

Improving young people's sexual health

Tackling the sexual health crisis in London

November 2005

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Chair's Foreword

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Rates of sexually transmitted infections are increasing dramatically, more so amongst London's young people. This is a public health crisis that affects us all – those suffering from infection and unwanted pregnancy, and all Londoners via the cost to the NHS.

In producing this report we talked to those working in the capital's sexual health services, educators, the voluntary sector, and perhaps most importantly, young people themselves. We thank them all for working with us and for sharing their views.

Young people need, and want, to know how to protect themselves and others. They often find they receive little, if any, education or advice on sexual health. Sexual health services are often remote and poorly signposted which makes access difficult. We should not make it hard for young people to act responsibly and our report looks at ways in which information and services can be delivered better.

There are, however, examples of excellent practice in London often designed with input from young people themselves. As part of our investigation we visited sexual health clinics and were impressed with the work being done with limited funding, often in cramped and unsuitable accommodation. We welcome the government's increased investment and focus on sexual health, but are concerned that funding is often diverted to other competing areas and that sexual health is not given the priority it deserves.

Our report makes recommendations which we believe will go a long way towards halting the rise in sexually transmitted infections amongst our young people and will provide long-term improvements in London's sexual health.



Joanne McCartney, AM
Chair, 24 November 2005

The Health and Public Services Committee membership & terms of reference

The membership and terms of reference for the Committee were agreed at the meeting of the Assembly on 11 May 2005. Geoff Pope replaced the original Liberal Democrat Member from 15 June 2005.

Joanne McCartney	Chair	Labour
Elizabeth Howlett	Deputy Chair	Conservative
Angie Bray		Conservative
Jennette Arnold		Labour
Geoff Pope		Liberal Democrat
Darren Johnson		Green

Terms of reference

1. To examine and report from time to time on -
 - the strategies, policies and actions of the Mayor and the Functional Bodies
 - matters of importance to Greater London as they relate to the promotion of health in London and the provision of services to the public (other than those falling within the remit of other committees of the Assembly) and the performance of utilities in London.
2. To liaise, as appropriate, with the London Health Commission when considering its scrutiny programme.
3. To consider health matters on request from another standing committee and report its opinion to that standing committee.
4. To take into account in its deliberations the cross cutting themes of: the achievement of sustainable development in the United Kingdom; and the promotion of opportunity.
5. To respond on behalf of the Assembly to consultations and similar processes when within its terms of reference.

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Comments on the findings and recommendations of this report are welcomed. Any comments will be considered as part of the review and evaluation of the work on this issue.

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Executive summary

The sexual health of Londoners is a major public health issue. The rate of sexually transmitted infections are increasing across the country, with the highest rates of increase in London. Our young people have been particularly affected, with 16 - 25 years olds displaying the largest increases in rates of infection.

Not only do these infections cause illness and distress for individual Londoners, but they also have an impact on the NHS and a wider economic cost. To provide focus for this investigation, we decided to consider young people's access to services, and their access to information and advice on sexually transmitted diseases.

We are concerned at the level of knowledge that young people have about the risks to themselves and others of unprotected sex. Schools play a significant role in the personal, emotional and social development of pupils. We believe that the single most important step to improve all young peoples' sexual health over the long-term is to implement a more comprehensive programme of sex and relationships education in secondary schools. This should be delivered by health personnel and/or teachers with specialist training, with support for teachers to develop their expertise in this subject.

There has been recent investment by central government into sexual health services which we welcome. However, as sexual health is not a priority target, it is still not given the importance or resources it deserves. This is not acceptable and needs to change.

The commissioning of services would benefit from innovative and strategic thinking. Young people want to access information and services in different ways such as at their local pharmacy, at school or a local youth project. Clinics and other treatment and testing services should address young people's needs, such as opening hours after school and at weekends.

More primary care services offering initial assessment and testing would allow the specialist clinics to concentrate on those with positive results requiring treatment. Waiting times are still often exceeding the target of 48 hours and this must not be allowed to continue.

We were told about examples of excellent practice on many aspects of information provision, advice, screening and treatment from the public, voluntary and private sectors. These include specialist clinics, fast-tracking young people, tailoring advice to different groups, integrating advice and treatment and housing services in places that young people already use. We welcome these examples and would encourage better sharing of good practice across the capital.

It was emphasized throughout our investigation that it is crucial to involve young people in all aspects of sexual health care and advice services that are aimed at supporting and treating them. We call on relevant groups to ensure that information and advice is appropriately designed for the needs of different groups and is delivered in appropriate settings. In a similar manner, providers of medical services should also consult young people about their design and delivery.

Equipping our young people with the knowledge and ability to protect themselves and others is essential if we are to stop this crisis in sexual health. Our recommendations follow.

Our recommendations

Recommendation 1

We recommend that the pan London Sexual Health Promotion Group and the London-wide Sexual Health Steering Group review what information and advice is currently available and develop future plans to ensure that information and advice is appropriately designed for the needs of different groups and is delivered in appropriate settings.

Recommendation 2

We recommend that Primary Care Trusts, commissioning bodies and providers respond to the needs of young people and consult young people about the design of their sexual health care and advice services. Providers should take steps to share information on effective service design.

Recommendation 3

We recommend that the Department for Education and Skills ensure that sex and relationships education, including sexual health matters, should be required to be taught in secondary schools, with parents retaining the option to withdraw their children. These sessions should be delivered within the broader framework of personal, social and health education.

Recommendation 4

We recommend that the Department of Health and the Department for Education and Skills ensure that specialist certification for personal, social and health education is extended to all schools in London as a matter of urgency.

Recommendation 5

We recommend that the Mayor together with the London-wide Sexual Health Steering Group and pan London Sexual Health Promotion Group explore with the London media the possibility of a London-specific media campaign on sexual health for young people.

Recommendation 6

We recommend that in order to assist in taking an inclusive and collaborative approach to young people's sexual health:

- Children and Young People's Partnership Boards (which all include voluntary and community sector representatives) explicitly include sexual health in their remit and
- targets to improve sexual health are set within Local Area Agreements

Recommendation 7

We recommend that London strategic health authorities direct:

- Primary care trusts to work together strategically in commissioning services within and across geographical sector; and
- Primary care trusts and acute trusts to work together to form clinical networks that will ensure delivery plans are co-ordinated and best practice is shared.

Recommendation 8

Funding designated for sexual health services should be transparent and monitored to ensure that it reaches GUM budgets. Where this does not happen, future funding should be ring-fenced.

Recommendation 9

We recommend that the Department of Health give sexual health the same priority as other core services and that the Healthcare Commission incorporate the performance of GUM clinics in its assessment process for primary care trusts and hospital trusts.

1 Introduction

- 1.1 London has a great deal to celebrate and be proud of. But where London has problems, like its successes, they can be on a bigger scale to the rest of the country. This is true of the sexual health crisis facing London's young people. Although rates of sexually transmitted infections (STIs) are increasing across the country, **they are increasing fastest in London.**¹
- 1.2 There are clear links between social deprivation and sexual health² and London has high levels of deprivation. It also has a diverse and mobile population, large health inequalities among children and adults and marked differences in levels of educational attainment³ – all factors that influence sexual health. In addition, young people themselves say that unprotected sex is more likely to occur along with high levels of alcohol consumption⁴. For this group, then, the need for good advice, prevention, support and sexual health services is all the more urgent.
- 1.3 Much of the need is focused in communities already experiencing health inequality. Teenage pregnancy and HIV deepen this inequality. **At the same time, HIV and sexually transmitted infections disproportionately affect black and ethnic minority communities and young people in London**⁵.
- 1.4 But the highest costs of all are the human costs. Unplanned pregnancy, sexually transmitted infections and HIV are life changing and life threatening events. **For young people, unwanted pregnancies and sexually transmitted illness can permanently damage their life chances.**
- 1.5 High levels of unsafe sex also have social costs to London. Having a sexually transmitted infection is not just bad news for the individuals concerned; it is bad for London collectively. London's NHS is facing serious economic consequences as a result of the growth in sexual health need in the capital. **HIV treatment costs in London are increasing by more than £15 million a year, with lifetime NHS costs in London increasing by £500 million each year. On top of this, hospital capacity is being taken up by people with HIV related illness, which could have been prevented with earlier diagnosis and treatment (or better education)**⁶. **The annual cost of chlamydia and its consequences across the UK is estimated at more than £100m⁷, towards which London will be making a major contribution with over 20 per cent of cases.**
- 1.6 Our investigation revealed many problems with the sexual health services young people receive, big gaps in the advice and information available to young people and plenty of worrying statistics. However, it also found many

¹ Choosing Health: A briefing on sexual health in London London Health Observatory and Health Protection Agency June 2005

² Family Planning Association written evidence to the committee

³ Regional Public Health Group written evidence to the committee

⁴ B. Hatherall, N. Stone, R. Ingham, J. McEachran, The Choreography of Condom Use; how, not just if young people use condoms, Department of Health, 2005, p.72.

⁵ Londonwide Sexual Health Framework, North West London Strategic Health. Authority, 2003.

⁶ Londonwide Sexual Health Framework, North West London Strategic Health. Authority, 2003.

⁷ www.dh.gov.uk/PolicyAndGuidance/HealthandSocialCareTopics/chlamydia

examples of good practice across the capital and evidence that in London we have many dedicated teams and individuals working with and for young people at risk of or suffering from sexually transmitted infections.

- 1.7 This report sets out the main issues, looks at policies in place to improve sexual health among young people, gives examples of some of the education and services that are already happening and makes recommendations about how the current situation can be improved.

About this investigation

- 1.8 Sexual health is a very wide and complex issue. To provide focus for this investigation, we decided to consider young people's access to services, and their access to information and advice on sexually transmitted diseases. We have defined the term 'young people' quite broadly to include young people of secondary school age up to their early twenties. Young people in London are highly diverse, differing in educational attainment, culture, age, race, family background and how much money they have. To meet their needs, different services and ways of providing information and advice need to be employed. Because young people are not all the same, the services on offer should not all be the same either. This makes it more complicated to get the services right.
- 1.9 Our work has included analysing information from the Department of Health, the NHS, voluntary sector organisations, and faith and community organisations. This has helped us to identify some of the main issues, and has enabled local organisations, that work closely with young people, to get involved in our scrutiny process. We thank them for their contribution. A full list of those who submitted written evidence can be found at Appendix A.
- 1.10 We visited the Chelsea and Westminster Healthcare NHS Trust, Clinical Directorate of HIV and Genito-urinary Medicine and the Victoria Clinic, which focuses on services for young people. This allowed us to meet professionals working in the field of sexual health and to visit clinics that provide sexual health services to young people. Our scrutiny review also included two formal hearings at which issues were discussed in more depth. Appendix A also gives details of these visits and hearings.
- 1.11 We held a day-long consultation event that was attended by approximately 100 young people aged from sixteen to eighteen, and professionals from health organisations and youth groups. We wanted to hear young people's opinions on sexual health issues and to seek their views on the types of sexual health services that they would like.

