Chlamydia screening evaluation – interim report

Wave One

Report prepared by TNS Healthcare for:

The Department of Health

125331  November 2005 - April 2006

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Introduction to the Wave One 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 1 report incorporates an evaluation from service launch to 30th April 2006.

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

Specimen and request forms returned to pharmacy then sent to lab.

Lab enters Test Request Form data and result onto database

Specimen collected (either at in-store toilet or away from pharmacy).

CSO informed of positive results

Negative and retest results: service user is notified by Boots

Service users treated by pharmacist following PGD. Patient Management Form completed

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

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. 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, September 2006 and July 2007.
Wave one: November 2005  
Focus groups  
National survey  
Local survey

Wave two: September 2006  
National survey  
Local survey  
Employee perceptions

Wave three: July 2007  
National survey  
Local survey  
Economic Evaluation  

Continuous tracking  
Service use and outcome data  
Service user perceptions

Wave one therefore 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 54. 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. 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.
Each of the above components are described in detail in the appendices, while the summary below presents the key findings from Wave One.

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 can be monitored during waves 2 and 3 of the evaluation.

National Survey

A national survey was undertaken with 2011 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 one: key findings

Service Uptake

- 7772 pharmacy screens were undertaken between 14th November (launch of the Pharmacy Chlamydia Screening Pathway) and April 30th 2006.

- Based on this uptake, 16,848 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 7772 screens, 7060 resulted in either a positive or negative test result and the remainder were inconclusive. Of the 7060 screens, 5952 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 has fallen, and stabilised, since the service was launched.

- 41% of the total number of kits given out between service launch and April 30th were returned, although a broad upward trend in return rates, over time, is apparent (see Return Rates on page 31). More than half of the screening kits received are not 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. 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 a third of service users were 23 or 24 years or age.

- Although service users are predominantly female (79%), male users comprise 21%. This proportion of male users exceeds the national rate reported in the National Chlamydia screening programme annual report 2004/5 of 12.5%.

- 68% 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. 69% of female users are white, compared with 64% of male users.
The overall positivity rate in this group is 7%; this is lower than the overall positivity rate reported in the National Chlamydia Screening Programme 2004/5 Annual Report, which was 11%. The positivity rate across all service users, including those out of age, was 8%.

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.

EPOS data shows that an additional 1394 screening kits were refused due to age criteria in the period from service launch to April 30th 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)

Approximately 50% of positive service users are treated at Boots; the remainder are treated elsewhere. This low proportion appears to be mainly due to the Patient Group Directive (PGD) protocol, which we understand is currently under review.

The highest proportion of positive screens was among Black Caribbean service users (14%) and the lowest among Chinese service users (3%). White service users had a positivity rate of 7%. While proportions differ, this mirrors the trend found nationally.

12% of positive males had had a new sex partner within the last 3 months, and 10% had 2 or more new sex partners within the last 12 months, slightly lower the National Chlamydia Screening programme data.

8% of positive females had had a new sex partner within the last 3 months and 7% 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 Oxford Street (Sedley Place) and Liverpool Street Station.

Liverpool Street Station and 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 are extremely low, at 3%. The mystery shopping exercise indicates that one reason for this is that evaluation forms are not given to all customers.

217 evaluation forms were completed between service launch and April 30th. 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. The feasibility of including the questionnaire in the screening kit is currently being explored.

143 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 217 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.

32% of the 217 were not using condoms during the previous two months, either because they were using other forms of contraception or not using contraception. Of the 143 who could be matched, 48% had 2 or more partners in the previous 12 months, suggesting that these service users are participating in high-risk behaviours.

26% of the 217 stated that ‘A’ levels or their equivalent were their highest educational qualification, while 24% 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 (71%) and not the presence of a private consultation area (1%). No one cited an ‘in-store toilet’ as the rationale for their choice.

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) & 24% neither comfortable nor uncomfortable (mid point).

4% of the 217 service users had previously undertaken an in-store chlamydia screen. Of these 4%, 5 could be traced back using an ID; 3 have repeat records (when matching by date of birth/postcode) and of these 3, only 2 had an inconclusive result.

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 21 treatment evaluation questionnaires returned between service launch and 30th April 2006.

19 of these service users were satisfied with the overall screening and treatment process (rating 4 or 5 on a 5 point scale). Two respondents gave a rating of 3.

17 were very likely to recommend the service

**Mystery shopping**

20 participating pharmacies were ‘mystery shopped’.

All 20 participating stores asked mystery shoppers their age which is a contractual requirement, and 2 also asked their date of birth.

Only 9 pharmacy staff asked the mystery shoppers if they had signs or symptoms. While discretion may be required here, the screening service is not intended for people with signs or symptoms of chlamydia.

Only 3 mystery shoppers received a service evaluation questionnaire and in one instance the questionnaire was included in the screening kit and not given personally. No pharmacy staff encouraged return of the questionnaire. It is vital, for the success of the evaluation, that all service users are given the opportunity to fill out the questionnaire.
Pharmacy staff were rated positively for their customer interactions, with a few exceptions e.g. not offering a bag for the screener kit. It is important that even these few exceptions are addressed, given that embarrassment appears to be a barrier to service uptake.

Staff encouraged mystery shoppers to return the screening kit.

Focus group data

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 had higher levels of awareness of chlamydia than those in the national survey.

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

Approximately 50% of respondents in the local survey recognised that chlamydia is the fastest increasing STI or that it can be symptom free.

Respondents in the local survey were more positive about the proposed pharmacy service than respondents in the national survey.

The local survey showed that 35-59 year olds were the most knowledgeable group about chlamydia.
- 17% of the local survey respondents were aware of the service prior to launch, indicating that initial PR had been successful in raising awareness.

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

- 6% of national respondents and 12% of local respondents had previously been screened for chlamydia.

- 37% of previously screened respondents, in both the local and national surveys, had been screened at a GUM clinic, approximately 25% had been screened at the GP and 10% had been screened at a family planning clinic.
Appendices

Appendix one: Wave One Service Uptake and Service Evaluations

Appendix two: Wave One Mystery Shopping

Appendix three: Wave One Focus Group Research

Appendix four: Wave One Local and National surveys
Appendix one: Service uptake and service evaluations
Chlamydia screening evaluation
Service Uptake and Service Evaluation

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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 217 questionnaires, which reflects the low return rate of 3%, received between December (when questionnaires were circulated) and April 30th 2006.

Treatment evaluation data is reported for the 21 questionnaires, again received between December (when questionnaires were circulated) and April 30th 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 April 30th 2006.

The total number of samples returned during this period was 7772 samples, which averages 324 returns per week.

This suggests that a total of 16,848 screens could therefore be expected over 12 months (324 x 52 = 16,848) 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 fallen since the service was launched, although there was an initial increase from November to December 2005, with a broad decline from January 2006. It is not known why numbers have declined, although one hypothesis is that publicity surrounding the service launch led to high numbers of people participating initially.

45% of service users hear about the service via in store promotion, and only 21% via external media, which suggests that increased external marketing could increase uptake. We understand that Boots and the DoH are currently reviewing marketing activity.

It may also be possible to increase screening uptake through the actions of pharmacy staff. The majority of kits are requested by service users (i.e. they are not offered by pharmacy staff). 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. Currently, less than half the kits are returned, a figure that is comparable to other services, but one which would ideally be improved upon. This is currently being reviewed to assess areas for improvement.

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 7772 screening kits returned to the pharmacy between launch and end of April, 7060 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). 5952 of these 7060 screens were amongst users within the designated 16-24 year age band.

Amongst the 7060 the total number of positive screens in this period was 579 or 8%. Amongst the 5952 (16-24 year olds) the number of positive screens was 412 or 7%. The National Screening Programme Annual Report 2004/5, for example, found an overall positivity rate of 11%. 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 February 28th (the most currently available data from the PCSO) 55% of those who tested positive for chlamydia via Boots received treatment from Boots stores. Almost one third of all those who tested positive for chlamydia through the PCSPf attended a GUM clinic for treatment (31%) and 5.8% 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 April 30th 2006, for all service users at venues other than Boots pharmacies:
## Treatment Venues (excluding Boots)

<table>
<thead>
<tr>
<th>Treatment Venues</th>
<th>Number of clients</th>
<th>% of total positives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Health Services</td>
<td>176</td>
<td>69.6%</td>
</tr>
<tr>
<td>GP</td>
<td>37</td>
<td>14.6%</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>2.3%</td>
</tr>
<tr>
<td><strong>Total confirmed as treated</strong></td>
<td><strong>218</strong></td>
<td><strong>86.2%</strong></td>
</tr>
<tr>
<td>Letters sent, no response, still attempting to contact</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>3 letters, no response, NFA</td>
<td>7</td>
<td>2.8%</td>
</tr>
<tr>
<td>Aware, Rx not confirmed, NFA</td>
<td>11</td>
<td>4.3%</td>
</tr>
<tr>
<td>Unaware uncontactable NFA</td>
<td>17</td>
<td>6.7%</td>
</tr>
<tr>
<td>Unaware still attempting to contact</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Aware, still being followed up</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>253</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Data supplied by Boots shows that 404 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 30th April 2006.

<table>
<thead>
<tr>
<th>Store ID</th>
<th>Location</th>
<th>Number of kits returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>0132</td>
<td>Sedley Place, Oxford St. London</td>
<td>375</td>
</tr>
<tr>
<td>0803</td>
<td>Octagon Arcade, Liverpool Street Station</td>
<td>147</td>
</tr>
<tr>
<td>1571</td>
<td>Tottenham Court Road, London</td>
<td>109</td>
</tr>
<tr>
<td>0132</td>
<td>Chimes shopping centre, Uxbridge</td>
<td>100</td>
</tr>
<tr>
<td>1521</td>
<td>Kingsway, Greenwich</td>
<td>99</td>
</tr>
<tr>
<td>0785</td>
<td>High Rd, Wood Green</td>
<td>98</td>
</tr>
<tr>
<td>1000</td>
<td>Regent Street. Piccadilly Circus</td>
<td>91</td>
</tr>
<tr>
<td>0926</td>
<td>The Liberty, Romford</td>
<td>90</td>
</tr>
<tr>
<td>0849</td>
<td>Union Street, Kingston Upon Thames</td>
<td>84</td>
</tr>
<tr>
<td>0001</td>
<td>Default stores</td>
<td>590</td>
</tr>
</tbody>
</table>
The store that has had the most returned samples is Sedley Place on Oxford Street (375 returns). This store is getting kits returned at over twice the rate of Liverpool Street Station (147 returns).

590 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.

The table below shows the 12 stores undertaking the highest number of treatments between service launch and April 30th 2006.

<table>
<thead>
<tr>
<th>Name of store</th>
<th>PCT</th>
<th>Number of treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Octagon Arcade, Liverpool Street St.</td>
<td>City &amp; Hackney</td>
<td>13</td>
</tr>
<tr>
<td>Chimes Shopping Centre, Uxbridge</td>
<td>Hillingdon</td>
<td>10</td>
</tr>
<tr>
<td>Regent Street, Piccadilly Circus</td>
<td>Westminster</td>
<td>9</td>
</tr>
<tr>
<td>The Liberty, Romford</td>
<td>Havering</td>
<td>8</td>
</tr>
<tr>
<td>Glades Shopping Centre, Bromley</td>
<td>Southwark</td>
<td>6</td>
</tr>
<tr>
<td>Sedley Place, Oxford Street</td>
<td>Westminster</td>
<td>5</td>
</tr>
<tr>
<td>High Street, Hounslow</td>
<td>Hounslow</td>
<td>5</td>
</tr>
<tr>
<td>London Bridge Station</td>
<td>Southwark</td>
<td>5</td>
</tr>
<tr>
<td>High Road, Wood Green</td>
<td>Haringey</td>
<td>5</td>
</tr>
<tr>
<td>High Street, Sutton</td>
<td>Sutton and Merton</td>
<td>5</td>
</tr>
<tr>
<td>Waterloo Station</td>
<td>Southwark</td>
<td>5</td>
</tr>
<tr>
<td>Waterloo Lane, Romford</td>
<td>Havering</td>
<td>5</td>
</tr>
</tbody>
</table>

In terms of the number of treatments provided by a Boots store, Liverpool Street Station has provided the most treatments at 13 and Chimes Shopping Centre has provided 10.

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>
</tr>
</thead>
<tbody>
<tr>
<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>
</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 April 2006.

