Chlamydia screening evaluation – interim report

Wave Two

Report prepared by TNS Healthcare for:

The Department of Health


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## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION TO THE WAVE TWO REPORT</td>
<td>1</td>
</tr>
<tr>
<td>WAVE TWO: KEY FINDINGS</td>
<td>7</td>
</tr>
<tr>
<td>APPENDIX ONE: WAVE TWO SERVICE UPTAKE AND SERVICE EVALUATIONS</td>
<td>16</td>
</tr>
<tr>
<td>APPENDIX TWO: WAVE ONE FOCUS GROUP RESEARCH</td>
<td>59</td>
</tr>
<tr>
<td>APPENDIX THREE: LOCAL AND NATIONAL SURVEYS WAVES 1 AND 2</td>
<td>126</td>
</tr>
<tr>
<td>APPENDIX FOUR: BOOTS EMPLOYEE PERSPECTIVE</td>
<td>209</td>
</tr>
<tr>
<td>APPENDIX FIVE: CSO IN-DEPTH RESEARCH</td>
<td>252</td>
</tr>
<tr>
<td>APPENDIX SIX: SERVICE USER IN-DEPTH RESEARCH</td>
<td>290</td>
</tr>
</tbody>
</table>
Introduction to the Wave Two Report

Background to this report

In 2006 the Department of Health launched a pilot scheme to deliver a free-to-user chlamydia screening service via community pharmacies, which was available to 16-24 year olds within the M25.

The drivers behind this initiative were:

- Chlamydia rates are steadily increasing in the UK
- 16-24 years represent the age group at highest risk
- Individuals with chlamydia are often symptom free and will not be actively seeking treatment
- The serious long-term consequences of chlamydia including Pelvic Inflammatory Disease, infertility and ectopic pregnancy.
- The success of previous local screening programmes in Portsmouth and Wirral

The Department of Health commissioned Boots The Chemists (BTC) Ltd to provide screening and treatment. The service was launched in November 2005 and chlamydia screening kits are now available from all Boots pharmacies across the 31 London PCTs.

This service is operating for two years initially, during which time this pilot service undergoes an independent evaluation by TNS Healthcare, following which the Department of Health will decide whether or not to extend the service nationally. This Wave 2 report incorporates an evaluation from service launch to 31st October 2006. Comparisons are made, where appropriate and relevant, with Wave 1.

Both the chlamydia screening service and the independent evaluation are explained in more detail below.
The pharmacy chlamydia screening service

The key features of the chlamydia screening service are shown in the following flow diagram:

16-24 year olds

Boots pharmacy
(31 London PCTs)

Screening requested
Screening offered

Screened out by age and if symptoms present
Testing kit provided
Testing kit refused

Kit not returned
Specimen collected (either at in-store toilet or away from pharmacy).

Specimen and request forms returned to pharmacy then sent to lab. Lab enters Test Request Form data and result onto database

CSO informed of positive results

Negative and retest results: service user is notified by Boots
Positive results: service user is informed by CSO and treatment location options are explained. CSO triage patients and discuss partner notification

Service users treated by pharmacist following PGD. Patient Management Form completed
Service user treated by GUM, GP or contraceptive services. Patient Management Form completed

Partners can be treated without screening
As shown above, the service targets 16-24 year olds, the age group at greatest risk of chlamydia. When the service was planned it was hoped that other high-risk groups, for example, young persons from lower social economic groups and different ethnicities would also use the service.

The flow diagram above also shows that, if service users test positive for chlamydia, their partners can be treated at the pharmacy, without being screened (which is accepted practice). This research is not assessing the effectiveness of partner notification.

The treatment for chlamydia is a course of antibiotics, and any service users who vomit within 3 hours of taking the medication, or have unprotected sexual intercourse within the first 7 days, can return to the store for repeat treatment.

The chlamydia evaluation programme

The evaluation programme, undertaken by TNS Healthcare, is a longitudinal programme of research. Fundamentally it evaluates the pilot service, not the service supplier, and was designed to address the following key objectives:

1. To assess the uptake of chlamydia screening
2. To understand the ‘pulling power’ of the scheme, and also whether kits are offered spontaneously
3. To understand the user perspective
4. To understand the employee perspective
5. To assess the wider impact of this service among the public
6. To assess the value for money of the community pharmacy approach

The design of this evaluation is shown in the diagram below. Essentially, the evaluation comprises a continuous tracking element (which monitors the uptake of screening kits and service evaluation) and three periods when additional data collection is undertaken. These three periods are November 2005, October 2006 and July 2007.
<table>
<thead>
<tr>
<th>Wave one: November 2005</th>
<th>Wave two: October 2006</th>
<th>Wave three: July 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus groups</td>
<td>National survey</td>
<td>National survey</td>
</tr>
<tr>
<td>National survey</td>
<td>Local survey</td>
<td>Local survey</td>
</tr>
<tr>
<td>Local survey</td>
<td>Employee perceptions</td>
<td>Economic Evaluation</td>
</tr>
<tr>
<td></td>
<td>Service Users</td>
<td></td>
</tr>
</tbody>
</table>

Continuous tracking
Service use and outcome data

Wave 1

Wave one comprised the following data collection:

*Service uptake data*

Boots supplies TNS Healthcare with uptake data on a monthly basis.

This data is collected from the Test Request Form, a form that is completed by all service users. A copy of this form is shown on page 51. Data that can identify individual service users is not supplied. Boots also supplies test result data.

*Service evaluation data*

Pharmacists or pharmacy assistants should give each service user an evaluation questionnaire when the screening kit is collected. They should encourage service users to return the completed evaluation questionnaire with their sample, and then write the user ID number on the outside of questionnaire envelope.

There were two aims for this research component. Firstly, the evaluation questionnaire included some additional important demographic questions, which space did not permit on the Test Request Form. These questions related to working status and contraceptive use. Secondly, the evaluation questionnaire assesses service users perceptions of the service.

*Mystery shopping*

A mystery shopping activity was undertaken in March 2006 amongst 20 Boots stores. This was not part of the original proposal, but was undertaken due to the extremely low return rate for evaluation questionnaires. The aim was to assess whether questionnaires are
provided to service users, and if so, whether service users are encouraged to complete them.

**Focus group research:**

Six focus groups were undertaken among both target and non-target audiences before the screening programme was launched. The aim was to explore respondents' awareness of chlamydia and views towards the proposed chlamydia screening service.

Two groups involved only males, two only females and there were two mixed groups. 3 groups involved younger respondents (16-24) and 3 groups older respondents (25-65). A range of ethnic groups and social classes were represented.

These groups were undertaken within the M25 during November 2005. The findings were used to help design the questionnaires used in the local and national surveys (see below), and the evaluation and treatment questionnaires.

**Local Survey**

A face-to-face survey was undertaken among 700 representative adult respondents, within the M25 circumference.

The aim of this survey was to quantify awareness and reactions to the new chlamydia screening service, and assess knowledge of STIs and chlamydia. Sub-group analyses were undertaken, and the findings were also compared with those from the national survey.

Fieldwork was undertaken in November 2005 before the screening programme was launched thus providing baseline data from which any changes in views could be monitored during waves 2 and 3 of the evaluation.

**National Survey**

A national survey was undertaken with 2,011 adults across the UK. These respondents were asked a sub-set of questions from the local survey. Again, the aim of this survey was to quantify awareness and reactions to the new chlamydia screening service, and also assess knowledge of STIs and chlamydia.

These findings were compared with those from the local survey. Fieldwork was undertaken in November 2005, again providing pre-launch baseline data.
Wave 2

Wave 2 comprised the following data collection:-

Service uptake data

As outlined in Wave 1, but with updated findings given the continuous research methodology.

Service Evaluation data

As outlined in Wave 1, but again with updated findings given the continuous research methodology.

Employee perceptions

Employee perception research amongst Boots employees (Pharmacists and Pharmacy Assistants) and CSO staff has been completed. A report is appended. ‘Local’ NHS staff research is currently being developed and the findings will be incorporated into the third and final wave of reporting.

Service users

Having obtained Ethics Committee approval to conduct research amongst service users, this element of the research process is currently being conducted. An interim report is appended based on completed interviews to date, and will be updated for the third and final reporting wave.

Completed elements to the research are described in detail in the appendices, while the following summary presents the key findings from Wave 2.
Wave two: key findings

Service Uptake

- 14,814 pharmacy screens were undertaken between 14th November (launch of the Pharmacy Chlamydia Screening Pathway) and October 31st 2006

- Based on this uptake, 15,080 screening kits will be returned in 12 months, a figure below the maximum 50,000 screens that could be undertaken within the allocated budget.

- Of these 14,814 screens, 13,423 resulted in either a positive or negative test result and the remainder were inconclusive. Of the 13,423 screens, 11,756 were in the age range 16-24 years (after removing ‘out of age’ users, including those who made an obvious mistake when giving their date of birth e.g. entered current year)

- Uptake of screening kits since the service was launched has shown a general decrease, particularly through the summer months. Most recently (August/September) there has been an increase, which appears to have levelled out.

- 48% of the total number of kits given out between service launch and October 31st were returned (13,485 returned; 28,231 handed out), although a broad upward trend in return rates, over time, is apparent (see Return Rates on page 30 and 31). However, after 24 weeks (Wave 1 report) the return rate was 41%, with this rate increasing to 57% for weeks 25 to 51. Potentially a greater explanation in store by Boots staff, highlighting the need to return the kit, may be a factor in increasing the rate.

- With more than half of the screening kits received not being returned, (something that has also been seen within previous trials), it is important that service users are sufficiently motivated to follow through the screening process.

- Service users are requesting (‘pulling’) screening kits and pharmacy staff rarely offer (‘push’) them. As highlighted in the Wave 1 report, we understand that this is in line with service contract discussions, when it was agreed that staff would make customers aware of the service as appropriate, but that this was not the main driver of service uptake.

Profile of 16-24 year old service users

- Within the 16-24 age range the service attracts predominantly older age groups. Over 4 in 10 of service users were 23 or 24 years or age.
Although service users are predominantly female (78%), male users comprise 22%. This proportion of male users exceeds the national rate reported in the National Chlamydia Screening Programme Annual Report 2005/6 of 18.6%.

66% of 16-24 year old service users are white. A higher proportion of men from non-white ethnic backgrounds use the service than do females from non-white ethnic backgrounds. 67% of female users are white, compared with 63% of male users.

The overall positivity rate in this group is 7%; (7% females; 9% males) this is lower than the overall positivity rate reported in the National Chlamydia Screening Programme Annual Report 2005/6, which was 10.1%. The positivity rate across all service users, including those out of age, was 8%. Additionally, the LSL Pharmacy project reflects a positivity rate of 8.3%.

The lower positivity rate (compared with the National Chlamydia Screening Programme) suggests that the service may be attracting those who are health conscious rather than ‘at-risk’, particularly among female users.

The demographic evidence suggests the typical service user profile is older, and likely to have obtained ‘A’ level or degree qualifications.

Boots Electronic Point of Sale (EPOS) data shows that an additional 1,887 screening kits were refused due to age criteria in the period from service launch to October 31st 2006. This figure is likely to be an underestimate as staff are unlikely to record every time that a kit has been refused. Given the age profile of service users it seems more likely that refusals are due to potential users being too old, rather than too young.

Profile of those tested positive (16-24 year olds)

Over half (58%) of positive service users are treated at Boots; the remainder are treated elsewhere.

The highest proportion of positive screens was among Black Caribbean service users (15%) and Black British (13%), with the lowest among Chinese/other Asian service users (4%). White service users had a positivity rate of 7%. While proportions differ, this mirrors the trend found nationally.

11% of positive males had had a new sex partner within the last 3 months, and 11% had 2 or more new sex partners within the last 12 months, slightly lower the National Chlamydia Screening Programme data.

9% of positive females had had a new sex partner within the last 3 months and 8% had had 2 or more within the last 12 months, also lower proportions than found nationally.
Store involvement

- The two pharmacies with the highest number of samples returned are at Sedley Place, Oxford Street and Octagon Arcade, Liverpool Street Station.

- Octagon Arcade, Liverpool Street Station and Chimes Shopping Centre, Uxbridge are the two pharmacies delivering the highest number of treatments.

- Stores in large shopping centres and at train and tube stations are undertaking more screenings, which may reflect the larger number of shoppers entering these stores, compared with smaller provincial pharmacies.

- There is no data to suggest that the availability of in-store toilets attract service users and little indication that a consultation area attracts users.

- There appears to be no relationship between the number of screens undertaken per store and the number of evaluation questionnaires returned.

Service Evaluation Data

- Return rates for screening evaluation forms remains extremely low, at 3%. The mystery shopping exercise indicates that one key reason for this is that evaluation forms are not given to all customers.

- 436 evaluation forms were completed between service launch and 31st October 2006. Without higher return rates it will not be possible to determine whether the service attracts high-risk groups; each service user should receive an evaluation form together with encouragement to complete and return it. It was noted in Wave 1 reporting that the feasibility of including the questionnaire in the screening kit was being explored and this is understood to be still under review.

- 285 could be matched with Treatment Request Forms (TRF) data. In the remaining cases no personal ID number had been included on the questionnaire or envelope.

- 15% of the 436 undertook screening because they had signs or symptoms that concerned them. This is a high percentage, given the service is intended to offer an opportunistic health screen to those without symptoms. The figure of 15% implies that some service users are choosing not to disclose symptoms initially, or that the pharmacy staff health check does not uncover them. (The latter would be potentially supported by the Mystery Shopping findings).

- 30% of the 436 were not using condoms during the previous two months, either because they were using other forms of contraception or not using contraception. Of the 285 who could be matched, 46% had 2 or more partners in the previous 12 months, suggesting that these service users are participating in high-risk behaviours.
In terms of qualifications, 27% of the 436 stated that ‘A’ levels or their equivalent were their highest educational qualification, while 26% had a first degree.

‘In store promotion’ is the single largest explanation of how service users first hear about the service. This suggests that more external marketing may be needed before service uptake will increase.

‘Convenience of location’ is the primary reason why service users select a particular pharmacy (70%) and not the presence of a private consultation area (1%).

20% of service users feel uncomfortable receiving the chlamydia screening kit in a pharmacy (bottom 2 ratings on a 5 point scale) - with 49% feeling comfortable (top 2 ratings) and 22% neither comfortable nor uncomfortable (mid point).

6% of the 436 service users had previously undertaken an in-store chlamydia screen. Those few records that could be traced back using an ID, suggest repeat usage is due to either inconclusive results or ‘checking’ if the treatment after an initial positive test was successful.

Service users are positive about the service. 90% are likely to recommend the service (top 2 ratings on 5 point scale). The challenge, therefore, is not how to improve the service but how to ensure that more kits are collected and service users are sufficiently motivated to follow through the screening process to return the kit.

Treatment Evaluation data

Data is reported for 27 treatment evaluation questionnaires returned between service launch and 31st October 2006.

25 of these service users were satisfied with the overall screening and treatment process (rating 4 or 5 on a 5 point scale).

22 were very likely to recommend the service.

Focus group data (for information from Wave 1)

Awareness of chlamydia was high although knowledge was patchy. Respondents did not always appreciate that chlamydia can be symptom free or that men are equally at risk as women.

All focus group respondents responded positively to the proposed chlamydia screening service. Enthusiasm sometimes decreased when respondents were asked to consider the value of a chlamydia screening service alongside other potential healthcare services.
The upper age limit of 24 years was queried in the focus groups. 16 years was considered acceptable for the lower age limit, but many respondents felt that the upper age limit was too low and did not appreciate the reasons for this cut off.

Embarrassment was considered to be the main factor that would prevent service uptake.

The younger focus group respondents, despite their positive views on the service, did not necessarily consider that they would use it. There was a tendency for respondents to indicate that, despite being sexually active, they would not consider themselves at risk of having an STI if they felt well and had no symptoms.

National and Local survey

Respondents in the local survey, at both waves, had higher levels of awareness of chlamydia than those in the national survey.

Less than 50% of respondents in the national survey, at both waves, recognised that chlamydia can affect both men and women.

Less than 50% of respondents in the local survey, at both waves, recognised that chlamydia is the fastest increasing STI or that it can be symptom free.

Around 1 in 6 (W1 17%; W2 15%) of the local survey respondents were aware of the chlamydia pharmacy screening initiative. PR and marketing activity therefore had some impact and post service launch.

Both the local and national surveys, at both waves, showed a trend for those from higher socio-economic classes to be more knowledgeable about sexually transmitted infections.

6% W1, 8% W2 of national respondents and 12% W1, 14% W2 of local respondents had previously been screened for chlamydia.

Around a third of previously screened respondents, in both the local and national surveys (at both waves), had been screened at a GUM clinic, approximately a quarter had been screened at a GP and around 10% had been screened at a family planning clinic (community contraceptive clinic).

The majority of local respondents (over 60% at both waves) believed that the pharmacy screening service would succeed and would be associated with positive outcomes.
Boots Employee Perspective

- The Boots staff showed high levels of knowledge of chlamydia, particularly in terms of ages at risk, symptoms and long-term effects. Pharmacists tended to show a more detailed understanding than non-pharmacists, although knowledge levels overall were good.

- Staff were generally very knowledgeable about the PCSPf, particularly around the role played by Boots, and their own individual responsibilities. However, they were far less knowledgeable about the role and involvement of external agencies, particularly the CSO.

- Staff claimed they were generally very pleased with their training, which was considered comprehensive and detailed. It was also considered to have a good balance between written information and face to face training. Some concerns were raised about the process for cascading training, and whether any groups of employees might miss out, such as new joiners, locum pharmacists and Saturday staff.

- Some concerns were also raised regarding more refresher training, since some staff have few PCSPf customers and have not had much experience of putting the training into practice. In these circumstances it was considered easy to forget aspects of the original training, hence the need for updates.

- Pharmacists were proactively offering kits when women attended for emergency contraception; otherwise the kits were given when requested. Customers are described as appearing embarrassed (which is in line with service users own feedback) and staff spoke of the need to deal with customers sensitively and/or to go somewhere private.

- Potential customers who are too old for PCSPf tended to be offered private kits and told of the NHS service, although in one or two instances they were told of the private kits only.

- Staff were generally very positive about the initiative, although they could identify both strengths and weaknesses. Strengths included accessibility, no stigma, no charge and open to partners. Weaknesses included that it is a chlamydia only screen, that there is low awareness and that the age band is restrictive. Suggested service improvements included wider use of vouchers and free condoms.

- The relationship with the CSO varied between respondents (some had never contacted, while others had). However, contact was normally about the non-receipt of test results, which is an inappropriate reason to contact the CSO.

- This confirms the confusion that was evident in the interviews with CSO employees, ie some Boots staff believe that the CSO has access to all results, not just the positives - suggesting the role of the CSO should be better explained to Boots employees.
Overall knowledge of the independent evaluation also varied. Some staff were aware of the screening and treatment evaluation questionnaires and had spontaneously made reference to giving them to customers; others were less sure about the questionnaires or whether they gave them to customers.

CSO Employee Perspective

After some initial teething problems involved in the set-up, the CSO staff are now generally satisfied with the service offered and there is a good level of understanding of the initiative.

The process of contacting clients with positive results is considered to be very thorough. However, the inability to contact a very small minority of clients can cause frustration

CSO staff are knowledgeable and comfortable discussing sensitive issues with clients

The relationship between Boots head office and the CSO was described as good, although there are some concerns about the nature of training provided to Boots staff and the lack of involvement of the CSO. In particular concerns were raised that some Boots staff make contact with the CSO when customers have not received their result, when they should actually contact Boots HQ. Clearly guidance for Boots staff would be an improvement.

Ultimately, the CSO would have preferred more contact with Boots on the shop floor, particularly in the involvement of training. A training plan was suggested for all new Boots starters, if not already in place, with follow up training 6 months later.

Some concerns were raised that partners may not always be automatically treated; as the CSO had spoken with partners who had experienced difficulty obtaining treatment.

Overall reactions to the service were very positive; it is considered to be a straightforward process that offers good accessibility to testing and treatment for both clients and their partners.

If the initiative is rolled out nationally, it was indicated there should be a central CSO database. This would ensure that all the data on positive testing service users would be stored in one place.
Service User Perspective

- Initial awareness of the free chlamydia screening is predominately in store, and this was sufficient amongst some service users to trigger usage.

- Information of chlamydia per se is not extensive, with key knowledge being a lack of signs/symptoms and causes infertility. Few took further action to learn more about the disease than that given in the literature/by Boots employees.

- The key barrier to use the service is embarrassment, potentially caused by being overheard in the queue and/or the indiscretion of Boots employees.

- Store selection is almost unanimously based upon location – local and convenience, and not in-store facilities.

- The receipt of the test result is predominately within the expected time period, although a variety of time periods were given – generally 1-2 weeks. However, one male respondent stated that after not receiving a test result, he opted to be tested at a GU clinic.

- Key strengths of the service are cited as the convenience, anonymity and no need for appointments.

- Suggested improvements include additional marketing activity to increase awareness (beyond initial in-store awareness); to re-iterate staff knowledge via staff training – potentially to include regular updates (particularly to enhance the service user experience and minimise indiscretion); the storage/positioning of the kits (e.g. under the counter vs top shelf to minimise embarrassment); to ensure privacy is maximised (either via the use of a consulting area or staff discretion).

- To date, a postal methodology has received mixed views, although these service users are commenting based upon their specific non postal experience. The key hurdle appears to be regarding confidence that the sample will reach its destination and a response received, coupled with the actual barrier of posting a urine sample in the general post.
Appendices

APPENDIX ONE: WAVE TWO SERVICE UPTAKE AND SERVICE EVALUATIONS
APPENDIX TWO: WAVE ONE FOCUS GROUP
APPENDIX THREE: LOCAL AND NATIONAL SURVEYS WAVES 1 AND 2
APPENDIX FOUR: BOOTS EMPLOYEE PERSPECTIVE
APPENDIX FIVE: CSO IN-DEPTHS RESEARCH
APPENDIX SIX: SERVICE USER IN-DEPTHS RESEARCH
Appendix one: Service uptake and service evaluations
Chlamydia screening evaluation
Service Uptake and Service Evaluation

Report prepared by TNS Healthcare for:

The Department of Health

125331  November 2005 – October 2006

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Background

The Department of Health, with Boots The Chemists (the commissioned provider) have launched a pilot scheme (the Pharmacy Chlamydia Screening Pathfinder or PCSPf) in order to assess a different venue to screen 16-24 year olds for genital chlamydial infection. Cases of genital chlamydia have been rising steadily since the 1990s with London having the highest rates. Age demographics have highlighted that chlamydia is more prevalent amongst 16-24 year olds. This is of particular concern as younger women may be more susceptible to developing complications of untreated chlamydial infection. Approximately one third of women with chlamydia later develop pelvic inflammatory disease (PID) which is associated with infertility, chronic pelvic pain and ectopic pregnancy. The cost of treating chlamydia and its complications is currently estimated to be more than £100 million in the UK.

The PCSPf has now been up and running since November 2005. The service offers free screening and treatment of chlamydia to 16-24 year olds through participating Boots The Chemists pharmacies across the 31 London PCT boundaries. Service users can collect a testing kit from a Boots pharmacy, complete the test, and then return the kit to any participating store.

TNS Healthcare is conducting an independent evaluation of the service for the Department of Health. The results will be used to inform the decision on whether to launch a national pharmacy chlamydia screening service.

Since the launch of the service, TNS has been monitoring service uptake and evaluating users opinions of the service. The anonymised service uptake data is supplied to TNS Healthcare monthly, which includes the number of kits handed out, the number of returns, test results and some demographic information on service users. The latter information comes from the Test Request Form (TRF) a form completed by service users at the time they return their sample (copy appended). A chlamydia test cannot be undertaken unless the minimum data fields on the Test Request Form are completed.

Electronic Point of Sale (EPOS) data showing the number of kits collected from stores is also supplied, along with the number of people refused a kit due to being outside the target age.

Service users should also be asked to complete a short questionnaire (copy of the questions appended) to be returned with their Test Request Form. Participation in the screening evaluation survey is voluntary and, again, all responses remain anonymous. The data collected from this survey can be matched to each TRF by means of a unique identification number. A unique identification number is printed on each Test Request Form, which is then entered on the screening evaluation questionnaire. As a result, all attitudinal data should also be analysable in terms of gender, age, ethnicity, test result and postcode.
In addition, those people who have a positive result and return to Boots The Chemists for treatment should be given a second questionnaire to evaluate the treatment phase of the service delivery.

Both the service uptake data and the screening evaluation data are reported here. Screening evaluation data comes from 436 questionnaires, which reflects the low return rate of 3%, received between December 2005 (when questionnaires were circulated) and October 31st 2006.

Treatment evaluation data is reported for the 27 questionnaires, again received between December (when questionnaires were circulated) and October 31st 2006.

Data is also supplied by the CSO and this documents where people have received treatment and which PCTs have been involved.
Objectives

The service uptake objectives are to identify:

- Numbers of tests being handed out (EPOS data)
- Numbers of tests being returned
- Numbers of positive tests
- Numbers of positive service users who are subsequently treated in-pharmacy
- Trends in service use over time
- Profile data on the service users
- The proportion of service users falling outside the age eligibility criteria
- The stores that are most active in both screening and treatment

The objectives of the screener evaluation survey are to identify:

- Service users overall perceptions of the screening process
- Whether the screening kits are requested by service users or offered by the pharmacy
- The reason for choosing a particular pharmacy (where kits are requested) e.g. location, private consultation area etc.
- Customer perceptions of staff knowledge and staff friendliness
- Ease of use of the chlamydia kit
- Convenience of the service
- Likelihood to recommend the service
- Customer perceptions of service confidentiality
- Issues of embarrassment
- How the user initially became aware of the service
- Service users levels of education
- Service users working status
- Service users contraceptive use

Treatment evaluation survey objectives:

- Perceptions of the result notification process
- Reasons for choosing treatment via Boots
- Perceptions of the treatment process (at Boots pharmacies only)
- Issues of embarrassment
- Satisfaction with the overall screening and treatment service
Methodology

Service uptake data

Boots provide the service uptake data to TNS Healthcare monthly on CD. The full data set includes anonymised data from Treatment Request Forms, together with data on the overall service statistics.

Service user evaluations

The methodology used to evaluate the pharmacy chlamydia screening pathfinder service is a pen and paper questionnaire. This questionnaire consists of one A4 sheet of questions, which can be completed in a minimal amount of time. Pharmacy staff should offer the questionnaire when the kit is handed out, and ask for it to be returned with the sample. It is important that this happens in order for the data to be robust, and to reduce the risk of bias. Although this may not be a written contractual obligation, it is a prerequisite for this type of methodological approach to be successful.

The pharmacist should ensure that the service user knows that completion of the questionnaire is entirely voluntary and that the data is anonymous. Respondents should enter their unique identifier number onto the questionnaire and the pharmacist should also write this on the outside of the questionnaire envelope. The unique identifier is printed on the Test Request Form. This procedure is important as it later enables data from the evaluation questionnaire to be matched with the data the Test Request Form, which includes age, gender and ethnicity.

At the point of kit return, pharmacy staff should collect the screening questionnaire and subsequently return it to TNS.

The content of this report is divided into two sections. The first section focuses on service uptake data and the second on the user evaluations. The service uptake data includes Laboratory data, EPOS data and CSO data. Laboratory data is more accurate than EPOS data and should be used as the basis for the evaluation wherever possible.
Service uptake

Service uptake and positivity rates: laboratory data

The laboratory data reported here spans November 14th 2005 (launch date) to October 31st 2006.

The total number of samples returned during this period was 14,814 samples, which averages 290 returns per week.

This suggests that a total of 15,080 screens could therefore be expected over 12 months (290 x 52 = 15,080) which is lower than the maximum 50,000 screens that could be undertaken within the allocated budget. There is, therefore, scope to encourage greater use of the service among 16-24 year olds. A maximum of 961 screens could be undertaken each week for the service to remain within budget. Steps are required to encourage higher levels of returns, in addition to greater service uptake, in order to move towards this maximum number of screens.

The number of screenings undertaken monthly has shown a general decrease since the service was launched, particularly through the summer months. Most recently (August/September/October) there has been an increase, which appears to have levelled out. It was highlighted in the Wave 1 report that it was not known why numbers had initially declined. One hypothesis is that publicity surrounding the service launch led to high numbers of people participating initially. Subsequently the most recent increase could be partly due to the further promotion (in store) of the kits which can be purchased.

48% of service users hear about the service via in store promotion, and only 18% via external advertising media, which suggests that increased external marketing could increase uptake. We understand that Boots and the DoH are continually reviewing marketing activity.

It may also be possible to increase screening uptake through the actions of pharmacy staff. In Wave 1 it was highlighted the majority of kits were requested by service users (i.e. they are not offered by pharmacy staff) and this has not changed. The option of proactively offering kits could be considered, as part of a strategy to increase the number of service users.

Screening rates would also improve if more customers could be persuaded to return their screening kits to the pharmacy. Overall, less than half the kits are returned, a figure that is comparable to other services, but one which would ideally be improved upon. However, since the Wave 1 report, the return rate has risen to 56% (weeks 24-51).
For reference, relatively comparable examples of return rates include a) A pilot randomised controlled trial (University of Glasgow); data was collected from 3 participating practices, with 48% (base 124) of the postal group returning samples; b) A population based chlamydia screening study (Netherlands) resulted in 41% participating, by sending in a urine sample and questionnaire.

Of the 14,814 screening kits returned to the pharmacy between launch and end of October, 13,423 yielded a conclusive test result, which means that 9% of samples did not result in a positive or negative test (which is in line with the 10% norm). 11,756 of these 13,423 screens were amongst users within the designated 16-24 year age band.

Amongst the 13,423 the total number of positive screens in this period was 1,070 or 8%. Amongst the 11,756 (16-24 year olds) the number of positive screens was 861 or 7%. The National Screening Programme Annual Report 2005/6, for example, found an overall positivity rate of 10.1%. This difference suggests that pharmacy service users may include the ‘lower risk’ groups, rather than those from the ‘at higher risk’ groups. The available demographic data (reported below) offers support for this hypothesis, as the service users tend to be older and better educated.

**Treatment Locations: PCSO data**

From launch until October 2006 58% of those who tested positive for chlamydia via Boots received treatment from Boots stores (this is based on data supplied by the CSO). Over a quarter of all those who tested positive for chlamydia through the PCSPf attended a GUM clinic for treatment (28%) and 6% went to a GP.

We understand that a potential explanation for the lower rate of in-store treatments is the PGD, which necessitates patients with quite a wide range of symptoms being referred elsewhere. The current PGD is being reviewed to hopefully enable wider treatment uptake at Boots.
The table below shows treatment locations between service launch and October 31st 2006, for all service users at venues other than Boots pharmacies:

<table>
<thead>
<tr>
<th>Treatment Venues (including Boots)</th>
<th>W1 14/11/05-30/04/06</th>
<th>W2 01/05/06-31/10/06</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of clients</td>
<td>% of total positives</td>
<td>Number of clients</td>
</tr>
<tr>
<td>Boots</td>
<td>323</td>
<td>55.2</td>
<td>300</td>
</tr>
<tr>
<td>Sexual Health Services</td>
<td>184</td>
<td>31.5</td>
<td>117</td>
</tr>
<tr>
<td>GP</td>
<td>37</td>
<td>6.3</td>
<td>32</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>0.7</td>
<td>3</td>
</tr>
<tr>
<td>Total confirmed as treated</td>
<td>548</td>
<td>93.7</td>
<td>452</td>
</tr>
<tr>
<td>Letters sent, no response, still attempting to contact</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>3 letters, no response, NFA</td>
<td>7</td>
<td>1.2</td>
<td>2</td>
</tr>
<tr>
<td>Aware, Rx not confirmed, NFA</td>
<td>12</td>
<td>2.1</td>
<td>30</td>
</tr>
<tr>
<td>Unaware uncontactable NFA</td>
<td>18</td>
<td>3.1</td>
<td>0</td>
</tr>
<tr>
<td>Unaware still attempting to contact</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Aware, still being followed up</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>Unaware, despite several contact attempts NFA</td>
<td>0</td>
<td>0.0</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>585</td>
<td>100</td>
<td>495</td>
</tr>
</tbody>
</table>

Data supplied by Boots shows that 935 people have been treated in store, since service launch, which also includes partners.

**Store activity: laboratory data**

The table below shows the 10 stores with the highest number of returned samples from launch until 31st October 2006.

<table>
<thead>
<tr>
<th>Store ID</th>
<th>Location</th>
<th>Number of kits returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>0707</td>
<td>Sedley Place, Oxford Street</td>
<td>584</td>
</tr>
<tr>
<td>0905</td>
<td>151 Oxford Street</td>
<td>362</td>
</tr>
<tr>
<td>0803</td>
<td>Octagon Arcade, Liverpool Street Station</td>
<td>236</td>
</tr>
<tr>
<td>1000</td>
<td>Regent Street, Piccadilly Circus</td>
<td>204</td>
</tr>
<tr>
<td>0132</td>
<td>Chimes Shopping Centre, Uxbridge</td>
<td>177</td>
</tr>
<tr>
<td>1521</td>
<td>The Kingsway</td>
<td>165</td>
</tr>
<tr>
<td>1571</td>
<td>Tottenham Court Road</td>
<td>165</td>
</tr>
<tr>
<td>0785</td>
<td>High Rd, Wood Green</td>
<td>163</td>
</tr>
<tr>
<td>0926</td>
<td>The Liberty, Romford</td>
<td>161</td>
</tr>
<tr>
<td>0866</td>
<td>Whitgift Centre, Croydon</td>
<td>155</td>
</tr>
<tr>
<td>0001</td>
<td>Default stores</td>
<td>1,256</td>
</tr>
</tbody>
</table>
The store that has had the most returned samples is Sedley Place on Oxford Street (584 returns). As at Wave 1, this store is getting kits returned at over twice the rate of Liverpool Street Station (236 returns), although this store is now third, behind 151 Oxford Street (362) at Wave 2.

1,256 samples cannot be linked to stores as there is no identifying number.

Stores in ‘anonymous’ locations such as rail and tube stations and shopping centres attract the highest number of service users, although these may also be that the stores that attract higher numbers of shoppers in general.

The screening evaluation data indicates that it is the convenience of the store location, rather than in-store facilities, which underpins store selection. This finding is consistent with other elements of the research programme, including the service user in-depths.

The table below shows the 10 stores undertaking the highest number of treatments between service launch and October 31st 2006.

<table>
<thead>
<tr>
<th>Store ID</th>
<th>Name of store</th>
<th>PCT</th>
<th>Number of treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>0803</td>
<td>Octagon Arcade, Liverpool Street St.</td>
<td>City &amp; Hackney</td>
<td>16</td>
</tr>
<tr>
<td>0926</td>
<td>The Liberty, Romford</td>
<td>Havering</td>
<td>13</td>
</tr>
<tr>
<td>1000</td>
<td>Regent Street, Piccadilly Circus</td>
<td>Westminster</td>
<td>13</td>
</tr>
<tr>
<td>0132</td>
<td>Chimes Shopping Centre, Uxbridge</td>
<td>Hillingdon</td>
<td>11</td>
</tr>
<tr>
<td>0206</td>
<td>Centrale Shopping Centre, Croydon</td>
<td>Croydon</td>
<td>10</td>
</tr>
<tr>
<td>0785</td>
<td>High Road, Wood Green</td>
<td>Haringey</td>
<td>10</td>
</tr>
<tr>
<td>6497</td>
<td>Waterloo Lane, Romford</td>
<td>Havering</td>
<td>10</td>
</tr>
<tr>
<td>0707</td>
<td>Sedley Place, Oxford Street</td>
<td>Westminster</td>
<td>9</td>
</tr>
<tr>
<td>0746</td>
<td>Brent Cross Shopping Centre</td>
<td>Barnet</td>
<td>9</td>
</tr>
<tr>
<td>0836</td>
<td>Glades Shopping Centre, Bromley</td>
<td>Southwark</td>
<td>9</td>
</tr>
</tbody>
</table>

In terms of the number of treatments provided by a Boots store, Octagon Arcade, Liverpool Street Station has provided the most treatments at 16, with The Liberty, Romford and Regent Street, Piccadilly Circus both providing 13.

Partners can be treated without a chlamydia screen. Figures for total numbers of partners treated in-pharmacy are shown below. The figures in brackets are the total number of people treated that month. 30% of treatments given by Boots are for partners.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7 (28)</td>
<td>17 (84)</td>
<td>27 (85)</td>
<td>25 (69)</td>
<td>26 (82)</td>
<td>19 (56)</td>
</tr>
<tr>
<td></td>
<td>11 (38)</td>
<td>12 (38)</td>
<td>13 (46)</td>
<td>21 (71)</td>
<td>32 (86)</td>
<td>23 (72)</td>
</tr>
</tbody>
</table>
### PCT activity: PCSO data

The table below shows the number of treatments provided through GUM clinics to service users, again from service launch until the end of October 2006.

<table>
<thead>
<tr>
<th>GU clinics by PCT</th>
<th>Number attended</th>
<th>% of total positives</th>
<th>Number attended</th>
<th>% of total positives</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td></td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barking &amp; Dagenham</td>
<td>3</td>
<td>1.7</td>
<td>3</td>
<td>2.6</td>
<td>2.0</td>
</tr>
<tr>
<td>Barnet</td>
<td>3</td>
<td>1.7</td>
<td>1</td>
<td>0.9</td>
<td>1.4</td>
</tr>
<tr>
<td>Brent</td>
<td>5</td>
<td>2.8</td>
<td>-</td>
<td>-</td>
<td>1.7</td>
</tr>
<tr>
<td>Bromley</td>
<td>7</td>
<td>4.0</td>
<td>4</td>
<td>3.4</td>
<td>3.8</td>
</tr>
<tr>
<td>Camden</td>
<td>27</td>
<td>15.3</td>
<td>12</td>
<td>10.3</td>
<td>13.3</td>
</tr>
<tr>
<td>City of London</td>
<td>6</td>
<td>3.4</td>
<td>-</td>
<td>-</td>
<td>2.0</td>
</tr>
<tr>
<td>Croyden</td>
<td>10</td>
<td>5.7</td>
<td>5</td>
<td>4.3</td>
<td>5.1</td>
</tr>
<tr>
<td>Ealing</td>
<td>2</td>
<td>1.1</td>
<td>1</td>
<td>0.9</td>
<td>1.0</td>
</tr>
<tr>
<td>Enfield</td>
<td>1</td>
<td>0.6</td>
<td>1</td>
<td>0.9</td>
<td>0.7</td>
</tr>
<tr>
<td>Hammersmith &amp; Fulham</td>
<td>6</td>
<td>3.4</td>
<td>5</td>
<td>4.3</td>
<td>3.8</td>
</tr>
<tr>
<td>Hackney</td>
<td>1</td>
<td>0.6</td>
<td>1</td>
<td>0.9</td>
<td>0.7</td>
</tr>
<tr>
<td>Haringey</td>
<td>7</td>
<td>4.0</td>
<td>1</td>
<td>0.9</td>
<td>2.8</td>
</tr>
<tr>
<td>Harrow</td>
<td>6</td>
<td>3.4</td>
<td>4</td>
<td>3.4</td>
<td>3.4</td>
</tr>
<tr>
<td>Havering</td>
<td>10</td>
<td>5.7</td>
<td>2</td>
<td>1.7</td>
<td>4.1</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>3</td>
<td>1.7</td>
<td>5</td>
<td>4.3</td>
<td>2.7</td>
</tr>
<tr>
<td>Hounslow</td>
<td>1</td>
<td>0.6</td>
<td>1</td>
<td>0.9</td>
<td>0.4</td>
</tr>
<tr>
<td>Islington</td>
<td>3</td>
<td>1.7</td>
<td>8</td>
<td>6.8</td>
<td>3.8</td>
</tr>
<tr>
<td>Kensington &amp; Chelsea</td>
<td>1</td>
<td>0.6</td>
<td>3</td>
<td>2.6</td>
<td>1.4</td>
</tr>
<tr>
<td>Kingston</td>
<td>3</td>
<td>1.7</td>
<td>5</td>
<td>4.3</td>
<td>2.7</td>
</tr>
<tr>
<td>Lambeth</td>
<td>3</td>
<td>1.7</td>
<td>6</td>
<td>5.1</td>
<td>3.1</td>
</tr>
<tr>
<td>Lewisham</td>
<td>0</td>
<td>0.0</td>
<td>3</td>
<td>2.6</td>
<td>1.0</td>
</tr>
<tr>
<td>Newham</td>
<td>5</td>
<td>2.8</td>
<td>4</td>
<td>3.4</td>
<td>3.1</td>
</tr>
<tr>
<td>Southwark</td>
<td>5</td>
<td>2.8</td>
<td>1</td>
<td>0.9</td>
<td>2.0</td>
</tr>
<tr>
<td>Sutton</td>
<td>4</td>
<td>2.3</td>
<td>-</td>
<td>-</td>
<td>1.4</td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>3</td>
<td>1.7</td>
<td>5</td>
<td>4.3</td>
<td>2.7</td>
</tr>
<tr>
<td>Waltham Forrest</td>
<td>5</td>
<td>2.8</td>
<td>6</td>
<td>5.1</td>
<td>3.8</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>11</td>
<td>6.3</td>
<td>6</td>
<td>5.1</td>
<td>5.9</td>
</tr>
<tr>
<td>Woolwich</td>
<td>9</td>
<td>5.1</td>
<td>4</td>
<td>3.4</td>
<td>4.4</td>
</tr>
<tr>
<td>Westminster</td>
<td>12</td>
<td>6.8</td>
<td>6</td>
<td>5.1</td>
<td>6.1</td>
</tr>
<tr>
<td>Out of London</td>
<td>14</td>
<td>8.0</td>
<td>11</td>
<td>9.4</td>
<td>8.5</td>
</tr>
<tr>
<td>PCT unknown</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>2.6</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>176</strong></td>
<td><strong>100.0</strong></td>
<td><strong>117</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Since launch in November 2005, clinics in Camden and Westminster London PCTs are providing the highest number of treatments. 8.5% of treatments are provided outside London.
Profile of service users: Laboratory data

Gender

In total 13,423 successful screens were undertaken between November 2005 and October 31st 2006, with 11,756 amongst users within the designated 16-24 year old age band. Of these 78% of service users were female and 22% were male. This proportion of male screens compares very favourably with the 2005/6 National Chlamydia Screening Programme, in which 18.6% of screens were male. The high level of males users is encouraging since many people still do not recognise that chlamydia affects men and women, and men are generally considered to be less health conscious than women.

93% of eligible service users (16-24 year olds, base 9,147), tested negative for chlamydia with 7% testing positive for chlamydia. However, 9.3% of the males tested positive compared with only 6.8% of females. This suggests that the service may be attracting more at-risk males than females. This compares with the National Chlamydia Screening Programme, which reported positivity rates of 10.2% in women and 10.1% in men. (2005/6 annual report)

Analysis of the data on a monthly basis (Nov 05-Oct 06) shows a consistent pattern over time.

Age (16-24 year olds)

The age data shows that service uptake is highest among older age groups, with very low levels of take-up among younger age groups. 24% of service users were aged 24 years and only 2% were aged 16 years old.
47% of males and 43% of females using the service were aged either 23 or 24 years old. So, although the service is attracting men, it is older males who are most likely to use the service.

Of the total 13,423 successful screens, 11% of service users were aged 25 years, and 1% did not give their age. Two individuals were aged 15, and a number of other individuals also appeared to be aged outside the 16-24 year old target group, although some are likely to stem from errors made when completing the Treatment Request Form e.g. 2 users aged 100, 1 user aged 8 and 1 user aged 1.

Similarly to gender, analysis of the data on a monthly basis for age shows a relatively consistent trend over time.
**Ethnicity (16-24 year olds)**

The majority of people screened were white (66%) with an additional 15% stating that they are of an ‘other’ ethnic origin. A small proportion of respondents were Black Caribbean (3%), from the Asian Subcontinent (3%), Black African (3%), Chinese or other Asian (2%) and Black British (2%).

67% of female users are white and 63% are male. It is estimated that 62% of 16-24 year old males in greater London are white and 61% are females (BARB data 2003).

9% of male users were black, compared with a London population estimate of 15% for 16-24 year olds (BARB data 2003).
Analysis of ethnicity on a monthly basis (Nov 05-Oct 06) indicates a broadly consistent trend over time (see below). However, it is worth highlighting that the service appears to be reaching a wider ethnic audience (particularly since Aug 06), with fewer whites and a greater number of ‘other’ ethnic origins.

Postcode data (16-24 year olds)

The majority of respondents (91%) lived in and around London (33% greater London, 59% central London). This is expected as the service is only on offer within the London SHA boundaries and only a small proportion of respondents reside outside these areas (9%).
On a monthly trend basis, the results are consistent over time, even when examining the data by specific postcodes e.g. N, SW, E, etc. This would suggest the ‘catchment’ area of the Boots stores, within the pilot scheme, has remained relatively constant.

**Previous partners (16-24 year olds)**

The diagram below shows that 35% of respondents have had a new partner in the last 3 months and 41% have had 2 or more new partners in the last 12 months.

![Diagram showing partner activity](image)

Partners in the last 3/12 months: Base 11756

Analysis by all respondents vs those testing positive for chlamydia indicates those who have been more ‘promiscuous’ in the past 3 or 12 months have a higher rate of testing positive.

<table>
<thead>
<tr>
<th></th>
<th>New partner in last 3 months</th>
<th>More than 2 new partners in last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Tested +ve</td>
</tr>
<tr>
<td>Yes</td>
<td>35</td>
<td>43</td>
</tr>
<tr>
<td>No</td>
<td>41</td>
<td>31</td>
</tr>
<tr>
<td>Refused</td>
<td>24</td>
<td>26</td>
</tr>
</tbody>
</table>

Analysis by partners over time, as with the other trend data, indicates a relatively consistent pattern for those indicating new partner(s) in the time frame. Interestingly those ‘refusing’ have increased over time for both males and females, with the males indicating a higher level of new partners compared to the females.
### New partner last 3 months

<table>
<thead>
<tr>
<th>Month</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
<th>Refused</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov-05</td>
<td>33</td>
<td>34</td>
<td>30</td>
<td>37</td>
</tr>
<tr>
<td>Dec-05</td>
<td>32</td>
<td>46</td>
<td>50</td>
<td>45</td>
</tr>
<tr>
<td>Jan-06</td>
<td>33</td>
<td>42</td>
<td>40</td>
<td>39</td>
</tr>
<tr>
<td>Feb-06</td>
<td>32</td>
<td>43</td>
<td>41</td>
<td>40</td>
</tr>
<tr>
<td>Mar-06</td>
<td>38</td>
<td>37</td>
<td>36</td>
<td>32</td>
</tr>
<tr>
<td>Apr-06</td>
<td>35</td>
<td>30</td>
<td>29</td>
<td>30</td>
</tr>
<tr>
<td>May-06</td>
<td>38</td>
<td>37</td>
<td>36</td>
<td>32</td>
</tr>
<tr>
<td>Jun-06</td>
<td>32</td>
<td>40</td>
<td>41</td>
<td>40</td>
</tr>
<tr>
<td>Jul-06</td>
<td>38</td>
<td>37</td>
<td>36</td>
<td>32</td>
</tr>
<tr>
<td>Aug-06</td>
<td>35</td>
<td>30</td>
<td>29</td>
<td>30</td>
</tr>
<tr>
<td>Sep-06</td>
<td>32</td>
<td>40</td>
<td>41</td>
<td>40</td>
</tr>
<tr>
<td>Oct-06</td>
<td>38</td>
<td>37</td>
<td>36</td>
<td>32</td>
</tr>
</tbody>
</table>

**Base:** All Males (2,534)

### 2+ partners last 12 months

<table>
<thead>
<tr>
<th>Month</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
<th>Refused</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov-05</td>
<td>48</td>
<td>42</td>
<td>43</td>
<td>49</td>
</tr>
<tr>
<td>Dec-05</td>
<td>43</td>
<td>42</td>
<td>41</td>
<td>44</td>
</tr>
<tr>
<td>Jan-06</td>
<td>42</td>
<td>41</td>
<td>44</td>
<td>42</td>
</tr>
<tr>
<td>Feb-06</td>
<td>38</td>
<td>42</td>
<td>41</td>
<td>43</td>
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**Base:** All Males (2,534)

### New partner last 3 months over time - Base: All Females (9,222)

<table>
<thead>
<tr>
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<th>No</th>
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<th>Refused</th>
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**Base:** All Females (9,222)

### 2+ partners last 12 months over time - Base: All Females (9,222)

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<th>Refused</th>
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<td>Oct-06</td>
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</tr>
</tbody>
</table>

**Base:** All Females (9,222)
Profile of chlamydia positive respondents

Positivity over time

Analysis of those who have tested positive over time shows a very consistent pattern. The overall positive levels (based on 11,756) is 7% with the monthly trend shown below.

Positivity by age among men and women (16-24 year olds)

Overall 9% of the males (n= 2,534) tested positive for chlamydia and 7% of females (n = 9,222).

The proportion of women who were positive for chlamydia, was greatest at age 18 years (11%). For men, the highest positivity rates were found in men aged 19 years (13%), 22 years (11%) and 23 years (11%), which highlights the need to attract younger men to the service.

Of the total 13,423 successful screens (which includes all those out of age), 6% of the 25 year olds were positive for chlamydia.
Positivity by age and gender (Base: 11,756)

Positivity by ethnicity (16-24 year olds)

The highest proportion of positive tests was amongst Black Caribbeans (15%), followed by those whose ethnicity was Black British (13%).

The lowest proportion of positive tests was amongst those who were Chinese or other Asian (4%). Further to this only 5% of those from the Asian Subcontinent tested positive for chlamydia. Of the 7,798 white respondents, 7% tested positive.

These findings match the trend reported in the National Chlamydia Screening Programme Annual Report 2005/6 which found that, nationally, Asian and Chinese groups had lowest levels of positivity (4.8% and 8.2%) and Black Caribbean and Black British the highest
(13.7% and 14.1% respectively). In the national programme positivity among White men and women under 25 years was 10%.

**Positivity by behavioural risk (16-24 year olds)**

11% of the men who had a new sex partner in the last 3 months tested positive while 9% of women who had a new sex partner in the last three months were positive. The national screening data, found that 12.1% of women who had a new sex partner in the past three months and 11.3% of men, were positive.

11% of males who had two or more sexual partners in the past 12 months were positive and 8% of females. The National Screening Programme found that 11.9% of men and 12.8 of women who had had two or more sexual partners in the past 12 months were positive.

