



Upper-tier local authority sexual and reproductive health epidemiology report

Wirral

16 August 2019

Key findings

- Overall, the number of new sexually transmitted infections (STIs) diagnosed among residents of Wirral in 2018 was 2,578. The rate was 799 per 100,000 residents, similar to the rate of 784 per 100,000 in England.
- Wirral ranked 65th highest out of 147 UTLAs for new STI diagnoses excluding chlamydia among young people aged 15-24 years in 2018, with a rate of 706 per 100,000 residents, better than the rate of 851 per 100,000 for England.
- The chlamydia detection rate per 100,000 young people aged 15-24 years in Wirral was 3,430 in 2018, better than the rate of 1,975 for England.
- The rank for gonorrhoea diagnoses (a marker of high levels of risky sexual activity) in Wirral was 80th highest (out of 147 UTLAs) in 2018. The rate per 100,000 was 61.6, better than the rate of 98.5 in England.
- Among sexual health service (SHS) patients from Wirral who were eligible to be tested for HIV, the percentage tested in 2018 was 45.9%, worse than the 64.5% in England.
- The number of new HIV diagnoses among people aged 15 years and above in Wirral was 13 in 2017. The prevalence of diagnosed HIV per 1,000 people aged 15-59 years in 2017 was 1.2, better than the rate of 2.3 in England. The rank for HIV prevalence in Wirral was 102nd highest (out of 150 UTLAs).
- In Wirral, in 2015 - 17, the percentage of HIV diagnoses made at a late stage of infection (CD4 count ≤ 350 cells/mm³ within 3 months of diagnosis) was 50.0%, similar to 41.1% in England.
- The total rate of long-acting reversible contraception (LARC) (excluding injections) prescribed in primary care, specialist and non-specialist sexual health services per 1,000 women aged 15-44 years living in Wirral was 44.6 in 2017, lower than the rate of 47.4 per 1,000 women in England. The rate prescribed in primary care was 17.4 in Wirral, lower than the rate of 29.2 in England. The rate prescribed in the other settings was 27.2 in Wirral, higher than the rate of 18.2 in England.

- The total abortion rate per 1,000 women aged 15-44 years in 2017 was 22.7 in Wirral, higher than the England rate of 17.2 per 1,000. Of those women under 25 years who had an abortion in 2017, the proportion who had had a previous abortion was 27.9%, similar to 26.7% in England.
- In 2017, the conception rate for under-18s in Wirral was 20.5 per 1,000 girls aged 15-17 years, similar to the rate of 17.8 in England.
- In 2017/18, the percentage of births to mothers under 18 years was 1.0%, similar to 0.7% in England overall.

Figure 1. Chart showing key sexual and reproductive health indicators in Wirral UTLA compared to the rest of England

The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average, the diamond shows the average for the North West PHE Centre.

Compared to England:

● Better ● Similar ● Worse ● Lower ● Similar ● Higher ● Not compared



Indicator names	Period	UTLA count	UTLA value	England value	England lowest/worst	England highest/best
New STI diagnoses (exc chlamydia aged <25) / 100,000	2018	1,392	705.9	850.6	3,823.1	379.5
Syphilis diagnostic rate / 100,000	2018	27	8.4	13.1	157.4	2.5
Gonorrhoea diagnostic rate / 100,000	2018	199	61.6	98.5	870.9	17.7
Chlamydia detection rate / 100,000 aged 15-24	2018	1,149	3,429.6	1,974.9	1,053.5	5,756.9
Chlamydia proportion aged 15-24 screened	2018	8,555	25.5	19.6	9.4	48.7
STI testing rate (exc chlamydia aged <25) / 100,000	2018	26,518	13,447.8	18,053.1	8,523.8	68,809.7
New HIV diagnosis rate / 100,000 aged 15+	2017	13	4.9	8.7	44.6	0.0
HIV late diagnosis (%)	2015 - 17	13	50.0	41.1	68.6	16.7
HIV diagnosed prevalence rate / 1,000 aged 15-59	2017	212	1.2	2.3	14.6	0.4
HIV testing coverage, total (%)	2018	3,539	45.9	64.5	29.0	84.8
Total abortion rate / 1,000	2017	1,236	22.7	17.2	26.4	10.7
Abortions under 10 weeks (%)	2017	1,028	83.8	76.6	66.6	86.7
Under 18s conception rate / 1,000	2017	111	20.5	17.8	43.8	6.1
Total prescribed LARC excluding injections rate / 1,000	2017	2,435	44.6	47.4	7.0	85.8
Violent crime (including sexual violence) - rate of sexual offences per 1,000 population	2017/18	661	2.1	2.4	0.8	5.3

