
66. Walker Z, Townsend J, Oakley L, Donovan C, Smith H, Hurst Z, et al. Health promotion for adolescents in primary care: randomised controlled trial. *BMJ* 2002;325(7363):524.
67. Thomas M. Sexual medicine. *BMJ. Letter* 1997;315:429.
68. Epstein R, Rice P, Wallace P. Teenagers' health concerns: implications for primary health care professionals. *J R Coll Gen Pract* 1989;39(323):247-9.
69. Oppong-Odiseng AC, Heycock EG. Adolescent health services--through their eyes. *Arch Dis Child* 1997;77(2):115-9.
70. Cowap N. GPs need to be more proactive in providing health care to teenagers. *BMJ* 1996;313(7062):941.
71. Milne AC, Chesson R. Health services can be cool: partnership with adolescents in primary care. *Fam Pract* 2000;17(4):305-8.
72. Allen I. *Family Planning and Pregnancy Counselling Projects for young people*: PSI Publishing, 1991.

73. Meyrick J. Reducing the rate of teenage conceptions: An overview of the effectiveness of interventions: Health Education Authority, London. 1998.
74. Nwokolo N, McOwan A, Hennebry G, Chislett L, Mandalia S. Young people's views on provision of sexual health services. *Sex Transm Infect* 2002;78(5):342-5.
75. McClean HL, Reid M, Scoular A. "Healthy alliances?"--other sexual health services and their views of genitourinary medicine. *Genitourin Med* 1995;71(6):396-9.
76. Wilkinson C, Hampton N, Bradbeer C. The integration of family planning and genitourinary medicine services. *Br J Fam Plann* 2000;26(4):187-8.
77. Roche C, Callander N, Dawson S. Adapt or perish? -- the challenge to clinics [letter]. *British Journal Of Family Planning*. 1996;21(4):155.
78. Desmond NN, Nwokolo NC, Callander N. An audit of chlamydia treatment and contact tracing in a sexual health service. *Int J STD AIDS* 1999;10(7):492.
79. Callander N, Dawson S, Roche C. Adapt or perish? -- the challenge to clinics [letter]. *British Journal Of Family Planning*. 1996;21(4):155.
80. Carlin EM, Russell JM, Sibley K, Boag FC. Evaluating a designated family planning clinic within a genitourinary medicine clinic. *Genitourin Med* 1995;71(2):106-8.
81. Doherty L. New approaches to sexual health services in a rural health board area: involving service users and primary care professionals. *Int J STD AIDS* 2000;11(9):594-8.
82. Jones M. Clients express preference for one-stop sexual health shop. *Nursing Times* 1996;21:32-33.
83. Feldblum P, Fortney, JA. Condoms, spermicides, and the transmission of human immunodeficiency virus: A review of the literature. *Am J Pub Health* 1988;78, 52.
84. Grimes D, Cates, W. Jr. Family planning and sexually transmitted diseases. In: Holmes KK M, P, Sparling PF, Wiesner, PJ, editor. *Sexually Transmitted Diseases*: New York: McGraw-Hill, 1990:85-89.
85. McGregor JA, French, J.I. and Spencer, N.E. Prevention of sexually transmitted diseases in women. *Journal of Reproductive Medicine* 1988;33(109).
86. North B. Effectiveness of vaginal contraceptives in prevention of sexually transmitted diseases. In: Alexander N, Gabelnick, HL, Spieler, JM, editors. *Heterosexual Transmission of AIDS*. New York: Wiley-Liss, 1990:273-288.
87. Stone K. Avoiding sexually transmitted diseases. *Obstetrics and Gynecology Clinics of North America* 1990;17(789).
88. Judson FN, Ehret JM, Bodin GF, Levin MJ, Rietmeijer CA. In vitro evaluations of condoms with and without nonoxynol 9 as physical and chemical barriers against Chlamydia trachomatis, herpes simplex virus type 2, and human immunodeficiency virus. *Sex Transm Dis* 1989;16(2):51-6.
89. Katznelson S, Drew WL, Mintz L. Efficacy of the condom as a barrier to the transmission of cytomegalovirus. *J Infect Dis* 1984;150(1):155-7.
90. Conant MA, Hardy, D., Sernatinger, J. and Levy, J.A. Condoms prevent transmission of AIDS associated retrovirus. *JAMA* 1986;255:1706.

91. Barlow D. The condom and gonorrhoea. *Lancet* 1997;11:811.
92. Aral, S.O. and Guinan, M.E Women and sexually transmitted diseases. In: Holmes KK MP, Sparling PF and Wiesner J, editor. *Sexually Transmitted Diseases*. New York.: McGraw-Hill, 1984:85-89.
