SCRUTINY REVIEW – SEXUAL HEALTH IN TEENAGERS

25 FEBRUARY 2010

REPORT OF THE CHAIR OF THE REVIEW PANEL

ISSUES PAPER

1. Introduction

1.1 The purpose of this paper is to bring together all of the significant evidence received in the course of the review and highlight what appear to be the key issues for discussion at the concluding meeting. The aim of this is to assist the Panel in reaching appropriate conclusions and recommendations.

Definition of Sexual Health

1.2 The World Health Organisation definition of sexual health Is as follows:

"A state of physical, emotional, mental and social well-being, related 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."

2. Overview

2.1 Young people (16-24 year old) are the most at risk of being diagnosed with a sexually transmitted infection (STI). Whilst they represent 12% of the population, they account for half of all sexually STIs diagnosed in the UK (2007), including:

- 65% of all Chlamydia
- 50% of genital warts
- 50% of gonorrhoea infections

2.2 Chlamydia, gonorrhoea, genital warts and genital herpes are most common STIs amongst young people. Genital Chlamydia infection is currently the most commonly diagnosed STI in the UK. Women aged 16-19 years and men aged 20-24 years have the highest rates of positive diagnoses. Bacterial gonorrhoea is the second most common STI with the highest positive diagnosis rates in people aged between 16-19 years for women and 20-24 years for men. 40% of infections in women are amongst teenagers.

2.3 Sexual health is not distributed equally amongst the population, with poorer outcomes experienced by women, gay men, teenagers, young adults and black and minority ethnic groups. A range of social, economic and cultural influences can determine the sexual well-being of individuals.

2.4 In July 2001, the Government published a Sexual Health Strategy for England. This stated that there should be a new model of working with three levels of service provision:

- Level 1; A basic level of sexual health provision, which is likely to be carried out in general practitioner (GP) surgeries and walk-in centres that do not wish to provide enhanced or specialist services.

- Level 2; An enhanced level of care, which includes all of the above and some level of specialist provision.

- Level 3; A specialist provision of sexual health care, which is likely to include most, if not all, aspects of the above plus expertise in research, education and training.

2.5 Sexual health outcomes are relatively poor in Haringey. There are higher levels of need in the east of the borough. Sexual health services are commissioned within Haringey by NHS Haringey and the Children and Young People's Service (C&YPS) to achieve the following outcomes:

- Prevention of unwanted pregnancy
- Detection and treatment/management of cases of sexually transmitted infections, including HIV as a long term condition
- Prevention of onward transmission of STIs/HIV through primary and secondary prevention interventions
- Improvements in psycho-sexual well-being

2.6 Haringey did not hit its target for chlamydia screening in 2007/8 but has been successful in meeting all its targets since then. The latest figures, which are for the first quarter of 2009/10, continue this trend. Targets for access to GUM clinics are being achieved with 98.9% of people being offered appointments within 48 hours, including young people.

2.7 In terms of teenage conceptions, Haringey has:

- The 8th. highest teenage pregnancy rate in England (70 per 1000 women under 18); and
- The 4th. highest rate in London

2.8 65% of conceptions led to abortion (2007 & 2008) and 28% were repeat abortions, including under 19s (highest regional level (2008)). Of boroughs classified as inner London, Haringey was the only borough showing an increase in teenage conceptions when compared to the 1998 baseline. However, statistics for the first two quarters of 2008 show an improvement in the rates of teenage pregnancy and indicate that progress is being made. The respective rates are 67.2 per 1000 for the 1st quarter and 61.2 for the second.

2.9 The Teenage Pregnancy Strategic Partnership Board (TPSPB) has overall strategic responsibility for addressing issues related to teenage conceptions. It is a partnership body chaired by the Cabinet Member for Children and Young People and including representatives from the Council, NHS Haringey, the College of North East London and a nominee from the voluntary sector. It reports to the Haringey Strategic Partnership.

A joint three year sexual health strategy was published by NHS Haringey and the Council in 2005 which set out a vision, principles, a framework for sexual health services delivery and a model for an integrated sexual health network. The strategy is now due to be revised. The process is being initiated through a needs assessment for the Borough.

