

## Recommended standards for sexual health services

Medical Foundation for AIDS & Sexual Health (2005)

### Summaries of references for key interventions

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#### Introduction

The evidence supporting the interventions within each standard has been summarised below, with the exception of sexual health networks. Given the paucity of research into sexual health networks, a list of further reading on networks in general and in other specialties has been included. These papers have not been summarised. The use of a double asterisk \*\* indicates that the evidence is from an abstract accepted at a national conference such as BHIVA, BASHH or the European Society of Contraception. Some of the papers included are opinion pieces. The intervention has therefore been labelled as having level V evidence. Where no papers have been listed the intervention is professional opinion and has also been labelled as level V evidence.

## Standard 1: Sexual health networks

The concept of networks is gaining momentum in the UK. Policy makers and managers are focusing their attention on the development of clinical networks that create linkages between primary, secondary and tertiary care. The purpose of networks is to improve patient care through more integrated approaches and to facilitate sharing of knowledge between professionals and organisations. Managed clinical networks have been developed in some specialty and disease areas (neurology, diabetes, cancer, cardiac care) and some locally developed networks are beginning to emerge in sexual health and HIV. The literature documents the development and implementation of networks. There is, however, little empirical evidence as to the effectiveness of clinical networks.

Baker CD, Lorimer AR (2000) Cardiology: the development of a managed clinical network. *BMJ* 321(11): 52-3.

Carter S, Garside P, Black A (2003) Multidisciplinary team working, clinical networks, and chambers; opportunities to work differently in the NHS. *Quality and Safety in Health Care* 12 suppl 1:i25-8.

Charlesworth J (2001) Negotiating and managing partnership in primary care. *Health and Social Care in the Community* 9:279-85.

Conner M (2001) Developing network-based services in the NHS. *International Journal of Health Care Quality Assurance* 14(6-7):237-44.

Department of Health (2000) *The NHS Plan: A plan for investment, a plan for reform*. London: Department of Health.

Department of Health (2001) *The national strategy for sexual health and HIV*. London: Department of Health.

Ebers M (ed) (1999) *The formation of inter-organisational networks*. Oxford: Oxford University Press.

Edwards N (2002) Clinical networks. Advantages include flexibility, strength, speed, and focus on clinical issues. *BMJ* 324:63.

Frater A, Gill M (2002) Clinical networks. Sum of the parts. *Health Service Journal* 112(5827):24-5.

King's Fund (2003) Care Pathways Reading List. (Available at: [www.kingsfund.org.uk/library](http://www.kingsfund.org.uk/library))

Lewis, C (2003) Clinical management where medicine meets management. Network Solutions. *Health Service Journal* 113(5876):28-9.

Moir D, Campbell H, Wrench J, Miller S (2001) First steps in developing a managed clinical network for vascular services in Lanarkshire. *Health Bulletin (Edinb)* 59(6): 405-11.

NHS London (2000) *Managed clinical networks for cancer services*. London: NHS London.

NHS (2004) *Developing clinical networks for paediatric HIV treatment & care in London*. A report by the London HIV Consortium Paediatric Sub-Group. (Available at: [www.bhiva.org/chiva/network/network.html](http://www.bhiva.org/chiva/network/network.html)).

O'Brien O, Lowbury R. (2002) Networking for quality in HIV treatment and care. London: Medical Foundation for AIDS & Sexual Health. (Available at [www.medfash.org.uk](http://www.medfash.org.uk)).

Pedler M (2001) *Issues in health development. Networked organisations - an overview*. London: Health Development Agency. (Available at: [www.publichealth.nice.org.uk](http://www.publichealth.nice.org.uk)).

## Standard 2: Promoting sexual health

1. Programmes and interventions which are multi-component are most effective in reducing sexual ill health. Interventions are more likely to be effective if they include use of theoretical models; are targeted for particular communities making use of needs assessment or formative research; and provide information and behavioural skills training (level I)

Ellis S, Grey A (2004) Prevention of sexually transmitted infections (STIs): a review of reviews into the effectiveness of non-clinical interventions. London: Health Development Agency.

This review of reviews found sufficient review level evidence to conclude that interventions are more likely to be effective if they use theoretical models, are targeted and tailored, make use of needs assessment or formative research, provide accurate unambiguous information, and use behavioural skills training. Recommendations for further research into the features of effective interventions were put forward. These include: a need for comparison of the effectiveness of interventions based on different theoretical models; the need for more formative research to inform interventions and an exploration of the extent of the transferability of pre-existing formative research; research to measure and report impact on health promotion outcomes such as knowledge and awareness; research to identify the effective elements of training and materials to support the providers of sexuality information, and research into the most effective behavioural skills training with different populations. The review also suggests that further evaluations and reviews are needed of multi-component interventions, investigating the relative contribution of the different components or 'ingredients' of interventions to effectiveness.

Shepherd J, Weston R, Peersman G, Napuli IZ (2000) Interventions for encouraging lifestyles and behaviours intended to prevent cervical cancer. *Cochrane Database of Systematic Reviews* (2):CD001035

A systematic review of the effectiveness of health education interventions to promote sexual risk reduction behaviours amongst women, in order to reduce the transmission of HPV, found that educational interventions targeting socially and economically disadvantaged women in which information provision is complemented by sexual negotiation skill development can encourage at least short term sexual risk reduction. The authors state that this has the potential to reduce the transmission of HPV, and thus possibly reduce the incidence of cervical carcinoma.

Kirby D (2002) Effective approaches to reducing adolescent unprotected sex, pregnancy, and childbearing. *Journal of sex research* 39(1): 51-7

In this US article 73 studies and their respective programs are summarised. Four groups of programs are described which have reasonably strong evidence that they delay sex, increase condom or contraceptive use, or reduce teenage pregnancy or childbearing. These four groups are sex and HIV curricula with specified characteristics; one-on-one clinician-patient protocols in health settings with some common qualities; service learning programs; and a particularly intensive youth development program with multiple components.

Kotchick BA, Shaffer A, Forehand R, Miller KS (2001) Adolescent sexual risk behaviour: a multi-system perspective. *Clinical psychological review* 21(4):493-519

This article proposes that research efforts into the factors that influence adolescent sexual risk behaviour have been hampered by the adoption of models and perspectives that are

narrow and do not adequately capture the complexity associated with the adolescent sexual experience. A review of the literature by the authors noted numerous variables from the self, family, and extrafamilial systems, which are related to adolescent sexual behaviour. They suggest that only recently have multi-system analyses taken place that capture the complexity of the adolescent experience. Evidence suggests that variables across different systems interact to increase the probability of risk taking behaviour. They propose that research adopts a multisystemic perspective.

