Project:	Joint Strategic Needs Assessment		
Profile Title:	Sexual Health		
Author/Priority Lead:	Lorraine Hughes		
Date of Submission:	11th September 2011		
Document Reference no:	[insert reference no here]	**Version no:**	1.0

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Version	Comments	Author	Date Issued	Status
0.1	In progress	Lorraine Hughes	11.9.11	**Draft**
0.2				
1.0	Version to be published	Lorraine Hughes	26.11.11	Final Version
1.1, etc	VCS Comments added	Rachel Atkins	17.2.12	

Introduction

Good sexual health is an important element of health and wellbeing and it is vital that people are able to make choices that are right for them in support of this. To support people in this they need to have access to the right information at the right time, services available which meet their needs and the confidence to access those services and make choices. There are four key strands to sexual health which need to be considered; contraception, abortion, sexually transmitted infections (STIs) and the human immunodeficiency virus (HIV). Within each strand variations are to be found according to age, gender, sexual orientation and race.

The consequences of poor sexual health can be far reaching, resulting in unintended pregnancies, abortion, sexually transmitted infections (STIs) or HIV. Significant inequalities exist within sexual health, and discrete groups of people can be identified for whom there are greater risks, particularly young people, men who have sex with men (MSM), women who have sex with women (WSW) and increasingly people aged over 25.

Teenage pregnancy is also a priority, being both a cause and a consequence of social exclusion, child poverty and far reaching health inequalities. There is much that needs to be done to significantly reduce levels of teenage pregnancy in Sunderland.

Key issues and gaps

- High rates of STIs in the younger (<25) population and an increasing rate of STIs in

the older (>45) population.

- Late diagnosis of HIV
- The total number of people infected with HIV is higher than the number receiving care, indicating the need to do more to support people who are diagnosed.
- Variable rates of positivity for the Chlamydia screening programme
- Inadequate provision of sexual health services for Lesbian, Gay, Bisexual and Trans populations
- Limited access to Long Acting Reversible Contraception (LARC) through primary care
- Loss of Emergency Hormonal Contraception (EHC) provision at a main city centre pharmacy and limited number of outlets – provision across Sunderland should be increased
- No significant consistent reduction in teenage pregnancy rates across Sunderland
- Reduction in the number of young people accessing Contraceptive and Sexual Health Services (CaSH) services over the last 12 months
- Survey data from college students suggests a tendency toward not using contraception
- Post termination follow up and support for future contraceptive use.

Recommendations for Commissioning

- Reduce the rate of late HIV diagnoses to improve outcomes for those infected.
- Increase the number of people in Sunderland who access care following a diagnoses of HIV.
- Commissioning of services which meet the 'You're Welcome' quality standards.
- Provision of contraception and sexual health advice through primary care, particularly Long Acting Reversible Contraception.
- Explore opportunities to expand Nucleic Acid Amplification Tests (NAAT) to primary care, to increase testing for gonorrhoea (and Chlamydia).
- Review the tiers of provision to ensure integrated pathways for STI testing and partner notification between Primary Care and Sexual Health Services
- Ongoing programme of workforce development for primary care staff.
- A core offer of Sex and Relationships Education (SRE) offered to all schools, with a targeted programme of support in teenage pregnancy hot spots
- Review provision of C-Card scheme at regular intervals through the development of regular performance monitoring to ensure equity of provision.
- Review provision of CaSH services (including administrative support) at regular intervals through the existing performance monitoring framework to ensure equity of

provision.

- Review provision of CaSH services in college sites to determine appropriateness and effective use of resources.
- The College Health Related Behaviour Survey completed in 2010 indicated 45% of students who completed the survey were not using contraception, and did not intend to do so in the future. This is a key group which will need to be engaged with and supported to access services.
- Undertake an equity audit of sexual health services in Sunderland.

1) Who's at risk and why?

The consequences of poor sexual health can be far reaching, resulting in unintended pregnancies, abortion, sexually transmitted infections (STIs) or HIV. Significant inequalities exist within sexual health, and discrete groups of people can be identified for whom there are greater risks of experiencing sexual ill health:- teenagers, women, gay men, young adults and black and minority ethnic groups.

Young people experience relatively high rates of unintended pregnancies and STIs. It is known that young people between the ages of 16 to 24 are most at risk of being diagnosed with a STI (excluding HIV). Whilst they represent 12% of the population they account for nearly half of all STIs diagnosed in GUM clinics, most frequently chlamydia, genital warts and gonorrhoea.[1] Females aged 16 to 19 have the highest reported rates of diagnosed Chlamydia and genital warts.

Whilst some of the increase in diagnosis rates of STIs in young people can be attributed to increased levels of case identification, as a result of greater levels of testing and improved diagnostics, it is also an indication of increased levels of unsafe sexual behaviour.