2.10 The emerging findings of the assessment have shown that there are issues that need to be addressed in the following areas:

- Targeting and tailoring of services
- Access
- Integration
- Partnership
- Pathway redesign; and
- Workforce development

2.11 The needs assessment exercise will be looking at the affect of the closure of some family planning clinics that had taken place in 2006. The final outcome of it is due shortly. The process could lead to services being moved to where the need was greater. One key issue is trying to encourage people to access level 1 or 2 services rather then just the GUM clinics. Actions such as ensuring that GPs have the necessary skills will assist in this process. There is a general need to ensure that all services are targeted and that access to services is available through community access points. People generally access services in a way that suits, their needs irrespective of the borough in which they are located. It is therefore considered by service commissioners that cross border arrangements need to be reviewed.

- Key future challenges facing services are:
- The need to adopt a flexible commissioning approach
- Commissioning for outcomes
- Ensuring that service users were central to all developments

3. Education

3.1 At present, it is compulsory for schools to teach the biological facts of reproduction in secondary school science lessons, while personal, social and health education (PSHE) classes, at any age, are optional. The mechanics of sexual behaviour are dealt with at key stage 3 (11 to 14 years old) and beyond as part of the national curriculum. Sex within relationships and the emotional aspects are explored as part of PHSE. However, the view was expressed to the Panel that messages that are put forward are not always supported within communities or individual homes. In addition, the quality of teaching of SRE was felt to currently be inconsistent.

3.2 Parents have the right to withdraw their children from sex education lessons. Efforts are made to persuade those parents to change their minds but a number of these are from extreme religious backgrounds and therefore difficult to influence as this can mean them changing their entire belief system.

3.3 All Haringey schools have been made aware of their current duties to deliver SRE as part of the national curriculum. PHSE lessons are to be given statutory status from 2010, making

compulsory what many schools are already teaching. However, parents will still have the right to withdraw their children from sex education lessons. From the age of seven, pupils will learn about puberty and five year olds will be taught about parts of the body and relationships. Secondary school pupils will learn about contraception, HIV and Aids, pregnancy and different kinds of relationships.

3.4 SRE is currently being tied in with the well being agenda as some schools are reluctant to engage with anything that refers explicitly to "sex". It is therefore included within the healthy schools programme. The borough is currently on target to reach its healthy schools target of 85% of schools by December 2009. 76% of all schools are currently on board with 4 more required to hit the target of 85% by the end of 2009. 6 out of the 11 Haringey secondary schools in the Borough have now achieved healthy schools status. 3 of these 6 are due to have their progress reviewed with a view to them achieving enhanced status. These are Park View Academy, Gladesmore and Hornsey Girls School. The secondary schools who have not achieved healthy schools status are Fortismere, St Thomas More, Highgate Wood, John Loughborough and Greig City Academy.

3.5 There is a correlation between aspirations and delaying starting a family. A key project that is addressing this issue is the Teens and Toddlers project. This is a 20 week youth development programme that involves getting at risk teenagers to work and play with toddlers in order to develop an awareness of the implications of parenthood. The programme aims to raise aspirations and asks what is needed to become a good parent. There is a mentoring aspect to it, with facilitators used to assist and also access to a life coach. Referrals came from schools and youth workers.

3.6 The scheme has produced good results so far. 84 young people have been on the course so far and only one has become pregnant, albeit before the course had begun. The majority of young people who attend the course are girls. Haringey facilitators are currently being trained so that they can run the course in the future. The research programme attached to the project is tracking the teenagers involved and will report its findings in 2010. The project currently operates in four hotspot schools - Hornsey Girls School, Park View Academy, Northumberland Park and Gladesmore. There is the opportunity to expand the programme but church schools are currently not enthusiastic about participating in the scheme. Woodside High, Greig City Academy and St Thomas More have all been offered the chance to participate.

3.7 In terms of programmes delivered by outside agencies, a sex education theatre/workshop event aimed at Years 7 and 8 is offered as a package to all schools. There is also a DVD. Similar packages had been offered on HIV. It was particularly important to increase the capacity of teachers to deliver teaching on these issues. However, there is now a need to arrange supply cover in advance and associated cost implications which had mean that a different approach has had to be adopted.