What do we mean by 'sexual health'?

- 1.12 The World Health Organisation's definition is:
"Sexual health is the state of physical, emotional, mental and social well-being, related to sexuality: it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."

2 London's sexual health

2.1 Since the mid 1990s, London has seen large increases in most sexually transmitted infections. This is all the more concerning because it follows a decline in most infections during the late 1970s and 80s. This decline is attributed to safer sexual behaviour due to awareness of the risk of HIV⁸.

- Up to one in ten sexually active young women in London are thought to be infected with chlamydia – much higher than the national average^{9 10}. Chlamydia is one of the most common sexually transmitted infections, but can easily be cured by antibiotics. However, if untreated in women it can lead to pelvic inflammatory disease, ectopic pregnancy (where the baby develops in the wrong part of the woman's womb) and infertility.

A friend of mine said she had [Chlamydia] and she said that, because I didn't realise how common it is, and she said [...] she didn't know how she'd caught it because the first person she slept with, they were both virgins and somehow she'd caught it, so I was really terrified after that so I went for a check and found out that I had it, but I'd only slept with one person

Young woman, aged 20¹¹

- Young people have experienced the highest rises in sexually transmitted infections, especially chlamydia¹².
- Between 1999 and 2004, the under 25s in London experienced an increase of 160 per cent in diagnoses of gonorrhoea to over 3,200 cases, and an even more dramatic 290 per cent increase in chlamydia diagnoses to 11,709 cases.¹³
- In 2004, 1,375 per 100,000 people between 20 and 25 years old were diagnosed with Chlamydia, an increase from a rate of 778 in 1999. A rate of 361 cases of gonorrhoea, per 100,000 in this age group, was recorded in 2004, up from 337 in 1999. The rates per 100,000 people at this age group for syphilis and herpes in 2004 are 12 and 230 – rates which have increased from 3 and 748 per 100,000 in 1999.
- There have been a number of major syphilis outbreaks in London over the last three years, even though it had been almost wiped out from the capital in the early 90s.

With STIs, there are lots of them about and stuff, but there's probably more chance of getting pregnant than having an STI, and seeing as I've already got one, chances are down a bit hopefully

Young woman, aged 17¹⁴

⁸ Epidemiological data on Sexually Transmitted Infections hpa website. www.hpa.org.uk

⁹ Family Planning Association written evidence to the committee

¹⁰ Department of Health press release 2005/0294

¹¹ B Hatherall, N Ston, R Ingham and J McEachran, The choreography of condom use: how, not just if, young people use condoms, The Centre for Sexual Health Research, University of Southampton, for Brook, 2005.

¹² http://www.lho.org.uk/HIL/Lifestyle_and_Behaviour/SexualHealth.htm - website of the London Health Observatory

¹³ Sexually transmitted infections in young Londoners HPA 2004 and updated data from HPA

¹⁴ B Hatherall, N Stone, R Ingham and J McEachran, The choreography of condom use: how, not just if, young people use condoms, The Centre for Sexual Health Research, University of Southampton, for Brook, 2005.

- HIV diagnoses in London are at their highest ever levels, with more than 3,000 people diagnosed in 2002. This is an increase of 80 per cent since 1996. Half of all under-25 year-olds in England seeking HIV treatment live in London. Worrying, too, is the estimation that there are currently 30,000 people living with HIV in London of whom 30 per cent remain undiagnosed. The total number of people with HIV in London is currently increasing by over 10 per cent each year.

2.2 There are some signs of improvement in the last two years for some conditions. Rates of gonorrhoea in the under 25s in London fell between 2002 and 2004, but even with this, diagnoses are increasing in gay and bisexual men. Rates of infection of herpes have also declined since 2002.

2.3 Despite these improvements, the HPA have stated publicly that “there is no room for complacency in relation to STI, and there should be no reduction in control and prevention efforts”.

2.4 London has very high rates of unwanted pregnancy and abortion and some of the highest rates of teenage pregnancy in the country. Across London, 51 in 1000 women 15-17 years old became pregnant in 2003. Seven of the ten local authorities with the highest under-18 conception rates are in London. Unlike the national pregnancy rate, the rate in London is not dropping. There are marked differences across London with 19 boroughs seeing a decrease in rates while others seeing a marked increase. Rates rose in between 1998 and 2003 Barnet, Barking and Dagenham, Redbridge, Enfield and Lambeth.¹⁵

¹⁵ Choosing health: a briefing on sexual health in London op cit

3 Sexual health policy

National policy

- 3.1 Improving young people's sexual health and reducing teenage pregnancy are government priorities. The 2001 National Strategy for Sexual Health and HIV aims to:
- reduce the transmission of HIV and sexually transmitted infections. Includes targets for reducing HIV and gonorrhoea diagnoses 25% by 2007.
 - reduce the prevalence of undiagnosed HIV and sexually transmitted infections
 - reduce unintended pregnancy rates
 - improve health and social care for people living with HIV
 - reduce the stigma associated with HIV and sexually transmitted infections
- 3.2 In November 2004 the Public Health White Paper *Choosing Health* also addressed the issue. It proposed:
- new funding to modernise sexual health services
 - speeding up the introduction of national screening for chlamydia to cover the whole of England by 2007
 - a 50 per cent reduction in the number of teenage pregnancies by 2010
 - setting a target that by 2008 everyone referred to a genitor-urinary medicine (GUM) clinic should have an appointment within 48 hours
 - a new national sexual health campaign
 - funding a young person's development programme to pilot ways of reducing teenage pregnancy and improving sexual health.
- 3.3 There is a National Teenage Pregnancy Strategy, which was launched by the Prime Minister in June 1999. The two national targets are to:
- halve the under 18 conception rate in England by 2010
 - increase the participation of teenage mothers in education, training or work to 60 per cent by 2010 to reduce the risk of long term social exclusion.
- 3.4 Another national strategy that has a bearing on the sexual health of young people is the National Healthy Schools Programme as we discuss in 5.13 – 5.19. This includes a National Healthy Schools Standard, one of the themes of which is sex and relationship education.

Sexual health policy for London

- 3.5 The London-wide Sexual Health Framework 2004 sets out a framework for the development and delivery of sexual health services in London. It was by agreed by the Chief Executives of the five strategic health authorities that cover London and produced by a London-wide Sexual Health Steering Group.
- 3.6 It has a vision for London; *'Over the next three years there will be a sustained improvement in the sexual health of Londoners. This will be achieved through*

the establishment of coordinated programmes of evidence-based sexual health promotion and HIV prevention work, and through improving access to and choice of diagnostic and treatment services.'

- 3.7 *'Services will be taken closer to the patient and to communities through increasing the role of primary care and community based Voluntary and Community Organisation services. These services will be supported by a strengthened role for GUM [genitor-urinary medicine] services overseeing clinical governance and the development and operation of managed service networks.'*
- 3.8 *'This should be underpinned by a greater focus upon self management supporting people to take a greater role in maintaining their sexual health. As a consequence of this work there should be an improved experience for people using sexual health and HIV services'*
- 3.9 Across London there is a great deal going on to address the sexual health needs of young people. This includes collaborative work to improve access to early contraceptive and sexual health advice; established strategies and programmes in London boroughs to prevent teenage conceptions and support teenage parents, and structures to support action in schools through the National Healthy Schools Programme, as well as extensive services provided by the voluntary sector.
- 3.10 The Mayor of London also has a programme to support the participation and engagement of Londoners in sexual health initiatives.

4 Involving young people and the community

- 4.1 It was emphasized throughout our investigation that it is crucial to involve young people in all aspects of sexual health care and advice services that are aimed at supporting and treating them.
- 4.2 Many areas are already involving young people to help review, develop and evaluate local programmes to address sexual health and teenage pregnancy. Young people can be effectively involved through school peer education programmes, mystery shopper surveys of local services and so on. Feedback from the workshops with young people that we held as part of this investigation concluded that young people are very interested in sexual health issues and want to get actively involved in promoting sexual health. It was noted that there is no point in providing any service for young people unless they are involved in designing and delivering it.

Old people don't want you to have sex. They don't want you to have fun... It's because they're jealous

Young woman aged 15¹⁶

- 4.3 Young people are more vulnerable to sexually transmitted infections and have been found to be less likely to comply with treatment. So it is important that they have access to appropriate information, support and advice. This information and support should be tailored specifically to the needs of young people, and sexual health services should undertake consultation with young people to ensure that their views are heard and their needs met.
- 4.4 All London boroughs and primary care trusts must develop a range of approaches to enable young people to access sexual health information, advice and services in locations that they already go to, which are designed in conjunction with and tailored for local young people.
- 4.5 At our consultation event delegates emphasised the need for more information about sexual health issues and felt that it could best be provided at school and places where they went, such as youth and sports centres. There is also a real need to distribute information through websites, on the radio or at young people's events and concerts.
- 4.6 Examples of how young people have been involved include work by Camden Primary Care Trust. As well as surveying young people who used its services, Camden conducted focus groups in schools and colleges to involve those who were not attending the young people's services to explore:
- the best location for sexual health services
 - the target age range of dedicated clinics and the acceptability of mixed gender clinics
 - potential barriers to attendance at screening for infections.

¹⁶ Young People's Perceptions of Contraception and Seeking Contraceptive Advice, Counterpoint (UK) Limited, for Department of Health, 2001.

How do we ensure the needs of all young people are met?

- 4.7 All young people are different and have different needs. For example, The 2001 census showed nearly one in eight pupils in London comes from a minority ethnic background, a figure expected to rise to around one in five by 2010. In London, over 300 languages are spoken. Young people come from many kinds of families, and many faiths or none.
- 4.8 Confidentiality cannot be guaranteed in school based sex education lessons and access to individual personal support does not always reflect the needs of pupils.¹⁷ The Committee received evidence regarding young people who may require more specific support than is available in a classroom. Conversely it was suggested that young people may welcome discussing sexual relationships in schools due to inability at home. This illustrates the complexity of addressing the issue of sexual health for young people.
- 4.9 Recent research shows that sex education programmes that include information on contraception as well as the option of abstinence are an effective means of informing and educating young people about sexual health. Within any sexual health programme of learning and advice young people must be given the full range of options so that they can make informed choices and know where to go for further advice and support when they need it. A range of different approaches will be needed but all approaches should be non-judgemental and allow young people to make informed choices.
- 4.10 Local communities have an important role in raising awareness of sexual health issues. Community involvement is a key area that needs to be addressed if there is going to be improvement in the sexual health of young people in the capital. This is an area where the work of the Mayor can add value to some of the ongoing interventions in London. One of the aims of the Mayor's health policy programme on sexual health is to promote the engagement of communities in activities aiming to improve sexual health. Recent mayoral initiatives have focused on young people and black and minority ethnic (BME) groups.
- 4.11 In the sections below we highlight certain groups and discuss how services should be tailored to these groups, but this list is not exhaustive.