<table>
<thead>
<tr>
<th>GU clinics by PCT</th>
<th>Number attended</th>
<th>% of total positives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking &amp; Dagenham</td>
<td>3</td>
<td>1.7%</td>
</tr>
<tr>
<td>Barnet</td>
<td>3</td>
<td>1.7%</td>
</tr>
<tr>
<td>Brent</td>
<td>5</td>
<td>2.8%</td>
</tr>
<tr>
<td>Bromley</td>
<td>7</td>
<td>4.0%</td>
</tr>
<tr>
<td>Camden</td>
<td>27</td>
<td>15.3%</td>
</tr>
<tr>
<td>City of London</td>
<td>6</td>
<td>3.4%</td>
</tr>
<tr>
<td>Croyden</td>
<td>10</td>
<td>5.7%</td>
</tr>
<tr>
<td>Ealing</td>
<td>2</td>
<td>1.1%</td>
</tr>
<tr>
<td>Enfield</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Hammersmith &amp; Fulham</td>
<td>6</td>
<td>3.4%</td>
</tr>
<tr>
<td>Hackney</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Haringey</td>
<td>7</td>
<td>4.0%</td>
</tr>
<tr>
<td>Harrow</td>
<td>6</td>
<td>3.4%</td>
</tr>
<tr>
<td>Havering</td>
<td>10</td>
<td>5.7%</td>
</tr>
<tr>
<td>Hillingdon</td>
<td>3</td>
<td>1.7%</td>
</tr>
<tr>
<td>Hounslow</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Islington</td>
<td>3</td>
<td>1.7%</td>
</tr>
<tr>
<td>Kensington &amp; Chelsea</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Kingston</td>
<td>3</td>
<td>1.7%</td>
</tr>
<tr>
<td>Lambeth</td>
<td>3</td>
<td>1.7%</td>
</tr>
<tr>
<td>Lewisham</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Newham</td>
<td>5</td>
<td>2.8%</td>
</tr>
<tr>
<td>Southwark</td>
<td>5</td>
<td>2.8%</td>
</tr>
<tr>
<td>Sutton</td>
<td>4</td>
<td>2.3%</td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>3</td>
<td>1.7%</td>
</tr>
<tr>
<td>Waltham Forrest</td>
<td>5</td>
<td>2.8%</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>11</td>
<td>6.3%</td>
</tr>
<tr>
<td>Woolwich</td>
<td>9</td>
<td>5.1%</td>
</tr>
<tr>
<td>Westminster</td>
<td>12</td>
<td>6.8%</td>
</tr>
<tr>
<td>Out of London</td>
<td>14</td>
<td>8.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>176</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

 Clinics in Camden and Westminster London PCTs are providing the highest number of treatments. 8% of treatments are provided outside London.
Profile of service users: Laboratory data

Gender

In total 7060 successful screens were undertaken between November 2005 and April 30\textsuperscript{th} 2006, with 5952 amongst users within the designated 16-24 year old age band. Of these 79\% of service users were female and 21\% were male. This proportion of male screens compares very favourably with the 2004/5 National Chlamydia Screening Programme, in which 12.5\% 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 because men are generally considered to be less health conscious than women.

93\% of eligible service users (16-24 year olds, base 5952), tested negative for chlamydia with 7\% testing positive for chlamydia. However, 9.6\% of the males tested positive compared with only 6.2\% 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 10.9\% in women and 11.9\% in men. (2004/5 annual report)

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. 25\% of service users were aged 24 years and only 1\% were aged 16 years old.

50\% of males and 44\% 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 7060 successful screens, 13\% of service users were aged 25 years, 1\% 26 years old and 2\% 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.

**Ethnicity (16-24 year olds)**

The majority of people screened were white (68%) with an additional 13% 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%).

69% of female users are white and 64% of male. It is estimated that 62% of 16-24 year old males in greater London are white and 61% of females (BARB data 2003).

10% of male users were black, compared with a London population estimate of 15% for 16-24 year olds. (BARB data 2003)

---

**Figure 3: Ethnicity: Base 5952**

- White: 68%
- Other: 13%
- Mixed: 5%
- Black Caribbean: 3%
- Asian Subcontinent: 3%
- Black African: 3%
- Chinese or other Asian: 2%
- Black British: 2%
Previous partners (16-24 year olds)

Figure 4 shows that 35% of respondents have had a new partner in the last 3 months and 42% have had 2 or more new partners in the last 12 months.

Postcode data (16-24 year olds)

The majority of respondents (92%) 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 (8%).
Profile of chlamydia positive respondents

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

Overall 10% of the males (n= 1227) tested positive for chlamydia and 6% of females (n = 4725).

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

Of the total 7060 successful screens (which includes all those out of age), 5% of the 25 year olds were positive for chlamydia.

Figure 6: Age, gender and test result (Base:5952)
Positivity by ethnicity (16-24 year olds)

![Bar chart showing positivity by ethnicity](chart.png)

The highest proportion of positive tests was amongst Black Caribbeans (14%), followed by those whose ethnicity was Black British (12%).

The lowest proportion of positive tests was amongst those who were Chinese or other Asian (3%). Further to this only 5% of those from the Asian Subcontinent tested positive for chlamydia. Of the 4066 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 (6% and 7%) and Black Caribbean and Black British the highest (15% and 14% respectively). In the national programme positivity among White men and women under 25 years was 11%.

Positivity by behavioural risk (16-24 year olds)

12% of the men who had a new sex partner in the last 3 months tested positive while 8% of women who had a new sex partner in the last three months were positive. The national screening data, however, found that 13% of women who had a new sex partner in the past three months and 14% of men, were positive.

10% of males who had two or more sexual partners in the past 12 months were positive and 7% of females. However, the National Screening Programme found that 14% of both men and women who had had two or more sexual partners in the past 12 months were positive.
The proportion of men (7%) who tested positive for chlamydia, despite not having had a new partner in the last 3 months, was slightly higher than females (4%). Again this was similar for those who had not had two or more new sex partner in the last 12 months (males 8%; females 4%).

Positivity by behavioural risk

- **A new partner in past 3 months**
  - Women: 8 (Yes) 4 (No)
  - Men: 12 (Yes) 7 (No)

- **More than two new partners in last 12 months**
  - Women: 7 (Yes) 4 (No)
  - Men: 10 (Yes) 8 (No)
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.

<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>1691</td>
<td>545</td>
<td>32%</td>
</tr>
<tr>
<td>Week 2</td>
<td>1272</td>
<td>468</td>
<td>37%</td>
</tr>
<tr>
<td>Week 3</td>
<td>1206</td>
<td>441</td>
<td>37%</td>
</tr>
<tr>
<td>Week 4</td>
<td>1153</td>
<td>459</td>
<td>40%</td>
</tr>
<tr>
<td>Week 5 (11/12/05)</td>
<td>1067</td>
<td>387</td>
<td>36%</td>
</tr>
<tr>
<td>Week 6</td>
<td>801</td>
<td>289</td>
<td>36%</td>
</tr>
<tr>
<td>Week 7</td>
<td>429</td>
<td>126</td>
<td>29%</td>
</tr>
<tr>
<td>Week 8</td>
<td>702</td>
<td>297</td>
<td>42%</td>
</tr>
<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>
<td>46%</td>
</tr>
<tr>
<td>Week 12</td>
<td>492</td>
<td>238</td>
<td>48%</td>
</tr>
<tr>
<td>Week 13 (05/02/06)</td>
<td>514</td>
<td>219</td>
<td>43%</td>
</tr>
<tr>
<td>Week 14</td>
<td>535</td>
<td>218</td>
<td>41%</td>
</tr>
<tr>
<td>Week 15</td>
<td>514</td>
<td>286</td>
<td>56%</td>
</tr>
<tr>
<td>Week 16</td>
<td>528</td>
<td>235</td>
<td>45%</td>
</tr>
<tr>
<td>Week 17 (05/02/06)</td>
<td>448</td>
<td>192</td>
<td>43%</td>
</tr>
<tr>
<td>Week 18</td>
<td>473</td>
<td>218</td>
<td>46%</td>
</tr>
<tr>
<td>Week 19</td>
<td>412</td>
<td>224</td>
<td>54%</td>
</tr>
<tr>
<td>Week 20</td>
<td>429</td>
<td>197</td>
<td>46%</td>
</tr>
<tr>
<td>Week 21 (02/04/06)</td>
<td>458</td>
<td>168</td>
<td>37%</td>
</tr>
<tr>
<td>Week 22</td>
<td>366</td>
<td>166</td>
<td>45%</td>
</tr>
<tr>
<td>Week 23</td>
<td>376</td>
<td>182</td>
<td>48%</td>
</tr>
<tr>
<td>Week 24</td>
<td>363</td>
<td>184</td>
<td>51%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>16,163</td>
<td>6,615</td>
<td>41%</td>
</tr>
</tbody>
</table>

The average return rate for the period week beginning 14th November through to the end of week 24 is 41%.
It is not possible to know why the return rate is not higher. One explanation might be that when customers request the screening kit they do not realise that they need to return a specimen to the pharmacy. Customers may believe that the test can be undertaken at home and consequently decide not to undertake the test once they are aware of the process.

Alternatively, some customers may feel too embarrassed to return the screening kits, as we know that embarrassment is a barrier to service use.

The return rate is comparable with other services, although an 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 also fallen since service launch. This suggests that the service is now attracting customers who fall within the appropriate ages of 16-24 or alternatively staff may no longer be recording this information.

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>
</tr>
</thead>
<tbody>
<tr>
<td>Weeks 5-8 (11/12/2005-7/1/2006)</td>
<td>242</td>
</tr>
</tbody>
</table>
Screening evaluation data

Screening questionnaire returns have been extremely low, with a return rate of 3%. 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 1) which led to mystery shopping being carried out in 20 participating pharmacies to see whether questionnaires were provided.

The feasibility of inserting an evaluation questionnaire in the chlamydia screening kits is currently being explored. This change would ensure that every service user receives an evaluation questionnaire, although verbal encouragement to complete and return the questionnaires would still be needed.
<table>
<thead>
<tr>
<th>Week commencing</th>
<th>Screening Returns</th>
<th>Running total</th>
</tr>
</thead>
<tbody>
<tr>
<td>W/c 28/11</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>W/c 5/12</td>
<td>22</td>
<td>42</td>
</tr>
<tr>
<td>W/c 12/12</td>
<td>7</td>
<td>49</td>
</tr>
<tr>
<td>W/c 19/12</td>
<td>2</td>
<td>51</td>
</tr>
<tr>
<td>W/c 26/12</td>
<td>5</td>
<td>56</td>
</tr>
<tr>
<td>W/c 2/1</td>
<td>0</td>
<td>56</td>
</tr>
<tr>
<td>W/c 9/1</td>
<td>1</td>
<td>57</td>
</tr>
<tr>
<td>W/c 16/1</td>
<td>6</td>
<td>63</td>
</tr>
<tr>
<td>W/c 23/1</td>
<td>0</td>
<td>63</td>
</tr>
<tr>
<td>W/c 30/1</td>
<td>0</td>
<td>63</td>
</tr>
<tr>
<td>W/c 6/2</td>
<td>2</td>
<td>65</td>
</tr>
<tr>
<td>W/c 13/2</td>
<td>17</td>
<td>82</td>
</tr>
<tr>
<td>W/c 20/2</td>
<td>5</td>
<td>87</td>
</tr>
<tr>
<td>W/c 27/2</td>
<td>23</td>
<td>110</td>
</tr>
<tr>
<td>W/c 6/3</td>
<td>10</td>
<td>120</td>
</tr>
<tr>
<td>W/c 13/3</td>
<td>10</td>
<td>130</td>
</tr>
<tr>
<td>W/c 20/3</td>
<td>10</td>
<td>140</td>
</tr>
<tr>
<td>W/c 27/3</td>
<td>17</td>
<td>157</td>
</tr>
<tr>
<td>W/c 3/4</td>
<td>9</td>
<td>166</td>
</tr>
<tr>
<td>W/c 10/4</td>
<td>10</td>
<td>176</td>
</tr>
<tr>
<td>W/c 17/4</td>
<td>28</td>
<td>204</td>
</tr>
<tr>
<td>W/c 24/4</td>
<td>13</td>
<td>217</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>217</strong></td>
<td><strong>217</strong></td>
</tr>
</tbody>
</table>

Table 1: Number of screening questionnaires returned on a weekly basis since the launch of the PCSPf service

Ten stores with the highest number of questionnaire returns

<table>
<thead>
<tr>
<th>Store ID</th>
<th>Location</th>
<th>Number of questionnaires returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>0926</td>
<td>The Liberty, Romford</td>
<td>16</td>
</tr>
<tr>
<td>6497</td>
<td>Waterloo Lane, Romford</td>
<td>15</td>
</tr>
<tr>
<td>0001</td>
<td>Default store</td>
<td>12</td>
</tr>
<tr>
<td>1479</td>
<td>Broad Street, Teddington</td>
<td>10</td>
</tr>
<tr>
<td>1525</td>
<td>High Street, Bromley</td>
<td>9</td>
</tr>
<tr>
<td>5060</td>
<td>Fleet Street, London</td>
<td>9</td>
</tr>
<tr>
<td>6461</td>
<td>Kew Retail Park, Kew, Richmond</td>
<td>8</td>
</tr>
<tr>
<td>0796</td>
<td>High Road, North Finchley</td>
<td>7</td>
</tr>
<tr>
<td>0783</td>
<td>Haverstock Hill, Belsize Park</td>
<td>5</td>
</tr>
<tr>
<td>0871</td>
<td>Balham High Road</td>
<td>5</td>
</tr>
</tbody>
</table>
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.