3.8 A lot of work has been undertaken in post 16 settings, such as the 6th form centre and CoNEL, including peer mentoring. In addition, Haringey has introduced the C-card scheme which was a registration and condom distribution scheme for young people. They also now have the Medi+vend, which was the vending machine that supported the C-card scheme.

3.9 It was noted that the Children and Young People's Service is currently developing a peer

mentoring scheme and identifying suitable graduates from within its Teens and Toddlers scheme. The only school currently offering Chlamydia screening was Alexandra Park, although it had been offered to all. Screening has now been incorporated into the school age health strategy.

4. Schools and Further Education

Secondary Schools

4.1 The Panel received evidence of the role played by Woodside High School from its Principal. The schools promotes the message of safe and responsible sex and focusses on its implications. Woodside believes in using properly trained specialist teachers to deliver sex education but some schools still used form tutors. The school has used borrowed models of babies to work with students. Their use has proven to be very successful and they are now looking to buy some as none are available through PHSE. The school wishes to ensure that all children get the chance to take one home. Some children had not realised before what caring for a baby entailed and many are very relieved to hand back the dolls. Sexually transmitted infections are currently covered in biology as part of the national curriculum and also included within PHSE lessons. Some work had also been undertaken within assemblies, including one that students had chosen to do on the implications of unsafe sex.

4.2 Children are given information sheets with details of a range of relevant websites. It had been found that a lot of children did not have a GP and the school had therefore decided to bring in a nurse for three days per week, although this has since been reduced to two due to funding issues. 278 children out of the school roll of 946 had used her in the last year. The nurse can help with information, refer students to 4YP and help them to register with a GP. Other schools do not have such a facility, which required significant investment. Only one student from the school has recently become pregnant and she had been a non attendee.

4.3 The view was expressed that a lot of young people are inhibited from seeking advice due to embarrassment. Large numbers still rely on their peers for guidance. There are still cultural barriers in some communities against the use of contraception, which could be considered as even worse then engaging in unprotected sex. It is difficult for young people from some communities to seek advice and they often feel it necessary to go to neighbouring boroughs to access services.

4.4 It was considered that the least effective way of reaching young people was through older people and the most effective way was through the use of peers. They had on occasion invited young people attending college, some of whom had babies, to come back to the school and talk to students. This had proven to be very effective.

4.5 Home should provide the start for children but some parents find the subject difficult to approach and do not wish to explore it with their children. Many parents of children at the school were not educated in Britain and do not have an understanding of the health service.

4.6 It was felt that the NHS needed a higher visibility within schools and their services made more accessible through, for instance, adopting opening hours that fitted in better with young people. A large number of young people do not like accessing services locally and efforts need to be made to make it easier for them to be more open by reducing stigma.

4.7 One key area which could be improved was the availability of appointments with GPs. A large number still only work from 9 till 5 which could make it difficult for young people to get appointments. Another possible area of improvement would be to provide services in locations which were less stigmatising. For example, people often feel less stigmatised visiting their GP then attending a special sexual health clinic.

Primary Schools

4.8 The Panel received evidence from the Headteacher of Welbourne School. Whilst the role of secondary schools in teaching SRE and promoting good sexual health is very important, the view was expressed that children needed to be introduced the subject at an earlier stage. Primary schools have an important role to play in educating younger children about sex and reproduction. However, they have more of a pastoral role then secondary schools. At primary school level, the teaching mainly covers acknowledging parts of the body and feelings.

4.9 The view was expressed that some primary schools are currently fulfilling their role well whilst others were not performing quite so well. It was nevertheless likely that all schools are covering the relevant issues in some way but the curriculum is crowded and it can be difficult to fit in. Teaching is currently led by non expert staff. There was felt to be scope for improvement in the training and support of primary school teachers. The quality of teaching could perhaps be improved if there was a core team that supported primary schools. Alternatively, support could be provided through secondary schools.

4.10 The role of parents was felt to be very important. There was clear evidence that they were considerably more effective at guiding their children on sexual issues then teachers. One particular initiative that could be undertaken was the development of a specific programme for schools involving active participation by parents.