Nation M, Crusto C, Wandersman A, Kumpfer KL, Seybolt D, Morrissey-Kane E, Davino K (2003) What works in prevention. Principles of effective prevention programs. *American Psychologist* 58(6-7):449-56

The authors used a review of reviews approach across four areas (substance abuse, risky sexual behaviour, school failure, and juvenile delinquency and violence) to identify nine characteristics that are associated with effective prevention programs. They feel that this synthesis can provide a rationale for multi-problem prevention programs that can be effective in preventing many of the problems facing children and adolescents. Programs were comprehensive, included varied teaching methods, provided sufficient dosage, were theory driven, provided opportunities for positive relationships, were appropriately timed, were socioculturally relevant, included outcome evaluation, and involved well-trained staff.

## 2. Programmes that focus on strengthening perceived norms that promote safer sex can lead to reduced sexual risk taking (for example, through use of peers or popular opinion leaders) (level II, V)

Kelly JA, Murphy DA, Sikkema KJ, McAuliffe TL, Roffman RA, Solomon LJ, Winett RA, Kalichman SC (1997) Randomised, controlled, community level HIV prevention intervention for sexual risk behaviour among homosexual men in US cities. *Lancet* 350(9090):1500-1505

Kelly JA (2004) Popular opinion leaders and HIV prevention peer education: resolving discrepant findings, and implications for the development of effective community programmes. *AIDS Care* 16 (2):139-150

Hart GJ, Williamson LM, Flowers P (2004) Good in parts: the Gay Men's Task Force in Glasgow - a response to Kelly. *AIDS Care* 16(2):159-165

Elford J, Bolding G, Sherr L (2004). Popular opinion leaders in London: a response to Kelly. *AIDS Care* 16(2):151-158

The evidence suggesting that programmes which focus on strengthening perceived norms that promote safer sex can result in reduced sexual risk taking comes from studies by Kelly et al in the States. Controlled trials over the past 10 years provide clear evidence that peer education can bring about a reduction in high-risk sexual behaviour among gay men. HIV prevention interventions that systematically identified, recruited, trained and engaged popular opinion leaders (POLs) made a significant impact on sexual behaviour at a community level. However, a replication of these trials in the UK failed to demonstrate any reduction in sexual risk behaviour for HIV infection. The reasons for failure were attributed to the difficulty of incorporating *all* of the core elements of POL that made it successful in the States. The papers listed explore this in more detail. The continued value of peer education in contributing to reductions in sexual risk behaviour for HIV infection is acknowledged.

**3. Sustained sexual health promotion campaigns, as part of multi-component programmes, can positively affect individual attitudes and intentions regarding safer sex (level IV)**

Yzer MC, Siero FW, Buunk BP (2000) Can public campaigns effectively change psychological determinants of safer sex? An evaluation of three Dutch campaigns. *Health Education Research* 15(3):339-52

One of the only studies that demonstrates empirically that sustained campaigns can positively affect individual attitudes and intentions regarding safer sex comes from an evaluation of three years of safer sex campaigns conducted in Holland. Yzer et al tested the hypothesis that variables (attitudes, perceived social norms, self-efficacy, and intentions regarding safer sex) become more positive when campaigns are conducted and less positive when campaigns are discontinued. The evaluation showed that the campaigns positively affected all variables and that when no campaign was conducted the level of all variables decreased. This suggests that interventions need to focus on sustainability and stabilisation. There is no UK evidence that supports this finding.

**4. High quality sexual history-taking and risk assessment can provide opportunities for targeted sexual health promotion to become a routine part of good patient care and enable people to receive appropriately targeted advice and information on prevention of STIs, HIV, and unintended pregnancy within clinical settings (level V)**

Matthews P, Fletcher J (2001) Sexually transmitted infections in primary care: a need for education. *British Journal of General Practice* 51(462):52-6

In this discussion paper the authors suggest that only a minority of those at risk of an STI attend GUM clinics. By contrast the great majority of adults will access primary care in any one year. They suggest therefore that general practitioners are likely to encounter patients from across the risk spectrum for infection, including many at no risk. The need for a risk assessment, in the form of a sexual history, therefore becomes a key clinical skill for GPs in the process of differential diagnosis and for enabling them to target sexual health promotion and care. The authors highlight that there is a need for improved undergraduate, postgraduate, and in-service training.

## Standard 3: Empowering and involving people who use services

1. Public and service user involvement mechanisms for facilitating feedback about services, in particular those which are user-centred and/or user-led, can contribute positively to improving quality of services (level IV)

Coulter A (2002) After Bristol: putting patients at the centre. *BMJ* 324: 648-651.

This paper discusses the need to place patients at the centre of the NHS and that patients should be treated by providers as 'equals with different expertise'. It suggests that appropriateness and outcome of care can be improved by engaging patients in treatment and management decisions. Safety could be improved and complaints and litigation reduced if patients were actively involved in their own care. Regular, systematic feedback from patients is essential to improve quality of care and for public accountability.

Murray L (2003) *Undercover in Sheffield - A young peoples sexual health service evaluation scheme; Phase 1 report*. Sheffield, Centre for HIV and Sexual Health.

The undercover young people's sexual health service evaluation scheme is part of Sheffield's Teenage Pregnancy Strategy. The aim of Undercover is to involve young people in the evaluation of clinic-based and outreach sexual health services using a 'mystery shopper' approach i.e. turning up to the service and presenting as an ordinary service user. Young people were trained as evaluators and then visited services on a range of dates. The main themes that came up were: accessing the service, physical environment - waiting areas, confidentiality, information given and experience at reception. The evaluation was successful and responses from service managers have shown a great degree of willingness to implement achievable recommendations.

Baraitser P, Blake G, Brown KC, Piper J (2003) Barriers to the involvement of clients in family planning service development: lessons learned from experience. *Journal of Family Planning & Reproductive Health Care* 29(4): 199-203

The aim of this study was to recruit and train clinic users to interview their fellow clinic users on sexual health service use and to document staff responses to the results of the consultations. The authors found that this methodology documents clients' experiences of a specific service and generates practical suggestions for improvement. The authors suggest that an iterative process of staff and client consultation may ensure that future service development proceeds in a direction that meets the needs of both groups.

Crawford MJ, Rutter D, Manley C, Weaver T, Bhui K, Fulop N, Tyrer P (2002) Systematic review of involving patients in the planning and development of health care. *BMJ* 325(7375): 1263

This paper reviewed published and grey literature between 1996 and 2000 that involved patients in the planning and development of health care. It found that 74% of studies were case studies and that papers often described changes to services that were attributed to involving patients. The authors conclude that there is evidence that involving patients has contributed to changes in the service provision across a range of settings but that there is no evidence for the effects on use of services, quality of care, satisfaction, or health of patients.