The proportion of men (8%) who tested positive for chlamydia, despite not having had a new partner in the last 3 months, was slightly higher than females (5%). Again this was similar for those who had not had two or more new sex partner in the last 12 months (males 7%; females 4%).
Service uptake: EPOS data

Return rates

Boots Electronic Point of Sale (EPOS) data provides the statistics for screening return rates. The EPOS process requires that all screening kits be scanned, both when given to the customer and when returned. EPOS data are not 100% accurate as, although staff are encouraged to use EPOS, there will be times when it is forgotten. Despite this, the EPOS data provides a useful indication of return rates, and this data cannot be collected by other means.

Wave 1

<table>
<thead>
<tr>
<th>Week/date</th>
<th>Kits handed out (EPOS data)</th>
<th>Screening kit returns (EPOS Data)</th>
<th>Return rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1 (14/11/05)</td>
<td>1,691</td>
<td>545</td>
<td>32%</td>
</tr>
<tr>
<td>Week 2</td>
<td>1,272</td>
<td>468</td>
<td>37%</td>
</tr>
<tr>
<td>Week 3</td>
<td>1,206</td>
<td>441</td>
<td>37%</td>
</tr>
<tr>
<td>Week 4</td>
<td>1,153</td>
<td>459</td>
<td>40%</td>
</tr>
<tr>
<td>Week 5 (11/12/05)</td>
<td>1,067</td>
<td>387</td>
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</tr>
<tr>
<td>Week 6</td>
<td>801</td>
<td>289</td>
<td>36%</td>
</tr>
<tr>
<td>Week 7</td>
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<td>126</td>
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<tr>
<td>Week 8</td>
<td>702</td>
<td>297</td>
<td>42%</td>
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<tr>
<td>Week 9 (08/01/06)</td>
<td>707</td>
<td>337</td>
<td>48%</td>
</tr>
<tr>
<td>Week 10</td>
<td>677</td>
<td>288</td>
<td>43%</td>
</tr>
<tr>
<td>Week 11</td>
<td>550</td>
<td>251</td>
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</tr>
<tr>
<td>Week 12</td>
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<td>238</td>
<td>48%</td>
</tr>
<tr>
<td>Week 13 (05/02/06)</td>
<td>514</td>
<td>219</td>
<td>43%</td>
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<tr>
<td>Week 14</td>
<td>535</td>
<td>218</td>
<td>41%</td>
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<tr>
<td>Week 15</td>
<td>514</td>
<td>286</td>
<td>56%</td>
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<tr>
<td>Week 16</td>
<td>528</td>
<td>235</td>
<td>45%</td>
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<tr>
<td>Week 17 (05/03/06)</td>
<td>448</td>
<td>192</td>
<td>43%</td>
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<td>Week 18</td>
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<td>Week 19</td>
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<tr>
<td>Week 20</td>
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<td>197</td>
<td>46%</td>
</tr>
<tr>
<td>Week 21 (02/04/06)</td>
<td>458</td>
<td>168</td>
<td>37%</td>
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<tr>
<td>Week 22</td>
<td>366</td>
<td>166</td>
<td>45%</td>
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<tr>
<td>Week 23</td>
<td>376</td>
<td>182</td>
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<tr>
<td>Week 24</td>
<td>363</td>
<td>184</td>
<td>51%</td>
</tr>
<tr>
<td>TOTAL (W1)</td>
<td>16,163</td>
<td>6,615</td>
<td>41%</td>
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### Wave 2

<table>
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<tr>
<th>Week/date</th>
<th>Kits handed out (EPOS data)</th>
<th>Screening kit returns (EPOS Data)</th>
<th>Return rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 25 (30/04/06)</td>
<td>307</td>
<td>123</td>
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<td>Week 26</td>
<td>336</td>
<td>150</td>
<td>45%</td>
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<td>Week 27</td>
<td>348</td>
<td>171</td>
<td>49%</td>
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<tr>
<td>Week 28</td>
<td>324</td>
<td>173</td>
<td>53%</td>
</tr>
<tr>
<td>Week 29 (28/05/06)</td>
<td>285</td>
<td>130</td>
<td>46%</td>
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<tr>
<td>Week 30</td>
<td>282</td>
<td>114</td>
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</tr>
<tr>
<td>Week 31</td>
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<td>44%</td>
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<td>Week 32</td>
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<td>183</td>
<td>57%</td>
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<td>Week 35</td>
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<td>60%</td>
</tr>
<tr>
<td>Week 37 (23/07/06)</td>
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<td>Week 38</td>
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<td>Week 42</td>
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<td>267</td>
<td>50%</td>
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<td>Week 43</td>
<td>582</td>
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<td>54%</td>
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<tr>
<td>Week 44</td>
<td>613</td>
<td>318</td>
<td>52%</td>
</tr>
<tr>
<td>Week 45 (17/09/06)</td>
<td>708</td>
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<td>Week 46</td>
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<td>71%</td>
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<td>Week 47</td>
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<td>Week 48</td>
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<td>59%</td>
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<td>Week 49 (15/10/06)</td>
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<td>Week 50</td>
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<tr>
<td>Week 51 (29/10/06)</td>
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<tr>
<td><strong>TOTAL (W2)</strong></td>
<td><strong>12,068</strong></td>
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<tr>
<td><strong>TOTAL (W1 &amp; W2)</strong></td>
<td><strong>28,231</strong></td>
<td><strong>13,485</strong></td>
<td><strong>48%</strong></td>
</tr>
</tbody>
</table>

The average return rate for the period week beginning 14th November through to the end of week 51 is 48%.

It is not possible to know exactly why the return rate is not higher than 48%. However, after 24 weeks (Wave 1 report) the return rate was 41%, with this rate increasing to 56% for weeks 25 to 51.
A number of factors may have led to this increase, possibly the likelihood of a greater explanation in store by Boots staff (emphasising the need to return the kit) and thus a greater understanding by the service user of the requirements and process.

We know embarrassment is a barrier to service use, so if a greater (sensitive) explanation has helped reduce any customer’s embarrassment levels and aided the increase response rate, so much the better.

The overall return rate is comparable with other services, although a constant aim should be to try and increase this.

**Age exclusion data**

The proportion of people that are being refused screening kits because they are out of the age range has generally decreased since service launch. Although an increase was apparent in mid 2006 (June/July), those out of age range have decreased to a minimal level in recent weeks. This suggests that the service is increasingly attracting customers who fall within the appropriate ages of 16-24 or alternatively staff may no longer be recording this information or indeed there may be a change of policy at the stores. It is noted that from October 2006, kits could be purchased at the stores, so those out of age may have been encouraged down this route.

No record is kept of whether refusals are due to customers being too young or too old, but the age profile of service users would indicate that it is more likely to be older people who are trying to access the service.

<table>
<thead>
<tr>
<th>Weeks/Date</th>
<th>Kits Refused – Out of age range EPOS data</th>
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<tbody>
<tr>
<td>Weeks 1-4</td>
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<td>Weeks 5-8</td>
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<tr>
<td>Weeks 9-12</td>
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<td>Weeks 17-20</td>
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<td>Weeks 21-24</td>
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<td>Weeks 29-32</td>
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<td>Weeks 41-44</td>
<td>82</td>
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<tr>
<td>Weeks 45-48</td>
<td>43</td>
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<tr>
<td>Weeks 49-51</td>
<td>8</td>
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</table>

* 3 week period
Screening evaluation data

Screening questionnaire returns have been extremely low, with a return rate of 3%. This rate of return has remained consistent since Wave 1 reporting. This is significantly lower than the expected return rate of 30% plus, which, based on previous experience, is considered feasible for this research.

Some of the demographic information of particular importance to the Department of Health is captured on the screening evaluation questionnaire (working status, level of education and contraceptive use), a decision made due to lack of space on the TRF. The lack of complete demographic data is worrying, since a primary objective of the evaluation is to assess whether high risk groups access the screening service.

The low return rate of evaluation questionnaires means that it is difficult to assess the true penetration rate of these groups. Return rates of questionnaires has not increased greatly since the launch of the service (see Table over). This led to a initial wave of mystery shopping being carried out in 20 participating pharmacies (November 2005) and a subsequent wave in 50 participating pharmacies (October 2006) to ascertain whether questionnaires were provided to service users.

The feasibility of inserting an evaluation questionnaire in the chlamydia screening kits is currently being explored. This change would ensure that every service user actually receives an evaluation questionnaire, however verbal encouragement to complete and return the questionnaires would still be a vital element of the process.
<table>
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<th>Screening Returns</th>
<th>Running total</th>
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<tbody>
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<td>20</td>
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<tr>
<td>W/c 05/12</td>
<td>22</td>
<td>42</td>
</tr>
<tr>
<td>W/c 12/12</td>
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<td>W/c 02/01</td>
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<td>56</td>
</tr>
<tr>
<td>W/c 09/01</td>
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<td>57</td>
</tr>
<tr>
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<td>63</td>
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<td>W/c 23/01</td>
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<td>204</td>
</tr>
<tr>
<td>W/c 24/04</td>
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</tr>
<tr>
<td><strong>Total (W1)</strong></td>
<td><strong>217</strong></td>
<td><strong>217</strong></td>
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</table>

<table>
<thead>
<tr>
<th>Week commencing</th>
<th>Screening Returns</th>
<th>Running total</th>
</tr>
</thead>
<tbody>
<tr>
<td>W/c 01/05</td>
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<td>229</td>
</tr>
<tr>
<td>W/c 08/05</td>
<td>3</td>
<td>232</td>
</tr>
<tr>
<td>W/c 15/05</td>
<td>6</td>
<td>238</td>
</tr>
<tr>
<td>W/c 22/05</td>
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<td>W/c 05/06</td>
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<td>8</td>
<td>276</td>
</tr>
<tr>
<td>W/c 24/07</td>
<td>5</td>
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</tr>
<tr>
<td>W/c 31/07</td>
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<td>281</td>
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<tr>
<td>W/c 07/08</td>
<td>3</td>
<td>284</td>
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<tr>
<td>W/c 14/08</td>
<td>11</td>
<td>295</td>
</tr>
<tr>
<td>W/c 21/08</td>
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<td>W/c 04/09</td>
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<td>W/c 18/09</td>
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<td>339</td>
</tr>
<tr>
<td>W/c 25/09</td>
<td>20</td>
<td>359</td>
</tr>
<tr>
<td>W/c 02/10</td>
<td>32</td>
<td>391</td>
</tr>
<tr>
<td>W/c 09/10</td>
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<tr>
<td>W/c 16/10</td>
<td>20</td>
<td>419</td>
</tr>
<tr>
<td>W/c 23/10</td>
<td>19</td>
<td>436</td>
</tr>
<tr>
<td><strong>Total (W1 &amp; W2)</strong></td>
<td><strong>436</strong></td>
<td><strong>436</strong></td>
</tr>
</tbody>
</table>

The number of screening questionnaires returned on a weekly basis since the launch of the PCSPF service is shown above.
Eight stores with the highest number of questionnaire returns (May – October 2006)

<table>
<thead>
<tr>
<th>Store ID</th>
<th>Location</th>
<th>Number of questionnaires returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>6497</td>
<td>Waterloo Lane, Romford</td>
<td>12</td>
</tr>
<tr>
<td>1626</td>
<td>Regent Street</td>
<td>10</td>
</tr>
<tr>
<td>1860</td>
<td>Kings Cross Station</td>
<td>9</td>
</tr>
<tr>
<td>1447</td>
<td>385-389 Oxford Street</td>
<td>8</td>
</tr>
<tr>
<td>726</td>
<td>Kings Road, Chelsea</td>
<td>6</td>
</tr>
<tr>
<td>1541</td>
<td>Wallington</td>
<td>6</td>
</tr>
<tr>
<td>842</td>
<td>Hare Street, Woolwich</td>
<td>5</td>
</tr>
<tr>
<td>5049</td>
<td>Fulham Broadway</td>
<td>5</td>
</tr>
</tbody>
</table>

In the Wave 1 report, when allocating screening questionnaires to pharmacies it was assumed that service users returned their sample to the pharmacy from where they collected a screening kit. This may not have been the case so all screening questionnaires were stamped with a store identifier (to avoid making this assumption) and a fresh batch sent to all participating stores. Thus the data above is from May – October 2006, rather than from the pilot launch.

The stores that have returned highest numbers of screener evaluation questionnaires are not those delivering the highest levels of screening, which supports the hypothesis that many stores do not offer screener evaluation questionnaires to service users.

Data match between TRF and screening evaluation questionnaire – 285 respondents

Of the 436 service users who filled in the screening evaluation questionnaire, 285 have been matched with the data collected by Boots from the TRF. The remaining 151 did not have their user IDs filled out on the questionnaire and therefore could not be matched.

In some instances, such as test result and partner profile, the data in the sample of 285 respondents is comparable with that from the 9,147 respondents (see table below).

In a few areas, the data that was collected varies between the two different samples. For example, a slightly higher proportion of females were included in the matched data set (82%) than in the larger, total sample (79%).

Overall, however, differences between the two groups appear slight.
<table>
<thead>
<tr>
<th></th>
<th>11,756 respondents</th>
<th>285 matched respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>22</td>
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<tr>
<td>Female</td>
<td>78</td>
<td>82</td>
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<tr>
<td>Not stated</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td><strong>Test result</strong></td>
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<td></td>
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<tr>
<td>Tested positive</td>
<td>7</td>
<td>9</td>
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<tr>
<td>Tested negative</td>
<td>93</td>
<td>90</td>
</tr>
<tr>
<td>Not stated</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td><strong>Age</strong></td>
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<td></td>
</tr>
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<td>2</td>
<td>-</td>
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<td>17</td>
<td>4</td>
<td>3</td>
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<tr>
<td>18</td>
<td>5</td>
<td>3</td>
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<td>8</td>
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<td>16</td>
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<tr>
<td>Out of age/Not stated</td>
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<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
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<tr>
<td>White</td>
<td>66</td>
<td>74</td>
</tr>
<tr>
<td>Other</td>
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<td>Mixed</td>
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<td>Black Caribbean</td>
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<td>4</td>
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<td>Asian Subcontinent</td>
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<tr>
<td>Black African</td>
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<td>3</td>
</tr>
<tr>
<td>Chinese other Asian</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Black British</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Not stated</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td><strong>New partner in past 3 months</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>No</td>
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<td>47</td>
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<tr>
<td>Refused</td>
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<td>18</td>
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<tr>
<td><strong>2 or more new partners in the last 12 months</strong></td>
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<td></td>
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<tr>
<td>Yes</td>
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<td>46</td>
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<td>No</td>
<td>33</td>
<td>35</td>
</tr>
<tr>
<td>Refused</td>
<td>25</td>
<td>18</td>
</tr>
<tr>
<td><strong>Area of residence</strong></td>
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<td></td>
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<tr>
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<td>45</td>
</tr>
<tr>
<td>Greater London</td>
<td>33</td>
<td>46</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>9</td>
</tr>
</tbody>
</table>

The results for the 436 screening evaluation questionnaires returned by October 31st 2006 are reported below.
Educational background and contraceptive use

In order to establish a socio-economic background two questions relating to work and education were asked. Respondents were also asked about their contraceptive use.

1. **Which of the following best describes your current situation?**

The majority of respondents were either working full time (49%) or were full time students (33%). Only 6% of respondents were both working and studying part time, only 2% were working part time, with 5% stating unemployed and seeking work.

![Bar chart showing current situations](chart)

SQ1. Which of the following best describes your current situation?  
Base: All respondents (436)

2. **What is the highest qualification you have gained? If you are still in education, tick the highest you have gained so far.**

27% of respondents were educated to A level or NVQ level 3 equivalent, 26% to first degree level, and 19% to GCSE/NVQ level 2 or equivalent. Only 3% of the sample had no qualifications.

Overall, the results reflect a relatively well educated population using the service. This is consistent with Wave 1 and continues to suggest that the key target audience of the service i.e. the at risk groups are not the key beneficiaries – those using are more ‘mass market’ and probably more educated than average.
3. Which of the following best describes your use of condoms and/or other contraceptives during sexual intercourse in the last 2 months?

When asked about contraceptive use, 28% of the total respondents were using a condom on some occasions along with another contraceptive and 24% were only using another form of contraceptive (e.g. cap, pill, coil). 22% used a condom on every occasion with 9% of these using a condom along with another contraceptive. Results are consistent with Wave 1 and may either reflect the general pattern of contraceptive use among this age group, or alternatively those who use condoms on a regular basis may be less likely to be tested for chlamydia.
The main body of the questionnaire was designed to evaluate user experiences and perceptions of the screening service.

**Route by which service was first heard of**

For 48% of respondents, the chlamydia screening service was discovered via an in store promotion with just over one fifth of users (21%) finding out through friends or family. The number who discovered the service through an in store promotion potentially suggests that many of those using the service are opportunistic users. A total of 18% first heard of the chlamydia screening service through advertising, 8% through advertising on the radio, 6% through advertising on TV and 4% through advertising in a newspaper.

![Diagram showing the route by which service was first heard of](image)

Looking at the matched sample (285 respondents), we can examine responses by gender. 53% of females heard about the service via in-store promotion, indicating that they were customers at the time. Only 32% of men heard about the service in this way. However, 32% of males heard of the service via friends and family, compared to 21% of females. These figures offer some support to the hypotheses that friends and partners may be instrumental in encouraging young men to be tested for chlamydia.
Signs and symptoms

The majority of people who collect the chlamydia screening test kit do not have any signs or symptoms. However, 15% stated that they decided to use the screening kit because they had signs and symptoms that concerned them. These results are consistent with Wave 1, and as highlighted then, this figure may be of concern since the service was set up to offer opportunistic screening.

Screening kits are being ‘pulled’ by customers and not ‘pushed’ by pharmacies.

Only 6% were offered a kit, which highlights that pharmacy staff, in line with contractual agreements, do not appear to be actively promoting use amongst the target age group. Although promotion by store personnel would require sensitivity, the original focus group data indicated that there are occasions when such an offer would be acceptable to service
users e.g. when purchasing or collecting contraceptives. As highlighted in Wave 1, when considering strategies for increasing service uptake, greater promotion by pharmacy staff is one that could be worthwhile considered. 

For the majority (94%), the test that they collected with the questionnaire was the first test they had used. This is consistent with Wave 1 and therefore would appear to suggest that service users are not ‘repeat’ users.

Choice of pharmacy

Location is the main determinant of users choice of pharmacy with 36% of respondents choosing a pharmacy close to home, and 35% choosing one close to work.
A small minority (3%) stated the reason for choosing a pharmacy was its location away from home and thus a level of anonymity. The fact that a pharmacy may have a private consultation area does not appear to influence a person’s choice of pharmacy, with only 1% stating this to be a reason for choosing one pharmacy over another.

The data from the screening evaluation questionnaire is consistent with the findings from Wave 1. However, at a national level, a private consultation was considered to be a more important service attribute than convenience of a store.

**Alternative locations for chlamydia testing**

If the chlamydia screening service was not available via Boots, 35% of respondents indicated that they would be tested in a hospital clinic (e.g. GUM) and 20% would go to a GP. Interestingly, over a quarter of respondents (29%) would not have taken a test if the chlamydia test had not been available through Boots. This finding is consistent with Wave 1 and continues to suggest that the PCSPf is successfully accessing a group of people that would otherwise have remained untested for genital chlamydia. 12% of all respondents would have alternatively gone to a family planning clinic and 7% to an NHS drop in health centre.

![Bar chart showing the percentage of respondents choosing different locations for chlamydia testing if the service from Boots was not available.]

**Comfort levels**

Respondents were asked to rate how they felt when asking for/being offered a screening kit in a pharmacy compared with other locations where they could have obtained a test for chlamydia. The question used a scale of 1 to 5 where 1 was very uncomfortable and 5 was very comfortable. Many appear relatively comfortable in asking for/being offered a screening kit in a pharmacy, with 45% being comfortable (a rating of 4 or 5) and 21% being uncomfortable (a rating of 1 or 2).
Q6. Compared to other places where you could have a test for chlamydia (for example GP surgery, GUM clinics), how did you feel:

Base: All respondents (436)

- Receiving the kit in a community pharmacy:
  - Very uncomfortable (1) 8
  - Very comfortable (5) 30

- Asking for/being offered a screening kit:
  - Very uncomfortable (1) 9
  - Very comfortable (5) 24

Similarly, when asked how comfortable they were receiving the kit in a community pharmacy, many appear relatively comfortable with 49% rating 4 or 5, and only 20% being uncomfortable (a rating of 1 or 2).

Confidentiality of the in pharmacy screening service

When asked how confidential the screening of chlamydia through a pharmacy was compared with other locations, broadly 50% perceived it to be as confidential as other locations (hospital clinic, GP, family planning clinic, and drop in health centre).

Compared with a GP surgery, the pharmacy screening service is seen by 19% of respondents as being more confidential compared to a hospital clinic (18%), and a family planning clinic or drop in health centre (15%).
Pharmacy staff

Respondents were asked to rate the pharmacy staff in terms of knowledge and friendliness on a scale of 1 to 5, where 1 was ‘not at all’ and 5 was ‘extremely’.

Q9. Please rate the following questions:
Base: All respondents (436)

Did you find the pharmacy staff knowledgeable?

<table>
<thead>
<tr>
<th>Rating</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>2</td>
<td>10</td>
<td>11%</td>
</tr>
<tr>
<td>3</td>
<td>32</td>
<td>74%</td>
</tr>
<tr>
<td>4</td>
<td>42</td>
<td>97%</td>
</tr>
</tbody>
</table>

Did you find the staff friendly?

<table>
<thead>
<tr>
<th>Rating</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>2</td>
<td>10</td>
<td>11%</td>
</tr>
<tr>
<td>3</td>
<td>32</td>
<td>74%</td>
</tr>
<tr>
<td>4</td>
<td>42</td>
<td>97%</td>
</tr>
</tbody>
</table>

77% of respondents perceived pharmacy staff as knowledgeable (rating of 4 or 5), with only 5% stating the pharmacy staff were not knowledgeable (rating of 1 and 2).

87% of respondents considered the pharmacy staff to be friendly (rating of 4 or 5) with only 4% rating the staff as not friendly (rating of 1 or 2).

Convenience and likelihood to recommend

Q10. Overall how convenient did you find this service? Q11. On a scale of 1 to 5 where 1 is highly unlikely and 5 is extremely likely, how likely are you to recommend this service to others?
Base: All respondents (436)

Convenience of service

<table>
<thead>
<tr>
<th>Rating</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9</td>
<td>3%</td>
</tr>
<tr>
<td>2</td>
<td>25</td>
<td>7%</td>
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<tr>
<td>3</td>
<td>64</td>
<td>77%</td>
</tr>
</tbody>
</table>

Likelihood to recommend

<table>
<thead>
<tr>
<th>Rating</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>22</td>
<td>6%</td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>2%</td>
</tr>
<tr>
<td>3</td>
<td>19</td>
<td>5%</td>
</tr>
<tr>
<td>4</td>
<td>71</td>
<td>81%</td>
</tr>
<tr>
<td>5</td>
<td>19</td>
<td>5%</td>
</tr>
</tbody>
</table>

Nearly two thirds of respondents (64%) considered the service to be extremely convenient (rating 5) and a further 25% considered the service to be fairly convenient (rating of 4).
90% of respondents said they were highly likely or likely to recommend the service to others (ratings 4 and 5). Only a minority rated the service not convenient (1%) and were unlikely to recommend (4%) the service to others.

Ease of use

12% of respondents had not yet used the kit. The kit was rated by most as either quite or very easy to use (74%) with a further 8% stating that it was neither difficult nor easy to use. Only 1% of the total respondents claimed that the chlamydia screening test kit was quite difficult to use.

Looking at the matched sample (285 respondents), we can examine responses by gender. 81% of males gave an ease of use rating of quite or very easy. This compares with 72% of females. 1% of females rated it as ‘quite difficult, while none of the male respondents chose this option.

In summary and as indicated in the Wave 1 report, service users appear to be very satisfied with the in-store service that they are receiving and with the screening procedure.

Treatment Evaluation Questionnaires

The treatment evaluation questionnaire was designed to assess how service users who were subsequently treated at Boots perceived the service.

Between service launch and 31st October 2006, 27 treatment questionnaires were completed. During this period 912 number of tests were undertaken in Boots pharmacies, giving a return rate of 3%.
These results are best considered as indicators of how people feel about the service, rather than robust quantitative data.

Of these 27 respondents 14 received their test result by telephone, 6 by text and 5 by letter. 2 people did not answer this question.

6 people received their results within 3 days, 12 within 4-5 days and 7 within 6-7. 2 people did not answer.

Respondents were asked to describe the tone of the communication they received informing them of their results. 19 people selected the option helpful, 19 friendly, 10 professional and 1 formal.

17 service users chose to return to a pharmacy for treatment because of the convenient location. 8 people returned because they were pleased with the service when they collected the kit, 7 for the convenient hours, and 6 because it seemed logical to get treatment from the same place as the screening kit and 5 because it is a confidential service.

17 respondents returned to the same pharmacy that they collected the chlamydia kit from, and 6 went to a different pharmacy. 2 people did not respond.

The reasons for choosing a different pharmacy were convenient location (7 responses) and ‘different opening hours’ (3 responses).

23 service users rated the pharmacist as knowledgeable, rating 4 or 5 on a 5 point scale. Three others gave a rating of 4 with no one giving a lower rating. 25 rated the pharmacist as friendly and helpful, giving a rating of 4 or 5. As at Wave 1, no one gave a rating of less than 3.

11 respondents said that they received free condoms when they collected their treatment, 10 received specific advice about chlamydia, 9 received advice on safe sex and 7 information on sexually transmitted diseases. All 27 received information about the treatment.

25 service users stated they were happy with the information and advice they received, giving a rating of 4 or 5. Three people gave a rating of 2.

24 respondents were satisfied with the level of confidentiality in the whole testing process, giving a rating of 4 or 5. 2 people gave a rating of 3 and one person gave a rating of 2.

Finally, 25 service users were satisfied with the overall screening and testing process. 2 people gave a rating of 3. 22 described themselves as ‘very likely’ to recommend this service to someone else. One respondent was ‘very unlikely’ and 4 were ‘quite likely’.
Questions asked on the Evaluation form:

1. **How did you first hear of the chlamydia screening service?**
   - Through advertising on radio/TV/newspapers etc ................................................... □
   - Pharmacist or counter assistant............................................................................. □
   - In store promotion ................................................................................................... □
   - Other Health Care Professionals, e.g. GPs ............................................................. □
   - Friends/family ........................................................................................................... □

2. **Why did you decide to use the chlamydia screening kit?**
   - I had signs/symptoms that concerned me ............................................................ □
   - I had no signs/symptoms but wanted a health check ............................................. □

3. **How did you come to receive a chlamydia screening kit?**
   - I asked for the screening kit ................................................................................... □
   - The pharmacist or counter assistant offered the screening kit .............................. □

4. **Why did you choose this particular pharmacy to use the chlamydia screening kit?**
   - **TICK ALL THAT APPLY**
     - Private consultation area..................................................................................... □
     - Location – close to home ...................................................................................... □
     - Location – away from home .................................................................................. □
     - In store toilet facilities ........................................................................................... □
     - Quiet/uncrowded store ........................................................................................... □
     - No reason in particular ........................................................................................... □
     - Other ....................................................................................................................... □

5. **How comfortable did you feel:**
   - **Very uncomfortable** 1 2 3 □ 4 5 □
   - **Very comfortable** 1 2 3 □ 4 5 □
   - Asking for a screening kit
   - Being offered a screening kit
   - Receiving the kit in a retail pharmacy

6. **How confidential do you consider screening of chlamydia through a pharmacy compared with the following screening locations?**
   - **Less confidential** □ **Equally confidential** □ **More confidential** □ **Unsure** □
   - Hospital clinic (e.g. GUM)
   - GP
   - Family planning clinic/ contraceptive service
   - Drop in health centre

7. **Please rate the following questions:**
   - Not at all 1 2 3 □ 4 □ 5 □
   - Extremely 1 2 □ 3 □ 4 5 □
   - Did you find the pharmacy staff knowledgeable?
   - Did you find the staff friendly?
8. Overall how convenient did you find this service?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Extremely</th>
<th>5</th>
</tr>
</thead>
</table>

9. On a scale of 1 to 5 where 1 is highly unlikely and 5 is extremely likely, how likely are you to recommend this service to others?

<table>
<thead>
<tr>
<th>Highly unlikely</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Highly likely</th>
<th>5</th>
</tr>
</thead>
</table>

10. How easy did you find the test to use? Please rate on a scale of 1 (very difficult to use) to 5 (very easy to use).

1 – very difficult
2 – quite difficult
3 – neither difficult nor easy
4 – quite easy
5 – very easy
6 – haven’t used it yet

SQ1. Which of the following best describes your current situation? (Tick one box only)

- Full time student
- Part time student
- Working part time and studying part time
- Working full time
- Working part time
- Full time parent or carer
- Unemployed and seeking work
- Other

SQ2. What is the highest qualification that you have gained? If you are still in education tick the highest that you have gained so far. (Tick one box only)

- No qualifications
- GCSE / NVQ Level 2
- A levels or NVQ level 3 or equivalent
- HND / HNC
- Diploma of higher education
- First degree (BA or BSc)
- Postgraduate qualification
- Higher degree (MA, MSc, PhD)
- Professional qualification
- Other (please specify)

SQ3. What of the following best describes your use of condoms and/or other contraceptives during sexual intercourse in last 2 months? (Tick one box only)

- Condom on every occasion, along with other contraceptive e.g. pill, coil, cap
- Condom on some occasions, along with other contraceptive e.g. pill, coil, cap
- Condom on every occasion, no other contraceptive
- Condom on some occasions, no other contraceptive
- Other contraceptive only (e.g. cap, pill, coil), no condoms
- No contraceptives used/safe period/withdrawal
- Not had sex in the last 2 months
Questions asked on the treatment questionnaire

Q1  How did you receive your test results?
   • Phone
   • Text
   • Letter

Q2  Was this how you requested your results to be sent?
   • Yes
   • No

Q3  How quickly did you receive your results, from the time that you returned the kit to the Pharmacy?
   • Under 3 days
   • 3 days
   • 4-5 days
   • 6-7 days

Q4  Regarding the communication you received, which of the following would you use to describe the tone when you were told your test result? (Tick all that apply)
   • Friendly
   • Helpful
   • Formal
   • Rude
   • Professional
   • Judgemental
   • Other (specify)

Q5  Why did you decide to return to a Pharmacy for treatment? (Tick all that apply)
   • Convenient location
   • Convenient hours
   • Pleased with the service when I collected the test
   • Confidential
   • Seemed logical to get treatment from same place as test
   • Other (specify)

Q6  Which of the following statements applies to you? (Tick only one)
   • This is the same Pharmacy that I collected the chlamydia test from
   • This is a different Pharmacy from the one that I collected the chlamydia test from

Q7  If you have returned your chlamydia test to a different Pharmacy from the one that you collected it from, why is this? (Tick all that apply)
   • Convenient location
   • Different opening hours
   • Embarrassed to return
   • Not happy with service at first Pharmacy
   • Other (please specify)
Q8 Please rate the following questions on a scale of 1 (not at all) to 5 (extremely):

a) Did you find the Pharmacist knowledgeable when talking to you about the treatment?
b) Did you find the Pharmacist friendly/helpful when talking to you about the treatment?

Q9 What information/advice did you receive from the Pharmacist when you returned to collect your treatment? (Please tick all that apply)

- Information about the treatment
- Advice on practicing safe sex
- Information on sexually transmitted diseases
- Free condoms
- More specific advice about chlamydia
- Other (please specify)

Q10 How happy were you with the information/advice you received? Please rate on a scale of 1 (not at all happy) to 5 (extremely happy).

- 5 (extremely happy)
- 4
- 3
- 2
- 1 (not at all happy)

Q11 On a scale of 1 (not at all satisfied) to 5 (extremely satisfied), how satisfied where you with the level of confidentiality in the whole testing process?

- 5 (extremely satisfied)
- 4
- 3
- 2
- 1 (not at all satisfied)

Q12 On a scale of 1 (not at all satisfied) to 5 (extremely satisfied), how satisfied are you with the overall screening and testing service?

- 5 (extremely satisfied)
- 4
- 3
- 2
- 1 (not at all satisfied)

Q13 How likely would you be to recommend this service to someone else?

- Very likely
- Quite likely
- Neither likely nor unlikely
- Quite unlikely
- Very unlikely
Copy of information of Test Request Form:

Please complete the blue sections in BLOCK CAPITALS.

SECTION A

Your details (confidential)

Title (tick one box only):  
- Mr  
- Mrs  
- Miss  
- Ms

Surname:  
First name:  

Date of birth:  

Home postcode:  

SECTION B

It’s important that we can contact you with your result. How would you like us to contact you? (Tick one box only)

Letter  
Phone  
Text

If you would like us to phone you with your result, is it OK to leave a message?

Yes  
No

Your phone number:  

Address (for results by letter only):

House No:  
Street:  

Town/city:  
County:  

Postcode:  

STORE USE ONLY

Complete date & time of sample return:

Date:  

Time:  

Store number:  

SECTION C

Ethnicity - please tick one box only. (You can leave this section blank if you prefer)

- White (W)
- Black Caribbean (BC)
- Black African (BA)
- Black British (BB)
- Asian subcontinent - Indian, Pakistani, Bangladeshi (AS)
- Chinese or other Asian (CH)
- Mixed (M)
- Other (OT)

CUSTOMER INFORMATION:

This slip contains your unique Customer Reference Number (CRN).

Keep it somewhere safe - you’ll need to quote this number if you have any questions about your test or if you need treatment.

If you haven’t received your test results within 7 days, please contact the pharmacist at your local participating Boots store (London area).

Please tear off this section & hand it to the customer.
Appendix two: Wave one focus group research
Chlamydia screening evaluation: Consumer focus groups

Report prepared by TNS Healthcare for:

The Department of Health

125331 December 2005

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Contents

EXECUTIVE SUMMARY.............................................................................................................. 62
BACKGROUND ..................................................................................................................... 64
OBJECTIVES..................................................................................................................... 68
METHODOLOGY .................................................................................................................... 69
FINDINGS ....................................................................................................................... 71
GENERAL AWARENESS AND KNOWLEDGE OF STIS.......................................................... 72
CHLAMYDIA AWARENESS........................................................................................................ 81
CHLAMYDIA SCREENING VIA THE PHARMACY ................................................................. 87
CHLAMYDIA TREATMENT VIA THE PHARMACY................................................................. 94
PHARMACY FACILITIES ........................................................................................................ 97
SERVICE IMPROVEMENTS ................................................................................................. 99
PREDICTED PUBLIC AND MEDIA RESPONSE................................................................. 101
PROMOTING THE SERVICE................................................................................................ 102
PREDICTED SERVICE UPTAKE.......................................................................................... 104
APPENDIX A: COMPLETED BUBBLE DIAGRAMS............................................................ 107
APPENDIX B: RECRUITMENT GUIDE ................................................................................ 115
APPENDIX C: DISCUSSION GUIDE .................................................................................. 121
Executive summary

Background
This research formed the first component of a longitudinal evaluation of Pharmacy Chlamydia Screening Pathfinder. The six focus groups (three with younger respondents and three with older) were undertaken immediately prior to the PCSP service beginning.

Methodology
Six focus groups were undertaken, two with males, two with females and two mixed groups. 3 groups involved younger respondents (16-24) and 3 groups older respondents (25-65). A range of ethnic groups and social classes were represented.

Aims
The overarching aim was to explore knowledge of chlamydia, and attitudes to the PCSP service, in order to understand the context in which the chlamydia screening service will be operate, to help interpret subsequent quantitative data and to help design subsequent evaluation questionnaires.

Findings
Awareness of different STIs was generally high, although knowledge of different infections was variable and not always well differentiated. Respondents showed some agreement on which STIs they considered to be most serious, although there was less consensus about rates of infection. Respondents had a broad understanding of where screening and treatment for STIs can currently be obtained. Awareness of chlamydia was high, but knowledge very patchy, particularly in terms of signs and symptoms and the impact of chlamydia upon men.

The pharmacy chlamydia screening pathway concept was received positively, although not everyone perceived this as a main priority healthcare service. Younger respondents particularly welcomed the practical benefits of the pharmacy service e.g. ease of access, no appointments or long waiting times and less stigma, whilst older groups tended to also acknowledge the benefits of long term health promotion. Although respondents approved the lower age of 16 they queried why the upper age was 24, thinking it should be older.

Other reservations about the service included the potential for service abuse (repeat tests, lying about age or symptoms), the possible lack of privacy, concerns about the quality of the tests and the lack of comprehensive STI testing.

Respondents believed that embarrassment would be the biggest barrier preventing people from seeking chlamydia screening. Strategies to reduce embarrassment, such as vouchers and consultation areas, were suggested. However, it was also felt that a belief that this ‘will
not happen to them' together with a lack of symptoms might also deter potential users. Females were considered to be more likely to use the service than men, as they were considered more health conscious and likely to attend with a friend.

In order to encourage service use, simple key messages were suggested on chlamydia, chlamydia rates and ease of treatment. TV and schools were the most popular forums for promoting the service, although radio, tubes, buss and GP services were also suggested. Respondents felt that unless the service was well promoted it would not be used, although younger respondents, in particular, stated they will tell others about it.
Background

The prevalence of genital chlamydial infection, in the UK, is unclear. As 70% of infected women and 50% of infected men are asymptomatic, it is assumed that a large proportion of cases remain undiagnosed. The National Survey of Sexual Attitudes and Lifestyles 2000, a stratified probability sample survey of men and women aged 16 to 44 years, reported overall prevalence of 1.5% in females and 2.2% in males (1) whilst a pilot opportunistic screening programme among 16-24 year olds instigated by the Department of Health (DH) in 1999-2000 found prevalence of chlamydia at 9.8% in Portsmouth and 11.3% in Wirral.(2)

The number of diagnoses has risen steadily since the 1990s, perhaps reflecting increased prevalence as well as raised awareness among both public and healthcare professionals (HCP).

Infection rates tend to correlate with urban areas, with London having the highest rates and the highest rates of chlamydia are among the younger population. This is of particular concern as younger women may be more susceptible to developing the complications of untreated chlamydial infection.

Around a third of women with chlamydia develop pelvic inflammatory disease (PID), which is in turn associated with chronic pelvic pain, infertility and ectopic pregnancy. Ectopic pregnancy represents 21% of deaths resulting from complications of pregnancy and childbirth with chlamydial infection estimated to account for 40% of ectopic pregnancies. Approximately 17% of women treated for pelvic inflammatory disease will become infertile, whilst a similar percentage will experience chronic pain. (3). The annual cost of chlamydia and its complications is estimated to be more than £100 million.

Following pilot schemes in Portsmouth and Wirral the Chief Medical Officer’s Expert Advisory Group on Chlamydia trachomatis concluded, in 1996, that evidence supports the effectiveness of chlamydia screening, and so the National Chlamydia Screening Programme (NCSP) was introduced. The aim of the NCSP is to control chlamydia through early detection and treatment of asymptomatic infection, in order to prevent complications and reduce onward disease transmission. 26 local programme areas have been designated so far, covering more than 25% of primary care trusts. Testing is offered in a number of settings, including GPs surgeries, contraception clinics, termination of pregnancy services, young person’s clinic and antenatal services.

The initial pilot scheme showed high acceptance and uptake of testing, with around 50% of the eligible population aged less than 25 years tested within the study period, and an acceptance rate of more than 75% when the test was offered (4). Awareness of chlamydia increased to around 75% among the population in the pilot areas, compared to just under half in the general population. Both HCPs and staff involved in the scheme perceived the programme to be valuable, notably in Portsmouth where 1 in 10 of those tested had proven
to be positive. 8 out of 10 HCPs/staff wished to see continued screening in their practice/clinic once the pilot ended.

The Department of Health is now evaluating the potential role of retail pharmacies in chlamydia screening. A pilot scheme (the Pharmacy Chlamydia Screening Pathfinder or PCSP) was launched in November 2005 within the M25 via Boots retail chain. Offers of screening will again be targeted at 16-24 year olds, who will be given a free test kit for completion at home or in pharmacy – depending upon the availability of on-site wash rooms – and then handed to the pharmacy.

The Pathfinder Chlamydia Screening Office (CSO) will then action positive results while negative or inconclusive results will fall to the pharmacy provider to action. The findings from the pilot scheme evaluation will subsequently be used to inform the decision on whether to launch a national pharmacy chlamydia screening service.

The independent evaluation is consists of an 18-month research programme involving:

- **Pre-service**
  - Qualitative focus groups to establish general awareness levels of sexually transmitted infections (STIs) and chlamydia in particular, as well as acceptability of the proposed screening service
  - A local population (within the same area as the pilot service) survey to understand the impact of the service on this group
  - A national population survey to measure attitudes towards chlamydia screening and the barriers to use

- **During the service**
  - Repeats of the local and national population surveys to track changes in views once the screening service is in operation
  - Ongoing evaluation of the screening and treatment service, to monitor who is using the service and their evaluation of the scheme
  - ‘Pulling power’ data to establish how many potential clients do not enter onto the chlamydia screening pathway
  - Feasibility study with Healthcare Professionals (HCPs) to gauge the benefits and drawbacks of the scheme, as experienced by those involved with service delivery
  - Repeats of the ‘pulling power’ data, local and national population surveys
  - A full economic analysis of the cost benefit to the Department of Health in rolling out the chlamydia screening service on a national basis
A full timeframe of the research is shown on the following page. This report captures the findings from the focus groups, which were undertaken prior to the launch of the chlamydia screening service.

(1) Trends in selected STIs: 1991-2001


(3) Summary and conclusions of CMO’s Expert Advisory Group on chlamydia

<table>
<thead>
<tr>
<th>Month 1 – Wave 1 (October ’05)</th>
<th>Months 2-5 (March ’06)</th>
<th>Month 6 – Wave 2 (March ’06)</th>
<th>Months 7-17 (March ’07)</th>
<th>Month 18 – Wave 3 (March ’07)</th>
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<tr>
<td>Focus groups (Sept ’05)</td>
<td>Ethics Committee (Jan ’06)</td>
<td>EPOS pulling power data (Feb ’06)</td>
<td>EPOS pulling power data (Feb ’07)</td>
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<td>Local population survey (Oct ’05)</td>
<td>Local population survey (Feb ’06)</td>
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<td>National population survey (Oct ’05)</td>
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<td>Screening evaluation (Nov ’05)</td>
<td>HCP feasibility study (Feb ’06)</td>
<td>Economic evaluation (Feb ’07)</td>
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Objectives

The primary objective of the consumer focus groups was to:

- Explore the acceptability of providing free chlamydia screening and treatment, via a high street pharmacy, to people aged 16-24 years

Secondary to this, a series of other objectives were addressed:

- Awareness of sexually transmitted diseases
- Awareness of current sources of treatment for sexually transmitted diseases
- Awareness of segments of the population most at risk
- Reactions to the concept of chlamydia testing via a pharmacy
  - Perceived benefits e.g. accessibility, convenience, spontaneous
  - Perceived drawback e.g. confidentiality, privacy, embarrassment
  - Acceptability and reasons
- Reactions to the concept of chlamydia treatment being offered via the pharmacist
  - Perceived benefits e.g. accessibility, convenience, spontaneous
  - Perceived drawback e.g. confidentiality, privacy, embarrassment
  - Acceptability and reasons
- The predicted impact and attractiveness of such a service
  - Predicted take-up
  - Reasons for refusal
  - Reasons for non-returns
- Suggested improvements to the outlined service
- Suggestions on how successfully promote or advertise such a service

The findings will be used to help design and interpret subsequent stages of the evaluation
Methodology

Six consumer focus groups were undertaken, with the following design:

<table>
<thead>
<tr>
<th>6 focus groups</th>
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<tr>
<td>■ 3 groups with 16-24 year olds</td>
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<tr>
<td>- 1 group males</td>
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<tr>
<td>- 1 group females</td>
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<tr>
<td>- 1 mixed gender</td>
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<tr>
<td>■ 3 geographical locations (within M25 radius)</td>
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<tr>
<td>■ Socio-economic mix</td>
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<tr>
<td>■ Ethnic mix</td>
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<tr>
<td>■ 3 groups 25-65 year olds</td>
</tr>
<tr>
<td>- 1 group males</td>
</tr>
<tr>
<td>- 1 group females</td>
</tr>
<tr>
<td>- 1 mixed gender</td>
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<tr>
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</tr>
<tr>
<td>■ Socio-economic mix</td>
</tr>
<tr>
<td>■ Ethnic mix</td>
</tr>
</tbody>
</table>

The profile of each group was:

**Group One: Epsom and Ewell Borough**
- Age: 16-24
- Gender: 5 females, 4 males
- Socio-economic class: 3 social class B, 3 social class C1 and 3 social class C2
- Ethnicity: 1 mixed and 9 white

**Group Two: London Borough of Lewisham**
- Age: 16-24
- Gender: 7 females
- Socio-economic class: 4 social class C1, 1 social class C2 and 2 social class D
- Ethnicity: 2 Asian subcontinent, 3 Black Caribbean, 1 mixed and 1 white

**Group Three: London Borough of Lewisham**
- Age: 25-65
- Gender: 7 males
- Socio-economic class: 1 social class C1, 3 social class C2, 2 social class D and 1 social class E
- Ethnicity: 2 Black Caribbean, 2 mixed and 2 white
**Group Four: London Borough of Barnet**
Age: 16-24  
Gender: 7 males  
Socio-economic class: 3 social class C1, 2 social class C2, and 2 social class D  
Ethnicity: 2 Black Caribbean, 1 Asian subcontinent, 1 other and 3 white

**Group Five: Epsom and Ewell Borough**
Age: 25-65  
Gender: 9 females  
Socio-economic class: 2 social class B, 3 social class C1, and 2 social class C2 and 2 social class D  
Ethnicity: 1 Asian subcontinent, 8 white

**Group Six: London Borough of Barnet**
Age: 25-65  
Gender: 4 females and 3 males  
Socio-economic class: 2 social class C1, 3 social class C2, and 2 social class D  
Ethnicity: 1 Asian subcontinent, 4 other and 2 white

**Sample**
Respondents were free found by TNS healthcare recruiters. Copies of the recruitment guidelines are shown in Appendix B.

**Ethical Issues**
Respondents were assured of anonymity and confidentiality. The names of participating respondents are not included and no quotes or statements are directly attributable to any individual.

Respondents were offered an incentive for their participation.

**Fieldwork**
Groups were held in the third week of September 2005.  
Each group lasted 90 minutes and each moderated by an experienced TNS healthcare moderator (one male and one female).  
A copy of the discussion guide is included in Appendix C.

**Analysis**
Each focus group was audio-recorded, thematically analysed and interpreted.
Findings

The findings are reported under the following themes:

- General awareness and knowledge of STIs
- Chlamydia awareness
- Chlamydia screening via the pharmacy
- Chlamydia treatment via the pharmacy
- Pharmacy facilities
- Service improvements
- Predicted public and media response
- Promoting the service
- Predicted service uptake
General awareness and knowledge of STIs

Awareness

Levels of awareness of different sexually transmitted infections (STIs) were generally high, with no discernable differences between older and younger respondents or between males and females.

The majority of the groups spontaneously cited the following STIs:

- Gonorrhoea
- Chlamydia
- Genital Warts
- Hepatitis
- Herpes
- Syphilis
- HIV
- AIDS
- Thrush
- Pubic Lice

In most of the groups, there was some confusion over which strain of hepatitis is sexually transmitted, with some respondents identifying a specific strain and others just mentioning hepatitis.

When asked directly, there was no awareness of chancroid in any of the groups and only very limited awareness of bacterial vaginosis.

When citing STIs respondents frequently distinguished between those STIs which they regarded as being exclusively sexually transmitted and those which they believed can also be transmitted in other ways. AIDS, HIV and thrush, were all considered examples of STIs that can also result from non-sexual routes. Blood was recognised as a source of infection for HIV/AIDS, for example.

Some respondents felt that thrush, in particular, should not be considered a sexually transmitted disease, because it occurs frequently and not necessarily as the result of sexual activity. For example, antibiotics and certain washing powders were both said to cause thrush.

Similarly, not everyone believed pubic lice to be sexually transmitted although the majority did.
Although respondents were aware of a variety of different STIs, they did not necessarily have in-depth knowledge of any particular STD. This was highlighted in the spontaneous discussions that arose when the diseases were listed, and in response to direct questions. While one group stated that someone might carry HIV but not develop AIDS, another believed that HIV inevitably develops into AIDS.

There was a misconception in the two male groups that men cannot contract thrush, a view not expressed in the female or mixed groups.

In general, respondents used medical terms rather than ‘slang’ when listing STIs. The only slang term that arose when discussing STIs was ‘crabs’. This term was used interchangeably with the term pubic lice or lice, in a couple of groups.

One person used the term ‘VD’ to mean a specific STI.

**Seriousness**

There were some interesting discussions when respondents were asked which STIs they considered the most serious. The most serious STIs were those perceived as incurable and/or fatal. These included AIDS, HIV, and hepatitis and all groups agreed that AIDS is the most serious.

> "Basically you could die from AIDS but you’re not going to die from the others if you’re treated" (25-65 mixed)

In general herpes was also considered to be a serious condition because it is incurable requiring long-term management.

> "I don’t think once you’ve got it (herpes), you can get rid of it, therefore you’re not going to die from it but you’ve got to live with it. If you get gonorrhoea and it’s treated then that’s better than getting herpes that you have to manage for the rest of your life" (25-65 mixed)

> "It’s a virus and you can’t cure it" (16-24 mixed)

However, some suggested that herpes is possibly less serious than other infections because it does not have side effects such as infertility:

> "Maybe herpes cannot be cured but it doesn’t affect your fertility. Chlamydia affects your fertility. It depends on what priority you may have. Maybe if you’re in your forties you might not mind if you are not planning to have a family but if you are...” (25-65, mixed)

> "It doesn’t actually do anything” (16-24, mixed)

> "It’s like living with arthritis in your knee, you can live with it but you can’t die from it” (25-65, mixed)

Chlamydia, syphilis and gonorrhoea were typically ‘grouped together’ and considered as equal in terms of seriousness of the infection. The fact that all three can be treated with
antibiotics influenced perceptions of their seriousness. These three STIs were considered to be less serious than the incurable/fatal STIs but more serious than thrush, since they require prescription medical treatment.