CONEL

4.11 Sexual health is covered at CoNEL as part of the tutorial system. This is provided as part of the enrichment programme. Amongst other things, advice on how to register with a GP is provided. The college has also held a sexual health week, drink awareness events and undertaken collaborative work with the NHS. They have links with 4YP and have a nurse on site for one day per week. They also have a counsellor, who can make referrals to a range of services, and a dedicated youth worker. Work is undertaken with the teenage pregnancy team and the college was soon to get a Medi+vend machine. There is a high take up for tests from 4YP when they visit CoNEL and a lot of young people feel comfortable with the approach that they follow.

4.12 The college has 15 peer mentors. Mentors provide a range of information for students and have undertaken presentations. They can also liaise with staff about referrals. Mentors undertake a two day training course to prepare them for work with their peers. Their brief is wider then just sexual health.

4.13 Barriers to improved sexual health were felt to include language difficulties and cultural issues. Many ESOL students do not have a GP and do not understand the concept of one.

They merely go to the hospital when ill. Measures could be taken by the NHS to encourage such young people to register. Services could also be improved by better accessibility such as a dedicated phone line. NEETs were probably the group at greatest risk. These tended to be boys.

Youth Service

4.14 The Head of the Youth Service reported that Youth Service staff have received training on Chlamydia screening. The service works closely with 4YP and this is written into their service plan. Connexions also refer to sexual health in their consultations. Medi+vend machines were being installed in two youth service facilities. The service also undertakes specific work with teenage fathers and is involved in the Teens and Toddlers scheme. The effectiveness of the service in addressing sexual health issues is not specifically evaluated.

4.15 The service comes into contact with a high percentage of young people in the borough between the ages of 13 and 19 and young people are generally felt to be well informed. Peer educators can be very effective as young people learn well from each other. Assistant youth workers, between the ages of 18 and 25, have been appointed and are being trained in SRE so they can work with their peers. The least effective way of getting the message across to young people was felt to be from literature alone – there needed to be at least some dialogue. Some people access information on line but the numbers are comparatively small.

4.16 A lot of young people had stated that they wanted good local provision and would prefer this to the option of going elsewhere. It was also thought that greater parental involvement would assist, although this was a sensitive issue and could put some young people off. It was felt that some young people can learn more from webpages whilst others benefit more from group discussions. A range of options need to be available to satisfy different preferences.

5. Health Services

Sexual Health, Contraception and Reproductive Services

5.1 It was noted that sexual health is now an integrated service and covers sexual health, contraception and reproductive services. There are now two sexual health clinics that are fully integrated and able to provide contraception and treatment for the full range of sexually transmitted infections (STIs) and the plan is to phase in full integration of the rest of the service over the next 6 to 12 months. All staff were being trained in both contraception and sexual health to enable a comprehensive seamless service for patients. This service now includes 4YP services, SHOC (sexual health outreach for female sex workers), chlamydia screening programme and a satellite HIV service to North Middlesex Hospital. IT was noted that the integration of services is proving to be a challenge for some older staff who had been used to just addressing well women issues, such as smears. However, the integrated set up makes better use of the skills of all staff. In addition, young people like to have as many services as possible located in the same place but not all tests can be undertaken in all settings though.

5.2 The service currently meets the target for 48 hour access to GUM services and is typically achieving 90 - 95% compliance. “Did not attend” (DNA) rates are disproportionately high at 17% and the service sometimes overbooks to compensate for this. A large percentage of Haringey residents – 60% - go out of borough to access services. 50% of users of Haringey services are from within the borough and the service was trying to increase this to 60%. It is not possible to stop people from going elsewhere as the VD Act means that people have the right to go wherever they wanted for services. Local commissioners are currently looking at the reasons why people go to other areas for services. There is a cross charging system between boroughs so payment is made irrespective of where services are accessed. However, the introduction of payment by results may have a significant impact on costs if this figure remains so high. It is likely that services are currently not working to their full capacity.

