The health of the nation : key area handbook: HIV/AIDS and sexual health / Department of Health.

THE HEALTH OF THE NATION

Key Area Handbook

HIV/AIDS AND SEXUAL HEALTH

DEPARTMENT OF HEALTH

HIV/AIDS AND SEXUAL HEALTH

A 3½″ computer disk, prepared in WordPerfect 5.1., is included at the back of this handbook.

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Continued...

PREFACE

This handbook forms part of a series of Health of the Nation Key Area handbooks. In The Health of the Nation White Paper published in July 1992 the Government said that the National Health Service Management Executive would commission handbooks on possible local approaches to each of the five Key Areas identified in the White Paper: Coronary Heart Disease and Stroke, Cancers, Mental Illness, Accidents and HIV/AIDS and Sexual Health.

The aim of the handbooks is primarily to assist managers and directors in purchasing authorities (DHAs, FHSAs and purchasing consortia) to develop local strategies for reducing mortality and morbidity in each Key Area. The handbooks also aim to disseminate widely information about local initiatives to managers and directors in provider organisations and to group together other relevant information. The handbooks may also be of interest to organisations such as local authorities and the voluntary sector which join together with the NHS in alliances for health.

The information in the handbooks is illustrative rather than prescriptive, and it is intended that they should be used as practical guides. NHS managers and others will wish to use the guides selectively and adapt them to suit local circumstances in the light of local priorities and available resources. The handbooks vary in length, structure and content as a result of the differences in subject matter, secondary audiences and the amount of prominence each Key Area has had in the past.

The handbook series is complemented by a range of other documents which the Department of Health has issued in order to help implement the Health of the Nation strategy. A supplement to the Public Health Common Data Set, which contains baseline data on the primary targets, was issued in October 1992. First Steps for the NHS, which sets out suggestions for management action for each Key Area, grouped by type of contract or plan, was issued in November 1992. A workshop on Alliances for Health was held in

November 1992 and a report will be published in Spring 1993. In addition, a sub-group of the Minister's Wider Health Group has been established to produce a handbook with guidance on how to form healthy alliances. The Department of Health also plans to publish a discussion document to advance the process of setting local targets.

The production of the Key Area handbooks has been the result of a joint working venture between the Department of Health, the NHS and other organisations. The handbooks could not have been published without the help and advice of colleagues from outside the Department and we are grateful to them for their valuable contribution.

The ultimate purpose of the Health of the Nation initiative is to bring about further continuing improvement in health. The intention of the Key Area handbooks is to contribute to that process.

Comments on this handbook are very welcome and should be sent to the people listed on pages 9 and 10.

The intention is to carry out an evaluation exercise later in the year based on feedback from users.

Further copies are available from:

BAPS,
Health Publications Unit,
Heywood Stores,
No 2 Site, Manchester Road,
Heywood, Lancashire OL10 2PZ.

INTRODUCTION

i Rewarding personal and sexual relationships promote health and well-being. However, sexual activity can also have undesired results such as unwanted pregnancies and the transmission of the Human Immunodeficiency Virus (HIV) and other sexually transmitted diseases (STDs).

ii HIV infection represents perhaps the greatest new public health challenge this century. Current evidence suggests that most people infected with HIV will eventually develop the Acquired Immune Deficiency Syndrome (AIDS), and about half will do so within ten years of infection. In the UK HIV is primarily transmitted through unprotected sexual intercourse or drug injecting, but can also be transmitted from a mother to her unborn child or through breast feeding.

iii Sharing injecting equipment is not only an effective route for the transmission of HIV but also other blood borne viruses such as Hepatitis B (HBV). Infected drug misusers then can and do transmit these infections to their sexual partners irrespective of the route by which they themselves acquired the infection.

iv Preventing the transmission of HIV therefore depends largely upon sustained changes in sexual or drug using behaviour. Safer sexual practices and the use of clean needles and syringes reduce the risk of infection.

v STDs can also cause ill-health, the possible long term consequences of which include infertility, ectopic pregnancy and genital cancers. In addition, the concurrent presence of some STDs may facilitate the transmission of HIV.

vi It has been estimated that almost half of all conceptions are in some sense unintended. By no means all such conceptions result in unwanted babies, but there is a need for strengthening educational programmes for young people and improving access to contraception information and family planning services.

vii For these reasons HIV/AIDS, STDs, drug misuse and sexual health, including family planning and contraception, were identified as Key Areas in The Health of the Nation[1]. The general objectives and specific targets are:

GENERAL OBJECTIVES

To reduce the incidence of HIV infection

To reduce the incidence of other sexually transmitted diseases

To develop further and strengthen monitoring and surveillance

To provide effective services for diagnosis and treatment of HIV and other STDs

To reduce the number of unwanted pregnancies

To ensure the provision of effective family planning services for those people who want them

SPECIFIC TARGETS

To reduce the incidence of gonorrhoea among men and women aged 15-64 by at least 20% by 1995 (from 61 new cases per 100,000 population in 1990 to no more than 49 new cases per 100,000)

To reduce the rate of conceptions amongst the under 16s by at least 50% by the year 2000 (from 9.5 per 1,000 girls aged 13-15 in 1989 to no more than 4.8)

To reduce the percentage of injecting drug misusers who report sharing injecting equipment in the previous four weeks by at least 50% by 1997, and by at least a further 50% by the year 2000 (from 20% in 1990 to no more than 10% by 1997 and no more than 5% by the year 2000)

HOW TO USE THE HANDBOOK

viii Much of the guidance in this handbook will be familiar since all District Health Authorities (DHAs) and Family Health Services Authorities (FHSAs) will already be implementing some, if not all, of the possible actions suggested. However, not all areas face the same problems so some parts of this handbook may be more or less relevant than others. It is intended to help in the development of realistic local sexual health and drug misusing strategies which aim to meet the Health of the Nation objectives and targets within available resources.

ix The handbook is divided into five chapters. Chapter 1 provides an overall framework for undertaking the preliminary work required for the development of a local sexual health and drug misuse strategy. Chapters 2-5 provide more specific information on the areas of HIV/AIDS, other STDS, drug misuse and family planning respectively. These chapters should be read in conjunction with Chapter 1. Examples of local initiatives are contained in the text and a list of possible actions by purchasers and providers can be found at the end of each chapter. A number of checklists and possible sources of further information are contained in the Appendices.

x To help a wider dissemination of all or parts of this handbook the accompanying WordPerfect 5.1 diskette can be used to make further copies for any other local agencies and voluntary bodies with an interest.

xi It will also be helpful to read this handbook in conjunction with "First Steps for the NHS"[2] (EL(92)80).

xii The Department of Health welcomes comments on this handbook, which should be addressed to:

In general and for HIV/AIDS

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206 Friars House
157-168 Blackfriars Road
London SE1 8EU
Tel. 071-972-3355

STDs	Dr Judith Hilton 337 Friars House as above Tel. 071-972-3284
Drug Misuse	Dr Anthony Thorley 543 Wellington House 135-155 Waterloo Road London SE1 8UG Tel. 071-972-4617
Family Planning & Young People	Alison Nicholls/ Annette Armstrong Room 423 Wellington House as above Tel. 071-972-4185/4184

CHAPTER 1

DEVELOPING AN OVERALL STRATEGY

DEVELOPING AN OVERALL STRATEGY

This chapter contains information which may be helpful in the development of an overall local sexual health and drug misuse strategy and follows the steps set out on the preceding page.

1.1 DEVELOPING LOCAL PROFILES

1.1.1 Local profiles should include:

- descriptive local demographic, epidemiological and sociological data which can be compared with adjacent districts, and regional and national figures where available. Such data should be available for at least the past five years – and future projections if possible
- identification of available resources (human, financial and material)
- identifying the availability and geographical location of current education, prevention, counselling, treatment and care services, and their overall costs
- an activity analysis of the number of people using or reached by the different services
- data from community care monitoring and inspection reports
- identifying any ongoing local epidemiological, behavioural and scientific research.

1.1.2 Local profiles thus:

- provide part of the base for a comprehensive needs assessment of the local population and of particular groups who may be at increased risk
- identify what services are already available and where these might need to be rationalised or strengthened
- identify gaps in the provision of, or information about, services
- act as a focus for the development of interventions across different agencies for improving the health of the local population
- promote realistic interim local target setting
- act as a baseline to facilitate the monitoring and evaluation of specific initiatives or overall strategy.

See Appendix 1 for possible sources of information relating to each key area

1.2 SEEKING LOCAL VIEWS

1.2.1 Local views, as well as professional knowledge and expertise, should be sought to help identify significant gaps in service provision and assist in setting priorities and developing service specifications. For example, views could be sought from:

- those who purchase the services
- those who refer to services, including voluntary agencies and GPs
- those who provide services, including local authorities and voluntary agencies
- those who use and, if possible, those who feel unable to use the services
- Community Health Councils and other local agencies
- any local sources of further expert, professional or academic advice.

1.3 DEVELOPING AND STRENGTHENING HEALTHY ALLIANCES

1.3.1 Improving and promoting sexual health is not the sole responsibility of the NHS. The Health of the Nation makes it clear that the key objectives cannot be achieved without involving other agencies and organisations which may have differing but complementary roles to play. These include Local Authorities, other statutory and non-statutory organisations, community services and voluntary groups. Healthy alliances offer imaginative and flexible approaches to local inter-agency co-operation, working across boundaries with the objective of improving the health of the population, as well as increasing collaboration between the different agencies and within the NHS.

Alliances can:

- **overcome barriers**
  by increasing agencies knowledge and understanding of each other
- **create synergy**
  added value is sometimes only available through sharing or joint working, for example in eliminating service gaps
- **avoid unnecessary duplication**
  maximising each agency's contribution and the efficient and effective use of skills and resources

- **act as a catalyst**

  helping to break ground in other areas that could benefit from joint endeavour, and bringing together groups who would not normally see themselves as having a role in promoting health
- **are participative**

  giving an opportunity for common ownership and sharing of tasks.

1.3.2 There are three broad types:-

- broad based alliances

  which take forward the wider public health agenda particularly in relation to the promotion of sexual health and prevention strategies and can promote close working links between purchasers and providers
- purchaser alliances
- provider alliances

1.3.3 As a first step, authorities will need to establish what networks and alliances are already in existence and look at their aims and objectives. It may be helpful to consider from the following points whether:

- the aims of existing alliances are compatible with the objectives and targets, and what progress is being made
- there is a need for new formal or informal alliances. Different alliances may be needed to address different issues and target groups, eg young people, gay men, black and ethnic minorities, etc
- there is scope to streamline joint working by collaborating with existing alliances
- the key people are involved, including those who manage resources and can make decisions about service delivery
- there is a need for development work with potential alliances to ensure that participants can make a realistic contribution eg the participants can reconcile the agendas of their own organisations with that of the joint group
- the lines of accountability are clear, including responsibility for resources
- the expectations on participants are realistic, particularly those placed on voluntary agencies

- alliances meet regularly at times and locations which encourage maximum attendance
- the aims and objectives of alliances are reviewed regularly.

1.3.4 Membership will need to be dependent on the specific aims of each alliance and appropriate to local circumstances but the potential agencies to be involved in such joint exercises will generally include:

- Local Authorities
- Education Authorities and schools
- the schools' health service
- other statutory services (eg police, prisons, probation)
- Social services
- Voluntary agencies.

See Appendix 2 for examples of purchasers, providers and others who participate in local alliances.

1.4 IDENTIFYING AVAILABLE INTERVENTIONS

1.4.1 Interventions cover two broad areas:

- health education and promotion
- provision of appropriate services.

1.4.2 Health education and promotion

Education can promote positive sexual health by increasing people's knowledge and awareness. With knowledge and skills they are more likely to use contraception, avoid risk behaviours, know what local services are available and be more likely to use them. Such education is a vital component of local sexual health and drug misuse strategies.

1.4.3 A number of initiatives should already be in place or planned which are relevant to all areas covered in this Handbook. Purchasers may wish to ascertain what is currently being undertaken, by whom and, where possible, at what cost. For example:

- information about how to avoid or reduce risk of infection or pregnancy:
  - ~ general education campaigns

- campaigns targeted at key population groups
- outreach and peer educational initiatives
- initiatives by local or national voluntary organisations
- education in formal settings (schools, colleges, residential care facilities)
- special publicity events, eg World AIDS Day (1 December)
- programmes for those with special educational needs
- the type of promotional materials available for each of the above and where it can be obtained.

- access to means to reduce the risk:
  - the provision of free or retail condoms in local clinics and a wide variety of retail outlets
  - the availability of needle/syringe exchange schemes and cleansing agents
  - the provision of appropriate contraceptive services through local clinics, GPs or young people's advisory centres
  - ensuring the implementation of appropriate infection control policies in health care and other appropriate settings.

Where possible, information should be sought about the resource and manpower costs of the above.

1.4.4 The aims of any further initiatives should include:

- informing people, especially succeeding generations of young people, of the potential adverse effects of sexual activity and drug misuse, and encouraging them not to adopt patterns of behaviour which will put them at risk; and
- encouraging sustained changes in established sexual or drug using behaviour which already place people at risk.

1.4.5 Sustained behavioural change is difficult to achieve and measure as it is subject to many different influences and factors. Initiatives to encourage this will therefore need:

- to reflect differing levels of knowledge and awareness
- to be sensitive to diverse cultural, linguistic, religious and social beliefs and practices
- to take account of factors such as age, gender and sexual preference
- to be backed up by the provision of appropriate services.

1.4.6 *Needs of black and ethnic minorities*

National mass media campaigns and other educational resources produced by a variety of agencies for general use should not automatically be assumed to meet the needs of all target populations, including different local ethnic minority groups. If locally appropriate, initiatives should be developed which:

- provide appropriate information in different languages
- take account of differing linguistic, cultural, religious and other factors
- are based on local needs
- have involved and reflect the views of the local communities' representatives.

1.4.7 Service provision

In establishing what services, both statutory and non statutory, are currently in place it should be possible to sketch a local picture of where and what type of services are available and the cost and demand for them. For example:

HIV/AIDS:

- where local people can seek advice and testing for HIV – eg GUM clinics and alternative testing facilities – and numbers seen
- where and what services for people with HIV are provided, and the case load
- what services are being provided by general practitioners and health authority community care services, including terminal care
- what is being provided by local authority community services
- local facilities for respite and terminal care
- what other support services are available, including those of voluntary or non-statutory groups.

Other sexually transmitted diseases:

- GUM clinics and outreach services attached to them.

Drug misusers:

- number and types of agencies where people can seek health and harm reduction advice
- local needle exchange or pharmacy based schemes or other initiatives to provide clean injecting equipment and cleaning agents
- other statutory, non-statutory and community care services.

Family Planning:

- number and type of family planning and contraceptive services, including any local outreach services or specific services for young people
- number of GPs providing family planning.

1.4.8 Purchasers may also wish to determine whether there is a need to provide any additional services, for example:

- providing alternative facilities for HIV counselling and testing; see 2.6.3 and Appendix 6
- where appropriate strengthening outreach services for HIV, GUM, drug misuse and family planning
- supporting self-help and peer-based support groups
- developing youth advisory centres; see 5.8.4.

1.4.9 Within available resources services should aim to:

- be flexible enough to meet individual preferences whenever possible
- be sensitive to differing cultural and personal needs and circumstances
- respect the rights of the individual to privacy and confidentiality
- be integrated with community care plans.

1.5 UNDERTAKING RESEARCH AND DEVELOPMENT

1.5.1 Research and development encompasses a wide range of activities involving the systematic collection and/or analysis of information, and may be able to provide answers to information gaps identified in the development of any local strategy. Research and Development in the NHS is being co-ordinated and promoted through an NHS Research and Development (R&D) strategy[3].

1.5.2 Priorities for research of national importance will be identified on the advice of the Central Research and Development Committee (CRDC) of the NHS. The NHS R&D strategy gives Regions a crucial role. Most of the management of R&D is devolved to them, and they are helping to identify NHS R&D needs, to research and respond to local needs and to prepare, publish, resource and implement their own R&D plans. Regions will develop their own structures in order to meet these

responsibilities. As part of this, they are developing mechanisms for obtaining input from a wide range of organisations and individuals.

1.5.3 Before commissioning any local research it is important to identify what is being or has already been undertaken locally, regionally, or nationally in order to avoid duplication of resources. The precise objectives of any proposed programme need to be clear as does the intended audience for the results. Research studies should:

- have been discussed with the Regional Directors of R&D
- contribute to the further development of strategies aimed at achieving the Health of the Nation objectives and targets
- be based on a clear, well defined protocol and timetable
- have had the protocol peer-reviewed
- have been cleared with the local research ethics committee
- report their findings so that they are open to critical examination and evaluation
- be conducted and reported in such a way that their results are of value to those with similar interests outside the particular locality or context of the project.

1.5.4 Sources of help and support

People with little research experience are recommended to seek advice before embarking on any projects. People who can help include:

- The Regional Director of R&D at the RHA, who will be able to offer advice on research methods and funding, will know about current local research, will be able to advise on whether the identified research question fits in with R&D priorities identified in the programme and will also know the local research community. He or she will also have details about information systems that are now being developed as part of the R&D strategy to provide information about ongoing research projects throughout the NHS and to provide overviews of research findings for managers and clinicians
- The Director of Public Health, who will also be able to give general advice about sources of information and research findings
- Epidemiology/Public Health Departments in local Medical Schools and Social Science departments in local universities, who may be able to give advice on

research design and data analysis

- the local Public Health Laboratory Services
- the national or local non-statutory organisations who may also be in touch with past and current research and may be able to offer help in the research process.

1.5.5 Surveys

Much research in this field will involve surveys. Standard questions and questionnaires have been developed and validated for a number of relevant issues, and the use of these is strongly recommended. Also the Health Survey Programme includes a number of initiatives which will provide national data which are relevant to the Health of the Nation key areas. Whilst these will also provide some sub-national data, local areas may wish to carry out their own surveys to assess the health needs of their populations. There are also plans to set up an NHS Survey Advice Centre[4] to provide information and expertise on survey methodology, and to help to ensure comparability between different areas. The Advice Centre will provide a focal point for training, advice and support as well as assisting local areas to carry out surveys.

1.6 SETTING LOCAL TARGETS

1.6.1 The Department of Health has published "Specification of National Indicators"[5] which sets out the key information which will, at national level, form the basis of monitoring progress towards the national targets in Health of the Nation. Although it will be of use and value at local level, it deliberately focuses on these primary targets and national monitoring. Its purpose therefore is to ensure that there are no misunderstandings in future years about what is being measured to assess progress so far as the national targets are concerned.

1.6.2 Further sub-national baseline data on target areas has also been provided, in so far as it is currently available, in "Public Health Common Data Set 1992: The Health of the Nation Baseline Data".[6]

1.6.3 These publications, together with the "First Steps for the NHS"[2] will provide some assistance to managers in taking forward discussions on how best to approach local

target setting, which will be supplemented by a general discussion document on local target setting which the Department of Health intends to publish in early 1993.

1.6.4 The ultimate intention of the 'Health of the Nation' White Paper is to reduce the harm done through ill health in the key areas. Most of the national targets relate directly to changes in mortality. They are thus 'outcome' targets in that they relate directly to the ultimate intention, and provide a basis for monitoring how far particular aspects of it have been fulfilled.

1.6.5 However, not all the desirable outcomes of action stimulated by the Health of the Nation can be directly monitored in a way that is useful for local management:

- morbidity and quality of life may be difficult to define, and costly to measure in a comprehensive or representative way
- some projects and activities will be aimed at relatively small populations, and even with comprehensive measurement the numbers of cases of disease or death prevented may not be large enough to be measured reliably within, say, a single year
- for HIV and AIDS there is likely to be a lag of several years before effective prevention strategies are followed by detectable falls in levels of morbidity or mortality.

1.6.6 Thus outcome indicators are unlikely to provide rapid enough feedback on the effectiveness of local action for the purposes of programme management or development. For this it will be necessary to set 'process' targets. For example:

- targets relating to the kinds of behavioural change that will, it is believed, be eventually followed by the 'outcomes' of improved health
- targets relating to levels of specific activities that will, it is believed, lead to the desired outcomes (either directly, or indirectly through behavioural change).

The better the evidence for the causal links involved, the greater the value of setting and pursuing such targets.

1.6.7 In some cases, particularly at early stages in local programmes, it may also be helpful to set 'structure' targets. For example:

- targets relating to organisational development

- targets relating to the commitment of the resources necessary to undertake the proposed action.

1.6.8 The following chapters contain some initial suggestions for local process or possible outcome targets.

1.7 AGREEING A LOCAL STRATEGY

1.7.1 Agreeing a local strategy based on identified needs will help purchasers, providers and other local agencies to focus on the Health of the Nation objectives and targets. Such a strategy should be published and will need a time-table for completion which should include consultation with other agencies and timescales for implementation, review and evaluation. It should also recognise that it may not be possible to do everything at once and should thus identify areas of higher priority for succeeding years. Using a matrix such as Fig 1 may help.

Possible Matrix for Service Planning

Figure 1

	GUM	Family Planning Services	Primary Health Care Teams	Drug Agencies	Schools	LAs, comm. care vol.orgs, etc	Others
Reduce incidence of HIV infection	●	●	●	●	●	●	●
Reduce incidence of Gonorrhoea amongst people aged 15-64 by 20% by 1995	●	●	●	●	●		●
Reduce rate of conception amongst under 16s by 50% by 2000	●	●	●		●	●	●
Reduce the number of people who share injecting equipment by 50% by 1997 (by a further 50% by 2000)			●	●		●	●

● indicates a need to define how each agency might most effectively intervene.

Examples of "others" which could be included in this matrix might include the probation service, voluntary youth counselling organizations, obstetric and gynaecological services, accident and emergency departments, school governors and retail pharmacies.

1.7.2 Elements of the strategy

The elements to form the strategy will vary according to local circumstances and should be based on information from a local needs assessment. Strategies need to be written with a clear understanding of the audience for whom they are being produced and need to take into account the inter-relationship between different services eg health promotion, treatment and care.

The strategy should also include:

- provision for and development of health education and promotion and treatment and care services which recognise the inter-relationship between HIV, other STDS, and drug and family planning services
- stating the aims and objectives of proposed initiatives
- setting interim targets and process indicators where possible
- stating the arrangements or protocols for the provision and monitoring of financial, personnel and material resources
- setting priorities for future years.

1.7.3 Quality

The development of a strategy offers an opportunity to stipulate a minimum quality level to which all agencies should adhere. Measures identified could include:

- specifying minimum service standards
- ensuring mechanisms for regular audit, monitoring and evaluation
- undertaking regular surveys of client satisfaction, consumer surveys, public complaints about services
- ensuring adherence to infection control procedures.

Providers can orientate their services so that they offer an assurance of high quality and standards and make explicit what quality measures they propose to implement and deliver.

1.8 ESTABLISHING ARRANGEMENTS FOR PURCHASING, MONITORING AND EVALUATION

1.8.1 Purchasers need to adopt a strategic and integrated approach to improving the health of the local population, working with other agencies as appropriate. This should be reflected in their corporate contracts. The range of services which best meets the service needs of the local community and maximises their health gain within available resources should be identified and commissioned, covering health education and promotion, diagnosis, treatment, care and support.

1.8.2 Local commissioners of health services should be encouraged to develop joint purchasing plans and to work with local social services departments to ensure the integration and harmonisation of the process of producing Community Care Plans and Purchasing Plans.

Suggestions for general action points can be found at the end of this chapter, and more specific actions that purchasers and providers may wish to consider can be found at the end of Chapters 2 to 5.

1.8.3 Once local strategies have been decided, mechanisms for monitoring and evaluating their implementation need to be established. This implies seeking answers to questions such as: "are we being provided with what we were seeking in our contract?" and "are we achieving what we set out to do, and if not why not?". Unless an activity is scrutinised in this way it cannot be properly managed.

1.8.4 Monitoring and evaluation should be based on a specific list of objectives for a service. These may relate to:

- when and where the service is available
- the appropriateness of the service to the groups in need
- levels of activity, and the coverage of the service in terms of the proportion of those in need who receive it
- the effectiveness of the service in achieving desired outcomes
- the satisfaction with the service expressed by the groups in need
- the efficiency of the service in achieving the desired outcomes at given cost.

1.8.5 Monitoring and evaluation will involve a variety of approaches to gathering

information. Some will be based on routine or sample-based collection of simple statistics on the process of care. For example:

- the times and places at which the service is available
- waiting times for an appointment
- waiting times at clinics
- waiting times for results of investigations
- the numbers of people in different groups provided with the service.

1.8.6 Some may involve collecting more detailed information by relatively intensive and costly methods, ranging from informal reviews of process and outcome to more formal, in-depth studies seeking answers to clearly formulated questions in much the same way as research. For example:

- to what extent the groups in need of the service know about and use it
- the level of satisfaction with the service of the people who use it
- why some people who need the service do not use it
- the effectiveness of the service in different population groups.

1.8.7 Evaluating the outcome of many initiatives relating to the HIV/AIDS drug misuse and sexual health targets is not straightforward since they relate to behavioural change which has many components. It may be helpful to consider:

- ensuring evaluation is built in from the start of the process. It is essential to involve participating agencies in all aspects of the evaluative process including planning, implementation and interpretation of the results;
- when planning services, consulting people with appropriate research experience, so as to inform decisions about relevant studies
- where possible, learning from the experiences of other purchasers and providers of services, especially if the demographic, structural and organisational issues are similar
- deciding whether the work involved in evaluation should be done 'in-house' or externally by academics, consultants or other specialists.

1.8.8 Monitoring use of resources

Purchasers should aim to improve the information available to them about the range of costs likely to be incurred from local initiatives. Contracts provide a formal

mechanism for stipulating a minimum set of financial data which will enable comparisons of costs to be built up over time. These comparisons will assist judgements about relative cost effectiveness.

1.8.9 Purchasers will wish to decide which costing elements should be included. In doing so such information should aim to be:

- simple to collect, collate and report
- relevant to managers and professionals providing the intervention
- easily understood
- of use for evaluation.

1.8.10 Purchasers may wish, in relation to particular interventions, to consider collecting financial data under some or all of the following headings:

- personnel
- training
- production (eg for educational materials)
- supply (eg condoms, needles and syringes, drugs)
- premises (including running costs)
- publicity/distribution
- capital equipment
- evaluation
- miscellaneous (eg reporting arrangements, meetings etc).

1.9 DEVELOPING STAFF SKILLS AND TRAINING

1.9.1 Few areas of health promotion and care provision impinge so directly on the personal knowledge, beliefs, experience and attitudes of staff as those of sexual health. Managers need to recognise the difficulty many people will experience in dealing with the sensitive issues in this area, and that further development work will be needed to change this. Few curricula for professional education contain sexuality as a component of learning but it is essential that all staff receive training on the emotional, social and behavioural issues around sexuality and drug misuse. This applies not only to health and social care professionals but also to other personnel, such as receptionists, who have some degree of contact with clients and patients.

1.9.2 Training should also be available to those in formal settings (eg school governors, teachers, lecturers, custodial care and residential care workers) and those outside formal settings (eg parents, youth workers, outreach workers, those working in community settings and in voluntary and religious organisations). School nurses and family planning nurses are a valuable resource in the area of health education, but they may require further training to work with either young people or teachers.

See Appendix 5 for a resource list of available materials or agencies who can help.

POSSIBLE GENERAL ACTION POINTS FOR DEVELOPING A LOCAL STRATEGY*

**based on extracts from "First Steps for the NHS"[2]*

DHA Corporate Contracts

DHAs may wish to consider:

- Assessing, on a continuing basis, the sexual health and drug misuse needs of the local population, focusing particularly on the needs of adolescents and young people, men who have sex with men, injecting drug users, and black and ethnic minority groups including refugees and victims of sexual abuse
- Taking the lead in developing a joint strategy to meet the sexual health and drug misuse needs of the local community, and agree intermediate process and outcome targets in collaboration with other agencies
- Working with FHSAs and GPs to develop purchasing plans which meet the sexual health and drug misuse service needs of the local community, particularly the needs of sub-groups of the population who may be at increased risk, taking account of local views
- Working with local social services to ensure the integration and harmonisation of the process of producing community care plans and purchasing plans, and to ensure, in particular, the provision of, and good access to, high quality social and community care for all HIV positive individuals
- Working with other relevant agencies, take a leading role in developing a shared commitment to improving the quality of education provision in all formal settings
- Reviewing the availability of training in sexual health, including sexuality, and the management of drug misuse for professionals working within and outside the health care sector.