**\*\*Ryan J, Jones M, Forde A, Weir M (2004) *Mystery shopper project to investigate how accessible and approachable sexual health services are in Barnet Enfield for young people.* BASHH/ASTDA Spring Meeting Bath 2004. Poster presentation.**

This study recruited and trained young people from local youth services. Pairs of young people visited services and recorded on dictaphone their responses to what they saw and experienced. This method was able to identify gaps and problems with service provision.

**2. Shared decision-making between professionals and individual service users can result in better health outcomes (level IV)**

Coulter A, Entwistle V, Gilbert D (1999) Sharing decisions with patients: is the information good enough? *BMJ* 318: 318-322.

This paper highlights that patients cannot express informed preferences unless they are given sufficient and appropriate information, including detailed explanations about their condition and the likely outcomes with or without treatment. The authors evaluated a range of information materials about treatment options. They concluded that if information material is going to be used to support patients' involvement in treatment decisions, it must contain relevant, research based data in a form that is acceptable and useful to patients. They found that much material omits relevant data, is patronising, fails to give a balanced view and ignores uncertainties. It is suggested that groups producing information materials start with needs defined by patients, give treatment information based on rigorous systematic reviews, and involve multidisciplinary teams (including patients) in developing and testing the material.

Coulter A (2002) *The autonomous patient: ending paternalism in medical care.* London: Nuffield Trust.

This book shows that most people want to be involved in decision making and their own care plans. But if this is to be done well, there must be training programmes for health professionals to ensure they can cope with the informed patient.

**3. Wider community-based access to some elements of sexual healthcare, such as pharmacy provision of emergency hormonal contraception (EHC), or STI screening and prevention interventions in community venues, alongside clear signposts and care pathways for access to mainstream services, can facilitate choice and control, and enhance service access (level V)**

Professional opinion - no published evidence available.

**4. Clear, easily accessible information about services - what is provided and where, including how they meet particular needs - can support individuals to select the service they need (level IV)**

Teenage Pregnancy Unit (2000) *Best Practice Guidance on the Provision of Effective Contraception and advice services for young people.* London: Department of Health  
[www.teenagepregnancyunit.gov.uk](http://www.teenagepregnancyunit.gov.uk)

## Standard 4: Identifying sexual health needs

1. Normalising sexual health as integral to general health and wellbeing can be achieved through discussion of sexual health during relevant opportunities within consultations (examples: new health checks, cervical cytology, travel clinics) (level IV)

James NJ, Hughes S, Ahmed-Jushuf I, Slack RC (1999) A collaborative approach to management of chlamydial infection among teenagers seeking contraceptive care in a community setting. *Sexually Transmitted Infections* 75(3): 156-61

In a teenage community-based health clinic selective screening for genital chlamydia trachomatis was undertaken among a) young women aged 13-19 years who were having a routine cervical smear test (before age of routine smear test = 20), b) those being referred for termination of pregnancy, and c) those who reported having behavioural risk factors, for, and/or symptoms of, genital infection. Collaboration with family planning, genitourinary medicine, and public health staff enabled effective management and follow up of positive results.

Matteelli A, Carosi G (2001) Sexually transmitted diseases in travellers. *Clinical Infectious Diseases* 32(7): 1063-7

In this paper the authors highlight that prevention of sexually transmitted diseases (STDs) is a low priority among travel clinic services, despite increasing evidence that travellers have an increased risk of acquiring such infections. They suggest that travellers with increased risk be identified for targeted interventions.

Health Protection Agency (2003) *HIV and other STIs in the United Kingdom in 2002: Annual Report*. London: Health Protection Agency. (Available at: [www.hpa.org.uk](http://www.hpa.org.uk))

In this annual report the Health Protection Agency (HPA) highlights research suggesting that those who engage in risky sexual behaviour overseas are also likely to have risky sexual lifestyles at home, thus underlining the importance of proactive sexual health and educational campaigns prior to departure. The HPA states that travel advisors should include safer sex as part of a range of health protection messages for international travellers.

Churchill D, Allen J, Pringle M, Hippisley-Cox J (2002) Teenagers at risk of unintended pregnancy: identification of practical risk markers for use in general practice from a retrospective analysis of case records in the United Kingdom. *International Journal of Adolescent Medical Health* 14(2): 153-60

This retrospective case control study was performed to determine whether it was possible to identify any markers that could alert general practitioners to the need to give appropriate opportunistic preventive advice. In the 12 months prior to conception approximately half of the cases had discussed contraception and two-fifths had been prescribed oral contraception. A significantly higher proportion of cases than controls had consulted for emergency contraception and also for urinary tract symptoms. Weaker associations were also found with younger age of starting contraception, recorded side-effects or dissatisfaction with contraception. Lapsed contraception and previous pregnancy were noted as other potential markers of risk. The findings from this study may assist primary care professionals in targeting opportunistic sexual health interventions at some teenagers who are at higher risk of unintended pregnancy.

**2. Training and structured sexual history-taking templates or case notes will facilitate a consistent approach to identifying sexual health needs across settings (level IV)**

\*\*Prime KP, Lloyd J, Robinson AJ, Edwards SG (2001) *Impact of a notes proforma on the management of HIV-positive women*. MSSVD Spring Meeting, Belfast, 2001

This study found that the introduction of a notes proforma increased discussion and documentation of cervical smear outcomes, sexual activity, contraceptive use, pregnancy plans and screening for STIs, for a cohort of HIV-positive women.

**3. Following national clinical effectiveness guidelines for STI screening (by the British Association for Sexual Health and HIV (BASHH)) will help identify asymptomatic infection in those who approach sexual health services and who, therefore, may have some degree of awareness of their risks (level IV)**

Clinical Effectiveness Guidelines of the British Association for Sexual Health & HIV (BASHH). (Available at: [www.bashh.org](http://www.bashh.org)).

Stokes T, Schober P, Baker J, Bloor A, Kuncewicz I, Ogilvy J, et al (1999) Evidence-based guidelines for the management of genital chlamydial infection in general practice. (Leicestershire Chlamydia Guidelines Group). *Family Practitioner* 16(3):269-77

This study aimed to develop valid guidelines for the management of genital chlamydial infection for use in British general practice through documenting current clinical practice and critically reviewing the evidence. A multidisciplinary group developed the guidelines which cover diagnosis, investigation, drug treatment and referral.

**4. The National Chlamydia Screening Programme, and other opportunistic screening which targets high need population groups, can detect infection in those who might otherwise not access sexual health services or be aware of their risks. The inclusion of community-based venues as screening sites can further identify infection or STI risk (level IV)**

LaMontagne DS, Fenton KA, Randall S, Anderson S, Carter P, on behalf of the National Chlamydia Screening Steering Group (2004) Establishing the National Chlamydia Screening Programme in England: results from the first full year of screening. *Sexually Transmitted Infections* 80:335-341

In the first phase of the National Chlamydia Screening Programme (NCSP), 16,413 opportunistic screens among young adults under 25 years of age were performed in non-GUM settings and testing volume increased over time. This first phase has demonstrated that opportunistic screening can and does occur in a wide variety of settings (contraceptive clinics, general practices, women's clinics, termination of pregnancy, colleges, universities, schools, military facilities).