“Those three things can be cleared up with antibiotics ... it’s not that serious. It all depends how quickly you catch it I suppose, that you realise you’ve got it. These three are harmless if you catch them soon enough. It’s only if you leave them for a year or something, like chlamydia, if you leave that for a long period of time it could make you infertile” (16-25, male)

All groups perceived thrush as the least serious infection, and as stated above, this was not always perceived as a ‘sexually acquired infection’:

“Women just develop it” (16-25, young)

Prevalence

All groups were asked which STIs are the most common in the UK. No one felt confident in stating which sexually transmitted diseases are more common than others (other than thrush) and a variety of views were put forward.

Some respondents acknowledged that whilst they may have heard of a particular STI, they were not knowledgeable about them:

“Some of these diseases I don’t know much about” (16-25 mixed)

Other respondents debated whether the amount of publicity about an STI is an indicator of how common it is. Some respondents felt AIDS must be common because it has received a lot of publicity; while others disputed this and said that the publicity was generated because AIDS is so serious.

“Being talked about doesn’t mean it is most common”

“But sometimes it does!” (16-24 female)

Thrush was generally agreed to be the most common STI, but chlamydia was occasionally mentioned as being the most common.

“Chlamydia you hear a lot about now, and AIDS you heard about a few years ago” (25-65, mixed)

“It’s [chlamydia] on the increase” (Male, 25-65)

Chlamydia, gonorrhoea and genital warts tended to be grouped together in terms of prevalence, but there was a mix of views.

“Genital warts is one of the least common STIs” (16-24, Male)
It’s (chlamydia) more common than genital warts and pubic lice” (16-24, mixed)

AIDS and HIV were considered to be the least common STIs, although in a marginal number of cases syphilis and herpes were also mentioned.

“AIDS is the least common but it kills” (16-24, mixed)

Although all groups initially stated that AIDS is the least common, some groups began to revise their opinion. They felt that people diagnosed with AIDS do not tell other people, which makes AIDS appear less common than it actually is.

“It’s not a topic you’d want to talk about; it’s not like getting a cut finger” (25-65 mixed)

“I’d possibly say that AIDS is the least common as for knowing people that have had it. You probably hear about it the most, but as for people that have it or know the have it…” (16-24 mixed)

One group decided AIDS is more common than syphilis.

“More people are getting diagnosed with AIDS than syphilis” (25-65, Male)

Some respondents commented that HIV/AIDS might also be under diagnosed because people are unwilling to have tests.

At risk groups

All focus groups were asked if there are any groups or types of people who are more at risk of acquiring sexually transmitted infections than others. A number of different groups were identified as high risk, and to some extent particular infections were linked to specific groups of people:

- Younger people/teenagers

In general, younger people were viewed as being more likely to catch an STI.

“Teenagers – they’re just learning things, experiencing things for the first time, they’re not aware of the proper precautions” (25-65, male)

In particular some diseases are viewed as being “teenagers diseases”

“[Gonorrhoea, syphilis, chlamydia] are more like teenager diseases...I would say that those three are the teenagers’ diseases. I’d say if you were going to catch a disease when you’re young. It’s going to be one of those three” (16-24, male)

Teenagers on the whole were perceived as more sexually active and adventurous than other groups of people. They were also thought, by most, to be less likely to use protection when having sexual intercourse, which would further increase their risk of catching an STI.
■ Older people/divorced

A small number of respondents perceived those who are older and divorced to be at a higher risk than others of contracting an STI. Older divorcees were considered to be more sexually active than others of the same age and therefore at increased risk of exposure to STIs.

“Because there are a lot more divorced people now, they are on their second phase of going out with people again and they’ve become sexually active again. They’re finding that they’re women of 40-55 are now increasing with all these sexual diseases because they’ve become sexually active again. So after 20 years with their husbands, there is divorce and they’re out on the market again” (25-65, mixed)

“Because of marriage breakdowns people in this age group are more sexually active” (25-65, female)

It was older respondents, perhaps reflecting a topic that is more salient to this group, who mainly expressed this view.

■ Gay community

Most respondents considered homosexual men to be a high-risk group, for AIDS and HIV, and only one person stated that homosexual females were also high risk.

■ African immigrants

Although AIDS and HIV were generally associated with homosexual males, a small minority highlighted that these diseases are prevalent in other groups, namely Africans/African immigrants.

“In Africa it is more heterosexual because it comes back to promiscuity that so many of the men are sleeping with other women. He’s taking it home to the family and the wife gets it and the children get it” (25-65, mixed)

■ Drug users

Another group considered high risk for catching STIs were IV drug users. Increased risk in this group was thought to occur as a result of sharing needles. Respondents associated HIV and AIDS with intravenous drug users and Hepatitis B was also mentioned by a couple of people.

■ Other ‘at risk’ groups

Further ‘at-risk’ groups were identified as those in the military, prostitutes, holiday representatives and those on vacation.

“They have a girl in every port” (25-65, male)

Nobody suggested that the risk of acquiring an STI relates to socio-economic class or ethnicity (with the exception of the reference to African immigrants).
At risk behaviours

Respondents were also asked if there are specific behaviours that place individuals at greater risk of catching an STI.

“It’s not about how much you drink, it’s about whether you can hold your drink. You don’t have to drink and lose control” (16-24, female)

A number of different behaviours were predicted to increase the risk of contracting an STI. In general, drug use and alcohol use were considered behaviours that put people at risk of contracting an STI because of their ability to impair decision-making processes.

There was uncertainty as to whether non-sexual behaviours can be ‘risk’ behaviours.

A few people thought that sharing clothing and towels could spread pubic lice. One person mentioned that chlamydia could also be contracted via non-sexual behaviours, however the method by which this was done was not understood.

“I remember reading a book once and I think you can catch chlamydia without having sex but I’m not sure” (16-24, mixed)

One person referred to being able to catch an STI from sun bed.

Others thought that STIs could be contracted through using public toilets. This view was expressed, to some extent in each group and debated by many respondents, particularly in relation to pubic lice and chlamydia.

“Bacteria may already be there” (25-65 mixed)

Not everyone agreed that STIs can be spread in this way, while a few people said that although they had been told that it is not possible to catch an STI from a public toilet they still doubted the credibility of this information.

“In school they said that you can’t [catch an STI from a toilet seat], but I think you can” (16-24, female)

“I don’t think that these things survive outside of the body but you might have that one in a million unfortunate experience” (25-65, mixed gender)

“I wouldn’t sit on a public toilet seat” (16-24, female)

Two further areas of confusion centred on whether STIs can be contracted in swimming pools or by drinking out of the same glass. While a minority only expressed these views, it did raise discussion among respondents as to whether these were a possible source of infection or not.
“It’s [AIDS] not actually in the water, it’s on the ground around the swimming pool. That’s why people wear flip flops” (16-24, mixed)

“Hepatitis B can be spread through drinking out of the same glasses because it’s germs” (16-24, female)

“There needs to be open wounds” (in a swimming pool) (16-24, mixed)

“It’s just conversation you hear. I don’t expect that you can catch AIDS if you have an open cut and someone else has an open cut” (16-24, mixed)

There was also some indecision over whether, and which, non-penetrative sexual behaviours increase the risk of contracting STIs. Intimate non-penetrative contact was considered by many to increase the risk of contracting an STI, specifically genital warts, but this risk was considered to be low.

There was uncertainty whether HIV and AIDS can be contracted from bodily fluids other than blood.

“I think you can get AIDS from bodily fluids like spitting. But you have to have gallons of it” (16-24, mixed)

Oral sex was thought by the majority to increase the likelihood of contracting a sexually transmitted infection. Some said that herpes and genital warts might be transmitted and a minority of people AIDS.

“How can you get AIDS? [through oral sex] It’s a virus it affects the blood” (16-24, mixed)

“Homosexuals get AIDS so there must be other ways to get it” (16-24, mixed)

“You don’t get AIDS through sex by blood, it’s anything that’s got your body cells in it” (16-24 mixed)

“If there were cuts in the mouth...” (16-24, male)

The majority of respondents agreed that having multiple partners increases the risk of contracting an STI, or having sex with someone who has had multiple partners.

“It’s a question of promiscuity. There is an issue that you might not have slept with a lot of people but your partner might have done. Therefore you are at a higher risk of contracting something because he or she has been at higher risk because they’ve been promiscuous” (25-65, mixed)
Failure to use condoms was also considered to be risk behaviour. It was recognised that while one partner may not have had many sexual partners, the sexual history of the other partner may be unknown.

**Avoiding STIs**

A variety of opinions were expressed as to how people could avoid STIs. Abstaining from sex was suggested as a way to avoid contracting STIs, however it was made clear that some (AIDS, thrush and hepatitis) could still be contracted by other means.

Having only one sexual partner was thought to reduce the risk of getting an STI, but only if the partners history was fully understood and they remained faithful. One person stated that this might be “as risky as with multiple partners” Although remaining totally faithful to one person was again thought to reduce the risk of getting an STI although AIDS and thrush were two infections that were highlighted as still being contractible through non-sexual behaviour.

Not having penetrative sex and always using a condom were other suggested ways of avoiding STIs.

**Screening and treating STIs**

Awareness of the different centres that currently offer screening and treatment of sexually transmitted infections was high. Most respondents had some knowledge of where STIs can be tested and treated, and the range of centres mentioned included GPs, family planning clinics, well-women clinics, and GUM or sexual health clinics. One or two respondents volunteered that they had experience of using such services.

- **GP surgery**

Most groups considered that testing for STIs could either be carried out at a GP surgery, or that the GP can refer for testing. Some respondents believed that certain infections such as thrush, chlamydia and genital warts could be screened for by the GP whilst other possible infections would be referred.

> “The GP may look at the condition but would not treat” (16-24, male)

- **Sexual health clinics/GUM clinics**

Sexual health clinics were spontaneously mentioned by half of the groups to be a place where people can be tested and treated for sexually transmitted infections. Some respondents considered sexual health clinics to be the same as GUM clinics, whilst others saw them differently.

One person commented that these clinics do not appear very welcoming:

> “...Some of the clinics, they are grotty. I can see why older women don’t want to go in them, they’re not particularly welcoming” (25-65, female)
One or two others mentioned problems of access, particularly by telephone:

“All with these clinics...they’re sizing down and for test results it’s a nightmare. They give one afternoon for test results; you can never get through to get any results. So these clinics are getting smaller and smaller” (25-65, female)

Although the majority of respondents knew the term GUM clinics they did not know what the acronym GUM represents. Some respondents used the phrase ‘special clinic’ and one or two commented that some hospitals may provide walk-in’ facilities and cater particularly for younger people.

The issue of whether it would be appropriate to attend A&E arose in some groups and the consensus was that attending A&E would not result in testing for sexually transmitted infections, but that people may be referred to the GUM clinic once there.

- **Family planning clinics**

Some respondents considered that family planning clinics offer STI testing, although others saw these as a referral hub where patients would be told where to go for STI testing.

“If you are under a family planning clinic then they will deal with you or tell you where to go” (25-65, mixed)

- **Well women clinics**

Although some respondents mentioned these spontaneously in general they arose only when prompted; most had heard the term but did not necessarily know if the management of STIs fell within their remit.

- **Others**

In one instance it was noted that testing is currently available for chlamydia in universities although this was not a widely acknowledged location for STI testing.

“In some universities you can get kits that you do yourself and send off, my daughter was saying” (25-65, mixed)

Some respondents spontaneously identified pharmacists as useful sources of information, whilst recognising that STIs tests cannot be done at a pharmacy.

“I find the pharmacist very good actually” (25-65, female)

“The pharmacist would tell you where to go” (25-65, male and female)

“..would only provide you with creams for thrush” (16-24, male)
Chlamydia awareness

Having discussed sexually transmitted infections in general, respondents were then asked to focus on chlamydia. All respondents were asked if they heard of chlamydia prior to the focus groups. Two younger females had not previously heard the term chlamydia whilst some other respondents stated that, although they were aware of chlamydia, they were not particularly knowledgeable.

“I know nothing about chlamydia” (16-24, mixed)

“I’ve heard it being mentioned but to be honest I haven’t ever really heard much about what it is or what it does” (25-65, male)

“I think most of us at the table are saying ‘what’s the difference between syphilis, gonorrhoea, chlamydia’? We just know they’re bad and you don’t want them. If you get them you’re in trouble.” (16-25 mixed)

Chlamydia: signs and symptoms

When questioned respondents tended to guess the symptoms of chlamydia, based on their general knowledge of STIs, (although some had specific knowledge) and suggested that there might be a ‘discharge’, ‘itching’, ‘pelvic pain’, ‘infection’, ‘stings when urinating’, ‘maybe it smells’, and ‘scabs’.

However, most groups also included some respondents who knew that chlamydia often has no signs or symptoms, and who were sometimes ‘educating’ other group members.

“I’m not aware there are any symptoms in women at all, so unless you have a blood test, and it’s not until these people have been for blood tests that is has come up” (25-65, mixed)

“Isn’t it chlamydia that you can have for years and years and not know that you have it?” (16-24, mixed)

“Women could be infected for years without knowing” (25-65 female)

“I’m surprised that there can be a lack of signs and symptoms” (25-65, male)

When asked how likely it is for someone with chlamydia to have no signs or symptoms, respondents’ estimates ranged from 20-40% in women and up to 90% men.
Some respondents commented that the lack of any signs makes it easier for chlamydia to be transmitted unknowingly:

“How do you know if you’ve got it unless you go to the GP? You can pass it on without even realising it” (25-65, mixed)

“If you think you’re ok and you don’t have a blood test, then you can carry it without knowing that you’ve got it” (25-65, mixed)

Because of the lack of signs, respondents felt that the transmission of infection was often ‘blameless’, as it was usually not the case that an infected person was ignoring signs of disease.

“Chlamydia is blameless” (25-65, mixed)

The long-term effects of chlamydia were also relatively well known. The main long-term effect that was highlighted by all groups was that chlamydia could result in infertility, an effect that was considered more relevant to females than males.

There was, in fact, some confusion about whether males can actually be infected with chlamydia, or whether they are ‘just carriers’ of the disease. Although a small number of people had some understanding of how chlamydia affects the fallopian tubes, the mechanism of how it might affect males was not known, although one person mentioned that it could affect the male urethra.

“Women are more at risk of becoming infertile than men” (25-65, males)

“If someone has been trying for a baby and they can’t get pregnant then they take a blood test and find that your fallopian tubes are blocked, then they’ll tell you that’s why” (35-65, mixed)

“It can affect unborn babies” (16-24, female)

“Not sure if there are symptoms in men” (25-65, mixed)

“Men pass it to the women” (16-24, female)
Chlamydia sufferers

When asked, “Who suffers from chlamydia?” the immediate response from most groups was “women”. This supported the general perception that chlamydia is a ‘female infection’, and, that the consequences of chlamydia are much worse for women than for men.

“Men can’t have babies so they won’t have to deal with being told that they’re infertile” (16-24, mixed)

Despite the focus on female health, some respondents did believe that chlamydia can result in infertility in men as well as women.

“More likely to make men infertile” (16-24, mixed)

Younger people were considered more at risk of chlamydia than older people, which corresponds with the consensus that younger people are at risk of contracting STIs in general.

“I thought it was getting more common in younger people because they’re not using condoms” (25-65, female)

Divorcees were again mentioned as a group who suffer from chlamydia, and the female 25-64 year age group again raised this.

When probed respondents did not consider that ethnicity, social class or education would be related to rates of chlamydia.

“Educated people are just as likely to suffer” (16-25, mixed)

“Any ethnic group” (25-65, female)

Chlamydia rates

In general, rates of chlamydia were believed to be increasing. This was thought by some, mainly younger age respondents, to be a result of commencing sexual behaviours at an earlier age, allowing for more years for the infection to be spread around.

“Kids these days are starting a lot earlier as well...a lot has changed definitely in the last 4 or 5 years since I was in school...it’s getting worse, I’ve definitely noticed a change since I was younger” (16-24, male)

“More girls at younger ages now, are sleeping with boys...and they probably don’t even worry about using protection” (16-24, female)
Some respondents also commented that younger people are more at risk due being more vulnerable and less mature.

“,,their brain is not as advanced as if they’d started at a decent mature age. |They’re more likely to be get involved with more different people”(16-24, female)

Others felt that rates of chlamydia might appear to be increasing due to increased levels of awareness and testing.

“It might have always been the same numbers but you’re just aware of the numbers now”
(25-65, female)

“It’s more common, you hear about it more, it’s more publicly known as well now rather than just hearing it from people you know, you see it in the media a bit more”(16-24, male)

“Clinics are testing a lot more for it, they’re getting out there, they want to reach people, not just young people, everybody”(25-65, female)

This however was an opinion of the minority with most considering that rates of chlamydia are on the increase.

**Treatning chlamydia**

All groups considered it necessary to treat those people who have contracted chlamydia as soon as possible.

“It would turn into an epidemic [if left untreated]”(16-24, male)

Treatment was considered necessary in order to prevent the spread of the infection, to improve general health of patients and to prevent infertility.

“It can’t be good for you anyway having an illness; it’s like having a permanent cold or something”(16-24, male)

Although chlamydia should be treated, most respondents believed that some positive cases would remain untreated due to the lack of symptoms. One person suggested that there should be annual chlamydia checks, in the same way that mammograms are offered, rather than waiting for people to request a test.

**Reasons for not seeking chlamydia screening**

Several reasons were highlighted as to why some people might not seek treatment or testing for chlamydia, the majority of which linked in with embarrassment.
Embarrassment

Above all, embarrassment was the factor that was considered to be the greatest influence in preventing people seeking treatment for chlamydia. This was a view that was expressed by almost all people in all groups, and the stigma attached to STIs was the main reason given as to why people would not go to seek screening for chlamydia.

“It’s the stigma attached, you associate sexually transmitted diseases with being promiscuous which is not the case at all” (25-65, female)

“It’s frowned upon isn’t it? If you catch a disease, say for example, meningitis, no one will look at you...they might think I’m not coming near you but they would feel more sorry for you rather than think it’s your own fault. I wouldn’t want to go near anyone with HIV or AIDS in case they breathed on me or something like that, I’m just being honest”(16-24 male)

This view was mentioned by a number of people and was thought, by some, to be particularly relevant to younger people, with one group believing that older youths would not be so embarrassed by others finding out.

“Especially when you’re at a young age...other people, older people probably think ‘little girl sleeping around’(16-24, female)

“I think the older ones are quite happy to talk about it and not be embarrassed”(25-65, female)

The issue of embarrassment and the ‘blame’ and ‘shame’ associated with STIs occurred in all the discussions

Fear

Fear of confirming that the infection is present was another reason, suggested by respondents, to explain why people might avoid being tested or treated for chlamydia:

“You just think the worst. You don’t think ‘I’ll get treated’, you think, ‘oh my god, I’ve got this disease inside of me’” (16-24, female)

“If you don’t know what you’ve got you can’t worry about it” (16-24, mixed)

The fear that people have for testing and treatment of chlamydia was thought by many to manifest itself in denial, with people not wanting to know whether they have the disease. This view was expressed by a large number of people.
relationship with GP

Some respondents felt that poor relationships with GPs may prevent people from seeking advice or testing:

“My GP is Christian, they won’t do birth control or anything like that, you certainly can’t go to mine” (25-65, female)

Mine is Asian and they’re really funny about that sort of thing as well, and that’s why he directed me straight to the clinic, he didn’t want to know” (25-65, female)

Ignorance

Some respondents suggested that the lack of symptoms and ignorance about chlamydia would prevent some people from being screened.

“They must just be doing it [not seeking testing of treatment] because there are no symptoms. If you found some unsavoury things down below, you would have to do something about it” (25-65, female)

It was also suggested that ignorance about where to go might prevent some people from seeking help, although not everyone agreed:

“It’s an education issue, where to go for help” (25-65, mixed)

“I think it is up to the parents, we’re not stupid, we know that we’ve got to educate our children…” (25-65, mixed)

“I think these days in schools they have all these other options…they seem to be giving out information left, right and centre about where you can go…..” (25-65, mixed)

The lack of symptoms was also suggested by a few to cause some patients not to finish their prescribed course of antibiotics, as there would be no tangible improvements in general health.
Chlamydia screening via the pharmacy

Initial reactions to the service

All groups were asked how they would feel if free chlamydia-screening kits were available for 16-24 year olds via high street pharmacies.

One instant reaction was that this new service confirmed respondents’ beliefs that chlamydia rates are increasing.

“So it must be well on the up if they have to introduce these sorts of schemes” (25-65, mixed)

It was also felt that the service and its’ anticipated advertising, would help to raise awareness of chlamydia:

“If this is done, then it will be advertised and a lot more people would know a lot more about it and get it done” (16-24, male)

The other aspect of the service that cased instant reactions was the intended age range. 16 was generally viewed as an appropriate lower age, but the proposed upper limit of 24 was more controversial.

“Definitely sixteen and up is fine,...I was a bit more worried that you would get your 12 year olds walking in...but I would be quite happy for a 16 year old” (25-65 female)

Although a few respondents considered a lower age preferable, others raised objections regarding children receiving screening tests without parental consent and one respondent commented that the use of screening tests requires a certain level of maturity, which may not be present among teenagers:

“I suppose only if you’ve got a conscience, you’d think, “hang on a minute, I’ve slept with 3 blokes in the last month, I didn’t use a condom, I’d better get myself checked out”” (25-65 female)

Reactions to the proposed upper age limit included:

“I don’t think there should be an (upper) age limit” (25-65 female)

“As we were saying, people don’t realise [they’re infected] and it’s not until maybe they’re starting a family or whatever and even then, they’re probably 26, 27...if they got chlamydia when they were 18 or 19 and it sat there for that long, then why can’t they walk into a Boots? Why should there be an age limit of 24, and why 24?” (25-65, female)
Only two people were already aware of the new screening service. Respondents typically gave positive reactions to the new service, and provided detailed feedback on ways to remove potential barriers and to make such a scheme successful.

However, when specifically asked what they thought about spending public money on this service, reactions were more mixed. Some respondents took the ‘longer term’ view and spoke of eventual cost savings, or commented that STIs have been relatively ignored:

“...They don’t have to pay for IVF treatment 10 years down the line. It’s preventative, one course of antibiotics and a test that might cost twenty quid, saves thousands of pounds later one.” (25-65, mixed)

“I think the area of STIs has been neglected a lot because everyone is always talking about terminal diseases. I don’t think a lot of action has been taken personally” (16-25, mixed)

Many respondents considered that the proposed service did not go far enough, as it will not screen for other STIs.

Although the chlamydia screening via a retail pharmacy was seen as a good use of public money, when this service was considered alongside those for chronic conditions such as cancer or diabetes, preference for the use of the money lay in these areas.

“The priority would lie with cancer ahead of chlamydia” (16-25, female)

“The older population won’t like it” (16-24, mixed)

Positive aspects associated with the screening service

- Free service

Respondents were pleased that the service is free, which in many ways is quite surprising since different health screens are currently freely available. Respondents checked that both the screening kit, and the prescription charge (if required) would be free, as they presumably did not expect a free service to be available on retail premises.

- Less embarrassment

Respondents felt that the service would help to avoid embarrassment, as there were none of the negative associations attached to clinic attendance.

“Good for avoiding the embarrassment of going to the doctors “ (25-65, male)

“Less stigma than going to a clinic” (25-65, mixed)
Some respondents commented that friends could collect the kit for them, or that they could collect a kit with a friend.

Privacy

The privacy associated with the service was considered to promote anonymity and thereby also reduce embarrassment.

“No need to inform parents” (16-24 mixed)

“There’s no need to worry about anybody else being there” (16-24, female)

“It can be done with discretion” (25-65 male)

“Don’t have to worry about infection being on your medical records” (16-24, male)

The ‘guaranteed’ privacy was also thought to encourage individuals to take responsibility for their own action.

“If you’re stupid enough to get yourself in that situation in the first place, they you should be mature enough to do something about it” (16-24, males)

Opportunity for health education and healthier populations

Older groups, in particular, tended to mention the longer-term health advantages that the service could provide, such as promoting safe sex and sexual health.

Can be used as an opportunity to promote safer sex (25-65, female)

More people can be tested (25-65, female)

“I’d hope that on the first treatment they’d say to you “Use protection because if you get it again we might not be able to treat you as easily” (25-65, female)

“It will slow the rate of infection as more people will know they have it” (25-65, male)

“I think it will encourage youngsters to take the test because if it is such a silent disease they wouldn’t know they had it anyway so there’s no urgency to go to these clinic places, so they might think, ‘Oh, it’s free, let’s just do it for peace of mind just to check that we haven’t got it’” (25-65, female)
Convenience

The younger groups, in particular, tended to focus more on the practical benefits of the service highlighting factors such as privacy, convenience, accessibility and availability of the service. The accessibility of this service was seen as a big benefit by many due to the availability of the service on the high street, the option of going to different locations and the availability at the weekends.

“You can go to any location to get the test” (16-24, male)

The convenience of the service centred on the fact that no appointments have to be made to access the service and that waiting times should be minimal.

“There is no waiting involved and no appointments” (16-24, female)

The lack of waiting time was seen to be a major plus for the screening service and respondents talked about being able to collect a kit in a lunch break.

Negative aspects associated with the screening service

Although reactions were favourable, respondents were able to identify potential barriers or negative aspects of the screening service. Some of these were the same issues that had been raised as positives, for example, embarrassment.

Embarrassment

Although the older groups considered that the screening service might reduce any embarrassment associated with STI testing, all groups noted that there could still be a high level of embarrassment involved in accessing such a service.

“You’d probably go out of your way to get the kit. Say you live in Lewisham, instead of going to Lewisham boots you’d go to like Stratford where nobody knows you” (16-24, male)

This factor was by far and away the most important barrier associated with offering chlamydia screening via a high street store. The majority of people highlighted many facets of embarrassment associated with this service including knowing someone in the store, knowing the pharmacist, asking for the kit and the pharmacists’ age and gender.

“It’s more public in a shop. You never know, your mum could walk past” (16-24, male)

“I think they would be more embarrassed going to a chemist. When you’re dealing with a doctor it’s one-to-one, no one would know except for you and the doctor” (25-64, male)

It was also felt there would be a greater chance of other people knowing why you are there.
“Have to wait in line to pick up from the pharmacy counter – people will know what you’re waiting for” (16-24, male)

Respondents spoke of waiting until the counter was empty before approaching, and did not want a separate ‘chlamydia’ area that would show why they were attending.

- **Chlamydia only screening**

Most of the groups believed that there was a major problem with the service in that it only tests for chlamydia. Most believed that the kit should test for a more extensive range of STIs than chlamydia alone. Specific diseases that were considered important to be tested for were syphilis and gonorrhoea. Respondents felt that a negative screen for chlamydia could leave other infections untreated.

“**It should be more widespread, it shouldn’t just be for chlamydia, it should be a wider range**” (16-24, male)

“I wouldn’t bother doing it now that I know it’s only that one thing [being tested]” (16-24, male)

Some respondents believed that screening only for chlamydia would result in lower than expected service use, as sexually active people would prefer to be screened for all infections.

- **Pharmacist versus doctor**

Although the convenience of offering this service in pharmacy was praised, some doubts were also raised about this location.

“I don’t think it should be in a high street chemist, I think it should be in a family planning clinic because the high street chemist is too open” (16-24, female)

One of the main concerns surrounding the pharmacy location was the availability of a trained professional to give appropriate guidance alongside the screening kit. Some respondents expressed concerns that the advice received from a pharmacist would not be of the same quality as that received from a doctor.

“Couldn’t get as much advice [from the pharmacist] as if you went to your GP or specialist, you might be able to but I don’t know if you’d have as much contact with the pharmacist. I know I’d rather talk to my GP than I would to the pharmacist. I might ask more questions because that is something that you want to keep private and will probably share more with the GP than the pharmacist” (25-65, mixed)
There was also uncertainty about the legal guidelines that pharmacists operate under, and whether they would keep records of those who have collected a screening kit.

“I’m sure they (pharmacists) are not under any legal obligation to keep it confidential like a doctor is (16-24, mixed)

- **Screening instead of safe sex**

A few older respondents were apprehensive that this service might encourage unprotected sex as young people might view it as a ‘quick fix’.

“You know how they give the morning after pill over the counter to the teenagers, they might look at this as a form of contraception. ‘Oh well, it doesn’t matter if I get it, I’ll just nip into Boots and get the antibiotics and it’s sorted.’” (25-65, female)

“If you didn’t have to go through all the trauma of treating it and clearing it, you might just think it’s that easy, it wouldn’t make you so aware to use condoms because you think, ‘oh well, if I get it again, I’ll just pop into Boots and get my antibiotics’” (25-64, female)

One respondent again suggested that, instead, chlamydia screening should be offered as a standard annual testing procedure for younger people.

“You’re 16, you go sleep with someone, you think ‘I’m going to get tested’, you decide to be responsible and go get tested. You’re negative, sex months later you sleep with somebody else, think ‘oh, right, I better get tested’...it’s never ending. Why aren’t they just advocating... that everyone has a test yearly? And if everyone is doing it, there’s no stigma attached to it, like a smear test or a mammogram or whatever. It’s a preventative measure rather than ‘oh I might be or I might not’” (25-65 mixed)

Although the idea that a free chlamydia screening service could encourage unprotected sex was voiced in the older groups, this was not a view that was expressed by the younger respondents. Some younger respondents explicitly stated that a screening service would offer reassurance and not encourage unprotected sex.

- **Record keeping and service abuse**

An associated topic was whether or not records would be kept, and whether the number of screenings obtained would be monitored, to see if the service was being ‘abused’.

“I’d prefer records not to be kept. (16-24, male)
“Maybe they keep a record system of someone who’s been in once and returns for multiple tests” (25-65 female)

Some questions were raised about people collecting the screening kit for use by others outside the age range, and wondered how this could be monitored.

- Age limits

The issue of target age group was again raised, as a specific barrier. This was perceived as being a limiting aspect of the service that potentially could miss out identifying large numbers of people who have chlamydia. For most, this was a restriction that could be combated by opening the service up to everyone.

“[Should be available to everyone]...I don’t see why not, it affects everyone in the same way doesn’t it? ...it won’t be long until this disease is in other age groups because all it takes is for a couple of young lads or birds to sleep with older people and their little friendship groups get going” (16-24, male)
Chlamydia treatment via the pharmacy

Positive aspects of treatment

- **Convenience**

The majority of respondents perceived treatment via retail pharmacy to be a good idea. The primary benefit was the convenience of accessing high street pharmacies, and respondents liked the idea of collecting the screening kit, results and treatment from the same location.

“If you go to the doctors you still have to go back to the chemist anyway” (16-24 female)

The pharmacy service was also considered to reduce waiting times for testing and for treatment, which were a current frustration for people wanting to arrange appointments with other health care professions.

“You can walk into a clinic any time but with those places (GP) you’ve got to book and you often can’t get through” (16-24, male)

“Often you can’t get an appointment at a GPs under two weeks wait” (25-65, male)

One person also mentioned that the ability to access chlamydia treatment through a pharmacy might reduce the stress that might be associated with collecting results/treatment at other locations.

“It’s quite stressful. Say for example, I needed to get treated for something and I was working, it would be easy for me to get time off work, but form someone who couldn’t get time off work they’d worry” (16-24, male)

Again, respondents made positive comments about opening hours.

- **Lack of embarrassment**

Once again the issue of embarrassment arose, with most respondents believing that collecting treatment in a pharmacy would not be too embarrassing.
For some the fact that the pharmacist is used to dealing with a variety of conditions was viewed as a positive aspect of this service.

“Anybody could go to the chemist and get antibiotics so there is no need to worry about what other people are thinking” (16-24, female)

Negative aspects of treatment

- Embarrassment

This was a continual theme throughout the focus groups and occurred again in the context of treatments. Respondents were concerned about being embarrassed when speaking to the pharmacist, when waiting in busy stores or queues, and if they met anyone they knew.

“Confidentiality may be an issue” (25-65, female)

Although embarrassment appears to be a huge barrier it is not unique to pharmacies, as highlighted by one respondent:

“Embarrassment is not a negative point exclusively for pharmacies, it’s a negative point for anything to do with STIs” (16-24, mixed)

- Test reliability

Questions were raised over test reliability, and whether the pharmacy test would be of the same standard as those used in other locations. Respondents were looking for reassurance that the pharmacy test would be as reliable as those from other sources.

- Lack of GP involvement

Some respondents were critical that the GP is not involved and felt that GPs should be informed if the test is positive.

“It may be from the chlamydia that you did get infertile and that’s something the GP should know” (16-24, female)

“The chemist should inform you, after you get your results to go and tell the GP (16-24, female)

“The GP knows your history….the pharmacist wouldn’t know about allergies” (25-65, mixed)
Partner involvement

Some respondents asked about the involvement of partners, stating that a clinic can provide a more comprehensive service than a pharmacy, and that screening via a pharmacy means the onus will be on the user to tell their partners.

“At the family planning clinic they contact your partner and let them know ....without them knowing it was you.” (16-24, female)

Limited opening hours

A minority of respondents had reservations about pharmacy opening times and requested Sunday opening and longer opening hours. However, as others pointed out pharmacy hours are currently longer than GP or GUM clinics, and there was a sense that some respondents were being more critical of the new service than of existing services.
Pharmacy facilities

All groups were asked what facilities, if any, participating pharmacies should ideally offer.

Store location

Although respondents felt that store facilities might affect whether the service was used, another deciding factor was simply the geographical location of a store and its distance from home.

The predominant feeling was that people would not go where they recognised store staff or where they may be recognised themselves. As a result people would opt to visit a store that was further away from home and sufficiently larger enough to offer anonymity.

“The smaller branches are so tiny that you can’t get away from being seen at the pharmacy store, whereas the bigger ones are so huge you could have a bit of a discretionary area there” (25-65, female)

Toilets

Mixed views were put forward about the advantage offered by in store toilets. Some felt these would be an advantage, particularly for teenagers who might not want to take the test home:

“It would probably make a difference to some. I’m sure some would rather do it in their own toilet and some would like a quick service. So if they can go to Boots and have the urine test there and then, they can get the results fairly quickly” (25-65, mixed)

Others viewed in store toilets less positively, as they thought they would make test use too obvious.

“...[there’d be] stigma attached to using toilets in a chemist (16-25, male)

Additionally some groups thought that people taking the test would prefer to do it at home.

“I’d rather go home” (16-24, mixed)

Staff

Most respondents wanted pharmacy staff to be dedicated, understanding of the situation, to behave as normal and to be professional about the service.
“[Staff should behave] as normal as possible. It’s like any other service, they’re just providing a service and they need to be professional about it” (25-65, male)

“No special treatment...just provide the service, there’s your kit, there’s a toilet if you want to use it, if not, bring it back” (25-65, male)

I’d prefer it to be an ‘old’ counter assistant (16-24, male)

“It would be more embarrassing working in the pharmacy than picking up the kit (16-24, male)

‘Behave normally’ appeared to be the key message, and at least one respondent said that if assistants try to be too caring they can appear patronising.

There were mixed views on whether it might be appropriate for a pharmacy assistant to inform people about the service. The most acceptable time was when a customer had purchased related products e.g. condoms

- Consultation area

A few people perceived this as a really good idea, as it would enable private conversations with the pharmacist:

“...if it was literally a booth then it would just be a case of you queue up and say to the pharmacist you’d like to go in private.” (25-65 females)

“It doesn’t have to have chlamydia on it!” (16-25, mixed)

Others were opposed to any facilities that might draw attention to the chlamydia service. There was a subtle distinction between offering a ‘good’ service and drawing attention to a service e.g. many did not want a separate counter because other customers would know why people were there.

“You wouldn’t go there if it said ‘chlamydia Counter.....whereas if there was a section that’s known for personal health and you know you can get, for example, ear wax cleaner and chlamydia testing kits that’s different, because no one know what you’re going there for.”(25-65, male)
Service improvements

After the proposed service was presented and discussed, respondents were asked for suggestions on how the service might be improved. Many of the improvements that were suggested addressed the perceived drawbacks of the service.

■ Testing for all diseases

The service was considered limited in terms of the scope of the testing, and one improvements that was suggested by both the young and older groups was expanding the tests to incorporate other STIs. Although there was some acceptance that there would be financial implications, respondents tended to assume that multi-screening is possible.

“It would make more sense if people were tested for everything” (25-65, mixed)

“It’s a lot of money for the government to test for everything” (16-24, mixed)

“It’s wasted on just chlamydia” (16-25, mixed)

■ Expanding services

Throughout the discussions there were hints that the chlamydia screening service does not go far enough, with the suggestions of annual screening, health education and in-pharmacy consultation areas. This surfaced again when groups were asked how the service might be improved. One of the older groups suggested that a support helpline would be appropriate to advise those being screened on sexual health matters.

“Most teenagers have mobiles now, so they can just find a quiet corner and just phone up. And if need be, the person can just say ‘well I think you need to go see someone’ or whatever. At least it gives them the chance to do it on their own, in their own space” (25-65, female)

Others suggested that more preventative measures should be available.

“I think prevention is better than curing, so they also need to be putting more money into awareness of using contraception and going back to basics about using condoms...I think that needs to be highlighted because I haven’t seen any advertising campaigns specifically about using condoms.” (25-65, female)

“Schools no longer teach about contraception” (25-65, female)

One other suggestion was that the kits should include a leaflet on sexual health and the need to use condoms.
■ **Embarrassment**

A couple of groups suggested ways to reduce embarrassment when requesting the test kit, by reducing spoken communications between the client and pharmacists. The main suggestion was the use of tickets/vouchers, which could be handed over at the counter whilst making other purchases. One person even suggested lists of ‘false’ diseases so that it is not obviously a chlamydia voucher.

This suggestion for vouchers mimics the coupons currently provided by Boots, which can be exchanged for a chlamydia screening kit.

■ **Quality of service**

Several comments were made that the service must offer high quality at all stages. This included the speed at which kits could be collected, the speed of results, anonymity and tests that are the same quality as elsewhere.

There was a concern that if queues were long people would not wait to collect the chlamydia screening test, as they would ‘lose their nerve’. Some respondents suggested that ideally results should be available within one hour i.e. on site testing.

The importance of anonymity was again stressed.

■ **Target age**

Once again there was a request to make the service available to older people. Some people commented that users may lie about their age in order to receive a screening kit.

■ **Advertisement**

Some respondents said that the service must be advertised, in order to be successful.

> “Just as long as it’s known. It’s all well and good you telling me this but if you’ve told only us in the whole of England, it’s unlikely you’re going to enquire about it. It will have to be well campaigned” (16-24, male)

One suggestion was to provide leaflets about the service when customers make a related purchase e.g. condoms

■ **No improvements**

Some respondents had no further suggestions for improvement.
Predicted public and media response

Most respondents anticipated a positive public reaction to the chlamydia screening service. Although many did not see chlamydia as the highest health priority, it was seen as important and there was a view that chlamydia and costs associated with it may increase if the issue was not tackled now.

“It’s preventative isn’t it? If they treat it with a course of antibiotics it’s quite cheap. Whereas if the person goes on to infertility, and it’s not just infertility, it does cause other issues as well, it will cost a hell of a lot more to put right, or on IVF or whatever, it will cost a hell of a lot more, so they’re doing it to save money in the long run” (25-65, female)

“It will be a bigger problem if it is not promoted now” (25-65, male)

“Any health issue should be a priority” (16-25, male)

It was generally acknowledged that there would be some complaints when news of the service became well known, but these were predicted to be minor rather than major issues.

“People complain about everything” (16-25, male)

The two specific groups of people who were predicted most likely to complain (although only by a minority of people) were old age pensioners and those who have just exceeded the upper age category i.e. just over age 24.

Respondents expected the service to be reported differently in different newspapers, although some younger respondents felt that, in general, newspapers adopt an anti-youth position.

The Sun – The Sun was expected to exaggerate the story and put a negative spin on the service. Further to this the service is only expected to get recognition if aligned with a celebrity/celebrity story.

The Times – The Times was expected to write a brief article showing how the service may improve society.

The Guardian – Again, coverage was expected to be brief, with one person commenting that report would appear “on the sports page!”
Promoting the service

Several methods of advertising were considered appropriate to promote the Pharmacy Chlamydia Screening Service.

Key messages

The key messages that would attract people to use the service were thought to be:

1. A simple message about chlamydia and its' lack of symptoms
2. A message on the high rates of chlamydia
3. The information that anybody can be at risk

“If you’ve had several sexual partners and not had safe sex, then anyone can be at risk” (25-65, female)

One person also suggested that it was important to highlight how easy it is to treat chlamydia.

“I think you need to add the fact that it can be cured easily. I’d feel a lot better going somewhere…” (16-24, male)

The ease by which chlamydia can be treated was thought to help increase the uptake of the chlamydia screening service, as was the message that the service is free and easy to use.

There were also discussions about the impact of using fear as a message to promote screening. Two of the older groups believed that possibility of infertility should be highlighted.

“Say that it’s silent and that long term it can affect you having children which I think lots of people do worry about” (25-65, female)

“I think there would be a mad rush of people [if scare tactics were used]” (16-24, mixed)

“Scare tactics sometimes work. There’s got to be something that will make them think about that at least” (25-65, male)

“You don’t need to be scared, you just need to be educated about everything…” (25-65, mixed)
Advertising sources

The two most popular suggestions were television and schools.

- Television

“A lot of young people watch television, so if they were to do this, then we would see it on TV” (16-24, female)

“It shouldn’t be a problem to promote it anywhere because it is a health safety things. It is the same as promoting cigarettes, AIDS – I don’t think it should be a problem, no one should be shy about it” (16-24, female)

Television was thought to be a medium by which the message would be most easily communicated, although one group was aware that this might be an expensive means of accessing the public.

“Money may be an issue in advertising on the TV” (16-24, female)

- Schools and colleges

Schools and colleges were also thought to be ideal places to promote the chlamydia screening service although this was acknowledged as slightly restrictive, since not everyone in the target age group attends school or college. Pamphlets and leaflets or in sex education classes, were considered the best ways to advertise the service in schools and colleges.

- Magazines

Another means by which people thought the service should be advertised was in magazines. If magazine advertising were an option it was suggested that a range of magazines should be targeted, covering both females (e.g. Hello, Close Up, OK) and males (e.g. Nuts, FHM) and teenagers (e.g. Bliss, Sugar).

- Radio

Radio was thought to access most of the target age group.

- Other

A number of other suggestions were made. These included billboards, the tube, buses, nightclubs, public toilets, GP surgeries and local community centres. Once again respondents wanted it to be simple to pick up information.

“Even when you are in a surgery and you see a chlamydia sign you still don’t want to pick it up [a leaflet’]” (16-24, female)

There was also a belief that word of mouth would play an important part:

“Once our generation finds out about something like this, you do tend to tell everyone about it...” (16-24, males)
Predicted service uptake

Reasons for using or not using the service

Most people believed that the service would be used, providing there was enough awareness of chlamydia among young people.

“If they were aware it was all over the place and could really harm them, they’d pay more attention to it” (25-65 male)

Respondents’ thought the service would be used because it offers convenience, confidentially and peace of mind. In addition young people could attend together.

The main reasons put forward as to why the service may not be used were associated with the theme of ignorance.

“People don’t generally care do they?...they youngsters today, they just get what they want and that’s it” (25-65, male)

“Ignorance plays a big part of it” (25-65, male)

“At that age you think you’re invincible” (25-65, male)

In addition, some respondents felt that people without symptoms would convince themselves that they were not infected.

“If it were available now I wouldn’t go and be tested” (16-24 mixed)

“I know it sounds stupid but I wouldn’t get it because I feel OK, even though I know there are no symptoms” (16-24, mixed)

Once again, embarrassment about accessing the service was believed to deter some people from collecting a kit.

“If people are too shy to go to the counter” (16-24, male)

There was also one suggestion that people may not bother with the test if their current partner has tested negative.
Reasons for not returning the screening kit

Most groups thought that there would be some instances in which people would collect a kit and not return it. The main reasons stated for this was fear: fear of a positive result and fear of other people finding out.

“What if someone finds out?” (16-24, female)

“People might find out and say things” (16-224, female)

“It’s harder to return a kit than pick up” (16-24, mixed)

For the younger groups, the emphasis was very much on the “others finding out” aspect of fear, which appeared to be the most important factor in why kits would not be returned. When asked directly the issue of other people not knowing was ‘very important’ to them. The embarrassment theme was discussed in all aspects of this service and thus seems to play a major role in understanding the restrictions surrounding a screening and treatment service such as this.

Several people commented that fear might be attached to the result.

“People are scared of the result” (25-65 female)

People ignore and don’t have to deal with it” (25-65 male)

It was also suggested that some people might collect kits and then not return them because their symptoms have cleared up.

High user groups

Respondents believed that females, rather than males, would be the main users of the service. When asked to quantify how many women aged 16-24 would use the service, it was suggested that between 50 and 70 percent of women would utilise the service, compared with 20 to 35 percent of men.

Females were considered to be more responsible than males and to have more of an interest in their own health. The risk of contracting chlamydia for females was thought to have worse consequences than for men i.e. infertility. There was also a suggestion that females would not want to risk a ‘bad reputation’.

“Girls are generally more settled with raising families, etc...I think from a young age women are thinking that if this can make you infertile, you pay more attention because this is almost a definite thing. I plan to have children” (16-24, female)

“They’re more mature” (25-65, male)
“Girls are more likely to go with friends, as a group” (16-224, male)

Only a small number of people thought that males were more likely to use the screening service. The reasons given for this was the privacy of the service and being allowed to use the test at home. One person felt that ‘male pride’ would restrict their use.

**Encouraging others to use the service**

In the younger groups, the general consensus was that the females would talk to their friends about the chlamydia screening service and as a result would actively encourage its use.

“I’d tell them even if it’s someone that I’ve just met, if it’s something that comes up in conversation” (16-24, female)

For the younger males there was some disagreement over whether they would discuss and encourage friends to use the service. For some, they would be happy to tell friends.

“I’d tell my friends about it, I worry about some of my friends” (16-24, mixed)

Others felt that they would be more likely to recommend a GUM clinic, because the chlamydia screening service is less comprehensive.

“I think everyone would [prefer to go to the clinic]. That’s why I can’t see...for me personally I wouldn’t do that [use the chlamydia kit only]” (16-24, male)

“If you did that on holiday you’d probably be more scared about the more serious diseases so you’d probably go to the clinic” (16-24 male)

Older groups were less likely to want to recommend or discuss the service with people in the target age group. Some stated that they would find it difficult to talk to younger people, as there may be a difference in knowledge levels.

“I couldn’t mention it to my grandkids. They know more about that than I do. They’re all teenagers, my oldest grandson is nineteen and he’d laugh at me” (25-65, male)

For others however, there were specific circumstances in which they would encourage others to use the service.

“I would encourage my nephew to use it, definitely” (25-65, males)

“I would emphasise it to boys because it tends to be seen as a girl problem” (25-65 males)

“If they’re open enough to tell a parent they’re likely to not be too embarrassed to go to the GP” (25-65, mixed)
Appendix A: Completed bubble diagrams

Respondents were asked to complete bubble diagrams, by writing the 1st thoughts that entered their minds. Some examples are shown below, and a predominant theme was embarrassment and self-consciousness.

Using the chlamydia screening service

Customer is thinking...

Oh god, I hope noone sees me

Customer says to pharmacist...

‘Do you provide free chlamydia screening?'

Pharmacist is thinking...

Another divorce

Female 25-65

Healthcare
Using the chlamydia screening service

Customer is thinking...
Oh no he thinks that I’m young and irresponsible

Pharmacist is thinking...
You must have a lot of courage asking for that

Customer says to pharmacist...
‘Do you provide free chlamydia screening?’

Mixed 16-24
Healthcare

Using the chlamydia screening service

Customer is thinking...
Wonder what they are thinking about me?

Pharmacist is thinking...
Do they have chlamydia

Customer says to pharmacist...
‘Do you provide free chlamydia screening?’

Female 16-24
Healthcare
Using the chlamydia screening service

**Customer is thinking...**

Why did I come?

**Pharmacist is thinking...**

Yep, another one who’s got it

**Customer says to pharmacist...**

‘Do you provide free chlamydia screening?’

Male 25-65

Healthcare

---

Using the chlamydia screening service

**Customer is thinking...**

I am so embarrassed

**Pharmacist is thinking...**

She is so young, hope we can help

**Customer says to pharmacist...**

‘Do you provide free chlamydia screening?’

Mix 25-65

Healthcare
Using the chlamydia screening service

Customer is thinking...
How embarrassing

Pharmacist is thinking...
Ok, let's get you some antibiotics

Customer says to pharmacist...
'My chlamydia result was positive'

Mix 16-24

Healthcare

Using the chlamydia screening service

Customer is thinking...
Shit, he knows I've got chlamydia

Pharmacist is thinking...
She's got chlamydia. She's sensible

Customer says to pharmacist...
'My chlamydia result was positive'

Female 16-24

Healthcare
Using the chlamydia screening service

Customer says to pharmacist...

‘My chlamydia result was positive’

I hope it’s ok

Sorry son

Pharmacist is thinking...

Customer is thinking...

Mix 25-65

Lewisham 25-65

Healthcare
Using the chlamydia screening service

**Customer is thinking...**

I'm f**ked

**Pharmacist is thinking...**

Another one bites the dust

**Customer says to pharmacist...**

'My chlamydia result was positive'

**Customer is thinking...**

I'm f**ked

**Another one bites the dust**

Male 16-24

Healthcare

Using the chlamydia screening service

**Customer is thinking...**

No what is chlamydia?

**Pharmacist is thinking...**

It's a good idea to check it out

**Customer says to pharmacist...**

I think I have

**Pharmacist says to customer...**

'Have you heard of the new chlamydia testing service that we offer....'

Mix 16-24

Healthcare
Using the chlamydia screening service

Customer is thinking...

Just want to find out about it

Customer says to pharmacist...

No, can I have an information pack please

Pharmacist is thinking...

Customer is thinking positively

Pharmacist says to customer...

‘Have you heard of the new chlamydia testing service that we offer….’

Female 16-24

Using the chlamydia screening service

Customer is thinking...

Do I look like I’ve got some kind of sexual issues? Maybe I do?

Customer says to pharmacist...

Yes I have, but could you tell me more about it?

Pharmacist is thinking...

This person seems to be between 16-24. I should offer him/her our free testing service

Pharmacist says to customer...

‘Have you heard of the new chlamydia testing service that we offer….’

Mix 25-65
Using the chlamydia screening service

Customer is thinking...

What are they asking that for? Maybe I have it. Why are they so open about it?

Pharmacist is thinking...

Should I have asked them. Don’t want to embarrass them.

Customer says to pharmacist...

No I’m ok thanks.

Pharmacist says to customer...

‘Have you heard of the new chlamydia testing service that we offer....’