However, when allocating screening questionnaires to pharmacies it has been assumed that service users return their sample to the pharmacy from where they collected a screening kit. This may not be the case and in future all screening questionnaires will be stamped with a store identifier to avoid making this assumption.

Data match between TRF and screening evaluation questionnaire – 143 respondents

Of the 217 service users who filled in the screening evaluation questionnaire, 143 have been matched with the data collected by Boots from the TRF. The remaining 74 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 area of residence, the data in the sample of 143 respondents is comparable with that from the 7060 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 (83%) than in the larger, total sample (79%), while the proportion of men in the matched group (17%) is slightly lower than in the total sample (21%).

Overall, however, differences between the two groups appear slight.
<table>
<thead>
<tr>
<th></th>
<th>7060 respondents</th>
<th>143 matched respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>21%</td>
<td>17%</td>
</tr>
<tr>
<td>Female</td>
<td>79%</td>
<td>83%</td>
</tr>
<tr>
<td><strong>Test result</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tested positive</td>
<td>8%</td>
<td>10%</td>
</tr>
<tr>
<td>Tested negative</td>
<td>92%</td>
<td>90%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>17</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>18</td>
<td>5%</td>
<td>3%</td>
</tr>
<tr>
<td>19</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td>20</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>21</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>22</td>
<td>13%</td>
<td>15%</td>
</tr>
<tr>
<td>23</td>
<td>17%</td>
<td>13%</td>
</tr>
<tr>
<td>24</td>
<td>21%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>69%</td>
<td>74%</td>
</tr>
<tr>
<td>Other</td>
<td>13%</td>
<td>8%</td>
</tr>
<tr>
<td>Mixed</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>3%</td>
<td>5%</td>
</tr>
<tr>
<td>Asian Subcontinent</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Black African</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Chinese other Asian</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>Black British</td>
<td>2%</td>
<td>1%</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>40%</td>
</tr>
<tr>
<td>No</td>
<td>44%</td>
<td>45%</td>
</tr>
<tr>
<td>Refused</td>
<td>21%</td>
<td>15%</td>
</tr>
<tr>
<td><strong>2 or more new partners in the last 12 months</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>42%</td>
<td>48%</td>
</tr>
<tr>
<td>No</td>
<td>36%</td>
<td>38%</td>
</tr>
<tr>
<td>Refused</td>
<td>22%</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Area of residence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greater London</td>
<td>60%</td>
<td>52%</td>
</tr>
<tr>
<td>Central London</td>
<td>32%</td>
<td>38%</td>
</tr>
<tr>
<td>Other</td>
<td>8%</td>
<td>10%</td>
</tr>
</tbody>
</table>
The results for the 217 screening evaluation questionnaires returned by April 30th 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 (52%) or were full time students (29%). Only 6% of respondents were both working and studying part time and only 2% were working part time. 5% of respondents, however, were unemployed and seeking work.

![Figure 11: SQ1. Which of the following best describes your current situation? Base: all respondents (217)](image-url)
2. **What is the highest qualification you have gained? If you are still in education, tick the highest you have gained so far.**

26% of respondents were educated to A level or NVQ level 3 equivalent. Of all the respondents questioned, 25% were educated to GCSE/NVQ level 2 or equivalent and 24% to first degree level. 4% of the sample had no qualifications.

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, 29% of the total respondents were using a condom on some occasions along with another contraceptive. 24% of respondents were only using another form of contraceptive (e.g. cap, pill, coil). 17% of respondents used a condom on every occasion with 6% of these using a condom along with another contraceptive. This 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 45% of respondents, the chlamydia screening service was discovered via an in-store promotion with just over one fifth of users (23%) finding out through friends or family. The number of respondents who discovered the service through an in-store promotion suggests that many of those using the service are opportunistic users. A total of 15% of respondents first heard of the chlamydia screening service through advertising, 8% through advertising on the radio, 7% through advertising on TV and 4% through advertising in a newspaper (see Figure 14).

![Figure 14: Q1. How did you first hear of the chlamydia screening service? Base: all respondents (217)](image)

51% 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, 28% 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

Figure 15 shows that the majority of people who collect the chlamydia screening test kit do not have any signs or symptoms. However, 15% of respondents stated that they decided to use the screening kit because they had signs and symptoms that concerned them. This figure may be of concern since the service was set up to offer opportunistic screening.

![Figure 15: Q2. Why did you decide to use the chlamydia screening kit? Base: all respondents (217)](image)

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

![Figure 16: Q3. How did you come to receive a chlamydia screening kit? Base: all respondents (217)](image)

Only 2% of respondents were offered a kit, which highlights that pharmacy staff, in line with contractual agreements, are not actively promoting use amongst the target age group. Although promotion by store personnel would require sensitivity, the 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. When considering strategies for
increasing service uptake, greater promotion by pharmacy staff is one that could be considered.

For almost all respondents (95%), the test that they collected with the questionnaire was the first test they had used. This suggests that service users are not ‘repeat’ users, something that can be monitored over time.

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.

3% of people also stated that the reason why they chose a pharmacy was because it was located away from home. 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% of respondents reporting this to be the reason why the pharmacy used was chosen over another pharmacy.

The data from the screening evaluation questionnaire contradicts the findings from the local and national survey, where a private consultation was considered to be a more important service attribute than convenience of a store. The screening evaluation data shows that only 1% of respondents chose a particular pharmacy for this reason.

Alternative locations for chlamydia testing

If the chlamydia screening service was not available via Boots, 34% of respondents stated that they would be tested in a hospital clinic (e.g. GUM) and 23% would go to a GP. Interestingly over a quarter of respondents (27%) would not have taken a test if the chlamydia test had not been available through Boots. This suggests 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 8% to an NHS drop in health centre.

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. This was undertaken on a scale of 1 to 5 where 1 was very uncomfortable and 5 was very comfortable. It appeared that respondents were relatively comfortable in asking for/being offered a screening kit in a pharmacy, with 43% being comfortable (a rating of 4 or 5) and 23% being uncomfortable (a rating of 1 or 2).
Similarly, when asked how comfortable they were receiving the kit in a community pharmacy, respondents appeared to be fairly comfortable with 49% giving a rating of 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, 50% of respondents 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 or hospital clinic, the pharmacy screening service is seen by 19% of respondents as being more confidential. 16% consider that screening through a pharmacy is more confidential than via a family planning clinic or a drop in health centre.
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’.

76% of respondents perceived pharmacy staff as knowledgeable (rating of 4 or 5), with 4% respondents stating that the pharmacy staff were not knowledgeable (rating of 1 and 2).
85% of respondents considered the pharmacy staff to be friendly (rating of 4 or 5) with only 2% rating the staff as not friendly (rating of 1 or 2).

Convenience and likelihood to recommend

Two thirds of respondents (66%) considered the service to be extremely convenient (rating 5) and a further 24% 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). No respondents rated the service ‘not at all’ convenient and only 1% was highly unlikely to recommend 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 (75%) with a further 7% 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.
88% of males gave an ease of use rating of quite or very easy. This compares with 69% of females. 2% of females rated it as ‘quite difficult, while none of the male respondents chose this option.

In summary, 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 30<sup>th</sup> April 2006, 21 treatment questionnaires were completed. During this period 418 number of tests were undertaken in Boots pharmacies, giving a return rate of 5%.

These results are best considered as indicators of how people feel about the service, rather than robust quantitative data.

Of these 21 respondents 10 received their test result by telephone, 5 by text and 4 by letter. 2 people did not answer this question.

5 people received their results within 3 days, 9 within 4-5 days and 5 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. 16 people selected the option helpful, 14 friendly, 8 professional and 1 formal.
13 service users chose to return to a pharmacy for treatment because of the convenient location. 6 people returned because they were pleased with the service when they collected the kit, 5 for the convenient hours, 5 because it is a confidential service and 5 because it seemed logical to get treatment from the sample place as the screening kit.

14 respondents returned to the same pharmacy that they collected the chlamydia kit from, and 5 went to a different pharmacy. 2 people did not respond.

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

18 service users rated the pharmacist as knowledgeable, rating 4 or 5 on a 5 point scale. Three others gave a rating of 3 and no one gave of rating lower than 3. 19 people rated the pharmacist as friendly and helpful, giving a rating of 4 or 5. No one gave a rating of less than 3.

9 respondents said that they received free condoms when they collected their treatment, 9 received specific advice about chlamydia, 7 received advice on safe sex and 6 information on sexually transmitted diseases. All 21 received information about the treatment.

19 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 3.

18 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 2 and one person gave a rating of 1, indicating ‘not at all satisfied’.

Finally, 19 people were satisfied with the overall screening and testing process. 2 people gave a rating of 3. 17 respondents described themselves as ‘very likely’ to recommend this service to someone else. One respondent was ‘very unlikely’ and 3 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:

<table>
<thead>
<tr>
<th>Very uncomfortable</th>
<th>Very comfortable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asking for a screening kit</td>
<td>1</td>
</tr>
<tr>
<td>Being offered a screening kit</td>
<td>1</td>
</tr>
<tr>
<td>Receiving the kit in a retail pharmacy</td>
<td>1</td>
</tr>
</tbody>
</table>

6. How confidential do you consider screening of Chlamydia through a pharmacy compared with the following screening locations?

<table>
<thead>
<tr>
<th>Less confidential</th>
<th>Equally confidential</th>
<th>More confidential</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital clinic (e.g. GUM)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>GP</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Family planning clinic/ contraceptive service</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Drop in health centre</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

7. Please rate the following questions:

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you find the pharmacy staff knowledgeable?</td>
<td>1</td>
</tr>
<tr>
<td>Did you find the staff friendly?</td>
<td>1</td>
</tr>
</tbody>
</table>
8. Overall how convenient did you find this service? [□] Not at all [□] 2 [□] 3 [□] 4 [□] Extremely

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>Highly likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
</tbody>
</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 were 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:

<table>
<thead>
<tr>
<th>SECTION A</th>
<th>SECTION B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Your details (confidential)</strong></td>
<td><strong>Ethisity - please tick one box only. (You can leave this section blank if you prefer)</strong></td>
</tr>
<tr>
<td>Title (box one box only):</td>
<td>White (WH)</td>
</tr>
<tr>
<td>Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐</td>
<td>Black Caribbean (BC)</td>
</tr>
<tr>
<td>Surname:</td>
<td>Black African (BA)</td>
</tr>
<tr>
<td>First name:</td>
<td>Black British (BB)</td>
</tr>
<tr>
<td>Date of birth:</td>
<td>Asian subcontinent: Indian, Pakistani, Bangladeshi (AI)</td>
</tr>
<tr>
<td>mm dd yy</td>
<td>Chinese or other Asian (ZH)</td>
</tr>
<tr>
<td>Home postcode:</td>
<td>Mixed (MX)</td>
</tr>
<tr>
<td>☐ ☐ ☐ ☐ ☐</td>
<td>Other (OT)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION C</th>
<th>STORI: USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete date &amp; time of sample return:</td>
<td>Date: _ _/ <em>/</em>/ _ _</td>
</tr>
<tr>
<td>Date:</td>
<td>Time: _ _ _ _</td>
</tr>
<tr>
<td>Store number:</td>
<td>Order code 00008</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION D</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>If it's important that we can contact you with your result, how would you like us to contact you? (Tick one box only)</td>
<td></td>
</tr>
<tr>
<td>Letter ☐ Phone ☐ Test ☐</td>
<td></td>
</tr>
<tr>
<td>If you would like us to phone you with your result, is it OK to leave a message?</td>
<td></td>
</tr>
<tr>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
</tbody>
</table>

| Address (for results by letter only): | |
| House No./name: | |
| Street: | |
| Town / City: | |
| County: | |
| Postcode: | |

---

**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 pathologist at your local participating Booth store (London area).
Appendix two: Wave one Mystery shopping
Chlamydia screening evaluation

Mystery shopping

Report prepared by TNS Healthcare for:

The Department of Health

125331 April 2006
Chlamydia Screening Mystery Shopping Exercise

Background

Given the extremely low response rate of questionnaires returned in the evaluation stage thus far (to date, only 25 of the 216 participating stores have returned questionnaires and only 157 questionnaires in total have been returned), a mystery shopper exercise was undertaken. The key objectives were:

- To understand if Pharmacy staff are giving out evaluation questionnaires
- If they are, to gauge the extent to which they are encouraging mystery shoppers to return their questionnaires
- Additionally, the exercise was used to ascertain whether those requesting kits were asked their age, date of birth and whether they had any symptoms
- A tertiary objective was to establish if Pharmacy staff are encouraging mystery shoppers to return their screening kits and also to evaluate the friendliness, helpfulness and discreteness of the interaction

Mystery shoppers

Ten mystery shoppers were selected to undertake the mystery shopping interviews. Eight of the mystery shoppers were TNS executives who are all market researchers. All are trained researchers, aware of the principles and purpose of mystery shopping.

