

# **JSNA Supplement**

**Sexual Health**

**December 2007**

## **HEALTH NEEDS ASSESSMENT OF SEXUAL HEALTH IN SOUTH TNESIDE**

*'Sexual health is an important part of physical and mental health. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease'*

*(The National Strategy for Sexual Health and HIV, 2001. Pg. 5)*

### **1. INTRODUCTION**

There is an increasing concern regarding; a rising number of people living with HIV, the rates of sexually transmitted infections and the high rate of unintended pregnancy and in particular within the teenage population. This reflects a complex picture of need and has resulted in a major public health concern.

The long term effects of sexual ill-health or unintended pregnancy are well documented and varied ranging from physical to emotional ill-health. The associated complications of sexual ill-health include links to cervical cancer, pelvic inflammatory disease, ectopic pregnancy,

infertility and psychological consequences amongst others (DH, 2001). The impact of unintended pregnancy particularly within the teenage population has been widely documented (SEU, 1999). Unintended pregnancy will lead to either termination (and associated consequences) or poor birth outcomes together with a complex web of education, health and social inequality (SEU, 1999). All interrelated consequences place huge pressures on individuals, their families, their support networks and the healthcare system (DH, 2001).

## **SEXUAL HEALTH INEQUALITY**

Within the overall increase in sexual ill-health there is recognition of further inequality relating both to geographical locations, poverty, social exclusion and within particular population groups. The Sexual Health Strategy acknowledges '*a clear relationship between sexual ill health, poverty and social exclusion*' (DH, 2001, Pg 3).

Groups that are highlighted as both at greater risk of experiencing sexual ill-health and poor access to services thus requiring specific targeting include:

- Men who have sex with men
- Certain ethnic groups (in particular asylum seekers and refugees)
- People from or who have visited areas of high HIV prevalence
- Sex workers (and their clients)
- The homeless
- Young people and particularly those in or leaving care
- People with a mental health problem, a conduct disorder and / or involvement in crime
- Teenage parents (or those who have already had an abortion)
- People with low educational attainment or no qualifications
- Disengagement from school
- Children of teenage parents
- Injecting drug users

There is also an acknowledgement that specific work with pregnant women is required to both improve outcomes and reduce risk for mother and baby.

(HPA, 2006, NICE, 2007 and DfES, 2006))

The NICE guidance (2007) identifies a number of behavioural factors that affect the probability of STIs. These behavioural factors include:

- Misuse of alcohol and/or substances
- Early onset of sexual activity
- Unprotected sex / poor contraceptive use
- Frequent change of and / or multiple partners

- Low self-esteem
- Lack of skills (for example, in using condoms)
- Lack of negotiation skills (for example, to say 'no' to sex without condoms)
- Lack of knowledge about the risks of different sexual behaviours
- Availability of resources, such as condoms or sexual health services
- Availability of sex and relationship education (SRE)
- Peer pressure
- Attitudes (and prejudices) of society which may affect access to services

This Health Needs Assessment aims to gather an array of information in order to develop a clear picture of both the health needs and gaps for the Sexual Health Strategy in South Tyneside; it also aims to identify required future measures and progress in delivering better prevention, treatment and support for people experiencing sexual ill-health.

## **2. WHAT IS SEXUAL ILL HEALTH?**

The notion of sexual ill health includes a variety of indicators. As noted above sexual ill health leads to further possible complications and can have a lasting effect on people's lives. For the purpose of this HNA the indicators included in the joint HPA and APHO publication '*Indications of Public Health in the English Regions; 6: Sexual health*' 2006 have been adopted. These indicators include;

- Teenage conceptions
- Births / fertility rate
- HIV: new diagnosis (Incidence)
- HIV: prevalence of diagnosed infection,
- Chlamydia
- Gonorrhoea
- Syphilis
- Hepatitis B and C, and
- Pelvic Inflammatory disease

An acknowledgement of a further two indicators under the heading of 'wider determinants and risk' include; sexual assaults and children a risk of sexual abuse. Whilst this report recognises the significance of these issues, local and regional discussion has not been provided due to the constraint of time for the completion of this report.

## **3. LIMITATIONS**

The report contains a number of limitations that require acknowledgement. Data presented within the report represents either national estimates which doesn't reflect regional variation or data based on the KC60 returns. KC60 data (SHA level and local) only includes diagnosis within GUM settings and therefore excludes diagnosis within other settings. For South Tyneside specifically there is recognition that the KC60 data provides an incomplete picture of need as a significant proportion of people access GUM services outside the area. Local data will not include recognition for the needs of these clients.

#### **4. THE POLICY CONTEXT**

##### **4.1 TEENAGE PREGNANCY STRATEGY (1999)**

In 1999 the Government launched the Teenage Pregnancy Strategy which highlighted significant inequalities in not only the outcomes experienced by teenage parents and their children but also inequalities related to the likelihood of teenage conception. In addition to this once a young person has experienced early conception the choice to terminate or continue is also surrounded by inequalities. The report highlighted that Britain had the worst record for teenage conception in Europe. Within this scope the strategy outlined groups who suffered further inequality in terms of likelihood of teenage conception

The report highlighted a four pronged approach that included, a national campaign, joined up action, better prevention and better support. Two key targets were included;

- Reducing the rate of teenage conceptions, with a specific aim of halving the rate of conceptions among under 18s by 2010
- Getting more teenage parents into education, training or employment, to reduce the risk of long term social exclusion.

Under the theme of 'better prevention' was the role of Sex and Relationship Education (SRE), information campaigns, enhancing contraception access for young people and targeting work with 'at risk' groups.

##### **4.2 SEXUAL HEALTH STRATEGY (2001)**

In 2001 the Government launched an ambitious ten year National Strategy for Sexual and HIV. This document pledged a nationwide programme of investment and reform with the aim of modernising services based on patient need, tackling inequalities and ensuring a focus on both prevention and treatment.

The Strategy outlines 5 key outcomes including:

- Reduce the transmission of HIV and STIs;

- Reduce the prevalence of undiagnosed HIV and STIs;
- Reduce by 50% unintended teenage conceptions by 2010;
- Improve health and social care for people living with HIV; and
- Reduce the stigma associated with HIV and STIs

These key aims require a combined multi-faceted approach to tackle the issues and inequalities associated with sexual ill health. The strategy outlined objectives required to fulfil this approach as:

- Providing clear information so that people can take informed decisions about preventing STIs including HIV;
- Ensuring there is a sound evidence base for effective local HIV/STI prevention;
- Setting a target to reduce the number of newly acquired HIV infections;
- Developing managed networks for HIV and sexual health services, with a broader role for those working in primary care settings and with providers collaborating to plan services jointly so that they deliver a more comprehensive service to patients;
- Evaluating the benefits of more integrated sexual health services, including pilots of one-stop clinics, primary care youth services and primary care teams with a special interest in sexual health;
- Beginning a programme of screening for Chlamydia for targeted groups in 2002;
- Stressing the importance of open access to GUM services and, over time, improving access for urgent appointments;
- Ensuring a range of contraceptive services are provided for those that needs them;
- Addressing disparities that exist in abortion services across the country;
- Increasing the offer of testing for HIV and setting a target to reduce the number of undiagnosed infections, thereby ensuring earlier access to treatment for those infected and limiting further transmission of the virus;
- Increasing the offer of hepatitis B vaccine;
- Setting standards for the treatment of STIs and for the treatment, support and social care of people living with HIV;
- Setting priorities for future research to improve the evidence base of good practice in sexual health and HIV; and
- Addressing training and development needs of the workforce across the whole range of sexual health and HIV services.

In addition to these objectives the plan highlights the crucial role that user consultation can play in service design / re-design. Building on this the strategy acknowledged the role of the wider public, service providers and health professionals.

The strategy documented aspired outcomes including a reduction in health inequalities alongside development of a modern, efficient and patient centred service with a reduction in the burden of sexual ill-health and HIV.

In line with the values and principles of the NHS plan the strategy aspires to:

- Improve services, information and support for all who need them;
- Reduce inequalities in sexual health; and
- Improve health, sexual health and well-being.

#### **4.3 CHOOSING HEALTH: MAKING HEALTHIER CHOICES EASIER (2004)**

In 2004 the government strengthened the focus on sexual health within the Choosing Health document. The White paper again highlighted the burden of inequality and detailed a focus on sexual health as one of six key areas for health service development. The White paper describes measures required in order to facilitate improved outcomes including prevention measures, service access and support.

Further commitment to the Teenage Pregnancy Strategy is highlighted within the white paper detailing a national campaign alongside better prevention through sex and relationship education, access to contraception services and support for young people experiencing early conception including the prevention of subsequent unintended pregnancies.

The White Paper highlights the inclusion of sexual health targets within the document *'National Standards, Local Action: Health and Social Care Standards and Planning framework (2005-06/2007-08*. The document outlines the role of Local delivery Plans in facilitating an improvement in sexual health.

The White paper outlines a vision for sexual health services including;

- Multidisciplinary teams headed by nurses linking between contraception, sexual health specialists (including GUM consultants) and community, youth services and sexual health liaison workers working within primary care providers as part of a comprehensive range of services;
- Extension of the roles of nurses, youth workers, community workers and pharmacists to include elements of sexual health;
- Peer educators / youth workers trained to use the latest technology;
- Mainstream primary care health programmes delivered by school nurses, health trainers, health visitors, community psychiatric nurses, midwives and practice nurses;

- 'Enhanced services' in the new primary medical care contacts; and
- More 'primary care practitioners with a special interest' working alongside sexual health experts in contraceptive, HIV and sexual health treatment services.

(Pg 146)

The White paper outlines the need to change the way services are delivered to meet the needs of the clients including the development of 'one stop' shops, community screening venues (e.g. supermarkets, workplaces etc) and outreach work. Linked to this is the role out of the National Chlamydia Screening Programme targeting young people under 25.

Finally the White paper documents the target of 48 hour access to GUM services by 2008.

## **5. TARGETS**

### **5.1 HEALTHCARE COMMISSION TARGETS**

New National Targets for 2006/2007 have been published by the Healthcare Commission. These include a new indicator concerning access to reproductive health services.

Assessment of performance against the new national targets is one component of the Healthcare Commission's 2006/2007 annual health check and will assess PCT performance in relation to each of the new national targets outlined in National Standards, Local Action, using the indicators detailed. Three sexual health indicators are included:

- Reducing the under-18 conception rates by 50% by 2010 (from 1998 baseline) as part of a broader strategy to improve sexual health
- Access to GUM clinics within 48 hours
- Access to reproductive health services

Access to reproductive health services is a new two-part target that will firstly assess access to contraception services using a process indicator; and secondly assess access to abortion services using an outcome indicator on the number of NHS funded abortions undertaken up to and including 9 completed weeks' gestation.

### **5.2 PSA TARGET – TEENAGE PREGNANCY**



Locally the Teenage Pregnancy target is one of the top ten Local Area Agreement priorities.

- Reducing the under-18 conception rates by 50% by 2010 (from 1998 baseline) as part of a broader strategy to improve sexual health

### 5.3 LDP TARGETS

#### 5.3a Chlamydia Screening

PSA11d: Broader Strategy to Improve Sexual Health: Percentage of people aged 15 to 24 accepting Chlamydia screening

Year	2006/07			2007/08			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4
The number of 15 - 24 year old persons screened or tested for chlamydia	0	0	373	746	746	746	746
The <i>population aged 15 - 24 years</i>	19900	19900	19900	19900	19900	19900	19900
Percentage: This is a calculated field using [Line 1] / [Line 2] * 100	0.00%	0.00%	1.87%	3.75%	3.75%	3.75%	3.75%

#### 5.3b GUM Access

PSA11b (Revised): Broader Strategy to Improve Sexual Health: Access to GUM Services

Target	2007 / 07											
Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total number of first attendances at the GUM service	200	217	234	251	268	285	300	307	315	323	331	338
Number of people attending a GUM service who were offered an appointment to be seen within 48 hours of contacting a service	120	137	154	173	193	214	237	255	274	294	314	338
Percentage: people attending a GUM service who were offered an appointment to	60 %	63 %	66 %	69 %	72 %	75 %	79 %	83 %	87 %	91 %	95 %	100 %

be seen within 48 hours of contacting a service												
Number of people who were seen within 48 hours of contacting a GUM service	100	115	131	146	162	177	193	208	224	239	255	270
Percentage: people who were seen within 48 hours of contacting a GUM service	50 %	53 %	56 %	58 %	60 %	62 %	64 %	68 %	71 %	74 %	77 %	80%

### 5.3 c Gonorrhoea rates

PSA11c: Broader Strategy to Improve Sexual Health: Decrease in rates of new diagnosis of Gonorrhoea

Year	2002	2003	2004	2005	2006	2007	2008
Number of new diagnoses of gonorrhoea in a calendar year	26	31	18	24	22	20	18
Population (provided)	152260	151685	150947	150234	149553	148903	148261
The number of new diagnoses of gonorrhoea per 100,000 population	17.1	20.4	11.9	16.0	14.7	13.4	12.1

## 6. SOUTH TYNESIDE PROFILE

South Tyneside is situated on the South bank of the River Tyne on the North East Coast of England. It is the smallest of the five Tyne and Wear districts and covers an area of 64.43 square kilometres. There is a population estimate of 151,316 (ONS 2005). South Tyneside has one PCT and is the smallest metropolitan borough in England. It is one part of the Northumbria Tyne & Wear Strategic Health Authority (SHA).

South Tyneside is an area which has seen a decline in its traditional industry and suffers from significant socio-economic deprivation. Using the Index of Multiple Deprivation 2004 South Tyneside has 103 Super Output Areas (SOA) within 20 Wards. The IMD 2004 highlights that for

overall deprivation South Tyneside has over 19.4% of SOA's in the worst 10% category and over 52% in the worst 20% for England. This is the largest proportion of areas falling into these categories in Tyne and Wear. 5 SOA's are in the 5% worst deprived category nationally including:

Rekendyke	ranked 546 (out of 32, 482)
Jarrow Town Centre	ranked 547
Horsley Hill	ranked 600
Cleadon Park	ranked 636
The Woodbine	ranked 795

A further 15 SOA's are in the 10% worst deprived including Fellgate and Boldon Colliery.

The Association of Public Health Observatories (APHO) produced a health profile for South Tyneside indicating that for life expectancy 13 of the 20 wards were significantly lower than the national average. Linked to this 15 of the 20 wards were shown in the most deprived 25% with 4 in the second most deprived.

The demographic profile for South Tyneside is shifting, with fewer births than the national average and an elderly (75+) population that is higher than the English average. The total population of South Tyneside has reduced from approximately 158, 000 in 1984 to approximately 151, 700 in mid 2005. The population of childbearing age (women aged 15 – 44) includes approximately 30, 372 women.

2.7% of the population are from minority ethnic groups and are housed primarily in two main wards which are Beacon and Bents and Rekendyke. This population largely comprises established communities living in South Tyneside. The known minority ethnic communities living in South Tyneside include the Arab, Bangladeshi, Indian, Black – African, Black - Caribbean, Chinese and Pakistani communities. The Arab community is one of the most established in the country; its origins can be traced back to 1890s with the arrival of Yemeni seamen. The Bangladeshi community is the largest minority ethnic group represented in South Tyneside. South Tyneside is also a National Asylum Seeker support (NASS) area as there is unused housing stock and available school places. The number of available properties was kept at 50 resulting in a small asylum seeker population (EMTRAS report, 22.01.07).

South Tyneside residents are serviced by one Metropolitan Borough Council, one Primary Care Trust, 30 GP practices, one Acute Trust (South Tyneside Foundation NHS Trust), and one specialist mental health NHS Trust. Services are also provided by voluntary sector organisations.

## POPULATION ESTIMATES

Population Type	Population Estimate
Total population over 14 years	125, 179
Young people aged 15 - 24	Total population 19, 935
	Female population 9, 839
	Male population 10, 096
Minority ethnic populations 2.7%	4086 total population all ages
	3379.8 Total population over 14
Women of childbearing age (15 – 44)	30, 372 women
Pregnant women	Circa 1, 450 (Foundation trust data)
Homosexual population (NATSAL estimate 5.4%)	Total male population over 15 = 59, 897
	Estimated homosexual population figure 3, 234
Female drug users in contact with substance misuse services in South Tyneside (NDTMS Submission as at 31st August 2006)	99 women one client was missing date of birth details 86.7% were of child bearing age (18-44)
Total number of clients in contact with substance misusing services	626 Total number 11% Injecting drug users (IDU) (N = 69) 87% Male (N = 547)

### South Tyneside population estimates mid – 2005 (ONS)

Age	Total	Male	Female
13 - 15	6181	3090.5	3090.5
16 – 19	8607	4303.5	4303.5
20 – 24	9289	4674	4615
25 – 34	17187	8661	8707
35 – 44	22750	10954	11796
45+	65307	30397	34910

## 7. GROUPS REQUIRING SPECIFIC TARGETING

### 7.1 Men who have sex with men (MSM)

The HPA (2006) provided evidence that MSM remain the population with highest risk of HIV infection within the UK. MSM comprise one

third of all HIV diagnosis during 2005 with 46% of all prevalence (diagnosis since 1981). Co-infection with other STIs remains a critical issue for the HIV-infected population with glaring evidence around increased risk and co-morbidity. The HPA (2006) highlighted data depicting a high proportion of MSM co-infected with HIV and other STI's including LGV (80%), syphilis (34%) and gonorrhoea (49%). HIV prevalence estimates amongst MSM aged 15 – 44 were 8.4% (London) and 3.6% (everywhere else) (pg. 68 HPA, 2006).

### **Behavioural Indicators**

MSM are acknowledged as a population group at increased risk of unsafe sexual behaviours. The HPA (2006) highlighted findings from the 2005 Sexual Health Survey of Gay men in London. This survey revealed that 50% of respondents reported unprotected anal intercourse (UAI) during the previous year. Almost half of this group again reported UAI with partners where they were of either different or unknown HIV status. Nearly a third of respondents who were unaware of their HIV status tested positive during the survey (29%). Respondents that tested positive during this study were significantly more likely to have displayed a variety of risk factors including;

- Unprotected Anal Intercourse
- More than one partner
- Casual partners
- Partners with either different or unknown HIV status.

Drug and alcohol use was also outlined as a contributing risk indicator linked to infection prevalence with around 67% of men reporting drug and alcohol use together with sexual activity during the previous year with a documented higher prevalence in drug use amongst HIV positive men.

The HPA (2006) outlined qualitative findings from the Investigation of New Seroconversions in Gay Men who have an HIV test (INSIGHT) study. The findings from this study demonstrated that despite an awareness of the risk associated with UAI, some MSM continue to practice unsafe sex due to a variety of psychosocial factors including;

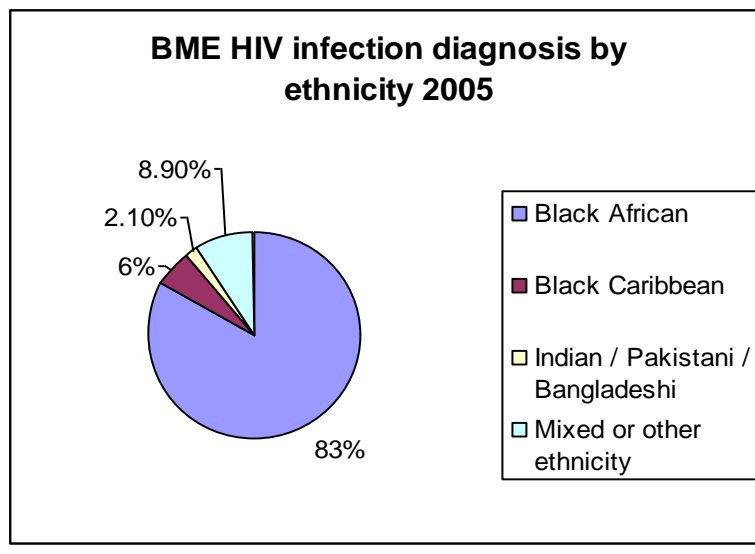
- Lower perception of risk with insertive, gentle or infrequent UAI
- Lack of control during period's of depression or low self-esteem
- Intimacy concerns
- Diminishing sense of risk (following repeated negative HIV tests)

In addition to HIV and co-infection the MSM population have an increased risk of acquiring other STI's. Data highlighted by the HPA, 2006 shows that the MSM population have higher diagnosis levels that have continued to rise during 2005, in relation to the five acute main STI's. Gonorrhoea diagnosis shows the steepest increase in this population with a 39% increase between 2000 and 2005. Data further

identified age related inequality with this increase disproportionately affecting the MSM population aged 25 – 34 years.

## 7.2 Black and Ethnic Minority Populations

Epidemiological evidence suggests that particular BME groups are at significantly greater risk of sexual ill-health. The HPA (2006) highlights that of all new diagnosis for HIV in the UK two thirds were among BME individuals with 83% of these amongst black Africans. HIV prevalence is greater in specific BME populations with a rate 46 times higher than the white population for black Africans (3.6%) and 3.7 times higher for black Caribbean's (0.3%).

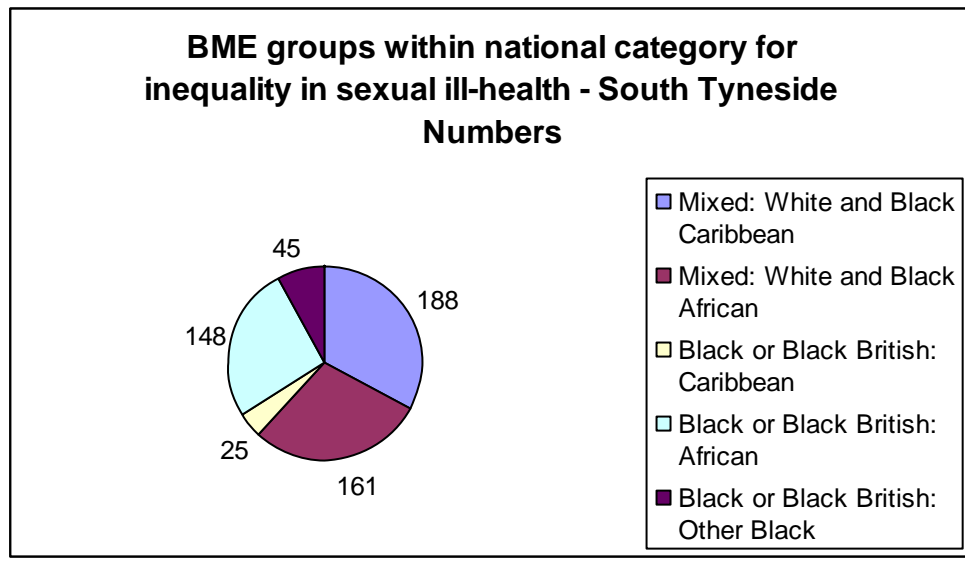


Infection routes are shown to be divergent within the BME population compared to the general UK population with 90% of individuals diagnosed with HIV acquired through heterosexual contact and in contrast just 6.5% MSM. Of the total heterosexual HIV diagnosis during 2005 where the country was documented 85% were acquired in Africa.

The prevalence of BME individuals living with diagnosed HIV varies between different ethnic groups with a high of 3.6% within the black African community (aged 15 – 59) to just 0.03% of the Indian / Pakistani / Bangladeshi population. Of all gonorrhoea diagnosed at sentinel clinics black Caribbean's made up 18% with other BME groups accounting for 23% of gonococcal infections during 2005. Black groups made up 33% of all syphilis diagnosed at GUM clinics.

In South Tyneside population groups fitting the most at risk category for sexual ill-health comprise a small proportion of the total BME population. As highlighted earlier the BME community is largely made up of Asian or Asian British: Indian, Pakistani, Bangladeshi or other Asian. The total population fitting the mixed: white and black, Caribbean or African or the black or black British: Caribbean, African or

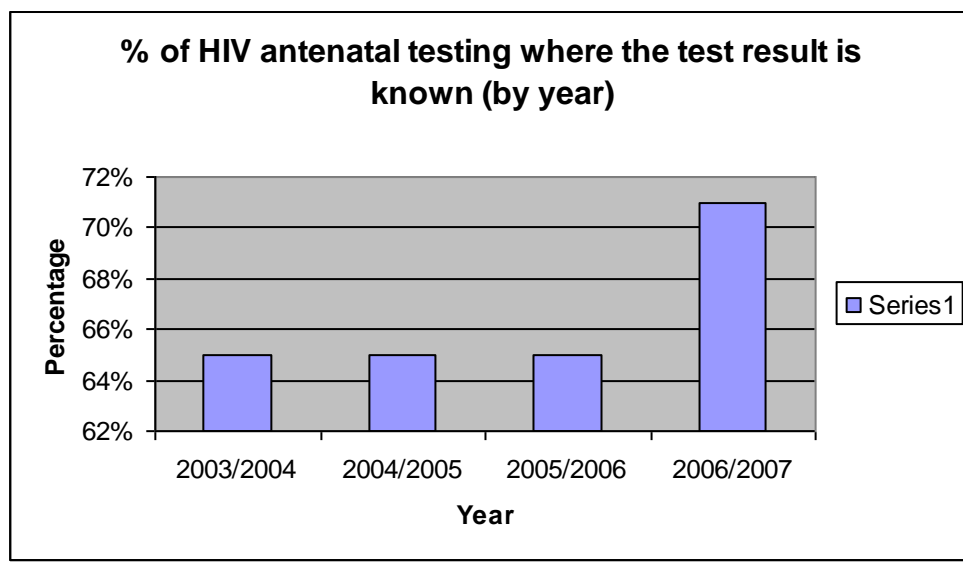
other black is roughly 0.37% (N = 567) (South Tyneside Statistics On Line).



### 7.3 Pregnant Women

Motivation for a targeted approach within this particular population lies within the realm of improving outcomes for the baby through reducing the risk of transmission from mother to baby alongside other benefits including early diagnosis for the mother. HPA (2006) data highlighted that 1 in every 450 pregnant women were infected with HIV during 2005. This incidence level has seen an increase over the past five years with an incidence of 0.04% in 2001, 0.11% in 2004 with incidence outside London reaching 0.13% in 2005. Ethnicity remains a significant factor in identifying risk with increase rates of 2.4% for women born in sub-Saharan Africa and 0.82 within women from Central America and the Caribbean countries with 0.04% of UK born women infected with HIV.

In response to this issue policy was introduced in 2000 to offer and recommend an HIV test as part of the routine antenatal care. Targets were set to increase uptake of testing to 90% by the end of 2002 and to diagnose 80% of infections prior to delivery. Local data highlights that South Tyneside has achieved a level of 71% of women accepting the test where the result is known for the year to date (2006 – 2007).



#### 7.4 Young People (aged 16 – 24)

Young people make up approximately 11% of new HIV diagnosis each year alongside a disproportionate representation within the diagnosis rates for Chlamydia, gonorrhoea and genital warts (HPA, 2006).

Young people are acknowledged as a group affected by increased behavioural risk. The HPA (2006) outline a number of different behavioural factors when compared to their older counterparts contributing to this increased risk:

- Higher number of sexual partners
- Higher number of concurrent partners
- Higher frequency of partner change
- Reducing age of first sex (NATSAL, 2000)

Concern has been expressed around the level of skill and confidence required to negotiate safer sex and the inadequate opportunities for this particular group to develop these skills. Early sexual activity has been linked to subsequent sexual health status (Wellings et al, 2001). Wellings et al (2001) outlined a number of factors associated with early sexual activity including;

- Early menarche
- Early school leaving age
- Family disruption and disadvantage
- Poor educational attainment

The document 'Teenage Pregnancy Next Steps (2006) outlines further risk indicators linked to self esteem and educational attainment. Educational attainment has also been linked to lack of contraceptive use with the likelihood of not using any contraception during first sex



increased with young people leaving school without qualifications. Data highlighted illustrates that around a third of girls and a quarter of boys leaving school with no qualifications reported no contraceptive use compared to just 6% of boys and 8% of girls leaving school with qualifications. The document also illustrates a link between sex before 16 and non-contraceptive use. Supplementary detail has been provided related to further inequality in relation to specific groups at increased risk of teenage pregnancy and therefore at increased risk of possible sexual ill-health. These groups include:

- Children in the Looked After System
- Daughters of teenage mothers
- Young people who have been sexually abused
- Young people who haven't discussed sexual matters with their parents
- Young people bullied at school
- Young people involved in crime
- Young people mis-using drugs or alcohol

Finally young people who display more than one risk factor will have an increased level of risk (Next Steps, 2006). Analysis of the 1970 British Cohort study found that young women experiencing five selected risk factors increased the risk of teenage conception by 31% and for young men the same analysis increased their risk of early fatherhood (before 23) by 23%. In terms of levels of sexual activity the National Survey of Sexual Attitudes and Lifestyles outlined that on average 27% of women and 28% of men were sexually active before the age of 16. However this figure is higher for the North East with 38% of young women sexually active under 16 thus leading to an increased risk of the various sexual health indicators.