Tackling teenage pregnancy continues to be a priority, given the high rates of teenage pregnancy in England and the irrefutable evidence that children born to teenagers are more likely to experience a range of negative outcomes in later life. The impact for teenage mothers is also significant, as they are at greater risk of living in poverty, suffering from post-natal depression or being without employment. Addressing the issue of teenage pregnancy is multi-faceted and complex, as it is both a cause and a consequence of social exclusion, child poverty and far reaching health inequalities.

People over 25 years are at an increasing risk from STIs, such as genital warts and genital herpes. Data suggests that whilst the overall rates of STIs are lower than that for young people the incidence is increasing. This is supported by information obtained from the voluntary and community sector who have highlighted an increasing number of STI's amongst the 50+ population. There is also an ageing group of people living with HIV, necessitating greater consideration of their needs within future policy and service development.

Other factors which can influence a person's experience of sexual health include sexual orientation, race and disability.

Sexual orientation can result in someone delaying seeking help for a health problem or accessing health screening, due to concerns about homophobic attitudes or a lack of services with the relevant knowledge and expertise about lesbian, gay, bisexual and trans people (LGBT). It is also known that women who have sex with women (WSW) are likely to have unmet sexual health needs, due to previous or current sexual contact with men. Amongst men who have sex with men (MSM) there has been a large rise in newly diagnosed HIV infections and they are also at increased risk of gonorrhoea

People from black and minority ethnic communities are at increased risk of certain STI's, such as HIV and gonorrhoea. The prevalence of diagnosed HIV in black African and black Caribbean communities in England is greater than that among the white population. The majority of new diagnoses among black Africans had acquired

[1] Health Protection Agency (2008) *Sexually Transmitted Infections and Young People in the United Kingdom*

their infection heterosexually in Africa. People who are infected from these communities are also at greater risk of receiving a later diagnoses.

2) The level of need in the population

Sexual Health

- STIs can affect anyone but are more common among those aged under 25 years;
- Many sexual infections have long lasting effects on health, including cervical cancer and infertility.
- The rate of diagnosis in Sunderland of Chlamydia, gonorrhoea, syphilis and genital herpes, and the rate of HIV-infected people seen for care, were all below regional (with the exception of gonorrhoea) and national averages.

Chlamydia:

- Chlamydia remains one of the most commonly diagnosed STIs in England. It affects both men and women and most people with this infection are asymptomatic. If undiagnosed it can lead to infertility, ectopic pregnancy, chronic pelvic pain and arthritis. Prevalence of infection is highest among young, sexually active adults, especially those under 25 years. In response to this a national screening programme was established in 2003, targeting young people age 15-24 years. PCT areas were given a percentage target of the population to screen.
- The National Chlamydia Screening Programme has found that 2 in every 25 people (8%) screened will test positive.
- Chlamydia remains the most common sexually transmitted infection in the North East. Data from the National Chlamydia Screening Programme shows that between April and December 2010 70,700 people age 15-24 years were screened in the North East. Of these screens 62% were female and 5.1% of all screens were positive. The group with the highest proportion of positive diagnoses (7.4%) were males aged 20-24. Overall females had a higher positivity rate (5.6%) than males (4.3%).
- For the same period Sunderland reported that 8,138 people age 15-24 years were screened, of which 62% were female and 5.6% of all screens were positive. The group with the highest proportion of positive diagnoses (9.8%) were males aged 20-24. Overall females had a higher positivity rate (6%) than males (5%).
- In Sunderland most cases of Chlamydia occur in the under 25 age group, followed by those aged 25 to 34 years. Of all those tested for Chlamydia in Sunderland 14.3% were found to have Chlamydia, with rates of infection higher in women (16.8%) compared with men (13.2%).

Gonorrhoea:

- Gonorrhoea is the second most common bacterial STI in the UK, with young people being most commonly infected and infection ; rates of incidence are highest in males aged 20-24 years and females aged 16-19 years. Infection is also concentrated in black and minority ethnic populations and homosexual / bisexual men. In 2007 black Caribbeans accounted for over a quarter (26%) of heterosexually acquired gonorrhoea diagnosed in a sample of genitourinary medicine clinics in England and Wales.
- In Sunderland the positivity rate for Gonorrhoea in 2010 was 1.4% of those having an STI screen, with the majority of infections being amongst those aged

16-19 years, followed by those 25-34 years. The proportion of men diagnosed with Gonorrhoea who were MSM rose to 14.6%, compared to 7% in 2009.

