MINUTES OF THE SCRUTINY REVIEW - SEXUAL HEALTH IN TEENAGERS
MONDAY, 16 NOVEMBER 2009

Councillors: Bull (Chair), Newton, Santry and Scott

Co-opted Members: Ms. H. Kania and Ms. S. Marsh

LC13. APOLOGIES FOR ABSENCE

None.

LC14. URGENT BUSINESS

None.

LC15. DECLARATIONS OF INTEREST

None.

LC16. IMPROVING SEXUAL HEALTH IN TEENAGERS - EVIDENCE FROM STAKEHOLDERS

The Panel received evidence from the following:

- Mesfin Ali from the Pan African and Caribbean Sexual Health Project (PACSH)
- Adrian Kelly, the Regional Teenage Pregnancy Coordinator from the Government Office for London
- Claire O'Connor, the Head of Sexual Health, Contraception and Reproductive Services, NHS Haringey.

Mr Ali stated that his service was not directly aimed at reducing teenage conceptions. Its main focus was on addressing the issues of HIV and Aids within the African and African Caribbean communities and this was what the project was funded to provide. It provided a range of services including information, distribution of condoms and awareness raising across the community. It also provided support for those who had been recently diagnosed with HIV. Testing was actively encouraged. The main focus of the service was on outreach work and it did this by working closely with local businesses and services that were used by people from the range of communities in question.

They had approximately 50 fully trained volunteers working for them, whose role was to go out into the community and talk to people who were potentially at risk and build relationships and awareness. 70% of the volunteers were women. They had a card which they gave to people which could be taken to the GUM clinic to arrange a test. Their aim in promoting HIV testing was to reduce the number of people who were undiagnosed.

Their *Love Safely* programme included specific reference to sexual health and infections and the provision of free condoms. If they came into contact with under 16s., they referred them onto either 4YP or the Teenage Pregnancy team. There was roughly an equal split between male and female clients on this programme. As part of it, they had so far handed out 50,000 condoms. They normally talked to clients before handing out condoms in order to ensure that they were aware of the correct way of

using them, how to spot counterfeit ones and the need to observe expiry dates. They also handed out female condoms and lubricants.

The stigma attached to STIs and, in particular, HIV was the biggest barrier that they faced in their work. In a number of countries where clients came from, homosexuality was illegal and this could provide an additional barrier in encouraging people to access services. There were also issues with some faith communities. In addition, there was denial of the problem in some communities.

The age range of the clients that they worked with was 16 – 50. They currently supported a number of teenagers in Haringey but most of their clients were in the 25-44 age range. The overall number of clients that they dealt had increased by 25%. There were currently more female then male clients. They had undertaken pieces of work with 6th. forms and CoNEL including presentations and workshops. Some work relating to sexual health and teenage pregnancy had also been undertaken with schools. They had also brought HIV positive speakers into schools to speak to young people. However, they were 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 had the capacity and would be prepared to broaden its scope if need be.

He felt that services could be improved by better communication between services so people had a greater awareness of the range of services that were available.

Adrian Kelly from GoL outlined his role in relation to supporting London boroughs in addressing the issue of teenage pregnancy. He managed relationships between central government and London boroughs and provided support and challenge. For example, intensive one to one support could be provided to individual teenage pregnancy coordinators in boroughs and appropriate research commissioned.

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

All local authorities were doing the ten things required by the government's teenage pregnancy strategy. It was therefore difficult to isolate particular factors that made a particular difference. It was nevertheless possible to identify some associated factors, such as girls who were absent from school. Work to reduce the risk of repeat conceptions through following up and providing appropriate contraception had nevertheless appeared to be particularly valuables.

He attributed the success in addressing the high rate of teenage pregnancy in Hackney, where he had previously worked, 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.

He felt that 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. He stated there had recently been a visit by the National Support Team for teenage pregnancy. Their view was that, in the light of the recent upheavals in Haringey, the progress that had been made despite this had been 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.

All authorities were doing the ten things that were required under the national strategy. 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".

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

There tended to be higher spending in areas with higher rates of teenage pregnancy and this could be a contributory factor to reducing rates. It was currently difficult to benchmark spending but the Department of Health was currently undertaking some work on this with the aim of developing a consistent way of approaching the issue. It was particularly important to be able to target effectively those most at risk. Particular groups that were at risk included young women on the CAF threshold and those in contact with youth offending teams and or who had undertaken recent abortions.

The "You're Welcome" quality criteria scheme aimed to make health services, including sexual health services, more accessible to younger people and could be particularly effective in respect of GP surgeries. Hackney and City PCT had 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.