Total aged 13 - 15	Estimated number by gender	NATSAL estimates for sexual activity	South Tyneside Estimate number sexually active
6181 (approximate)	3090	38% of young women sexually active (North East average)	1174.2
	3090	25% of young men sexually active (North East average)	772.5

## 7.5 Injecting Drug Users (IDU)

IDU have a greater risk of HIV infection than the general population (HPA, 2006). HIV-infection transmitted through IDU is documented with fairly low average numbers of 136 per year in the UK. Reflecting other diagnosis analysis HIV-infection is more prevalent in London compared to the rest of the country with 3.2% of the IDU population infected in contrast to 1.2% elsewhere.

Whilst a level of caution is required due to the apparent small numbers the incidence of IDU HIV-infection outside London increased by 100% between 2004 (0.6%) and 2005 (1.2%). Country of infection is different to heterosexual contact with 50% of infections acquired within the UK (31% in Southern Europe). IDU infections explain 5.6% of the overall HIV diagnosis. Within this population three quarters were male with one quarter female. Ethnicity for the group was largely white (72%). Alongside HIV-infection IDU are regarded as at high risk for a variety of other viral and bacterial infection including Hepatitis C, B, A, Human T-Cell Lymphotropic virus, Type II, (viral) and Staphylococcus aureus, Group A Streptococcal and Clostridial Infections (bacterial) amongst others (HPA, *'Shooting Up: Infections among injecting drug users in the UK 2005. An update'*. October 2006).

Incidence rates of Hepatitis C as with HIV show geographical variation with a higher prevalence in London (over 50% of IDUs) compared to the North East (less than 25% of IDUs). Over 20% of IDU's have been infected with HepB (HPA, 2006). There are a number of risk and protective factors identified including:

### Risk factors

- Sharing needles and syringes
- Sharing injecting equipment (filters, spoons etc)
- Injecting environment
- Poor needle hygiene
- Previous experience of prison or young offenders institution
- Multiple syringe use
- Association between crack cocaine use and higher HIV and Hep C levels
- Area of the body used for injecting
- Low levels of condom use

### Protective factors

- Hepatitis B vaccination take up
- Hepatitis C testing
- Needle Exchange facilities
- Increasing the number of sterile needles and syringes available

## **Local data**

Data collected by the Drug Treatment Monitoring System (NDTMS) outlines that between April 2006 and January 2007 there were 626 clients in treatment in South Tyneside. Of this total number approximately 11% (N = 68) were injecting as indicated by the route field on the NDTMS submission. Of this number 87% were male. The age of client ranged from 22 to 60 years. The main primary drug injected was heroin.

For comparable years April 2005 – March 2006 the total number in treatment was 750 with 8.8% injecting (N = 66) comprising of 88% men. During the financial year April 2004 to March 2005 the number in treatment was 672 of which 8.5% were injecting. Again of the total number injecting men were over represented with 82.5% of the total number. This data suggests whilst relatively small numbers a higher proportion of IDU within the past ten months.

## **Local Research with women misusing substances in South Tyneside**

(Charlton, S. (2005) *Barriers Facing Women Accessing Drug Service Provision within South Tyneside* South Tyneside DAT)

*'The data detailed here was derived from qualitative approaches using semi structured questionnaires with open ended questions through a process of sample snowballing. All interviews of drug users were conducted by female drug users / ex drug users who were adequately trained in research techniques using an evidence based learning portfolio. The structure of the questionnaire was designed by the female researchers in an attempt to address issues identified as barriers by drug users themselves. 45 female respondents were been interviewed for this research.'* (Charlton Page 5)

## **Data Overview**

Respondents ranged from 22 years to 40+ (1 respondent). A significant proportion of respondents identified multiple risk characteristics. These include the proportion of respondents within the detailed categories outlined below.

Care of local authority	42.2% (n19)
Exclusion from school	64.4% (n29)
Truant regularly	86.6 (n39)
Left school with formal qualifications	35.5% (n16)

Poly drug use was prevalent within this study with 77.7% of the sample taking two or more drugs (Page 16). The table below details ways in which drugs are administered (Page 18).

Drug	Swallow	Sniff / Snort	Smoke / Chase	IV	Skin Popping
Heroin			47.8%	47.8%	4.4%
Methadone (prescribed)	100%				
Subutex					
Cocaine Powder	25%	75%			
Crack			88.8%	11.2%	
Amphetamine	42.8%	42.8%		22.2%	
Alcohol	100%				
Cannabis	10%		90%		
Benzo's	75%			25%	

Significant harm reduction issues were also identified in injecting behaviour with 37.5% using a syringe 2- 4 times, 37.5% using it 5 – 8 times and 6% using it over 15 times. 62.5% reported sharing their equipment.

### **Sexual Health**

When asked about where they would access for their sexual health women detailed five possible services including:

G.P	71.1% (n32)
Hospital	11.1% (n5)
Drug and Alcohol Service	6.6% (n3)
Other drug agency	2.2% (n1)
Talk to friends	2.2% (n1)

17.7% had visited a service listed above in the previous year with a sexual health issue.

55.5% of women had been tested for hepatitis C, 24.4% had definitely not been tested with 19.9% of respondents not knowing if they had

been tested or not (Page 26). With regards for Hepatitis B only 28.8% (n13) of respondents had been immunised, whereas 42.2% (n19) stated that they had not been immunised and 28.8% (n13) did not know or could not remember.

## 8. SEXUAL HEALTH PREVALENCE

### Overview

In 2005 over 790, 000 acute STIs were diagnosed in Genitourinary Medicine clinics (GUM) with over 1.8 million attendances in total. The numbers presenting with an STI at GUM clinics in the UK has increased by 60% with an increase in workload of 268% alongside a three-fold increase in people seen for HIV care over the past ten years (HPA, 2006). This increase in demand for sexual health services has been acknowledged to result in delays in the diagnosis and management of STIs and HIV with a concern that these may lead to further transmission and increase the likelihood of serious complications (HPA, 2006). There is again recognition that the burden of disease falls disproportionately on marginalised population groups.

### Sexual activity levels (an indicator of risk)

The NATSAL (Johnson et al, 2001) survey suggested a median age of between 16 and 17 for first sexual experience with 27% of young women and 28% of young men having sex under the age of 16. For the North East this figure is even higher with approximately 38% of young women estimated to be sexually active before 16. In contrast only 25% of young men in the North East were sexually active before aged 16 which is lower than the national average. This data also suggests that a significant proportion of young women sexually active in the North East would be with partners of an older age. Further analysis of sexual ill-health suggests that the burden of disease falls within distinct age groups with higher rates of chlamydia, warts and herpes within younger females than males also reflecting age related variation. Brook et al (2000) suggests that by aged 20 almost 90% of young people are sexually active. Data from the population estimates 2005 (ONS) suggests that there are approximately 6181 young people in the 13 – 15 age group. If there were approximately equal proportions of young women and men in this age bracket this suggests there are 3090 in each gender group. Whilst it is accepted that this proportion wouldn't be equally split in terms of gender for the purpose of estimations of prevalence this calculation will be applied.

Age	Estimated number by gender	NATSAL estimates for sexual activity	South Tyneside Estimate
Total aged 13 - 15 6181	3090	38% of young women sexually active (North East	1174.2

(approximate)		average)	
	3090	25% of young men sexually active (North East average)	772.5
Total aged 16 - 19	8, 697	50% estimated sexually active	4348
		90% estimated sexually active	7827
Total aged 20 - 24	9, 289	90% estimated sexually active	8360.1

## 8.1 Teenage Conceptions

### Indicator description

Three indicators are included based on the number of conceptions in 'those aged under 18' per 1, 000 population aged 15 – 17:

- Percentage reduction in teenage conception rates, 1998 – 2005
- Teenage conception rates, 2005
- Inequality in teenage conception rate between South Tyneside and the National and Regional Average

### Outcome target

- To reduce by 50% the under 18 conception rate by 2010, with an interim target of a 15% reduction by 2004

### Rationale and background

The teenage conception rate in England is higher than in any other Western European country (Social Exclusion Unit Report, June 1999). Whilst the overall rate remains high there are significant variations in the conception rate experienced in different areas of the country. Teenagers who grow up in poverty and disadvantage or have low educational attainment or a dislike of school are more likely to experience early conception. Other groups of young people who are particularly vulnerable to becoming teenage parents include those excluded from school, young people in or leaving local authority care, children of teenage parents and young people involved in crime (DFES 2006).

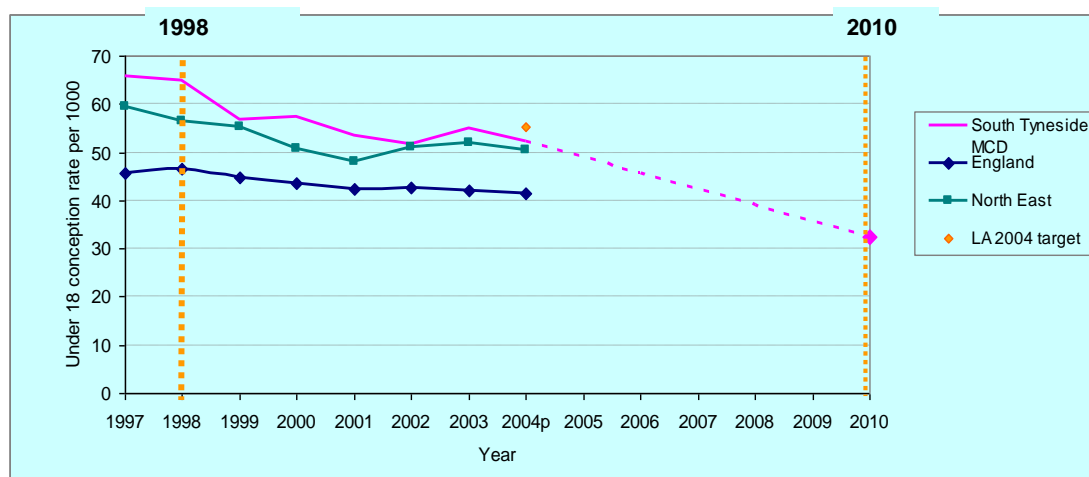
Teenage mothers have an increased predisposition to poor antenatal health, low birth weight and infant mortality. Teenage mothers have also been shown as less likely to finish their education, less likely to find a good job, and more likely to end up both as single parents and bringing their child up in poverty. The children themselves have also been outlined as running a much greater risk of poor health, and have

a much higher chance of becoming teenage mothers themselves (DfES, 2006).

### Latest data

The latest conception data (2005) for South Tyneside shows an overall reduction of 25.7% since the 1998 baseline. The interim target of a 15% reduction by 2004 was exceeded in South Tyneside. The trajectory set to ensure the target is met has been exceeded for 2005. The National Teenage Pregnancy Unit highlighted the Local Strategy during 2006 as one of the top performing areas in the country with both a significant reduction and excellent services. Despite a significant reduction the teenage conception rate in South Tyneside remains considerably higher than the national average.

### Under 18 Conception Rate and trajectory required to meet the target

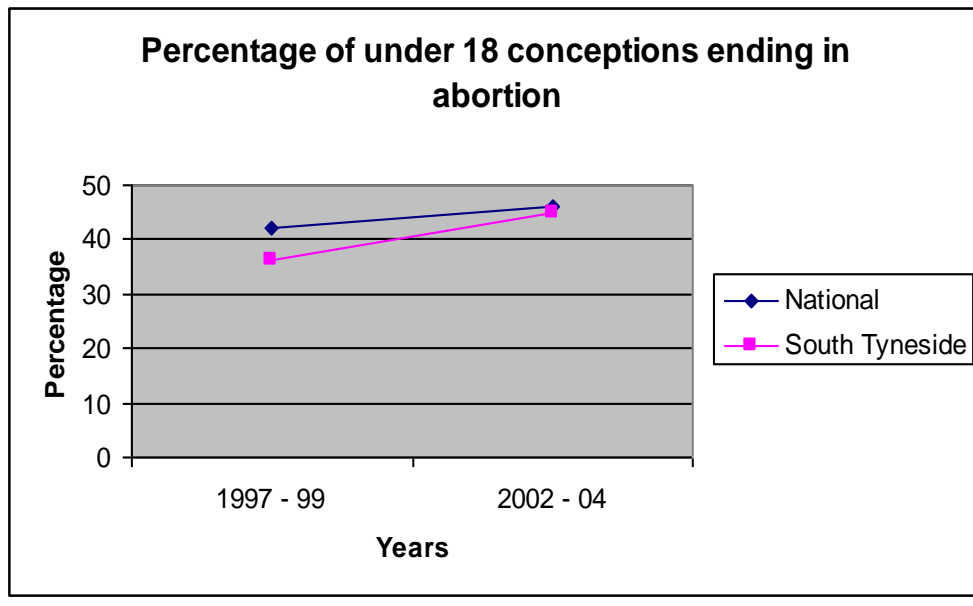


### Under 18 Conception Rate

Year	1998	1999	2000	2001	2002	2003	2004	2005
South Tyneside	64.9	56.8	57.3	53.6	51.7	55.0	52.1	Target 48.9
								Actual 48.2
% Change	0	- 12.4	- 11.7	- 17.4	- 20.4	- 15.3	- 19.7	Target-- -24.7%
								Actual -25.7%
North East	56.5	55.3	50.8	48.2	51.0	52.1	50.5	Actual _12.2%
England	46.6	44.8	43.6	42.5	42.6	42.1	41.5	Target 38.5
								Actual 41.1
% Change	0	- 4.1	- 6.4	- 8.9	- 8.6	- 9.8	- 11.1	Target- 17.5
								Actual



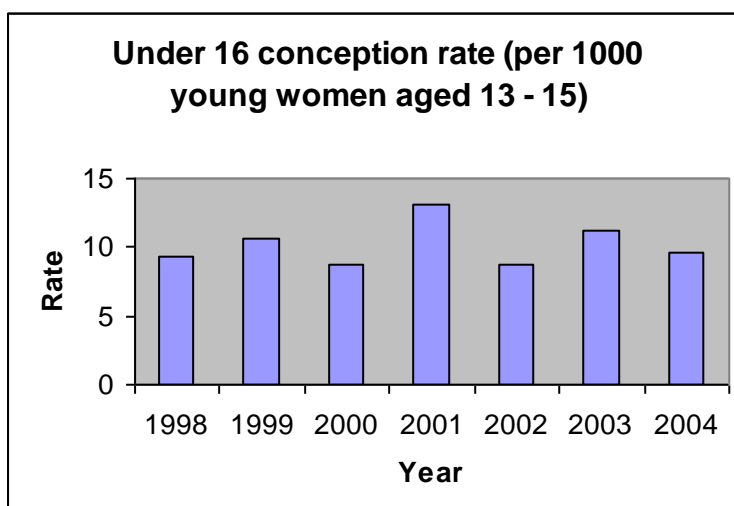




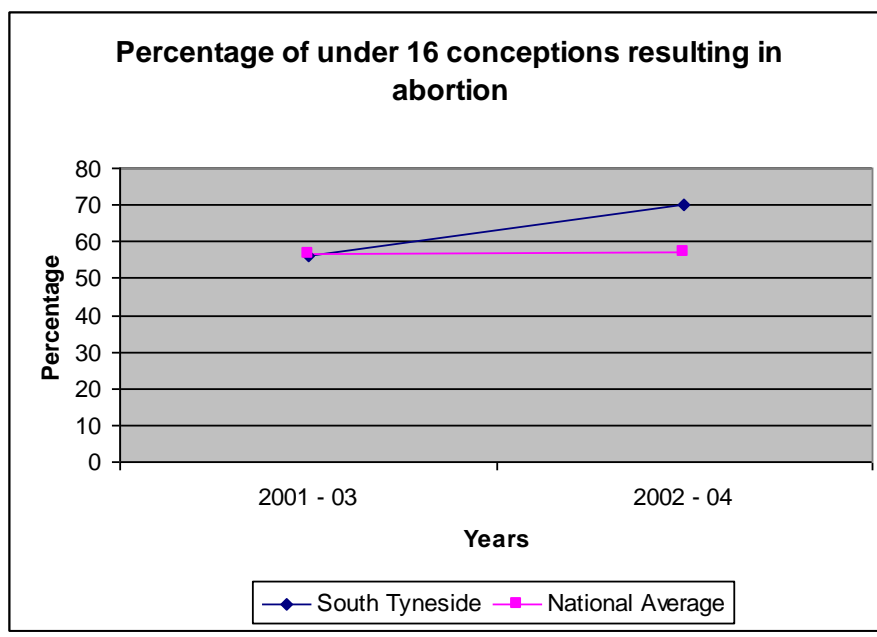
### Conceptions under 16

The under 16 rate of teenage conceptions (per 1000 young women aged 13 – 15) represents very small numbers and thus at a National level was considered to be undulating to such an extent that a specific target for this age group was deemed unrealistic. With recognition of the specific limitations regarding monitoring this age group there remains an acknowledgement locally of the crucial role in reducing this rate.

The actual number of under 16 conceptions in South Tyneside has ranged from 28 to 43 with an average of 32 per year. The under 16 rate is currently showing a 4.2% increase from 1998 to 2004 however the actual number is one. Using aggregated data for 2002 – 04 the South Tyneside rate is above the average for England at 9.9 per 1000 compared to 7.8 per 1000 at a National level. The table below presents the under 16 conception rate in South Tyneside from 1998 to 2004.



Young people under 16 are known to be more likely to opt for termination than their older counterparts. Interestingly data shows that young women conceiving under 16 in South Tyneside are more likely to opt for termination than the national average with a substantial increase in this proportion in recent years. Again a level of caution is required based on the small numbers involved.



### Hotspot Wards

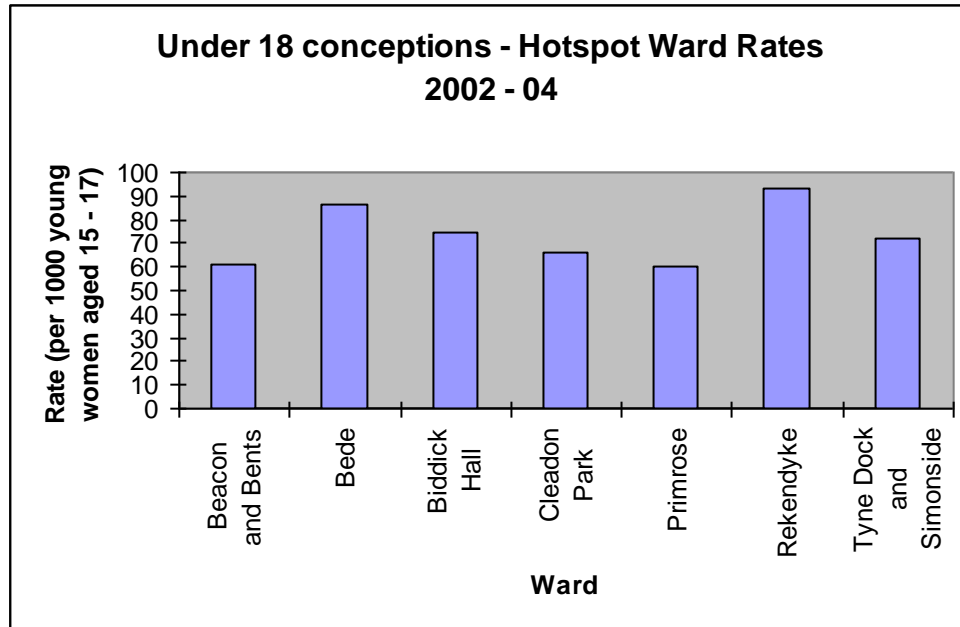
Hotspot areas are wards with an under18 conception rate among the highest 20% in England. Out of the 20 wards in South Tyneside, nine were identified as 'hotspot' areas based on the 2000 – 02 data.

<b>Primrose</b>	<b>Biddick Hall</b>	Boldon Colliery
<b>Bede</b>	Hebburn Quay	<b>Cleadon Park</b>
<b>Rekendyke</b>	Whiteleas	Horsley Hill

Teenage conception data for the aggregated years 2002 – 2004 was received in January 2007. This data highlights only seven wards remaining to fit the criteria for a 'hotspot' ward (Rate above 54.3 per 1000). The data also demonstrates that there has been a change in 'hotspot' wards as the latest data contains five of the original nine with two further additions. Four of the original nine ward level conception rates have moved below the level to fit the criteria as a 'hotspot ward'. However it is important to note that ward conception numbers are relatively small (even when aggregated over three years) and thus rates should be interpreted with some caution as they can vary markedly from year to year. Despite this level of caution this apparent reduction in 'hotspot' wards signals a shift in South Tyneside and provides an indication for the third indicator highlighting a move

towards a reduction in inequality between wards in South Tyneside and the National average.

**Hotspot wards 2002 – 04 (Rate over 54.3 per 1000 young women aged 15 – 17)**



**Ethnicity**

Young women from certain ethnic groups have been outlined nationally at an increased risk of teenage conception. This finding is not reflected locally with young women from a 'white' ethnic background featuring disproportionately in the teenage conception rate when compared to the national average (98.6% versus 89.3%. The only other small ethnic population group featuring within this rate in South Tyneside is the Bangladeshi population who comprise 1.4% of the teenage conception rate in South Tyneside compared to 0.7% nationally (ONS, 2001).

Population	South Tyneside	England
White	98.6%	89.3%
Bangladeshi	1.4%	0.7%

Whilst in South Tyneside the Bangladeshi proportion of the total teenage conceptions is low compared to the white population it is important to note that BME groups only make up 2.7% of the total population in South Tyneside.

**8.2 Births**

**Indicator description**

- General fertility rate: total live births per 1, 000 female population aged 15 – 44 (2004)
- Percentage breakdown of age-specific live birth rates by age group of mother (2004)
- Total Period Fertility Rate: a measure of the average number of live-born children per woman if women experienced the current age-specific fertility rates throughout their childbearing years (2004)

### **Rationale and background**

Delaying childbirth has been shown to increase the risk of miscarriage, multiple births or having a baby with Down's syndrome. According to the HPA (2006) an average of 2.1 children per woman is required to facilitate the population cycle in the long-term.

### **Latest data**

The General Fertility Rate is lower in the North East at 54.10 (per 1000) than the rest of England (58.51) and lower again in South Tyneside (50.34). The Total Period Fertility Rate also highlights South Tyneside as lower than both the North East and the rest of England with 1.64 in South Tyneside, 1.71 in the North east and 1.79 in the rest of England.

By applying these rates to South Tyneside's resident population estimates of women of childbearing age (30, 372 number of female aged 15 - 44) shows approximately 1528 births. Birth data from South Tyneside District Hospital reflects this figure showing that the large majority of these births occur within South Tyneside.

### **Number of maternities at South Tyneside Foundation Trust for 2004/2005 and 2005/2006 (Hospital IT System)**

<b>Year</b>	<b>Number of maternities</b>
2004 / 2005	1427
2005/2006	1468

## **8.3 Chlamydia: New diagnosis**

### **Indicator description**

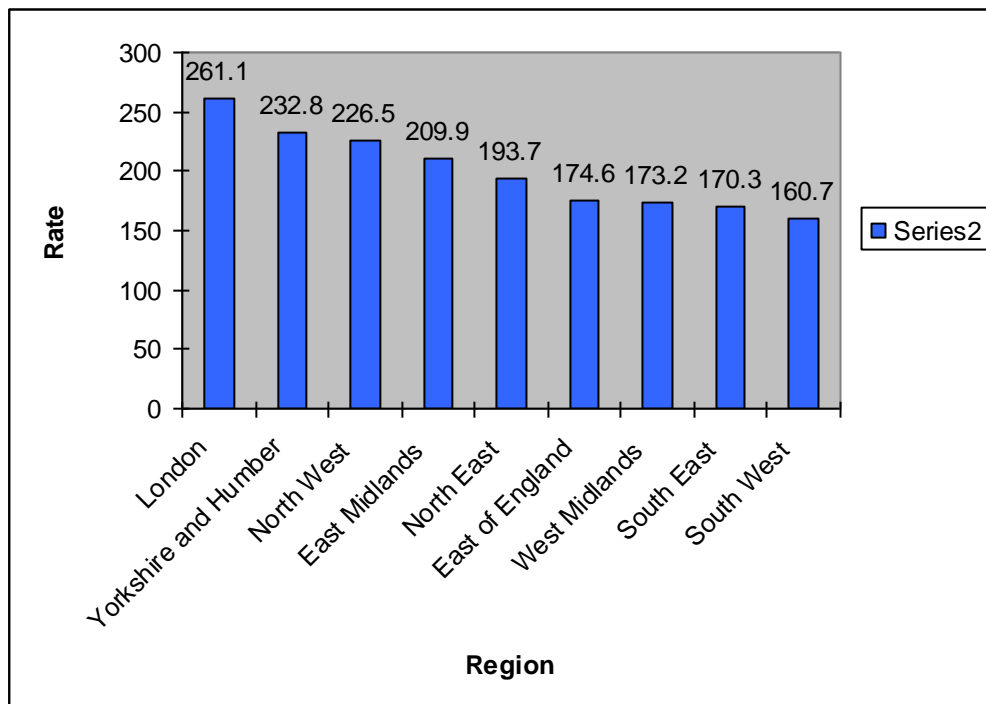
- Rate of new diagnosis of uncomplicated Chlamydia in genitourinary medicine (GUM) clinics (age standardised rate) per 100, 000 population, 2005.

### **Rationale and Background**

Chlamydia is the most commonly curable sexually transmitted infection (STI) diagnosed in genitourinary medicine (GUM) clinics during 2003

(HPA, 2004). In England the number of uncomplicated Chlamydia diagnoses rose by 5% between 2004 and 2005 (HPA, November 2006). The percentage change in diagnoses between 1996 and 2005 demonstrated a 234% increase in the UK (HPA, November 2006). However again the picture is variable between regions with the highest rate being in London (340 per 100, 000) and the lowest being in the South West (161.8 per 100, 000). Just over half of those testing positive for the infection during 2005 were women (53%, HPA and APHO, 2006). This significant increase were attributed to a variety of aspects including increased testing, increased public awareness alongside increased transmission. Regional variation has been partly attributed amongst other things to a variation in testing patterns. It is therefore crucial to note that Northumberland, Tyne and Wear Strategic Health Authority had not begun a programme of screening when this data was collected. Screening in South Tyneside began as part of a regional approach in January 2007.

**Rate of new diagnosis of chlamydia in GUM clinics per 100, 000 population, 2005 (Population aged over 13) Age - Standardised**



The risks associated with Chlamydia Trachomatis are varied and serious. Chlamydia Trachomatis is largely asymptomatic with 70% of women and 50% of men (CMO, 1998). However the sequelae associated with Chlamydia is often serious, particularly for women. One of the most commonly reported sequelae is Pelvic Inflammatory Disease (PID) (La Montange et al 2004). Ectopic pregnancy is also a potential complication of chlamydia with possible life threatening consequences. The CMO report estimates that chlamydia is the cause of 40% of all ectopic pregnancies.

La Montange et al (2004) notes that areas involved in the NCSP have reported reductions in the prevalence and incidence of PID. This evidence reiterates previous data highlighted in the CMO report documenting a study in the USA that found introducing a targeted Chlamydia Screening Programme reduced the incidence of PID by 53% (Grun et al, cited in CMO, 1998).

Other risks to health include cervical cancer (National Strategy for Sexual Health and HIV), eye infections in newborn babies (HPA), chronic pain, urethritis, epididymitis, Reiters syndrome (La Montange et al 2004), vaginal discharge, cervical abnormalities and upper reproductive tract infection (CMO 1998). The CMO report 1998 highlighted Westrom (1982) who showed that 8% of those testing positive for Chlamydia also had Salingitis. The CMO report also noted that the younger a woman was the increase in risk of developing complications

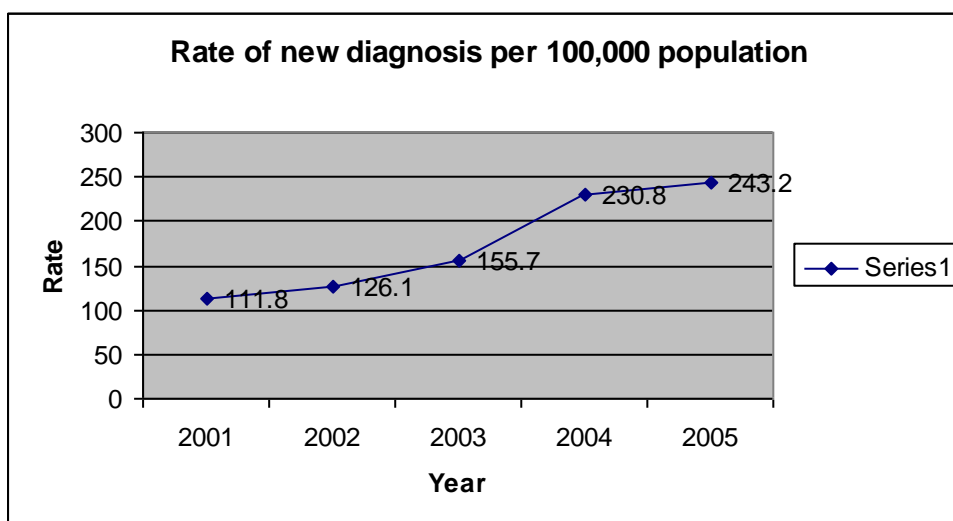
### **North East**

The North East has reflected this national increase showing a significant increase in the diagnosis of Chlamydia over the past 10 years. This increase has been in all groups but with a disproportionate increase amongst men who have sex with men (MSM). HPA data updated on 22<sup>nd</sup> November 2006 highlights this increase also showing that the North East make up 5% of total diagnosis across the UK.