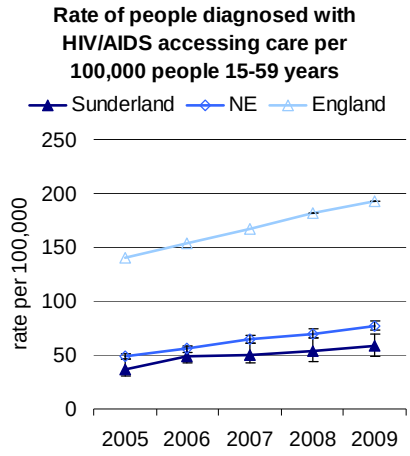
Genital Warts:

- Genital warts are the most common viral STI diagnosed in the UK, with rates of new cases highest among 20-24 year old men and 16-19 year old women. In 2009 the diagnostic rate of genital warts was higher in Sunderland than the North East and significantly higher than the England average. In 2010 17% of all first attendances at Genito Urinary Medicine (GUM) were due to genital warts.
- Nationally there has been an increase of those aged 45 years and over, with STIs. Between 2001 and 2010 there was a 138% increase in the rate of diagnosis of Chlamydia amongst the over 45 population. Gonorrhea, Syphilis, Herpes and Warts all saw significantly high rises in the rate of diagnosis for those aged 45 year and over in comparison to all other age groups.

HIV:

- There has been a steady rise in the number of people living with diagnosed HIV, due to the ongoing high rates of HIV diagnosis and reducing deaths from AIDS. There is highly effective treatment for HIV available today availability of highly effective treatment, meaning that for those who are diagnosed and treated early there can be an expectation of a normal life span. However, of those newly diagnosed with HIV each year more than half are diagnosed late, increasing their risk of early death.
- Recent data from the Health Protection Agency showed that in 2009 there were an estimated 86,500 people living with HIV in the United Kingdom, 26% of whom were unaware of their infection, therefore increasing the risk to others of becoming infected with HIV.
- It is estimated that the number of people living with HIV in the United Kingdom (diagnosed and undiagnosed) will reach 100,000 in 2012.
- Whilst men who have sex with men (MSM) remain the major risk group for HIV infection heterosexually acquired infections are becoming of increasing concern. Since 1999 the number of HIV diagnoses among heterosexuals who most likely acquired their infection in the UK has risen from 210 to 1,150 in the 2010.
- The prevalence of diagnosed HIV in black African and black Caribbean communities in England is estimated to be 3.7% and 0.4% respectively, compared to 0.09% among the white population.
- In 2007 there were 2,691 new HIV diagnoses among black Africans, representing 40% of all new diagnoses in the UK. The majority had acquired their infection heterosexually and in Africa. The number of new diagnoses among black Caribbeans remained low (189 in 2007), representing 3% of new diagnoses in 2007.
- The percentage of late diagnoses of HIV in 2007 was highest among black Africans (42%). Twenty-seven percent of HIV diagnoses among black Caribbeans were late.
- It is recognised that the total number of people infected with HIV is higher than the number receiving care. However, the number of HIV-infected people receiving care is readily available and is therefore a good guide to relative levels of infection in different areas of the UK and among different population groups. Available data shows the following:

- There has been a consistent increase in the rate of people diagnosed with HIV/AIDS accessing care in recent years in Sunderland, the North East and England. However the rate in Sunderland is 20% lower than the regional rate (58 per 100,000 population 15-59 years compared to 77 per 100,000). The average rate across England is skewed by a very high rate of prevalence in London.



Source: Survey of Prevalent HIV Infections Diagnosed (SOPHID), Health Protection Agency

- In Sunderland the majority of people diagnosed with HIV and accessing care come from the white and black African ethnic groups in equal proportions. As the black African population is much smaller than the white population in Sunderland, the rate of prevalence among the black African population is much higher. This trend is reflected in national statistics.

- In 2003 more females than males diagnosed with HIV or AIDS in Sunderland were accessing care. This balance was reversed in 2005 and in 2010 there continues to be a higher proportion of males than females among the group of people known to have HIV/AIDS.

- Nationally the number of people who have been diagnosed with HIV as a result of infection acquired through drug use have fallen since a peak in the 1980's, with prevalence remaining below 1-2% of this population due to the availability of needle exchange programmes.

- In 2010 the uptake of HIV testing was 76% of all first attendances in Sunderland, exceeding the national target of 60%.

- The estimated rate of HIV infection in Sunderland is 58 per 100,000 population age 15-59 years.

- There is a 100% update for HIV testing as part of antenatal screening in Sunderland.