Pimenta JM, Catchpole M, Rogers PA, Perkins E, Jackson N, Carlisle C, et al (2003). Opportunistic screening for genital chlamydial infection I: acceptability of urine testing in primary and secondary healthcare settings. *Sexually Transmitted Infections* 79(1):16-21

Pimenta JM, Catchpole M, Rogers PA, Perkins E, Jackson N, Carlisle C, et al (2003). Opportunistic screening for genital chlamydial infection II: prevalence among healthcare attenders, outcome, and evaluation of positive cases. *Sexually Transmitted Infections* 79(1): 22-7

The results from the UK chlamydia pilot studies demonstrated that an opportunistic model of screening for chlamydial infection in primary and secondary care settings is a practical, universally acceptable method of screening. Prevalence of infection outside GUM clinics is substantial and opportunistic screening using urine samples is an acceptable method of reaching individuals with infection who do not normally present at specialist clinics.

McKay L, Clery H, Carrick-Anderson K, Hollis S, Scott G (2003) Genital chlamydia trachomatis infection in a subgroup of young men in the UK. *Lancet* 361(9371):1792

Fenton KA. (2000) Screening men for chlamydia trachomatis infection: have we fully explored the possibilities? *Communicable Disease and Public Health* 3(2): 86-89

The papers by McKay et al and Fenton highlight the importance of opportunistically screening men for chlamydia. The availability of urine testing offers new opportunities for actively including men in disease prevention.

## Standard 5: Access to services

1. Production and dissemination of regularly updated local service information, including location, opening times and services provided, using a range of formats and media, can influence perceptions about sexual health services and improve uptake of services (level IV)

McClellan HL, Reid M (1997) Use of GUM services and information and views held by first time service users in a large UK city: implications for information provision. *International Journal of STD & AIDS* 8(3): 154-8

This questionnaire study aimed to explore the relationship between information and views held by service users before obtaining help from a genitourinary medicine (GUM) service. The main source of information about the service was through general practitioners, with personal contacts as the second most common information source. The authors found that service users were significantly more likely to feel nervous when they had no information about the service than if they knew something about the service ( $p < 0.01$ ). Most service users (92.1%) favoured more information about GU services and the authors suggest there is a clear need to project increased awareness and information about GU services so as to encourage use and promote more positive feelings about the service.

Teenage Pregnancy Unit (2000) *Best practice guidance on the provision of effective contraception and advice services for young people*. London: Department of Health

This document emphasises that publicity materials should have resonance with the target group and that information about services, including the address, telephone number and opening times, should be provided to schools, colleges, community centres, leisure centres, bars, clubs and cinemas, and should be in local phone directories. All professionals working with young people should also be provided with this information to ensure widespread dissemination.

2. Clearly advertised, welcoming and accessible services for those who may need them can facilitate improved access (level IV)

Hamilton EL, Wallis MG, Barlow J, Cullen L, Wright C (2003) Women's views of a breast screening service. *Health Care Women* 24(1):40-8

This qualitative focus group study explored women's breast screening experience. The authors found that women wanted a local, easily accessible service and a 'cosy, non-clinical' atmosphere. They also suggested that the service be advertised more widely and that more detailed information be given before and after the procedure.

Teenage Pregnancy Unit (2000) *Best practice guidance on the provision of effective contraception and advice services for young people*. London: Department of Health

This document highlights that research with young people has identified the features of a trusted and accessible service. These include an age-specific focus, confidentiality, non-judgmental staff, accessible locations and opening hours, a friendly atmosphere and publicity in places where young people meet.

3. Explicit and demonstrable confidentiality can be a key determinant in access and uptake of services (level IV)

Blake DR, Kearney MH, Oakes JM, Druker SK, Bibace R (2003) Improving participation in chlamydia screening programs: perspectives of high-risk youth. *Archives of Pediatric & Adolescent Medicine* 157(6):525-9

This study aimed to describe young people's beliefs and opinions about obstacles to and motivators for obtaining testing for chlamydia and to provide recommendations for how to improve youth participation in chlamydia screening. In terms of confidentiality, participants emphasised the need to make sexually transmitted infection screening services more private and confidential.

Teenage Pregnancy Unit (2000) *Best practice guidance on the provision of effective contraceptive and advice services for young people*. London: Department of Health

This document highlights that research with young people has identified the features of a trusted and accessible service. These include an age-specific focus, confidentiality, non-judgmental staff, accessible locations and opening hours, a friendly atmosphere and publicity in places where young people meet.

\*\*Thomas N, Murray E, Rogstad KE (2004) *If confidentiality is lost will young people still access sexual health services?* Poster. BASHH/ASTDA Spring Meeting, 2004

This questionnaire study aimed to determine the importance of confidentiality of sexual health services to adolescents and its effect on their willingness to access services. 55% thought confidentiality the most important feature of the service. 87% were more likely to use the service if it were confidential. 90% would be honest if the service were confidential. This study shows that a lack of confidentiality would prevent adolescents using the service and affect what they disclosed.

Dixon-Woods M, Stokes T, Young B, Phelps K, Windridge K, Shukla R (2001) Choosing and using services for sexual health: a qualitative study of women's views. *Sexually Transmitted Infections* 77(5): 335-9

This study explored women's accounts of choosing and using specialist services for sexual health. The authors found that women's willingness to access services is mediated by psychosocial factors such as embarrassment. Their priorities for services are that their feelings of stigma and embarrassment are managed appropriately, that staff communicate well and sensitively, that they are 'in control' when obtaining test results, and that confidentiality is preserved.

## Standard 6: Detecting and managing sexually transmitted infections (STIs)

### 1. Adherence to evidence based guidelines leads to optimal management and/or resolution for people with STIs (level I)

Thomas LH, McColl E, Cullum N, Rousseau N, Soutter J, Steen N (1998) Effect of clinical guidelines in nursing, midwifery, and the therapies: a systematic review of evaluations. *Quality in Health Care* 7(4): 183-91

This systematic review provides some evidence that care driven by a guideline can be effective in changing the process and outcome of care. However, the authors point out that caution is needed in generalising these findings to other settings and that many of the studies fell short of the criteria of the Cochrane Effective Practice and Organisation of Care Group (EPOC) for methodological quality. The authors suggest that more research is clearly required in the development, dissemination, implementation, evaluation, and cost effectiveness of clinical guidelines as a strategy for improving professional practice in nursing and professions allied to medicine.