As things stood, it was currently not possible to force schools to teach sex education. However, new legislation would address this issue and it would soon be compulsory for all schools to teach sex education, including areas which some schools currently preferred to avoid covering.

Mr Kelly was of the view that young women did not often get pregnant on purpose – it was more down to carelessness. They tended to justify their inaction by saying that

they had got pregnant in order to get a house, although it had not been premeditated and was not strictly true. The media tended to portray such women as hate figures. The fathers in many cases were much older then the mothers. In the past, follow up on abortions by services had not tended to be very good. Services were now a lot more assertive in their approach, often using outreach. It was very important to ensure that the right women accessed services.

Social networking had been used by some authorities to get their message across but it was difficult to get right. One particular scheme had involved the use of pop ups to distribute “health bites” across schools and colleges, which covered a number of health issues.

There were a number of areas where there was scope for improvement. The chlamydia rate in London was the highest in the country and was showing amber on the relevant target. It was essential to ensure that core services, such as GPs, contraception services and pharmacists, were getting it right. Even if authorities were doing everything possible, including the ten actions referred to in the strategy, it was still possible for things to go wrong. Particular issues of concern were 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.

Ms O'Connor reported that the 4YP bus provided sexual health advice and limited treatment in a range of locations. 26 visits were made per month to a range of sites across the borough. Some of these were regular visits whilst others were one-offs. They were also drop in sessions. Condoms were available on the bus. The services also ran clinics that provided level 1 and 2 services in leisure centres and other settings. These provided basic contraception and LARC (long acting reversible contraception). In addition, there was a sexual health clinic at St Ann's Hospital that was open from 2:30 to 5:00 during the week. There was also 4YP+ at Lordship Lane Health Centre which was aimed at young women up to the age of 20. The service also provided training for GPs and practice nurses. Some GP’s now also prescribed LARC but the majority only prescribed the pill.

More women then men tended to access the clinic and very few young men came in for contraceptives. Boys were more likely to use the bus and mainly came in for condoms.
Family planning was now referred to as contraception services.

The service currently met the target for 48 hour access to GUM services and was typically achieving 90 - 95% compliance. There were high “did not attend” rates and the service sometimes overbooked to compensate for this. It was likely that services were currently not working to their full capacity. 50% of service users were from Haringey and the service was trying to increase this to 60%

She acknowledged that the opening hours of the afternoon clinic at St Ann’s were not convenient for young people and it was therefore planned to change the hours to between 3:30 p.m. and 7:00 p.m. The service for men who have sex with men (MSN) would also have to be moved. It was also aimed to introduce an additional session and to be open for six days per week. STI testing would also be available at all outlets.

The choice of locations for the bus was based on known hotspots and local intelligence. Word of mouth information was also used. Locations also needed to be able to take the bus, with sufficient parking space. Those who were not close to where the bus stopped could access services through the clinics. Outreach work was also undertaken with looked after children and the Roma community. Two new nurses had been appointed to work with hard to reach groups. Services were publicised via the 4YP website, posters and leaflets. These were placed in a range of locations including GP surgeries.

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

Stigma and embarrassment were key factors in discouraging young people from using sexual health services when needed. In addition, schools who refused to distribute condoms and teachers who would not cover sex education were also a barrier.

National statistics showed that 80% of people received their contraception from their GP. This was mainly the pill. Many young people did not like to their GP to receive sexual health services. This was partly due to the perception that their GP might not keep information confidential. They also could feel that their GP was more likely to be judgemental then 4YP. I

Getting through to young men was challenging. 4YP was originally set up due to the fact that young men were not accessing services. The services had some male staff and they had discussed setting up a young mens clinic at Lordship Lane Health Centre but this could not be staffed solely by male staff.

4YP used to have a peer project as part of a particular scheme but this was no longer running. She felt that schools could take on a more assertive role with more use made of class tutors and other teachers who children saw every day. Developing primary care was also important and the sexual health in practice (SHIP), which as being set up locally, could be effective in persuading GPs to take a more active role. As an incentive, it offered them the opportunity to undertake testing themselves and access to free condoms. Only one GP had opted out entirely from providing sexual health services. She felt that GPs should be the main gateway to services. However, it was difficult for single handed male GP services especially when a chaperone was needed.

The service could refer people with mental health problems onwards, although it was sometimes difficult to identify that such issues. There was currently nothing specific in place to address the needs of people with learning difficulties.

The Panel thanked Mr Ali, Mr Kelly and Ms O'Connor for their participation.

Cllr Gideon Bull
Chair

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