Black and Minority Ethnic (BME) young people

- 4.12 The diversity of BME communities needs to be recognised, with different sexual health issues affecting different communities. Levels of HIV infection are higher for people from Africa and of African origin. Certain other sexually transmitted infections, such as gonorrhoea, are a particular problem for people of African-Caribbean origin¹⁸.
- 4.13 The way in which information and advice is given about sexual health should be sensitive to these cultural differences and reflect the realities of the

¹⁷ Ofsted report on PSHE in secondary schools, January 2005

¹⁸ SHAKA project in Lambeth, Lewisham and Southwark, reported in submission on behalf of the Regional Public Health Group London and London Strategic Health Authorities

burden of disease. There may be particular taboos around sexual issues and a resultant inability to talk freely if the right approach is not found. The aim should be to raise awareness of issues relevant to specific communities, develop interventions and also provide input to the local health and social care sector on how best to address these issues.

- 4.14 Because of the difference in how different groups are affected and the importance of culture in behaviour, involving and supporting diverse local communities to be involved in health promotion is particularly crucial. Such community groups are familiar with the issues faced within their communities, as well as the norms that operate to shape young people's awareness and actions. This approach will enable the development of sexual health promotion that is specific to different communities' cultural norms.
- 4.15 For many communities, faith is an intrinsic part of their lifestyle and culture and so information on sexual health should consider this. It may be most appropriate for some young people that awareness raising takes place within their own faith context, thus enabling them to develop a deeper understanding of the issues at hand, as well as enabling them to make informed choices.
- 4.16 This type of community engagement will not be without its challenges, but in London with a highly diverse population it is crucial to success. More must be done through engaging community leaders, particularly those who already work with young people. To suit their use, information on sexual health services should also have details of supportive faith community representatives, alongside other sources of counselling and advice.
- 4.17 However, it should also be remembered that for some young people over-reliance on delivering education through this route would be inappropriate because their sexuality or lifestyle choices would lead them to be less open in a community or faith group setting than in an anonymous one.

Gay and Lesbian young people:

- 4.18 The written submissions emphasise the fact that gay and lesbian, bisexual or transgender young people often suffer implicit and explicit discrimination, particularly in terms of their access to sexual health information, advice and services. Sex and relationships education commonly focuses almost exclusively on heterosexual relationships, and thus may be insufficient. Young people may miss out on comprehensive and useful education on issues regarding sexuality, and some may be made to feel as if their sexuality and experiences 'don't count'. High quality information is key to people's understanding and acceptance of sexual orientation, and by challenging negative stereotypes can help to positively support the needs of all young people and should support the needs of young people regardless of their sexuality.

Young Men

- 4.19 There is a particular need to support young men with information, advice and services. Traditionally sex education has focused on reproduction and therefore predominantly on women. This does not enable young men to

develop their understanding and ability to make responsible decisions. Services may also treat them as problematic, especially when they turn up to a service in groups. In addition, family planning and contraceptive services are primarily targeted at women.

- 4.20 In order for sex and relationship education (SRE) and sexual health services to be effective it is vitally important that young men are equally targeted in order to change their attitudes and behaviour – it is the responsibility of both partners in a relationship to make safe choices. **It is important to ensure that sex and relationship education caters for the particular needs of young men as well as young women**, that sexual health information portrays young men in a range of positive ways, and that it shows that sexual health is just as much an issue for young men as for young women.

Young people who are not in school

- 4.21 School-based sex and relationship education is clearly an important means of delivering accurate and comprehensive information about sex and relationships to the majority of young people. However, there must be other means to deliver this information for those who do not regularly attend school or who are excluded from school altogether. The written submissions show that sexual health is taught in pupil referral units. However these units must ensure that their programme is tailored to the needs of each young person who attends the Unit.

- 4.22 The provision of advice and information in other settings such as youth and community services is one way of addressing the advice and information needs for those young people who have left school and are not receiving further education. Youth workers are well placed to reach young people who are not in school, but they will need sexual health education training, which includes work on self-esteem and relationships.

Young Asylum Seekers

- 4.23 People claiming asylum are entitled to all NHS services, until such time as their asylum application is refused. People who are refused asylum are not entitled to any free NHS hospital services, except a small list of those allowed on public health grounds (which includes all sexually transmitted infections apart from HIV). Therefore if a person is refused asylum and then discovers that they have syphilis, they will be entitled to free treatment for the syphilis, but if they discovered that they had HIV they would not be entitled to any treatment for the virus. The only exception to this is where someone was already following a course of treatment when their asylum claim was refused. If they were already on treatment, this could continue for as long as they were in the country. The Government is currently considering changes to free eligibility of non-nationals for health services especially in respect to primary care. Therefore in providing advice and treatment for some young people, there may also be the need to address the specific issue of entitlement.

Recommendation 1

We recommend that the pan London Sexual Health Promotion Group and the London-wide Sexual Health Steering Group review what information and advice is currently available and develop future plans to ensure that information and advice is appropriately designed for the needs of different groups and is delivered in appropriate settings.

Recommendation 2

We recommend that Primary Care Trusts, commissioning bodies and providers respond to the needs of young people and consult young people about the design of their sexual health care and advice services. Providers should take steps to share information on effective service design.

5 Education, Information and Advice

How do young people learn about sexual health?

- 5.1 Young people learn about sex from a variety of sources including friends, parents, school, older siblings, television programmes and magazines. Some of these sources and negative peer pressure, can lead to the development of myths about sex and may lead to unsafe sexual activity. At the consultation event young people acknowledged that friends, and on occasion family members do not always give correct information¹⁹.

You read about it in magazines, but you talk to your mates about it, never to someone like your mother

Young woman aged 17²⁰

- 5.2 Evidence also commented on the dual standards of our society today which on the one hand presents young people with images and messages that highly sexualise youth, but on the other hand do not back up the sexualisation with adequate learning, skills and resources. The attitude of the media was also criticised for similar double standards – seeming to ‘promote’ sex but too ready to condemn initiatives to teach understanding of sexual issues to young people.^{21 22}

- 5.3 National research on sexual behaviour in Britain shows that the median age of first heterosexual sex for men and women is now 16 years and that only half of young people used a condom the first time they had sex²³. The prevalence of sexually transmitted infection is higher amongst men and women for whom first intercourse occurred before age 16, and amongst those whose main sources of information about sexual matters was friends and others.

It just seems really odd. Condoms just seem mostly for like anti-pregnancy I'd say

Young woman, aged 20 years²⁴

- 5.4 Awareness of the dangers of unprotected sex has reduced among young people. A survey by the School's Education Unit showed that in 1993 26 per cent of boys aged 12 to 15 years were concerned about HIV, in 2003 only 6.5 per cent of similar boys were concerned.²⁵

¹⁹ Written submission from the Regional Public Health Group and London Strategic Health Authorities

²⁰ Young People's Perceptions of Contraception and Seeking Contraceptive Advice, Counterpoint (UK) Limited, for Department of Health, 2001.

²¹ Written submission from the Royal College of Nursing

²² London Assembly Health and Public Services Committee witness session on sexual health of young people

²³ National Survey of Sexual Attitudes and Lifestyles (2000)

²⁴ B Hatherall, N Stone, R Ingham and J McEachran, The choreography of condom use: how, not just if, young people use condoms, The Centre for Sexual Health Research, University of Southampton, for Brook, 2005

²⁵ Schools education Unit (2004) and Trends: Young People and Emotional Health and Well Being incorporating Bullying 1983-2003

Interviewer: *Do you worry about HIV?*

Interviewee: *It's just one of those big, scary things, like now apparently there's a cure for it, isn't there? [...] They can treat it. But like, you know, it is, it used to be, didn't it, like a big killer HIV?*

Young woman 20 years²⁶

- 5.5 At our consultation event young people discussed the best way to raise awareness of sexual health issues. Some young people said they had good discussions in sex education classes at school whilst others had received little education or information. They thought that the best way to achieve increased awareness would be through a combination of good quality school based sex education and discussions with parents.

Sex and Relationship Education – what is taught in school?

- 5.6 Schools play a significant role in the personal, emotional and social development of pupils. All schools must have a sex and relationships education policy. The Government expect this to be delivered as part of personal, social and health education, but do not determine what elements are taught.²⁷ In addition, personal, social and health education is a non-statutory part of the national curriculum. This means that the only elements of sex and relationship education that are statutory are the biological aspects taught within the science curriculum.

The variability of provision of sex and relationship education in compulsory education settings is clearly failing vast numbers of young people, generation after generation. ²⁸

- 5.7 Guidance has been issued to schools to support and promote the teaching of sex and relationship education. This states that primary school children should be taught about puberty and menstruation and at secondary school children should be taught about contraception, abortion and sexually transmitted infections, including HIV and AIDS. The guidance states that this teaching should be delivered having regard to the age and cultural background of the young people and be contained within a moral framework.²⁹ However the guidance is non-statutory.
- 5.8 The non-statutory nature of personal, social and health education gives rise to perceived low importance of sex and relationship education in some schools. There is no guarantee that young people will be taught about sexual health issues within the school setting.
- 5.9 We received evidence that schools will often offer education about preventing pregnancy as part of the National Teenage Pregnancy Strategy. This would provide a good opportunity to discuss the wider dangers of unprotected sex, but it is often missed.

²⁶ B Hatherall, N Stone, R Ingham and J McEachran, *The choreography of condom use: how, not just if, young people use condoms*, The Centre for Sexual Health Research, University of Southampton, for Brook, 2005.

²⁷ Sex and relationships Education Guidance July 2000, DFES

²⁸ Written evidence from the Royal College of Nursing

²⁹ Sex and relationships Education Guidance July 2000, DFES

- 5.10 Two of the organisations which submitted evidence suggested that education about sexual health was a problem in some faith schools, where there was a lack of recognition that young people have sexual relations. For example, the Jewish Aids Trust said from its experience little, if any, sex and relationship education is being provided in the 84 Jewish schools in the UK.^{30 31}
- 5.11 On the other hand, evidence from Oasis Esteem noted that many faith groups recognise their role in delivering responsible and non-judgemental sexual health and relationship education for young people. Faith communities are the largest providers of youth work in the UK. The Christian Church employs two thirds of salaried youth workers in England³² and also has a network of 86,000 volunteers. Oasis has been offering sex and relationship education since 1988. It offers training to equip volunteers to go into schools and youth groups to deliver a variety of lessons concerning sex and relationship education.
- 5.12 Young people want to talk about relationships, emotions and feelings. They want to develop skills of negotiation and to talk about sexual health issues from their own family backgrounds, cultures or personal perspectives. The quality of sex education varies across schools in London with some schools doing very well and encompassing the broader issues and others only providing the statutory minimum.