<b>Population</b>	<b>% increase between 2004 / 2005</b>	<b>% increase between 1996 / 2005</b>
Male	11%	204%
MSM	49%	2650%
Female	1%	165%

### **Northumberland, Tyne and Wear SHA Incidence of Chlamydia**

Northumberland, Tyne and Wear Strategic Health Authority area have an average rate of 243.2 per 100, 000 in 2005 (HPA, 2006). This figure varies dependent on the age of the population with a significantly higher rate of 1889.8 (per 100, 000) for young women aged 16 – 19 and 1412.3 (per 1000) young men aged 20 - 24. For young people under 25 including under 16s the rate is 947.3 per 100, 000. Excluding the under 16 rate as this distorts the prevalence this figure rises to 1380 per 100, 000 young people aged 16 to 24. This rate of chlamydia diagnosis has increased dramatically over the past 5 years from an overall rate of 111.8 in 2001.



The figures are met with some caution as they represent diagnosis in GUM and thus exclude diagnosis in GP's, family planning, young people's clinics etc. The data also clearly excludes undiagnosed infection in those not tested and therefore indicates levels of incidence not prevalence.

### Estimated incidence (South Tyneside 2005)

By applying the Northumberland, Tyne and Wear SHA rates (HPA, 2006) to the population estimates for South Tyneside (ONS) it is possible to estimate the expected incidence.

Age	Male	Female	Total	Population Estimates ONS 2005	Estimated incidence - South Tyneside (number)
<16	10.9	157.6	82.0	6181 (13 – 15 years)	5
16 – 19	767.4	1889.8	1316.4	8, 697 (15 – 19 years)	114.5
20 – 24	1412.3	1475.3	1443.6	9, 289	134.9
25 – 34	517.4	331.6	422.9	17, 187	72.9
35 – 44	139.1	35.7	86.4	22,750	19.6
45+	12.7	6.0	9.2	20, 628 (45 – 54 years)	1.9
<b>Total</b>	<b>235.1</b>	<b>250.8</b>	<b>243.2</b>		<b>348.8</b>

### Estimated prevalence

The disparity between the observed incidence of Chlamydia and the expected incidence is the difference between the number diagnosed and the expected (based on evidence). This aspect is particularly crucial when exploring variation in South Tyneside as no routine screening programme has been available at the point of data collection thus any observed rate specified is naturally lower than the expected rate.

Data from the National Chlamydia Screening Programme (1<sup>st</sup> April 2003 – 31<sup>st</sup> March 2006) found that the prevalence of the infection was 10.4 % for women and 10.7 % for men. It has been outlined that there are varying diagnosis levels based on both age (as above) and the screening venue ranging from 17.3% in GUM clinics to 8.1% in general practice (Adams et al 2004). As with other STI's patterns of prevalence are acknowledged to differ based on both levels of sexual activity and risk taking. It follows therefore unsurprisingly that people accessing GUM will fit the criteria for 'risk' than a more general audience in General Practice.

Accepting the NCSP findings from the second year of the programme suggests that 10.4% young women and 10.7% of young men have Chlamydia. This figure is taken from the screening group aged 15 – 24. In order to apply this figure to the under 16 population consideration is required as to the proportion of young people sexually active. As Adams (2004) suggests sexual behaviour is a crucial determinant of prevalence and young people accepting the screen are likely to be sexually active and thus a distortion of the figures is possible. In order to facilitate this estimate data has been taken from the NATSAL survey (2001) in relation to the proportion of young people sexually active by aged 16.

**Estimated prevalence of Chlamydia infection in young people under 16 in South Tyneside**

Total aged 13 - 15	Estimated number by gender	NATSAL estimates for sexual activity	South Tyneside Estimate number sexually active	Estimated incidence under 16 with Chlamydia
6181 (approximate)	3090	38% of young women sexually active (North East average)	1174.2	122.11
	3090	25% of young men sexually active (North East average)	772.5	82.65



This estimate suggests that there is a significant proportion of unmet need in relation to under 16 Chlamydia diagnoses with the HPA data showing diagnosis of approximately 3.2 compared to the estimate based on the NCSP findings showing a prevalence of approximately 122 young women and 83 young men under 16.

### **Estimated prevalence of Chlamydia infection with young people over 15 by age (South Tyneside)**

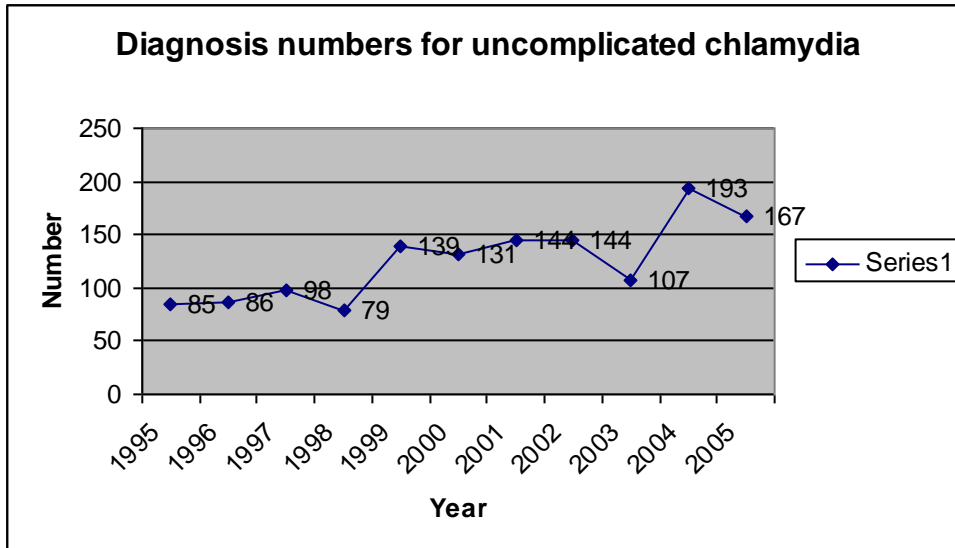
The prevalence calculations for this table have been based on estimated levels of sexual activity ranging from a median age of 16 for first sexual intercourse to Brook's (2000) estimate of 90% sexually active by age 20. For this purpose two figures have been provided for the 15 – 19 age group to show the scope of the possible prevalence based on 50% (NATSAL, 2001) or 90% (Brook, 2000) of the population being sexually active.

<b>Age group</b>	<b>Total population (10.55%)</b>		<b>Male (10.7%)</b>		<b>Female (10.4%)</b>	
16 – 19	8, 697		4348.5		4348.5	
Proportion sexually active (estimated)	50% 4348.5	90% 7827.3	50% 2174.25	90% 3913.6	50% 2174.25	90% 3913.6
<b>Estimated prevalence</b>	<b>458.8</b>	<b>825.8</b>	<b>232.6</b>	<b>418.8</b>	<b>226.1</b>	<b>407</b>
20 - 24	9, 289		4, 674		4, 615	
Proportion sexually active (estimated)	90% 8360.1		90% 4206.6		90% 4153.5	
<b>Estimated prevalence</b>	<b>881.99</b>		<b>450.11</b>		<b>431.96</b>	

Using these calculations it could be estimated that the total prevalence of Chlamydia in South Tyneside within the 13 – 24 age group ranges from **1546 to 1913** (dependent on levels of sexual activity). This 'expected' number is much higher than the number outlined by applying the SHA rate to the population estimates (ONS) suggesting a significant proportion of unmet need.

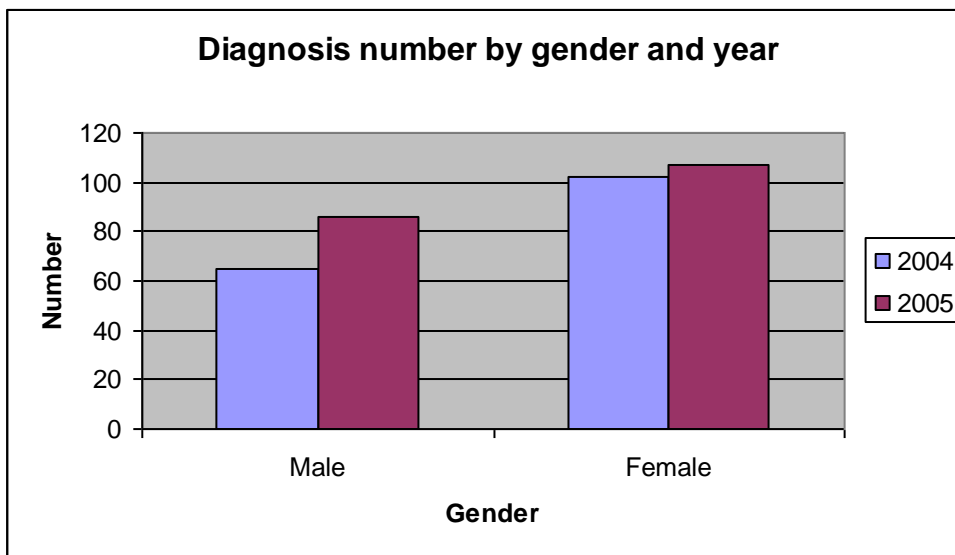
### **South Tyneside Data (KC60)**

Data presented using South Tyneside's KC60 returns highlight that the number diagnosed with chlamydia infection (observed number) differs from the expected number based on the SHA rates (number 374.3). This disparity reinforces further the suggestion of a significant level of unmet need in relation to the South Tyneside population



### Rates of diagnosis by gender in South Tyneside

Data for South Tyneside between 2004 and 2005 shows despite an overall increase in diagnosis there is consistently higher diagnosis numbers within the female population.



### Rates of diagnosis in South Tyneside (April – December 2006)

This gender inequity appears to have reversed in relation to diagnosis between April and December 2006 with a slightly higher incidence of Chlamydia within the male population. With recognition that this data relates only to a part year and an acceptance that the total for the financial year 2006 / 07 will be considerably higher it is interesting that this gender balance has reversed reflecting the diagnosis balance identified within the NCSP.

<b>Diagnosis</b>	<b>Females</b>	<b>Males</b>	<b>Total</b>
Complicated Chlamydial Infection – Including PID and epididymitis	3	3	6
Epidemiological treatment of NSGI	9		9
Epidemiological treatment of suspected Chlamydia	25	41	66
Uncomplicated Chlamydial infection	75	73	148
Uncomplicated non-gonococcal / non-specific urethritis in males or treatment of mucopurulent cervicitis in females	3	43	46
Chlamydia infection - Diagnosed outside GUM (Grapevine Clinics)	6	0	6
<b>Total</b>	<b>115</b>	<b>160</b>	<b>281</b>

**Expected number of positive diagnosis if the LDP targets are met (based on an estimated overall prevalence level of 10.55% within the 15 – 24 age groups)**

Quarter	Number of Screens	Number of positive diagnosis expected
Q4 (2006 / 2007)	373	39.35
Q1 (2007 / 2008)	746	78.7
Q2 (2007 / 2008)	746	78.7
Q3 (2007 / 2008)	746	78.7
Q4 (2007 / 2008)	746	78.7
<b>TOTAL</b>	<b>3357</b>	<b>354.16</b>

If this screening target is achieved this would identify between 18.5% and 23% of the estimated infected population in South Tyneside by March 2008.

#### **8.4 Pelvic Inflammatory Disease (PID)**

##### **Indicator description**

- Rate of hospital admissions for PID (recorded as a primary diagnosis, age-standardised rate) per 100,000 female population 2004/05.
- Rate of hospital admissions for ectopic pregnancy in women aged 15 – 44 (recorded as primary diagnosis, age standardised rate) per 100,000 female population 2004/05)

## Rationale and background

PID describes infection and inflammation of the upper genital tract. This definition includes conditions such as endometritis, salpingitis, tubo-ovarian abscess and pelvic peritonitis. STI's including chlamydia and neisseria gonorrhoea can cause PID although other micro-organisms are also drawn in. Complications of PID may include ectopic pregnancy, infertility and chronic pelvic pain (HPA and APHO, 2006).

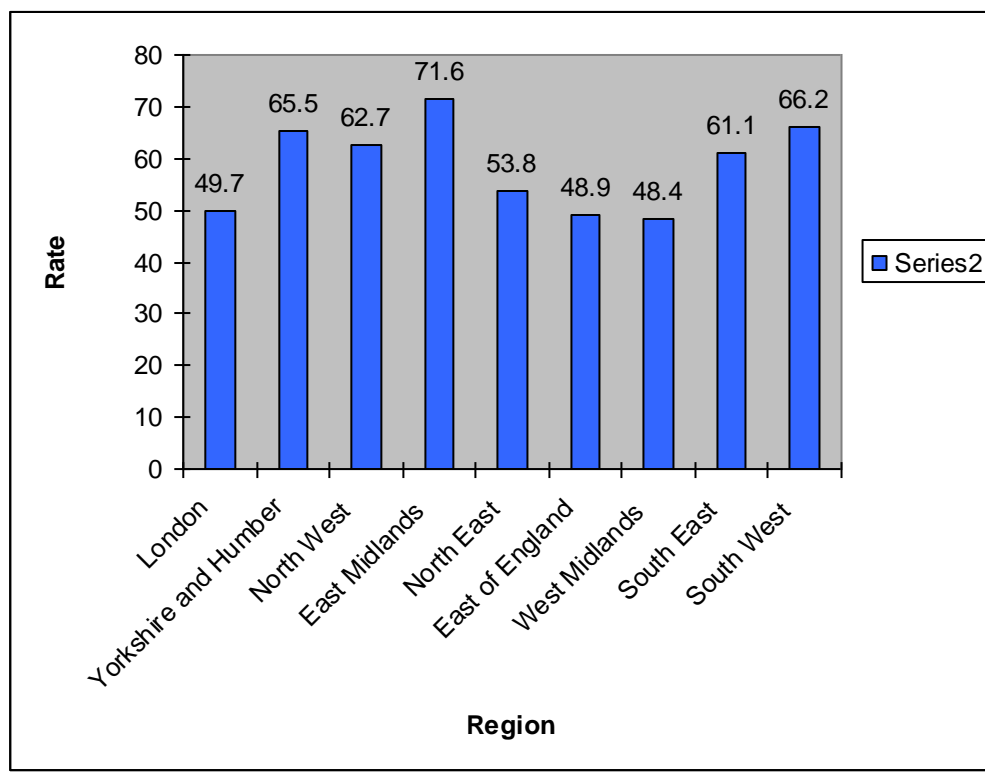
The CMO report (1998) highlights an increase in the last 30 years of hospital admissions for the treatment of acute PID with this trend even more prevalent in women under 30 years of age. 81% of PID admissions were within the 15 – 44 age group. The highest age specific rates for hospitalisation and treatment of acute PID are women aged 30 -34 and 35 - 39 years (HPA, APHO, 2006). PID has been linked to Ectopic Pregnancy and Infertility with estimates that around 17% of women treated for PID become infertile (CMO, 1998). For ectopic pregnancy women aged 30 – 34 accounted for the largest proportion with 30% with 25 – 29 showing 25% and 35 – 39 with 20% of the total. Further estimates have shown that of all cases of infertility 50% is caused by PID and 10% of women with PID who do conceive experience and ectopic pregnancy (CMO, 1998). The CMO report highlights that in industrial countries ectopic pregnancy is the leading cause of maternal deaths in the 1<sup>st</sup> trimester where Chlamydia is estimated to cause 40% of all ectopic pregnancies.

## Hospital Admission Rates

Hospital admission rates per 100,000 females in 2004 / 05 in South Tyneside show a crude rate of 52.9 per with an age standardised rate of 56.7. The actual number of admissions was 41. These rates are higher than the North East average of 52.1 and 53.8 but lower than the England average at 57 and 58 respectively.

Area	Admission Number	Crude Rate	Age – Standardised Rate
England	14, 558	57.0	58.0
North East	681	52.1	53.8
South Tyneside	41	52.6	56.7

**Age Standardised rate of PID admissions (primary diagnosis)  
2004/05 per 100,000 females in 2004/05**



## 8.5 HIV

### Indicator description

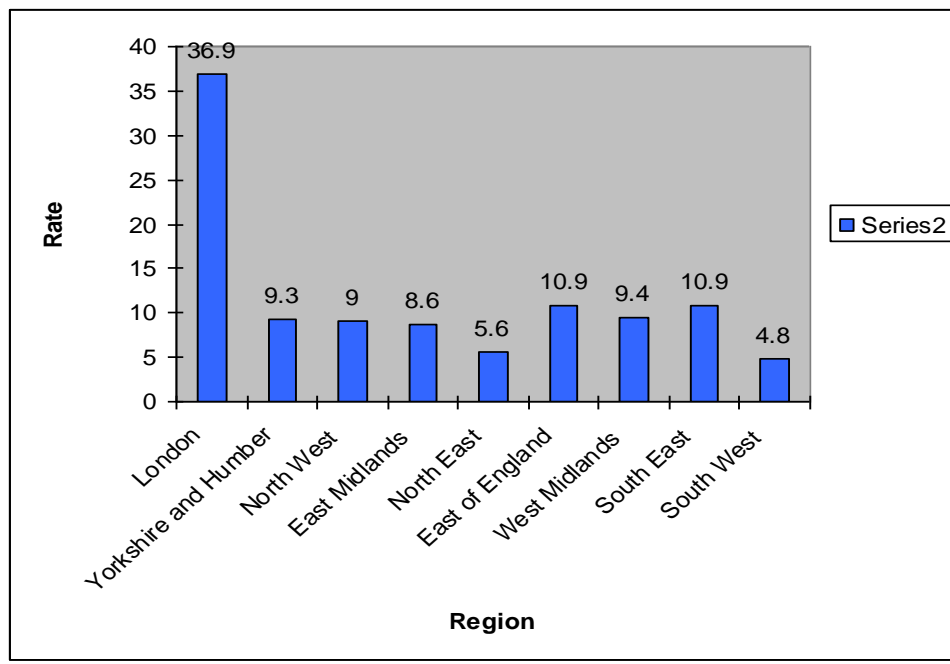
- Rate of new HIV diagnoses (age-standardised) per 100,000 population, 2004;
- Percentage change in rates of new HIV diagnoses, 2002-04;
- Percentage breakdown of how infections were acquired in terms of heterosexual contact, sex between men or other exposure route, 2004;
- Percentage breakdown of where infections in heterosexuals were acquired – categorised as UK, Africa or 'other world region', 2004
- An estimate of incidence of HIV (newly acquired infections) in men who have sex with men (MSM) 1995 – 2004, comparing London with other regions combined.

### Rationale and background

2006 marked the 25<sup>th</sup> anniversary of the first reported case of AIDs in the UK. During this period epidemiological trends have varied alongside a shift in the patterns of transmission. Early HIV diagnosis was principally reported amongst men who have sex with men (MSM), recipients of blood products and injecting drug users (HPA, 2006). From 1999 a move in reported diagnosis occurred with a rise in diagnosis amongst the heterosexual population (HPA, 2006).

The HPA (2006) provided evidence outlining in 2005 there were approximately 63,500 adults aged 15 – 59 in the UK living with HIV-infection. This figure includes an estimate of 32% of the total prevalence attributed to people living with undiagnosed HIV (circa 20,100). Diagnosis rates of HIV highlights that a significant proportion of newly acquired infections were within the population of men who have sex with men (MSM). Estimates suggest that of the total MSM population accessing GUM services the incidence of HIV is 3.2% in London with 2.4% in the rest of the country. The prevalence of previously undiagnosed HIV infection in MSM which is measured with HIV-infection diagnosed in the under 25 year age group (an indicator for recent transmission) 1.3% (outside London). Nearly half of all new HIV-infection diagnosis was within London (46%) with the North East region second lowest in the country (6 per 100,000)

**Age-standardised rate of new diagnosis of HIV per 100,000 population, by Region, 2004**



Of the HIV-infected heterosexual population a significant proportion have been acquired in Africa (1996 = 67%, 2005 = 68%). Women screened antenatally have shown to have an prevalence of 0.13% in 2005 with 0.09% of these being amongst women who were previously undiagnosed. However again there is significant variation with antenatal prevalence rates at 0.21% in London and 0.04% everywhere else in England and Scotland. 82% of children with HIV-infection acquired their infection from their mother. With 89% of mother to child transmission cases the mother was infected in Africa. The majority of children remaining were infected with HIV-Infection through blood or blood products before viral inactivation of blood products commenced. (All data taken from the HPA annual report, 2006)

Minority ethnic groups have been shown to have varying risk for HIV levels with a prevalence of 3.6% amongst Black Africans and 0.3% amongst Black Caribbean's living in the UK. Within the white heterosexual population the prevalence is estimated at 0.08%.

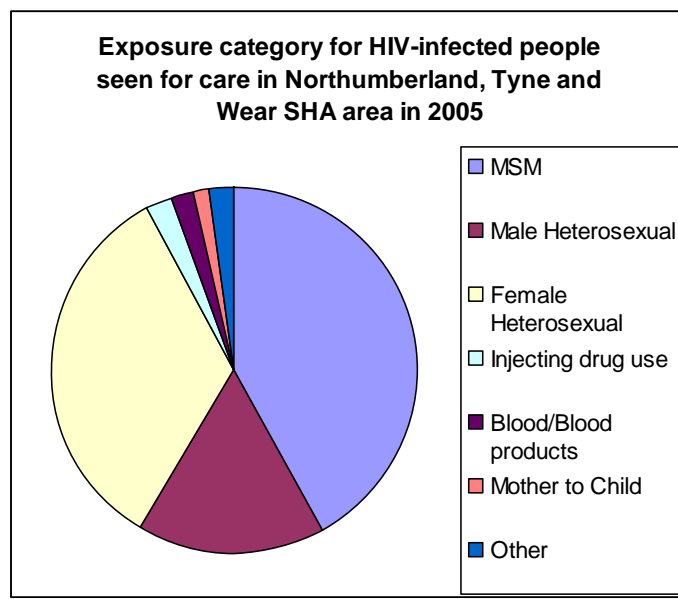
### Diagnosis levels

Data included here is based on the HPA calculations for the year 2004. Rates are calculated per 100, 000 of the population.

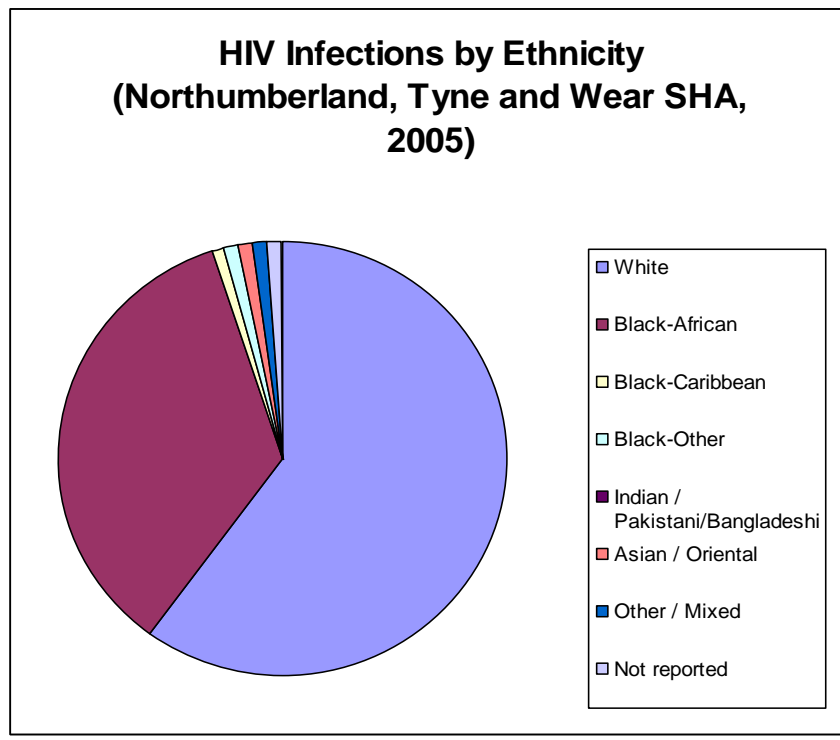
North East			Northumberland, Tyne and Wear SHA		
		<b>+32% Unknown</b>			<b>+32% Unknown</b>
Number of new diagnosis	139	<b>183</b>	Number of new diagnosis	105	<b>139</b>
Crude rate	5.5	<b>7.26</b>	Crude rate	7.5	<b>9.9</b>
Age standardised rate	5.6	<b>7.392</b>	Age standardised rate	8.0	<b>10.56</b>

During the year 2005, 754 people were seen for HIV care in the North East (SOPHID, HPA, 2005). Applying the unknown estimate (HPA, 2006) to this figure shows that there are approximately a further 241 people living in the North East with undiagnosed HIV-infection. Within the Northumberland, Tyne and Wear SHA levels of HIV-infection appear higher comprising approximately 67% of the total number in the North East (507 individuals). Of these 507 individuals approximately 50% of people seen for care were infected through heterosexual contact (16.3% men, 33.9% women),

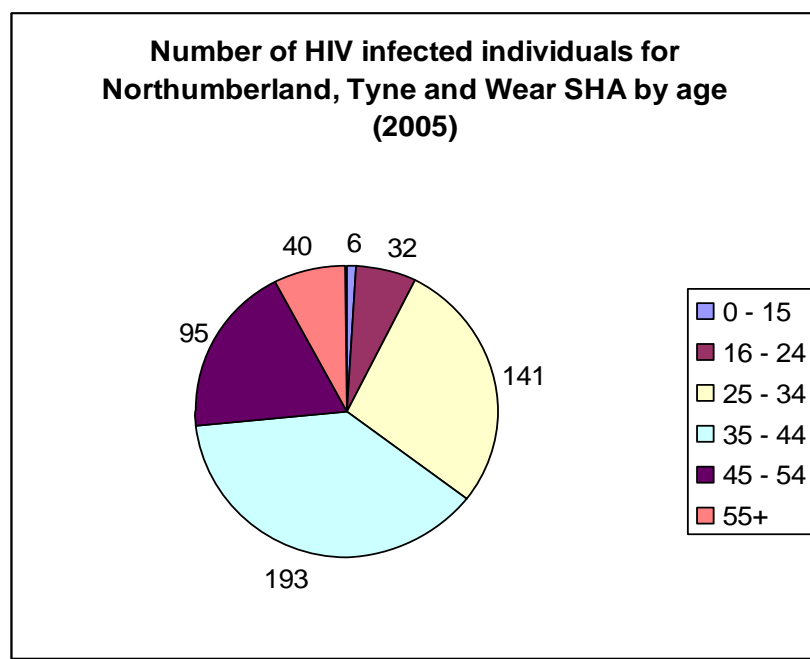
### Exposure method (SOPHID, HPA, 2005) for HIV-Infected People



**Ethnicity of HIV-infected people seen for care in Northumberland, Tyne and Wear SHA during 2005 (SOPHID, HPA, 2005)**

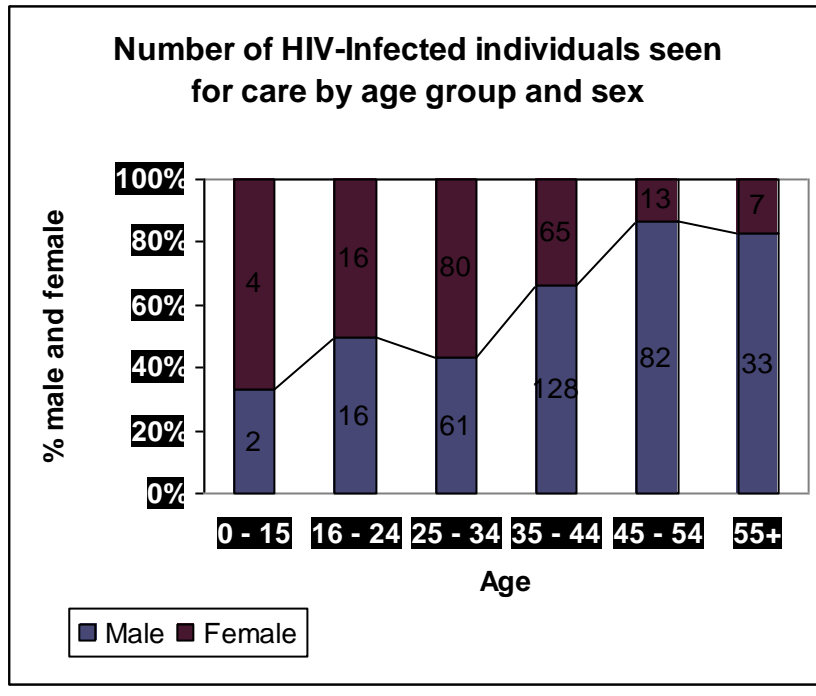


**Numbers of HIV-infected individuals seen for care in Northumberland, Tyne and Wear SHA by age group (SOPHID, HPA, 2005)**



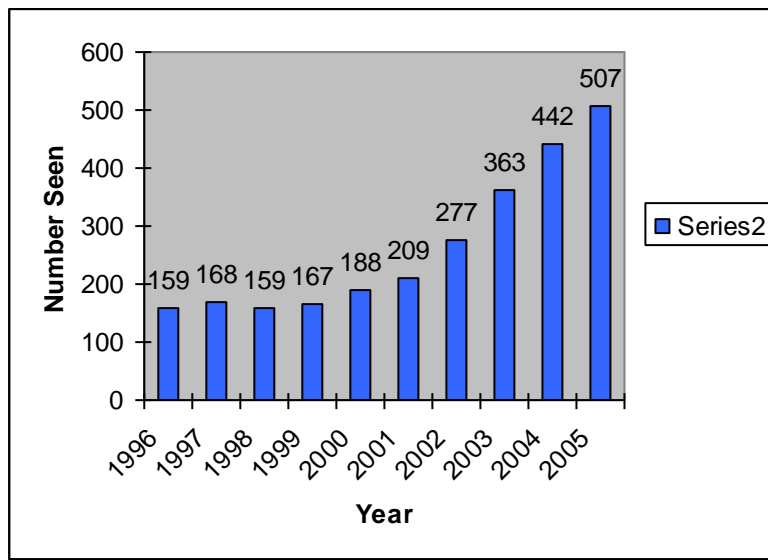


**Proportion of individuals seen for care in Northumberland SHA by age and sex (SOPHID, HPA, 2005)**



**Numbers of HIV-infected individuals seen for care in the region of Northumberland, Tyne and Wear SHA: 1996 – 2005**

Data showing the prevalence of HIV-infected individuals in the Northumberland, Tyne and Wear SHA area demonstrates a significant increase over the past decade (SOPHID, HPA, 2005).