Contraceptive and Sexual Health Services:

- Data for clinic attendance at Contraceptive and Sexual Health Services (CaSH) services shows that the number of under 18's, under 25s and all ages has decreased between 2009 (2827) and 2010 (2624). During this time over 90% of

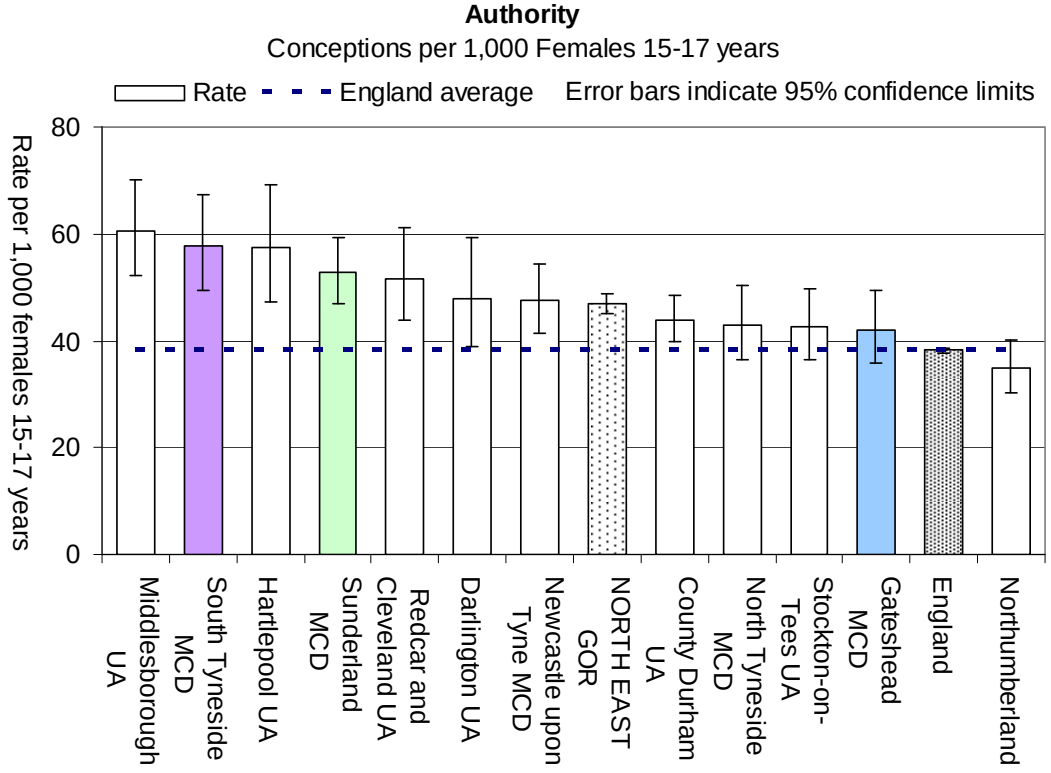
people accessing CaSH services were female, although this can in part be understand due to the nature of the services offered, including pregnancy testing and termination of pregnancy.

Teenage Pregnancy

- Between 1998 and 2009 Sunderland's under-18 conception rate, reduced from 63.1 per 1,000 to 52.8 (288) per 1,000, a decrease of 16.3%. During the same period the rate for the North East decreased by 17% and England decreased by 18.1%

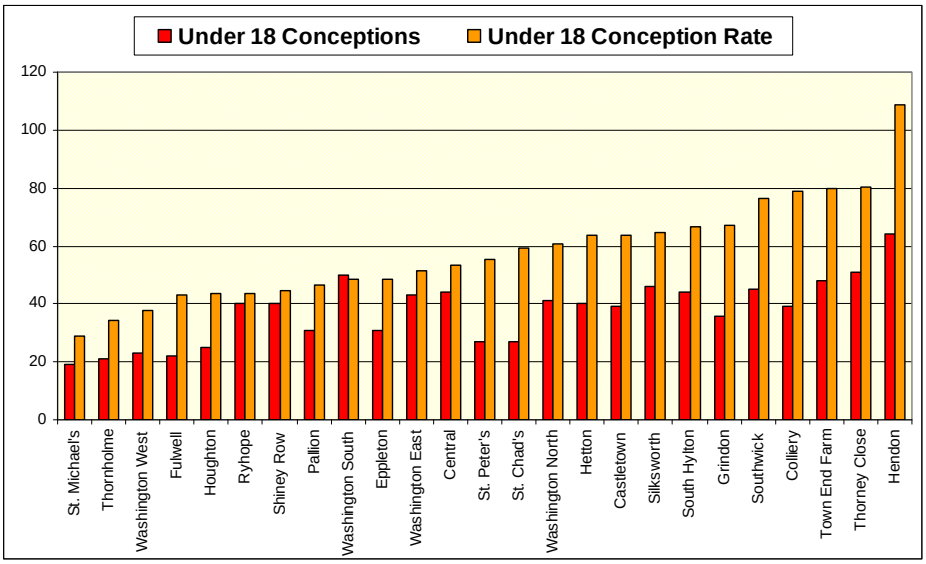
- The latest full year data available in 2009 shows a rate of 52.8 (288) per 1,000, considerably higher than both the North East (46.9 per 1,000), and England (38.2 per 1,000).