Purchasers

may wish to consider:

- commissioning a full range of complementary local services as suggested in Chapters 2-5

- agreeing process targets and monitoring arrangements with each provider for inclusion in purchasing contracts
- requiring providers to work closely with each other and with primary care
- identifying opportunities and interventions which contribute to meeting the objectives and targets and including these in purchasing negotiations
- commissioning public awareness campaigns about sexual health and drug misuse, and other community-based initiatives
- where possible specifying in contracts, both with laboratories and clinics, what sexually transmitted or other infections should be locally reported and the mechanisms for this. Many of these will be via voluntary confidential reporting systems but the contracts should be written such that reporting mechanisms are specified and encouraged.

Providers

may wish to consider:

- regularly reviewing the implementation and effectiveness of infection control procedures
- establishing continuing staff training programmes in HIV/AIDS, drug misuse and sexual health
- ensuring that the issue of blood-borne infections, including Hepatitis B and C, and HIV infection, is addressed in health and safety at work and employment policies
- ensuring all health care professionals who might be exposed to infected body fluids receive Hepatitis B vaccination
- regularly reviewing the effectiveness of policies for dealing with needle-stick injuries
- addressing the rights and responsibilities of employees who are HIV or Hepatitis B positive
- ensuring that all donors of blood, blood products, organs, tissues, breast milk and gametes are screened for HIV and Hepatitis B
- ensuring that all donors of blood, blood products, organs and tissues are screened for Hepatitis C

- ensuring that donor screening policies are reviewed regularly in the light of recommendations from the Department of Health and national organisations such as the Human Fertilisation and Embryology Authority
- working with other providers and agree guidelines to ensure easy and rapid referral between different sectors of the service.

Health Promotion Units

may wish to consider:

- taking a lead role in working with other agencies to improve the provision of health education about sexual health and drug misuse in all settings such as schools (including grant maintained and independent schools), institutions of further and higher education, youth clubs, residential care settings, health care settings, workplaces and custodial settings
- working with the District HIV Prevention Co-ordinator, co-ordinating the input into public awareness and health education programmes on sexual health and drug misuse provided by other health professionals, including school nurses and doctors and doctors and nurses working in family planning, GUM and drug misuse services
- in liaison with other agencies, taking the lead in organising public awareness campaigns about sexual health and drug misuse, and other community-based initiatives
- liaising with school governors who are responsible for determining what further sex education, beyond the requirements of the national curriculum, should be offered in their schools
- providing advice and information on sexual health to school governors and parents, as well as teachers and pupils. They should also consider offering assistance in determining and effecting suitable policies for sex education to school governing bodies.

Common issues for Primary Care

Primary care services can contribute to the development of interventions to meet sexual health and drug related objectives and targets by:

- assisting in the development of local strategies in sexual health care

- evaluating and auditing practice policies or strategies
- developing, in collaboration with consultants and other specialist colleagues, practice policies that actively promote and provide advice and information on sexual health and healthy lifestyles, which are available to all appropriate patients
- making available in waiting rooms/clinics an up to date supply of health education leaflets, in other languages where appropriate
- publicising the range of services that the practice provides
- having knowledge of all local services to enable appropriate referral to:
    - GUM clinics
    - Family Planning Clinics
    - Psychosexual counselling
    - Sterilisation services
- participating with consultants and other appropriate professionals in the development of shared guidelines for the management of patients with STDs, HIV/AIDS or drug misuse problems
- participating in feasibility studies for the provision of free condoms in the general practice setting
- supporting the setting up of local needle/syringe exchange schemes in pharmacies and other appropriate settings
- having in place proper hygiene precautions and infection control procedures
- ensuring that all staff, including receptionists receive training according to their needs.

CHAPTER 2

HIV AND AIDS

HIV/AIDS

2.1 INTRODUCTION

2.1.1 This chapter contains additional information which will be helpful in meeting the objectives relating to HIV and AIDS. It should be read in conjunction with Chapter 1, the list of possible actions for purchasers and providers at the end of the chapter and the relevant appendices.

2.1.2 "The Health of the Nation" has set the following broad objectives in relation to HIV and AIDS:-

GENERAL OBJECTIVES

To reduce the incidence of HIV infection

To develop further and strengthen monitoring and surveillance

To provide effective services for diagnosis and treatment of HIV

2.1.3 HIV is transmitted:

- by unprotected penetrative sexual intercourse with an infected person (between men or between men and women)
- through infected blood, which in the UK is usually a result of drug misusers sharing infected injecting equipment
- from an infected mother to her baby before or during birth or through breast feeding.

2.1.4 "The Health of the Nation" did not set specific targets for HIV infection and AIDS because it is not yet possible to establish baseline rates of incidence and prevalence in the population against which to measure achievements in the future. Instead, the targets for gonorrhoea and drug misuse, which are targets in their own right, also act as proxy targets for reducing the likelihood of HIV transmission. Initiatives to meet the target for family planning can also contribute to healthy sexual behaviour in relation to HIV and other STDs.

2.1.5 HIV reports (of which there were over 18,000 in the UK to September 1992) reflect only those people with HIV who have been tested. Other infected people may not have sought testing, either because they do not consider themselves to have been at

risk or for other reasons. AIDS case reports (of which there were over 6,500 in the UK to September 1992, of whom over 4,000 had died) reflect in part some of the current burden of HIV related disease, but do not reflect the current epidemiological picture of HIV transmission since people with AIDS may have been infected for 10 years or more.

2.1.6 The current prevalence of HIV is focal with significant variations around the country. The four Thames Health Regions report the majority of positive HIV tests and AIDS cases although this may in part reflect the fact that people with HIV are currently seeking services based within these areas.

2.2 DEVELOPING A LOCAL PROFILE

See Appendix 1 for a checklist of possible sources of local demographic, epidemiological and other information.

2.2.1 In certain areas further epidemiological data may be available from named voluntary testing eg in antenatal clinics, additional testing facilities and local prevalence studies. Section 2.5.6 contains details of further possible national surveillance initiatives.

2.2.2 Other sources of information may be available which highlight particular local factors. For example:

- local surveys of attitudes and knowledge of HIV amongst specific groups, for example young people or black and ethnic minority communities
- local authority Community Care Plans which should reflect the needs of people with HIV
- seasonal or occupational variations in the population eg tourism
- the location and numbers of:
  - ~ local higher education facilities
  - ~ prisons/custodial settings
  - ~ military bases, etc.

2.2.3 Purchasers also need a comprehensive picture of the resources available to them and current or planned services. A starting point will be the annual local AIDS (Control)

Act report[7]. If possible, data on activity levels and service use by resident and non-resident population should be collated, especially identifying any significant in or outflows of patients for diagnosis and treatment services.

Local Initiative

West Midlands is establishing a regional surveillance system. Each District has started to collect a detailed confidential data set on every person with HIV infection receiving services in their district. The use of Soundex Code rather than name ensures that the data set remains confidential. It includes postcode of residence, DHA of residence, DHA of care, exposure category and latest CD4 count. The individual district data sets will be updated annually and merged to form a Regional database. Each record will have a unique Regional number. Use of this number when providers of services are billing purchasers will further guarantee confidentiality while at the same time allowing the collection of data to help in planning appropriate services.

Contact: Sally Gleaves, South Birmingham Health Authority, Vincent Drive, Edgbaston, Birmingham B15 2TZ. Tel. 021-627 2056.

2.2.4 In particular, as much information as is required should be collected about the local needs of the key groups listed at 2.4.5. For example, local surveys of sexual knowledge attitudes and beliefs may have been conducted which will help highlight particular factors.

2.2.5 Initial findings from the National Survey of Sexual Attitudes and Lifestyles published in December 1992[8] show that larger numbers of sexual partners were reported by single people, younger people and those who report first intercourse at an early age. In addition 1 in 28 men reported ever having had a homosexual partner, and 1 in 74 reported a homosexual partner in the past 5 years. This rises to nearly 1 in 20 living in London. Recent homosexual experience is more common in younger men.

2.3 DEVELOPING HEALTHY ALLIANCES AND SEEKING LOCAL VIEWS

See sections 1.2 and 1.3 for a general overview and Appendix 2 for a list of possible participants.

2.3.1 A hallmark in the development of HIV- related services has been the role of agencies in the voluntary sector which have often been the originators of many of the innovatory services in prevention, treatment and care. Many statutory and non-statutory organisations within the field of HIV have already recognised the need to develop healthy alliances which play an important part in the development of local strategies for HIV. However there is still scope to strengthen these alliances even further. Annual guidance from the Department on the HIV/AIDS allocations continues to stress the importance of inter-sectoral collaboration in both purchasing and operational matters.

2.3.2 The role of local authorities

Local authorities have played and continue to play a significant part in providing a range of community-based services for people with HIV. From April 1993 local authority purchasers will have the central role in planning and commissioning the assessment and provision of care of people with HIV in the community. They are also employers and through contacts with the community well placed to develop interventions which aim to raise awareness or to prevent transmission of HIV.

Local authorities may wish to strengthen their corporate response by:

- contributing, through social services and other departments, to the development of coherent overall strategic plans for sexual health
- encouraging, in conjunction with local education authorities, the development, implementation and review of sex education policies by school governors
- ensuring Community Care plans reflect the needs of people with HIV or AIDS
- developing models of good practice in prevention and service delivery and sharing their experience through existing networks. Local authorities have a diverse range of opportunities for introducing HIV awareness into their services – eg leisure and recreation, housing, tenants' associations,

environmental health, youth services, community education

- purchasing and financing various services to meet practical needs and particular requirements, including counselling, of people known to be infected, their partners, families and carers
- developing appropriate HIV training initiatives for staff
- helping to foster better links between other statutory and non-statutory services, including joint commissioning with the NHS.

2.3.3 The Local Authority Associations' Officer Working Group on AIDS based at the Local Government Management Board (contact: Les Woods 0582 451166) has two principal aims:

- to bring the issues and concerns of local government to the notice of central Government departments, in particular in negotiating funding
- to issue policy and practice guidance on the whole range of HIV-related issues for all local authorities.

They undertake extensive training and development programmes for local authority HIV Co-ordinators and are developing initiatives on inter-sectoral healthy alliances.

2.3.4 The role of voluntary organisations

The voluntary sector has and continues to play a major role within the UK in helping the community at large, health and local authorities and Government to respond to the continuing challenge of HIV. For example the London Lesbian and Gay Switchboard and Terrence Higgins Trust have provided advice and information about HIV since the early 1980s and many grew out of a response from those communities directly affected in the initial stages. Many voluntary organisations in little more than a decade have quickly established a high reputation for providing a wide and innovative range of services. Some of the factors which distinguish the voluntary sector and which can help contribute to further successful interventions are:

- close links with the community providing a vehicle for gathering together views and representing them to other agencies
- their ability to meet emerging care and support needs quickly and to develop imaginative approaches which are responsive and sensitive to individual and local circumstances

- less bureaucracy and formality: some people may for a variety of reasons find voluntary services more "user friendly" than statutory based services. Voluntary organisations can therefore act as a gateway to other services
- willingness to act as advocates for those people who may be less able or have less opportunity to make their views or needs known.

2.3.5 Purchasers and providers will wish to build on existing links or seek to encourage greater voluntary sector participation by developing or commissioning a range of HIV related services, including education and prevention. Whilst a number of larger specific HIV and AIDS voluntary organisations are centred on London, the South East and other major metropolitan areas, many of these have a national remit in prevention. There are also local agencies or branches of other national organisations who also have an interest in HIV, for example Barnardos, Brook or Relate which can also be invited to join a local alliance.

See the list of organisations at the end of the handbook for further details.

2.3.6 Initiatives on which voluntary agencies can offer advice or may be best placed to provide themselves include:

- awareness, information and education generally or for specific sections of the population. For example London East AIDS Network has produced leaflets in twelve ethnic minority languages, including Swahili, Vietnamese and Luganda
- bringing education and prevention initiatives to the community through outreach or detached work
- helping identify and address the different health care, emotional and practical needs of particular groups affected by HIV, for example helplines, 'buddy' or befriending services, and offering legal advice
- helping identify and develop ways of meeting training and support needs of those working in the field.

2.3.7 Purchasers and providers can themselves support effective voluntary sector initiatives by:

- clarifying current funding arrangements and procedures for applications for funds and where appropriate ensuring such arrangements provide secure and regular access to funds

- considering whether joint purchasing and monitoring mechanisms may help to reduce the administrative burden on the voluntary sector
- providing appropriate training events, including management and financial issues
- providing access to local facilities for meetings, day care centres etc
- ensuring local agencies recognise the importance of providing advice and social support systems for people with HIV who are well.

Local Initiatives

In North West Thames, a voluntary sector co-ordinator has been appointed with specific responsibility for fostering closer liaison with voluntary agencies, including developing the role of health authority funding

Contact: Jane Carrier, North West Thames. Tel. 071-725-5300.

A Young People's Needs Assessment project is under way in Sheffield involving representatives from the Youth Service, Education Department, the voluntary sector and the Centre for HIV and Sexual Health. This is undertaking a full review of HIV work with young people in the city since 1987, identifying gaps in provision and new target groups and making recommendations for further action.

Contact: Jo Adams, Sheffield Centre for HIV and Sexual Health, 22 Collegiate Crescent, Sheffield S10 2BA. Tel. 0742 678806.

Following a major inter-agency conference on designing a coherent model of AIDS care for Sheffield, an extensive consultation was undertaken. As a result a document outlining "Guidelines on Inter-Agency Practice" has been produced, detailing suggested procedures under three headings: Confidentiality Issues, Discharge from Hospital, and Counselling.

Contact: Jo Adams (as above)

King's Healthcare (part of the SELCA area) commissioned the Health and Education Research Unit, Goldsmiths' College to undertake a four month enquiry into the HIV health promotion needs of gay and bisexual men in the Camberwell District area. The study involved in-depth consultation and interviews with key workers from the statutory and voluntary agencies locally, as well as from clients and service users themselves. The report was published in July 1992 and SELCA is using the findings to commission HIV prevention services for this population group in 1993/94.

Contact: Paul Ward, Contracts Manager, SELCA. Tel. 071-955 4379.

2.4 IDENTIFYING INITIATIVES TO REDUCE THE INCIDENCE OF HIV INFECTION

2.4.1 Health education and promotion

With no prospect of a cure or vaccine within the next few years, a key objective of any local HIV strategy is to reduce the incidence of HIV transmission. Local education and prevention work should aim:

- to improve, where indicated, levels of knowledge and awareness about HIV amongst the local population in general and amongst specific population groups
- to encourage people to adopt healthy or safer patterns of sexual behaviour
- to encourage people who may be at continued risk to modify and sustain changes in their sexual behaviour.

2.4.2 Although there is good evidence that knowledge amongst the general population of how HIV is transmitted is high, the challenge is to encourage people to translate this awareness into sustained behavioural change. Furthermore, levels of knowledge are not uniform across the population and educational initiatives to heighten awareness will need continual reinforcement. Even where the overall level of knowledge is high, this is not necessarily enough. For example amongst gay men, there is disturbing evidence of continuing risk behaviour, as indicated by recent rises in cases of rectal gonorrhoea in young men (see "On the State of the Public Health 1991" page 96)[9].

Evidence from the Communicable Disease Surveillance Centre (CDSC) of the Public Health Laboratory Service (PHLS) also indicates that some gay men who have previously tested negative have subsequently tested positive indicating a need for more intensive counselling and support to be offered to sustain safer sexual practices amongst this group. Anecdotal evidence suggests some younger gay men regard HIV as only affecting older men.

2.4.3 The Department of Health continues to encourage the development of local HIV prevention initiatives aimed at the general population and for key population groups who may be at increased risk. Districts may wish to review their current HIV prevention strategies in relation to this and the objectives and targets in this handbook.

Examples of such strategies, including the local priorities for intervention may be obtained from:

South East London Commissioning Agency (SELCA)
Contact: Margaret Webster, Mary Sheridan House, 15 St. Thomas Street, London SE1. Tel. 071-955 4386.

Camden and Islington
Contact: Julia Smith, Health Promotion Department, St. Pancras Hospital, 4 St. Pancras Way, London NW1 0PD. Tel. 071-387 1908.

Ealing
Contact: Su Harnett, District Offices, St. Bernard's Hospital, Uxbridge Road, Southall, Middlesex UB1 3EU. Tel. 081-967 5689.

2.4.4 District HIV Prevention Co-ordinators (DHPCs) are well placed to assist in the development of local purchasing strategies and the commissioning of further local initiatives because of their developing links with and between purchasers and providers. Purchasers should ensure maximum collaboration with DHPCs to include their views when considering resource allocations where they are not already part of the core purchasing function.

2.4.5 Purchasing authorities and local alliances, including DHPCs, will wish to examine critically current initiatives to ensure that resources are focused on those population groups whose levels of knowledge or behaviour may place them at increased risk of HIV infection, in particular:

- men who have sex with other men; especially
  - younger gay men
  - those who may not be part of regular social networks reached by current educational initiatives
  - those who consider themselves to be in 'steady' relationships (evidence from Project Sigma indicates that some of these men are likely to discontinue safer sexual practices[10])
- those who attend GUM clinics (see also chapter 3): latest results from the programme of anonymised HIV surveys show that amongst those who attended certain inner London GUM clinics, 1 in 150 heterosexual women, 1 in 90 heterosexual men and 1 in 5 gay men are HIV positive
- injecting drug users and their sexual partners (see Chapter 4)
- certain black and ethnic minority communities, including refugees
- sexually active adolescents and young people – especially those who may be more vulnerable eg:
  - young offenders
  - the homeless
  - young people leaving care
  - young people with multiple sexual partners
- sex workers and their clients
- those in custodial settings.

An extensive list of possible audiences for targeted prevention work is given in Appendix 4. The list is illustrative of the range of audiences that may need to be considered.

Some examples of local initiatives

Gay Men

In collaboration with NE Thames, districts in NW Thames are developing a peer led volunteer outreach programme for men who have sex with men. The programme includes a needs assessment component as part of its work, and separate independent evaluation. The programme will be developed in association with voluntary organisations and is modelled on the "Stop AIDS" Project from Sydney and San Francisco. The innovative approach will involve using volunteers as safer sex educators in their everyday activities.

Contacts: G. Lucas, HIV Project, N.West Thames RHA. Tel. 071-724 7443.

Exeter DHA are running a wide range of prevention initiatives for men who have sex with men, eg workshops on safer sex, availability of condoms and social events with support materials within targeted pubs and clubs.

Contact: John Bewick, Dean Clark House, Southernhay East, Exeter EX1 1PQ. Tel. 0392-406232.

Bristol and District Health Authority in conjunction with the Aled Richards Trust are funding two Project Workers whose work will focus primarily on the commercial gay scene. A Steering Group has been set up involving the owners and managers of gay, lesbian and bisexual venues in Bristol. Innovative ideas for promoting safer sex messages have been developed, and the project will continue for 1993/94.

Contact: Sue Bandcroft, 10 Dighton Street, Bristol BS2 8EE. Tel. 0272 766623.

In Sheffield a group of gay men has been recruited and trained as peer educators. They have produced safer sex publicity materials and run HIV prevention events on the commercial scene. In addition a gay men's health needs assessment group has been established to identify gaps in provision. Sheffield also plan a project specifically aimed at the HIV education needs

of young gay men, including those working as prostitutes. Districts in NE Thames and NW Thames are developing similar programmes.

Contact: Jef Jones, Sheffield Centre for HIV and Sexual Health, 22 Collegiate Crescent, Sheffield S10 2BA. Tel 0742-678806.

Ethnic Minorities

In Leicestershire, the multi-disciplinary Asian Languages Materials Group is currently developing new materials in Asian languages rather than translating them from existing English language materials. The new Media Researcher and Trainer (Sexual Health) based at BBC Radio Leicester's CSV Action Desk will train HIV workers in media skills and provide broadcasting opportunities relating to sexual health. Half of the officer's time will be targeted at ethnic communities.

Contact: Kala Chauharu, Black HIV/AIDS Forum, 29 New Walk, Leicester. Tel. 0533-85595.

In Leeds the Black Community's AIDS Team deal with local communities through religious groups, cultural events, local radio and rap artists.

Contact: Christine Burnett, Leeds Health Care, St. Mary's House, St. Mary's Road, Leeds LS7 3JX. Tel. 0532-781341 Ext 443.

Young People

In Sheffield, young people have contributed their ideas, views and experiences to a video "It only happens to Pop Stars". This contains the authentic voice of young people talking about how HIV and AIDS is affecting their lives and how they can make healthy choices and change.

Contact: Tracey Nathan, Sheffield Centre for HIV and Sexual Health, 22 Collegiate Crescent, Sheffield S10 2BA. Tel. 0742-678806.

Students from Sheffield University have been trained over a period of two years as Peer Educators and have run over 50 HIV awareness sessions

with fellow students at Halls of Residence and in Union Societies. A similar initiative is being developed with students at the new Sheffield Hallam University.

Contact: Kate Quail, Sheffield Centre for HIV and Sexual Health (as before).

A major campaign was planned and carried out between Hounslow DHA and Hounslow Borough Council to raise awareness of the risks of HIV transmission when travelling targeting the 16-25 age group. Work has been planned in three stages over two years. The final stage is a poster campaign and distribution of a free booklet.

Contact: Judith Taylor-Fishwick, West London Health Promotion Agency. Tel. 081-967 5028.

In 1990 Northern Regional Health Authority produced and evaluated an HIV and AIDS health education programme based on a play and drama workshop in 26 schools, youth clubs and colleges. This was followed in 1992 by "Body Talk", a further theatre in health education programme designed to promote a change in attitudes and intended sexual behaviour of young people.

Contact: Dr R. McEwan, Health Promotion Officer, Northern Regional Health Authority, Benfield Road, Newcastle Upon Tyne NE6 4PY. Tel. 091-224 6222.

A successful Peer Education Project has been developed for sixth formers in Hillingdon. It is funded jointly by the DHA and LA and managed by the LA. There is now a video available which explains the process and can be used for talking to head teachers, parents and school governors.

Contact: Angela Flux, London Borough of Hillingdon. Tel. 0895-250165.

Both Hounslow and Spelthorne and Hillingdon Health Authorities now

provide regular Young People's Sexual Health Clinics. In Hillingdon it is run by the Brooke Advisory Service and in Hounslow and Spelthorne it is managed as part of the Community Family Planning Services.
Contact: Rochelle Bloch, West London Health Promotion Agency. Tel. 081-967 5028.

Action AIDS is a drama based learning pack for young people developed by Northampton DHA and the Local Education Authority. It continues to be used widely and the Region is planning to investigate the use of this training pack as part of a wider review of the role of the Arts in HIV prevention.
Contact: Dawn Bason and Chris Boyce, Northampton DHA. Tel. 0604-35681.

An outreach project for young people (under 25) has been established in Rotherham to identify those needs of young people around HIV/AIDS and sexual health issues and to make recommendations for future work depending on the outcomes of the project. This research project is based around a council estate in the East Herringthorpe/Dalton areas where the teenage pregnancy rate is high in relation to other estates in Rotherham.
Contact: Richard Hart, District HIV Prevention Co-ordinator, Rotherham DHA, Rivlin House, Moorgate Road, Rotherham S60 2SW. Tel. 0709 820000 Ext 6400.

In Doncaster the town centre Youth Agency, Jigsaw, will open in 1993 to address the educational and social needs of young people. The first magazine allied to the project, "Jigsaw – AIDS edition", has been distributed to a sample of the population and its awareness raising potential and acceptability of the young people of Doncaster has been evaluated.
Contact: Sue Parrish or Marie Tate. Tel-0302-739508.

Prisons

East Anglian RHA has established links with Suffolk Probation Service, providing funding for ring-fenced AIDS monies for three full-time Probation Health Co-ordinators responsible for HIV/AIDS education in prisons. This service is currently being evaluated.

Contact: Jessica Shellard, Regional HIV Prevention Co-ordinator. Tel. 0223-330355.

Peter Mortimer, Assistant Chief Probation Officer. Tel. 0473-210675.

Chris Williamson, Probation Health Co-ordinator. Tel. 0440-820611 ext 280.

Three four-day residential training courses for the staff of prisons and outside agencies are being jointly funded by the Prison Service and Yorkshire RHA.

Contact: Joan Holmes, Yorkshire Regional Health Promotion Officer. Tel. 0423-500066 ext 2178.

Northampton Health Promotion Department has developed an education programme for all staff and residents at a local Young Offenders institution. The HIV and sexual health education for the residents includes separate components for the different age groups of 14-16 year olds and 17-21 year olds. The initiative has led to the formation of a steering group to consider the wider health needs of staff and residents.

Contact: Dawn Bason, Northampton DHA. Tel. 0604-356818.

Learning Difficulties

In Nottingham, the Project Worker (Men's Health) has given talks on safer sex to people with learning difficulties, and the Health Shop has also provided safer sex workshops for this client group. In addition a sexual health project has been carried out at the Shepherd School, a school for students with learning difficulties and the AIDS Development Officer (Nottingham Social Services) has commenced training with MENCAP

management and staff. The Shepherd School project continued until June 1992 and a full report will be produced. It is hoped to publish guidelines for staff working with people with learning difficulties.

Contact: Gary Quarless, HIV/AIDS Team, Nottingham Community Health, Forest House, Berkley Avenue, Nottingham. Tel. 0602-691691 ext 49415.

Prostitutes

In Nottingham a study was carried out to investigate the sexual health needs of prostitutes, clients and their managers. Some prostitutes were trained as research interviewers and gathered data from prostitutes as well as providing information on health services and offering condoms and lubricants whilst working in the field. A Prostitutes Outreach Worker Programme has developed from the research programme.

Contact: Pam Gillies, Department of Public Health Medicine, University Hospital, Nottingham. Tel. 0602-421421.

2.4.6 Partner notification

The Department of Health recommends that people testing positive for HIV should be encouraged wherever possible to inform their current and previous sexual and drug sharing partners[11]. This is already standard practice in GUM clinics for people with other STDs and, increasingly, for HIV. Staff at these clinics, particularly the health advisors, are well placed to offer support and advice. Local systems should be developed which enable the same support to be offered for people who have tested positive in settings other than GUM clinics. Some people who consent to allowing their partners to be informed may not wish to undertake this personally and may request clinic staff to undertake this on their behalf. Local mechanisms may need to be agreed for such provider referral.

See Appendix 8.

2.4.7 Infection control

Providers of services where invasive procedures are undertaken will want to ensure that a basic standard of practice is applied to all patients to prevent transmission of blood borne viruses, including HIV, between patients, from patients to health care workers, and from health care workers to patients.

2.4.8 General protective measures are to:

- apply good basic hygiene practices with regular hand washing
- cover existing wounds or skin lesions with waterproof dressings
- avoid invasive procedures if suffering from chronic skin lesions on hands
- avoid contamination of person by appropriate use of gloves and other protective clothing
- protect mucous membrane of eyes, mouth and nose from blood splashes.

2.4.9 Specific practices are to:

- institute approved procedures for sterilisation and disinfection of instruments and equipment
- clear up spillages of blood and other body fluids promptly and disinfect surfaces
- handle and dispose of sharps safely, ie:
  - ~ avoid sharps usage wherever possible
  - ~ never resheath needles unless there is a safe means for doing so
  - ~ dispose of needles and other sharps in a specially designed and approved container complying with British Standard 7320
  - ~ modify surgical techniques and equipment to avoid puncture injuries.

2.4.10 The above recommendations apply in all health care settings, laboratories, mortuaries and to skin piercers (eg electrolysists, tattooists, acupuncturists) working outside normal health care settings.

2.4.11 Although the risk of transmission of HIV from an infected health care worker to a patient is probably very small, those who consider themselves at risk must seek medical advice and, if appropriate, antibody testing. If found to be infected, those who undertake invasive procedures must seek occupational advice on the need to alter work practices[12].

2.4.12 Guidance has been issued by the Department of Health on all aspects of HIV infection control. For further information please see the Resource List[13].

Local Initiative

South Derbyshire plan a pilot project in 1992/93 to develop an audit of infection control procedures within 10 general practices.

Contact: Kate Ward, South Derbyshire Health Authority. Tel. 0332-363971.

2.5 IDENTIFYING INITIATIVES TO DEVELOP AND STRENGTHEN FURTHER MONITORING AND SURVEILLANCE

2.5.1 Current HIV/AIDS surveillance is based on:

- voluntary confidential reporting of AIDS cases by clinicians to the PHLS Communicable Disease Surveillance Centre (CDSC)
- voluntary confidential reporting of newly identified HIV seropositive tests to CDSC from laboratories
- the MRC/CDSC Prevalence Monitoring Programme. A series of unlinked anonymous surveys in selected sites gives prevalence measures in defined population groups (eg genito-urinary medicine clinic attenders, women attending antenatal clinics, hospital patients etc). A survey of HIV prevalence amongst injecting drug users should also contribute towards monitoring the national target of decreased needle sharing
- a collaborative study by PHLS in eighteen laboratories gives aggregate data on individuals tested for HIV for the first time.