Male 16-24

Healthcare
Appendix B: Recruitment Guide
RECRUITMENT QUESTIONNAIRE
125331 – ADULT SEXUAL HEALTH (BIRMINGHAM – FEMALE 16-24)

RESPONDENT DETAILS
(TO BE DETACHED AND KEPT SEPARATELY FROM FIELDWORK DOCUMENTS)

Name: ____________________________________________
Full Address: _____________________________________
Post Code: _________________________________________
Mobile Number: ___________________________ Date & time of Interview: ________________________
Length of interview: __________________________ Location of interview: _______________________

Print interviewer name: __________________________ Number: _________ Telephone No.: _________________

Our interviews are carried out in accordance with current Market Research Society guidelines and Data Protection Laws. In line with this we require your specific permission to record the interviews in any way. Please read the statements below and tick the appropriate response, signing at the bottom once you have done this.

1. For this research, the interview may be audio/video taped/viewed by clients for analysis purposes. Your personal details will remain strictly confidential. The information you provide will be reported at a country rather than individual level. Do you agree to be audio/video taped/viewed by client under these conditions?
   Yes [ ] No [ ]

2. Would you be willing for the audio/video taped interview to be shared with our client? This material will be confidential and would be used for internal market research purposes only.
   Yes [ ] No [ ]

3. Would you be willing for TNS to re-contact you for help with future surveys?
   Yes [ ] No [ ]

4. Many respondents complete surveys via the Internet. Would you be willing to participate in future TNS surveys that were internet based?
   Yes [ ] No [ ]

Please enter your email address in the box below. Please take a few moments to double-check for accuracy as even the slightest error may mean we are unable to contact you.

Email: @

Your details will be held for market research purposes only and will not be shared with a third party.

Moderator/recruiter: If respondent agrees with all the above information, please ask them to sign below.
**RECRUITMENT QUESTIONNAIRE**

<table>
<thead>
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<th>CARD</th>
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<th>PROJECT NUMBER</th>
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</table>

Print interviewer name: ____________________  Number: ______  Telephone No.: ______

**INTERVIEWERS’ DECLARATION**

I confirm that before returning this questionnaire I have checked that it meets and was carried out in accordance with the requirements outlined in the instructions supplied to me for this study and conducted within the Code of Conduct of the Market Research Society. I understand that the information given to me during the interview must be kept confidential and only made available to TNS Healthcare.

Signed: ____________________________________________________________
RECRUITMENT QUESTIONNAIRE
ADULT SEXUAL HEALTH

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<th>CARD</th>
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<td>9</td>
<td>10</td>
<td>11 12 13 14</td>
<td>1 2 5 3 3 1</td>
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P1  Age

Under 16  1
16-24  2
25-65  3
65+  4

SHOW CARD
CLOSE
CLOSE
CLOSE

P2  Gender

Male  1
Female  2

CLOSE

P3  INTERVIEWER, PLEASE CODE SOCIAL CLASS FROM RESPONSES TO THE FOLLOWING QUESTIONS:

COLLECT OCCUPATION OR PREVIOUS OCCUPATION DETAILS OF CIE OR IF CIE NOT WORKING AND THERE IS A CWE, COLLECT CWE DETAILS.

What is the type of firm where the CIE/CWE works?
What is the job actually done by the CIE/CWE?
What is the title, rank, grade, etc of the CIE/CWE?
Does the CIE or CWE have any qualifications?

SOCIAL CLASS:

A
B
C1
C2
D
E

Recruit a mix of social class
### P4
Which of the following conditions are you aware of?

<table>
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<th>SHOW CARD</th>
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<tbody>
<tr>
<td>AIDS/HIV</td>
</tr>
<tr>
<td>Syphilis</td>
</tr>
<tr>
<td>Genital herpes</td>
</tr>
<tr>
<td>Chlamydia</td>
</tr>
<tr>
<td>Gonorrhoea</td>
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<tr>
<td>Genital warts</td>
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#### Get a mix of chlamydia awareness

### P5
**Ethnicity**

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<td>Black Caribbean (BC)</td>
</tr>
<tr>
<td>Black African (BA)</td>
</tr>
<tr>
<td>Black British (BB)</td>
</tr>
<tr>
<td>Asian subcontinent – Indian, Pakistani, Bangladeshi (AS)</td>
</tr>
<tr>
<td>Chinese or other Asian (CH)</td>
</tr>
<tr>
<td>Mixed (MX)</td>
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<tr>
<td>Other (OT)</td>
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</tbody>
</table>

#### Recruit a mix of ethnic background
Recruitment instructions

Please recruit 1 group of 8 respondents

TARGET GROUP – Please recruit 8 females
   Age 16-24
   A variety of socio-economic status
   A variety of ethnicities
   A mix of those who are aware and unaware of chlamydia

General Criteria

- All interviews are to be audio and video recorded on good quality equipment.
- All respondents to be articulate and clearly spoken
- All respondents to be shown the recruitment letter briefing them about the group and to fully understand what the group discussion will involve – especially in terms of the topic
- Respondents must answer questions P1, P4 and P5 from the show cards provided
- Group interviews will be 1.5 hours in length
- All recruitment screeners are to be signed, on the front page, by the respondent and provided for the TNS execs carrying out the interviews prior to the fieldwork commencing
- Respondents to be paid £xx for participation
Appendix C: Discussion Guide

Introduction (3 minutes)
- Introduce self and TNS Healthcare (independent market information company)
- MRS guidelines and Data Protection Act
- Reassure regarding confidentiality
- No right or wrong answers
- Explain audio taping

Interviewer:
TNS is a market intelligence company. I work in the health care division, which means that all the research I am involved with is connected with health. Our clients are typically pharmaceutical companies, patient charities or public organisations. The research that we are doing today has been commissioned by the Department of Health.

Today we are looking at the topic of health care screening, in other words screening people to see if they have a disease or illness. In particular we are going to focus on sexual health and screening for sexually transmitted infections. During the group I will be asking about your views on such screening, whether it should be available to the public and how it might be made available. Please be assured that, while this is a sensitive subject area, we will not be asking you to reveal embarrassing information about yourself or your own sexual experiences. We are just interested in your awareness and understanding of sexually transmitted infections.

There are no right or wrong answers, and are interested in hearing everyone’s views. You might find that you agree with what other people are saying or you might find that you have a different viewpoint. Please tell us what you think as we are interested in hearing the full range of views that people hold on this topic.

As a market research company we comply with the Market Research Society guidelines which prevent us telling who took part in the research. Your names will not be disclosed and we feed back the results at an aggregate group level, for example reporting on whether younger people held different views to older, or men to women.

We are tape recording this discussion in order that we can listen to the points you make again afterwards and do not have to spend time today taking notes. However, the tapes do not leave our company premises.

INTRODUCTIONS (5 minutes)
Just to begin, let’s go round the table and can you tell me please your first name and just a little bit about yourself – perhaps your job or your hobbies.

AWARENESS OF SEXUALLY TRANSMITTED INFECTIONS (general)
I want to start by thinking about sexual health in general. Let’s begin by thinking about different types of sexually transmitted infection. What sexual diseases are you aware of?
LIST ON FLIP CHART: Include any slang terms stated e.g. Clap and ask whether anyone knows the term that a doctor would use for that one

For each stated disease ask “How many others have heard of that one?”
PROBE (spontaneous): Any others? Any more?

PROMPT (using list): Gonorrhoea, Syphilis, Genital Warts, chlamydia, HIV/AIDS, Genital herpes, thrush, pubic lice, chancroid, bacterial vaginosis

3. Knowledge of Sexually Transmitted Infections (general)

Now I want to look at the list and see what we know, as a group, about these different infections.

First of all, let’s think about how serious we consider each of these infections to be.
- Which one of these infections would you consider the most serious sexually transmitted infection? Why that one?
- And which would you consider the least serious sexually transmitted infection? Why that one?
- If you had to rank these infections in terms of how serious they are, how would you rank them?

And now let’s think about how common these infections are in the UK.
- Which of these infections do you think is the most common sexual infection occurring in the UK? What makes you say that?
- Which of these infections do you think is the least common sexual infection in the UK? What makes you say that?
- How would you rank these infections in terms of how common they are?

Do you think there any groups or types of people who are more at risk of acquiring a sexually transmitted infection than others.
- Which groups of people in the UK population would you think are more at risk of acquiring a sexually transmitted infection than others?
- What makes you say that?
- Anything else?

PROMPT: How does xxx affect the risk of acquiring a sexual infection?: Abstinence, monogamous relationship, multiple sexual partners, safe/unsafe sex, oral sex, use of condoms, toilet seats, clothing, doorknobs, heavy drinking/use of drugs, education etc.

And where can people in the UK go to be tested and treated for sexually transmitted infections?

FLIP CHART RESPONSES
PROMPT: Anywhere else? Any more?

PROMPT: How about any of the following?: GP, GU clinics, Family planning clinics, Well-Women clinics, retail chemist, Drop in health centres, A&E

4. KNOWLEDGE OF CHLAMYDIA

So far, we’ve talked about sexually transmitted infections in general. For the rest of the session, I’d like to focus on chlamydia. You’ve already told me some key things about chlamydia…for example you’ve already told me that you consider it a… serious/less serious, common/less common STI.

Is there anything else that you know about chlamydia?

PROMPT: What are the signs and symptoms of chlamydia? What else?

Who suffers from chlamydia? Anyone in particular? Why do you think that is?

PROMPT men/women? Ethnic background? Age? Anyone else?

Can someone have chlamydia without any signs or symptoms? How likely do you think that is?

Do you think rates of chlamydia in the UK are increasing, staying level or falling? What makes you say that?
Does it matter if chlamydia is not treated or tested? What would happen to someone who did not receive treatment or testing?

Why do you think that some people might not seek treatment or testing for chlamydia? FLIPCHART ALL RESPONSES and discuss
PROBE: What makes you say that? Why would that put someone off seeking treatment or testing?
PROMPT:
~ Embarrassment?
~ Denial?
~ Ignorance?
~ Do not know where to go for screening and treatment
~ Do not want to visit family GP
~ Under age/confidentiality issues

5. CHLAMYDIA SCREENING VIA RETAIL PHARMACY
How would you feel if chlamydia screening kits were available to anyone aged between 16-24, for no charge, at high street chemists? Young people could request a screening kit and then return their sample to the chemist.
PROBE:
In principle, would you see this a good thing?
Why?
Why not?
Let's organise some of this….
So what do you think are the pluses or benefits associated with offering chlamydia screening via a high street store:
FLIP CHART and discuss
PROBE: Any more? What else?
PROMPT: Spontaneity, convenient location, anonymous staff, weekends, no appointment, no stigma attached,

And what do you think are the negatives or drawbacks associated with offering chlamydia screening via a high street store:
FLIP CHART and discuss
PROBE: Any more? What else?
PROMPT: Embarrassment, worries about confidentiality, setting too public, lack of in-store facilities, not a health priority, poor use of public money,

What else would you like to see as part of this service? Why would that be important to you?

What else could be done to improve this service and its uptake? Why would that help?

6. CLAMYDIA TREATMENT VIA RETAIL PHARMACY
And what if anyone testing positively for chlamydia could then return to a retail pharmacy for treatment, which is a prescribed course of antibiotics.

What do you think are the pluses or benefits associated with treating people at the high street pharmacy instead of them going somewhere else?
FLIP CHART and discuss
PROBE: Any more? What else?
PROMPT: Convenient location, greater anonymity, treatment take-up more likely, Weekends, less embarrassing, speedier process etc
What do you think are the negatives or drawbacks associated with treating people at the high street pharmacy instead of going to their GP etc?

FLIP CHART and discuss
PROBE: Any more? What else?
PROMPT: GP will not have full patient history, other important health advice may not be given, need to go elsewhere for further testing, encourages non-safe sex, lack of privacy etc

If a person has a choice of two local stores what factors will influence their decision non which one to go to and why?

What facilities would participating stores have, ideally?

PROBE and discuss
PROMPT: Toilets, private area, consultation area, someone to ask, knowledgeable staff, non-judgemental staff

What would a retail chemist need to do to make sure the scheme was successful?

**BUBBLE DIAGRAMS**
I’d now like to do something a little different.
I have some diagrams here that I am going to pass around showing an interaction between a customer and a pharmacist.
I’d like you to write on the sheet what each person is thinking and saying in this situation.

It is important not to spend time thinking about what you write – just write the first thing that comes into your head when you see the diagram.

**7. PREDICTED UPTAKE**
Do you think that young people, in general, would use this service?
What are the reasons why they would use it?
FLIP CHART and discuss

What are the reasons why they would not use it?
FLIP CHART and discuss

**Younger groups only:**
Is this something that you would talk about with your friends?
Would you encourage your friends to use such a service?

**Older groups only:**
Is this something that you might talk about with people that you know such as your children, or younger friends or colleagues?
Would you encourage anyone to use this service?

What do you imagine would be the predicted uptake of such a service?
How many people aged 16-24 would use the service, out of every 100?
What makes you say that?

Are there any groups of young people that would use it more than others do you think?
Discuss answers
PROMPT: Females/males, younger or older people, high risk versus lower risk groups etc.

Do you think some young people might refuse to use such a service? Why would that be?
PROBE and discuss
PROMPT:

Do you think there might be people who would collect a kit and not return it?
Why would that be?
8. PUBLIC ATTITUDES
How do you think the UK public would react to such a service?

Do you think there are any groups of people who would oppose such a chlamydia screening and treatment service?

How do you think such a service would be reported by The Sun? By The Times?

How would you feel if your local pharmacy was offering this service?

Do you think the service should be used by ‘request’ only, or should pharmacy assistants inform people about it? (Discuss)

9. FUTURE SUCCESS
We’d like you to imagine that such a high street service was being set up.

How should the service be promoted or advertised?
PROBE: What should the advertising campaign focus on?
What should the key messages about the service be?
What messages are most likely to encourage people to use it?

Where should the service be promoted or advertised?
PROMPT: TV, radio, magazines, newspapers, GPs, in-store
Rank in order of importance

THANK AND CLOSE
Appendix 3: Wave two local and national surveys
Chlamydia screening evaluation: 
Local and National surveys  
Waves 1 and 2

Report prepared by TNS Healthcare for:  
The Department of Health

125331 January 2007

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# Contents

<table>
<thead>
<tr>
<th>Page No.</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>129</td>
<td>EXECUTIVE SUMMARY</td>
</tr>
<tr>
<td>132</td>
<td>BACKGROUND</td>
</tr>
<tr>
<td>135</td>
<td>OBJECTIVES – LOCAL AND NATIONAL POPULATION SURVEYS</td>
</tr>
<tr>
<td>136</td>
<td>METHODOLOGY</td>
</tr>
<tr>
<td>139</td>
<td>FINDINGS</td>
</tr>
<tr>
<td>140</td>
<td>AWARENESS OF STIS</td>
</tr>
<tr>
<td>146</td>
<td>WHERE CAN PEOPLE GET TESTED FOR STIS? (LOCAL)</td>
</tr>
<tr>
<td>149</td>
<td>ATTITUDES SURROUNDING CHLAMYDIA</td>
</tr>
<tr>
<td>160</td>
<td>PERCEIVED SELF RISK OF CONTRACTING CHLAMYDIA</td>
</tr>
<tr>
<td>168</td>
<td>ACCEPTABILITY OF SERVICE</td>
</tr>
<tr>
<td>171</td>
<td>PERCEIVED ADVANTAGES AND DISADVANTAGES OF THE INITIATIVE</td>
</tr>
<tr>
<td>175</td>
<td>IMPORTANCE OF SERVICE ATTRIBUTES</td>
</tr>
<tr>
<td>178</td>
<td>CONFIDENTIALITY AND RELIABILITY OF THE SERVICE</td>
</tr>
<tr>
<td>181</td>
<td>PREVIOUS SCREENING/TESTING FOR CHLAMYDIA</td>
</tr>
<tr>
<td>185</td>
<td>FACTORS AFFECTING UPTAKE (LOCAL SURVEY ONLY)</td>
</tr>
<tr>
<td>187</td>
<td>LEVEL OF CONFIDENCE IN THE SUCCESS OF THE SERVICE (LOCAL SURVEY ONLY)</td>
</tr>
<tr>
<td>188</td>
<td>IMPACT OF THE CHLAMYDIA INITIATIVE (LOCAL SURVEY ONLY)</td>
</tr>
<tr>
<td>191</td>
<td>LOCATIONS DEEMED APPROPRIATE FOR OFFERING CHLAMYDIA TEST KITS (LOCAL SURVEY ONLY)</td>
</tr>
<tr>
<td>193</td>
<td>CHEMIST CHAIN MOST FREQUENTED</td>
</tr>
<tr>
<td>195</td>
<td>KNOWLEDGE OF OTHERS USING BOOTS SCREENING SERVICE</td>
</tr>
<tr>
<td>196</td>
<td>DESCRIPTION OF SEXUAL ORIENTATION</td>
</tr>
<tr>
<td>197</td>
<td>REFERENCES</td>
</tr>
<tr>
<td>199</td>
<td>APPENDIX</td>
</tr>
</tbody>
</table>
Executive summary

Background

The number of diagnoses of chlamydia has risen steadily in recent years in the UK, with younger age groups (16-24 year olds) being most at risk. Infection rates also correlate with urban areas, with London having the highest rates.

The lack of any signs or symptoms in many cases of chlamydia means that the infections may go undiagnosed and untreated. This is of particular concern for younger women who are susceptible to developing complications. These include pelvic inflammatory disease, infertility and ectopic pregnancy. This can represent misery for the individual and a growing burden on the UK health economy.

Previous pilot studies have supported the introduction of opportunistic screening through a number of settings including GP surgeries and family planning clinics (community contraceptive clinics). Following this, a pilot Pharmacy Chlamydia Screening Pathfinder scheme was planned, in which chlamydia screening kits will be available free via Boots pharmacies to 16-24 year olds. Boots stores within the M25 will offer this service.

Prior to the launch of the screening service, research was undertaken to identify initial reactions to the planned service, both in the service region and nationally. This data forms a benchmark against which subsequent shifts in attitudes, knowledge and behaviours can be evaluated.

Methodology

The two baseline face-to-face surveys were undertaken nationally (across the UK) and locally (within the M25 radius) in October-November 2005. 2011 adults participated in the national survey and 718 in the local survey. This fieldwork was completed prior to the launch of the service.

These surveys were then repeated in Oct-November 2006, when 1947 participated in the national survey and 716 in the local survey. This report includes the findings from both wave one and wave two surveys. A third wave is scheduled for July 2007.

Aims

The aims of the surveys were to explore awareness and reactions to the new chlamydia screening service, and assess knowledge of STIs and chlamydia, and to compare national and local responses and sub groups within these, for example, different genders, age groups, social classes and ethnicities.
Findings

Key findings were:

- Respondents were aware of a number of different STIs. Chlamydia came sixth (out of ten presented STIs) in both the national and local surveys in both Wave 1 and Wave 2.

- Respondents in both waves of the local survey showed more awareness of all STIs compared to the national survey.

- Females were more aware of chlamydia than males in both 2005 and 2006 in both the national and local surveys

- The key target audience of 16-24 year olds are not the age group with highest awareness of chlamydia.

- There are some trends for higher social groups to be more aware of STIs than lower social classes

- Over 70% of respondents in both surveys (at both waves) identified GP surgeries and hospital clinics as places where chlamydia screening can take place.

- Retail pharmacies were identified by the lowest proportion of respondents as a place that people can go to be tested for chlamydia; this result was found both nationally and locally and in both waves.

- Less than 50% of national respondents recognised that chlamydia can affect both men and women, in both Wave 1 and Wave 2.

- Less than 50% of local respondents at both waves, recognised that chlamydia is the fastest growing STI, with a similar proportion appreciating that it often has no signs or symptoms. Around one third of local respondents recognised that treatment is simple and effective, and that is it most prevalent among younger people.

- A very small proportion of respondents in both surveys (11% or less) believed that there were no long-term complications from chlamydia if left untreated. Similar proportions believed that it can be contracted from towels or glasses (12% or less).

- Younger people were more likely to regard themselves as being at risk of acquiring chlamydia.

- Around 1 in 6 (W1 17%, W2 15%) of local respondents were aware of the chlamydia pharmacy screening initiative.
The majority of respondents believe that such a service is acceptable, although there are local and national differences in the degree of positive levels expressed.

The chief spontaneous advantage offered was that such a service will raise awareness of chlamydia. Embarrassment featured as a key disadvantage and was identified as a main reason affecting take up.

Confidentially was rated in both surveys (at both waves) as the most important service attributes.

The in-pharmacy screening service is perceived as equally confidential and reliable compared to other screening locations.

The majority of respondents had not previously undergone chlamydia screening. Those who had were more likely to perceive the pharmacy roll-out positively.

The majority of local respondents (over 60% at both waves) believed that the pharmacy screening service would succeed and would be associated with positive outcomes. In addition to pharmacies, respondents suggested that other locations would be appropriate for offering chlamydia test kits, including GP surgeries, schools and colleges.

In summary:

There are national and local differences in reactions to the service, and in levels of awareness and knowledge of chlamydia. Overall, the local population is more knowledgeable about STIs and more positive about the service. Furthermore levels of awareness and knowledge tend to be related to gender, age and social class.

The results indicate that there is plenty of scope for education on chlamydia; presumably poor levels of awareness and knowledge will reduce levels of screening uptake.

Although the service was regarded positively, there were concerns regarding issues of embarrassment and confidentiality, which also implies that service attributes or store facilities could result in people declining to take up in-store screening. If these criteria are met successfully then there is more likelihood that the initiative will be successful.


Background

Prevalence of genital chlamydial infection is unclear. As 70% of infected women and 50% of infected men are asymptomatic, it is assumed that a large proportion of cases remain undiagnosed. The National Survey of Sexual Attitudes and Lifestyles 2000, a stratified probability sample survey of men and women aged 16 to 44 years, reported overall prevalence of 1.5% in females and 2.2% in males (1) whilst a pilot opportunistic screening programme among 16-24 year olds instigated by the Department of Health (DH) in 1999-2000 found prevalence of chlamydia at 9.8% in Portsmouth and 11.3% in Wirral (2).

Regardless, the number of diagnoses has risen steadily since the 1990s, with a further increase of 8% between 2002 and 2003 (England, Wales and Northern Ireland) (3) reflecting perhaps increased prevalence as well as raised awareness among both public and healthcare professionals (HCP). Infection rates tend to correlate with urban areas, with London having the highest rates.

Age demographics highlight that the highest rates of chlamydia are among the younger population, with 58,083 of the 89,431 diagnosed cases occurring among 16-24 year olds (3). This is of particular concern, as younger women may be more susceptible to developing the complications of untreated chlamydial infection. Around a third of women with chlamydia develop pelvic inflammatory disease (PID), which is in turn associated with chronic pelvic pain, infertility and ectopic pregnancy. To underline the seriousness of chlamydia, ectopic pregnancy represents 21% of deaths resulting from complications of pregnancy and childbirth with chlamydial infection estimated to account for 40% of ectopic pregnancies. Further, approximately 17% of women treated for PID will become infertile, whilst a similar percentage will experience chronic pain. (4). Consequently, the annual cost of chlamydia and its complications represents a growing burden in the UK, estimated to be more than £100 million.

In 1996, The Chief Medical Officer’s Expert Advisory Group on chlamydia Trachomatis concluded that evidence supports the effectiveness of chlamydia screening, and following the pilot schemes in Portsmouth and Wirral, the National Chlamydia Screening Programme (NCSP) was introduced. The aim of the NCSP is to control chlamydia through early detection and treatment of asymptomatic infection, to prevent the development of complications and reduce onward disease transmission. When the Wave 1 report was written 26 local programme areas had been designated, covering more than 25% of primary care trusts. Testing is offered in a number of settings, including GPs surgeries, contraception clinics, termination of pregnancy services, young persons’ clinic and antenatal services. To update this, phase 3 has started and it was anticipated that all of England would be screening by April 2007.

The initial pilot scheme showed high acceptance and uptake of testing – with around 50% of the eligible population aged less than 25 years tested within the study period, and an acceptance rate of more than 75% when the test was offered (6). Indeed, awareness of
chlamydia increased to around 75% among the population in the pilot areas, compared to just under half in the general population. Both HCPs and staff involved in the scheme perceived the programme to be valuable, notably in Portsmouth where 1 in 10 of those tested had proven to be positive. This was borne out in that 8:10 HCPs/staff wished to see continued screening in their practice/clinic once the pilot ended. Similarly, the screened population reported benefiting from the programme. However, there is evidence that a diagnosis of chlamydia does cause anxiety, and recommendations have been made that chlamydia needs to be destigmatised.

The Department of Health is now evaluating the potential role of retail pharmacies in chlamydia screening. A pilot scheme (the Pharmacy Chlamydia Screening Pathfinder or PCSP) has been launched in London via Boots retail chain. Offers of screening will again be targeted at 16-24 year olds, who will be issued with a test kit, DH information leaflet and request form. These will be completed at home or in pharmacy – depending upon the availability of on-site wash rooms – and either handed back to the pharmacy or posted in pre-paid envelopes. Actions on positive results will be the responsibility of the Pathfinder Chlamydia Screening Office (CSO). Negative or inconclusive results will fall to the pharmacy provider to action.

While there have been numerous economic evaluations of chlamydia screening programmes [7-22], none have focussed on an opportunistic community pharmacy approach, and this will also form part of the pilot scheme evaluation.

The findings from the pilot scheme evaluation will subsequently be used to inform the decision on whether to launch a national pharmacy chlamydia screening service.

The independent evaluation will be conducted by TNS Healthcare, and consists of multi-tiered 18-month research programme involving:

- **Pre-service**
  - Qualitative focus groups to establish general awareness levels of sexually transmitted infections (STIs) and chlamydia in particular, as well as acceptability of the proposed screening service
  - A local population (within the same area as the pilot service) survey to understand the impact of the service on this group
  - A national population survey to measure attitudes towards chlamydia screening and the barriers to use

- **During-service**
  - Repeats of the local and national population surveys to track changes in views once the screening service is in operation
- Ongoing evaluation of the screening and treatment service, to monitor who is using the service and their evaluation of the scheme

- ‘Pulling power’ data to establish how many potential clients do not enter onto the chlamydia screening pathway

- Feasibility study with Healthcare Professionals (HCPs) to gauge the benefits and drawbacks of the scheme, as experienced by those involved with service delivery

- Repeats of the ‘pulling power’ data, local and national population surveys

- A full economic analysis of the cost benefit to the Department of Health in rolling out the chlamydia screening service on a national basis

This report contains the findings from Wave 1 (pre-service local and national population surveys undertaken in October-November 2005) and from Wave 2 local and national surveys, the latter undertaken in October-November 2006
Objectives – Local and National Population Surveys

The primary objectives of these surveys were to:

- Measure attitudes towards chlamydia screening in retail pharmacies
- Differentiate attitudes at a national level and a level local towards the Pharmacy Chlamydia Screening Pathfinder
- Monitor any changes or differences between local and national attitudes over time
- Ascertain the perceived advantages and barriers of the Pharmacy Chlamydia Screening Pathfinder
- In addition a number of secondary objectives were addressed:
  - Measure levels of awareness of chlamydia and other STIs
  - Measure levels of awareness of screening and treating chlamydia both in general and through retail pharmacies
  - Identify preferred venues for chlamydia testing kits to be available
  - Measure the predicted success of the Pharmacy Chlamydia Screening Pathfinder

The local survey in Wave 2 also included some additional objectives on shopping patterns and perceptions of different retail pharmacy chains.
Methodology

National population survey

The national survey was undertaken using TNS Healthcare’s weekly omnibus, known as Omnimas, the UK’s largest weekly consumer survey. Each week, a nationally representative random sample of approximately 2,000 adults aged over 16 is interviewed face to face in the respondent’s home.

The interviews are conducted via a CAPI (computer-aided personal interviewing) methodology. The survey collects demographic information from all respondents and their households, including gender, age, social class, working status, household size and tenure.

Local population survey

To achieve a sufficiently large sample, a customised survey was utilised, within the catchment area of the Pathfinder programme, i.e. inside the M25.

Respondents were free found and interviewed using a similar CAPI methodology to the national population survey. Where appropriate, question wording was identical to the national survey to allow a juxtaposition of the two surveys. The local questionnaire contained more questions than the national survey.

Copies of each questionnaire are included in the appendix. Only minor amendments were made to each questionnaire between waves. These changes mean that responses remain comparable, whilst permitting some further exploration of important issues.
Research Considerations

Sample

The national population survey comprised 2,011 representative adults from across the UK in Wave 1 and 1,947 in Wave 2, allowing an accurate measure of attitudes towards chlamydia. By repeating the survey any significant changes in attitudes or knowledge during the Pathfinder programme can be detected.

The local population survey involved 718 interviews from the London area in Wave 1 and 716 in Wave 2. The local survey included only the catchment area of the Pathfinder programme. As with the national survey, responses can be tracked over time, to see if awareness and attitudes towards chlamydia have changed during the 18-month screening service.

A full breakdown of the respondent demographics, for both Wave 1 and Wave 2 is shown in the table below:

<table>
<thead>
<tr>
<th></th>
<th>Local survey (%)</th>
<th>National survey (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wave One</td>
<td>Wave Two</td>
</tr>
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<td>10</td>
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<td>3</td>
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</tr>
</tbody>
</table>

Demographic breakdown national and local surveys
Bases: Wave 1: 2011 (National survey), 718 (Local survey)
Wave 2: 1947 (National Survey) 716 (local survey)
Respondent demographics for the national surveys and for the local populations are comparable across the two waves. Ethnicity data for the local surveys reflect the more diverse population of this area. Age parameters are also different when comparing local vs national surveys, but again this is a reflection of the population, as representative quotas were utilised.

**Ethical Issues**

Respondents were assured of anonymity and confidentiality. No information was collected that could identify individual respondents, and no quotes or statements in this report can be directly attributed to an individual.

**Timings**

Fieldwork for Wave 1 surveys took place in November 2005, with both completing before the official start of the Pathfinder programme (November 14th 2005). As such, they act as good baseline or ‘control’ groups.

Fieldwork for Wave 2 surveys took place in October for the national survey, and between October into November 2006 for the local survey, when the pathfinder service had been running for almost one year.

It should be noted that October 2006 saw the introduction at Boots of the ‘paid for’ chlamydia screening kits for customers outside of the 16-24 age range. Potentially this greater availability and promotion of such kits and service may have an impact on the awareness levels of chlamydia and the acceptability of the service (for example) in the future. A third and final wave of research is scheduled for July 2007, which may highlight any such changes.
Findings are presented under the following headings:

- Awareness of STIs
- Where can people get tested for STIs?
- Attitudes surrounding chlamydia
- Perceived risk of contracting chlamydia
- Awareness of chlamydia screening service (Pathfinder) in London
- Acceptability of service
- Perceived advantages and disadvantages of the initiative
- Importance of service attributes
- Confidentiality and reliability of the service
- Previous screening/testing for chlamydia
- Factors affecting uptake
- Level of confidence in the success of the service
- Impact of the chlamydia initiative
- Locations deemed appropriate for offering chlamydia test kits (local survey only)
- Chemist chain most frequented
- Knowledge of others using Boots screening service
- Description of sexual orientation

- The local and national surveys are compared primarily along the following demographic dimensions:
  - Age
  - Gender
  - Ethnicity
  - Social economic class

These dimensions relate to the intended audience of the new screening programme e.g. 16-24 year olds and associated higher risk groups.
Awareness of STIs

Respondents were asked initially about their awareness of STIs. A list of ten STIs was shown to each respondent who identified those that they were aware of.

**Overall awareness**

Awareness was higher for all sexually transmitted infections in the local survey rather than the national survey, in both waves.

In both wave 1 and Wave 2 awareness of AIDS and HIV was higher than for any other STI. 13% of national respondents were not aware of any STIs in Wave 1 and 16% in Wave 2. 1% of the local population were not aware of any STI in Wave 2 compared with 2% in Wave 1.

Similar levels of awareness for Gonorrhoea and Syphilis were found in both waves of the national and the local surveys, again supporting the qualitative findings in which respondents tended to associate these two diseases.


Chlamydia was the sixth known STI in both waves, both nationally and locally. The proportion of the two populations aware of chlamydia did not change across the two waves,
and there is no evidence that awareness of chlamydia has increased in London over the past year.

**Gender**

In both the local and national surveys females were more aware of chlamydia than males:

**Awareness of chlamydia**

<table>
<thead>
<tr>
<th>Wave 1</th>
<th>Wave 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local</td>
<td>National</td>
</tr>
<tr>
<td>68</td>
<td>60</td>
</tr>
<tr>
<td>77</td>
<td>65</td>
</tr>
</tbody>
</table>

However, the greater awareness among females does not explain the differences between genders in their service uptake. The larger difference in service uptake must be due to other factors such as knowledge and beliefs or greater reluctance by males to seek medical attention.

**Age**

In the Wave 1 local survey, respondents aged between 35 and 50 demonstrated greatest awareness of STIs. This was most evident for chlamydia and the 35-50 year olds were significantly more aware of chlamydia than all other age ranges. In Wave 2 no significant differences were found in the local survey for awareness of chlamydia at difference ages:
In both waves of the national survey there was a more pronounced trend for awareness of sexually transmitted infections to be significantly less in those aged 66 years or over. The table below shows this for chlamydia:

Social class

There is a general tendency for respondents from high social classes to show greater awareness of sexually transmitted infections than those from lower social classes. The charts below show this trend for awareness levels of chlamydia:

Local Survey Awareness of chlamydia by social class by survey wave
Base: 718 W1 & 716 W2 (Local survey)

In Wave 2 of the local survey social class B respondents showed significantly greater awareness than social classes C, D and E for all STI’s other than AIDs and HIV. (at either 95% or 99% significance level)

National Survey Awareness of chlamydia by social class by survey wave
The table below shows awareness of all included STIs by social class for each wave of the national survey:

<table>
<thead>
<tr>
<th>STI</th>
<th>Social class A W1</th>
<th>Social class A W2</th>
<th>Social class B W1</th>
<th>Social class B W2</th>
<th>Social class C1 W1</th>
<th>Social class C1 W2</th>
<th>Social class C2 W1</th>
<th>Social class C2 W2</th>
<th>Social class D W1</th>
<th>Social class D W2</th>
<th>Social class E W1</th>
<th>Social class E W2</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>75</td>
<td>81</td>
<td>80</td>
<td>84</td>
<td>85</td>
<td>81</td>
<td>78</td>
<td>78</td>
<td>80</td>
<td>71</td>
<td>76</td>
<td>67</td>
</tr>
<tr>
<td>HIV</td>
<td>81</td>
<td>84</td>
<td>76</td>
<td>83</td>
<td>84</td>
<td>81</td>
<td>76</td>
<td>79</td>
<td>76</td>
<td>70</td>
<td>72</td>
<td>63</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>65</td>
<td>76</td>
<td>66</td>
<td>76</td>
<td>78</td>
<td>75</td>
<td>67</td>
<td>69</td>
<td>65</td>
<td>60</td>
<td>60</td>
<td>55</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>72</td>
<td>80</td>
<td>68</td>
<td>76</td>
<td>75</td>
<td>72</td>
<td>64</td>
<td>67</td>
<td>60</td>
<td>56</td>
<td>58</td>
<td>52</td>
</tr>
<tr>
<td>Syphilis</td>
<td>70</td>
<td>82</td>
<td>70</td>
<td>76</td>
<td>79</td>
<td>72</td>
<td>66</td>
<td>65</td>
<td>58</td>
<td>57</td>
<td>57</td>
<td>53</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>69</td>
<td>79</td>
<td>67</td>
<td>72</td>
<td>71</td>
<td>69</td>
<td>59</td>
<td>61</td>
<td>53</td>
<td>52</td>
<td>46</td>
<td>43</td>
</tr>
<tr>
<td>Genital herpes</td>
<td>67</td>
<td>76</td>
<td>64</td>
<td>69</td>
<td>68</td>
<td>64</td>
<td>57</td>
<td>60</td>
<td>47</td>
<td>53</td>
<td>44</td>
<td>41</td>
</tr>
<tr>
<td>Genital Warts</td>
<td>60</td>
<td>63</td>
<td>59</td>
<td>65</td>
<td>67</td>
<td>64</td>
<td>53</td>
<td>59</td>
<td>50</td>
<td>50</td>
<td>41</td>
<td>42</td>
</tr>
<tr>
<td>Pubic lice</td>
<td>65</td>
<td>68</td>
<td>54</td>
<td>61</td>
<td>62</td>
<td>59</td>
<td>50</td>
<td>54</td>
<td>45</td>
<td>50</td>
<td>45</td>
<td>43</td>
</tr>
<tr>
<td>Bacterial vaginosis</td>
<td>25</td>
<td>23</td>
<td>28</td>
<td>25</td>
<td>31</td>
<td>29</td>
<td>29</td>
<td>24</td>
<td>18</td>
<td>20</td>
<td>25</td>
<td>23</td>
</tr>
</tbody>
</table>

Awareness of STIs between different social classes in the national survey. White areas indicate significant differences (95% level) from social class C1.

Overall, it can be noted that the higher social classes have greater awareness of STIs than the lower social grades. Since it is known that members of lower socio-economic classes are at greater risk of contracting STIs, possibly due to such lack of awareness, the chlamydia screening programme needs to target these groups appropriately in order to promote screening.

There is no evidence that awareness among lower social classes within London has improved since the service was launched. However, while there has been wide spread marketing activity, there has also been targeted activity e.g. contacting universities, which is unlikely to reach the lower social-economic classes.
Ethnicity

In the Wave 1 national survey, the Asian sub-group was the ethnic group with the lowest awareness of chlamydia of only 24%, although in Wave 2 this figure was 39%, and it was the Irish and ‘Other’ who were lowest with awareness levels of 35% and 10% respectively. White British respondents showed significantly higher levels of awareness at 66% in Wave 1 and 65% in Wave 2.

In the local population White British respondents again showed highest levels of chlamydia awareness at 84% in Wave 1 and 81% in Wave 2. Here the Asian sub group was again lowest with awareness levels of 43% in Wave 1 and 55% in Wave 2.

Summary

There is greater awareness of STIs among the local population than among the national. This may reflect the relatively greater concentration of young single people who live in London than in the rest of the UK and differences in life styles.

Those aged 66+ show least awareness of STIs, but they do not form a high risk group. However, while younger age groups show more awareness overall, that awareness is greater for some STIs e.g. HIV and AIDS than it is for chlamydia.

Females show more awareness of chlamydia than males, and higher social classes show highest awareness of STIs. Both males and lower social groups (the latter in particular) still need educating about chlamydia as they are potentially most at risk of contracting it.
Where can people get tested for STIs? (local)

Respondents in the local surveys only were asked where people can be tested for STIs. This was asked as an open question following which respondents were prompted with a pre-determined list of those venues not already mentioned.

<table>
<thead>
<tr>
<th>Place of testing</th>
<th>Total Responses</th>
<th>Spontaneous responses</th>
<th>Prompted responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>W1</td>
<td>W2</td>
<td>W1</td>
</tr>
<tr>
<td>Hospital clinics e.g. GUM</td>
<td>77%</td>
<td>71%</td>
<td>57%</td>
</tr>
<tr>
<td>GP</td>
<td>73%</td>
<td>79%</td>
<td>56%</td>
</tr>
<tr>
<td>Family Planning clinic</td>
<td>64%</td>
<td>57%</td>
<td>39%</td>
</tr>
<tr>
<td>NHS Drop in centre</td>
<td>61%</td>
<td>54%</td>
<td>35%</td>
</tr>
<tr>
<td>Well woman/well man</td>
<td>51%</td>
<td>43%</td>
<td>30%</td>
</tr>
<tr>
<td>Hospital A &amp; E</td>
<td>43%</td>
<td>45%</td>
<td>27%</td>
</tr>
<tr>
<td>Retail pharmacist</td>
<td>13%</td>
<td>19%</td>
<td>6%</td>
</tr>
<tr>
<td>Not Stated</td>
<td>29%</td>
<td>20%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Overall awareness of testing locations  Local survey only. Base: 718 W1 and 716 W2

In Wave 1 approximately three quarters of people in the local survey (both spontaneous and prompted mentions) suggested that people could be tested for STIs in a hospital clinic e.g. GUM (77%) or GP surgery (73%). Wave 2 shows that these remain the most popular choices.

In Wave 1 approximately two thirds of all respondents (64%) believed that family planning clinics and NHS drop in health centres (61%) are places in which testing of STIs take place. Additionally around half the respondents suggested that STI testing can be carried out in a well woman/man clinic (51%) or hospital A&E (43%). The proportions of people identifying these as possible testing venues in Wave 2 remain similar.

In Wave 1 13% of all respondents named retail chemist/pharmacist as a place to obtain testing for STIs. This is not surprising as the survey took place prior to the launch of the chlamydia screening programme and publicity at this time was limited. In Wave 2 the proportion identifying retail pharmacists as a screening venue had increased to 19%
although remained lowest despite PR and marketing during 2006 and the launch of pay-kits just prior to the survey.

**Gender**

In Wave 1 significantly more females (72%) than males (54%) identified that family planning clinics were places that people be tested for STIs, and this difference was repeated in Wave 2 at 61% and 53% respectively.

Significantly more females (57%) than males (43%) also cited, in Wave 1, that well woman/man clinics offer STI testing. This significant difference was repeated in Wave 2 when 52% of females identified well women clinics compared with 33% of males.

However, approximately equal proportions of males and females identified retail pharmacists as somewhere that people can go to be tested for STIs, with 13% of males and 12% of females correctly identifying pharmacies in Wave 1 and 20% of females and 18% of males in Wave 2.

Although more females than males are using the screening service, it does not appear that this is because they are more likely than males to consider pharmacies to be a testing venue.

**Age**

There were no significant differences, by age, in the proportion of respondents who responded that testing can take place in a retail pharmacy in either Wave 1 or Wave 2.

<table>
<thead>
<tr>
<th></th>
<th>16-24 yrs</th>
<th>25-34 yrs</th>
<th>35-50 yrs</th>
<th>51-65 yrs</th>
<th>66+ yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total proportion Wave 1</td>
<td>11%</td>
<td>14%</td>
<td>15%</td>
<td>9%</td>
<td>11%</td>
</tr>
<tr>
<td>Total proportion Wave 2</td>
<td>22%</td>
<td>22%</td>
<td>18%</td>
<td>19%</td>
<td>13%</td>
</tr>
</tbody>
</table>

**Proportion of respondents who are aware that retail pharmacies offer chlamydia screening by age. Base: 718 W1 and 716 W2**

While there are no significant differences between age groups, it can be seen that overall levels of awareness have increased. Encouragingly the greatest increase in awareness was among the younger age groups, in particular the 16-24 year olds.
**Social Class**

As with the awareness of sexually transmitted infections, higher social class respondents tended to demonstrate greater awareness of testing locations than other groups.

While there are no significant differences between social class and awareness of retail pharmacies as chlamydia testing locations in Wave 2 it is the only testing location for which awareness increased across all social classes between Wave 1 and Wave 2:

<table>
<thead>
<tr>
<th>Location</th>
<th>Social class A</th>
<th>Social class B</th>
<th>Social class C1</th>
<th>Social class C2</th>
<th>Social class D</th>
<th>Social class E</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>W1  W2</td>
<td>W1  W2</td>
<td>W1  W2</td>
<td>W1  W2</td>
<td>W1  W2</td>
<td>W1  W2</td>
</tr>
<tr>
<td>GP surgery</td>
<td>90  81</td>
<td>87  82</td>
<td>69  79</td>
<td>71  78</td>
<td>76  77</td>
<td>70  76</td>
</tr>
<tr>
<td>Hospital clinic</td>
<td>90  90</td>
<td>83  75</td>
<td>75  72</td>
<td>80  64</td>
<td>81  62</td>
<td>72  76</td>
</tr>
<tr>
<td>Family planning clinic</td>
<td>70  95</td>
<td>69  55</td>
<td>59  56</td>
<td>64  58</td>
<td>71  51</td>
<td>65  58</td>
</tr>
<tr>
<td>NHS drop in health centre</td>
<td>90  81</td>
<td>72  62</td>
<td>62  54</td>
<td>58  50</td>
<td>57  58</td>
<td>56  47</td>
</tr>
<tr>
<td>Hospital A&amp;E</td>
<td>20  67</td>
<td>43  50</td>
<td>39  45</td>
<td>38  42</td>
<td>56  43</td>
<td>49  44</td>
</tr>
<tr>
<td>Well woman/well man</td>
<td>70  71</td>
<td>59  41</td>
<td>49  40</td>
<td>45  45</td>
<td>55  49</td>
<td>53  37</td>
</tr>
<tr>
<td>Retail pharmacist</td>
<td>20  29</td>
<td>10  19</td>
<td>13  20</td>
<td>14  22</td>
<td>11  10</td>
<td>13  18</td>
</tr>
</tbody>
</table>

_Awareness of testing locations across social classes._ (local survey).  Base: 718 W1 and 716 W2

**Ethnicity**

In Wave 1 there were significant differences between the responses of White British and Asian groups only. White British were more likely to spontaneously mention hospital clinics, family planning clinics or well woman/well man clinics than Asian respondents whose responses focused on the GP. In Wave 2 only the significant difference between these two groups was in the spontaneous mention of hospital clinics, which was again mentioned more by White British than Asian.

There were no significant differences between different ethnicities and the likelihood to recognise that retail pharmacies can screen for chlamydia.

**Summary**

Similar themes emerge from this question as with the overall awareness of STIs.

Females and higher social class respondents typically show a higher level of awareness than their male counterparts.
Attitudes surrounding chlamydia

In both the national and local survey respondents were asked to state whether each of nine statements applied to chlamydia. Some statements were accurate and others were inaccurate; the aim of this part of the survey was to identify prevailing knowledge and attitudes about chlamydia. The following statements were shown:

- Both men and women can be infected with chlamydia
- The signs and symptoms of chlamydia can include discharge and abdominal pain
- The majority of people with chlamydia have no signs or symptoms
- Chlamydia can be spread by sharing towels with an infected person
- Chlamydia rates in the UK are increasing faster than for other sexually transmitted infection
- Untreated chlamydia does not lead to any long term complications
- You can catch chlamydia by sharing a glass with an infected person
- Treatment for chlamydia is simple and effective
- Chlamydia is more prevalent amongst younger people

Statement 1: Both men and women can be infected by chlamydia

44% of Wave 1 national survey respondents and 37% of Wave 2 agreed with this statement compared with 61% of local respondents in Wave 1 and 59% of Wave 2.

The Wave 1 local survey also showed significant age differences. Significantly more 16-24 year olds (64%) and 25-34 year olds agreed with the statement in the local survey than those aged 66 years or over (48%). In Wave 2 25-34 year olds were significantly more likely to agree with this statement than those aged 35 and over.

<table>
<thead>
<tr>
<th></th>
<th>16-24 yrs</th>
<th>25-34 yrs</th>
<th>35-50 yrs</th>
<th>51-65 yrs</th>
<th>66+ yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>W1</td>
<td>W2</td>
<td>W1</td>
<td>W2</td>
<td>W1</td>
</tr>
<tr>
<td>Local survey</td>
<td>64</td>
<td>59</td>
<td>65</td>
<td>70</td>
<td>61</td>
</tr>
<tr>
<td>National survey</td>
<td>53</td>
<td>44</td>
<td>50</td>
<td>46</td>
<td>49</td>
</tr>
</tbody>
</table>

Proportion of respondents agreeing with ‘Both men and women can be infected by chlamydia’ shown by age. Base size: Local survey 718 W1, 716 W2 National survey: 2011 W1, 1947 W2
In Wave 1 there was no significant difference in the proportion of males or females who recognised that this statement applies to chlamydia in either survey. In Wave 2 there were significant differences, with females significantly more likely to agree with the statement than males in both the local and national survey.

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>W1</td>
<td>W2</td>
<td>W1</td>
<td>W2</td>
</tr>
<tr>
<td>Local survey</td>
<td>58</td>
<td>55</td>
<td>63</td>
<td>62</td>
</tr>
<tr>
<td>National survey</td>
<td>43</td>
<td>32</td>
<td>46</td>
<td>41</td>
</tr>
</tbody>
</table>

Proportion of male and female respondents agreeing with ‘Both men and women can be infected by chlamydia’ shown by age. Base size: Local survey 718 W1, 716 W2. National survey: 2011 W1, 1947 W2

In the Wave 1 national survey, significantly more respondents from social class C1 (50%) agreed than those of social class C2 (43%), D (39%) or E (38%). In Wave 2 all classes were significantly more likely to agree than social class E.

The local survey showed no differences between respondents of different ethnicity in Wave 1 or Wave 2.

Those who have previously undergone chlamydia screening were more likely to agree with this statement than those who have not. In the Wave 1 national survey 63% of those previously screened recognised the truth of the statement compared with 48% of those non-screened in Wave 1 and in Wave 2 these figures were 65% and 38%, also statistically different. The corresponding figures for the Wave 1 local survey were 72% and 60% also significantly different. In Wave 2 the proportions were 63% and 58% and showed no statistical difference.

The responses for males and females indicates that males in particular must continue to be messaged; this group will not attend for screening (as speculated in the qualitative research) if they are ignorant that chlamydia can affect males.

**Statement 2: Chlamydia rates in the UK are increasing faster than for other sexually transmitted infections**

In Wave 1 29% of all respondents in the national survey believed this statement to be true, and 31% in Wave 2. 45% of respondents in the Wave 1 local survey agreed with 40% agreeing in Wave 2.
However, although significantly more females than males agreed with this statement in both Wave 1 surveys, the difference was not significant in the Wave 2 local survey:

Agreement with statement ‘chlamydia rates in the UK are increasing faster than for other sexually transmitted infections’ by Gender  Local base: W1 718, W2 716 National base: W1 2011, W2 1947

Age differences were less notable in the Wave 2 surveys. However the proportion of 16-24 years olds who believe in this statement continues to be less than 50% in both the local and national surveys.

<table>
<thead>
<tr>
<th>Age</th>
<th>Local survey</th>
<th>National survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>W1</td>
<td>W2</td>
<td>W1</td>
</tr>
<tr>
<td>16-24 yrs</td>
<td>45</td>
<td>41</td>
</tr>
<tr>
<td>25-34 yrs</td>
<td>37</td>
<td>34</td>
</tr>
<tr>
<td>35-50 yrs</td>
<td>34</td>
<td>39</td>
</tr>
<tr>
<td>51-65 yrs</td>
<td>28</td>
<td>26</td>
</tr>
<tr>
<td>66+ yrs</td>
<td>38</td>
<td>36</td>
</tr>
</tbody>
</table>

Agreement with statement ‘chlamydia rates in the UK are increasing faster than for other sexually transmitted infections’ by age. Local base: 718 W1, 766 W2, National base: 2011 W1, 1947 W2

In the Wave 1 national survey classes B and C1 were more likely to agree with this statement than classes D or E. In the Wave 2 national survey social classes A, B and C1 were more likely to agree than classes C2, D or E.