The remaining two mystery shoppers were recruited externally and trained to undertake the mystery shop. This decision was taken in order to achieve a wider spread of ages and backgrounds.

The mystery shoppers were then briefed/trained by the evaluation team. They were told what to do, and what should and should not be said, and how to complete the questionnaire.

Methodology

20 mystery shopper interviews were conducted across a variety of Boots Pharmacies participating in the Chlamydia screening programme. The stores surveyed were an equal mix of inner London and suburban chains, and included both larger, flagship stores and smaller pharmacies.

Interviewers entered the store, requested a free Chlamydia screening kit, but offered no other information about themselves. In all cases, they gave their age (and date of birth if asked), but replied 'no' if asked about signs or symptoms.
Otherwise, the mystery shoppers engaged in a natural conversation with the Pharmacist (or Pharmacy staff). The interviewers did not request an evaluation questionnaire, or ask any questions about returning the screening kit.

After leaving the pharmacy, the mystery shoppers completed a short questionnaire regarding their experience in-store. A copy of the questionnaire is included at the end of this report.

**The initial interaction**

Of the 20 completed mystery shops, 13 mystery shoppers were seen by the Pharmacist, 5 by the Counter Assistant and 2 were not sure.

All 20 were asked their age, as required by the service. The screening service is only available to the 16-24 age group, so it is part of the Pharmacy Staffs’ role to check the age. Of these 20, 2 were asked their actual date of birth, although this is not a contractual requirement.

9 of the 20 mystery shoppers were asked if they had any signs or symptoms that caused them to believe they had Chlamydia. In reality, all should have been posed this question.

**Evaluation of the Pharmacy Staff**

The mystery shoppers were asked to rate the Pharmacy staff in terms of their apparent knowledge of the screening process, how friendly, how discrete and how helpful they were. For each attribute, the interviewer ranked the Pharmacy on a scale of 1 (not at all) to 5 (extremely).

<table>
<thead>
<tr>
<th>Knowledgeable</th>
<th>Friendly</th>
<th>Discrete</th>
<th>Helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely (5)</td>
<td>3</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>4</td>
<td>7</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Not at all (1)</td>
<td>4</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Mean score/5</td>
<td>3.1</td>
<td>3.8</td>
<td>3.4</td>
</tr>
</tbody>
</table>

On the whole, the Pharmacy Staff were seen to be friendly. Responses were slightly more varied for ‘knowledgeable’ and ‘discreet’, with a few comments on Pharmacy Staff calling questions and instructions across the store which other customers could hear, though these were in the minority.

**Distribution of evaluation questionnaire**

Of the 20 mystery shops conducted, only 3 mystery shoppers were given the evaluation questionnaire. Furthermore, 1 of these was put inside the screener kit and not mentioned by the Pharmacy Staff.
In the 2 cases that a questionnaire was given to the mystery shopper, it was simply pointed out and the mystery shopper was not encouraged to return the questionnaire.

These results go a long way to demonstrating why return rates of the questionnaire are so low. The success of this methodology is dependent upon the buy-in of the Pharmacy Staff, to help encourage those requesting kits to return a questionnaire.

The evaluation questionnaire is an integral part of the Chlamydia screening programme, as it allows the Department of Health to assess the success of the scheme, as well as linking up the demographics of those returning kits with the data collected by Boots. As such, the number of questionnaires offered is very disappointing.

**Returning screening kits**

For each mystery shop, mystery shoppers were asked the extent to which the Pharmacy staff encouraged them to return their screening kits.

<table>
<thead>
<tr>
<th>How strongly encouraged to return kit?</th>
<th>Number of mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very strongly (4)</td>
<td>0</td>
</tr>
<tr>
<td>Quite strongly (3)</td>
<td>10</td>
</tr>
<tr>
<td>Not very strongly (2)</td>
<td>1</td>
</tr>
<tr>
<td>Not at all (1)</td>
<td>9</td>
</tr>
<tr>
<td>Mean score/4</td>
<td>2.0</td>
</tr>
</tbody>
</table>

The results differed greatly from store to store, with an equal number of interviewers claiming that the Pharmacy Staff did encourage them to return screening kits as those who did not.

It is positive that a good number of Pharmacy Staff are encouraging those collecting kits to return them, as this is essential to the continuation of the programme. To the same extent, though, it is clear that more must be done to raise awareness amongst all Pharmacy Staff about the importance of encouraging kit returns.

**Other comments**

The comments listed below are some of the verbatim comments that interviewers made about their interaction with Pharmacy Staff:

<table>
<thead>
<tr>
<th>Comments</th>
<th>Number of mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generally a good service</td>
<td>2</td>
</tr>
<tr>
<td>The Pharmacy Staff had to read the pack to give me advice</td>
<td>1</td>
</tr>
<tr>
<td>I was told how long I had to return the kit</td>
<td>1</td>
</tr>
<tr>
<td>I was told how to get best results from the kit</td>
<td>1</td>
</tr>
<tr>
<td>Told that I could return the kit to any Boots</td>
<td>1</td>
</tr>
<tr>
<td>Emphasised that I must return the kit within 6 hours of doing the test</td>
<td>1</td>
</tr>
<tr>
<td>I was not offered a bag to hide the kit</td>
<td>1</td>
</tr>
</tbody>
</table>
Conclusions

Overall, it is encouraging that Pharmacy Staff do seem to be asking the protocol questions (age reliably, although symptoms less so), as this is part of their directive.

However, there are areas where the Pharmacy Staff need to be briefed more clearly about their role in the screening programme in terms of the independent evaluation. Without the Pharmacy Staff distributing questionnaires and encouraging their return, the Department of Health will not be able to measure the success of the programme against the pre-defined criteria.
Chlamydia screening mystery shopping

Aims:

Chlamydia testing kits are currently available free, from any Boots store situated within the M25, for people aged between 16-24.

They are not available for people outside this age range, or to people who have specific symptoms. (These people are referred elsewhere)

TNS Healthcare is currently running an evaluation of the service and what service users think of it. In order to do this, everyone who collects a test kit should also be given a TNS evaluation questionnaire.

The aim of this mystery shop is primarily to check that these questionnaires are provided to all service users. The secondary aim is to collect further information about the actual process of collecting a kit.

It is important that you complete all the questions on the questionnaire

Instructions:

Please enter the agreed Boots store at a day and time that is convenient for you.

Go the pharmacy counter only

Please ask: “Could I have one of your free Chlamydia kits please”

Don’t offer any other information about yourself.

If asked, give your age. (Must be between 16-24 years)

If asked, give your date of birth. (Must place you between 16-24 years)

If asked about signs/symptoms, say that you do not have any

The remainder of the interaction should be as natural as possible…ask questions/seek clarification if you are told things that you do not understand, or that you feel you would naturally ask.

DO NOT request an evaluation questionnaire – just wait to see if this provided

Please complete the questionnaire below AFTER you have left the store. Please complete a separate questionnaire for each store.

Return screener kits and anything else provided within the store to Catherine Isherwood.
Mystery shopping protocol and questionnaire

Aims:

Chlamydia testing kits are currently available free, from Boots pharmacies situated within the London PCT boundaries, for people aged between 16-24.

They are not available for people outside this age range, or to people who have specific symptoms. (These people are referred elsewhere)

TNS Healthcare is currently running an evaluation of the service and what service users think of it. In order to do this, everyone who collects a test kit should also be given a TNS evaluation questionnaire.

The aim of this mystery shop is primarily to check that these questionnaires are provided to all service users. The secondary aim is to collect further information about the actual process of collecting a kit.

It is important that you complete all the questions on the questionnaire

Instructions for the mystery shoppers:

Please enter the agreed Boots store at a day and time that is convenient for you.

Go the pharmacy counter only

Please ask: “Could I have one of your free chlamydia kits please”

Don’t offer any other information about yourself.

If asked, give your age. (Must be between 16-24 years)

If asked, give your date of birth. (Must place you between 16-24 years)

If asked about signs/symptoms, say that you do not have any

The remainder of the interaction should be as natural as possible…ask questions/seek clarification if you are told things that you do not understand, or that you feel you would naturally ask.
DO NOT request an evaluation questionnaire – just wait to see if this provided

Please complete the questionnaire below AFTER you have left the store. Please complete a separate questionnaire for each store.

Return screener kits and anything else provided within the store to Catherine Isherwood.
Mystery shop questionnaire

Name of mystery shopper: ____________________________________________________________

Boots Store Location:

Street name: ___________________________________________________________________

London Location: __________________________________________________________________

Day:  Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday [ ] Sunday [ ]

Time of day:

1. Who served you with the chlamydia screening kit?
   - Pharmacist [ ]
   - Pharmacy assistant/Counter assistant [ ]
   - Unsure [ ]

2. Were you asked your age?
   - Yes [ ]
   - No [ ]

3. Were you asked your date of birth?
   - Yes [ ]
   - No [ ]

4. Were you asked if you have any signs or symptoms?
   - Yes [ ]
   - No [ ]

5. Please rate the following questions:
   - Did you find the pharmacy staff knowledgeable? 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ]
   - Did you find the staff friendly? 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ]
   - Did you find the service discrete? 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ]
   - Did you find the staff helpful? 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ]
6. Were you given a TNS research questionnaire?
   Yes ☐
   No ☐

7. If given a TNS research questionnaire, which of the following applies?
   - Nothing was said about the research questionnaire ☐
   - The research questionnaire was pointed out to me ☐
   - The research questionnaire was pointed out to me, and I was encouraged to complete and return it ☐

8. How strongly did the Pharmacist encourage you to return your screening kit?
   - Very strongly ☐
   - Quite strongly ☐
   - Not very strongly ☐
   - Not at all ☐

Do you have any other comments on this mystery shop? E.g. what worked well, was there anything that would have made this better?

Please return completed mystery shop questionnaire to Catherine Isherwood.
Appendix three: Wave one focus group research
Chlamydia: consumer focus groups

A research report prepared by TNS Healthcare for:

Department of Health

December 2005

125331

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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</th>
<th>Month 6 – Wave 2 (March ’06)</th>
<th>Months 7-17</th>
<th>Month 18 – Wave 3 (March ’07)</th>
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<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>
<td></td>
</tr>
<tr>
<td>Local population survey (Oct ’05)</td>
<td>Local population survey (Feb ’06)</td>
<td>Local population survey (Feb ’07)</td>
<td></td>
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<tr>
<td>National population survey (Oct ’05)</td>
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<td>REPORT</td>
<td>REPORT</td>
<td>REPORT</td>
<td></td>
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</tbody>
</table>
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>
</tr>
</thead>
<tbody>
<tr>
<td>3 groups with 16-24 year olds</td>
</tr>
<tr>
<td>- 1 group males</td>
</tr>
<tr>
<td>- 1 group females</td>
</tr>
<tr>
<td>- 1 mixed gender</td>
</tr>
<tr>
<td>3 geographical locations (within M25 radius)</td>
</tr>
<tr>
<td>Socio-economic mix</td>
</tr>
<tr>
<td>Ethnic mix</td>
</tr>
<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>
</tr>
<tr>
<td>3 geographical locations (within M25 radius)</td>
</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:

“Also 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.