2.5.2 Purchasing authorities will wish to consider what, if any, further measures are needed to improve understanding of the local picture in order to ensure that education and prevention initiatives and services are being directed to those most in need.

2.5.3 Purchasing authorities can help establish reliable baseline information and improve overall quality of national data by:

- ensuring that laboratory reports of new cases of HIV infection and clinician reports of new diagnoses of AIDS are returned with minimum delay to CDSC
- in higher prevalence districts considering the possible scope for further local surveillance of severe HIV disease not classified as AIDS by the use of CD4 counts below 200. The local pathology department or CDSC[14] may be able to advise on this recent development.

2.5.4 Local surveys

Local prevalence surveys, carried out in specific groups of patients who have given consent, for example amongst GUM clinic attenders, may help obtain a clearer picture of local prevalence of HIV infection although care will be needed in their interpretation. One other use of such surveys is to monitor trends in infection over an extended period of time. Some authorities and units are also undertaking local anonymised HIV surveys either independently or as part of the national CDSC programme[14].

2.5.5 In determining whether to commission local surveys, authorities will need to consider;

- what is already known about local prevalence – sufficient information may be available from named testing
- the likely overall costs
- the likely yield of positive results based on current trends
- training for staff involved in any such programmes
- the availability of information about any proposed anonymous surveys so that people can choose whether to take part or not
- the need to have ready access to voluntary named testing for those participating in any anonymised studies but who wish to know their serostatus.

All proposed studies must be cleared by the local ethics committee.

Local Initiatives

In Trent a Regionwide initiative has been launched to encourage the co-ordination of information on numbers of HIV positive individuals sub-

divided by CD4 counts. This is seen as a useful indicator of the demands which patients are likely to make upon health services.
Contact: Dr K. Allen, Trent Health, Fulwood House, Old Sheffield Road, Sheffield S10 3TH. Tel. 0743-630300.

AIDSPLAN II: The Department of Health in collaboration with Parkside DHA has developed a computerised forecasting and costing model to help allocate resources for treatment and care services. A revised programme available in 1993 will include default costs which can be overwritten with local figures and will contain updated costing and forecasting data.
Contact: Linda Johnson-Laird, Department of Health AIDS Unit, Friars House, 157-168 Blackfriars Road, London SE1 8EU. Tel. 071-972 3302.

2.5.6 National Surveillance Initiatives

To support work locally, current national surveillance may be strengthened by the following CDSC initiatives:

- the collation, on a district of residence basis, of information on the numbers of HIV positive patients currently receiving health care
- more widely available results from the anonymised HIV prevalence monitoring programme
- continuing monthly/quarterly publication by CDSC of AIDS case and HIV reports which are available in the Communicable Disease Report (CDR) of the PHLS. These include paediatric data compiled in partnership with the Institute of Child Health
- the development of a system for surveillance of severe HIV disease not AIDS (ie CD4 counts below 200) to supplement existing reporting mechanisms
- sentinel surveillance of STDs with GUM clinics in some areas enabling the earlier return of STD figures acting as a proxy for HIV infection
- through the collaborative laboratory study, establishing the numbers of people being tested for HIV and the seropositivity rate.

2.6 SERVICES OFFERING ADVICE, COUNSELLING AND TESTING

2.6.1 People who are concerned that they may have been at risk of HIV infection should have easy access to appropriate counselling and testing services. The early detection of HIV seropositivity can help:

- the individual:
  - ~ to receive counselling and advice about the appropriate measures to prevent further risk of transmission to their sexual or drug equipment sharing partners
  - ~ if female, to seek advice and make decisions about pregnancy
  - ~ to obtain optimum medical and supportive care including treatments which may delay progression to AIDS and appropriate prophylaxis against opportunistic infections
- the community, because people with HIV can be offered counselling and advice on sustaining safer behaviours, in order to limit possible onward transmission to sexual or drug sharing partners.

2.6.2 Programmes of partner notification may also assist in the earlier diagnosis of infection amongst contacts of HIV positive people.

See also 2.4.6. and Appendix 8.

2.6.3 *The availability of counselling and testing services*

In order to ensure easy access to advice, counselling and testing if requested, such services should be available from a number of local agencies. For example from:

- local GUM and drug misuse clinics whose staff may also wish to consider offering discussions and voluntary testing to all patients considered to be at risk
- local GPs, either themselves or by referral to the appropriate local agencies
- additional test sites, for example such as the same day test clinic at the Royal Free Hospital. Anecdotal evidence suggests some people may be reluctant to go to a GUM clinic or discuss their concerns with their GP. The Department of Health has issued guidance on this[15]

See also Appendix 6.

- antenatal clinics in higher prevalence areas who may wish to offer voluntary testing to all women attending for care. The Department of Health has also issued guidance in this area[16].

See also Appendix 7.

2.6.4 Discussions or counselling about HIV without the test may be available in a number of other settings – for example local voluntary organisations such as women's health groups or peer groups. Counsellors at such facilities will need to know to where people who decide they wish to take a test can be referred. Appropriately trained staff in family planning services may also be able to provide this service.

Local Initiative

Training on issues around counselling for the HIV test has been provided on a rolling programme for GPs in Rotherham. This not only provides GPs with the knowledge to develop pre- and post-test counselling skills, but also helps to allay unfounded fears and anxieties about the risks involved in caring for HIV positive patients.

Contact: Bev Bridgwater, SHPO in Sexual Health, Rotherham DHA. Tel. 0709-820000.

2.6.5 *Guiding principles for HIV testing*

Named testing for HIV can only be done with the person's explicit informed consent. Pre-test discussion or counselling should aim to develop a position of trust between patient and counsellor or health care worker and, ideally, the same person should give the result. The General Medical Council has issued guidance about testing in circumstances when such consent is not available[17].

2.6.6 *Pre-test discussions or counselling should:*

- be conducted confidentially. Purchasers should also ensure provider contracts include how to record store and retrieve confidential information, label specimens etc in line with the provisions of the NHS Venereal Disease

Regulations 1974

- include provision of information about preventing the transmission of HIV and other STDs (including for those who are seronegative) and encourage voluntary partner notification procedures should a test prove positive
- be sensitive to culture and religion, particularly when English is not the client's first language.

2.6.7 *Results of tests:*

- should be available as quickly as possible, preferably within twenty four hours to minimise anxiety
- should be given in person, and not over the phone, to ensure confidentiality and that any questions or concerns are adequately addressed as well as reinforcing safer sex and drug misusing messages to those who test negative
- may prove cheaper and quicker through contracts with some private laboratories – for example, in 1992, public health laboratory costs amongst a sample of three sites ranged from £7.50-£15.

2.6.8 *People who have a positive test should:*

- be referred to the local physician caring for HIV positive people (arrangements should be in place to ensure such referrals can be immediate if necessary)
- have ready access to information about the full range of statutory and non-statutory support services and local self help agencies
- have ready access to continuing support and counselling to encourage the adoption of healthy lifestyles and sustain changes to behaviour to prevent onward transmission to sexual or drug equipment sharing partners
- be encouraged and offered help to notify their sexual or drug sharing partners (see 2.4.6)
- if an HIV positive person agrees that partners should be notified but does not wish to do this personally then staff should be available to help (provider referral).

2.6.9 *Circumstances under which a repeat test may be necessary*

Within three months after infection (but occasionally much longer) the body produces antibodies to HIV. Detection of these antibodies in the blood forms the

basis of the commonly used laboratory tests for HIV infection. These tests are negative before the antibodies appear (the 'window' period). Some people, having received an initial HIV negative result, may therefore be advised to return at a later date for a repeat test in order to confirm or otherwise the initial result.

2.6.10 *People who have a negative test result*

People who have been at risk but found to be uninfected should, where appropriate, be counselled on avoiding risk behaviours in the future.

2.6.11 *People who present for regular repeat tests*

There is anecdotal evidence that some people who believe they have been at repeated risk of HIV present for regular tests as a way of monitoring their health status. CDSC report that some gay men who initially tested negative have subsequently seroconverted and that such seroconversions are not associated with the window period. In such circumstances purchasers may wish to review current counselling and testing procedures to ensure that those who present for regular tests are offered such support as they may need about safer sexual and injecting practices. Access to testing services should not be withheld to those who have previously been tested.

2.7 SERVICES FOR PEOPLE WITH HIV INFECTION, HIV RELATED DISEASE OR AIDS

People with HIV related disease will have a changing variety of needs and may require a wide range of services from a number of different agencies. Figure 2 outlines some of the services that may be needed. Such services should aim:

- to meet individual preferences whenever possible
- to be sensitive to differing cultural and personal circumstances
- to respect the need for individual autonomy, dignity and confidentiality.

Figure 2

2.7.1 A description of some of the services that may be required for adults and children with HIV infection

Asymptomatic	Acutely ill	Chronically ill	Terminally ill
Counselling and medical evaluation	Psychosocial and ongoing medical care	Psychosocial and ongoing medical care	Psychosocial and ongoing medical care
Testing facilities and partner notification	In-patient services	Day care Out-patients	Intensive home nursing
Education	Out-patient services	Transportation	In-patient or hospice services
Out-patient follow-up and treatment including prophylaxis	Rehabilitation services	Emergency telephone assistance	Bereavement services to family, friends
Psychological and other support services	Home care services	Home delivered meals	care services for children whose parents are terminally ill
	Childcare support as necessary	Other practical support in the home	
		some home nursing	
		sheltered housing	
		residential or respite care	
		childcare support as necessary	

Uninfected family members, including children, will also need a variety of support services

2.7.2 Services for asymptomatic HIV positive people

The aim of these services should be to delay as far as is possible the onset of HIV related disease and to offer ongoing psychosocial support. In particular:

- regular clinical, haematological, virological, and immunological follow-up should be available to asymptomatic individuals
- discussion about when prophylactic treatments may be of benefit
- FHSAs will need to ensure that people with HIV have full access to local general practitioner and dental care
- infected women and children need accessible services to be developed to meet individual and family needs. Some authorities are developing family clinics

where all family members can receive out-patient care at the same time with appropriate links to inpatient and community care services and support if necessary

- support services should be available for other family members or partners who, though not infected, will be affected by HIV
- children infected with HIV have other special needs. See "Children and HIV" Guidance for Local Authorities which has recently been published by the Department of Health[18].

Local Initiative

Leicestershire Royal Infirmary will extend out-patient services by establishing a family out-patients clinic to cater specifically for the needs of adults and their children affected by HIV.

Contact: Dr Rosemary Shannon, Consultant Paediatrician, Leicestershire Royal Infirmary. Tel. 0533-541414.

2.7.3 Services for people with symptomatic HIV disease or AIDS

There are a significant number of people with severe HIV infection who do not fulfil the current AIDS case definition, but nonetheless require similar services. Both groups of people may need access to a range of primary and community health services both statutory and non-statutory, local acute hospital services and services provided from specialist treatment centres over the course of their illness. Strong links and a high degree of liaison between all of these services are likely to lead to:

- better continuity of care for the patients concerned
- a higher quality of care
- more efficient use of resources.

2.7.4 Purchasing authorities should consider encouraging the development of shared care initiatives between primary, secondary and tertiary services and ensure that there is appropriate liaison and co-ordination of services for and with individuals between:

- hospital services locally and regionally
- primary health care services

- the local authority
- non-statutory agencies
- drug misuse services
- haemophilia services
- services providing respite or terminal care

as appropriate to the needs of each individual, respecting any expressed wishes about confidentiality and only involving other services if consent is given. Lessons learnt may provide models of care for other chronic diseases and vice versa.

2.7.5 *Services outside hospital*

Many people with symptomatic HIV disease or AIDS require only short spells of inpatient treatment. Because some may be socially isolated, living away from parents, friends or family, or feel unable to turn to them, a variety of support services are needed to care for them in the community. In addition, some may wish to spend their last months at home and this should be respected if at all possible. For those for whom this is inappropriate or no longer possible local non-institutional accommodation may also need to be available. There will be a need to develop a co-ordinated community approach including in and out patient units, community units, primary care, local authority services and non-statutory agencies. Sections 2.3.2 and 2.3.4 include information about the roles local authorities and voluntary organisations can play in developing a range of initiatives, including shared care. The types of services that may be required include:

Primary and Community Care:

- access to local GPs and dentists who offer a confidential and sympathetic service. Local GPs should be able to call on expert advice as necessary and be supported in any local shared care arrangements
- access to community nursing services which may be able to provide:
  - ~ regular visits
  - ~ nurses able to administer drugs and maintain IV lines
  - ~ 24 hour cover in an emergency or during the terminal phase
  - ~ a local clinical nurse specialist in HIV/AIDS
- access to local authority services which may be able to provide:
  - ~ home help and shopping

- meals on wheels
- a night sitting service in emergencies
- housing advice on adaptations, rehousing or homelessness.

Local Initiatives

North West Thames RHA are establishing two part time fellowships for GPs to assist in the development of local primary health care strategies for people living with HIV.

Contact: Dr W. Styles, Regional Adviser in General Practice, NWTRHA. Tel. 081-743 0367.

On behalf of NWTRHA, Ealing DHA are managing a three year research project aimed at supporting and developing the role of GPs in providing primary care for people with HIV and thus moving the focus of treatment and care away from the acute setting. The HIV consultants at Ealing Hospital Trust and Hammersmith Hospital are key players in this project.

Contact: Suzanne Smith, Project Director. Tel. 081-740 3193.

In Riverside, the Community Liaison Team aims to provide optimum care for patients and their carers following discharge into the community. This is achieved through effective discharge planning and subsequent communication with the primary care team and the utilisation of the appropriate health, social and voluntary services. This nursing and medical team is not a specialist team providing services direct to patients, but a specialist resource to primary carers, mainly GPs and district nurses, whose role is to promote the use of generic primary care services by patients with HIV disease.

Contact: Dr S. Mansfield, St. Stephen's Hospital, Kobler Centre, 369 Fulham Road, London SW10 9HT. Tel. 081-846 6161.

King's Healthcare have produced a leaflet for people with HIV entitled "Your Mouth and HIV". The leaflet was produced with the help of patients

at King's specialist Community Dental Service for people with HIV and University College Hospital. The project was funded by the HIV and GUM Care Group at King's.

Contact: Debbie Lewis, Community Dental Service, Myatt's Field Health Centre, Patmos Road, London SE9. Tel. 071- 582 6371.

In Leicestershire DHA patients can choose to undertake at home, with appropriate support, the administration of drugs required to combat HIV infection through a Hickman Line, a tube enabling drugs to be put directly into the bloodstream. The DHA plans to review its teaching packs on this to extend its use to children and will complete a series of client information packages on a variety of opportunistic infections and treatments.

Contact: Maggie Gamble, Clinical Nurse Specialist, HIV Community Unit, Tavers Hospital, Leicester. Tel. 0533-461948.

In Sheffield DHA, Community Liaison Nurses advice on discharge/ referral processes; they are supported by HIV Resource Nurses and an HIV Link Worker inter-agency network as well as by Health Visitor support to families affected by HIV.

Contact: Cheryl Few, Community and Priority Services Unit, Brunswick House, 299 Glossop Road, Sheffield S10 2HL. Tel. 0742-766444.

Liaison with hospital services and other professionals:

- back up hospital services with agreed protocols for liaison and discharge procedures
- liaison between professionals in meeting any additional needs, for example those arising from drug misuse, haemophilia or mental illness
- development of shared care between regional or national specialist centres, local hospitals and primary care.

Respite and Terminal Care:

- local statutory and non-statutory facilities may be able to provide respite care to people with HIV disease and their carers, for example:
  - ~ local hospices who have staff trained and willing to accept people with HIV disease for respite or terminal care
  - ~ local Macmillan nurses trained to provide appropriate care
  - ~ outreach teams from other local facilities – for example the London Lighthouse
  - ~ 'buddy' support networks from local voluntary organisations.

Services for Women and Children:

- a network of local childminders prepared to provide emergency or respite care during bouts of parental illness, as well as regular day care facilities
- childcare facilities for hospital attendances
- specialised local services as outlined in the recent Department of Health Guidance for Local Authorities on Children and HIV[18]
- arrangements for adoption and fostering.

Other services:

- advice on welfare rights, benefits and other financial matters such as debt management to enable individuals to retain economic independence, eg from social services, Citizens' Advice Bureaux
- advice on living wills and wills of testament and discussion of funeral arrangements
- counselling services including those for the infected person and their partners, families and friends and the bereaved
- sympathetic pastoral personnel or services willing to meet religious, spiritual and pastoral needs.

Local Initiative

Oxford RHA is undertaking a review of respite and terminal care provision in the Region with a view to recommendations for service developments using the full range of statutory and voluntary agencies.

Contact: Rowena Clayton, Oxford RHA. Tel. 0865-226736.

2.8 SETTING LOCAL TARGETS

2.8.1 As discussed in 2.1.4, no specific targets can currently be set for HIV. However, authorities may wish to consider setting realistic process targets which will contribute to the overall objectives. Such targets could include:

- in collaboration with other statutory and non-statutory agencies, agreeing within a specified time a joint sexual health strategy which takes account of existing or planned HIV prevention strategies
- developing or reviewing needs assessments for those groups identified within this strategy who may be at increased risk of HIV infection within an agreed period of time
- assessing the potential for and development of educational, outreach or detached work interventions within an agreed timescale for:
  - gay men
  - black and ethnic minorities
  - prostitutes and sex workers
  - young people
- contacting the relevant Local Education Authority officers to offer advice, assistance and, where sought, information on appropriate educational materials on an annual basis
- similarly establishing links with a range of organisations able to reach young people outside schools (eg youth groups, churches etc)
- reviewing sources of retail and free supplies of condoms on an annual basis
- reviewing staff skills and training needs on an annual basis.

POSSIBLE ACTION POINTS

Purchasers

having taken account of Department of Health Guidance on HIV/AIDS resource allocations, purchasers may wish to consider:

- reviewing and developing a local HIV strategy and appropriate services in conjunction with other statutory and non-statutory agencies
- an audit of current HIV prevention initiatives, paying particular attention to those groups who may be at increased risk
- supporting the provision of HIV education in schools and other educational settings
- establishing minimum quality standards for delivery of HIV services including clinic facilities (See Appendix 3)
- further support for HIV-related services to other statutory and voluntary agencies
- ensuring ease of access to local facilities for pre/post HIV test discussion and testing including the development of additional sites as necessary
- the recent Department of Health guidance on antenatal clinics in areas of higher prevalence offering voluntary HIV tests to women attending for care
- encouraging GUM and drug misuse services to offer voluntary tests to patients perceived to be at risk of HIV infection
- ensuring HIV positive drug users have access to the full range of HIV/AIDS services
- encouraging adoption of voluntary partner notification programmes at all facilities for HIV testing including GUM clinics
- developing local protocols for the provision of treatment and care services for those who test positive
- ensuring Community Care plans and services reflect needs of those with HIV/AIDS and include reference to Local Authority assessment and care management purchasing plans
- reviewing scope for enhancing surveillance data collection as a coincidental benefit of voluntary named testing programmes, especially where these are developed because of a higher local prevalence of HIV infection

- encouraging adoption of appropriate infection control guidelines at all facilities which undertake invasive procedures including GPs, dentists and private clinics
- continually reviewing the availability and suitability of health promotion/ education materials
- reviewing information and knowledge about local services
- an audit of local training needs for relevant professional staff
- support training needs of other agencies (eg schools, voluntary organisations)
- reviewing sources of free or retail condoms
- reviewing with all agencies available data on HIV.

Providers

may wish to consider:

- developing shared care policies and guidelines for care for the management of patients with HIV/AIDS in partnership with staff in other settings
- ensuring confidential pre-test discussions or counselling are available to all people seeking or being offered an HIV test
- training staff to offer such discussions or counselling and partner notification procedures as appropriate
- ensuring confidentiality of records
- designating a member of staff to ensure timely HIV/AIDS case returns to CDSC
- ensuring strict adherence to infection control guidelines at all times
- drawing up local protocols for the provision of treatment and care services
- identifying working relationships with other Departments or agencies and reviewing these on a regular basis
- identifying where supplies of condoms may be obtained
- encouraging staff working in HIV/AIDS services to be involved in advising on education and training to other health professionals, voluntary and local organisations as necessary
- ensuring the provision of a wide range of educational materials which are appropriate to the specific audiences and are sensitive to different cultural and linguistic needs

- ensuring all staff receive continual training, including a knowledge of the management of drug misuse
- undertaking a regular audit of services, including consumer surveys
- providing regular activity returns.

FHSAs and GPs

may wish to consider:

- ensuring the adequate provision of general practice and dental care for HIV positive people
- FHSAs encouraging GPs to undertake counselling and testing for HIV on request or if there are clinical indications as well as ensuring GPs are aware of where other services for HIV counselling and testing are available
- developing local shared care plans between the hospital services and primary care
- ensuring all GPs receive up to date information about HIV/AIDS, including opportunities for training.

CHAPTER 3

OTHER SEXUALLY TRANSMITTED DISEASES

OTHER SEXUALLY TRANSMITTED DISEASES

3.1 INTRODUCTION

3.1.1 This chapter contains additional information which will be helpful in meeting the target relating to the reduction in gonorrhoea and should be read in conjunction with Chapter 1.

3.1.2 The Health of the Nation set the following target and objectives for Sexually Transmitted Diseases:

TARGET

To reduce the incidence of gonorrhoea among men and women aged 15-64 by at least 20% by 1995

(from 61 new cases per 100,000 population in 1990 to no more than 49 new cases per 100,000)

GENERAL OBJECTIVES

To reduce the incidence of sexually transmitted diseases

To provide effective services for diagnosis and treatment of STDs

To develop further and strengthen monitoring and surveillance

3.1.3 Reports of gonorrhoea (GC) and syphilis had been steadily decreasing until 1989, since which time there has been a rise in reports of rectal gonorrhoea, particularly in younger men. Syphilis, however, continues to decline. Reports of non-specific genital infections (including chlamydia) peaked in 1986 and have tended to decrease since then whilst reports of pelvic inflammatory disease (PID) are still increasing. Among viral sexually transmitted diseases (STDs), reports of herpes simplex continue to increase, whilst wart virus infections are showing signs of reaching a plateau.

3.1.4 Apart from education about their primary prevention, the early diagnosis and treatment of STDs plays an important part in reducing their incidence by shortening the time during which people can pass on infection to others. Prompt treatment also reduces the likelihood of long term ill effects.

3.1.5 The target for reducing gonorrhoea should not be regarded as an end in itself, nor simply as a proxy for HIV transmission. A continued reduction in the number of cases of gonorrhoea should also be accompanied by a reduction in the incidence of other STDs. Good quality surveillance data is essential for the accurate monitoring of trends.

3.1.6 The recent preliminary report of the National Survey of Sexual Attitudes and Lifestyles[8] highlights the central role Genito-urinary Medicine (GUM) clinics play in promoting sexual health. The findings showed that a high proportion of those with multiple sexual partners reports GUM clinic attendance. More specifically:

- more than one in seven of those with five or more heterosexual partners in the past five years had attended in that time
- more than one in five of those reporting ten or more partners since becoming sexually active had ever attended
- more than half of men with five or more homosexual partners in the past five years had attended in the same period.

3.2. DEVELOPING A LOCAL PROFILE

3.2.1 Data collected by local GUM clinics may not reflect the true local incidence of STDs because people do not always attend their local clinic, they may move from clinic to clinic, and some are treated by GPs without referral to a GUM clinic. Ideally the following further information should be available, or collected if resources permit:

- the proportion of those attending the local GUM clinic who are resident in the district
- the other clinics local residents may attend. Ease of travel (road, rail, buses) and commuting patterns may be important in identifying these
- if possible, the extent to which local GPs see and treat patients without referral to a GUM clinic.

3.2.2 It may also be helpful to supplement GUM clinic data with local data from other sources, eg consultations for PID and subfertility, gonorrhoea or other STDs in general practice and family planning or gynaecology clinics. Local HIV seroprevalence studies may also prove helpful.

3.2.3 Information about clients attending the local GUM clinic may help to identify specific at risk populations in the community, particularly those not in contact with other services. Information on the age, sex, sexual preference and ethnic group of clinic attenders may be available.

3.2.4 There may also be other specific features of the local population, for example large numbers of young people in the area, perhaps due to tourism or because of higher education facilities. Special local features which may historically be associated with populations at increased risk of STDs include seaports, holiday camps, summer schools, and military barracks.

Local Initiatives

Linked with the development of the South West Thames RHA's Research and Development programme has been the development of an STD surveillance database which should be operational by early summer 1993. **Contact:** Dr Helen Maguire, St George's Hospital. Tel. 081-672 9944 ext 56256.

In Brighton the Principal Clinical Psychologist for HIV/AIDS has conducted a sexual beliefs and attitudes study with GUM attenders to examine the correlation between beliefs and risk behaviour in relation to HIV/AIDS. This information will enable preventive work with GUM attenders to be targeted more effectively.
Contact: Wendy Moreton, Commissioning Manager, Directorate of Public Health, Brighton Health Authority. Tel. 0273 696011.

See Appendix 1 for possible sources of information.

3.3 IDENTIFYING AVAILABLE INTERVENTIONS

3.3.1 Health education and promotion

There is scope for further strengthening local education and prevention initiatives, not only as part of the overall promotion of good sexual health but also specifically

for sexually transmitted diseases. A wide variety of leaflets should be available in local facilities such as chemists as well as clinic or GPs' waiting areas, and these should also be given to patients during the consultation.

3.3.2 Publications, including the range produced by the Health Education Authority (HEA) are available from District Health Promotion Units. They include:

- general guides to the common STDs, which include a brief description of the causative organisms, safer sex, symptoms, treatment, and where to go for advice and treatment. For example the HEA leaflet "Guide to a healthy sex life"[19]
- disease specific information for those newly diagnosed which also include advice on sexual practice during and after treatment, and on informing partners about infection. For example HEA leaflets "Gonorrhoea", "Genital warts", "Chlamydia and NSU", "Vaginal infections", "Herpes", "Thrush" and "Cystitis". The HEA also produce a poster advertising the availability of these leaflets[19].

3.3.3 Services for diagnosis and treatment

Services for the resident population will be provided by local clinics, local outreach work or by clinics in adjacent districts or towns for the reasons identified in 3.2.1. The self-referral nature of GUM services also means that local clinics may be seeing people not resident in the district.

3.3.4 In reviewing the services provided by the local clinic it will be helpful to:

- review the implementation of the Report of the Working Group to examine workloads in genito-urinary medicine clinics, more commonly known as the Monks report[20]
- review current services against the clinic suggestions in Appendix 3
- check clinic standards against those set in the Building Note "Genito-Urinary Medicine Clinics"[21].

3.3.5 Role of General Practitioners

Many patients will consult their GP first about symptoms of STDs. Research shows that young heterosexual men in particular tend to do this rather than going immediately to the GUM clinic. All GPs should have regular updated information on

the range of GUM services in the locality plus posters and leaflets to display in their waiting rooms.

3.3.6 A few GPs may undertake some sessions in local GUM clinics or have had previous experience in the treatment of STDs. Local level discussions between GUM specialists and GPs should be encouraged with a view to promoting training and further education for GPs and to establish local guidelines on the diagnosis and treatment of STDs. GPs may need access to expert advice about partner notification from the local GUM clinic staff for any infected patients who are unable or unwilling to attend a clinic.

Local Initiative

In Croydon GPs are being offered training on a regular basis in GUM clinics, and in other districts such as Worthing, GP clinical assistants are working in GUM clinics.

Contact: Croydon: Maggie Davies. Tel. 081-680 2008.
Worthing: Billie Dawson. Tel. 0903 502566.

3.3.7 If possible, GPs should be given supplies of free starter packs of condoms. EL(92)18[22] refers to the provision of condoms to GPs. They should also be informed of where they can obtain regular supplies of health education leaflets for practice waiting rooms.

3.3.8 Family planning clinics

Family planning clinics are also well placed to provide advice about safer sex and STDs, and to refer people to GUM clinics. Good cross referral arrangements need to exist between the local facilities with cross training or staff experience where appropriate.

3.4 SETTING LOCAL TARGETS

3.4.1 The Department of Health will be publishing a discussion document on the setting of local targets in early 1993. However, in setting a local target for gonorrhoea it may

be helpful to establish a regional target first and then look at each clinic's contribution to it in the light of local clinic attendances.