The National Healthy Schools Standard

- 5.13 The Committee welcomes the National Healthy Schools Programme and the commitment to achieving better health for children. The National Healthy Schools Standard was introduced in 1999 to support and complement the personal, social and health education framework within schools. The effective delivery of sex and relationship education is part of the success criteria of the standard. The National Healthy Schools Standard criteria for sex and relationship education are as follows:
- staff have a sound basic knowledge of sex and relationships issues and are confident in their skills to teach sex education and discuss sex and relationships.
 - staff have an understanding of the role of schools in contributing to the reduction of unwanted teenage conceptions and the promotion of sexual health.
 - the school has a planned sex and relationships education programme (including information, social skills development and values clarification) which identifies learning outcomes, appropriate to pupils' age, ability, gender and level of maturity and which is based on pupils' needs assessment and a knowledge of vulnerable pupils.
 - the school has a policy which is owned and implemented by all members of the school including pupils and parents and which is delivered in partnership with local health and support services.

³⁰ Written evidence from the Jewish Aids Trust

³¹ Written evidence from Brent Primary Care Trust

³² Rev Danny Brierley, Oasis Trust evidentiary hearing

- 5.14 Local education and health partnerships between primary care trusts (PCTs) and local education authorities (LEAs) are the key delivery agents of the National Healthy Schools Standard. In London there are 33 local education and health partnerships. The partnerships are supporting schools to address the above criteria. Of the 2,486 schools in London, 324 are registered on the National Healthy Schools Programme database as having achieved the specific national criteria for sex and relationship education, with a further 283 currently working towards its achievement. (This is in the context of 667 London schools having achieved national healthy school status and a further 950 schools working towards national healthy school status). Primary care trusts and local authorities should seek to encourage local schools to work towards obtaining the national criteria for sex and relationship education.
- 5.15 In managing the local healthy schools programme a key role for the education and health partnership is to broker support from a range of service providers on behalf of schools and to signpost schools to this support. The partnerships also play a key role in quality assuring the contribution of outside agencies to work in schools– this is particularly valued by schools in relation to sex and relationship education where there may be concerns about how the values and ethos of outside agencies complement those of the school.

Improving sex and relationship education in schools

- 5.16 Sex and relationship education must equip young people with the knowledge and confidence to make informed choices about whether or not to embark on a sexual relationship and how to withstand negative peer pressure. It is imperative that if they choose to embark on a sexual relationship they have the necessary knowledge to protect themselves and others. Children and young people must be given age-appropriate education before they become sexually active in order to prevent unsafe patterns of behaviour forming.
- 5.17 We would stress that this education must be appropriate for all pupils. It should consider cultural appropriateness and the need of minorities. An example of guidance that can help on this was ‘Stand up for Us’ issued by the Department of Health on challenging homophobia.³³ We would encourage the use of health personnel and teachers with specialist training to deliver sessions on sex and relationship education.
- 5.18 The Committee believe that **the single most important step to improve all young peoples’ sexual health over the long-term is to implement a much more comprehensive programme of sex and relationships education, that would be required to be taught in schools.**
- 5.19 In the absence of comprehensive sex and relationships education as statutory within the school curriculum, there is no clear route through which to give information and advice about sexual health to young people, leading to widespread variations by school. This ‘hit and miss’ approach means that some young people may have access to excellent, targeted and relevant information, whereas others have access to nothing that is specifically tailored for them.

³³ ‘Stand up for us: challenging homophobia in schools’, Department of Health 2004

5.20 The Committee believe that the scope of sex and relationship education that is required to be taught in secondary schools should be broader than at present. This view stems from the central role that schools play in most young people's lives and is in line with the recommendations of the House of Commons Health Select Committee in 2003 and 2005. At present only some schools offer a good standard of sex and relationship education, and the Committee believe that all young people should have access to high quality information through their school. However, we believe that parents should retain the option to withdraw children from these sessions.³⁴, ³⁵

Recommendation 3

We recommend that the Department for Education and Skills ensure that sex and relationships education, including sexual health matters, be required to be taught in secondary schools, with parents retaining the option to withdraw their children. These sessions should be delivered within the broader framework of personal, social and health education.

Supporting teachers

5.21 We were informed that there are challenges that need to be addressed in order to improve the way sex and relationship education is taught. People at our consultation event reported varying experiences, with some describing teachers being chosen arbitrarily, without reference to relevant skills, experience or aptitude, and other delegates disagreeing. Some teachers feel embarrassed talking about sex and often do not have the confidence to deal with issues surrounding sex and relationship education, such as sexuality. However, it was agreed that young people want to talk with teachers and youth workers, and because of their close involvement with young people, teachers and youth workers are ideally placed to do this.

5.22 These concerns have been recognised by the Office for Standards in Education (Ofsted) which has recently reported that:

- the quality of teaching by specialist teachers remains considerably better than that of non-specialist form tutors. Tutors who teach personal, social and health education are given insufficient training to help them improve their subject knowledge and the teaching skills needed in personal, social and health education
- some schools do not provide personal, social and health education in any form
- too few schools involve pupils in policy development as a way of ensuring that personal, social and health education is relevant to their needs
- in too few personal, social and health education lessons were pupils given opportunities to analyse, reflect, speculate, discuss and argue constructively about their understanding of issues

³⁴ This could follow the model of requirement for schools to offer 'collective acts of worship' with a parent having the right to withdraw their child, first introduced in the Education Act 1944 and re-enacted through schedule 19 School Standards and Framework Act 1998

³⁵ Two Members of the Committee, Darren Johnson and Geoff Pope do not agree that parents should have the right to withdraw their children from sex and relationship education.

- monitoring and evaluation procedures of personal, social and health education are a significant weakness in too many schools³⁶.

5.23 The Government has recognised the need to improve the quality of sex and relationship education teaching and has recently attempted to improve teachers' capacity in terms of their continued professional development, through a certification of personal, social and health education via the National Healthy Schools Programme. By March 2006 every secondary school with 20% free school meals (an indicator of social disadvantage) or more is to be targeted by the Healthy Schools programme and should have a teacher who has achieved PHSE certification and access to the knowledge and skills of a certified community nurse.³⁷

5.24 The Committee welcomes the specialist certification for personal, social and health education and welcome the emphasis on schools in areas of disadvantage, as this corresponds with higher STI rates. **The Committee would wish, however, to see this scheme extended urgently to all schools.** Where schools involve tutors in delivering personal, social and health education rather than specialist teachers, all those involved should receive specialist training to help them improve their subject knowledge and their use of appropriate teaching methods. This was emphasised at the consultation event where it was felt that many teachers did not have appropriate training and were already burdened by heavy workloads.

Recommendation 4

We recommend that the Department of Health and the Department for Education and Skills ensure that specialist certification for personal, social and health education is extended to all schools in London as a matter of urgency.

The role of parents

5.25 The role of parents in meeting the sexual health and emotional needs of young people is also extremely important. There is good evidence that including parents in sexual health information and prevention programmes is effective. Young people whose parents discuss sexual matters with them are more likely to use contraception at first intercourse. Parents should be offered information and support from the school.

I think my mum knows I'm having sex with my boyfriend, but as long as I don't kind of officially tell her, she doesn't bother me
Young woman aged 15³⁸

5.26 Many parents find it difficult to talk to their children about sex and relationships. It is therefore important that much more is done to inform and support parents, to enable them to communicate openly with their children about sex and relationships. At the consultation event there were discussions

³⁶ Ofsted report on PSHE in secondary schools, January 2005

³⁷ Department of Health written submission

³⁸ Young People's Perceptions of Contraception and Seeking Contraceptive Advice, Counterpoint (UK) Limited, for Department of Health, 2001

about how this could be achieved in practice, particularly where there are taboos in some communities about discussing sex with young children.

Case study – Speakeasy

Speakeasy is a community-based education programme that provides parents/carers with the skills and confidence needed to talk to their children about sex. The programme offers an opportunity for parents and carers to learn together and acquire the confidence and skills they need to talk to their children about sex and sexuality. It is designed to be fun and relaxed, providing an atmosphere where parents/carers can learn together from their own experiences.

Courses are run in selected areas of high teenage pregnancy and consist of seven weekly workshops. Although there are specific course outcomes, the content is needed and participants actively influence and shape the sessions. Coursework is eligible for accreditation through the Open College Network. Recruitment is through partnership working with local voluntary and statutory organisations.

In an independent evaluation of the programme *Speakeasy* was described as “mature and successful”, and “effective and appreciated”³⁹.

The Role of the school nurse

5.27 The involvement of school nurses could provide a direct way of improving young peoples sexual health through the provision of advice and by giving information about GUM and other sexual health services. One of the difficulties with this is that many schools do not have a school nurse. At the consultation event, we were informed that under-investment in school nurses is acute and that in some areas, school nurses cover as many as 10-20 schools.⁴⁰ School nurses will need to be supported in this role and be adequately trained to ensure that they have the ability to advise young people in a non-judgemental manner.

5.28 There is also a role for the involvement of other health care workers in school based sex and relationship education programmes. We were informed that in Lambeth and Southwark there is a long history of running mock family planning clinics, where as part of the sex education programme groups of schoolchildren are taken into a clinic. At the clinic, they are taken through the process of registration and they are shown what happens when they come for advice or treatment. Through this process, they become familiar with the people at the clinic and the clinic environment.⁴¹

Community and voluntary organisations

5.29 Community organisations can play a valuable role in improving the sexual health of young people in a number of ways:

- promoting and displaying information – for example advertising and campaign posters (such as those available for the Family Planning

³⁹ Described in the written evidence from the Family Planning Association

⁴⁰ Minutes of Meeting 17th March 2005

⁴¹ Minutes of Meeting 8th February 2005

Association's Contraceptive Awareness Week and Sexual Health Week), providing leaflets and other materials for people to take away, and signposting to local sexual health services

- hosting information and education sessions on-site – encouraging participation among those who attend the organisation's normal activities
- hosting health sessions on-site – for example linking in with local health providers, and providing testing and treatment for sexually transmitted infections (as proposed in the Public Health White Paper).

5.30 Young people are more likely to welcome information and advice about sexual health in settings where they already feel comfortable, therefore the use of existing community organisations to deliver these messages is a vital means of reaching young people, particularly those who reject more formal sources of information and services. Community organisations can also provide a useful springboard for further outreach work, and can link with local healthcare providers for a more integrated approach and service⁴².

Peer educators

5.31 An example of how helpful it can be to involve young people is in the area of giving advice. Young people told us that it is generally older people who give advice on sexual health. They advocated that one or two young people should accompany anyone delivering sexual health education. These people are known as peer educators.

5.32 This kind of project work is particularly effective in areas of social disadvantage where there is a culture that limits young people's aspirations, and where academic success is often neither encouraged nor considered important for acceptance. Young people were keen to get involved in peer education. They emphasised that they did not want repeated discussions; they wanted to take action that would have tangible outcomes. They felt that centres should be available throughout London where young people could receive training and education so they could go out and educate other young people.

I think it was good that younger people were discussing it – you get more embarrassed if older people talk to you so I thought it was better.