The Survey of Prevalent HIV Infections Diagnosed (SOPHID) provides an insight into method of HIV transmission for people receiving care

during the year 2005. Northumberland, Tyne and Wear data depicts high levels of transmission within both MSM and heterosexual contacts

### **Ethnic variation**

HPA and APHO (2006) outlined evidence showing that 74% of new HIV diagnoses in the UK through heterosexual contact during 2004 were acquired in Africa with just 11% acquired in the UK. The North East showed the highest proportion of heterosexually acquired HIV infection within the UK at 22% (with recognition of small numbers affecting the percentage). Data available through the audit (Barnardos', 2006) highlighted that of families affected by HIV in South Tyneside there were 6 female patients in 2003. Of this total three were Black African, one Indian and two White. By March 2005 a further two women fitted this category and by ethnic origin were Black African. Further data provided by SOPHID (2005) shows that of the HIV-infected population in South Tyneside over half were amongst MSM. Amongst the heterosexual infected population, whilst its recognised to contain small numbers, a majority were attributed to the BME population (70.9%. Number = 12 / 15).

### **Estimated HIV-Infection based on SHA Level and National Rates**

The first estimate has been calculated by applying the Northumberland Tyne and Wear SHA level incidence data (2005) to South Tyneside's population numbers. In addition to diagnosed numbers the HPA (2006) estimate a further prevalence of 32% with unknown infections. This 'unknown' figure has been applied to the estimated observed figures to provide an expected level of annual incidence. The second calculation is derived by applying the national estimate around HIV prevalence within the heterosexual population. As this prevalence figure includes the estimated unmet need the first calculation (estimated incidence) is not required.

Population estimates	Estimated rate / %	Estimated incidence (diagnosis)	Expected (+ 32% unknown)
Total population (over 14) 125, 179	8.0 per 100, 000 population (new diagnosis)	10	13.2
Total white heterosexual population over 15 = 118,419	0.08% (Total prevalence in population including unknown estimate, HPA, 2006)		94.7

There are a number of issues around the application of these estimates that require acknowledgement:

- The national estimates don't account for regional variation and data shows significant regional variation.
- The SHA incidence rate includes diagnosis within Newcastle, Northumberland, Gateshead and Sunderland. Diagnosis levels may vary between areas.
- When applying the 32% unknown figure to the 'known' number provided by SOPHID there is significant variation between different figures.

## **MSM**

Population estimates among men who have sex with men are calculated differently due to a higher incidence. HPA and APHO (2006) suggest that 2.4% (outside London) of the MSM population accessing GUM have the HIV infection. This incidence rate is acknowledged to vary depending on age with the highest incidence in those aged 35 – 44 at 4.5%. Within the under 25 age group the figure shows 1.3% outside London. This last indicator is deemed a valuable indication of recently acquired infection (HPA, 2006). The HPA (2006) estimated an overall prevalence within the MSM population of 8.4% within London compared to 3.6% in the rest of England and Wales (pg. 68).

For the purpose of this needs analysis three different calculations have been provided. Firstly an estimated incidence based on the number of the MSM population accessing GUM services in South Tyneside. Secondly the application of the estimated prevalence based on the total estimated MSM population in South Tyneside (3.6%). Thirdly the application of the estimated age related incidence based on national figures of MSM accessing Gum but applied to the total estimated MSM population within the specific age bands.

The application of these figures to the South Tyneside population provides a particularly crude indicator of potential need for a number of reasons;

- The proportion of the population fitting the criteria MSM is estimated based on NATSAL data (5.4% of the total male population) and may not be a true reflection of local variation.
- Data suggests significant geographical variation with higher rates in parts of the South East and North West which is not accounted for within any of the estimates.
- The first calculation is based on KC60 data which documents MSM accessing GUM. The number of MSM accessing the service is small and thus may not reflect the total number of MSM with potential need. Anecdotal evidence suggests that locally MSM seek services and support elsewhere so the number used for this calculation may not reflect the total need within the MSM population.

- The second calculation is a national estimate and therefore contains the second limitation above. In addition to this the figure includes an estimated 32% unaware of their infection. This estimate of 32% unaware will also be affected by service provision and regional variation and won't necessarily reflect local need.
- The third calculation uses the total estimated MSM population within specific age bands (Under 25 and 35 – 44) and it is vital to recognise that the incidence estimate used was originally based only on the numbers accessing GUM services. These figures will be likely therefore to show a higher number than the true picture.

These figures illustrate extremes of all measures and whilst the calculations are clearly flawed it is vital to acknowledge the importance of this issue and the additional need required within this particular population.

### Estimates based on MSM attending GUM in South Tyneside

Year	Number of MSM accessing GUM	Estimated incidence rate / %	Estimated incidence (diagnosis)	Expected incidence (+ 32% unknown)
2005	34	2.4%	0.816	1.1
2006	22	2.4%	0.528	0.7

### Prevalence estimates based on the total estimated population

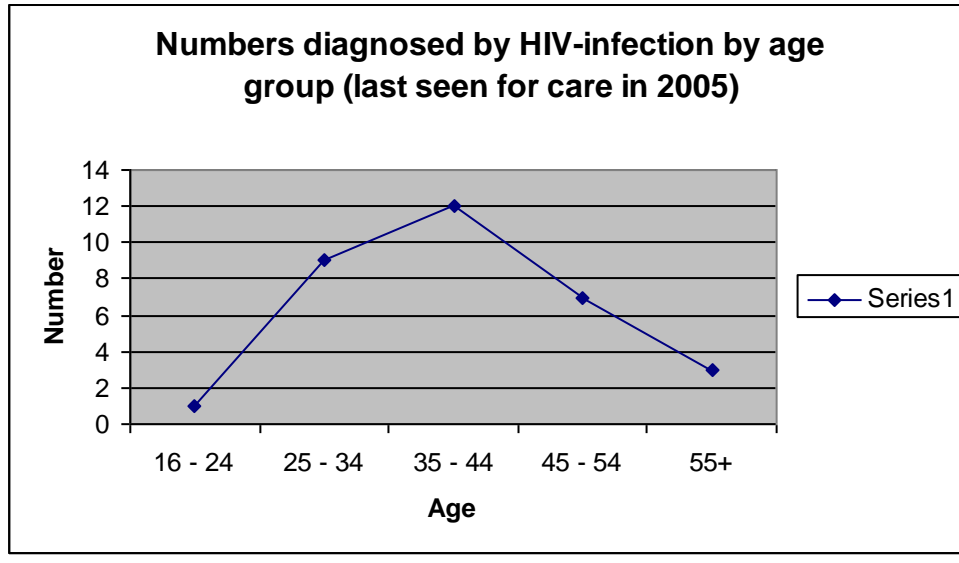
Population estimates	Estimated prevalence rate / %	Estimated incidence (diagnosis)	Expected (+ 32% unknown)
Total MSM population (5.4 % Total male population aged 15 – 44 = 29,500) <b>1593</b>	3.6% of MSM (outside London, HPA 2006)		57.3 (Total prevalence)
Total MSM population, 15 – 25 years (5.4% Total male population 10, 096) <b>545</b>	1.3% (Clinic attendees outside London)	7	9.2 (Incidence)
Total MSM population 35 – 44 (5.4% Total male population 10,954) <b>591.5</b>	4.5% accessing GUM services (National Average)	26.6	35 (prevalence)

### **Local Data (StreetLevel Audit)**

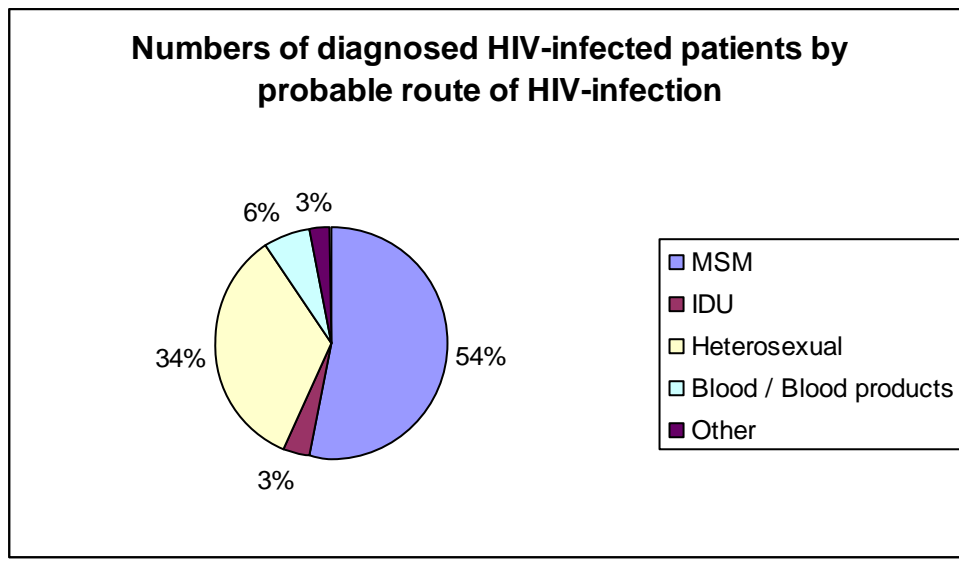
In 2006 South Tyneside PCT commissioned Street Level Barnardos' to complete an audit of HIV need in South Tyneside. This audit presented regional and local data. Activity data taken from Ward 25 South Tyneside Foundation Trust (HIV Outpatient and Inpatient Care) showed that there were a total of 30 patients seen during 2004. This figure had risen from 21 patients in 2003. In addition to this number a further 2 cases were identified as receiving care from either a different ward or region. The audit outlined GUM diagnosis figures which demonstrate that there were only 3 positive diagnoses for HIV infection between the years 2002 and 2004 (2001 = 1, 2004 = 2). However anecdotal data suggested that the majority of people supported by the HIV Case manager (Street Level, Barnardos') were diagnosed elsewhere. The audit also presented data from consultation questionnaires which highlighted that 67% of respondents were diagnosed elsewhere (8/11). The audit identified 32 people receiving care in South Tyneside for HIV and acknowledged the contribution of a further unknown proportion. By applying the HPA (2006) figure of 32% unknown this shows approximately 42 people living in South Tyneside infected with HIV. This number is significantly lower than the prevalence estimates based on HPA diagnosis rate (2004) or the HPA (2006) population estimate suggesting that South Tyneside has a relatively low diagnosis rate compared to the national and regional average or that the level of undiagnosed infections is higher than the estimated average (32%).

### **HIV – SOPHID data – South Tyneside**

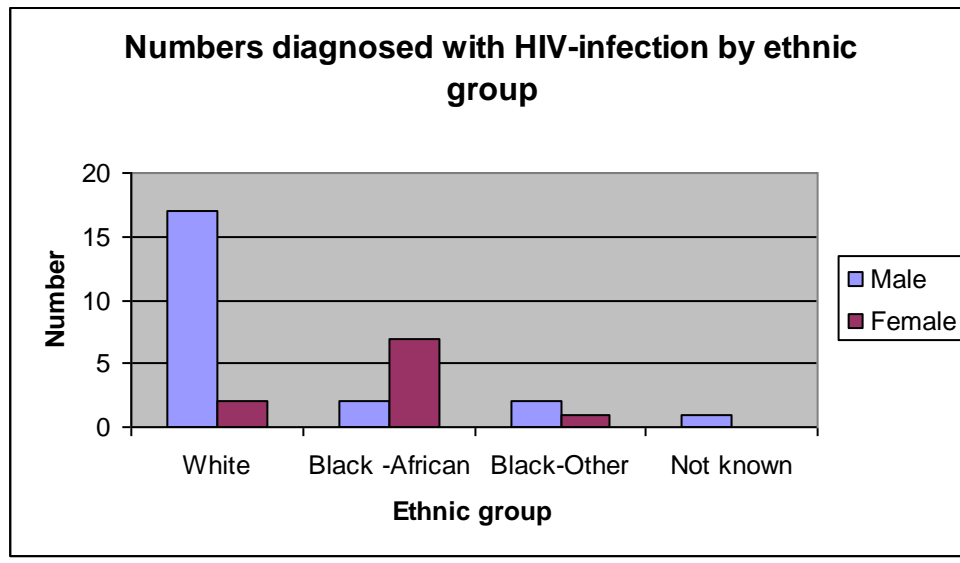
Data provided by the Survey of Prevalent HIV Infections Diagnosed (SOPHID) shows based on data for HIV-Infected patients last seen for care in 2005 in South Tyneside there is a peak in people living with HIV within the age group 35 – 44. This peak reflects national analysis of a higher rate in this age group within the MSM population.



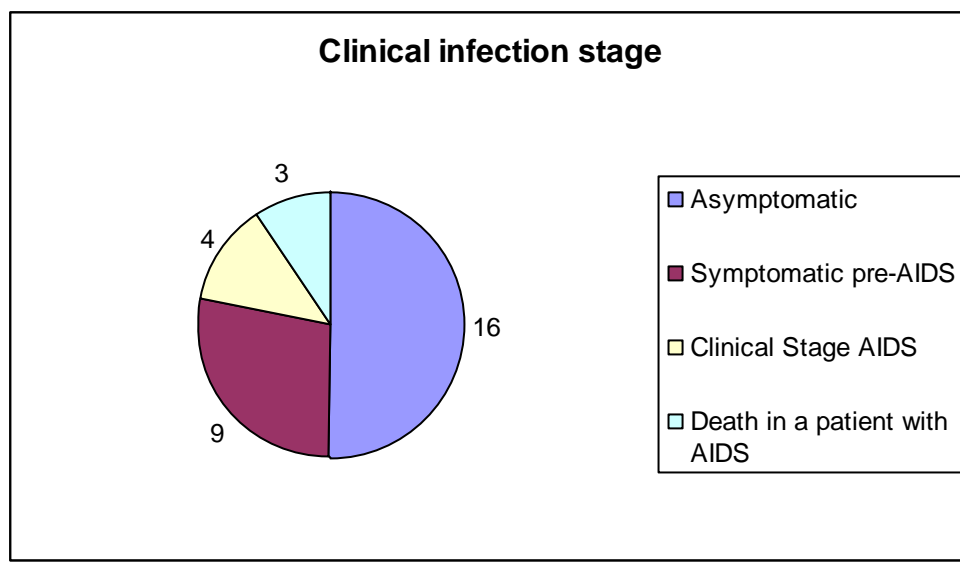
Based on the data provided by SOPHID there are 32 people living with HIV in South Tyneside. Within this number there were 22 men and 10 women. Possible route of infection shows that 54 % MSM, 3% IDU, 34% heterosexual, 6% Blood / blood products, 3% other.



Ethnicity and gender distribution of HIV-infection in South Tyneside highlights that for the male HIV-infected population the majority are white (77%) in direct contrast to the female HIV-infected population who are largely black-African (70%). Excluding the variation between genders the majority of HIV-infected people in South Tyneside were white (59%) with the remaining people comprising black-African, black-other or unknown.

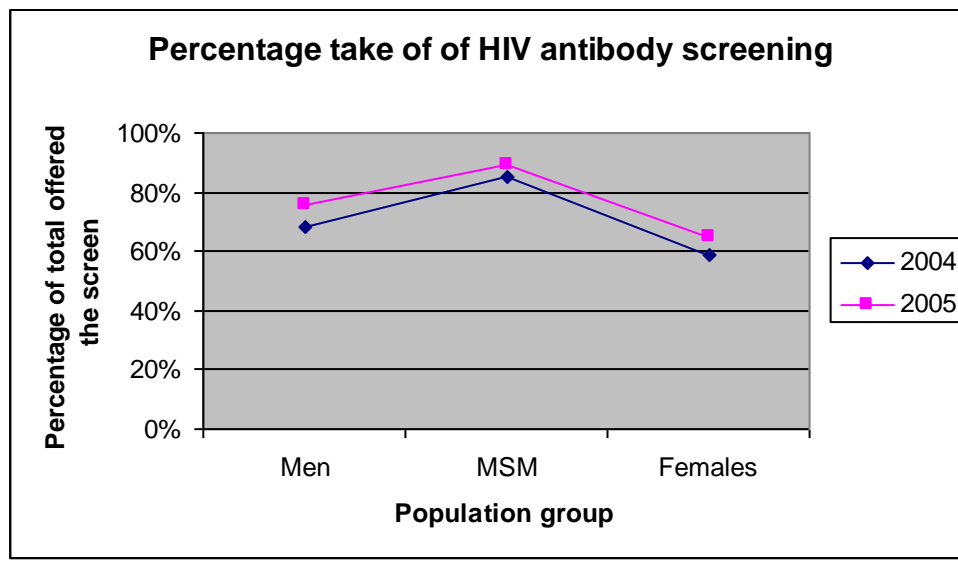


Numbers of diagnosed HIV-infected patients by most advanced clinical stage of infection and level of anti-retroviral therapy when last seen for care.



### Take up of HIV screening

Data collected on South Tyneside's KC60 template demonstrates a variation in the take up of HIV antibody testing. The data for 2004 and 2005 reflects an increase in take up across all population groups with MSM being the most likely group to accept the test. Females remain the group with the least likely take up of HIV screening ranging from 58.78% in 2004 to 65.04% in 2005. The percentage overall shows take up of the screen rising from 64.32% in 2004 to 71.45% in 2005. This data outlines a considerable number of people not accepting the screen.



## Conclusion

There are a variety of indicators estimating both incidence and prevalence of HIV infection amongst different population groups. By applying these figures to the South Tyneside population estimates this demonstrates a significant variation in the expected rate.

For the purpose of needs analysis with a note of caution due to unidentified regional variation it is possible to provide an expected number of 57 MSM and 95 heterosexual people within the South Tyneside population living with HIV-Infection (including the estimated 32% unknown). This picture clearly doesn't reflect the local known picture even after applying the possible 32% unknown.

When considering the currently observed local prevalence of 32 and applying the 32% unknown an estimate of approximately 10 people living with undiagnosed HIV could be predicted. However as outlined when applying the national prevalence estimates to the local population a significantly higher unmet need could be estimated. Whilst accepting the limitations around all estimates presented consideration is required that due to previously lower levels of GUM attendance (particularly within the MSM population) there may be a higher proportion of unmet need in South Tyneside than the national estimate reflected in the variation in expected rate.

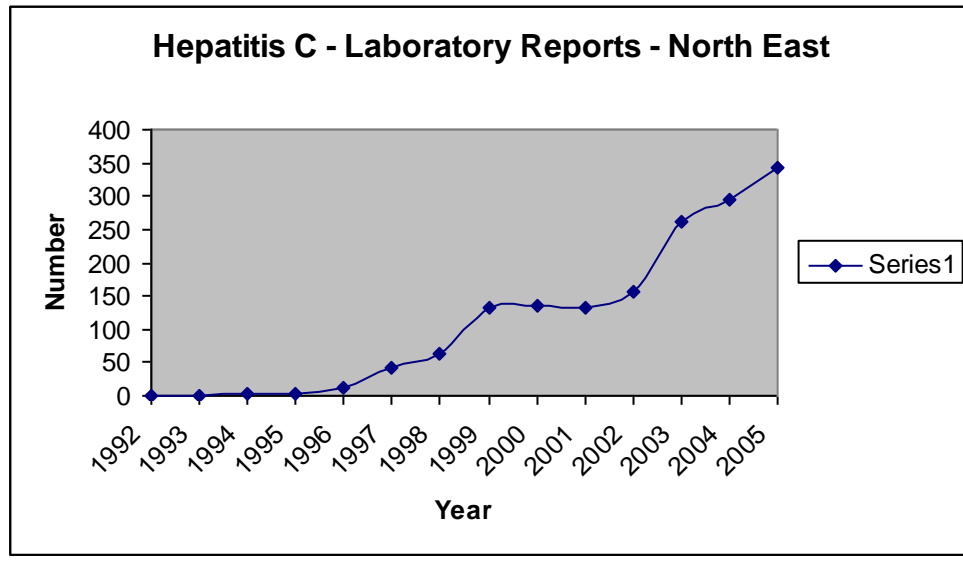
The South Tyneside Audit (Barnardos', 2006) shows that of all HIV-infected respondents included in the survey only a minority were diagnosed in South Tyneside (approximately 27%). This data further reflects either a significant unmet need in relation to South Tyneside or a lower prevalence both than other areas in the SHA or national prevalence with an expectation from local services that it is somewhere in between.



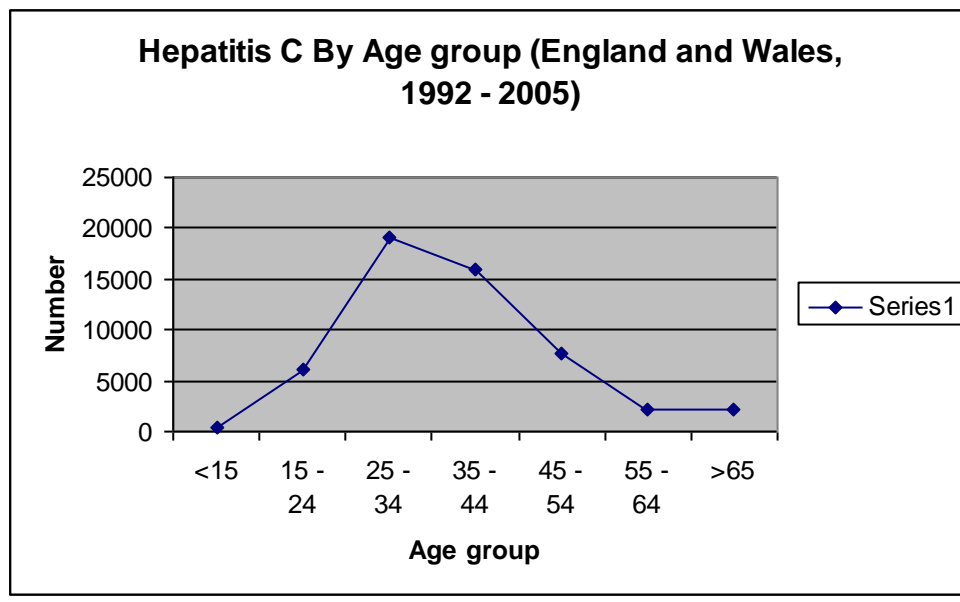
## 8.6 Hepatitis

### Hepatitis C

Data provided by the HPA (July 2006) demonstrates an undoubtedly increasing trend in Hepatitis C diagnosis within the North East Region.



When national incidence data is further analysed and age range extrapolated based on all incidence between 1992 and 2005 it emerges that there is a clear peak between the ages of 25 and 34. This apparent age related peak is reflected in the year on year data.



### KC60 - Hepatitis incidence

Data provided through the KC60 collection shows small numbers of Hepatitis B incidence between 2004 and 2005 (calendar years). During

2004 two men were diagnosed with Hepatitis B with a further three diagnosed with other viral hepatitis. According to the KC60 data none of the infections were homosexually acquired during this period. In 2005 there was just one viral hepatitis diagnosis and one viral hepatitis C diagnosis. Again neither of these are recorded as homosexually acquired.

## **8.7 Gonorrhoea**

### **Indicator description**

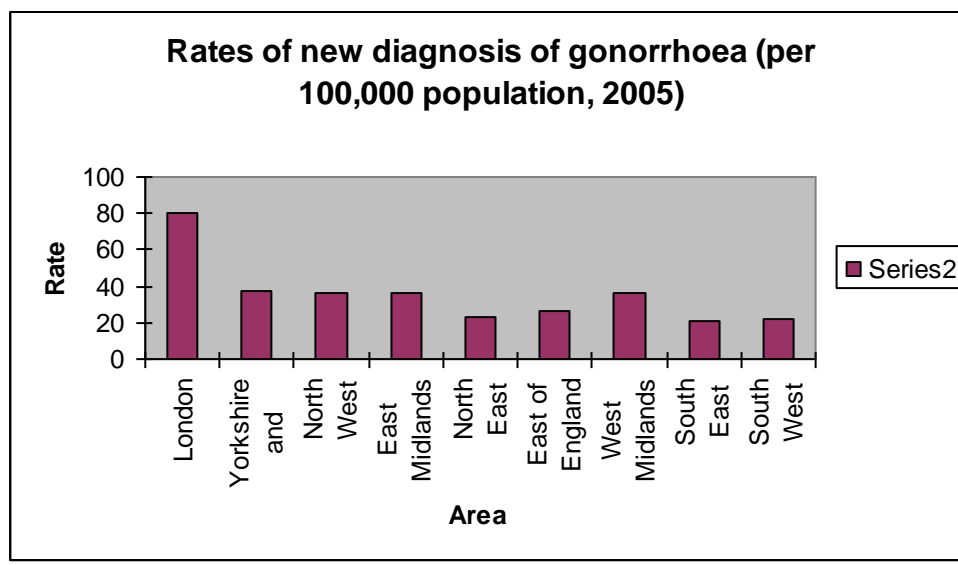
- Rate of new diagnosis of uncomplicated gonorrhoea in GUM per 100,000 population, 2005
- Percentage change in crude rate of new diagnoses of uncomplicated gonorrhoea in GUM clinics, 2002-05
- Percentage of Neisseria gonorrhoea isolates from sentinel GUM clinics demonstrating resistance to the antibiotic ciprofloxacin, 2000-04

### **Rationale and background**

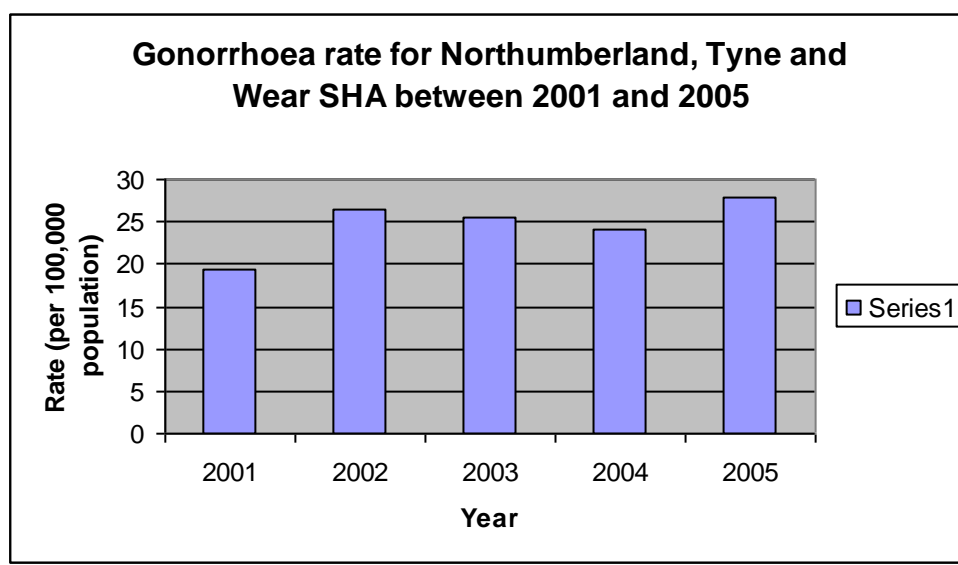
Gonorrhoea is the second most common STI diagnosed within GUM clinics nationally (APHO & HPA, 2006). The risks associated with Gonorrhoea are varied and serious for all. However the sequelae associated with Gonorrhoea is often serious for women with very similar outcomes to that of chlamydia including, PID, ectopic pregnancy and infertility. There has been a national decrease between 2003 and 2005 with the majority of diagnosis in 2005 within the male population (72%). This inequality is less surprising as women may be asymptomatic whereas men are more often symptomatic (HPA, 2006). The most affected age groups were women between 16 and 19 and men between 20 and 24. The HPA and AOPHO (2006) outline stark inequalities in prevalence within MSM communities, some black communities and amongst young women.