3.4.2 Currently the overall reports of gonorrhoea are falling and if this national trend continues there may be a 20% decrease by 1995. If this remains the case then more challenging targets should be considered, for example by superimposing a 20% reduction on the national trend.

3.4.3 In projecting current trends, demographic changes will need to be taken into consideration. For example, if there is a decrease in the number of young adults aged 20-34, the peak ages for STDs, then this will tend to reduce the number of STDs reported, including gonorrhoea.

3.4.4 Target setting may be unrealistic in clinics which treat very few patients with gonorrhoea. It may be impossible to achieve a decrease in cases where the number of cases seen is small and when year on year fluctuations may conceal any reduction achieved. Areas in which such clinics are located may not necessarily have a low incidence of gonorrhoea as patients may go elsewhere for treatment, yet may see a larger number of patients with other STDs such as chlamydia and wart virus infection. Consideration could therefore be given to setting a target for one of these more common infections as a marker for improved sexual health.

3.4.5 *Supplementary local targets for monitoring effectiveness of prevention strategies*

The target setting described above recognises that local GUM clinic figures may give a poor indication of the success of local STD prevention strategies. Data which may reflect local trends more faithfully may come from gonorrhoea and chlamydia screening if undertaken in local family planning or gynaecology clinics. It may also be instructive to monitor these strategies using data on other markers such as hepatitis B and pelvic inflammatory disease (PID) from other sources, although none of them should be taken in isolation. The relatively low incidence of hepatitis B, the fact that many cases are asymptomatic and the availability of an effective vaccine may reduce its usefulness as a marker. Similarly PID may not present for many years until it manifests itself as infertility.

3.5 DEVELOPING A LOCAL STRATEGY

3.5.1 In addition to the general health education and promotion suggestions in Chapter 1 and 3.3.1, other possible actions to consider include:

- reviewing service provision as suggested in 3.3
- ensuring appropriate protocols exist for partner notification for gonorrhoea, syphilis, chlamydia and other STDs as appropriate, and monitoring this by:
  - the proportion of partners notified attending within seven days
  - the proportion of these found to be infected
- ensuring timely returns of STD data to enable more accurate surveillance of trends
- discussing the option of an HIV test with all patients with a perceived risk of infection
- strengthening management structures and establishing clear managerial and professional lines of accountability, including those of nursing staff and health advisors
- reviewing job descriptions and roles within clinics to optimise the use of trained staff and avoid unnecessary duplication
- involving GUM staff in decisions about priorities and resources
- considering further training and career development for all clinic staff
- introducing audit and regular evaluation, including client surveys
- updating the information systems used by GUM clinics
- fostering links with other hospital services, both in-patient and out-patient
- fostering community links so that staff expertise can be used for health education and promotion and for partner notification in settings outside the GUM clinic
- ensuring local GPs, family planning clinics, obstetric and gynaecology services and drug misuse clinics have access to specialist advice from GUM clinics and are kept informed of how and where this can be obtained
- offering specialised assistance with partner notification to patients diagnosed outside the GUM clinic.

Local Initiatives

In Northern Region some GUM clinics play a part in multidisciplinary training programmes and give talks to community groups. The staff in one clinic were involved in an education programme designed for people in custody at the local young offenders institution.

Contact: Dr. Nichol Black, Regional HIV Co-ordinator, Northern Regional Health Authority, Benfield Road, Newcastle upon Tyne NE6 4PY. Tel. 091-224 6222.

In North Derbyshire parties of youth trainees and school and college students are encouraged to visit the GUM Department where they are shown round and participate in sexual health promotion discussions.

Contact: Rosanne Brown, Health Promotion Department, North Derbyshire Health Authority. Tel. 0246-31255.

3.6 MONITORING PROGRESS

The target for reduction in gonorrhoea is set for 1995 but the timetable for process targets should be reviewed prior to this. By March 1991, RHAs were required to have agreed a three year strategy with DHAs for the implementation of the recommendations of the Monks Report. If further strategies in service provision are set for 1994, they could be considered when the full three year strategy is reviewed.

POSSIBLE ACTION POINTS

Purchasers

may wish to consider:

- when commissioning GUM services:
  - ~ that the recommendations of the Monks report have been considered.[20]
  - ~ the suggestions for clinics in Appendix 3.
  - ~ clinics should be easily accessible by public transport, and well signposted
  - ~ opening hours should suit patients – possibly one late night and/or weekend session
  - ~ the physical surroundings should be hospitable and not deter patients from attending
  - ~ a full range of counselling and testing services for STDs and HIV should be provided
  - ~ partner notification protocols should be agreed and identified
  - ~ the need for regular audit.

Providers

may wish to consider:

- ensuring all patients have access to the full range of STD diagnosis and treatment services
- ensuring local protocols for partner notification have been agreed
- sexual health advice is offered pro-actively
- acting as a resource for further training for GPs, family planning clinic staff and other health care professionals
- offering HIV counselling and testing to patients who may have been at risk
- ensuring staff receive ongoing training and have a working knowledge of the principles of drug misuse and family planning
- providing condoms if available
- providing a wide range of health education and promotion material, both in the waiting room and during consultations
- providing access to a health advisor
- providing access to both male and female doctors if possible

- ensuring access to inpatient services if required
- providing outreach services if required.

FHSAs and GPs

- GPs should have up to date information about the range of local GUM services including clinic opening times and phone numbers
- GPs should have access to a wide range of health promotion material for display in the waiting rooms
- Some districts are providing GPs with free starter packs of condoms
- GPs should have easy access to laboratory facilities and advice from GUM specialists.

CHAPTER 4

DRUG MISUSE

DRUG MISUSE

4.1 INTRODUCTION

4.1.1 This chapter contains additional information which will be helpful in meeting the target and overall objectives relating to drug misuse and HIV. It should be read in conjunction with Chapter 1 and the relevant appendices.

4.1.2 The Health of the Nation set the following target and objective:

TARGET

To reduce the percentage of injecting drug misusers who report sharing injecting equipment in the previous four weeks by at least 50% by 1997, and by at least a further 50% by the year 2000 (from 20% in 1990 to no more than 10% by 1997, and no more than 5% by the year 2000)

OVERALL OBJECTIVE

To reduce the incidence of HIV infection

4.1.3 The overall objective is to reduce the incidence of HIV transmission and the target sets specific reductions in the number of drug misusers who share injecting equipment to achieve this end. However drug misuse prevention also contributes more broadly to HIV prevention, and any strategies targeted at drug misusers must be seen as part of an overall HIV and sexual health strategy.

4.1.4 The preliminary results of the National Survey of Sexual Attitudes and Lifestyles[8] show that less than 1% of the population reported having injected drugs (other than those medically prescribed) in the last five years – a total of roughly 100,000 in England and Wales. More than half these reported sharing equipment.

4.1.5 Drug misusers who share equipment are at high risk of contracting HIV. The containment of the spread of HIV among drug misusers has, to date, been partially successful in England where it is estimated that 1-5% of injecting drug misusers have become infected. Available evidence indicates that there have already been changes in drug using behaviour as a result of HIV, particularly following the expansion of services providing advice and counselling and the introduction of needle exchange schemes. However there is scope for these to be developed and strengthened further.

4.1.6 Strategies to reduce the incidence of HIV among drug misusers who can transmit the virus should aim to reduce:

- the sharing of contaminated syringes and other injecting equipment
- unprotected sexual intercourse.

These strategies are also likely to reduce the incidence of Hepatitis B (HBV), which is transmitted by the same routes.

4.1.7 Purchasers and providers need to develop combined strategies to ensure a broad range of health service and local community responses to the sexual and drug risk taking behaviour and health care needs of drug misusers.

4.1.8 Drugs services should aim to:

- prevent people from starting injecting drugs
- encourage the cessation of drug use, especially injecting drug use and use of substances that are likely to be injected
- minimise the harm to those who continue to inject drugs, through access to needle and syringe exchange and disinfectant materials
- minimise the risk of drug misusers contracting or transmitting HIV and HBV through unprotected sexual intercourse.

4.1.9 One of the primary goals of drug services should be the prevention of the spread of HIV among drug misusers. A local strategy for HIV prevention should therefore include all drug misusers in the community. This will include targeting those drug injectors, including those currently injecting, smoking or inhaling amphetamine and cocaine, who appear to have had limited service contact to date. Particular attention also needs to be paid to those drug misusers who are not currently in contact with services and others who may have particular needs, such as women and black and ethnic minority groups.

Local Initiative

Nottingham DHA's Department of Public Health Medicine has completed a study designed to ascertain the prevalence of steroid misuse in the city and to identify gaps in service delivery.

Contact: Mr Ira Unell, Senior social worker, Mapperley Hospital, Porchester Road, Nottingham. Tel. 0602-691 300.

4.2 DEVELOPING A LOCAL PROFILE

4.2.1 Developing a clear picture of the range and nature of the local drug problem is central to developing an appropriate local strategy.

See Appendix 1 for possible sources of information.

4.2.2 It is also helpful if possible to identify the local at risk population by more specific groups, eg:

- the dependent misuser (the addict)
- the injecting drug misuser
- the non-dependent or episodic misuser
- the non-injecting drug misuser

Local Initiatives

Frischer et al in Glasgow collected identifier information on all drug misusers who had contact with a range of social, health and criminal justice agencies over a defined period of time. Using a capture recapture method they estimated a drug injector prevalence for Glasgow of 29 per 1000 in the 20-24 year old age group; in males aged 20-24 the rate is estimated to be 43 per 1,000[23].

The North West Thames Regional Health Authority has compiled a report "Drugs: The State of the Region". This report provides an invaluable guide to the range of sources of information on drug misuse data within the region. It particularly highlights the importance of identifying all local research in this area.

Contact: Centre for Research on Drugs and Health Behaviour, 200 Seagrave Road, London SW6 1RQ. Tel. 081-846 6565.

4.2.3 In clarifying what services are available locally, consideration needs to be given to those available in primary, community and secondary care. Most drug services typically straddle health and social services, and may also exist in either the statutory or non-statutory sector or a combination of both. District-level services for drug takers are generally categorised under five broad areas:

- education and prevention
- management of physical complications
- counselling
- withdrawal
- longer term treatment plans.

Local Initiative

Community Drug Project, a voluntary street agency, with support from the local FHSA provide a well users clinic where a primary care physician provides advice and treatment to drug users as well as contraceptive and gynaecological advice. This service specifically excludes prescribing for the treatment of drug dependence.

Contact: Mr D Tweedy, Co-ordinator, CDP, 30 Manor Place, London SE17 3BB. Tel. 071-703 0559.

4.3 DEVELOPING LOCAL ALLIANCES AND SEEKING LOCAL VIEWS

4.3.1 Local views should be sought in helping to establish priorities and planning local strategies. Local participants could include service providers, both statutory and non-statutory and local criminal justice agencies who can also provide valuable information on local activities.

4.3.2 Stronger alliances should be developed within the health service and between drug services and HIV and STD services. In many areas the District Drug Advisory Committee performs the co-ordinating role. Community based groups and other voluntary agencies need to be linked into such services together with the police, probation services and social services. In the broader educational and preventive approach full use of educational, social services and primary care services are key parts of a powerful local network. Also Social Service Departments, in drawing up Community Care plans, have a responsibility to assess the overall needs of the local population and will be key participants in any alliance due to their overall responsibility for care in the community.

See Appendix 2 for possible suggestions.

4.3.3 It may also be possible to obtain the views of past, present and possible future service users and to determine whether they are able to communicate their concerns directly

to purchasers and providers. A communications strategy may be helpful in ensuring that the views of these groups are considered in service planning, particularly with respect to access to clinics etc.

4.4 IDENTIFYING AVAILABLE INTERVENTIONS

4.4.1 The report on prevention from the Advisory Council on the Misuse of Drugs[24] identifies two goals: preventing drug use in the first instance, and reducing the harm of such drug use as occurs.

4.4.2 Health Education and Promotion

The twin aims of local education and promotion initiatives are:

- to encourage people, and in particular young people, not to start using drugs in the first place, but if they do so not to inject
- to encourage those who use drugs to stop or to seek harm reduction advice including not sharing needles or syringes.

4.4.3 Initiatives to encourage young people not to use drugs include:

- broad based educational programmes
- where possible taking more specific programmes to both formal education settings, for example local schools and colleges of further education, and to settings where young people meet out of school
- increasing parental awareness of drug misuse eg through Parent/Teacher Groups
- targeted local health educational campaigns for specific audiences, examples of which can be found in Appendix 4.

4.4.4 Examples of initiatives aimed at those already using drugs, including those who do not use the local services, include:

- targeted, innovative campaigns aimed at:
  - ~ those in contact with services
  - ~ those who are not in contact with services (where risk taking behaviour and the sharing of injecting equipment may be higher)
- Outreach work with hard to reach populations, eg:
  - ~ injecting drug users including steroid and amphetamine injectors

- ~ sex workers with associated drug use
- ~ ethnic minority populations including those of other European member states with high reported levels of HIV seroprevalence among injecting drug users
- ~ the drug using prison population including sentenced and remand prisoners and other residential settings
- ~ the under age drug user/injector
- ~ the gay drug user/injector.

4.4.5 To date attention has tended to be focused on people who frequently and indiscriminately share drug injecting equipment, which is now probably a minority activity. Drug misusers who inject less frequently contribute the largest proportion of overall injectors and thus the largest proportion of those at risk. Providers should therefore:

- sustain and develop further initiatives among those who share frequently
- aim to develop activities targeted at those who share less frequently but may constitute a larger overall at risk population.

Local Initiatives

The Lifeline project in Manchester has developed a comic style booklet "Smack in the Eye" targeted at injecting drug misusers.

Contact: Lifeline, 101-108 Oldham Street, Manchester M4 1LW. Tel. 061-839 2054.

In Newcastle a specific service has been developed to address the needs of the young (under 18) drug user.

Contact: Dr Alish Gilvarry, Plummer Court, Cerliol Place, Newcastle Upon Tyne NE1 6UR. Tel. 091-230 1300.

4.4.6 Any strategy must also recognise that HIV infection acquired through contaminated injecting equipment can also be transmitted by unprotected sexual intercourse and that drug misusers may also acquire or transmit the infection through this route. At

present safer sex counselling and education on a routine basis remains a minority activity within drug services.

4.4.7 Therefore local strategies should also aim to:

- increase and sustain the level of knowledge about the risks of unprotected sex and encourage behavioural change
- ensure that all people in contact with drug services receive appropriate advice on safer sexual practices
- increase the level of condom usage among the drug injecting population
- identify routes of access to local family planning, GUM and HIV and primary care services for drug misusers, and disseminate such information to providers and people seeking such services.

4.4.8 Service Provision

Services for advice, treatment and care can be provided by:

- specialist services
- general NHS/Trust in or out patient services
- primary and community care, including social services.

4.4.9 A variety of specialist drug services may be provided by the local health authority, social services and other statutory agencies as well as the voluntary sector. They include:

- needle and syringe exchange programmes where advice on safer injecting and the provision of sterile injecting equipment and cleaning agents is readily available. These may also be pharmacy or peer-based and should ideally be managed separately from the drug prescribing services. Such schemes play a key role in attaining the target of reducing the number of users sharing injecting equipment
- community or voluntary-based agencies offering general support and advice
- outreach programmes for hard to reach drug users including strategically placed information, for example in phone booths for street workers
- specialist services and clinics providing access to detoxification programmes or methadone maintenance as strategies to maintain behavioural change.

Methadone prescribing plays an important role in reducing the frequency of injecting and sharing amongst dependent drug users

- those specialised HIV services which are also able to provide the broad range of care for HIV positive drug misusers
- services specifically addressed to the needs of the HIV positive drug user with adequate provision of medical care, good liaison with HIV services ensuring adequate monitoring of general health and HIV progression and appropriate support for partner with counselling on safer sexual practice.

Local Initiatives

South East London Commissioning Agency (SELCA) has supported the development of a methadone maintenance programme in the Maudsley Hospital where an MRC funded research programme will evaluate the impact of methadone prescribing on risk taking behaviour.

Contact: Dr John Strang, National Addiction Centre, Institute of Psychiatry, 4 Windsor Walk, London SE5 8AF.

The Griffin Project. A residential service providing respite care for symptomatic HIV positive drug misusers with links to community based home support services.

Contact: Mr E Kelleran, The Griffin Project, Turning Point (see List of useful organisations for address)

Two major research projects have been carried out in Sheffield on drugs and HIV. The findings of the first (on effectiveness of the Needle/Syringe Exchange Scheme) were contained in a publication printed in 1990 and the second (on the development of HIV outreach work with drug injectors in the city) will be available in early 1993.

Contact: Jo Adams, Sheffield Centre for HIV and Sexual Health, 22 Collegiate Crescent, Sheffield S10 2BA. Tel. 0742-678806.

4.4.10 Other in or out patient services who may also see and treat drug misusers include:

- local Accident and Emergency Departments
- general medical services
- psychiatric services
- obstetrics and gynaecology.

Where possible joint local strategies should be agreed with clear lines of referral to other departments or specialist services where appropriate.

4.4.11 Residential services can provide short or long stay treatment for individuals where community based interventions have been unable to provide adequate support. From April 1993 local authorities will be responsible for assessing the needs of people in residential care and for meeting the costs and collecting a means tested contribution from clients if appropriate.

4.4.12 All drug misusers should have access to general medical and dental care. The primary health care services offer an important source of information and education on health promotion and harm reduction activity, safer sex and family planning services. In addition Community Drug Teams form a bridge between specialist drug services and other services particularly where general practitioners work closely with such teams.

Local Initiative

In Wirral a primary care drug team is funded by the FHSA.

Contact: Mr S Dalton, Administrative Director, St Catherine's Hospital, Church Road, Birkenhead, Wirral L42 0LQ. Tel. 051-678 5111 ext 3415.

The Department of Health has published "Drug Misuse and Dependence. Guidelines on Clinical Management"[25]. These guidelines were written for the generalist doctor and provide guidance on the management of the problem drug user.

4.5 SETTING LOCAL TARGETS

4.5.1 It is important that purchasers set realistic interim targets for the reduction of needle sharing that can actually be monitored. The Department of Health will be publishing a discussion document on local targets in 1993.

4.5.2 The progress towards achieving the specific Health of the Nation injecting target should ideally be monitored for clients in contact with services and drug injectors not in contact with services. For the latter group national demonstration projects are being considered to identify methods of achieving this. Monitoring may need to be developed in a range of settings, for example in:

- NHS/Trust hospital services
- GUM services
- Primary Health Care
- Drug Advice and Treatment Agencies
- Needle Exchange Programmes
- Community Pharmacies.

4.5.3 Stimson et al[26] have described the development of needle exchange monitoring. This has included provision of information from routine demographic and drug taking data collected from the individuals attending these schemes, as well as a provisional activity analysis (for example giving figures on the numbers of returns per attendance, and the proportion of subjects who attend for second, third and subsequent occasions). They have also described how some of the functions of needle and syringe provision, collection and concurrent health promotion may be provided by adaptation of the service historically delivered by pharmacists.

4.5.4 Drug Misuse Services and needle exchange programmes may be able to monitor the risk taking behaviour of their clients on a regular basis as a valuable audit tool to assess what interventions are required in the face of present levels of injecting and sharing behaviour of their client group. A number of instruments have been developed. One such instrument is the DIRQ (Drug Injecting Risk Questionnaire). Contact Dr M Gessop, National Addiction Centre, Institute of Psychiatry, 4 Windsor Walk, London SE5 8AF.

4.5.5 The nature of some of the brief contacts in needle exchange and in community pharmacies might make such monitoring difficult. Methods for structured sampling of these more transient populations may need to be considered.

4.6 DEVELOPING A LOCAL STRATEGY

4.6.1 The preceding sections have identified a wide variety of possible local initiatives which are summarised in the possible action lists at the end of this section. In developing a local strategy purchasers, with the help of local alliances, may wish to consider whether:

- the current services are accessible to a broad enough population
- there are gaps or duplication in service provision
- there are particular populations who are under-represented in service take-up
- there is adequate targeting of the population taking into account demographic and drug using variables
- primary care services are involved in the provision of health care to drug misusers – particularly in areas with clearly identified high prevalence of problem drug misuse
- the profile of clients attending drug services approximate to the pattern of problem drug misuse as indicated from available local needs assessments.

In drawing up such strategies both providers and their clients need to be aware of the type of drugs likely to be injected and which drugs, via which routes, can lead to dependence.

4.6.2 A number of Regions have developed minimum service frameworks for guidance on district purchasing of drug services, for example the North East Thames Regional Health Authority – contact Ms J Batliwala, Regional Drugs Co-ordinator, NETRHA.

4.6.3 The Health Education Authority have produced a book of guidance for District HIV Prevention Co-ordinators. The chapter on prevention of HIV among drug users provides a comprehensive review of drug prevention and treatment strategies[27].

4.6.4 In addition the reports of the Advisory Council on the Misuse of Drugs; AIDS and Drug Misuse I (1988) and II (1989)[28] provide further recommendations. An updated report will be published in 1993.

POSSIBLE ACTION POINTS

Purchasers

may wish to consider:

- commissioning general and targeted education and prevention campaigns
- commissioning a comprehensive mixture of drug services including, in conjunction with the FHSA, needle exchange or pharmacy based exchange schemes
- developing specific outreach services targeted at those at risk who do not take up use of service
- placing contracts which specify that safer sex counselling and sex education should be available to drug misusers in touch with local services
- ensuring local availability of sterile injecting equipment and information on methods to clean contaminated equipment and facilities for safe disposal in liaison with the FHSA
- providing support and advice services for families and partners of those affected by problem drug use
- ensuring providers have established local protocols for the management of drug misusing patients with local GPs
- ensuring providers have good working links with a range of local agencies and health care services dealing with HIV, family planning, psychiatry etc
- commissioning outreach and information services aimed at client groups not in touch with services or those who have difficulties in accessing them.

Providers

may wish to consider:

- ensuring that injecting drug misusers have open access to a full range of drug misuse services, including advice on risk reduction and harm minimisation, access to clean injecting equipment and detoxification and other substitute prescribing programmes
- in collaboration with other agencies, provide outreach and information services for drug users, particularly those reluctant to use the statutory services. The aim should be to discourage recruitment into injecting in the first place, to

facilitate the cessation of injecting, and to promote the adoption of safer injecting practices

- providing ongoing education and training for GPs, and developing joint protocols for treatment and care
- establishing clear communication links with GPs to provide advice etc
- providing regular and opportunistic advice and information on safer sex to all clients, together with supplies of condoms if available
- offering Hepatitis B testing and vaccination if appropriate
- offering HIV counselling and testing if appropriate facilities are available
- providing, in collaboration with other agencies, outreach and information services for drug misusers, particularly those reluctant to use the current services
- widely publicising these services
- ensuring all staff are appropriately trained, and receive continuing training including the delivery of safer sex advice
- encouraging their staff to be involved in the provision of training about drug misuse for professionals working in health care and other settings
- in collaboration with health promotion officers and other agencies, encouraging their staff to be involved in the provision of information and education about drug misuse in educational establishments, workplaces and other settings
- ensuring all staff adhere to the appropriate infection control policies and have procedures for minimising and handling the risk of needle stick injuries
- together with purchasers developing agreed policies and guidelines and regularly monitoring and evaluating the services provided.

FHSAs and GPs

may wish to consider:

- participating in the development of guidelines and joint protocols with the specialist services for the provision of shared care for drug misusers
- working with DHAs to facilitate the setting up of needle/syringe exchange schemes in pharmacies and other primary health care settings

- encouraging local practices to display appropriate drug related education material and information about local services
- providing updated information on the counselling and management of drug misusers
- ensuring a full range of general medical and dental services are available to local drug misusers.

CHAPTER 5

FAMILY PLANNING

FAMILY PLANNING

5.1 INTRODUCTION

5.1.1 This chapter contains additional information which will be helpful in meeting the target and objectives relating to family planning, including information on the provision of services and education to young people. It should be read in conjunction with Chapter 1.

5.1.2 The Health of the Nation set the following target and general objectives:

TARGET

To reduce the rate of conceptions amongst the under 16s by at least 50% by the year 2000 (from 9.5 per 1,000 girls aged 13-15 in 1989 to no more than 4.8)

GENERAL OBJECTIVES

To reduce the number of unwanted pregnancies

To ensure the provision of effective family planning services for those people who want them

5.1.3 Planned parenthood provides benefits for the health of individuals, families and communities. Family planning services aim to promote this by providing access to contraception, sterilisation and advice on unplanned pregnancy. Additionally, education, counselling and health promotion can enable prospective parents to choose healthy lifestyles and increase the chances that their children will be wanted and healthy. Delaying and spacing pregnancies and limiting family size contributes to the physical and mental health of mothers and children and general family well-being. The effective use of condoms or other barrier methods of contraception also promotes sexual health by giving protection against sexually-transmitted diseases.

5.1.4 Purchasers should be aware of the potential of family planning services to improve health by the prevention of unplanned pregnancies and by other health promotion strategies and should work with all the appropriate agencies to ensure that services available to local people are complementary and meet identified needs.

5.1.5 Women who work outside the home or who are in full-time education may need services close to the workplace or outside normal working hours which may not necessarily be in their own district. Funding arrangements should recognise that family planning is a self-referral service.

5.1.6 Young people may need separate, less formal arrangements (see Section 5.8). Older women may need advice on the menopause. Domiciliary services can help to meet the needs of ethnic minorities (who may also need interpreting facilities), clients with physical disability, mental illness or learning difficulties, and those living in situations where there is social and family stress. Outreach services may be needed for special groups such as drug-misusers, prostitutes, the homeless, or women in refuges or residential care. Trained family planning doctors may have a useful role in services provided for the victims of sexual abuse and assault. Men and women who do not require contraception may attend local clinics to seek advice on HIV, STDs or other matters of concern.

5.2 DEVELOPING A LOCAL PROFILE

5.2.1 Local epidemiologically-based needs assessment, primarily for women in the reproductive age group 15-44, should be used to plan family planning services which are complementary, culturally sensitive, and adequate for the local population including those with special needs.

Appendix 1 contains a general and specific list of information in this area.

5.3. SEEKING LOCAL VIEWS AND DEVELOPING HEALTHY ALLIANCES

5.3.1 Some Districts have set up inter-agency family planning policy groups which are proving helpful in coordinating services and developing new initiatives. Suggestions for possible participants can be found in Appendix 2, and the following may be particularly useful sources of help in designing services for young people:

- school nurses
- local voluntary organisations eg Brook Advisory Centres

- social service officers concerned with:
  - ~ statutory responsibility for child's protection
  - ~ early teenage mothers and girls in care
- Local Education Authority, including health education co-ordinators, school governors, teachers, and parents, including parents from different cultural backgrounds
- youth services:
  - ~ those involved in pastoral care in:
    schools
    further education
    custodial settings.

Local Initiative

South Lincolnshire have sought to inform their family planning services for young people by carrying out interview-based research with 300 16-19 year olds on sexual health needs including contraception services and advice. Results will form part of a major review and will assist in planning adolescent health services throughout the District.

Contact: Mr I Harkess, Director of Health Promotion, South Lincolnshire DHA. Eastgate, Sleaford, Lincs NG34 7EB. Tel. 0529-414166.

5.3.2 There are advantages if such family planning policy groups are led by a consultant in family planning or a senior clinical medical officer who can lead and co-ordinate the provision of family planning, sterilisation and related services. They should also include local GPs.

5.3.3 Close links with departments of obstetrics and gynaecology are essential in order to provide co-ordinated services, including colposcopy, fertility and sterilisation, as well as services for the assessment and management of unplanned pregnancy. Where there are medical schools and postgraduate centres, academic links should also be fostered in order to provide undergraduate and postgraduate teaching in family planning. Links with colleges of nursing are needed to ensure family planning training for nurses.

5.4. IDENTIFYING AVAILABLE INTERVENTIONS

5.4.1 Intervention by family planning services may include primary prevention of unwanted pregnancy by contraception and sterilisation; secondary prevention after unprotected sexual intercourse by emergency contraceptive methods (hormonal and the IUD) and tertiary prevention by the provision of advice and counselling on unplanned pregnancy. Emergency contraception and information about where it can be obtained should always be available, ideally from family planning clinic doctors and GPs. Hospital Accident and Emergency Departments may wish to develop protocols in conjunction with family planning services and local GPs to include this in the range of services which they provide. Family planning doctors and nurses should be trained to work in assessment clinics for patients who seek advice after becoming pregnant in order to ensure that advice and information on future contraceptive needs is also given.

