ANNUAL CONFERENCE REPORT 2001

BISHOP STORTFORD

18th – 20th April

SOCIETY OF HEALTH ADVISERS

IN SEXUALLY TRANSMITTED DISEASES

Conference Team: Sandra Jarrett, Debbie Burnett

Introduction

Sandra Jarrett: SHASTD Conference & Education Officer

Dear Colleagues,

This year's conference took place at Whitehall College, Bishops Stortford, Hertfordshire, and again provided an excellent opportunity for health advisers to present their work, learn and discuss, meet old and new colleagues and share ideas. It included regional workshops, a revamped AGM, and a "heated debate", as well as a very high standard of presentations, workshops and posters.

The President of MSF, Brenda Warrington, gave the opening speech, and showed great interest and encouragement in the work of SHASTD and its members within the sexual health field.

The conference highlighted the skills, experience and qualities within health advising, and helped towards a greater awareness and understanding of the health adviser role, as well as a commitment to the development of the profession.

The conference team hoped that participants would find it challenging, stimulating and enjoyable.

This was my first conference as SHASTD Conference Officer, although I have been involved with the organisation of previous conferences for several years. I would like to thank David Cox (ex-Conference Officer) for all his support and useful tips, and SHASTD Council members for all their help. I would especially like to thank Debbie Burnett and Jan Hyland for being a fantastic conference team.

Finally, I would like to thank the presenters and facilitators for all their hard work, the sponsors, and all the participants for their energy and enthusiasm in making it a unique annual conference.

A model for Health Advising: The findings of a national research project

The research team: Jo Greenaway, George Leach, Simon Paragreen, Jane Sudlow, Dawn Whittaker,

Health Advising - a profession that needs to speak

The culture of Health Advising

We come from other professions
We are influenced by models from other professions
We need to integrate and synthesise what is borrowed
The Health Advising culture has an influence itself

Making a model

Clinical models all have common elements (Pearson and Vaughan 1986)
The Research Team used this framework to structure a model for Health Advising

Is there a model?

How do we know there is one?
How do we find out what it is?
Making the implicit explicit
The role of action research

Questions to make the model explicit

What are the expectations of clients and Health Advisers in relation to the Health Advising role?
What are the philosophical beliefs and values that inform Health Advising practice?
What are the intended outcomes and goals of Health Advising for both the practitioner and the client?
What are the principles involved in the process of Health Advising that aim to achieve these goals?
What knowledge, skills and attitudes do Health Advisers need in order to participate in this process?

Methodology

First focus groups 9.4.99
16 participants
13 women, 3 men
9 rest of UK, 7 London
HA experience 6 years (median)

National survey April-May 2000

116 respondents (44% response rate)
94 women, 21 men
Estimated rest of UK: London *:*
HA experience 1 - 21 years (median 6)

Final focus groups 2.12.2000

14 participants: 11 women, 3 men
10 rest of UK, 4 London
8 Senior Health Advisers
HA experience 4 - 13 years (median 10)

Findings

95% of us think clients do not know what to expect of Health Advisers on a first visit
Over 90% think we influence client expectations most by the way we work, and by directly informing clients about our role
External liaison was seen as a less important influence
What should we call ourselves? 72% of us do not want to change our title
Of those that did, most would opt for 'Sexual Health Adviser'
Whatever the title the problem of explaining and promoting the role would be the same

…the bad and the ugly

Excessive workload
Being undervalued by the multidisciplinary team
Administration
Lack of job/professional status
Difficult clients
Clinic politics

Client expectations: Personal qualities

Being non-judgemental		90%	
Working well in a team		72%	
Having good boundaries		72%	
Self-awareness			65%
Being sensitive		56%	
Being respectful		52%	
Flexibility		49%	
Being genuine		48%	
Humour	48%		
Maturity		34%	
Confidence		34%	
Honesty		29%	
Assertiveness		19%	

Qualities related to our effect on others (adaptability and sensitivity) rated more highly than qualities belonging to the individual, such as assertiveness, honesty and confidence.

We are chameleons, aren't we? fg1

Essential elements underpinning good practice

Reflect on and learn from experience	100%
Work co-operatively within clinic team	99%
Keep up to date (research/literature)	99%
Time for development work	98%
Developing protocols for practice	96%
Ongoing training	95%
Learning from other Health Advisers	94%
Clinical supervision	93%
Monitoring, auditing and evaluating	93%
Developing evidence based practice	91%
Effective managerial supervision	91%
Representation - clinic management	85%
Representation - NHS structures	85%
Opportunity at work to let out stress	84%
Formal academic HA training	66%

Elements seen as less essential

33% neutral about need for formal academic HA training
Promotional and 'professionalising' elements valued less

The influence of the multidisciplinary team

Multi-disciplinary working is highly valued
BUT underlying feelings of insecurity and vulnerability are often expressed
Do we have the kind of safe space that we try to provide for our clients?

The multidisciplinary team

Certain people see you as superfluous, and that makes you feel de-skilled, devalued. There is a constant pressure that they are looking at whether you are dispensable, and that is bound to make you feel your role is not valued as it should be fg2

The 'how' of one to one work

First impressions are very important
Explaining who we are
Working to put client at ease through demeanour, dress and relaxed manner

Assessment

We've done so much assessment - from the person walking in the door and sitting on the chair, seeing the notes, what's happened so far - we're actually making very quick assessments fg1

Client-centred assessment - starting with individual in front of us and their issues

A difficult balance

Complex process of prioritisation and juggling - within time constraints, and between the task and what the client seems to need
Setting clear boundaries
Building a relationship
Building a trusting relationship with an emphasis on confidentiality
Being supportive, providing empathy and reassurance
Building confidence and an awareness that the client has choices
Pushing the limits
Working with and acknowledging negative and difficult aspects for the client
    being real, telling it how it is fg1
    going where others don't go fg4
Challenging what clients say
    Health Advisers have developed a dialogue for stigma fg 4
Facing and containing strong feelings and distress
Talking and listening
Language is important - simple, clear, matter of fact, non-judgemental, with open questions
Listening is key - listening to what people want and need fg 4
        ...and listening to what's not being said fg2
How much can we deal with?
Containment and referral are always kept in mind
    Tread balance of opening up issues and keeping people safe fg4
    It's like a sifting process, thinking, 'Where can I refer on to?' fg1

Counselling or advice?

Spectrum or synthesis?
Counselling skills are integral to (effective) advice work:
    Counselling skills always come into the consultation - cannot have one without the other quest

Outreach and prevention

Health Advisers work to de-stigmatise sexual health and improve access into the service
    It's about making sexual health accessible - it's real, it's normal, it's OK fg 1

HAs are the public face of the clinic. We promote the clinic and sexual health outside the clinic through outreach work
    Ambassadors for sexual health fg 2
Link between the clinic and the local community
Intermediaries, facilitating and personalising clinic visits for hard-to-reach clients
Importance of gaining in-depth knowledge of local community and its epidemiology of sexually transmitted infections
    Passionate about prevention fg 2
BUT outreach and prevention work is prioritised less than one-to-one work
    We are drowning in the work in our own clinics fg 3

Findings

Core knowledge

STIs, transmission and treatment	98%
HIV, transmission and treatment	95%
Clinic protocols and guidelines	91%
Diff. types of sexuality and lifestyles	83%
Referral (internal and external)	81%
Sexual behaviour (and change)	68%
Counselling theory	48%
The law and legal issues	40%
General health promotion issues	37%

'Top ten' skills

Counselling skills	91%
Working in a multi-disciplinary team	81%
Normalising sexual health (services)	71%
Telephone skills	67%
Processing (addressing client issues)	62%
Taking a sexual history	59%
Advising	59%
Referring to appropriate services	56%
Working independently	46%
Crisis management	42%

Skills in context

Telephone skills are most used skill - 86% use them 'to a great extent' in our work
Clinical skills (e.g. taking blood) used by 47% of Health Advisers
Promotional skills not valued - networking and public relations are the least prioritised skills
Management skills are less valued

Findings

Beliefs are principles accepted as true or real, especially without proof OED
Values are the moral principles or accepted standards of a person or group OED
Beliefs and values - social
There should be respect for difference, 98%
Individuals have a right to make informed decisions and choices, 98%
Individuals have a right to equal opportunities regarding service access and provision, 98%

Beliefs and values - professional

Health advising is a valuable profession within the field of sexual health, 97%
Confidentiality is essential, 97%
Public health policy and statutory guidelines are integral to Health Advising, 78%

Beliefs and values - personal

Individuals have the right to enjoy sexual health, 97%
Sexual health is an integral part of emotional health, 96%
Individuals have the ability to change, 82%
Individuals have the ability to care for themselves, 68%
There is more ambivalence about the personal belief statements than the social and professional value statements
There are inherent tensions between these statements, e.g. public health v the rights of the individual

Goals and outcomes

Very high level of agreement
Normalising sexual health issues
Improving access to services
Helping people make informed choices
Advocacy
Identify people at risk of infection and work to reduce the risk
Holistic approach
More neutral response
Increasing the visibility of the work
Give sexual health a higher profile
Enable modification of behaviour to reduce STI transmission
Goals and outcomes - qualitative data
Goals and outcomes - qualitative data
Partner notification
Sexual health promotion
Pre- and post- HIV test counselling
Health education and information giving
Counselling and using counselling skills

Partner notification

Reducing the spread of STIs
Public health "contain", "control", "limit"
Legal duty
Opportunity to identify client concerns
Prevent re-infection and consider future health
Partner notification:

To support people in working out if anyone else should be contacted and offered screening for sexually acquired infections quest

To ensure the maximum number of contacts are treated in the shortest possible time without undermining the responsibility of the index patient quest

Sexual health promotion

Inform, Educate, Raise awareness, Give information

Sexual health promotion:

To enable individuals to express their sexuality and enjoy their sex life, without risk to their own or other people's health quest

Freedom from those aspects, both physical and psychological that inhibit the enjoyment of sexual relationships and the expression of sexuality quest

Pre- and post- HIV test counselling

A consistent trend emphasising the importance of neutrality and informed consent
Offering the client a personal space to assess their needs, not just recommending the test for public health reasons
Post-test discussion hardly mentioned
Pre- and post-HIV test counselling

To discuss with patient their understanding of HIV, transmission, risk, test, etc; to counsel around their anxiety and fears; to correct misinformation and inform about relevant issues; to support patient over decision to test or not and follow through for result and beyond quest

Health education and information giving

Assessment
Increasing awareness to facilitate decision making about behaviour and lifestyles
Informed choice
Increasing autonomy
Implied linear process that is necessary in order to achieve goals and outcomes related to the reduction of the spread of infection
Health education and information giving

Ensuring patients and the community are given information appropriate for their needs and situation and packaging this in a way that will be best received and used. Responding to patients' self-identified information gaps quest

Counselling and using counselling skills

Context building (containment, trust, etc.)
Client centred exploration and disclosure
Increased self-awareness
Outcome focused behaviour rather than specific 'end-point' outcomes
Trauma and crisis work
Counselling and using counselling skills

Offering containment, holding and support and providing, where appropriate, opportunity to work through issues related to and/or impeding patients' sexual health, within realistic time frames. To use skills to convey complex information and allow patients to explore emotional responses that might obstruct absorbing information or achieving sexual well being quest

Goals and outcomes

Medical outcomes or Health Adviser outcomes?