In the first wave of the local survey those in social class B were significantly more likely to state that chlamydia rates were increasing (59%) than those in social class C2, D or E. In the wave 2 local survey those in social class B were more likely to agree than those in social class E.

<table>
<thead>
<tr>
<th>Class</th>
<th>A</th>
<th>B</th>
<th>C1</th>
<th>C2</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>W1</td>
<td>W2</td>
<td>W1</td>
<td>W2</td>
<td>W1</td>
<td>W2</td>
</tr>
<tr>
<td>Local survey</td>
<td>60</td>
<td>76</td>
<td>59</td>
<td>49</td>
<td>47</td>
<td>39</td>
</tr>
<tr>
<td>National survey</td>
<td>27</td>
<td>53</td>
<td>34</td>
<td>39</td>
<td>34</td>
<td>36</td>
</tr>
</tbody>
</table>

Agreement with statement ‘chlamydia rates in the UK are increasing faster than for other sexually transmitted infections’ by class Local base: 718, National base: 2011
In Wave 1 of the national survey Asian respondents showed the lowest level of agreement with this statement, 8% compared with 31% of white British. In Wave 2 White British are significantly more likely to agree than either Asian or Black respondents. 32% of white British agreed compared with 18% of Asian and only 8% of black respondents.

The wave 1 local survey showed a higher level of agreement among the Asian respondents (31%) and one which was comparable with the levels of agreement seen among Black respondents (36%) although still a smaller proportion than seen among the white British respondents (52%). A similar picture was found in 2"nd wave local survey, where 46% of white British agreed, significantly more than the 23% of Asian respondents and comparable with the 36% of Black respondents.

In the wave one local survey respondents who had previously been screened for chlamydia were statistically more likely to agree with the statement than those who had not (66% versus 42%). There was no difference in the wave 2 survey but this was because screened respondents showed less agreement (49% versus 39%). Nationally a difference was found between screened and unscreened respondents in wave one (61% v 30%) and in Wave 2 (55% v 32%).

Statement 3: The majority of people with chlamydia have no signs or symptoms

32% of Wave 1 national respondents agreed that the majority of people with chlamydia have no signs or symptoms and 42% of local respondents agreed. In Wave 2, the figures are 31% and 40% accordingly. Females were statistically more likely to agree than males. The chart below shows that in Wave 2 females are statistically more likely to agree than males, and supports the picture that local respondents are more knowledgeable than national.

Agreement with statement ‘The majority of people with chlamydia have no signs or symptoms’ by gender Local base: 718 W1, 716 W2 National base: 2011 W1, 1947 W2

The results indicate that there remains scope to educate on chlamydia. Presumably many potential service users will not participate in the free screening programme if they assume that a lack of symptoms is synonymous with infection-free. Further education of males
would also appear to be a key requirement, if more men are to consider chlamydia screening.

In the Wave 1 local survey those who were 35-50 were more knowledgeable and were significantly more likely to hold this view than those aged 51-65 or aged 66 or over. In Wave 2 those aged 25-34 and 35-50 were more likely to agree than those aged 66 or over:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>16-24 yrs</th>
<th>25-34 yrs</th>
<th>35-50 yrs</th>
<th>51-65 yrs</th>
<th>66+ yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>W1</td>
<td>43</td>
<td>34</td>
<td>42</td>
<td>51</td>
<td>33</td>
</tr>
<tr>
<td>W2</td>
<td>42</td>
<td>43</td>
<td>43</td>
<td>43</td>
<td>42</td>
</tr>
<tr>
<td>Local survey</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>National survey</td>
<td>42</td>
<td>31</td>
<td>43</td>
<td>33</td>
<td>26</td>
</tr>
</tbody>
</table>

Agreement with statement 'The majority of people with chlamydia have no signs or symptoms'

Local base: 718W1, 716W2, National base: 2011W1, 1947W2

However, less than 50% of the key group of interest (16-24 year olds) were aware that the majority of people with chlamydia have no signs or symptoms. More worryingly there are indications at a local and national level that fewer people of this age agree with this statement than did so one year ago.

In the Wave 1 local survey social class B respondents (54%) were significantly more likely to state that the majority of people with chlamydia have no signs or symptoms than those of social class C2 (40%), D (32%) and E (34%). In wave two social class B respondents were significantly more likely to agree that Class D, 47% compared with 25%

Again, the similar trends are appearing, insomuch as it is females and higher social grades that are aware of the potentially asymptomatic nature of chlamydia, while some more at-risk groups are not aware.

Finally, ethnicity is again related to response. In the wave 1 surveys White British in the national survey showed statistically greater knowledge here than Asian respondents (33% versus 12%) a finding repeated in the local survey (48% versus 26%). In the Wave 2 local survey 44% of white British agreed, compared with 20% of Asian respondents, while 32% of white British agreed nationally, compared with 17% of Asians and 15% of Black respondents. However, Black respondents at the local level were much better informed with agreement levels of 41%.

In practical terms these results indicate that there remains a high need for education, since the majority of people do not believe that chlamydia typically presents asymptotically. This belief is not compatible with choosing to use an opportunistic screening service.

**Statement 4: Treatment for chlamydia is simple and effective**

In Wave 1 28% of national respondents and 33% of local agreed with this statement. In Wave 2 these proportions remained at 28% nationally and 38% locally.
Once again female respondents in both surveys showed significantly greater accuracy of knowledge:

Agreement with statement ‘Treatment for chlamydia is simple and effective’ by Gender National base: Local base 718 W1, 716 W2, 2011 W1, 1947 W2,

However, higher knowledge levels are seen among males in the 2nd wave of the local survey and this picture was not repeated nationally.

Responses for respondents from different social classes continue to show the same lower awareness in lowest social classes. In Wave 1 of the local survey 46% of social class B agreed compared with 16% of class D. In Wave 2 local survey these figures were 46% and 25% respectively.

In Wave 1 of the national survey 38% of class B agreed compared with 20% of class D and in Wave 2 it was 36% and 20% respectively.

Asian respondents in the national survey showed the lowest amount of agreement with this statement in both wave 1 (12%) and wave 2 (9%). As a comparison, white British showed a 28% response rate in the Wave 2 national survey.

In the Wave 2 local survey 23% of Asian respondents agreed compared with 43% of white British, compared with 24% and 41% in Wave 1.

Respondent who have previously undergone screening are more likely to agree that treatment is simple and effective. Presumably not everyone who received screening required treatment, which suggests that those who are tested either seek out or are provided with information on treatment.
Statement 5: Chlamydia is more prevalent amongst younger people

In the Wave 1 surveys 37% of national respondents held the view that chlamydia is more prevalent amongst younger people and 33% of local respondents agreed. In the Wave 2 these proportions were 29% and 38%.

37% of males and 38% females agreed in the Wave 1 national survey and one third of both males and females agreed in the Wave 2 local survey. In the Wave 2 local survey 37% of males and 39% of females agreed, which compared with 27% and 32% nationally. Only the last comparison is significantly different (at 95%), and so this is one statement where there is relatively little difference between males and female beliefs. It may be that respondents tend to consider sexually transmitted infections in general to be more widespread among younger people.

In Wave 1 the findings showed some significant age differences in the national survey (51-65 year olds were significantly more likely than 16-24 year olds to attribute chlamydia to younger people) but this was not echoed in the local survey, where there were no significant age differences. Wave 2 also found that 51-65 year olds were more likely to agree than either of the two lowest age groups.

It appears that younger people are unaware or tend to deny the relationship between age and prevalence of chlamydia. Again, awareness needs to be increased in order for this age
group to understand the benefits of undergoing opportunistic screening. The low rate of agreement among over 66 year olds in the national Wave 2 can be attributed to a high level of ‘Don’t Know’ responses.

In the Wave 1 national survey the broad trend of higher social class showing greater knowledge than lower social classes continued and those respondents classified as social class B (40%) and social class C1 (37%) were significantly more likely to have this opinion than those of social class C2 (25%). This picture continued into Wave 2 where 37% of the national social class B respondents agreed, compared with only 21% of social class D and 18% of social class E.

Wave 2 of the local survey also found a significant difference between social class B and social class D, with 48% of B respondents agreeing with the statement compared with 32% of social class D. Such social class differences highlight the need to target these groups, in particular, with information on chlamydia and the screening process.

It should be noted that while social class differences can be observed, ratings among the best performing social classes may not be high. For example, less than 50% of social class B understand that chlamydia is more prevalent among younger people. So while targeting of lower social class groups may be necessary due to the higher risk that they face, higher social class groups should also be included.

**Statement 6: The signs and symptoms of chlamydia can include discharge and abdominal pain**

In Wave 1 27% of national respondents and 32% of local respondents were of the view that the signs and symptoms of chlamydia can include discharge and abdominal pain. In Wave 2 these figures were 26% and 33%, indicating no change.

In Wave 1 some gender differences were apparent although these were not large. 29% of men and 35% of women agreed in the local survey – a non-significant difference. The national difference of 25% of men and 29% of females was significant at the 95% significance level. In Wave 2 the picture was similar with 30% of men and 37% of females agreeing in the local survey, and 21% and 31% at the national level. The latter results are significantly different. (99% level)

Once again, these findings support the overall picture that women hold more accurate knowledge about chlamydia than men.

In the Wave 1 national survey, 16-24 year olds were statistically more likely to accept this statement than the over 51 year olds, a finding that was repeated in Wave 2.

However, in both instances, this was still only 33% of this age group, indicating that only a minority of people in this age group understand the possible signs and symptoms of chlamydia.
The Wave 1 local survey showed no age differences with approximate one third of the respondents in each age band agreeing with that discharge and abdominal pain are included among the signs and symptoms of chlamydia. However, in Wave 2, 45% agreed with the statement a higher proportion than was found in three of the older age groups.

In Wave 1 social class B respondents showed stronger agreement in both the national and local surveys. In the local survey, for example, those in social class B (39%) were significantly more likely to be of this view than those of social class E (27%). Additionally those of social class C1 (35%) and C2 (35%) were significantly more likely to hold this view than those of social class D (17%).

In Wave 2 there were no significant social class differences at the local level, although the national survey still showed greater agreement among social class B (26%) than for social class D (18%) and E (16%)

In the Wave 2 local survey respondents who had already been screened were significantly more likely to agree, 53% versus 30%. This mirrored the results of the Wave 1 local survey where screened respondents showed a 47% level of agreement compared with 31% from unscreened respondents.

There were no differences between respondents from different ethnic backgrounds in the Wave 2 local or national surveys. In the Wave 1 local survey white British were more likely to agree than Asian respondents at 95% level, a finding that was echoed nationally.

Statement 7: Untreated chlamydia does not lead to any long term complications

In Wave 1 6% of respondents in the national survey and 10% in the local survey thought that this statement applied to chlamydia. In Wave 2 the figures were again 6% nationally and 11% nationally. These are reasonably encouraging figures, because although there may be widespread lack of knowledge about the specifics of chlamydia it is at least recognised that it potentially leads to long term complications.

11% of females in the local population agreed in Wave 1 and this figure was repeated in Wave 2, again implying that approximately 1 in 10 London females do not understand the long term importance of screening for chlamydia.

3% of the 16-24 year olds in the wave 1 local survey (men and women) agreed with the statement in the local population, and in wave 2 this figure was 8%. There were no differences in age bands in the Wave 2 local survey.

There were no social class or ethnicity difference in either of the local surveys. The 2 national surveys showed no ethnicity differences and there were some minor class difference in the direction observed in other questions.
Statement 8: Chlamydia can be spread by sharing towels with an infected person

This statement was included in the survey because the earlier qualitative research indicated that there was sometimes uncertainty as to whether this behaviour raised any risk or not. Once the idea had been raised in a focus group it tended to generate discussion and raise doubts.

The results of the quantitative research shows that very few people believe that chlamydia can be spread by sharing towels with an infected person. 5% of respondents in the Wave 1 national survey agreed, while 9% of Wave 1 local respondents believed in the statement “chlamydia can be spread by sharing towels with an infected person”.

The table below shows gender differences across the surveys:

<table>
<thead>
<tr>
<th></th>
<th>Local W1</th>
<th>Local W2</th>
<th>National W1</th>
<th>National W2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>12</td>
<td>11</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Female</td>
<td>8</td>
<td>9</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Agreement with statement ‘chlamydia can be spread by sharing towels with an infected person’ by Gender. Local base 718 W1, 716 W2, National base: 2011 W1, 1947 W2

In the Wave 1 national survey 16-24 year olds were significantly more likely to believe this statement than any one aged 35 or over. 10% of the 16-24 year olds considered the statement true in Wave 1 and 9% in Wave 2, indicating that younger people nationally still hold myths about STIs. In the wave 2 local survey 15% of 16-24 year olds agreed with the statement significantly more than the proportion of 25-34 year olds.

Social class E was significantly more likely to agree with the statement than social class B in the wave 2 local survey, at 96% significance. Nationally however social class C1 was more likely to agree than either social class D or E.

In the local wave 2 survey Asian respondents were more likely to agree with the statement than either White British or Black respondents (95% significance). 17% of Asian respondents agreed compared with 9% of white British and 7% Black. There were no ethnic differences in either of the two National surveys.
Statement 9: You can catch chlamydia by sharing a glass with an infected person

This statement was included for the same reasons as statement 8. Very few respondents agreed with this statement across either the local (5%) or national (1%) Wave 1 and Wave 2 surveys.

There were no age differences in the 2 national surveys or in the Wave 1 local survey. In Wave 2 local survey 16-24 year olds were more likely to agree (7%) than 25-34 year olds (2%), at 95% significance. However, the age band most likely to agree with the statement was the over 66 years of whom 11% agreed.

There were no differences for social class or ethnicity in either wave for the national surveys.

In the Wave 1 local survey the socio-economic group E (11%) showed more agreement than groups C1 (3%), C2 (3%) or D (1%). In Wave 2 of the local survey this group showed more agreement (11%) than either social class C1 (4%) or C2 (5%). No ethnic differences were observed.

Although the proportions who agree with these last two statements are low, it does appear that both lower social classes and younger people are more likely to hold mistaken beliefs about chlamydia.

Summary

There remains a general trend for females, higher social class and white ethnic groups to be more knowledgeable. London respondents are typically better informed than national, with a few exceptions.

The results show that basic knowledge about chlamydia is lacking among the national and local populations. For example, only 63% of respondents nationally are even aware of chlamydia.
Perceived self risk of contracting chlamydia

Respondents in both national and local surveys were asked to judge their own personal risk of catching chlamydia. While this is a subjective question, it is interesting to see, especially amongst the target groups, how at risk they perceive themselves to be and whether these personal risk estimates match prevalence figures.

Local survey

Perceived personal risk of contracting chlamydia. Base 718 W1, Base 716 W2

- W1: 2 Very low risk, 78 Quite low risk, 13 Quite high risk, 3 Very high risk
- W2: 6 Not stated, 74 Very low risk, 12 Quite low risk, 5 Quite high risk, 4 Very high risk

National survey

Perceived personal risk of contracting chlamydia. Base 2011 W1, Base 1947 W2

- W1: 27 Not stated, 62 Very low risk, 7 Quite low risk, 31 Quite high risk
- W2: 29 Not stated, 59 Very low risk, 8 Quite low risk, 32 Quite high risk
Once again, respondents in both surveys generally considered themselves to be at very low risk of infection. Slightly larger proportions in the local surveys (quite low risk through to very high risk) consider themselves to be at some risk, compared with the national surveys.

There were no differences, in either local survey, in the proportion of males and females perceiving themselves as being at very high or quite high risk.

In Wave 2 of the national survey significantly more females than males considered themselves to be at very low risk, 63% females and 55% males. 9% of males considered themselves to be at quite low risk compared with the 6% of females, and 4% of males rated themselves at quite high risk compared with 2% of females, differences which were significantly different at 95%. It appears that nationally females consider themselves at slightly less risk of contracting chlamydia than males. However, some men may be rating themselves as low risk in the mistaken belief that males cannot be infected with chlamydia.

The table below shows the perceived risk of chlamydia infection in relationship to age.

<table>
<thead>
<tr>
<th>National population surveys</th>
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<tbody>
<tr>
<td>16-24</td>
</tr>
<tr>
<td>W1</td>
</tr>
<tr>
<td>Very High</td>
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<tr>
<td>Quite High</td>
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<tr>
<td>Quite low</td>
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<tr>
<td>Very low</td>
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<tr>
<td>Not stated/DK</td>
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<table>
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<tr>
<th>Local population surveys</th>
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</thead>
<tbody>
<tr>
<td>16-24</td>
</tr>
<tr>
<td>W1</td>
</tr>
<tr>
<td>Very High</td>
</tr>
<tr>
<td>Quite High</td>
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<tr>
<td>Quite low</td>
</tr>
<tr>
<td>Very low</td>
</tr>
<tr>
<td>Not stated/DK</td>
</tr>
</tbody>
</table>


In the local population survey, the 16-24 group (28%) were significantly more likely to describe themselves as ‘quite low risk’ than any other group in Wave 1 and in Wave 2 more likely to describe themselves as ‘quite low risk’ than those aged 51 or older.
In the local survey Wave 1 the age groups from 25 to 66+ were significantly more likely to cite ‘very low risk’ (25-34 75%; 35-50 88%; 51-65 87%; 66+ 83% compared to 16-24 59%) but in Wave 2 this was seen only in ages 35 and older.

A similar trend was seen in the Wave 1 national survey, with the proportion of the target age group (16-24 16%) claiming to be at ‘quite low risk’ being significantly higher than other age groups (35-50 6%; 51-65 3%; 66+ 2%). The same picture was found in the Wave 2 in which 16-24 years olds were more likely to rate themselves as quite low risk than other age groups.

The percentage of people rating themselves as very high risk is low in both populations, although higher in the younger age groups. In the Wave 2 national survey 16-24 years olds were significantly more likely to rate themselves as ‘high risk’ than all ages 35 years and above. There were no significant differences in the local survey though.

There were no differences in the proportion of respondents from different ethnic groups who placed themselves in the ‘very high risk’ category.

Respondents in the local surveys were more likely to answer the question and more likely to place themselves in the high risk category. However, since positivity testing for chlamydia runs at approximately 10% nationally, there seems to be an underestimate of personal risk among the 16-24 year olds.
Pharmacy chlamydia screening awareness

In Wave 1 across both the local and national surveys respondents were asked if they were aware of the Pharmacy chlamydia screening service that was about to be launched in London. In Wave 2 the wording of the question changed to “Are you aware that free chlamydia screening and treatment are available for 16-24 year olds in high street pharmacies across London?”


In Wave 1 there was 15% national awareness and 17% locally, demonstrating that there was no significantly higher awareness in the local populace, as might initially have been expected.

Wave 2 data shows that awareness of the chlamydia screening process has increased both locally and nationally in the past year. However, there is still no greater awareness in the local population than there is across the UK.

Wave 1 showed some gender differences with awareness significantly higher amongst females in the national population survey (17%, compared to 13% for males). This difference continued into Wave 2 with 25% of females aware compared with 20% of males.

While there were no gender differences in the local population for Wave 1, this changed by Wave 2 when 27% of females were aware compared with only 16% of males. Again it seems that males need to be better educated about the service if more males are to be screened.

16-24 years in the Wave 2 local survey showed greater awareness than other age groups (32%), and significantly more so than all those aged over 35 years. The corresponding figure in Wave 1 was 15%. It is extremely good news that the proportion of local 16-24 year olds aware of the service has doubled since the service was launched. More perplexing is that national awareness among this age group is even higher. Nationally, the proportion of 16-24 year olds who were aware of the service in Wave 2 was higher than in the local service (42%), which compares with only 18% in Wave 1.

Social classes A, B and C1 were significantly more likely to know about the service than social class E in the Wave 2 national survey. However no social class differences were observed in the local survey.

Both national and local respondents who had previously been screened for chlamydia were statistically more likely to be aware of the new service than those who had not in both Wave 1 and Wave 2. Those who saw themselves as being at greater risk of chlamydia were no more likely to be aware than those who did not.

In the Wave 2 local survey those who consider in-pharmacy chlamydia screening to be acceptable were more likely to know about the free screening (24%) than those who were unsure about the acceptability (9%).

Sources of awareness (local population survey only)

Respondents in the local service who knew about the proposed pharmacy service were then asked how they became aware of it via an open question.

In Wave 1 over half of these respondents cited radio, TV or newspaper publicity as their source of awareness for the chlamydia screening service. This proportion reduced significantly for Wave 2, and other sources such as schools and colleges became influential. By Wave 2 a small proportion of respondents had forgotten how they heard of the service.
Another change between Wave 1 and Wave 2 is that in-store publicity became more influential. Surprisingly perhaps awareness via the pharmacist or counter assistant decreased between waves.

Source of awareness – local survey. Base: 122 W1 & 155 W2 (all aware)

Knowledge of chlamydia screening service (local population survey only)

Local respondents who were aware of the proposed pharmacy screening service were asked what they knew about it. This was again an open question and responses were coded. The chart below shows the results for both waves.
In Wave 1 most spontaneous mentions related to the process involved in testing, while in Wave 2 the highest number of mentions related to the store providing the service.

There were no differences relating to age, gender or ethnicity differences among respondents in either wave.

In Wave 1 those respondents who had previously been screened for chlamydia knew significantly more about some aspects of the service than those who had never been screened. 15% of this group understood that the service was for chlamydia only (compared with 6% of the unscreened group) and 9% understood that no visit to the GP or hospital was required (compared with 3% of unscreened respondents). No significant differences were found between these groups in Wave 2.

**Action taken (local and national)**

A new question was added in Wave 2 and asked against those aware of the free chlamydia service in both the local and national surveys.

“And has this [awareness] prompted you to take any action yourself?”

This was again an open question and responses were coded. The chart below shows the results for both surveys.

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**Action taken following awareness of service. Base Local W2 155, National W2 395**
The vast majority stated awareness had not lead to any specific action (local 82%; national 71%). Of all actions taken, visit their GP was most likely outcome (local 10%, national 18%). Awareness also stimulated discussions with a pharmacist, background reading/research, and some it stimulated to take a test, either at Boots or a ‘clinic’.

Although base sizes are small, thus making comparisons across sub groups less worthwhile, a greater proportion of 16-24 year olds claimed to take action by visiting a GP or discussing with a pharmacist, and these were also more likely to be from D or E social grades.
Acceptability of service

Respondents in both surveys were asked whether a chlamydia screening service offered through high street chemists was acceptable.

The perceived acceptability of providing chlamydia screening and treatment within high street chemists has not changed, either locally or nationally, across the two waves.

Local respondents are much more likely to believe that offering chlamydia screening through chemists is an acceptable proposition.
Older groups (51-65 and 66+) in the national survey were significantly more likely to find the service unacceptable through a chemist (12% and 13% respectively) in Wave 1. In the second wave only those over 66 were significantly more likely to consider it unacceptable than younger age groups.

Social classes D and E were significantly more likely to consider the service as unacceptable than classes A, B and C in both waves of the National survey. For example, 65% in social class A in Wave 2 considered the service acceptable compared with 42% in social class E.

Younger ages in all surveys were more likely to consider the survey acceptable than older age groups. For example 84% of 16-24 year olds in Wave 2 local survey viewed the service as acceptable compared with 70% of those aged over 66 years.

However, although local respondents are more accepting overall, those at higher risk showed more ambivalence in both waves. 23% of those who put themselves at higher risk stated they were not sure about the acceptability of the screening service compared with 9% of those not at risk in Wave 1 compared with 27% and 11% in Wave 2.

Wave 1 showed no significant differences in the local survey between respondents who had previously been screened or not, and respondents who were aware of the forthcoming service or not. In Wave 2 respondents who were aware of the service showed greater acceptability. 89% of aware respondents considered it acceptable compared with 76% of unaware.

It should be noted that October 2006, when the research was conducted, saw the introduction at Boots of the ‘paid for’ chlamydia screening kits for customers outside of the 16-24 age range. Potentially this greater availability and promotion of such kits may have an impact on awareness and acceptability of the service (for example) in the future. A third and final wave of research is scheduled for July 2007 which may highlight any such changes.

Views on chlamydia screening as a use of public/NHS money (national survey)

Opinions on use of public money. Base: 2011 W1, 1947 W2
Respondents in the national survey only were asked if they felt that a chlamydia screening service for 16-24 year olds was an acceptable use of public money. For both waves, in general these respondents felt that the chlamydia screening service was an acceptable use of public money, with only 1/10 disagreeing.

In Wave 1 the 66+ age group (mean score 0.5) were significantly more likely to disagree with the use of public money on such a service. Similarly, this was true in Wave 2 (mean score 0.4). Interestingly, it was this older group that was identified in the qualitative stage of research as being most likely to disagree with the use of public money being spent on such a service for the younger proportion of society.
Perceived advantages and disadvantages of the initiative

Advantages of the initiative (open)

Respondents from both the national and local surveys were asked to spontaneously state their top 3 perceived advantages of the proposed screening service.

Local survey

Advantages of the initiative. Base: 718 W1, 716 W2

Perceived benefits generally fall under ‘awareness of the condition’, ‘accessibility’, ‘reduces embarrassment’ and the fact that the ‘service is free’.

Across both waves, ‘raises awareness of chlamydia’ and the ‘prevention of the disease spreading’ appear the advantage mentioned by many.
Advantages of the initiative. Base 2011 W1, 1947 W2

It is worth noting that a much greater proportion of respondents in the national survey have ‘no opinion’ about an advantage of the scheme. As previously, this is likely to be related to the fact that the scheme is not immediately applicable to them.

It is also interesting that in the earlier qualitative stage of research, convenience appeared to be considered a much greater advantage.

Disadvantages of the initiative (open)

Similarly, respondents were asked to spontaneously give their top three perceived disadvantages of the scheme.
Local survey

Disadvantages of the initiative. Base 718 W1, 716 W2

The key themes in the local survey were embarrassment, encouraging unprotected or unsafe sex and concerns over receiving correct medical advice.

National survey

Disadvantages of the initiative. Base 2011 W1. 1947 W2
The topics mentioned by the national populace are relatively similar to those stated in the local survey. The most notable difference is the 5% (for both waves) claiming the cost to the NHS to be a disadvantage of the service. This could be due to respondents in the national service will be ‘paying’ for a service that does not affect their locality.

It is also noteworthy that the embarrassment factor appears in both surveys, as it did within the qualitative project. Clearly there is a section of respondents for whom this would be a barrier though it does seem a relatively small proportion.
Importance of service attributes

Respondents in both surveys were presented with seven attributes of the chlamydia screening service and asked to rank them in order of importance.

The chart below shows both surveys, and depicts the relative importance of each attribute by mean score (out of 7).

The order of importance is identical in both surveys. Confidentiality is clearly the most important attribute across the two surveys, with respondents also looking for reliable results, helpful staff and the fact that no appointment is required. A private consultation area is also deemed important.

Neither national nor local respondents consider an in-store toilet to be particularly important.

Complete confidentiality

In the Wave 1 local survey, complete confidentiality was significantly more important for men (mean score 5.3) and for social classes A, B, C1 and C2 (6.1, 5.3, 5.2 and 5.3 respectively). In Wave 2, there are no significant differences by sub groups. However, the pattern of social class remains, but women (5.3) now view complete confidentiality more important than men (5.1). From the national surveys, both at Wave 1 and Wave 2, the 16-24 (W1 5.2; W2 4.9) age group cited this significantly lower than the 35-50 group (W1 5.5; W2 5.4).
Helpful/knowledgeable staff

At Wave 1, females (mean score 4.5) in the national survey rated ‘helpful, knowledgeable staff’ significantly lower than their male counterparts (4.7), although at Wave 2 both males and females rate similarly (4.5).

Reliable results

At Wave 1, social classes D (4.8) and E (4.8) perceived the importance of ‘reliable results’ to be significantly higher than social class B (4.4) in the national survey. At Wave 2, social class E (4.8) perceived the statement to be significantly higher than B (4.5), C1 (4.6) and D (4.5).

At Wave 1, White respondents (mean score 4.7) in the local survey rated the importance of reliable results significantly higher than Asian (4.0) or Black (4.0) respondents. At Wave 2, although this pattern exists, the results are not significant: White (4.4), Asian (4.2), Black (4.0).

No need for appointment/easily accessible

At Wave 2, it was notable in the national survey that the 16-24 age group (4.4) found this attribute to be less important than any other age group (4.8 was the overall mean score). This is a similar finding to Wave 1.

At Wave 2, respondents in the local survey from social class B (mean score 4.9) rated ‘no need for appointment/easily accessible’ significantly higher than classes C1, C2 or D (4.4, 4.2 and 3.8 respectively). Again, this is a similar pattern to Wave 1.

Private consultation area

At Wave 1, Asian respondents (mean score 4.8) in the local survey were significantly more likely than British (4.3) or Irish (3.8) respondents to cite this factor as important. At Wave 2, Asian (4.4), Black, (4.5) and British (4.3) view as important, but not significantly so.

Convenience of store location

At both Waves, for males (mean score W1 3.5; W2 3.6) in the local, target population area, the convenience of the store location was significantly more important than for females (W1 3.2; W2 3.3). Similarly, those of social classes D (W1 3.5; W2 3.7), E (W1 3.5), C2 (W2 3.6) and C1 (W2 3.4) cite this factor as important.
In-store toilet

Having an in-store toilet was the least important service factor by some way, across both surveys. The younger (16-24: 2.5; 25-34: 2.3) respondents in the national survey indicated a higher importance than 35+ year olds.

Implications for the service

Clearly, the service must take into account the need for complete confidentiality. This theme emerged from both surveys, but was especially important for male respondents in Wave 1. Given the significantly lower levels of awareness about chlamydia and STIs amongst males, it is of particular importance to address anything that can be done to ensure maximum uptake of the screening service.

Similarly, males also cited ‘helpful, knowledgeable staff’ significantly higher in importance than their female counterparts, at Wave 1 (similar levels at Wave 2) so it is clearly a factor that should be considered when Pharmacy staff are dealing with clients in order to be empathetic to any concerns they may have.

It is a positive finding that in-store toilets are not rated important, as many Boots stores do not have this facility. However, it does mean that service users may need to make more effort to return the screening kit to the store after use. The current return figures do suggest that many service users collect the kit, leave the store and then fail to return.
Confidentiality and reliability of the service

Service confidentiality

Across both surveys, respondents were asked to rate how confidential they felt In-Pharmacy screening would be compared to other screening locations.

Given that confidentiality is the most important factor to arise from the service attributes, it is crucial to gauge if the Pharmacy Pathfinder screening is perceived to be a confidential service in relation to other service providers.

A comparison of mean scores shows that respondents from both the national and local population surveys felt that In-Pharmacy chlamydia screening would be as confidential as other screening locations.

Inspection of the % figures (see below), indicates confidentiality overall (more/as confidential) is higher in the local vs national survey.
### National

<table>
<thead>
<tr>
<th>Service Type</th>
<th>W1</th>
<th>W2</th>
<th>W1</th>
<th>W2</th>
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### Local

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**Perceived confidentiality of service in relation to other service providers. Base: 718 W1; 716 W2 (local) 2011 W1; 1947 W2 (national)**

**Perceived reliability of the chlamydia screening service**

Respondents in both surveys were asked to rate how reliable they believed the results from the new service to be, relative to existing screening locations.

![Bar Chart](chart.png)

**Perceived reliability of the service (mean scores excl. unsure). Base: 718 W1, 716 W2 (Local survey), 2011 W1, 1947 W2 (National survey)**

Overall, nationally and locally, the results obtained via the new service were perceived to be as reliable as all other existing screening locations.
Inspection of the % figures (see below) indicates reliability overall (more/as reliable) is again higher in the local vs national survey.

<table>
<thead>
<tr>
<th>National</th>
<th>Hospital clinic (GUM)</th>
<th>GP</th>
<th>Family planning clinic</th>
<th>NHS drop in centre</th>
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<td>13</td>
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<td>D/K</td>
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</tr>
<tr>
<td>More/As reliable</td>
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<table>
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</tr>
<tr>
<td>As reliable</td>
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<td>58</td>
<td>58</td>
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<td>Less reliable</td>
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Perceived reliability of the service in relation to other service provider. Base: 718 W1, 716 W2 (Local), 2011 W1, 1947 W2 (National)

The key sub group analysis is by age, focussing upon the key target audience for the in-pharmacy service.

In the national surveys, the younger ages (16-24, 25-34) perceive the in pharmacy service to be more reliable than any of the other 4 screening locations. This applies for both waves.

In the local surveys it is generally the older age groups (35+) who perceive the in-pharmacy service as more reliable.

As highlighted in the initial Wave 1 report, this implies that there is scope to increase the confidence of 16-24 year olds in terms of service confidentiality. In particular there maybe some challenge in convincing this age group of the quality of the testing service.
Previous screening/testing for chlamydia

Respondents in both surveys were asked if they had ever been screened for chlamydia and if so how recently.

In both the national and local survey the majority of respondents had never been screened for chlamydia. In both surveys more females than males had been previously screened for chlamydia.

National survey

Previous screening for chlamydia. Base: W1 2011; W2 1947 (National)

At Wave 1, 84% of respondents in the National survey had never previously been screened or tested for chlamydia. At Wave 2 a similar level of 82% had never previously been screened. More males than females had never been tested. W1: males 86%, females 81%; W2: 85%, 79%.

Unsurprisingly, the older age ranges contained significantly larger proportions of ‘never tested’ respondents: 35-50 (W1 88%, W2 87%), 51-60 (W1 87%, W2 87%) and 66+ (W1 84%, W2 78%), than the 16-24 (W1 80%, W2 78%) and 25-34 (W1 75%, W2 75%) age group.
At Wave 1 respondents in social class B were more likely to have been tested than any other social class. Similarly at Wave 2, respondents from social class B and C1 were more likely to have been tested.

At Wave 1, lower levels of D (80%) and E (78%) indicated they had never been tested, although higher levels (16%) refused. A similar pattern was seen at Wave 2: never; D (73%), E (78%) with refusals at 19% ad 18% respectively.

In respect to ethnicity, no major differences in screening rates between different ethnic groups were noted.

At Wave 1, 7% of respondents who perceived themselves to be ‘at risk’ had been tested within the past 6 months, significantly more than the 2% from the ‘not at risk’ group. In total, 22% of the ‘at risk’ group had been tested (vs 8% ‘not at risk’), and this was broadly mirrored at Wave 2, with 17% vs 8%. This finding implies that people who consider themselves to be at risk of chlamydia are prepared to take health care action.

Local survey

Previous screening for chlamydia. Base: W1 718, W2 716 (Local)

At Wave 1 85% of all local respondents stated that they had never previously been tested for chlamydia. 88% of males and 82% of females had not previously been tested. At Wave 2, 84% had never been previously tested, again males (86%) higher than females (82%).

At Wave 1 significantly more of those aged 25-34 (12%) reported that they had been tested over 12 months ago for chlamydia than those aged 16-24 (3%), 51-65 (3%) or 66+ (2%). Similarly at Wave 2, significantly more of those aged 25-34 (12%) had been tested over 12 months ago than those aged 16-24 (4%), or 66+ (0%). The younger age groups also
indicate they have been screened with the last 6 months, 16-24, 9% and 25-34, 8%, which is significant to 35-50 (2%), 51-65 (1%), 66+ (0%).

<table>
<thead>
<tr>
<th></th>
<th>16 – 24 yrs</th>
<th>25 – 34 yrs</th>
<th>35 – 50 yrs</th>
<th>51 – 65 yrs</th>
<th>66+ yrs</th>
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<td>3</td>
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<td>1</td>
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</table>

Chlamydia screening by age Base: 718 W1, 716 W2.

Both waves reflect there are no relationships between previous screening and social class or ethnicity.

However, at Wave 1 those who believe themselves to be at risk are again more likely to have been screened when compared with those who do not consider themselves to be at risk, 13% within the last 6 months versus 4%. At Wave 2, there are no similar differences by at risk vs not at risk subgroups.

Previous screening/testing locations

National respondents who had previously been tested (W1 6%, W2 8%) attended a variety of screening/testing locations, the majority using a hospital clinic (W1 37%, W2 23%), or GP surgery (W1 25%, W2 39%).

Gender and ethnicity are not connected with place of testing.

Locations in which respondents had previously been tested. Base: All those previously tested W1 116, W2 120 (National)
Of the 1% of respondents indicating they had been previously screened at a retail chemist/pharmacist, all indicated they had used an independent pharmacy. This was an additional question for Wave 2.

In the local survey, as in the national survey, the most popular place for testing appears to be a hospital clinic (W1 37%, W2 39%) or GP surgery (W1 27%, W2 25%).

Locations in which respondents had previously been tested. Base: All those previously tested W1 108, W2 101 (Local)

As in the national survey there was no association between screening location and gender, age, class or ethnicity.

As per the national survey, those who indicated they had been screened at a retail chemist/pharmacist, were subsequently asked which specific retail store.

Of the 3 respondents claiming to have been screened at a chemist, 2 stated Boots and 1 an independent pharmacy.
Factors affecting uptake (local survey only)

In the local survey only, respondents were asked to rank, in order of influence, six factors that might prevent screening uptake in a retail pharmacy. The factors were derived from the qualitative research findings.

Factors preventing uptake - mean scores. Base: 718 W1, 716 W2 (Local).

Embarrassment was considered to be the factor most likely to prevent someone from taking a test in a retail pharmacy and was ranked first place by 41% W1, 42% W2 of respondents. Concern over confidentiality, on the other hand, was rated most important by only 14% W1, 13% W2 of respondents. Embarrassment was a key theme to emerge from the qualitative research and it does appear consistently, wave on wave from the quantitative research that this may be a real potential barrier for service uptake.

At Waves 1 and 2, there were no gender, age or social class differences in views on embarrassment. At Wave 1, ‘embarrassment’ was ranked significantly more important by White British respondents (4.8) than other white respondents (4.1) or those of ‘any other’ ethnicity (3.3). At Wave 2, other white (4.7) and British (4.6) ranked embarrassment higher than other ethnic groups, but not at significant levels.

At Waves 1 and 2, respondents who had already been screened did not attach any less importance to managing embarrassment.
Some sub-groups expressed more concern about ‘lack of confidence’ in the results than others. The mean score was significantly higher (95% level) for males than females at Wave 1 and higher at Wave 2, albeit not significant. Social groups C1, C2, D and E all attached more importance to this ‘lack of confidence’ than group B, again at both waves.

At both Waves, those who do not consider in-store pharmacy screening to be an acceptable service also attached significantly more importance to this factor than those who considered it to be acceptable.

At Wave 1, it was noted that the female respondents (3.6) ranked ‘Busy pharmacy/lack of privacy’ significantly more important than males (3.2). The qualitative research indicated that there is more stigma attached to females who have an STI than males, which may be influencing the need for privacy. However, at Wave 2, this difference is not apparent: females 3.8, males 3.7, although the findings from the original qualitative research should not be ignored.

Finally, at Wave 1, those of social class B (3.6) ranked ‘Denial of being at risk’ as significantly more important than those of social class D (2.9). At Wave 2, social class C2 (2.6) indicated the lowest level of ‘denial of being at risk’.

It is probably fair to assume that there is some overlap in the top three factors, since lack of confidentiality and lack of privacy would presumably contribute to feelings of embarrassment.

It would therefore seem that the most important service barrier is embarrassment. Although sexual imagery may be widespread in the UK, this survey highlights that personal embarrassment exists around the topic of sexually transmitted infections. Again, this supports the qualitative findings, where, females in particular spoke of the negative connotations associated with sexual infections.
Level of confidence in the success of the service (local survey only)

Respondents in the local survey only were asked to indicate how confident they were that the pharmacy chlamydia screening service would succeed.

61% of these respondents stated that they were very or relatively confident of the success of the service at Wave 1, 63% at Wave 2.

Confidence in future success of the service. Base: 718 W1, 716 W2 (Local).

There were no differences in either Waves in confidence levels between males or females or between ages. Social class was not related to predicted success either.

At Wave 1, white British respondents showed a higher mean predicted success rating than Asian respondents, 3.81 versus 3.44. The Asian respondents (50%) were significantly more likely to give a neutral opinion as to whether the service will succeed than British (27%), any other white (22%) and Black (30%) respondents.

Interestingly at Wave 2, Asian respondents (3.7) were the most positive with 65% being very or relatively confident, compared to British (3.7), other white (3.6) and black (3.6).

Those who consider the in-pharmacy screening to be an acceptable service at both Waves were significantly more likely to have confidence in its future success than those who viewed it as unacceptable.

There was, however, no link between previous screening and predicted success, again at both Waves.
Impact of the chlamydia initiative (local survey only)

Local respondents were asked to predict how likely it was that the pharmacy chlamydia screening would lead to four other occurrences. These were encouraging unprotected sex, increased awareness of STIs, increased awareness of chlamydia and a decrease in rates of chlamydia among 16-24 year olds. These four were derived from both desired service outcomes and views expressed in the qualitative research.

Potential impact of the chlamydia screening service – mean scores. Base: 718 W1, 716 W2 (Local)

Overall, similar responses were received wave on wave, with ‘increase awareness of STIs’ decreasing the most at Wave 2. Additionally, the three positive outcomes were all considered more likely to happen than the negative outcome.

Increased awareness of chlamydia

At Wave 1, the overwhelming prediction was that the initiative will increase awareness of chlamydia and this is still true at Wave 2. The majority of respondents believe that the initiative will result in greater awareness (very or quite likely W1 80%, W1 77%) and with low levels of rating it very or quite unlikely (W1 6%, W2 8%).

There was no significant difference between males and females or across ages or was there any association between likelihood of increased awareness and social class. In terms of ethnicity, Wave 1 showed no differences but at Wave 2 British/whites indicated a greater likelihood that the chlamydia initiative would result in an increase awareness of chlamydia.
At Wave 1, those who consider the service acceptable were more likely to believe that increased awareness will result, than those who consider it unacceptable (mean of 1.2 versus 0.7). At Wave 2, there was no difference, however, comparisons by those ‘at risk’ (0.7) are less likely to see an increase in awareness of chlamydia vs those ‘not at risk’ (1.0).

**Increased awareness of STI**

The vast majority of respondents believe that increased awareness of STI will be a significant outcome of the pharmacy-screening programme (very or quite likely W1 76% W2 73%). Only a minority considered it very or quite unlikely: W1 7%, W2 9%).

Males and females were equally optimistic, as were social classes and ethnic groups wave on wave. In terms of age, at Wave 2, the younger age groups (16-34) are more optimistic than 35-50 year olds.

At Wave 1 those who consider the service appropriate hold significantly more optimistic views on the impact of this factor than those who believe it to be inappropriate (means of 1.0 vs 0.7). Similarly at Wave 2 (1.0 vs 0.8), albeit not significant.

**Decreasing the number of cases of chlamydia in 16-24 year olds**

At both waves, while respondents showed broad agreement with this statement they did not consider it as likely as the two ‘raising awareness’ outcomes.

Again at both waves, those who considered the service appropriate were more likely to perceive this as a potential outcome than those who were opposed or unsure. At Wave 2, the younger age groups (16-24; 0.8, 25-34; 0.7) are more positive.

**Encourages unprotected sex**

This was the only negative impact presented to respondents and it stemmed from the qualitative findings.

The majority of respondents considered that this outcome was not highly likely (W1 0.2, W2 0.2). There were no gender differences.

At both waves those respondents in the age 66+ category were more likely to rate the service as encouraging unprotected sex than all other age categories (significantly at Wave 1).

<table>
<thead>
<tr>
<th>Mean score</th>
<th>16 – 24 yrs</th>
<th>25 – 34 yrs</th>
<th>35 – 50 yrs</th>
<th>51 – 65 yrs</th>
<th>66+ yrs</th>
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<td>-0.2</td>
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</tbody>
</table>

Likelihood of encouraging unprotected sex by age. Base: 718 W1, 716 W2 (Local)
Asians and Non-British White respondents also gave a significantly more negative mean rating than White British at both waves, as did Blacks at Wave 2:

<table>
<thead>
<tr>
<th>Mean score</th>
<th>White British</th>
<th>Irish</th>
<th>Other White</th>
<th>Mixed</th>
<th>Asian</th>
<th>Black</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
<td>W1</td>
<td>-0.3</td>
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<td>-0.3</td>
<td>0.1</td>
<td>0.1</td>
<td>-0.1</td>
</tr>
</tbody>
</table>

Likelihood of encouraging unprotected sex by ethnicity Base: 718 W1, 716 W2 (Local).
Locations deemed appropriate for offering chlamydia test kits (local survey only)

Respondents in the local survey were asked where else it would be appropriate to offer chlamydia test kits. This was an open question and responses were coded based on possible locations that stemmed from the qualitative research.

Over half of all respondents (W1 52%, W2 58%) considered GP surgeries as appropriate venues to offer chlamydia test kits to 16-24 year olds.

Respondents appear to have been able to give an answer/location at Wave 2, (DK/nothing, 2%) coupled with a general increase for each location, compared with Wave 1, potentially suggesting that greater ‘access’ to test kits is appropriate.

Appropriate locations for testing. Base: 718 W1, 716 W2 (Local)

Females were significantly more likely to suggest family planning clinics and well woman clinics than males at both waves.
At Wave 1, those aged 35-50 (53%) were significantly more likely to mention family planning clinics as appropriate locations for testing than those aged 16-24 (34%) and 25-34 (39%). Additionally, those aged 51-65 (50%) were significantly more likely than those aged 16-24 (34%) to state that family planning clinics are appropriate locations for testing. At Wave 2, these differences did not exist.

Those aged 16-24 (40%) at Wave 1 were significantly more likely than those aged 66+ (19%) to state that colleges were an appropriate location for offering chlamydia test kits. Similarly 16-24 (36%) were more likely to mention schools as an appropriate location to offer chlamydia test kits than those aged 25-34 (22%), 35-50 (21%) and 66+ (17%).

At Wave 2, 25-34 (40%) and 35-50 (41%) were also more likely to state colleges than older respondents (51-65 33%; 66+ 24%).

At Wave 1, white British respondents were significantly more likely (55%) to feel that a GP surgery was appropriate for offering chlamydia test kits than those of any other white origin (39%). At Wave 2, again these differences have disappeared, and all white respondents have similar likely levels.

At Wave 1, those who were Asian were significantly less likely (26%) to state that family planning clinics were appropriate locations to offer 16-24 year olds chlamydia test kits than Black respondents (50%) and British respondents (49%). At Wave 2, this pattern exists but not at significant levels (Asian 28%, Black 43%, British 41%).
Chemist chain most frequented

At Wave 2, some additional questioning was included to incorporate some specific areas. One open question asked ‘which chain of high street chemist/pharmacist do you shop at most frequently?’

Chain of high street chemist frequented. Base: Local W2 716, National W2 1947 (%’s in brackets represent 16-24 year olds)

Boots appears to dominate the market place in terms of high street chemists most frequented, followed by Superdrug. This is likely to reflect the respective chemists covered in the greater London area in particular and nationwide generally.

In the local survey, gender or age show no major differences of shopping habits. However, by social class, Boots appears to attract a ‘higher’ (A 62%, B 49%) social class of shopper, whereas Superdrug attracts a ‘lower’ class (D 33%, E 26%). By ethnicity there are no major differences.

In the national survey, older (66+ years) are less likely to shop most frequently at Boots (30% vs 45% total) and more likely at an independent pharmacy (22% vs 13% total).
Analysis by the 16-24 year olds (see % figures in brackets in above chart) are relatively similar to the total. Key differences include the marginally higher usage of Boots and Superdrug in both the local and national surveys, with a lower level using independent pharmacies.

Social class differences appear to affect shopping habits. Boots attracts the ‘higher’ social classes (A 68%, B 50% vs 45% total) with Lloyds attracting the ‘lower’ classes (D 10%, E 13% vs 8% total), with many claiming not to visit a high street chemist (D 17%, E 18% vs 10% total).
Knowledge of others using Boots screening service

An additional question added in both local and national surveys for Wave 2 was ‘Do you know of anyone who has used the Boots free chlamydia testing service?’

In both surveys levels were low local 3%, national 1%. As could probably be expected, greater knowledge of others using is amongst the 16-24 years age group – the key target audience – for both surveys (local 6%, national 4%).

Again, in both surveys, the levels are also higher amongst those perceived at risk (local 5%, national 7%) and those aware of the service (local 10%, national 4%).
Finally, one last additional question was included in both local and national surveys at Wave 2, about the respondent’s sexual orientation (asked via a show card).

Description of sexual orientation: Local W2 716, National W2 1947

The vast majority of respondents in both surveys are heterosexual/straight (local 89%, national 86%), although a few ‘preferred not to say’ (local 7%, national 12%).
(1) Trends in selected STIs: 1991-2001


(3) HPA, Epidemiological Data, 2004

(4) Summary and conclusions of CMO’s Expert Advisory Group on chlamydia


Appendix

Local population survey/Wave 2

SQ1 Gender (to quota)
- Male
- Female

SQ2 Age (to quota)
- Under 16 – CLOSE
- 16-24
- 25-34
- 35-50
- 51-65
- 66+

SQ3 Ethnicity (to quota)
- List

SQ4 Social class (to quota)
- A
- B
- C1
- C2
- D
- E
(Social class questions)

1. Which of the following sexually transmitted infections have you heard of before today?
   Show list to respondents
   - Gonorrhoea
   - Chlamydia
   - Syphilis
   - AIDS
   - HIV
   - Genital warts
   - Genital herpes
   - Hepatitis B
   - Pubic lice
   - Bacterial vaginosis
   - Other – please specify

2. Where can people go to get tested for sexually transmitted infections?
   Spontaneous first then show list to respondent
   - GP
   - Hospital clinic (e.g. GUM)
   - Hospital A&E
   - Family Planning Clinic
   - NHS drop in health centre
   - Retail chemist/pharmacist
   - Well woman/man clinic
3. Which of the following statements do you think apply to chlamydia?
Please tick all that apply

- The signs and symptoms of chlamydia can include discharge and abdominal pain
- The majority of people with chlamydia have no signs or symptoms
- Chlamydia can be spread by sharing towels with an infected person
- Chlamydia rates in the UK are increasing faster than for other sexually transmitted infection
- Untreated chlamydia does not lead to any long term complications
- You can catch chlamydia by sharing a glass with an infected person
- Both men and women can be infected with chlamydia
- Treatment for chlamydia is simple and effective
- Chlamydia is more prevalent amongst younger people

4. To what extent do you think you are personally at risk of chlamydia?

- Very high risk
- Quite high risk
- Quite low risk
- Very low risk

5. Are you aware that free chlamydia screening and treatment are available for 16-24 years olds in high street pharmacies across London?