5.4.2 Clients who choose condoms as a primary method of birth control or as an additional precaution against infection should be provided with reasonable supplies or starter packs in order to reinforce the message that protection depends upon consistent use.

Local Initiatives

Barking and Havering FHSA and Havering and Brentwood DHA have been working jointly to purchase primary and community care as part of a Unified Commissioning Project (UCP). As a result of a comprehensive review of contraceptive services, areas were identified for contracting out these services to a variety of providers, including a young person's clinic and health advice clinics in secondary schools. The FHSA will supply copies of the "Review of Contraceptive Services in Barking and Havering" and the "Contraceptive Services Specification" on request.

Contact: Fedelma Winkler, Director of Service Planning, St George's Hospital, Hornchurch, Essex. Tel. 0708-472011.

West Berkshire DHA has produced special family planning packs for men and women which are used for discussion on the whole range of family planning options. The project is evaluated through users' feedback. By the end of the 1992/93 academic year, the health authority hopes to have received substantial feedback for evaluation.

Contact: Ann Wylie, SHEO, West Berkshire DHA. Tel. 0734-586161.

5.5 SETTING LOCAL TARGETS

5.5.1 Any local process targets should be jointly set and monitored between DHAs and FHSAs. These may be monitored in part by the routine collection of Korner data from community or hospital clinics (eg KT31). Similar information may also be available from FHSAs and GPs or through local surveys. Use of the FHSA Exeter system for this purpose is being explored. Attempts should be made to improve on this basic data and collect other information eg use of condoms in addition to other methods of birth control and referral rates to GU Medicine clinics, or the ethnic origin of service users, and use of interpreting services and/or health promotion link workers. A joint decision should be made on whether the balance of provision by GP, community and hospital providers currently meets local needs.

5.5.2 Outcome targets are more difficult to define because information about all unplanned pregnancies is difficult to collect. However, local birth and abortion rates by age group may be useful indicators. It is reasonable to make the general assumption that pregnancies in those under 16 are not wanted, but their reduction is dependent not only on the provision of services but also on improvement in related areas such as the quality of sex education.

5.6 ESTABLISHING PURCHASING AND MONITORING ARRANGEMENTS

5.6.1 The Family Planning Association (FPA) has published a model specification for family planning services which will help purchasing authorities when drawing up contracts for clinic provision. (Family Planning Services: A Model for District Health Authorities – FPA November 1990[29]). Purchasers can use the introductory checklist as a guide to writing the level, range and quality of services required into contracts.

The possible purchaser and provider action lists at the end of this chapter may also prove helpful.

5.6.2 Statistics on activity levels by provider units can be monitored regularly. Quality standards may be monitored by self-report, spot-checks or consumer satisfaction surveys. Financial information will also be required on a regular basis so that costs can be monitored.

5.6.3 Clinical and medical audit can contribute towards identifying the need for change, agreeing it, and monitoring its implementation. Joint audit in family planning should be encouraged across community/hospital/general practice boundaries.

5.7 STAFF TRAINING

5.7.1 Purchasers will need to ensure that contracts provide for the necessary basic and in-service training of administrative, reception, medical and nursing staff, particularly practice nurses, involved in family planning. FHSAs have an important role in encouraging, facilitating and supporting the training and development of all GP employed staff. There are recognised professional qualifications in family planning for

doctors (JCC certificates) and nurses (ENB 901, 985, and A08 certificates). A working group has been established in conjunction with the English National Board (ENB) to explore the feasibility of a modular approach to family planning training for nurses, including practice nurses, midwives and health visitors. This will enable these staff to build up knowledge and expertise over time by taking training courses one section at a time. Training for administrative and reception staff should be tailored to local requirements.

See also Training resource list in Appendix 5.

5.7.2 Clinics in the community and in GP premises should be encouraged to seek accreditation for training purposes. The need to preserve and improve training facilities should be an integral part of any review of services and the balance of provision.

5.8. IMPROVING CONTRACEPTIVE SERVICES FOR THE YOUNG

5.8.1 Some surveys have shown that up to half of young people have experienced sexual intercourse before they are 16. Young people therefore need to have access to the full range of appropriate education and contraceptive services. Services need to be provided in such a manner as to attract young people and to give them the confidence to seek advice and help. Experience in the Netherlands, which has the lowest teenage conception rate in Europe, shows the value of a combined approach to sex education and service provision.

5.8.2 Education and contraceptive services must include the needs of young men. Young men on their own seeking contraceptive supplies should be welcomed, since they are making a positive step to help reduce unwanted pregnancies or infection. They can be given the opportunity to learn how to use a condom correctly and to learn about the availability of emergency contraception.

5.8.3 Young people should be free to attend the service of their choice, where they feel most comfortable. This may be their family doctor, a doctor in the same or another practice, a family planning clinic or a young people's centre. Providers should

recognise that young people often choose to travel outside their district for advice because of fears over confidentiality and privacy.

5.8.4 Most young people do not consider the term "family planning" to be applicable to them since it is thought to apply to older women planning a family. More specific titles like "youth advisory centre" or "young people's service" have been found to be more appropriate and more welcoming, although they still form part of the family planning programme. The suggested family planning policy group can be invaluable in coordinating services, developing new ideas and responding to the needs of the district.

5.8.5 *Issues of confidentiality*

Young people are unlikely to use a service if they are not reassured about confidentiality. Health records relating to contraceptive advice will have the same high degree of confidentiality as applies to other types of health records.

5.8.6 *Parental access to medical records*

Since 1 November 1991 adults can request access to their medical notes compiled on or after that date. The record can only be disclosed to a second party if they have the written authorisation of the patient concerned. If a patient is under 16 years old and capable of understanding a parental request for access to his or her records then he or she can prevent access. If the young person is not capable of understanding, a doctor or other health professional can still deny parental access if it is felt to be in the patient's best interests. Information relating to a person other than the patient should not be disclosed unless that person has consented to the disclosure.

5.8.7 *Age of young people*

Generally speaking a patient has the right under common law to give or withhold consent to examination or treatment prior to that examination or treatment. In the case of young people under 16 years of age, their consent is required by a doctor or other health professional making an examination or giving treatment if the doctor or other health professional is satisfied that they fully understand what is involved. Parental consent should always be obtained where a young person under 16 does not have sufficient understanding of the proposed treatment. In the case of contraceptive

advice, guidelines are set out in DH circular HC(86)1 which resulted from the House of Lords' decision in the case of Gillick v West Norfolk and Wisbech Area Health Authority in 1985. This sets out certain exceptional circumstances where family planning services and treatment may be made available to young people under 16 without parental consent. The guidance requires doctors to seek to obtain the young person's agreement to obtaining parental involvement but if this is not successful then they must have regard to the five specific criteria set out in the House of Lords' judgement, and only if doctors are satisfied that these are met may they provide contraceptive advice or treatment without consulting the parents. These criteria are set out in HC(86)1 and should always be followed.

5.8.8 *Counselling*

Young people often need to discuss, in a confidential non-judgemental setting, aspects of their life which can have a direct bearing on their sexual health. This may include relationships with parents or peers; a disturbed or non-existent family life; pressure to be sexually active; a history of sexual abuse; homelessness; depression; alcohol or drug addiction. Some doctors and nurses may have the counselling skills but, if resources allow, a trained counsellor could also be available.

5.8.9 *Making services more accessible*

The family planning policy group (see para 5.3.1) should consider, within available resources, what further initiatives could be made to provide young person's clinics or to take clinical services to young people outside the usual health service premises, eg colleges of education or sixth form centres.

Local Initiatives

North Staffordshire DHA has opened a young person's advice centre aimed at those under 20 who are unlikely to attend other clinics. One session is provided in each of the two local health centres. One on Saturday morning, the other after school on a weekday. The sessions are well attended.

Contact: Dr Pedrazzini. Tel. 0782-744-444.

Harrow DHA has appointed a senior nurse with responsibility for developing outreach services for young people. She has established links with Social Services, School Health, the LEA, Health Promotion Department and local voluntary agencies for disability, drug and alcohol dependency, church and youth groups. In addition a multidisciplinary working party has been established which aims to be an advisory group to facilitate the development and promotion of the young people's service. Leaflets and posters for young people are being designed and a wide distribution followed by evaluation is planned.

Contact: Dr Bela Reed, Family Planning and Well Woman Services, Harrow DHA. Tel. 081-863 7004.

Dorset DHA set up a Sexual Health Steering Group in February 1992. The prevention of unplanned pregnancy was identified as a priority and work in this area has focused on the service and sex education needs of young people. In developing a local, comprehensive and integrated strategy for sexual health, the work of the steering group will also focus on the full range of sexual health issues. A young person's sexual health advisory service is to be set up which will operate from a number of accessible sites. Opening hours will be designed to meet the needs of young people, including access to emergency contraception after the weekend.

Contact: Dr Catherine Woodward, Dorset DHA Tel. 0202-893000.

Rotherham Family Planning Services, in conjunction with the local education authority, have provided information, counselling and advice on sexual health through "sexwise" evening clinics for young people. These clinics are presently run from "Youth Start", situated in Rotherham's city centre. However, as the service has proved very successful and demands have put a strain on these facilities, the service will be further extended in December to include other outlying areas in Maltby and Dinnington.

Contact: Dr Sayed/Dr English, Youth Start Clinic, Starting Point,

Eastwood Lane, Rotherham S65 1EG. Tel. 0709-822828 (Tuesdays after 4pm).

Following successful work in schools and given the District's high rate of unwanted pregnancies, Canterbury and Thanet DHA have developed a very successful young people's family planning initiative. In conjunction with local schools and local environmental health departments, the scheme was launched in April 1991. The in-built monitoring and evaluation measures meant that it was easy to identify the success of the project as the numbers of people attending the special clinics increased considerably. The project developed specific staff training and look at the provision of a wider range of condoms being available.

Contact: Mary Jones, DHPC Canterbury and Thanet DHA. Tel. 0843-594592 ext 5310.

In Sheffield, a Youth Clinic operating three sessions a week has been successful in promoting condom use by clinic users and in making services accessible to young men (including young gay men) as well as women.

Contact: Jo Adams, Sheffield Centre for HIV and Sexual Health, 22 Collegiate Crescent, Sheffield S10 2BA. Tel. 0742-678806.

5.8.10 *Liaison with the community*

The family planning policy group should establish contacts with the local community and consider inviting local groups concerned with the young, for example parents, school governors, youth workers and health professionals to see for themselves how local family planning centres operate. School party visits to these centres can also be helpful as a part of a planned sex education programme. Regular open and discussion days have also proved helpful.

5.8.11 *General Practice Services For Young People*

Many young people, particularly in rural areas, seek advice from their GP. Indeed, being able to go to a surgery where no-one knows the reason for the consultation

may be an advantage for some. However, a welcoming non-judgemental approach on the part of all staff is particularly important with young people who may need reassurance that the consultation itself is entirely confidential. A poster on the wall confirming this can be helpful.

5.8.12 Barriers to access to GPs or practice nurses should be kept to a minimum. Some young people are put off by appointment systems. If emergency or "drop-in" sessions are available these should be publicised, together with a list of other facilities available for same day counselling or provision of contraception, including emergency contraception, especially on Mondays. Receptionists should not ask young people why they wish to be seen.

5.8.13 For many young people the first contact is for emergency contraception or for a pregnancy test. Many practices provide these services, but where they do not, FHSAs may wish to consider encouraging their development. If a specific request for emergency contraception or a pregnancy test cannot be dealt with at the surgery on the day requested then advice on other local facilities providing the service should be given and displayed. GPs may wish to provide pregnancy testing on request when there is a clinical indication or know where to refer anxious patients. Many young people will not be able to afford a test at the chemist or a home test kit, and some may not be sophisticated enough to undertake the test themselves at home or be able to cope alone with the emotional reaction to the result. There needs to be close liaison with local youth advisory services so that those with more complex difficulties can be referred for further counselling.

5.8.14 FHSAs may wish to identify those practices which do not offer contraceptive services to the under 16s. Then, if needed, complementary services can be developed in geographically strategic areas.

Local Initiative

In Northumberland a young people's clinic set up in a general practice in September has found that most of those attending want information on safer sex and contraception. Parents of young people under 16 are sent a letter explaining the aims of the clinic.

Contact: Jo Tatram, Health Promotion Facilitator, Northumberland FHSA. Tel. 0670-519039.

5.8.15 *Other sources of advice for young people*

The following people or agencies may be asked for advice about the availability of services for young people and should know where and when they are available:

- School nurses
- Postnatal staff, including Community Midwives and Health Visitors, who care for teenage mothers
- HIV co-ordinators
- Staff at young people's centres, youth clubs etc
- Genito-Urinary Medicine Clinics: There should be close liaison with local GUM clinics where young people may present for treatment, but who are also in need advice and provision of contraception. Because referrals are not always followed up, it is valuable for some GUM staff to be trained in family planning and provide the service at the centre. If this is not feasible, staff should know of and refer to local young people's services.

5.9 EDUCATION FOR YOUNG PEOPLE

This section outlines the current legislation regarding sex education in schools and then identifies possible steps towards the development of an overall local educational strategy for young people.

5.9.1 "The Health of the Nation" recognises that sex education is a vital element in promoting sexual well-being and in reducing the rates of unwanted pregnancy and other undesirable outcomes of sexual activity. Education about avoiding drug misuse

is equally vital. Under the Education (No 2) Act 1986 school governors were given the responsibility for deciding whether any further sex education should be included in their school's curriculum beyond the requirements of the National Curriculum.

5.9.2 The Sex Education Forum[30] recommends that Sex Education should:

- be an integral part of the learning process, beginning in childhood and continuing into adult life
- be provided for all children, young people and adults, including those with physical, learning or emotional difficulties
- encourage exploration of values and moral issues, consideration of sexuality and personal relationships and the development of communication and decision-making skills
- foster self-esteem, self awareness, a sense of moral responsibility and the skills to avoid and resist unwanted sexual experience.

Further guidance is provided in the leaflet produced by the Sex Education Forum entitled "A Framework for School Sex Education"[31].

5.9.3 Such education, planned or incidental, takes place from an early age in a number of contexts – the home, the school and other settings where people live, work and learn. Those responsible for the delivery of formal education should acknowledge and work within the context of different faiths, cultures, gender, age and social constraints.

5.9.4 The provision of biological information alone is not adequate in enabling people to act responsibly if they decide to become sexually active. There is also a need to develop interpersonal and negotiating skills and a sense of self-worth.

5.9.5 The need for effective provision of sex education and family planning services, and for training for professionals with access, to information has been recognised in recent documents, particularly the Report of the RCOG Working Party on Unplanned Pregnancy[32] and the Department of Health's Guidelines for Reviewing Family Planning Services (1992)[33]. Both stress the need for co-operation among the many agencies involved. All those involved at local level need to work together to develop strategies to improve systems and structures within which professionals and consumers can work together to ensure that sex education is fully effective.

5.9.6 As a first step, NHS managers should identify local individuals and agencies who have contact with schools eg Local Education Authority personnel, Health Promotion staff, school nurses etc. It is important to evaluate carefully the current situation and to identify the changes that are needed before embarking on new initiatives. Sex education is one of the topics on which specific guidance is offered in the National Curriculum Council's Curriculum Guidance 5: Health Education 1992[34]. The Department for Education's circular 11/87 to all LEAs, "Sex Education at School", is also helpful. Additionally, the Health Education Authority and the Family Planning Association can supply details of resources and training. Their addresses can be found in the list of useful organisations at the end of the handbook.

5.9.7 When considering strategies for sexual health education in their localities, NHS managers can benefit from the experiences of other health authorities.

5.9.8 *Relevant Legislation*

The most relevant legislation is:

- The Education (No 2) Act 1986
- The Local Government Act 1988
- The Education Reform Act 1988
- The Education (National Curriculum) (Attainment Targets and Programmes of Study in Science) Order 1991.

5.9.9 *The Education (No 2) Act 1986*

Under the provisions of this Act school governing bodies are responsible for:

- deciding whether any further sex education should be included in their school's curriculum, beyond the requirements of the National Curriculum
- maintaining a written record of that decision, and the content and organisation of any sex education they decide should be provided.

5.9.10 Section 46 requires that any sex education which schools provide, whether or not it is required as part of the National Curriculum, should be given in such a manner as to encourage pupils to have due regard to moral considerations and the value of family life.

5.9.11 *The Local Government Act 1988*

Section 28 of this Act prohibits local authorities from intentionally promoting homosexuality or from publishing material with the intention of promoting homosexuality. It also specifically prohibits a local authority, in exercising its statutory function, from promoting the teaching in any maintained school of the acceptability of homosexuality as a pretended family relationship. Section 28 does not, however, prohibit the objective discussion of homosexuality in the classroom and the counselling of pupils concerned about their sexuality in accordance with section 46 of the Education (No 2) Act 1986, nor does it prohibit anything being done for the purpose of treating or preventing the spread of HIV.

5.9.12 *The Education Reform Act 1988*

Section 1 of the Act requires the curriculum of every maintained school to:

- promote the spiritual, moral, cultural, mental and physical development of its pupils and of society
- prepare such pupils for the opportunities, responsibilities and experiences of adult life.

As a part of this preparation all pupils must now be taught those aspects of sex education contained in the National Curriculum.

5.9.13 *The Education (National Curriculum) (Attained Targets and Programmes of Study in Science Order) 1991*

This order requires that pupils at Key Stage 3 (ie 11-14 year olds) should:

- "study ... life processes, ... behaviour, growth, reproduction ... particularly as they relate to human beings"
- study ... the physical and emotional changes that take place during adolescence ... and understand the need to have a responsible attitude to sexual behaviour"
- "extend their study of the ways in which the healthy functioning of the human body may be affected by diet, lifestyle, bacteria and viruses (including Human Immunodeficiency Virus (HIV))".

5.9.14 Governing bodies have no discretion as to whether these topics should be taught: the law requires that they must be. However, the inclusion of these topics in the Science

Order does not mean that they must be taught within science lessons. Schools may, for example, prefer to include them within programmes of personal and social education. The requirement is that the topics must be taught at some point during the specified Key Stage. The main guidance document is "Curriculum Guidance 5: Health Education"[34].

5.9.15 *The role of Local Education Authority advisory staff*

Each LEA will have one or more advisory staff with the responsibility for overseeing the area of the curriculum into which it considers the HIV/AIDS education falls. There may be an adviser for Personal and Social Education. There may also be a Health Education Co-ordinator (HEC) who has responsibility for co-ordinating drugs and HIV/AIDS education along with perhaps a more general health education role. It is usually HECs who train staff and provide support for teachers and youth workers in order to promote the development of good practice in HIV/AIDS education, as part of the Personal and Social Education curriculum.

5.10 DEVELOPING A LOCAL STRATEGY FOR THE SEXUAL HEALTH EDUCATION OF YOUNG PEOPLE

5.10.1 Developing a local profile

Local profiles are a first step towards determining the needs of young people in the area. They should include:

- relevant epidemiological data as in Appendix 2 with particular reference to conception rates in the under 16s, terminations of pregnancy, etc
- sociological data:
  - ~ the number of young people in local schools and institutions of further and higher education
  - ~ numbers of those in custodial, residential or other settings
  - ~ numbers of young homeless (the local police may be able to provide information)
  - ~ local black and ethnic minority communities with different cultural and linguistic identities

- school attendance:
  - ~ levels of truancy in local schools
  - ~ numbers of young people not in touch with schools
  - ~ numbers of young people with special educational needs
- number and proportion of local schools with a written sex education policy
- identifying local young people's advisory centres
- identifying other statutory/non-statutory young people's services in the area
- any local surveys on levels of knowledge and awareness among young people.

5.10.2 Developing local alliances and seeking local views

See 5.3.1 and Appendix 2 for a list of possible alliances, and people who can provide local views.

A local alliance concerned with the sexual health education of young people may be able to:

- assist in developing a local profile
- identify what sources of training are available for teachers, health and education professionals and school governors
- identify type and sources of information for young people in and out of school and ways to improve and extend this
- identify what resources (eg teaching packs) are available to schools and how number and access might be improved
- identify means whereby health professionals might assist schools with policies and programmes for sex education
- identify initiatives with parents and assess further potential for sex education work
- develop programmes for hard to reach young people, including the homeless or those in care or custody.

5.10.3 Identifying possible interventions for health education in schools

Young people between the ages of 5 and 19 are almost one fifth of the population of England. School-based health education is an important contribution to ensuring the health and well-being of future adults. Creating an environment in which young

people and adolescents can acquire health-related knowledge, skills and practices is an important precursor to healthy human relationships in adulthood.

5.10.4 Recent HEA research indicates that the majority of schools (86%) do have a policy on sex education. The priority is therefore to assess and support its implementation at a local level. In-service training for teachers is essential if they are to feel confident and competent to teach appropriately about sexual matters. See Appendix 5 on Training for possible resources. The LEA, in conjunction with others in a local alliance for education for young people may wish to identify how many local schools have

- a written policy for sex education
- a health education co-ordinator
- a continuous and developmental curriculum for health education
- training for teachers and governors
- contact with local community initiatives.

Local Initiatives

South Warwickshire DHA has set up a project where a health promotion specialist works closely with local schools on sexual health education. The aims are to reduce unwanted conception rates in young women, to reduce the incidence of sexually transmitted diseases and to promote sexual health.
Contact: Ms L Lawton. Tel. 0926-4520-021.

Southport and Formby DHA Health Promotion Unit and the Health Education Co-ordinator at Sefton LEA have adopted a collaborative approach to health education and promotion. Each year they provide a programme of training events designed both for governors and teaching staff. Sex education is incorporated into a cross-curricular approach through specially designed programmes. The Health Promotion Unit and LEA have also collaborated to produce Health Education Guidelines for the Borough of Sefton, which include sex education.
Contact: Mark Haig, Southport and Formby Health Promotion Unit. Tel. 0704-547471 or Norman Scott, LEA Health Education Co-ordinator. Tel. 0519- 288741.

In Norwich young mothers are being trained to give presentations in schools about their experiences and to lead discussions on family planning. This peer education project is due to start in January 1993.

A project has been set up in a large secondary school in Norwich to introduce and formally evaluate peer group education as a means of encouraging young people (over 16) to take charge of their own sexual health. Norwich District Health Authority has appointed a peer education co-ordinator to extend the project to five schools and colleges.

Contact: Liz Thornton. Tel. 0603-300600.

North Staffordshire DHA have published leaflets for school leavers dealing with a range of health issues, including sexual health.

Contact: Dr Pedrazzini. Tel. 0782-744-444.

Croydon Community Health Trust and Croydon Local Education Authority have established a joint team composed of a project officer from the health authority and a schools advisor from the LEA. A sex education conference was held on 25 June 1992 to develop Borough Guidelines on Sex Education, to implement and develop sex education policies and to raise awareness of inter-agency co-operation. Production of the Borough Guidelines on Sex Education is being funded by South West Thames RHA.

Contact: Margaret Howard, Project Officer, Croydon Community Health NHS Trust. Tel. 081-680-2008 ext 255.

5.10.4 Identifying possible interventions for health education for young people outside schools

Apart from education in schools it is equally important to focus on providing appropriate education materials to young people:

- outside the school setting, eg in youth clubs, guides, scouts, leisure and recreational facilities
- not in contact with schools
- who are homeless or disaffected
- in care, or custody.

5.10.5 In the development of any further strategies for young people it may be helpful to identify:

- what information is currently available and how it is disseminated
- whether young people who receive them find current educational materials relevant, helpful and appropriate
- what methods and messages young people themselves would find most appropriate.

Local Initiative

Together with East Staffordshire District Council, the South East Staffordshire DHA is commissioning an arts company to show young people how to make videos. The young people will receive training on the whole area of sexual health, will choose an aspect of this for their videos and then, with the help of the arts company, take the video to youth clubs and schools to inform and educate their peers.

Contact: Nikki Orton, Health Promotion Unit. Tel. 0534-673914.

POSSIBLE ACTION POINTS

Purchasers

may wish to consider:

- commissioning contraceptive services to complement those provided locally by GPs and other providers, ensuring sufficient choice and paying particular attention to the needs of young people. Services commissioned should include family planning clinics, emergency contraception advice, psychosexual counselling, sterilisation and pregnancy counselling services
- setting up a district family planning policy group which includes links with the education sector
- identifying a clinical co-ordinator of family planning. Consultants in family planning and reproductive health can provide such leadership
- commissioning and publicising a local 24 hour answer service with details of all local family planning and reproductive health care services, possibly together with neighbouring districts to reduce costs
- commissioning at least two sessions a week dedicated to young people which are well advertised and easily accessible by public transport
- exploring the possibility of ensuring emergency contraception is available during working hours on any day from all family planning clinics, GPs providing contraceptive services and local accident and emergency departments should this be required
- placing contracts which specify:
  - ~ minimum criteria for clinics (see Appendix 3 for suggestions)
  - ~ that staff be appropriately trained and also be aware of issues surrounding HIV/STDs and drug misuse and to know where to refer as appropriate
  - ~ regular service monitoring and evaluation
  - ~ regular activity returns
  - ~ adherence to infection control procedures
- the availability of appropriate information on STDs and HIV
- the provision of condoms through clinics and general practices (EL(92)18 refers)[22]
- the provision of hospital services for family planning and counselling in

gynaecology and maternity out and in patients, including sterilisation and vasectomies

- exploring the need for outreach services to people unable to attend the local facilities.

Providers

(including family planning clinics, youth advisory centres and GPs where appropriate) should, within available resources, consider providing:

- education, information and advice on reproductive health care to both men and women which is sensitive to the needs of people of different races, cultures, ages and religions
- fullest possible range of contraceptive methods or referral if appropriate
- same day access to or referral for emergency contraception, including providing a list of local GPs prepared to undertake this service
- widely publicised services, especially for young people
- advice on safer sex, HIV and STDs with referral as appropriate
- same day pregnancy testing and results with subsequent counselling if resources are available
- counselling, assessment and referral for male or female sterilisation (EL(92)63 refers)[35]
- counselling and treatment or referral for sexual relationship problems
- preconception care (assessment of lifestyle, genetic, obstetric factors, rubella immunity, haemoglobinopathy, smoking cessation)
- general health education and provision of leaflets, eg those provided by FPA
- diagnosis and treatment or referral for co-incidental disease eg STDs, gynaecological disorders including cervical screening where indicated
- regular staff training for all staff working in the services, including receptionists
- regular audit and activity returns
- advice and help to chairmen of school governors, principals at further education colleges and directors of youth centres.

FHSAs and GPs

may wish to consider:

- encouraging and facilitating GPs to develop guidelines and standards for the

provision of contraceptive services and sexual health counselling, and encourage audit of the services provided against these standards

- encouraging the provision of services which the young will use
- providing an emergency contraception service, and advertising the availability of this
- offering family planning services from a GP other than the one with whom the client is registered
- exploring with GPs and local pharmacies the provision of rapid pregnancy testing which, ideally, should be accompanied by counselling and referral
- liaising with GP fundholders to ensure that they make appropriate provision in purchasing plans for sterilisation services
- encouraging all staff, including receptionists and especially those providing contraceptive services, to participate in training
- participating in feasibility studies for the provision of condoms including starter packs in the general practice setting
- publicising the services provided in the practice
- FHSAs to provide detailed statistical evidence of the family planning work of GPs (commensurate with KT31) or through local surveys.

APPENDICES

Appendix 1

DEVELOPING LOCAL PROFILES: POSSIBLE SOURCES OF INFORMATION

Demographic and epidemiological data

1. General demographic information:
   - Relevant sections from Public Health Common Data Set 1992 and supplements as available
   - Census data: age/sex (OPCS)
   - Local Authority Planning Department information on population groups, age structure, 5 year projections
   - underprivileged area scores, eg Jarman index, Carstairs, Townsend or Balarajan;
   - ethnic composition
   - specific local demographic features such as holiday camps, military bases, seaports, custodial settings, colleges of higher education
   - FHSA age/sex breakdowns
   - number of children attending school (state, grant or independent).

2. **HIV/AIDS**

   NB Information on STDs, drug misuse and family planning will also be helpful.
   - Local, regional and national epidemiological data such as HIV and AIDS case reports and trends over time compared to adjacent Districts and within Region
   - District and Regional AIDS (Control) Act Reports
   - anonymised HIV serosurvey results as part of national CDSC study or local initiatives
   - local prevalence studies from GUM, Drug Misuse Clinics etc
   - local authority case loads etc
   - data on calls to local helplines.