Treatment of gonorrhoea is further exacerbated by the capacity of Neisseria gonorrhoea to demonstrate resistance to the antibiotic ciprofloxacin. An increase in resistance in England has been noted between 2003 (9%) and 2004 (14%). This increase has been documented as exclusively due to an increased resistance in the MSM population (HPA and APHO, 2006).

As with other STIs there is significant geographical variation in the rate of people diagnosed with gonorrhoea. This table depicts age-standardised rates by region based on diagnosis within GUM services.



The National Strategy for Sexual Health and HIV includes a target to reduce (based on the 2002 data) by 25% the rate of gonorrhoea by 2007. Nationally rates have fallen between 2002 and 2005. This picture doesn't appear to be replicated in the local SHA area with a small increase in 2005 above the rate for 2002.



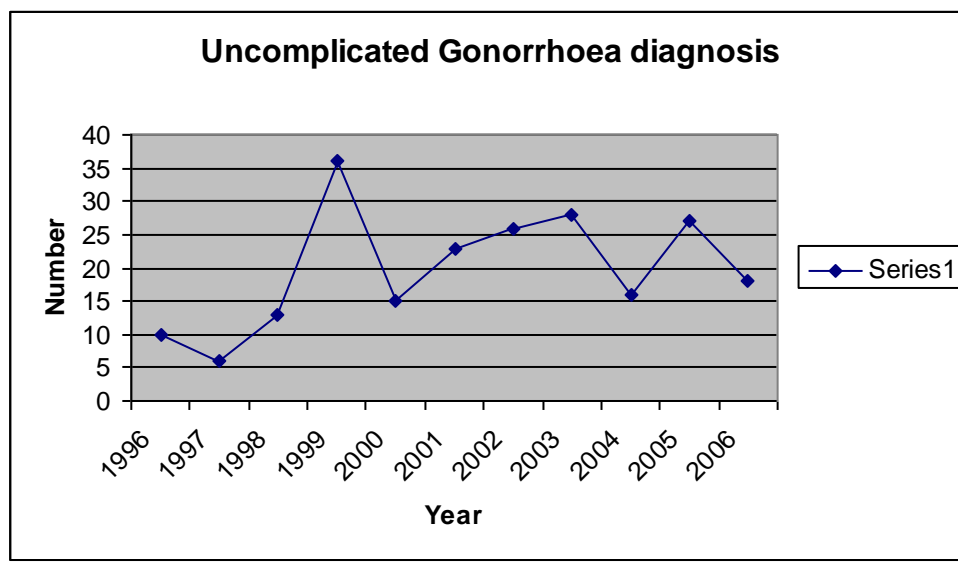
Data provided by the SHA enables estimates of expected diagnosis levels based on the HPA analysis. By applying the HPA rate by age group for gonorrhoea during 2005 to South Tyneside's population estimates demonstrates an expected number of 38 diagnoses.

Age	Male	Female	Total	Population Estimates ONS 2005	South Tyneside estimates (number)
<16	3.6	15.4	9.3	6181 (13 – 15 years)	0.58

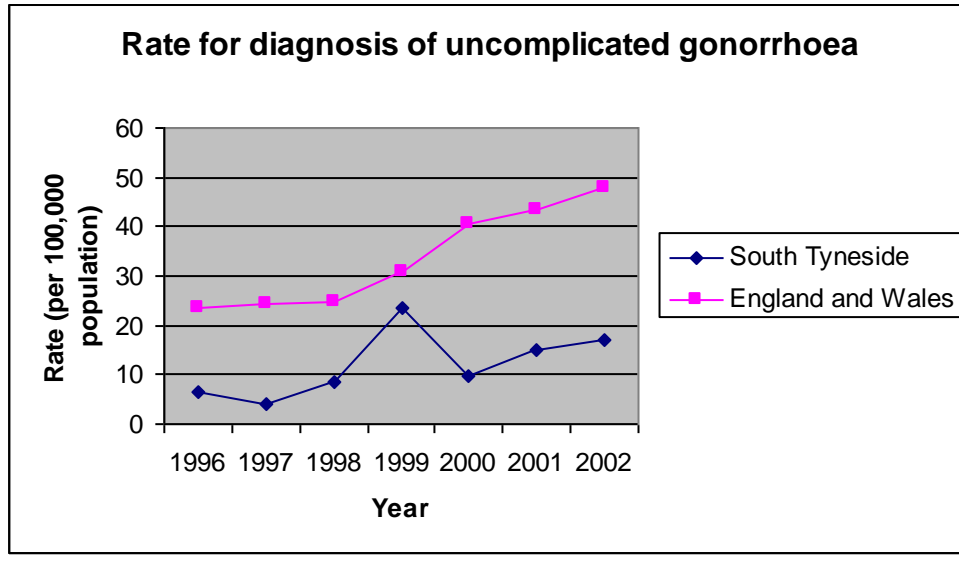
16 – 19	118.1	83.1	101	8607 (15 – 19 years)	8.69
20 – 24	196.5	72.3	134.7	9, 289	12.5
25 – 34	103	26.9	64.3	17, 187	11.06
35 – 44	38.2	3.8	20.6	22,750	4.69
45+	8	1	4.2	20, 628 (45 – 54 years)	0.86
<b>Total</b>					<b>38.38</b>

### South Tyneside PCT (KC60 returns)

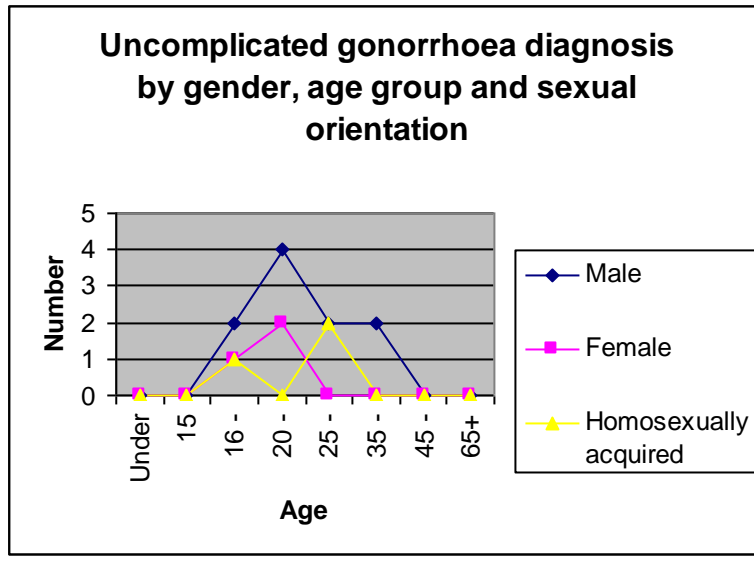
Data from South Tyneside GUM concerning the number of cases of uncomplicated gonorrhoea diagnosed shows a fluctuating number over the last 10 years with a peak in 1999. Whilst accepting the fluctuating rate the reduction between the number in 2002 (26) and the number in 2006 (18) is approximately 31%.



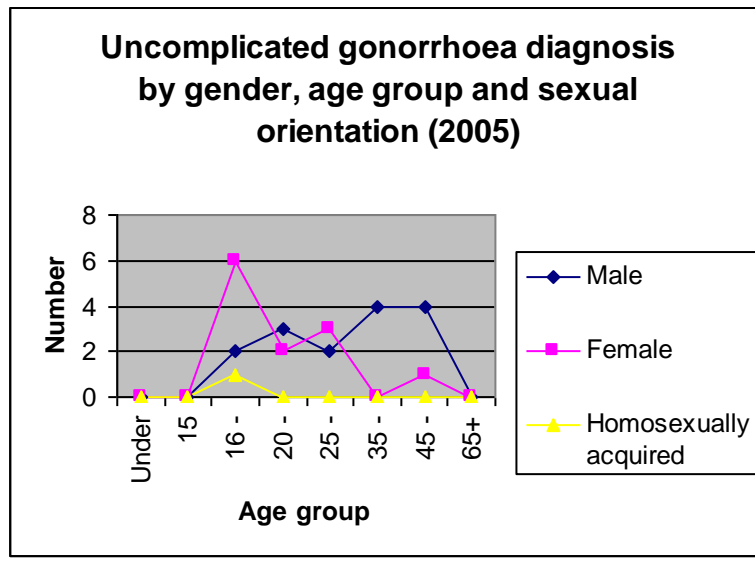
Despite the 1999 peak the rate of diagnosis for South Tyneside consistently remained lower than the national average between the years 1996 and 2002.



Further interpretation for South Tyneside shows that during calendar year 2004 there were a total of 16 diagnosis for uncomplicated gonorrhoea with the highest number in the 20 – 24 age group (N=6). Heterosexual men were disproportionately affected overall with 10 cases compared to 3 of each within female and homosexually acquired infection.

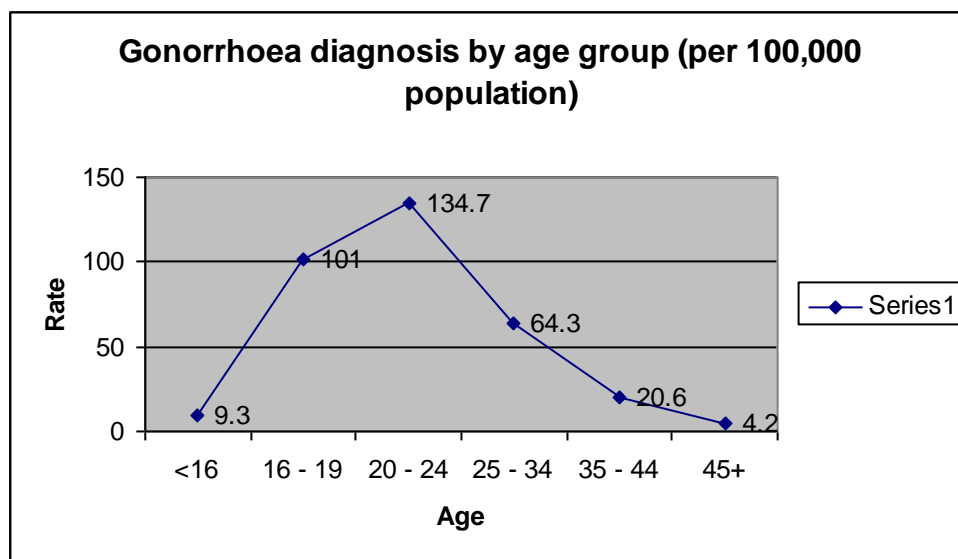


During 2005 the figure for new diagnosis of uncomplicated gonorrhoea increased to a total diagnosis number of 28 with only one acquired through homosexual contact and a significant increase in female diagnosis (3 in 2004 and 12 in 2005).



Data provided for the part financial year April and December 2006 (year to data) show there were a total of 8 cases of uncomplicated gonorrhoea diagnosed in South Tyneside. In addition to this number there were a total of 5 cases of epidemiological treatment of suspected gonorrhoea. This figure illustrates that whilst it relates to small numbers there were slightly more females than males diagnosed (7 opposed to 6).

HPA data for 2005 highlights particularly high rates within the 16 to 24 age group. By applying this data to South Tyneside this suggests that there is less diagnosis within South Tyneside than the rest of the SHA area. As outlined the expected number based on applying the HPA rate for gonorrhoea during 2005 to South Tyneside's population estimates demonstrates an expected number of 38 diagnoses with an actual number of 28 outlining either, an unmet need of approximately 10 cases (26%), a lower incidence within South Tyneside or that people access services elsewhere.



## 8.8 Syphilis

### Indicator description

- Age-standardised rates by region of diagnosis
- Map of crude rates, by SHA of diagnosis and by gender

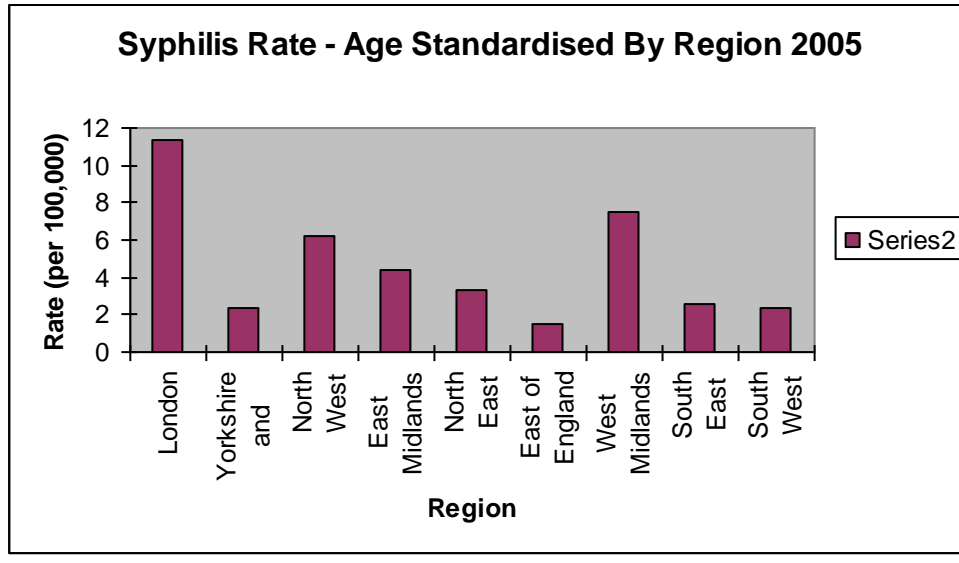
### Rationale and background

Syphilis is an STI caused by a bacterium. The condition is particularly significant in pregnant women where the infection can cause miscarriage, still birth or foetal abnormality. If diagnosed during pregnancy maternal infection can be easily treated thus preventing further transmission to the baby. Symptoms are not specific but can often begin with one or more painless sores (primary infection) that usually clear up untreated within two to six weeks. Secondary symptoms include a rash on the palms or soles usually 6 weeks to 6 months later. Late symptoms occur four or more years after an untreated infection leading to serious complications and even death. Long-term sequelae include damage to the heart, respiratory tract or central nervous system. Left untreated syphilis will cause symptoms in 40% of cases.

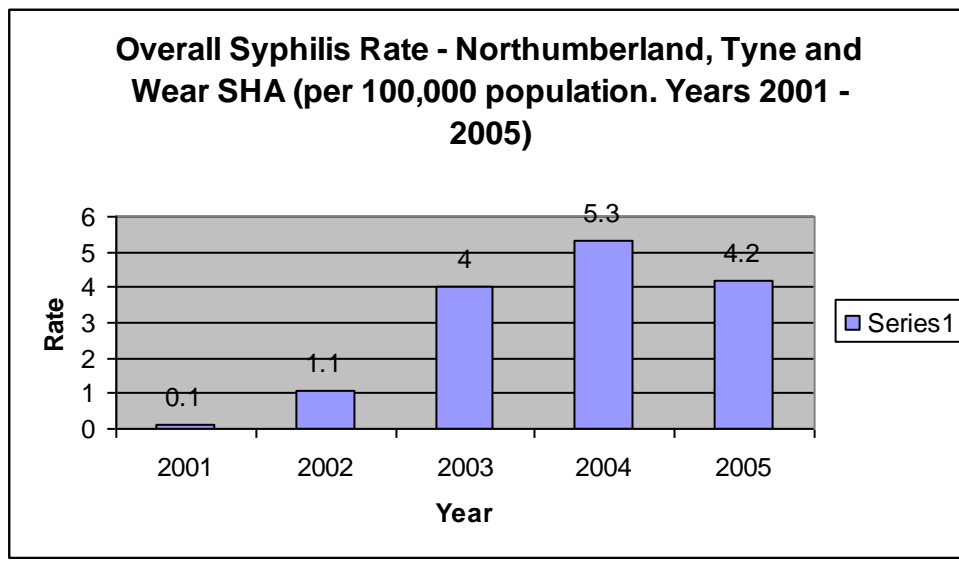
Syphilis infection has seen a significant increase in incidence over the past few years with a national increase of 27% between 2004 and 2005 and a 701% increase from 2000. The increase was even more prevalent in the female population (2.5 times higher). However despite this uneven increase men still accounted for the majority of cases (84%) with 58% of these within the MSM population. In direct contrast to other bacterial STI's the incidence of syphilis is lower in the teenage population with the highest rates for women aged 20 -24 and men 25 – 34.

### Syphilis Rate by Region

As with other STI's there is significant regional variation in the diagnosis rates for syphilis. Data for 2005 showed a significantly higher rate of diagnosis within London (11.4 per 100,000) followed by the West Midlands (7.5 per 100,000). The North East showed a rate of 3.3 per 100,000 but again Northumberland, Tyne and Wear SHA area illustrated a higher rate of 4.2 per 100,000 (HPA, 2005).

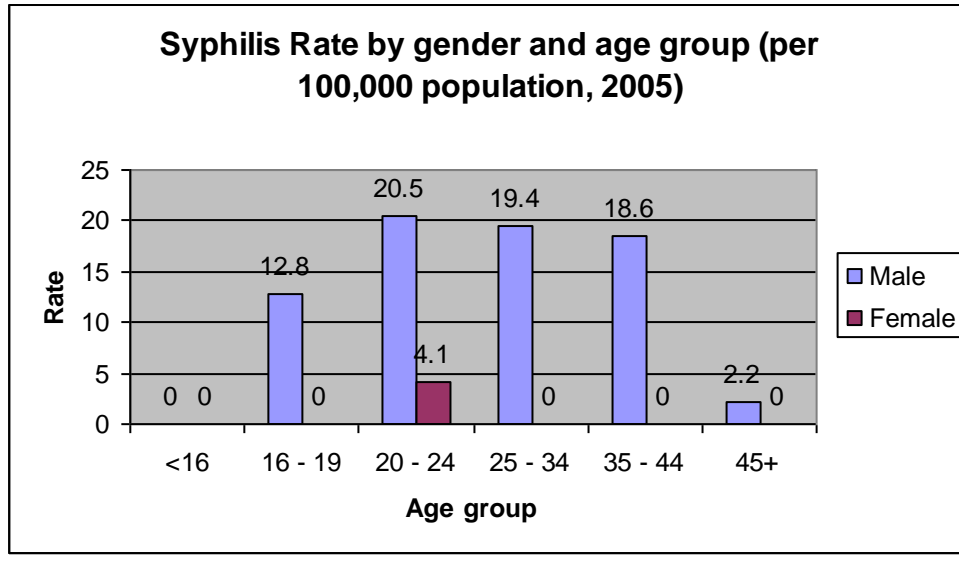


The overall rate of syphilis in Northumberland, Tyne and Wear has seen an increase over the past five years. Data highlights a large increase between 2001 and 2003 with an undulating rate between 2003 and 2005.



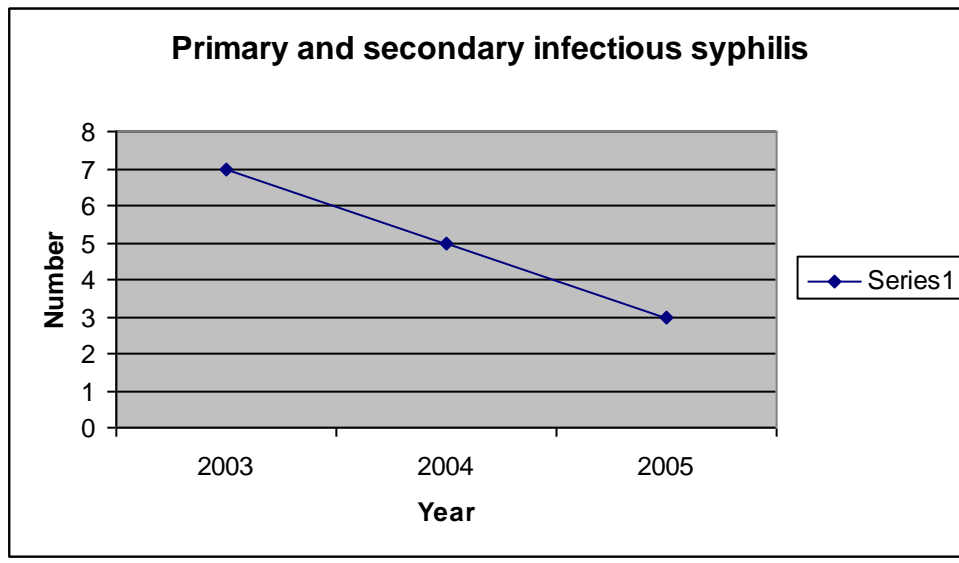
The crude rate of Syphilis diagnosis by age group shows for Northumberland, Tyne and Wear SHA the highest overall rate is within the 20 – 24 age group with high levels specifically for men in the 20 – 44 age group. Data illustrates particularly low rates overall for women with a peak within the 20 – 24 age group.





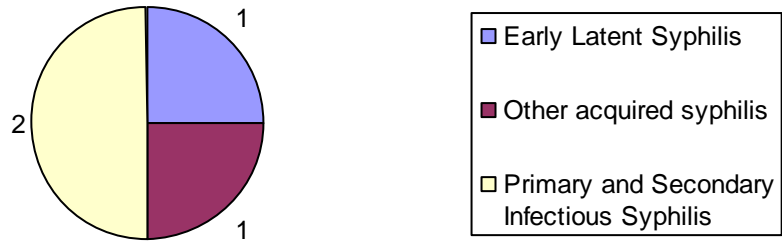
### South Tyneside Data (KC60)

Data provided on the KC60 returns for South Tyneside show a steady decline in the numbers of people diagnosed with primary or secondary infectious syphilis between 2003 and 2005.



Data collected between April and December 2006 (year to date) illustrates a total number of four syphilis infections suggesting a slight increase during 2006.

**Syphilis infection - diagnosed in South Tyneside  
GUM April - December 2006**



## **SECTION 2**

### **Sexual Health Strategy (2001) themes**

This second section outlines the themes identified in the sexual health strategy alongside providing some local interpretation and discussion of progress towards meeting the local need. The two themes identified included broad titles for better prevention and better services. A further commitment was made within the local strategy to ensure meaningful user involvement. This aspect forms a third local theme and provides a crucial back-drop to strategy development.

## **9 User involvement**

### **9a TP Action Planning**

The annual teenage pregnancy action planning event has provided a forum for young people to input their views into the way services are delivered. This action planning event includes a focus on Contraception and Sexual Health Services and Sex and Relationship Education. The consultations includes a specific look at the needs of young people in school, vulnerable young people, parents and workforce development. The event has taken place every year since 2004 and involves around 30 young people.

### **9b Mystery Shopper Project**

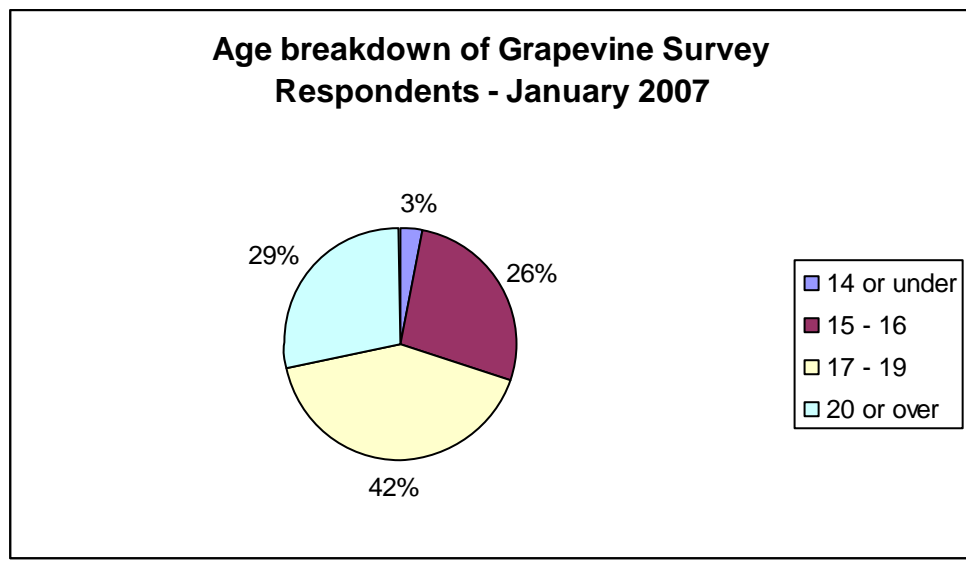
During 2005 five young people were recruited and subsequently trained to visit services in South Tyneside with regard to their appropriateness as a young person friendly service with specific focus on confidentiality for under 16's. The team visited 10 GP practices alongside the dedicated contraception service for young people (Grapevine) and the Matrix (drug and alcohol service for under 18's. The recommendations were used within individual services and at the 2006 Teenage Pregnancy Action Planning event (January 2006) to help shape strategy development.

### 9c SRE evaluation

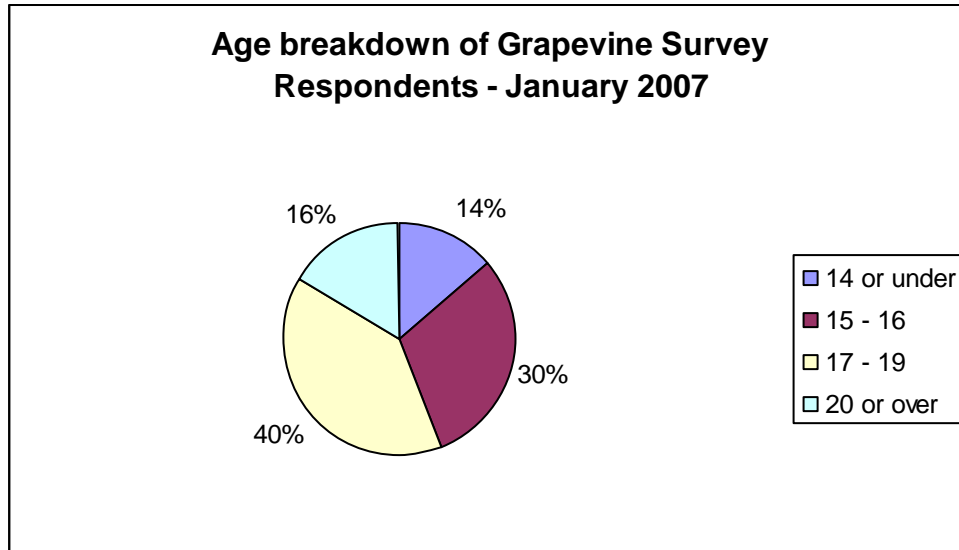
All young people receiving a school based SRE session are provided with the opportunity to evaluate the SRE sessions they have accessed. During the academic year 05/06, 2184 of the 2669 pupils who received the SRE programme completed an evaluation (82%). Recommendations from the young people included a request for more single gender sessions and more time spent on the emotional aspects of SRE. The SRE programme has been amended to take account of pupil's views.