We need to find ways to evaluate and promote our own outcomes
For example, enabling a client to re-attend is a non-medical but essential outcome relating to Health Advisers' core beliefs about accessibility and empowerment

The Martian

A Martian attending a sexual health clinic would probably be sent to be seen by the Health Adviser, who would probably do a good job
What attitudes and abilities do Health Advisers have that would make us confident that this would be the case?
Learning without making assumptions
Good at finding out about people
Accepting the Martian
Good at defusing situations
We may be the first person to recognise the differences
Being different for different people
Ideal for Martians

The Model

Into the room….and out again
Inside the room
Implications - training
Training needs to be consistent with the way Health Advisers work and develop
Needs to be built around core roles, and core knowledge and skills base

Training

Some qualities cannot be taught
Reflection on experience - the role of supervision
Apprenticeship - a formal 2 year process?
Formal academic course

Implications: Professional

Promoting and explaining ourselves are essential components of our one-to-one work with clients
It is important that we promote and explain ourselves as a profession
Need for professional assertiveness and boundaries
Be clear about our role, and promote and demystify it (e.g.: by training other staff groups)
Health advising is skillful and complex work
We need to own and value how we work and our Health Advising goals
Allow others into the room
Raise the profile of our work outside the room
Reclaim and proclaim our identity

THE END

SYPHILIS – A BLAST FROM THE PAST

Classical and antiquity – no evidence of syphilis.
Syphilis and gonorrhoea were considered one disease.
Chaudepisse.
Boneache.

MIDDLE AGES

Geoffrey Chaucer, 1342 – 1400.
Christopher Columbus, 1393.
Siege of Naples, 1395.
"Syphilis sive morbus Gallicus."
Francaster, 1530
Rabelais, 1492 – 1534.

ELIZABETHAN ERA – THE POX

Shakespeare.
Folk lore remedies.
Intercourse with a virgin.
Earthworms in oil or wine.
One night with Venus – Two years with Mercury.

VICTORIANS

Silence… Dickens, 1812 – 1870.
Lock Hospitals.
Contagious Disease Act, 1865.
Josephine Butler, 1886.
American in Paris, Philip Ricord, 1799 – 1889.
Beer mixed with cow dung.
Chalk mixed with Brandy.

THE FEROCIOUS NEWCOMER

Huge primary Ulcers.
Violent bone pain.
Headaches.
Impaired vision.
Destruction of palate and nose.

THE BREAKTHROUGH

Fritz Schaudin & Eric Hoffmann, Berlin 1905.
Paul Erlich, Berlin 1905.
Salvarson 606.
Bismuth & Arsenic.
Alexander Flemming 1881-1955.

EARLY TWENTIENTH CENTURY

Royal Commission, 1913 – 1916.
Venereal Diseases Act, 1917.
Clinics set up Nationally.
Lt. Harrison.
Dr. Ross.

WORLD WAR II

Syphilis rates soar.
Emergency Regulations 33B, 1942.
Flemming's Penicillin and Triage.
Lady Almoners, Health Visitors, 1944.
The Wakefield Scheme, 1948.

UP TO DATE

Post war syphilis rates plummet.
"Gay revolution" a blip.
Former Soviet Union.
Weekends – Prague and Amsterdam.
Manchester and Dublin.
Beware the Grey Army.

CASE STUDY

"Syphilis is the wrath of God and no physician should have any dealings with it."
Samuel Solly, 1887.

S. 42 years old. Married. White. Professional. In-patient, Infectious Diseases Unit.

HISTORY

High fever, sweats.
Rigors, headache.
Deranged L.F.T.s.
Macular / Papular rash.
STS negative.
LSI husband four weeks ago.
Previous UPSI eighteen months ago.
Last blood donation Sept 1999.

NEXT VISIT

STS – Elisa positive
RPR 32
TPHA 1280
Treatment – Doxycycline 200mg bd x 3/52
Re-treat after 1/12
Reaction – Stunned and upset.
Review four days.
PHL Lab. error STS also positive.

CONTACT INTERVIEW

Admits to 'swinging' and sex with strangers.
Has recently become bi-sexual.

CONTACTS:

Business Person
Civil Servant
Chief Executive
Doctor
Probation Officer
Tax Official

DEMOGRAPHY

Cheshire
Derbyshire
Greater Manchester
Lancashire
Merseyside
NB. – Boyfriend will attend tomorrow (he is donating blood today), girlfriend will attend shortly.

MORE HISTORY

'Lump' at entrance of vagina.
Harder edge.
Painless – No discharge.
? Primary "many weeks ago."
Last blood donation July 2000.
Feeling nauseous on treatment.
NB. – partner N. STS negative, repeat 3/12.
partner A. STS negative, repeat 1/12.

FURTHER CONTACT DETAILS

S and N visit Sauna
S contact with 6 women plus N a few times
" Several men"
Details of venue sketchy
Later informed has closed
S has had other casuals

ONE MONTH AFTER TREATMENT

No change in STS.
N. attended 3/12 STS negative.
Three other contacts informed.
Advised still no intercourse.

THREE MONTHS AFTER TREATMENT
Elisa positive. TPR 8. TPHA 2120. Retest 1/12.

RESULTS
Elisa positive RPR 16.
TPHA 5100.
Admits vomited on treatment.
Took vitamin tablets with iron.
?? treatment failure.
STS repeated – RPR 16 TPHA 10,500.

STAFF INVOLVED SO FAR
Four consultants
One associate specialist
Laboratory staff
One SPR
One very confused Health Adviser
One exceedingly baffled patient

FURTHER MANAGEMENT
Repeat course of Doxycycline.
Nine days later – vomiting again.
Attended with boyfriend.
? Serofast.
Long discussion re. serology.
Commenced erythromycin 500 mg qds 1/52.
HIV offered to exclude sero conversion sickness when in-patient.

PROGRESS
HIV negative.
Sickly on antibiotics.
Will attend with girlfriend for her STS.
Fed up, refuses more tablets.
Agreed to try ciproxin 500 mg bd x 3/52.

VIROLOGY AND P.H.L.
Sept' 2000 P.H.L. RPR 64u TPHA 64u
Oct' 2000 P.H.L. RPR 128u TPHA 128u
Sept' 2000 Virology RPR 32 TPHA 1280
Quandry …… Medical and lab' staff all in confusion.
Harrison 1928: Standardisation of syphilis serology – eighty years later, still waiting.

Sexual Health Services – What do young people want?

Gill Hennebry – Victoria Clinic.

The Victoria Clinic is a small, community based sexual health service in Central London. It is one of 3 sexual health services, attached to Chelsea & Westminster hospital. At the time the questionnaire was undertaken, the clinic was planning to move to a nearby health centre, and we were looking at ways of focusing and developing our services.

Why young people?

Teenagers in the UK have one of the highest teenage pregnancy rates in Europe.

The birth rate in the UK is twice that of Germany's, 3 times that of France and 6 times as high as the Netherlands.

The incidence of STI's is rising rapidly amongst all ages in the UK but the fastest increase is amongst teenagers.

Teenagers attending sexual health services are far more likely to be diagnosed with a sexually transmitted infection than older clients.

Improving the sexual health of young people is now a national priority. This has been endorsed by the recent development by the government of the Teenage Pregnancy Unit and the Sexual Health Strategy.

Background to the Project.

The Victoria Clinic has a long history of outreach work in local schools. We belong to the schools health team, which is organised by the health authority. When the clinic had moved from the basement of the old Westminster Hospital, to an off site unit, we noticed a sharp increase of teenagers attending our service. As our schools work has increased, so has the attendance rate. We needed to respond to this by providing a more appropriate service for young people.

Why do this Questionnaire?

We held a clinic meeting to discuss a service for young people. We identified that most existing young people's services had been planned with little or no input from young people. Much of the research had used the opinions of young people already using a service. We realised that we were all far too old to know what teenagers really wanted, and so asking them seemed the obvious answer.

Questionnaire Development

We were currently doing some work in Pimlico School, so it was very simple to recruit six year 12 students to be a part of our focus group. We did have some concerns about how this meeting would work, but these were dispersed within the 1st few minutes of the meeting. Our meeting was held on Friday lunchtime, the first of many – as we had promised a picnic lunch – we had pizza – also the 1st of many!

The first focus group meeting was a revelation! It lasted well over 2 hours and as well as laughing all the way through, we had obtained the foundation of our questionnaire. This was typed up and approved by the teenagers by the middle of the next week!

Method – Focus group

The focus group consisted initially of six, year 12 students – 3 boys and 3 girls, but 1 of the girls left school after the first meeting, and wasn't replaced.

From the clinic staff we had enlisted a consultant, and charge nurse, a health adviser and a receptionist.