Young person talking about a peer education project⁴³

5.33 We heard about some research done by APAUSE⁴⁴. In this project, adults were trained to run the same sessions as the peer educators. Although older people (experts, teachers and health professionals) may seem to communicate better than young people, some of the ideas and beliefs that young people hold are nearly twice as likely to be challenged by young people who are peer educators than by adults.

⁴² Family Planning Association written evidence

⁴³ Involving Young People in Peer Education: a guide to establishing sex and relationships peer education projects, Teenage Pregnancy Unit, Department of Health, 2002, p16.

⁴⁴ Dr John Rees at committee hearing 17 March 2005

They come up to me and ask me all sorts of questions. The way they speak to me is different from the way they speak to teachers, they show more respect for me. They talk to me because I can talk on their level. I can talk in their lingo and I suppose that's what they like.

Young mother and peer educator⁴⁵

- 5.34 At the consultation event participants said, that peer educators can be lost when they move on to college or to employment. As a result of this, training of peer educators may not justify the cost. There is also the disadvantage that young people do not always have an understanding of clear boundaries in providing advice to others. A programme of NVQs (national Vocational Qualifications) or other accreditation could encourage peer educators to build transferable skills that will be recognised by other employers.
- 5.35 It was felt that there is considerable potential to develop community-based, accredited work with young people in this area. This would not only address sexual health, but would also contribute to the enhancement of communication and self-determination skills and enable young people to develop the assertiveness skills essential for the effective negotiation of all types of relationships. It is important that such peer education schemes are assessed to see how effective they are.

⁴⁵ Involving Young People in Peer Education: a guide to establishing sex and relationships peer education projects, Teenage Pregnancy Unit, Department of Health, 2002, p16.

6 Promoting good sexual health

- 6.1 At the consultation event young people examined current websites and literature dealing with sexual health and commented on their relevance and usefulness. Young people reviewed websites and literature from a wide variety of organisations including 4YP, RU Thinking, Brook, Terrence Higgins Trust, Staying Alive, the Family Planning Association and Sexwise.
- 6.2 Young people assessed whether the information displayed at the consultation event was clear and accessible; whether it said anything new and how it could be improved. Generally, delegates said they preferred to access information from websites rather than leaflets. They approved of the RUThinking website, saying it was clear and easy to use. The MTV site at www.staying-alive.org was felt to be aimed at 18–21 year olds. Young people said they would log on to good, interesting and informative sexual health websites in their own time, as well as during school time. Advertising on other websites or in chat rooms could help to promote these.
- 6.3 It should be remembered that not all young people will have easy or unsupervised access to the web and that there are issues for supervision, blocking and privacy. We support the recommendation from the Health Select Committee: “We recommend that the Department for Education and Skills and the Department of Health work together to compile a resource for schools detailing websites with high-quality information on sexual health which should be exempted from any filters schools may apply to their I.T. systems”.
- 6.4 Some leaflets that young people examined gave just a brief summary of information. In this way, they could be regarded as being similar to rave flyers and useful for alerting people to the issues. In general, however, more detail was helpful. One youth worker pointed out to us that the information included with the contraceptive pill was not in a format or language that would cause it to be read by many young people. This is especially true for young people most at risk of not using the contraceptive correctly.⁴⁶
- 6.5 Everyone agreed that different levels of information were needed for different age groups. The young people we talked to found some leaflets rather childish but acknowledged that they could be useful for younger age groups. The group also discussed the use of graphic images, saying they helped to increase awareness of sexually transmitted infections. They suggested that shocking illustrations of the effects of sexually transmitted infections could be used in a similar way to the explicit images used in anti-drug campaigns. This contrasts with the view of professionals at the 4th March hearing who felt that scare tactics such as the iceberg of the 80s would not be helpful. This conflict of views illustrates the need for young people to be involved in the design of literature and information that is specifically produced for them.
- 6.6 We asked young people if they thought that there could be more effective ways of raising awareness of sexual health issues than are currently used. These were some of their ideas:

⁴⁶ Sarah Murray, Youth Worker, written evidence

- internet booths
- posters at bus stops
- information in public telephone boxes
- slogan t-shirts especially if worn or endorsed by celebrities and of decent quality and stylish – a sexual health message could be as acceptable as wearing a designer label.

6.7 Young people are interested to suggest appropriate ways in which messages should be put across: “young people could come up with modern things that can appeal to their own kinda age group, and they know what can capture their imagination” and “I think they should have famous people on it [a commercial]”.⁴⁷

Media campaigns

6.8 *Choosing Health* outlines the Government’s plans to develop a new £50 million national campaign targeted particularly at younger men and women to ensure that they understand the real risk of unprotected sex and persuade them of the benefits of using condoms to avoid the risk of STIs or unplanned pregnancies. While this is very welcome, Dr Sheila Adams, chair of the London-wide Sexual Health Steering Group told the committee that any media campaign must be sustained and connect to local services, and provide information on where young people can go for further help and advice. Local services must also be prepared for the increase in numbers of people accessing services and seeking advice. This may include making sure the right staff are in place to cope with an increase in demand for services. This might also include the need to increase capacity in terms of buildings and the need to refurbish GUM premises.

6.9 Media campaigns must address the specific needs of young people. Campaigns for young people must take account of youth sub cultures and be displayed in places where young people go. Campaigns must be developed in consultation with young people.

6.10 The Mayor has also put resources into campaigning to improve the sexual health of young people. For example, a page in *The Londoner* was given over to the issue on two occasions in the last year.

6.11 At the consultation for this investigation it was recognised that national publicity about sexual health issues has been most successful when it is in reaction to something sensational, such as court cases regarding HIV infection, or young girls getting pregnant. Often within this sensationalist media reaction, the issues around safe sex are lost. There was a general feeling that professionals need to find more innovative ways to publicise information and where possible use the occasions of sensational media stories to raise awareness.

6.12 Where young people are concerned, media campaigns will be more effective where led by a person who is popular with young people. It was felt that

⁴⁷ Quotes from young people involved in research on creating campaigns to change behaviour in young people– *Young London speaks* London Assembly Environment Committee February 2004.

presenters of Saturday morning shows are in an ideal position and popular with early teens to communicate sexual health messages for them. For older children, other celebrities or role models would have to be identified.

- 6.13 The sustainability of such campaigns is crucial. To raise awareness, messages have to be repeated constantly. There is a need to ensure that any media campaign is sustainable over the long term. It was felt that as young people mature there will always be a new cohort of young people who need to hear the same messages. Sexual health campaigns should therefore be aired constantly in the same way that the NHS runs smoking campaigns and with the same intensity as road safety campaigns.
- 6.14 It was felt that the reduction in campaigning on HIV with the consequent drop in awareness among young people is an example showing the need for continuous sexual health campaigning. In the 1980s the HIV awareness campaigns did much to educate people, but the current lack of prominent adverts has led young people to believe that HIV no longer affects them, which encourages them to take risks.
- 6.15 We welcome the £50 million that the Government intends to spend on the sexual health media campaign. However we believe that this campaign must be sustained and must provide a signpost to local services.

The wider role of the media

- 6.16 Young people's television programming could be used to raise awareness of sexual health. At the consultation event, an example was given of a storyline in a popular TV programme, where a girl became pregnant. It was felt that the programme failed to address relevant issues on sexual health, even though there was opportunity to do so. Producers of such programmes should provide accurate advice when featuring issues about sexual health in their programmes.

Case study

We heard about direct ways in which media companies such as Viacom have become involved in sexual health and HIV awareness campaigning. MTV has developed an HIV and STI awareness campaign programme known as Staying Alive. In the UK Staying Alive is a partnership between Viacom, MTV Networks International, the National AIDS Trust and the Kaiser Family Foundation. Other partners include Family Health International, USAID, UNAIDS, The World Bank, and other organisations. Staying Alive informs young people about HIV, promotes safe lifestyle choices, provides information about local organisations and mobilises young people to overcome the stigma and discrimination surrounding HIV/AIDS and to fight for an end to the spread of HIV/AIDS.

Staying Alive began in 1998 as an Emmy award-winning documentary profiling the lives of six young people from around the world infected with or affected by HIV/AIDS. Growing from the tradition of annual documentaries, Staying Alive has expanded to include a multi-tiered campaign, including a website available in 10 languages, outdoor and grassroots activities to promote awareness about and prevention of HIV/AIDS in the international youth community.

- 6.17 We recognise that there are difficulties in evaluating the impact of media campaigns in terms of success in reducing unsafe sexual behaviour, but they may benefit the young people who access these programmes, and can be used to direct them to relevant services and raise awareness of issues such as sexual health testing. It is clear that for young people the media are very influential and further research needs to be done on the way the media can address and educate young people on sexual issues particularly safer sex and sexual health services.

Recommendation 5

We recommend that the Mayor together with the London-wide Sexual Health Steering Group and pan London Sexual Health Promotion Group explore with the London media the possibility of a London-specific media campaign on sexual health for young people.

7 Sexual health services in London

- 7.1 Primary care trusts are responsible for providing sexual health services, either directly or by commissioning services from other organisations both in and outside of the public sector. The London Sexual Health Framework will be delivered by primary care trusts and monitored by the five London strategic health authorities. The structure of primary care trusts and strategic health authorities is currently under review as part of the 'Commissioning a patient-led NHS' process.
- 7.2 The written submissions to this investigation emphasise the need for primary care trusts to work more closely together to develop and provide sexual health services. The committee heard of instances of genitor-urinary clinics in the same strategic health area being asked to meet different strategic priorities and different standards of care.⁴⁸
- 7.3 Some GP practices provide sexual health services, but they are not part of the package of the 'essential' services that GPs have to provide under the new GP contract. However, the contract allows practices, if they wish, to provide 'enhanced' services - one of which is 'a more specialised sexual health service'. To take on this service, practices will need to have the right skills and facilities.
- 7.4 The London-wide Sexual Health Framework calls for the development of networks that bring together the skills and resources of professionals in primary care, genito-urinary and other sexual health services, including those in the voluntary sector.
- 7.5 In a similar vein the Medical Foundation for Aids and Sexual Health (MedFASH) has produced policy guidelines highlighting the need for the delivery of sexual health and NHS HIV services to be provided through established networks to enable service providers to meet shared standards of care. These concerns were echoed at our hearings where it was felt that there is a clear need to go beyond the 'one answer is going to solve our problems' scenario, and look at sexual health service networks where there are a number of different providers offering a number of different types of service at different sites, but the services are linked both horizontally and vertically. Such a co-ordinated but flexible multi-faceted approach would reflect what young people themselves told us about their needs.

Case study - networks

A sexual health network has been developed to support sexual health work across Croydon. This consists of the Sexual Health and HIV Partnership Board setting priorities and leading the way in monitoring progress on HIV and sexual health locally. There are three sub-groups (support for people living with HIV, sexual health services and prevention) that take the lead on implementing key sexual health priorities in the community and with sexual health services.