- Yes – go to question 6
- No – go to description after question 7b

6. IF YES: How did you become aware of this free chlamydia screening initiative? Spontaneous – fit to code.

- Through advertising on radio/TV/newspapers etc
- Pharmacist or counter assistant
- In store promotion
- Other Health Care Professionals, e.g. GPs
- Friends/family

7a. What do you know about this initiative?

- Only testing for chlamydia
- Self testing
- Urine test
- No visit to NHS Clinic/GP required
- Available at Boots

7b. And has this prompted you to take any action yourself?

- Background reading/research (if specific, please indicate research undertaken in ‘other’ below e.g. via internet)
- Talk/discuss/ask pharmacy advice
- Visit GP
- Visit GUM clinic/specialist service
- Ask/pick up a kit from Boots
- Ask/pick up a kit from Boots & undertake the screening test
- Other (please specify)
- No/nothing/no action
From November 2005, screening/testing kits for chlamydia have been available, for free, from Boots pharmacies in the London area for all 16-24 year olds. Those who pick the kit up can test themselves in privacy (using a simple urine sample test), take the kit back to the pharmacist who then sends it away for testing. Customers are informed of their result within 7 days. If the result is positive, the person is informed and they are able to collect the treatment from any participating pharmacy.

8. In your view is free screening and treatment of chlamydia an acceptable service for high street chemists to provide?
   - Yes
   - No
   - Not sure

9. What are the advantages of such an initiative?
   OPEN: Take up to 3 responses/top of mind (i.e. Record order)

10. What are the disadvantages of such an initiative?
    OPEN: Take up to 3 responses/top of mind (i.e. Record order)

11. Rank the following in order of importance, in order for this service to be a success:
    - Private consultation area within store
    - In store toilet
    - Complete confidentiality
    - Reliable results
    - Helpful, knowledgeable staff
    - Convenience of store location
    - No need for appointment/easily accessible

12. How confidential would you perceive screening of chlamydia to be through a pharmacy compared with the following screening locations?

<table>
<thead>
<tr>
<th></th>
<th>Less confidential</th>
<th>Equally confidential</th>
<th>More confidential</th>
<th>Unsure</th>
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<tbody>
<tr>
<td>Hospital clinic (e.g. GUM)</td>
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<td>GP</td>
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<tr>
<td>Family planning clinic/</td>
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<td>Contraceptive service</td>
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<tr>
<td>NHS drop in health centre</td>
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</tbody>
</table>

13. How reliable would you perceive the results of chlamydia testing to be through a pharmacy compared with the following locations?

|                                  | Less reliable | Equally reliable | More reliable | Unsure |
|----------------------------------|              |                 |              |        |
| Hospital clinic (e.g. GUM)       |              |                 |              |        |
| GP                               |              |                 |              |        |
| Family planning clinic/          |              |                 |              |        |
| Contraceptive service            |              |                 |              |        |
| NHS drop in health centre        |              |                 |              |        |
14. What factors do you think may prevent someone from taking a test in a retail pharmacy? Please rank these 6 in order of likelihood to prevent

Embarrassment
Lack of confidence in the results
Denial of being at risk
Busy pharmacy/lack of privacy
Prefer to see a different health care professional such as GP or nurse
Concerns over confidentiality

15. How confident are you that this service will succeed?

Very confident
Relatively confident
Neutral
Relatively unconfident
Very unconfident

16. On a scale of 1 to 5 where 1 is very unlikely and 5 is very likely, how likely is it that the chlamydia testing initiative will:

Encourage unprotected sex 1 2 3 4 5
Decrease the number of cases of chlamydia in 16-24 year olds 1 2 3 4 5
Increase awareness of chlamydia 1 2 3 4 5
Increase awareness of sexually transmitted infections 1 2 3 4 5

17a. Other than retail pharmacies, what other locations do you feel are appropriate to offer 16-24 year olds chlamydia test kits?

Do not read aloud

Schools
Colleges
Family planning clinics
Well women/man clinics
GPs
Youth clubs
Places of work
Other _____________________

17b. Which chain of high street chemist/pharmacist do you shop at most frequently? Read Out

Alliance Unichem/Unichem
Boots
Lloyds
Moss
Superdrug
Supermarket pharmacy
Independent pharmacy
Other _____________________

18. Have you ever been screened for chlamydia?

Never
Within the last 6 months
7-12 months ago
Over 12 months ago
19a. (If respondent has been screened, i.e. not ‘never’ at Q18) Where were you screened?

- GP
- Hospital clinic (e.g. GUM)
- Hospital A&E
- Family Planning Clinic
- NHS drop in health centre
- Retail chemist/pharmacist
- Well woman/man clinic

19b. (If respondent stated retail chemist/pharmacist) Which retail chemist/pharmacist were you screened at?

- Alliance Unichem/Unichem
- Boots
- Lloyds
- Moss
- Superdrug
- Supermarket pharmacy
- Independent pharmacy
- Other_____________________

20. Do you know of anyone who has used the Boots free chlamydia testing service?

- Yes
- No
- DK/not sure

21. How would you describe your sexual orientation? Show Card

- A) Heterosexual/straight
- B) Bisexual
- C) Gay man
- D) Gay woman/lesbian
- E) Other
- F) Prefer not to say

Thank and close
Consumer perspective: National survey (chlamydia 125331)/WAVE 2

1. Which of the following sexually transmitted infections have you heard of before today? Show list to respondents (randomise)

Gonorrhoea
Chlamydia
Syphilis
AIDS
HIV
Genital warts
Genital herpes
Hepatitis B
Pubic lice
Bacterial vaginosis
Other – please specify

2. Which of the following statements do you think apply to chlamydia? Please tick all that apply (randomise)

The signs and symptoms of chlamydia can include discharge and abdominal pain
The majority of people with chlamydia have no signs or symptoms
Chlamydia can be spread by sharing towels with an infected person
Chlamydia rates in the UK are increasing faster than for other sexually transmitted infections
Untreated chlamydia does not lead to any long term complications
You can catch chlamydia by sharing a glass with an infected person
Both men and women can be infected with chlamydia
Treatment for chlamydia is simple and effective
Chlamydia is more prevalent amongst younger people

3. To what extent do you think you are personally at risk of chlamydia?

Very high risk
Quite high risk
Quite low risk
Very low risk

4a. Are you aware that free chlamydia screening and treatment are available for 16-24 years olds in high street pharmacies across London?

Yes
No

4b. IF YES: And has this prompted you to take any action yourself? Do not read out

Background reading/research (if specific, please indicate research undertaken in ‘other’ below e.g. via internet)
Talk/discuss/ask pharmacy advice
Visit GP
Visit GUM clinic/specialist service
Ask/pick up a kit from Boots
Ask/pick up a kit & undertake the screening test
Other (please specify)
No/nothing/no action
5. In your view is free screening and treatment of chlamydia an acceptable service for high street chemists to provide?
   Yes
   No
   Not sure

6. To what extent do you agree that free screening and treatment of chlamydia for 16-24 years olds via high street chemists is a good use of public (or NHS) money?
   Strongly disagree
   Slightly disagree
   Neither agree nor disagree
   Slightly agree
   Strongly agree

From November 2005, screening/testing kits for chlamydia have been available, for free, from Boots pharmacies in the London area for all 16-24 year olds. Those who pick the kit up can test themselves in privacy (using a simple urine sample test), take the kit back to the pharmacist who then sends it away for testing. Customers are informed of their result within 7 days. If the result is positive, the person is informed and they are able to collect the treatment from any participating pharmacy. If this initiative proves to be effective, it will be rolled out over time across the whole of the UK.

7. What are the advantages of such an initiative?
   OPEN: Take up to 3 responses/top of mind (i.e. in order)

8. What are the disadvantages of such an initiative?
   OPEN: Take up to 3 responses/top of mind (i.e. in order)

9. Rank the following in order of importance, in order for this service to be a success:
   Private consultation area within store
   In store toilet
   Complete confidentiality
   Reliable results
   Helpful, knowledgeable staff
   Convenience of store location
   No need for appointment/easily accessible

10. How confidential would you perceive screening of chlamydia to be through a pharmacy compared with the following screening locations?

<table>
<thead>
<tr>
<th></th>
<th>Less confidential</th>
<th>Equally confidential</th>
<th>More confidential</th>
<th>Unsure</th>
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<tbody>
<tr>
<td>Hospital clinic (e.g. GUM)</td>
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<td>Family planning clinic/contraceptive service</td>
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<tr>
<td>NHS drop in health centre</td>
<td></td>
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</tr>
</tbody>
</table>
11a. How reliable would you perceive the results of chlamydia testing to be through a pharmacy compared with the following locations?

<table>
<thead>
<tr>
<th>Location</th>
<th>Less reliable</th>
<th>Equally reliable</th>
<th>More reliable</th>
<th>Unsure</th>
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<tbody>
<tr>
<td>Hospital clinic (e.g. GUM)</td>
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<tr>
<td>NHS drop in health centre</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

11b. Which chain of high street chemist/pharmacist do you shop at most frequently? Read Out

- Alliance Unichem/Unichem
- Boots
- Lloyds
- Moss
- Superdrug
- Supermarket pharmacy
- Independent pharmacy
- Other _______________________

12a. Have you ever been screened for chlamydia? (Don’t ask – show screen to respondent).

- Never
- Within the last 6 months
- 7-12 months ago
- Over 12 months ago

12b. If respondent has been screened, i.e. not ‘never’ at Q12a) Where were you screened?

- GP
- Hospital clinic (e.g. GUM)
- Hospital A&E
- Family Planning Clinic
- NHS drop in health centre
- Retail chemist/pharmacist
- Well woman/man clinic

12c. If respondent stated retail chemist/pharmacist) Which retail chemist/pharmacist were you screened at?

- Alliance Unichem/Unichem
- Boots
- Lloyds
- Moss
- Superdrug
- Supermarket pharmacy
- Independent pharmacy
- Other _______________________

13. Do you know of anyone who has used the Boots free chlamydia testing service?

- Yes
- No
- DK/not sure
14. How would you describe your sexual orientation? Show Card

A) Heterosexual/straight  
B) Bisexual  
C) Gay man  
D) Gay woman/lesbian  
E) Other  
F) Prefer not to say

Thank and close
Questions used to determine Social class of respondents.

Working status of Chief Income Earner (CIE)

1. Employed
2. Self-employed
3. Not working, dependent on state benefit
4. Not working, other income

Collect occupation or previous occupation details of CIE

What is the type of firm where the CIE works?

What is the job actually done by the CIE?

What is the title, rank, grade, etc of the CIE?

How many people work there altogether?

How many is the CIE responsible for?

Does the CIE have any qualifications (such as apprenticeships, professional qualifications, university degrees, diplomas etc.)?

1. Yes
2. No

Enter qualifications
Appendix 4: Boots employee perspective
Chlamydia screening evaluation:
Boots employee perspective

Report prepared by TNS Healthcare for:
The Department of Health

125331 March 2007

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## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>212</td>
</tr>
<tr>
<td>BACKGROUND</td>
<td>214</td>
</tr>
<tr>
<td>METHODOLOGY</td>
<td>216</td>
</tr>
<tr>
<td>FINDINGS</td>
<td>217</td>
</tr>
<tr>
<td>KNOWLEDGE AND UNDERSTANDING OF CHLAMYDIA</td>
<td>218</td>
</tr>
<tr>
<td>KNOWLEDGE AND UNDERSTANDING OF THE PCSPF</td>
<td>221</td>
</tr>
<tr>
<td>PERCEPTIONS OF PCSPF TRAINING</td>
<td>223</td>
</tr>
<tr>
<td>IMPACT OF PCSPF ON WORKLOAD</td>
<td>225</td>
</tr>
<tr>
<td>TYPICAL CUSTOMER EXPERIENCES</td>
<td>227</td>
</tr>
<tr>
<td>PERCEIVED STRENGTHS AND WEAKNESSES OF PCSPF</td>
<td>233</td>
</tr>
<tr>
<td>SUGGESTED SERVICE IMPROVEMENTS</td>
<td>239</td>
</tr>
<tr>
<td>RELATIONSHIP WITH THE CSO</td>
<td>241</td>
</tr>
<tr>
<td>UNDERSTANDING OF THE INDEPENDENT EVALUATION</td>
<td>243</td>
</tr>
<tr>
<td>APPENDIX A: RECRUITMENT QUESTIONNAIRE</td>
<td>245</td>
</tr>
<tr>
<td>APPENDIX B: DISCUSSION GUIDE</td>
<td>249</td>
</tr>
</tbody>
</table>
Executive summary

Background

This research formed one component of the longitudinal evaluation of the Pharmacy Chlamydia Screening Pathfinder. Sixteen telephone depth interviews were undertaken with Boots employees based in different stores. Each respondent had been involved in the Pharmacy Chlamydia Screening Pathfinder service by supplying screening kits, providing treatment or both.

Methodology

Sixteen respondents, all Boots employees, participated in telephone depth interviews. Each interview lasted for up to one hour.

Aims

The aim was to explore perceptions of the Pharmacy Chlamydia Screening Pathfinder from the perspective of staff on the shop floor. In particular, the aim was to explore perceptions of the strengths, limitations and any scope for improvement. These insights can then inform the decision on whether, and how, to roll out the programme nationally.

Findings

The Boots respondents showed high levels of knowledge of chlamydia, particularly in terms of ages at risk, symptoms and long-term effects. Pharmacists tended to show a more detailed understanding than non-pharmacists, although knowledge levels overall were good. Respondents were less aware that ethnicity and social class are also risk factors.

Respondents were generally very knowledgeable about the PCSPf, particularly around the role played by Boots, and their own individual responsibilities. Respondents were far less knowledgeable about the role and involvement of external agencies such as the CSO and the independent evaluation.

Respondents were generally very pleased with the training they had received, which was considered comprehensive and detailed. It was considered to have a good balance between written information and face to face training. Some concerns were raised about the process for cascading training, and whether any groups of employees might miss out, such as new joiners, locum pharmacists and Saturday staff. Some concerns were also raised regarding more refresher training, since some staff have few PCSPf customers and have not had much experience of putting the training into practice. In these circumstances it was considered easy to forget aspects of the original training, hence the need for updates.
Pharmacists were proactively offering kits when women attended for emergency contraception; otherwise the kits were given when requested. Customers are described as appearing embarrassed (which is in line with customers' own data) and respondents spoke of the need to deal with customers sensitively, to go somewhere private etc.

Potential customers who are too old for PCSPf tended to be offered private kits and told of NHS service; in one or two instances they were told of the private kits only.

Respondents were generally very positive about the initiative, although they could identify both strengths and weaknesses. Strengths included accessibility, no stigma, no charge and open to partners. It was also suggested that it enhanced the role of pharmacists. Weaknesses included that it is a chlamydia only screen, that there is low awareness and that the age band is restrictive. Suggested service improvements included wider use of vouchers and free condoms.

The relationship with the CSO varied between respondents – some respondents had never contacted, while others had. However, contact had been about the non-receipt of test results, which is an inappropriate reason to contact the CSO.

These responses confirm the confusion that was evident in the interviews with CSO employees, in that some Boots staff believe that the CSO has access to all results, not just the positives. This suggests the role of the CSO should be better explained to Boots employees.

Knowledge of the independent evaluation also varied. Some respondents were aware of the screening and treatment evaluations questionnaires and had spontaneously made reference to giving them to customers. Others were less sure about the questionnaires or whether they gave them to customers.
Background

The Department of Health is currently evaluating the potential role of retail pharmacies in chlamydia screening. A pilot scheme (the Pharmacy Chlamydia Screening Pathfinder or PCSP) was launched in November 2005 within the M25 via Boots’ retail chain. 16-24 year olds can collect a free test kit for use at home or in pharmacy, which they then return to the pharmacy. Users are subsequently notified of their test results (positive results are actioned by the Chlamydia Screening Office and negative by Boots) and users with positive results have the option of returning to Boots for treatment.

The findings from the pilot scheme evaluation will subsequently be used to inform the decision on whether to launch a national pharmacy chlamydia screening service. The independent evaluation is an 18-month research programme involving:

- Pre-service
  - Qualitative focus groups to establish general awareness levels of sexually transmitted infections (STIs) and chlamydia in particular, as well as acceptability of the proposed screening service
  - A local population (within the same area as the pilot service) survey to understand the impact of the service on this group
  - A national population survey to measure attitudes towards chlamydia screening and the barriers to use

- During the service
  - Repeats of the local and national population surveys to track changes in views once the screening service is in operation
  - Ongoing evaluation of the screening and treatment service to monitor who is using the service and their evaluation of the scheme
  - In-depth interviews with service users, Boots employees and appropriate healthcare professionals/PCT staff.
  - An economic analysis of the cost benefit to the Department of Health in rolling out the chlamydia screening service on a national basis

The findings from the interviews with Boots employees are reported here.
Objectives

The primary purpose of interviewing Boots employees was to establish, from their perspective, the feasibility of offering chlamydia screening via a high street pharmacy:

Specific secondary objectives were to address the following:

- Knowledge and understanding of chlamydia
- Knowledge and understanding of the chlamydia screening initiative
- Awareness of segments of the population most at risk
- Perceptions of the training provided on PCSP
- Ease of implementing the screening process including any perceived barriers or facilitators
- Exploration of any concerns about the screening process
- Interactions with service users, and the typical customer experience
- Likelihood to proactively offer a screening kit
- Issues around screen-outs e.g. advice to the over age
- Working arrangements with CSO
- Suggested improvements to the current service
- Understanding of the independent evaluation
Methodology

Design

Sixteen telephone depth interviews were undertaken, as follows:

<table>
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<th>16 telephone depth interviews</th>
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<td>6 depths with non-pharmacists</td>
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<tr>
<td>- Dispensers and pharmacy assistants</td>
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<tr>
<td>10 depths with pharmacists</td>
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</table>

Sample

Boots area managers asked if staff wanted to volunteer for the study.

Staff volunteered from a number of different stores, and there was no sense that staff had either been ‘cherry picked’ or pressured into taking part.

Respondents were interviewed in their own time. This mainly included interviews undertaken in the evenings and on days off, and also some interviews undertaken during the lunch hour.

Ethical Issues

Respondents were assured of anonymity and confidentiality. The names of participating respondents are not included and no quotes or statements are directly attributable to any individual. No information is included that would identify the store.

Respondents were offered an incentive for their participation.

Fieldwork

Interviews took place in February 2007.

Each interview lasted up to one hour. Pharmacists tended to speak for longer than non-pharmacists, where they had been involved in both screening and treating.

A copy of the discussion guide is included in Appendix B.

Analysis

Each interview was audio-recorded, thematically analysed and interpreted.
Findings

The findings are reported under the following themes:

- Knowledge/understanding of chlamydia
- Knowledge/understanding of the chlamydia screening initiative
- Perceptions of the PCSPf training
- Impact of PCSPf on workload
- Typical customer experiences
- Perceived strengths and weaknesses of the PCSPf
- Suggested service improvements
- Relationship with CSO
- Understanding of the independent evaluation
Knowledge and understanding of chlamydia

Respondents overall showed high levels of knowledge and understanding of chlamydia.

When asked what chlamydia is, most respondents rapidly identified it as a sexually transmitted disease that can affect both males and females. Many added that it may not have any signs or symptoms, that younger people are most at risk and that it can cause long term complications.

“Under 24 are the largest age group. I don’t think there is any difference between men and women but obviously it causes problems in women in later life.” Pharmacist

“The disease itself is bacterial in origin, it has symptoms but certainly has no immediate symptoms so that’s why it can come and go undiagnosed for a while. The symptoms that become apparent later on are pelvic pain, and a little bit of bleeding and sometimes joint pain….sometimes there can be conjunctivitis. It can be transmitted though oral and vaginal intercourse but it can’t be transmitted thought saliva. It is more likely in 19-24 year olds…it is most likely to cause complications in the younger age groups.” Pharmacist

“It’s spreading highly within the community – this is one way of preventing worldwide spread, between the ages of 16-24 in young women and older men.” Pharmacist

“In ladies there may be pelvic or abdominal pain, discharge, pain on passing urine” Pharmacist

“The most common STD” Pharmacist

Wide ranging complications if left untreated...inflamed scrotum in men, discharge in both sexes, lower abdominal pain.” Pharmacist

“No symptoms unless untreated for a long time” Pharmacist

“Symptoms if left untreated are similar to symptoms of other STDs” Pharmacist

“No associated complications in men other than they can pass it on” Non-pharmacist

“Most people are unaware they have chlamydia until they experience problems in trying to conceive.” Pharmacist

“Pain in the scrotom” Pharmacist

Several respondents spontaneously cited less common facts about chlamydia:

“It can cause cervical cancer in women.” Non-pharmacist
“Complications include eye infections and lung infections” Pharmacist

Several respondent spontaneously mentioned prevalence, or knew when asked. 10% was the only cited prevalence rate:

“One in 10 youngsters have it” Non-pharmacist

“One in ten people in this age group in London have chlamydia” Pharmacist

One respondent stated that rates of chlamydia infections have decreased since the beginning of the Boots initiative (Non pharmacist)

Some respondents said that they did not know much about chlamydia before the PCSPf began:

“I didn’t know that much about it until Boots did their in-house training, there was a training booklet that came with it and then we had group training.” Non-pharmacist

Only one respondent claimed to know very little about the disease.

“To be honest not much at all” Non-pharmacist

One respondent stated that she had done additional reading on chlamydia after the official training, by searching on the Internet.

Overall respondents were generally extremely good at recognising that chlamydia is widespread, is frequently symptom free and can result in long term complications.

A few respondents appeared to assume that the presence of any signs or symptoms indicated that the patient must have had chlamydia for a long time.

Respondents were probed on the demography of chlamydia. Whilst they quickly identified that young people were at greater risk than older people, they found it more difficult to identify other demographic high-risk groups, other than anyone having unprotected sex, and particularly those with multiple partners. Respondents often added that people of any age could contract chlamydia, although younger people are at greater risk. One person cited homosexuals as being at greater risk than heterosexual.

Discussions on the relationship between social class or ethnicity and risk of chlamydia tended to arise only in response to direct probes. There was often some uncertainly about the relationship between social class and risk, or ethnicity and risk.

“Education is important ...I can’t remember the statistics” Pharmacist
“There’s not relationship with social class or ethnicity…..well lower social classes may be less well educated and less aware. Higher social classes are more aware, more likely to read about in the newspaper….” Pharmacist

Where probed, many respondents did not identify any particular ethnic groups as being at higher risk; others stated that Black Africans and Caribbean were at more risk.

In summary, respondents knew that there may or may not be symptoms, considered chlamydia to be more serious among women, and identified younger people having unprotected sex, or multiple sexual partners as being at greatest risk.

The impact on overall workload was generally considered slight. Those who raised most concerns here were pharmacists, and their concerns were in relation to treating positive clients. Pharmacists may be busy dispensing and also expected to treat a positive customer who arrives for treatment. Because treatment takes 30 minutes or so, the customer is either kept waiting or the dispensing falls behind.

Respondents agreed that they had seen mainly older, female customers. This perception is supported by the service uptake data. Customers are described as appearing shy or awkward, and the respondents spoke of the need to talk to them in a private area. Customers typically arrive alone, although pairs are not uncommon and occasionally groups of people. Boots staff typically spoke of feeling very confident in dealing with PCSPf customers. Respondents were broadly consistent in the process they described, and all said that they would ask a customers age. It seems that not all of the respondents always ask about health, something that was also found in the mystery shopping exercise.

Respondents were also inconsistent regarding the time period in which they told customers to expect their results, which ranged from 3 to 7 days.

Stores with toilets were felt to offer an advantage in terms of collecting specimens, although interestingly the customer data shows that customers do not select stores that have toilet facilities.
Knowledge and understanding of the PCSPf

Boots employees showed a good understanding of the chlamydia initiative. It should be remembered that all respondents volunteered to talk about the initiative.

Almost all respondents summarised that the initiative provides free chlamydia screening for 16-24 year olds, that service users collect and return a screening kit and that they receive their test results several days later.

Respondents generally commented that the overall aim was to protect people from chlamydia and to raise awareness about chlamydia.

“To keep teenagers informed of the risks of unprotected sex” Non-pharmacist

“Raising awareness of the disease” Pharmacist

“It gives information about general sexual health” Non-pharmacist

Some respondents also mentioned …

“It’s a pathfinder service, it’s a tender and Boots made a bid for it and they won, if that’s the word to use” Pharmacist

“It’s an NHS London based initiative that is being trialled by Boots in the London area” Pharmacist

“A pilot scheme being run in London for the NHS” Non-pharmacist

“A trial for the Department of Health for 2 years” Pharmacist

“Gives Boots a high profile” Non-pharmacist

Respondents spontaneously mentioned as key facts, the age range that the service addresses and the fact that there is no charge.

“Open to 16-24 year olds with no symptoms, otherwise they have to go to their GP” Non-pharmacist

“Free of charge” Pharmacist
Respondents also tended to refer to the detail of the service, for example highlighting time periods by which sample must be returned, or by which users receive their results

“People return the sample, must be afresh sample not more than 6 hours old” Pharmacist

“Must bring the urine sample in within 2 hours of producing it” Non-pharmacist

“Customer receives their result within 3-7 working days by text, telephone or letter. If it’s positive the CSO will talk to them and help” Pharmacist

“It requires them to disclose all their sexual partners if they get a positive result” Non-pharmacist

Overall, respondents appeared knowledgeable about the service and who it is intended for.

Some respondents referred to the pathfinder initiative and the pay-to-use service together, which may be of some concern:

“If 16-24 years then it’s free but outside that age group the test kit costs £25” Non-pharmacist

Likewise one respondent, when describing her customer interactions, subsequently stated that if a person was outside the age range, she would offer the £25 kit, and not suggest that they visited their GP or a GU clinic.
Perceptions of PCSPf training

Respondents reported that training course was provided by Boots to employees. Store staff attended the face-to-face training, (both pharmacists and other grades) who were then expected to cascade the training internally within their stores. Respondents reported the training as either one day or ½ day in length.

Perceptions of the training provided were generally very positive. Respondents typically remarked on the thoroughness of the training.

“There was a trainer workbook in advance and ‘what-if’ scenarios” Pharmacist

“We had to do a pack which was quite comprehensive on chlamydia. The we also had to do a 2 hour group session with the pharmacy manager on chlamydia, part of that group was to do with the paperwork that we have to do with the pack, because we have to do quite a lot of paperwork with the test. We then went to another session with other pharmacists and a group pharmacy manager, and then we had a test to make sure that we were totally up to standard.” Pharmacist

“The whole training was very comprehensive” Pharmacist

“We’ve spent a lot of time on training. Pharmacists have been pulled away to our training rooms in London and they’ve gone through the whole protocol, record keeping, chlamydia, what it is, customer service, how we check for eligibility, symptoms, sample and eventually the treating if there is a positive results.” Pharmacist

“There was a training booklet and then we had group training” Non-pharmacist

“For my purposes the training has been sufficient. We have mock patient consultations to do, because you know, pharmacists are new to consultations. We’re not used to one to one consultations with patients in an environment like a consultation room. We were shown videos and then observed by our area pharmacists and only those with enough knowledge were passed to the PGD and others had to redo and relearn and then be re-observed.” Pharmacist

“A half day at the Charing Cross Store” Non-pharmacist

There were some suggestions that the training could have been more thorough for specific groups of staff, although these were made by a small minority of respondents:

“It could have been more intensive for the assistants because we’re not the only port of call. Quite often patients will talk over the counter rather than see a pharmacist” Pharmacist
It was also stressed that it is not only the pharmacists who must know about the screening programme:

“Dispensers give them out and HCA’s. And Saturday staff” Pharmacist

It was therefore seen as important that the training covered everyone. Some pharmacists spoke of their role in cascading the information back at the store. These pharmacists spoke of training counter staff in such aspects as knowledge of the disease, questions to ask about health, how to check for eligibility, giving information booklets to customers, being discreet and referring to pharmacist if experiencing symptoms or outside age range.

The first big question around the training were concerns about how well it reaches everyone that it needs to know, for example, new staff and Saturday staff. Locum pharmacists were also highlighted as people who should be trained about the service:

“That’s a personal concern. 90% of pharmacists are locums. How will they approach a client. And the client views them as a member of staff” Pharmacist

The second main point was that ‘top up training’ would be beneficial.

“It needs reinforcing every now and then” Pharmacist

Those who mentioned ‘top up training’ commented that there was a lot to take on board initially and the training may not be put into practice frequently, so it was easy to forget things.

“If I had to treat someone I would look back to make sure” Pharmacist

“I didn’t come across one for six months and had to revisit the training” Pharmacist

“Top up is always necessary a few months down the line – top up is useful” Pharmacist
Impact of PCSPf on Workload

PCSPf does not add greatly to overall workload; however, it can be difficult for pharmacists to treat a positive customer and also remain on schedule with dispensing. In this situation the customer may be asked to wait or return.

All respondents who had been involved in treatments agreed that it takes longer to treat a customer than to issue a kit. The actual estimates of time spent at the three different stages were broadly consistent.

- **Time required to give the kit**

All respondents were asked how long it took to issue a screening kit.

“No more than 10 minutes. I would say on average between 5 and 7 minutes. Explaining to them what they need to do, showing them the form and then ringing it through the till.”

Pharmacist

“The very least it would take is about 6-7 minutes, but on average I would say a good 10-12 minutes” Pharmacist

“You just have to ask them their age, check they don’t have any obvious symptoms and then hand the kit out and explain how to pass the urine sample and how long you can keep it for. It takes between 2-5 minutes” Pharmacist

- **Time required to receive the sample**

This required the least amount of time, and minimum estimates were 2-3 minutes.

“That doesn’t take very long, about 6-7 minutes at the most” Pharmacist

“Once they return it we need to check the CRN number and that the details are filled out correctly and run it through the till. Then we put it in the fridge and the dispenser, at the end of the day, puts it into the wadding and into the bag ready for the driver. That will take about 5-10 minutes normally.” Pharmacist

- **Time required to treat a positive patient**

Treatment requires the most time, and there was broad agreement that this takes around 30 minutes, with pharmacists’ estimates varying from 15 minutes at the shortest up to 40 minutes.
"Treatment is the longest part of the process...minimum, I would say about 20 minutes, but it probably takes about 30 minutes for the full customer consultation." Pharmacist

"Treatment takes about 20-30 minutes. I find that takes the longest because you've got to explain the procedure to them, you have to check your list for any exclusion to antibiotic, then advise the customer on the treatments and any complaints. I actually find that this takes the longest." Pharmacist

Respondents had experience with varying numbers of customers. The number of kits given out in per store varied from between 2 per month to 9 per week, and individual respondents tended to personally give out slightly less.

The number of kits returned was lower than the number given out for all respondents.

The main issues associated with the chlamydia screening workload are remembering the sequence of actions (which appears more difficult for staff in stores that do not give out many kits) and finding enough time to spend with customers when pharmacists should also be dispensing.

“You can go a couple of weeks and not have one. That's the problem, it's quite infrequent, so the staff can struggle with the procedures when we do get one. It doesn't take up a lot of my time.” Pharmacist
Typical customer experiences

Respondents were all asked to talk through a typical screening or treatment customer experience, in terms of how the conversation is initiated, how it progresses and the characteristics of a typical customer.

- Initiating the conversation

In general respondents felt that the customer initiates the request for a chlamydia screening kit. However, several pharmacists said that they will use the opportunity, when providing emergency contraception, to raise the chlamydia screening service.

“The majority of my patients, that I see, are to do with the morning after pill so it is very easy to encourage them to take the test.” Pharmacist

“It (emergency contraception) is the biggest opportunity to highlight chlamydia. Pharmacist

“I say that it’s a “good idea to get checked out just in case.” Pharmacist

One pharmacist commented that a large percentage go away with a kit and another that those customers who decline are given a leaflet.

Respondents were typically less comfortable with the idea of raising the idea with individual customers outside of this context.

“It’s quite a sensitive subject, would you be implying something?” Pharmacist

- Typical screening interaction

Most respondents talked about the need to ask age and health status, although age was mentioned more readily. It appears that a few respondents did not enquire about health, as they only confirmed asking age.

“They tend to be 19, 20 and 21 both male and female. We have to ask their age because obviously they need to be within the age group, but that’s all I ask them.” Pharmacist

“I ask age and any obvious symptoms” Pharmacist

One pharmacist said that she usually asks:
“Are you well? Are you feeling alright?” Do you have any pain?” Pharmacist

Another pharmacist commented that she always makes a point of explaining why she is asking about symptoms. A non-pharmacist said that she says what the symptoms are.

Some respondents talk through how to use the kit in a fair degree of detail, and the 2 hour and 6 hour deadlines appear to be often mentioned.

“I go through the kit and explain that it needs to be at least 2 hours since they last went to the toilet, and that it must come back to the store within six hours” Pharmacist

“I bring out the kit and go through it step by step” Pharmacist

In addition to telling patients about the 2 and 6 hours, Boots staff may also explain to customers how to fill in the form.

One respondent stated that customers are told not to eat for 2 hours before producing the sample.

Some respondents spontaneously commented that they encourage the customers to return the kit.

One or two respondents referred to leaflets that they also provide with the kits.

The respondents appeared sensitive to customers’ emotional needs. One pharmacist commented that if the customer appears embarrassed then he tries to keep the consultation short and private. Another tells customers that chlamydia is common and simply to treat, and so there is nothing to be embarrassed or worried about. One non-pharmacist said she tells customers that she herself has had chlamydia, in order to help put them at ease. Another non-pharmacist spontaneously mentioned the need to always put the kit in a bag. One or two respondents said that they considered the customers to be quite brave in asking for the kit in a pharmacy. Another said that they always ask the customer if they are happy to talk in the area he has led them to, as there is no consultation room.

It seems that customers generally ask very few questions at this stage, although customers who are positive and return for treatment typically ask far more questions.

“We tell them far more than they tell us”. Non-pharmacist

Respondents differed in how soon they tell customers to expect results:
“3-5 days” Pharmacist

“4-5 days” Non-pharmacist

“3-7 days” x 2 Pharmacists

“Approximately 7 days” x 2 Pharmacists and 1 Non-pharmacist

One non-pharmacist said that the results take at least 2 weeks to come back.

- Typical return sample interaction

This was felt to be the simplest activity, and involves relatively little customer interaction. Staff talked of checking details with the customers e.g. contact details and date of birth, followed by ‘process’ activity e.g. putting sample in the fridge, completing the ‘fridge form’ and giving samples to the van driver the next day.

One pharmacist also checks with customers that the sample has been kept cool since it was produced.

Respondents commented that the number of returns is less than the number of kits given out. One respondent comment that about 75% of their kits were returned.

- Typical treatment interaction

Here patients appear to always be taken to a consultation or quiet area. The pharmacist checks on the computer that the customer does have a positive result.

Most pharmacists talked about checking for symptoms (in which case they refer to a GU clinic) and then prescribe azithromycin unless the patient is allergic in which case Oxycyclin is prescribed. Customers are told to abstain from sex for 7 days and provided with general sexual health advice. They are also told that their partner should be treated.

One pharmacist mentioned that they also tell treated customers that the antibiotic may reduce the efficacy of the oral contraceptive pill.

One pharmacist mentioned that he advises customers to contact all previous sexual partners within the last six months, and that it can be done anonymously using the CRN slips. One pharmacist also suggests that customers have a full sexual screening. One pharmacist spoke of giving vouchers for free condoms.
Another pharmacist mentioned that there had been a problem in treating a partner who had arrived with the CRN slip but not said that he was a partner. Boots staff believed that he was enquiring about a test result and it was only when he returned and explained that he was in fact a partner that he was treated.

- In-store facilities

Many respondents commented on how the presence or absence of in store facilities, such as a consultation area or a toilet, can impact on the customer interaction. Those stores without a consultation area try to find a more quite area to talk.

“It’s embarrassing to discuss something so personal in a public queue” Pharmacist

“Customers are concerned about being overheard” Non-pharmacist

“It would be better if there was a consultation room available” Non-pharmacist

Those stores with a consultation area use it to give out the chlamydia kit, in addition to treating customers.

Stores with toilets appear to be encouraging customers to supply a sample immediately, in the expectation that this will increase return rates.

“I try to convince customers to use the public loo and to return kits straight away to increase the % of returns” Pharmacist

“It would be better if we had an in-store toilet as people could use it to test straight away and we would probably get more back that way.” Pharmacist

- Typical customer

Respondents commented that ‘typical’ customers tend to be older and female.

It was felt that the majority of customers collect the kit by themselves, although sometimes in pairs and there have been occasions when groups of young people request the kit as two pharmacists mentioned that they sometimes have groups of friends asking for the kit, and one mentioned students arriving from a local college.

“Most people tend to come alone” Pharmacist

“Quite a few girls come in pairs” Pharmacist
“I haven’t seen many boys I must admit. They seem to come in pairs and they both want one and they usually giggle. I don’t know whether they are doing it for a laugh or whether it’s serious...I suppose its just nervousness.” Pharmacist

“19-24, young female and black” Pharmacist

Sometimes people want to collect the kit for others but the kit cannot be given out then.

Several respondents commented on customers appearing embarrassed or anxious. In case where customers have vouchers they do not have to ask for the kit by name, and customers without vouchers will sometimes point at the kit and ask for ‘one of those’.

“More women than men, looking embarrassed and shy.” Pharmacist

“You can spot the people who want one as they look nervous and shady” Non-pharmacist

- Out of age range

If customers are not aged within 16-24, respondents typically suggest alternative NHS services and the private kit too if they are over the age limit.

One pharmacist, for example, explained that he would provide details to 15 years olds about the local GUM clinic which also has a walk-in service, or suggest the GP. In the case of older customers he would also offer the private kit.

“I give them a card for the local GUM clinic or offer them a test kit for £25” Non-pharmacist

In one or two instances respondents seem to tell customers about the private screening kit, but not about alternative NHS services.

“If over 24 I tell them it will cost £25, but most are willing to pay as they see it as better than going to the GP” Non-pharmacist

- Confidence

Respondents were asked how confident they feel in dealing with customers in the initiative, and their confidence levels were very high with 9-10 frequently cited.

One pharmacist rated his confidence as 9, saying that if he gave out more tests then it would be 10.
"I feel confident in myself that I can deliver and answer any questions if they have any, and if not then I can look them up...about a 9 or 10.” Pharmacist

“I’m very confident, we’re very easy to talk to and very accessible” Pharmacist

“Initially a little nervous, so 3-4 but now 7-8” Pharmacist

This pharmacist also said that all it would take to reach ‘10’ would be a higher volume of customers.

Only one person, a non-pharmacist felt that she would benefit from more training, ‘a brush-up’ in order to feel more confident.

- Customer feedback

One non-pharmacist said that customers had thanked her for putting them at ease, and for taking them to taking them of the public eye to a private area.

In general respondents felt that the initiative had been well received, although there does not appear to have been much specific feedback.

One pharmacist noted that no negative feedback had been received.

“No problems so far – no difficult or aggressive customers” Pharmacist
Perceived strengths and weaknesses of PCSPf

The majority of respondents were absolutely in favour of offering a screening service in retail pharmacy, and could put forward a number of reasons why such screening was a positive health care initiative. One respondent was opposed to pharmacy based chlamydia screening and one was equivocal.

Strengths

- **Convenience**

  “It reaches more people. To go to a GUM clinic you actually have to go to a hospital. It is not out of your way, it’s on the high street” Pharmacist

  “You don’t have to make an appointment like you would with a doctor and we have all the information, that we can provide to people.” Pharmacist

  “I think if it is convenient people are more likely to use the service. The accessibility of it is attractive” Pharmacist

  The ones I’ve offered treatment to are very happy that they can come to us instead of having to wait hours in the GU clinic or wherever – I think it is the access they’re happy with.” Pharmacist

  “It’s seven days a week” Pharmacist

- **Anonymity/GP not informed**

  “I can understand them not wanting to go to their GP, same as their parents etc. This is anonymous” Pharmacist

  “More anonymous to go to a pharmacy than your own GP” Pharmacist

  “16-24 year olds may be concerned about talking to their GP as it’s probably been their family doctor since childhood.” Pharmacist

- **Less embarrassing**

Several respondents stated that using the service in Boots saved the embarrassment of going to either a clinic or to the GP.

  “People are ashamed to go the GUM clinic” Non-pharmacist
• Raises awareness of chlamydia and STI

  “It reaches more people” Pharmacist

• Long term health investment

  “As a cost benefit to the NHS, trying to treat the disease afterwards is a lot more expensive than screening for it.” Pharmacist

  “It prevents long term damage” Non-pharmacist

• Good for partners

  “Partners benefit – partners can be any age and still benefit from free treatment.” Pharmacist

• Good for Boots

  One or two respondents suggested that it was good for Boots’ reputation and business overall.

• Good for pharmacists

  “For a start it increases our professionalism. I’m more interested in the treatment...5-10 years ago you wouldn’t have dreamt of providing antibiotics over the counter but it increases our service.” Pharmacist

  “It links in with the new contract” Pharmacist

• Long term decrease in chlamydia rates

  A potential long term decline in chlamydia and other sexually transmitted infections was also cited as a strength of the scheme.

Weaknesses

Respondents could also identify weaknesses or areas for improvement in the PCSPf.

• Chlamydia only screen

  “Any one that is sexually active is going to be exposed to a lot of other sexually transmitted diseases, not just chlamydia. I think that is a limitation of the service.” Pharmacist
“I think young patients think it is a full screen, although we explain that it’s only for chlamydia, because they don’t have the knowledge to understand.” Pharmacist

“I don’t know the cost implications for a full screen but if it can be made available then it should be.” Pharmacist

“They have to go to a clinic for other tests” Pharmacist

One or two respondents queried whether screening only for chlamydia was actually cost effective.

- Age range is too narrow

A number of respondents raised concerns about the upper age limit. Some suggested that the upper age should be raised, and one that there should not be an upper age.

“I think the 24 age could be lifted to 27. Maybe if you raised it to 26 you would still capture those people that are still single” Pharmacist

“I think this would benefit anyone under the age of 30. We had quite a few people in that age bracket, that don’t qualify, and we seem to get more of them than the teenagers.” Pharmacist

“Sixteen and over would be fair” Pharmacist

“A lot come in out of range. It would benefit people up to 30, a lot of 25, 26 and 27 year olds are coming forward.” Pharmacist

“It should be freely available to all age groups not just 16-24 as they are not the only ones who are promiscuous. I’ve sold quite a lot of kits to ‘ladies who lunch’ which really makes you wonder what they get up to in the afternoon.” Non-pharmacist

Another suggestion was to exclude 16 and 17 years olds and make the upper age limit 26 or 27 years. The reasons for wanting to see the upper age changed related to current demand i.e. older people are currently being turned away and fairness e.g. older people would be screened if they attended a clinic. In addition it was pointed out that older people are also sexually active. Nobody who suggested that the current age range is a weakness raised the topic of which ages are most at risk of chlamydia.

Some respondents emphasised that they can only ask someone their age, they cannot police it, and there is no way of knowing whether someone is the age they claim or not.
Low awareness of the scheme

Several respondents felt that there was a lack of awareness about the scheme. Respondents commented on the need for more advertising, and more publicity outside the store. A common theme was the need for greater local promotion.

“I would like to see more awareness. I don't know whether it’s the DoH, but locally speaking if the youth workers knew about it, it might work better...a higher number coming in”
Pharmacist

“I don’t think people are aware of the service” Pharmacist

“We’ve got lots of posters inside the store, but we should have more outside the store.”
Pharmacist

“Uptake has gone down and more advertising is needed. Not many people know about it”
Pharmacist

“Should be advertised in young peoples magazines to raise awareness” Pharmacist

“The service should be promoted more in schools” Pharmacist

“Should advertise in nightclubs, sport centres etc...anywhere young people congregate”
Pharmacist

The majority of respondents did not appear aware of the marketing and advertising that has already been undertaken; although some made reference to previous activity.

Lack of privacy

A few respondents commented on the lack of a consultation or guaranteed privacy, and the possibility that other people can overhear conversations.

“They may feel embarrassed if there is no consultation room or privacy” Pharmacist

Lack of in-store toilet

One respondent commented on the lack of an in-store toilet, and how there would probably be more kits returned if there was one.

Certainly respondents working in stores with toilets tended to encourage customers to use the kit straightaway in the store toilet.
No medication history

One respondent, who was equivocal about chlamydia screening in retail pharmacists, did not like the fact that it’s not possible to know what other medication the service user is taking when prescribing treatment.

Repetitive record keeping

One respondent only complained about the amount of record keeping required, and that it is repetitive, saying that the same data has to be recorded for both Boots and for the DoH.

“It takes a long time – 15-20 minutes, and has to be entered twice. Meanwhile people are waiting so I have to complete it in between.” Pharmacist

As said, one respondent (non-pharmacist) felt that it was not appropriate to offer chlamydia screening in a retail pharmacy. The reasons given in support of this view is that a pharmacy is too public for such a private topic to be discussed, that it takes too much time up when the pharmacist is busy, and finally that GPs should be responsible as it is not a pharmacists role.

This particular respondent said that she feels quite confident when talking to customers about the screening service, but feels that the patient is embarrassed so “tries to keep it short and simple.”

Lack of time

One pharmacist highlighted that lack of time can be a problem because treatment takes about 30 minutes, which can be a long time in a store with only one pharmacist. The pharmacist does not know in advance when people will attend for treatment.

On one occasion a partner arrived for treatment and the pharmacist asked him to wait while he was dispensing However, the customer was “very angry with his partner” and the pharmacist had to stop dispensing to calm him down.

Lack of accredited pharmacist

One respondent mentioned that her store did not currently have an accredited pharmacist. If a customer who screened positive returned to that store for treatment they would be referred to another Boots store.
One or two respondents mentioned chlamydia screening alongside other screening services, such as cholesterol, blood sugar and blood pressure and suggested that offering such services was the right way forward for pharmacies.

“It is a place where people are used to going to seek health advice.” Pharmacist

One pharmacist who supported the initiative also felt that it was important for the kit to be obtainable only where medical advice is available.

“It shouldn’t be available from petrol stations!” Pharmacist

Respondents were much more positive about the service overall than they were negative. All respondents except one supported the service:

“The positives outweigh the negatives” Non-pharmacist

“It’s a good offering.” Non-pharmacist

“I would like to see it rolled out across the country” Pharmacist
Suggested service improvements

A number of the improvements that the respondents suggested related directly related to the ‘weaknesses’ already discussed.

Thus the improvements included suggestions for more advertising, screening for other STIs in addition to chlamydia, extending the age that the service is for and offering more privacy in store.

A number of other suggestions were also made:

- Greater use of vouchers

One suggestion was that there should be wider access to vouchers so that potential users do not need to ask for a kit. One respondent suggested that these should be given out during health education classes at school.

Another suggested:

“They should give vouchers for testing kits to young people at youth clubs – they could bring them into the pharmacy and hand it over without the embarrassment of having to ask for the kit by name.” Pharmacist

- Subtle labels on the screening kits

“They have a huge label saying chlamydia on the front which can be seen by other customers in the queue, if the staff member is not sufficiently discreet - would be better if they had more subtle labelling.” Pharmacist

- GP referral letters

One respondent suggested that if customers have to be referred it would be better if a referral letter could be sent rather than patients have to go and explain themselves as

“some people feel uncomfortable starting this conversation with their GP.”
Free condoms

A few respondents suggested that free condoms, or more 50% money off vouchers should be part of the service to encourage safe sex.

Separate Queues

One person felt that a separate queue for people wanting a chlamydia screening kit would offer more privacy. However, other suggested that a separate queue would be more embarrassing since it would be very obvious to everyone else in the stall why they were there.

Other suggestions

Some suggested improvements highlighted a lack of understanding of the service. For example, one respondent said that there is no way of knowing if a patient had attended a GP or GUM clinic or not, and suggested that this be improved. This suggests that the function of the CSO in following up patients may not be understood.

The same respondent stated that there should be another way to inform past contacts other than an anonymous slip in the post. Again, this also indicates a lack of understanding of the role of the CSO.
Relationship with the CSO

All the pharmacists except one were aware of the CSO while none of the non-pharmacists had heard of the CSO.

However, pharmacists tended to say that the CSO was the organisation to call if service users had not received their results. Both by pharmacists who had contacted the CSO, and those who had not, stated this.

These responses confirm the confusion that was evident in the interviews with CSO employees, that some Boots staff believe that the CSO has access to all results, both negative and positive.

“I’ve never had reason to phone them but I understand that if someone came into see us because they haven’t receive their result then to contact them.” Pharmacist

“We’ve got the number. I suppose if the test result hasn’t been received then we might use it but I’ve never used it” Pharmacist

“I will phone if the result is not received or has gone missing” Pharmacist

“Quite a bit of contact. Always been helpful, they’ve helped out with late results” Pharmacist

“Very helpful. Put the customers mind at rest” Pharmacist

One pharmacist said that he’d had no contact with the CSO but would if

“the system broke down.”

Some pharmacists added slightly more detail about the role of the CSO:

“The CSO provide the computer system that pharmacy use to access details and results” Pharmacist

“CSO also offer a tracing service for previous sexual partners of customers who get a positive result – provide their names to the CSO and contact them anonymously on the customers’ behalf.” Pharmacist

One pharmacist mentioned that it is not possible to contact the CSO at the weekend.
Interestingly, one pharmacist commented that the CSO did not appear closely involved:

“Seems very remote and detached from the people involved at the coal face of the initiative”
   Pharmacist

“We are never told what happens to the information that has been gathered” Pharmacist

As said, all the non-pharmacists were unaware of the CSO:

One dispenser stated that

“Shedidn’treallyknowwhotheywerebutwouldlikesomeinformation” Non-pharmacist

Another simply said, when asked about the CSO

“I have absolutely no idea” Non-pharmacist
Understanding of the independent evaluation

Knowledge of the independent evaluation varied between respondents. Some were obviously aware of the evaluation and the blue and yellow questionnaires, while others claimed not to have heard of the evaluation until it was raised in the interview: Some respondents remembered hearing about the evaluation during their training.

There did seem to be any relationship between grade (pharmacist and non-pharmacist) and likelihood to be aware of the evaluation. Some examples of the levels of awareness include:

One of the non-pharmacists had not heard of the independent evaluation before taking part in the interview and was not aware of any blue questionnaires. This respondent worked in a store that typically gave out 3 kits per week, although they were usually given out by the pharmacist.

A pharmacist who gave out 1 or 2 kits per week was also unaware of the evaluation before the interview. Another pharmacist who was aware said that they did not hand out the blue questionnaires all the time, but had recently received a message asking for that to happen.

