Access to Public Health Commissioned Sexual Health Services

Health Equity Audit 2024

Durham Insight
Insight & intelligence to inform

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Key Findings

Sexual health is not equally distributed within the population; this means that some groups are more vulnerable to poor sexual health than others for example gay, bisexual, and other men who have sex with men, people living in areas of deprivation, black and minority ethnic communities and young people.

Whilst the County Durham burden of disease for sexual health is lower than other local authority areas, there is variation across the county which leads to further health inequalities for its residents.

This Heath Equity Audit (HEA) is concerned with equity for County Durham residents accessing Durham County Council public health commissioned sexual health services only. The HEA has analysed data between January 2021 and December 2023 and has generated the following key findings.

Overview

- More than half of attendances (53.2%) are made by people aged 25-49 years.
- Over 95% of attendances are made by people of white ethnicity.
- The majority of ISHS face to face attendances occur at the two hospital sites within County Durham, University Hospital North Durham, and Bishop Auckland Hospital. Almost 3 out of 5 (58.7%).
- Peterlee Health Centre and Stanley Health Centre are the most well attended community clinics receiving just over 10% of attendances each, 11.3% and 11.0% respectively.
- 57% of all contacts with Integrated Sexual Health Service (ISHS) are for contraception services, of which 99.5% were females.

Contraception

- 99.5% of contraception service attendances were female; 0.5% were male.
- There are **7** Middle Super Output Areas (MSOA) with significantly lower contraception access rates than the County Durham average for females aged 15 – 24 years; these are in deprivation deciles 1 -3, predominantly located in east Durham and south Durham.
- There are **9** MSOAs with significantly lower contraception access rates than the County Durham average for females aged 25 – 49 years; these are in deprivation deciles 1-3, predominantly located in east Durham and south Durham.

- For the 15-24 years age group, more attendances are made from the more deprived areas; this indicates that the service is reflecting some level of anticipated need for this age band.

- Although low numbers, females aged 50 years and over are accessing the ISHS for contraception services, this should be further explored.

- There are seven GP practices in deprivation decile 1 – 3 that do not have an active service level agreement (SLA) with the ISHS to provide Long Acting Reversable Contraception (LARC), 4 of these are in east Durham.

- There are 20 pharmacies in deprivation deciles 1-3 do not have an SLA with the ISHS to provide Emergency Hormonal Oral Contraception (EHOC).

Sexually Transmitted Infection (STI) Care

Comparisons of the rate between males and females should be done with the acknowledgement of the higher rate of females attending for contraceptive care. This will give the service greater opportunity for provide opportunistic and holistic sexual health care which is likely to include STI care and advice.

- Around 75% of STI care attendances were female and around 25% were male.

- The largest proportion of attendances were in those aged 25-49 years, 54.5% and 51.8% for males and females respectively.

- A smaller proportion of attendance by males were amongst those aged 15-24 years compared to females; 25.5% compared to 41.9%.

- Conversely a higher proportion of attendances by males were amongst those aged 50-74 years compared to females; 19.0% compared to 5.2%.

- Attendance rates per 1,000 for STI care at ISHS for females decrease significantly with age.

- Access rates for younger females (15 – 25yrs) are more closely aligned to deprivation, the slope of inequity becomes shallow as the age groupings increase.

- There are **8** MSOAs with significantly lower STI access rates than the County Durham average for females aged 15 – 24 years; these are in deprivation deciles 1 -3 predominantly in east Durham and south Durham.

- There are **10** MSOAs with significantly lower STI access rates than the County Durham average for females aged 25 – 49 years; these are in deprivation deciles 1 -3 predominantly in east Durham and south Durham.

- Some of the highest rates of males aged 15 – 24 and 25-49 years accessing STI care are closely aligned to some areas of highest deprivation in County Durham. However, the data highlights that males who live in some of the most deprived MOSA's in east Durham and south Durham are underrepresented in this cohort.

- The attendance rate for STI care at ISHS for males is statistically similar for the ages 15-24 years and 25-49 years.
- The attendance rate for males aged 49-74 years is statistically significantly lower than those in the two younger age bands.

- There are **7** MSOAs with significantly lower STI access rates than the County Durham average for males aged 15 – 24 years; these are in deprivation deciles 1 -3 predominantly in east Durham and south Durham.

- There are **12** MSOAs with significantly lower STI access rates than the County Durham average for males aged 25 – 49 years; these are in deprivation deciles 1 -3 predominantly in east Durham and south Durham.

- Access rates for males aged 15-24 years of most deciles (1 to 5 and 9, 10) are statistically similar to the county value. There is no evidence of an inverse social gradient to evidence greater access to meet the anticipated greater need in the more deprived areas.

- For males aged 25-49 years there is a significant variation in the access between the deciles however there isn't strong evidence of an inverse social gradient to evidence greater in the more deprived areas.

Online STI testing

- More than half of attendances (53.2%) are made by people aged 15-24 years. This is different to the face-to-face service where more than half are made by those aged 25-49 year.

- Over 94.8% of attendances are made by people of white ethnicity.

- Of the 39,682 kits requested, the majority of requests came from females 25,745 (64.9%), 13,238 (33.4%) from males, 331 (0.8%) were non-binary and 368 (0.9%) identified as other or preferred not to say.

- The MSOA with the highest access rate for both females and males in age band 15-24 years is Durham City in Decile 8. This suggests that the student

population and other young residents in this area prefer online services despite physical clinics being located in their vicinity.

Recommendations

1 Review of the delivery model to ensure that the service is distributed more equitably to enable greater access form residents living in deprivation deciles 1 – 3.

2 Review the existing delivery model and develop targeted social marketing campaigns and wider communications to increase the engagement of young people aged under 25 years,

3 Increase the opportunities for women to access LARC provision via GP practices in deciles 1 – 3.

4 Using the Approach to Wellbeing, work with partners to ensure that women can access contraception services within their communities and from a provider of their choice.

5 Work with pharmacies to increase the opportunities for women to access free EHOC deciles 1 – 3.

6 Increase opportunistic conversations regarding contraception with male and other non-female service users.

7 Develop targeted campaigns to increase the engagement of male service users and other non-females in particular those in living in deciles 1 – 3.

8 Work to understand where and why 15% of County Durham residents access sexual health services in other areas.

9 Work to increase awareness of the online service for STI kits particularly for young people in decile 1-3 and amongst those aged 50 and over.

10 Consider further HEA work that looks at the outcomes of service users with a particular focus on vulnerable groups, particularly gay, bisexual, and other men who have sex with men.

Introduction

The World Health Organisation (WHO) defines sexual health as, "*a state of physical, emotional, mental, and social wellbeing in relation 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." (WHO, 2006a)*

The ability of people to achieve sexual health and well-being depends on their:

- access to comprehensive, good-quality information about sex and sexuality.
- knowledge about the risks they may face and their vulnerability to adverse consequences of unprotected sexual activity.
- ability to access sexual health care.
- living in an environment that affirms and promotes sexual health.

Sexual health-related issues are wide-ranging, and encompass sexual orientation and gender identity, sexual expression, relationships, and pleasure. They also include negative consequences or conditions such as:

- infections with human immunodeficiency virus (HIV), sexually transmitted infections (STIs) and reproductive tract infections (RTIs) and their adverse outcomes (such as cancer and infertility):
- unintended pregnancy and abortion.
- sexual dysfunction.
- sexual violence; and
- harmful practices (such as female genital mutilation, FGM).

The purpose of the Health Equity Audit (HEA) is to assess whether the County Durham Integrated Sexual Health Service is having an impact on health inequalities and to identify how services are accessed by gender and age relative to deprivation levels across the county. This includes access in relation to face to face contraceptive and STI services and access to online ST kits. The aims are to:

1. Assess equity of access of individuals accessing the service between January 2021 and December 2023
2. To inform future service remodelling activity

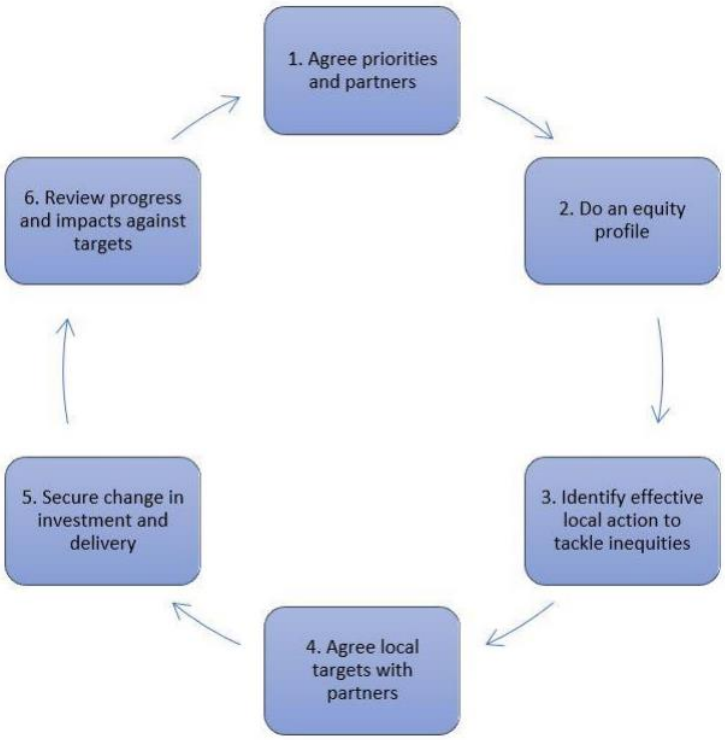
What is a Health Equity Audit

Health Equity Audit (HEA) is a form of needs assessment. HEA is concerned with how causes of ill health, access to services or health outcomes are distributed within a population and systematically reviews this distribution for the presence of inequity. The aim of HEA is to support the distribution of resources relative to need.

HEA is an important tool to use when considering how to reduce health inequalities and inequities through the provision and planning of local services and this is its purpose in this HEA. The audit identifies the distribution of access to Integrated Sexual Health Services (in terms of attendances) are distributed relative to deprivation levels within County Durham.

HEA is a cyclical process as illustrated in figure 1. The first output of a health equity audit is the production of a health equity profile. This should identify and quantify both the need and any existing inequality. A health equity profile only becomes a HEA once the cycle is complete i.e., once changes in resource allocation have been made and outcomes of this change have been reviewed. This process should normally take no less than three years. This is the first time a HEA on access to Sexual Health Services has been conducted in County Durham.

Figure 1: The HEA cycle. Source: OHID (2020)

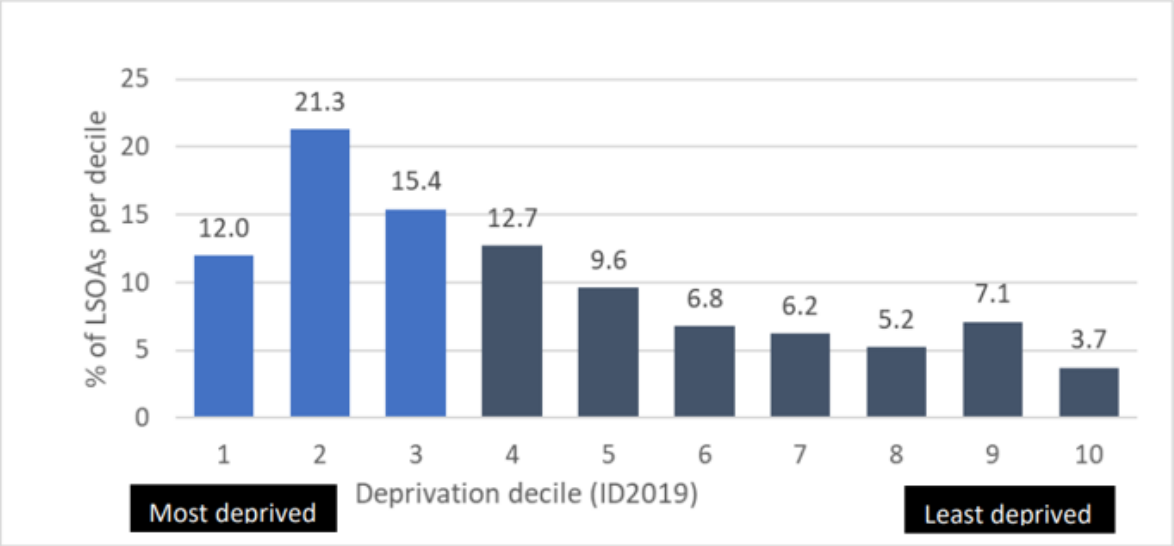


Deprivation and Maps

The Index Deprivation (ID) is the official measure of relative deprivation in England. The latest release of the index is 2019 and it is comprised of seven domains of deprivation which, when combined and weighted, form the ID 2019. County Durham is a large and diverse area and experiences higher levels of deprivation than the national average. County Durham is ranked as the 48th most deprived upper-tier local authority out of 151 nationally. It should be noted that pockets of relative deprivation exist across the County, even in more relatively affluent areas such as

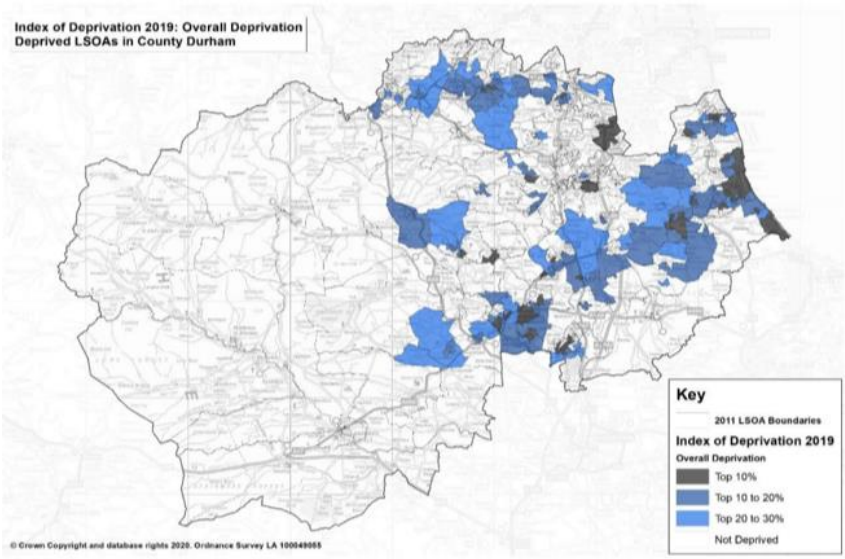
Durham and Chester-Le-Street. The indices are calculated at Lower Super Output Area (LSOA) level. There are 324[1] LSOAs in County Durham and almost half (49%, n=158) are in the 30% most deprived nationally (deciles 1 to 3). The proportion in each decile can be seen in figure 4 below. Over 47% of our population live in these relatively deprived areas.

Figure 2: Proportion of LSOAs in each deprivation decile level of the ID 2019, County Durham. Source: Deprivation in County Durham, Durham Insight



The location and distribution of the most deprived areas in County Durham can be visualised in the map (figure 3) below.

Figure 3: Map of LSOAs in County Durham, shaded by ID 2019 top 30% deciles. Source: ONS and DCC Research and Intelligence Team.



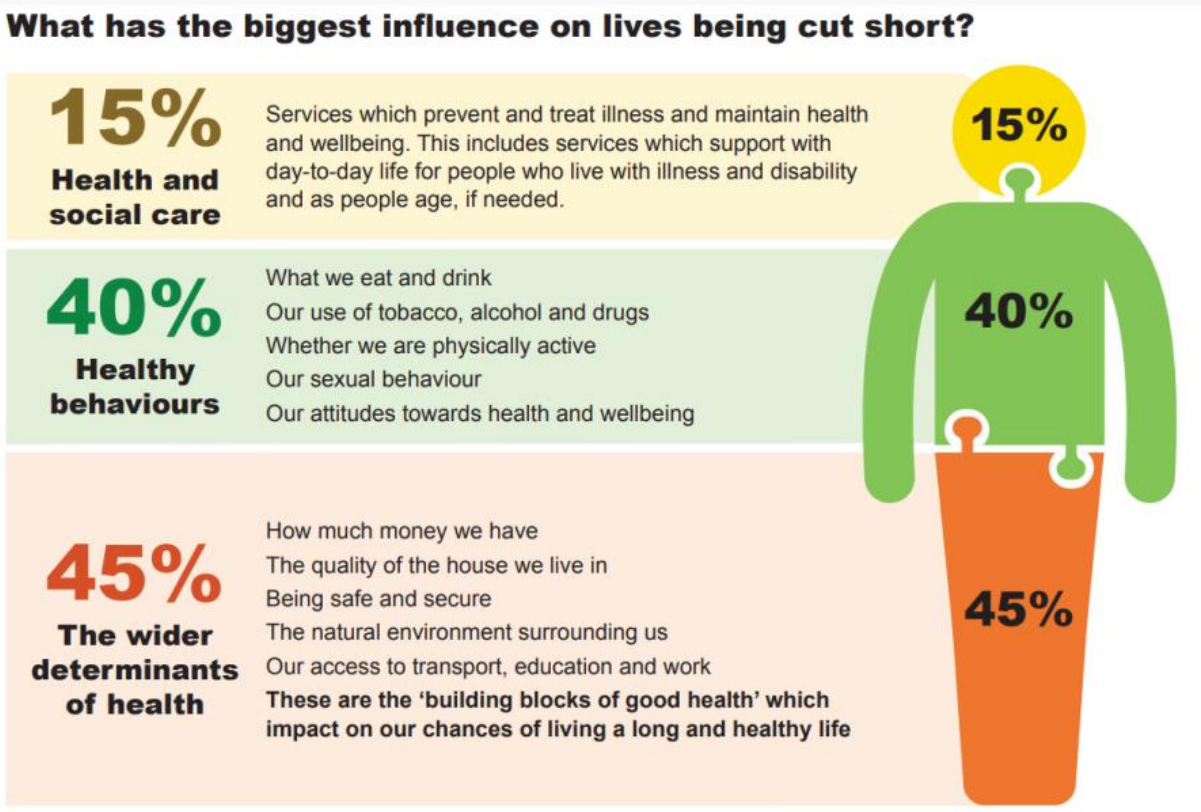
[1] Following the Census 2021 changes were made to the number of LSOAs in England, including County Durham. However the ID 2019 has not been re-cast and the information in Figures 2 and 3 reflect 2011 geography.

Health Inequalities and the Wider Determinants of Health

Health inequalities are disparities between population groups that are systematically associated with socio-economic and environmental factors. Often these inequalities are geographical with health status or outcomes worse in more deprived areas (the social gradient); they can also be experienced by different groups of people, for example the young and elderly, veterans, or homeless people. Such variations in health are avoidable and unjust. The health inequalities are the result of a complex relationship between our genes, and the broader factors of health care, our behaviours, and the wider determinants of health. Improvements in health outcomes, cannot be made without action in these wider determinants.

In **Figure 4** below we show an estimate of the contribution that these wider factors have on health and wellbeing and ultimately lives being cut short. What happens within an individual's social context, the early years, education, income, skills development, employment and work all impact on their health and length of life, more so than access to and quality of health care and behavioural risk factors.

Figure 4: Infographic showing the impacts on the health and wellbeing of the population. Source: County Durham Joint Local Health and Wellbeing Strategy 2023 - 2028



McGinnis, J.M., Williams-Russo, P. and Knickman, J.R. (2002) cited in The King's Fund (n.d.). Time to Think Differently. Broader determinants of health: future trends. Available at: https://www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health (Accessed: 9 March 2023).

Inequalities and Sexual Health – Local Need

Sexual health is not equally distributed within the population, evidence tells us that some groups are more effected than others. Some groups at higher risk of poor sexual health face stigma and discrimination, which can influence their ability to access services.

Whilst the County Durham burden of disease for sexual health is lower than other local authority areas, there is significant variation across the county which leads to further health inequalities for its residents. Between 2,000 and 3,000 new STI's are diagnosed in County Durham each year.

In relation to need around contraception and reproductive health, we have significantly higher rates of teenage conceptions and numbers of teenage mothers compared to England. Our prescribing rates of LARC has been at a significantly lower rate than the North East and England since 2016 and there are significant gaps between abortion rates and repeat abortions when you compare County Durham to England.

More information on these topics can be found in the Insight reports for Teenage Conception and Sexual Health which form part of our Joint Strategic Needs and Assets Assessment (JSNAA).

County Durham's mix of rural, costal, and urban towns and villages mean that service delivery models must be flexible, and sexual health services located in areas that ensure all residents, particularly those in areas of greatest need, can access services should they need to.

Poverty and the cost-of-living crisis means that more people are struggling financially, this may have a negative impact on their ability access sexual health services for example travel costs and resources including contraception.

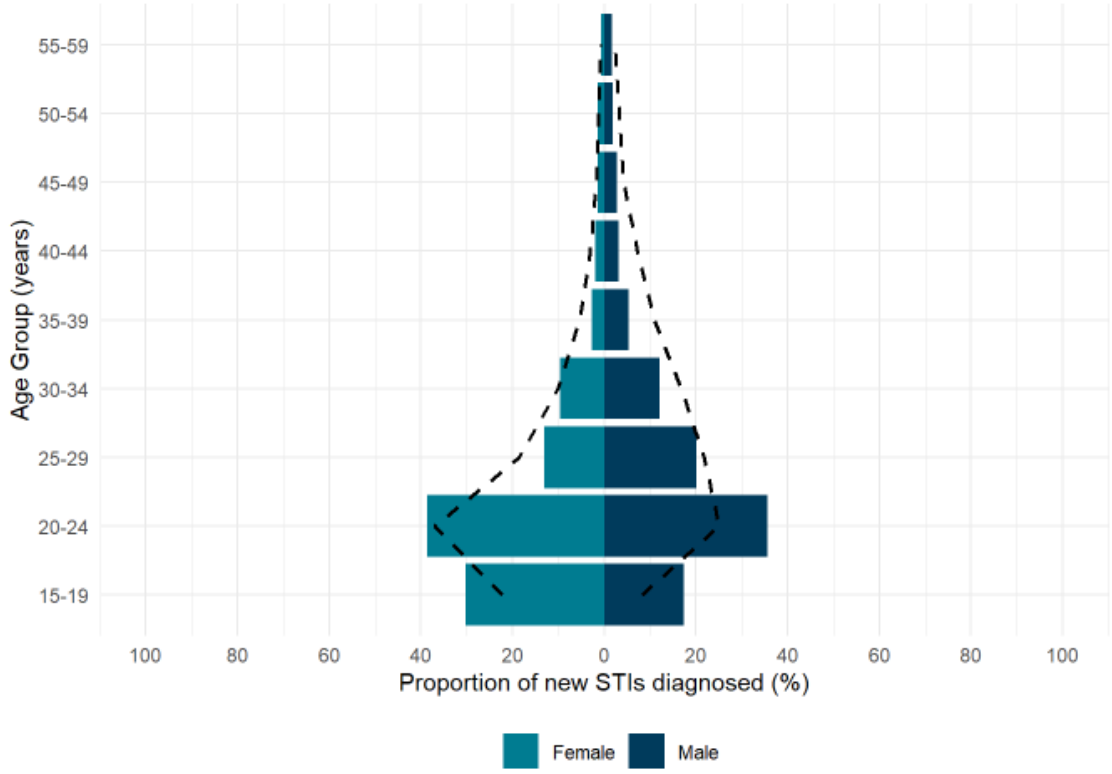
Age and gender

Evidence shows that young people aged 15 – 24 years old experience the highest diagnosis rates of the most common STIs. Young women are more likely to be diagnosed with an STI than young men.

Chlamydia is the most commonly diagnosed STI in England, young women aged 15 – 24 years bare the greatest burden of disease as Chlamydia is often asymptomatic and can cause fertility complications if left untreated.

In 2022, 61% of diagnoses of new STI's of County Durham residents were in young people aged 15 – 24 years old. This compares to 44.5% in England. Overall, of those County Durham residents diagnosed with a new STI in 2022, 49.3% were men and 50.7% were women (Source: UK Health Security Agency Splash Supplement Report, 15 January 2024).

Figure 5: Proportion of new STIs by age group and gender in County Durham (bars) and England (lines), 2022. Source: UK Health Security Agency Splash Supplement Report, 15 January 2024



Access to specialist contraceptive services amongst both males and females aged under 25 years is significantly below the England average for each year between 2014 and 2022. The rates are also low compared to other LAs in the North East. This indicates there could be unmet local need.

Sexual orientation

According to Census 2021 data, over 12,000 County Durham residents identify as either, lesbian, gay, bisexual or have a sexual orientation other than heterosexual; this equates to 2.85% of the over 16 years population.

STI's are more likely to be diagnosed in gay, bisexual, the trans community, other men who have sex with men (MSM).

Despite HIV new diagnosis numbers declining in the UK, inequalities exist in late diagnosis of HIV. Higher proportions of late diagnoses are seen in females, older people, black ethnic minorities, heterosexual men, and females and those living outside of London.

Black Minority and Ethnic populations

According to Census 2021 data, 94.8% of County Durham are white British compared to 73.5% across England.

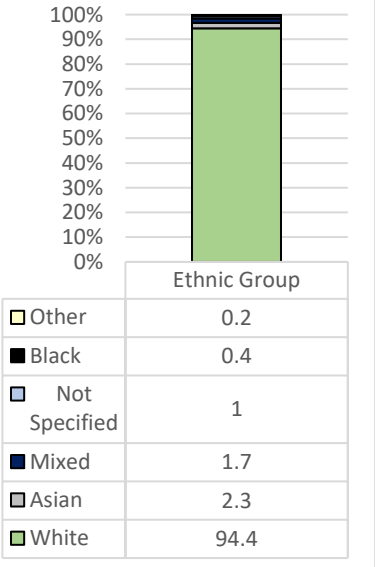
Across England, people of black ethnicity have the highest rates of new STI diagnoses, with the highest rates in Black Caribbean ethnicity[2]. The high STI rates among black ethnic communities are likely an outcome of the complex relationship between cultural, economic, and behavioural factors.

In County Durham the 2021 Census estimates our black population to be 1,741 which makes up 0.33% of our overall population, compared to 4.22% across England as a whole.

Figure 6 below shows the proportion and rate of new STI diagnoses of County Durham resident by ethnic group. Most STIs are diagnosed amongst white residents (94.4%) and the rates by ethnic category show a different pattern to England. The data used to calculate rates come with a **data warning** to use with caution as the numbers for all categories except for white are under 100.