5.3 The 4YP bus offers both clinical and non clinical services for young people. Best practice is being followed by increasing the amount of provision available in a range of young people's settings such as though the youth service or at CoNEL. Mobile phones are increasingly used as a means of contacting young people. Records are kept electronically so that they can be accessed irrespective of the location of the service. The 4YP service is now attracting considerably more clients then previously – up to approximately 9,000 in 2008 from 4,000 previously with significantly more girls attending.

5.4 The bus provides sexual health advice and limited treatment in a range of locations. 26 visits are made per month to a range of sites across the borough. Some of these are regular visits whilst others are one-offs, whilst others are “drop in” sessions. Condoms are available on the bus. The service also runs clinics that provide level 1 and 2 services in leisure centres and other settings. These provide basic contraception and LARC (long acting reversible contraception.

5.5 The choice of locations for the bus is based on known hotspots and local intelligence. Word of mouth information is also used. Locations also need to be able to accommodate the bus, with sufficient parking space. Those who are not close to where the bus stops can access services through the clinics. Services are publicised via the 4YP website, posters and leaflets. These are placed in a range of locations including GP surgeries.

5.6 There are two clinics that are specifically aimed at younger people. One is aimed at under 19s, based at St Ann's Hospital and open from 2:30 to 5:00 during the week. More women then men tend to access the clinic and very few young men come in for contraceptives. Boys are more likely to use the 4YP bus and mainly came in for condoms. The other clinic – 4YP+ - is for under 19 women only and based at Lordship Lane Health Centre. This is women only due to the fact that women can find groups of young men intimidating. In the west of the borough, services are provided from Hornsey Neighbourhood Health Centre, including the provision of condoms but the need is greatest in the east.

5.7 Influencing young men is a challenge. 4YP was originally set up due to the fact that young men were not accessing services. Young men often feel more comfortable talking to a man. The service has some male staff and they have discussed setting up a young mens clinic at Lordship Lane Health Centre but this could not be staffed solely by male staff

5.8 Young people do not tend to stick to appointments and a “one stop shop” arrangement is better. The walk in clinics that were held are quite well attended. Patients are often late

attending the Tuesday clinic and it is acknowledged that the opening hours of the afternoon clinic at St Ann's are not convenient for young people. It is therefore planned to change the hours to between 3:30 p.m. and 7:00 p.m. to fit in better with school times. The service for men who have sex with men (MSN) will also be moved. It is also aimed to introduce an additional session and to be open for six days per week. STI testing will also be available at all outlets.

5.9 Many young people access services in Hackney as it is relatively close to Haringey and can be accessed easily by local buses. In addition, some people may prefer to access services close to their work places. The view was expressed that it is possible that not everyone knows where Haringey's services are based and therefore better promotion might be required. However, 4YP is well known, as is its logo. More information is being sought through the setting up of a forum with young people and representatives of relevant services. The website is currently being upgraded to provide better information and it is intended to emphasise the full range of 4YP services and not just the bus. It is also possible that not all patients are currently aware of the full range of services that are available. Full integration will assist in addressing this issue. There is now self triage available so patients could decide what service was the most appropriate for them.

5.10 It was felt that there needs to be better follow up on women who have had a termination. A scheme to address this is shortly to be introduced. It is important to intervene quickly in such cases as women in such situations are often indecisive and can have difficulty coping. It is possible for professionals to introduce contraception before termination, when the opportunity best presents itself. There needed to be better overall management of young people during the termination process and the process made less complex.

5.11 It was noted that 4YP had been decommissioned by Enfield a few years ago. Following this, the service had been mainstreamed. School visits are now more limited then previously, although they still take place. There is also some limited work that takes place with the Youth Service. The limitations are due to the small number of staff – 4.5 – that the service have. The service does, however, undertake training of youth workers, all of whom are now trained. However, youth workers and teachers can sometimes feel uncomfortable talking to young people about sex as they feel that it can cause barriers between them and the young people that they work with.

5.12 4YP used to have a peer project as part of a particular scheme but this is no longer running. Stigma and embarrassment are felt by them to be key factors in discouraging young people from using sexual health services when needed. In addition, schools who refuse to distribute condoms and teachers who will not cover sex education could also be a barrier.