### 9d Grapevine Survey

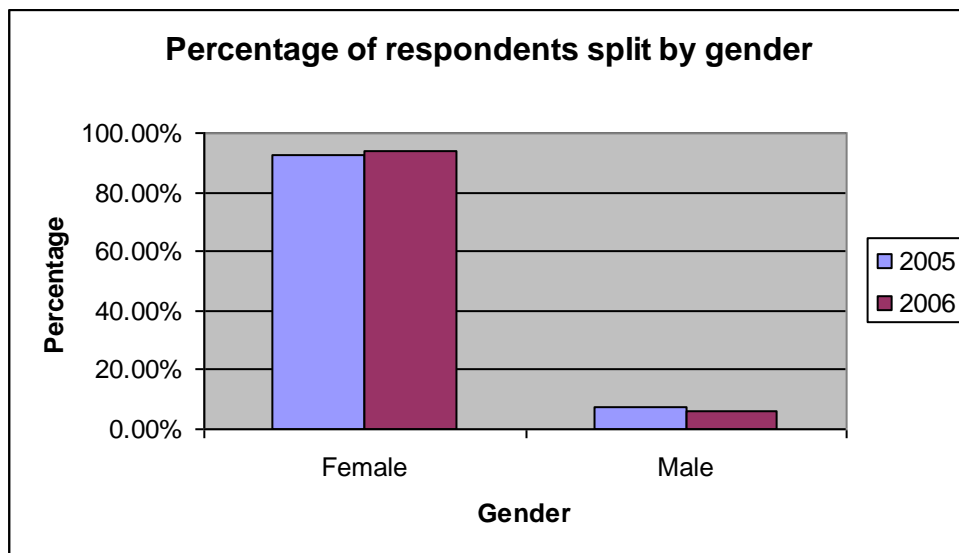
A regular 'snapshot' survey has been undertaken with young people accessing the dedicated Grapevine services at particular points in time. The most recent survey was completed in January 2007 and provided exceptionally positive feedback from young people accessing the service. Data revealed that young people ranged from 14 (or under) to 25 and over with the majority of respondents featured within the 17 to 19 age group.



Comparable data from the survey undertaken in May 2005 showed that the respondent population comprised of a greater percentage of the 14 and under group with slightly less in the over 20 group.



During both surveys detailed the large majority of respondents were female.



During both surveys detailed the majority of respondents were white (91%) and of the remainder several were undisclosed with a very small proportion black or Asian.

The surveys explored the type of relationship that the young people were in. The 2007 survey outlined that the majority of young people (66%) were in a steady relationship with a further 30.3% either not in a relationship or in a casual relationship. The 2007 the average age of first sex was just over 15 years which is a lower age than the National average 16 years cited within the NATSAL survey (2000). Of the total number of respondents nearly 90% were heterosexual with around 3.4% gay or lesbian and just over 5% with undisclosed sexuality.

In 2007 over 58% of the young people were accessing the service for contraceptive advice, nearly 12% for pregnancy and 4.5% for STI's. Over 90% of respondents felt that an integrated contraception and GUM service would be of benefit. In addition 85% of respondents felt that services provided specifically for young people were of benefit.

Feedback from the surveys outlined that the majority of young people found the clinic environment positive. The young people unanimously found the clinic staff (receptionists, doctors and nurses) helpful, friendly, welcoming, discreet and approachable.

## **10. BETTER PREVENTION**

### **Information for the public**

#### **10a Campaign work**

Local campaign work has taken place on a regular basis over the past few years. The Primary Care Trust have signed up and delivered sexual health campaigns in line with nationally driven awareness events including sexual health awareness, World AIDS day and contraceptive awareness week. This material has been widely available from the PCT resource department. Numbers show that around 236 people signed up to the World AIDs day campaign during both 2005 and 2006. Sexual Health week was successfully supported during 2006 with 170 people signing up to access campaign materials. Sexual Health week planned for 2007 shows a small increase in numbers with 178 people requesting the campaign material.

Contact has been made with each school and youth service provision to ensure a named contact in each facility to receive the material and take responsibility for displaying it. National campaigns disseminated by the Teenage Pregnancy Unit have been locally supported through the identified mailing list.

In addition to National Campaigns South Tyneside has delivered a number of local campaigns targeted at key points including Valentines Day and before the Christmas period. Campaign work has often been undertaken through the Teenage Pregnancy Partnership Board linked closely to the Sexual Health Strategy group. Local print and radio media have reported on campaigns favourably.

#### **10b Information about STI's and services**

Local media has been developed and widely disseminated regarding STI's and local services. This material has been targeted towards young people through schools and youth centre links as detailed above.

#### **10c Websites**

The South Tyneside Drugs Action Team (DAT) developed a website [www.jonnylonglife.com](http://www.jonnylonglife.com) which contains information about local services alongside sex and relationship education.

The national website [www.ruthinking.co.uk](http://www.ruthinking.co.uk) has access to up to date clinic times for the local area and provide young people with an opportunity to identify appropriate services.

#### **10d Flowchart (Possibly pregnant)**

A flowchart for young women 'possibly pregnant' was developed in 2003 and has been updated on an annual basis since its inception. The purpose of the flowchart is to provide professionals with a clear referral pathway to ensure appropriate referral and necessary follow-up of young women who are possibly pregnant.

#### **10e Research – Local awareness of service provision**

The South Tyneside DAT commissioned a health related behaviour survey in 2000 and 2006. This survey was completed in seven of the ten secondary schools in years eight and ten with a total of 1177 respondents. They compared the data between South Tyneside respondents and a reference sample comprising other areas who commissioned the same survey. This data highlighted that:

- Lower proportions of South Tyneside recorded scores of high self-esteem (38% compared to 43%)
- Higher proportions said they got drunk in South Tyneside (24% compared to 19%)
- **Higher proportions of South Tyneside said they were aware of specialist contraception and advice services available locally (37% versus 23%)**

(The Schools Health Education Unit, 2006)

#### **10f HIV prevention**

Raising awareness of HIV/AIDS goes on throughout the year via the SRE schools programme. However a number of events on December the 1<sup>st</sup> 2006 were well supported in South Tyneside.

World AIDS day was supported through several events for young people and adults.

Adults- Staff at the PCT took part in a "RED ALERT" day. The focus of the day was the discrimination people living with HIV/AIDS face. Local press coverage ensured a wider audience for this message.

16-15 year olds - Students at South Tyneside College were offered red ribbons and access to free condoms through the day long campaign.

13-15 year olds - An evening World AIDS day event was held at a youth centre in South Tyneside. 48 young people from across the borough attended the event which was supported by the PCT, young people's drug and alcohol service, the Youth Service and Connexions.

### **10g National Healthy School Standard**

One of the key public health and partnership interventions identified by the HPA and APHO (2006) aimed specifically at young people includes the Healthy School Programme. To achieve Healthy Schools Status schools are required to meet criteria across four core themes:

- Personal, social and health education (PSHE) – Includes sex and relationship education (SRE) and drug education
- Healthy eating
- Physical activity
- Emotional health and well-being

To meet the core standard related to SRE schools have to demonstrate:

- Up to date SRE and child protection policies developed through consultation
- A programme of study and supporting schemes of work, with monitoring, evaluation and assessment built in
- A senior, named and appropriately trained member of staff
- External agency in put (e.g. school nurses etc)
- Protocols for referring young people to C&SH services and secondary school pupils aware how to access the services
- PSHE professional development for staff
- Use of local data to inform activities and support national priorities such as reducing teenage pregnancies.

South Tyneside has 72 schools in total (including 4 nurseries, 5 special schools and 1 Pupil Referral Unit). 42 schools had achieved Level 3 of the old National Healthy School Standard by December 2006 (58%). In line with the Choosing Health agenda (2004) there is a named school nurse for each secondary school.

#### *Local Targets for HSP*

Trajectory agreed by Government Office North East as outlined in Healthy School Headline Plan includes targets based on the new healthy school criteria including;



- Eight schools will have achieved National Healthy School Status by July 2007 –
- 37 schools (55%) achieved National Healthy School Status by December 2007
- 44 schools (65%) achieved National Healthy School Status by December 2008
- 50 schools (75%) achieved National Healthy School Status by 2009

#### *National Target for HSP*

All schools working towards National Healthy School Status by 2009

### **10h Sexual health information / education for specific groups'**

#### ***Young people and especially those in or leaving care***

Universal sex and relationship education is provided through a multi-agency team delivering in all the secondary schools in South Tyneside. The team comprises a co-ordinator, school nurses and youth workers amongst others. The team has delivered to every year eight and ten pupil during the financial year 2006 – 2007 which includes 2669 young people between 13 and 15 years old.

#### ***Children Looked After***

An initial assessment of the health needs of young people in local authority care includes examination of the needs of young people in relation to sexual health from 2006 in South Tyneside. The assessment recognises the increased risk that those in LA care can face due to amongst other things a lack of a trusted adult to discuss physical and emotional changes with. Also many children and young people in local authority care may have had changes in school and may not have received SRE in an educational setting. An assessment of needs can identify needs for access to services or enhanced SRE, which is then offered through a member of the Young People's sexual health project.

Training has also taken place with all residential care staff to enable them to deliver of opportunistic SRE and have a greater knowledge of the local Contraception and Sexual Health services. Staff also fed into Sexual Health policy via this training (Appendix 1).

#### ***Local Authority outreach sexual health team***

The youth service has developed a local sexual health team comprising two youth workers, one funded by the Teenage Pregnancy LIF and one funded by the big lottery. The team provides outreach SRE to vulnerable groups alongside staff training to facilitate opportunistic SRE

### ***Black and minority ethnic groups***

Local cervical screening services have been developed within Apna Ghar a specialist community provision for BME women. This service was developed in response to an identified need regarding 10% of this population not accessing generic screening services. Apna Ghar now includes a treatment room which provides the accommodation for this population group to access cervical screening. Contraception advice is also provided alongside a referral into specialist services.

### ***Gay and bisexual men***

In South Tyneside the MSM population are provided with support from the STAG project (South Tyneside and Gateshead). This service offers a range of facilities including a confidential helpline, one to one support, group support, safer sex resources, a gay press / library and training to facilitate greater awareness of gay and bisexual men's issues.

Further support services are provided by MESMAC which is a gay and bisexual men's support service covering the North East. MESMAC works with this specific population to increase the range of choices open to them.

Services include:

- Phone information and advice (including a helpline with a 24-hour answer machine)
- Group work
- One to one counselling
- Sexual health advice
- Free condoms and lube
- Anti-violence services
- Drop in services
- Helpline with 24 hour answer machine
- Archive research resources
- Training around homophobia and sexual health

### ***Injecting drug users***

Drug and alcohol services are well developed within the borough largely provided by three linked services; Street Level, Drug and Alcohol Service (DAS) and First Contact a service established by GP's with a special interest based in Primary Care. A further specialist service for young people has been developed known locally as the Matrix. Specific provision within these services for contraception and sexual health were outlined as inconsistent by service providers within the HNA substance misuse and pregnancy (South Tyneside PCT, 2006). Some drug and alcohol services offer a limited provision of

contraception services ranging from condom distribution to Depo-Provera injection. However provision is patchy and often a full range is not often available.

### ***Adults and children living with HIV and other people affected by HIV***

Locally support is provided by a HIV case manager accommodated within Street Level which is a Barnardos' project based in South Tyneside working both with people with HIV (and their families and carers) and people substance misuse problems. Referrals are taken from a variety of venues with the majority through Ward 25 at Newcastle General Hospital (Barnardos' Audit, 2006). The HIV Case manager is involved with assessments and care planning with links to further support within the Social Care and Health department as required. The service provides holistic support including:

- Assessment of needs (including hospital discharge plans)
- Involvement of needs assessment for children affected by HIV
- Co-ordination of services
- Support for accessing drug therapies (if necessary)
- Support for people with drug or alcohol problems
- Support for asylum seekers
- Financial / benefits support
- Housing support
- Joint work with a variety of other professionals (occupational therapy, physiotherapy, district nurses, health visitors and children's centre staff)
- Emotional well being (stress, relationship problems)
- Other opportunities including; training, leisure, employment
- Support for families (including bereavement)
- Pre-test discussions (HIV or Hepatitis)

### **Sex workers**

There are no specific services in South Tyneside for women involved in the sex industry.

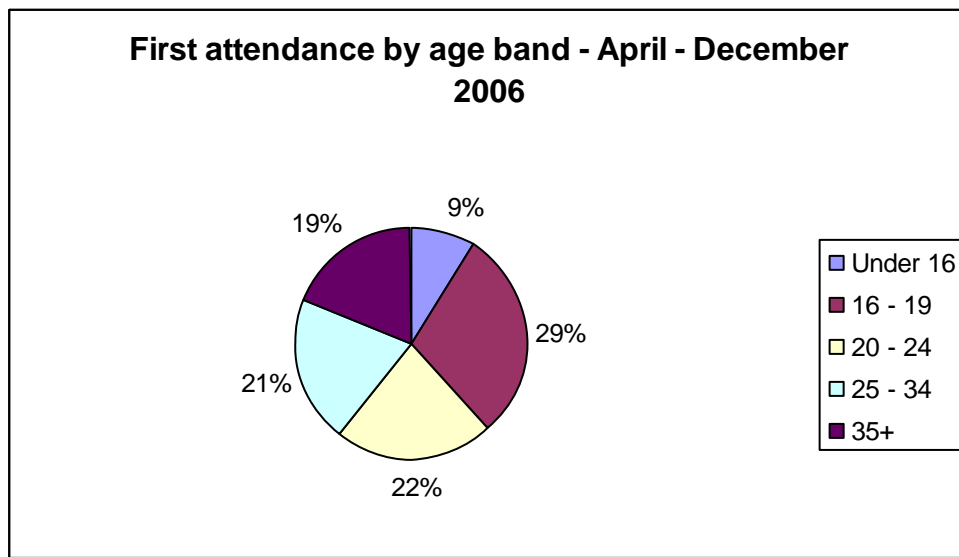
### **People in prison and youth offending establishments**

Some service provision is currently being targeted at this group, i.e. The Youth Offending service has been provided with SRE to aid opportunistic interventions and appropriate referral into specialist services.

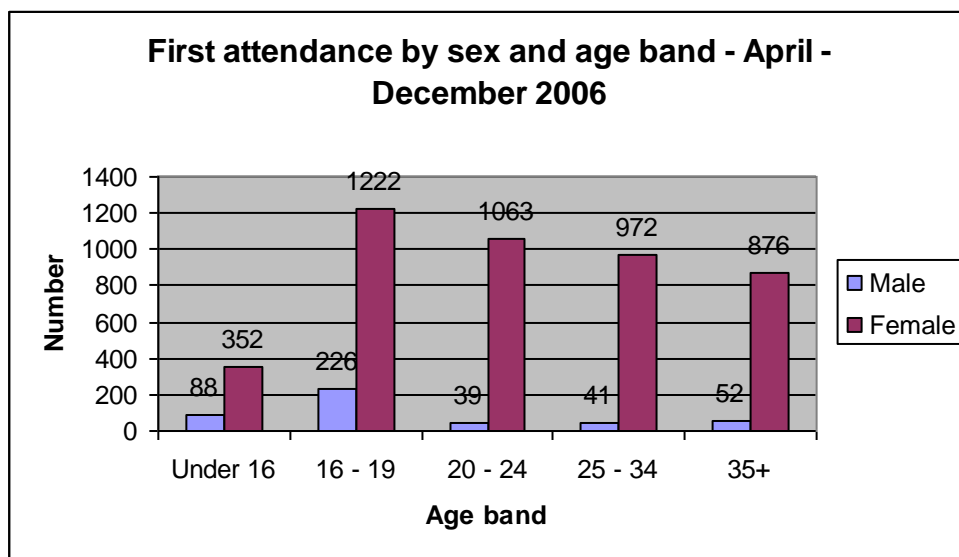
## **11. BETTER SERVICES**

### **11a Contraceptive services**

Contraception services are available 7 days per week with emergency contraception available on a Sunday from the Foundation Trust. Excluding the emergency contraception clinic on a Sunday there are a further 11 clinics running at seven venues across the borough six day per week. Within these 11 clinics there are three dedicated sessions for young people under 25 (Grapevine). In addition to the mainstream services a further specialist smear clinic has been established at Apna Ghar a community provision for the BME population. Between April and December 2006 there were a total of 4931 first attendances at these clinics. The age group 16 – 19 accounted for the largest proportion of these attendances with 29%.

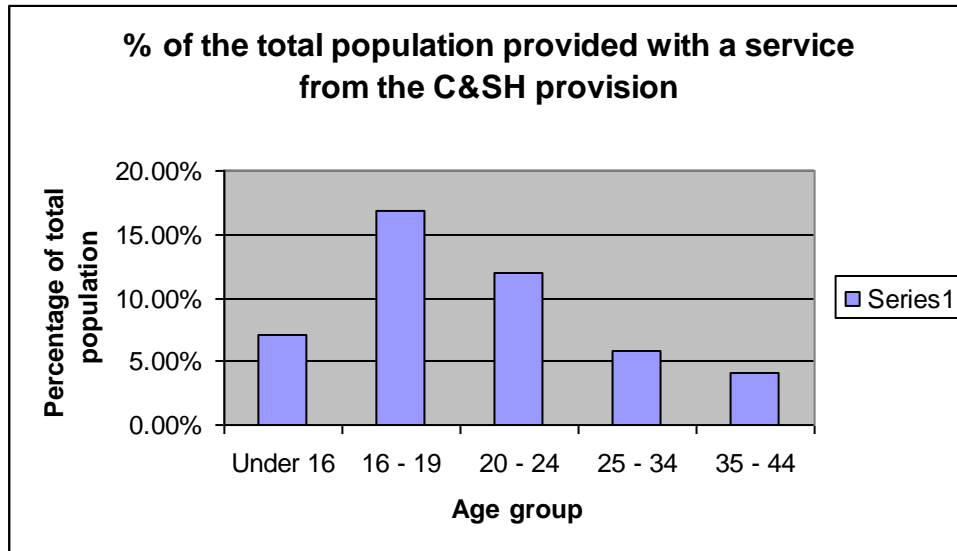


Females accounted for 91% of all attendances. The highest attendance overall was with females aged 16 – 19 (1222 attendances).

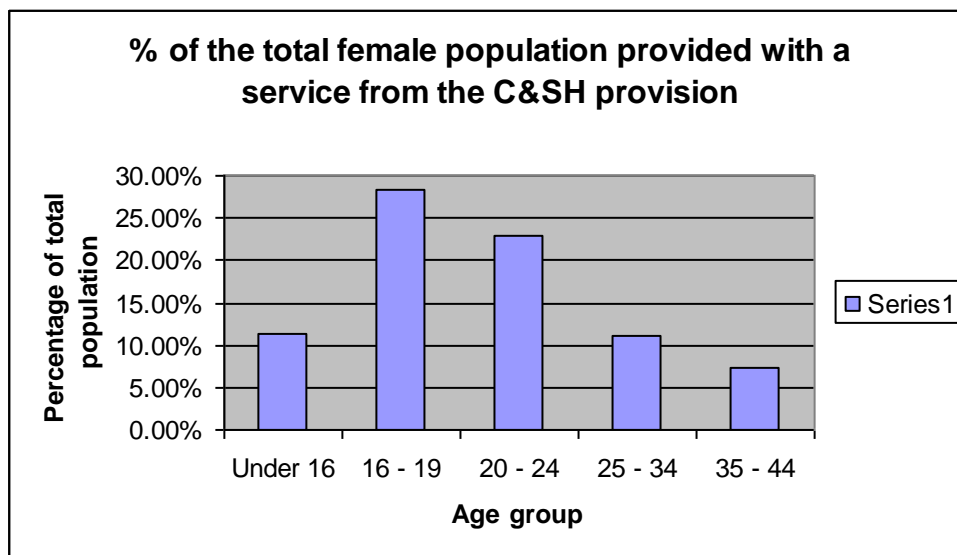


This data highlights based on the previously documented population estimates (ONS) that the C&SH provision have supplied a service for

7.7% of the total South Tyneside population (men and women) between April and December 2006 (based on activity data detailing first attendance). As this data includes only 9 of a twelve month period there is an expectation for contact with a further 2.5% of the total population by the end of the financial year (March 2007).

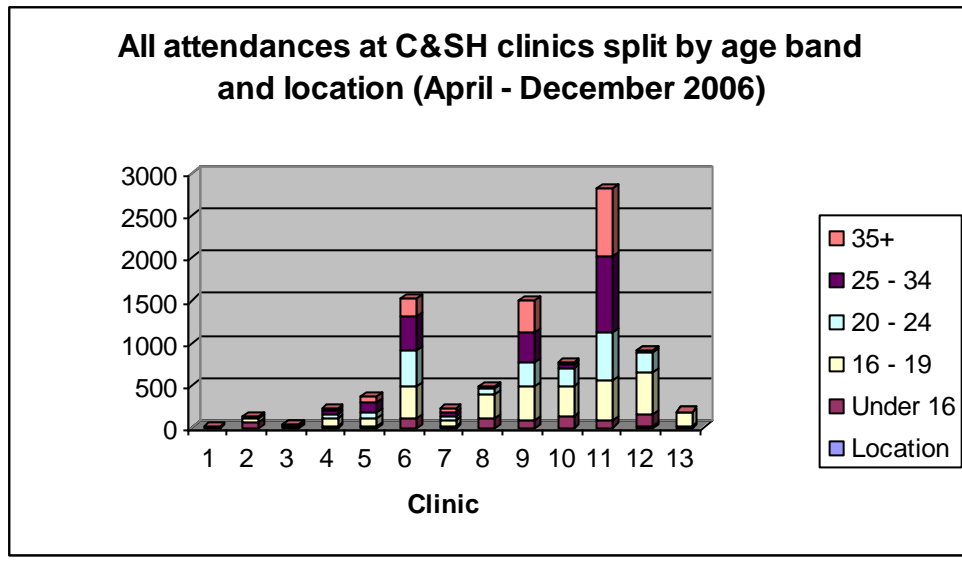


When this figure is broken down further the service has supplied between 7.4% and 28.4% of the female population with access to contraception and sexual health depending on age.



Data shown illustrates that the most frequently used C&SH clinic is Stanhope Parade Health centre however this is unsurprising as there are 4 available C&SH sessions, one Grapevine session, two procedure clinics and one smear clinic per week. Young people appear to use a variety of access points with higher attendance at Palmer community hospital, Stanhope parade health centre, out patient department STFT

and Ocean Road Community Association. With the exception of the out patient department all these venues have a mainstream clinic and a specialist Grapevine clinic.



1. Apna Ghar (BME Clinic) – Specialist smear clinic
2. Boker lane Condom Clinic
3. Cleadon park Condom Clinic
4. Gynae Ward ST Foundation Trust (STFT)
5. Heburn Health Centre
6. Out Patient Department STFT
7. Ocean Road Community Association
8. Ocean Road Community Association – Grapevine
9. Palmer Community Hospital
10. Palmer Community Hospital – Grapevine
11. Stanhope Parade Health Centre
12. Stanhope Parade Health Centre – Grapevine
13. South Tyneside College (Only established in September 2006)

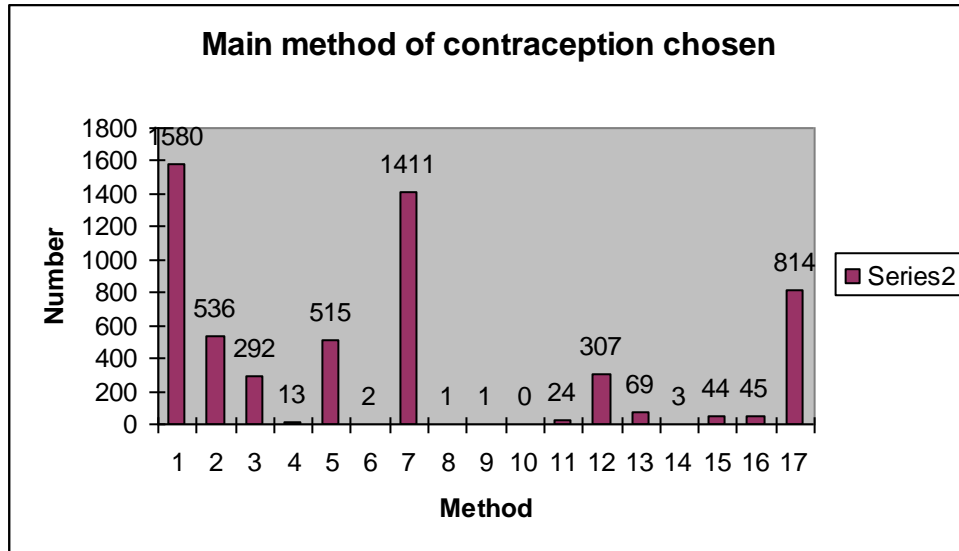
### Method Uptake of Contraception

Data collected locally outlines that the preferred method of contraception for women (based on the first contact KT31) over a three year period as combined oral preparations. This data excludes contraceptive treatment provided during subsequent visits and also at other venues (including GP practices). The coding system below has been used for the graphs provided which detail contraceptive choices for the previous three full years encompassing data from April 2003 – March 2006.

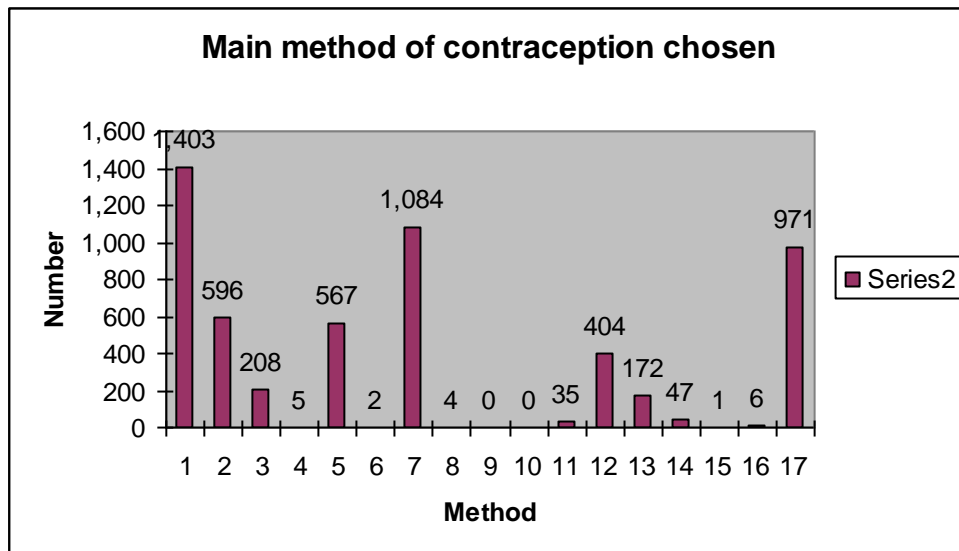
- 1 Combined oral preparations
- 2 Progesterone oral preparations
- 3 IUCD at insertions or check
- 4 Cap or Diaphragm

- 5 Injectables –DEPO
- 6 Other Chemicals Spermicides
- 7 Condom Male
- 8 Condom Female
- 9 Fertility indicators
- 10 Fertility devices
- 11 Female Sterilisation

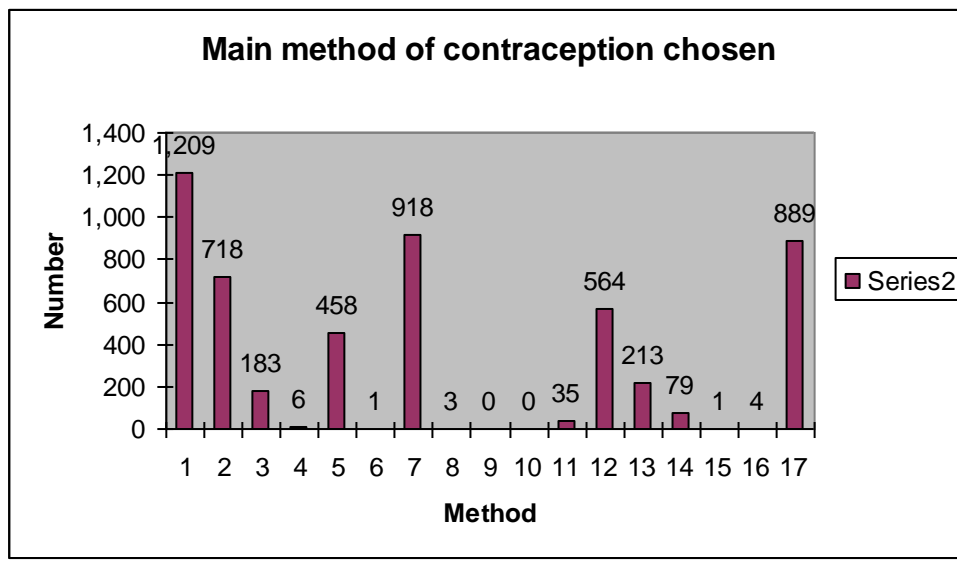
**April 2003 – March 2004**



**April 2004 - March 2005**



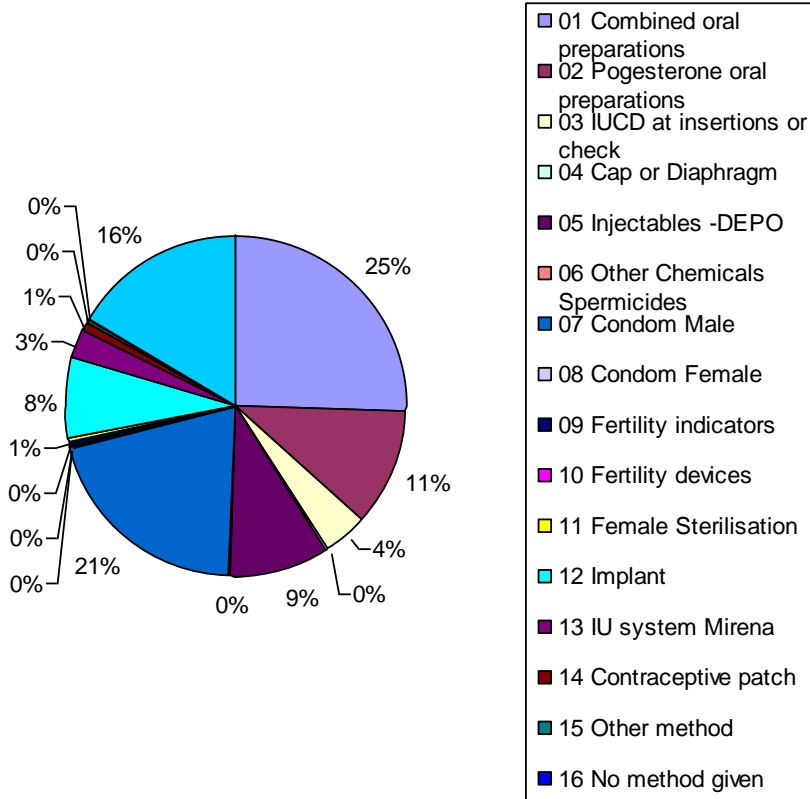
**April 2005 – March 2006**



The pie chart below outlines contraceptive choices for females during their first contact with the contraception and sexual health services between April 2003 and March 2006. The % relating to 0 often refer to a minority choice of less than 100 over the three year period.