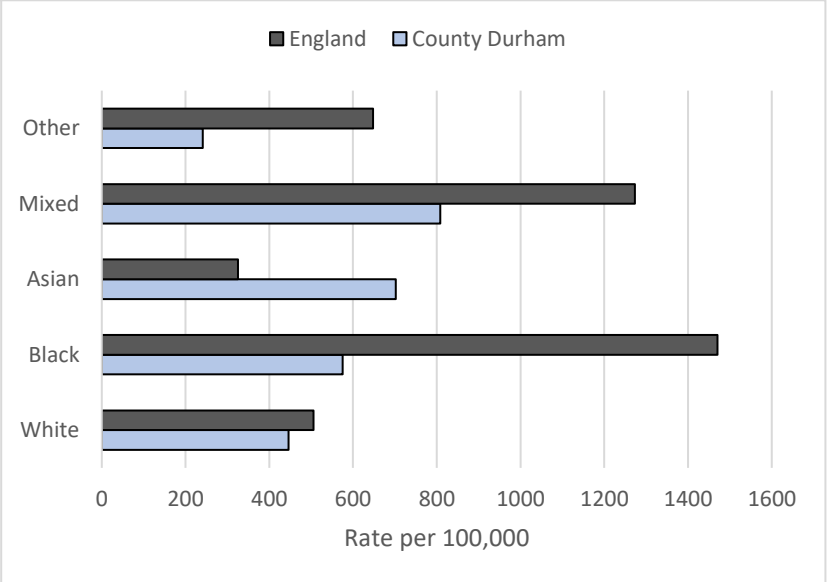
Figure 6: Distribution of new STIs by ethnic group category in County Durham. Proportion by category (6a) and rates by category (6b). Source: UK Health Security Agency Splash Supplement Report, 15 January 2024

6a



Ethnic Group	
Other	0.2
Black	0.4
Not Specified	1
Mixed	1.7
Asian	2.3
White	94.4

6b



Deprivation

Strong links exist between deprivation and STI's, STI's are avoidable health risks that can cause sexual and reproductive illness. Early detection and treatment can reduce long-term consequences such as infertility.

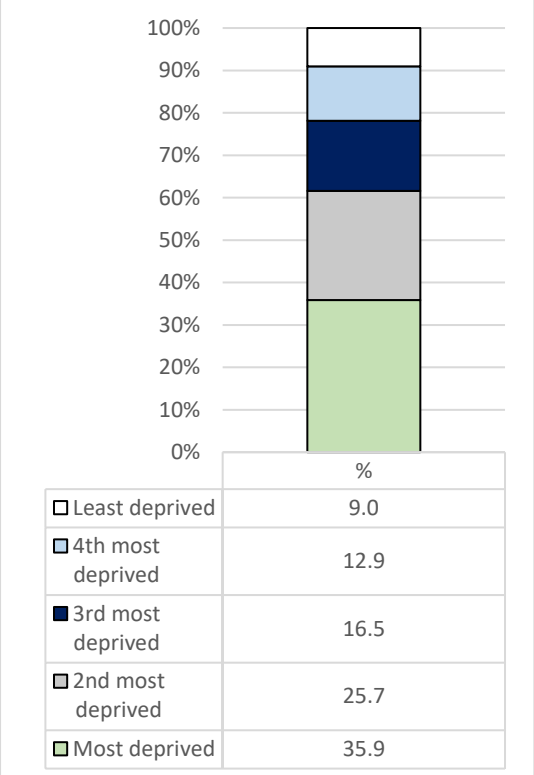
[2] Sexually transmitted infections and screening for Chlamydia in England 2023: report UKHSA

Figure 7 below highlight that the proportion and rates of new STI diagnosis in County Durham have a correlation with deprivation. This means that rates of new STI diagnoses are highest in County Durham's most deprived communities.

Over 60% of new STI diagnoses are in the top two most deprived quintiles for deprivation. The rate of new diagnosis indicates a social gradient where the highest rate of new diagnoses are in the most deprived areas.

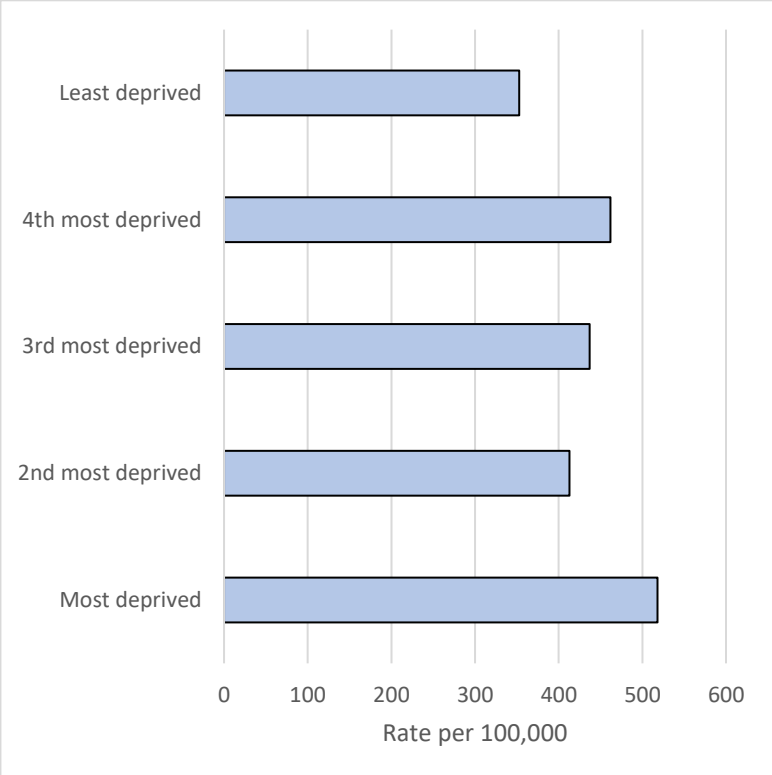
Figure 7: Distribution of new STIs by deprivation category in County Durham. Proportion by category (7a) and rates by category (7b). Source: UK Health Security Agency Splash Supplement Report, 15 January 2024

7a



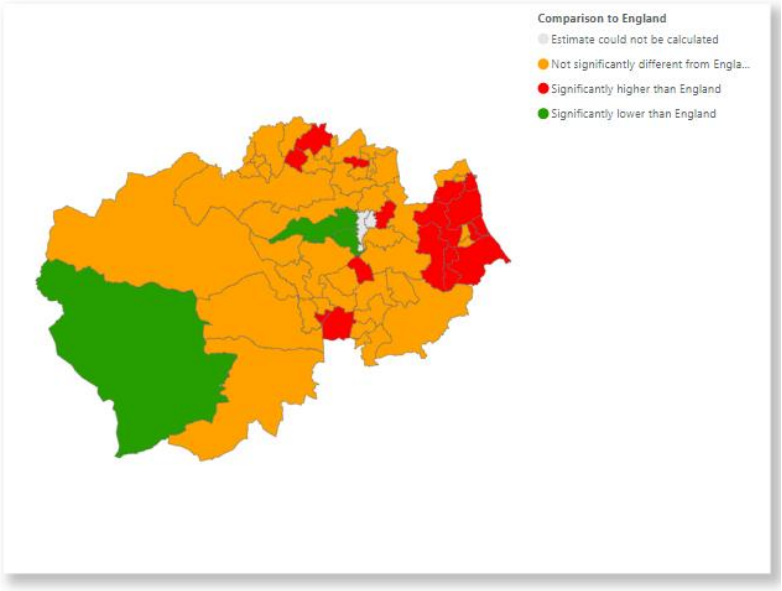
	%
Least deprived	9.0
4th most deprived	12.9
3rd most deprived	16.5
2nd most deprived	25.7
Most deprived	35.9

7b



Strong links also exist between deprivation teenage conceptions and abortions. Teenage pregnancy is both a cause and consequence of health and education inequalities. Teenagers have the highest rate of unplanned pregnancy with disproportionately poor outcomes. Child poverty and unemployment have a strong influence on under 18 conception rates and links can be made to rates of under 18 conceptions and areas of high deprivation. Figure 8 shows the 16 wards in County Durham where rates of teenage conceptions are significantly higher than England.

Figure 8: Rates of teenage conceptions in County Durham wards and significance compared to England, 2018-2020. Source: Durham Insight, [Teenage Conceptions in County Durham JSNAA Insight Report]



Conceptions Statistics: ONS data

Having a planned pregnancy ensures that people are prepared for parenthood. Planned pregnancies enhance the chances of having a healthy pregnancy and reduces any potential risks. There is limited local data on inequalities in terms of abortions however it is useful to understand the picture for England. This shows that in the most deprived deciles the rate of abortions amongst females are higher than the least deprived areas, including repeat abortions and abortions following a birth. This indicates a need for greater access to contraceptive services in more deprived communities. We would expect to see a similar social gradient in County Durham, if not more so given greater levels of relative deprivation.

Figure 9: Selected indicators demonstrating inequality in terms of abortion rates in England. Source: Sexual and Reproductive Health Profiles, OHID. Accessed May 2024.

Abortion	Measure	Most deprived	Least deprived	England
Under 18s abortion rate (2021)	per 1,000	8	4.5	6.5
Under 25s abortion after a birth (2020)	%	31.3	20.1	27.1
Under 25s repeat abortions (2021)	%	31.6	27.1	39.7
Over 25s abortion rate	per 1,000	21.8	14.6	17.6
Total abortion rate	per 1,001	23.7	15.1	19.3

National and Local Context

In November 2023, County Durham's Health and Wellbeing Board ratified the County Durham Sexual Health Strategy 2023- 2028. This strategy was developed in line with a range of national guidance documents including:

- Sexual and reproductive health and HIV: applying All Our Health
- A Framework for Sexual Health Improvement in England
- Syphilis Action Plan
- Females' Health Strategy for England
- British Association for Sexual Health and HIV

The County Durham strategy informed by best evidence, research and intelligence from the JSNAA and local service data, has identified the following key priority areas:

- Relationship education, and relationship, sex and health education across the life course
- Teenage conceptions, pregnancy and support for young parents
- Contraception
- Sexually transmitted infections and HIV
- Reproductive health

Sexual Health as a System

Sexual health is a system, it is important to understand who has responsibility for each element and how organisations must work together to reduce inequalities.

Since the introduction of the Health and Social Care Act 2012, Local Authorities have the responsibility to provide, or secure the provision of, open access sexual health services in its area. This means that Durham County Council are responsible for screening and treatment for Sexually Transmitted Infections (STI's), Chlamydia screening, HIV testing, partner notifications, contraceptive services, services in pharmacies and some elements of Psychosexual Counselling.

Integrated Care Boards (ICB) are responsible for the commissioning of Termination of Pregnancy services, sterilisation and vasectomy, non-sexual health aspects of Psychosexual Counselling and gynaecology including the use of any contraception for non-contraceptive purposes.

NHS England commissions HIV treatment and care including the drug costs for post exposure prophylaxis (PEPSE) following sexual exposure, promotion of opportunistic testing and treatment for STI's and patient requested testing by GP's, sexual health elements of prison health services, sexual assault referral centres, cervical screening, and specialist foetal medicine services.

The County Durham Integrated Sexual Health Service

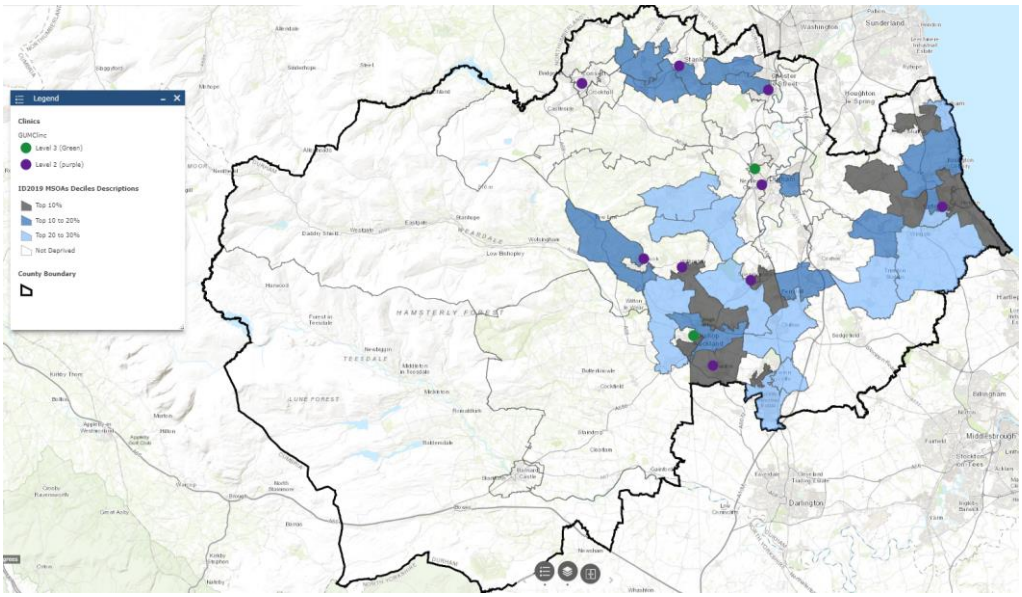
The County Durham Integrated Sexual Health Service (ISHS) commissioned by Durham County Council (DCC) is delivered by County Durham and Darlington NHS Foundation Trust (CDDFT).

In 2018 the service was remodelled into a fully integrated service, meaning CDDFT became responsible for all elements of the open access provision, including developing Service Level Agreements (SLA) directly with GP practices to deliver LARC Services within local communities and SLAs with local pharmacies to deliver Emergency Hormonal Oral Contraception (EHOC).

The ISHS is delivered through a hub and spoke model, this means that people can access support through the two main hubs that are located within University Hospital of North Durham (UHND) and Bishop Auckland Hospital, or through a number of outreach venues including pharmacies across the county. Service delivery includes:

- Specialist Services including Genitourinary Medicine (GUM)
- Contraception and sexual health (CASH) services to the community
- Pharmacy provision
- GP LARC SLA
- Digital offer for STI, HIV testing and condom distribution
- Sexual health promotion
- C Card services and wider condom distribution

Figure 9: Map showing locations of hub and spoke model of County Durham's ISHS and areas of highest deprivation (ID2019), as at March 2024



Key:
- Level 3 Hub GUM and CASH clinic provision
- Level 2 CASH, community-based settings

Not every venue is able to offer the full suite of services, some clinical and specialist aspects are only available at the two main hubs. The fitting of coils in community-

based settings is also dependent on which staff are working and the clinical facilities of the setting.

County Durham has settlements which border other North East local authorities. Some residents may choose to access sexual health services provided by other local authorities; those attendances will not be captured in this HEA and further work should be undertaken to understand why some residents access sexual health services outside of the boundaries of County Durham.

NHS Digital publication of Statistics on Sexual and Reproductive Health Services confirms that the majority of County Durham residents access CDDFT's services. In 22/23, 13,100 sexual and reproductive health contacts were recorded by County Durham residents of these 86.3% attended CDDFT clinics.

This HEA is concerned with how our locally commissioned service is meeting the needs of County Durham residents, but we acknowledge that there will be instances where service users choose to and/or it is appropriate for them attend other services offered by other providers.

As part of the integrated model, CDDFT have entered a subcontracting arrangement with provider SH:24 to deliver a 24-hour digital service. This means that County Durham residents can access free STI testing, including HIV testing, condoms, and some contraceptive pills through an online platform.

The platform can be reached through SH:24 webpage or via a link from the County Durham Sexual Health Service website making it easily accessible. The digital offer requires users to be 16 years or over[3].

Whilst this HEA is primary concerned with access to physical clinics, the introduction of the digital offer has not resulted in any decrease in face-to-face appointments, potentially indicating previously unmet need.

Online STI testing is a much narrower category of service provision in comparison to the wide range of clinical and non-clinical interventions, testing, treatment, and advice offered in face-to-face clinic attendances. They are not like for like, however we do compare the two to inform understanding of which population groups have potential preferences or ease of access to one over the other.

For the purposes of this HEA, we will aim to have better understanding of the County Durham residents who access the digital offer.

[3] Anyone under 16 years is automatically directed back to local services for a face-to-face consultation.

The Impact of Covid 19 on the Integrated Sexual Health Service

The Covid 19 pandemic, including the time periods when lockdowns and other restrictions were in place, had a significant impact on the delivery of sexual health services. Services from community venues were ceased and 'walk in'[4] appointments were no longer available.

In addition to the government Covid-19 specific guidelines, the service developed and implemented a telephone triage system and enhanced their digital services to include greater availability of STI and HIV testing kits and access to online ordering of condoms and some types of contraceptive pills.

Whilst these interventions had some long-lasting positive impacts locally, changes in delivery model may have unintentionally exacerbated health inequalities by potentially reducing opportunities for people to access the service without an appointment and limiting capacity in community venues.

Nationally the evidence suggests that young people and those reporting sexual risk behaviours[5] were at greatest risk during this time and a decrease in STI testing and diagnoses occurred during 2020 – 2021, this is reflected national trends[6] and requires further local exploration.

Methods of analysis

Data on access to ISHS has been collated into age specific groupings, deprivation deciles and where numbers allow, mapped against MSOA[7] boundaries.

- The **age groups** applied throughout the HEA profile have been chosen as follows:
  - 15 – 24 years
  - 25 – 49 years
  - 50 – 74 years
- These groups have been developed in this way as they reflect the burden of sexual health related disease and activity. It is recognised that individuals aged outside of these groups do access the ISHS, however are not included in the analysis due to small numbers.
- The denominator **populations by age and gender** used are ONS mid-year estimates for 2022 (the middle year of the time period of focus for the HEA which is 2021 to 2023).
- The **MSOA boundaries** used are from the 2021 Census boundaries. There are 65 MSOAs in County Durham

[4] Walk in refers to appointments that did not need prior booking.
[5] Those with new sexual partners and condomless sex
[6] Impact of the Covid-19 pandemic on sexual and reproductive health service use and unmet need in Britain
[7] MSOAs are a Census geography. They have an average population of 8,100 and a range of 4,200 to 16,000.

The following calculations have been performed:

- **Age specific access rates per 1,000** broken down by age and gender.
- **Confidence intervals** calculated using the Byar's method.

To conduct this HEA profile the Slope and Relative Indices of Inequality are calculated and analysed. Both of these measures quantify the socio-economic dimension to inequalities in health using a linear regression.

The **Slope Index of Inequality (Sii)** quantifies the absolute inequality gap. The Sii allows the absolute gap between the least and most deprived areas in a given geography to be shown for a particular measure. It takes into account the position of all groups and the population size of each group simultaneously.

The **Relative Index of Inequality (Rii)** quantifies the relative inequality gap. The Rii is the size of the gap between the least and the most deprived MSOA expressed as a percentage of the overall value for the whole population. This permits comparisons to be made over time.

Data sources - Face to Face and online access

SRHAD

The Sexual and Reproductive Health Activity Data Set (SRHAD) is anonymised, patient -level, electronic collection from all sexual and reproductive health services. CDDFT are required to submit a SRHAD return on an annual basis. It is acknowledged that some people may choose to access services outside of County Durham, however this HEA profile is concerned with equity for County Durham residents accessing DCC public health commissioned sexual health services only.

The equity profile is constructed from the most recent complete data returns for calendar years 2021, 2022 and 2023.

The data was taken from CDDFT's patient management system, Inform Sexual Heath; a bespoke system designed for sexual health service record keeping and data management.

The files received contained a pseudonymised list of all attendances at CDDFT clinics. The data was filtered for residents of County Durham Local Authority only, of which there were 74,603 attendances. The following data fields were selected and used in the analysis:

1. Clinic ID
2. Gender
3. Age
4. Ethnicity
5. Local Authority of residence
6. Lower Super Output Area (LSOA) of residence

7. Consultation medium used
8. Contraception method status
9. SRH care activity

SRHAD records both face to face and telephone consultations. See Figure 10. The higher number of telephone consultations in 2021 and then decline is as a result of the Covid-19 pandemic and the service's transition to business as usual. As one of the aims of this HEA is to understand access to physical clinic sites, we focus on the 53,577 face-to-face attendances in the SRHAD and exclude telephone consultations.

Figure 10: Number of attendances by consultation medium, SRHAD 2021-2023

	2021	2022	2023	Total
Telephone	13,057	5,271	2,698	21,026
Face to face	15,138	18,781	19,658	53,577
All	**28,106**	**24,052**	**22,356**	**74,603**

EPR

CDDFT also hold a separate source of patient level data; an electronic patient record (EPR). This includes additional information on gender identity and sexual orientation which is not available in the SRHAD.

The ISHS provided tables which summarised 30,763 patient records who attended the ISHS, extracted from the EPR for the relevant 3-year period for County Durham residents only. The data set comprised of face-to-face appointments only, and duplicate records removed; this will account for some discrepancies in numbers when comparing to the SRHAD. But allows comparison to population figures collected in the 2021 census.

Figure 11: Number of individuals attended CDDFT's ISHS, EPR 2021-2023

	2021	2022	2023	Total
All	**8,910**	**11,204**	**10,649**	**30,763**

SH:24

The service provided a data set relating to requests for home STI test kits for the three-year time period 2021, 2022 and 2023. It contained the following data fields:

- Age
- Ethnicity
- Gender Identity
- Gender Identity and birth sex
- LSOA of residence
- Sexuality

In the three-year period there were 39,682 requests for STI tests.

Figure 12: Number of requests for online STI Tests, SH:24 2021-2023

	2021	2022	2023	Total
All	**12,220**	**11,805**	**15,657**	**39,684**

Descriptive statistics of the Sex, Gender and Sexual orientation breakdown of service users

The three data sets give insight into the demographic profiles of ISHS clients. However, understanding is limited due to different question types used for data collection and differences between categories/labels used by organisations who deliver services and the ONS 2021 Census.

In terms of gender/sex, females access services more than males. It is anticipated that a key reason for attendance at the ISHS for women is contraception services and this will skew the data when looking at the data set as a whole; the splits is 80/20 in favour of females. Females access contraceptive services more than males and make more repeated visits this is confirmed in figure 13. In comparison, access to online STI tests shows a greater proportion of access is by males and those who identify as non-binary, transgender or other.

Figure 13: Gender/Sex of service users captured by the three data sources, 2021-2023.

		SHRAD attendances		Individual patients (EPR)		SH:24 online test kits	
		Number	%	Number	%	Number	%
Gender/Sex	Male	11,015*	20.6	5,634	18.4	13,238	33.4
	Female	42,560*	79.4	24,987	81.5%	25,745	64.9
	Non-binary/transgender	<5	<0.01	35	0.1	331	0.8
	Described in another way/prefer not to say	N/A		12	0.0	368	0.9
	Total	**53,577**	**100**	**30,668**	**100**	**39,682**	**100**

* Rounded values

** SHRAD guidance states this category should be used for transgender patients

The SRHAD doesn't collect information on a person's sex being the same or different to that registered at birth, this information is collated through the EPR. The most recent census conducted in 2021 included a new data collection on gender identity (however the census collects gender and gender identity separately and therefore there is a known discrepancy between the categories used in figures 13 and 14).

Figure 14: Gender identity of service users captured in EPR and SH:24 data sources, 2021 to 2023, and compared to Census 2021.

		Individual patients (EPR)		SH:24		Census 2021	
		Number	%	Number	%	Number	%
Gender Identity	Same as sex registered at birth	30,557	99.6	39,246	98.9	412,558	95.1
	Different from sex registered at birth	112	0.4	324	0.8	625	0.1
	Trans woman, Trans Man or Other	N/A			N/A	976	0.2
	Not answered	N/A		112	0.3	19,800	4.6
	Total	**30,668**	**100%**	**39,682**	**100%**	**433,959**	**100%**

Sexual orientation and gender are different; gender can be described as how a person sees themselves and sexual orientation relates to who a person is attracted too.

Good sexual health and reproductive health is important for everyone, however sexual ill health effects some population groups such as gay, bisexual, and other men who have sex with men, more than others[8].

Therefore, as part of this HEA profile it is important to review access data (where available) in relation to sexual orientation. Sexual orientation is not captured the SRHAD, and the following tables compare the EPR and SH:24 with Census 2021 figures for County Durham.

Figure 14 shows that Census 2021 estimates around 2.8% of the population define their sexuality as not heterosexual/straight[9]. Analysing service access data, the proportion of non-heterosexual attendees is higher than population estimates. This also varies significantly when data is reviewed by gender identify breakdown.

Figure 15: Sexuality of service users captured in EPR and SH:24 data sources, 2021 to 2023, and compared to Census 2021

		Individual Patients (EPR)		SH:24		Census 2021	
		Number	%	Number	%	Number	%
Sexual Identity/orientation	Heterosexual	27,170	88.6	31,873	80.3	396,553	91.4
	Gay	1,436	4.7	2,611	6.6	6,142	1.4
	Bisexual	845	2.8	3,809	9.6	5,154	1.2
	Not asked	185	0.6	N/A		N/A	
	All other sexual orientations	N/A		244	0.6	1,074	0.2

[8] Sexually Transmitted Infections: promoting the sexual health and wellbeing of gay, bisexual, and other men who have sex with men. Public Health England 2021.
[9] Durham Insight 2024

	Not answered/other	1,032	3.4%	1145	2.9	25,035	5.8
	Total	**30,668**	**100%**	**39,682**	**100%**	**433,958**	**100%**

Figure 16: Cross tabulation of sexual identity by gender* captured in the EPR data source, 2021 to 2023.

		Male		Female		Non-Binary	
		Number	%	Number	%	Number	%
Sexual Identity/orientation	Heterosexual	3,850	68.3	23,309	93.3	7	20
	Gay	1,283	22.8	143	0.6	10	28.6
	Bisexual	309	5.5	521	2.1	10	28.6
	Not asked	36	0.6	148	0.6	0	0
	Not answered/other	156	2.8	866	3.5	8	22.9
	Total	**5,634**	**100**	**24,987**	**100**	**35**	**100**

**Numbers of those who describe their gender in another way within each sexual orientation category have been suppressed due to low* numbers. *Caution should be given when interpreting the sexuality of non-binary service users due to very low numbers.*

As stated previously, the primary reason for attendance at the ISHS for women is contraception services, therefore it was anticipated that heterosexual women would make up a significant proportion of the cohort.

This differs significantly when the data is analysed against those who describe their gender identify as male and are accessing the service as shown in figure 16 above; around 32% of males describe their sexual orientation as non-heterosexual. This reflects the wider evidence base that suggests MSM are overrepresented in sexual health services[10].

Although small numbers, those who describe their gender identify as non-binary, appear to show higher percentages of individuals who describe their sexual orientation as non-heterosexual.

Data used for the equity analysis of face-to-face access by age, gender, and deprivation.

As outlined above, the face-to-face attendances data set consisted of 53,577 attendances. The descriptive statistics in figure 17 help us to understand that of these:

- More than half of attendances (53.2%) are made by people aged 25-49 years.
- Over 95% of attendances are made by people of white ethnicity.

[10] Sexually transmitted infections: promoting sexual health and wellbeing of gay, bisexual, and other men who have sex with men. From research to public health practice 2021.