93. Crowley T, Horner P, Greenhouse P, Price J, Carey H, Foley D. Sexual health of adolescents in the UK. *Int J STD AIDS* 2000;11(11):759-60.
94. Masters L, Nicholas H, Bunting P, Welch J. Family planning in genitourinary medicine: an opportunistic service? *Genitourin Med* 1995;71(2):103-5.
95. Asboe D, Boag F, Evans B. Women's health: potential for better co-ordination of services. *Genitourin Med* 1992;68(1):65.
96. Queen H, Ward HF, Smith, C, Woodroffe C. Women's health potential for better co-ordination of services. *Genito-Urinary Medicine* 1991;67:215-219.
97. Singaratnum A, Asboe D, Boag F, Barton S, Hawkins D and Lawrence A. Preventing the spread of HIV infection. *Br Med J* 1991(302):469.
98. Eversley RB, Policar M, White V, Grinstead O, Newsletter A, Avins A, et al. Self-reported sexually transmitted diseases among family planning clients: ethnic differences in sexual risk behavior and HIV risk reduction. *Ethn Dis* 1993;3(2):181-8.
99. Mosher WD, Aral SO. Testing for Sexually Transmitted Diseases Among Women of Reproductive Age: United States. *Fam Plann Perspect* 1991;23(216).
100. Wasserheit JN, Harris JR, Chakraborty J, Kay BA, Mason KJ. Reproductive tract infections in a family planning population in rural Bangladesh. *Stud Fam Plann* 1989;20(2):69-80.
101. Frank T. The demand for fertility control in Sub-Saharan Africa. *Studies in Family Planning* 1987;18:181.
102. Scoular A, Duncan B, Hart G. "That sort of place...where filthy men go...": a qualitative study of women's perceptions of genitourinary medicine services. *Sex Transm Infect* 2001;77(5):340-3.
103. Dixon-Woods M, Stokes T, Young B, Phelps K, Windridge K, Shukla R. Choosing and using services for sexual health: a qualitative study of women's views. *Sex Transm Infect* 2001;77(5):335-9.
104. Forrest JD. The delivery of family planning services in the United States. *Family Planning Perspectives* 1988;20(88).
105. McCarthy GA, Cockell AP, Kell PD. Do women prefer single-sex GUM clinics? *Nurs Times* 1993;89(15):59.
106. McCarthy GA, Cockell AP, Kell PD, Beevor AS, Boag FC. A women-only clinic for HIV, genitourinary medicine and substance misuse. *Genitourin Med* 1992;68(6):386-9.
107. Nyman V. Going Dutch - a pipe dream? *Br J Fam Plann* 1993:200-203.
108. Graves J. Computerized Patient-Flow Analysis of Local Family Planning Clinics. *Fam Plann Perspectives* 1981;13(164).

109. Cooper P. Quality measures in Family planning Services: Summary report and recommendations.: Wessex Regional Health Authority, England. 1992.
110. Dawe F, Rainford L. Contraception and Sexual Health, 2003. A Report on research using the ONS Omnibus Survey produced by the Office for National Statistics on behalf of the Department of Health: ONS, London. 2003.
111. Ashton J, Marchbank, A, Mawle, P. Family planning, abortion, and fertility services. In: Stevens A RJ, editor. *Health Care Needs Assessment*. Oxford: Radcliff Medical Press. 1994.
112. TPSE Team. Audit of General Practice. Evaluation of the Teenage Pregnancy Strategy. An audit of contraceptive service provision in general practice. Internal Briefing Number 8: London School of Hygiene and Tropical Medicine and University College London. TPU, 2003.
113. Hine A, Oakeshott, P. Health services can be cool: partnership with adolescents in primary care. *Fam Pract* 2001;18(4):305-8.
114. Seamark CJ, Pereira Gray DJ. Do teenagers consult general practitioners for contraceptive advice? *The British Journal of Family Planning* 1995;21:50-51.
115. Walsh J. Family planning provision in genitourinary medical clinics: a quiet revolution. *British Journal. of Family Planning* 1996;22:27-30.
116. NATSAL. National Survey of Sexual Attitudes and Lifestyles. Unpublished Data. 2002.
117. Seamark CJ, Pereira Gray DJ. Do teenagers consult general practitioners for contraceptive advice? *The British Journal of Family Planning* 1995;21:50-51.
118. Hughes D, McGuire A. The cost-effectiveness of family planning service provision. *J Public Health Med* 1996;18(2):189-96.
119. Aggleton P Chalmers H, Daniel S & Warwick I. *Promoting Young People's Sexual Health. A compendium of family planning service provision for young people.*: HEA, London. 1996.
120. Garside R, Ayres R, Owen MR, Pearson VH, Roizen J. General practitioners' attitudes to sexual activity in under-sixteens. *J R Soc Med* 2000;93(11):563-4.