Peer Design

The questionnaire was peer designed. It identified issues, which may encourage or discourage future service users. We were aiming to improve access to the service for boys, who are notoriously poor users of sexual health services. Both the pilot and the modified questionnaire were approved at all stages by the students in the focus group.

Pilot – 224

The original questionnaire was piloted in Pimlico School – which is a large, mixed comprehensive school. As we had just finished some work with year 10 students, we went back to them with the questionnaire and also to the year 12 and 13 students at Pimlico.

The focus group felt that it was vital that the questionnaire was only handled by students and clinic staff, so that the project was not influenced by the views of the teachers.

We took the questionnaire to each class involved, introduced it and assisted students who had reading or language difficulties. We had a surprising amount of assistance and co-operation from the students and thanks to them we had a 100% response rate. The data was entered onto Microsoft Access by myself and it became clear that the questionnaire needed simplifying. This was discussed at a focus group meeting and with the help of Chelsea & Westminster's audit department we made it more user friendly.

The Modified Questionnaire – 522

This was taken out to 6 more schools: -

Marylebone School – Church of England girls school – mixed 6th form.

Westminster Community School – Large mixed comprehensive school.

The London Nautical School – All boys.

Greycoats Hospital – Church of England girls school

Westminster City School – Church of England boys school.

Westminster Pupil Referral Unit – Mixed unit for excluded pupils.

We had enormous support from all the schools we visited, both from staff and pupils. It was this support that allowed us to complete 746 questionnaires in 5 months.

What did we ask them?

As the majority of students may have never used a sexual health service, we planned the questionnaire accordingly. The only personal questions we asked were age and gender.

The_Basics – included the following

What services would they want to use? E.g. relationship advise, emergency contraception, STI screening etc.

What age group did they think the service should be for?

How should we advertise the service? E.g. schools, GP's chemists visits etc.

Who would they attend with? Friends, partner, parent etc.

Appointments/walk-in service?

Where should the clinic be? – Offered several alternatives but the results clearly showed that it should be away from a main hospital, preferably near to school, in a side street, with easy access to public transport.

Waiting to see someone.

This included questions about the waiting room, how they would like to be called by clinic staff, and most importantly how long would they wait to be seen.

Clinic Staff

Questions in this section asked how they would like to: -

Address the staff e.g. Dr or by their 1st name.

How the staff should dress e.g. Uniform or casual

Gender preference of staff

Important staff qualities

What are the most important things about the person you see?

	Female	Male	Total
Friendly	93% [418]	88% [261]	91%
Confidential	84% [377]	69% [205]	78%
Non-judgemental	84% [377]	66% [102]	77%
Same person each visit	77% [350]	65% [192]	72%
Takes time to explain	72% [325]	55% [163]	65%
Give me what I came for	64% [290]	62% [183]	63%

What are the most important things about the person you see?

	Female	Male	Total
Let me stay in control	74% [259]	48% [143]	54%
Don't speak to me outside clinic	39% [176]	34% [100]	37%
Gender of staff	26% [116]	27% [80]	26%
Age of staff	16% [72]	27% [81]	20%
Staff clothing	6% [27]	17% [50]	10%

Confidentiality

This was understandably a very important issue and was identified on many of the questionnaires in the comment section.

The definition of confidentiality for young people in our area appears to have some subtle differences to the 1974 VD regulations. I.e. most girls wish to be seen in large groups with their friends present.

When we meet in the street, I am regularly told their latest news – in full earshot of anyone else walking down the street!

Getting Information

Questions were asked about their current sources of information, and what would encourage or discourage them from using a sexual health service.

On the modified questionnaire we included clinic details In a 'tear off' section.

Comments

The comments section was particularly impressive, as many of the students obviously thought very carefully about the service. It was clear from this that the respondents liked being asked their opinion, and they expressed a lot of support for the project. They also had a lot to say about what they wanted, some good ideas and some hilarious.

These we broadly grouped into the following categories.

Confidentiality

Attending if something was specifically wrong

Reassurance / Information

Staff Attitude

Pleasant clinic environment – these has many suggestions on décor, cleanliness and smell!

Easy access

Non judgmental staff

Payment

Embarrassment

These are 2 of my favourites: -

Fear – not of being recognised but just seeming like an inexperienced fool.

The geezer with the baldhead was polite – cool geezer.

Findings

Many of our findings agreed with existing data

Time of the clinic – after school

Attending with friends

Walk in service

Confidentiality

There were differences in the answers according to age and sex.

Significant Findings

84% of students thought the clinic should be held more than once a week.

73% of students did not mind a mixture of ages in the waiting room. (This challenges existing views and has significant cost implications for service provision) – young people's services can run alongside existing services: allowing more frequent opening.

23% of students would not wait any longer than 15 minutes to be seen – some less than 5!

So – what do they want?

The clear message from this questionnaire is that age, gender and clothing of staff is of least importance

In practice gender of staff may be a real issue – many clients both male and female preferring to see a women.

Young people want friendly, confidential, non-judgemental staff who can provide continuity of care.

Interpersonal skills, and understanding the issues surrounding young people's sexual health are important qualities when choosing staff.

Unexpected outcomes

Confessions of the teachers!
In every school we visited, whilst the students were filling in their questionnaire, the teachers used their 'spare time' to read the questionnaires. It clearly reached through to their own adolescent experiences, and without exception I had various personal stories, some horrific, some funny, related to me. Some of these disclosures required a restorative cup of coffee in a private corner afterwards.

Tribulations
As with any new service provision, there were complications, which added an extra dimension to our experience!

Unexpected deadline - The health authority had received our bid for funding just after the end of the summer term, when the questionnaire had been completed. We heard nothing for several months and were suddenly told that we had been given the money – but … it must be before the end of the financial year.
The Cont@ct service was set up, very quickly as a result of this.

Budget cut.
Our total clinic budget was significantly cut in preparation for our relocation to the new site.

Moving site
The site we moved to was smaller than our previous clinic. So in addition to the stress of moving we had enormous room and space constraints to contend with.

Achievements of the Focus Group
The focus group set itself an unusual and creative task, which it achieved, in a very short time. We think that our questionnaire is one of the largest surveys of its kind.

Development of a new service, using the views of young people.

Design of clinic card and poster – choosing a name for the service

'Lovebites' – a Saturday morning TV programme shown by LWT.
The 2 girls presented the Contact service on this programme.

One of the teenagers from the focus group took part in the staff interviews, when we were recruiting staff for the contact service.

The girls have also presented a sexual health awareness film clip made by the local health authority.

The contact focus group reached the finals of the NHS Team of the Year and thanks to the younger members of the team won 'Best Presentation' award.

A rare freedom was established in this team to develop a new service, which although it entailed lots of hard work was a hugely enjoyable process, which we all felt passionately involved in.

Conclusions

Contact challenges existing models of service provision. It was created and guided by the opinions of non-service users.

Setting up a new service may not necessarily require extra space or money.

It does require enthusiasm and relevant training for existing staff from all disciplines.

I would like to conclude with some of the statements made by the teenagers involved with this project were really proud of this service.

It's our clinic.

We didn't think you'd really listen to us – but we fancied a pizza.

Even though they have now all left school and started another life they have committed themselves to continue helping us with the design of a web site and a peer education project.

Drug Rape : the Challenge

The Roofie Foundation is neither a pro nor anti drugs organisation. As an organisation it has no political bias. It has been founded solely with the intention of addressing the situation of drug related date rape. We feel strongly that information about the danger of date rape drugs should be dissipated to everyone in the country. To members of the public, police, licensees, and student campuses but especially to all women who frequent pubs and clubs, especially prior to the commencement of the Christmas season and office parties.

The Roofie Foundation (TRF) is a voluntary organisation awaiting charity status. It has been brought into existence to achieve a number of aims -

- To create massive public awareness of the dangers and the misuse of the drug Flunitrazepam, other derivatives, and other drugs better known as "date rape" drugs.

- To make Britain's police forces aware of the existence of such drug related date rapes and for them to be more sympathetic in their approach towards its victims.

- To make available to the police and victim alike a pool of evidence and expertise on which to draw upon in terms of evidence and diagnosis.

- To establish a help line number where any "date rape" victim can talk in confidence to people experienced with the problem, who can advise and counsel.

- To establish a legal advisory system to enable date rape victims to privately sue their rapists.

Graham Rhodes
The Roofie Foundation
www.faze.com/trf/index.htm
24 hour helpline – 0800 783 2980

Taking a Risk: the Failure of Sexual Health Strategies.

Dr. Eamonn O'Moore,
SpR in Public Health / Senior Research Fellow in HIV Medicine and Sexual Health :
Berkshire Health Authority.

Following wide consultation with various professional bodies and social partners, the new National Sexual Health Strategy is currently awaiting publication. This strategy is being drawn up against a background of increasingly alarming statistics. Between 1990 and 1999, the number of all episodes seen in GUM clinics in the UK has doubled, reaching 1.2 million cases by the end of the decade. Total numbers of new diagnoses of acute STIs rose by 31% over the decade. The UK has the highest rate of teenage pregnancies in Western Europe. Between 1995 and 1999, diagnoses of new cases of gonorrhoea rose by 55%, genital chlamydia infection by 76% , genital warts by 20% and infectious syphilis by 54%. The sharpest rise for all conditions was in both males and females under the age of 20 years. In the period 1999/2000, the rate of new HIV infections in the heterosexual community outstripped that of the gay community for the first time ever. Some of the rises in new diagnoses may due to wider public awareness and greater availability of testing. However, undoubtedly many of the new infections are due to increasing unsafe sexual behaviour, especially among young heterosexuals and young gay men. Issues regarding sex and sexuality have never been more widely disseminated nor discussed. Why then have indicators of sexual health continuously disimproved over the last decade, especially among the young at the outset of their sexual careers? The devil is in the detail. Many of the people behind the statistics belong to ethnic minorities or the economically or socially excluded. Sexual health should not be defined as purely the presence or absence of disease. I propose a new definition of sexual health: the ability of a person to fully realise their potential as a sexual being in an informed and empowered state, free from negative social, political or economic constraints in a safe and fulfilling way. Therefore, ensuring the sexual health of the nation requires 'joined up thinking' and co-operation between health care providers, educationalists, social services and the media, to name but a few. Respectful of cultural and religious sensitivities, we should nevertheless strive to ensure that all our young people have access to information and a sense of their own value. Sexual health embodies an idea of respect. We must take the whole person into consideration, not just what they do with their genitals!