Under 18 Years Teenage Conception Rate, 2009, by North East Local Authority



- As at Qtr 2 2010 the rate of under-18 conceptions in Sunderland rose by nearly 2% from Qtr2 2009. During the same period the North East rate of under-18 conceptions fell by 3%; the rolling quarterly average has now fallen over the last nine quarters.

- There is a strong correlation between levels of teenage pregnancy and poverty and ward based data for Sunderland supports this. Between 2007 and 2009 rates of teenage conceptions were significantly higher than the average rate across England in the wards of 'Colliery', 'Grindon', 'Hendon', 'Silksworth', 'South Hylton', 'Southwick', 'Thorney Close', 'Town End Farm', and 'Washington North'.



- In Sunderland 60 out of 188 (32%) local super output areas (LSOAs) are amongst the top 20% most deprived LSOAs in England for children under 16 years.

- 51% of children in Sunderland are within the Government definition of 'poverty' compared to 44% in the North East and 42% in England.

- Particular groups of young people are more likely to be teenage parents than others, with young people who have been in care at increased risk. For example, a quarter of young people who had been in care were parents by the age of 20, and 40% were mothers. The prevalence of teenage motherhood amongst looked after girls under-18 is 3 times higher than the corresponding rate amongst girls looked after in England.

- Babies of teenage mothers have a 60% higher risk of dying in their first year.

- In 2008, 41% of under-18 conceptions in Sunderland led to abortion – compared to the England average of 50%.

- In 2008 8.5% of women aged under 19 years in Sunderland had previously had an abortion. This was lower than the England average of 11.0%.

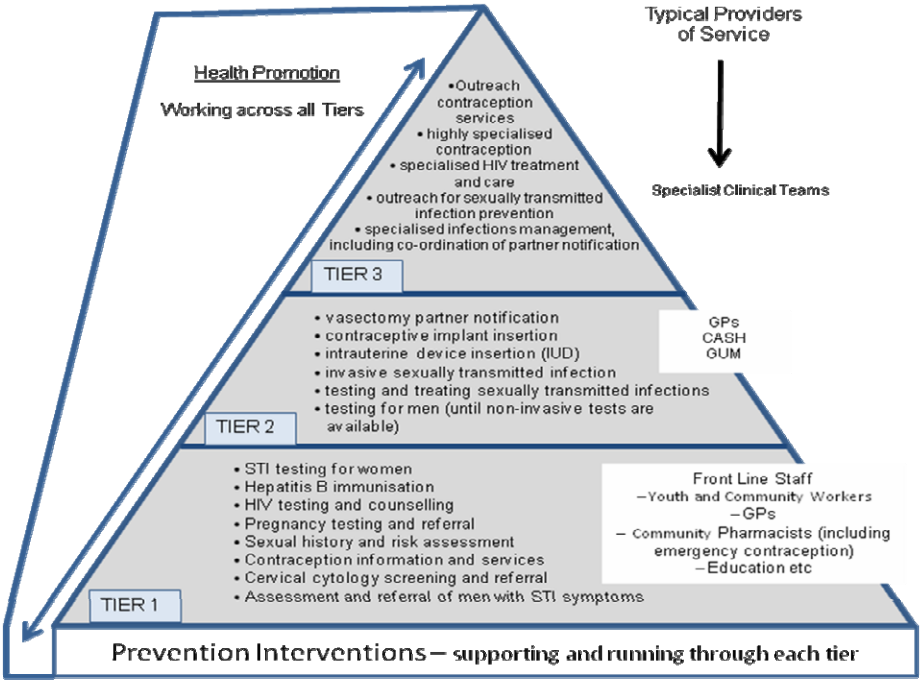
3) Current services in relation to need

The National Strategy for Sexual Health and HIV (2001) identified a three tiered approach to the provision of modern, comprehensive and integrated sexual health services. This model is mirrored in Sunderland, with a full sexual health service across all three tiers provided by City Hospitals Sunderland and some provision across Tiers 1 and 2 in Primary Care, including access to Long Acting Reversible Contraception (LARC). A new Local Enhanced Service has been developed for the provision of LARC within primary care, which will enhance patient choice and make it easier for people to access a wider range of contraception choices within the primary

care setting.

We'ar Out are working with MESMAC to provide 1 hour HIV screening for all residents, and are working in conjunction with GUM to ensure people are signposted to services appropriately.