**Treating 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 all the trauma of treating it and clearing it, you might just thing it 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 again the convenience of accessing high street pharmacies, and respondents like 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 improvement 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!”
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?’

---

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?’

---

Mixed 16-24
Healthcare

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 is thinking...

I hope it’s ok

Pharmacist is thinking...

Sorry son

Customer says to pharmacist...

‘My chlamydia result was positive’

Lewisham 25-65

Healthcare

Using the chlamydia screening service

Customer is thinking...

Need to be treated

Pharmacist is thinking...

Simple test

Customer says to pharmacist...

‘My chlamydia result was positive’

Mix 25-65

Healthcare
Using the chlamydia screening service

Customer is thinking...

I'm f**ked

Customer says to pharmacist...

'My chlamydia result was positive'

Pharmacist is thinking...

Another one bites the dust

Male 16-24

Healthcare

Using the chlamydia screening service

Customer is thinking...

No what is chlamydia?

Customer says to pharmacist...

I think I have

Pharmacist is thinking...

It's a good idea to check it out

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...

Pharmacist is thinking...

Customer says to pharmacist...

Pharmacist says to customer...

Just want to find out about it

Customer is thinking positively

No, can I have an information pack please

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

Female 16-24

Healthcare

Using the chlamydia screening service

Customer is thinking...

Pharmacist is thinking...

Customer says to pharmacist...

Pharmacist says to customer...

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

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

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

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

Mix 25-65

Healthcare
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....’

Healthcare

Male 16-24
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: 
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/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.

@ 

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.
Respondent’s signature: ___________________________ Date: ________________

RECRUITMENT QUESTIONNAIRE

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<thead>
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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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P1  Age

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

SHOW CARD
CLOSE
CLOSE
CLOSE

P2  Gender

Male      1
Female    2
CLOS

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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<td>AIDS/HIV</td>
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<td>Chlamydia</td>
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<td>Gonorrhoea</td>
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<td>Genital warts</td>
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</tbody>
</table>

### P5
Ethnicity

<table>
<thead>
<tr>
<th>SHOW CARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>White (WH)</td>
</tr>
<tr>
<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>
</tr>
<tr>
<td>Other (OT)</td>
</tr>
</tbody>
</table>
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
Discussion Guide – Public Opinion – 125331
Attitudes and Views on chlamydia testing in the community

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?

PROBE: 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
PROBE: 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?

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

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

PROBE 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 as 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 them 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?
PROBE and discuss
PROMPT: Symptoms go away, ‘spoil’ the kit in some way, forget or ‘lose the moment’, embarrassment etc.

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 four: Wave one local and national surveys
Chlamydia: Local and national surveys

A research report prepared by TNS Healthcare for:

Department of Health

125/331 January 2006

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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. 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 this 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 will be evaluated.

Methodology

Two face-to-face surveys were undertaken, nationally (across the UK) and locally (within the M25 radius). 2011 adults participated in the national survey and 700 in the local survey.

The surveys were conducted in November 2005 and are due to be repeated twice over the following 18 months.

Aims

The aims of the survey were to explore awareness and reactions to the new chlamydia screening service, and assess knowledge of STIs and chlamydia. The aim was 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.

- Respondents in the local survey showed more awareness of all STIs.

- In both surveys females were more aware of chlamydia than males.

- 16-24 year olds are not the age group with highest awareness of chlamydia, even though they are the high risk group. Locally, 35-50 year olds showed significantly higher awareness than other age groups.

- There are clear trends for higher social groups to be more aware of STIs than lower social classes.

- Around 75% of respondents in both surveys identified GP surgeries and hospital clinics as places where chlamydia screening can take place.

- Less than 50% of national respondents recognised that chlamydia can affect both men and women.

- Less than 50% local respondents recognised that chlamydia is the fastest growing STI, with a similar proportion appreciating that it often has no signs or symptoms. One third of local respondents recognised that treatment is simple and effective, and that it is most prevalent among younger people.

- A very small proportion of respondents in both surveys (10% or less) believed that there were no long-term complications from chlamydia if left untreated. Smaller proportions believed that it 9% or less believed that it can be contracted from towels or glasses.

- Younger people were more likely to regard themselves as being at risk of acquiring chlamydia.

- 17% 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 positivism 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 as the most important service attributes.

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 (61%) 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.

The subsequent national and local surveys will show if there has been any change in view points.
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. Thus far, 26 local programme areas have 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. A further wave of local programmes is scheduled.

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) is being 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

A full timeframe is shown on the next page.

This report contains the findings from the pre-service local and national population surveys.
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Objectives – Local and National Population Surveys

The primary objective of this stage of the study was 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
- 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
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 2,000 adults aged over 16 are 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.
Research Considerations

Sample

The national population survey comprised 2,011 representative adults from across the UK, allowing an accurate measure of attitudes towards chlamydia. By repeating the survey in waves two and three (months 6 and 18), any significant changes can be detected in attitudes during the Pathfinder programme.

The local population survey involved 700 interviews from the London area, replicating the catchment zone 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 is shown below:

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<th>National survey (%)</th>
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</tr>
<tr>
<td>D</td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td>E</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>British</td>
<td>49</td>
<td>83</td>
</tr>
<tr>
<td>Irish</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Any other white</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Mixed</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Asian</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Black</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>Refused</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 1. Demographic breakdown national and local surveys  Base: 2011 (National survey), 718 (Local survey)

There is clearly a more diverse ethnic spread in the local (London) area.
Ethical Issues

Respondents were assured of anonymity and confidentially. No identifying information was collected and no quotes or statements in this report can be directly attributed to an individual.

Timings

Fieldwork for both surveys took place in November 2005, with both completing before the official start of the Pathfinder programme (November 14th). As such, they act as good control groups and are not as affected by any latent attitudes or awareness caused by the new programme.
Findings

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)

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 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 infections in the local survey rather than the national survey.

In each survey awareness of AIDS and HIV was higher than for any other STI, with Aids showing 94% awareness locally and 81% nationally.

Similar levels of awareness for Gonorrhoea and Syphilis were found in both the national and the local surveys. This supports the qualitative findings in which respondents tended to mentally ‘place together’ these two diseases.

![Chart showing awareness of STIs](image)

**Figure 1.** Awareness of STIs. Base: 2011 (National survey), 718 (Local survey)

Almost three quarters (73%) of those interviewed in the local survey were aware of the infection, with slightly less being aware of genital herpes (71%), genital warts (69%) and pubic lice (67%).

In the national survey, the pattern was much the same, although levels of awareness of each infection were lower. Almost two thirds (63%) of national respondents were aware of chlamydia and it was still the sixth known STI. 13% of national respondents were not aware of any STIs.
Gender

In the local survey males and females showed comparable levels of awareness for all STIs except for chlamydia. Significantly more females (77%) were aware of chlamydia than males (68%).

This pattern was repeated in the national survey where 65% of females were aware of chlamydia and 60% of men.

Females in the national survey also showed significantly greater awareness of genital warts (60% versus 54% males), pubic lice (57% versus 52% males) and bacterial vaginosis (31% versus 24% males).

Overall it would appear that females have a greater awareness of several STIs, and specifically of chlamydia. Clearly this may have implications on the uptake of the chlamydia screening service and the profile of the people who use it; before males use the service they will need to have developed an awareness and basic understanding of the disease.

Age

In the 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.

![Figure 2. Awareness of chlamydia. Base: 1260 (National survey), 526 (Local survey). ** = Significant at 99% level](image)

This significant difference was not demonstrated in the national survey. In the national survey there was a trend for awareness of sexually transmitted infections to diminish significantly in those aged 66 years or over. Figure 2 shows this in relation to chlamydia but it applies also to AIDS, HIV, genital warts, genital herpes and pubic lice. While older adults do not comprise a high-risk group for sexually transmitted infections, the difference between...
local and national older populations is surprising. Nationally, 19% of the over 66 year olds did not recognise any infections.

Social class

Although both surveys included some social class A respondents numbers were small, making statistically robust comparisons difficult. In the local survey, however, social class A respondents were highly aware of all sexually transmitted infections (80% or more) with one exception, bacterial vaginosis (50%).

A stronger example of social class differences can be seen between social class B respondents and social class E respondents in the local survey. The former were statistically more likely to be aware of all the presented sexually transmitted infections than those of social class E:

![Chart showing STI awareness by social classes B and E](chart.png)

**Figure 3.** Local Survey STI Awareness of social classes B and E. Base: 87 (social class B), 144 (social class E)  * - Significant at 95% level  ** - Significant at 99% level

Social class B respondents also demonstrated more awareness of sexually transmitted infections for those of social class D (see figure 4).
This pattern of results was again evident when looking at differences between awareness of those in social class B and those of social class C2. Here it is clear that awareness of STIs amongst those of social class B is generally higher than those in social class C2.
Interestingly, the social class showing the highest awareness of Sexually Transmitted Diseases in the national survey was social class C1, which tended to show higher awareness than social B:

<table>
<thead>
<tr>
<th>STI</th>
<th>Social class C1</th>
<th>Social class A</th>
<th>Social class B</th>
<th>Social class C2</th>
<th>Social class D</th>
<th>Social class E</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>85%</td>
<td>75%</td>
<td>80%</td>
<td>78%</td>
<td>80%</td>
<td>76%</td>
</tr>
<tr>
<td>HIV</td>
<td>84%</td>
<td>81%</td>
<td>76%</td>
<td>76%</td>
<td>76%</td>
<td>72%</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>78%</td>
<td>65%</td>
<td>66%</td>
<td>67%</td>
<td>65%</td>
<td>60%</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>75%</td>
<td>72%</td>
<td>68%</td>
<td>64%</td>
<td>60%</td>
<td>58%</td>
</tr>
<tr>
<td>Syphilis</td>
<td>79%</td>
<td>70%</td>
<td>70%</td>
<td>66%</td>
<td>58%</td>
<td>57%</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>71%</td>
<td>69%</td>
<td>67%</td>
<td>59%</td>
<td>53%</td>
<td>46%</td>
</tr>
<tr>
<td>Genital herpes</td>
<td>68%</td>
<td>67%</td>
<td>64%</td>
<td>57%</td>
<td>47%</td>
<td>44%</td>
</tr>
<tr>
<td>Genital Warts</td>
<td>67%</td>
<td>60%</td>
<td>59%</td>
<td>53%</td>
<td>50%</td>
<td>41%</td>
</tr>
<tr>
<td>Pubic lice</td>
<td>62%</td>
<td>65%</td>
<td>54%</td>
<td>50%</td>
<td>45%</td>
<td>45%</td>
</tr>
<tr>
<td>Bacterial vaginosis</td>
<td>31%</td>
<td>25%</td>
<td>28%</td>
<td>29%</td>
<td>18%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Table 2. Awareness of STIs between different social classes in the national survey. White areas indicate significant differences (95% level) from social class C1

Table 1 clearly shows that overall awareness of STIs for those of social class C1 was higher than other social classes. C1 did not vary significantly from social class A and was significantly higher than C2, D and E. Awareness for chlamydia in these social classes was also low when compared with the same social classes in the local survey who had 69%, 69%, and 66% respectively.

Overall, it can be seen 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 will need to target these groups appropriately in order to promote screening take up via Boots.
Ethnicity

In the national survey, the Asian sub-group was the ethnic group with the lowest awareness of chlamydia of only 24%. White British respondents showed significantly higher levels of awareness at 66%.

In the local population White British respondents again showed highest levels of chlamydia awareness at 84%. Here the Asian sub group was again lowest with 43% awareness.

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.

It is reassuring to see that the target age group (16-24) are equally as aware of STIs as other age groups. Those aged 66+ are least aware, but they do not form a high risk group.

Females show more awareness of chlamydia than males, and social classes B and C1 show highest awareness of STIs. It is reasonable to deduce from this that both males and lower social groups (the latter in particular) will need educating as they are potentially most at risk of contracting chlamydia.

These differences will be interesting to monitor going forwards, especially after the screening programme is rolled out across the London region.
Where can people get tested for STIs? (local)

Respondents in the local survey only were asked where people can be tested for STIs. This was asked as an open question after which respondents were prompted with a pre-determined list of those venues not already mentioned.