Regional Workshops

SOUTHERN REGION

STRENGTHS		DIFFICULTIES
Close together	Lots of clinics	Big difference between London - outside London
Well supported by other services	Asylum seekers	Transient population and size of population.
Larger teams can support each other	HIV	Problems with partner notification.
Expertise	Sexual health strategy	Working alone - need inter clinic support
Targeting "in need" groups		Expensive
Response to change		Time consuming
Collaborative working		Less likely to network
Involvement with NHS restructuring (PCT's)		Attendance at regional meetings
Challenge of partner notification		Poverty
Internet possibility		
Training opportunities		

IDEAS

1. Regional and national HA's chat room on internet
2. Newsletter
3. North, South, East and West split - carve up London.
   Splitting: Would a split encourage more people to come forward. Reps would have qualitative contact with their areas.
4. Time of meetings; getting time off; rotation of venue.
   Can MSF call delegates to a meeting?
5. SHASTD Representative to visit clinics. ? 2 - 3 monthly.
   Rep to be more visible.
   Would a smaller regional area encourage more people to become Reps (+ District Reps).
   Link Rep in clinic to liaise (in large clinics)
10. Training / updates / ongoing development.
11. Promoting HA role in individual clinics.
12. Less often - yearly ?.
    Aims: Need to be explicit and quantifiable.
    Ways of welcoming new members.
13. Agendas from each clinic.
    With Representatives from each clinic.
14. Clinic exchanges / research / collaboration.

THE SWOTS OF THE NORTHERN REGION !!

Strengths	**Weaknesses**
Involvement in strategic planning for sexual health services	Lack of understanding of HA role by other professionals
Development and delivery of education / training of multidisciplinary groups	Time constraints for training
Ability to fulfil the public health role	Lack of depth and diversity of HA training
Willingness to communicate and share best practice across the region	Lack of clinical supervision in some areas
Integrated sexual health model	Limited HIV funding in some DGHs migrates clients to "specialist areas"
Management of HIV and STIs outside GUM	Lack of guidelines for practice
	Little sharing of good practice out of region
SEXUAL HEALTH STRATEGY	

Opportunities	**Threats**
Health Adviser profile increasing as result of ante-natal HIV screening : education of midwives, etc. Commitment of members to enable regular regional meetings Primary care trusts Funding from "teenage pregnancy" for young peoples' sexual health services Inter-agency collaboration	Over dominance of medical models in some areas, undermines Health Adviser role Underfunding creating lower profile of sexual health services

RECOMMENDATIONS

Development of evidence based standards, protocols and policies for HA role
Sharing of working tools, eg practice, guidelines nationally
Regional meeting used as a forum for widening the focus of the HA role
Registration and professionalisation of health advisors expedited
SHASTD proactive in health adviser research - promote and encourage

NORTH WEST / CENTRAL

Rural and city clinics - impacts upon larger clinics

Size of clinics - very small and large

Reduction in clinics

Demand for services that cannot be met

Lack of accessibility to clinics

Lack of suitable accommodation - inadequate

Many HA led initiatives (community based), but these have an obvious (negative) impact upon GUM services

Not many teams of health advisers in area, many HAs working in isolation

Central have mostly teams of Health Advisers. Is this why there is a lack of representation? Do they feel well supported already?

Syphilis outbreak that is out of control - no appointments available

Greater awareness of STI's, more customers. More peer education.

Raising HA profile by:

(a) GUM (Health Adviser) led - sexual health model
(b) Encouragement of student nurses / midwives / Doctors
(c) HIV antenatal screening
(d) School nurse training

Increase in nurse practitioners has increased profile of services.

NORTH - EAST

Area covers: Yorkshire and Trent - Regional Health Authorities
There is no SHASTD Representative or Regional meetings for this year.

DIFFICULTIES

Poor membership of SHASTD - not allowed work time for meetings

Clinics without health advisers - poor partner notification service.

single HA's	}	lack of time for health promotion and audit
poor resources	}	isolation
small speciality	}	lack of robust and guidance and support

Management does not understand role of Health Adviser - or even GU Medicine.

Role boundaries within multidisciplinary teams

Patient empowerment versus public health

Strengths

Regular regional chlamydia audit (management and partner notification)
Highlights different levels of achievements between clinics with and without HA's.
BUT - is done by medics!

Partner notification inc. provides referral.

New technology - mobile phones, internet, e-mail, etc.

Inter-clinic liaison / co-operation

Shared values

Motivated to provide high quality care

RECOMMENDATIONS

Regional Health Adviser meetings - 2 x per year (and non-SHASTD members).
Overlap with existing AGUM meetings where some Health Advisers are already gathered

Negotiate time to attend in work time

Consider merging SHASTD boundaries (in view of no local rep)

MIDLANDS / SOUTH WEST

MIDLANDS

1. Large City Clinic 3 Posts - 2 Vacant

- Inner city - violent = safety issues
- Good relationships between health advisers and nurses
- Poor supervision
- Low pay grade

2. Small part-time clinic = 1 health adviser

- Good communication - all staff
- Good team work
- HA cover between 2 clinics for holiday / sick leave
- Good supervision

SOUTH WEST

- Less than 2 feet equivalents in one clinic - therefore problems covering the service.
- Grading issues
- HA's set up counselling service - abuse and counselling sessions for female rape victims
- Good multidisciplinary approach and networking
- Prison outreach work.
- Health promotion work.
- Chlamydia research project - funded by NHS Executive.
- Sexual Assault Suite
- Commercial Sex Workers - outreach work.

MIDLANDS & SOUTH WEST

DIFFICULTIES

- Bridging the gap when Rep not available (i.e. long-term sick leave)
- Being pro-active in recruiting Rep. where there is no-one in post.
- Grading issues - consistency, not replacing HA's and down grading.
- Some HA's not receiving clinical supervision.
- Environmental issues - working conditions
- Discrepancy in HA's ratio per patient.

EASTERN REGION

Issues

Single handed consultants - holiday cover
Inadequate locum cover
Clinical decision often made by HAs.

Single handed HA's - who provides cover?

Rural locations - travel problems for patients.

Increase workload - complex, genuine problems time consuming. Waiting times to get appointments.

STRESS lack of supervision for some HA's.
Combined HA / Manager roles.

Inadequate accommodation - no office / counselling room. Shared with doctor's and/or nurses.

Recommendations

1. Raise profile of HA / GU services.
2. Improve communications with related services.
3. Job swaps - HA exchange with HA in neighbouring clinics.
4. Fighting for clinical supervision.
5. 3 monthly regional meetings.
6. Involvement in regional clinical audit meetings.

SCOTLAND

Differences

Existence of another HA organisation
- All HA's in Scotland - of whom 50% = SHASTD members
- Network of HA's in Scotland Vs. NHS Scotland

Institutional Differences
- Separate legal system
- Scottish MSSVD
- Scottish Executive
- Scottish Sexual Health Strategy (Pending)
- Different country

Geography
- Very large area
- Relatively small number of HA's

Relatively low ethnic minorities population

Very low HIV positive population in some areas

Good Points Practice	**Communication Between Clinic Teams**
Excellent peer support Very high turnout at meetings National (Scottish) Partner Notification Audit Stable Group (low turnover) Development of Young People's Services Several good research projects - chlamydia - partner notification	Good informal network Regular meetings

MAIN ISSUES / DIFFICULTIES

Lack of supervision in many clinics

Lack of managerial support

Invisibility

Absence of senior H/A posts in most clinics

Lack of training resources

Very difficult situation in Edinburgh (staffing and workload)

Infrequency of National (Scottish) meetings
at present - 2 x per year
Mixed SHASTD / Non-SHASTD meetings / Agenda

Difficulty of findings resources for analysis of audit data

Action Points

Introduce regular meetings for SHASTD members ONLY
in addition to joint NHS / SHASTD meetings
in Stirling - for max accessibility

More training meetings
e.g. HA model;
Supervision
Invite non SHASTD HA's (charging fee) - to attract new members

Approach Scottish MSSVD regarding HA membership : suggest lower membership fee in order to increase HA membership

Support teams seeking creation of senior health adviser posts

Support Edinburgh team in negotiations with management

Workshop: 'Provider Referral- Something Old, Something New!'

Facilitators: Chris Faldon, Pat Young Newcastle GUM Clinic

Introduction

This workshop set out to explore very practical issues relating to 'provider' referral partner notification. Newcastle GUM clinic has a long history of contact tracing. Many of the methods have emerged from custom and practice built up over decades. However, information technology affords new opportunities to further refine and develop procedures. Some of these will be examined.

Chris Faldon completed his MSc research in 2000 by looking into consumer perspectives on 'provider' referrals. Pat Young has worked in GUM for 4 years and has some good experiences to share on tracing contacts.