Three Tiered Approach to Sexual Health



In Sunderland genito-urinary medicine (GUM) and CaSH clinics are provided by City Hospitals Sunderland, providing a range of services include HIV tests, STI screening, contraception and termination of pregnancy services. Since June 2011 they have also been part of the C-Card scheme. They are an all age provision, although dedicated young person clinics are provided within the mainstream provision. This includes at colleges and universities, although uptake in some of the sites has been lower than anticipated and activity is monitored regularly.

There are a number of organisations from the voluntary and community sector within the City who deliver/facilitate events which promote sexual health. Springboard in partnership with NECA, hosted a recent event where young people were offered Chlamydia testing and sexual health advice.

Sunderland also provides an options counsellor for young people, so those who have an unplanned pregnancy and want specialist support and advice can do so in a friendly, non threatening environment. This was funded through the Teenage Pregnancy Grant previously, but will be funded by the Primary Care Trust from 2011.

Locally young person CaSH services are knows as Answers, and have for many years been delivered from a Citywide location. In the summer of 2010 this provision closed and following a review of all CaSH services efforts were made to increase young person dedicated provision from 1 city centre base to 5 across the City. However, data in Table 1 suggests this has led to an overall reduction of 203 young people (75% female) accessing Answers in 2010 compared to 2009. However, within this period access increased in Washington by almost 200 visits.

Attendance at CaSH clinics for under 18s and all-age attendance is monitored using a national data system and will be available for quarterly reporting going forward. It is possible to see from the data which clinics people choose to access by area of residence, which will be very helpful when considering future commissioning arrangements. CaSH services are being supported to publicise their services more proactively, particularly for people under 25, through www.yourhealthsunderland.com which was launched in 2010 and provides a one stop shop for information on a range of health topics and details of services available locally. The site receives 600 visitors per month, and the sexual health pages are the most frequently visited.

Table 1

Number of under 18's attending clinics for Under 25's and All Ages	**Quarterly Difference: 2009 & 2010**				
	Jan - Mar	**Apr - Jun**	**Jul - Sep**	**Oct - Dec**	**Annual**
Answers (moved to Royal Hospital from Aug10	-61	-1	-102	-194	**-358**
Chester Lodge, Sunderland Royal Hospital	-4	-14	+31	+8	
Washington Primary Care Centre	+83	+55	+41	+38	**+217**
Victoria Road Health Centre, Washington	-77	-41	+30	+79	**-9**
Houghton Primary Care Centre	-12	-4	+4	+3	**-9**
Bunny Hill	+7	+2	-1	-3	**+5**
Springwell	-3	-5	-8	-5	**-21**
Total <18 female	**-67**	**-8**	**-5**	**-73**	**-153**
Total <18 male	**-51**	**+21**	**-8**	**-12**	**-50**

When considering access to Long Acting Reversible Contraception (LARC) in the under 18 age group the numbers accessing Depo has increased by 52% between 2009 and 2010. In the same period the numbers accessing Implanon has increased by 71%. The clinic with the greatest rate of increase in 2010 for both Depo and Implanon was Washington Primary Care Centre.

Access to GUM amongst under 18s has reduced between 2009 and 2010, with a 23% reduction in females and a 10% reduction in males. This will need to be monitored, alongside access rates to CaSH, to ensure people who need sexual health services are accessing them.

Through the risk and resilience model of working adopted by the Local Authority there is continued support for a core offer of Sex and Relationships Education (SRE) within schools, including the expansion of peer education, work with parents through speakeasy and social norms.

The electronic C-Card scheme was launched in June 2011, offering an electronic system and a greater choice of outlets for young people. Over 1,500 young people have registered since the launch, with a regular number of repeat users. Over 180 people have been trained to provide the C-Card and it is delivered in over 65 outlets.

EHC is available in a small number of pharmacies across Sunderland and there is an increasing demand for further training to expand provision. The inclusion of EHC as

part of the Healthy Living Pharmacy will improve access further.

4) Projected service use and outcomes in 3-5 years and 5-10 years

- 17.5% (49,400) of the population of Sunderland are aged between 0-15 years. This is comparable with the North East, but slightly less than England.
- Projected population estimates show that between 2009 and 2020 the number of people aged under 15 is estimated to increase by 2.6%. This trend will reverse by 2030, with the expectation that overall between 2009 and 2030 the number of people aged under 15 will reduce by 2%. This will mean that in the medium to long term there will be a greater number of young people in Sunderland, an at risk group for STI's and teenage pregnancy. This will potentially increase the demand on services and highlights the importance of continuing with interventions to reduce risks.
- It is not possible to predict future changes to black and minority ethnic group populations. However, data for 2001 and 2007 shows a 76.7% increase in the number of people classified as non-White British, from 8,600 to 15,200.
- As research suggests teenage pregnancy is closely interlinked with poverty, it seems likely that the city will continue to experience higher levels of teenage pregnancies than the England average unless wider socio-economic demographic factors affecting child poverty are addressed.