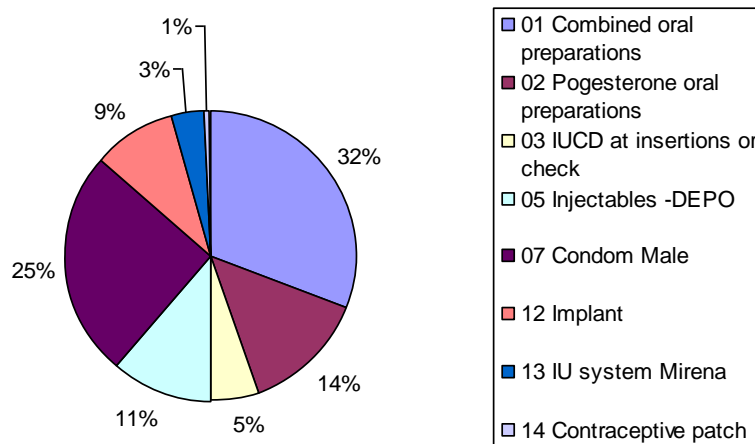


**Contraceptive choice for females during first contact (South Tyneside 2003 - 2006)**



In order to illustrate the favoured contraception choice over the three year period this next pie chart includes only choices where the take up number has been more than 100 over the three year period.

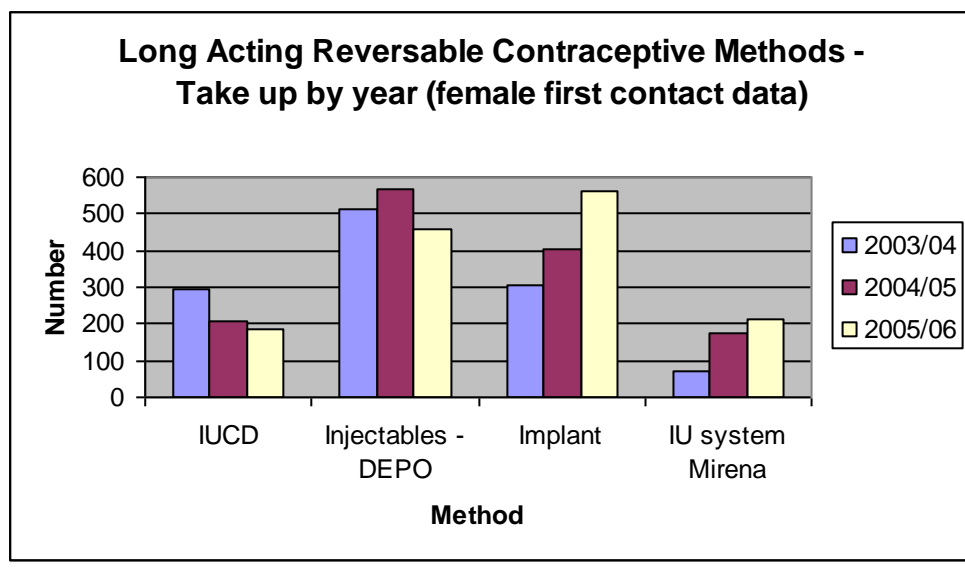
**Contraceptive choices for females by first contact (2003 - 2006) after removing any numbers less than 100 over the 3 year period**



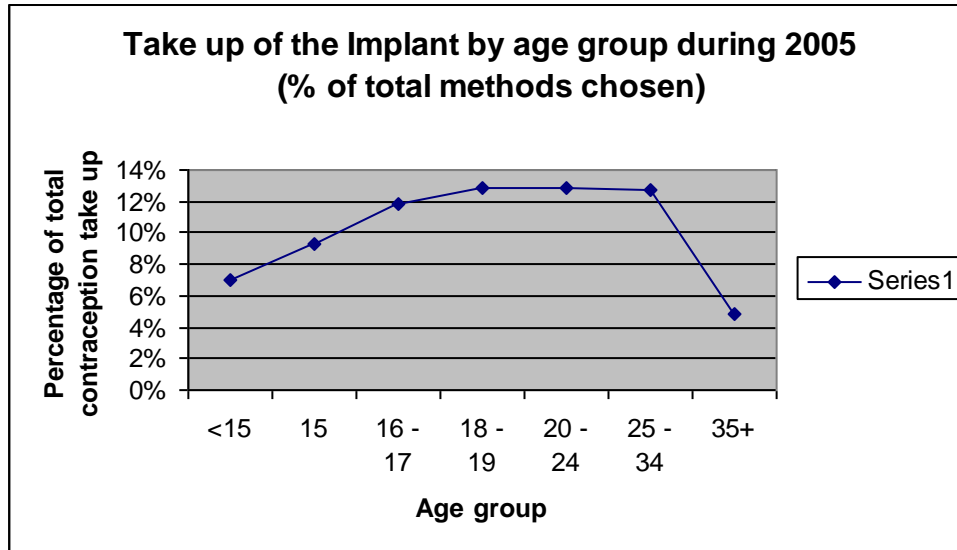
In October 2005 NICE produced guidelines on long acting reversible contraception (LARC). These guidelines recommend;

*‘Women requiring contraception should be given information about and offered all methods including long acting reversible contraception methods... Contraception service providers increasing the uptake of LARC methods will reduce the numbers of unintended pregnancies and therefore offer cost savings to the NHS... All LARC methods are more cost-effective than combined oral contraceptive pill (and injectable contraception) because they reduce the likelihood of unplanned pregnancy’ (NICE, October 2005)*

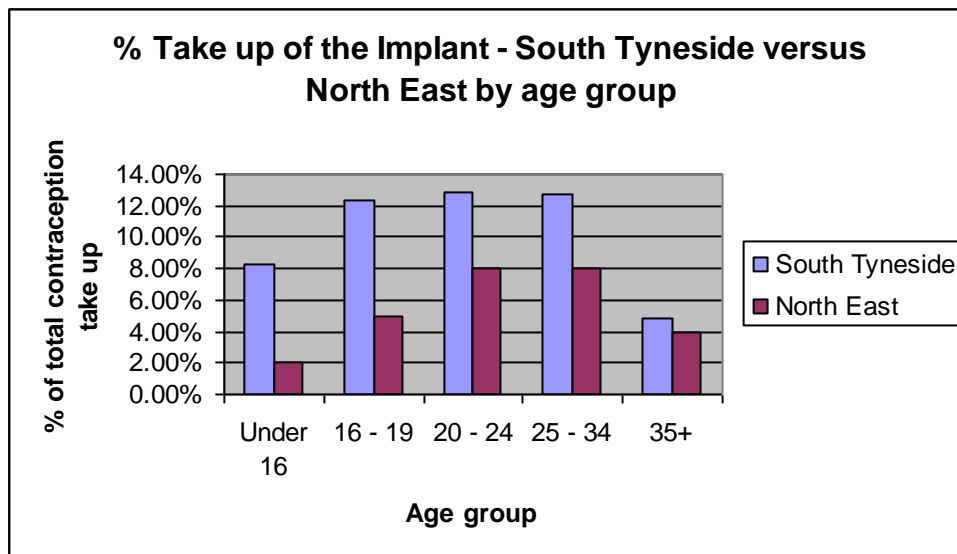
In line with the recommendation services have aspired to provide women with the full-range of contraceptive methods where possible.



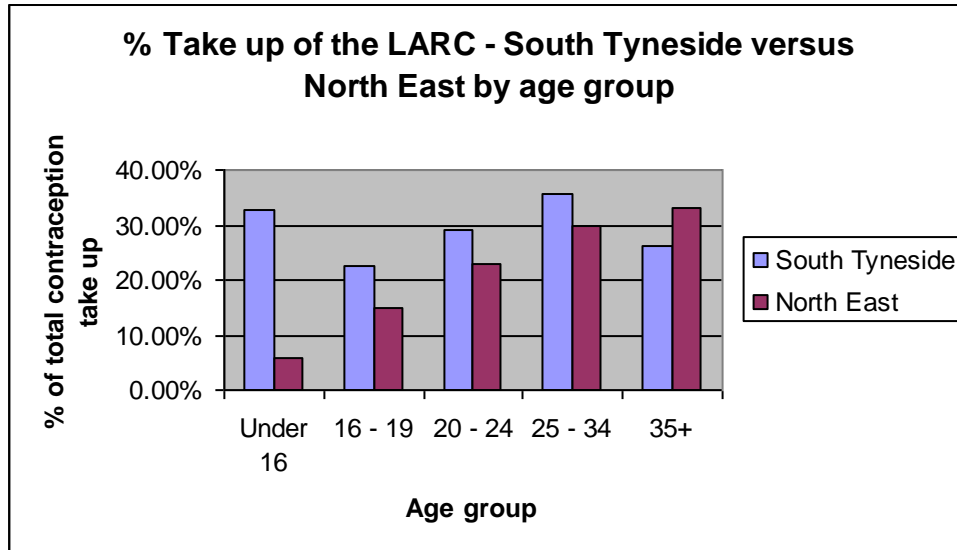
Within the contraception and sexual health service this drive has resulted in an 83% increase in the up take of the Implant from 307 in financial year 2003 / 2004 to 564 in 2005 / 2006. As the earlier tables showed the Implant contributed to approximately 8% of all methods chosen over the three year period. However during 2005/06 the Implant accounted for an overall 11% of the chosen methods for females during their first contacts.



South Tyneside's data is higher than the North East average for Implant uptake where the figure fluctuates by age group from 2% (Under 16) to 8% (20 – 34 years) with an overall average of 6%. Data for 2005 – 2006 shows that in South Tyneside the percentage by age group taking up the Implant ranges from 4.9% of women over 35 – 12.9% of women aged 18 – 24.

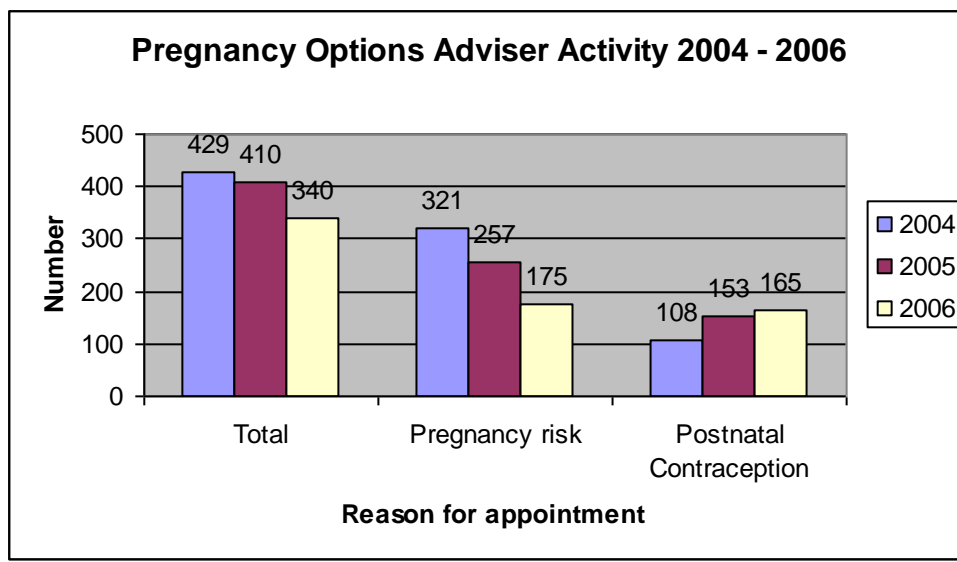


When all methods of Long Acting reversible contraception methods are included South Tyneside appears favourably when compared to the North East as a whole. South Tyneside administers a higher proportion of LARC in all age groups with the exception of women over 35. The average up take of LARC over all age groups in South Tyneside is 26.8% compared to an average of 22% in the North East.



### 11b Pregnancy Options Service / Postnatal contraception planning

The contraception and sexual health service encompasses a well-established pregnancy options service. The intention of this provision is to offer women (particularly young women) an opportunity to explore potential options if they are possibly pregnant. The service provides a counselling provision with the hope of empowering women to make an individual choice. In addition the service offers women who have experienced a risk of possible pregnancy support in order to facilitate future choices around aspects of sexual health including contraception and screening.



Data provided by the pregnancy options services illustrates a small decline in the number of young women accessing the service for 'pregnancy risk' appointments. The number seen for postnatal contraception has increased significantly over the last three years.

Data outlined by the TPU (2006) suggests that 20% of under 18 conceptions were repeated conceptions and it is hoped that this data indicates evidence of this reduction alongside an over all reduction in unintended pregnancy.

### **11c Postnatal contraceptive planning**

The Young Women's Pregnancy Service (YWPS) in South Tyneside is a dedicated specialist maternity service for young women under 20 years of age. Since its establishment in 1986 the YWPS has developed a multidisciplinary, multi-agency team approach to care, aimed at supporting young parents throughout pregnancy and into parenthood. The value of this integrated approach was cited as a model of innovative practice in May 2005 (Sawtell, 2005).

In 2004, the YWPS further developed its service provision to include a dedicated postnatal contraception service, which ensures that contraception planning is integral to young women's antenatal and postnatal care. Collaboration between key service providers from the Primary Care and Acute Hospital Trust supports the efficient and effective delivery of the contraception plan.

Comprehensive information leaflets about postnatal contraception are readily available however a number of young women expressed the view that too much information and irrelevant information acted as a deterrent to them reading the leaflets. The young women largely saw information about sterilisation, caps and diaphragms as unnecessary and irrelevant. This led to the development of a user friendly, easy to read leaflet which was specific to the needs of young women, giving a brief overview of each method and including information about postnatal ovulation, menstruation and condom use. This introductory leaflet is supplemented by providing the Family Planning Association method specific leaflets as appropriate.

Key intervention and information points for discussion about contraception were identified to correspond with the young women's attendance at the antenatal clinic. A pre printed contraception plan is generated as part of the case note documentation and updated at each intervention/discussion point (Appendix 2).

Discussion first takes place at the antenatal booking appointment to explore any previous contraceptive use; whether the pregnancy was planned or unplanned and whether contraceptive method/user failure was a factor. The introductory contraception leaflet "Contraception Choices" can be given at this point.

The next planned discussion takes place at 28 weeks and begins with helping young women identify the factors that they feel influence their choice and sustained use of contraception. Stevens-Simon et al (1998) suggested that one of the deterrents to continued contraceptive use by

young women in the postnatal period was concerns about side effects and, therefore, discussion in the YWPS clinic includes exploration of the factors, which might influence the young woman's choice of postnatal contraception. Issues such as likes and dislikes, perceived advantages and disadvantages in relation to previously used contraception, preferred time interval before next pregnancy, reliability of chosen method, ease of use, any concerns about side effects e.g. altered body image due to weight gain, possible effects on menstrual cycle e.g. irregular cycle/ amenorrhoea are all explored.

Further discussion and information giving takes place at 34 weeks and 38 weeks with the aim of supporting young women to plan a contraceptive method choice prior to delivery, which can then be implemented post delivery. As the written contraception plan remains within the case notes, it is readily available for the midwives to refer to when the young woman has delivered. The Pregnancy Options Advisor also visits the postnatal ward twice a week to see young women who have had their babies and to take details for further contact about those young women who have been discharged. This collaboration ensures that a young woman's individual contraception plan can be implemented at the optimal postnatal interval in accordance with NICE guidelines 2005 and within the most appropriate service.

A comprehensive review of the postnatal contraception plan for 2005 – 2006 took place in February 2007. This review highlighted that 85% of all young women under 20 choose to receive their care from the Young Women's Pregnancy Service. In 2005, 153 young women accessed postnatal contraception planning and, of these 121 gave birth during the year. In 2006, 165 young women accessed postnatal contraception planning and, of these 135 gave birth during the year. Data presented shows the take up of methods for young women during this time.

### **Key**

COC = combined hormonal oral contraceptive pill

POP = progestogen only contraceptive pill

Patch = EVRA combined hormonal contraceptive patch

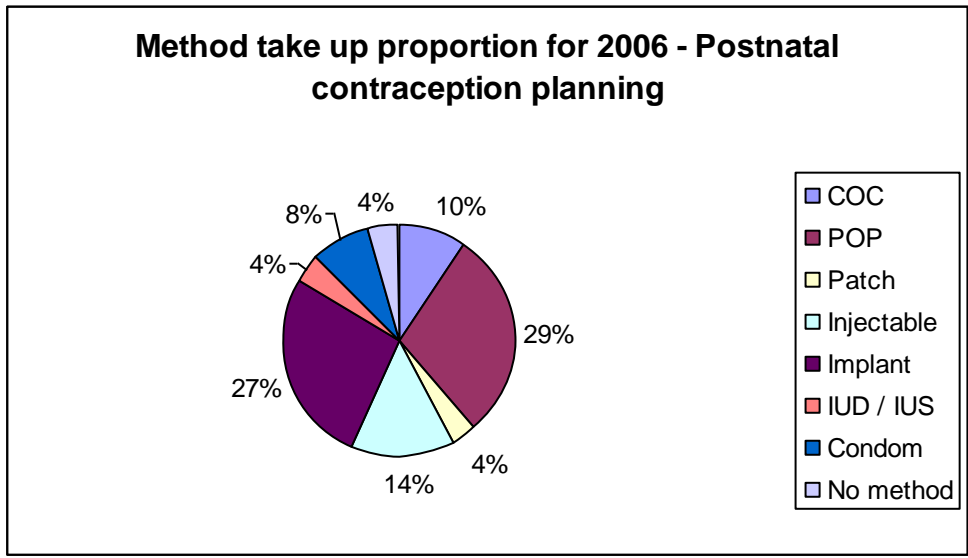
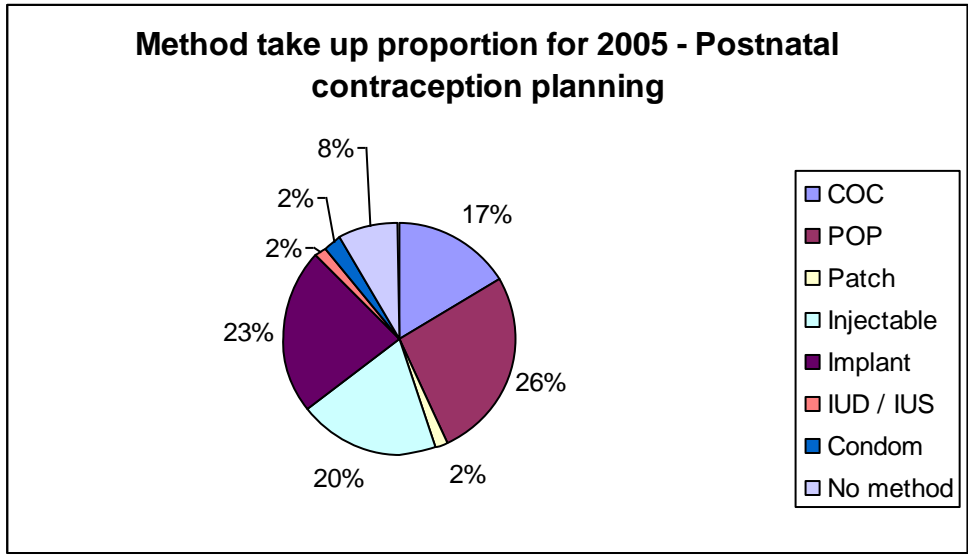
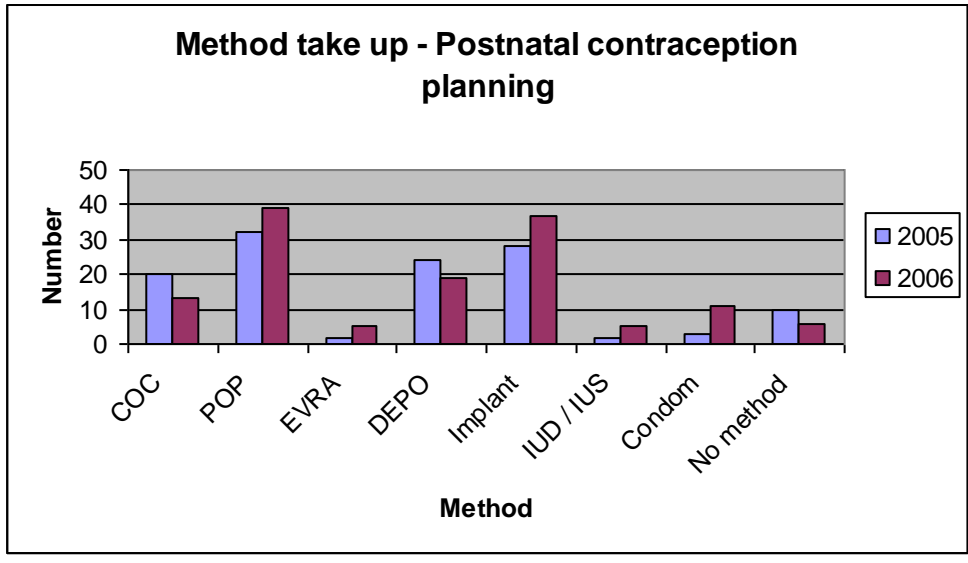
Depo = progestogen only injectable contraceptive (LARC method)

IUD/IUS = non hormonal intrauterine contraceptive device/progestogen intrauterine system (LARC method)

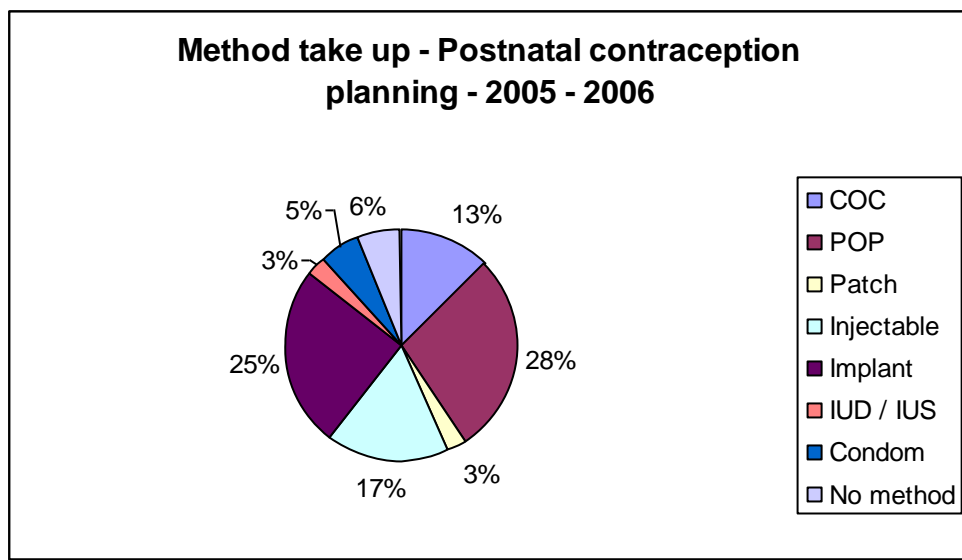
Imp = Implanon<sup>progestogen</sup> only subdermal implant (LARC method)

Cond = condoms only given

No method = declined to choose any method of contraception



This data outlines an increase in the number of people accessing the service. Whilst the data shows that 45% opted for long acting reversible methods over both years the data highlights an increase in the overall proportion of people accessing the implant alongside a small reduction in young people accessing the injectable method (Depo). This data also demonstrates a reduction of almost 50% in the proportion of young people not accessing contraception after delivery.



This data highlights that within this service 45% of the total population opted for long acting reversible contraceptive methods which is significantly higher than the general population.

#### **11d C Card (condom distribution) and sexual health drop in clinics.**

South Tyneside launched its C Card scheme in September 2006. 545 young people signed up to the C card scheme in its first quarter. 786 individual contacts were made with you people. Appendix 3 details the geographical distribution of young people signed up to the card scheme.

C card outlets now include:

- South Tyneside College
- Alternative education
- Places for people (young parent's housing project)
- Matrix (young people's drug and alcohol project)

Requests for C card training have been received from:

- Detached youth workers
- Doctors Surgery



- 2 community associations (Lukes lane and Horsley Hill)

In addition to the C-Card provision sexual health drop in sessions are available at South Tyneside College. The sessions operate on a Monday, Wednesday and Friday across both college sites, offering free condoms, pregnancy testing, emergency contraception and referral into mainstream contraception and sexual health services. The drop in sessions is staffed by a contraceptive and sexual health outreach nurse. The college service also facilitates a pathway on to South Tyneside's young people's drug and alcohol project "Matrix".

Health clinics, including access to free condoms, pregnancy testing and emergency contraception will be available in two secondary schools by the summer term 2007.

### **11e Termination of Pregnancy service (TOP)**

The Termination of Pregnancy Service is provided by ward 3G (Gynae) for medical terminations and Ward 4 (day ward) for surgical terminations at South Tyneside District Hospital. There were a total of 400 abortions in South Tyneside during 2005 (by PCT residence) according to an email sent to sexual health leads on the 24 / 01 07. The HPA provided data outlining the numbers of TOP by PCT for 2005. This data highlights that the service undertook 379 TOP's during 2005. Of these 246 (64.9%) were under 10 weeks gestation. This percentage is the higher than the England and North East average (63.5% and 62.3% respectively).

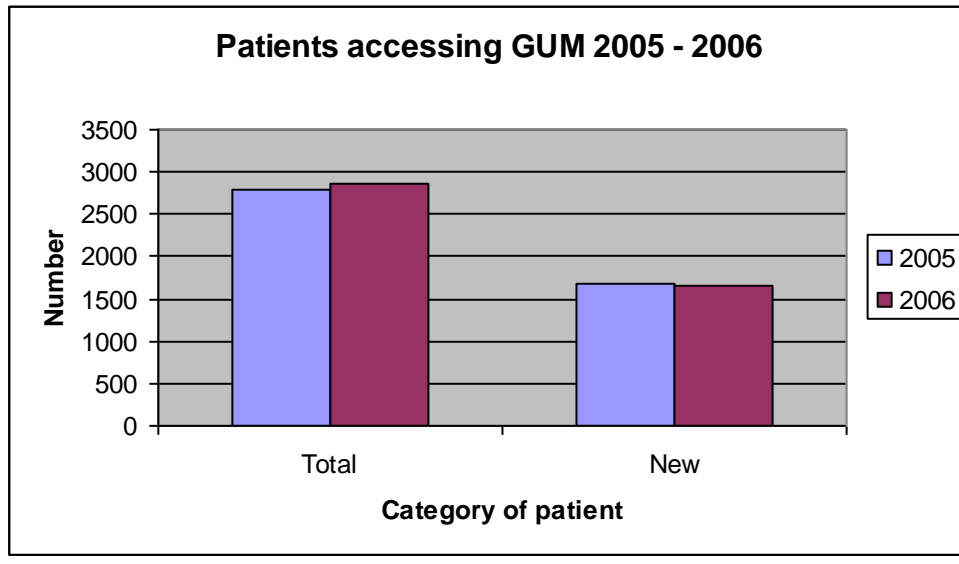
During 2003 the Foundation Trust completed an audit of the TOP service in South Tyneside (Esen et al, 2006). This audit illustrated that 25% of all TOP's were repeat TOP's. A total of 85 women had undergone a previous termination with a range from one to four previous terminations. 5% of the women accessing the service had used emergency contraception.