Overall

<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>Hospital clinics e.g. GUM</td>
<td>77%</td>
<td>57%</td>
<td>20%</td>
</tr>
<tr>
<td>GP</td>
<td>73%</td>
<td>56%</td>
<td>17%</td>
</tr>
<tr>
<td>Family Planning clinic</td>
<td>64%</td>
<td>39%</td>
<td>25%</td>
</tr>
<tr>
<td>NHS Drop in centre</td>
<td>61%</td>
<td>35%</td>
<td>26%</td>
</tr>
<tr>
<td>Well woman/well man</td>
<td>51%</td>
<td>30%</td>
<td>21%</td>
</tr>
<tr>
<td>Hospital A &amp; E</td>
<td>43%</td>
<td>27%</td>
<td>16%</td>
</tr>
<tr>
<td>Retail pharmacist</td>
<td>13%</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>Not Stated</td>
<td>2%</td>
<td>27%</td>
<td></td>
</tr>
</tbody>
</table>

Table 3. Overall awareness of testing locations. Local survey only. Base: 718

Around three quarters of people in the local survey (combined spontaneous and prompted mentions) suggested that people could be tested for STIs in a hospital clinic (e.g. GUM) (77%) or GP surgery (73%). It is interesting that GP receives so many mentions. It is not known whether respondents believed that testing takes place within a GP practice or whether a GP would arrange a referral.

Around 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%).

Only 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.
Gender

Significantly more females (72%) than males (54%) identified that family planning clinics were places that people be tested for STIs. Significantly more females (57%) than males (43%) also cited that well woman/man clinics offer STI testing.

As with awareness of STIs themselves, it appears that females are more knowledgeable in this area. However, equal proportions of males and females (6% of each) identified retail pharmacists as somewhere that people can go to be tested for STIs.

Age

Those aged 35-50 years were the group most knowledgeable about test locations. 71% of those aged 35-50, for example, identified an NHS drop in centre as a place to obtain STI testing. This was significantly higher than those aged 16-24 (60%) or 66+ (61%).

There were no significant differences, by age, in the proportion of respondents who responded that testing can take place in a retail pharmacy for either spontaneous or prompted questions. However, the actual numbers giving this response were very small.

Social Class

As with the awareness of sexually transmitted infections, social class B respondents had greater awareness of testing locations than other groups. This was most apparent when comparing levels of awareness for GP surgeries and NHS drop in clinics. (See table 2 which shows the combined spontaneous and prompted responses)

<table>
<thead>
<tr>
<th>Location</th>
<th>Social class B</th>
<th>Social class A</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>GP surgery</td>
<td>87%</td>
<td>90%</td>
<td>69%</td>
<td>71%</td>
<td>76%</td>
<td>70%</td>
</tr>
<tr>
<td>NHS drop in health centre</td>
<td>72%</td>
<td>90%</td>
<td>62%</td>
<td>58%</td>
<td>57%</td>
<td>56%</td>
</tr>
</tbody>
</table>

Table 4. Awareness of testing locations across social classes. (local survey)

Although awareness is higher amongst those of social class A than other groups the base size of this group is particularly small and therefore statistical comparisons with other groups are not possible.
Ethnicity

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.

However, when spontaneous and prompted responses are combined, equivalent proportions of both groups identified hospital clinics; although Asian respondents were less likely to spontaneously recall these, they were aware of the role played by GU clinics when prompted.

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 national survey respondents agreed with this statement compared with 61% of local respondents.

There was no significant difference in the proportion of males or females who recognised that this statement applies to chlamydia in either survey.

Once again there were significant age differences. Significantly more 16-24 year olds (64%) and 25-34 year olds agreed with the statement in the local survey than 66 year olds and over (48%). There were no other significant age differences in the local survey.

In the national survey there was a significant split between the under and over 50 year olds. Significantly more respondents aged 50 or under believed the statement, than respondents aged 51 or above:

<table>
<thead>
<tr>
<th></th>
<th>16-24 yrs</th>
<th>25 – 34 yrs</th>
<th>35-50 yrs</th>
<th>51-65</th>
<th>66+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local survey</td>
<td>64%</td>
<td>65%</td>
<td>61%</td>
<td>55%</td>
<td>48%</td>
</tr>
<tr>
<td>National survey</td>
<td>53%</td>
<td>50%</td>
<td>49%</td>
<td>41%</td>
<td>31%</td>
</tr>
</tbody>
</table>

Table 5. Proportion of respondents agreeing with ‘Both men and women can be infected by chlamydia’ shown by age. Base size: Local survey 718 National survey: 2011
Additionally, in the national survey, significantly more respondents from social class C1 (50%) agreed than those of social class C2 (43%), D (39%) or E (38%). However, there were no social class differences in the local survey where 67% of class B respondents, for example, agreed with the statement compared with 58% of social grade E.

The local survey showed no differences between respondents of different ethnicity although the national survey again found a significant difference between White British and Asian sub groups.

Those who have previously undergone chlamydia screening were more likely to agree with this statement than those who have not. In the national survey 63% of those screened recognised the truth of the statement compared with 48% of those non-screened. These figures were 72% and 60% in the local survey, which was also a significant difference.

Again, it is reassuring to see that the young are more knowledgeable since the Pharmacy Chlamydia Screening Pathfinder aims to attract this group. The similar responses for males and females suggests that if males do not attend for screening (as speculated in the qualitative research) it will not be due to ignorance that chlamydia can affect males.

Statement 2: Chlamydia rates in the UK are increasing faster than for other sexually transmitted infections

29% of all respondents in the national survey believed this statement to be true, compared with 45% of respondents in the local survey.

Significantly more women than men agreed in each survey:

Figure 6. Agreement with statement 'Chlamydia rates in the UK are increasing faster than for other sexually transmitted infections' by Gender. Local base: 718, National base: 2011
Age differences were again notable. Worryingly less than half of the 16-24 years olds in the local survey believed this statement, a proportion that fell further nationally.

<table>
<thead>
<tr>
<th></th>
<th>16-24 yrs</th>
<th>25 – 34 yrs</th>
<th>35-50 yrs</th>
<th>51-65</th>
<th>66+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local survey</td>
<td>45%</td>
<td>39%</td>
<td>52%</td>
<td>37%</td>
<td>45%</td>
</tr>
<tr>
<td>National survey</td>
<td>37%</td>
<td>36%</td>
<td>33%</td>
<td>26%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Table 6. Agreement with statement ‘Chlamydia rates in the UK are increasing faster than for other sexually transmitted infections’ by age. Local base: 718, National base: 2011

The table below shows that social class B respondents in the local survey are more likely to agree that chlamydia rates are increasing than social classes C2, D or E.

<table>
<thead>
<tr>
<th></th>
<th>Class A</th>
<th>Class B</th>
<th>Class C1</th>
<th>Class C2</th>
<th>Class D</th>
<th>Class E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local survey</td>
<td>60%</td>
<td>59%</td>
<td>47%</td>
<td>41%</td>
<td>36%</td>
<td>38%</td>
</tr>
<tr>
<td>National survey</td>
<td>27%</td>
<td>34%</td>
<td>34%</td>
<td>28%</td>
<td>24%</td>
<td>18%</td>
</tr>
</tbody>
</table>

Table 7. 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

Asian respondents in the national survey showed the lowest level of agreement with this statement, 8% compared with 31% of white British. The 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%).

Once again those respondents who had previously been screened for chlamydia were statistically more likely to agree with the statement than those who had not.
Statement 3: The majority of people with chlamydia have no signs or symptoms

32% of national respondents agreed that the majority of people with chlamydia have no signs or symptoms and 42% of local respondents agreed.

Females were statistically more likely to agree than males:

![Bar chart comparing agreement by gender and survey type]

Figure 7. Agreement with statement ‘The majority of people with Chlamydia have no signs or symptoms’ by gender Local base: 718, National base: 2011

The low agreement among males is worrying. Men are often assumed to be less health conscious then women, and any lack of awareness that chlamydia can be symptom free is unlikely to promote uptake of the screening pathway.

Once again, age and knowledge were related. The national survey again shows a steeper decline in knowledge across the age groups than the local survey. In the 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.

<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</th>
<th>66+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local survey</td>
<td>43%</td>
<td>42%</td>
<td>51%</td>
<td>33%</td>
<td>33%</td>
</tr>
<tr>
<td>National survey</td>
<td>42%</td>
<td>43%</td>
<td>33%</td>
<td>26%</td>
<td>19%</td>
</tr>
</tbody>
</table>

Table 8. Agreement with statement ‘Chlamydia rates in the UK are increasing faster than for other sexually transmitted infections' by age Local base: 718, National base: 2011

However, less than 50% of the key group of interest (16-24 year olds) were aware that chlamydia may have no signs or symptoms. Since the Pharmacy Chlamydia Pathway is providing opportunistic screening for symptom free individuals, it is essential that there is greater awareness here in order to encourage screening uptake.
Beliefs about this aspect of chlamydia were associated with social class in each survey. In the national survey respondents from class B and C1 show statistically more agreement than lower social grades.

In the 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%). Additionally those of social class C1 (47%) were significantly more likely to have this opinion than those of social class D (32%) and E (34%).

<table>
<thead>
<tr>
<th>Class</th>
<th>Local survey</th>
<th>National survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class A</td>
<td>60%</td>
<td>30%</td>
</tr>
<tr>
<td>Class B</td>
<td>54%</td>
<td>38%</td>
</tr>
<tr>
<td>Class C1</td>
<td>47%</td>
<td>38%</td>
</tr>
<tr>
<td>Class C2</td>
<td>40%</td>
<td>27%</td>
</tr>
<tr>
<td>Class D</td>
<td>32%</td>
<td>24%</td>
</tr>
<tr>
<td>Class E</td>
<td>34%</td>
<td>22%</td>
</tr>
</tbody>
</table>

*Table 9.* Agreement with statement ‘the majority of people with chlamydia have no signs or symptoms’ by class. Local and National survey

Again, the similar trends are appearing, insomuch as it is the 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. 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%).

**Statement 4: Treatment for chlamydia is simple and effective**

28% of national respondents and 33% of local agreed with this statement.

Once again female respondents in both surveys showed significantly greater accuracy of knowledge:

*Figure 8.* Agreement with statement ‘Treatment for chlamydia is simple and effective’ by Gender National base: 2011, Local base 718
Responses for respondents from different social classes continue to show the same lower awareness in lowest social classes:

<table>
<thead>
<tr>
<th>Class</th>
<th>Class A</th>
<th>Class B</th>
<th>Class C1</th>
<th>Class C2</th>
<th>Class D</th>
<th>Class E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local survey</td>
<td>50%</td>
<td>46%</td>
<td>39%</td>
<td>29%</td>
<td>16%</td>
<td>27%</td>
</tr>
<tr>
<td>National survey</td>
<td>37%</td>
<td>38%</td>
<td>32%</td>
<td>25%</td>
<td>20%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Table 10. Agreement with statement ‘Treatment of chlamydia is simple and effective by class. National base: 2011, Local base 718

Nationally, a significantly higher proportion of respondents from social class B responded accurately than from classes C2, D or E.

In the local survey social class B respondents (46%) were significantly more likely to state that the majority of people with chlamydia have no signs or symptoms than those of social class C2 (29%), D (16%) and E (27%). Additionally those of social class C1 (39%) were significantly more likely to have this opinion than those of social class D (16%) and E (27%).

Once again Asian respondents in the national survey showed the lowest amount of agreement with this statement (12%). In the local survey 24% of this respondent group agreed, which was still the lowest level of ethnic sub-group agreement except for ‘other’.

Statement 5: Chlamydia is more prevalent amongst younger people

In the national survey 37% of people held the view that chlamydia is more prevalent amongst younger people and 33% of local respondents agreed.

Interestingly there were no differences between male and female responses to this statement. 37% of males and 38% females agreed in the national survey and one third of both males and females agreed in the local survey.

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:

<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</th>
<th>66+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local survey</td>
<td>31%</td>
<td>30%</td>
<td>37%</td>
<td>33%</td>
<td>34%</td>
</tr>
<tr>
<td>National survey</td>
<td>34%</td>
<td>38%</td>
<td>35%</td>
<td>46%</td>
<td>34%</td>
</tr>
</tbody>
</table>

Table 11. Agreement with statement ‘Chlamydia is more prevalent among younger people’ by age National base: 2011, Local base 718
Once again there were social class differences, with the broad trend of higher social class being more knowledge than lower social classes continuing. For example, the national survey shows that 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%).

The national survey also showed a higher proportion of agreement among White British and Asian respondents although the local survey also showed no difference in responses among respondents from different ethnic groups.