5) Evidence of what works

<u>Sexual Health</u>

As outlined above a fully comprehensive and integrated model of sexual health provision across all 3 tiers is needed to ensure people are able to experience positive sexual health. This needs to be underpinned by a programme of workforce development to provide people with the skills and knowledge to discuss sexual health and undertake screening as appropriate. This will ensure that people of all ages, gender, sexuality and race are able to access:

- screening at the earliest opportunity, including via partner notification processes;
- a full range of contraception choices and sexual health advice in a range of settings;
- ongoing care and support following diagnosis with a STI.
- Options counselling, termination and post termination support.

<u>Teenage Pregnancy</u>

Teenage pregnancy is a complex issue, associated with a large range of risk factors. It is also acknowledged that whilst any young person can become a teenage parent there are some specific at risk groups, for which there should be targeted support and intervention. This includes pupil referral units, NEETs, Looked After Children and Care Leavers, young people in homeless units and supported housing and teenage parents.

National policy suggests there are 10 key factors for effective strategies to address teenage pregnancy. These are outlined below.

- Teenage Pregnancy Champion and strategic leadership
- SRE in schools and out of school settings
- Supporting parents to discuss sex and relationships
- Young people friendly contraceptive services

- Strong messages to young people and partner agencies
- Workforce training on SRE
- Strong youth service – things to do, places to go
- Targeted SRE work with young people at risk
- Strong use of local data
- Building aspirations and self esteem

In Teenage Pregnancy Strategy: Beyond 2010 it was clear that the strongest evidence internationally for reducing rates of teenage conceptions is for a combination of the following:

- comprehensive information advice and support – from parents, schools and other professionals

- accessible, young people-friendly sexual and reproductive health (SRH) services.

6) User Views

The Youth Offending Service (YOS) developed a specific teenage pregnancy / sexual health intervention targeting young people on Intensive Supervision and Surveillance (ISS), as a group most likely to be involved in a range of 'risk taking' behaviours. The intervention covers a range of sexual health issues including contraception, teenage pregnancy / parenting, safe sex and risks. Group facilitation sessions highlighted concerns regarding the young men's attitudes towards contraception. Whilst many of the young men stated that they thought contraception was a shared responsibility, when questioned further they demonstrated very negative attitudes towards females carrying condoms.

A further anecdotal finding reported by group facilitators was that the majority of the young men in the group did not have a good understanding of sexual health matters despite being sexually active. Facilitators reported the young people as having a 'street knowledge' of sex education with a lack of clarity about some of the facts. Examples of this were that whilst the young men were aware of STIs they did not necessarily understand the potential long term health issues. There was also a lack of clarity in relation to sex and the law and a lack of understanding of where to go to ask for help. Several of the young people identified that they had received no formal sex education and / or had not received any specific information from parents. The group facilitators suggested that the lack of formal sex education reported was likely to be a direct result of ISS young people being young people who are most likely to be those who are not in education or are on part time education timetables where sex education may not be received and / or have previously missed education. Whilst the majority of the young people were identified as being sexually active (11 of the 12 receiving the group sessions), few reported having a stable partner. The group facilitators described the young people as demonstrating a lack of understanding of the emotional aspects of sexual relationships such as understanding of 'respect' in relationships and the possible emotional impacts of 'one night stands'.

During March and April 2010 consultation was undertaken with a group of teenage parents and young people in Sunderland, to gain an understanding of their views and knowledge about sex and contraception. The findings are limited to a small number of people consulted with through a particular service; the majority of teenage parents were engaged with through the Bumps to Baby plus (B2B+) service. Attempting to consult with teenage fathers was problematic because they do not routinely access

services relating to their child. Additionally, the young people that were consulted with in a focus group environment were all teenage mothers i.e. the decision they made was to continue with their pregnancy. The views of other young people who are affected by teenage conception but not a teenage parent are not included in the analysis. Feedback and key findings from the consultation are around the following themes:

- *Attitudes towards sexual behaviour*: peer pressure is the main reason why young people start having sex; because their friends are having sex, it is seen as the normal thing to do and because they want to. It was the opinion of those engaged that more people are having sex at a younger age.

- *Circumstances of becoming pregnant:* The majority of pregnancies involving young people are unplanned. The reason for becoming pregnant is not using contraception because they didn't think becoming pregnant would happen to them; through not becoming pregnant from previous unprotected sex; not using contraception due to alcohol consumption and not having future aspirations.

- *Decision making linked with support from services:* The majority of young girls felt comfortable making their own decisions about their pregnancy and professional advice made little impact on their decision. The reason for this was that some young people see abortion as morally wrong despite pressure from family to have a termination.