3. **Other STDs**
   - KC60 returns: aggregate data on the number of diagnoses by major diagnostic category, age, sex, and sexual orientation are provided on returns sent quarterly by all GUM clinics, via Regional Health Authorities, to the Department of Health. Sex and age group totals by region for a selected number of acute infections exist (including gonorrhoea, herpes and chlamydia);

- laboratory based reporting of certain organisms to the PHLS CDSC. For example:

Gonorrhoea	antibiotic resistant isolates and non genital infections (these represent only a small proportion of laboratory detected infections)
Herpes Simplex Virus	laboratory reports of HSV include reports of genital infections. Reporting does not distinguish primary (incident cases) from secondary attacks;
Chlamydia	laboratory reports include those of genital infections
Ophthalmia neonatorum	reports where an organism – either chlamydia or gonorrhoea – is detected

- there are no denominator data on the number of investigations requested for laboratory reports of STDs. Apparent changes in disease incidence or presentation may represent changes in test application and availability
- there is voluntary confidential reporting of cases of laboratory confirmed acute hepatitis B infections
- data from any local sentinel surveillance scheme that may be introduced by PHLS for the more rapid monitoring of STDs. These may only be in place in a few hospitals since their main purpose is to enable a more rapid detection of emerging trends in a limited range of STDs and to gather more detailed epidemiological data to help interpret them
- comparison of local incidence and trends of STDs, particularly gonorrhoea with Regional and National figures
- local trends in STDs over time – particularly gonorrhoea which might indicate a rise in unsafe sexual behaviour.

4. Drug Misuse

National Data:

- the Home Office Addicts Index data will provide some data on local treatment activity
- data on police seizures may provide information on possible levels of drug availability

- occasional national surveys of pharmacists and general practitioners may provide information for local use.

Regional Data:

At a regional level data will be available on national and local characteristics of drug users in contact with various general and specialist services through the new anonymised regional databases which have been established in all regions in the UK. The database will provide important data on the numbers injecting and the ratio of injectors to non-injectors.

Local Data:

- local drug misuse database information, eg local KO 71 data
- local data on HIV/AIDS and proportions of injecting drug misusers tested
- comparison of local data to national figures for both Regional Drug Misuse Database and Home Office Addicts Index, and HIV/AIDS data
- monitoring activity data from local services
- drug misusers attending needle and syringe exchange schemes, or involved in special pharmacy exchange schemes
- local drug arrest figures
- information gathered by the police on local drug activity
- local probation services estimates of drug problems.

5. Family Planning:

Fertility statistics including those in Public Health Common Data Set:

- general fertility rate
- total period fertility rate
- livebirths by maternal age and birthweight
- stillbirths (no. and rate) and by maternal age
- abortions by age of woman, gestational age and place
- abortion rate by age of woman.

General Household Surveys 1983, 1986, 1989 and 1991 (preliminary data):

- use of sterilisation and contraception by age and marital status.

plus

Any other local information available for groups with special needs eg unemployed,

homeless, recent immigrants/refugees, travellers, single parents, people with learning difficulties, physically disabled, drug misusers, prostitutes, and ethnic minorities.

DHA

Korner data for Community Health Family Planning Services (KT31) – any other routinely collected statistical data.

FHSA

Data on family planning activity in general practice (FP1001, FP1002, FP1003) plus any other collected data or local surveys.

Health authorities may find it advantageous to identify a common target population for DHAs and FHSAs.

Hospital statistics:

Family planning activity in hospitals (Korner plus other data)

Number of vasectomies and tubal sterilisations performed by NHS on resident population plus waiting list times for procedures

Number of district residents treated in fertility and assisted conception units. Waiting lists.

Current service provision

Financial information:

DHA (HSI) data: Total expenditure by DHA on FP services per female aged 16-44 resident in district (Source: FP01 HSI derived from FR14 and OPCS population data)

Total expenditure by DHA on FP services per 1st contact at FP clinic (Source: FP03 HSI derived from FR14 and KT31)

Sources of further statistical information can be found in Appendix C of "Guidelines for Reviewing Family Planning Services". (Circular HSG(92)6)

Appendix 2

HEALTHY ALLIANCES

Examples of possible participants

Purchasing Alliances

Possible people to involve include:

- District Health Authority personnel, including
  - ~ Directors of Corporate Development/Planning and Purchasing
  - ~ Commissioning Agencies
  - ~ Directors of Public Health
  - ~ Service Co-ordinators (HIV Prevention Officers, Drugs, Family Planning)
  - ~ Research and Development officers
  - ~ Consultants in Communicable Disease Control
  - ~ Finance officers
  - ~ Intelligence and Information Networks – eg Institutes of Public Health
- NHS Managers who have a purchasing responsibility for:
  - ~ GUM clinics and outreach services
  - ~ Family Planning Clinics
  - ~ Drug misuse services
- Managers of Family Health Services Authorities
- GP fundholders
- Local professional organisations eg Local Medical Committees
- Local authority managers or others with responsibility for
  - ~ social services and community care
  - ~ environmental health
  - ~ leisure and tourism
  - ~ housing
  - ~ local education services (including health education co-ordinators)
  - ~ youth services
  - ~ grant aid to voluntary organisations
- Corporate local authority HIV co-ordinators
- Health Promotion Departments
- Community Care Services

Other statutory agencies etc.

- Health and Safety Executive
- police/prison services
- military forces
- probation service.

Provider alliances

- Managers of DMUs/Trusts/etc eg:
  - ~ health promotion services
  - ~ in-patient/out-patient services
  - ~ managers and staff in GUM, family planning and drug misuse services
  - ~ services
  - ~ additional test sites
  - ~ service co-ordinators (HIV, drugs, alcohol)
  - ~ relevant professionals
  - ~ occupational health
  - ~ pathology/microbiology units
  - ~ addictive behaviour units
  - ~ communicable disease units
- Family Health Service Authorities
- GPs and practice nurses
- Primary health care teams/workers (eg midwives, school nurses, health visitors, district nurses)
- Dentists/pharmacists
- School health services
- PHLS laboratories and local pathology services
- Local authority managers or others with responsibility for
  - ~ social services and community care
  - ~ home help services
  - ~ care workers – residential/custodial
  - ~ leisure and tourism
  - ~ environmental health
  - ~ housing

- local education services (including health education co-ordinators)
- youth services
- grant aid to voluntary organisations

- Corporate local authority HIV co-ordinators
- District Drug Advisory Committees

Other agencies

- Residential/nursing homes
- Police/prison/custodial and probation services

Voluntary groups

- local peer and self help groups
- HIV specific and non-specific organisations (eg Body Positive, Terrence Higgins Trust, Barnardos, Relate, drug and alcohol agencies)
- helplines
- other service providers – eg respite and care, befriending, training and consultancy agencies
- informal groupings

Private/independent sector

- Managers of private health care facilities
- Health care professionals working in the private sector
- market research agencies

Academic bodies and other agencies

- local academic departments/post graduate researchers
- training schools for the medical, dental and nursing professions, and professions allied to medicine

Broader based alliances

to take forward local educational and prevention initiatives. In addition to the lists above it may also be helpful to consider:

- school governors, PTAs, teachers, parents
- community groups eg Toc H, women's groups, local health projects
- religious and ethnic groups – elders and leaders

- voluntary groups/peer groups
- representatives of groups being addressed
- lesbian and gay organisations – specialist (eg counselling services/helplines) or generalist (eg social groups)
- professional or business groups – Chambers of Commerce, Rotary, Inner Wheel
- specialist professional advisors (eg legal advice)
- Tenants Associations
- Local arts groups
- Local media and journalists

Locally based representatives of national organisations

- Health and Safety Executive
- branches of CBI, Employers' Federations, Trades Unions
- Mother's Union, Townswomen's Guild
- Youth associations
- other counselling or help and advice services – eg Citizen's Advice Bureaux

Appendix 3

CLINICS

1. There are a number of common features and more specific features which can increase the effectiveness and efficiency of clinics providing services for HIV, GUM, drug misuse and family planning. In general, clinics should be:

   - available
   - accessible
   - appropriate.

Availability

- people should have access to clinics outside their area of residence (eg close to workplace, college, school)
- clinics should:
  - be open when people can use them, including some evenings and possibly Saturday mornings
  - offer a mixture of appointments and "walk-in" service
  - have a 24 hour answering machine service giving opening times and alternative sources of emergency advice
  - minimise waiting times (see Queue Action – a guide to tackling waiting times in outpatient departments. NHSME 1991)
  - offer outreach services to those who are unable to attend.

Accessibility

- clinics should be accessible, for example:
  - be well signposted both outside and within buildings and be conveniently situated for public transport
  - provide access for the disabled
  - have well lit entrances and access routes
  - have access to interpreters if required.
- clinics should be well advertised, for example:
  - by prominent and extensive local posters in public places, GPs' surgeries, libraries, chemists, youth clubs, colleges, etc
  - being listed in yellow pages and Thompsons Directory under accessible headings, eg family planning, birth control, young people's advice etc

- ~ by use of local media, including radio
- ~ advertised in appropriate ethnic languages.

Appropriateness

- premises should be comfortable and clean with adequate heating and toilet facilities
- if possible provide consultations with male or female staff on request
- have adequate private consultation rooms and soundproofing
- where possible provide facilities for children – eg baby changing facilities, play space, secure area for prams
- provide a wide variety of health education/promotion leaflets, including those in minority languages
- provide adequate supplies of condoms
- employ properly trained reception staff
- undertake regular audit, including:
  - ~ regular and timely activity returns and notifications of diseases etc
  - ~ regular client satisfaction surveys
  - ~ regular review of waiting times.

3. Additional suggestions for HIV and GUM services

- clinics should meet the specification of the Health Building Note[21]
- clinics should have working links with:
  - ~ other hospital Departments and in-patient beds
  - ~ local GPs providing care
  - ~ Family Planning Services
  - ~ Rape/Incest Crisis Centres
  - ~ local HIV/AIDS services
  - ~ Social Services
- confidential referral mechanisms should be in place to and from all of the above
- professional staff should all have received appropriate training
- a local protocol for partner notification for HIV and STDs should be agreed

- clinics should employ health advisers to provide counselling and health education for patients, and advice on partner notification
- clinics should have written protocols for treatment and care.

4. Additional suggestions for family planning clinics or young people's advisory centres

Purchasers may wish to consider commissioning or developing:

- a full range of contraceptive services and supplies
- timely emergency contraception
- same day pregnancy testing
- a further range of services to meet other needs, for example:
  - ~ counselling for young people
  - ~ menopause counselling and treatment for older women
  - ~ domiciliary services:

    for ethnic minorities

    for the disabled

    in social/family stress situations
  - ~ outreach services to:

    prostitutes

    the homeless

    women's aid refuges
- working links with services for rape/sexual assault/abuse cases
- academic links with local medical schools, post graduate centres or nursing schools
- working links with, and referral service to, other appropriate gynaecological or obstetric services
- services for men. The involvement of both partners should be encouraged but there should be the facility for people to be seen individually or together
- training programmes for staff and regular review. Staff should be fully trained and where appropriate have recognised professional qualifications in family planning. Experience or knowledge of Genito-urinary medicine will also be of benefit.

Appendix 4

POSSIBLE TARGET POPULATIONS FOR FURTHER EDUCATIONAL AND PREVENTION INITIATIVES

This appendix contains an extensive list of population groups to consider in terms of developing local education initiatives for sexual health and drug misuse strategies. Priorities will vary from one location to another and should be based on the results of local needs assessment. There will obviously be overlap between group.

1. General population

- women/men
- defined age groups
- those with special needs
- in defined settings: eg workplace, community/leisure organisations
- 'singles' clubs
- travellers

2. Young people

- at home in family context
- at schools and in further education (colleges, universities)
- those with special needs
- community organisations (eg youth groups, church, clubs)
- in care, or in contact with social work departments
- homeless/on the street/in hostels
- leisure activities and social events (eg discos, sporting facilities, arcades)
- on holiday
- those who work with young people (eg teachers, school nurses), teacher training
- youth services
- young people in workplace

3. Black and ethnic minority populations

- women/men
- established in or new to UK
- broad OPCS categories – white, black (African, Caribbean), black other (Indian, Pakistani, Bangladeshi, Chinese), and other ethnic groups including Romanies

- defined age groups
- isolated/enclosed population groups
- refugees/asylum seekers
- people whose first language is not English
- people who work for or with black and ethnic communities

4. Men who have sex with other men

- defined age ranges
- 'gay' and 'bisexual' men, on or off the 'scene'
- holidaymakers, within UK or abroad
- links with formal/informal networks and those who work with gay and bisexual men
- men who have sex with other men but do not identify as 'gay' or 'bisexual'

5. Drug and substance misusers *(See also Drug Misuse section)*

- injecting, oral or other
- 'dependent' or 'recreational'
- on the street, mobile and transient
- socio-economic grouping or informal social settings (eg workplace, clubs and pubs)
- specific settings – recreational and sporting activities
- sexual partners of drug and substance misusers
- people who provide care for drug and substance misusers
- alcohol networks
- those in contact with existing services
- those unknown to existing services

6. Prostitutes and sex workers

- female/male, and defined age ranges
- injecting drug users
- sex workers – 'informal' eg street workers and 'rent' boys versus 'formal' or commercial settings eg saunas, massage parlours
- their clients

- their sexual partners
- people who provide care for prostitutes and sex workers

7. People in Custodial Settings

- prisons: adult/young offenders, male/female
- remand centres
- youth detention centres
- probation services and parole services
- other custodial settings (police)
- staff and those who work with offenders

8. GUM clinic attenders

- female/male
- different age ranges and populations
- recurrent attenders
- partners of attenders

9. All caring professions eg

- Health professionals
- Health promotion and educational professions
- Occupational Health nurses and physicians
- Primary health care teams/GP practice nurses
- those who provide training support and resources for health care and other workers
- Community nurses/midwives
- Dentists and their staff
- Pharmacists and their staff

10. Other audiences/settings

- Infection control in health care settings, home etc.
- Workplace (eg travel industry, young people)
- Employers' networks and Trades Unions/Staff federations
- Police/Emergency services
- Military forces – regulars, territorials, auxiliaries, cadets

- Travellers both within and to and from the UK, and New Age travellers
- Statutory services (eg housing, NHS)
- those with special needs in terms of sensory/physical/mental impairment or learning difficulties
- those who are homeless or in temporary accommodation and their partners
- Haemophiliacs, their families, carers and support groups

Appendix 5

EDUCATION AND TRAINING

Doctors:

HIV & AIDS: The Issues. An education pack for Doctors.

Contact: Dr Peter Exon, AIDS Unit, Department of Health Tel. 071-972-3218.

British Postgraduate Medical Federation Postgraduate Course in STDs including AIDS.

British Postgraduate Medical Federation Advanced Course in STDs.

Nurses, Midwives and Health Visitors:

English National Board Course 934: A ten day course on caring for people with AIDS and HIV related conditions. There are 36 such courses now approved throughout England and so long as the majority of participants are nurses, others can attend ie social workers, probation officers, police officers, prison officers. A list of approved colleges is available from ENB.

English National Board Course 280: An advanced modular course for practitioners involved with the direct care and management of people with AIDS and HIV infection. Details of approved colleges from ENB.

Distance Learning Package – "Meeting the Challenge": To complement courses 934 and 280 or to stand alone. Available from ENB.

English National Board Course 276: A modular course which so long as the majority of participants are nurses is open to other professionals to study the care of persons with genito-urinary infections and related problems. Details of approved colleges available from ENB.

Video Training Packs – Nursing and AIDS Series:

1. A General Approach
2. Community Nursing
3. Midwifery and AIDS
4. Child Health Issues
5. Issues Relating to Young People
6. Psychological and Emotional Aspects
7. Drug Misuse

The videos are available on free loan or to buy on VHS format from CFL Vision, PO Box 35, Wetherby, West Yorkshire, LS23 7EX. Tel. 0937-541010.

Education in Schools:

HIV and AIDS. A Guide for the Education Service, facts for teachers, lecturers and youth workers. Department for Education.

A Framework for School Sex Education – National Children's Bureau. The need, nature and role of sex education. Aimed at teachers and lecturers.

Primary (age 5-11):

Health for Life: Health Education in the Primary School, Books 1 and 2, Health Education Authority, Published by Nelson, 1989.

My Body, Published by Heinemann Educational 1991.

Secondary (age 11-16):

The Health Education Authority runs a National in-service Training Project, based at Christ Church College, Canterbury for Education and Health Professionals who work with Teachers.

Telephone for details: Tel. 0227-767700.

Health and Self, Health Education Authority, Published by Forbes, 1992.

Teaching about HIV/AIDS – available separately and included within Health and Self.

16-19 year olds:

Health Education Pack, Health Education Authority, New Edition 1993. For staff working with 16-19 year olds.

Relationships and Sexuality: a Selected Resource List for Professional Educators of 13-18 year olds, Health Education Authority.

Massey D, School Sex Education: Why, What and How: A Guide for Teachers, Family Planning Assocation, 1991.

The Health Education Authority produces a comprehensive resource list of HIV/AIDS and Sexual Health and selected resource lists on HIV/AIDS for use with young people and adults with learning difficulties.

Local Authorities

Living and working with HIV, a training pack contains The UK HIV Trainers directory, which lists over 1,600 courses provided by 253 trainers from the voluntary, private and statutory sectors in the UK. Available from CCETSW, Derbyshire House, St Chads Street, London WC1H 8AD. Tel. 071-278-2455.

Appendix 6

GUIDANCE ON ESTABLISHING ADDITIONAL SITES FOR HIV ANTIBODY TESTING [Extract from PL/CO(92)5]

1. Anyone who wishes to have an HIV antibody test should be able to do so with the minimum of inconvenience. The Department of Health therefore encourages Health Authority and Trust managers and professionals to consider, as part of the future development of local HIV and/or sexual health strategies, the provision of additional open access sites for HIV testing.

2. In the United Kingdom testing for HIV antibodies is available through Genito-Urinary Medicine (GUM) and other specialist clinics, a few private clinics and General Practitioners. Drug misusers may seek or be offered testing in drug dependency clinics and some hospitals in higher prevalence areas are offering voluntary tests to pregnant women. Any doctor may request an HIV test as part of a diagnostic work-up.

3. There is anecdotal evidence that some people, including women, members of ethnic minority groups and younger gay men, may not feel comfortable with the GUM clinic setting nor do they necessarily wish to discuss their anxieties or request a test from their family doctor. Experience suggests that where available, many people would prefer to attend a clinic separate from other services.

4. On balance there may be clinical advantages for the individual in terms of treatment available to know their HIV antibody status. In addition, someone who is aware they are HIV positive can take steps to avoid infecting their sexual partners and avoid sharing injecting equipment if they are drug misusers. The Department therefore advises that those who believe themselves to have been at risk should seek a test. The introduction of additional sites for HIV testing will help the further development of such a policy since more people will be able to seek a test with the following benefits:

    - extra choice available to those who currently feel unable to utilize the existing services; this should permit the identification of some people whose seropositivity would otherwise be unknown
    - the earlier diagnosis of HIV infection enables:
        - ~ access to medical care and support and if necessary the use of therapies to

prevent opportunistic infection and/or delay progression of HIV disease

- ~ an earlier opportunity for the individual to be counselled on ways of preventing onward infection to sexual or drug-sharing partners
- ~ women who may have been infected may wish to be tested to help them decide whether to take steps to prevent conception and to help them make decisions about the management of a pregnancy and about breast feeding
- ~ through partner notification the identification of current or previous partners who may be infected. They, too, would also derive earlier clinical benefit as well as giving them the opportunity to change behaviours so that the risk of transmitting the virus to others is minimised

- the opportunity to counsel those who had been at risk but found to be uninfected on avoiding risky behaviours in the future
- a subsidiary epidemiological benefit is that the results may give a more accurate picture of local seroprevalence which is helpful in planning services and targeting local educational initiatives more effectively. (Managers should ensure that cases of HIV infection identified in additional testing sites are notified to the PHLS AIDS Centre at the Communicable Disease Surveillance Centre through the existing voluntary reporting scheme).

5. Such clinics will need to include facilities for pre- and post-test counselling in private to ensure fully informed consent. It will be necessary to ensure that those with a history suggesting that they have been at risk of, or have, other sexually transmitted diseases can be quickly referred to the local GUM services. Such clinics will also need to have strong links to the clinical and other support services so that those found to be HIV positive receive immediate care, treatment and support.

6. Waiting for the result of a test for a week or more is stressful and clients welcome being given their test results quickly. Some clinics are providing results later the same day and the Department wishes to see such "same day" testing available for people being tested in whatever setting whenever practicable. Ideally results should be obtainable on the same or following day in most dedicated additional testing sites.

7. As with the introduction of any new service, and indeed for existing services, it is important that these additional testing sites be carefully monitored and evaluated to

assist in the further development of such services. There are many possible approaches to delivering such a service, some of which may be more appropriate to one area than another. A check list of issues to consider and practical advice drawing on the experience of the Same Day Testing Clinic at the Royal Free Hospital can be found in Annex A. Annex B discusses the possible costs of an additional test site.

8. Managers should ensure that any new or existing HIV testing facilities comply with the provisions of The HIV Testing Kits and Services Regulations 1992.

9. The adequacy, both in quality and local appropriateness of testing services will be an important measure of the overall adequacy of HIV/AIDS services in a particular District or Region. Reference to the need for this will be made in the guidance circular to be issued to the NHS on use of AIDS allocations in 1993/94.

10. The Department of Health is proposing to evaluate some existing and some planned additional test sites. The results and the lessons learned will be published to assist in the future development of such facilities.

Annex A

CHECKLIST FOR THE DEVELOPMENT OF ADDITIONAL TESTING FACILITIES FOR HIV

1. Information gathering

Sketch local picture:

- number of tests carried out and number positive
- where are the gaps in testing provision – and which at risk groups are hard to reach?

2. When drawing up a protocol you will need to consider:

- people you need to involve
- where such testing should be offered
- how to publicise the service to those most likely to wish to use it
- staff needed on site to provide pre-test discussion and post-test counselling
- how and where will people be investigated for possible other STDs when this is appropriate
- who can be contacted in case of urgent need for medical help/additional counselling etc
- how will results be given: where, by whom, and how to handle an HIV positive result
- who will those identified as HIV positive be referred to
- the need for confidentiality and how this will be preserved
- the impact on the laboratory services
- several types of service may be developed:
  - ~ initial advice or information available by phone
  - ~ truly anonymous, eg barcoded or numbered samples
  - ~ named confidential testing
  - ~ same day testing if practical
  - ~ accessibility – timing of clinic hours

3. **Monitoring and evaluation is essential for any new service. In particular consider:**

- uptake of services
- demographic profile of those attending (as far as is possible)
- number of positives and estimate of number of positives that would otherwise have gone undetected
- consumer surveys to determine whether those tested were glad they attended for a test, whether it was positive or negative, and how they feel the service could be improved
  - ~ was the service friendly and efficient
  - ~ how could it be improved etc
- staff appraisal.

4. **Resource issues – you will need to consider**

- the most appropriate source of funds – the 1992/3 AIDS Allocation letter will be mentioning this as a priority area. Improved surveillance of HIV is also an Health of the Nation objective.

ROYAL FREE HOSPITAL SCHEDULE FOR THE OPEN ACCESS SAME DAY TESTING CLINIC

1. A clinic protocol should be available for all staff working in an open access same day testing clinic.

2. A dedicated telephone hotline manned by trained telephone counsellors is needed. Regular in-service training is essential to ensure that telephone counsellors have up to date information on HIV/AIDS.

3. Privacy at the clinic should be ensured.

4. A team of trained counsellors to provide pre-test discussion and post-test counselling must be available.

5. In service training and consultation to ensure up to date information and maintain standards on HIV/AIDS for all staff including counsellors.

6. Phlebotomy services must be available on site.

7. Alternative facilities need to be available to provide in-depth counselling for clients who need more time than that available in the same day testing clinic setting to consider whether they want to have an HIV test.

8. A policy on confidentiality of records and for results must be drawn up.

9. Close liaison with the virology laboratory is essential; the virologist should, if possible, be available to discuss equivocal or unexpected results and all results should be sent to the clinic in writing (by fax if necessary). Results should not be given to a client on the basis of a telephone report.

10. On site medical back-up at a senior level must be available at all times for the testing clinic and to provide immediate medical follow up (including confirmatory testing) for those found to be infected.

11. Close liaison with local genito-urinary medicine service to ensure that patients needing assessment can be referred with minimal delay.

12. Where a client wants a written report (for insurance, travel etc) it is essential that he or she understands a negative result shows only that there was no evidence of infection at the time the blood was taken.

13. A significant number of clients will be seen with psychological or physical problems that need more specialist care and support. Arrangements should be in place to refer these on appropriately.

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Annex B

COSTS OF ADDITIONAL TEST SITES

1. The costs have been estimated by discussion with clinics currently providing such a service, both inside and outside London. Calculating the costs associated with the testing service has proved difficult because in every case the staff and the accommodation were also used for other services. The costs of the service will form part of the evaluation of existing and planned sites which the Department of Health will carry out and publish.

2. In clinics with a high throughput of clients and where testing was carried out by a laboratory on the same site, the cost per client ranged from £21.85 to £24.98. The cost effectiveness of the service is obviously related to the local HIV prevalence. In this case, the cost per HIV positive client identified would be £1,092-£1,249 if the prevalence among clinic attenders were 2% and £10,925-£12,490 if it were 0.2%. The annual running costs of such a clinic for, say, 1,000 clients would be in the region of £22,000-£25,000.

3. In a clinic where the samples have to be sent by courier to a laboratory elsewhere for testing, and where the throughput of testing is not very high, the cost per client could be as high as £77.78. In this case the cost per HIV positive client identified would be £3,889 if the prevalence among clinic attenders were 2% and £38,890 if it were 0.2%.

4. The costs do *not* take account of the capital costs of providing a space for the clinic, or the costs of treatment and care for those identified as HIV positive.

Appendix 7

GUIDELINES FOR OFFERING VOLUNTARY NAMED HIV ANTIBODY TESTING TO WOMEN RECEIVING ANTENATAL CARE [Extract from PL/CO(92)5]

Introduction

1. For the past few years some hospitals have offered voluntary named HIV antibody tests to selected women attending for antenatal care, either because the women were perceived to be at higher risk or because they themselves requested a test. A few hospitals have taken this policy further and offered voluntary named tests to all pregnant women and have consequently identified infected women of perceived low risk who otherwise would have been missed.

2. In 1991 the preliminary results of the Department of Health's anonymised serosurveys showed that 1 in 500 pregnant women attending certain antenatal clinics in London were HIV positive with a prevalence of between 1 in 200 and 1 in 1,000 in those London districts participating in the study. Similar rates have been reported in the anonymised HIV surveys undertaken by the Institute of Child Health using neonatal Guthrie cards.

3. Anecdotal evidence suggests that a significant number of HIV seropositive women are aware of their infection but choose to conceal it for fear of discrimination, pressure to have a termination or pressure to have the child fostered or adopted.

4. This guidance has been prepared to assist professionals and health service managers in deciding when it is appropriate to offer named voluntary HIV testing to all women attending an antenatal clinic and to assist the development of such a service. The Department of Health wishes to encourage the introduction of this policy in areas of known or suspected higher prevalence of HIV because, on balance, there may be clinical benefits to the mother and to her child of knowing their serostatus. In low prevalence areas those with risk factors (based on the clinical history) or those who request a test should continue to be offered one.

Issues to Consider

5. *Consent to testing*

As with other tests performed on pregnant women there must be no assumption of

consent to a test for HIV antibodies. Explicit consent to testing should be obtained after appropriate pre-test information and discussion to ensure that the woman understands the purpose of the test, what it determines, the benefits and possible problems for herself, her partner and her unborn child of having a test, when the results will be available and that these results are confidential. Some women will wish to involve their partner in a decision about the test and provision will need to be made for this. It is particularly important for women from black and ethnic minorities that the discussion and counselling takes account of their language and culture.

6. *Confidentiality*

6.1 All health professionals owe a common law duty of confidentiality. The consent of the woman will be required before the result of a test is given to anyone. Only those with direct clinical responsibility should be informed that a woman is seropositive.

6.2 The United Kingdom Central Council for Nursing, Midwifery and Health Visiting states in its Code of Professional Conduct that its registered practitioners should *"Respect confidential information obtained in the course of professional practice and refrain from disclosing such information without the consent of the patient/client except where disclosure is required by law or by the order of a court or is necessary in the public interest".*

6.3 Similarly the Guidance from the General Medical Council states *"The Council believes that, where HIV infection or AIDS has been diagnosed, any difficulties concerning confidentiality which arise will usually be overcome if doctors are prepared to discuss openly and honestly with patients the implications of their condition, the need to secure the safety of others, and the importance for continuing medical care of ensuring that those who will be involved in their care know the nature of their condition and the particular needs which they will have."*

7. The Benefits of Voluntary Named Antenatal Testing

For the Woman

7.1 If the test results are available early enough the woman and her partner will have time to consider fully the options for future care during and after the pregnancy, including whether to breast feed (see paragraph 7.5) and the question of possible

early termination of the pregnancy (provided the requirements of the Abortion Act 1967 are met).