### 2. Rapid and early diagnosis and management of STIs minimises associated complications and can break the chain of transmission, limiting further spread (level IV)

Ovaskainen OT, Grenfell BT (2003) Mathematical tools for planning effective intervention scenarios for sexually transmitted diseases. *Sexually Transmitted Diseases* 30(5):388-94

The goal of this study was to examine the impact of potential interventions, such as reducing probability of transmission (e.g. by condom use), reducing the duration of infectiousness (e.g. by early diagnosis and treatment), or reducing the number of new contacts. The results showed that intervention measures should be targeted especially promptly if the goal is the complete eradication of the disease.

Kretzschmar M, van-Duynhoven YT, Severijnen AJ (1996) Modeling prevention strategies for gonorrhoea and chlamydia using stochastic network simulations. *American Journal of Epidemiology* 144(3): 306-17

In this study spread of STIs was modelled in an age-structured heterosexual population with a highly sexually active core group. Contact tracing strategies, screening of various subgroups, and the effect of condom use were compared. The authors conclude that contact tracing is very effective as a prevention strategy, that screening should be targeted to the highly active core group, that age is not sufficient as a determinant for high sexual activity to make screening of certain groups useful, and, finally, that consistent condom use by a fraction of the population can contribute substantially to the prevention of STIs.

### 3. Increased awareness among professionals and the public about STIs and associated health problems leads to increased uptake of STI testing and use of services (level IV)

Armstrong B, Kinn S, Scoular A, Wilson P (2003) Shared care in the management of genital chlamydia trachomatis infection in primary care. *Sexually Transmitted Infections* 79(5):369-70

This study investigated the impact of a health adviser from genitourinary medicine who offered support and training in the management of chlamydia to clinical staff in a large inner

city health centre. The results showed that the intervention was effective in increasing staff awareness and that testing of the target population increased both in absolute terms and as a proportion of the number of tests carried out. The study does, however, highlight the difficulties that general practice faces in attempting to manage chlamydia effectively and holistically (from diagnosis through to effective follow up and partner notification).

**4. Increased uptake of HIV testing can be achieved by introducing 'universal recommendation' or 'opt-out' approaches and by providing people with information either verbally or in the form of a leaflet to outline the process and benefits of HIV testing (level II, IV)**

Rogstad KE, Bramham L, Lowbury R, Kinghorn GR (2003) Use of a leaflet to replace verbal pretest discussion for HIV: effects and acceptability. *Sexually Transmitted Infections* 79(3):243-5

This study aimed to determine the effect of using a leaflet to replace formal verbal pretest discussion and assess its acceptability to patients. The authors found that using the leaflet increased the proportion of patients undergoing testing and patients found it acceptable.

Wickramasinghe TK, Rogstad KE (2002) Which patients attending genitourinary medicine clinics have HIV tests? *International Journal of STD & AIDS* 13(12): 843-6

This questionnaire study identified factors associated with the uptake of HIV testing in GU. Variables associated with having an HIV test were: being tested previously, given a leaflet, told about the window period, told about the availability of counselling, given insurance advice, and a past history of sexually transmitted infections. The authors conclude that patients who are well informed about HIV testing are more likely to accept a test.

Simpson WM, Johnstone FD, Boyd FM, Goldberg DJ, Hart GJ, Prescott RJ (1998). Uptake and acceptability of antenatal HIV testing: randomised controlled trial of different methods. *BMJ* 316(7127): 262-7

This trial aimed to determine the uptake and acceptability of different methods of a universal offer of voluntary HIV testing to pregnant women. Four combinations of written and verbal communication were given to pregnant women followed by a direct offer of a test. Testing was available on request for the control group. The authors found the universal offer of HIV testing acceptable and that offering the test to all women resulted in higher uptake. However uptake depended more upon the midwife than the method of offering the test.

**5. Integrated care pathways to diagnose and treat STIs and facilitate onward referrals for more specialist care, can improve the co-ordination of care (level IV)**

Blackwell A, Linton D, Emery S, Calvert J (2003) Chlamydia trachomatis infection in a colposcopy unit: an audit of a fast track referral system for infected patients to a genitourinary medicine department and a survey of patients' demography, clinical findings and partner details. *International Journal of STD & AIDS* 14(10):661-4

This study presents an audit of a formal protocol for managing women who test positive for chlamydia when attending a colposcopy unit. The interdepartmental protocol was devised for fast track referral of infected patients to a genitourinary medicine (GUM) health advisor who arranged treatment and follow up. The authors found that the protocol resulted in all

patients being adequately managed with minimal use of doctor time or disruption to routine GUM services.

Campbell H, Hotchkiss R, Bradshaw N, Porteous M (1998) Integrated care pathways. *BMJ* 316:133-7

This paper outlines the aims, format and use of integrated care pathways, discusses their benefit, and examines some barriers to implementation. The authors point out that though evidence of effectiveness exists for some of the different elements that make up a care pathway (e.g. implementation of evidence based guidelines), few evaluations have been done to assess the cost of developing and implementing them or to assess their effectiveness in changing practice and improving outcomes.

#### 6. Treatment at the site issuing STI results may increase service user satisfaction and treatment uptake (level IV)

Department of Health. *A pilot study of opportunistic screening for genital chlamydia trachomatis infection in England (1999-2000)* Detailed Report: Wirral pilot site. London: Department of Health (Available at: [www.doh.gov.uk/sexualhealthandhiv](http://www.doh.gov.uk/sexualhealthandhiv))

In the Wirral pilot study, about one third of patients were referred to GU medicine for management of a positive result. Those who did not wish to be referred were treated through patient group directions at the community screening office initiated by the pilot, and some were treated by the site initiating the test. This enabled a choice of service to suit client need and ensured as many cases as possible were adequately followed up.

Jones K, Webb A, Mallinson H, Birley H (2002) Outreach health adviser in a community clinic screening programme improves management of genital chlamydia infection. *Sexually Transmitted Infection* 78(2): 101-5

In this study a genitourinary medicine (GUM) based health adviser helped to develop testing and undertook outreach management of clients diagnosed with chlamydia at a community young people's clinic. The health adviser who also holds a family planning qualification facilitated referral to GUM or gave antibiotic treatment based on GUM-derived patient group directions. The authors found that this approach was effective in reducing the growth of identified but untreated genital chlamydia infection consequent upon community-based screening.

## Standard 7: Contraceptive advice and provision

1. Ensuring accessible provision of the full range and choice of methods will maximise effective contraceptive use and so help prevent unintended pregnancy, benefiting individual and public health (level V)

Professional opinion - no published evidence available.

2. Providing contraceptive services and supply of the full range of contraceptive methods is cost effective (level IV)

Hughes D, McGuire A (1996) The cost-effectiveness of family planning service provision. *Journal of Public Health Medicine* 18(2): 189-96

McGuire A, Hughes D (1995) *The Economics of Family Planning Services*. London: Family Planning Association.