121. McPherson A, Macfarlane A, Donovan C. The Health of Adolescents in Primary Care. How to promote adolescent health in your practice. Exeter: Exeter publications Office: The Royal College of General Practitioners., 1996.
122. Newman M Bardsley M, Morgan D & Jacobson. Contraception and Abortion Services in London.: The Health of Londoners Project. East London & The City Health Authority, 1997.
123. DoH. Family Planning Clinic Services, Summary Information, DoH England. 1999
124. Djuretic T, Catchpole M, Bingham JS, Robinson A, Hughes G, Kinghorn G. Genitourinary medicine services in the United Kingdom are failing to meet current demand. *Int J STD AIDS* 2001;12(9):571-2.
125. Foley E, Patel R, Green N, Rowen D. Access to genitourinary medicine clinics in the United Kingdom. *Sex Transm Infect* 2001;77(1):12-4.
126. The British Cooperative clinical group. Provision for sexual health care of adolescents in genitourinary medicine clinics in the United Kingdom. *Genitourinary Medicine* 1997;73:453-456.

127. Forster G Dale A, Brook G, Daniels D, Tomlinson D. FP provision in GUM clinics. *Br Jr Fam Plann* 2000;26(4):244.
128. West J, Hudson F, Levitas, R & Guy WL. Young People and Clinics: Providing for Sexual Health in Avon.: Department of Sociology, University of Bristol., 1995.
129. West J, Hudson F, Levitas R, Guy WL. Young People and Clinics: Providing for Sexual Health in Avon.: Department of Sociology, University of Bristol., 1995.
130. Rogstad KE, Ahmed-Jushuf IH, Robinson AJ. Standards for comprehensive sexual health services for young people under 25 years. *Int J STD AIDS* 2002;13(6):420-4.
131. Cooper P, Diamond I, & High S. Choosing and Using Contraceptives: Integrating Qualitative and Quantitative methods in Family Planning in: Preventing Teenage Pregnancy, Conference Proceedings, IHPS Occasional Paper: University of Southampton, 1994.
132. Pearson S, Cornah D, Diamond I, Ingham R, Peckham S & Hyde M. Promoting young people's sexual health services: Report Commissioned for the Health Education Authority, London. 1996.
133. Phillips D, Owen M, Marshall M, Pearson V, Coleman LM. Family Planning Services in General Practice and Family Planning Clinics: A Devon Case Study, England. 1994.
134. Wilson S, Denman, S et al. Purchasing services to promote the sexual health of young people- contraceptive care for teenagers. *European Journal of Public Health* 1994:207-212.
135. TPSE, Team. Evaluation of the National Teenage Pregnancy Strategy. Final Synthesis Report. 2004.
136. Evans D, Farquhar C. An interview based approach to seeking user views in genitourinary medicine. *Genitourin Med* 1996;72(3):223-6.
137. Jones M. Teenage Pregnancies; who is responsible? *Education and Health*. 1992;10(2):21-26.
138. Hill M. Do Family Planning facilities meet the needs of the sexually active teenager? *British Journal of Family Planning* 1987;13(143-151).
139. Harrison NA. Young People's Advisory Services. *Health Bulletin* 1982;40:133-139.
140. Evans A, Carlin E, Slack R, Allaby M. Termination of pregnancy, chlamydia and contact tracing. *Int J STD AIDS* 2000;11(1):70.
141. Evans D Farquar C. *Identifying and Addressing User Views in Genito-urinary Medicine: A Report of in-depth Research in Bristol and District.*: IHPS University of Southampton, 1995.
142. Cave T. *A Review of Family Planning Services for young people in West Dorset.* Report to West Dorset Community NHS Trust., 1991.
143. Chambers J. Condom Survey in: *Birth Control Trust. Men, Sex and Contraception.* London FPA, 1984.
144. Matthews M. *Young people's advisory centres Staff speak:* FPA Education and Training Department, London. 1994.
145. Philpott A. *Young Women's Sexual Health Project: Needs Assessment Report,* Salisbury: Young Women's Sexual Health Project., 1995.

146. McAvoy BR, Raza A. Asian women: contraceptive services and cervical cytology. *Health Trends* 1988;20:14-17.
147. Beardsell S, Weatherburn P, Davies PM. GUM services in Central London: A review of provision. Sigma Research: A Report Commissioned by the Inner London HIV Health Commissioners Group, 1997.
148. Prasad S. Towards better health care provision for ethnic minorities in Britain: reproductive health and family planning in the Asian community. *British Journal Of Family Planning*. 1994;19:283-289.
149. Severy LJ, McKillop K. Low-income women's perceptions of family planning service alternatives. *Fam Plann Perspect* 1990;22(4):150-7, 168.