5.13 National statistics show that 80% of people receive their contraception from their GP. This is mainly the pill. In addition, some GP surgeries provide STI testing. The view was expressed that there is scope for more to be undertaken by GPs, some of whom were currently not motivated to undertake such services. This is for a variety of reasons – some are not sufficiently trained, others are singled handed practices and do not have the facilities whilst others do not feel comfortable providing such services. However, there are others who are more proactive and motivated. The clinics support GPs and some GPs have undertaken clinics at St Ann's. It is important that all staff in GP surgeries were involved, such as practice nurses and receptionists. It is possible that a well trained receptionist could deal

with requests for condoms. Encouragement needed to be given for more GPs to provide services.

5.14 The view was also expressed that many young people did not like to go to their GP to receive sexual health services. This is partly due to the perception that their GP might not keep information confidential. They can also feel that their GP is more likely to be judgemental then services such as 4YP. It is also possible that there is a perception that they will not be welcome. From time to time, the sexual health clinics receive referrals that are inappropriate from GPs. However, it is probably better that GPs refer patients onwards if they are not comfortable in dealing with them. It is also better to provide as much as possible when patients present as they might not turn up if referred onwards. The perception of some patients was that it is better to go to the expert sexual health team rather then go to their GP and possibly be referred onwards anyway, especially as it sometimes took a while to get an appointment. GP opening hours were important as was their ability to provide same day appointments. However, young people need the confidence to say what their problem is to the receptionist.

GP Services

5.15 The view of the lead GP for sexual health in the north east collaborative was that sexual health services should be an integral part of the job of a GP and therefore undertaken by them all. GP surgeries have particular advantages – they are anonymous so people do not know why individuals were attending and they are also open for a wide range of hours on numerous different sites. GP services are also available to schools and colleges. The disadvantage that GP surgeries have is the link that they have with the rest of young people's families. Only one GP has opted out entirely from providing sexual health services. It is felt that GPs should be the main gateway to services although it is difficult for single handed male GP services especially when a chaperone is needed.

5.16 She felt that some young people are either unaware or do not believe that that GP services are confidential and it is therefore essential that there is a clear message given out that they are completely confidential. It is hard to tell whether or not young people feel comfortable talking to their GP about sexual health but some young people clearly do not like talking to adults about it. Young men are difficult to engage with and can be hard to talk to. GP services can continue to try to educate people about the services that they offer and there is also a lot of evidence that many young people are already visiting their GP for sexual health services. One possible option would to have a young persons health check at the age of 18 that would cover sexual health issues but this would have resource implications.

5.17 It can be difficult to get GP services to pull together. They are independent contractors and can feel threatened by such initiatives. Nevertheless, it is important to get GPs involved and enthused if they are to be more proactive and engaged From March 2010, a scheme called sexual health in practice (SHIP) was being introduced which would encourage GPs to take a more proactive role in sexual health issues and provide an enhanced service. The scheme included training for practice nurses and GPs. As an incentive to participation, practices were being offered the opportunity to provide free condoms and pregnancy testing. GPs can currently test for Chlamydia for women, gonorrhea, hepatitis B, C and HIV The PCT do not currently give GPs access to free condoms for their patients although they are provided to sexual health clinics and 4YP.

5.18 There is now a dedicated family planning clinic at Lordship Lane Health Centre. However, the Centre has shared patient lists, which means that it is not always possible to see the same clinician. Current opening hours of services were considered not to affect access as there are already a range of options available for people who wanted sexual health services. The current lack of integration between Family Planning and Sexual Health services did not present any particular challenges. Many people preferred separate services and it is important to have flexibility.

5.19 The view was expressed that there is only so much that services can do to improve sexual health as majority of the drivers for it are socio economic. In terms of GPs, people need to feel comfortable visiting them and GPs needed to also make them feel welcome once they had arrive.

5.20 In reference to making appointments and access to doctors, it was felt that there had to be some sort of gateway in place to determine who patients needed to see but people could state that the reason for their visit was personal or book on line. It was felt that peer schemes had the potential to work well with young people.