Hughes & McGuire used two measures of output to calculate the cost-effectiveness of family planning services: number of pregnancies averted and couple year of protection. Their calculations show that family planning services are highly cost effective and result in resource savings for the NHS.

Sonnenberg FA, Burkman RT, Hagerty G, Speroff L, Speroff T (2004) Costs and net health effects of contraceptive methods. *Contraception* 69: 447-459

The authors of this paper carried out an analysis comparing 13 methods of contraception to non-use of contraception with respect to health care costs and quality adjusted life years (QALYs). They found that compared with use of no contraception, contraceptive methods of all types result in substantial cost savings over two years and QALY health gains. They conclude therefore that increasing the use of more effective methods even modestly at the expense of less effective methods will improve health and reduce costs.

3. Sufficient time during consultations and provision of accurate, up-to-date information, including leaflets, can enable individuals to choose a method of contraception best suited to their needs and to use contraceptives correctly and consistently (level II, III)

Little P, Griffin S, Kelly J, Dickson N, Sadler C (1998) Effect of educational leaflets and questions on knowledge of contraception in women taking the combined contraceptive pill: randomised controlled trial. *BMJ* 316(7149): 1948-52

This trial looked at the impact of provision of two types of educational leaflets on contraception and/or a questions-and-answers exchange with a family planning provider on contraceptive knowledge of 523 women. The authors found that singly all three interventions produced modest improvements in oral and emergency contraception knowledge. The largest effect on knowledge was recorded among women who received both a summary card and were asked questions.

Steiner MJ, Dalebout S, Condon S, Dominik R, Trussell J (2003) Understanding risk: a randomized controlled trial of communicating contraceptive effectiveness. *Obstetrics and Gynecology* 102(4): 709-17

This trial aimed to assess which of three tables presenting pregnancy risk increased women's understanding of risk of pregnancy associated with different contraceptive methods. The

authors found that a table with categories of risk communicated relative contraceptive effectiveness better than tables with numbers. However, they also found that without being presented with numbers, participants grossly over estimated the absolute risk of pregnancy using contraceptives. They suggest that a combination of categories may provide the most accurate understanding of both relative and absolute pregnancy risk.

Smith LF, Whitfield MJ (1995) Women's knowledge of taking oral contraceptive pills correctly and of emergency contraception: effect of providing information leaflets in general practice. *British Journal of General Practice* 45(397): 409-14

This study aimed to determine the factors associated with women's knowledge of taking the contraceptive pill correctly and of emergency contraception, and to investigate if their knowledge could be improved in general practice by providing women with Family Planning Association information leaflets. The authors found that providing leaflets to women improves their knowledge. They suggest that this increased knowledge might reduce the number of unplanned pregnancies in the UK but that it warrants further study.

- 4. Well advertised and accessible provision of both emergency contraceptive (EC) methods (including the option of free pharmacy provision of EHC), will enable women to access EC within the relevant time limits and may help to reduce unwanted pregnancies (level V)**

Professional opinion - no published evidence available.

## Standard 8: Pregnancy testing and support

1. A defined care pathway for pregnancy testing and support, agreed and implemented by all providers, can ensure women, and their partners where relevant, receive consistent management and access to relevant services, including access to further support with their decisions (level V)

Mcilveen H (2004) *Pregnancy Options*. Chapter 10 pp 163-175 In *The Manual for Sexual Health Advisers*. London: Society of Sexual Health Advisers.

(Available at: [http://www.ssha.info/public/manual/ha\\_manual\\_2004\\_complete.pdf](http://www.ssha.info/public/manual/ha_manual_2004_complete.pdf))

2. Availability of pregnancy testing which is free and/or provided in a variety of settings may support timely access to antenatal services, and for women seeking abortion, enable them to access services at early gestations (level V)

Diggory P (1989) Reducing late abortions. *British Journal of Obstetrics & Gynaecology* 96(2): 132-4

This report discusses the provision of abortion services in the UK and covers many specific issues including the need for better provision of early pregnancy testing in general practice and in community clinics, the early detection of fetal abnormality, and the great regional variations in the provision of abortion within the NHS.

3. Opportunities for impartial discussion of pregnancy options can enable women with unintended pregnancies to make an autonomous and informed choice about continuing, or not, with a pregnancy (level V)

Professional opinion - no published evidence available.

4. Risk assessments may help to identify women who need additional support or specialist counselling during or after decision making related to unintended pregnancy (and so help to reduce psychological distress) (level V)

Professional opinion - no published evidence available.

5. Discussion of test results may increase the uptake and effective use of regular contraception and also can also facilitate discussion of safer sex, risks of STIs and how to access STI screening (level IV)

Boise R, Petersen R, Curtis KM, Aalbory A, Yoshida CK, Cabral R, Ballentine JM (2003) Reproductive health counseling at pregnancy testing: a pilot study. *Contraception* 68(5): 377-83.

This study piloted reproductive health counselling and access to contraception for women obtaining pregnancy testing who did not desire pregnancy. Women who tested positive were referred to standard care and not followed up in the study. Women who tested negative were given the counselling intervention. Changes in contraceptive behaviour were evaluated. Following the intervention 41% of participants improved their use of contraception (from no use or from less effective use to more effective use) and 29% continued highly effective use. Of those participants with risk of STIs, 14% began using condoms consistently, while 5% continued using condoms consistently. The authors conclude that the observed behavioural changes may be effective in increasing effective use of contraception.

## Standard 9: Abortion service provision

1. The earlier in pregnancy an abortion is performed, the lower the risk of complications. A central booking and referral service, including arrangements for self-referral, for abortion services can enable women to have abortions at early gestations (level IV)

Glazier A, Thong JK (1991). The establishment of a centralised referral service leads to earlier abortion. *Health Bulletin* 49: 254-259

This paper describes the establishment in Edinburgh, Scotland, in 1988 of a centralised abortion referral service, which resulted in a significant decline in the time elapsed before pregnant women are seen by a gynaecologist and before pregnancy termination is performed.

**\*\*Oloto EJ (2004) *Improving access to abortion services: a local model. Abstract. The European Journal of Contraception & Reproductive Health Care.* The 8<sup>th</sup> Congress of the European Society of Contraception, Edinburgh June 2004**

The aim of this study was to put a comprehensive system in place to facilitate early access to and choice for abortion services in the local population. One aspect of this was the establishment of a community-based centralised referral system for the efficient co-ordination of appointments at the various clinics, theatre, and wards. Other aspects included harmonisation of paperwork and protocols, portable ultrasound scan machine, expansion of existing services, effective contraception back ups, staff training, recruitment of staff, and establishment of a robust database.