The session could have been repeated twice over, such was the interest by delegates to attend. Lively discussion emerged as three small groups were set a task of exploring scenarios. Our collective experience of provider referrals was recorded by looking at;
Resources & strategies employed
Obstacles and commonly encountered difficulties
Future work required at local and national level

The participants

Fifteen health advisers (excluding the 2 facilitators) signed up for the workshop. There was a good geographical mix. Thirteen completed evaluation forms. Prior to the beginning of the discussions everyone was invited to record their **principal interest in attending**. Responses were as follows;

P/N in GUM is the core-role of H/A and the "specialist skill" of H/A
Learn new methods?
How others do this. What are the variations?
Done audit in PR – contact tracing main area of interest.
Increasing amounts of P/N due to approved C4 testing making it more difficult for H/A to keep on top of it. In brief:- looking for a more effective way
Sounded very relevant to my work. I need to improve my skills in contact tracing.
Up date on current practice and sharing of others approach to provider referral
Currently there is a syphilis outbreak, and feel in need of re-evaluation and skills update/ development in this area of uncertainty etc.
To find out other H/As practice in hope of improving my own.
Had been re-writing the recall policy
Because I need some reassurance that I am doing it in the best way
"Bread and Butter" of H/Advising – daily activity. Am I doing as well as I can?
Because it is my job to follow up provider referrals. I'm not sure if I'm doing it right

Group work

Three groups of 5 health advisers considered a different hypothetical client based scenario as well as an administrative 'teaser'. They were as follows;

Group 1

(A) Scenario

Cheryl attends GUM and provides her full details on registration. She is subsequently found to have chlamydia. She had no signs or symptoms. Her reason for attending was because her new boyfriend, Mike, wants to stop using condoms. Discussion with the health adviser reveals that they are living together. She took a contact slip for him and expects he will attend your clinic later in the week.

On further discussion with the health adviser she also reveals that her previous partner was the man in charge of the 'Afterburner' at the Fairground, which made its annual visit to the town 3 months ago. His name is David Wetherall and is 27 years old. However she hasn't a clue where he is now, because he lives in a mobile home and moves around the country with the fair.

Unfortunately you did not see Cheryl when she returned for her test of cure. There was no record of Mike having attended.

How would you go about tracing David? What approach would you take with Mike?

(B) Administrative task

A newly appointed health adviser with no previous GUM experience calls you to ask for advice. He has been given a dedicated telephone line and answer machine for health adviser use only. He is wondering how to make best use of it for partner notification purposes. What issues will he need to consider?

Group 2

(A) Scenario

Steven attends GUM with discharge that started one week ago. He is diagnosed with gonorrhoea. Discussion with the health adviser reveals that he had a recent casual partner. His name is Patrick and they met in a gay pub 3 weeks ago. Steven was hopeful he might see him again. They had unprotected anal sex. He knows that he is a student at the local university and lives in Newcastle during term time, but he has just returned to Northern Ireland for the Summer holidays. It will be 10 weeks before he comes back for the new term. He thinks his surname is O'Hara or O' Hare but can't be certain of this. Steven is however sure that Patrick is studying French and Business Studies at Northumbria

University. He does not know his address in Newcastle and only knows that he lives in Port Stewart in Northern Ireland. His father is a Presbyterian Minister. He wants us to do a provider referral.

How would you try and trace Patrick?

(B) Administrative task

A newly appointed health adviser with no previous GUM experience calls you to ask for advice. Writing letters to contacts is her main area of concern. What issues would she need to address?

Group 3

(A) Scenario

Tom is 23 and attends the Newcastle clinic for a check-up having just got back from Ibiza. He had the routine tests and was found to have a chlamydia infection. When asked about sexual partners, he states he met Victoria from Southend whilst away. They had unprotected sex 3 times. He has no means of getting in touch with her but is willing for a health adviser to contact her as long as his confidentiality is preserved. When noting the details it emerges that she is 15 years of age and is living at home with her parents and younger brother. Her surname is believed to be Brown. He shows you her Grammar school photograph that she gave him. Tom remembers she lives on Leigh Avenue. After further discussion he discloses that he had been in Thailand 3 months earlier and had sex with 6 bargirls out there. He couldn't be too sure if condoms were used. No way is he to consider an HIV test.

How would you go about tracing Victoria?

(B) Administrative task

You have encountered a problem in trying to trace a contact. You have the full name, age but only partial address details of someone strongly suspected to have both gonorrhoea and chlamydia. They however live 100 miles away and the local clinic will only entertain a provider referral with firmer information. What options are open to you?

Discussion summary

- **Resources/Strategies**

- See index patient again. A subsequent interview can yield more contact information
- Get sufficient information on contact to avoid mistaken identity. ie do father and son in household have same name.
- Reminder letter for T.O.C. or letter to IP re non-attendance of contact
- Different arguments for letter content being vague or specific. Named sender.

- Use postage stamp rather than hospital franking system to reduce suspicion. Mark 'Private', 'Confidential', 'Addressee Only'.
- Best not to post letters at end of a week. Arrive at address no later than Thursday for full time clinics to allow call to be made before weekend.
- Telephone call to index regarding contact information.
- Mobile numbers. Take at registration. E-mail addresses may also be useful.
- Family Practitioner Committee (FHSA contractor agencies) Sometimes difficult to get information from these. Especially if no date of birth available.
- GP's. Health Visitors can help here. VD regulations allow for information to be shared with health professionals if for the purpose of treatment and prevention
- School nurses. College/University Health centres
- Mail forwarding service – Universities will do this if you know the name and course of a student. Put in double envelope. Other institutions may offer this.
- Directory enquiries. Not always helpful. Their Internet site more useful.
- Internet addresses – www.bt.com ; www.192.com Latter a rich source of information from various databases ie electoral rolls.
- Showman's Guild. Have good Internet site. May identify where fairs are and owners of particular rides/attractions.
- Contact slips. Generally less useful these days. Patchy usage across country.
- Paid clerical assistant. PN is extremely time consuming. Better use of resources to devolve certain searching tasks to a clerical worker. Not just a luxury item. Dedicated worker for health adviser team should be standard provision.
- "Hello I work for the GU Services Network". A phrase some have employed when contacting partners outside their area if local service not placed to make the call.
- Leaflet "What about partners". Used in Newcastle to give more information on PN to patients.

- **Obstacles & commonly encountered difficulties**

- Insufficient information.
- High numbers of patients/pressure of work
- Medical and nursing staff do not re-refer back to HA
- Clinics not sending contact slips back
- Time consuming to telephone patients
- No dedicated telephone line
- No Internet access
- London – high numbers of clinics.
- Rural problems:- clinic only open once a week?
- Ethical problems/grey areas. Differences of opinion exist across/within clinic teams
- Differences in boundaries. Local protocols/restraints. Leads to some clinics refusing or reluctant to follow through on PN instigated by another. Some clinics more proactive than others. Will attempt to glean more information. Others will offer an attendance check and no more.

- **Action: Local /National**

- Looking at different styles of practice. Clinical 'placement'. A "fly on the wall" can be helpful. ie HA's to sit in with one another or visit other clinics to see their procedures/ approaches.
- Protocol – telephone calls made etc
- Dedicated health adviser phone line. Internet access for Health Advisers
- Clarify legal situation. Checking by legal department of letters
- National guidelines for C/T. Detailed. Mechanics of PN needed not just principles. 21st Century Edition of 'Orange Book' long overdue.
- Standardisation of approaches i.e. letters, telephone answer machine messages. Website may offer vehicle for this
- More research on PN. Not just outcome focussed. Process issues to be looked at.

Session Evaluation

Participants were asked 3 questions at the close.

1. "What I found the most interesting".
- The variation in standards/values and approaches of H/As was frequently mentioned.
- The Public health role was adapted in some clinics due to the inability of some health advisers to contact trace because of time constraints.
- Discussion about rights and wrongs of provider referral without explicit consent of index patient was valued. Also different strategies for tracing contact with sketchy information.
- Opportunity to discuss with others this complex area of health advising.
- Look in detail at a case study, with shared experience and different approaches was a good method to employ
- Sharing others experiences and gaining ideas and options as to how to proceed in "difficult" situations with provider referral

2. "What I will take back with me to work"
- I need a more structured approach/model to partner notification
- "GU services network" when ringing contacts out of our area
- Patient information leaflet about P/N
- Use of Internet. Ask for my own access to Internet
- Ask again for my own direct telephone line
- Encouraged me to ask for more clerical support
- Ideas about improving provider referral in my clinic in London

3. "What issues SHASTD could consider"
- Legal implications of provider referral & of failing to inform contacts.
- Consent required from index patient before undertaking provider referral?
- Specific national guidelines for varying situations that commonly occur with P.N.
- National standardisation. New edition of 'Orange Handbook'.
- Encourage more shared working.

- Study days set up dedicated to P.N.
- Encourage more research into P.N.
- Use of Internet. Recommendations to members on available resources.
- Develop SHASTD website further to promote good P.N. practice and facilitate communication between health advisers.

Summary

This was a thoroughly enjoyable and stimulating workshop to take part in. It was felt that 'partner notification' in general, and specifically 'provider referral', was a subject of crucial importance to tackle at Conference. The workshop merely scratched the surface of a deep and complex activity at the core of the health adviser role. However it did provoke much discussion and each participant left with tangible projects to work on. Direction was given for SHASTD to consider at a national and organisational level. Perhaps more time could be dedicated to this subject at Conference 2002.

WORKSHOP: HIV Pre-test discussion training for Oxfordshire midwives, in light of antenatal testing.

Margaret Rings, Health Adviser, Harrison Department of Genito-Urinary Medicine, Oxford.

The aim of the workshop was to explore the issues around antenatal pre-HIV test discussion and training for midwives in light of routine antenatal testing. Included in the workshop presentation was the feedback from recent training in Oxfordshire. A supplementary aim was to share information with other health advisers who may have been involved in similar training.

The content of the workshop included:

1. A brief introduction to the training programme as delivered to Oxfordshire midwives.
2. The introduction of the role-play exercise used in the training.
3. Identification of possible obstacles in setting up this type of training service
4. Development of an evaluation tool for training.
5. A brief presentation of evaluative feedback from training programme
6. Discussion.

Four SHASTD conference delegates attended the workshop. All of those received a copy of the booklet devised for the original training programme. The booklet was designed as an information pack for health care workers, covering all aspects of the antenatal testing procedure including the pre-test discussion issues.

CONTENT OF TRAINING SESSONS TO MIDWIVES.

The original training was scheduled as a three hour session with a break for refreshments and included:

- Definition of HIV/AIDS.
- HIV transmission.
- Risk assessment.
- Aims of pre-test discussion.
- Pre-test counselling issues.
- Post-test discussion.
- Language use and personal beliefs.
- Referral procedure.
- Role-play exercise and feedback.
- Question time.