- The majority of ISHS face to face attendances occur at the two hospital sites within County Durham, University Hospital North Durham, and Bishop Auckland Hospital. Almost 3 out of 5 or 58.7%.
- Peterlee Health Centre and Stanley Health Centre are the most well attended community clinics receiving just over 10% of attendances each, 11.3% and 11.0% respectively.

Figure 17: Face to face clinic attendances broken down by age, ethnicity and clinic attended. Source: SHRAD 2021-23.

		Number of attendances	%
Age	Under 15	474	0.9%
	15-24	20,390	38.1%
	25-49	28,469	53.1%
	50-74	4,142	7.7%
	75 and over	97	0.2%
	Total	**53,577**	**100%**
Ethnicity	White	51,002	95.2%
	Asian or Asian British	602	1.1%
	Black or Black British	585	1.1%
	Mixed	521	1.0%
	Not stated or unknown	414	0.8%
	Chinese	295	0.6%
	Any other ethnic group	158	0.3%
	Total	**53,577**	**100%**
Clinic attended	Bishop Auckland Hospital	15,780	29.5%
	UHND	15,205	28.4%
	Peterlee Health Centre	6,070	11.3%
	Stanley Primary Care Centre	5,871	11.0%
	Chester-le-Street Community Hospital	2,908	5.4%
	Spennymoor Health Centre	2,503	4.7%
	Glenroyd House, Consett	2,417	4.5%
	Crook Health Clinic	652	1.2%
	Patient's Home	341	0.6%
	Pelton Lavender Centre	284	0.5%
	Educational Premises	167	0.3%
	Other	1,379	2.6%
	Total	**53,577**	**100%**

Access to in person Contraception Services

The following section describes the results of the HEA in relation to face to face level 2 and 3 contraception services provided by CDDFT's Integrated Sexual Health Service.

The data relates to face-to-face activity from the 2 main hub sites and the 7 community-based settings which were operating between 2021 and 2023.

Attendances for contraception were defined as:

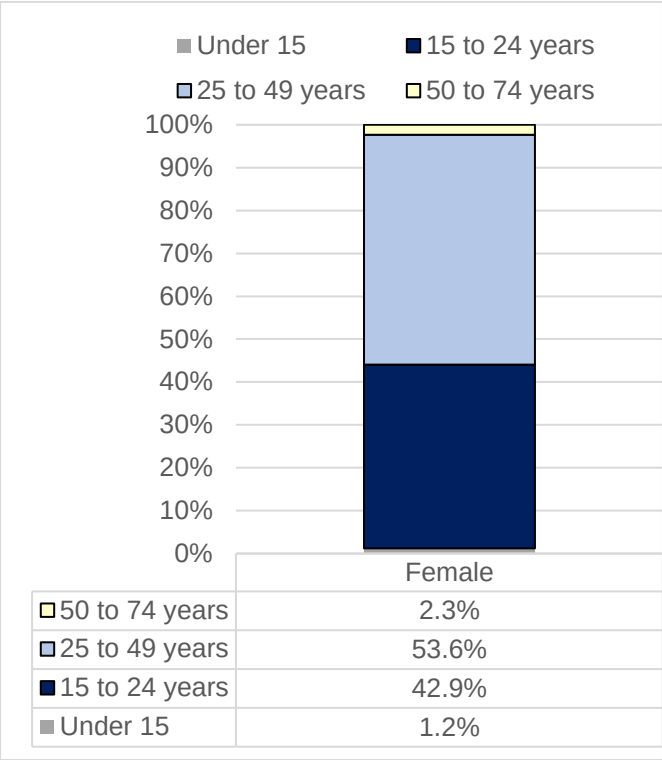
Appointments where the recorded contact included either a change, maintain or new contraception or pre-contraceptive advice was given.

Overall

Of the 53,577 attendances, 57.8% (30,972) involved contact regarding contraception. The majority of attendances were by females 30,842 (99.5%). Less than 0.5% of attendances were by males and less than 5 where gender was unable to be classified. The male female skew was expected and due to the low numbers, there is no further analysis of male's attendance for contraception. There are less contraception options for males however contraception should be considered when males attend the ISHS, and males should be encouraged to talk about contraception with their partners.

The age profile of female attendances is shown in figure 18. The largest proportion of attendances were made by females aged 25-49 years (53.6%) followed by females aged 15-24 years (42.9%).

Figure 18: Percentage of attendances for contraception care by age band. Source: SRHAD 2021-23

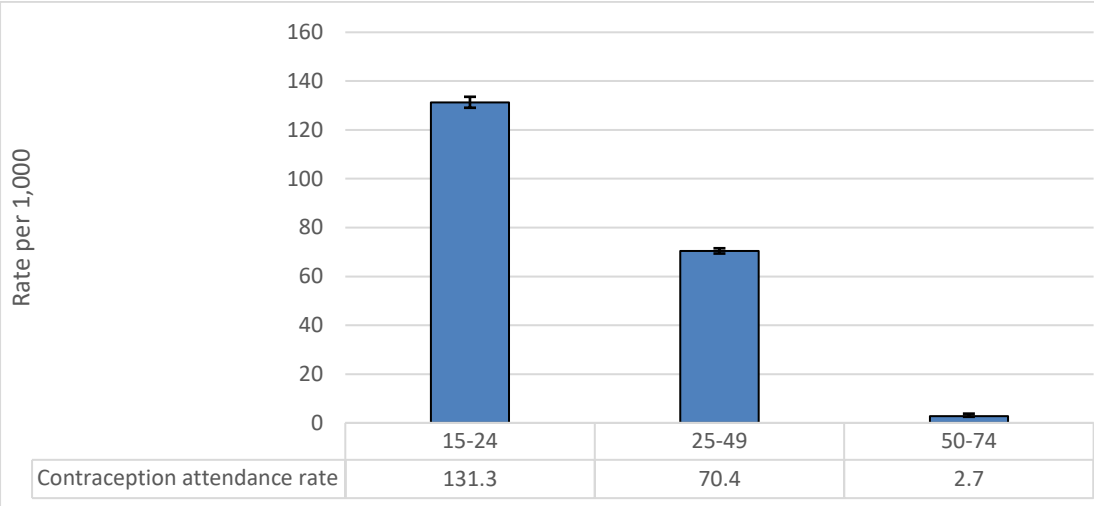


	Female
50 to 74 years	2.3%
25 to 49 years	53.6%
15 to 24 years	42.9%
Under 15	1.2%

Attendance rates per 1,000 for contraceptive services at ISHS decrease significantly with age and this is in line with the anticipated need in the youngest age band. When considering the 50 years plus category we acknowledge that females become less fertile as they age, however may still choose to access services for contraception support. Figure 19 shows:

- The attendance rates for contraception are statistically significantly higher for females aged 15-24 than the other two age categories.
- The attendance rate for females aged 25-49 years is statistically significantly higher than those aged over 49 years.

Figure 19: Rates of females accessing ISHS for contraception per 1,000 population, by age category. Source: SHRAD 2021-23, ONS mid-2022 population estimates



Females aged 15-24 and 25 to 49 years

The HEA has shown that access rates to contraception services in the ISHS are highest amongst the youngest age groups. Now we look at variation within the county.

There is a large range in access rates across the 65 MSOAs within the County (figure 20).

Figure 20: Summary of contraception access rates per 1,000 for females aged 15 to 49 years. Source: SHRAD 2021-23, ONS mid-2022 population estimates

	15-24 years		25-49 years	
	MSOA	Rate per 1,000	MSOA	Rate per 1,000
Highest	Stanhope and Wolsingham	336.9	Crook North, Howden -le-Wear and Tow Law	159.9
Lowest	Bournmoor and Great Lumley	18.7	Newton Aycliffe East	16.5
County Durham average		131.3		70.4

Figures 21 and 22 below illustrate that some of the highest rates of females aged 15–24 and 25-49 years accessing contraception services are closely aligned to several MSOAs of highest deprivation in County Durham. However, the data also highlights that also the opposite is true.

For each age band, there are MSOAs in the top 30% most deprived areas of the county where access rates are significantly below the county value; seven areas for those aged 15-24 years and nine areas for those aged 15-49 years. Six MSOAs

appear in both and the majority of these are located in the east and south of the county.

It should also be noted that some of these areas are MSOA's that border with other local authority areas and residents may travel to other service providers; this should be further explored with CDDFT.

Figure 21: List of MSOAs in most deprived 30% with significantly lower contraception access rates that the County Durham average

Decile and MSOA name	**Dark blue indicates significantly lower access rates compared to CD**	
Decile 1	15-24	25-49
Coundon and Willington South		
Dalton-le-Dale and Deneside		
Newton Aycliffe Central		
Decile 2		
Gilesgate Moor		
Decile 3		
Aycliffe Village Newton Aycliffe South		
Chilton and Ferryhill Station		
Dawdon and Seaham Harbour		
Fishburn and Trimdons		
Newton Aycliffe East		
Total number of MSOAs	**7**	**9**

Figure 22: Contraception access rate per 1,000 for females aged 15 – 24 years by MSOA and ID 2019 deprivation decile. Source: SHRAD 2021-23, ONS mid-2022 population estimates

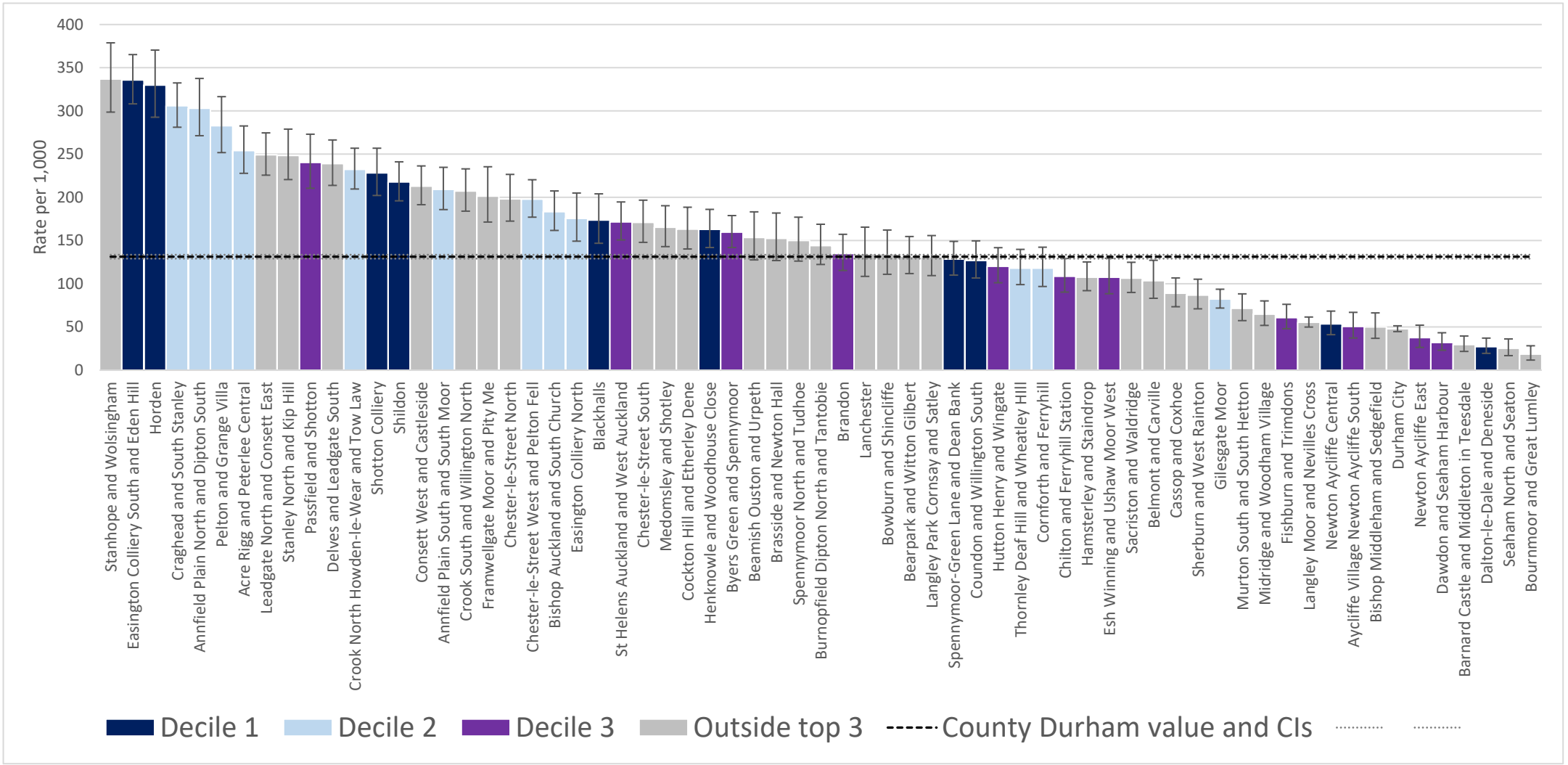
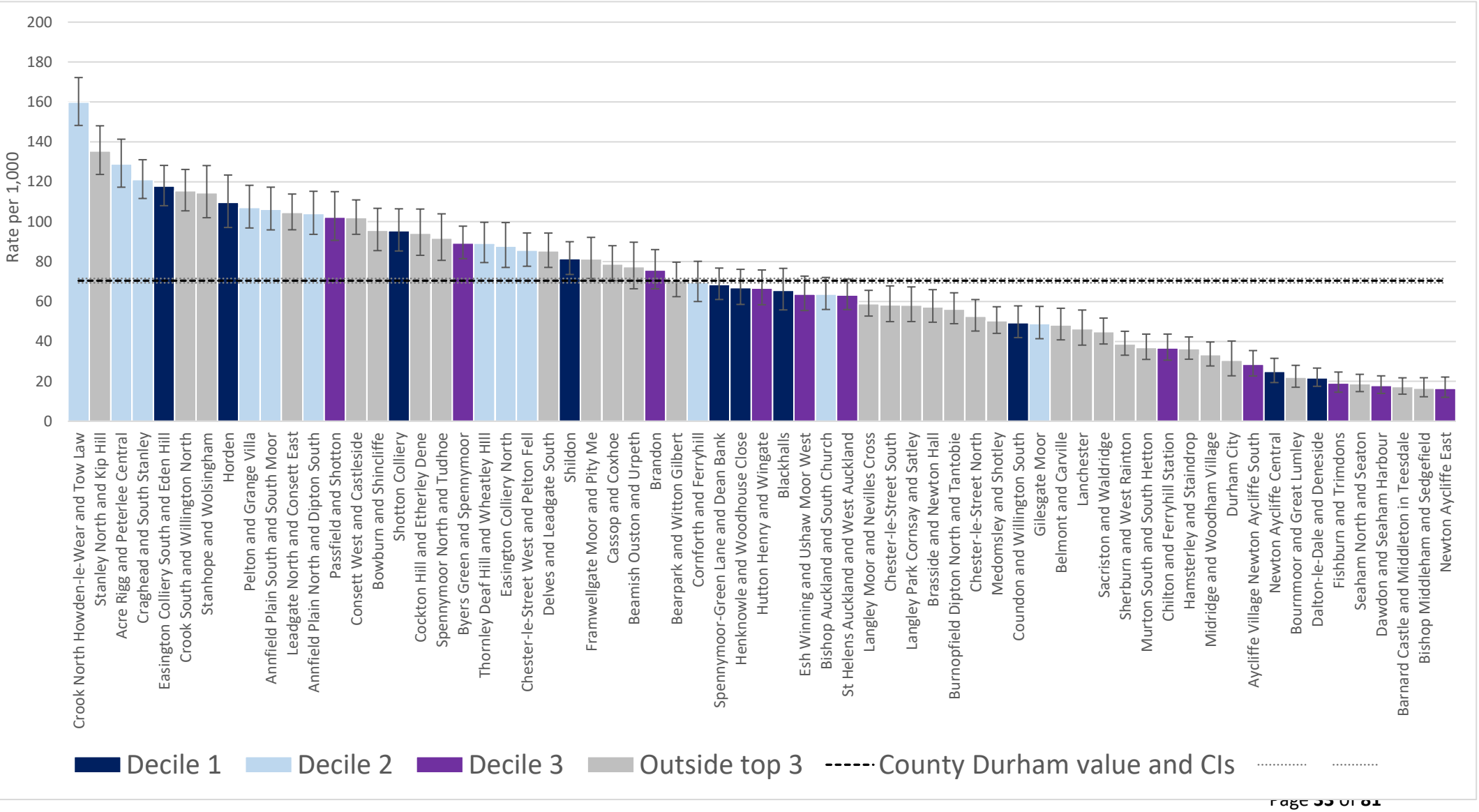


Figure 23: Contraception access rate per 1,000 for females aged 25 – 49 years by MSOA and ID 2019 deprivation decile. Source: SHRAD 2021-23, ONS mid-2022 population estimates



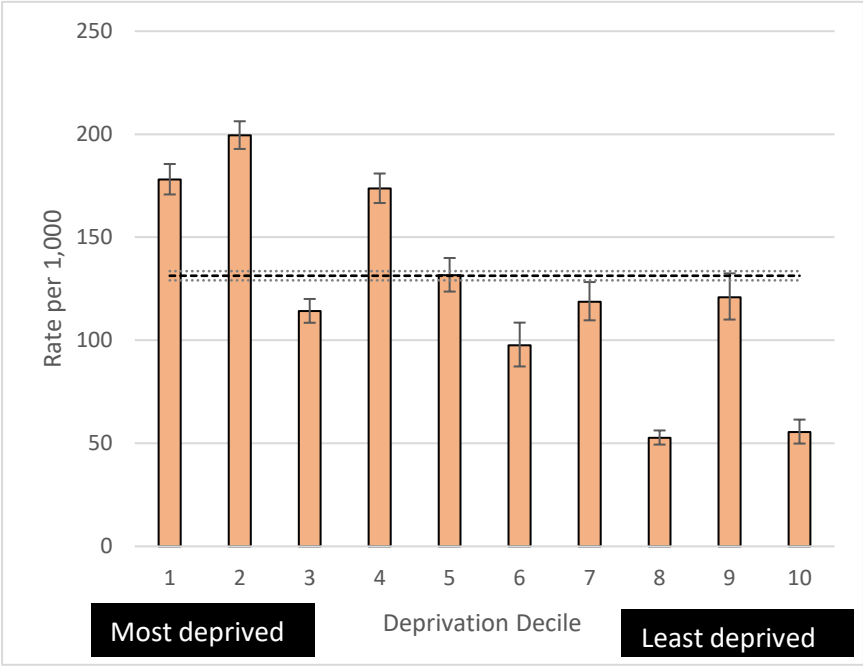
Grouping MSOAs into deprivation deciles in Figure 24 shows some evidence of an inverse social gradient in line with anticipated need for both age groups. For females aged 15-24 years living in deciles 1, 2 and 4 are accessing the ISHS for contraception services at a significantly higher rate than County Durham as a whole and the other deciles. Those living in decile 3 are accessing the contraceptive service at a statistically significantly lower rate the county as a whole and those living in deciles 4 and 5.

For females ages between 25-49 years but there is a less pronounced social gradient. Females living in deciles 2 and 4 are accessing the ISHS for contraception services at a significantly higher rate than County Durham as a whole and the other deciles. In addition, those living in deciles 1 and 3 are not.

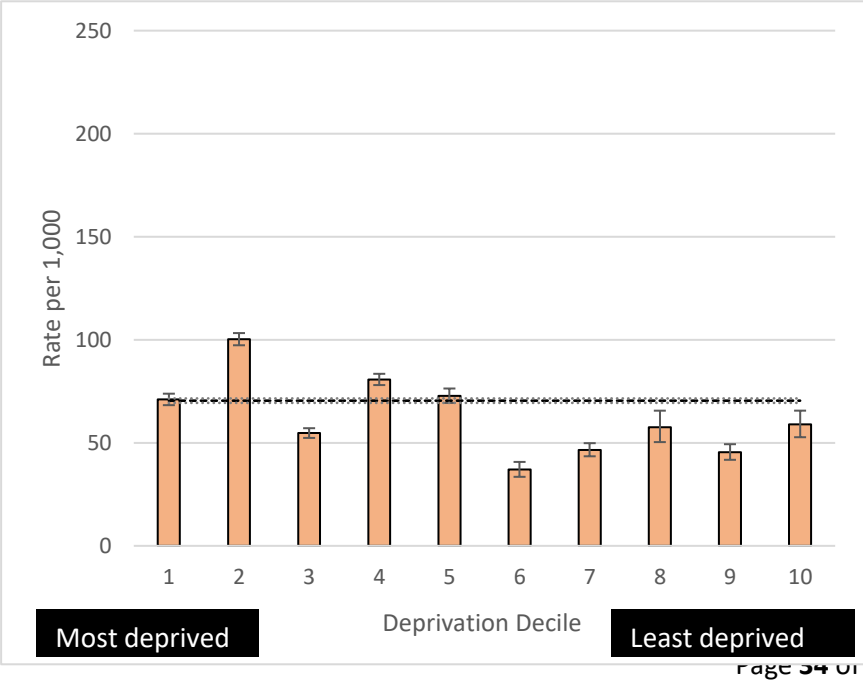
For both age groups, a higher access rate by residents in decile 3 is required to align access rates to anticipated need by deprivation.

Figure 24: Contraception access rates per 1,000 for females by deprivation decile**.** Source: SHRAD 2021-23, ONS mid-2022 population estimates, ID 2019

Aged 15-24 years



Aged 25-49 years

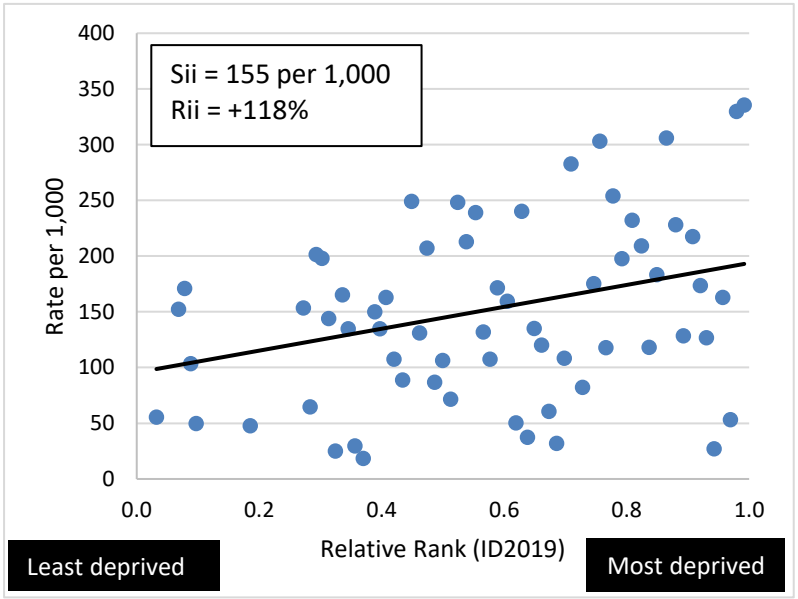


The Sii and Rii for access to contraception services for the youngest two age bands have been calculated (figure 25). For the 15-24 years age group, rates accessing by deprivation are unequal. More attendances are made from the more deprived areas. This indicates that the service is reflecting the anticipated need. The absolute difference between the least and most deprived is 155 per 1,000 and the size of the inequality gap is 118%.

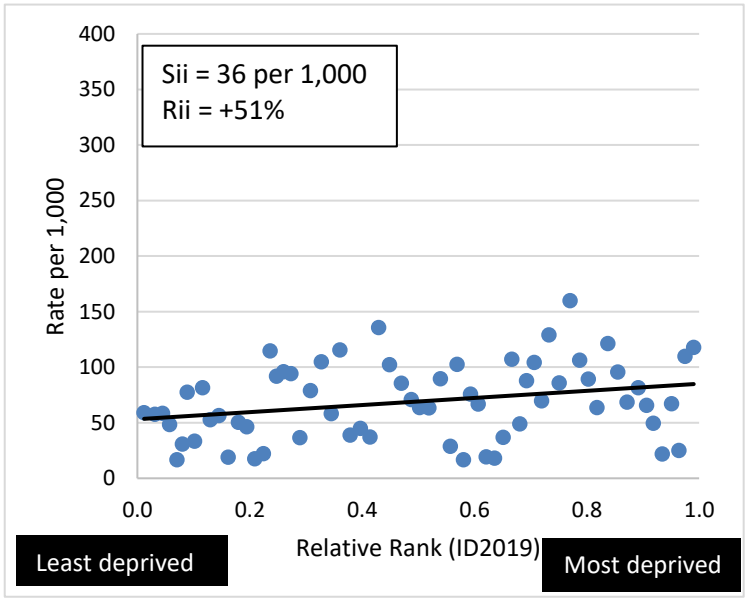
For the 25-49 years age group, rates accessing by deprivation show a shallower slope of inequity. There are more attendances made from the more deprived areas however at a reduced degree when compared to the youngest age band. The absolute difference between the least and most deprived is 36 per 1,000 and the size of the inequality gap is 51%.