150. Wardle S, Wright, PJ. Family Planning Services- the needs of young people. A report from mid Staffordshire. *British Journal of Family Planning* 1993;19:158-160.
151. Atkinson D, Winzelberg, A & Holland, A. Ethnicity, locus of control for family planning, and pregnancy counsellor credibility. *J. Couns. Psych* 1985;32(3):417-421.
152. Harvey SM, Beckman LJ, Murray J. Health care provider and contraceptive care setting: the relationship to contraceptive behavior. *Contraception* 1989;40(6):715-29.
153. Philliber SG, Jones J. Staffing a contraceptive service for adolescents: the importance of sex, race, and age. *Public Health Rep* 1982;97(2):165-9.
154. Simmons R, Elias C. The study of client-provider interactions: a review of methodological issues. *Stud Fam Plann* 1994;25(1):1-17.
155. Donabedian A. Promoting quality through evaluating the process of patient care. *Medical Care* 1968;6:191-202.
156. FPA. A Model for District Health Authorities Appendix A: Client needs: Checklist for purchasers; Appendix B Services to be purchased for the DHA's clients. FPA, 1990.
157. Yellin S, Wardman G. A survey of community based Family Planning and well women services in Leeds. *British Journal of Family Planning* 1993;19:160-162.
158. Peckham S, Ingham R. Teenage pregnancy: Prevention and Programmes: Institute for Health Policy Studies University of Southampton., 1996.
159. Graham N. Access to Sexual Health Clinics in Glasgow for Disabled People. What are the barriers?: Glasgow Centre for Family Planning and Sexual Health., 1997.
160. Kubba A. Family Planning in the inner cities. *British Journal of Sexual Medicine* 1992:96-97.
161. Ross G. Teenage clinics - the rough guide. *British Journal of Sexual Medicine*. 1996:18-22.
162. Kumar S, Jain, A, Bruce, J. Assessing the quality of family planning services in developing countries.: Population Council. Programs Division. Working Papers No. 2, 1989.
163. Montgomery J. The Law and the Under 16s in: *Preventing Teenage Pregnancy Conference Proceedings IHPS Occasional Paper* March. IHPS, 1994.
164. Webb A, Morris, J. Practice of postcoital contraception - the results of a national survey. *British Journal of Family Planning* 1993.

165. Peckham S. Unplanned pregnancy and teenage pregnancy: A review.: Institute for Health Policy Studies University of Southampton., 1992.
166. Bruce J, Jain A. Improving the quality of care through operations research. (Paper presented at the International Operations Research Conference and Workshop 1990. Jun. Using Operations Research to Help Family Planning Programs Work Better): The MORE Project, Columbia, Maryland, 1990:11-14.
167. Bruce J. Fundamental elements of quality of care; a simple framework. *Studies in Family Planning* 1990;21:69-89.
168. Ketting E. Quality of care: an overview of major issues. *Planned Parenthood Challenges (caring for quality)*. 1994;2:28-30.
169. Paine K, Thorogood M, Wellings K. The impact of family planning services on the safety and efficacy of contraceptive use. A Literature Review for the WHO, 1998.
170. Bruce J. Quality of care: a brief history and a look ahead. *Planned Parenthood Challenges (caring for quality)*; 1994;2:2-5.
171. DoH Department of Health. National Service Framework for Children, Young People and Maternity Services. Key Issues for Primary Care.: Department of Health, 2004.
172. Timyan J BS, Measham DM, Ogunleye B. Access to care: more than a problem of distance. In: Koblinsky M TJ, Gray J., editor. *The health of women: a global perspective*. San Francisco and Oxford: Westview Press, 1993.
173. Rees Lewis J. Patient views on quality in general practice: a literature review. *Soc Sci Med* 1994;39:655-70.
174. DoH. A first class service quality in the new NHS. London: Department Of Health, 1998.
175. Bertrand JT, A. Indicators for Reproductive Health Program Evaluation. Report for the evaluation Project.: Carolina Population Centre. University of North Carolina at Chapel Hill. Chapel Hill, NC., 1995.
176. Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess, R, editor. *Analysing Qualitative Data*.: London: Routledge, 1994.
177. Kerry SM, Bland JM. Sample size in cluster randomisation. *BMJ* 1998;316(7130):549.
178. Kerry SM, Bland JM. The intracluster correlation coefficient in cluster randomisation. *BMJ* 1998;316(7142):1455.
179. Elwyn G, Seagrove A, Thorne K, Cheung WY. Ethics and research governance in a multicentre study: add 150 days to your study protocol. *BMJ* 2005;330:847.
180. Stone N, Ingham R. When and why do young people in the United Kingdom first use sexual health services? *Perspect Sex Reprod Health* 2003;35(3):114-20.