EVALUATION OF MIDWIFE TRAINING.

Evaluation of the initial training indicated that 88.5% of the participants were very satisfied with the value of the training. The remaining 11.5% was satisfied.

The materials and handouts used were seen as valuable aspects of the training.

70% believed that theoretical information, pre-test issues, information about GUM services and referral and the resource book were the most valuable part of the training.

Proposed action, by the midwives, as a result of the training was listed as:

- More confident implementation of the testing initiative (53%).
- Development of good practice for the initiative (28.5%)
- To access further training and reading on issues raised (10%).
- No response (8.5%).

Individual comments raised the issues of the emotive response of the midwives to this initiative.

FACILITATOR FEEDBACK, FROM MIDWIFE TRAINING.

The issues that emerged from these training sessions were many. The fourteen sessions at 3 different venues proved to be very stimulating. Some particular aspects were highlighted mainly the diversity of practice in antenatal care. As a result of this, practice guidelines would need to be developed by individual practices.

There is a need for patient information to be available to patients prior to testing.

The midwives raised real concerns about the time available to them to carry out this discussion with their patients and the context in which this happens.

The midwives were concerned about the change in discussion that this might bring for them, in particular to include sexuality and sexual behaviour. This changes the discussion where sexual behaviour is implicit to having to make it explicit. Many felt that further training would be needed in this area of discussion.

A follow up study to evaluate the training has been proposed. This study would include ongoing training needs and the identification of future training.

SHASTD DELEGATE FEEDBACK.

In light of the overall conference attendance, this workshop was poorly attended. However there was lively and useful discussion. The inclusion of the role-play exercise brought the usual response, "not role-play" but everyone joined in enthusiastically.

ROLE-PLAY EXERCISE.

The object of the exercise in the initial training was to allow the midwives to focus on some of the issues raised in pre-test discussion. The health advisers in the workshop found that the time limit of 5 minutes per discussion was very restricting and were able to appreciate how daunting this could be for a midwife.

IDENTIFICATION OF OBSTACLES.

A discussion on the possible obstacles that could present in setting up this type of training focussed on:

1. Midwives feelings and beliefs.
2. Time aspects of discussion.
3. Short staffing situation among midwives which might make setting up and execution of training difficult.
4. Actual training time available or allowed.
5. Why talk about it at all? Is there a need for training?
6. Midwife/patient process, the assumptions that may be made particularly in light of sex and sexuality.

DEVELOPMENT OF AN EVALUATION TOOL FOR TRAINING.

This part of the workshop did not identify any main areas for evaluation. One of the main reasons for including this item in the workshop content was to gain some insight into how others have overcome some of the issues around good and useful evaluation. In my opinion the evaluation tool used in the initial training was limited and a more useful one is in the process s of development.

Feedback form the SHASTD delegates suggested that they found the workshop session to be useful and informative with many interesting issues raised. It was suggested that a more interesting title might have elicited more attention from SHASTD delegates. A lesson learnt, `find a catchy title`
ANY SUGGESTIONS?

Sperm washing: Sexual Health meets Assisted Conception

Debbie Vowles, Womens' Services Health Adviser, Chelsea and Westminster Hospital, London SW10 Tel 0208 846 6150

Audit of programme at Chelsea and Westminster Hospital 2000 plus an Update
Preconception counselling issues
Case Histories
Ethical Issues
Guidelines for the Service

Sperm washing

What it is?

Technique based on premise that HIV is present in seminal fluid rather than sperm.
Involves separating fluid from sperm cells by centrifugation and "washing".
The"washed" sperm (combined with artificial semen solution) is inseminated into HIV negative woman when she is ovulating.
It is a risk reduction technique, developed by Semprini in Milan in the early 1990s
Idea behind development was that HIV discordant couples intent on having a child might risk HIV transmission to woman and thereby risk vertical transmission if she became pregnant at same time.

What does it involve?

Preconception counselling in Sexual Health Clinic
Full sexual health check for both partners including HIV tests for woman
Sperm analysis
Fertility and hormone workup for woman
What does it involve cont.
Usually done by inter-uterine insemination although if underlying infertility problems discovered in woman IVF offered
Several visits required of woman – follicle tracking, hcG injections, etc to monitor cycle and offer best possible chance of pregnancy
On the day of insemination, man attends to provide sample early morning – spinning and V/L tests done. Insemination in the evening. Pregnancy test done at home 2 weeks later.

What it costs?

Not available on NHS
Approx £2400 for preliminaries and 3 attempts of inter-uterine insemination
Some health authorities are willing to pay for at least one set.
Audit of programme at Chelsea and Westminster Hospital

Carried out by Gillian Hamer (gh)and Anne-Marie Lewis (aml), Womens Services Health Advisers in 2000

Sperm Washing Couples
Length of relationship
Length of time diagnosed with HIV
Access to HIV medical services
Male partner's treatment
Female partner's experience of HIV testing
Previous attempts to conceive
Other children
Type of safer sex practised

Length of relationships

4 couples	>10 years
12 couples	5-10 years
6 couples	2-5 years
3 couples	<2 years

Number of years since man diagnosed HIV positive

7 men	>15 years
3 men	10-15 years
10 men	5 – 10 years
5 men	2-5 years
0 men	<2 years

Access to HIV medical Services

23 men regularly attended
2 men had not attended in last 5-8 years

Male partners treatment

18 men received combination therapy
7 men no treatment

Female partners experience of HIV testing

5 women	never tested
5 women	regularly (6-12 monthly)
15 women	1-2 times over length of relationship

Attempts to conceive when couples knew of HIV discordant status

18 couples	no attempts
1 couple	IVFx9 and UPSIx3
2 couples	Donor insemination
2 couples	Sperm washing
2 couples	UPSI in fertile period

Number of children

20 couples	No children

5 couples 1 child each
1 from previous relationship
1 UPSI knowing HIV +ve
1 donor insemination
2 conceived before diagnosis

Type of safer sex practised in the relationship

20 couples used condoms and practised penetrative vaginal intercourse
1 couple had no penetrative vaginal intercourse

Update – April 2001

No. of couples	30
No of inseminations	IUI 34/IVF 14
No of babies	4
No of ongoing pregnancies	4
No of miscarriages	5

3 women pregnant on first insemination
1 woman 5 X IUI and 3 X IVF (still trying)
Some have one insemination and leave the programme

Semprini results up to Jan '99 (courtesy of Dr Semprini)

No. of inseminations	1690
No of women	543
Pregnancies	240
Pregnancy rate	14%
Delivered	184
Live births	211
Maternal seroconversions	0
Vertical transmission	0

First stages of programme
Take place in Sexual Health Clinic -

Preconception counselling – couple seen together and individually
Full sexual health check for both – results sent to ACU
Man's viral load and CD4 also taken
HIV test for woman (repeated throughout the programme and for six months after leaving)
Preconception counselling
Why? why now? (any particular pressures)
Consideration of HIV risk to woman, and if so, to possible child
What if man's health deteriorates/he dies
What if discover infertility problems
What if don't become pregnant? How many inseminations?
Parenting issues
Safer Sex issues
Observations from preconception counselling

Variable knowledge of HIV
Poor knowledge about conception details
Most couples have considered issues raised in counselling
Counselling session often confronts couples with full impact of the diagnosis

Further observations

Female partner often more willing to accept possible HIV transmission risk than male partner
Male partners often needed time to adjust to possibility of parenthood
Very often HIV status is only known to the couple – no family or friend as source of support for woman (or man). Relief to talk to counsellor
Some couples separate during the process

Case history 1

Man 35yrs, haemophiliac, living with HIV for approx 15 years. Undetectable viral load
Partner 34 years. Married 8 years
Had considered all issues re parenting
Health authority agreed to pay
Pregnant on first insemination
Woman more concerned re having girl (risk of haemophilia carrier) than HIV

Case History 2

Man 39years. Diagnosed 4 years ago. Undetectable viral load
Woman 41years.
5 X IUI. Very large fibroids revealed. Advised to deal with this before trying IVF
No one else knew about HIV – woman very distressed to realise infertility difficulties of her own

Case History 3

Man 31 years – infected when working as sex worker in late 80s. Still having sex with men but living with woman aged 19
Man on salvage therapy but doing well
Known to have had gonorrhoea 8 months previously. (1 C/S for CMP given by H/A)
Woman absolutely determined to have a baby

Ethical concerns - Sexual Health meets Assisted Conception

What about the effects of triple combination on sperm
Patients strong desire for a child – feeling ?blackmailed
Different "culture" of sexual health clinics and assisted conception units
VD Act and HFEA rulings – different emphases
Sex (and ?death) and Birth
Rights of Indiv/Couple and Welfare of the child
Infection control anxieties - special suite for sperm washing programme
Very few hospitals offering fertility treatment to HIV positive women – why, in the light of reduction in vertical transmission

Our Guidelines

Stable, monogamous, heterosexual, long term relationship
No unsafe sex in previous six months – and written guarantee of none during and after programme for 6 months
No IV drug use for 6 months before, during and after programme

REFERENCES

Semprini Augusto MD, et al "Insemination of HIV-seronegative women with processed semen of HIV seropositive men: an update" in The AIDS Reader, November/December 1993 pp 184-190
Mandelbrot L, Heard I, et al, "Natural conception in HIV negative women with HIV infected partners" Lancet Mar22,1997: 349: 850-51
Gilmour J., Gotch F et al "Evaluation of Sperm washing as a potential method of reducing HIV transmission in HIV discordant couples wishing to have children" AIDS 1999

Post Exposure Prophylaxis for Sexual Exposure to HIV.

Presented by Mike Jones, Senior Health Adviser.
With thanks to Dr Paul Benn , Specialist Registrar for the use of his data and notes.
The Mortimer Market Centre, Camden and Islington, CHS NHS TRUST.

The Background

Prior to mid 1990's and advent of HAART.