Figure 25: Contraception access rates per 1,000 for females by MSOA and relative rank of deprivation**.** Source: SHRAD 2021-23, ONS mid-2022 population estimates, ID 2019

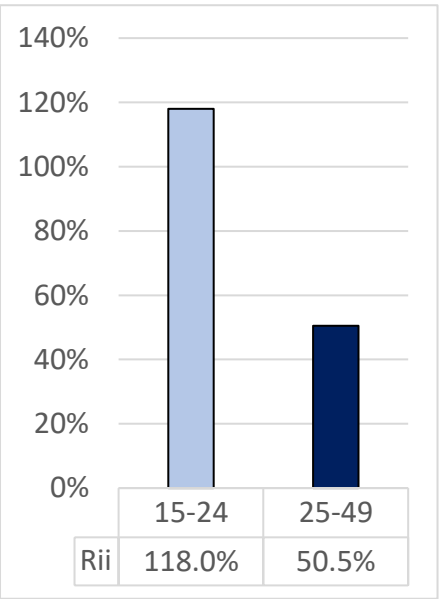
<u>Aged 15-24 years</u>



<u>Aged 25-49 years</u>



<u>Rii %</u>

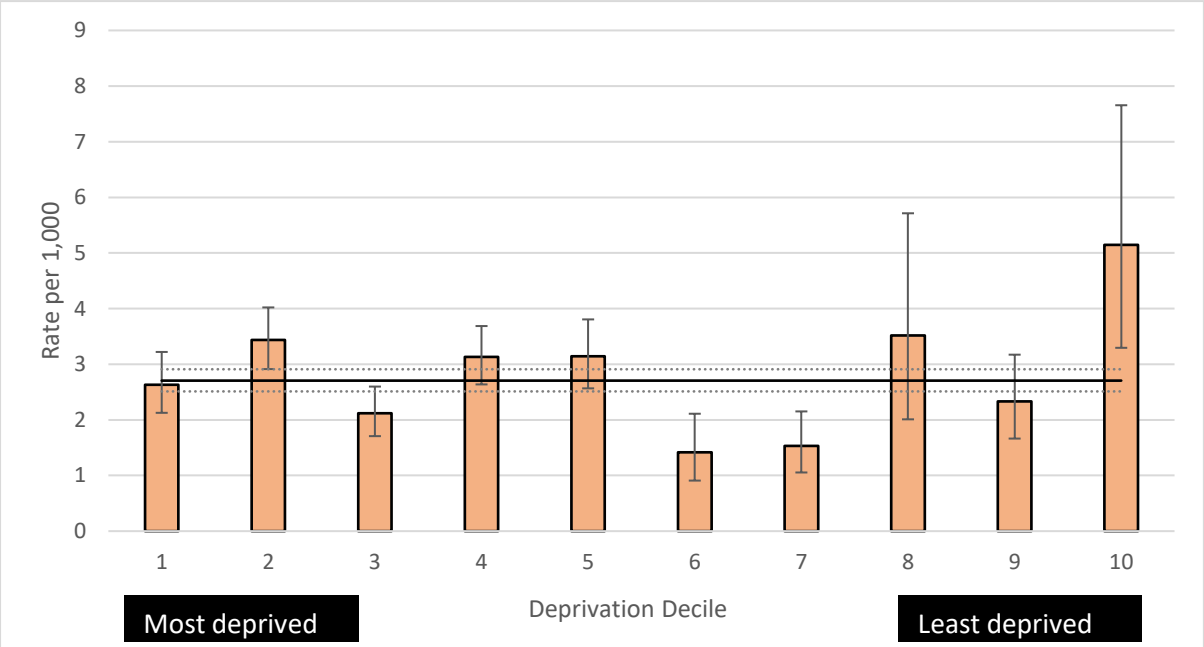


Females aged 50-74 years

It is expected that need for contraception decreases with age however the analysis does reveal that females aged 50 and over are accessing the ISHS for contraceptive services, albeit at a much-reduced rate compared to the young age groups, at 2.7 per 1,000.

Although low numbers (an average of 241 attendances per year), further work should be undertaken to understand the reasons for older females aged 50-74 years accessing contraception services from the Integrated Sexual Health Service and to ensure their needs are being met by the most appropriate service.

Figure 26: Contraception access rates per 1,000 for females aged 50 – 74 years by deprivation decile



N.B. The Y axis in figure 26 is a different scale to that used in figure 24

Figure 26 above shows that for most deciles, the access rate is statistically significantly similar to the county average. However, females aged 50-74, living in the least deprived decile 10 are accessing the ISHS for contraception care at a significantly higher rate than the county as a whole and deciles 1 and 3.

Due to low overall numbers which result in very low numbers at the MSOA level it is not possible to look at a further geographical breakdown of attendances for this age group.

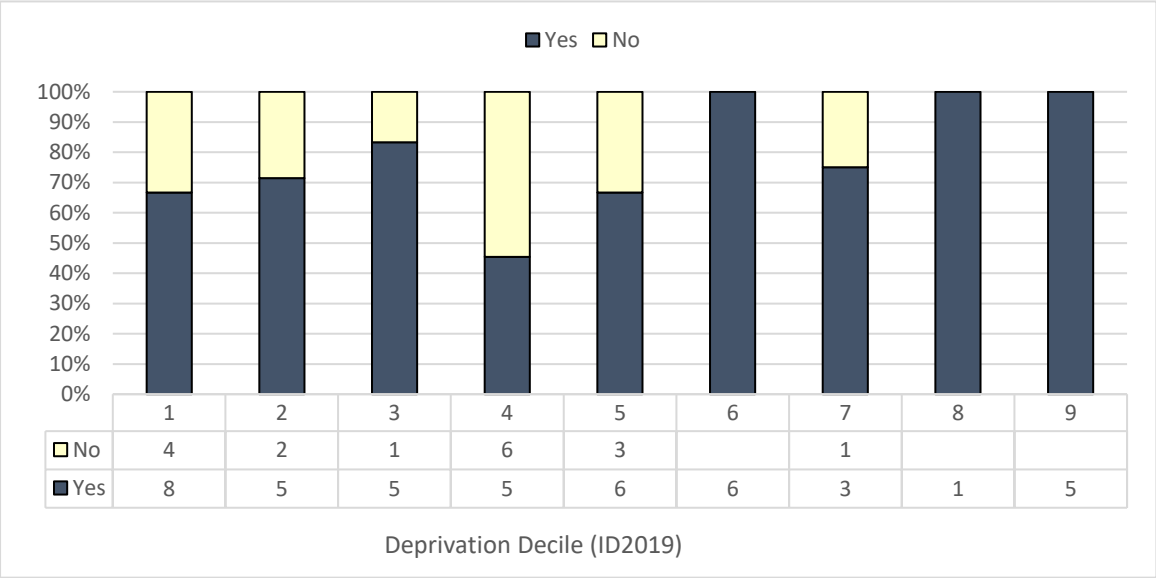
GP delivered Long Acting Reversable Contraception (LARC)

Having a planned pregnancy allows people to prepare for parenthood, it enhances the chances of a healthy pregnancy and reduces potential risks. Increasing the use of LARC's is a key ambition of County Durham's sexual health strategy.

In addition to the ISHS, GP practices across County Durham can enter an SLA with the ISHS to provide LARC fitting and removal to their patients. An increase in the provision of LARC is a proxy measure for wider access to the range of possible contraceptive methods and should also lead to a reduction in rates of unintended pregnancy. GP provision is intended to enhance access to these methods and ensure that women can access services in their community reducing health inequalities.

Of the 61 GP practices in County Durham 44 (72%) have an active SLA in place. Amongst GP practices which are in the areas of highest deprivation (deciles 1-3), the majority do have an SLA with the ISHS. However, there are seven GP practices in deciles 1-3 without an SLA.

Figure 27: GP LARC Provision take up by deprivation decile. Source: CDDFT ISHS and ID 2019

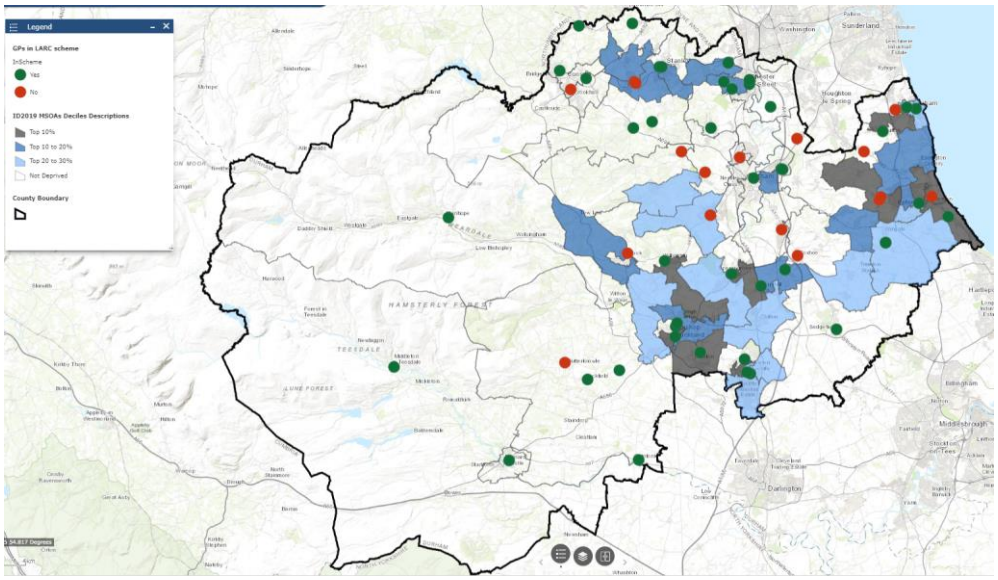


	1	2	3	4	5	6	7	8	9
No	4	2	1	6	3		1		
Yes	8	5	5	5	6	6	3	1	5

Whilst overall take up by GP practices is over 70%, there is variation across the county. Data shows that engagement in LARC provision by GP practices is higher in deprivation deciles 6 – 10; lowest take up in decile 4 where less than half of GP practices are offering this service.

This means that females in living in some of County Durham's most deprived communities need to access the ISHS for LARC fitting and/or removal. This potential lack of local access may contribute to an increase health inequality for this population.

Figure 28: Locations of County Durham GP practices who do and do not hold a LARC SLA with the ISHS, as at March 2024. Source: CDDFT ISHS and ID 2019



Pharmacy delivery of Emergency Hormonal Oral Contraception (EHOC)

Pharmacies in County Durham can enter an SLA with the ISHS to deliver free EHOC. Of the 131 pharmacies in County Durham 85 (65%) have an active SLA in place. Amongst pharmacies which are in the areas of highest deprivation (deciles 1-3), the majority do have an SLA with the ISHS. Over half of pharmacies with an SLA are within deciles 1-3 (55% n.47). However, there are 20 pharmacies in deciles 1-3 without an SLA.

Figure 29: Locations of County Durham pharmacies who do and do not hold a EHOC SLA with the ISHS, as at February 2024. Source: CDDFT ISHS and ID 2019

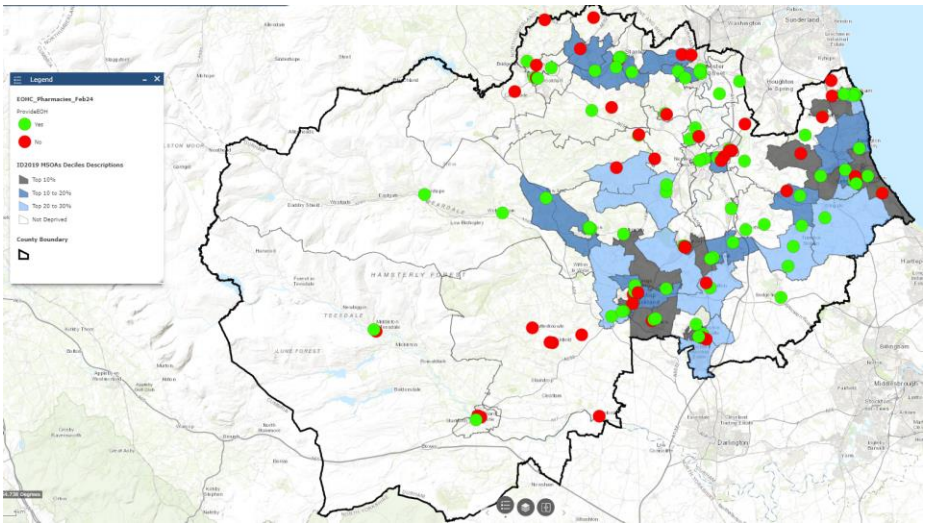
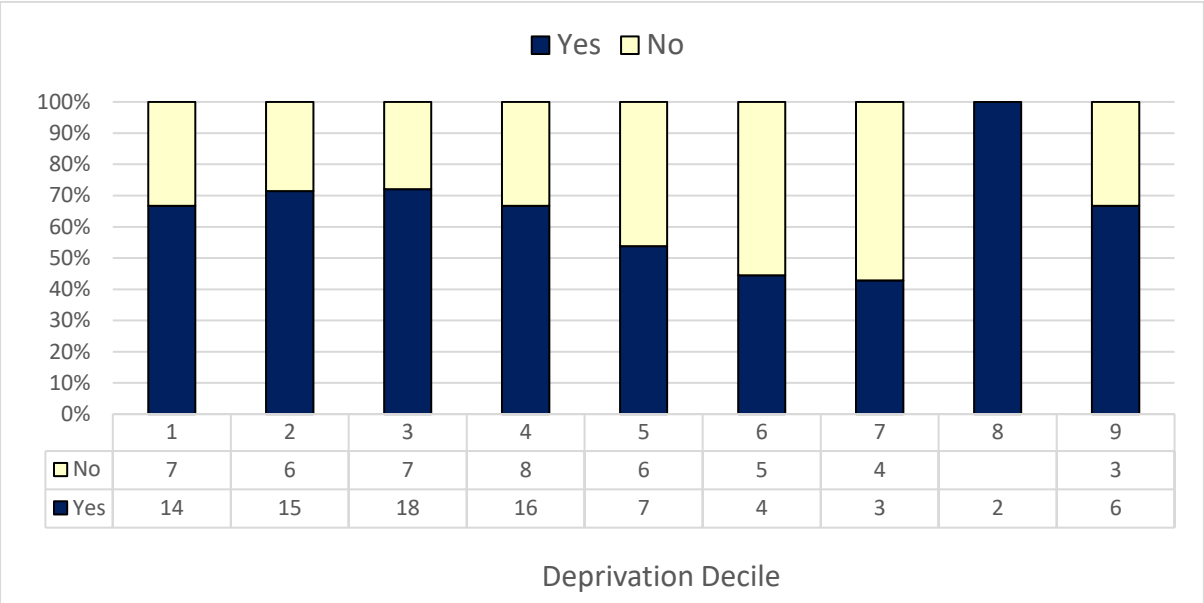


Figure 30: Pharmacy EHOC coverage by deprivation decile. Source: CDDFT ISHS and ID 2019



	1	2	3	4	5	6	7	8	9
No	7	6	7	8	6	5	4		3
Yes	14	15	18	16	7	4	3	2	6

Access to in person Sexually Transmitted Infection Services

The following section describes the results of the HEA profile in relation to males and females accessing STI services provided by CDDFT's Integrated Sexual Health Service.

The data relates to face-to-face activity from the 2 main hub sites and the 7 community-based settings which were operating between 2021 and 2023.

Attendances for STI services were defined as:

Appointments where the care activity information included 'STI related care' in any of the six care activity fields available.

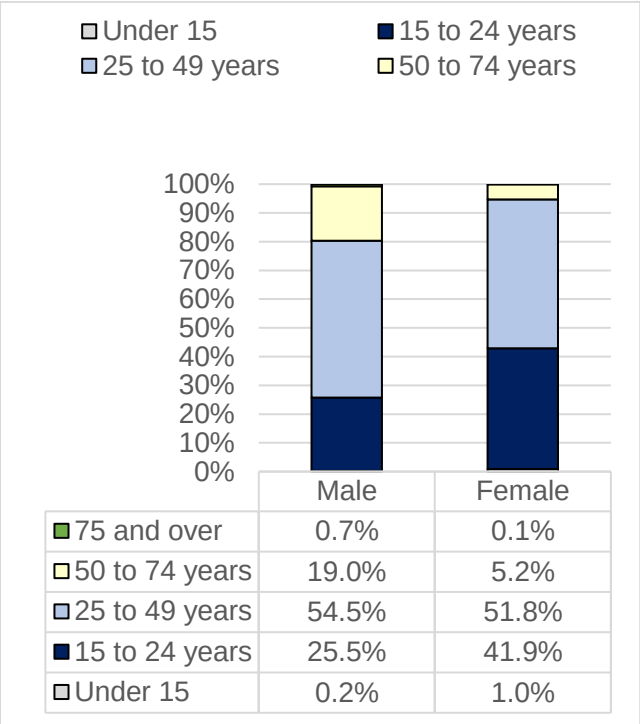
Overall

Of the 53,577 attendances, 80.3% (43,045) involved contact regarding STI care. Most attendances were by females 75% with around 15% attendances by males. Less than 5 attendances were recorded as gender 'unable to be classified'.

The age profile of attendances by females and males is shown in figure 31.

- The largest proportion of attendances were in those aged 25-49 years; 54.5% and 51.8% for males and females respectively.
- A smaller proportion of attendance by males were amongst those aged 15-24 years compared to females; 25.5% compared to 41.9%.
- Conversely a higher proportion of attendances by males were amongst those aged 50-74 years compared to females; 19.0% compared to 5.2%.

Figure 31: Percentage of attendances for STI services by gender and age band. Source: SRHAD 2021-23



	Male	Female
75 and over	0.7%	0.1%
50 to 74 years	19.0%	5.2%
25 to 49 years	54.5%	51.8%
15 to 24 years	25.5%	41.9%
Under 15	0.2%	1.0%

Attendance rates per 1,000 for STI services at ISHS for **females** decrease significantly with age (figure 32):

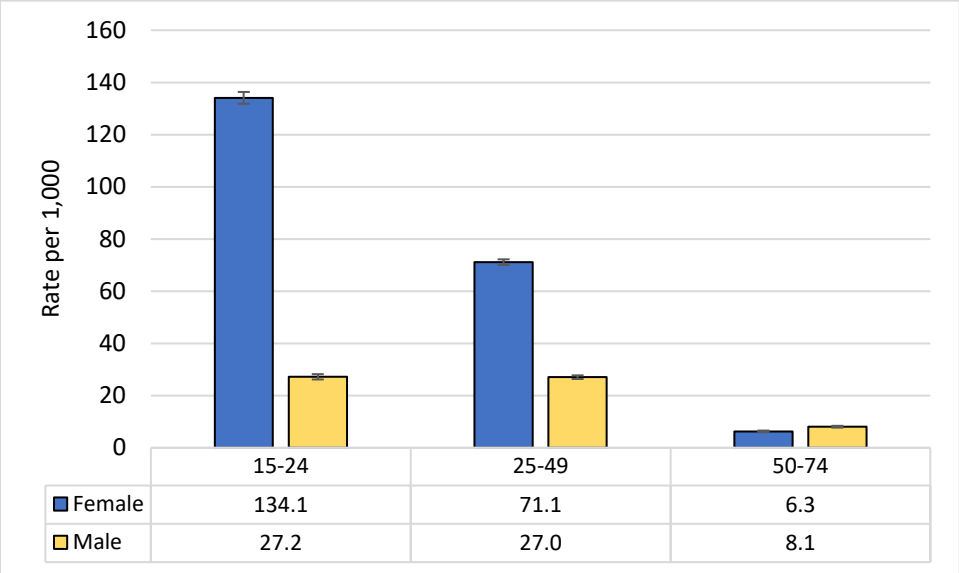
- The attendance rates for STI care statistically significantly higher for females aged 15-24 than the other two age categories.
- The attendance rate for females aged 25-49 years is statistically significantly higher than those aged over 49 years.

The attendance rate for STI services at ISHS for **males**:

- Is statistically similar for the ages 15-24 years and 25-49 years.
- The attendance rate those aged 50-74 years is statistically significantly lower than those in the two younger age bands.

Comparisons of the rate between males and females should be done with the acknowledgement of the higher rate of females attending for contraceptive care. This will give the service greater opportunity for provide opportunistic and holistic sexual health care which is likely to include STI care and advice. It is of note however that in those aged 50-74 years, the male attendance rate is statistically significantly higher than the rate for females.

Figure 32: Rates of females and males accessing ISHS for STI services per 1,000 population, by age category. Source: SRHAD 2021-23, ONS mid-2022 population estimates.



In the following section the HEA profile focuses on variation within the county in terms of access rates to STI care. It looks at the age categories 15-24 and 25-49 together for females and then males. This is then followed by analysis for those aged 50-74 years and compares males and females.

Females aged 15-24 and 25-49 years

The HEA has shown that access rates for STI care for those in the two youngest female age groups are the highest in terms of gender and age. Now the profile looks at the variation within for those two groups. There is a large range in access rates across the 65 MSOAs within the County (figure 33)

Figure 33: Summary of STI services access rates per 1,000 for females aged 15 to 49 years. Source: SHRAD 2021-23, ONS mid-2022 population estimates

	15-24 years		25-49 years	
	MSOA	Rate per 1,000	MSOA	Rate per 1,000
Highest	Stanhope and Wolsingham	317.7	Crook North, Howden-le-Wear and Tow Law	148.4
Lowest	Bournmoor and Great Lumley	23.7	Seaham North and Seaton	15.6
County Durham average		134.1		71.1

Figures 35 and 36 below illustrate that some of the highest rates of females aged 15–24 and 25-49 years accessing STI care are seen in several MSOAs of highest deprivation in County Durham. However, the data also highlights that the opposite is

true in some cases; which is the same conclusion drawn in the analysis of access to contraceptive services. In terms of deprivation, it is clear that whilst some of the areas with highest access rates (left hand side of the chart) are in our most deprived areas, there are also areas of high deprivation with low access rate.

For each age band, there are MSOAs in the top 30% most deprived areas of the county where access rates are significantly below the county value; eight areas for those aged 15-24 years and ten areas for those aged 15-49 years. Seven MSOAs appear in both (figure 34)

Figure 34: List of MSOAs in most deprived 30% with significantly lower STI services access rates that the County Durham average, females aged 15-49 years

Decile and MSOA name	**Dark blue indicates significantly lower access rates compared to CD**	
Decile 1	15-24	24-49
Blackhalls		
Dalton-le-Dale and Deneside		
Newton Aycliffe Central		
Decile 2		
Gilesgate Moor		
Decile 3		
Aycliffe Village Newton Aycliffe South		
Chilton and Ferryhill Station		
Dawdon and Seaham Harbour		
Fishburn and Trimdons		
Newton Aycliffe East		
Hutton Henry and Wingate		
Esh Winning and Ushaw Moor West		
Total	**8**	**10**

Figure 35: STI services access rate per 1,000 for females aged 15 – 24 years by MSOA and ID 2019 deprivation decile. Source: SHRAD 2021-23, ONS mid-2022 population estimates

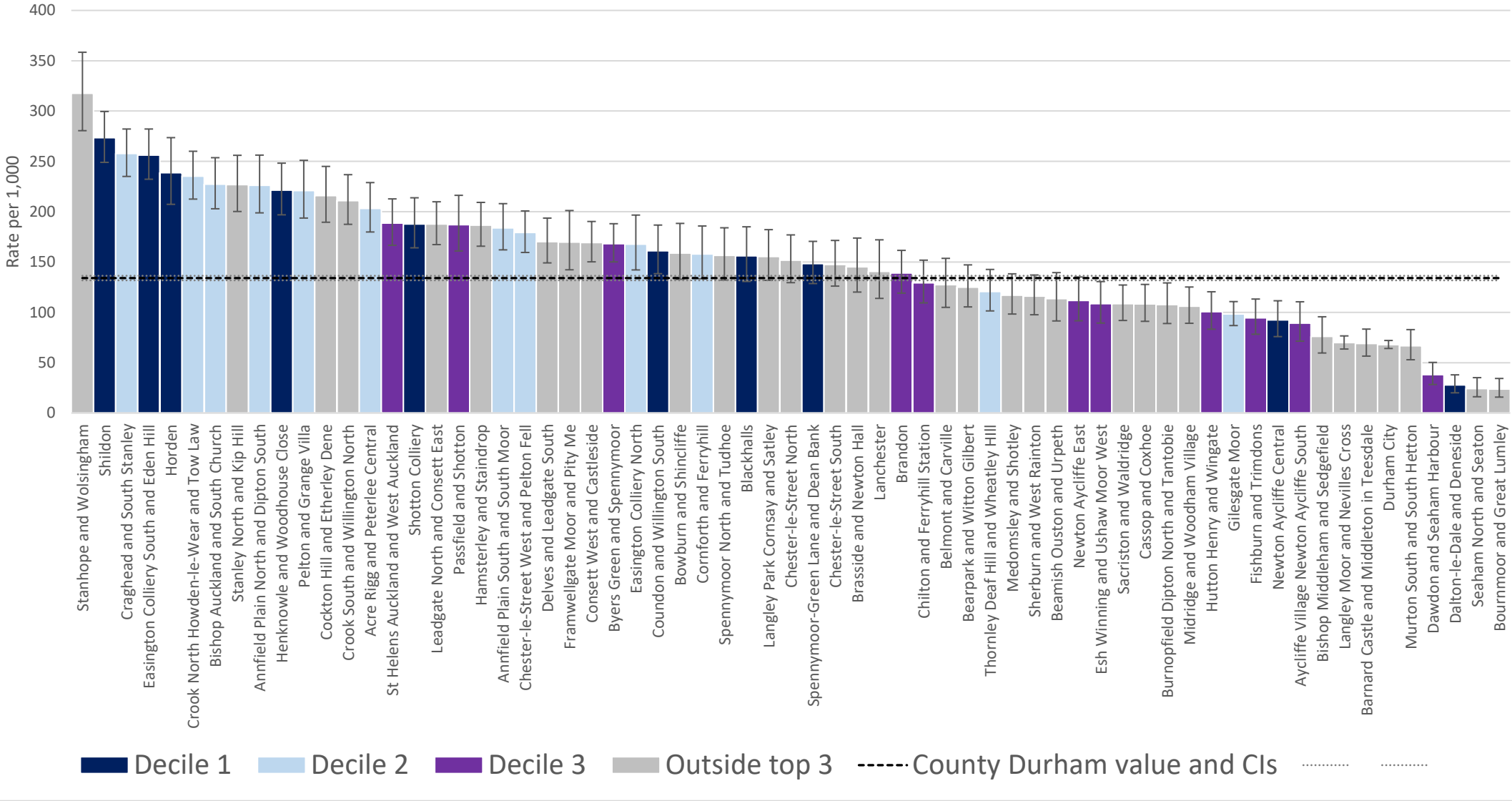
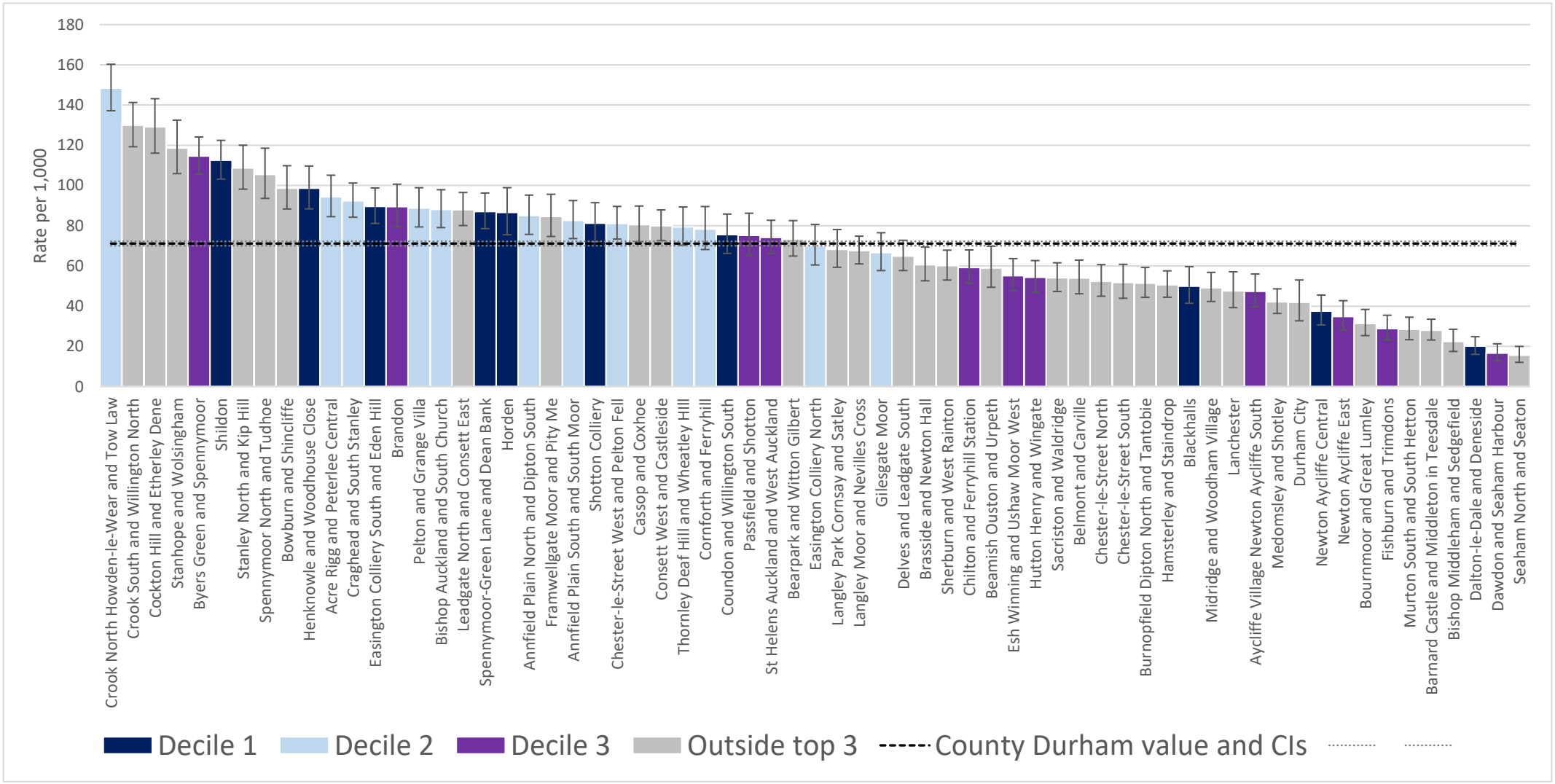