- 7.6 Unfortunately sexual health is not an assessable target for primary care trusts and therefore may be given a low priority.

⁴⁸ Committee visit to the Chelsea and Westminster Healthcare NHS Trust, Clinical Directorate of HIV and GUM Medicine

Community based services

7.7 As we have noted, there are a number of examples of community-based sexual health services run by organisations other than primary care trusts. For example PULSE in Islington offers contraceptive services and Brook runs a weekly nurse-led screening and diagnostic clinic targeting young women under 25, also in Islington. 'Girlzone at Barnados' is a Neighbourhood Renewal Fund project in Archway that aims to reach isolated and socially excluded children who are vulnerable, at risk of or being sexually exploited and the Brandon Centre, also in Archway offers sexual health promotion and chlamydia screening.⁴⁹

7.8 Voluntary sector organisations have played and continue to play a very significant role in providing sexual health advice and services to young people. It is important that this role, and the experience of the voluntary sector, is recognised in the design and planning of services by the statutory sector.

7.9 Many boroughs are establishing Children and Young People's Partnership Boards to oversee how they respond to duties under the Children's Act 2004. These Boards are made up of representatives from the local authority, health services and the voluntary sector and will set priorities for all local services working with children and young people. The definition of children and young people's services includes health promotion and treatment and so these Boards should help improve community based services for sexual health.

7.10 Under the Act, local authorities, primary care trusts and strategic health authorities have a duty to co-operate in the delivery of services for children and young people and must develop a Children and Young People's Plan. The Plan will also form the basis of how services for children and young people in an area will be integrated and how Children's Trusts, or equivalent, will operate in the borough.

7.11 Local Area Agreements could also be influential in how sexual health services are delivered locally. These are where local authorities, primary care trusts and central government jointly negotiate budgets and targets for local services paid through central funding. Some of these agreements already consider targets such as reducing teenage pregnancy rates, but we would like additional targets around sexual health promotion or the reduction of STIs. We suggest it would be most appropriate to use existing Performance Indicators for the PCTs as these targets.

Recommendation 6

We recommend that in order to assist in taking an inclusive and collaborative approach to young people's sexual health:

- **Children and Young People's Partnership Boards (which all include voluntary and community sector representatives) explicitly include sexual health in their remit and**
- **targets to improve sexual health are set within Local Area Agreements**

⁴⁹ Camden Primary Care Trust written evidence

GUM clinics

- 7.7 Although sexually transmitted infections can be assessed in a variety of different settings, the most common are the Genito-Urinary Medicine clinics, generally known as GUM clinics. People are either referred to GUM clinics, by their GP for example, or go there directly – known as ‘self-referral’. This is a distinguishing feature of sexual health services from other hospital-based services.
- 7.8 According to the British Medical Association, GUM clinics are “inadequate and oversubscribed, leading to unacceptably long waits”. These problems were highlighted by several of the organisations that submitted written evidence. The Mayday Healthcare NHS Trust, for example, said that it would need a large increase in staffing if it was to meet the 48 hour target set out in *Choosing Health*. Health First, the specialist NHS health promotion agency for Lambeth, Southwark and Lewisham also commented on long waiting times. Some clinics reported that they do not have the means to carry out on-site tests for all sexually transmitted infections, which clearly affects the speed at which patients can be given their results⁵⁰.
- 7.9 The problem of access to specialist GUM clinics is particularly acute and well recognised. The Government is committed to a 48 hour maximum waiting time for GUM appointments and clinics have until 2008 to meet that target for all their patients. A recent survey by the Health Protection Agency shows that nationally, only 40 per cent of 16-24 year olds who attended GUM clinics were seen within 48 hours. A quarter of people currently wait more than two weeks to be seen at a GUM clinic. The situation is likely to be slightly better in London which has the highest number of patients being seen within 48 hours of any region, but this is still only 62 per cent.⁵¹
- 7.10 **The Committee believes that if there were better integrated and more primary care services offering initial assessment and testing this would lighten the burden on the specialist GUM clinics. An increase in the levels of screening will necessarily lead to more positive tests and referrals to specialist GUM services. The development of a primary care referral network would allow GUM clinics to concentrate on providing specialist acute services which the committee believes will be a better utilisation of specialist acute services.**
- 7.11 New methods of contacting patients such as by sending appointment reminders, test results and call-ups by text or email which is being used successfully by some services should be extended and could also relieve pressure on GUM clinics in particular⁵². By pooling resources services such as one telephone number for a geographical area can be created whereby the soonest appointment in that area can be booked avoiding a lengthy wait at the nearest service. Opening times across geographical areas could be co-ordinated to ensure that access is available for everyone.

⁵⁰ Mayday Healthcare NHS Trust written evidence

⁵¹ Terence Higgins Trust press release 6 October 2005

⁵² Committee visit to the Chelsea and Westminster Healthcare NHS Trust, Clinical Directorate of HIV and GUM Medicine

7.12 The Committee believes that such strategic partnership work is essential for service commissioning and should be done on a sector wide or London wide basis in order to prevent duplication of effort at local levels and to meet specific needs. The Committee was concerned that although primary care trust local delivery plans are monitored by the strategic health authority there was no mechanism in place to give the strategic health authority leverage to enforce delivery of sexual health services.

Recommendation 7

Strategic working - we recommend that London strategic health authorities direct:

- **Primary care trusts to work together strategically in commissioning services within and across geographical sector; and**
- **Primary care trusts and acute trusts to work together to form clinical networks that will ensure delivery plans are co-ordinated and best practice is shared.**

Providing better services at GUM clinics

You shouldn't have to wait and sit down, you should be seen straight away cos people sit there yeah and say... what's he there for? They sit there and just watch you thinking about what's wrong with them

Young person talking about experience of attending a GUM clinic⁵³

- 7.13 There are a range of modernisation initiatives that can help to improve services at GUM clinics. These include
- Clinic organisation – for example, increasing the numbers of spaces in walk-in clinics, introducing a closed booking period or having a dedicated member of staff to answer incoming calls.
 - Clinical pathways management – this involves allowing more patients to be seen by reducing the number of staff contacts and concentrating on doctors seeing more urgent cases rather than other disorders such as urinary tract infections. This also involves referring cases that can be appropriately managed outside the GUM, for example by a GP and developing the roles of nurses and health advisors.
 - Limiting follow-up appointments and therefore freeing-up new appointments. For example, this could mean only contacting patients if results are positive (except for HIV), introducing telephone result appointments and increasing home-based treatments for some conditions.⁵⁴

Case study – waiting times at GUM clinics

By introducing a system where patients were given timed appointment 'slots' throughout the day, Kings College cut the average waiting time from more than four hours to an average of one hour and twenty minutes.

⁵³ Young People's Perceptions of Contraception and Seeking Contraceptive Advice, Counterpoint (UK) Limited, for Department of Health, 2001.

⁵⁴ Sexual Health Advisory Group of South West London

Funding

- 7.14 Unlike most primary care services, people are often treated outside their local area because they feel that this offers greater anonymity, even though patients do not have to give personal details at sexual health clinics. It is impossible to track patient costs back to the primary care trust responsible for them. However, the new system of 'payment by results' (where hospitals and other providers of health care will be paid for the activity they carry out) may lead to fairer funding for GUM services.

My family doctor's known us for 20 years. I wouldn't dare walk in and say "give me this or that 'cos I'm going to have sex"

Young woman aged 16⁵⁵

- 7.15 From 2002-04, the Department of Health made more funds available to improve access to GUM services. There are recognised issues surrounding the ability of GUM services to meet extra demands given the constraints on infrastructure such as buildings and staffing needs⁵⁶. Poor facilities which can often appear unwelcoming are not attractive to young people⁵⁷.
- 7.16 The Committee welcomes these extra funds. However, there is evidence to suggest that where this extra funding for sexual health services has been given to primary care trusts rather than directly to GUM clinics, some of the money has been diverted to other health services.⁵⁸ There is widespread belief that as sexual health is not a priority target, and attracts no penalties if not delivered, it is not given the importance or resources it deserves. **This is not acceptable and the Committee believes that funding should reach front line services and not be siphoned off to other competing areas.**
- 7.17 The Government has now earmarked a total of £300 million for sexual health services over the next three years:
- £130 million capital and revenue funding over three years for GUM services.
 - £50 million to fund a health education campaign.
 - £40 million to fund an audit of contraceptive services and to rectify problems.
 - £80 million to fund the chlamydia screening programme.
- 7.18 The Committee welcomes this extra recurrent funding and in particular welcomes the Department of Health's efforts to ensure transparency in the allocation of this money. Funding allocations for each primary care trust have recently been given which enables those providing services to examine the extra money given to primary care trusts and to track where this money is

⁵⁵ Young People's Perceptions of Contraception and Seeking Contraceptive Advice, Counterpoint (UK) Limited, for Department of Health, 2001.

⁵⁶ Committee visit to the Chelsea and Westminster Healthcare NHS Trust, Clinical Directorate of HIV and GUM Medicine

⁵⁷ Committee witness session 8 February 2005 and workshops with young people on 10 March 2005

⁵⁸ Sexually Transmitted Infections: Tackling a growing crisis Terence Higgins Trust October 2005

spent⁵⁹. Although this funding is not ring-fenced the Committee firmly believes that this extra money should go directly to sexual health services in addition to existing budgets. Assuming it is used for the purpose it is designed for, the extra funding should lead to a marked improvement in sexual health services.

- 7.19 We also believe that funding designed for sexual health services should be spent on sexual health services and not siphoned off to other services either at primary care trust or acute trust level. There should be transparent systems in place to ensure that the money reaches the budgets and service priorities for which it was intended. It will also be important that London receives its fair share of the funding according to levels of sexual healthcare needs.

Recommendation 8

Funding designated for sexual health services should be transparent and monitored to ensure that it reaches GUM budgets. Where this does not happen, future funding should be ring-fenced.

- 7.20 The Committee believes that in order to improve sexual health services in the face of competing service priorities, sexual health provision should be given priority comparable with the core targets that influence the Healthcare Commission's annual assessment of primary care trusts and hospital trusts. These are waiting times for elective surgery, at accident and emergency and out-patient appointments. Ensuring a maximum 48 hour wait for sexual health services is assessed would raise the importance attached to sexual health and ensure that appropriate resources are allocated.

Recommendation 9

We recommend that the Department of Health give sexual health the same priority as other core services and that the Healthcare Commission incorporate the performance of GUM clinics in its assessment process for primary care trusts and hospital trusts.

Barriers to young people using sexual health services

- 7.21 There are a number of barriers that make it difficult for young people to use sexual health services. Kings College Hospital's evidence said that a relatively small percentage of young people have historically accessed mainstream GUM services because the service may be biased towards an adult service that does not take account of the needs of younger patients who are becoming or are sexually active.
- 7.22 Hours of opening for many clinics are likely to be a barrier for young people as clinics tend to be open during the day. Evening sessions would be popular with young people – and other patients – but they are unpopular with staff⁶⁰ unless they get time off during the day in lieu. In Mayday's case this is not possible because the medical staff are all involved in HIV inpatient care. Levels and availability of staff can limit changes to hours of opening.