7.2 Some women may wish to consider having the child fostered or adopted. Advice and counselling for these women should be available. (See "HIV Infected Children: Guidance for Local Authorities" Department of Health, December 1992).

7.3 The woman can be referred to a specialist for further follow-up, management and treatment of her infection. This can include the option of prophylaxis against opportunistic infections or the use of antiretroviral drugs at an appropriate time according to her clinical state.

7.4 The woman can also be counselled on how to avoid transmitting the infection to her sexual or drug injecting partner.

For the baby

7.5 Avoidance of invasive procedures before and during labour (eg rupture of membranes, the application of fetal scalp electrodes and blood sampling) may reduce the incidence of transmission from mother to child.

7.6 HIV infection is transmitted through breast feeding. Current estimates are that breast feeding about doubles the risk of transmission from mother to child. The World Health Organisation advises that in developed countries breast feeding by HIV infected mothers should be discouraged. The Department of Health supports this and recommends that women at risk should be counselled about the dangers of transmission by breast feeding.

7.7 All babies born to HIV positive women carry the maternal antibody for 6-10 months (and sometimes up to 18 months) and thus will test positive at birth. Although current estimates are that in Western countries only approximately 15-20 per cent of these babies are infected they should all be referred to a paediatrician for follow up. New diagnostic procedures are being developed that may eventually enable infected babies to be identified soon after birth. This means it will be possible to introduce prophylactic therapies which may delay or prevent the onset of life threatening opportunistic infections with more confidence at an earlier stage. A few vertically

infected children are living into their teens and it is possible that these prophylactic therapies may allow more to do so.

8. Potential Disadvantages of Being Tested

The potential disadvantages of having a test will also need to be discussed with the woman before she consents to testing. They include:

8.1 If found to be infected:

- the need to cope with the medical, psychological and social implications of knowing she has a potentially lethal infection and the significance of this for herself, her child and other family members
- the impact this diagnosis might have on her personal and family relationships (including discrimination) and the possible need for further individual and group support.

8.2 If found to be negative:

- there has been concern over the possible difficulties in obtaining life insurance after a negative test result. However, the Association of British Insurers has issued a statement of reassurance for women being tested as part of their antenatal care. (Annex A.)

Implementing Antenatal Clinic Testing

9. *WHO should be offered a test?*

9.1 Studies have demonstrated that offering the test selectively to women considered to be at higher risk or who request the test will miss those who are infected but believe themselves to be at little or no risk. Therefore in higher prevalence areas there is a need to consider offering the test to all women.

9.2 In low prevalence areas women should also be given information about the HIV antibody test. This could be included in information given them about their pregnancy, about the tests that are usually offered to all women and the tests that are sometimes offered (or which are available on request). The HIV antibody test should be offered to those requesting it and to others where the history suggests that they may have been at risk.

9.3 Offering an HIV test to all women receiving antenatal care has resource implications and it would not be sensible to introduce it throughout the country, especially in rural areas with a very low prevalence of HIV. Higher levels of infection are likely to be found in urban areas, particularly in the inner cities.

9.4 The decision to offer HIV antibody testing to all women attending an antenatal clinic should be based on knowledge of the local prevalence of HIV infection, the local demography and on any other information that suggests that there could be a significant incidence of HIV infection in the area, for example the prevalence of injecting drug misuse. The local policy should therefore be decided following consultation with the consultant obstetrician(s), the head of midwifery, local Director of Public Health Medicine, the pathology services and the local director of anonymised antenatal studies if these are being carried out in the locality. Alternatively, the Communicable Disease Surveillance Centre could be consulted about anonymised serosurvey results in demographically similar districts. Annex B sets out a costings model prepared by the Department's Economics and Operational Research Division which should assist in reaching a decision.

10. *WHEN to offer testing?*

Ideally testing should be offered as early as possible in pregnancy. This may miss a very small proportion of women who are in the window period of seroconversion or who become infected during their pregnancy. Women who believe that they have been at recent risk of infection but test negative should be offered a further test later in pregnancy. They should be counselled to ensure that they understand that in spite of the negative test they may be infected and infectious. Women who book late in pregnancy should also be offered the test in the same way as those who book early.

11. *HOW to offer such testing?*

11.1 The test must only be performed with the woman's explicit consent (see paragraph 5) obtained after appropriate pre-test discussion in private. Consent may be obtained by midwives or doctors who have received training about the issues or by specialist counsellors.

11.2 Some clinics have found that it is helpful to provide women with written information

about the test *before* they attend the clinic. As with the pre-test discussion, leaflets should pay regard to the languages, cultures and education of those attending the clinic.

11.3 Where it is local practice for the initial blood tests in pregnancy to be taken by primary care staff then general practitioners, their staff and community midwives will need education and training about HIV and about obtaining consent as testing for HIV antibodies is most appropriately done at this time.

11.4 Some women, both in hospital and in primary care clinics, may need referral to a specialist counsellor before deciding whether to have a test if they have particular anxieties or difficulties. Such a specialist counsellor may or may not be attached to the antenatal clinic but ideally they should be available to see the woman during that clinic attendance.

11.5 The management of the pregnancy of a woman who decides not to be tested should be the same as that of others attending the clinic. The woman's decision should not be taken as an indication that she is infected or that she has been at risk of infection.

11.6 It should be remembered that the test is carried out for the benefit of the woman and her baby, not for the protection of those involved in her care. Infection control considerations should be met by strict adherence to a basic standard of personal hygiene and safe working practices. Published recommendations should be applied to all women before, during and after delivery.

12. ***HOW to inform the woman of the test result.***

12.1 Policy will be needed on how and where all women will be informed of their results (this should be in person, whether they are positive or negative) so that the information can be given in privacy and immediate anxieties addressed. Particular care needs to be taken over the post-test counselling of HIV positive women and which member of staff should inform them. It could be the GP, clinic doctor or midwife – as long as they have been appropriately trained – or they may wish to use the support of a specialised counsellor. There should be strong links too with clinicians with expertise in HIV disease so that those found to be infected can receive any necessary immediate care and support.

12.2 Waiting for the result of an HIV antibody test is stressful for many people, especially those who believe that they have been at risk and the delay between a person being tested and receiving the result should be as short as possible. This is particularly important in antenatal testing as women may wish to discuss the question of continuing the pregnancy. The local pathology services should be involved in drawing up a protocol for antenatal clinic testing as they will need to make arrangements for performing the tests and providing results in a timely way.

13. ***WHAT services will be required for the infected women and their children?***

13.1 Mechanisms need to be in place to care properly and sensitively for those found to be HIV antibody positive. In practice this will mean that before the introduction of such a programme the following services need to be identified and in place:

For the Pregnant Woman

13.2 Appropriately trained midwives with the knowledge to support the woman and co-ordinate her care throughout the pregnancy.

13.3 In addition to the obstetrician, a physician with an interest in HIV infection to provide specialised care during and after the pregnancy.

For the Baby

13.4 A paediatrician with appropriate expertise involved with the care of the woman before as well as after the birth of the child.

13.5 The paediatrician and microbiologist need to make arrangements to obtain the more specialised investigations that may be required to establish as early as possible whether the child is infected or not.

13.6 Health visitors with knowledge and expertise about HIV infection and AIDS.

For the Family

13.7 The care and support needs of the family will need to be co-ordinated. The services offered should pay regard to the wishes of the woman. A number of agencies are likely to be involved in providing medical, psycho-social and respite care when required. Policies will need to be drawn up with the assistance of local General

Practitioners, Directors of Midwifery, the Social Services of Local Authorities and of voluntary organisations.

13.8 Arrangements need to be made for the medical follow up of the woman, the seropositive baby and other infected family members. Ideally facilities should be available to enable all the infected family members to be seen together if that is their wish. In some areas there may be sufficient numbers of infected families to justify setting up specialised "family clinics".

A checklist is at Annex C.

14. Conclusion

14.1 The Department of Health wishes to encourage the introduction of a policy of offering named voluntary testing to all women attending antenatal clinics in areas of known or suspected higher prevalence of HIV infection.

14.2 Testing for HIV antibodies should only be performed with the woman's explicit consent obtained after appropriate pre-test information and discussion (in private) with a midwife or doctor who have received education and training about HIV or with a specialised counsellor. Information and pre-test discussion should be available that pays regard to the languages and cultures of women from ethnic minorities attending the clinic.

14.3 A programme of education and training for doctors and midwives in the hospital services and in the community and for health visitors should be in place before a such a policy is adopted.

14.4 Professionals and managers should ensure that services are available for any women and their seropositive children and for their family who are identified by the testing programme.

Annex A

STATEMENT AGREED BETWEEN THE DEPARTMENT OF HEALTH AND THE ASSOCIATION OF BRITISH INSURERS ON THE IMPLICATIONS FOR WOMEN TESTED FOR HIV ANTIBODIES WHILE RECEIVING ANTENATAL CARE

"The results of an HIV test taken as part of antenatal care need to be declared on any future proposals for life insurance (existing policies will not be affected). If the result is negative your application for life insurance will not be affected in any way provided you make it clear that the test was taken as part of routine antenatal care. However, where there is a serious medical condition or there are other risks unconnected with the test, normal underwriting considerations will apply and it may be that a very small percentage of those taking part will still be charged an additional rate of premium."

Annex B

COSTS OF VOLUNTARY NAMED ANTENATAL TESTING FOR HIV

Summary

- The cost to a district caring for 3,500 women with an 80% uptake of testing would be in the region of £28,000. (Given certain assumptions detailed in the Table.)
  (Table 1)
- In such a district the cost per truly infected child detected would range from, for example £18,000 if the prevalence of HIV infection among pregnant women were 1:200 to £870,000 if the prevalence were 1:10,000.
  (Table 1)
- The take up rate of testing has a major effect on the cost-effectiveness of the scheme.
  (Table 2, paragraphs 6-8)
- If the test is offered by the GP, the costs to the district would be increased by about £16,000.
  (paragraph 9)
- Some districts may decide that the population they serve would need more than basic pre-test counselling. This could increase the cost per district by up to £21,000.
  (Table 3, paragraph 10)
- These figures do not include the capital costs of providing additional space at the clinic, or the costs of caring for women and children identified as HIV positive.

1. A basic model has been developed to estimate the costs of introducing a programme of voluntary named antenatal testing. It takes into account HIV prevalence among pregnant women, proportion of women tested, estimates of the likelihood of transmission of HIV from mother to baby, women requesting terminations and costs of testing and pretest counselling.

2. The estimated cost associated with performing the test takes account of costs of obtaining the sample, administrative costs, reagent costs, confirmatory testing,

laboratory staff time, senior supervisory staff time, laboratory equipment costs and the costs of laboratory space. It is based on the best estimates currently available, in advance of full evaluation of existing HIV test schemes. Depending on the number of tests carried out and the standard set for the time to provide a result, it may be possible to reduce the costs by carrying out the tests in large batches. This calculation assumes there is no large scale batching.

3. The costs of pre-test counselling are included. It is assumed that the counselling will generally be carried out by the midwife and that the average time taken will be 10 minutes, with some women requiring longer and some taking less time. This calculation only applies to the costs associated with testing. Thus, none of the costs of providing treatment, care and counselling to infected women and children are included.

4. Table 1 shows the figures for one year, for a district caring for 3,500 pregnant women and assuming 80% of all women, regardless of HIV antibody status, choose to be tested for HIV antibodies. The Table shows, for different local HIV prevalences, the number of women likely to be found HIV positive, the number of truly infected children identified, and the average cost for each infected child identified and the total cost to the district. As not all women choose to take the test, some children will be born to mothers who are HIV positive but do not realise it. The estimated number of these cases is shown in the last line of the table.

5. The four columns of the Table represent seroprevalences of 1:200, 1:500, 1:1,000 and 1:10,000 respectively. The figures used are based on the results of anonymised-unlinked serosurveys among pregnant women and neonates (published May 1991). The worst affected districts in inner London had a prevalence of about 1:200, the average for inner London was 1:500, for outer London, the figure was 1:1,000 and in areas outside London areas the prevalence was about 1:10,000 or less.

6. Experience to date shows that the uptake of testing is very dependent on the type of counselling given. Some clinics have found that uptake can be as low as 40%. Table 2 contains the results of the calculations if uptake of testing is only 40%. This shows the effect of uptake of testing on the likelihood of identifying infected women and

babies, and the cost per truly infected child identified.

7. So far, we have assumed that women who are at high and low risk of infection are equally likely to take a test. This may not be the case. If the counselling process is effectively informing and reassuring women and 80% of those who are infected choose to take a test (but 50% of those who are not infected decide they are at very low risk of infection and a test would be unnecessary) the number of truly infected children identified in a district with 1:500 seroprevalence would be 0.6 and the cost per child detected £35,000.

8. However, if women who consider themselves at risk of HIV infection are afraid of negative consequences following a positive test, and if the counselling does not reassure them, take up of testing may be lower amongst HIV positive women. For example, again in a district with a prevalence among pregnant women of 1:500, if 50% of HIV positive women, and 80% of HIV negative women choose to be tested, the number of truly infected children identified in a year would be 0.4, and the average cost per child identified would be £71,000.

9. Some districts are considering offering the HIV test when the pregnant woman visits her GP. This would probably mean that the GP provided the pre-test counselling. In a district with prevalence of 1:500 and assuming an 80% take up of testing, (comparable with column 2 of Table 1) this would increase the cost to the district to £44,000 and the cost per truly infected child identified to £73,000 (compared with £28,000 and £44,000 if the counselling is provided by the midwife).

10. In some areas it may be necessary to spend more time on pre-test counselling, for example in a high prevalence area where the clinic is seeing more women at risk of HIV infection. Table 3 shows the costs for a district where 80% of women choose to be tested (comparable with Table 1) if the average time spent on pre-test counselling by the midwife is 21 minutes, and a part time Senior Health Adviser is employed to give more in depth counselling where necessary. In a high prevalence area (1:200) this would only increase the costs per truly infected child detected by £13,000. It would not be desirable to do this in an area of low prevalence for example 1:10,000 where the additional cost per truly infected child detected would be £680,000.

11. These costings include an estimate of the running costs of accommodation in the clinic for additional staff, but no capital costs for extra space which may be required. They also exclude the costs of providing care for any women and children identified.

Table 1

Estimated Cost Effectiveness Assuming High Take Up of Testing by all Women and Pre-Test Discussion with Health Care Worker

	HIV PREVALENCE AMONG PREGNANT WOMEN			
	1:200	**1:500**	**1:1,000**	**1:10,000**
Number of Infected Women Identified	13.3	5.3	2.7	0.27
Cost/HIV Positive Woman Detected	£2,100	£5,300	£10,400	£104,000
Children Born to Known HIV Positive Mothers	11.3	4.5	2.3	0.23
Truly Infected Children Identified	1.6	0.6	0.3	0.03
Cost/Truly Infected Child Identified	£18,000	£44,000	£87,000	£870,000
Cost of Named Voluntary Antenatal Testing	£28,000	£28,000	£28,000	£28,000
Births to HIV Positive Mothers whose infection is not known	3.5	1.4	0.7	0.07

Number of HIV infections likely to be identified in women and children and cost per truly infected child identified. Assuming an average of 3,500 births per year, take up of testing is 80% among all women, cost of performing test £7.21, cost of counselling £2.33, 15% of HIV infected mothers request a termination, 14% transmission rate from mother to child during or before birth.

Table 2

Estimated Cost Effectiveness Assuming Low Take Up of Testing by all Women and Pre-Test Discussion with Health Care Worker

	HIV PREVALENCE AMONG PREGNANT WOMEN			
	1:200	**1:500**	**1:1,000**	**1:10,000**
Number of Infected Women Identified	6.6	2.7	1.3	0.13
Cost/HIV Positive Woman Detected	£2,700	£6,700	£13,800	£138,000
Children Born to Known HIV Positive Mothers	5.7	2.3	1.1	0.11
Truly Infected Children Identified	0.8	0.3	0.2	0.02
Cost/Truly Infected Child Identified	£23,000	£56,000	£117,000	£1,170,000
Cost of Named Voluntary Antenatal Testing	£18,000	£18,000	£18,000	£18,000
Births to HIV Positive Mothers whose infection is not known	10.1	4.0	2.0	0.20

Number of HIV infections likely to be identified in women and children and cost per truly infected child identified. Assuming an average of 3,500 births per year and take up of the test is 40% among all women. Other variables as shown in Table 1.

Table 3

Estimated Cost Effectiveness Assuming High Take Up of Testing by all Women and Pre-Test Discussion with Additional Specialist Counselling

	HIV PREVALENCE AMONG PREGNANT WOMEN			
	1:200	**1:500**	**1:1,000**	**1:10,000**
Number of Infected Women Identified	13.3	5.3	2.7	0.27
Cost/HIV Positive Woman Detected	£3,700	£9,200	£18,100	£181,000
Children Born to Known HIV Positive Mothers	11.3	4.5	2.3	0.23
Truly Infected Children Identified	1.6	0.6	0.3	0.03
Cost/Truly Infected Child Identified	£31,000	£78,000	£155,000	£1,550,000
Cost of Named Voluntary Antenatal Testing	£49,000	£49,000	£49,000	£49,000
Births to HIV Positive Mothers whose infection is not known	3.5	1.4	0.7	0.07

Number of HIV infections likely to be identified in women and children and cost per truly infected child identified. Assuming an average of 3,500 births per year, take up of testing is 80% among all women, cost of performing test £7.21, cost of counselling £9.04, 15% of HIV infected mothers request a termination, 14% transmission rate from mother to child during or before birth.

Annex C

CHECKLIST FOR THE INTRODUCTION OF VOLUNTARY NAMED ANTENATAL HIV TESTS

1. Information gathering

Sketch local picture:

- Numbers of reported AIDS cases and reports of seropositive people in the District or Region and their breakdown by age, sex and route of transmission
- Local demography, in particular are there women especially at risk of HIV infection, eg injecting drug users or the sexual partners of drug users, ethnic minorities from countries with a high prevalence of HIV infection in the heterosexual population
- Published or unpublished information on incidence of seropositive women attending local antenatal clinics and numbers of HIV infected children attending paediatric clinics
- Information from any local anonymised serosurveys in antenatal clinics or of Guthrie tests of neonates.

2. When drawing up a protocol appropriate to local circumstances you will need to consider:

- People you need to involve:
  - Obstetric staff
  - Midwives and nursing staff
  - Physician responsible for HIV services
  - Paediatric staff
  - Pathology services
  - Counselling services
  - Local GPs providing maternity services
  - HIV Co-ordinator/DHPC
- Whether to consult patient's representatives eg CHCs and voluntary groups including those representing black and ethnic minorities
- Whether testing should be offered to all or whether testing should be offered on a selective basis
- How to provide information at or before first attendance about investigations

usually offered (eg rubella screening etc) and those offered in particular circumstances

- How and where the pre-test discussion and result giving will be handled and the need for privacy
- Management of HIV positive woman during pregnancy and labour
- Other issues to consider:
  - ~ availability of a service for early termination of pregnancy
  - ~ issues of confidentiality
    - how result will be recorded
    - which staff need to be informed
    - the need for consent to inform GP of result
  - ~ at what point to involve the paediatrician and family support services
- Clinical management of HIV positive baby
- Need for care and support of the family
  - ~ provision of appropriate psycho-social support and counselling
  - ~ involvement with local GP
  - ~ access to social services for benefits if needed
  - ~ consider how, if needed, all infected members of a family could be cared for at the same clinic
  - ~ fostering and adoption policies for HIV positive children (See "HIV Infected Children: Guidance for Local Authorities" Department of Health, December 1992).
- Laboratory services:
  - ~ how results will be reported and how quickly.
- Training
  - ~ all clinical staff will need education and training about HIV infection and the issues it raises.
- Monitoring and evaluation
  - ~ programmes should be monitored and evaluated to assist in their further development eg:
    - uptake of testing and could it be improved
    - why women refuse and is there a practical solution to this
    - demographic breakdown of the characteristics of those who accept and refuse testing

Appendix 8

GUIDANCE ON PARTNER NOTIFICATION FOR HIV INFECTION [Extract from PL/CO(92)5]

Introduction

1. The purpose of this guidance is to assist health care professionals, Health Authorities and Trusts in the development of local policies and guidelines aimed at identifying sexual or drug injecting partners of people infected with HIV who might have been put at risk of the infection and who may wish to consider whether to seek an HIV antibody test. Partner notification should be part of comprehensive, co-ordinated HIV and STD prevention, care and support programmes, not an isolated activity.

Development of Partner Notification

2. Partner notification (contact tracing) for sexually transmitted disease (STD) has been a central activity in the control of STDs in the UK for more than 40 years. In the early years of the HIV epidemic, when many of those infected had multiple partners over many years, it was the view of some experts that it was impractical and unproductive as a method of limiting the spread of the infection. Nevertheless, the majority of physicians have always counselled those infected with HIV about the need to inform their sexual or drug injecting partners.

3. Because of the advent of therapies which delay the progression of HIV disease and also because of changes in the nature of the epidemic (ie spread to heterosexuals in low prevalence areas where those infected might not perceive themselves at risk) there has been increasing discussion about, and research into, the importance of partner notification, including notification by clinic staff ("provider referral" – see definitions below).

Definitions: (from WHO consultation document WHO/GPA/ESR/89.2)

"**Partner notification**: that public health activity in which sexual partners of individuals with HIV infection and those sharing injecting equipment are notified, counselled about their exposure, and offered services. Partner notification consists of two general approaches: patient (index person) referral; and provider referral.
Patient (index person) referral: the approach by which HIV-infected persons are encouraged to notify partners of their possible exposure to HIV, without the direct involvement of health care providers. In this approach the health care provider counsels the HIV-infected person with regard to the information to be passed on to their partners and ways of doing it.
Provider referral: the approach by which health care providers or other health workers notify an HIV-infected person's partners. In this approach HIV-infected persons give their partners' names to health care providers or other health workers, who then confidentially notify the partners directly. This notification can be undertaken in the context of primary health care and may involve the index person as well as the health care providers or other health workers."
[Note – for the purposes of this document partner notification is synonymous with contact tracing.]

4. While most physicians actively encourage partner notification by or with the consent of the infected person, practice varies, most partner notification being undertaken by the infected person with the support of the clinic.

The Benefits of Partner Notification

5.0 Partner Notification can be of benefit to the person notified and to the public health

- identification of contacts who are given the opportunity to consider whether they wish to be tested
- those who have unknowingly been infected may wish to know that they are to enable them to take steps to prevent transmission to others
- women who may have been infected may wish to be tested to help them decide whether to take steps to prevent conception and to help them make decisions about the management of a pregnancy and about breast feeding
- access of infected contacts (including children of infected mothers) to treatment and support programmes so that they may benefit from long term monitoring of their clinical condition and from appropriate therapies (ie prophylaxis against pneumocystis pneumonia and possibly anti-retroviral therapy) and from appropriate psychological support
- identification of uninfected contacts who could also, where appropriate, be counselled about avoiding risky behaviour in the future.

Issues to Consider and Potential Disadvantages

Informed consent to testing and to partner notification

6. Seeking an HIV antibody test is voluntary. Because of the medical, psychological and social implications of being found to be infected the test should only be carried out following appropriate pre-test discussion and with the explicit consent of the individual. The General Medical Council and the United Kingdom Central Council for Nursing, Midwifery and Health Visiting guidance on HIV testing both state: "...the test should be carried out only where the patient has given explicit consent."

7. Partner notification by the provider should be undertaken only with the infected individual's explicit consent obtained without undue pressure. The General Medical Council has issued guidance on the exceptional instances when partner notification

without consent might be considered. ("HIV Infection and AIDS: The Ethical Considerations". General Medical Council April 1991).

The infected person should understand the consequences for himself or herself of notifying partners and the consequences for those partners. For example:

- for the infected person
  - ~ when the index case informs partner(s) (or where information implicitly identifies the index case) there will be automatic loss of confidentiality about his or her HIV status to those partners who may then inform others
  - ~ consequent risk of discrimination and of harassment.
- for the person notified
  - ~ anxieties about possibly having a potentially lethal illness
  - ~ the need to decide whether to seek a test
  - ~ possible future difficulty obtaining insurance for those not infected.

Confidentiality

9. All health professionals owe patients a common law duty of confidentiality and additionally within Health Authorities and Trusts are bound by the duty of confidentiality imposed under the NHS (Venereal Disease) Regulations 1974 and the National Health Service Trust (Venereal Disease) Directions 1991 which apply to all Health Authority and Trust clinics.

10. That patients have a right, albeit not an absolute right, to medical confidentiality is well recognised by health care workers.

11. Equally there is the need to recognise that confidentiality helps to protect the public health. Without it patients with sexually transmitted diseases, including HIV infection, may be unwilling to come forward for diagnosis, treatment and counselling.

Undue pressure

12. Clinic attenders have a right to expect to be treated sensitively and not to be put under undue pressure to notify partners or to agree to provider referral. There is also the danger that if there is a perception that patients are put under pressure to reveal names of partners then those at risk might be deterred from coming forward.

Partner notification in settings other than Genito-urinary medicine (GUM) clinics

13. HIV infection is not always a sexually **acquired** disease and some patients have always been cared for in settings outside GUM services. However it is always a sexually **transmissible** disease.

14. When HIV infected people are cared for in settings other than GUM clinics the question of notifying sexual partners should be part of any counselling provided. (See paragraphs 29-32).

Resources

15. Partner notification by the infected person may have few implications for resources as discussion and counselling about telling partners that they may be infected is already part of good clinical practice and should be raised during pre-test discussion and post-test counselling.

16. The Department also wishes to encourage provider referral for those sexually transmitted diseases (including HIV infection) for which it is appropriate and when infected persons are willing for partners to be informed but are unable or unwilling to make the approach themselves. The Department recognises that extra resources will be required for this. These should be met from mainstream allocation of funds and from AIDS allocations. The possible costs of partner notification are discussed in the Annex.

Research and evaluation

17. The effectiveness and benefits of partner notification will vary depending on the setting. Research and evaluation studies will be necessary to determine, for example:

- the general effectiveness of partner notification including its cost/benefits, as a component of the Authority's HIV and STD prevention programmes
- the relative effectiveness and acceptability of the various strategies adopted
- the evidence for sustained behaviour changes as a result of the partner notification
- the outcome of referral of notified persons for diagnosis, treatment, care and support
- any effect of offering partner notification on attendance at the clinic.

Implementing Partner Notification for HIV infection

WHAT is needed?

18. The Department accepts that the way in which Health Authorities implement policies on partner notification will vary depending on a number of factors including the local prevalence, the populations served and the geographical setting.

19. When a policy on partner notification for HIV infection is being developed managers will need to draw on the professional skills and knowledge of the medical, nursing and health advisory staff in GUM services. In addition it may be helpful to consult other clinical disciplines that care for people with HIV infection and with voluntary organisations and others with an interest.

20. When formulating and implementing partner notification programmes it is essential to take into account the attitudes, beliefs, practices and language needs of black and ethnic minorities likely to attend the clinic.

21. Managers will need to ensure that services are quickly and easily available for people notified that they have been exposed to HIV and other STDs to minimise the period when they have no access to expert support. They will also need to ensure that facilities are available to provide long term follow up, treatment, care and support for those found to be infected with HIV.

WHEN should partner notification be encouraged?

22. Preliminary discussion about the need to tell sexual or drug using partners should be part of every pretest discussion about testing for HIV antibodies.

23. Ultimately each individual found to be infected will make his or her own decision about whether to tell a partner or partners at risk and how to tell them. Health workers responsible for informing a person that he or she is infected must be prepared to discuss whether and how that person's partners are to be told and to put to the person the benefits and disadvantages of the notification in a clear and unbiased way.

WHO should discuss informing partners with the client?

24. A variety of caring professionals (doctors, nurses, midwives, health advisers etc) may

be called upon to tell someone that he or she is infected with HIV. Appropriate training for these workers will be essential to enable them to discuss with the person the need to tell the partner or partners. The health care worker will need to discuss with the infected individual how notification is to be achieved and what support is needed for the notifier and notified.

25. When an infected person requests the assistance of the clinic in notifying partners (provider referral) then the special skills of health advisers may be needed.