Figure 36: STI services access rate per 1,000 for females aged 25 – 49 years by MSOA and ID 2019 deprivation decile. Source: SHRAD 2021-23, ONS mid-2022 population estimates



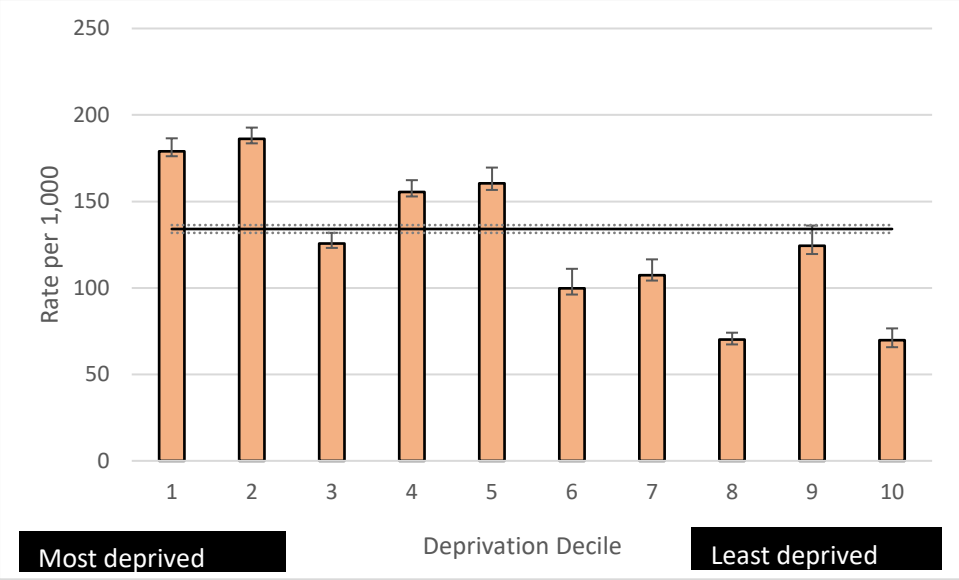
Grouping MSOAs into deprivation deciles in Figure 37 shows some evidence of an inverse social gradient in line with anticipated need for both age groups. For females aged 15-24 years, those living in deciles 1, 2, 4 and 5 are accessing the ISHS for STI services at a significantly higher rate than County Durham as a whole and the other deciles. The access rates for those living in deciles 3 and 9 are statistically similar to the county as a whole.

For females aged 25-49 years there is significant variation in access rates between deprivation deciles and a less pronounced social gradient than the younger age group as deciles 3 and 10 do not follow the pattern. The access rate in deciles 1, 2, 4 and 5 are statistically significantly higher than the county value and all other deciles except for decile 10. The access rate in the least deprived decile (10) is statistically similar to the rates in deciles 1, 3 and 4.

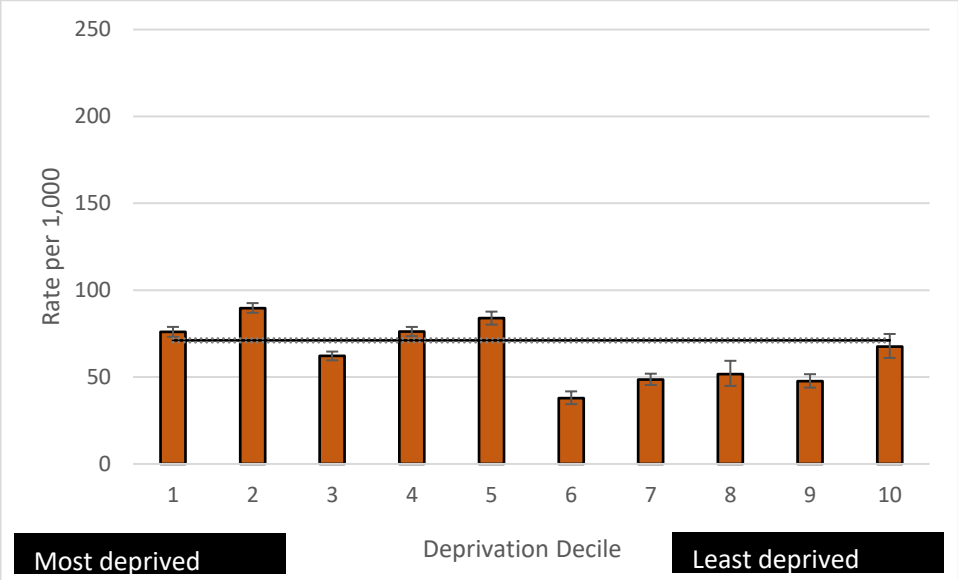
For both age groups, a higher access rate by residents in decile 3 is required to align access rates to anticipated need by deprivation.

Figure 37: STI access rates per 1,000 for females aged 15-49 years by deprivation decile**.** Source: SHRAD 2021-23, ONS mid-2022 population estimates, ID 2019

Aged 15-24 years



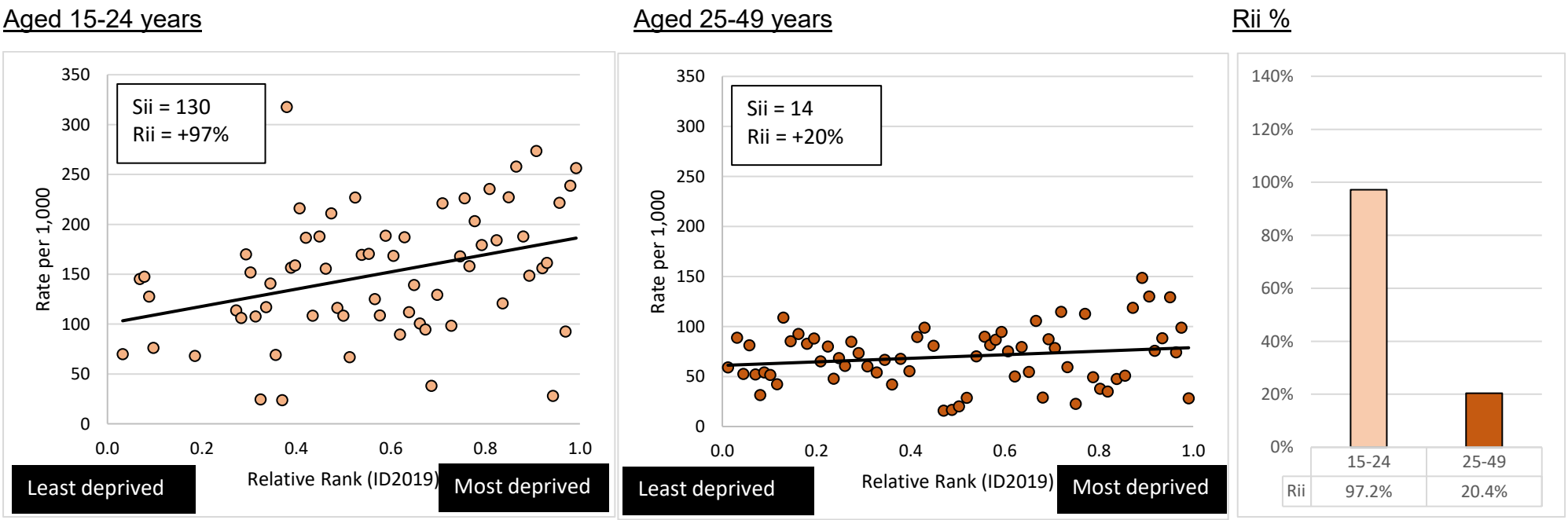
Aged 25-49 years



The Sii and Rii for access to STI services for the two youngest female age bands have been calculated (figure 38). For the 15-24 years age group, rates accessing by deprivation are unequal. More attendances are made from the more deprived areas. This indicates that the service is reflecting the anticipated need. The absolute difference between the least and most deprived is 130 per 1,000 and the size of the inequality gap is 97%. The Rii is large and positive meaning there is a higher rate of access to services in the more deprived areas.

For the 25-49 years age group, rates accessing by deprivation show a shallower slope of inequity. There are more attendances made from the more deprived areas however at a reduced degree when compared to the youngest age band. The absolute difference between the least and most deprived is 14 per 1,000 and the size of the inequality gap is 20%. The Rii is positive however it is small and close to zero, in other words closer to a horizontal line of best fit, indicating close to equality of access across the deprivation groups.

Figure 38: STI services access rates per 1,000 for females aged 15-49 years by MSOA and relative rank of deprivation**.** Source: SHRAD 2021-23, ONS mid-2022 population estimates, ID 2019



Males aged 15-24 and 25-49 years

The HEA has shown that access rates for STI services for those in the two youngest male age groups are statistically similar to each other. Now the profile looks at the variation within for those two groups. There is a large range in access rates across the 65 MSOAs within the County for each age band (figure 39)

Figure 39: Summary of STI services access rates per 1,000 for males aged 15 to 49 years. Source: SHRAD 2021-23, ONS mid-2022 population estimates

	15-24 years		25-49 years	
	MSOA	Rate per 1,000	MSOA	Rate per 1,000
Highest	Shildon	58.5	Henknowle and Woodhouse Close	68.7
Lowest	Seaham North and Seaton	4.5	Dalton-le-Dale and Deneside	4.4
County Durham average		27.2		27.0

Figures 42 and 43 below illustrate that some of the highest rates of males aged 15-24 and 25-49 years accessing STI services are seen in the MSOAs of highest deprivation. However, the data highlights that males who live in some of the most deprived MOSA's in are underrepresented, particularly in the east of the county.

For each age band, there are MSOAs in the top 30% most deprived areas of the where access rates are significantly below the county value; seven areas for those aged 15-24 years and twelve areas for those aged 25-49 years. Six MSOAs appear in both.

As noted above in the analysis for females, it is clear some of these areas are MSOA's that border with other local authority areas and residents may travel to other service providers.

Figure 40: List of MSOAs in most deprived 30% with significantly lower STI access rates that the County Durham average, males aged 15-49 years

Decile and MSOA name	**Dark blue indicates significantly lower access rates compared to CD**	
Decile 1	15-24	24-49
Easington Colliery South and Eden Hill		
Blackhalls	*	
Dalton-le-Dale and Deneside		
Shotton Colliery		
Horden		
Decile 2		
Acre Rigg and Peterlee Central		
Easington Colliery North		
Annfield Plain North and Dipton South		

Decile and MSOA name	Dark blue indicates significantly lower access rates compared to CD	
Pelton and Grange Villa		
Decile 3		
Dawdon and Seaham Harbour		
Fishburn and Trimdons		
Hutton Henry and Wingate		
Passfield and Shotton		
Total	7	12

* The numbers of males aged 15-24 years accessing STI services from Blackhalls (D1) were 5 or less and due to disclosure control the rate has been supressed.

Figure 41: STI access rate per 1,000 for males aged 15 – 24 years by MSOA and ID 2019 deprivation decile. Source: SHRAD 2021-23, ONS mid-2022 population estimates

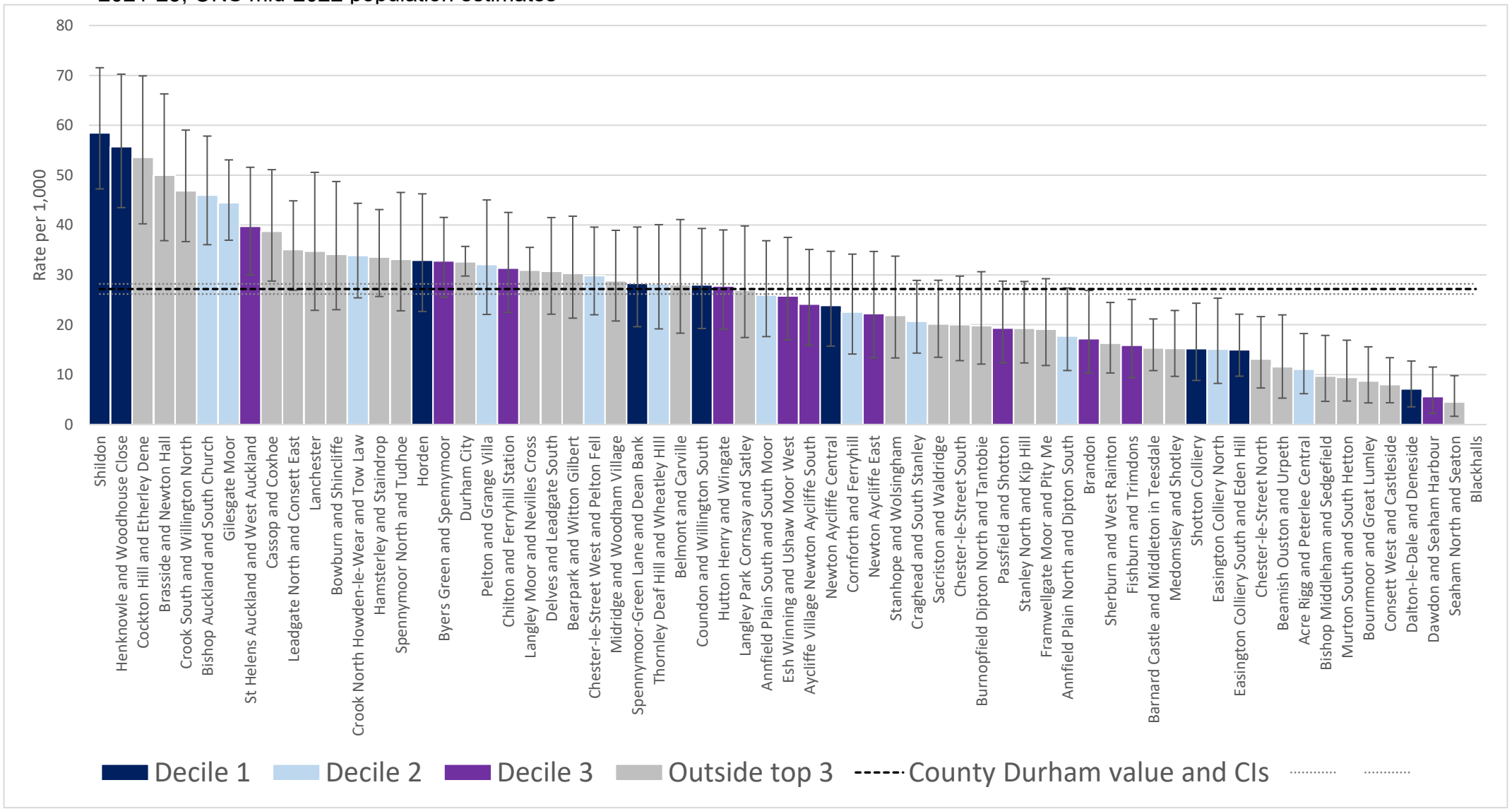
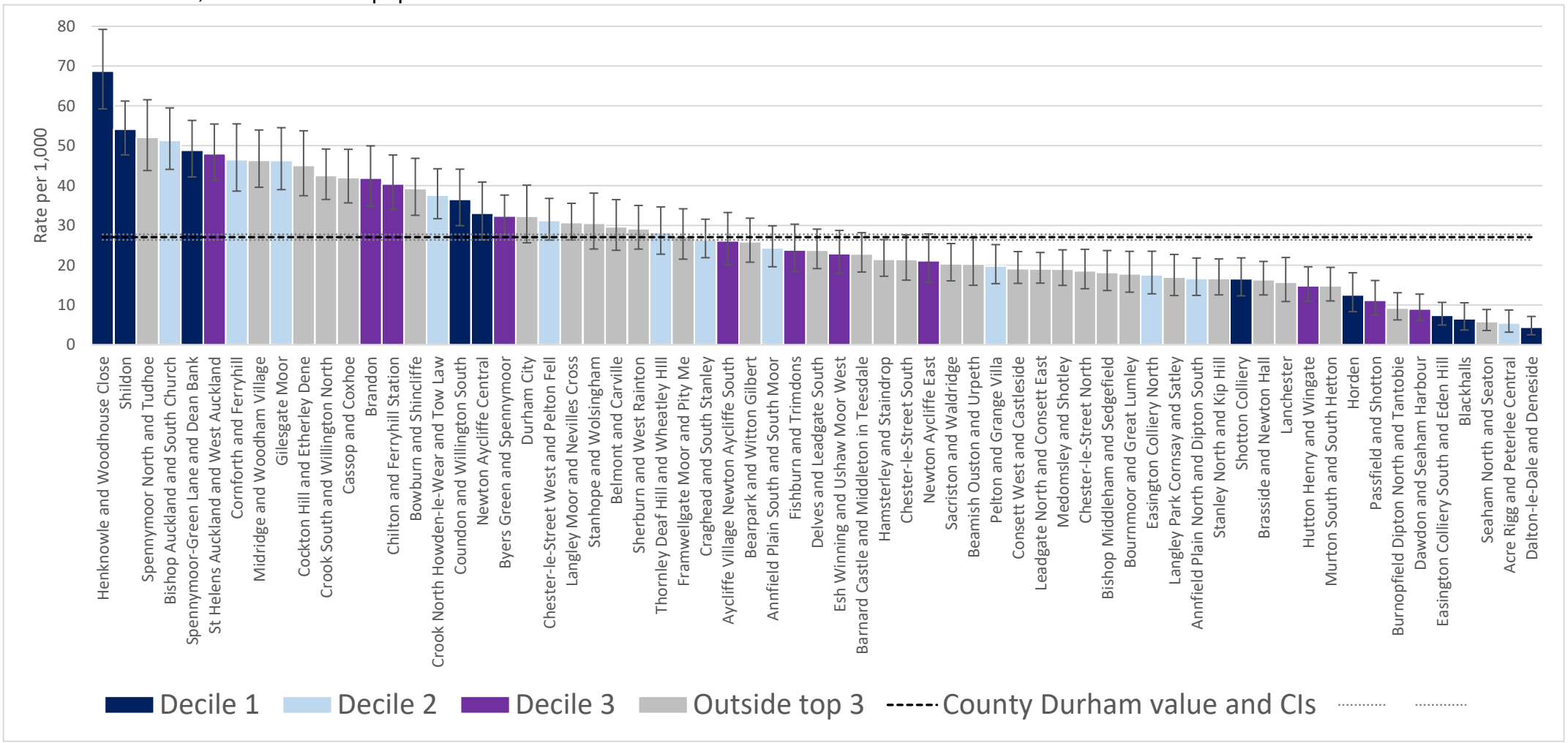


Figure 42: STI access rate per 1,000 for males aged 25 – 49 years by MSOA and ID 2019 deprivation decile. Source: SHRAD 2021-23, ONS mid-2022 population estimates



Grouping MSOAs into deprivation deciles in Figure 43 shows the access rate for those aged 15-24 years of most deciles (1 to 5 and 9, 10) are statistically similar to the county value. There is no evidence of an inverse social gradient to evidence greater access to meet the anticipated greater need in the more deprived areas.

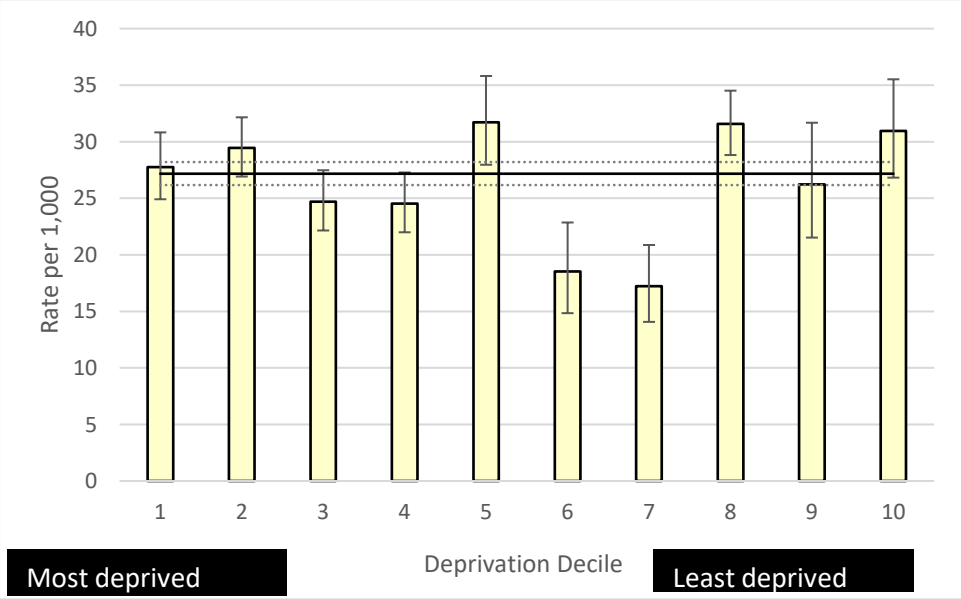
Attendances for STI care by residents of decile 8 are statistically significantly higher than the county value however not statistically different to the rate in the majority of the other deciles.

For males aged 25-49 years figure 43 shows significant variation in the access between the deciles however there isn't strong evidence of an inverse social gradient to evidence greater in the more deprived areas. It is positive that the access rate for male residents in decile 1 is statistically significantly higher than the county value however it is not statistically different to the rate in several of the other deciles including deciles 8 and 10.

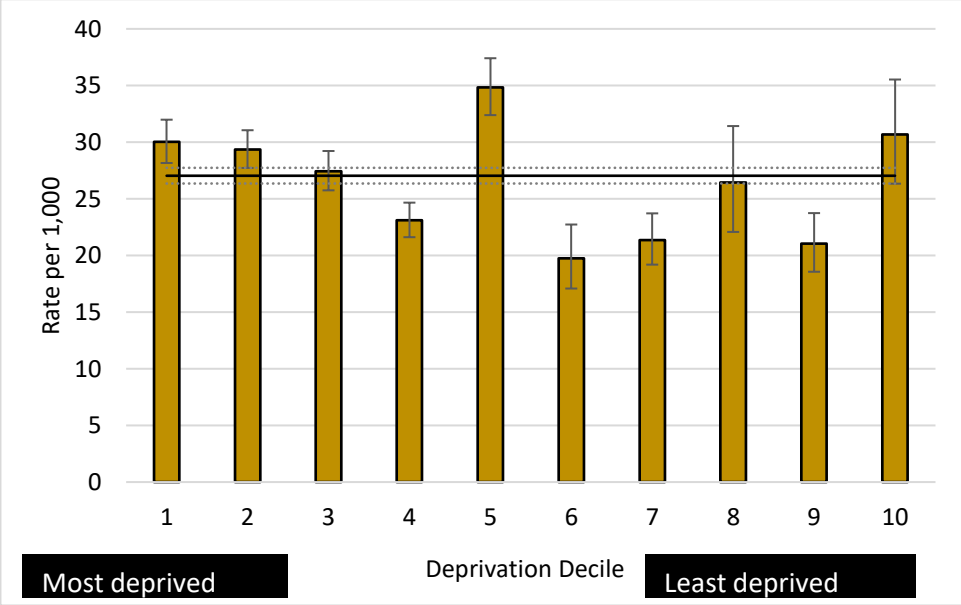
For both age groups, higher access rates by residents in decile 1-3 are required to align access rates to anticipated need by deprivation.