The worrying finding is the majority of respondents did not agree with this statement suggesting that a basic understanding of high risk groups is missing for many, including those for whom the pharmacy screening pathway is intended.

**Statement 6:** The signs and symptoms of chlamydia can include discharge and abdominal pain

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.

Although some gender differences were apparent 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 the 95% significance level. These findings support the overall picture that women hold more accurate knowledge about chlamydia than men.

Nationally, 16-24 year olds were statistically more likely to accept this statement than the over 51 year olds. However, this was still only 33% of this age group, suggesting that there is a need for more education among younger, higher risk people.

Interestingly a greater proportion of young respondents agreed that the majority of people are symptom less which is probably the key information for this age group to understand if the chlamydia pathway is to be a success.

The 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.

Once again 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%).
Statement 7: Untreated chlamydia does not lead to any long term complications

6% of respondents in the national survey and 10% in the local survey thought that this statement applied to chlamydia.

Although there were no significant gender differences, 11% of females in the local population agreed implying that 1 in 10 London females do not understand the importance of seeking screening or treatment for chlamydia.

Fortunately only a small proportion of these sit in the 16-24 age group, as only 3% of this group overall (men and women) showed agreed with the statement in the local population, rising to 11% among those aged 25 to 34 and 35 to 50 years. This suggests that the local target age group are aware of the long-term implications of untreated chlamydia.

The national survey shows no age differences and approximately 6% of respondents in most age bands agree with the statement.

There are also no social class or ethnicity differences in the either the national or the local survey.

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, on occasion, 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.

5% of respondents in the national survey agreed, while 9% of local respondents believed in the statement “Chlamydia can be spread by sharing towels with an infected person”.

While no gender differences were observed in the national survey, low significant differences (95% significant) were noted in the local survey:

![Figure 9 Agreement with statement 'Chlamydia can be spread by sharing towels with an affected person' by Gender. National base: 2011, Local base 718](image-url)
In the 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, suggesting that younger people nationally still hold myths about STIs.

There were no age differences in the local survey and neither survey showed any social class or ethnicity effects. Do note, however, that the base sizes for this question were small.

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%) surveys. The only significant demographic difference relates to social class. Socio-economic group E (11%) showed more agreement than groups C1 (3%), C2 (3%) or D (1%) in the local survey.

Although the proportions who agree with these last two statements are low, it is interesting that it is the lower social grade (E) who are most likely to be mistaken about them. This emphasises social class as a risk factor.

Summary

These findings are in line with the earlier STI awareness data. There is 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.

In addition to these demographic findings, the results show that basic knowledge about chlamydia is lacking overall. Only 44% of national respondents recognised, for example, that chlamydia is an infection that affects both males and females.
Perceived self risk of contracting Chlamydia

Respondents in both 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 personal risk estimates match prevalence figures.

Local survey

Figure 10. Perceived personal risk of contracting chlamydia. Base 718.

Respondents in both surveys generally considered themselves to be at very low risk of infection. There were no differences, in either survey, in the proportion of males and females perceiving themselves as being at very high or quite high risk.

National survey

Figure 11. Perceived personal risk of contracting chlamydia. Base 2011.
Perceived personal risk of chlamydia infection showed some relationship to age:

<table>
<thead>
<tr>
<th>National population survey</th>
<th>16-24</th>
<th>25-34</th>
<th>35-50</th>
<th>51-65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very High</td>
<td>3%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Quite High</td>
<td>9%</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Quite low</td>
<td>16%</td>
<td>14%</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Very low</td>
<td>50%</td>
<td>61%</td>
<td>68%</td>
<td>67%</td>
</tr>
<tr>
<td>Not stated/DK</td>
<td>21%</td>
<td>23%</td>
<td>28%</td>
<td>38%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Local population survey</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Very High</td>
<td>7%</td>
<td>5%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Quite High</td>
<td>5%</td>
<td>4%</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Quite low</td>
<td>28%</td>
<td>13%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Very low</td>
<td>59%</td>
<td>75%</td>
<td>87%</td>
<td>88%</td>
</tr>
<tr>
<td>Not stated/DK</td>
<td>1%</td>
<td>3%</td>
<td>1%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Table 12. Perceived personal risk broken down by age National base size: 2011, local base size 718

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, while 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%).

A similar trend was seen in the 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%).

Overall, the 16-24 group do seem more likely to consider themselves at risk of contracting chlamydia. However, this is not to say that they are likely to opportunistically test themselves, as they generally still apply the label ‘quite low risk’.

This trait emerged in the qualitative stage of research too, and this ‘it will happen to someone else’ mentality seems to prevail in this quantitative stage as well. Only 3% of the local population 16-24 year olds consider themselves at high risk although results from opportunistic screening suggest that 1 in 10 could test positive for chlamydia.
Pharmacy Chlamydia Screening awareness

Respondents across both the local and national surveys were asked if they were aware of the chlamydia screening service that was about to be launched in pharmacies in London.

Overall

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.

Some gender differences were apparent. Awareness was significantly higher amongst females in the national population survey (17%, compared to 13% for males).

There were, however, no gender, age or ethnic differences in the local population.

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 had not.

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. This was an open question and responses were coded to a choice of five possible response options.

Over half of these respondents cited radio, TV or newspaper publicity as their source of awareness for the chlamydia screening service. Healthcare Professionals were mentioned by almost a third of these respondents and females were significantly more likely than males to mention this source.
Knowledge of chlamydia screening service (local population survey only)

Again, those 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 to fit any of five possible responses:

- Only testing for Chlamydia
- Self testing
- Urine test
- No visit to NHS/Clinic/GP required
- Available at Boots

Around 4/10 of these aware respondents knew that the service was self-administered and that it only tested for chlamydia. 2/10 were aware that the service was available from Boots Pharmacies.
There were no differences relating to age, gender or ethnicity differences among these respondents.

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).
Acceptability of service

Respondents in both surveys were asked whether a chlamydia screening service offered through high street chemists was acceptable.

<table>
<thead>
<tr>
<th>Local survey</th>
<th>National survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Not sure</td>
<td>Not sure</td>
</tr>
<tr>
<td>Not stated</td>
<td>Not stated</td>
</tr>
<tr>
<td>8%</td>
<td>10%</td>
</tr>
<tr>
<td>10%</td>
<td>35%</td>
</tr>
<tr>
<td>2%</td>
<td>10%</td>
</tr>
<tr>
<td>80%</td>
<td>55%</td>
</tr>
</tbody>
</table>

Figure 15. Acceptability of high street screening service. Base: 718 (Local survey), 2011 (national survey).

Respondents in the local survey were much more likely to believe that offering chlamydia screening through chemists is an acceptable proposition. One hypothesis is that, in the short term, this service would benefit them more directly than respondents outside the pilot area hence they are more accepting of the service. The higher proportion in the national survey (35%) stating ‘don’t know’ supports this interpretation.

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) as were social classes D (48%) and E (47%).

This trend was mirrored in the local survey, with the 16-24 (84%) and 35-50 (84%) age groups being significantly more likely to find this acceptable than the 51-65 (73%) and 66+ (69%) groups.

However, although local respondents are more accepting overall, those at higher risk appear to be more ambivalent. 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.

There were 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.
Views on chlamydia screening as a use of public/NHS money (national survey)

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. In general these respondents felt that the chlamydia screening service was an acceptable use of public money, with only 1/10 disagreeing.

The 66+ age group (mean score 0.5) were significantly more likely to disagree with the use of public money on such a service. 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.

White British respondents (0.8) were significantly more likely to agree with the service than those of an Asian background (0.5).
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

![Bar chart showing perceived advantages of the initiative](chart.png)

- Raises awareness of Chlamydia: 14
- Cheap/free treatment: 11
- Stop Chlamydia spreading: 11
- Quick/saves time: 11
- Less embarrassing: 10
- Accessible: 9
- Early detection/treatment: 8
- No appointment: 8
- Easy: 7
- Private: 6
- No need to see GP: 6
- Convenient: 6
- Encourage more people to go for testing: 6
- Don’t know: 14

Figure 17. Advantages of the initiative. Base: 718

Perceived benefits generally fall under ‘awareness of the condition’, ‘accessibility’, ‘reduces embarrassment’ and the fact that the ‘service is free’.

‘Raises awareness of chlamydia’ was the advantage mentioned top-of-mind by most respondents from across the two surveys (8%).
National survey

It is worth noting that a much greater proportion of respondents in the national survey have 'no opinion' about an advantages 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

The key themes in the local survey were embarrassment, encouraging unprotected or unsafe sex and concerns over receiving correct medical advice. The response cited top-of-mind most often was ‘concerns over accuracy of test’ (4%).

National survey

The key themes in the national survey were embarrassment, encouraging unprotected or unsafe sex and concerns over confidentiality. The response cited top-of-mind most often was ‘cost/expense to NHS’ (5%).
The topics mentioned by the national populace are very similar to those stated in the local survey. The most notable difference is the 5% claiming the cost to the NHS to be a disadvantage of the service. This could be because respondents in the national service will be ‘paying’ for a service that does not affect their locality and because they had previously been asked for their views on cost. The order of these questions will be changed in the next wave.

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 local survey, this factor 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). From the national survey, the 16-24 (5.2) and 25-34 (5.2) age groups cited this significantly lower than the 35-50 group (5.5).

Figure 21. Perceived importance of the service attributes. Base: 178 (Local survey), 2011 (National survey)
Helpful/knowledgeable staff

Females (mean score 4.5) in the national survey rated ‘helpful, knowledgeable staff’ significantly lower than their male counterparts (4.7).

Reliable results

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.

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.

No need for appointment/easily accessible

From the national survey, it was notable that the 16-24 age group (4.1) found this attribute to be significantly less important than any other age group (4.6 was the overall mean score).

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 (4.3, 4.2 and 3.8 respectively).

Private consultation area

Asian respondents (mean score 4.8) in the local survey were also significantly more likely than British (4.3) or Irish (3.8) respondents to cite this factor as important.

Convenience of store location

For males (mean score 3.5) in the local, target population area, the convenience of the store location was significantly more important than for females (3.2). The same applies to social classes D (3.5) and E (3.5) over social class B (2.9).

In-store toilet

Having an in-store toilet was the least important service factor by some way, across both surveys. Consequently, there were no significant differences across the demographic subsets.
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. Given the significantly lower levels of awareness about chlamydia and STIs amongst this group, it is important 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, so it is clearly a factor that must 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.

![Graph showing perceived confidentiality of service]

**Figure 22.** Perceived confidentiality of service. Base: 718 (local survey) 2011 (national survey)

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. However, 25% of national respondents and 24% of local respondents believed it would be less confidential than a GUM clinic.

The national population survey also shows that respondents aged 16-24 (mean score 2.0) are significantly more likely than those aged 66+ (1.8) to believe that the In-Pharmacy service is more confidential than a hospital clinic. Respondents aged 16-24 (2.0), 25-34 (2.0) or 35-50 (1.9) are significantly more likely than those aged 66+ (1.8) to believe that the new service is more confidential than an NHS drop-in centre. These are impressive assertions of confidence in the new service, coming as they do from the appropriate ‘target’ demographics. Social class E (2.0) is also significantly more likely than class B (1.8), C1 (1.9) or C2 (1.9) to cite that the new service is more confidential than a GP consultation.
However, the local survey results show some differences from this national picture. In the local survey, the 25-34 (mean score 1.9), 35-50 (1.9) and 66+ (2.1) age groups are significantly more likely than the 16-24 (1.7) and 51-65 (1.6) groups to believe that the In-Pharmacy service is more confidential than a GP consultation. This implies that there is scope to increase the confidence of the 16-24 year olds in service confidentiality.

Social classes A (1.4) and C1 (1.7) are significantly less likely than social class B (2.0) to state that the new service is more confidential than an NHS drop-in centre. British White respondents (1.8) are significantly more likely than Asian respondents (1.5) to claim that the In-Pharmacy service is more confidential than a family planning service.

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.

![Figure 22. Perceived reliability of the service. Base: 718 (Local survey), 2011 (National survey)](image)

Overall, nationally and locally, the results obtained via the new service were perceived to be as reliable as all other existing screening locations.

In the local survey, however, the 16-24 age group (mean score 1.7) were significantly more likely to consider that test results from the In-Pharmacy screening service would be less reliable than a GP than all other age groups (overall mean score 1.9). This age group also viewed the pharmacy results service as less reliable than both a family planning clinic (1.7) and NHS drop in centre (1.6) compared with the 25-34 (1.9 and 1.8 respectively), 35-40 (2.0 and 1.9 respectively) and 51-65 (1.9 and 2.0 respectively) age groups.
Figure 23. Perceived reliability of In-pharmacy screening compared with other screening locations: Percentages for ‘As reliable as’ – local survey. Base: 718  ** = significant at 99% level

Again this suggests there may be some challenge in convincing this age group of the quality of the testing service.