AZT monotherapy PEP proven to reduce risk of HIV seroconversion.
Health Care Workers exposed to HIV via sharps injury or exposure via mucous membranes
Risk of seroconversion without PEP following sharps injury
Estimated at 3 in 1000 on average (other factors increase/decrease risk)
Risk of seroconversion with PEP
(4 weeks AZT Monotherapy started within 24 hours)
Risk reduced by 80%

THE ADVENT OF HAART (Mid 1990's onwards)

Understanding of significance of viral load in HIV transmission and progression to AIDS.

Evidence of effectiveness of various drug regimes in reducing mother to baby transmission in neonates.
15% to 25% risk in Western Europe reduced to 1% or less with prophylactic treatment of mother and baby and other risk reduction practices.

Therefore, with the evidence we have for reduction of risk to HCW and in vertical transmission, PEP for Sexual Exposure might reduce the risk of seroconversion

Despite the lack of hard evidence either for or against, there is general acceptance that PEPSE is likely to reduce the risk of seroconversion in relevant patients.

It is a subject of debate within medical services and within the media, especially the gay media.

At risk patients, in particular gay men and heterosexual women with known positive partners and sexual assault victims are most likely to attend clinics or casualty
with concerns around HIV and PEPSE.

The Problem of PEPSE.

Lack of Human Studies to confirm efficacy.
Health Economics/risk evaluation

Eligibility Criteria
Which drug regime?
For how long?
Adherence
Follow up.
The 'morning after pill' debate.

Studies.

No completed human studies. Very large numbers of participants required.
There is an ongoing study in San Francisco (Katz et al) funded by a drug company in which gay men 'at risk' can ring a hotline and are referred for PEPSE.

Regime is dual therapy AZT/3TC for 4 weeks.
78% of participants have completed 4 weeks of therapy
Must commence within 72 hours.
Very few participants have requested PEPSE more than once.
In UK MMC auditing PEPSE and involved in future study involving 10 centres prescribing PEPSE.

Animal studies. 1997 study (Bottinger D et al). Monkeys exposed to SIV or HIV 2 via rectal inoculation to mimic human mucosal exposure.
Strong evidence that PEP can reduce risk of seroconversion in this study.
PEP for mucosal exposure should commence within 24 hours and be maintained for 4 weeks (100% effective)
If commenced later, especially after 72 hours, little benefit.
Same regime given for 10 days was only 50% effective.

The problem of evaluating risk.

Estimates of how likely it will be that someone will contract HIV following UPAI
Or UPVI vary.
In the case of receptive UAI with a known positive partner figures range from
1 in 300 to 1 in 100 risk of seroconversion depending on viral load, other STI's present etc
Estimated that it might require treating 500 at risk patients to avoid one case of HIV seroconversion. In the case of a very high-risk patient this is felt to be
justifiable in terms of long term treatment costs and possible inability to work if unwell.

The problem of what to prescribe and for how long.

In the absence of clear evidence the guidelines used by most clinics prescribing PEPSE are those used for prescribing PEP for occupational exposure.
DOH guidelines for occupational or similar non-sexual risk PEP.
AZT/3TC/Indinivir (Or Nelfinivir) for 4 weeks.
Commence asap, ideally within hours. Can be prescribed within two weeks.

Camden and Islington Policy for occupational PEP.

We used to prescribe D4T/3TC/Nevirapine because of concerns about drug resistant strains. Regime will depend on circumstances like donor already on regime or has failed on previous regimes.
There were several severely adverse drug reaction events related to Nevirapine
So nelfinavir or indinavir more likely to be given by this clinic for occupational or sexual risk.

The development of PEPSE policy and practice at MMC: The History.

From 1997 onwards we have been prescribing PEPSE to 'at risk' patients.
In the early days we had no formal policy and documentation/standardisation of practice and follow up was poor.
The clinic realised that PEPSE would continue to be requested by or offered to 'at risk' patients.
Potentially increasing numbers year on year.
We therefore required protocols to standardise practice,to monitor outcomes and for the purposes of audit and research.

Our Concerns in the early days of PEPSE

We receive no extra funding for PEPSE.
The average cost of 4 weeks HAART is £650, which comes out of our already stretched drugs budget.

Some major HIV treatment centres have in the past refused to prescribe PEPSE because of cost and unproven efficacy.

How do we decide who is eligible? Do we have a right to refuse PEPSE ?

Policy/protocols have evolved in response to the experience of both clinic staff and patients.

The predicted 'deluge' of requests for PEPSE, particularly from gay men, has not happened.

Articles in the gay press by men prescribed PEPSE have made it clear that PEPSE is difficult to take and is not a problem free 'a morning after pill'.

Giving the patient clear information about the pro's and con's of PEPSE based on the facts we know usually enable the patient to make up his or her own mind.

Very unusual for someone for whom PEPSE is unlikely to be appropriate to go ahead once they are aware of the realities of taking PEPSE

Current Mortimer Market Protocols for prescribing PEPSE.

1) Patient has up to 72 hours in which to commence PEPSE
   Ideally should start within 24 hours.
   May be appropriate to start within up to 2 weeks but no research evidence for this.

2) Initial presentation should be to our male or female floor ,sometimes our HIV …..clinic where the patient will be seen by the health adviser.

2) Health Adviser discussion

   Risk assessment (? Known + donor etc)
   Time since risk
   Pro's / cons of PEPSE
   Side effects/adherence
   Support
   Sexual risk reduction (condoms during widow period for example)
   Baseline HIV test and pre test discussion
   Importance of 3 and 6 month follow up Ab test.

   The health adviser is not the 'gatekeeper' for PEPSE.
   We give the patient all the facts they need to make an informed choice about proceeding.
   Some decide not to proceed.
   If they wish to take PEPSE or require further discussion they are referred to our on call HIV Spr doctor.

3) Following further discussion with the doctor, if the patient wishes to proceed with PEPSE the following procedures are followed.
   Base line bloods Haematology, chem path (LFT's etc)
   These to be repeated at 2 and 4 weeks.
   A full GU screen will be offered if appropriate or advised for 2/52
   HIV, Hep B and C tests should be taken.
   A 5 day HAART starter pack will be issued.

4) Patient returns in 5 days for HIV and other results.
   ….If HIV negative and other results not problematic then two more weeks of ….HAART issued.

5) Patient returns for mid PEPSE check up and bloods and final part of HAART issued.

6) At 4 weeks patient returns for final LFT's etc and doctor discussion/follow ….up.

   (NB Health Adviser support is available throught the period of taking PEPSE and whilst awaiting HIV ab test results following PEPSE.

HAS IT WORKED ??

It is vitally important that the patient understands that s/he must return for both a 3 month and a 6 month follow up HIV ab test.
PEPSE may delay seroconversion.
One documented case of a woman in the USA seroconverting between 3 and 6 months following PEPSE.

MMC STATISTICS FOR PEPSE Requests/prescriptions

(Derived from Dr Paul Benn's audit of all cases of PEP and PEPSE Jan 97 to Nov 1999

1997.	6	documented cases
1998.	25	documented cases
1999.	17	documented cases (Jan to Nov inclusive)

Total of 48 cases where PEPSE was discussed - to end of Nov 99.

Out of these 48 --- 40 Prescribed PEPSE / 8 did not proceed.

Risks factors of 40 patients prescribed PEPSE

UPRAI	60%
UPAAI	22%
UPRVI	10%

Of these 40 patients prescribed PEPSE

75% reported a known HIV positive donor

The median time of starting PEPSE was 23 hours (range 9 to 192)

This compares unfavourably with Occ PEP where the median time to starting drugs was 2 hours (range 1- 48)

24 completed the full 4 weeks of therapy

20 took an Ab test at 3 months

9 took an Ab test at 6 months.

1 patient tested positive at baseline

1 patient seroconverted at 6 months.

There was a follow up rate on average of 75%

10% of all patients on PEP/PEPSE required a change of drug therapy.

9% of all PEP/PEPSE patients had severe adverse events.
These were all linked to Nevirapine (severe rash, abnormal LFT's)

24% of all patients had minor adverse events.

The Future

A gradual increase in sexual risk taking has been documented amongst sexually active gay men.

Increasing number of people living with HIV.

Increase in awareness of PEPSE in general population.

Overall the demand for PEPSE is likely to increase even if the once expected 'deluge' of demand never materialises.

Requests for PEPSE at GU clinics. (BCCG Questionnaire)

	1997. (135)	1999 (132)
No of clinics reporting requests For PEPSE	29	56
No of requests	64	242
Clinics Prescribing	13	39
Prescriptions	18/64	130/242

60% of requests were directed at 9 clinics
64% of prescriptions issued by 6 clinics, 4 in London.

CONCLUSIONS

- Lack of evidence for efficacy
- Theoretical basis for PEPSE
- Lack of national guidelines
- Availability and experience may vary

- Prevalence of genotype mutations/need to 'tailor' PEPSE
- Time to starting PEPSE important
- Difficult to take/adherence
- Toxicities
- Effect on mood/relationships
- Safer sex counselling
- Importance of good advice/counselling/informed consent.
- Screen for other STI's , Hepatitis
- Baseline HIV test and PTD
- Importance of follow up HIV testing at 3 and 6 months.

Discussion

What does your clinic do now ?

Does it have a policy ?

What would you like to see in place to enable you and your colleagues to work effectively with patients you are advising about PEPSE ?

Are there agenda's about who does and does not 'deserve' PEPSE ?

Summary of discussion following presentation.(15 Health Advisers in attendance)

1) All Health Advisers present work at clinics where PEPSE will be offered in certain circumstances. None worked at clinics where PEPSE would be refused outright.
2) Several clinics represented have written guidelines on PEPSE, the majority do not.
3) The few clinics with written PEPSE guidelines are clinics where the high level of demand for PEPSE has led the development of protocols.
4) Concerns were raised by HA's working in clinics without a written policy about the lack of clarity and consistency around prescribing and follow up of the patient
5) There continues to be a debate in some clinics about who 'deserves' or should be eligible for PEPSE.
6) Concerns were also expressed by two Health Advisers about the policy of HIV testing patients starting PEPSE. Their main issues were around the distress and confusion that patients might be experiencing at this time so if the patient is unwilling to test should they be denied PEPSE ? There was a discussion about how this policy evolved. The experience of clinics with a high number of PEPSE patients is that all patients are willing to test providing they are fully informed about the reasons for this.