Figure 43: STI access rates per 1,000 for males aged 15-49 years by deprivation decile**.** Source: SRHAD 2021-23, ONS mid-2022 population estimates, ID 2019

<u>Aged 15-24 years</u>



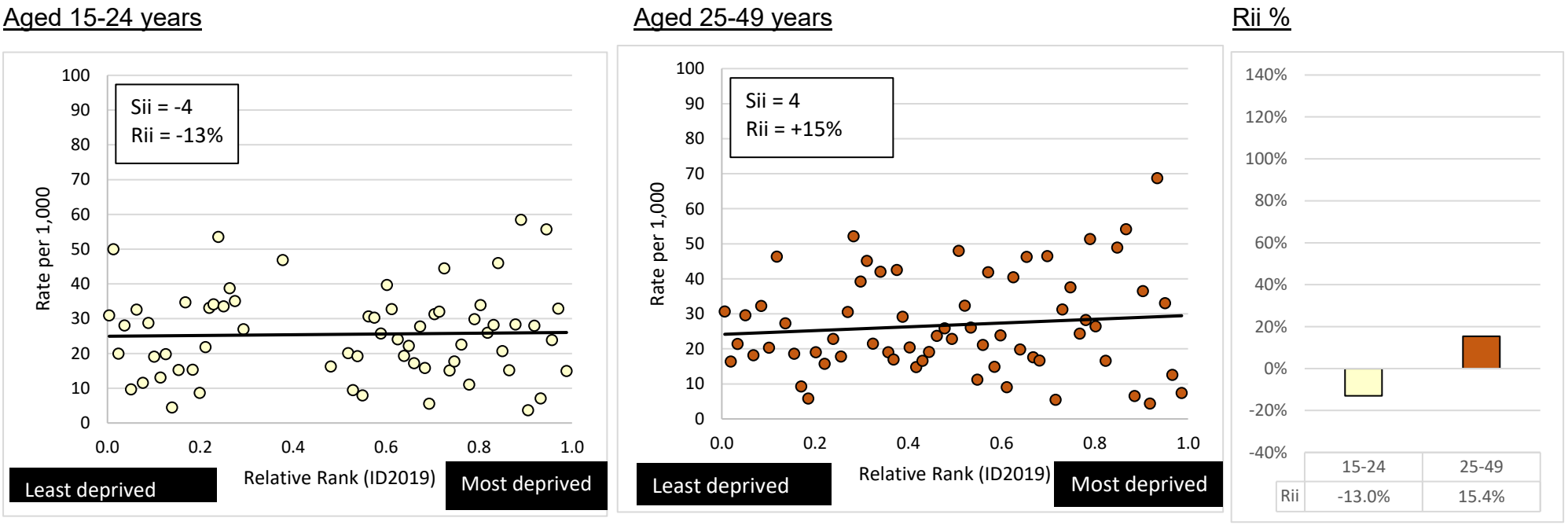
<u>Aged 25-49 years</u>



The Sii and Rii for access to STI services for the two youngest male age bands have been calculated (figure 44). For the 15-24 years age group, rates accessing by deprivation show a picture of close to equality of access across the age groups. There are not more attendances made from the more deprived areas, indeed access is marginally higher in the least deprived areas of the county. The absolute difference between the least and most deprived is -4 per 1,000 and the size of the inequality gap is 13%. The Rii is negative and close to zero.

For the 25-49 years age group, there is a small absolute and relative difference. There is evidence of unequal access in favour of those in the more deprived areas, but it is smaller compared to females of the same age. The absolute difference between the least and most deprived is 4 per 1,000 and the size of the inequality gap is 15%. Both charts indicate that the service has scope to improve access in relation to the anticipated need.

Figure 44: STI services access rates per 1,000 for males by MSOA and relative rank of deprivation**.** Source: SHRAD 2021-23, ONS mid-2022 population estimates, ID 2019



Females and Males ages 50-74 years

The burden of STI infection decreases with age however it is present. Females and males aged 50 and over are accessing the ISHS for STI services, albeit at a reduced rate compared to the young age groups, at 6.3 and 8.1 per 1,000 respectively.

On average females aged 50-74 years made 561 attendances each year and males made 687 attendances per year. Although low numbers, it is important to understand the variation in access rates. The HEA has shown that access rates for STI care for males is statistically significantly higher than females. Now the profile looks at the variation within for those two groups. There is a large range in access rates across the 65 MSOAs within the County for each age band (figure 45).

Due to low numbers accessing from this age band in several MSOAs, the access rates could not be calculated for all 65 MSOAs. This means only a partial picture by small area geography can be provided. For females, seven MSOAs recorded 5 or less attendances and due to disclosure control the rate has been supressed. For males five MSOAs recorded 5 or less attendances and due to disclosure control the rate has been supressed.

Figure 45: Summary of STI services access rates per 1,000 for females and males aged 50-74 years. Source: SHRAD 2021-23, ONS mid-2022 population estimates

	Females		Males	
	MSOA	Rate per 1,000	MSOA	Rate per 1,000
Highest	Durham City	27.4	Coundon and Willington South	26.1
Lowest	Acre Rigg and Peterlee Central	1.8	Langley Park, Cornsay and Satley	1.8
County Durham average		6.3		8.1

Figure 46 below illustrates that some of the highest rates of STI services access for those ages 50-74 years closely aligned to some areas of highest deprivation in County Durham. However, the data highlights that some who live in some of the most deprived MOSA's in East Durham and South Durham are underrepresented in this cohort.

The MSOA with the highest access rate for females is Durham City in Decile 8. It is interesting to note that this is not found in the younger two age categories. Access rates for face-to-face STI services in Durham City residents is significantly lower than the county average for both 15-25 year olds and 25-49 year olds despite the student population linked to Durham University.

For males and females, there are MSOAs in the top 30% most deprived areas of the county where access rates are significantly below the County Durham average (figure 46). Five MSOAs appear in both.

It should be noted that some of these areas are MSOA's that border with other local authority areas and residents may travel to other service providers; this should be further explored with CDDFT.

Figure 46: List of MSOAs in most deprived 30% with significantly lower STI services access rates that the County Durham average for 50 to 74-year-olds

Decile and MSOA name	**Dark blue indicates significantly lower access rates compared to CD**	
Decile 1	Females	Males
Blackhalls		
Horden		
Easington Colliery South and Eden Hill		
Shotton Colliery		
Decile 2		
Acre Rigg and Peterlee Central		
Easington Colliery North		
Annfield Plain North and Dipton South		
Decile 3		
Fishburn and Trimdons		*
Passfield and Shotton		
Brandon		
Total	**7**	**8**

*The numbers of males aged 50-74 years accessing STI services from Fishburn and Trimdons (D3) were 5 or less and due to disclosure control the rate has been supressed.

Figure 47: STI access rate per 1,000 for females aged 50 – 74 years by MSOA and ID 2019 deprivation decile. Source: SHRAD 2021-23, ONS mid-2022 population estimates

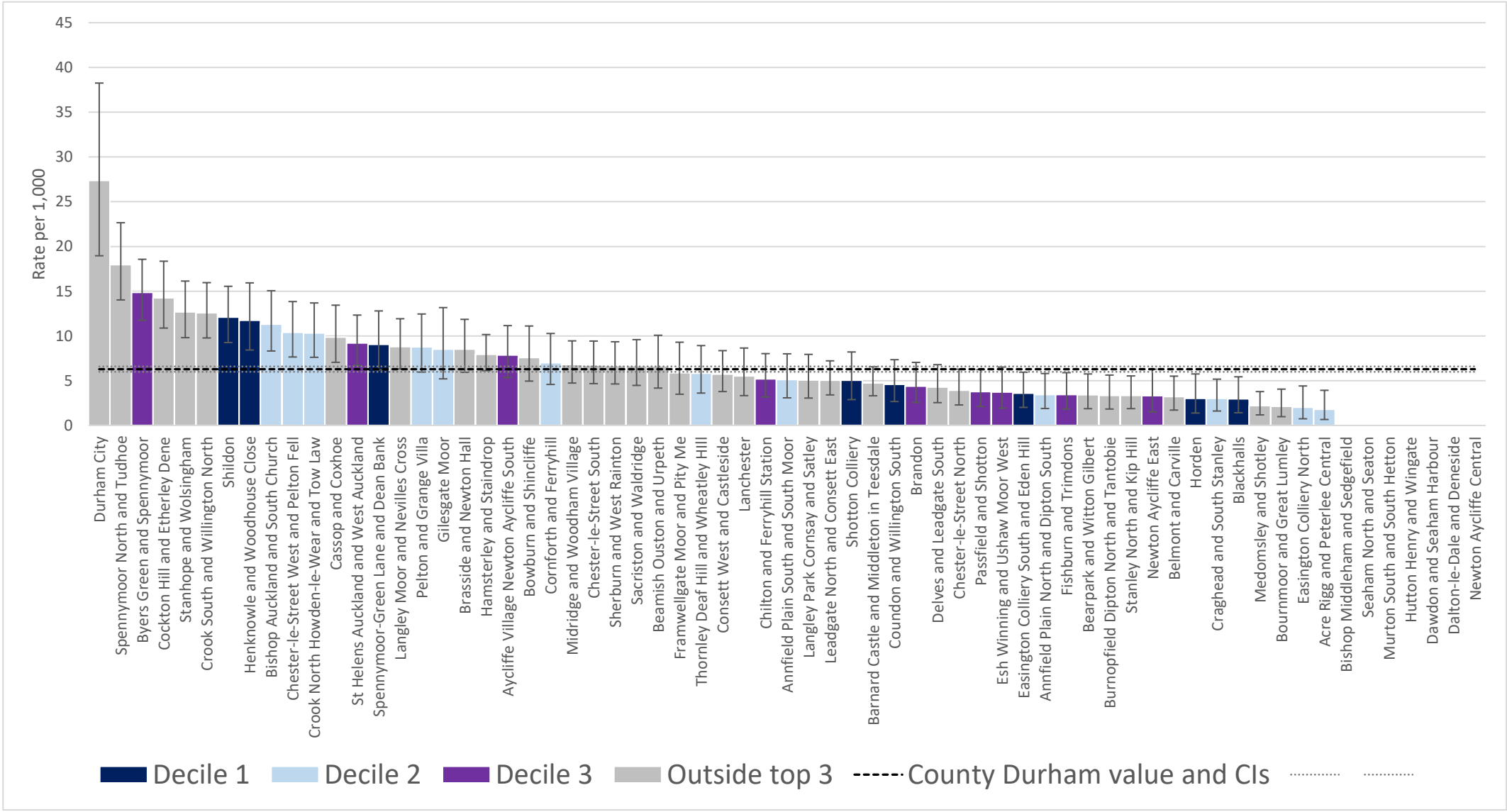
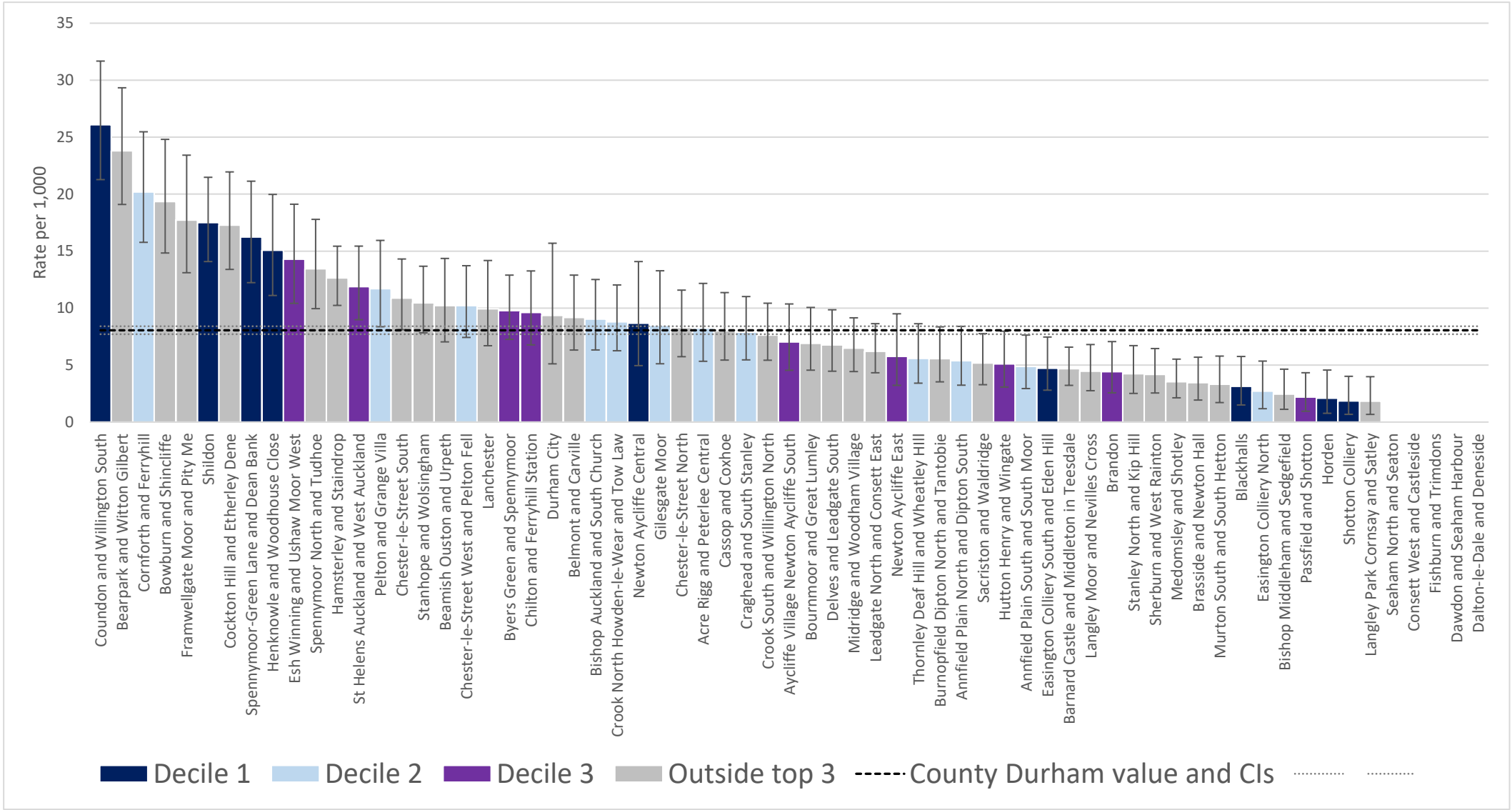


Figure 48: STI access rate per 1,000 for males aged 50 – 74 years by MSOA and ID 2019 deprivation decile. Source: SHRAD 2021-23, ONS mid-2022 population estimates

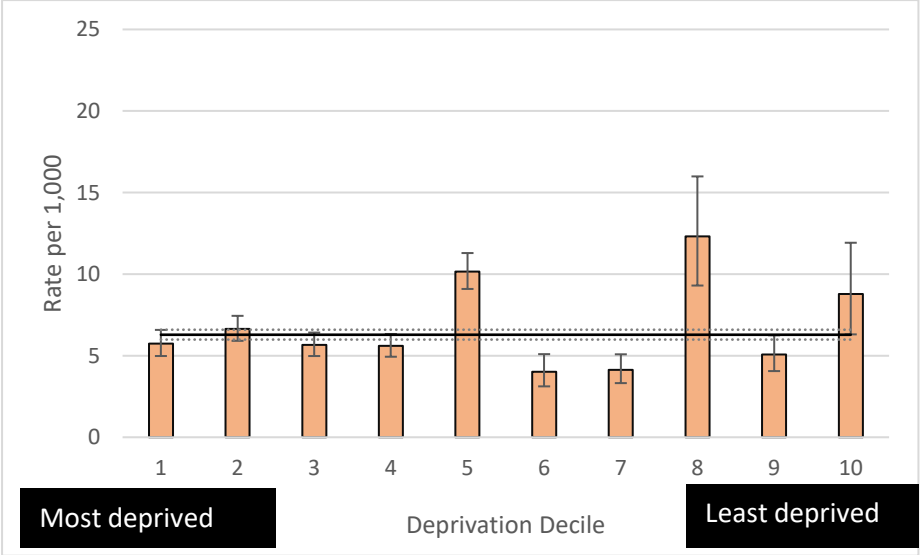


For females, grouping MSOAs into deprivation deciles in figure 49 shows little evidence of social gradient in any direction to evidence greater access to meet the anticipated greater need in the more deprived areas. The deciles with the highest access rates are 5 and 8; not the most deprived areas of the county. Deciles 1-4 and 9 have an access rate statistically similar to the county value and to each other.

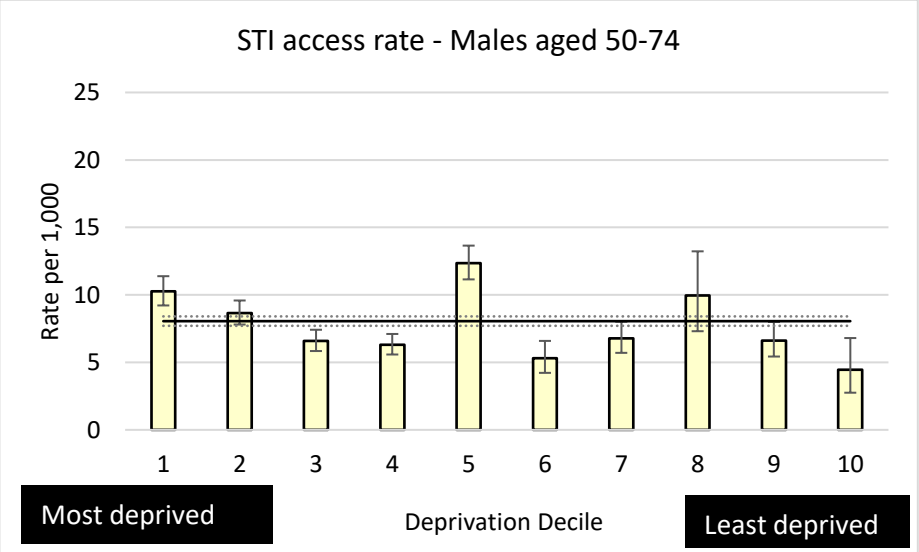
For males figure 49 shows some significant variation between deciles and deciles compared to the county values however no evidence of social gradient in any direction. The access rate for male residents in decile 1 is statistically significantly higher than the county value. However, the rate of access is not statistically different to the rate observed by residents in the less deprived areas in deciles 5 and 8. The access rate for those living in decile 3 is statistically significantly lower than the county value and significantly lower than the rates observed in deciles 1 and 2.

Figure 49: STI access rates per 1,000 for females and males ages 50-74 years by deprivation decile**.** Source: SHRAD 2021-23, ONS mid-2022 population estimates, ID 2019

Females



Males



Due to suppression being applied to several MSOAs it is not possible to calculate an Sii or Rii for 50-74 years old females or female accessing STI services.

Online access to STI testing

Data used for the equity analysis of access to online STI testing by age, gender and deprivation

As described above, the SH:24 data set included 39,682 requests for STI tests. The descriptive statistics in figure 50 help us to understand that of these:

- More than half of attendances (53.2%) are made by people aged 15-24 years. This is different to the face-to-face service where more than half are made by those aged 25-49 year.
- Over 94.8% of attendances are made by people of white ethnicity.

Figure 50: Requests to online STI testing broken down by age and ethnicity. Source: SH:24 2021-23.

		Number	%
	Total	**39,682**	**100%**
Age	Under 15	0	0.0
	15-24	20,828	52.5
	25-49	17,862	45.0
	50-74	983	2.5
	75 and over	9	0.0
	Total	**39,682**	**100%**
Ethnicity	White	37,628	94.8
	Asian or Asian British	409	1.0
	Black or Black British	187	0.5
	Mixed	775	2.0
	Not stated or prefer not to say	140	0.4
	Chinese	316	0.8
	Gypsy or Irish traveller	71	0.2
	Any other ethnic group	156	0.4
	Total	**39,682**	**100%**

Access to online STI testing services

The following section describes the results of the HEA in relation to males and females accessing online STI tests via the sub-contracting arrangements CDDFT's Integrated Sexual Health Service hold with SH:24.

Access to online services were defined as:

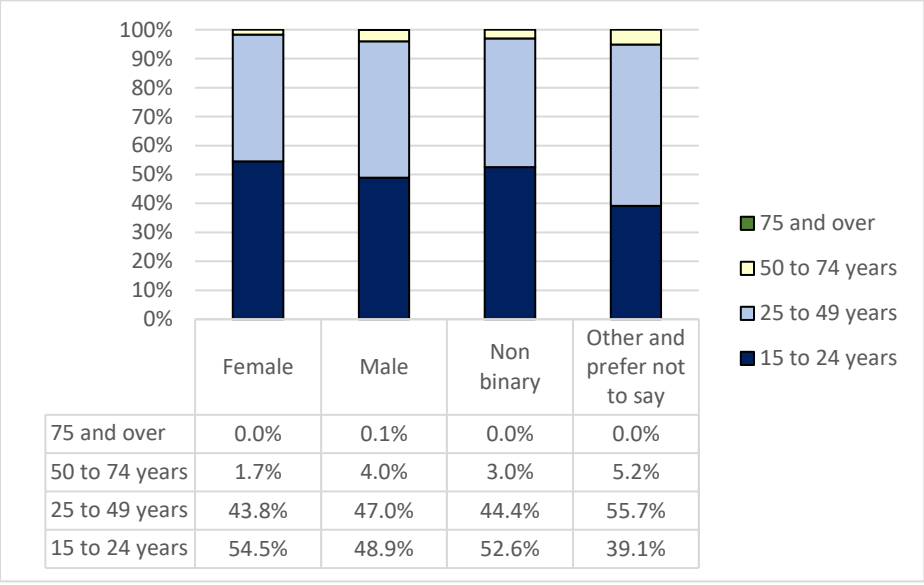
Any completed postal request for any form of STI testing kit

Overall

Of the 39,682 kits requested, the majority of requests came from females 25,745 (64.9%), 13,238 (33.4%) from males, 331 (0.8%) were non-binary and 368 (0.9%) identified as other or preferred not to say.

The age profile of requests by gender identity is shown in figure 51. The largest proportion of requests came from those aged 15-24 years for the females, males and non-binary residents. For those who responded other or prefer not to say, the largest number of requests came from those aged 25-49 years.

Figure 51: Percentage of attendances for STI services by gender and age band. Source: SH:24 2021-23



	Female	Male	Non binary	Other and prefer not to say
75 and over	0.0%	0.1%	0.0%	0.0%
50 to 74 years	1.7%	4.0%	3.0%	5.2%
25 to 49 years	43.8%	47.0%	44.4%	55.7%
15 to 24 years	54.5%	48.9%	52.6%	39.1%

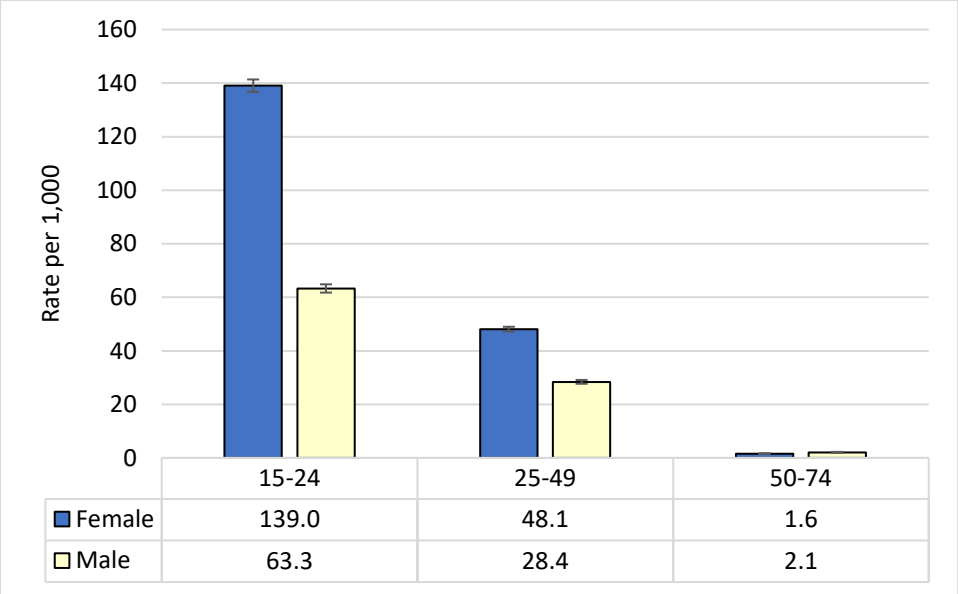
Figure 52 shows that requests of access to online STI kits for **females** decrease significantly with age and so follow a similar pattern as face-to-face STI care at the ISHS. For the ages 25-49 and 50-74 years, requests for testing kits are significantly lower than the rate at which females access face to face STI services.

Requests for online STI kits for **males** decrease significantly with age and this is different to face-to-face STI care at the ISHS where rates are similar between the ages 15-24 and 25-49 years. Males aged 15-24 access years online tests at a significantly higher rate than face-to-face STI care. In a similar pattern to females,

males aged 50-74 years request tests online at a significantly lower rate than they attend for face-to-face STI services.

It is important to note that despite the fact that the online provision of STI testing does not cover contraception, females ages 15-24 years and 25-49 years continue to access at a much higher rate than males.

Figure 52: Rates of females and males requesting online STI testing kits per 1,000 population, by age category. Source: SH:24 data 2021-23, ONS mid-2022 population estimates.



In the following section the HEA profile focuses on variation within the county in terms of access rates to STI care. It looks at the age categories 15-24 and 25-49 and 50-74 in turn compares males and females within each category.

Requests by those aged 15-24

The HEA has shown that access rates for online STI kits are highest for males and females in this youngest age category. Now the profile looks at the variation within for those two groups. There is a large range in access rates across the 65 MSOAs within the County (figure 53)

Figure 53: Summary of online STI kit access rates per 1,000 for females and males aged 15 to 24 years. Source: SH:24 2021-23, ONS mid-2022 population estimates

	Females		Males	
	MSOA	Rate per 1,000	MSOA	Rate per 1,000
Highest	Durham City	200.3	Durham City	125.3
Lowest	Beamish, Ouston and Urpeth	59.9	Hutton Henry and Wingate	24.4
County Durham average		139.0		63.3

The MSOA with the highest access rate for both females and males in this age band is Durham City in Decile 8. (The MSOAs of Langley Moor and Neville's Cross and Gilesgate Moor are also ranked in the top 5 MSOAs and these are popular locations for Durham University students in Halls of Residents and private rented accommodation). It is interesting to note that Durham City is not a statistically significantly high MSOA for this age band face to face attendances at ISHS (either for contraceptive or STI services). This suggests that the student population and other young residents in this area have a preference for the online service despite physical clinics being located in their vicinity (see figure 9). It is important to understand if the locations and opening times of these clinics are convenient and known or understood by this population. Face to face appointments should be accessible to this population due to the anticipated need in young people and face to face appointments may be necessary once online test results are received for further testing, treatment and advice.

Figures 55 and 56 show the complete range of access rates for County Durham MSOAs.

For males and females, there are MSOAs in the top 30% most deprived areas of the county where access rates are significantly below the county value; ten areas for females and 17areas for males. Eight MSOAs appear in both.