Conversely another pharmacist described always giving out both the blue and yellow questionnaires.

One pharmacist said that she made a point of always giving out the blue questionnaire with the kit and then requesting it when the sample was returned.

“If it’s forgotten I’ll ask them to pop it back in.” Pharmacist

Another pharmacist said that in his store the questionnaires have been put next to the kits.

“I proactively ask them to return them. Most do.” Pharmacist

The same pharmacist spontaneously said that she gave out the yellow questionnaire when treating patients.

Another non-pharmacist became quite confused when asked if she gave out the evaluation questionnaires:
“I don’t think we do actually. Not that I’m aware of … I don’t know where it is. I have so many books I don’t know which one it will be in. Is it in a book?”

The respondent was then told that one questionnaire was yellow and one was blue.

“That rings a bell. Is it the one that says “What you need to know about chlamydia…?” Non-pharmacist

Respondents were generally favourable towards the idea of an evaluation:

“It’s a good idea to see how well the service works and what improvements can be made.”
Non pharmacist”

“I didn’t know it happened until today. As it’s a pilot scheme in London I think it’s a very good idea, as it helps to refine the service before it is rolled out to the rest of the country. It ensures it is working properly for all people involved.” Pharmacist

“As long as the information is used to improve the service then it is a very worthwhile exercise” Pharmacist

“It’s essential for initiatives like this as the DoH cannot easily identify any problems, or improvements required without asking the people who are involved on a day to day basis.” Pharmacist

“We should do the same sort of evaluation for the morning after pill” Pharmacist

“A good way to identify any problems with the service” Pharmacist

Only one respondent was cynical about the evaluation:

“It may be worthwhile for the people providing the kits, but not for Boots staff as nothing ever changes based on their opinions!” Non-pharmacist
Appendix A: Recruitment Questionnaire

RECRUITMENT QUESTIONNAIRE
BOOTS EMPLOYEE

CARD COUNTRY RESPONDENT NUMBER PROJECT NUMBER
1 2 3 4 5 6 7 8 9 10 11 12 13 14
0 1

RESPONDENT DETAILS
(TO BE DETACHED AND KEPT SEPARATELY FROM FIELDWORK DOCUMENTS)

PLEASE PRINT

Name: ________________________________

Full Address: ________________________________________________________________

Post Code: ____________________________ Telephone Number: ____________________________

Mobile Number: ____________________________ Date & time of Interview: ____________________________

Length of interview: ____________________________ Location of interview: ____________________________

Print interviewer name: ____________________________ Number: ____________________________ Telephone No.: ____________________________

Our interviews are carried out in accordance with current Market Research Society guidelines and Data Protection Laws. In line with this we require your specific permission to record the interviews in any way. Please read the statements below and tick the appropriate response, signing at the bottom once you have done this.

1. For this research, the interview may be audio taped for analysis purposes. Your personal details will remain strictly confidential. The information you provide will be reported at a total rather than individual level. Do you agree to be audio taped under these conditions?

   Yes [ ] No [ ]

2. Would you be willing for the audio taped interview to be shared with our client? This material will be confidential and would be used for internal market research purposes only.

   Yes [ ] No [ ]

3. Would you be willing for TNS to re-contact you for help with future surveys?

   Yes [ ] No [ ]

4. Many respondents complete surveys via the Internet. Would you be willing to participate in future TNS surveys that were internet based?

   Yes [ ] No [ ]

Please enter your email address in the box below. Please take a few moments to double-check for accuracy as even the slightest error may mean we are unable to contact you.

@

Your details will be held for market research purposes only and will not be shared with a third party.
# RECRUITMENT QUESTIONNAIRE
## BOOTS EMPLOYEE

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<th>CARD</th>
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Print interviewer name: ___________________________ Number: ________ Telephone No.: __________

**Moderator/recruiter:** If **respondent** agrees with all the above information, please ask **them** to sign below.

Respondent’s signature: __________________________ Date: __________

**INTERVIEWERS’ DECLARATION**

I confirm that before returning this questionnaire I have checked that it meets and was carried out in accordance with the requirements outlined in the instructions supplied to me for this study and conducted within the Code of Conduct of the Market Research Society. I understand that the information given to me during the interview must be kept confidential and only made available to TNS Healthcare.

Signed: ________________________________________________
**RECRUITMENT QUESTIONNAIRE**

**BOOTS EMPLOYEE**

<table>
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<tr>
<th>CARD</th>
<th>COUNTRY</th>
<th>RESPONDENT NUMBER</th>
<th>PROJECT NUMBER</th>
</tr>
</thead>
<tbody>
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<td>1</td>
<td>2 3 4 5 6 7 8 9 10 11 12 13 14</td>
<td>1 2 5 3 1 1</td>
</tr>
</tbody>
</table>

**P1** Are you a
- [ ] Pharmacist
- [ ] Pharmacy Assistant
- [ ] Other

**P2** Gender
- [ ] Male
- [ ] Female

**P3** Have you been involved in the initiative of supplying free chlamydia kits to customers?
- [ ] Yes
- [ ] No
- [ ] DK

**P4** *IF PHARMACIST*: Have you personally treated any customers who have returned to the store, having been diagnosed positive?
- [ ] Yes
- [ ] No/DK

**P5** *IF PHARMACIST*: How long have you been qualified?
- [ ] Less than 2 years
- [ ] 3-10 years
- [ ] 11-20 years
- [ ] 21-30 years
- [ ] Over 30 years

**P6** How long have you been working for Boots?
- [ ] Less than 2 years
- [ ] 3-10 years
- [ ] 11-20 years
- [ ] 21-30 years
- [ ] Over 30 years

**P7** And how long have you been working at this Boots store?
- [ ] Less than 2 years
- [ ] 3-10 years
- [ ] 11-20 years
- [ ] 21-30 years
- [ ] Over 30 years
**RECRUITMENT QUESTIONNAIRE**

**BOOTS EMPLOYEE**

**Recruitment instructions**

Please recruit a total of 16 Boots employees for a telephone in depth
8 x Boots Pharmacists; 8 x Boots Pharmacy Assistants

**P.1** Recruit 8 x pharmacists; 8 x pharmacy assistants

**P.3** Ensure employees have been involved in the process of handing out/discussing with customers/etc free chlamydia kits

**P.4** IF PHARMACIST: Ensure a minimum 3 pharmacists have been involved in the treatment of customers diagnosed as positive

**P.8/9/10** Standard Market research exclusion questions

**General Criteria**

- All telephone in depths to be audio recorded.
- Ensure Boots employee appreciates their involvement will be greatly valued, comments will not be assigned to individuals & their involvement is a part of the on going/overall research being undertaken
- Recruitment during office hours, but telephone in depth at their convenience eg lunchtime, after work (evening), etc.
Appendix B: Discussion Guide

125331/CHLAMYDIA
IN-DEPTH GUIDE
BOOTS STAFF

Introduction

Introduction re TNS (see separate sheet)
Background to the research
Requirements/next 45-60 mins
No right/wrong answers
MRS Code of Conduct
Confidentiality/anonymity

Role/General

What is your role within the pharmacy
Main duties
Experience/years in the position
Experience/years with Boots

Understanding of Chlamydia Screening Initiative

What understand/know about Chlamydia Screening Initiative
What told
What discovered/learnt
What training been given. Sufficient. Why/why not
What more, if anything, would like to know
What specific areas

Knowledge of chlamydia

What know about the disease chlamydia
Signs/symptoms
Who suffers in particular
PROBE: men/women; ethnic background; age; anyone else
Are rates increasing/decreasing/remaining constant. Why say that
How did you find out about chlamydia. General knowledge; training; other

Role/Chlamydia Screening Initiative

How involved in Chlamydia Screening Initiative
How involved in other ‘initiatives’ (non day-to-day Boots work)

In average week (month) how much time does it take up. Actual. Percentage
How many kits do you hand out
How many kits does the store hand out
Time

Thinking about ‘per person’, on average……..

1. When a customer collects the kit, how long/much of your time does it take to discuss/hand it out? _______ Minutes

2. When a customer returns the kit, how long/much of your time does it take to discuss/collect? _______ Minutes

3. When a customer comes in for treatment, how long/much of your time does it take to discuss/treat? _______ Minutes

Process

Talk me through a ‘typical’ customer experience (or the last couple of experiences)
DESCRIBE

PROBE if necessary:-
What do you ask
What do customers ask
Is there a typical customer
Age. Under/over age band.
What do if outside these ages. Refer to GP. GUM clinic. Other
Do customers offer information. What
Do you have to ask for information. What
Do you feel customers at ease. Why/why not
Do they normally come on own or with a friends
Are you at ease. Why/why not

On scale 1-10, how confident do you feel in dealing with customers in Initiative
Why feel that way

How well does the process work
What would make it better. Where can improvements be made
Any areas missing
Any areas difficult to undertake

Customers

What, if any feedback from customers. Good, bad
How think they feel about service
Any suggested improvements

Have customers ever complained (to you) about the service. Why/what about

Service/General

Do you feel screening should be available via pharmacy. Why/why not
Do you feel you should be involved. Why/why not
Who else should be involved
How feel about offering screening kits at Boots
PROBE: good, bad. Why
What are the pluses/benefits
PROBE: free, avoid embarrassment, privacy, convenience, no GP involvement (anonymous)
What are the negatives/drawbacks
PROBE: embarrassment, only tests for chlamydia, pharmacist vs GP, age restrictions

Relationship with CSO

What know about the CSO
What relationship with CSO
Any extra information requirements. What

Independent Evaluation

What know about independent evaluation before today
Where else does or should evaluation help, get involved

Summary

INTERVIEWER TO BRIEFLY SUMMARIZE KEY FINDINGS:-
What improvements can be made
What have you learnt from last 45-60 mins
Appendix 5 : CSO in-depths research
Chlamydia screening evaluation: CSO In-depths Research

Report prepared by TNS Healthcare for:

The Department of Health

125331 April 2007

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<table>
<thead>
<tr>
<th>Contents</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>BACKGROUND</td>
<td>255</td>
</tr>
<tr>
<td>OBJECTIVES</td>
<td>256</td>
</tr>
<tr>
<td>METHODOLOGY</td>
<td>257</td>
</tr>
<tr>
<td>SUMMARY AND CONCLUSIONS</td>
<td>258</td>
</tr>
<tr>
<td>FINDINGS</td>
<td>259</td>
</tr>
<tr>
<td>THE PCSPF</td>
<td>260</td>
</tr>
<tr>
<td>NOTIFICATION PROCESSES</td>
<td>262</td>
</tr>
<tr>
<td>TYPICAL SERVICE USER INTERACTIONS</td>
<td>264</td>
</tr>
<tr>
<td>INITIAL REACTIONS</td>
<td>264</td>
</tr>
<tr>
<td>MORE DIFFICULT SERVICE USER INTERACTIONS</td>
<td>267</td>
</tr>
<tr>
<td>COMPARISON OF PCSPF TO NCSP</td>
<td>270</td>
</tr>
<tr>
<td>RELATIONSHIP WITH BOOTS</td>
<td>272</td>
</tr>
<tr>
<td>STRENGTHS AND WEAKNESSES</td>
<td>276</td>
</tr>
<tr>
<td>IMPROVEMENTS AND RECOMMENDATIONS</td>
<td>280</td>
</tr>
<tr>
<td>APPENDIX A - CSO RECRUITMENT INTRODUCTION</td>
<td>281</td>
</tr>
<tr>
<td>APPENDIX B - CSO STAFF SCREENER</td>
<td>282</td>
</tr>
<tr>
<td>APPENDIX C - CSO IN-DEPTH INTRODUCTION</td>
<td>286</td>
</tr>
<tr>
<td>APPENDIX D - CSO DISCUSSION GUIDE</td>
<td>287</td>
</tr>
</tbody>
</table>
Background

As part of the independent evaluation of the PCSPf initiative, the key stakeholders are asked for their experiences and perceptions of this pharmacy based service. Key stakeholders include the service users, pharmacists, dispensers or counter assistants employed at Boots and involved in the initiative, and Chlamydia Screening Office personnel.

This report focuses on the experiences of the CSO employees. Camden PCT supported the PCSPf when it was launched both as the lead commissioning PCT for Patient Group Directives, and through the provision of services. The CSO team co-ordinates the management of service users who have positive test results and provide advice on treatment referral and partner notification.

The CSO establishes with a service user the treatment options available. If the client does not fall within the PGD criteria, the coordinator will help the client to access treatment via a sexual health clinic or other NHS service. Clients who do meet the PGD criteria, have the additional option of being able to return to Boots for free treatment.

The CSO also raises the subject of partner notification. Partners can attend Boots using the index client’s customer reference number, and there is no upper age limit for the partner to be treated. After assessment by the pharmacist, providing the partner is asymptomatic, the partner can also receive treatment. Symptomatic partners are referred to other NHS services.

The CSO also carries out two-week follow-up phone calls to check: the client’s treatment attendance, treatment compliance and partner notification outcomes.

CSO employees were asked for their views and experiences of being involved in these services via in-depth telephone interviews.
Objectives

The primary objective of this aspect of the evaluation was to gain insights into how the PCSPf initiative is perceived from the perspective of the CSO staff. Specific objectives were to:

- Assess the level of involvement by CSO staff in the initiative
- Explore how CSO staff operate, including
  - Informing customers of positive results
  - Partner notifications
- Identify any perceived strengths and weaknesses of the service (from the CSO perspective)
- Explore any differences for CSO staff between the PCSPf initiative and the NCSP
- Explore communications between CSO and Boots
- Explore any suggestions for improving the PCSPf
- Identify feelings towards pharmacy screening in general
Methodology

Methodology

In depth telephone interviews were undertaken with three employees from the CSO. Each telephone interview lasted up to one hour.

Sample

The three employees interviewed represent the full complement of CSO employees who are currently working on this initiative, and comprised 2 chlamydia co-ordinators and 1 more senior member of staff.

Recruitment

CSO staff were contacted by an experienced TNS Healthcare recruiter and an appropriate date/time was arranged for the researcher to undertake the telephone in-depth.

Copies of the CSO recruitment introduction (Appendix B) and the CSO staff screener (Appendix C) are included.

Anonymity and confidentiality

Respondents were assured of anonymity and confidentiality. The names of participating respondents are not included in the report and no quotes or statements are directly attributable to any individual.

Fieldwork

The recruitment process commenced in January 2007, and the interviews were conducted between 6th and 13th February 2007.

A copy of the discussion guide (Appendix E) and the in-depth introduction (Appendix D) are appended accordingly.

Analysis

Each telephone in-depth was audio-recorded and then thematically analysed.
Summary and conclusions

- After some teething problems involved in the set-up the CSO staff are now generally satisfied with the service offered.

- There is a good level of understanding of the initiative and CSO staff are mostly satisfied with the way the service is implemented.

- There were initially some concerns that the Boots initiative was having a negative impact on the NCSP due to staffing issues – but these would now seem to have been resolved.

- The process of contacting clients with positive results is considered to be very thorough. The inability to contact a very small minority of clients can cause frustration.

- CSO staff are knowledgeable and comfortable discussing sensitive issues with clients.

- The relationship between Boots head office and the CSO was described as good.

- There are some concerns about the nature of training provided to Boots staff and the lack of involvement of the CSO.

- Concerns were raised that some Boots staff make contact with the CSO when customers have not received their result, when they should actually contact Boots HQ.

- The CSO would have preferred more contact with Boots on the shop floor.

- Concerns were raised that partners may not always be automatically treated; as the CSO had spoken with partners who had experienced difficulty obtaining treatment.

- Only a few differences between the PCSPf and the NCSP were highlighted; a wider range of overall benefits with the PCSPf were cited, along with some weaknesses and thus areas for improvement.

- Overall reactions to the service were very positive; it is considered to be a straightforward process that offers good accessibility to testing and treatment for both clients and their partners.
Findings

The findings are reported under the following themes:-

- The PCSPf
- Notification processes
- Typical service user interactions
- More difficult service user interactions
- Relationship with Boots
- The independent evaluation
- Comparison of the PCSPf with the NCSP
- Strengths and weaknesses
- Improvements and recommendations
The PCSPf

Familiarity

Unsurprisingly all CSO respondents were all familiar with the pharmacy screening initiative and could summarise it knowledgeably:

“It’s a path finder to assess whether pharmacists can provide chlamydia screening for 16-24 year olds; it’s only in London.”

“It was commissioned by the Department of Health and transpired from the ‘Choosing Health’ White Paper”

“It’s only within London and within 214 pharmacies”

“It’s being evaluated by you”

Pre-launch

The roles and workload of the CSO employees had evolved over time. At pre-launch criticisms were made of the initial confusion over launch dates, and of the rush with which the service was subsequently launched. The service was originally anticipated to commence in summer 2005 and CSO staff had made their annual leave arrangements accordingly. However, the service did not commence until November, and so some CSO staff were on annual leave for day one of the service.

The weeks prior to service launch were described as “very busy” and “very, very stressful” with a huge increase in workload, that could not all be completed during a normal working day. This additional work included large documents circulated for comment, often with feedback requested within 48 hours. This was only achievable by working late in the office e.g. to 8.00 p.m. or by taking work home. As a consequence the amount of time devoted to the national chlamydia service suffered over these weeks.

The CSO would have preferred the service to launch in January 2006. This would have provided a longer period for recruitment. Recruitment typically takes a minimum of three months and there was inadequate time to appoint new personnel prior to launch.

Launch

Upon launch the pharmacy screening service was very busy and there were not enough CSO staff in place. A new member of staff did not join until shortly after the service commenced. Again this period was described as very stressful, because the service itself was both very busy and new.
“Boots started with a flourish; 15-20 per day”
“40-50% of my week in the early stages”

The initial high numbers of service users, together with high levels of contact from Boots employees who were uncertain about procedural aspects of the service, meant that the early days were very busy.

“I have been doing this for 9 months – I was brought in after the pilot had started as they needed extra manpower”

Current situation

The number of clients and queries has now dropped to a constant level, and difficult situations are more unusual now. Two members of staff work on the initiative and the manager’s involvement on a day to day basis has reduced to an advisory capacity.

The current number of enquiries now received is manageable.

“It feels comfortable”

However, because the CSO telephone number was included on the original Standard Operating Procedures that were circulated among Boots, the CSO continues to receive telephone queries from pharmacists or counter staff. These queries typically relate to service users who have not received their automated (negative) results, something that the CSO is not involved with. Ideally, this telephone number would not have been circulated at the outset.

In addition to notifying PCSPf service users of positive results the CSO staff have a range of other responsibilities. These include responsibilities for the national screening programme, line management and appraisal, and data analysis.

“My main role is managing the team co-ordinators, to ensure that all the positive clients referred to us have the information about chlamydia they need”

“Another part of the job is to make sure that the data is collected and presented to my project manager monthly”

“I also represent the team at the joint service meeting.....it is about professional development within the team as well, making sure that they have the correct courses needed to do the job and are developing and have the support needed to do the job”

The CSO staff have also been involved in trying to raise awareness of the initiative.

“We set up a marketing initiative in the summer to try and make people more aware of the campaign.....it is quite time consuming”

“We also did leaflet drops around central London, in internet cafes and around Soho”
Notification processes

Notifying clients

Following the receipt of the computer files from Boots, paper files are created for each positive client.

“We only get the chlamydia positives, Boots deal with all the negatives”

Depending on the client’s choice of method for receiving their result (Text, Phone, Letter) the client is informed in the appropriate way. All service users with positive results are meant to be contacted within 48 hours.

“It’s my job to contact the client: via text, if that’s what they requested, or call them or send out a letter. I do that on the day the file is received in our office”

“It’s in our contract to attempt to contact them within 48 hours, so an attempt has to be made within 48 hours of receiving the file”

Having informed the client that their result is ready, the CSO employees then wait for the client to contact them. If the client does not contact the CSO within 3 days of the message being sent, then the client is called as treatment is a priority at this stage.

All CSO staff spoke of the need to make sensitive contact with service users:

“If I need to phone then I check very carefully that I am talking to the correct person, I would say ‘Is that {name}. This is {name}, I am calling about your recent Boots visit – please can you confirm for me your date of birth and Customer reference number’. I won’t give the result until I am completely satisfied that it is the correct person”

If the client has selected text as their preferred method then a text is sent to them asking them to call the CSO for their result

“We would send a text that says ‘Your Boots result is now ready. Please call {number} for your result’”

Client call backs

The majority of clients make contact on the same day that the text was sent, or the following day if they were informed by letter. Reminders are sent out for those for those who do not.
However, a minority of clients do not call back at all despite being telephoned or sent
reminders and the CSO is unable to contact them.

CSO employees felt that the notification process generally worked well, and that the 48 hour
window represented a high standard.

There was some frustration around the number of queries relating to missing results, and
also some frustration that occasionally people could not be contacted. However, the latter
represented very low numbers.
Typical service user interactions

Initial reactions

The majority of notifications were described as straightforward and the CSO staff focus on treatment options:

“Once I have told them that their result was positive, I discuss with them why Boots are doing the screening and explain that it is very common and easily treated”

“We always explain why it is important to go for prompt treatment, and the complications that may arise if they delay treatment”

Typically service users are not overly shocked, but are more concerned with the possible consequences of having chlamydia and what it can do.

Where service users are asymptomatic the CSO respondents believed that, typically, they want to return to Boots:

“Boots is seen as flexible and they want to go back.”

“Surprise is the most common reaction, because people are mostly without symptoms”

Frequently asked questions

Clients were considered to vary in the number of questions asked, although it was said to be unusual for a client to ask a huge number of questions, as much of the time they spend listening.

One of the questions most frequently asked by clients who receive a positive result is related to the length of time they have had chlamydia. Clients often appear to need to know that, although it is a difficult question to answer. In some cases it can be estimated based on the other information given, for example

- If the client has been previously tested and found to be negative then they must have contracted chlamydia somewhere between the two dates

- If the client is male and has developed symptoms, then they have probably had chlamydia for 2 to 4 weeks

However, if a client has never been tested previously, and has no symptoms – then they could have had the infection indefinitely
“How long they have had the infection....that is the most common question”

“There is no way of knowing how long it has been there and we try to move away from a blame culture”

“If a patient is without symptoms we have no idea. Over half of men carry it without symptoms and with women there are almost no symptoms”

“People usually want to pin point it to a particular time – which we can’t.

“Quite a few will ask how long they’ve had it for, concerns about fertility, concerns about infidelity.”

There was some suggestion that women ask more questions than men, often about the long term effects and the possible impact on fertility.

“The more in depth conversations we have are with women, usually because of the potential implications to their fertility – whereas men don’t seem to be as bothered”

“The main question I tend to get asked is what next and the infertility question.”

Follow up contact

A couple of weeks after a client is supposed to have received their treatment the CSO will contact them again to ask if they went for the treatment. If an appointment has been made for a client at a GUM clinic then the CSO will call the clinic 2 weeks after the appointment to check that the client actually attended for their treatment.

If it transpires that the client did not attend their appointment then another appointment is made for them and they are contacted again to tell them of their revised appointment. If the client is not contactable by phone, then a letter will be sent out to them.

“It is a very thorough process.”

Typical Clients

The CSO respondents felt the ‘typical’ client does not exist, although they did feel that service users understand the advice and information that they are given:

There was some suggestion that they communicate with more heterosexual than homosexual clients.

“Most of the clients we see are heterosexual, we very rarely hear from homosexuals. That may be because homosexuals are more aware of sexual health services available – certainly clinics within London”
"The average young heterosexuals are not really thinking about having an STI, so often it’s opportunistic in terms of free test available, going along with a friend etc”

Partner Notifications

The CSO also raises with service users the need to inform sexual partners from within the past six months, who may also be at risk from chlamydia. The client has the option of informing them personally or giving their details to the CSO, who will contact them on the client’s behalf.

“I encourage them to contact their partners themselves, or if they feel this would be too difficult then we can contact partners anonymously on their behalf”

It is most often former and casual partners that the CSO are asked to contact. Although the CSO does not tell the partner who the client is, depending on the situation, the partner may work it out for themselves.

“We would take the partners details and cold call them to say that ‘We have reason to believe that you may have come into contact with chlamydia and that you should be tested’ and then explain to them about the disease and the treatment options”

It can be more difficult informing contacts, as most of the time the call ‘comes out of the blue’.
More difficult service user interactions

Informing the client of a positive result

Having contacted the service user to request that they call for their result, the CSO staff wait for the client to call back. The name, date of birth and reference number are then checked and the client is informed that the test result is positive for chlamydia. Treatment options, and reasons for seeking prompt treatment, are then discussed.

The initial call to deliver the result and give the relevant treatment information can take only 10-15 minutes if the client has no symptoms and intends to return to Boots for treatment.

In these situations the initial call can be “quite a straightforward conversation.”

“It’s usually quite straightforward with the Boots clients because they’ve actually gone into Boots and picked up a kit, they’re usually quite well informed as to what they’re testing for. Although the result can often be a surprise, they made a conscious decision to do the test.”

All of the CSO respondents were confident in their roles:

“I am a sexual health counsellor and advisor, so I have experience ringing up and talking to people about chlamydia”

“I have been working as a sexual health advisor for 16 years within a sexual health clinic”

Respondents estimated that only a minority of notifications are difficult.

“On the whole most cases are straightforward. Less than 10% are difficult cases”

While most conversations are straightforward, the following tended to be trickier:

- Difficulties in confirming identity
- Conversations in which the service user becomes tearful or upset
- Facilitating people to a GU service if they are not returning to Boots

Difficulties in confirming identity

“I think for me one of the most difficult things of the job is getting hold of them, to inform them. And, if they’re not going to Boots to then facilitate them to get to a sexual health clinic.”
The CSO occasionally contact people who have provided a false name or date of birth, which they cannot recall, and so the result cannot be given until the CSO is confident that they have got through to the correct person.

Making initial contact is also difficult if the person responding does not appear to be the same person who undertook the screening. For example, the CRF may indicate one gender while the person on the telephone sounds the opposite gender.

“We’ve had a few situations where it’s a male that we are calling but a female answers the phone – we have a consultant to advise us in these situations”

There have also been a few situations in which a different person (not the person tested) has answered a telephone, or responded to a message:

“I had one situation where I had sent a text to a 17 year old girl, and we actually had a male call back – it was her father – that was quite difficult, but it is a very unusual situation”

However, all three respondents were keen to stress that these were not typical interactions. If the service user cannot be contacted then they will continue to try and make contact. If contact is not made then the result cannot be given.

**Tearful service users**

Informing a client of a positive result is usually quite straightforward as they have made a conscious decision to take the test – even if the result is a bit of a surprise. However, there are occasions where the client is quite upset by the result, and these clients are more difficult to talk to about treatment and implications. If service users become upset or tearful when given their results then it can be difficult to hold a conversation:

“I have had some people in tears which is actually quite difficult to deal with – they may ask for a few minutes and you try to call them back later – but then it can be difficult to get hold of them again”

“When clients are distressed it’s difficult. It’s usually when there are suspicions of infidelity going on that they are tearful on the phone”

Respondents talked about trying to move away from a blame culture by focusing on treatment options.

**Referral to GU services**

If the client has already started to experience symptoms, this will result in a referral to a sexual health clinic. Clients are often more reticent to attend such a clinic than to return to a pharmacy for treatment.
“It is less straightforward if the client is already experiencing symptoms – they often don’t want to go to a clinic”

Part of this initial conversation involves eliciting enough information to prevent an unnecessary visit to Boots, and so the CSO staff will work through a PGD checklist

“I’m trying to save them a journey”

If a client has symptoms then the call generally takes longer. If the client does have symptoms they can either make an appointment for a GU clinical or it can be made for them by CSO staff. In these instances the client must be called back and there is sometimes a difficulty in contacting clients to inform them of when the appointment has been made.

However, the CSO felt it was often simpler for them to make the appointment, because they are familiar with the GU services available.

“It can be quite difficult to get hold of a patient to let them know you have made an appointment for them at the GUM clinic – this can be very frustrating, and we need to be very persistent to ensure that people actually do get treated”

“It can be a back and forth process.”

“I spoke to a young lady yesterday and the difficulty was actually getting hold of her to let her know that I had actually made an appointment at the clinic for her, it’s easier for me to make the appointment than it is for her, because I know my way around the services”
Comparison of PCSPf to NCSP

A number of points of difference were made between the PCSPf and the NCSP:

**Method of testing**

The method of testing for the Boots initiative is a urine test, whereas the NCSP offer the opportunity to take a vaginal swab. The CSO respondents highlighted that although not all women choose to do this nationally, there is some suggestion that a swab is a more sensitive screening process.

**Accessibility**

Accessibility was described as a big difference between the National Chlamydia Screening Programme and screening at Boots. No appointments are needed at Boots for either the screen or the treatment.

“The big difference is that it is so accessible”

“It is easy to go back for treatment”

**Partner notification**

CSO respondents felt that in a sexual health clinic it is typically a more pronounced part of the management process to talk to partners. Few users take up the CSO offer to contact past partners, although this reluctance is also met in the NCSP. When the partner lives outside of London then the CSO lets the local GU clinic inform the partner.

The suggestion was made that the Treatment Form should be changed so that it would be easier to contact partners.

**Partner screening**

In the Boots service, partners of clients who receive a positive result can be treated, provided that they supply the original CRN number to Boots. This treatment will be provided regardless of their age.

NCSP client partners are screened for chlamydia and only treated if the result is positive. One CSO respondent stated that via the PCSPf, ideally she would like the partners to be screened rather than treated.
Treatment uptake

Nationally, if someone moves location between the screening and their treatment they will still be treated. In the PCSPf a few people had moved out of the area and not automatically treated, instead they had been asked to have another screen.

48 hours

The PCSPf target to contact everyone with a positive test result within 48 hours was said to be different to the national programme, where the parameter was longer.

This target was considered more achievable now than in the early days of the service, partly because test results are notified to the CSO earlier in the day.

Kits requested or offered

In the National Chlamydia Screening Programme kits are offered, but in the pharmacy initiative kits are typically requested rather than offered.

CSO respondents indicated that they would be pleased to see Boots offer the kits, partly because it has the potential to save embarrassment, but also acknowledged that this is a very different environment compared with other organisations where screening might be offered. It was felt that it could be appropriate to offer kits when supplying emergency contraception, pregnancy testing kits or when people are purchasing condoms.

It was not felt that kits should be offered to young people who are purchasing toiletries. It was felt that not only would staff be reluctant or embarrassed to do this, but that it would not be appropriate anyway.
Relationship with Boots

Head office

The relationship between Boots and the CSO was described as very good, and this seemed to be particularly the case between CSO staff and the head office Boots employees.

“<Name> is very available. I feel <name> tries to correct the things that we raise.”

“We want the same outcome”

“Good links with <name>”

“A very good relationship”

“We have quite frequent communication...more us contacting them regarding results”

“<Name> is a speedy point of contact”

The regular meetings that had taken place originally, between Boots and the DoH had also been very useful.

Negative results

Many of the communications with Boots head office staff concern service users who have not received their negative results and who have been brought to the attention of the CSO. As mentioned earlier, some Boots staff and clients contact the CSO about negative results, even though the CSO does not have access to this information. The number of queries was initially much higher, but has now settled to between 5-10 per week. This miscommunication was mentioned by all 3 respondents.

“There are usually a few a week who don’t get their negative results – I am not really sure how this happens, but we send their details through to the staff at Boots Head office and they deal with it”

“They are people that are chlamydia negative and they haven’t heard from the automated service that Boots have. The staff in stores then give out our number but we don’t have access to the negatives so we refer them back to head office... and they’ll make sure that those customers get their negative result”

One of the frustrations for the CSO is that these calls originate because the CSO telephone number was included on a Standard Operating Procedure that was circulated to all
participating stores. The Boots staff should be telephoning head office for any queries regarding negative results:

“We quite often get calls from people who have not had their results and have been incorrectly advised by Boots staff to call the CSO – and of course we can’t help them, which is frustrating for them”

“We even get called by Boots store staff – so they obviously don’t know the protocol for referring patients that have not received their results”

“Often the calls we get are from in store staff, so surely they should have access to the negative, we only deal with the positive? I’m not sure why we get calls from people and I wonder if that could be dealt with in a different way to avoid any unnecessary delay for those people waiting for their result.”

“We get people phoning up for their negative results, this includes pharmacists as well as clients, assuming that we have a data base attached to Boots which isn’t the case. That can be a bit difficult and personally I think that’s a training issue with pharmacists.”

“The only time the pharmacist should really contact us if they’re not quite sure and had a client issue in regards to their management i.e. whether to refer them or not, whether they fall out of the PCG or not, things like that they should be phoning us for.”

To try and reduce the number of queries regarding negative calls, the CSO has been monitoring calls, (to see if it is particular stores that call) and Boots head office staff have tried to cascade the new number down.

**Communication with stores**

The CSO respondents felt that their working relationships with individual Boots stores could be closer with the service being described as ‘feeling disjointed’. There are good communications with Boots head office, but the CSO staff do not have any first hand experience of how things actually work on the shop floor.

One CSO respondent requested more contact with group managers in order to raise such issues as training, partner treatments, contacting the CSO and also feedback regarding any issues that they might have.

One area where the CSO would particularly like to strengthen the relationship was training.

“Initially I believed that our training involvement would be greater”

“We’ve had little <training> involvement really”
The CSO felt that they could have contributed usefully to the training, indicating a desire to have been involved in the face to face training.

There was also some dissatisfaction that the CSO does not have a good understanding of what happens on a day to day basis within stores, including how any new initiatives are rolled out in store.

“At times I feel frustrated at not knowing what’s happening on the ground floor”

“I don’t know how Boots get together and share learnings….do they have a team meeting”

“We really want that extra bit of communication”

“Is there just one store that turns partners away, for example?”

**Transfer of data**

The process for sending encrypted data files via e-mail was described as working well, with only the occasional blip since the initiative was launched.

The CSO stores the data on only one computer, in order to avoid purchasing a multiple user licence, when in hindsight it would have been more convenient to store the data on more than one computer.
Independent evaluation

CSO staff were aware of the independent evaluation, although the amount of detailed knowledge varied.

Respondents were generally aware that clients received questionnaires from Boots staff to complete regarding their opinions and experiences of the service. They are also aware that TNS won the contract for the independent evaluation and that this evaluation included several different components.

“If they’re not offered a questionnaire we ask them to ask for one”

In addition to the customer questionnaires, respondents commented on the (initial) focus groups, the mystery shopper exercise and the interviews with Boots personnel.

The CSO staff believe that it is good to have customer feedback on the initiative in order to ensure that clients are happy with the service offered, and that any issues can be resolved before the initiative is rolled out nationwide.

They also appreciated that the evaluation is not only customer feedback about the service itself, but also includes information on past behaviours (e.g. has the client been tested elsewhere or not) plus an analysis on the number of screens, results etc.
Strengths and weaknesses

Strengths and benefits

The overall reactions to this service were very positive and the CSO respondents believed the scheme to be successful:

“I think it is of a high enough quality. Boots isn’t perfect, the DoH isn’t perfect. I think it’s good enough.”

“I view the scheme as a success”

“I did not think as many people would test”

“I think it works really well”

Specific advantages or benefits of the PCSPf included:

- Accessibility of both testing and treatment
  
  “It’s a good place for screening and for treatment”

  “It’s very easy for partners to get treatment – they don’t need to be tested”

  “One of the great things about the scheme is that it’s very straightforward”

- Reaching people who would not ordinarily have gone to a GU clinic
  
  “The Boots project catches up with people who normally wouldn’t test and wouldn’t get picked up”

  “How many people have accessed Boots that would not go elsewhere?”

- Raising awareness of chlamydia
  
  “It’s a good campaign as it raises awareness”

- Positive feedback from clients

Where clients commented on the service it seems to be generally positive. Service users generally want to return to Boots for treatment if possible.
“Most people we speak to are happy and appreciative of the service”

- Offering an anonymous contact service
- More space for the Camden CSO

“The new portacabin was good!”

- Better links with other screening agencies

“We got to know other services and how they work, which was a plus”

“It opened up a network”

- Insights into private companies

CSO respondents claimed that the experience of working with a private company had been interesting:

“I’ve learnt quite a lot about how the private sector works”

However, the experience has led them to perceive the private sector as less flexible than the public.

Weaknesses and disadvantages

Respondents emphasised that they viewed the PCSPf as a success overall, but could identify the following weakness or disadvantages

- Boots vouchers

Boots vouchers were cited as a “brilliant idea” but it was felt that these needed to be more visible. One respondent commented that she would like vouchers to be given out with purchases and to be available at every till.

“I did not see them enough”

- Negative feedback

Clients, if they have said anything, have generally been very positive about the service. The CSO has heard a few negative comments e.g. “Speaking loudly” or “Shouting for a chlamydia kit.” This feedback is consistent with some of that received from the service users themselves.
- **Negative results not communicated**

  There were concerns that some clients are not receiving their negative results via the automated service, and then when clients return to Boots to enquire, they are wrongly referred to the CSO.

  "**Continuity of service issues only seem to be a problem with the negative results**"

- **Service user refused treatment**

  The CSO were aware of some instances when a client had been unable to receive treatment when returning to the store, for example if no pharmacist was available. The CSO is concerned that clients may not go back at all.

  "If someone goes to Boots for treatment and there is no pharmacist available that day, they will not be able to receive treatment – these incidents are reported back to head office in an attempt to smooth out the service."

  "There has been the odd occasion in stores where it seems the Boots staff aren’t clear of the treatment, but it is just a case of ensuring all the Boots staff are clear…. the pharmacists are clear about who they’re giving treatment to…. so that when customers go there they are given the appropriate treatment and are not kept waiting or sent away"

- **Partners refused treatment**

  There are occasional concerns that partners have sometimes been turned away when they should have been offered treatment.

  "Some stores do not seem to realise that partners can just walk in and ask for treatment providing that they have a valid CRN from the positive client and that no further paperwork is required.

- **Little CSO involvement with stores**

  Despite good links with the lead personnel at Boots the CSO would like more contact with the pharmacy group managers in order to raise some of the ‘process’ issues identified above.

- **Insufficient CSO involvement with training**

  As previously indicated, the CSO would like to be more ‘hands-on’ in staff training, and to have seen the training first hand.
■ Information cascading issues

Cascading information from Boots head office to individual stores has been problematic e.g. not to contact CSO regarding negative screens.

■ Chlamydia screening only

A perceived weakness of the service is that it screens for chlamydia only, and does not encourage service users to be tested for other STI’s. It was suggested that anyone treated for chlamydia should be encouraged to undergo a full sexual health check, and even those with a negative test result should be reminded of this.

“It’s not a full sexual health check – only chlamydia”

“It’s a good place for treatment – I’ve concerns that it is not a full sexual health check”

“Most people we talk to will have had sex without a condom and are therefore at more risk of other infections”

■ Relocation

Some service users moving out of London may be asked to re-test and have not been automatically treated.

■ Lack of flexibility/transparency

It was commented that the DoH and CSO sometimes showed more flexibility and transparency than Boots.

“I find them helpful when we do talk to them but then at the same time quite far removed. They’re a closed shop and I don’t really think we know what’s going on, whereas we’re quite transparent.”

“If you want something to roll out nationally, people need to know what the processes are in your organisation, especially the DoH”
Improvements and recommendations

The following recommendations for improvements were made:

- Clearer guidance for Boots staff on when to contact the CSO. Boots staff should be able to check their computer system for negative results and only refer the client to the CSO if the client is not on the negative list, and would therefore be a positive result.

- The CSO respondents want to be more involved in the training of Boots staff, which particularly includes how to talk to people about sexual health issues.

- Procedures in place so that partners will not be refused treatment at any pharmacy, providing that they have the CRN.

- The CSO feedback recommended follow up training for Boots staff after 6 months.

- Additionally, the CSO recommended a training plan for all new starters, if not already in place.

- If the initiative is rolled out nationally there should be a Central CSO database which would ensure that all the data on positive testing service users would be stored in one place.

- Further, if the service is extended nationally the CSO should continue to be involved, and if Boots is involved they should demonstrate an increased transparency e.g. 'spot checks'.

- All service users should be reminded at the outset that the screening kit tests only for chlamydia, and all should be encouraged (but particularly those who test positive) to undergo a full sexual health check.

- It was felt that a prompt card would be useful in the pharmacy, so that all relevant questions about symptoms are asked. The point was made that the CSO always asks very specific questions, and that service users may not associate particular symptoms with GU conditions.

- With hindsight, the data supplied by Boots would be stored on more than one computer within the CSO.
Appendix A - CSO recruitment introduction

125331/CHLAMYDIA
RECRUITMENT INTRODUCTION
CSO

I am telephoning on behalf of TNS & the government (Dept of Health). TNS is a market intelligence company & I am working on behalf of the healthcare division. TNS have been involved with Boots/CSO & the Dept of Health on the Chlamydia Screening Initiative. We are involved in the overall evaluation & assessment of the Initiative, in particular trying to find about areas where the service could be improved.

We have been supplied with your name/telephone number & believe you are involved in the initiative?

ENSURE SPEAKING TO APPROPRIATE CSO EMPLOYEE WHO CAN HELP

We appreciate you are busy, so this call will not take long. We are intending to arrange a number of in-depth telephone interviews with a colleague at TNS at your convenience. This interview would last approximately 45-60 mins. It could be undertaken over your lunch break, before you start work or after you finish work in the evening.

As a thank you for participation, an incentive of £xx will be sent to you, following completion of the interview.

There are no right or wrong answers we are just interested in hearing everyone’s views. We will be undertaking a x-section of interviews amongst CSO employees to ensure we obtain a widespread view on the service.

OBTAIN CONSENT TO PARTICIPATE & ARRANGE SUITABLE DAY/TIME

For you information, as a market research company we comply with the Market Research Society guidelines. We will report back to the Dept of Health at an aggregate level, we will not be attributing comments you make to yourself.

We will tape record the interview in order that we can listen back to afterwards, so we do not prolong the interview unnecessarily by taking notes. However, the tape will not leave our premises.

ENSURE CORRECT NAME, ADDRESS TO SEND INCENTIVE (ON INTERVIEW COMPLETION) & TELEPHONE NUMBER IS OBTAINED & THANK CSO EMPLOYEE FOR ‘FUTURE’ PARTICIPATION
RECRUITMENT QUESTIONNAIRE
CSO EMPLOYEE

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RESPONDENT DETAILS
(TO BE DETACHED AND KEPT SEPARATELY FROM FIELDWORK DOCUMENTS)

PLEASE PRINT
Name: ____________________________________________
Full Address: ______________________________________
_________________________________________________
Post Code: ___________________________ Telephone Number: ___________________________
Mobile Number: ___________________________ Date & time of Interview: ___________________________
Length of interview: ___________________________ Location of interview: ___________________________
Print interviewer name: ___________________________ Number: _________ Telephone No.: _____________

Our interviews are carried out in accordance with current Market Research Society guidelines and Data Protection Laws. In line with this we require your specific permission to record the interviews in any way. Please read the statements below and tick the appropriate response, signing at the bottom once you have done this.

1. For this research, the interview may be audio taped for analysis purposes. Your personal details will remain strictly confidential. The information you provide will be reported at a total rather than individual level. Do you agree to be audio taped under these conditions?

   Yes [ ] No [ ]
RECRUITMENT QUESTIONNAIRE
CSO EMPLOYEE

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Print interviewer name: ___________________________ Number: ________ Telephone No.: __________

Recruiter: If respondent agrees with all the above information, please ask them to sign below.

Respondent’s signature: ___________________________ Date: __________

INTERVIEWERS’ DECLARATION

I confirm that before returning this questionnaire I have checked that it meets and was carried out in accordance with the requirements outlined in the instructions supplied to me for this study and conducted within the Code of Conduct of the Market Research Society. I understand that the information given to me during the interview must be kept confidential and only made available to TNS Healthcare.

Signed: ____________________________________________________________________________
## RECRUITMENT QUESTIONNAIRE

### CSO EMPLOYEE

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**P1** Are you a

- CSO employee 1
- Other 2

**P2** What is your role/job title?

- Senior Chlamydia Co-ordinator 1
- Chlamydia Co-ordinator 2
- Other 3

**P3** Have you been involved in the DoH chlamydia initiative, through Boots?

- Yes 1
- No 2
- DK 3

**P4** How long have you been working for the CSO?

- Less than 2 years 1
- 3-10 years 2
- 11-20 years 3
- 21-30 years 4
- Over 30 years 5

**P5** Gender

- Is respondent (no need to ask but fit to code)
  - Male 1
  - Female 2

**P6** Have you participated in any market research in the last three months?

- Yes 1
- No 2

**P7** Are you or any members of your family employed by a market research firm, advertising or PR agency?

- Yes 1
- No 2
RECRUITMENT QUESTIONNAIRE
CSO EMPLOYEE
Recruitment instructions

We believe there are 3 CSO employees who are involved in the initiative (& inform people of their results).
2 x Chlamydia Co-ordinators & 1 x Senior Chlamydia Co-ordinator

Please recruit ALL 3 employees for a telephone in depth

P.1/2/3  Please only recruit appropriate CSO employees

P.4      For information purposes

P.6/7/8  Standard Market research exclusion questions

General Criteria

• All telephone in depths to be audio recorded.
• Ensure CSO employee appreciates we are ‘not checking up on them’ but trying to understand the overall process & where it can be improved
• Ensure CSO employee appreciates their involvement will be greatly valued, comments will not be assigned to individuals & their involvement is a part of the ongoing/overall research being undertaken
• Recruitment during office hours, but telephone in depth at their convenience eg lunchtime, after work (evening), etc.
Thank you for agreeing to take part in this important research which we are undertaking, it is greatly appreciated.

This in depth will last approximately 45-60 mins. As a thank you for participation, an incentive of £xx will be sent to you, following completion of the interview. (CHECK CORRECT ADDRESS SUPPLIED)

For reference, TNS is a market intelligence company & I work in the healthcare division, which means that all research I am involved with is connected with health. Our clients are typically pharmaceutical companies, patient charities or public organisations. As you are probably aware from the recruitment telephone call, the research we are doing today is on behalf of the Dept of Health on the Chlamydia Screening Initiative, which Boots is participating (CSO are involved in). TNS is involved in the overall evaluation & assessment of the Initiative, in particular trying to find about areas where the service could be improved.

Please remember throughout the conversation that there are no right or wrong answers we are just interested in hearing your views, not what you think we want to hear but your honest thoughts, feelings & experiences of the Initiative. We will be undertaking a x-section of interviews amongst staff in participating Boots stores (CSO staff), to ensure we obtain a widespread view on the service.

For you information, as a market research company we comply with the Market Research Society guidelines. We will report back to the Dept of Health at an aggregate level, we will not be attributing comments you make to yourself or the specific Boots store (CSO staff).

We will tape record the interview in order that we can listen back to afterwards, so we do not prolong the interview unnecessarily by taking notes. However, the tape will not leave our premises.

Do you have any questions before we begin?
Appendix D - CSO discussion guide

125331/CHLAMYDIA
IN DEPTH GUIDE
CSO

[KEY OBJECTIVE = What, if anything, do CSO staff do differently with Boots customers vs NCSP; if so, how?]

Introduction

Introduction re TNS (see additional sheet)
Explain the background to the research
Explain the requirements for the next 45-60 mins
Explain there are no right or wrong answers
Emphasise the MRS Code of Conduct
Emphasise confidentiality & anonymity
NB: Unless specifically indicated we are talking about the Boots Chlamydia Screening Initiative

Role/General

What is your role within the CSO?
What are your main duties?
How experienced/years in position?
How experienced/years at CSO?

Understanding of Boots Chlamydia Screening Initiative

What do you understand/know about the Boots Chlamydia Screening Initiative?
What have you been told?
What have you discovered/learnt?
What additional training (if any) has been given? (*NCSP duties will be very similar*)
What more, if anything, would you like to know? Any specific areas?

Role in Boots Chlamydia Screening Initiative

What role do you personally play in the Boots screening initiative?
Have your personal responsibilities changed?
Has your involvement increased your workload?
Has it impacted on your work with the NCSP? Where/how?
In an average week (month) how much time do the Boots tasks take up? (Actual? Percentage?)
Boots Customer Process

Talk me through a ‘typical’ experience with a Boots customer (or the last couple of experiences)
DESCRIBE

PROBE IF NECESSARY
Difficulty, or otherwise, of informing +ve outcome?
What reactions do you receive?
How do you deal with these?
What happens if you cannot contact customer?
Do customers ask many questions? What? How do you answer?
Do you feel customers understand what a +ve outcome means?
How long is a typical customer contact/conversation?
Do you feel comfortable talking to customers? Why/why not?

On a scale of 1-10, how confident do you feel in dealing with customers in the Boots Initiative?
Why do you feel that way?

How well do you feel the process works?
How, if at all, could it be improved?

How does dealing with a Boots customer (+ve) compare with dealing with +ve patients identified through the NCSP?
Are there any differences in arranging treatment for positive patients (Boots vs NCSP)?
How is Partner Notification managed through the Boots screening initiative? Are there any concerns? How does this compare to the NCSP?

Customers

Are those screened through the Boots initiative any different to other patients? How? Are there any differences in their reactions? If so, what is different?
What, if any, feedback do you get from Boots customers? Is this different to the NCSP customers?
How do you think Boots customers feel about service? Is this any different to NCSP customers?
Have Boots customers ever complained (to you) about the service? Why/what about? Again, is this any different to NCSP customers?
Service/General

What has the impact of the Boots initiative been on your CSO office?
Are there any continuity issues? i.e. Boots undertaking the screening and dealing with negatives, while CSO deal with positives and Partner Notification,? If so, what? How do you feel these can these be addressed (in the future)?
How do Boots compare with other screening venues?
Is there a role for CSO to play in pharmacy screening schemes? Why/why not? If not, who else should be involved?
What are the benefits/drawbacks for CSO involvement?
What implications do you see if the current approach (with any improvements) was rolled out (nationally)?

Relationship with Boots

Have you ever had contact with Boots staff?
How often do have contact with Boots staff?
Who instigates the contact, CSO or Boots?
What do these matters typically relate to? PROBE: treatment, information requirement
What do you envisage the role of Boots staff to be?
How would you assess your relationship with Boots staff?
What, if any, improvements would you suggest?
How does dealing with Boots as a screening venue compare with other screening venues?

Independent Evaluation

Were you aware that DoH has commissioned an independent evaluation of the Boots screening scheme, prior to this discussion?
What did you know?
What do you think the evaluation should illustrate about the scheme?
If you were to write the ‘conclusions’, what would you say?

