Written evidence from The Eddystone Trust

1. The Eddystone Trust is an independent charity covering the South West of England, we are funded through the following Councils: Cornwall County Council; Plymouth City Council; Devon County Council; Torbay Council; Somerset County Council; Gloucestershire County Council; North Somerset; and South Gloucestershire. We are also funded through private trusts and grant making organisations covering Bath & North East Somerset, Herefordshire and Worcestershire. We have been in existence for over 30 years and have seen many changes in the funding associated with the third sector for the provision of HIV Support and HIV and Sexual Health Prevention services.

HIV Support Services

2. Over recent years since HIV was identified as a long-term condition and not the death sentence that it once was, we are seeing a desire to ‘mainstream’ the services provided by organisations such as ourselves for HIV Support.

However, the stigma, discrimination and misunderstanding of HIV remains a major issue, which for some people with the virus makes it impossible for them to disclose their status to their family and friends let alone a professional they come across when faced with financial difficulties, housing problems and many many more issues that might adversely affect their condition. As an example the mental health of those with HIV is of significant concern and the ability to disclose status has an adverse impact as stigma remains a significant issue in the South West of England.

We recently undertook a survey of people’s understanding of Undetectable = Untransmittable; nearly 250 people at events across the area took part and the results were as follows:

- 64% understood the meaning of U=U in a HIV context
- however only 43% would actually date someone with HIV
- only 14% would partake in condomless sex with an individual who is Undetectable.

3. Public Health funding for the HIV Support services is under pressure and a number of councils are reviewing the provision of their existing contracts. Many of the HIV+ people we work with across the South West do not feel that they are able to disclose their status and more work related to the acceptance of a HIV diagnosis within the general public is required if HIV is ever to truly become ‘just’ a lifelong condition. Stigma and discrimination in the South West remains around HIV and as such service users are unwilling to come forward to complain unlike those in large Urban areas where HIV is more accepted, thereby marginalising even further an already marginalised group.

HIV & Sexual Health Prevention
4. Attending a sexual health clinic has always been an issue for some individuals. The current trend is to move to a digital offer to give some of these individuals the opportunity to obtain a test while, at the same time, reducing demand at clinics. However, the statistics available illustrate that the digital offer only increases the number of tests delivered and does not achieve the anticipated savings that were originally predicted. We have been delivering Community Point of Care Testing at venues throughout the South West for a number of years, with nearly a 1,000 tests being delivered, we see a sexuality split of 44% heterosexual, 17% bisexual and 38% gay, further illustrating the need for delivering testing in a community setting away from the traditional clinical settings.

5. In addition, the missed opportunity for a behavioural change intervention at for example a community setting delivering a pop-up clinic by a third sector organisation, has an effect of continuing the behaviour that the individual has previously been undertaking, thereby continuing with the circle of risk and test.

6. During 2017 Freshers events across the South West we surveyed over 3,000 young people aged between 16 and 25, with 74% of them stating that they don’t and wouldn’t want to get tested at a sexual health clinic, preferring to be tested at their GP’s or community settings.

7. To deliver any type of cost saving to the system, there needs to be an investment in community services to deliver behaviour change programmes to those most at risk of acquiring an STI. This is a longer-term strategy more likely to achieve the changes required, however, currently the budgets constraints and reductions are preventing proper consideration and investment in these types of strategies.

8. Funding of sexual health through Local Authority rather than NHS budgets causes confusion and frustration within the system. Often looking and feeling like NHS Services they do not, however, receive the protection that is afforded to the NHS. In addition, the cuts to Public Health funding is creating a need to reshape service delivery on economic grounds rather than via a thought through process based on evidence of need and best practice.

9. Local Authority contracts are also of a short duration making the longer-term planning required to achieve the changes required, both within the system and the lives of the people who use the system, more difficult.

**Workforce**

10. Sexual health is not a standalone issue - it is affected by and impacts on many areas of a person’s life - a good example being how, when and where young people learn about sexual health. It is imperative that training about sexual health is delivered in a way that moves beyond the clinical incorporating the WHO definition of sexual health as a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. To achieve this, training programmes should therefore be inclusive of the wider determinants of health, include behaviour change methodologies and be developed in partnership with groups most affected by poor sexual health outcomes.
11. The workforce is often narrowly defined to include staff that are employed in clinics or by NHS employers. In reality the professionals who might have the greatest influence on early interventions, prevention and self-management and, in turn, sexual health outcomes are often those employed outside clinical settings. It is vital that we expand the training offer to allied professionals working in organisations which encounter sexual health ‘patients’ in their daily lives and can ‘meet them where they are’. This includes (but is not exclusively) drug and alcohol teams, homelessness workers, children and young people’s social care staff, teachers, mental health professionals and parents.

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