Figure 54: List of MSOAs in most deprived 30% with significantly lower online STI kits request rates that the County Durham average for 15-24 year-olds

Decile and MSOA name	**Dark blue indicates significantly lower access rates compared to CD**	
Decile 1	Females	Males
Shotton Colliery		
Shildon		
Newton Aycliffe Central		
Coundon and Willington South		
Dalton-le-Dale and Deneside		
Easington Colliery South and Eden Hill		
Henknowle and Woodhouse Close		
Decile 2		
Thornley Deaf Hill and Wheatley Hill		
Crook North Howden-le Wear and Tow Law		
Acre Rigg and Peterlee Central		
Bishop Auckland and South Church		
Easington Colliery North		
Decile 3		
Brandon Fishburn and Trimdons		
Chilton and Ferryhill Station		
Passfield and Shotton		
Hutton Henry and Wingate		

Esh Winning and Ushaw Moor West		
Aycliffe Village and Newton Aycliffe South		
Byers Green and Spennymoor		
Total	**10**	**17**

Figure 55: Online STI kit access rate per 1,000 for females aged 15 – 24 years by MSOA and ID 2019 deprivation decile**.** Source: SH:24 2021-23, ONS mid-2022 population estimates

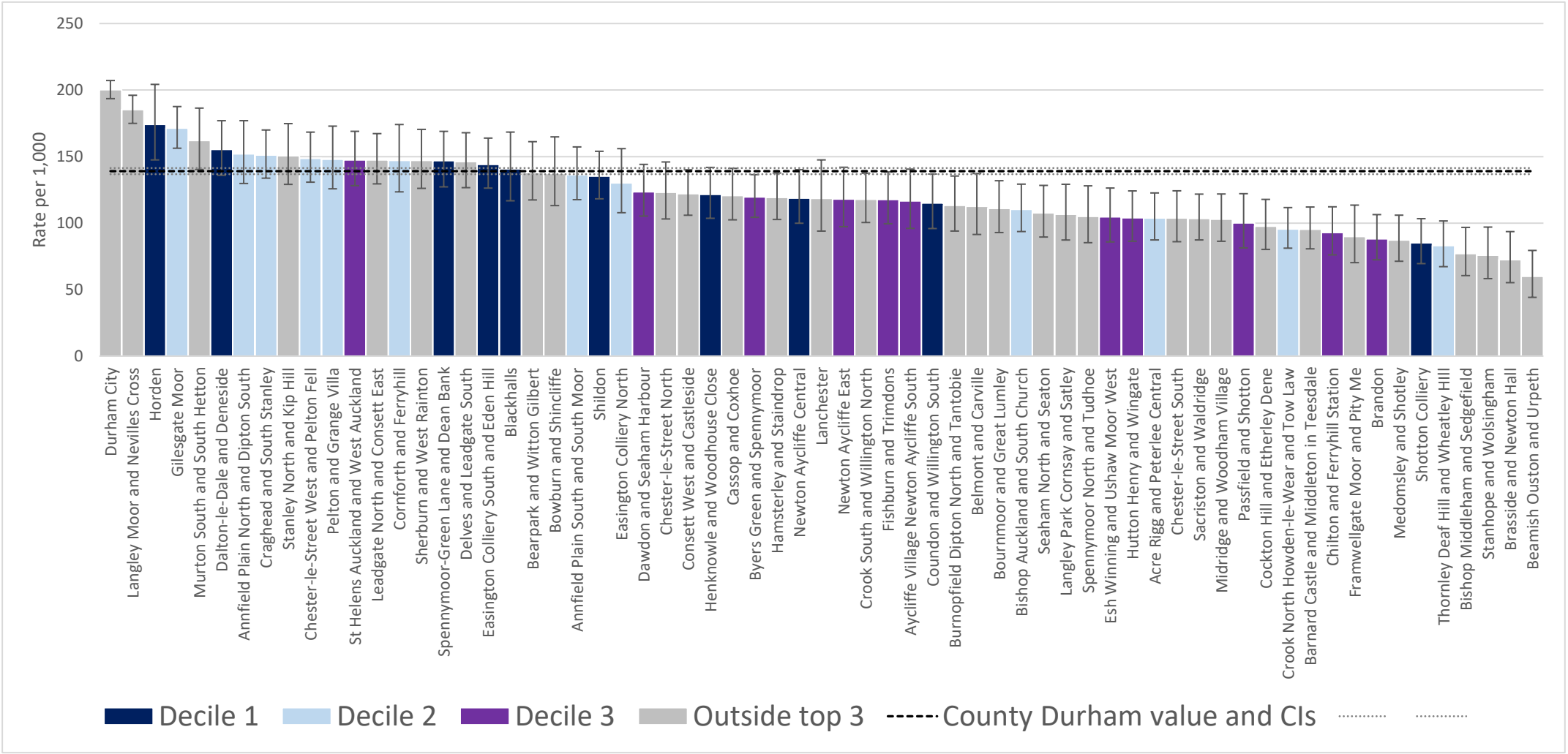
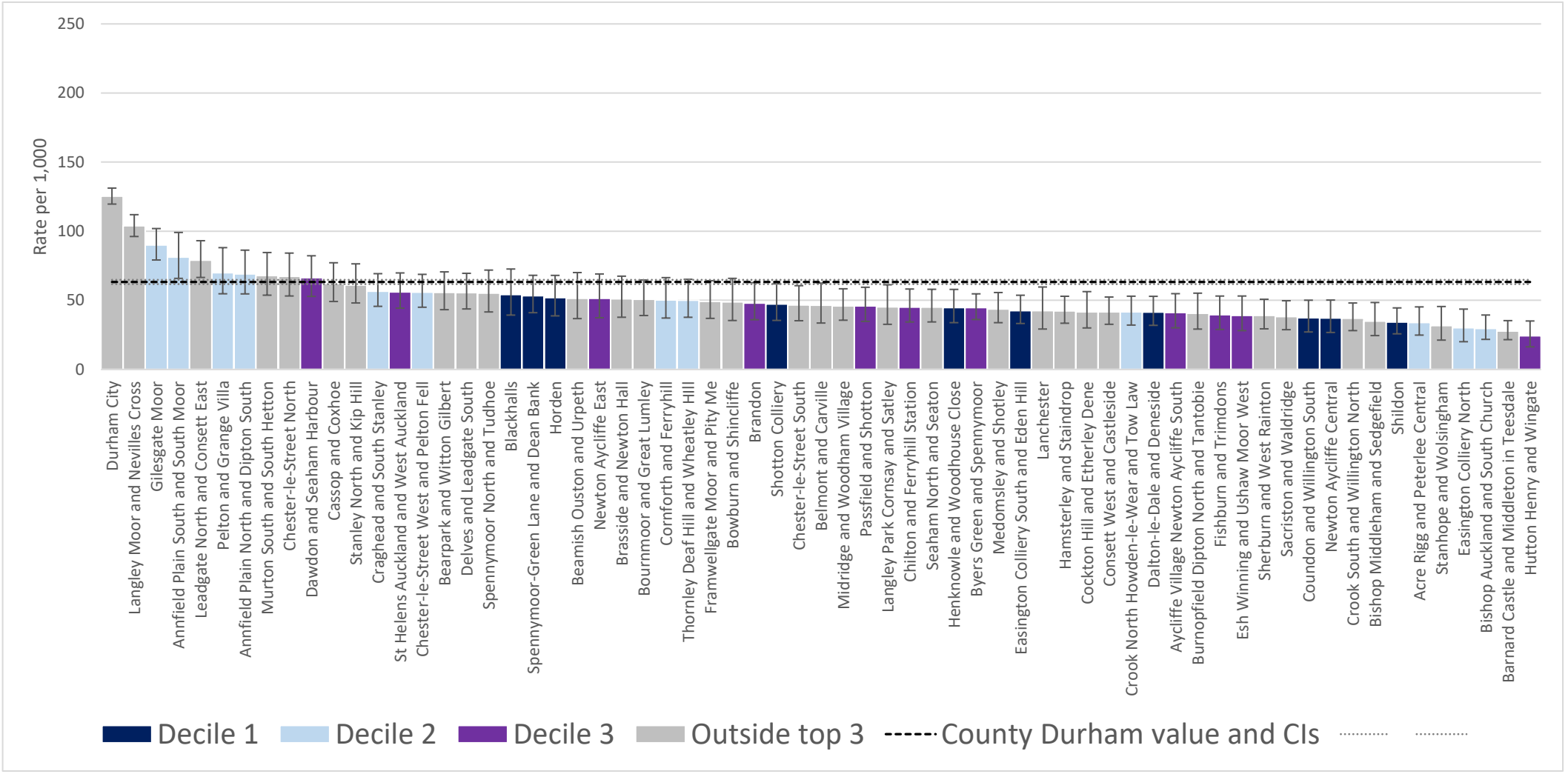


Figure 56: Online STI kit access rate per 1,000 for males aged 15 – 24 years by MSOA and ID 2019 deprivation decile**.** Source: SH:24 2021-23, ONS mid-2022 population estimates

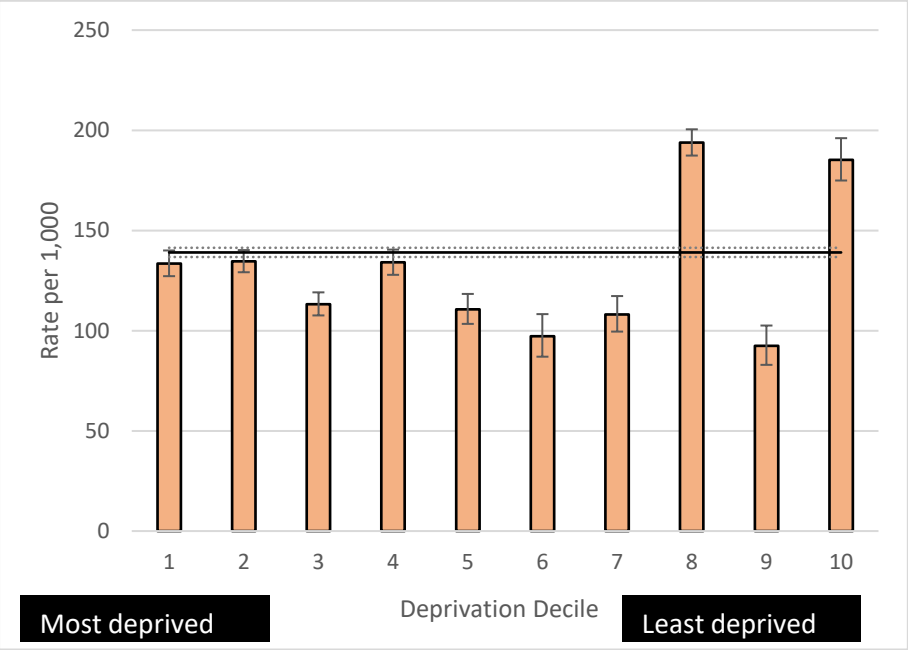


For females, grouping MSOAs into deprivation deciles in Figure 57 shows little evidence of social gradient in any direction to evidence greater access to meet the anticipated greater need in the more deprived areas. Significant variation is seen in Deciles 8 and 10, the least deprived areas of the county, where access rates are statistically significantly higher than the county average. Deciles 1, 2 and 4 have access rate statistically similar to the county value and to each other.

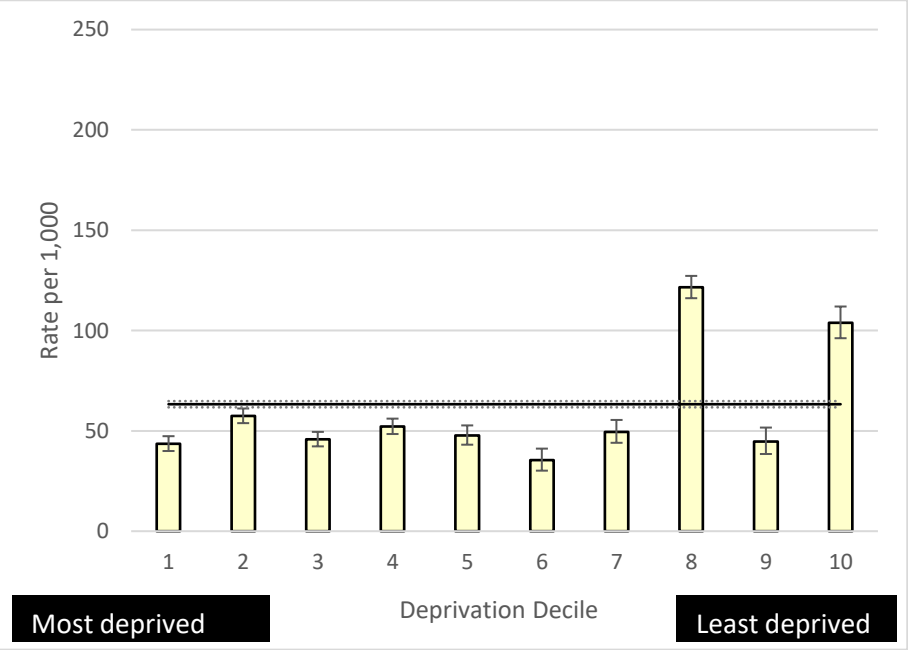
For males, Figure 57 shows some significant variation between deciles and deciles compared to the county values however, the same pattern for females is clear, where deciles 8 and 10 have access rates which are statistically significantly higher than the county. The access rates for male residents in decile 1 and 3 are statistically significantly lower than the county value. For all deciles the male access rate is statistically significantly lower than the equivalent rate for females.

Figure 57: Online STI kits access rates per 1,000 for females and males ages 15-24 years by deprivation decile**.** Source: SH:24 2021-23, ONS mid-2022 population estimates, ID 2019

Females



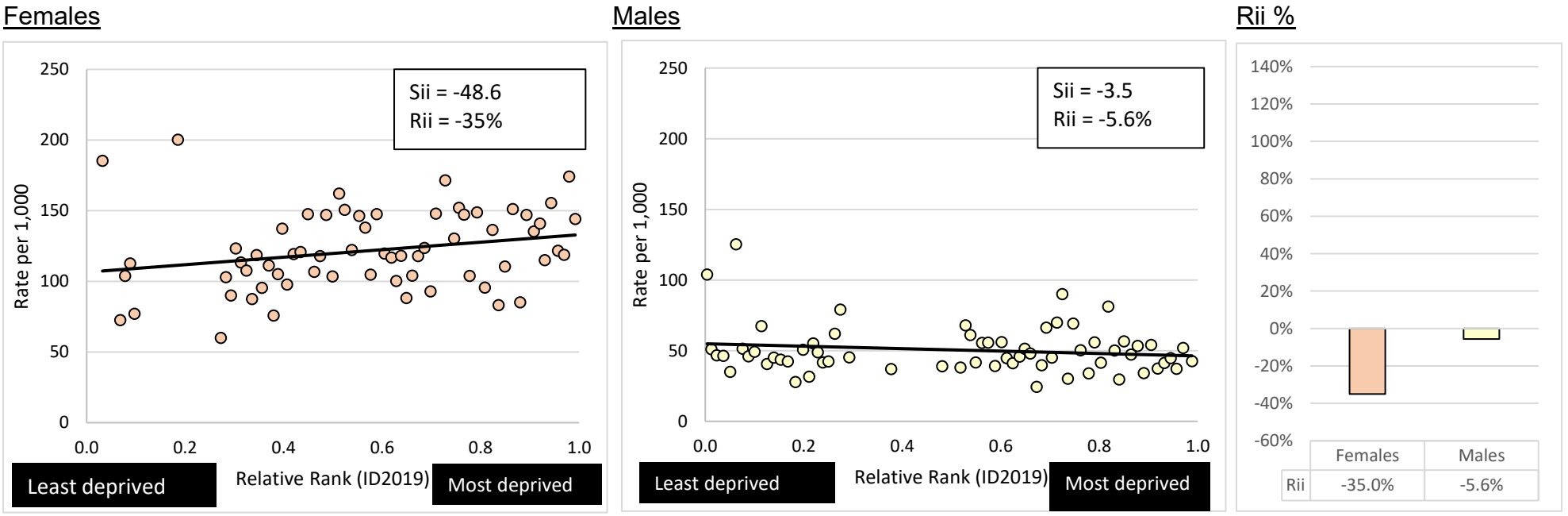
Males



The Sii and Rii for requests for online STI kits for the 15-24 years old age band (figure 58) have been calculated. For females, rates by deprivation are unequal. More requests are made from the least deprived areas. This indicates that the online service is not reflecting the anticipated need in terms of deprivation. The absolute difference between the least and most deprived is -48.6 per 1,000 lower in the least deprived area and the size of the inequality gap is -35%. The Rii is moderate and negative meaning there is a higher rate of access online STI kits in the least deprived areas.

For males, rates accessing by deprivation show a shallower slope compared to females and in the same direction. There are more attendances made from the least deprived areas however at a reduced degree when compared females. The absolute difference between the least and most deprived is -5.6 per 1,000 lower in the more deprived areas and the size of the inequality gap is -5.6%. The Rii is negative however it is small and close to zero, in other words a horizontal line of best fit, indicating close to equality of access across the deprivation groups.

Figure 58: Online STI kits request rates per 1,000 for 15-24 years olds by MSOA and relative rank of deprivation**.** Source: SH:24 2021-23, ONS mid-2022 population estimates, ID 2019



Requests by those aged 25-49

The HEA has shown that access rates for online STI kits are statistically higher amongst females compared to males in this age category. Now the profile looks at the variation within for those two groups. There is a large range in access rates across the 65 MSOAs within the County (figure 59)

Figure 59: Summary of online STI test access rates per 1,000 for females and males aged 25 to 49 years. Source: SHRAD 2021-23, ONS mid-2022 population estimates

	Females		Males	
	MSOA	Rate per 1,000	MSOA	Rate per 1,000
Highest	Chester-le-Street West and Pelton Fell	71.9	Chester-le-Street West and Pelton Fell	46.1
Lowest	Brasside and Newton Hall	20.4	Brasside and Newton Hall	16.1
County Durham average		48.1		28.4

Figures 61 and 62 show the complete range of access rates for County Durham MSOAs.

For males and females, there are MSOAs in the top 30% most deprived areas of the county where access rates are significantly below the county value; three areas for females and three areas for males. Only one MSOAs appear in both.

Figure 60: List of MSOAs in most deprived 30% with significantly lower online STI kits request rates that the County Durham average for 25-49 year-olds

Decile and MSOA name	**Dark blue indicates significantly lower access rates compared to CD**	
Decile 1	Females	Males
Blackhalls		
Decile 2		
Thornley Deaf Hill and Wheatley Hill		
Decile 3		
Brandon		
Hutton Henry and Wingate		
Passfield and Shotton		
Total	**3**	**3**

Figure 61: Online STI tests access rate per 1,000 for females aged 25-49 years by MSOA and ID 2019 deprivation decile. Source: SH:24 2021-23, ONS mid-2022 population estimates

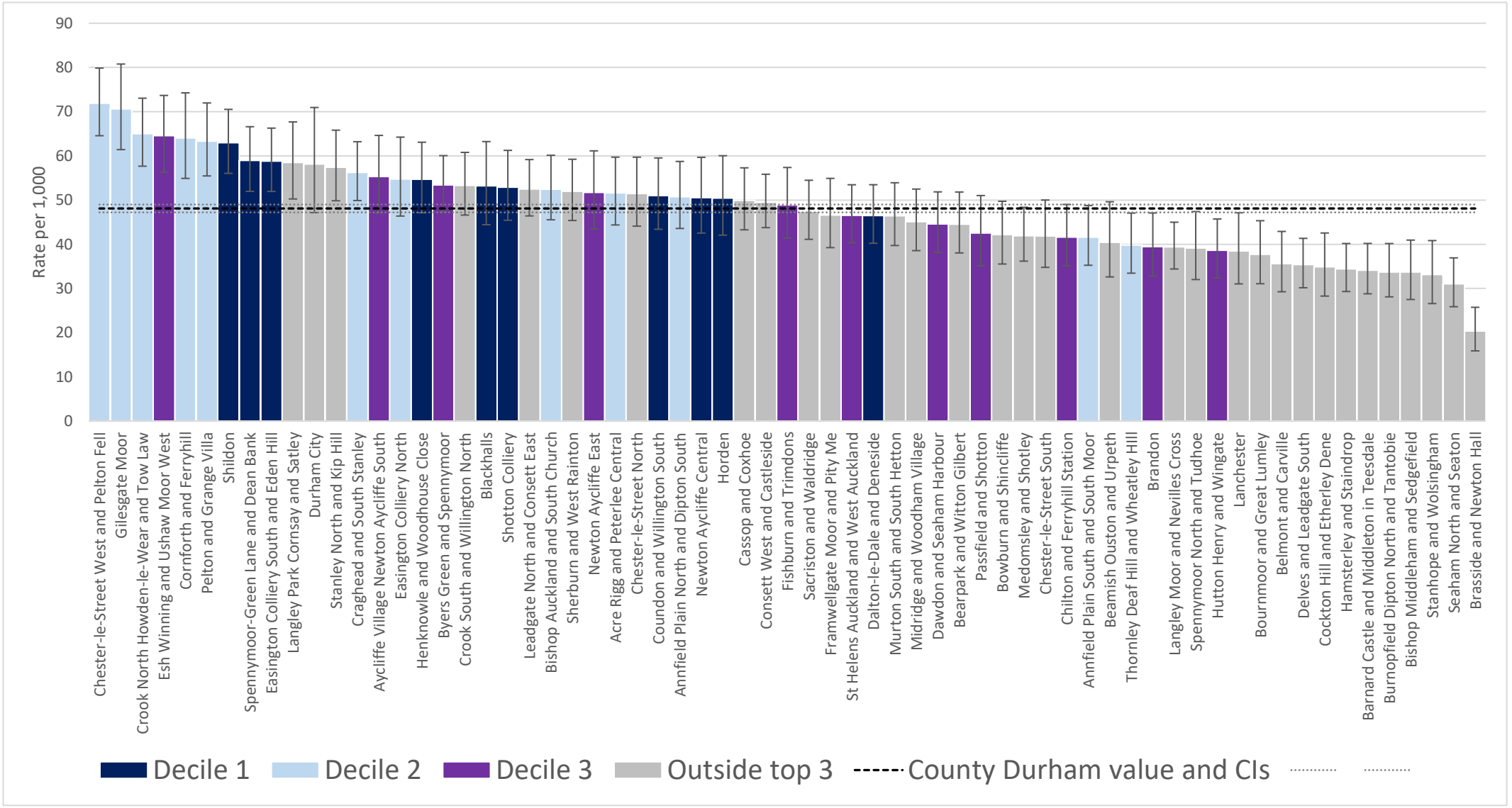
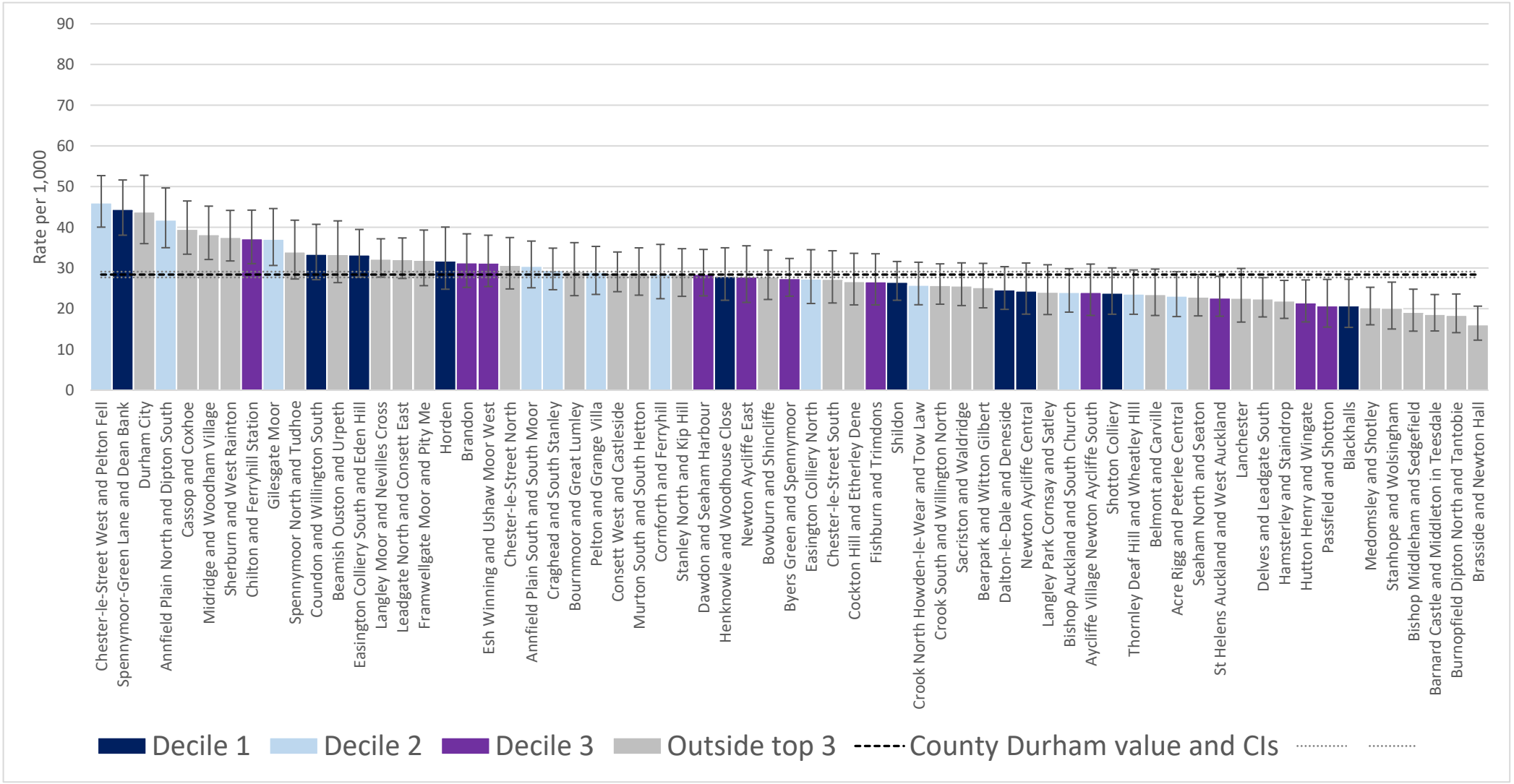


Figure 62: Online STI tests access rate per 1,000 for males aged 25-49 years by MSOA and ID 2019 deprivation decile. Source: SH:24 2021-23, ONS mid-2022 population estimates

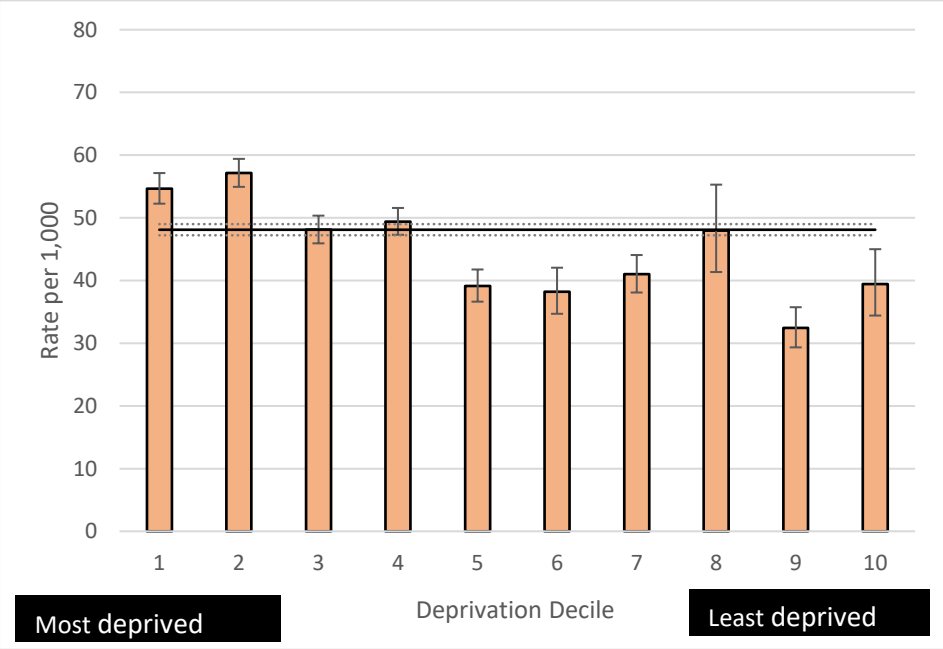


For females, grouping MSOAs into deprivation deciles in Figure 63 shows some evidence of an inverse social gradient in line with anticipated need. Those living in deciles 1 and 2 access online STI kits at a significantly higher rate than County Durham as a whole and the other deciles (except for 8). The access rates for those living in deciles 3, 4 and 8 are statistically similar to the county as a whole.