Voluntary Sector

5.21 The Pan African and Caribbean Sexual Health Project (PACSH) is not directly aimed at reducing teenage conceptions. Its main focus is on addressing the issues of HIV and Aids within the African and African Caribbean communities, which was what the project is funded to provide. It provides a range of services including information, distribution of condoms and awareness raising across the community. It also provides support for those who have recently been diagnosed with HIV. The main focus of the service is on outreach work and it has done this by working closely with local businesses and services that are used by people from the range of communities in question.

5.22 They have approximately 50 fully trained volunteers working for them, whose role is to go out into the community and talk to people potentially at risk and build relationships and awareness. 70% of the volunteers are women. Their aim in promoting HIV testing is to reduce the number of people who are undiagnosed.

5.23 Their *Love Safely* programme includes specific reference to sexual health and infections and the provision of free condoms. If they come into contact with under 16s., they refer them onto either 4YP or the Teenage Pregnancy team. There is roughly an equal split between male and female clients on this programme. As part of it, they have so far handed out 50,000 condoms. They also hand out female condoms and lubricants.

5.24 The age range of the clients that they currently work with is 16 – 50. Whilst they currently support a number of teenagers in Haringey, most of their clients are in the 25-44 age range. The overall number of clients that they deal with has increased by 25%. There are currently more female then male clients. They have undertaken pieces of work with 6th. forms and CoNEL including presentations and workshops. Some work relating to sexual health and teenage pregnancy have also been undertaken with schools including bringing in HIV positive speakers to speak to young people. However, they are not directly funded to work with younger people and an appropriate project would need to set up and funded to address

issues with them. In addition, outreach workers would need to be appropriately trained. Nevertheless, the service has the capacity and would be prepared to broaden its scope if need be.

5.25 The stigma attached to STIs and, in particular, HIV is the biggest barrier that they face in their work. There are also issues with some faith communities and denial of the problem in some communities.

6. External Views

GoL

6.1 The view expressed on behalf of GoL was that the hostile attitude of the print media was a barrier to improving sexual health. However, 86% of parents are in favour of the teaching of sex education in schools. The mixed messages that young people receive about sexuality can lead to confusion. Economic inequality and deprivation are the principal drivers behind teenage pregnancy. In overall terms, only the US has worse rates then the UK. There are limits to what could be done without addressing the issue of economic inequality as the relationship between it and teenage pregnancy levels is so strong. Haringey's conception rate currently exceeded its deprivation score so there is still some scope for improvement.

6.2 All local authorities are fulfilling the ten actions required by the government's teenage pregnancy strategy. It is therefore difficult to isolate specific factors that make a crucial difference. It is nevertheless possible to identify some associated factors, such as girls who are absent from school. Work to reduce the risk of repeat conceptions through following up and providing appropriate contraception has nevertheless appeared to be particularly valuable.

6.3 Success in addressing the high rate of teenage pregnancy in Hackney could be attributed to a number of factors. Service commissioners and providers had been honest in saying what was wrong with services and schools had provided strong leadership. Peers had also been used successfully. Resources had been provided, with the local strategic partnership providing £1 million in extra funding. Services had also been persistent and resilient in addressing the problem. Consultation had taken place with young people, whose view was that enough was enough.

6.4 Haringey's commitment amongst its leadership to addressing the issue, as evidenced by the attendance that he had recently witnesses at a Teenage Pregnancy Executive Board, was exceptionally good. There had recently been a visit by the National Support Team for teenage pregnancy and their view was that, in the light of the recent upheavals in Haringey, the progress that had been made was remarkable. There had also been recent reductions in the quarterly rates, which were exciting. The authority had been unlucky with the increase in teenage conceptions that had taken place in 2007, which had been mirrored everywhere to some degree. A lot also depended upon the year from which the baseline had been set. Some outer London boroughs had been affected by population changes and, in particular, the size of the teenage population. The targets had been based on populations staying the same which had meant that those authorities affected by the demographic changes were having to "run to stay still".