In the national survey, those in the 66+ age group (see figure 19) were significantly less likely to perceive the In-pharmacy screening as equally as reliable as all other screening locations compared with the other age groups.

The national survey also found that those of White British origin (50%) were significantly more likely to perceive the new screening service as equally as reliable as screening via a hospital clinic than those of Asian (35%) and black (32%) origin. Additionally, White British respondents (68%) were significantly more likely to perceive the new screening treatment to be as equally as reliable as screening via a GP surgery than those of Black origin (28%).

Differences were also noted, in the national survey, between social classes. Those of social class C1 (54%) being significantly more likely to consider the new screening service to be as reliable as a hospital clinic, compared to all other social classes. Social class C1 (53%) and C2 (50%) were also significantly more likely to consider the reliability of test results received via In-pharmacy screening to be as reliable as from a GP surgery than those of social class E (41%). Social class C1 (56%) were also significantly more likely to consider the test results from the new service to be as reliable as those from a family planning clinic and an NHS drop in centre than both social class D (43% & 44% respectively) and E (43% & 41% respectively).
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 significantly more females than males had been previously screened for chlamydia.

**National survey**

![Pie chart showing screening intervals](chart.png)

**Figure 24.** Previous screening for chlamydia. Base: 2011

84% of respondents in the National survey had never previously been screened or tested for chlamydia. 86% of males had been tested compared with 82% females.

Unsurprisingly, the older age ranges contained significantly larger proportions of ‘never tested’ respondents: 35-50 (88%), 51-60 (87%) and 66+ (84%), than the 16-24 (80%) and 25-34 (75%) age group.

Respondents in social class B were more likely to have been tested than any other social class. However, significantly more of those in social class C1 (86%) than those in social class E (78%) stated that they’d never previously been tested for chlamydia.

No differences in screening rates between different ethnic groups were noted.

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. This finding implies that people who consider themselves to be at risk of chlamydia are prepared to take health care action.
Local survey

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.

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%).

<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</th>
<th>66+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>85%</td>
<td>78%</td>
<td>86%</td>
<td>92%</td>
<td>89</td>
</tr>
<tr>
<td>Within past 6 month</td>
<td>7%</td>
<td>5%</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>7-12 months</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Over 12 months</td>
<td>3%</td>
<td>3%</td>
<td>7%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Not stated</td>
<td>1%</td>
<td>3%</td>
<td>1%</td>
<td>2%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Table 13: Chlamydia screening by age Base: 718

There was no real indication that target 16-24 year olds are more likely to have been screened than others, with the exception of one significant difference (at 95%) which showed that they are more likely to have been screened within the last 6 months than over 51 year olds.

There was no relationship between previous screening and social class or ethnicity.

However, those who believe themselves to be at are were 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%.
Previous screening/testing locations

The 6% of national respondents who had previously been tested attended a variety of screening/testing locations. The majority using a hospital clinic (37%).

Gender and ethnicity were not connected with place of testing.

There was a tendency (95% sig.) for 16-24 year olds to favour drop in centres above other age groups. This is encouraging as it suggests they are willing to use opportunistic testing, without a personal relationship with a Health Care Professional.

![Figure 22. Locations in which respondents had previously been tested. Base: All those previously tested (116)](image-url)
In the local survey, as in the national survey, the most popular place for testing appears to be a hospital clinic (see figure 23).

**Figure 27.** Locations in which respondents had previously been tested. Base: All those previously tested (108). Local survey

As in the national survey there was no association between screening location and gender, age, class or ethnicity.
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.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embarrassment</td>
<td>4.54</td>
</tr>
<tr>
<td>Concerns over confidentiality</td>
<td>3.63</td>
</tr>
<tr>
<td>Busy pharmacy/lack of privacy</td>
<td>3.44</td>
</tr>
<tr>
<td>Denial of being at risk</td>
<td>3.28</td>
</tr>
<tr>
<td>Prefer to see different HCP</td>
<td>3.15</td>
</tr>
<tr>
<td>Lack of confidence in results</td>
<td>2.97</td>
</tr>
</tbody>
</table>

Figure 28. Factors preventing uptake- mean scores. Base: 718

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% of respondents. Concern over confidentiality, on the other hand, was rated most important by only 14% of respondents. Embarrassment was a key theme to emerge from the qualitative research and it does appear from the quantitative research that this may be a real potential barrier for service uptake.

There were no gender, age or social class differences in views on embarrassment. ‘Embarrassment’ was ranked significantly more important by White British respondents (4.8) than other white respondents (4.05) of those of ‘any other’ ethnicity (3.29).

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. Social groups C1, C2, D and E all attached more importance to this than group B.

Further differences between ethnicities were noticed. ‘Lack of confidence in the results’ was significantly more important to ‘other white’ (3.35), Asian (3.44) and Black (3.33) respondents than White British (2.62) or Irish (2.17) respondents.
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.

It was also noted that the female respondents (3.59) ranked ‘Busy pharmacy/lack of privacy’ significantly more important than males (3.23). 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. White British respondents also showed more concern for privacy than Black respondents.

Finally, those of social class B (3.55) ranked ‘Denial of being at risk’ as significantly more important than those of social class D (2.85).

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 seems therefore 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.

Figure 29. Confidence in future success of the service. Base: 718

There were no differences in confidence levels between males or females or between ages. Social class was not related to predicted success either.

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.

Those who consider the in-pharmacy screening to be an acceptable service 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.
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.

The findings are shown in Figure 30 below:

![Figure 30. Potential impact of the chlamydia screening service – mean scores. Base: 718](image)

The three positive outcomes were all considered more likely to happen than the negative outcome.

**Increased awareness of chlamydia**

The overwhelming prediction was that the initiative will increase awareness of chlamydia. The majority of respondents believe that the initiative will result in greater awareness and only 6% rated it very or quite unlikely.

There was no significant difference between males and females or across ages in their prediction of this. Over 66 year olds were, however, more likely than some younger age groups to not state an opinion.

Neither was there any association between likelihood of increased awareness and social class or ethnicity and mean scores.

Those who consider the service acceptable were more likely to believe that increased awareness will result than those who consider it unacceptable. (mean of 1.15 versus .74)
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. Only 7% considered it very or quite unlikely.

Males and females were equally optimistic, as were all age groups, social classes and ethnic groups.

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 1.02 versus .69)

Decreasing the number of cases of chlamydia in 16-24 year olds

While respondents showed broad agreement with this statement they did not consider it as likely as the two ‘raising awareness’ outcomes.

Those who considered the service appropriate were more likely to perceive this as a potential outcome than those who were opposed or unsure. There were no age, gender or ethnicity differences.

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 and the overall mean score was -.017. There were no gender differences.

Those respondents in the age 66+ category were significantly more likely to rate the service as encouraging unprotected sex than all other age categories:

<table>
<thead>
<tr>
<th></th>
<th>16-24 yrs</th>
<th>25 – 34 yrs</th>
<th>35-50 yrs</th>
<th>51-65</th>
<th>66+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean score</td>
<td>-0.31</td>
<td>-0.19</td>
<td>-0.18</td>
<td>-0.20</td>
<td>-0.33</td>
</tr>
</tbody>
</table>

Table 14. Likelihood of encouraging unprotected sex by age. Base:
Asians and Non-British White respondents also gave a significantly more negative mean rating than White British:

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>-0.29</td>
</tr>
<tr>
<td>Irish</td>
<td>-0.54</td>
</tr>
<tr>
<td>Other White</td>
<td>0.09</td>
</tr>
<tr>
<td>Mixed</td>
<td>-0.41</td>
</tr>
<tr>
<td>Asian</td>
<td>0.11</td>
</tr>
<tr>
<td>Black</td>
<td>-0.03</td>
</tr>
<tr>
<td>Other</td>
<td>-0.10</td>
</tr>
</tbody>
</table>

Table 15 Likelihood of encouraging unprotected sex by ethnicity Base: 718

Those for whom the service is unacceptable consider it more likely that the initiate will result in unprotected sex than those who support it, means of –0.23 versus +0.26/
Locations deemed appropriate for offering Chlamydia test kits (local survey only)

Respondents in the local survey were then asked where else it would be appropriate to offer chlamydia test kits. This was an open question and responses were coded to a list of eleven possible locations that stemmed from the qualitative research.

Over half of all respondents (52%) considered GP surgeries as appropriate venues to offer chlamydia test kits to 16-24 year olds,

![Bar chart showing percentages for different locations.]

Fig. 31. Appropriate locations for testing. Base: 718

Females were significantly more likely to suggest family planning clinics and well woman clinics than males.

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.

Those aged 16-24 (40%) were significantly more likely than those aged 66+ (19%) to state that colleges were an appropriate location for offering chlamydia test kits and more likely to mention schools as an appropriate location to offer chlamydia test kits than those aged 24-34 (22%), 35-50 (21%) and 66+ (17%).

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%).
Well woman/man clinics were also significantly more likely to be mentioned by respondents who were British (32%) than those who were Asian (16%) or of any other white origin (17%).

Additionally 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%).
References

(1) Trends in selected STIs: 1991-2001


(5) HPA, Epidemiological Data, 2004

(6) Summary and conclusions of CMO’s Expert Advisory Group on Chlamydia


Appendix

Local population survey questionnaire

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 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

4. To what extent do you think you are personally at risk of chlamydia?  

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Ticks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very high risk</td>
<td>☐</td>
</tr>
<tr>
<td>Quite high risk</td>
<td>☐</td>
</tr>
<tr>
<td>Quite low risk</td>
<td>☐</td>
</tr>
<tr>
<td>Very low risk</td>
<td>☐</td>
</tr>
</tbody>
</table>

5. Are you aware that free chlamydia screening and treatment will soon be available for 16-24 year olds in high street pharmacies across London?  

- Yes – go to question 6b
- No – go to question 7

6. 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 ☐

7. If yes: What do you know about this initiative?  
Do not read aloud

- Only testing for chlamydia
- Self testing
- Urine test
- No visit to NHS Clinic/GP required
- Available at Boots

From the middle of November, screening/testing kits for chlamydia will be available for free from Boots pharmacies in the London area for all 16-24 year olds. Those who pick the kit up will be able to test themselves in privacy (using a simple urine sample test), take the kit back to the pharmacist who
will then send it away for testing. If the result is positive, the person will be informed and they will be able to collect the treatment from the 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>Location</th>
<th>Less confidential</th>
<th>Equally confidential</th>
<th>More confidential</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital clinic (e.g. GUM)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>GP</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Family planning clinic/contraceptive service</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>NHS drop in health centre</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

13. 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>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital clinic (e.g. GUM)</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Anita – in future waves, we will ask ‘do you know of anyone who has collected a chlamydia test from a retail pharmacy?’
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
   - Decrease the number of cases of chlamydia in 16-24 year olds
   - Increase awareness of chlamydia
   - Increase awareness of sexually transmitted infections

17. 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 _____________________

18. Have you ever been screened for chlamydia?
   - Never
   - Within the last 6 months
   - 7-12 months ago
   - Over 12 months ago

19. (If respondent has been screened, ie 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
National population survey

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 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

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

4. Are you aware that free chlamydia screening and treatment will soon be available for 16-24 years olds in high street pharmacies across London?

Yes
No

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 the middle of November, screening/testing kits for chlamydia will be available free from Boots pharmacies in the London area for all 16-24 year olds. Those who pick the kit up will be able to test themselves in privacy (using a simple urine sample test), take the kit back to the pharmacist who will then send it away for testing. If the result is positive, the person will be informed and they will be able to collect the treatment from the 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?

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<tr>
<td>NHS drop in health centre</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. How reliable would you perceive the results of chlamydia testing to be through a pharmacy compared with the following locations?

<table>
<thead>
<tr>
<th></th>
<th>Less reliable</th>
<th>Equally reliable</th>
<th>More reliable</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
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<td>Hospital clinic (e.g. GUM)</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>NHS drop in health centre</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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, ie not ‘never’ at Q12a) Where were you screened?

- GP
- Hospital clinic (eg GUM)
- Hospital A&E
- Family Planning Clinic
- NHS drop in health centre
- Retail chemist/pharmacist
- Well woman/man clinic

**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