⁵⁹ White Paper funding Allocations for Sexual Health, Briefing Note for PCT and SHA Sexual Health Leads, Department of Health

⁶⁰ Mayday Healthcare NHS Trust written evidence

- 7.23 If the local GUM service is not open, is in an inaccessible place, or is not particularly receptive to young people these also act as barriers to access. Young people want services to be available at a convenient time such as lunch times, immediately after school, and at weekends. Services should also be available close to home. A doctor at the consultation event said that young people using her clinic had revealed in questionnaires that they wanted to use the clinic after school. They also wanted a Saturday service, but money and resources were unavailable.
- 7.24 Young people want to be seen quickly when they attend sexual health services as they often have a limited time available. Long delays may result in young people leaving without testing or treatment. Where there are long queues, or a large number of people within the waiting area this deters them from seeking testing, treatment and care. If they are not treated then they may continue to infect others and face a range of other health problems. Young people often need more time with health care workers for support, counselling, information and education. This additional consultation time is often lost in busier clinics and therefore the provision of services to younger people is affected disproportionately.
- 7.25 We discovered from our visit to the clinic in Chelsea and Westminster that two types of care are important – a talking/advice phase and a medical care phase. Young people may not initially be open about their needs or symptoms until a follow-up visit having first approached a clinic for more general information and advice.

They need to make it more comfortable, somewhere to go where you can go and talk about what you want to talk about. It is scary when you're [sitting there] cos all these things go through your head. They need to liven it up a bit.
 Young person talking about attending a GUM clinic⁶¹

- 7.26 Waiting times are also likely to put young people off attending GUM clinics, while the Southwark Muslim Women's Association said that young people may be "intimidated and embarrassed to walk into the centres...[and]...fear that people they know may see them" and judge them. They also thought people might fear judgment by the staff.⁶²
- 7.27 Confidentiality is an issue for many young people. Research shows that young people will not seek advice or disclose personal problems to a professional unless they are reassured about the confidentiality of the discussion. This evidence was supported by the young people at our consultation event. It is therefore crucial that these services are confidential, non-judgemental and that young people perceive them as such. If young people believe consultations with health professionals are not confidential, they will simply put off seeking help. This may result in young people being placed at greater risk of sexually transmitted infections.⁶³

⁶¹ A Qualitative Report of Young People's Views on Contraceptive and Sexual Health Services in Hammersmith and Fulham, September 2004

⁶² Southwark Muslim Women's Association written evidence

⁶³ Family Planning Association and British Medical Association written evidence and consultation event with young people on 10 March 2005

They're supposed to keep it confidential but it's not true.
Young woman aged 15, talking about GPs⁶⁴

- 7.28 The experience of Kings College with its clinic for under-20s, suggests that one of the ingredients for success in providing sexual health services to young people is to make sure that staffing is culturally and age appropriate.

⁶⁴ Young People's Perceptions of Contraception and Seeking Contraceptive Advice, Counterpoint (UK) Limited, for Department of Health, 2001

8 Examples of good practice

- 8.1 While the investigation revealed some of the difficulties in providing sexual health services that are appropriate for young people, it also heard about examples of ideas and initiatives that are helping to overcome those problems.
- 8.2 The Committee visited Cont@ct - a sexual health service for young people set up by the Victoria Clinic in Westminster. This is a twice-weekly walk-in sexual health service for under 18s. It provides regular support for secondary schools in Westminster. A newsletter for young people is distributed each term, and the clinic provides regular sex and relationship education support for secondary schools and youth groups in the area. The clinic offers a range of services including testing and treatment for STIs, pregnancy testing and information, termination of pregnancy counselling and a full family planning service.
- 8.3 It is important to understand how people use the service and develop confidence to ask about the services they need. We were told that girls tend to come in groups initially to get general advice with one person then returning on her own for specific advice, testing or treatment.
- 8.4 Young people attending local secondary schools were involved in all aspects of setting up the service, including designing the clinic logo, card and poster and interviewing for a specialist nurse post. A 'no white coats policy' was established to help young people feel at ease.
- 8.5 Since setting up the service, the number of teenagers accessing help has risen dramatically and a new service providing care for HIV positive teenagers is currently being developed.

One-stop shops

- 8.6 The submission from Brent Primary Care Trust suggested that a 'stand alone holistic service' should be developed for young people across boroughs. A young person should be able to access a range of services, not just sexual health, from one site. The Sexual Health Advisory Expert Group of the South West London Strategic Health Authority noted that young people frequently request that all their sexual health needs be met under one roof, for example through an integrated service for the full range of sexually transmitted infection testing alongside contraception and advice or support services. This type of one-stop shop can also help reduce the stigma associated with attending sexual health clinics.
- 8.7 A good example of a one-stop clinic is Barts and the London's YPC@AKC. This is a weekly walk-in service for under 20s. It provides a full range of sexual health and family planning services, but through its links with local voluntary organisations also has staff from those organisations on hand to advise on a range of issues such as housing, careers, drug and alcohol use.
- 8.8 Barnet Primary Care Trust saw more focused services such as one-stop shop style sexual health clinic, especially for the under 20s in deprived areas as a way to alleviate the pressures on existing GUM clinics.

Case study – one-stop shop

To improve the sexual health service to young people, a dedicated adolescent sexual health service has been developed by the Jefferiss Wing Centre for Sexual Health, St Mary's Hospital. The aim of the service is to provide a comprehensive 'one-stop' clinic with GUM and contraceptive services. Between its launch in October 2003 and January 2005 the clinic saw 600 patients. The average age of young people attending is 17 although the clinic has seen people as young as 13. The clinic is situated in a separate waiting area from the main GUM clinic and sexual health material tailored for young people is available. The clinic is open once a week between 3 and 5pm and with more resources could be expanded to a daily service.

Fast-tracking young people

8.9 When young people use the same services as adults, some clinics 'fast-track' the young people. For example Barts and the London NHS Trust fast-tracks all patients aged 16 years attending its walk-in service. At the Jefferiss Wing Centre for Sexual Health, St Mary's Hospital, under 20s attending general walk-in clinic are fast-tracked to the Sexual Health Information Protection Team, who use an age-specific sexual history form to assess if the young person should be regarded as vulnerable.

8.10 Some clinics have a system for fast tracking young people, especially those on a follow-up visit or who have been referred from elsewhere. An example of this is the green card system seen during our Chelsea and Westminster visit.
[add details]

Dedicated sessions for young people

8.11 As noted earlier, GUM clinics are often biased towards the needs of adults. To make the services accessible to young people, some clinics hold sessions just for young people. One example is the Caldecot Centre [Kings College Hospital] which has a dedicated Thursday afternoon session for young people. The service was promoted in the media, with emphasis being put on the age-appropriate nature of the information given and the confidentiality of the service. After a slow start, attendance rose sharply after six months and the clinic thinks this is due to a good reputation spreading by word of mouth among young people.

Providing services where young people go

8.12 As the Family Planning Association points out in its evidence, it is important that young people feel confident about accessing sexual health and advice services which are tailored to their needs. On-site services for young people in schools and other education and youth service settings can be particularly effective. The Family Planning Association suggests that extended schools would be an ideal place for such services as part of their job to serve the needs of their community.

Case study - KISS

KISS (Keep it Safe and Sexy) sexual health services for young people have been set up in a youth club and in a voluntary youth counselling agency by Richmond and Twickenham PCT. Staffed in the youth club by a family planning nurse and young

people's sexual health worker KISS allows the provision of contraception alongside more informal education and information sessions and one-to-one advice, and condom distribution. A chlamydia testing pilot has been run in one of the sessions.

- 8.13 Outreach services included Harrow's 'clinic in a box', provided by the Family Planning Service. This is a weekly clinical outreach service set up in one school, one college, one young parents' group and the youth offending team. The clinic provided at the youth offending team is an interagency clinic with the health advisor from the GUM and family planning mainstream services. Targeted work takes place with the unaccompanied minors, asylum seekers and children looked after by the local authority⁶⁵.
- 8.14 Enfield and Haringey Primary Care Trust currently provide a sexual health advice bus (4YP) – a mobile sexual health clinic which can travel across primary care trust areas and provide the degree of flexibility in opening times that is necessary for young people. Young people can suggest where they would like the bus to go, and can request that the bus visits their school. The bus also acts as a link to the local GUM clinics and encourages young people to seek further treatment from the GUM clinics where needed. A nurse works on the 4YP bus, providing advice, emergency contraception, contraceptive injections and pills. The nurse also provides chlamydia screening and pregnancy testing.
- 8.15 Initiatives to integrate health services in schools have already proved to be very successful. Moreover, 21 per cent of children and young people who responded to the *Every Child Matters* consultation in 2003 asked for health services to be available within their schools, including at weekends. Children and young people want these services to include confidential help, support and advice on contraception and sexual health.
- 8.16 There is also scope to extend both health and information services within Further Education colleges and other educational settings which cater for over 16s.

Use of local pharmacies

- 8.17 Testing for certain sexually transmitted infections is available at some pharmacies. A major high street chemist⁶⁶ has been awarded a contract for chlamydia testing. Providing pharmacies could offer a high degree of confidentiality and privacy, it seems likely that young people would use such services as young people are currently accessing emergency contraception via their local pharmacies⁶⁷.
- 8.18 4YP, as part of their wider health and information services, endorse accredited pharmacies which provide services tailored for young people. 4YP promote their whereabouts through their literature and websites and mark participating pharmacies with logos. This helps young people know that it will provide a certain level of service.⁶⁸

⁶⁵ London Borough of Harrow written evidence

⁶⁶ Department of Health/Boots Press release 8Feb 2005

⁶⁷ Paula Barrista at committee hearing 8 February 2005

⁶⁸ www.4yp.co.uk/pharmacy/index.html

- 8.19 The Department of Health is running a pilot in some London boroughs to examine whether community pharmacies are an appropriate setting where young people can access screening. Services are provided free of charge for those aged under 25. **The Committee believes that enabling local pharmacies to offer these services would be of benefit, provided pharmacists were trained appropriately and could signpost young people to other services if required. If these pilots are successful the Committee would like them extended to all areas of London.**

Provision of condoms

- 8.20 There should also be greater development of free condom provision in locations such as community settings, pubs, clubs, and other leisure locations. Although condoms are available to buy, they are very expensive, and the lack of availability of free condoms is a significant barrier to access, particularly for young people. If we want young people – and especially young men – to make safe and responsible choices about sex and relationships, there must be free and equal access for all to the means of making such choices. There are examples of schemes to make free condoms widely available – for example SHOC, a voluntary agency in Brent and Harrow, supports 22 voluntary agencies in the area to distribute condoms.
- 8.21 The Mayor has commissioned a report to look at the availability and accessibility of condoms for young people at high risk of sexual ill health. The report, expected to be released in Autumn 2005, documents examples of good practice in social marketing in London, and makes recommendations to strengthen condom provision in local and regional sexual health and teenage pregnancy strategies.
- 8.22 The Committee will continue to monitor the Mayor's work on sexual health. We will be interested to see how the Mayor's work will improve the availability of condoms for young people.