Summary

INTERVIEWER TO BRIEFLY SUMMARIZE KEY FINDINGS:-
What improvements can be made?
What have you learnt from last 45-60 mins?
Appendix 6 – Service users in-depths research
Chlamydia screening evaluation:
Service User In-depths Research

Interim Report prepared by TNS Healthcare for:

The Department of Health

125331 March 2007

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Contents

OBJECTIVES ..................................................................................................................... 293
METHODOLOGY ................................................................................................................ 294
SUMMARY AND CONCLUSIONS ..................................................................................... 299
FINDINGS ...................................................................................................................... 300
AWARENESS OF INITIATIVE ......................................................................................... 301
INITIAL ACTIONS .......................................................................................................... 302
STORE SELECTION ........................................................................................................ 306
STORE EXPERIENCE ..................................................................................................... 308
AFTER LEAVING BOOTS ............................................................................................. 312
RETURNING THE KIT .................................................................................................... 313
TEST RESULT RESPONSE .......................................................................................... 315
TREATMENT .................................................................................................................. 317
OVERALL SERVICE ....................................................................................................... 318
IMPROVEMENTS .......................................................................................................... 320
SERVICE RECOMMENDATION ..................................................................................... 321
AFTER THE SCREENING ............................................................................................ 322
POSTAL ....................................................................................................................... 323
APPENDIX A - SERVICE USER RECRUITMENT INTRODUCTION .................................... 324
APPENDIX B - SERVICE USER SCREENER ................................................................... 325
APPENDIX C - SERVICE USER IN-DEPTH INTRODUCTION ........................................... 330
APPENDIX D - SERVICE USER DISCUSSION GUIDE ..................................................... 331
Objectives

The primary objectives of the service user in-depths were to:-

- Explore the process from a service user perspective
- Understand the strengths and weaknesses, from a customer perspective, of the free chlamydia screening service, provided through Boots
- Aid in developing/suggesting improvements

The specific objectives were as follows:

- Understand how service users became aware of the initiative
- Identify what triggered usage of the service
- Identify service users knowledge of chlamydia
- Identify what barriers, if any, exist in using the service
- Explore customers reasons for selecting a specific store
- Explore how service users feel at each stage of the process i.e.
  - Entering the store
  - In store
  - Leaving the store
  - Returning with their sample
  - Receiving treatment within pharmacy
- Explore whether service users expectations are being met, or not, regarding receipt of test results
- Assess if service users are likely to recommend the service to others
- Explore overall strengths and weaknesses of pharmacy screening
- Explore reactions to a postal service option
- Explore whether customers behaviours have changed following the screening process
Methodology

Ethics Committee

Given the nature of the research, and more importantly the type of respondents to be included in the research process, TNS Healthcare had to obtain Ethics Committee approval.

This process involved:-

- Completing a detailed form on-line
- Forwarding the form, signed on 13 November 2006, along with all the relevant information
- Attending a subsequent Ethics Committee meeting at a local PCT (St Helier) on 13 December 2006.
- Receiving written confirmation of approval (approval was given in principle and verbally at the meeting).

The Ethics Committee granted approval for the market research to be undertaken, with minor amendments to the documentation i.e. reduction in the level of ‘personal’ information requirements, at both the recruitment (screening questionnaire) and in-depth (discussion guide) stages.
Profile

A target of 25 telephone in-depths with service users is scheduled. This element of the research is ongoing. At the time of writing this report, (to coincide with the other elements i.e. Treatment/Local/National/other in-depths - Boots staff and CSO) a total of 13 have been completed as follows:

<table>
<thead>
<tr>
<th>No.</th>
<th>Gender</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Test outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>23</td>
<td>White -ve</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>23</td>
<td>White -ve</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>21</td>
<td>Black African +ve</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>F</td>
<td>27</td>
<td>Mixed -ve</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>24</td>
<td>White -ve</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>22</td>
<td>White -ve</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>21</td>
<td>White -ve</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>F</td>
<td>27</td>
<td>White +ve</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>M</td>
<td>24</td>
<td>White -ve</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>F</td>
<td>23</td>
<td>White -ve</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>F</td>
<td>23</td>
<td>White -ve</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>M</td>
<td>23</td>
<td>White no result received</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>M</td>
<td>29</td>
<td>White -ve</td>
<td></td>
</tr>
</tbody>
</table>

It can be noted from the above:

1) Female respondents predominate. This is a reflection of the available sample being heavily skewed towards females.

2) To date, 3 service user respondents are outside of the age, although they did obtain the service free.
Sample

Service users who complete and return the blue screening questionnaires and yellow treatment questionnaires have the opportunity to supply their name and telephone number.

Given the low level of questionnaire returns (as highlighted in previous reports) the potential sample to contact has been relatively limited.

<table>
<thead>
<tr>
<th>Available details by month/year:-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screened</td>
</tr>
<tr>
<td>2006</td>
</tr>
<tr>
<td>September 9</td>
</tr>
<tr>
<td>October 15</td>
</tr>
<tr>
<td>November -</td>
</tr>
<tr>
<td>December 9</td>
</tr>
<tr>
<td>2007</td>
</tr>
<tr>
<td>January 17</td>
</tr>
<tr>
<td>February 12</td>
</tr>
<tr>
<td>Screened total 61</td>
</tr>
<tr>
<td>Treated total 12</td>
</tr>
<tr>
<td>TOTAL 74</td>
</tr>
</tbody>
</table>

Following Ethics Committee approval, names and numbers were collated– in total 74 to date – and recruitment commenced.

Recruitment

Service users were telephoned by an experienced TNS Healthcare recruiter. If the service user was willing to become a respondent, an appropriate date/time was arranged for the TNS executive to call back and undertake the telephone in-depth.
The success/outcome of the recruitment process is as follows:-

<table>
<thead>
<tr>
<th></th>
<th>Screen</th>
<th>Treat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unavailable (phone always off/never answer)</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Unobtainable (wrong number/dead number)</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Answerphone</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Refusals</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Works in market research</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>English language too poor</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Failed to interview/reschedule</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Provisional appts.</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Untried numbers</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Complete</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>62</strong></td>
<td><strong>12</strong></td>
</tr>
</tbody>
</table>

Copies of the service user recruitment introduction (Appendix B) and the service user screener (Appendix C) are appended accordingly.

**Ethical issues**

Respondents were assured of anonymity and confidentiality. The names of participating respondents are not included and no quotes or statements are directly attributable to any individual.

Respondents were offered an incentive for their participation.

**Fieldwork**

The recruitment process was commenced in January 2007, following Ethics Committee approval in December 2006.

The first telephone in-depth was conducted 25th January 2007.

The process is now on-going. When additional questionnaires are received with service user details completed, these are passed to the TNS recruiter. By conducting relatively soon after questionnaire completion/experiencing the process, it is hoped a greater strike rate will be achieved.
Each telephone in-depth lasts between 30-45 minutes and is undertaken by an experienced TNS Healthcare moderator (both male and female).

A copy of the discussion guide (Appendix E) and the in-depth introduction (Appendix D) are appended accordingly.

Analysis

Each telephone in-depth is audio-recorded, thematically analysed and interpreted.
Summary and conclusions

- Initial awareness of the free chlamydia screening is predominately in store, and this was sufficient amongst some service users to trigger usage.

- Information of chlamydia per se is not extensive, with key knowledge being lack of signs/symptoms and causes infertility. Few took further action to learn more about the disease than that given in the literature/by Boots employees.

- The key barrier to use the service is embarrassment, potentially caused by being overheard in the queue and/or the indiscretion of Boots employees.

- Store selection is almost unanimously based upon location – local and convenience, and not in-store facilities.

- Receipt of test result is predominately within the expected time period, although a variety of time periods were given – generally 1-2 weeks.

- One respondent stated that after not receiving a test result, he opted to be tested at a GU clinic.

- Key strengths of the service are cited as the convenience, anonymity and no need for appointments.

- Suggested improvements include additional marketing activity to increase awareness (beyond initial in-store awareness), re-iterate staff knowledge via staff training – potentially regular updates (particularly to enhance the service user experience and minimise indiscretion) and the storage/positioning of the kits (e.g. under the counter vs top shelf to minimise embarrassment).

- To date, a postal methodology has received mixed views, although these respondents are commenting based upon their specific non postal experience. The key hurdle appears to be regarding confidence that the sample will reach its destination and a response received, coupled with the actual barrier of posting a urine sample with the general post.
Findings

The findings are reported under the following themes:-

- Awareness of initiative
- Initial actions
- Store selection
- Store experience
- After leaving Boots
- Returning the kit
- Test result response
- Treatment
- Overall reactions to service
- Service improvements
- Service recommendation
- Postal option
Awareness of initiative

Initially heard

Following the introduction and explanation of the in-depth by the TNS executive, service user respondents were initially asked:-

“Tell me how you initially heard about the chlamydia screening service at Boots?”

The majority claim to have heard about the service through being in store, either noticing the in store promotion or actually seeing the kit on the counter/on display

“Large, can’t miss it, the empty box on the stand.” (White, female, 23, -ve)

“….. on a poster in the window.” (White, female, 24, -ve)

“I hadn’t heard of it before seeing the poster, I was with friends and had time to kill so we went in and asked.” (White, female, 24, -ve)

Others knew about chlamydia screening either through their own, or their friends, previous experiences, and this helped them to appreciate the Boots offering:

- A friend had been tested and the result was positive, so this had helped to heighten awareness when seen in store.

- Respondent had seen information at their GPs, but had not taken much notice at the time, but when further prompted by seeing in store, had taken subsequent action.

- One respondent had been screened about a year previous through their GP/GUM clinic, so in seeing in Boots, took action.

- One male respondent said that his girlfriend had brought the Boot’s service to his attention.

One respondent stated that they heard of the service via the radio, and another via leaflets in a magazine.

Overall, service users are claiming that the marketing activity in store is the main factor in creating awareness of the initiative. Potentially overtime, as the service receives greater publicity and a wider audience become aware and actually use, then word of mouth, through friends, etc may develop into a greater avenue for awareness.
Initial actions

Knowledge of chlamydia

Overall, knowledge of chlamydia appears ‘patchy’ amongst those service users interviewed. Most had some background knowledge, which was reinforced and sometimes enhanced when discussing the screening with the pharmacist.

However, for many the knowledge is somewhat limited, and only a small minority took further action to learn more about the disease via different means.

“NHS Direct website.” (White, female, 23, -ve)

“I didn’t know what it was” (Mixed, male, 29, -ve)

Key knowledge includes the lack of visible symptoms and the potential for women to become infertile in the future if not detected and treated.

“No signs or symptoms .... can become infertile when older .... and I want a family ” (White, female, 23, -ve)

“Can be treated and cured.” (White, female, 23, -ve)

“Nasty things .... infertility.” (White, female, 22, -ve)

“9 out of 10 don’t have signs or symptoms” (White, male, 23 no result)

One woman stated that she felt reasonably knowledgeable because she had previously had chlamydia.

Time between awareness and visiting Boots

After hearing about the screening service, the service users generally undertook one of three approaches:-

1) Discussed with friends/partners and then collected kit (and was then tested)

“.... I discussed it with a mutual friend of me and my partner, almost to gain her approval .... I think that was almost a motivating factor in itself because she thought it was a good idea.”

(White, female, 23, -ve)

“Had a coffee with my friend, and chatted about it. You wouldn’t know you had it ... went back an hour later and got the kits.” (Black African, Female, 21, +ve)
One respondent said that she had telephoned a number on the Boot’s website and was told to visit her local store.

Nobody mentioned discussing with their GP.

2) Took kit immediately (and was then tested)

People in this category picked up the kit as quickly as ‘within an hour’, later the same day or the next day.

“Went straight into Boots and up to the pharmacy counter.” (White, female, 22, -ve)

“Might as well get it over and done with.” (White, female, 23, -ve)

A minority claimed to discuss the screening process and chlamydia per se with the pharmacist in the Boots store.

3) One or two people left it longer before going back.

“…. 1 week ….not near a Boots, so next time I was back.” (White, female, 23, -ve)

Another respondent had seen the publicity when collecting her eczema prescriptions in the past, and so had returned to her usual Boots store to collect the screening kit.

**What triggered or prompted testing**

For some, actually being in the Boots store, looking for/buying something else, and noticing the ‘promotion’ was sufficient to trigger to ask for a kit.

“I was just buying sandwiches.” (White, male, 24, -ve)

For others, it was a level of curiosity or thinking it was just a good idea.

“Interesting to find out” (White, female, 22, -ve)

“Seemed like a bit of fun with my friends” (White, female, 24, -ve)

Conversely, the trigger for some service user respondents was to do with experiences of their partner, a feeling that something was potentially wrong or that their experiences warranted a test.

“My partner slept with someone else. He was tested as well.” (White, female, 23,-ve)

“My partner, that I’ve been with for 6 years, had been sleeping with someone else.” (White, female, 23, -ve)
“…. something down there not good.” (Mixed, female, 27, -ve)

“I’m 24 …. need to know what’s happening ... you know what I mean .... I’ve had a lot of girls” (White, male, 24, -ve)

Another male chose to be tested after having unprotected sex while on holiday.

Barriers

In the course of the in-depth interview, service user respondents were asked if they felt any barriers in going into a Boots store and requesting a test kit. This questionnaire originates from the findings in the initial qualitative research, which indicated a number of potential barriers to usage, in particular, embarrassment.

This research appears to support the initial qualitative findings. Key barriers included:-

“Embarrassment .... people pre-judging you, looking down their nose at you in the store.”
(White, female, 23, -ve)

“It was a bit daunting going in, because the Boots I went into was very open and busy and it’s sort of embarrassing asking for a chlamydia kit without everybody looking at you like you’re someone that has had 18 sexual partners.” (White, female, 23, -ve)

“I was shy, embarrassed .... felt ashamed, don’t know what I have .... a sickness .... feel dirty.” (Mixed, female, 27, -ve)

“Queue of people. Even when buying condoms, people are looking.” (White, female, 23, -ve)

“I was scared to go and then possibly be told I had a positive result, and then I would have to tell him and he is probably going to think that I was seeing someone else.” (White, female, 23, -ve)

Some of the older service user respondents with more ‘outward’ confidence, appeared less worried about the situation, but could relate to those younger (teenagers) being more apprehensive.

One older user said that at 23 year old he wasn’t too bothered about asking for the test, but did not think that he could have done so when he was sixteen due to embarrassment.

Other respondents mentioned being pleased that the counter assistant was the same sex as themselves, as that reduced embarrassment.

In addition to the above, the issue of confidentiality was probed/asked (if not mentioned spontaneously). Confidentiality of the result was not regarded as an issue, although confidentiality in store was for some respondents:
“Not much privacy” (Mixed, male, 29, -ve)

“Not discreet in front of the customers...we went to the side of the counter but I think people could tell I was asking for a kit” (White, male, 23, no result)

“The shop was empty... I wasn’t worried about anybody hearing me, if I was I may have talked a bit quieter.” (White, female, 24, -ve)

Another respondent spoke of waiting for the counter to be quiet before approaching.

For a couple of service users interviewed, it was the female who entered the store and sorted everything out, with the male ‘loitering’ outside or being beckoned in towards the end of the discussion (with the pharmacist) to pick up the kit.

“I had tried to go before, but my boyfriend had bottled it. This time he waited outside .... I just seized the moment.” (Mixed, female, 27 -ve)

Some respondents felt that the issue of confidentiality was very well addressed, and referred to the use of consultation areas.
Store selection

Reasons for choosing a store

Almost unanimously, service user respondents claimed they chose or decided on a particular store due to its location – local and convenient.

“Store is local to me .... it’s just down the road from where I live.” (White, female, 23, -ve)

“It’s next door to my gym, and I just felt that if I went there that I would have been more likely to take it [the kit] back because I go to the gym on alternate days.” (White, female, 23, -ve)

“.... where I normally shop.” (Mixed, female, 27, -ve)

“My local Boot’s” (Mixed, male, 29, -ve)

Overall the choice of store was not perceived as a major decision for service users, in fact, for some there was no decision process as they were already in the store, saw the ‘promotion’ and just picked up a kit. For others it was there ‘usual’ store, or one which was convenient to go to in the lunch hour or after work.

A couple of service users, on questioning, indicated they may have considered an alternative store if they felt they might have tested positive or where they were not known/anonymous but ultimately they “couldn’t be bothered” – convenience was more important.

Elements important in store choice

Although store choice is driven by convenience, service users were prompted from a list (which mirrors that in the quantitative research) and asked the importance of the elements in choosing a store.

- Private consultation area within store
- In store toilet
- Complete confidentiality
- Reliable results
- Helpful, knowledgeable staff
- Convenience of store location
- No need for appointment/easily accessible
For many, all elements were described as important but ultimately location is the key driver. Additionally, there was a perception that some of these elements are ‘a given’ and would be expected without question i.e. reliable results, complete confidentiality and helpful/knowledgeable staff.

“Being able to talk to staff in a private area is most important” (White, female, 21, -ve)

“No need for an appointment. It can take 4-6 weeks to get an appointment [at GP/GUM clinic] .... and you can wait around to be seen.” (White, female, 23, -ve)

The store toilet was the least mentioned, as many took the kit home to use. However some respondents mentioned that staff encouraged them to use the in store or local public facilities:

“.... in store toilet .... but used the train station toilet and was given 20p by Boots staff.” (Mixed, female, 27, -ve)
Store experience

Entering the store

Many claimed to be “nervous” when they initially entered the store (having decided to collect the kit). However, with the decision already been make, it was generally just a case of ‘plucking up courage’, walking in and asking for a kit at the counter.

“I was quite nervous, but was quite adamant I was going to go in there and get what I wanted to know.” (White, female, 23, -ve)

“It was quite hard, I was quite worried.” (White, male, 24, -ve)

“Strange, but I should do it.” (White, male, 24, -ve)

“…. shy …. embarrassed.” (Mixed, female, 27, -ve)

A few claimed they were not embarrassed or nervous.

“They are a pharmacist at the end of the day.” (White, female, 27, -ve)

“Bit more nervous than normal, but not particularly.” (White, female, 22, -ve)

Some, who went in with friends, said that this moral support reduced their anxiety levels on entering the store.

“It was a bit daunting, it is a busy store, there are people taking their prescriptions in and things like that, but I took my friend with me and we just laughed it off.” (White, female, 23, -ve)

“More of a laugh, went in with a friend.” (White, female, 23, -ve)
In store experience

For those who felt nervous on entering the store, this level of anxiety still prevailed while the service user was at the counter. Additionally, if there was a queue this, for some, highlighted their feelings ‘of being looked at’ and ‘being over heard’

“I had to wait [in a queue.] I felt a little uneasy.” (White, female, 21, -ve)

“I was conscious of other people hearing me in the queue.” (Mixed, female, 27, -ve)

“…. there was no queue, so this made it easier.” (White, female, 22, -ve)

The use of a ‘quiet’ or consultation area would have been advantageous for some, whilst others were actually taken to such an area.

“I was taken to a quiet area behind the counter.” (White, female, 21, -ve)

“They tried to provide some privacy….separate from the other shoppers” (Mixed, male, 29, -ve)

“I felt that maybe it would be better if you can talk to someone regarding the screening and they can take you into a sub-section, where it’s just you and that person …. and you don’t feel like everybody else is listening to your conversation.” (White, female, 23, -ve)

“There was a consultation area, but I was never offered it.” (White, female, 23, -ve)

Even the existence of a consultation area is not always sufficient to prevent a level of embarrassment. One respondent indicated that the kit was taken off the top shelf and they were taken to private area, but with a gap in the screens, so they felt

“everyone could see in and know why they were there.” (White, female, 23, -ve)

For some, the experience was not particularly ‘daunting’ or ‘intimidating’ and there were no embarrassing situations. However, there is still an underlying level of being conscious of the situation they are in, and thus minimising any potential embarrassment.

“ I felt fine …. there were few people at the counter. I ushered over the staff …. I didn’t need to use a consultation area, even if there was one, I whispered what I needed to do.” (White, female, 23, -ve)

The manner of the staff appears important in helping reduce embarrassment. A couple of respondents commented that the staff did not appear too sure of the process which in turn drew attention to what they were doing. Others commented that if the staff were confident and knew what they were doing, it helped them
Questions

Service user respondents were asked whether the pharmacy staff had asked any specific questions or if indeed they themselves asked any.

Key questions asked by staff included:-

- **Age**

  One older male said that he wasn’t asked his age initially, and because his girlfriend was aged 19 though that the pharmacy staff probably assumed he was of a similar age. When it turned out he was over the age limit, he was allowed to have the test for free anyway.

- **Any signs or symptoms**

  Some respondents indicated that staff specifically mentioned lower abdominal pain.

- **General health**

  This appeared to be asked to a lesser extent, although it may be that respondents no longer remember the question.

Many service users did not ask any questions, either because they did not feel the need (as everything is covered by the Boots staff) or, for some, they did not want to prolong the in store experience.

“I just wanted the assistant to hand over the kit and go.” (Black African, Female, 21, +ve)

Questions asked by service users included the following:-

“Can you be discreet .... can we go to a private area?” (White, female, 23, -ve)

“I did ask how long it takes for the results to come back, and is it just the 4 tablets you take [if you are positive]?” (White, female, 23, -ve)

How the kit was handed over

For the vast majority of service user respondents the kit was given in a bag. This clearly aided discreetness and helped respondents feel more at ease in the process.

However, not all were given a bag:-

“.... I had to go back for one [a bag].” (White, female, 23, -ve)
Pharmacy staff

The majority of service user respondents commented positively on how they had been dealt with by the pharmacy staff:

“Warming, helpful, knowledgeable.” (White, female, 23, -ve)

“Friendly, smiling.” (White, female, 23, -ve)

“Nice.” (White, male, 24, -ve)

“Helpful” (Mixed, male, 29, -ve)

“Polite …. quiet …. talked softly and made me feel at ease.” (Mixed, female, 27, -ve)

Only one respondent felt the pharmacist was non friendly albeit knowledgeable. This only made them feel more nervous, embarrassed and coupled with a queue behind, for the experience to be over quickly.

“…. he was about 50, rather abrupt and blunt and judgemental.” (White, female, 23, -ve)

In terms of knowledge, again the feedback suggests Boots staff do generally know the procedure, (or ask the pharmacist for help) and undertake the process with the appropriate discretion.

“He definitely knows what he was talking about.” (White, female, 23, -ve)

However, in one instance, the service user felt the Boots staff member was more ‘flustered’ than she was, and in another the service user complained that the pharmacy member had not been sure of the process.

“She was more conscious than me.” (White, female, 22, -ve)

“She was dithering...it took 40 minutes” (White, male, 23, -ve)
After leaving Boots

If service users had felt any anxiety in entering the store, then in many cases this was eased when talking to the staff.

“It was fine because it was in a carrier bag, they are see-through but not that much .... and I went straight out of the store and into my car.” (White, female, 23, -ve)

The kit itself was regarded as ‘easy’ to use, simply, self-explanatory and the instructions similarly so (even if non-English).

“English is not my first language .... read it one time and another time .... understood 90%.”  
(White, male, 24, -ve)

Some took the kit home to use, while others used a nearby toilet and thus were able to return the kit immediately.

“It seemed like a bit of fun, to go and pee in McDonalds.” (White, female, 24, -ve)

“I went home and came straight back .... less than 1 hour.” (White, female, 21, -ve)

“I used the station toilet.” (Mixed, female, 27, -ve)

The majority claimed to either use the kit immediately or returned it the next day. For many, having made the decision to utilize the service, the momentum ensured they undertook and returned the kit.

“I wanted to use as soon as possible .... I wanted to know.” (Mixed, female, 27, -ve)

One respondent claimed to take it home and “put on their wardrobe shelf” while pondering her next steps. This was exasperated by her experiences in store with the pharmacist and coupled with her apprehension in getting tested.

Clearly the Boots staff can play a vital role in putting (potential) service users at ease and aiding a swift turnaround of kit usage. In addition the suggestion to use either local public toilets or in-store facilities may drive a swifter return rate.
Returning the kit

Store choice

All service user respondents, not surprisingly, returned their kit to the same store. Given all had chose the store based on locality and convenience, with these factors not changing, the decision was straight forward.

A few claimed, when questioned, that they had thought about a different store but ultimately “convenience” drove the choice.

It does not seem that service users select a non local store for anonymity.

The process

The key level of ‘intrepedation’ was at the initial stage of entering the Boots store and approaching the counter/Boots staff. For the majority, having been reassured at the first visit, this second visit was less daunting – there was a level of familiarity in both the store, store layout and staff, as well as a knowledge of what is expected and what needs to be returned.

Some returned their sample within a couple of hours if they had used a nearby toilet, with others returning the next day (or soon after).

If the same Boots staff were seen, then feedback indicates that on the whole the staff were “friendly and knowledgeable”.

“My Boots staff were fine.” (White, female, 24, -ve)

However, a couple of respondents claimed their experience was less than acceptable. One saw a different staff member who appeared to lack the required knowledge and was not discreet.

“When I took it back the lady wasn’t discreet at all. They have to scan it in and she didn’t know the code to get them for free. She had to walk to the other end of the store and ask for the code. I just wanted the ground to swallow me up there and then.” (White, female, 23, -ve)

This respondent was relatively confident, but claimed if there had been a queue or for younger and less confident service users, what she experienced would have been very daunting.

One other respondent claimed the staff member appeared to lack the required knowledge, was not particularly discreet and had to ask the pharmacist’s advice.
One user mentioned that the process of returning the kits was not as simple as might be, and questioned why it took so long:

“...It’s not as easy as ‘there it is, see you later’” (White, male, 23, no result)

In addition, another respondent also commented upon the return policy of the test kit and urine sample being in a clear plastic bag.

“.... everyone can see the colour of your wee, which was well embarrassing.” (Black African, female, 21, +ve)

Service users appear to want the experience of collecting and returning the kit to be as simple as possible, and to require minimal interaction with others. Some respondents, for example, suggested that it should be possible to simply pick kits up from an in store public display.

**Result expectations**

As part of the ‘returning’ process, service user respondents were asked if they were informed of how long their result would take.

Although many received their test result within the time period stated (see next section), varying periods were given by respondents - these were from as little as “3 days” to “2 weeks”, although many fell within the “1-2 week” bracket.
Test result response

Timeframe

For many service users, their test result response was received within the timeframe given by the Boots staff. Often, the response was quicker.

“I was told 3-7 days and was texted in 3.” (White, female, 23, -ve)

“Heard after 6 days, was told within 7.” (White, female, 22, -ve)

“I opted for text, I was quite surprised how quickly I got the text, I got it 5-7 days after, but I was surprised at the time, around 8pm.” (White, female, 23, -ve)

However, not all test results were received in the perceived time period nor was a response even received.

“I think I received it within a week which was a bit late …. a couple of days late.” (White, female, 21, -ve)

“My boyfriend received his in 2-3 days. I had a re-test, and I still received nothing.” (Mixed, female, 27, -ve)

“I had no response” (White, male, 23, no response)

Method

The service users interviewed here received their results by all three methods, text, phone and letter.

Those receiving a text claimed it was straightforward and it came up “Boots” on their mobile or it was obviously from Boots before indicating the result. Those receiving a telephone response indicated it was “automated and sounded like a women”. Again it gave the information required.

Those receiving a letter were also complimentary about the method.

However, one respondent, who received a text indicating an inconclusive result felt the explanation was poor and not very helpful.

“It made me feel like a prize draw. Sorry this time, please try again.” (White, female, 22, -ve)
This respondent was not worried about the test, or the result they expected, but they felt if someone was concerned, this would have heightened their anxiety and maybe deterred taking a further test.

No result

One male respondent said that he had not received a result, and so decided to go the local GU clinic to be tested, which he described as inconvenient as it had required an appointment.

This particular male had been recommended to the Boot’s service by a friend. However, because he did not receive a test result he had not been impressed by the service. Interestingly this service user had not attempted to find out the result by re-contacting Boots, but had instead gone to a GU clinic to be tested. This particular respondent had previously been tested at a GU clinic, and had actively chosen the pharmacy service over this, based on his past experience.

Positive test result

Those service users who received a positive test result were also complimentary about the process.

Those notified by text received a message indicating that someone would call.

Others opting for a letter method, indicated the letter explained how to contact Boots and receive their result.

Respondents were positive about the ensuing phone calls and felt the speakers ‘put them at ease’.

“The person who called me was very helpful and understanding.” (Black African, female, 21, +ve)

Additionally, comments indicated those calling had a thorough understanding of the issues and imparted this in a manner which was easily comprehensible. A telephone conversation, for some, was also more appreciative than a face-to-face approach.

“It was less embarrassing to get a phone call for the results than have to speak to someone [face-to-face], especially if other people could overhear [in store].” (Black African, female, 21, +ve)
Treatment

Not everyone who participated in this research was aware that Boots undertook treatment if tested positive. This highlights an area for improvement, as there appears to be scope to emphasise that the service can also include treatment, if required.

Two of those who tested negative were unaware that treatment at Boot’s was an option. If this lack of understanding is wide ranging, then it might be a barrier to taking up of the screening service.

“I didn’t know they did it...” (White, male, 23, no result)

One of these respondents instantly agreed that he would opt for treatment at Boots, while another said that he would still go to a clinic because ‘Boot’s is not a health centre” (Mixed, male, 29, -ve)

Those participating in this in-depth research who received a positive result went to Boots for treatment either the next day or as soon as they could.

Given their favourable experience up to the point of receiving their result, returning to Boots for treatment seemed the logical approach.

“Local .... I had plenty of help and assistance.”(White, female, 27, +ve)

As with the majority of previous comments highlighted, Boots staff appeared understanding, helpful and friendly. They were also relatively discreet, although the importance of privacy at this point of the process should not be overlooked.

“.... Spoke in a quiet corner .... but would have been happier in a quiet consultation room .”

(Black African, female, 21, +ve)

The explanation about how to take the ‘tablets’ was understood, although as highlighted by the research the desire to “get out of the store” due to feeling “uncomfortable” can be a factor at this point of the process.

Interestingly, one respondent thought about the positive result and subsequently visited an NHS drop in clinic for a full STD screening. The experience, for her, was less uncomfortable as she felt everyone was there for the same reason.

“.... not looking at me funny.” (Black African, female, 21, +ve)
Overall service

Strengths

Overall, the in-pharmacy service was viewed as positive and had a number of key strengths as follows:

- Free (for 16-24 year olds)
- Convenient
- Anonymous/confidential
- GP is not informed (who maybe is family GP/known for years)
- No appointment required (as compared to GP/clinic)

“... far better things to do than go to the doctors.” (White, female, 22, -ve)

“Doctors appointments are over subscribed .... clinics are grim.” (White, female, 23, -ve)

- No need to return for results
- Friendly, understanding staff
- Quick and simple; test results received quickly
- Better use of NHS resources; prevention vs cure

“Brilliant idea.” (White, female, 23, -ve)

“Believe in what Boots are doing .... really think it’s a good idea.” (White, female, 23, -ve)

The male who did not receive his test result stated that he would not use the service again, but recognised that others probably have a much better experience. He had originally been recommended the service by a friend, who had experienced no problems.

Weaknesses

Some weaknesses highlighted included:

- Embarrassment .e.g. customers in the queue overhearing; feeling judged by other customers
- Clear plastic bag to return urine sample
Inconclusive text message

Lack of in store (or easily accessible) toilet

Lack of Boots staff discretion

Lack of in store ‘private’ or consultation area

Age restriction (16-24)

Only tests/screens for chlamydia

Overall, the level of strengths (as discussed in the in-depth interviews) far outweighs the weaknesses. Although a few respondents did have a relatively poor experience in store and in receiving their test, the overall perception is positive.

The key negative is in store and the potential level of embarrassment.

“Some of the staff were discreet, others are less discreet, If there could have some enclosed area where no one can listen and look in [from the queue].” (White, female, 23, -ve)

This research finding is consistent with the findings from other elements of the research programme.

Availability

The over-riding feeling amongst those service users interviewed is that the chlamydia screening should be available through a pharmacy, in addition to other locations.

Although there are advantages/disadvantages of each location, in-pharmacy is perceived as a valuable additional service for all the reasons previously noted.
Improvements

A number of possible improvements from their perspective were highlighted:-

1. General increase in awareness via marketing. Initial awareness was via the in store ‘promotion’ rather than any other medium.

2. Potential to reiterate staff knowledge through training, to ensure all in store staff can deal with a customer service user in a discreet and knowledgeable manner, and thus minimise any embarrassment. (This is reinforced by the findings from the Boots employee element of the research programme).

3. In some stores, kits were more visible, e.g. behind the counter on the top shelf. There is potential to keep in drawer under the counter so the kit can be slid unobtrusively into a bag? However, users were divided on whether kits should be more or less visible within stores.

4. The distinctive colour of the pack also adds to the heightened perceived prominence for service users in store.

5. The potential to have a re-test following a positive result and treatment as part of the service (although there is nothing to stop a service user taking another ‘free’ test).

6. If a chlamydia screen, via urine, is easily accessible via a pharmacy, can other screens/full STD be so easily available?

7. For some, the lack of an in store toilet, or an accessible toilet could have enhanced the service. However, this is not unanimous and for some McDonalds or a station was an easy alternative. (In the quantitative research, an in store toilet is not viewed as important).

8. Potentially have a separate, specific queue? Although this was also felt to highlight the reason why you would be in store (and then only heighten embarrassment). Discreetness and use of a private area should be the best approach.

9. Increase the age availability for the ‘free’ service, particularly the old age group.

   “I don’t see why there is a limit” (White, male, 23 no result)

10. Increase the amount of privacy:

   “Not all Boots stores are really suited because of the privacy” (White, male, 23 no result)
Service users claimed they would recommend the service to others, but many had not. A few had “told a friend”, although this was often just in passing, while a couple claimed to have told a number of people:

“…. including my sister.” (Mixed, female, 27, -ve)

One respondent was quite open about it all. They told friends who they were with at the time of receiving the text.

“Guess what guys, I don’t have chlamydia.” (White, female, 24, -ve)

When it came to partners, those still in a relationship had generally been tested with their partner, so the information was shared. Conversely, those whose then partner was now an ‘ex’ were less likely to communicate the result, almost regardless of the outcome.

“If positive I maybe have told him. I have moved on.” (White, female, 21, -ve)

“I have no involvement now.” (White, female, 27, +ve)

The male respondent who had not received his result said that he would still tell people about the service, although he would also tell them about his experience.
After the screening

Did behaviours subsequently change

For many of the service users participating in this research, their habits did (and have not) changed following undertaking a chlamydia screening. Some claimed to already be following “safe sex”. These respondents were generally in a (long term) relationship.

“No my habits haven’t changed, I always use protection.” (White, female, 24, -ve)

Some claimed they would (try and) be more careful. One male was pragmatic, saying that he knew what he should do, in terms of using protection, but that things did not always work out that way.

In a few cases more ‘radical’ changes in habit were claimed.

“…. I would now wear a condom for the first 6 months of a new relationship …. I would get my partner tested first after 6 months, before I had unprotected sex.” (White, female, 23, -ve)

Another female also said that she would wait longer before having sex in her next relationship. These more ‘radical’ comments appear to be cited by service user respondents who had experienced infidelity by a partner, or who were received a positive result.
Postal

As part of the in-depth interviews, service user respondents were asked:

“If you could have returned the kit by post, would this have been useful to you?”

The question received a mixed response. Some felt that returning to a Boots store and physically handling the kit to a Boots employee, gave a level of ‘security’.

“I would worry that it got mixed up with something else [in the post] .... and didn’t get there.”
(White, female, 23, -ve)

“You can trust the staff to take care of it.” (White, female, 21, -ve)

“Where does it go?” (Mixed, female, 27, -ve)

Ultimately, if the sample is returned to a Boots employee, service users know it has been returned, the form/sample is also checked for correctness and there is therefore a sense of knowing that it is all taken care of.

Others indicated that such a postal option would potentially save a trip/journey to Boots and it was probably easier to find a post box than a Boots store. However, this only raised further questions about sending a urine sample through the (general) post.

“It must fit into the letter box.” (White, female, 23, -ve)

Other recognised that a postal service might offer more convenience, but did not view it as a huge benefit:

“It’s not a great strain”

For some, the concept of putting a urine sample in the (general) post was too far removed from the current process and too risky. A postal drop off point within a Boots store was more accepting.

“.... maybe a special post service at Boots.” (White, female, 23, -ve)

However, this approach would still require service users to return to a Boots store. Although dropping off their sample would avoid Boots employee contact and potentially some level of (further) embarrassment, as previously highlighted the key area of embarrassment is predominately at the initial visit.

One respondent felt that it was inappropriate to post urine specimens:

“It is not right – it’s a health hazard to others” (White, male, 29, -ve)
Appendix A - Service user recruitment introduction

125331/CHLAMYDIA
RECRUITMENT INTRODUCTION
SERVICE USER – 13/11/06

Can I talk to <INSERT SERVICE USER NAME> please?

ENSURE SPEAKING TO CORRECT PERSON

Good morning/afternoon/evening, my name is <INSERT NAME> & I am telephoning on behalf of TNS Healthcare

You completed one of our evaluation questionnaires when you visited a Boots store, and said that you were willing to be re-contacted. Do you remember?

I’m just calling to see if you are still willing to take part in a telephone interview and if so to arrange a convenient time?

CONFIRM THEY ARE HAPPY TO CONTINUE/BE INVOLVED

The telephone interview would last approximately 45-60 mins. It could be undertaken at any time convenient to you, either during the day or in the evening.

As a thank you for participation, an incentive of £xx will be sent to you, following completion of the interview.

The aim of the interview is to discuss the chlamydia screening service and hear your views on the service. We will be undertaking a number of interviews amongst people who completed a TNS evaluation questionnaire, to ensure we obtain a widespread view on the service.

As a market research company we comply with the Market Research Society guidelines and your identity will not be disclosed in the final report.

OBTAIN CONSENT VIA SCREENER

ARRANGE SUITABLE DAY/TIME

We will tape record the interview in order that we can analyse it afterwards, however, the tape will not leave our premises.

ENSURE CORRECT NAME & TELEPHONE NUMBER(S) – PREFERABLY LANDLINE - IS OBTAINED & THANK SERVICE USER FOR ‘FUTURE’ PARTICIPATION. OBTAIN ADDRESS IF OFFERED.

IF ASKED, INFORM SERVICE USER THE CLIENT IS THE DEPT OF HEALTH.
Appendix B - Service user screener

RECRUITMENT QUESTIONNAIRE
SERVICE USER – 13/11/06

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RESPONDENT DETAILS
(TO BE DETACHED AND KEPT SEPARATELY FROM FIELDWORK DOCUMENTS)

PLEASE PRINT

Name: ____________________________________________________________________________
Full Address: _____________________________________________________________________

Post Code: ___________________________________ Telephone Number: ____________________
Mobile Number: ___________________________ Date & time of Interview: ____________________
Length of interview: ______________________ Location of interview: ______________________
Print interviewer name: ____________________ Number: __________ Telephone No.: __________

Our interviews are carried out in accordance with current Market Research Society guidelines and Data Protection Laws. In line with this we require your specific permission to record the interviews in any way. Please read the statements below and tick the appropriate response, signing at the bottom once you have done this.

1. For this research, the interview may be audio taped for analysis purposes. Your personal details will remain strictly confidential. The information you provide will be reported at a total rather than individual level. Do you agree to be audio taped under these conditions?
   Yes [ ] No [ ]

2. Would you be willing for the audio taped interview to be shared with our client? This material will be confidential and would be used for internal market research purposes only.
   Yes [ ] No [ ]

3. Would you be willing for TNS to re-contact you for help with future surveys?
   Yes [ ] No [ ]

4. Many respondents complete surveys via the Internet. Would you be willing to participate in future TNS surveys that were internet based?
   Yes [ ] No [ ]

Please enter your email address in the box below. Please take a few moments to double-check for accuracy as even the slightest error may mean we are unable to contact you.

@ _______________________________________________________________________________

Your details will be held for market research purposes only and will not be shared with a third party.
RECRUITMENT QUESTIONNAIRE
SERVICE USER – 13/11/06

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Print interviewer name: ___________ Number: _________ Telephone No.: ___________

**Recruiter:** If respondent agrees with all the above information, please ask **them** to sign below.

Respondent's signature: ___________ Date: ___________

**INTERVIEWERS' DECLARATION**

I confirm that before returning this questionnaire I have checked that it meets and was carried out in accordance with the requirements outlined in the instructions supplied to me for this study and conducted within the Code of Conduct of the Market Research Society. I understand that the information given to me during the interview must be kept confidential and only made available to TNS Healthcare.

Signed: ___________________________________________
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**P1** Can I just check, you collected & returned a free chlamydia kit to a Boots store?
- Yes 1
- No 2

**P2** How old are you?
- Under 16 years 1
- 16-18 years 2
- 19-21 years 3
- 22-24 years 4
- Over 24 years 5

**P3** Which of the following best describes your current situation?
- Student 1
- Working full time 2
- Working part time 3
- Parent or carer 4
- Looking for work 5
- Other 6
- Refused 7

**P4** What is the highest qualification you have gained?
- No qualifications 1
- GCSE/NVQ level 2 2
- A levels or NVQ level 3 or equivalent 3
- HND/HNC/Diploma 4
- Degree (BA/BSC) or higher (inc professional) 5
- Other 6
- Refused 7

**P5** Which of the following best describes your ethnicity?
- White 1
- Black Caribbean 2
- Black African 3
- Black British 4
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**P6** Which Boots store(s) did you visit when completing our/TNS questionnaire?
- Write in 1
- Write in 2
- Write in 3

**P7a** What was the result of your test? Was it....
- Negative 1
- Positive 2
- Needed to be repeated 3

**P7b** What was the result of the repeat test? Was it....
- Negative 1
- Positive 2

**P8** Gender
Is respondent (no need to ask but fit to code)
- Male 1
- Female 2

**P9** Have you participated in any market research in the last three months?
- Yes 1
- No 2

**P10** Are you or any members of your family employed by a market research firm, advertising or PR agency?
- Yes 1
- No 2

**P11** Are you or any members of your family employed by a pharmaceutical company?
- Yes 1
- No 2
RECRUITMENT QUESTIONNAIRE
SERVICE USER
Recruitment instructions

P.1 Please only recruit respondents who have returned a kit/sample (all of those supplying details should be eligible)

P. 7a/b Recruit to quota – ideally 20 negative (TYPE S) and 5 positive (TYPE T)

P.9/10/11 Standard Market research exclusion questions

General Criteria

- Recruit 25 service users in total
- Recruit a mix of users with negative and positive results – ideally 20 negative (TYPE S) and 5 positive (TYPE T)
- All telephone in depths to be audio recorded.
- Ensure the ‘service user’ appreciates we are ‘not trying to ascertain personal details’ but trying to understand the overall process & where it can be improved, from their experiences
- Ensure ‘service user’ appreciates their involvement will be greatly valued, comments will not be assigned to individuals & their involvement is a part of the on going/overall research being undertaken (amongst a x-section of people who are involved in the initiative, both users, like themselves, as well as those delivering the service)
- Recruitment during office hours, but telephone in depth at their convenience e.g. lunchtime, after work (evening), etc.
Appendix C - Service user in-depth introduction

Thank you for agreeing to take part in this important research which we are undertaking, it is greatly appreciated.

This in depth will last approximately 45-60 mins. As a thank you for participation, an incentive of £xx will be sent to you, following completion of the interview.

IF RESPONDENT ASKS, INDICATE THEIR ADDRESS WILL BE COLLECTED AT THE END OF THE INTERVIEW

For reference, TNS is a market intelligence company & I work in the healthcare division, which means that all research I am involved with is connected with health. Our clients are typically pharmaceutical companies, patient charities or public organisations. As you are probably aware from the recruitment telephone call, the research we are doing today is on behalf of the Dept of Health on the Chlamydia Screening Initiative. TNS is involved in the overall evaluation & assessment of the Initiative, in particular trying to find about areas where the service could be improved.

Please remember throughout the conversation that there are no right or wrong answers we are just interested in hearing your views & experiences. We will be undertaking a x-section of interviews amongst service users who have experienced the service to ensure we obtain a widespread overall view.

As a market research company we comply with the Market Research Society guidelines. We will report back to the Dept of Health at an aggregate level, and no ones identity will be disclosed.

We will tape record the interview in order that we can analyse it afterwards. However, the tape will not leave our premises.

Do you have any questions before we begin?
Appendix D - Service user discussion guide

Introduction

Introduction re TNS (see additional sheet)
Explain the background to the research
Explain the requirements for the next 45-60 minutes
Explain there are no right or wrong answers
Emphasise the MRS Code of Conduct
Emphasise confidentiality & anonymity

Awareness of initiative

Tell me how you initially heard about the chlamydia screening service at Boots?
Did you notice when you went into store? Told/heard through a friend? Heard through marketing activity? Did you ask for the kit or did staff point it out? How did staff approach you?

Initial Action

Tell me what happened after you heard about the screening service?
Did you talk with anyone?
Did you seek any advice? With who; e.g. friends/GP/pharmacy?
Did you find out anymore about chlamydia? What did you find out?

What do you know about the disease chlamydia?
Does it have any signs or symptoms?
Where did you learn about the disease? Back ground reading? Internet? From pharmacist? From GP?

In learning about chlamydia have your habits changed? What, if anything, has changed?
What did you do before learning, which you do not do now?
What do you do now, which you did not do before?

Store visit

How long was it between hearing about the service & visiting Boots for a kit?
Did you go immediately or did you think about it first?
What made you go immediately/wait?
What triggered/prompted you to go into a store for a kit? Back ground reading/research (internet, etc)? Talking with pharmacy? Visit to GP?
What encouraged you to go?
Were there any barriers? What concerns, if any, did you have e.g. confidentiality?

Selecting the store

How did you decide on which store to visit?
Was it local, convenient, busy, on your way to work, anonymous, or what?
Was choosing a store a major decision for you? Why/why not?
Was there anything you were particularly looking for from this store?
How important are any of the following in choosing a store: private consultation area within store; in store toilet; complete confidentiality; reliable results; helpful, knowledgeable staff; convenience of store location; no need for appointment/easily accessible?

**Entering the store**

What did you feel when you entered the store?
How easy was it to make the decision? Why do you say that?
What made it easy/difficult?
Did you go into the store on your own/with friends? Why?

**In store**

How would you describe the experience of requesting a chlamydia screening kit?
How did you feel when you asked for the kit?
Were you nervous, calm, worried, unworried when you asked/were at the counter?
What happened when you asked for the kit?
What questions did the staff ask you?
Did they ask about your general health? Your age? Anything else?
Did you ask any questions? What?
Were you concerned that anyone in the queue would hear what you asked for?
Did you have any embarrassing moments/situations? Please explain these to me?

How was the kit given to you? In a bag?
Did they discuss it with you in a quiet/consultation area?
*(NB: not a Boots contract requirement)*
IF NO: Would this have been helpful? Why/why not?

**Boots staff**

How were the Boots staff?
Were they understanding?
Did they appear apprehensive in any way?
Were they knowledgeable? Friendly? Helpful? Discreet?
Did they make you feel at ease? Why/why not?
Was there anything that you particularly liked about the service?
Was there anything that you felt could be done differently or improved?

**After leaving Boots**

How did you feel about carrying the test kit? Were you given a bag?
Did you have any concerns/worries?
Where did you use the kit? Home? In store?
How easy/difficult was it to use?
Were the instructions easy/difficult to follow? Why?
How soon after the store visit did you use the kit? Same day; next day; same week; next week?
Why did you use it straight away/why wait?

**Returning the kit**

Did you return the kit/sample to the same store? Why/why not?
Why did you choose the ‘new’ store?

How were the Boots staff when you returned the kit?
Did they know what to do?
Were they understanding?
Were they knowledgeable? Friendly? Helpful? Discreet?
Did they make you feel at ease? Why/why not?
Was there anything that you particularly liked about the service?
Was there anything that you felt could be done differently or improved?
Were you told how long your results would take?

If you could have returned the kit by post, would this have been useful to you? Why/why not?
Would you have used this option, if available to you? Why/why not?
Overall, what do you think of a postal return option?

Response

How soon did you hear?
Was that as expected?
How did you receive your result? Txt? Telephone? Letter?
Was your test negative/positive?
How was it handled?
Were they understanding?
(NB: For negative/retest result notification by txt or phone – automated phone service)
What, if anything, did they tell you to do now?
Did you feel at ease? Why/why not?
(NB: Not relevant for negative/retest – standard messaging as per Boots contract)

IF POSITIVE TEST RESULT:
What happened after you received your result?
Did you go to a store for treatment? Why/why not?
IF NOT:
Where did you go for treatment?
Why did you go there?
Did you know you could go to Boots for treatment?

IF TREATED AT BOOTS
How long did you wait before attending for treatment?
Why did you go immediately/why did you wait?
Did you go back to the same store for treatment? Why/why not?
Were the Boots staff understanding?
How would you describe your treatment experience?
Were they knowledgeable? Friendly? Helpful? Discreet?
Did they make you feel at ease? Why/why not?
What could have been done differently?
Any suggested improvements?
Anything you particularly like?
Service overall

Would you recommend the service to anyone? Why/why not?
Overall did you find the process easy/difficult? Why/where?
What are the overall strengths?
What are the overall weaknesses?
Do you have any suggested improvements?

Anyone else use?
Have you told anyone about the service?
What did you say about it?
Did you recommend the service to anyone? Why/why not?
Did you recommend it to your partner? Why/why not?
Do you know if they used the service?

Have any of your friends/colleagues used the service?
IF YES:-
What were their experiences?
Did their experiences differ to yours? Where/why?
Are their experiences better, worse or same? Where/why?

Feelings towards screening in pharmacy

Do you feel chlamydia screening should be available through a pharmacy? Why/why not?
Where else should it be available? Hospital clinic (e.g. GUM)? GP? Family planning clinic/contraceptive service? NHS drop in centre?
What do you see as the positives of such a pharmacy based service? Free; avoid embarrassment; privacy; convenience; no GP involvement (anonymous)?
What do you see as the negatives of such a pharmacy based service? Embarrassment; only tests for chlamydia; pharmacy vs GP; age restrictions (16-24)?

Personal

How many times have you used the service?
Was this at different stores? Why/why not?
Have you had any other STI tests? Which?
How would you describe your sexuality? Heterosexual/straight; bisexual; gay man; gay woman/lesbian; other; prefer not to say/refused?
How many partners have you had in the last 3 months? The last 12 months?
Do you use contraception during intercourse?

Summary

INTERVIEWER TO BRIEFLY SUMMARIZE KEY FINDINGS:-
Are there any further/other improvements which can be made (which have not mentioned)?
Finally, is there anything else you would like to add (that we have not previously covered)?

THANK & CLOSE

OBTAIN OR CHECK ADDRESS TO SEND INCENTIVE