**\*\*Nixon H (2004) *Implementation of holistic care for women requesting referral for termination of pregnancy: following a local review. The Sandyford Initiative, Glasgow, UK.* Poster. The 8<sup>th</sup> Congress of the European Society of Contraception, Edinburgh June 2004**

The 'Mrs Brown' referral service at the Sandyford Initiative allows women to be seen by a specially trained nurse to explore options and feelings around unplanned pregnancy and to be referred to local hospital services for termination, if this is the chosen outcome. Women can self refer and are allocated a 30 minute appointment with a nurse to explore their options and make an informed choice in as non-threatening environment as possible. Prior to this service 50% of women were being seen in busy drop in clinics. The Mrs Brown service provides an easily accessible, specialist holistic service developed to help meet the needs of women seeking support and referral for termination of pregnancy (TOP).

2. Referral for abortion early in pregnancy can facilitate access to a choice between medical and surgical abortion procedures. Choosing an early medical abortion may also facilitate faster access to an abortion (level IV, V)

Mawer C, McGovern M (2003) *Early abortions - promoting real choice for women.* London: Family Planning Association

This report makes recommendations about early abortions, defined as those carried out before 12 weeks. It states that there are variations between different areas in the number of women who have their abortion under ten weeks, and so could have chosen a medical abortion or a manual vacuum aspiration. In order to facilitate access and choice for women

they recommend that there be a target waiting time of 72 hours for abortion from the time a woman first contacts a health professional, with one week as a minimum standard.

3. High rates of genital chlamydial infection in populations of women having abortions necessitate screening and treatment, or prophylactic treatment at the time of the abortion procedure, to reduce the risk of ascending genital tract infection. Screening has the advantage of enabling women with diagnosed infection, and their sexual partner(s), to access the optimum treatment, reducing their risks of complications associated with undetected infection or of re-infection (level I, II, IV)

Sawaya GF, Grady D, Kerlikowske K, Grimes DA (1996) Antibiotics at the time of induced abortion: the case for universal prophylaxis based on meta-analysis. *Obstetrics and Gynecology* 87(2): 884-890

The authors of this paper conclude that their meta-analysis revealed a substantial protective effect of antibiotics in all sub-groups of women undergoing therapeutic abortion, even women in low risk groups. They state that no more placebo-controlled trials should be performed because it exposes women to a preventable risk.

Blackwell AL, Thomas PD, Wareham K, Emery SJ (1993) Health gains from screening for infection of the lower genital tract in women attending for termination of pregnancy. *Lancet* 342(8865): 206-10

This study assessed the prevalence and sequelae of genital tract infection in patients undergoing termination of pregnancy and estimated the costs and potential benefits of introducing screening and prophylaxis for the most commonly found organisms. The authors found that the estimated costs of hospital admissions for complications of chlamydial infection were more than double the costs of providing routine screening for chlamydia and prophylactic treatment. They conclude that screening for chlamydia before termination is essential and that prophylactic treatment for chlamydia and anaerobic vaginosis should also be considered.

Blackwell AL, Emery SJ, Thomas PD, Wareham K (2000) Universal prophylaxis for chlamydia trachomatis and anaerobic vaginosis in women attending for suction termination of pregnancy: an audit of short term health gains. *International Journal of STD & AIDS* 11(2): 552-3

This audit found that the introduction of universal prophylaxis against chlamydia and anaerobic vaginosis significantly reduced morbidity in patients obtaining a termination of pregnancy and also resulted in substantial financial savings.

Penney GC, Thomson M, Norman J, McKenzie H, Vale L, Smith R, Imrie M (1998) A randomised comparison of strategies for reducing infective complications of induced abortion. *British Journal of Obstetrics and Gynaecology* 105(6): 599-604

This randomised trial found that universal antibiotic prophylaxis is at least as effective as a policy of screen-and-treat in minimising the risk of short-term infective morbidity and is far more cost efficient.

Cameron ST, Stewart S, Sutherland S (2002) Can a busy abortion service cope with a screen and treat policy for chlamydia trachomatis infection? *International Journal of STD & AIDS* 14(1):50-4

The authors of this study found that with a screen-and-treat policy in a busy surgical and medical abortion service most positive results were available before surgical abortion (97%) but only 76% were available before a medical abortion. This may be due to the faster 'processing' of women since the medical method is only available at up to nine weeks gestation. The authors suggest that this challenge to the screen-and-treat policy is likely to become more common as medical abortion becomes more widely adopted.

Uthayakumar S, Tenuwara W, Maiti H (2000) Is it evidence-based practice? Prophylactic antibiotics for termination of pregnancy to minimize post abortion pelvic infection. *International Journal of STD & AIDS* 11: 168-169

This study recruited 100 consecutive patients over a 4 month period at a TOP counselling clinic. Endocervical swabs were taken for chlamydia trachomatis. All infected patients were invited to attend for counselling, further STI screening and contact tracing. 6% of patients tested positive for chlamydia. The authors state that providing universal prophylaxis 94% of patients would have received antibiotics unnecessarily and those with positive chlamydia results would have been re-infected by their untreated partners. They conclude that screening for chlamydial infection is therefore essential and that routine prophylactic antibiotic cover may not be beneficial.

Groom TM, Stewart P, Kruger H, Bell G (2001) The value of a screen and treat policy for chlamydia trachomatis in women attending for termination of pregnancy. *The Journal of Family Planning and Reproductive Health Care* 27(2): 69-72

The authors of this study suggest that a policy of screen-and-treat for chlamydial infection may confer greater benefit for the patient and also make a more significant impact on the reservoir of infection in the community (through contact tracing and treatment of partners), when compared with a policy of universal prophylactic antibiotic treatment at the time of termination.

**4. Accurate, printed information on the abortion procedure and aftercare, and on possible complications and negative outcomes of abortion, can support verbal advice (level IV, V)**

Edwards MH (1990) Satisfying patients' needs for surgical information. *British Journal of Surgery* 77: 463-465

This article reports a retrospective survey of 200 patients, which showed that those receiving leaflets on surgical procedures were significantly more satisfied with information than those not receiving leaflets. This was especially the case for information about post-operative progress. The authors suggest that this system is cheap, effective and popular with both patients and staff.

Wong SS, Bekker HL, Thornton JG, Gbolade BA (2003) Choices about abortion method: assessing the quality of patient information leaflets in England and Wales. *BJOG* 110(3): 263-6

This study assessed the quality of patient leaflets regarding choice between medical and surgical abortions. The authors found that on average, leaflets provided only half the information possible about the risks and procedures of medical and surgical methods and that readability was rated difficult in over half of leaflets.