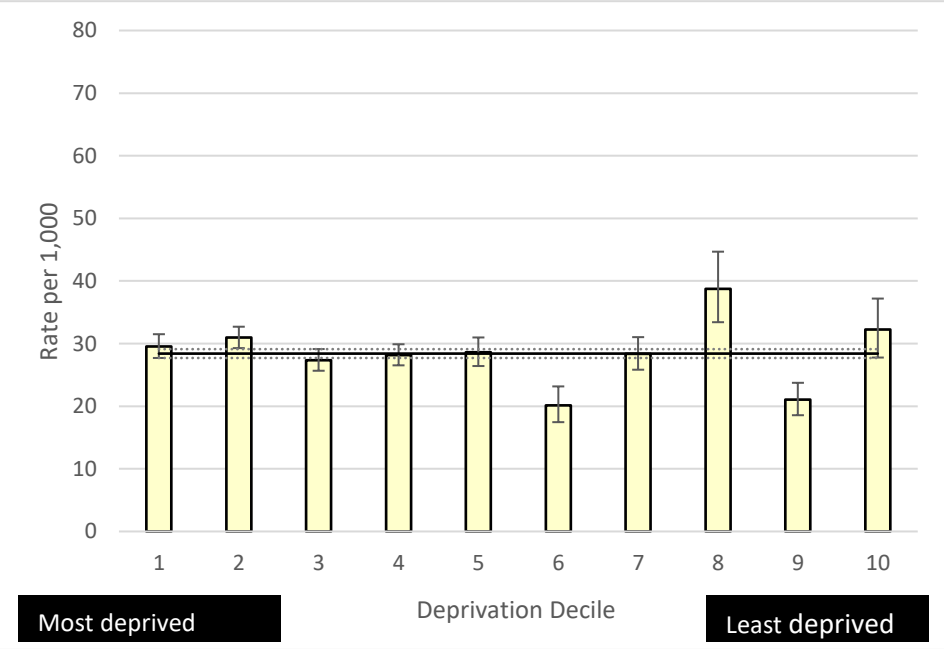
For males aged 25-49 years figure 63 shows some significant variation in the access between the deciles however there isn't strong evidence of an inverse social gradient to evidence greater access in the more deprived areas. The access rate for male residents in deciles 1 to 3 is statistically similar to the county value. Decile 8 is the only decile where access rates are statistically significantly higher than the county average.

Figure 63: Online STI kits access rates per 1,000 for females and males ages 25-49 years by deprivation decile**.** Source: SH:24 2021-23, ONS mid-2022 population estimates, ID 2019

Females



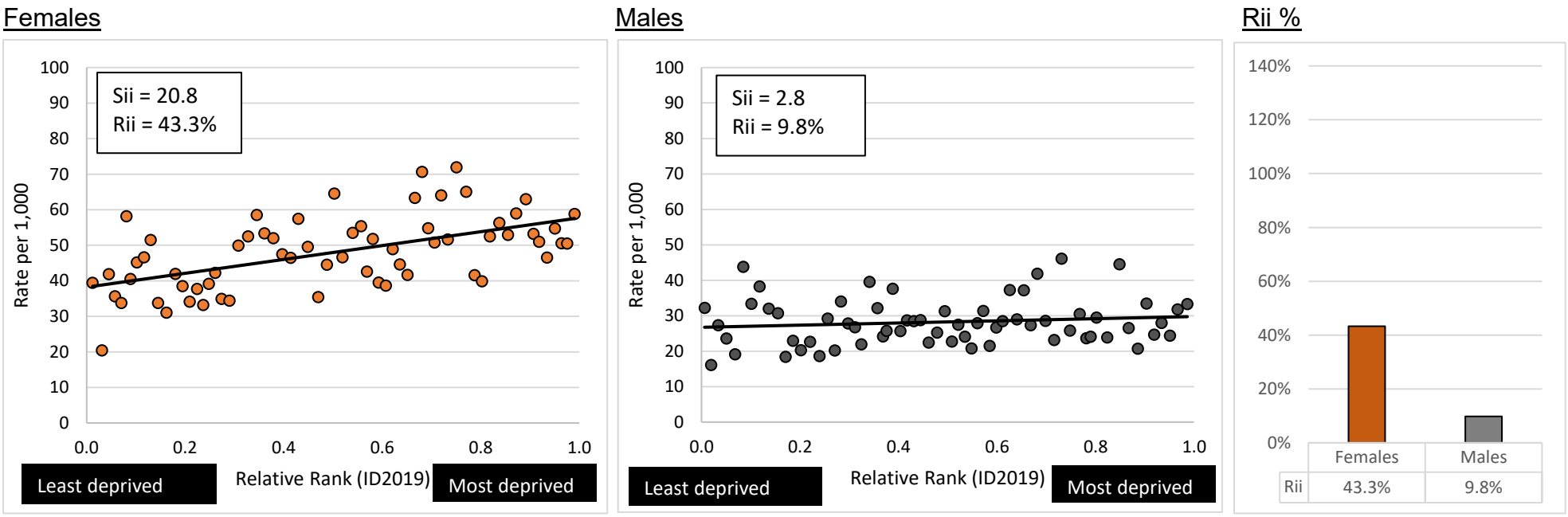
Males



The Sii and Rii for requests for online STI kits for the 25-49 years old age band (figure 64) have been calculated. For females, rates by deprivation are unequal. More requests are made from the most deprived areas. This indicates that the service is reflecting the anticipated need in terms of deprivation. The absolute difference between the least and most deprived is 43.3 per 1,000 higher in the more deprived area and the relative size of the inequality gap is 43.3%. The Rii is moderate and positive meaning there is a higher rate of access online STI kits in the most deprived areas.

For males, rates accessing by deprivation show a different pattern compared to females. There are marginally more attendances made from the least deprived areas. The absolute difference between the least and most deprived is 2.8 per 1,000 higher in the more deprived areas and the size of the inequality gap is 9.8%. The Rii is positive however it is small and close to zero, in other words a horizontal line of best fit, indicating close to equality of access across the deprivation groups.

Figure 64: Online STI kits request rates per 1,000 for 25-49 years olds by MSOA and relative rank of deprivation**.** Source: SH:24 2021-23, ONS mid-2022 population estimates, ID 2019



Requests by those aged 50-74

The HEA has shown that access rates for online STI kits are lowest for males and females in this, the oldest age category. Now the profile looks at the variation within for those two groups. Due to low numbers accessing from this age band in a large proportion of the 65 MSOAs, the access rates could not be meaningfully calculated for MSOAs. It was possible to group by deprivation decile however some suppression was necessary for females due to low numbers.

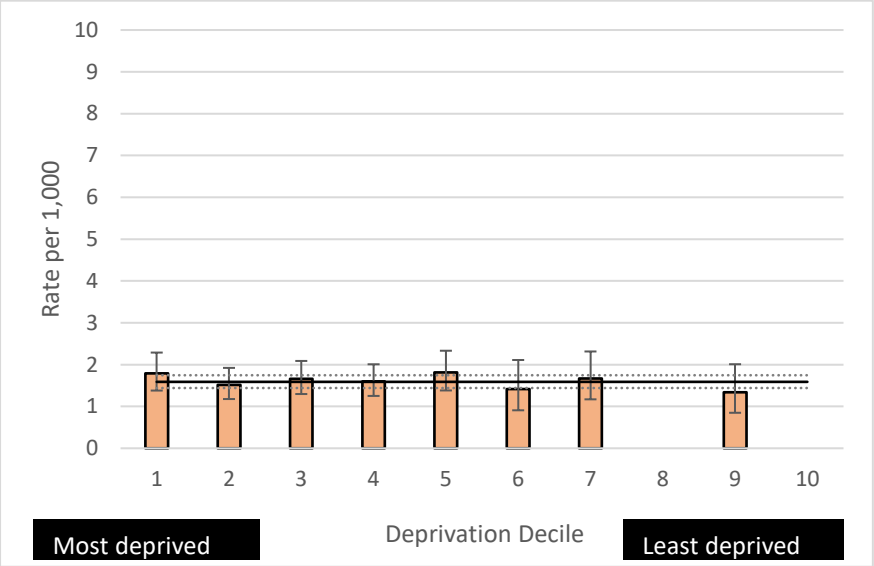
For females, grouping MSOAs into deprivation deciles in figure 65 shows no evidence of social gradient in any direction to evidence greater in the more deprived areas. The chart shows shows no significant variation in the access between the deciles and all deciles where the rate could be calculated are statistically significantly similar to the county value.

For males figure 65 shows some significant variation between deciles and deciles compared to the county values and evidence that of a social gradient The access rate for male residents in decile 1 is statistically significantly lower than the county value. The access rates for those living in deciles 5, 8 and 10 are statistically significantly higher than the county value.

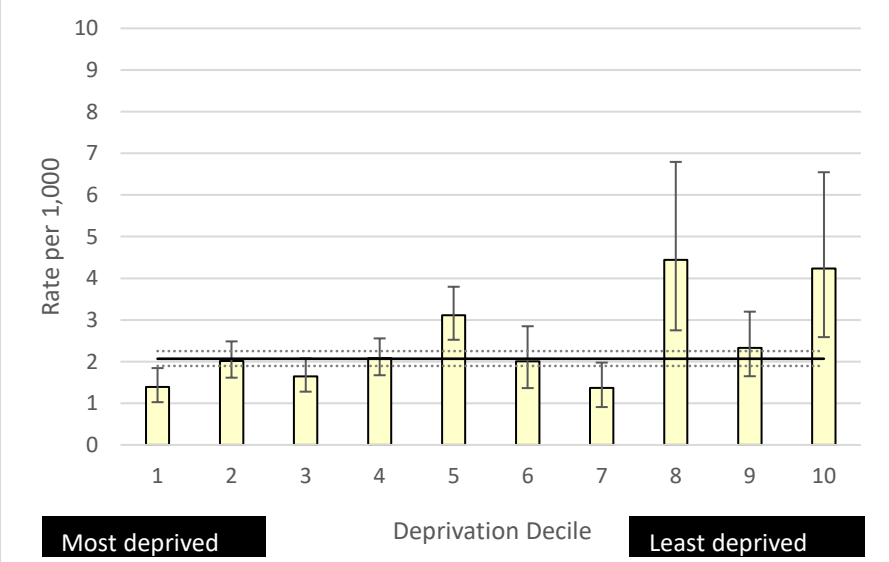
Due to suppression being applied to many MSOAs it is not possible to calculate an Sii or Rii for 50-74 years old females or female accessing online STI kits.

Figure 65: Online STI kits access rates per 1,000 for females and males ages 50-74 years by deprivation decile**.** Source: SH:24 2021-23, ONS mid-2022 population estimates, ID 2019

Females



Males



Conclusion

This HEA highlights the importance that good sexual health plays in contributing to a person's overall health well-being and the key role of specialist sexual health services. The HEA profile has set out the challenge in the County Durham population of a relatively higher burden of poor sexual health experienced by young people, despite statistically significantly lower attendance rates of under 25's accessing ISHS for contraception services than north east and England; and people who live in our areas of highest deprivation.

The HEA finds that young females (aged 15-24 years) access face to face contraception services, STI services and use the online service to request home STI kits at significantly higher rates than any other female or male age group.

It was anticipated that females would be more likely to access contraception services at a higher rate, however the HEA profile suggests that females are potentially receiving a more holistic service as they are routinely asked about STI care at each contraception appointment; data from the SRHAD identifies that there is a concerning trend that for young males the STI face-to face access rates are relatively low and they are accessing very little contraceptive care, suggesting that males are not routinely asked about contraception when attending for STI care.

The rate of access to online STI kits is significantly higher for younger people compared to those age 25 and over which is positive. However, the gap between the female and male access rates for those aged 15-24 years is significant and large. Acknowledging that that in 2021 the National Chlamydia Screening Programme updated its primary objectives for opportunistic screening to target young females, sexual health services remained unchanged, therefore we conclude that there should be greater equity of access between males and females in this age group to reduce the age-based inequalities in overall new STIs diagnoses.

People aged 50-74 years old use the ISHS but at a much lower rate than the other age groups for STI care and contraception. Women become less fertile as they age and despite the smaller numbers accessing contraception services, more work is required to understand this age band and whether the access rates observed are in line with need.

Males in this category do access both the face to face and online services at significantly higher rather than females. However, rate of online requests for STI tests for both males and females are very low, less than 3 per 1,000 and it is likely for this increase in trend to continue.

The analysis of access by deprivation, has demonstrated that the ISHS is targeting provision in relation to need for young females (aged 15-24) for face-to-face contraception and STI services. The gradient is less evident for 25–49-year-old females, however the findings are broadly positive for face-to-face services for this age group too.

The equivalent picture for males is less positive. There is no evidence of increased access in our more deprived communities across all age bands.

It is evident from the HEA analysis that access rates for contraception services and STI care in some of County Durham's most deprived communities are significantly below the County Durham average; these areas are predominantly located in East Durham and South Durham.

In addition, the HEA has explored where women can access LARC provision across the county through their local GP practices. Analysis has concluded that there are 7 GP practices in deprivation deciles 1-3 without an active SLA, of these 4 practices are located within East Durham.

As with face-to-face access to the ISHS, residents living in some of County Durhams areas of greatest need are unable to access LARC provision in their community. This is inequitable and will contribute to further increasing inequalities for those communities.

The HEA identified that around 15% of County Durham residents access sexual health services not in County Durham. It should be noted that some areas with lower access rates are communities that border other local authority areas, and in the absence of local service delivery, some residents may access support from other areas sexual health services; further work is required to understand this cohort.

The results of the analysis for the online service are mixed. For 15-24 years olds the findings are impacted by the high rate of requests made by those living in and around Durham City; these areas are known to be the location of the majority of Durham University student accommodation and imply that university students may be utilising the online service over face-to-face provision.

The equity analysis concludes that greater access is available to females in the least deprived areas of the county however the oppositive is true for females aged 25-49 years, which is a positive finding. For males of both ages, the access is best described as equitable across the range of deprivation groups. This indicates that there is scope for greater targeting of the online offer for males and younger females.

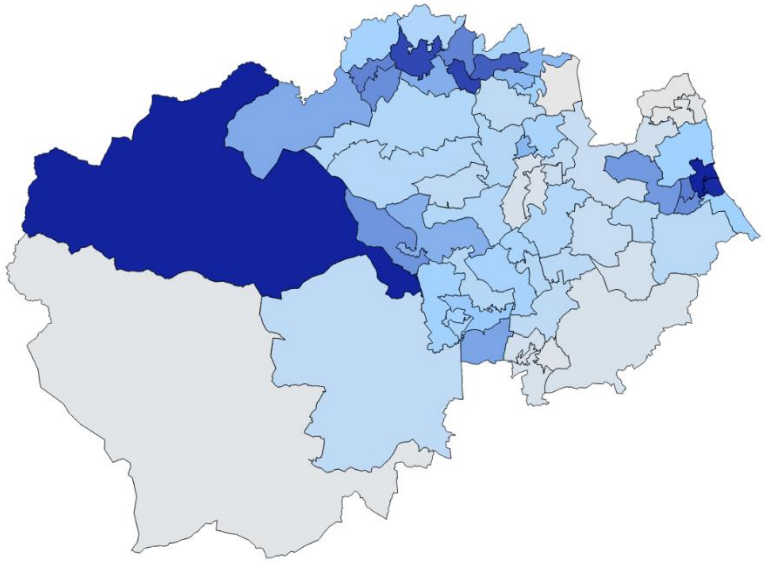
The HEA profile has been able to quantify numbers of people accessing the ISHS by gender and sexual orientation but has been unable to link individuals' sexual orientation with reason for attendance due to the information being held on separate recording systems; this is an area for further development. The attendance data has identified that the service is predominately accessed by heterosexual females, this is unsurprising as the profile also identifies that most are attending for contraceptive purposes. The data also shows that for other genders, gay, bisexual, and other men who have sex with men are disproportionately represented in the data. Again, this finding is in line with the existing evidence base. As this HEA looked at access only, further work may be of benefit to understand if the service is meeting needs by undertaking work that looks at service user outcomes.

The sexual health system, including local authority, the ISHS, primary care and wider NHS partners must collaborate to ensure that the service effectively targets access in order to improve outcomes and prevent health inequalities.

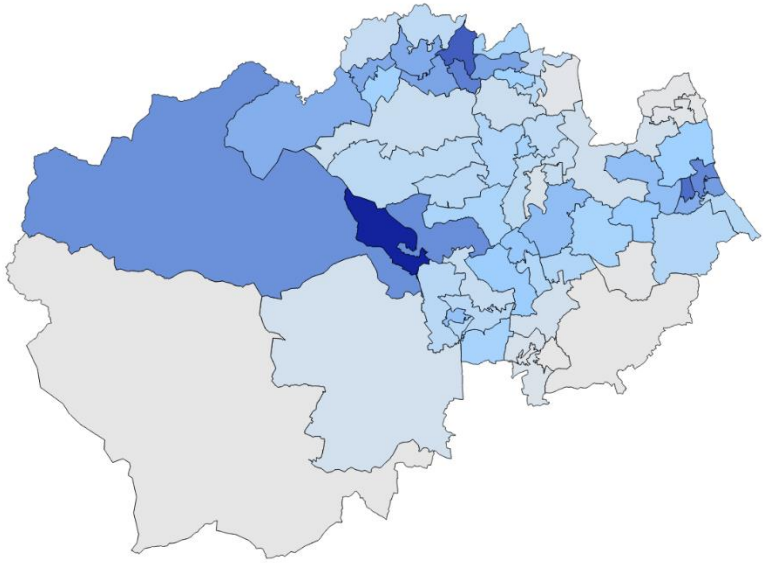
Appendix A: Maps

Access to in person contraception services, females, rate per 1,000. Source: SHRAD 2021-23, ONS mid-2022 population estimates.

Ages 15-24 years



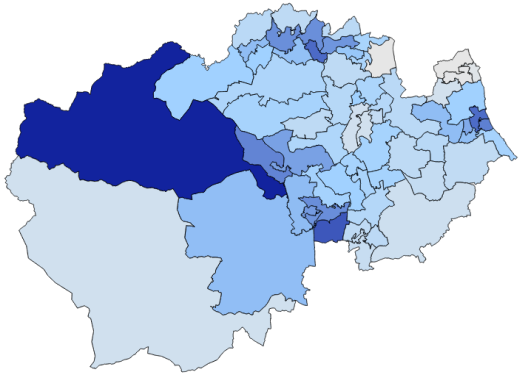
Ages 25-49 years



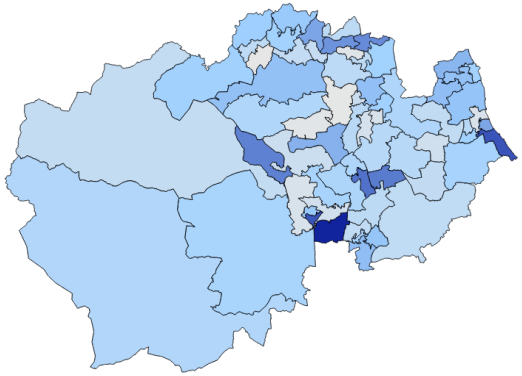
Gradient Key:	
Maximum	
Centre	
Minimum	

Access to in person STI services, females (top row in blue) and males (bottom row in orange), rate per 1,000. Source: SHRAD 2021-23, ONS mid-2022 population estimates

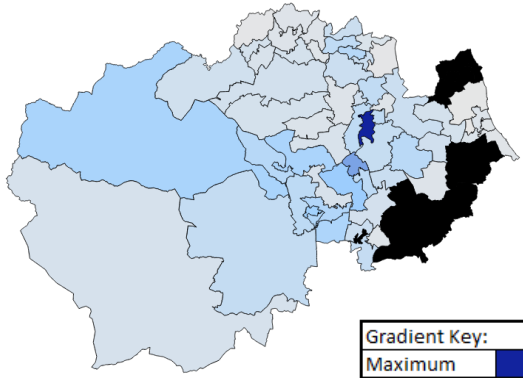
Ages 15-24 years



Ages 25-49 years



Ages 50-74 years



Gradient Key:	
Maximum	
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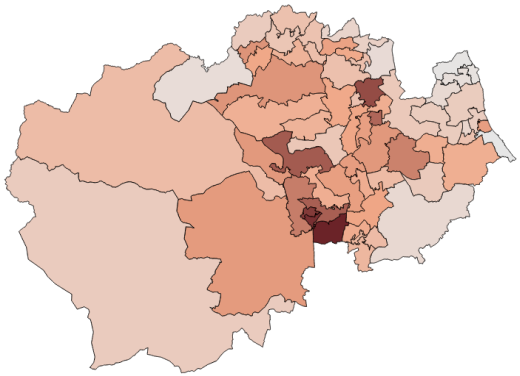
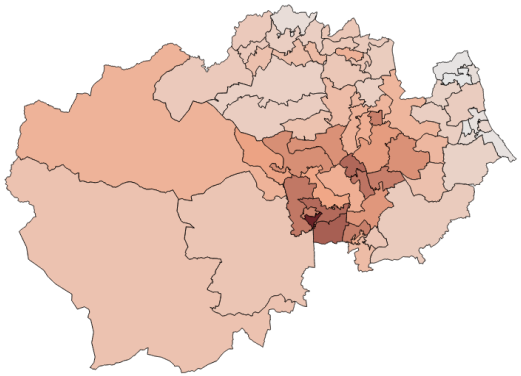
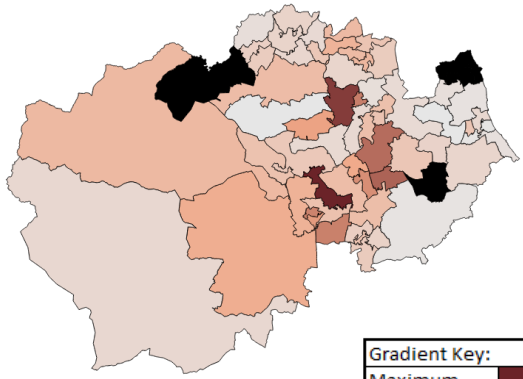
Ages 15-24 years



Ages 25-49 years



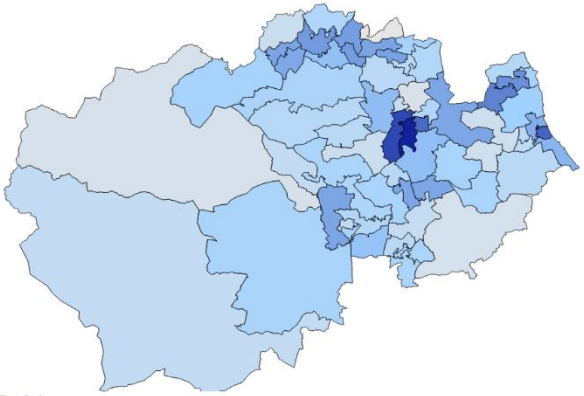
Ages 50-74 years



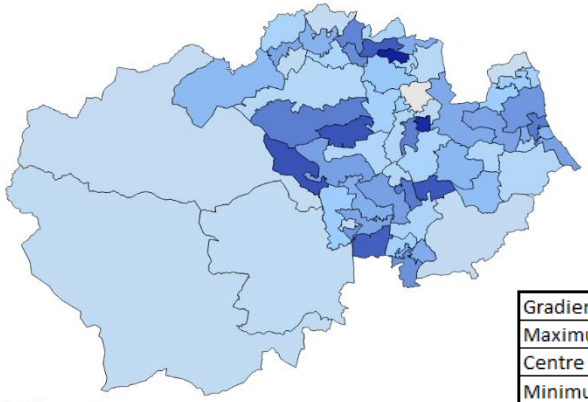
Gradient Key:	
Maximum	
Centre	
Minimum	
Suppressed	

Access to online STI services, females (top row in blue) and males (bottom row in orange), rate per 1,000. Source: SH:24 2021-23, ONS mid-2022 population estimates

Ages 15-24 years

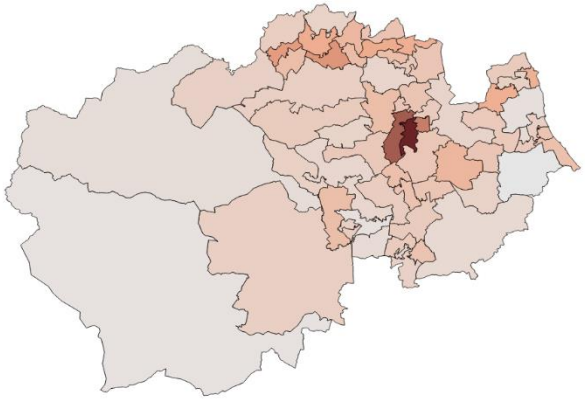


Ages 25-49 years

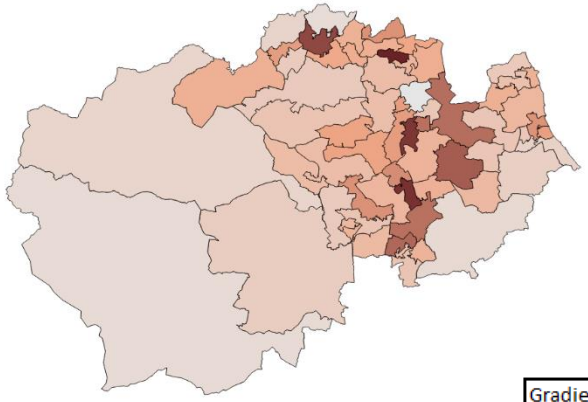


Gradient Key:	
Maximum	
Centre	
Minimum	

Ages 15-24 years



Ages 25-49 years



Gradient Key:	
Maximum	
Centre	
Minimum	