- *Knowledge of contraception / sexual health linked with sex education:* The majority of teenage parents said the education they received was poor. This was because the education was mostly puberty talks as opposed to sex education. All participants agreed that sex education should be taught at a younger but appropriate age so that young people take it seriously i.e. puberty.

- *Future aspirations:* The majority of young parents do have future aspirations before becoming pregnant but feel they are unable to get back into education because of cost and their benefits will be taken off them. Young people who were likely to continue with their pregnancy had fewer aspirations, tended to live alone or with partners and less likely to be with the partner of their child. On the other hand, young people likely to have a termination were more likely to live with both parents, have aspirations to go on to further education and likely to still be in a relationship with their partner.

The Health Related Behaviour Surveys conducted in 2010 in secondary schools and college sites show that levels of self esteem and knowledge of sexually transmitted infections are higher in Sunderland than the national average, yet awareness of local services and quality of sex education appears to have fallen dramatically.

Feedback obtained from a local voluntary and community sector event, highlighted the need for more training for mentors within colleges and schools to allow better signposting to services.

7) Equality Impact Assessments

Throughout this document consideration has been given to the issue of equality, from the perspective of age, gender, race and sexual orientation. It is also acknowledged that disability and religion or belief can also impact on a person's sexual health and therefore services need to respond accordingly. Service provision is available to all regardless of the above, and where necessary changes can be made to provision. For example the core SRE offer has been adapted for delivery in special schools

within Sunderland. Furthermore some faith schools have embraced the core SRE offer and are using it in a supportive way to work with their pupils, whilst always giving precedence to the teachings of their faith. However, not all pupils in Sunderland are receiving the same information and support and alternative ways to deliver this will need to be considered.

Key preventative groups for teenage pregnancy are the hard to reach, high risk and most vulnerable e.g. young people, young people not in education, employment or training (NEET), teenage parents, homeless, people with drug and alcohol problems,

During the next 12 months a Health Equity Audit (HEA) is planned of CaSH and GUM services which will explore how services are delivered across the South of Tyne and Wear (SoTW) region. Further HEAs to ensure equity of uptake of other services in relation to need could help to better identify gaps in service provision.

8) Unmet needs and service gaps

There remains a need to better understand the sexual health issues and needs of both the younger (<25) and older (>25) populations as well as address the levels of STIs within these groups. This could be supported by better targeting the Chlamydia screening programme and reviewing the provision of STI screening across GUM, CaSH and primary care settings.

Provision for LGBT populations is not as comprehensive as it could be, and should be explored in further detail. Suggestions include displaying service friendly literature in primary care settings and ensuring all females receive cervical screening, regardless of sexuality.

Access to contraception, screening and sexual health advice through primary care is inconsistent and should be strengthened.

Provision of EHC should be increased, and where possible opportunities to link this with access to contraception through the C-Card should be taken forward.

Teenage pregnancy rates are not reducing as quickly as they need to and it will be important to continue to monitor uptake of the C-Card and CaSH services by young people and the engagement of schools with SRE.

The total number of people infected with HIV is higher than the number receiving care, indicating the need to do more to support people who are diagnosed and increase the number accessing care.

Post termination service support to reduce second and subsequent pregnancies needs to be established.

9) Recommendations for Commissioning

- Commissioning of services which meet the 'You're Welcome' Standards
- Provision of Long Acting and Reversible Contraception and sexual health advice through primary care
- Quality programme of core SRE offered to all schools, with a targeted programme of support in teenage pregnancy hot spots
- Review provision of C-Card scheme at regular intervals through the development of regular performance monitoring to ensure equity of provision.
- Review provision of CaSH services at regular intervals through the existing

performance monitoring framework to ensure equity of provision

- Review provision of CaSH services in college sites to determine appropriateness and effective use of resources.
- The College Health Related Behaviour Survey completed in 2010 indicated a high number of students were engaging in unsafe sexual behaviour, and had plans to do so in the future. This is a key group which will need to be engaged with and supported to access services.
- Equity audit of GUM and CaSH
- There is a need to increase the number of people diagnosed with HIV and accessing care in Sunderland

10) Recommendations for needs assessment work

a) Review the access of CaSH and GUM by young people to improve access, and ensure services are proportionately delivered in areas of need.

b) A training needs analysis should be completed to inform the development of a workforce development programme.

c) Map the provision of LARC across primary care settings and referral to sexual health services from primary care.

d) Undertake a needs assessment to better understand the sexual health needs of the LGBT communities, the services they would like and how / where they would wish to access them.

e) It would be helpful to better understand the attitudes of young people to sexual health, contraception services and risk taking behaviour, building on the findings of the Health Related Behaviour Survey.

Key contacts

Lorraine Hughes, lorraine.hughes@sotw.nhs.uk

CaSH, Tel: 0191 569 9966.

GUM, Tel: 0191 569 9021