6.5 Boys and young men tend to respond best to more explicit learning information, which is not appropriate in formal settings. It is easy to ignore the needs of boys, many of whom are anxious about their sexuality. One key aspect is that they want to know how to perform well. In addition, homophobia is often targeted at them. Boys also often have little sense of what it means to be a man. One particular scheme of note was a Brazilian one called Pro Mundo which was aimed at young men in deprived and violent areas and which sought to address sexual violence against women.

6.6 There tends to be higher spending in areas with higher rates of teenage pregnancy and this can be a contributory factor to reducing rates. It is currently difficult to benchmark spending but the Department of Health is currently undertaking some work on this with the aim of developing a consistent way of approaching the issue. It is particularly important to be able to target effectively those most at risk. Particular groups that are at risk include young women on the threshold of intervention being required by services, those in contact with youth offending teams and those who had undertaken recent abortions.

6.7 The “You're Welcome” quality criteria scheme aimed to make health services, including sexual health services, more accessible to younger people and can be particularly effective in respect of GP surgeries. Hackney and City PCT have appointed a GP champion to assist in this process, which had proven to be of assistance. A number of GPs did not feel comfortable talking to young people about sex and therefore needed to be encouraged to be more proactive.

6.8 There are a number of general; areas where there was scope for improvement. The Chlamydia rate in London is the highest in the country and is showing amber on the relevant target. It is also essential to ensure that core services, such as GPs, contraception services and pharmacists, were getting it right. Particular issues of concern are the fact that Chlamydia appeared to be being regarded as a rite of passage by some young people, the lack of role models for some boys and the migration to Britain of some children who had been traumatised by witnessing sexual violence in their homelands.

7. The Views of Young People

6.1 A survey was undertaken through Haringey Youth Council in summer 2008 on sexual health and included a number of action points. In addition, there was also a survey undertaken with year 6 pupils in early 2009 on health related behaviour which included questions on sexual health. In addition to both of these, there has also been a survey undertaken by the UK Youth Parliament in 2006-7 which included the views of 21,000 young people.

6.2 There are some common themes in all of these surveys, which are the need for:

- More interesting and interactive methods of teaching
- Greater emphasis on personal relationships and emotional aspects plus managing risk;

6.3 The general view of young people appears to be that that SRE is too little, too late, too biological and does not provide enough information on relationships. In response to these surveys, C&YPS has undertaken the following:

- More interesting and interactive teaching methods; Theatre groups have been used to communicate the message to young people, with the roll out of the SexFM play to ten local secondary schools. The "Beat them join them" play has also been rolled out to all secondary schools this term for year eight pupils. The play focuses on risky behaviour including sexual activity, drug and alcohol and emotional health and wellbeing. In addition, training has been provided to teaching staff in schools, funded by the Healthy Schools project.

- The Use of DVDs; All schools had been provided with a copy of the SexFM DVD which complements the play, but can be used independently of it. The Blueberry Condom DVD has been distributed to all schools and youth settings.

- Improvements in the teaching of SRE through staff training; SRE training through the Christopher Winter Project, which has been highly successful in Hackney, has been offered to all secondary schools and a cohort of 12 primary schools (2 teachers per school). 4 out of 10 secondary schools took up the offer. All schools taking part were provided with the Christopher Winter teaching resources. There has also been ongoing engagement with the National PSHE continuing professional development programme, the aim of which is to improve the skills confidence and knowledge of teachers delivering PSHE.

- Improved knowledge of local/national services: A Health and Wellbeing notice board is being introduced for all secondary schools (phase 1). This will provide information on local national services, web links and positive well-being. Phase 2 will roll this out to primary and special schools.

8. Suggested Issues for discussion

8.1 Arising from the evidence received by the Panel to date, the following issues would appear to be warrant further discussion:

- Joint working and co-operation between NHS Haringey with other PCTs
- Enhancing the role of primary care and GPs
- Improving links between sexual health services and schools
- Ensuring participation by all schools in educational initiatives aimed at improving sexual health
- Enhancing accessibility of services e.g. opening hours, making services more welcoming to young people,
- Publicising and raising awareness of services
- The provision of specific services for boys and young men
- Training and support for Primary school teachers

- The use of peers
- The role of parents
- Diversity
- Improving the environment at clinics with, for instance, confidential receptions areas
- Condom distribution