CONCLUSION

The most important conclusion gained from our discussion is that every clinic should have written protocols for prescribing PEPSE.
Written protocols are essential for consistency of prescribing, patient care and follow up. There will also be an increasing emphasis on audit and research into the effectiveness of PEPSE.

HIV/AIDS & SEXUAL HEALTH: AN AFRICAN PERSPECTIVE

African communities in the UK traditionally have a high prevalence of HIV infection. Africans are the second largest group affected by HIV/AIDS in this country. There is also evidence that majority of women testing HIV positive in the ante-natal clinics are that of African origins. There is a need to target these communities for sexual health promotion, HIV prevention work, as well as highlighting advantages of HIV screening and on-going medical care.

It is therefore important to focus on the needs of African communities living with HIV/ AIDS. Africans are generally socially marginalized and tend to access sexual health services only when there are symptoms of an 'illness' and their GP may be their first point of contact. This is because their health concern may not be their main priority or because of lack of information and advice of where people go for screening. Africans are known to present late for HIV testing, and care. This is also a particular issue with regard to the implications in vertical transmission.

When working with African patients, healthcare professionals need to be aware that HIV and sexual health are not isolated issues for African communities. This must be understood in context with other social, cultural and economic issues. Healthcare professionals require better understanding and to increase their knowledge and awareness of African cultural issues in relation to HIV/AIDS and other issues relevant to the diversities of African people and the non-homogeneity of Africa

The Debate.

Personal Reminiscences of Debater 1- Ronald Seery, Senior Health Adviser, Royal London Hospital

"This House believes that Health Advisers should be proactive in HIV Partner Notification"

When Sandra Jarrett, the conference organiser, telephoned me to ask if I would participate in the debate on the last day of the 2001 conference I was delighted. Memories of my school debating team flooded back and I agreed readily.

Nearer the time and I was becoming a little more apprehensive. There were to be two debaters, Miriam Mackie from St. George's Hospital, and myself. I would not be on a debating team; I was the debating team. That seemed to carry a bit more responsibility than I really wanted or was used to. I asked around the clinic for opinions as to what stance I could take opposing the motion that Health Advisers should be more proactive in Partner Notification in H.I.V. and received some helpful comments.

A week before the conference and my search for yet more opinions was becoming slightly frenetic. People started moving away in the opposite direction, their heads buried in case notes when they saw me approaching.

The conference was extremely well planned and run and I settled into the enjoyable process of getting to know new Health Advisers and comparing how things were up and down the country. This was such an enjoyable time that Sandra had to ask me thrice to introduce myself to the chair of the debate, Dr. Eamonn O'Moore. This I eventually did during the dinner on Thursday night. As a scrupulous fellow Hibernian, he very diplomatically declined my offer of a bribe to rig the result and I, in abject shame, went on to make a show of myself on the dance floor.

Miriam arrived for communal breakfast the next day and we were asked to stay outside the hall while the assembled Health Advisers took a pre-debate vote on the motion. We were then to debate and then another vote would be taken following discussion from the floor.

This was a particularly nervous time for me as I wondered what 70+ Health Advisers would be voting, for or against the proposal? Miriam stunned me slightly by affecting a leather biker jacket, but kept me sane in those anxious few minutes by making pleasantries about clinic work, the weather and holidays. She did not seem in the slightest bit adversarial.

I registered an expectant frisson of excitement among the audience as we were led in to the conference hall. I was very glad of the water on the table as I found I was one human being who could not be charged with transmission of a well-known disease. I had no bodily fluids it seemed, particularly in my mouth and throat.

The chair introduced us and Miriam was to speak first. She launched in to her reasoned argument and I thought with panic that she was making a few of the points I thought would

be unique to my side of the debate. I started making notes in a state of panic but then stalled as I realised her overall argument was a bit too reasonable.

Ten minutes was the time allocated to each debater and mine seemed like ten seconds when I started and then had to hurriedly finish. My occasional quip went down well. There was a lot of considerate attention to what was after all a very serious topic.

Eamonn O'Moore was a good chairman and whipped up some impassioned comments from the floor, for and against the motion. Miriam and I were criticised for dwelling too much on the pedantic and people were awed by the comments of the Scottish Health Advisers on the recent trial of the man accused of willingly infecting his girlfriend with H.I.V.

There were some shocking surprises for me when I thought that certain Health Advisers would be very against the motion were in fact for it and vice versa. It was a salutary lesson against stereotyping for me as I listened to comments. Afterwards, I thought it was indicative of the change in the nature of the role and the increasing business of clinics everywhere with H.I.V. care.

At several points I thought that the proposed motion would be accepted outright but when the final vote was cast it seemed a fifty-fifty split. This was a severe disappointment to me until the chair said that the pre-debate vote was a sea of papers voting for the motion.

Several Health Advisers said to Miriam and I afterwards that it had been edifying to consider the pros and cons of practice and would be something they would take away from the conference to consider.

Result!!

Evaluation Summary.

Sandra Jarrett, Conference Co-organiser

67 delegates attended the conference.
40 forms were completed and returned.

Conference facilities

The facilities at Whitehall College were rated as good overall, a few delegates rating them as excellent and some as fair.
The main complaints were that some of the showers were temperamental, the lack of tea and coffee making facilities in the main bedrooms, and the fact that the pool was out of action.
The staff were generally seen as friendly and helpful, although one delegate did complain about one of the kitchen staff who had been particularly rude. This was reported back to the college management, as well as the more positive feedback.

Content

The content was rated by the majority of delegates as excellent, by a few as good and a couple as fair.
Delegates commented on a varied and stimulating programme, and the fact that health advisers led the majority of presentations and workshops.
Delegates felt informed, empowered, energised and motivated by the content, and had a chance to network and share ideas and common dilemmas in working practice.
Delegates felt that the emphasis on Health adviser practice and the roles and responsibilities of SHASTD helped to foster understanding and a feeling of belonging within the profession.

Organisation

The organisation of the conference was rated by the majority of delegates as excellent, and by the rest as good.
Delegates reported that it was well run and well structured by an efficient and friendly conference team. Some first timers reported that it surpassed their expectations and those who had been to conference before, reported that it was the best ever, and liked the new structure with the AGM in the middle and workshops on the first evening.
It was the first time that positive comments had been made about the AGM, and delegates felt that Council members were more approachable and less 'cliquey'.
Delegates commented on the relaxed and friendly atmosphere.
The only negative comments were regarding the dinner on the Thursday night, with some delegates commenting about the distance from Whitehall College, the cold, and the fact that there was no smoking in the building.

The organisers would like to explain that it proved extremely difficult to find a suitable venue in the area that would provide facilities for both dinner and entertainment. In previous years the dinner had been held at Fanhams Hall, however, they changed their criteria on minimum numbers and were not prepared to negotiate with us. This meant we could not afford to return to that venue on those terms and had to seek an alternative. The reason there was no smoking was that the venue chosen was an 800 year old barn which had very strict fire regulations (we had to hire their own specific candles) and not, as one delegate asserted, because we were health fascists. The organisers explained quite clearly in writing and at the beginning of the conference that there would be a no smoking policy, but that people could smoke outside in the grounds. It was rather unfortunate that it happened to be extremely cold that night and therefore the back door was continually in use. The organisers hope that it did not spoil the enjoyment of the delegates too much.

Presentations

All the presentations were rated as quite or very relevant, and delegates commented on the high standards, and that the topics were all relevant to health advising practice.
The two presentations that were particularly singled out were 'A model of health advising' by Jo Greenaway, Jane Sudlow, George Leach, Simon Paragreen and Dawn Whittaker and ' Sexual health strategies' by Dr Eamonn O'Moore.
The presentation on drug assisted rape by Graham Rhodes also provided many comments, and although delegates found the topic and facts presented as fascinating, there was a lot of concern as to Graham's agenda, and the level of professionalism and training provided at the Roofie Foundation. Many delegates said they would not feel comfortable in referring patients to this service and felt they would have liked more time to discuss issues raised with him. However, it certainly seemed to have provoked stimulating discussion and debate on this subject.

Workshops

All the workshops were rated as quite or very relevant, and delegates' comments indicated that these were very well presented and stimulating, with the workshop on partner notification provider referral particularly singled out.
Delegates indicated that they would have liked to attend more than one workshop, and that the workshops could have been longer.
Delegates also found the regional workshops very useful, in understanding the difficulties within their own area, and meeting others from their neighbouring clinics. It also gave delegates a chance to meet with their regional SHASTD representative (or to realise the rep. position was vacant) and gain a greater understanding of the structure and function of the Council.

Debate

This was rated overwhelmingly as very relevant. Delegates found this highly enjoyable and stimulating, and a good innovation for the Friday morning!

It was a lively affair with a lot of very interesting and thought provoking comments from the floor. Some delegates felt that the debaters did not make their positions very clear, and therefore the motion itself was not clear in delegate's minds when they were voting. However, this did not seem to detract from the positive feedback received for this new addition to the annual conference.

Summary

The feedback received from this conference was extremely positive, particularly the changed structure of the conference, and the greater involvement of SHASTD representatives and Council members in ensuring delegates felt welcome and included with a greater clarification and definition of the health adviser role.
Most of the complaints were regarding the facilities, and the no smoking policy at the dinner, which the organisers expected to some extent.
Many of the suggestions and comments from previous conferences have been actioned, and from the feedback, seem to have worked!
The high standard of presentations and workshops by health advisers has continued and the conference provided an opportunity for networking and learning, as well as inspiring and energising delegates with new ideas and methods of working.

With thanks to Debbie Burnett and Jan Hyland for all their hard work in helping the conference run so smoothly, to all the sponsors, and to all the speakers and delegates for their contribution, support and feedback.

Conference 2001 Report compiled by Chris Faldon, SHASTD Vice President