9 Conclusions

- 9.1 The Committee finds it completely unacceptable that London's sexual health has worsened over the last decade and young people continue to suffer higher levels of sexually transmitted infection than in the rest of the country. We are appalled that young people are at greater risk of catching diseases and face additional barriers to accessing services to improve their sexual health.
- 9.2 This level of ill health cannot continue and we expect further action. Young people should be involved from the outset in the design, assessment and, where possible, the delivery of these services. Young people's needs vary according to their age, their culture, and what diseases they are most likely to catch. In order to address this variety of needs, information, testing and treatment should be tailored to ensure that services are appropriate to improve their sexual health.
- 9.3 During our investigation we heard evidence from a wide range of people including young people, those working in sexual health and visited a clinic that provide sexual health services to young people. We were pleased to see the examples of excellent practice from voluntary, public and private sector. The challenge is to make sure that all information, education and treatment services across London achieve these levels of excellence and that all young Londoners can access the services they deserve.
- 9.4 The Committee will be sending this report to all primary care trusts and the strategic health authorities in London as well as providers of services and other interested groups. We ask those responsible to respond to us about how they will address our recommendations, and in what other ways they will be improving services. The Committee will review responses and consider any progress towards providing young Londoners with the services they deserve.

Appendix A – Evidence and visits

To obtain any of the evidence listed, please contact Fiona Campbell at City Hall, e-mail fiona.campbell@london.gov.uk

Committee meetings

The Committee held two meetings with those providing information listed below.

Transcripts of the hearings can be downloaded from:

www.london.gov.uk/assembly/health_ps/index.jsp

8 February

Dr Gareth Goodier, Chief Executive, North West London Strategic Health Authority

David Evans, Royal College of Nursing

Dr Greta Forster, Barts & the London & St Mary's NHS Trust

Dr Paula Baraister, Clinical Champion, Lambeth & Southwark Sexual Health
Modernisation Programme

Dr Jan Welch, Caldecot Centre, King's College, London

17 March

Dr John Rees (Department of Children's Health, Exeter University)

Bryan Teixeira (Director, Naz Project London)

Dr Sheila Adam (Director of Public Health, North East London Strategic Health
Authority)

Catriona Martin (Oasis Esteem Team Leader)

Rev Danny Brierley (Head of Youth Action, Oasis Trust)

Georgia Franklin (Vice President, Public Affairs, MTV Networks International)

Cathy Phiri (Public Affairs, MTV Networks International)

Helen Cameron (Advisory Teacher for PSHE and Citizenship)

Alison Robert (Development Manager, Brook London)

Anjan Ghosh (Education Outreach Worker, Brook London)

Visit

On 17 January, Members of the Committee visited Chelsea and Westminster Healthcare
NHS Trust, Clinical Directorate of HIV and Genito-urinary Medicine

Victoria Clinic, Chelsea and Westminster

Consultation event with young people and workers in sexual health

Young People's Sexual Health Consultation - 10 March 2005, City Hall

Written evidence

Anonymous

Barnet PCT

Barts and the London NHS Trust

BMA House

Brent PCT

Camden LEA

Camden PCT

Chelsea and Westminster NHS Trust

City and Hackney PCT

Croydon Primary Care Trust

DFES

Diocese of Westminster

Ealing Hospital NHS Trust

Edmund Adamus

Essex Islamic Trust
Evangelical Brotherhood Church
Family Education Trust
Family Planning Association
GLA - Mayors Health Policy Team
Hammersmith & Fulham LEA
Hammersmith & Fulham PPIF
Hammersmith and Fulham PCT
Havering PCT
Health Protection Agency
Jewish Aids Trust
Kings College Hospital
Kingston Primary Care Trust
Lambeth PCT
LB Barking and Dagenham
London Borough of Hammersmith and Fulham
London Borough of Harrow
London Borough of Tower Hamlets
London Ecumenical Aids Trust
London Health Observatory
Mayday Healthcare NHS Trust
Mr MA Shah Siddiqi
NHS Health First
Oasis Esteem
Plus VE, Eton House,
Redbridge PCT
Regional Public Health Group and London Strategic Health Authorities
Richmond and Twickenham PCT
Royal Borough of Kingston
Royal College of General Practitioners
Royal College of Nurses
Sarah Murray
Sexual Health Expert Advisory Group
Southwark Muslim Women's Association
St Georges
St Mary's Hospital
The Hillingdon Hospital
United Reformed Church

Appendix B – Summary statistics

- Young people have experienced the highest rises in sexually transmitted infections, especially of Chlamydia.
- Between 1999 and 2004, the under 25s in London experienced an increase of 160 per cent in diagnoses of gonorrhoea to over 3,200 cases, and an even more dramatic 290 per cent increase in chlamydia diagnoses to 11,709 cases.
- London, says the HPA, continues to bear the brunt of the syphilis epidemic (an increase of 18 per cent in heterosexual men, 12 per cent in women and 11 per cent in gay and bisexual men (2004)).
- The rates per 100,000 people between 20 and 25 years old group for syphilis and herpes in 2004 are 12 and 230 – rates which have increased from 3 and 748 per 100,000 in 1999. There has been a 33 per cent rise in gonorrhoea infections in Londoners below the age of 25 since 1999 and a 68.2 per cent rise in chlamydia in under-25s since 1999.
- HIV diagnoses in London are at their highest ever levels, with more than 3,000 people diagnosed in 2002. This is an increase of 80 per cent since 1996.
- Half of all under-25 year-olds in England seeking HIV treatment live in London.
- It is estimated that there are currently 30,000 people living with HIV in London of whom 30 per cent remain undiagnosed.
- The total number of people with HIV in London is currently increasing by over 10 per cent each year.
- HIV treatment costs in London are increasing by more than £15 million a year, with lifetime NHS costs in London increasing by £500 million each year.
- The annual cost of chlamydia and its consequences across the UK is estimated at more than £100m. Up to one in ten sexually active young women in London are thought to be infected with Chlamydia.
- National research on sexual behaviour in Britain shows that the median age of first heterosexual sex for men and women is now 16 years and that only half of young people used a condom the first time they had sex.
- The prevalence of sexually transmitted infection is higher amongst men and women for whom first intercourse occurred before age 16, and amongst those whose main sources of information about sexual matters was friends and others.
- A survey by the School's Education Unit showed that in 1993 26 per cent of boys aged 12 to 15 years were concerned about HIV, in 2003 only 6.5 per cent of similar boys were concerned.
- A recent survey by the Health Protection Agency shows that nationally, only 40 per cent of 16-24 year olds who attended GUM clinics were seen within 48 hours

These statistics are sourced in the main report, but are predominantly based on information from the Health Protection Agency, London Health Observatory, London Strategic Health Authorities and the Family Planning Authority.

Appendix C – Acronyms and glossary

AIDS (Acquired Immune Deficiency Syndrome) - A set of conditions associated with the last stages of HIV disease.

APAUSE – the project Added Power and Understanding in Sex Education

Bacterial STI -- Such as syphilis, gonorrhoea and chlamydia. These usually respond effectively to antibiotic treatment, unless the strain of the disease is resistant to treatment.

BMA – British Medical Association

BME – Black and minority ethnic

Chlamydia – sexually transmitted bacteria that can cause sterility in women and men. As many as 85 percent of cases in women and 40 percent of cases in men are symptomless. If untreated, chlamydia can lead to serious complications, particularly in women - causing up to half of the cases of pelvic inflammatory disease (PID).

DH – Department of Health

DfES – Department of Education and Skills

Ectopic Pregnancy - A life-threatening pregnancy that develops outside the uterus, often in a fallopian tube.

fpa – Family Planning Association

GP – General Practitioner or family doctor

Gonorrhoea - A sexually transmitted bacterium that can cause sterility, arthritis, and heart problems.

GUM (clinic) Genito-urinary Medicine (clinic) - Genito-Urinary Medicine is a department within hospitals that specialise in sexual health and diagnosis and treatment of sexually transmitted infections.

HPA - Health Protection Agency

HPV (Human Papilloma Virus) - Any of 90 different types of infection, some of which may cause genital warts. Others may cause cancer of the cervix, vulva, or penis.

Herpes (Herpes Simplex Virus) - A virus that can be sexually transmitted. Symptoms are a recurring rash with clusters of blistering sores.

HIV (Human Immunodeficiency Virus) - An infection that weakens the body's ability to fight disease and can cause AIDS

Ofsted – Office for standards in education

LEA - Local Education Authority, in London these are the boroughs

MedFASH - Medical Foundation for Aids and Sexual Health

NHSS - National Healthy Schools Standard

PCT - Primary Care Trust

PID (Pelvic Inflammatory Disease) - An infection of a woman's internal reproductive system that can lead to sterility, ectopic pregnancy, and chronic pain. It is often caused by sexually transmitted infections such as gonorrhoea and chlamydia.

PSHE – Personal, social and health education

SHA – Strategic Health Authority

SRE - Sex and relationship education

Sexually Transmitted Infections (STIs) - Infections that are often or usually passed from one person to another during sexual or intimate contact.

Syphilis - A sexually transmitted bacteria that can lead to disorders, or death.

Appendix D

Terms of reference

- To consider the current prevalence and types of sexual ill health of young people in London.
- To consider the way young people are currently accessing and using NHS Genitourinary (GUM) clinics and other sexual health services, with particular regard to the racial and social diversity of London's population.
- To consider how access to sexual health services for young people might be improved.
- To consider the various ways that sexual health promotion, education and advice are provided for young people and identify how these might be better provided.
- To make recommendations for action (as appropriate) to the Mayor, Government, and appropriate public and other bodies.

Appendix E: Orders and translation

How to order

For further information on this report or to order a copy, please contact Sue Riley, Committee Co-ordinator, on 020 7983 4425 or email to sue.riley@london.gov.uk

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Appendix F: Principles of scrutiny

The powers of the London Assembly include power to investigate and report on decisions and actions of the Mayor, or on matters relating to the principal purposes of the Greater London Authority, and on any other matters which the Assembly considers to be of importance to Londoners. In the conduct of scrutiny and investigation the Assembly abides by a number of principles.

Scrutinies:

- aim to recommend action to achieve improvements;
- are conducted with objectivity and independence;
- examine all aspects of the Mayor's strategies;
- consult widely, having regard to issues of timeliness and cost;
- are conducted in a constructive and positive manner; and
- are conducted with an awareness of the need to spend taxpayers money wisely and well.

More information about scrutiny work of the London Assembly, including published reports, details of committee meetings and contact information, can be found on the London Assembly web page at www.london.gov.uk/assembly.

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