The largest single age group requesting a TOP was within the 15 – 19 age group accounting for 33.8% of the total percentage of TOP. This figure was closely followed by the 20 – 24 age group who accounted for a further 31.7%.

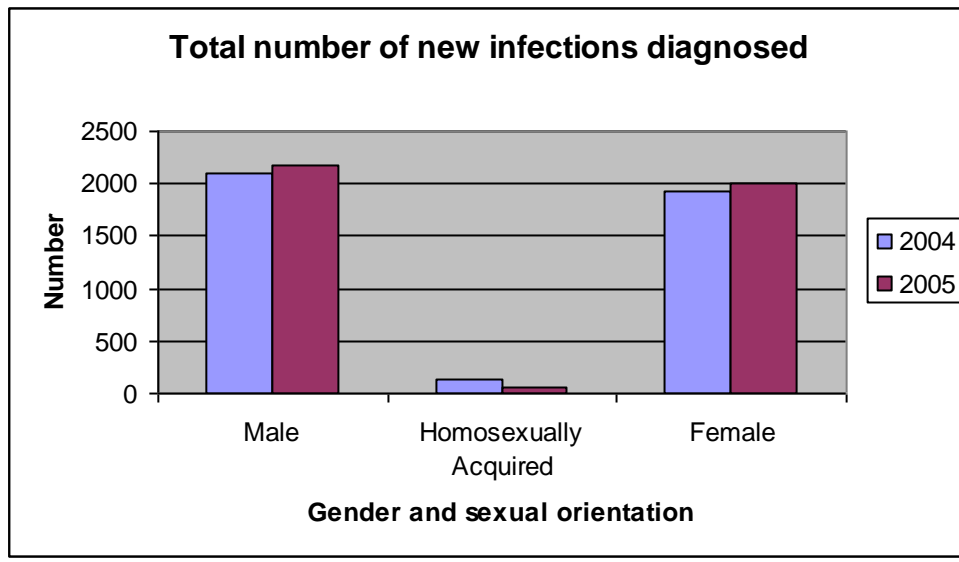
Due to the high proportion of repeated TOP requests the service developed access to contraception and within this offer access to the Implant was made available. During 2005 the TOP service inserted 94 Implants. As outlined earlier the service performed a total of 379 TOP's during 2006 thus the percentage take up of the Implant within this service during 2005 was 25%. During the calendar year 2006 the number of Implants had risen to 192 assuming over a 100% increase.

### **11f GUM Services**

GUM services are available six days a week via a drop in service based at Stanhope Parade Health centre. Services are run by consultants and appropriately trained doctors and nurses. During 2005 the services saw a total of 2801 patients which included 1685 new patients. During 2006 the service saw a fraction more with 2864 patients including 1649 new patients (a lower number than 2005).



GUM services in South Tyneside diagnosed an average of 4088 new infections during the years 2004 and 2005. Data illustrates a small increase in 2005 across both gender groups with a significant reduction in the number of infections homosexually acquired.

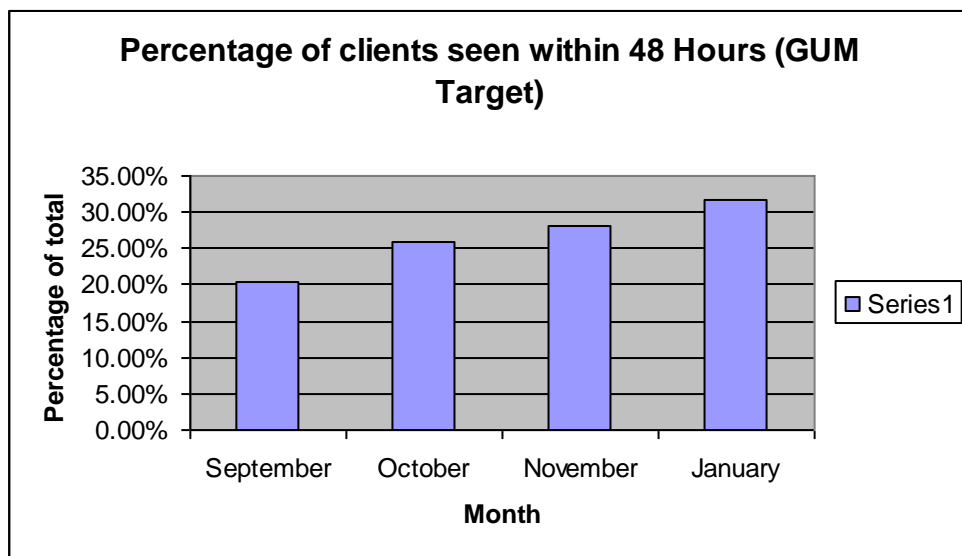


PSA11b (Revised): Broader Strategy to Improve Sexual Health: Access to GUM Services

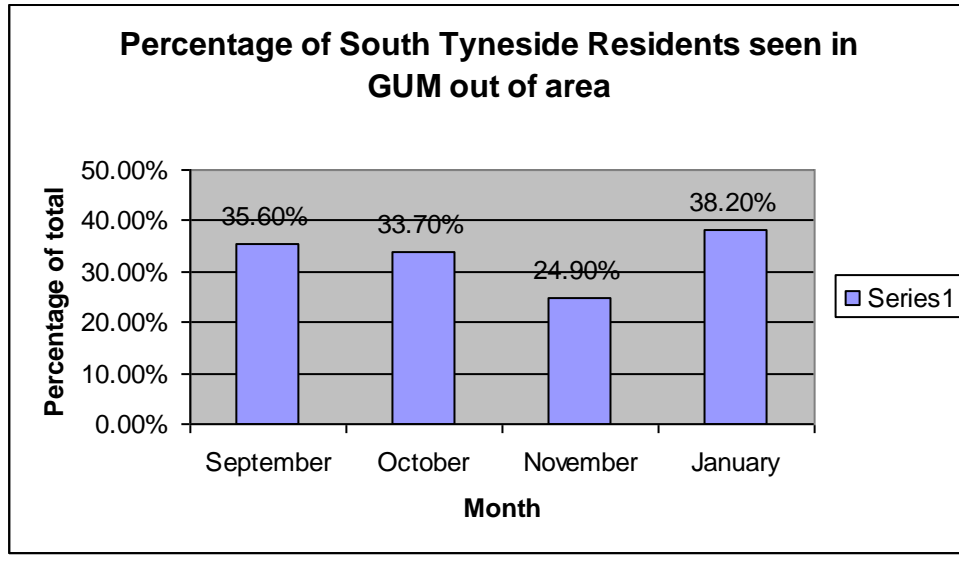
- Total number of first attendances at the GUM service

- Number of people attending a GUM service who were offered an appointment to be seen within 48 hours of contacting a service
- Percentage: people attending a GUM service who were offered an appointment to be seen within 48 hours of contacting a service
- Number of people who were seen within 48 hours of contacting a GUM service
- Percentage: people who were seen within 48 hours of contacting a GUM service

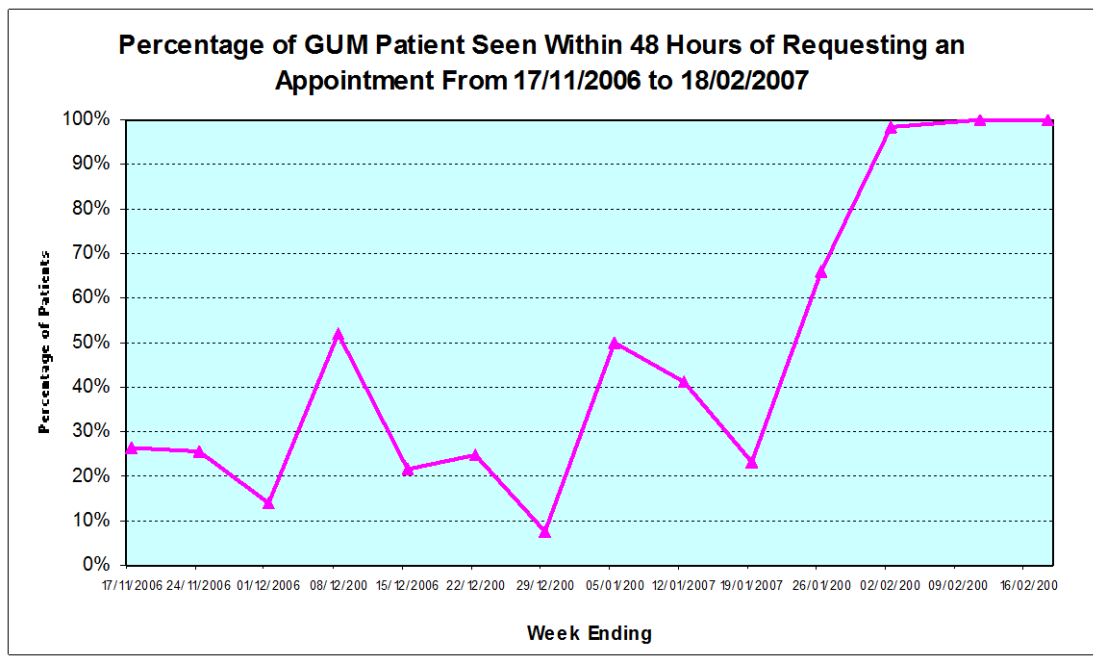
Data for South Tyneside has shown that the majority of patients seen between September 2006 and January 2007 did not meet the PSA11b target around access to GUM within 48 hours.



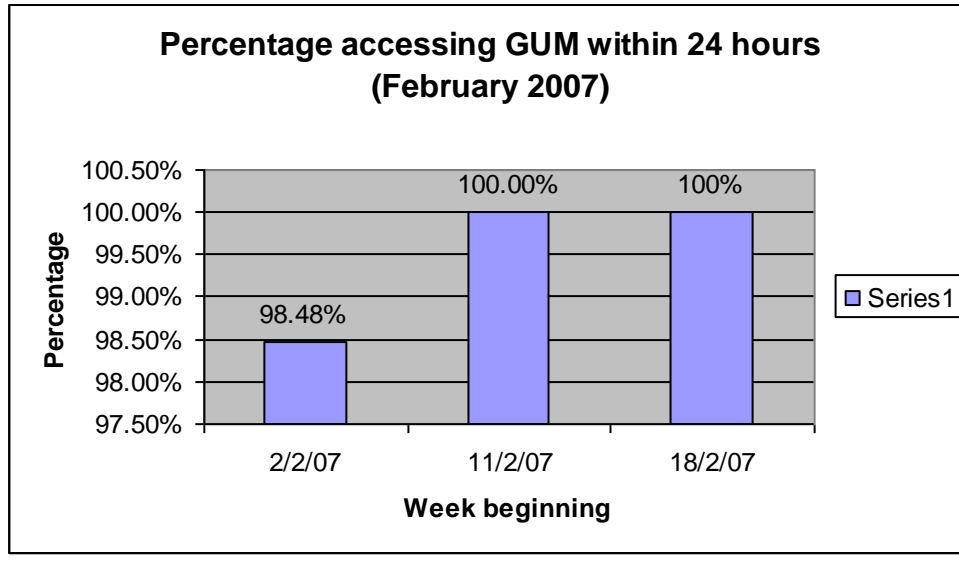
During these same months in 2006 a significant proportion of patients were seen outside the area. Of patients seen out of area the majority attended clinic at either City Hospital Sunderland (approximately 15%) or Newcastle PCT (approximately 14.6%).



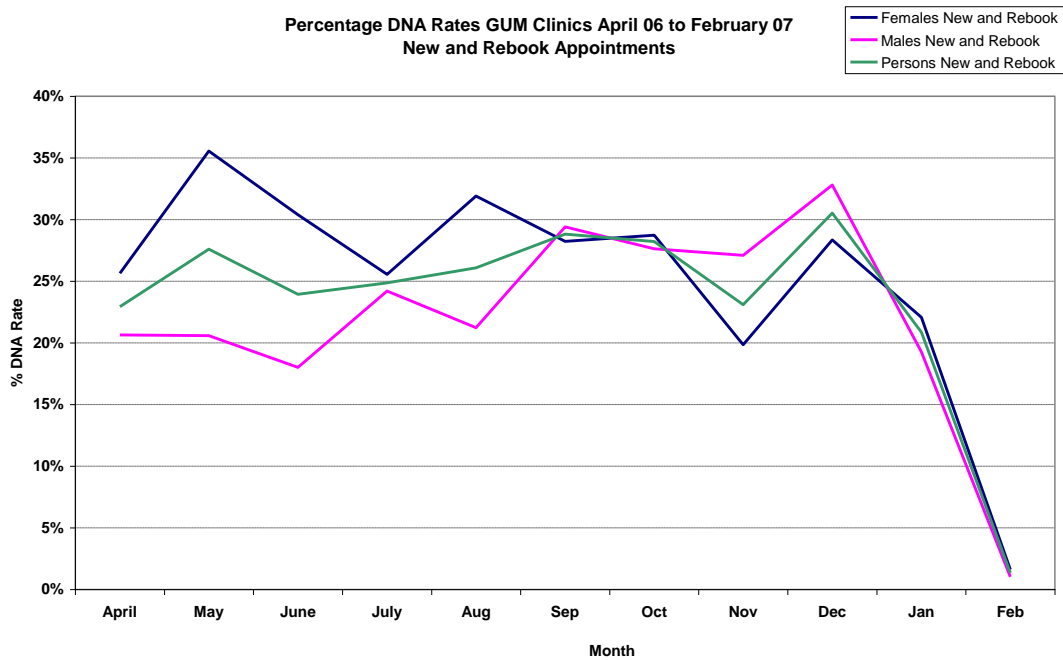
It is vital to note that considerable work has been focused on the 48 hour target and the above representation is no longer apparent. In recent weeks data shows that the target for February of 95% has been exceeded ensuring that the overall target of 100% by March will be achievable.



The next table shows the picture for the first three weeks in February 2007 outlining achievement of the 48 hour target.



In addition to the 48 hour target analysis of appointments made and not attended (DNA) show prior to February a range of 18 to 36%. DNA rates for the GUM service have experienced a significant reduction in line with the development of a drop in service.



### 11g Hepatitis B immunisation

Routine vaccination is available in GUM for those who have not been immunised previously, are immuno-naïve and who are:

- Men who have sex with men (essential to offer and promote vaccination to all such gay/bisexual men)
- HIV positive (should also receive hepatitis A vaccination if immuno-naïve)

- Sex workers
- Victims of rape whose assailant is unknown or known to have high risk factors (e.g. injecting drug user). This is specifically relevant to those who have been raped within the past 3 weeks (as it may be preventative), or those who may be subject to serial rape.

Additional unusual situations can also be considered e.g. if sexual contact occurs with proven Hepatitis B infection, it may also be appropriate to commence vaccination. Other patients where hepatitis B vaccination may be relevant include injecting drug users and those who have received needle-stick injuries. Doses given as part of a course of vaccination should be appropriately timed and may be one of the following regimes:

- Routine primary vaccination: one dose at 0, 1 and 6 months
- Accelerated primary course: one dose at 0, 1, 2 and 12 months
- Super-accelerated primary course: one dose at 0, 7, 21 days and 12 months.

The choice of regime is dependant upon the likelihood of whether the patient will return to GUM department for completion of course. The super-accelerated regime has the advantage of a potentially higher uptake of the full course.

A booster dose should be given to individuals who have received a primary course and achieved a detectable but suboptimal surface antibody titre (HBsAb 10-100miu/ml)

A second primary course should be given to those whose first primary course does not result in a detectable surface antibody titre (HbsAb <10miu/ml).

### ***Harm Reduction Nurse (South Tyneside).***

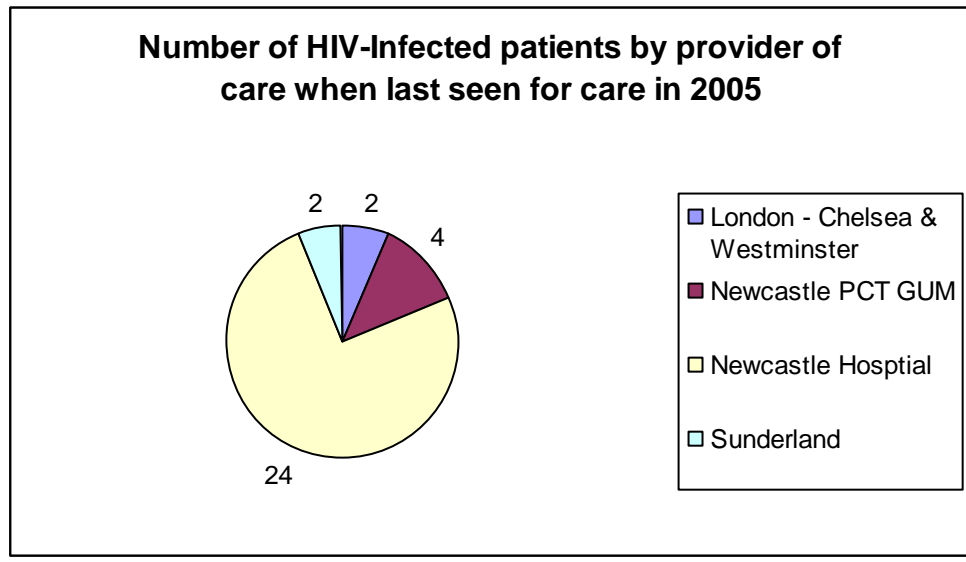
The Harm Reduction Nurse provides a Harm Reduction Service across drug treatment agencies in South Tyneside. There are currently 155 clients on the Harm Reduction database. The first client recorded dates back to March 2006.

At January 2007 there were 626 clients in drug treatment in South Tyneside. This figure demonstrates that 25% of clients in drug treatment have accessed the harm reduction nurse.

18% of the clients seen by the Harm Reduction Nurse are injecting. One client who is injecting is HIV+.

### 11h HIV treatment

In relation to the provision of treatment for HIV-infected individuals in South Tyneside the majority of treatment is provided by Newcastle Upon Tyne Hospitals (75%) with a smaller number accessing care from three other organisations.



### 11i National Chlamydia Screening Programme (NCSP)

The NCSP was outlined in the Sexual Health Strategy (2001) and further reinforced through commitment for the role out within the Choosing Health White Paper (2004). The programme is intended to provide screening to young people in the most 'at risk' age group (15 – 24 years). The NCSP has a key target around the percentage of young people aged 15 – 24 accepting the screen which is included within South Tyneside's Local Delivery Plan. The programme includes screening, partner notification, treatment and follow-up.

In South Tyneside the programme is provided through a regional arrangement led by Newcastle PCT. The programme began in January 2007 and currently includes screening venues within all contraception and sexual health services, the local College, some GP practices and the Termination of Pregnancy Service. There is an intention for the programme to be rolled out to a number of other venues including:

- The Matrix service (young people's drug and alcohol service),
- Supporting Independence project (supported housing provision for young people and young parents under 25)
- School nurses (through the enhanced drop in provision)

- Sure Start Plus (young parents) and the Young Women's Pregnancy Service (maternity service for young women under 20)
- GP Practices

The targets agreed for the local LDP are highlighted earlier in this report and encompass a total number of 3357 screens within the total population of 19935 young people within this age group in South Tyneside by March 2008 (approximately 17% of the total population). Screening this number of young people would expect to identify 354 positive infections. As outlined if this target is achieved this would identify between 17% and 21.5% of the estimated infected population in South Tyneside by March 2008.

### **11j Services that address psychological and sexual problems**

The Service in South Tyneside was formally set up in 1999 and works across two services areas in the PCT (Mental Health and Sexual Health). The service expanded during 2005 and now provides eleven appointments a week over four days. This includes eight out of hour's appointments and three during usual working hours, from four venues across the borough. Increasing the number of appointments available has been successful in reducing the waiting time to less than 21 weeks (from a high of 3½ years in March 2005).

Psychosexual therapists are fully trained counsellors who have taken further professional training in sexual therapy. The service provides counselling to both couples or individuals and addresses the psychological, behavioural and attitudinal aspects of sexuality and its expression in sexual activity.

A full booking system operates; referred clients are sent a form to complete on which they tick boxes indicating their availability to attend appointments. A franked envelope is enclosed for the return of this form. An information leaflet is enclosed with the above form as well as a covering letter informing of the waiting list and giving information about alternative services in the voluntary sector. When an appointment slot becomes available it is offered to the person waiting the longest who has indicated their availability for that day/time/venue. This helps keep the DNA rate down (7% for 2005-6 and for the 6 months from 01/04/06 it is 4%).

A leaflet is available for Health Professionals outlining both the service provided and the referral pathway.

Treatment regimes are designed for clients' unique sexual difficulties. Schedules of assignments are given to be carried out at home, offering opportunities to:

- Undo faulty learning about sexuality;



- Improve understanding about sexual needs;
- Diminish performance anxiety;
- Encourage positive communication and changed behaviour.

Progress is discussed in detail and reviewed at regular therapy sessions. Length of treatment varies from one to 20 sessions but typically entails about 12 sessions of therapy.

A letter following full assessment is sent to the referrer and copied to the GP. A further letter detailing the outcome of therapy is sent at the end of treatment, and a discharge letter following the 3 month follow-up appointment.

The interface between the two services has proved beneficial to all staff with the psychosexual counsellor being able to access the support of colleagues in the Sexual health service which has provided her clients with access to physical health checks of genitalia; rapid treatment of infection; access to contraception and teaching about contraception. The psychosexual counsellor has provided an internal referral pathway as well as support and advice in regard to a range of mental health issues as well as specific to the specialty of sexual dysfunction. The psychosexual counsellor also provides tutorials for Doctors undertaking training placements in the department, taken the role of mentor for nursing staff when appropriate, and has participated in the provision of training workshops for GP's.

### **The Client Journey**

Client sees a health professional that will have identified the problem and any co-morbidity and a referral letter is generated.

Referral received – date stamped; logged onto Lillie generating the unique identifier; letter acknowledging receipt of referral and giving information, enclosing client information leaflet; return envelope; form to be completed and returned within 4 weeks; is sent to client. Client plastic pocket keeps documentation together in Waiting List file at Stanhope Parade health Centre (SPHC).

Client completes and returns form giving their availability against appointment slots. Date stamped and database updated with relevant information. Any queries are responded to. If the client does not respond a letter is sent to the referrer.

Responding Client is placed on waiting list – database updated with information from the form.

Appointment becomes available – letter inviting client to appointment with their partner. Appointment is logged onto databases.

Initial assessment carried out gathering client information; relationship information; attitude to problem and commitment to therapy. Client is given information; confidentiality is discussed and a statement of understanding is completed; CORE- OM scales are completed; IIEF-5 scale is completed if appropriate; appointment schedule is agreed; if the GP has not generated the referral the client is asked for permission to copy letters to their GP - this may be withheld (and logged on Lillie); clients are asked if they want copies of letters; client/s take home a booklet about Psychosexual counselling and a relaxation pack. All appointments/attendances are logged onto databases. A case file is made up. If wanted the client is sent a copy of the letter sent to the referrer.

Client/s attends individually for full history taking - on average they each attend 2 appointments. After this all appointments for couple therapy are joint appointments (there may occasionally be exceptions to this). The formulation is written and an appropriate sex therapy programme generated with assignment handouts put into the client file ready for the weekly sessions. If wanted the client is sent a copy of the update letter to referrer.

1st Therapy appointment – the formulation is presented and discussed with the couple/individual; goals for therapy are agreed; assignments to be carried out at home are discussed. If there is time sex education material is discussed. All sex therapy assignments are accompanied by handouts.

Subsequent sessions have an agenda of taking feedback on the assignments; discussing key issues; cognitive restructuring work; sex education; setting assignments, until the programme has been completed. The number of sessions this takes will depend on the dysfunction being treated; the number of dysfunctions being treated; the couple and their relationship; the number of missed appointments. The programme may be modified according to the feedback from clients.

At the last appointment CORE – OM and IIEF-5 scales are repeated and a 3- month follow-up is arranged.

3-month follow-up involves an informal review of the process by discussion and relapse prevention work. Discharge is agreed and a discharge letter is sent to the referrer and copied to the GP. The databases are updated and the file is moved into discharge files at SPHC.

## **Referrals**

	2005-2006		2006 <sup>3</sup> / <sub>4</sub> Year to date	
GP	29	80%	22	51%
F.Plan	1	3%	5	11%
PCMHT	1	3%	4	9%
Gynae	5	14%	3	7%
Urology	0		3	7%
GUM			3	7%
Psychiatry			2	4%
CMHT			1	2%
H.V.			1	2%
<b>Totals</b>			<b>36</b>	

### Interventions

Intervention	2005-2006		2006 <sup>3</sup> / <sub>4</sub> Year to date	
	Sex Therapy - CBT	124	35%	139
History Taking	84	23%	54	17%
Assessments	40	11%	32	10%
Formulation	21	6%	13	4%
Couple Counselling	16	4%	2	1%
Individual Counselling	9	3%	6	2%
Follow – ups	9	3%	11	4%
Cancellations	29	8%	39	13%
DNA	26	7%	13	4%
Totals	358		309	

### Gender of clients referred

Gender	2005-6		2006	
Male	20	54%	22	50%
Female	17	46%	22	50%

### Age Groups of Clients referred

Age Range	2005 - 06		2006	
Under 19	1	3%	3	6%
20 - 64	35	94%	41	94%
Over 65	1	3%	0	

### List and number of problems assessed

	2005-6		2006	
Erectile Dysfunction	15	40%	3	14%
Female Hypoactive Desire Disorder	5	13%	5	22%
More than 1 dysfunction	4	11%	1	5%
Retarded Ejaculation	3	8%	0	
Vaginismus	3	8%	3	14%
Other	3	8%	1	5%
Premature Ejaculation	1	3%	4	17%
Gender Issues	1	3%	0	
Male Hypoactive Desire Disorder	1	3%	4	17%
Sexual Aversion	1	3%	0	
Dyspareunia	0	0%	1	5%

## Recommendations

The data collected for this HNA assessment suggest a significant level of unmet need spanning both vulnerable groups and the main STI indicators. A dual approach to better prevention and better services is required to permeate these inequalities.

### Better services

The first recommendations comprise the development of services to facilitate improved access including:

#### Universal

- Achieve the 48 hour GUM target
- The integration of C&SH and GUM services
- Ensure user involvement remains central to service development
- Advertising of services to promote an understanding of the developments within the services to increase awareness and reduce the stigma associated with attendance
- Secure continued funding for the Options Adviser
- Secure continued funding for the TOP Implant insertion service
- Develop access to contraception and sexual health support, advice, signposting including limited availability (condoms, pregnancy testing, chlamydia screening and emergency contraception) through the school nurse drop-in in secondary schools
- Further develop a range of venues able to provide the C-Card
- Develop a range of young people's venues able to provide Chlamydia Screening
- Benchmark the C&SH and GUM services against the MedFASH standards
- Complete an audit regarding the range and availability of contraception and sexual health within General Practice
- Continue the development of young person friendly services in line with the national 'Your Welcome' criteria and the locally identified benchmarks
- Continue data collection and monitoring within the sexual health strategy

#### Targeted

- Continue and monitor the postnatal and post TOP contraception services
- Explore a range of opportunities for a varied approach to meet the needs of particularly vulnerable groups (IDU, young people and BME)
- Explore opportunities for the LAC nurse to provide a level of contraception and sexual health support, advice, signposting including limited availability (condoms, pregnancy testing, chlamydia screening and emergency contraception)

- Explore opportunities for the Youth Offending service to provide a level of contraception and sexual health support, advice, signposting including limited availability (condoms, pregnancy testing, chlamydia screening and emergency contraception)
- Develop a targeted campaign to increase the numbers of the MSM population accessing the service
- Increase the take up of HIV screening in pregnancy
- Monitor services targeted towards the MSM population
- Secure continued funding for services to support the MSM population
- Implement the findings from the local audit related to HIV support

### **Better prevention**

Prevention recommendations range from the universal provision of local campaigns and sex and relationship education to the more specific targeted work required within certain population groups.

#### Universal

- Provide support for schools to achieve healthy school status in line with the local and national targets
- The provision of comprehensive sex and relationship education for secondary schools in the borough
- Support the implementation of the primary SRE resource within local schools
- Support the implementation of national campaigns raising awareness and reducing stigma
- Develop a local campaign encouraging the notion of a sexual health M.O.T.
- Encourage the availability and take up of SRE for parents (based on the speakeasy model) in both Children's Centres and Extended Schools
- Provide training for all staff working with the public to increase capacity and understanding of sexual health needs and services
- Develop a programme of peer education with young people
- Implement a local campaign to tackle stigma and discrimination associated with HIV

#### Targeted

- Develop specific SRE sessions for vulnerable groups (BME, YOS, LAC and MSM amongst others)
- Develop a local campaign to advertise services and raise awareness within vulnerable groups
- Ensure professionals working with vulnerable groups are able to signpost clients to services
- Develop a local campaign to increase the up take of screening within the pregnant population

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