5. Clear and up-to-date information and advice for women on the range of available contraceptive methods, initial supply and access to a contraceptive provider for ongoing care may help to increase uptake of regular contraception and so reduce the risk of a further unintended pregnancy (level IV)

\*\*Schunmann C, Glasier A (2004) Improving contraceptive use after abortion: a cluster randomised controlled trial of personalised, expert contraceptive advice and provision at the time of termination of pregnancy. Poster. The 8<sup>th</sup> Congress of the European Society of Contraception, Edinburgh June 2004

This study used a cluster randomised controlled design in which 613 women undergoing TOP in Edinburgh were randomised to receive personalised contraceptive advice and immediate provision of their chosen method or standard care with limited method provision. 16 weeks after procedure all women were contacted to determine their pattern of contraceptive use. The authors found that women who received tailored advice were significantly more likely to be using a long acting, user independent method of contraception (IUD/IUS, injectable or implant). But evidence as to whether this would reduce further unintended pregnancies is not established and would require long term follow up.

\*\*Graham O. (2004) Audit of contraception before and after termination of pregnancy. Poster. The 8<sup>th</sup> Congress of the European Society of Contraception, Edinburgh June 2004

This audit looked at the contraceptive practices of clients before their last TOP and what they intended to use after their last TOP and compared these with what was being used when they returned for another TOP. The authors found that although clients chose good, effective contraceptives after TOP, their use was not always maintained after the procedure. They suggest that further work is needed to understand why this is the case and to find ways to increase acceptability and accessibility of effective contraception.

## Standard 10: Protection and use of sexual health information

1. A service or practice policy on confidentiality, applicable to all staff and displayed prominently, will help encourage uptake of services. This is particularly the case for young people (level IV)

Teenage Pregnancy Unit (2000) *Best practice guidance on the provision of effective contraceptive and advice services for young people*. London: Department of Health (Available at: [www.teenagepregnancyunit.gov.uk](http://www.teenagepregnancyunit.gov.uk))

This document highlights that research with young people has identified the features of a trusted and accessible service. These include an age-specific focus, confidentiality, non-judgmental staff, accessible locations and opening hours, a friendly atmosphere and publicity in places where young people meet.

Thomas N, Murray E, Rogstad KE (2004) *If confidentiality is lost will young people still access sexual health services?* Poster. BASHH/ASTDA Spring Meeting, 2004

This questionnaire study aimed to determine the importance of confidentiality of sexual health services to adolescents and its effect on their willingness to access services. 55% thought confidentiality the most important feature of the service. 87% were more likely to use the service if it were confidential. 90% would be honest if the service was confidential. This study shows that a lack of confidentiality would prevent adolescents using the service and affect what they disclosed.

Dixon-Woods M, Stokes T, Young B, Phelps K, Windridge K, Shukla R (2001) Choosing and using services for sexual health: a qualitative study of women's views. *Sexually Transmitted Infections* 77(5): 335-9

This study explored women's accounts of choosing and using specialist services for sexual health. The authors found that women's willingness to access services is mediated by psychosocial factors such as embarrassment. Their priorities for services are that their feelings of stigma and embarrassment are managed appropriately, that staff communicate well and sensitively, that they are 'in control' when obtaining test results, and that confidentiality is preserved.

Burack R (2000) Young teenagers' attitudes towards general practitioners and their provision of sexual health care. *British Journal of General Practice* 50(456): 550-4

This questionnaire study aimed to determine the opinions and attitudes of 13-15 year olds towards general practice-based sexual health care. 58% of teenagers were concerned about their confidentiality not being preserved by their GP. This highlights the importance of confidentiality to young people.

Thrall JS, McCloskey L, Ettner SL, Rothman E, Tighe JE, Emans SJ (2000) Confidentiality and adolescents' use of providers for health information and pelvic examinations. *Archives of Pediatrics and Adolescent Medicine* 154(9): 885-92

This study examined the relationship between adolescents' perception of the confidentiality of care provided by their regular health care provider and their reported use of this provider

for private health information and for pelvic examinations. The authors found that of the teenagers surveyed 76% wanted to obtain confidential health care but only 45% perceived their regular provider to provide this. The likelihood of having discussed sexually transmitted diseases, pregnancy prevention and/or the facts about sex with their provider was greater among teens who received a confidentiality assurance than for teens who did not. Among sexually active females, the likelihood of a recent pelvic examination for those who received a confidentiality assurance was greater than for those who did not. This study therefore provides further evidence of the link between confidentiality and discussion of risky behaviours and ultimately the appropriate use of services.

2. **The local implementation of the sexual health services common dataset will allow more comprehensive data to be collected in both primary care and in specialist sexual health service settings (level V)**
3. **Use of structured case notes for sexual history-taking will enable a more consistent approach across services and facilitate the collection of sexual health services common dataset requirements (level V)**

Professional opinion - no published evidence available.

4. **Use of electronic patient records (subject to appropriate confidentiality provisions) will allow for improved capture of relevant data, improve national and local surveillance and support local multi-agency working (level V)**

Pringle M (2003) Improving quality: bridging the health sector divide. *International Journal of Quality in Health Care* 15(6): 457-62

This paper discusses the need to have electronic records in all settings before we can understand and quality assure the whole health care system. In the UK, primary care has been leading the way in adopting information technology and can now use databases for individual clinical care, for quality assurance, and for research. It is suggested that electronic health records will be under the control of the patient concerned, will be shared with the explicit consent of the patient and will form the vehicle for quality assurance across all sectors of the health service.

Van der Lei J (2002) Closing the loop between clinical practice, research, and education: the potential of electronic patient records. *Methods of Information in Medicine* 41(1): 51-4

This paper discusses the scope of electronic patient records. The authors highlight that the data recorded in computer memories can be easily retrieved and re-used for a variety of purposes; it can be easily transported; and because physicians (and patients) are using computers to record medical data, the same electronic record can be used to introduce other computer programs that interact with the user. The authors point out that electronic medical records will facilitate research that relies on data recorded in routine medical practice but that the challenge is to close the loop between clinical practice and research.

Pyper C, Amery J, Watson M, Crook C. (2004) Patients' experiences when accessing their on-line electronic patient records in primary care. *British Journal of General Practice* 54(498): 38-43

Patient access to on-line primary care electronic patient records is being developed nationally. The authors of this qualitative study exploring patients' views on electronic records found that patients have strong views on what they find acceptable regarding access to electronic records. They suggest that working in partnership with patients to develop electronic patient records is essential to their success. Further work is needed to explore the legal and ethical issues associated with electronic records and to evaluate their impact on patients, providers and service provision.

5. Development and use of referral protocols can help ensure secure transfer of relevant sexual health information between providers (level V)

Professional opinion - no published evidence available.

6. Comprehensive surveillance and epidemiological data relating to sexual health should be available for all PCTs and strategic health authorities to assist local service planning and monitoring (level V)

Professional opinion - no published evidence available.

7. Comprehensive national data relating to sexual health are essential to monitor the implementation and effectiveness of *The national strategy for sexual health and HIV*, and to inform the policy development and resource allocation at national and local level (level V)

Professional opinion - no published evidence available.