26. Employing authorities have the responsibility to ensure that the skills associated with partner notification are enhanced for all care professionals involved in the process. In particular they need to provide specific education and training (including domiciliary work) for all Health Advisers.

WHERE should partner notification be discussed?

27. Only a proportion of tests for HIV infection are performed in GUM clinics. Managers and clinicians should ensure that those found positive in other settings are offered support and counselling about the question of informing their partners.

28. They should also consider whether there is a need for provider referral notification programmes in these settings. If there is a need then managers should consider how best to utilise the expertise of Health Advisers in these settings.

29. The need to inform drug users' sexual or injecting partners is a particularly difficult area, not least because the use of drugs is illegal, but the Department wishes to encourage partner notification in drug dependency settings.

30. Partner notification arrangements for those found positive in general practice, in maternity services, haemophilia and other specialties will also need to be provided.

Conclusion

31. There should be discussion about informing sexual and drug injecting partners whenever a person is found to be infected. The person should be encouraged to inform his or her partner(s) but should be counselled in an unbiased way and not put under undue pressure.

32. Each Health Authority or Trust, in consultation with health professionals and other interested parties, should provide adequate facilities for partner notification by clinic staff (provider referral) when this is requested by the infected person.

33. Partner notification both by the infected person and through provider referral is an issue for all settings in which testing for HIV infection is performed. Managers and clinicians will need to consider how best to utilise the expertise of Health Advisers in settings other than GUM clinics.

34. All staff with responsibility for informing a person that he or she is infected with HIV should have appropriate education and training about partner notification and the need to maintain confidentiality.

COSTS OF PARTNER NOTIFICATION

1. The costs of partner notification will vary according to the local prevalence, the populations served and the geographical setting. These will influence factors such as the proportion of patients requesting provider referral, the amount of support required to help patients with patient referral, the average number of contacts for each index patient, the amount of time required to follow up each contact.

2. Current practice around the country is very varied with regards to the extent of patient and provider referral. This has two consequences. Firstly, information about costs is only available for clinics serving some populations, generally in lower prevalence areas. Secondly, the extent to which implementing formal partner notification implies additional activities and thus resources, varies across the country but is generally greatest in higher prevalence areas. As discussion of partner notification is an integral part of pre and post-test counselling, and the ongoing support of the patient, it is not easy to estimate the time actually attributable to partner notification.

3. Costs and effectiveness will form part of an evaluation of partner notification which will be carried out and published.

4. In order to estimate the costs of partner notification the Department held discussions with a number of professionals working in different areas of the country in an attempt to capture the spectrum of variable factors in a range of costs.

5. For the purposes of cost estimation, it has been assumed that the work will be carried out by Health Advisers. This would be the case for provider referral, but discussion of provider referral during pre and post-test counselling may be done by doctors, nurses or midwives.

6. Information from a range of settings suggests that for each index case, about 4-5.5 hours of Health Adviser's time would be required for partner notification. The approximate cost per index case would be £106-£133 (including estimated costs of travelling, stationary, telephoning and so on).

7. This includes the cost of HIV testing for partners notified and the Health Adviser's

time discussing partner notification with the index case and contacting and providing initial counselling to the partners. It excludes the costs of any other tests performed and the ongoing costs of care and support for the partners. The capital costs of providing accommodation for additional staff are also excluded.

8. Thus, in a region seeing 500 new HIV infected people (average for the Thames regions) per year, about 2,000-2,750 hours of Health Adviser's time would be taken up solely by partner notification for HIV. The full running costs of the service would be in the region of £53,000-£66,500. In addition to these costs, it would be necessary to provide ongoing training for each Health Adviser involved in partner notification. Carrying out provider referral is demanding and stressful and a certain amount of time needs to be allocated to management and support of the Health Advisers. Thus the overall cost to the region would be about £58,000-£71,500.

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Guidance for Clinical Health Care Workers, Protection Against Infection with HIV and Hepatitis Viruses, Recommendations of the Expert Advisory Group on AIDS, HMSO, January 1990 (ISBN 0 11 3212496)
AIDS-HIV Infected Health Care Workers: Occupational Guidance for Health Care Workers, their Physicians and Employers, Recommendations of the Expert Advisory Group on AIDS, DH, December 1991.

14. Contact in CDSC for advice on anonymous surveys or CD4 counts:
PHLS AIDS Centre at
PHLS Communicable Disease Surveillance Centre
61 Colindale Avenue
London NW9 5EQ
Tel. 081-200-6868

15. Department of Health PL/CO(92)5 Guidance on alternative test sites (reproduced in Appendix 6).

16. Department of Health PL/CO(92)5 Guidance on antenatal clinics (reproduced in Appendix 7).

17. General Medical Council, HIV Infection and AIDS: The Ethical Considerations, April 1991.

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19. Guide to a Healthy Sex Life, (HEA STD 23 ISBN 0 903652 70 6)
Gonorrhoea – What it is and What to do about it (HEA 1992 ISBN 1 85448 292 0)
Genital Warts – What they are and What you can do about them (HEA 1992 ISBN 1 85448 282 3)
Chlamydia and NSU – What they are and What you can do about them (HEA 1992 ISBN 1 85448 277 7)
Vaginal Infections – What they are and What to do about them (HEA 1992 ISBN 1 85448 287 4)
Herpes. What it is and What to do (HEA STD 98)
Thrush. A Self Help Guide (HEA M 93 ISBN 0 903652 66 3).

20. Department of Health and Social Security, Report of the Working Group to examine Workloads in Genito-Urinary Medicine Clinics, 1988. Known as the Monks Report.

21. Supplement 1 to Health Building Note 12, HMSO 1990.

22. EL(92)18, Allocation for HIV and AIDS Work, March 1992, deals with the provision of condoms through GPs. Copies can be obtained from DOH Store, Health Publication Unit. See List of useful organisations.

23. Frischer M (1992), Estimating the Prevalence of Injecting Drug Use in Glasgow, British Journal of Addiction, 87, 2, 235-243.

24. Prevention. Report of the Advisory Council on the Misuse of Drugs, Home Office, HMSO 1984.

25. Department of Health, Drug Misuse and Dependence: Guidelines on Clinical Management, HMSO (1991).

26. Donoghue M, Dolan K and Stimson G V, (1992), The Impact of Syringe Exchange Schemes in England: Service Delivery and Organisation, Client Characteristics and HIV Risk Behaviour. Report to the Department of Health, London, The Centre for Research on Drugs and Health Behaviour.

27. Working Where the Risks Are: Issues in HIV Prevention, Chapter "Health, Drug Users and HIV Prevention, (Farrell M and Strong J), Health Education Authority, 1992.

28. AIDS and Drug Misuse Part 1. Report of the Advisory Council on the Misuse of Drugs. Department of Health and Social Security, London, HMSO, 1988.
AIDS and Drug Misuse Part 2. Report of the Advisory Council on the Misuse of Drugs. Department of Health, London, HMSO, 1989.

29. Family Planning Services: A Model for District Health Authorities, The Family Planning Association, 1990.

30. The Sex Education Forum is an independent body representing organisations involved in providing support and information to those who provide sex education to young people.
Contact: The Information and Development Officer, The Sex Education Forum, National Children's Bureau, 8 Wakeley Street, London, EC1V 7AE.

31. A Framework for School Sex Education. Sex Education Forum 1992.

32. Report of the Royal College of Obstetricians and Gynaecologists Working Party on Unplanned Pregnancy, September 1991 (ISBN 0 902331 54X)
Copies can be obtained from: The RCOG, 27 Sussex Place, Regents Park, London NW1 4RG.

33. Guidelines for Reviewing Family Planning Services, Guidance for Regions, January 1992.
Copies can be obtained from DOH Store, Health Publications Unit, No. 2 Site, Manchester Road, Heywood, Lancs OL10 2PZ.

34. National Curriculum Council 5: Health Education, 1990
(ISBN 1 872676 23 5), National Curriculum Council, 15-17 New Street, York YO1 2RP.

35. EL(92)63, Provision of NHS Sterilisation Operations, May 1991. Copies can be obtained from DOH Store, Health Publication Unit.

NAMES AND ADDRESSES OF USEFUL ORGANISATIONS

PUBLICATIONS:

Department of Health Store

Health Publications Unit

No. 2 Site

Manchester Road

Heywood, Lancs

Department of Employment

ID6, Caxton House

Tothill Street

London SW1H 9NF

Department for Education

Publications Centre

PO Box 2193

London E15 2EU

HMSO Books

Publications Centre

51 Nine Elms Lane

London SW8 5DR:

EDUCATION AND TRAINING:

Health Education Authority

Hamilton House

Mabledon Place

London WC1H 9TX

Tel. 071-383-3833

A special NHS Authority concerned with Health Promotion in England.

HEA Health Promotion Information Centre

Tel. 071-413-1994/5

This provides a wide range of services and resources for both specialist and generalist use. Its library is open to all who work or study in health promotion/education.

Brook Advisory Centre

Education and Publications Unit

24 Albert Street

Birmingham B4 7UD

Tel. 021-643-1554

Can provide educational materials about safer sex including condom demonstrator and materials about sex for adults with learning difficulties and for teenagers.

Joint Committee on Contraception (JCC)

27 Sussex Place

Regents Park

London NW1 4RG

Tel. 071-723-3175

English National Board

Victory House

170 Tottenham Court Road

London W1P 0HA

Tel. 071-388-3131

Central Council for Education and Training in Social Work

Derbyshire House

St Chad's Street

London WC1H 8AA

Local Authority Associations' Officer and Working Group on AIDS

The Local Government Management Board

Management Practice and Development Group

Arndale House

The Arndale Centre

Luton

Bedfordshire LUI 2TS

The National AIDS Counselling Training Unit (NACTU)

St Charles' Hospital

Exmoor Street

London W10

Tel. 081-968-8514/5

Department of Health funded organisation, runs training courses on HIV/AIDS counselling.

HIV/AIDS:

Department of Health

AIDS Unit

Friars House

157-168 Blackfriars Road

London SE1 8EU

Tel. 071-972-2000

Co-ordinates the response of the Department of Health and other government departments to the epidemic.

The All-Party Parliamentary Group on AIDS

1 Abbey Gardens

Great College Street

London SW1P 3SE

Tel. 071-219-5761/6928/6792

Provides information on HIV/AIDS for Parliamentarians and acts as a link between Parliament and HIV/AIDS organisations.

National Aids Helpline

PO Box 1577

London NW1 3DW

(Administration 071-387 6900)

or

PO Box 5000

Glasgow G12 9JQ

(Administration 041-357 1774)

Helplines:

Tel. 0800-567-123. A 24-hour national phone line offering advice, information and referral on any aspect of HIV and AIDS for anyone. The call is free.

Tel. 0800-282-447 – Arabic Languages (6-10pm Weds)

Tel. 0800-282-445 – Asian Languages – Bengali, Gujarati, Hindi, Punjabi and Urdu (6-10pm Weds)

Tel. 0800-282-446 – Cantonese (6-10pm Tues)

For people who are deaf or hard or hearing:

Minicom Tel. 0800-521-361 – Daily 10am-10pm

Call 0800-555-777 for free leaflets about HIV and other health topics.

The Terrence Higgins Trust

52-54 Gray's Inn Road

London WC1X 8LT

Helpline: Tel. 071-242-1010 (3-10pm every day)

Provides health education, information and a wide range of support to people affected by HIV and AIDS.

Black HIV and AIDS Network

111 Devonport Road

London W12 8PB

Tel. 081-749-2828

Provides services to Asian, African and Caribbean people affected by HIV. These include counselling, home care and support. Education courses also offered to statutory and voluntary organisations.

Blackliners

49 Effra Road

London SW2 1BZ

Tel. 071-738-5274

Counselling, care and support service to people affected by HIV/AIDS.

Body Positive

51b Philbeach Gardens

London SW5 9EB

Helpline: Tel. 071-373-9124 (7-10pm Mon-Fri)

Offers a wide and developing range of services and self-help for people who are HIV antibody positive.

Positive Partners

10 Rathbone Place

London W1

Tel. 071-249-6068

Support and self help group for those affected by HIV and AIDS and partners, friends, family and carers.

Positively Women

5 Sebastian Street

London EC1V 0HE

Tel. 071-490-5515

Provides counselling and support services for women with HIV or AIDS.

The Aled Richards Trust

54 Colston Street

Bristol BS1 5AZ

Tel. 0272-297963 (Office)

Helpline: Tel. 0272-273436 (7-9pm Mon-Fri)

Provides a wide range of services to people living with or affected by HIV or AIDS.

Crusaid

21a Upper Tachbrook Street

London SW1 1SN

Tel. 071-834-7566

The National AIDS Trust

14th Floor Euston Tower

286 Euston Road

London NW1 3DN

Tel. 071-388-1188 Ext 3200

Promotes and co-ordinates the voluntary sector response.

NAM Charitable Trust

52 Eurolink Centre

49 Effra Road

London SW2 1BZ

Tel. 071-737-1846

Produces the National AIDS Manual which gives information on HIV related issues and resources and also produces a treatments and trials directory (priced documents). Additionally a monthly newsletter about treatments.

London Lighthouse

111-117 Lancaster Road

London W11 1QT

Tel. 071-792-1200

Large residential and support centre offering a wide range of services.

Mildmay Mission Hospital

Hackney Road

London E2 7NA

Tel. 071-739-2331

Cares for men, women and children affected by HIV or AIDS.

PACE (Project for Advice Counselling and Education)

London Lesbian and Gay Centre

67-69 Cowcross Street

London EC1M 6BP

Tel. 071-251-2689

LEAN (London East AIDS Network)

35 Romford Road

London E15 4LY

Tel. 081-519-9545

Provides a range of support services to people affected by HIV/AIDS in East London. Runs a Black Communities Development Project and publishes leaflets in 12 languages.

British Medical Association for AIDS

BMA House

Tavistock Square

London WC1N 9JP

Tel. 071-387-4499 or 071-383-6345

(Gives advice for physicians only on all aspects of HIV, especially public health policy, human rights and ethical issues).

AIDS Ahead

Head Office: 144 London Road

Northwich, Cheshire

Tel. 0606-330472

Minicom Tel 0606-330472

London Office: FACTS Centre

23-25 Weston Park

Crouch End

London N8 9SY

Tel. 081-342- 8791

Minicom Tel. 081-342-8791

Information for deaf people on HIV and AIDS and on the availability of interpreting services and minicoms for deaf people with AIDS.

British Association for Counselling

1 Regent Place

Rugby CV21 2PJ

Tel. 0788-578-328

Maintains a directory of national and local counselling agencies.

British Association of Social Workers

Special Interest Group HIV

16 Kent Street

Birmingham B5 6RD

Holds regular information seminars.

Bureau of Hygiene and Tropical Diseases

Keppel Street

London WC1E 7HT

Tel. 071-927-2274

Issues AIDS Newsletter 17 times a year giving a comprehensive and up to date abstracts of the latest medical, epidemiological, legal and social aspects worldwide.

London School of Hygiene and Tropical Medicine

Address as above

Tel. 071-631-4408

Extensive reference library open to visitors. Offers consultancy on AIDS and personnel management and a Medical Advisory Service for Travellers Abroad.

Communicable Disease Surveillance Centre

61 Colindale Avenue

London NW9 5EQ

Tel. 081-200-6868

Publishes CDSC Bulletin, with detailed quarterly figures on HIV infections and AIDS in the UK.

Disability Alliance

Universal House

88-94 Wentworth Street

London E1 7SA

Gives advice and information on welfare benefits for people with disabilities.

Durex Information Service for Sexual Health

North Circular Road

London E4 8QA

Provides information on condoms and guide to lubricants which are safe or unsafe to use with condoms.

Employment Medical Advisory Service

Daniel House

Trinity Road

Bootle

Merseyside L20 7HE

Gives free advice from health professionals for employers, employees and trade unions about HIV and AIDS and occupational health.

Haemophilia Society

123 Westminster Bridge Road

London SE1 7HR

Tel. 071-928-2020

Books and leaflets on living with haemophilia and HIV.

Health and Education Research Unit

Department of Policy Studies

Institute of Education

University of London

55-59 Gordon Square

London WC1H 0NT

Tel. 071-612-6820

Publications on HIV and training arising from research on work with young people, adult education, work with men and care needs assessment and evaluation.

London Voluntary Services Council HIV/AIDS Support Unit

68 Chalton Street

London NW1 1JR

Tel. 071-388-0241

Provides networking information for voluntary organisations. Holds a resource directory for voluntary organisations, London HIV/AIDS Voluntary Sector Resource Handbook.

National HIV Nutrition Team

The Interface Partnership

High Street

Hatfield Broad Oak,

Essex CM22 7HE

Provides information on nutrition for people with HIV and AIDS.

National Youth Agency

17-23 Albion Street

Leicester LE1 6GD

Tel 0533-471200

Supports work with young people

Royal National Institute for the Blind

224 Great Portland Street

London W1N 6AA

Tel. 0733-370777

Braille versions and audiotapes of Terrence Higgins Trust and SCODA pamphlets and material available.

FAMILY PLANNING:

Family Planning Association – FPA

27-35 Mortimer Street

London W1N 7RJ

Tel. 071-636-7866

Brook Advisory Centres

153A East Street

London SE17 2SD

Tel. 071-708-1234

The Association to Aid Sexual and Personal Relationships of People with a Disability (SPOD)

286 Camden Road

London N7 0BJ

Tel. 071-607-8851

National Association of Family Planning Doctors – NAFPD

27 Sussex Place

Regents Park

London NW1 4RG

National Association of Family Planning Nurses – NAFPN

Enterprise House

4 Chipstead Station Parade

Chipstead

Surrey CR3 3TE

Sex Education Forum

8 Wakley Street

London EC1V 7QE

The Catholic Marriage Advisory Council (CMAC)

Clitherow House

1 Blythe Mews

Blythe Road

London W14 0NW

Tel. 071-371-1341

Margaret Pyke Centre

15 Bateman's Buildings

Soho Square

London W1V 5TW

DRUG MISUSE:

Standing Conference on Drug Abuse (SCODA)

1-4 Hatton Place

London EC1N 8ND

Tel. 071-430-2341

Compiles a directory of drug services.

Institute for the Study of Drug Dependence (ISDD)

1 Hatton Place

London EC1N 8ND

Tel. 071-430-1991

National Information Service on drug issues.

Release

169 Commercial Street

London EC1 6BW

Tel. 071-729-9904

Advice, information, training and referral on legal and drug-related problems.

Turning Point

New Loom House

101 Backchurch Lane

London E1 1LU

Tel. 071-702-2300

Provides extensive range of counselling, advice and support centres for drug misusers, families and friends through a network of branches throughout the country.

Alcohol Concern

305 Grays Inn Road

London WC1X 8QF

Tel. 081-831-3471

A national organisation with advice and information about local services.

Drugs, Alcohol, Women, Nationally (DAWN)

39-41 North Road

London N7 9DP

Tel. 071-700-4653

Advice and information for women with drug or alcohol problems.

Families Anonymous

5-7 Parsons Green

London SW6 4UL

Tel. 071-731-8060

Advice and support for the families and friends of drug users.

Narcotics Anonymous

Self Help Groups

PO Box 246

c/o Milmans Street

London SW10

Tel. 071-377-6794

Freephone Drug Problems

A recorded message which lists a drug service for every county in England and telephone numbers for Northern Ireland, Scotland and Wales. Dial 100 and ask the operator for Freephone Drug Problems.

FURTHER READING

HIV AND AIDS:

National AIDS Manual, available from NAM Publications Ltd., Unit 52, Eurolink Business Centre, 49 Effra Road, London SW2 1B7. (Priced document.)
Tel. 071-737-1846

Volume 1: Covers topics such as advising on safer sex, dealing with people's anxieties about HIV and AIDS, testing issues, facts and myths and legal issues.

Volume 2: Lists HIV and related services by geographical area. Aims to cover all social services, health care, needle exchanges, drug agencies, body positive and other self help groups, helplines and drop in centres. Also lists gay and lesbian organisations, young people's agencies, women's agencies and services for black people. Contains information on condoms and lubricants, health education materials in minority languages, complementary and alternative medicine, and prison and probation services.

Volume 3: A comprehensive listing of treatments available at the time of going to press, clinical trials in progress, as well as information about the life cycle of HIV, and an A-Z of opportunistic infections and tumours.

Miller D, Living with AIDS and HIV, Macmillan Education, 1987

Adler M, Ed., ABC of AIDS, British Medical Journal, 1987

Yelding D, Ed., Caring for Someone with AIDS, Consumers Assocation 1990

Pye M, Kapila M, Buckley G, Cunningham C, Eds., Responding to the AIDS Challenge, Health Education Authority, London, 1989 (ISBN 0582 064341)

Curtis H, Ed., Promoting Sexual Health, British Medical Foundation for AIDS, May 1992 (ISBN 0 7279 0745)

Miller D, Weber J, Green H, Eds., The Management of AIDS Patients, MacMillan Press, 1986

Men Who Have Sex with Men Working Group (MESMAC): The Learning So Far Guide, Health Education Authority. Details of the lessons learnt so far from the MESMAC projects work.

Aggleton P, Does it Work? Perspectives on the Evaluation of HIV/AIDS Health Promotion, Health Education Authority. Describes some of the different approaches being used to monitor and evaluate local HIV/AIDS Work in Britain. Examines a range of activities in Health Authorities, Local Authorities and voluntary organisations.

Aggleton P, Evaluating HIV/AIDS Health Promotion, a Resource for HIV/AIDS Health Promotion Workers in Statutory and Voluntary Organisations, Health Education Authority.

Evans B et al, Working Where the Risks Are. Issues in HIV Prevention, Health Education Authority. Papers from District HIV Prevention Co-ordinators' Second Conference, London 13-14 November, 1991.
Includes detailed papers on prevention work with gay men, young people, drug misusers and black and ethnic minorities.

Schwarz C and Knight L, Preventing the HIV Spread, The Together Publishing Company, November 1992.

Mc Evan R and Bhopal R, HIV/AIDS Health Promotion for Young People: A Review of Theory, Principles and Practice, Health Education Authority, HIV/AIDS and Sexual Health Programme Series: Paper 12.

Padel U, et al, HIV Education in Prison: A Resource Book, Health Education Authority.

Dada M, Multilingual AIDS: HIV Information for the Black and Minority Ethnic Communities, Health Education Authority. Report evaluating the appropriateness of HIV Education Materials targeting black and ethnic minority groups.

All Party Parliamentary Group on AIDS.

HIV/AIDS: Is the Heterosexual Population at Risk, 1990. Occasional Paper No 1

HIV and AIDS in the Community, 1991. Occasional Paper No 2

HIV/AIDS and Sex Education for Young People, 1992. Occasional Paper No 3

Out of the Agency and on to the Streets: A Review of Outreach in Health Education in Europe and the United States, 1991. Rhodes T, Hartnoll R, and Johnson A. London, Institute for the Study of Drug Dependence Research Monograph 2.

Hard to Reach or Out of Reach? An Evaluation of an Innovative Model of HIV Outreach Health Education, 1991. Rhodes T, Holland J, and Hartnoll R. University of London, Drug Indicators Project, Birkbeck College

A Survey of HIV Outreach Intervention in the United Kingdom, 1990. Hartnoll R. Rhodes T, Jones S, Holland J, and Johnson A. University of London, Drug Indicators Project, Birkbeck College.

HIV Outreach Health Education: National and International Perspectives. A Summary Report to the Department of Health, 1991. Rhodes T, Holland J, Hartnoll R, and Johnson A. University of London, Drug Indicators Project, Birkbeck College.

Report of the work of the Ministerial AIDS Action Group will be made available in early 1993 to local statutory authorities.

'HIV prevention – A working guide for professionals': Ed Jones P. For the Health Education Authority, ISBN 1 85448 423 0. Price £24.95 net.

> Contains comprehensive information including about contracting, inter-sectoral work, needs assessment, monitoring and evaluation and planning and development together with a number of case studies for HIV prevention work.

'Building Healthy Alliances': report of the third national DHPC conference to be published in early 1993 (HEA)

Local Authority Associations' Officer Working Group on AIDS has published:

> 'Towards a Corporate Response' (£20) which draws on experience of policy and practice in local authorities
>
> 'HIV infection and the black communities' 1990: (£5) which includes a framework for action on policy, services and training development

'Providing services for gay men and bisexual men' (to be published in early 1993)

North West Thames RHA HIV Project has published various papers on HIV prevention work including:

Rooney M: 'Risks worth taking' – developing effective HIV prevention work with gay men and other men who have sex with men. Report of a joint-sector conference in December 1991

King E et al: July 1992: 'HIV prevention for Gay Men – a survey of initiatives in the UK'. Gives information on current HIV prevention work aimed at gay men and makes recommendations on development work.

DRUGS:

Treatment and Rehabilitation. Report of the Advisory Council on the Misuse of Drugs, Department of Health and Social Security, London, HMSO, 1991.

Drug Misuse and Drug Dependence: Guidelines on Clinical Management. Report of a Medical Working Group, Department of Health, Scottish Home Office and Health Department, Welsh Office, London, HMSO, 1991.

Hartnoll R, Lewis R, Daviaud E and Mitcheson M, Drug Problems: Assessing Local Needs, Drug Indicators Project, London, 1985.

FAMILY PLANNING:

Matthews G and Gooch C, Family Planning in Ramsgate: A Community Study of Unmet Need, Community Medicine 1979 1, 286-294

Manning H, An Integrated Service: the Role of the Clinic Doctor, The British Journal of Family Planning 1981, 7 80-83

Laing W A, Family Planning: The Benefits and Costs, Policy Studies Institute, 1982

Bolter V and Horler A, Consumer Views of a Clinic Service, British Journal of Family Planning 1982, 8, 11-15

Snowden R, Consumer Choices in Family Planning, Family Planning Association, 1985

Rowlands S, Family Planning: General Practice and Clinic Services, Journal of Royal College of General Practioners, April 1985

Hibble A and Elwood J, Health Promotion for Young People, The Practitioner, 1992, Vol. 236, 1140-1143.

McAvoy B R, Communication Skills and Family Planning Clinic Doctors, British Journal of Family Planning 1985, 11, 44-49

Wellings K, Trends in Contraceptive Method and Usage since 1970, British Journal of Family Planning, 1986, 12, 15-22

Thompson P, A Strategy in Three Parts for Improving the Uptake of New or Established Family Planning Services, British Journal of Family Planning, 1987, 12, 122-26

Marsh G and Channing D, Narrowing the Health Gap between a Deprived and an Endowed Community, British Medical Journal, Vol 296

Cartwright A, Unintended Pregnancies that lead to Babies, Soc Sci Med, Vol 27, No.3

McAvoy B R, Asian Women
i. Contraceptive Knowledge, Attitudes and Usage
ii. Contraceptive Services and Cervical Cytology
Health Trends, 1988, Vol 20

Estaugh V and Wheatley J, Family Planning and Family Well-being, Family Policy Studies Centre, 1990

Burton R and Savage W, Knowledge and Use of Post-coital Contraception: A Survey among Health Professionals in Tower Hamlets, British Journal of General Practice, August 1990

Kirkman R, The Future of Women's Health – The Family Planning Clinic, British Journal of Family Planning 1990, 15(Suppl), 39-43

Family Planning Association, Family Planning Services: A Model for District Health Authorities, 1990

Burton R and Savage W, The Morning After Pill is the Wrong Name for It: Women's Knowledge of Post-coital Contraception in Tower Hamlets, British Journal of Family Planning, 1990, 15, 119-121

Selman P and Calder J, Family Planning Clinic Attenders 1989: Report of a Consumer Survey, Newcastle Community Health Council, June 1990

Duncan D et al, Termination of Pregnancy: Lessons for Prevention, British Journal of Family Planning, 1990, 15, 112-117

Report of the Royal College of Obstetricians and Gynaecologists Working Party on Unplanned Pregnancy, September 1991

Rowlands S, Two Year Audit of Emergency Contraception in a General Practice, British Journal of Family Planning, 1991, 17, 23-24

Allen I, Family Planning and Pregnancy Counselling Projects for Young People, Policy Studies Institute

Queen H G, Ward H, Smith C and Woodroffe C, Women's Health: Potential for Better Co-ordination of Services, Genitourin Med 1991, 67: 215-219

South East Thames Regional Health Authority, Review of Family Planning and Abortion Services, 1991

Pretlove V, Setting up a Family Planning Clinic, Practice Nurse, Jan 1991 pp 443- 447

Rowlands S, Raising Standards in Family Planning Services, British Journal of General Practice 1991, 41, no. 345, 138-139

Guidelines for Reviewing Family Planning Services, Guidance for Regions, January 1992 (obtainable from Health Publication Unit).

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