Introduction

Aim

This report describes sexual and reproductive health in a local area in an integrated way, including sexually transmitted infections (STIs), HIV, teenage conceptions, abortions and contraception.

This is produced alongside other PHE local HIV, sexual and reproductive health intelligence tools to help inform local Joint Strategic Needs Assessments (JSNAs) so that commissioners can effectively target service provision.

Information used in this report

Unless otherwise indicated this report is compiled from publically available data on the online [Sexual and Reproductive Health Profiles](#). Please access this tool for further data analysis and more information about the data included in this report which is described in the 'definitions' tab for each indicator.

Please note that City of London and Isles of Scilly and not included in the rankings in this document. Where comparisons are made to Hackney or Cornwall, please note that the data for these areas may have been combined with City of London and Isles of Scilly respectively. Please check the online Profiles.

For an introductory guide on sexual health data sources, please access <https://www.gov.uk/government/publications/sexual-and-reproductive-health-in-england-local-and-national-data>.

Viewing this report and converting to PDF

This report has been developed for the best viewing experience in Google Chrome. It has also been tested with Internet Explorer 11 and Microsoft Edge, but some content may look different (for example, the table of contents is not available in Internet Explorer).

When viewed in Google Chrome, this report can be converted to a PDF through the Print menu. Select "Save as PDF" as the destination. For the best result, it is recommended to select the "background graphics" option, and deselect the "headers and footers" option.

Some other browsers also offer PDF conversion, but the formatting may not display as intended.

STIs

As STIs are often asymptomatic, frequent screening of risk groups is important. Early detection and treatment can reduce important long-term consequences, such as infertility and ectopic pregnancy. While vaccination is a measure that can be used to control genital warts, hepatitis A and hepatitis B, control of other STIs relies on consistent and correct condom use, behaviour change to decrease overlapping and multiple partners, ensuring prompt access to testing and treatment, and ensuring partners of cases are notified and tested.

Over the past decade, diagnoses of gonorrhoea and syphilis have increased considerably in England, most notably in males, while diagnoses of genital warts have decreased.¹ The full-scale implementation of the National Chlamydia Screening Programme (NCSP) in 2008 led to increases in diagnoses rates in men and women. More STI testing in sexual health services and through the NCSP with routine use of more sensitive diagnostic tests, such as nucleic acid amplification tests (NAATs), will partly explain increases in the early part of the decade, although ongoing high levels of condomless sex will have played a role.

The burden of STIs in England continues to be greatest in young people, gay, bisexual and other men who have sex with men (MSM) and black ethnic minorities. Of all age-groups, the highest STI diagnosis rates in England are in young people aged 15-24 years.

The number of STI diagnoses in MSM has risen sharply in England over the past decade. Several factors may have contributed to this, including behavioural changes such as an increase in partner numbers and condomless anal intercourse, as well as, for some high risk MSM, 'chemsex' (the use of drugs before or during planned sexual activity to sustain, enhance, disinhibit or facilitate the experience) and group sex facilitated by geosocial networking applications. More screening of extra-genital (rectal and pharyngeal) sites in MSM using NAATs will also have improved detection of gonococcal and chlamydial infections, although this will have had less impact in recent years as these developments have become more established.

High levels of gonorrhoea transmission are of particular concern due to the emergence of extensively drug resistant gonorrhoea (XDR-NG) in England. In 2018, a case of infection with *Neisseria gonorrhoeae* with ceftriaxone resistance and high-level azithromycin resistance was detected in a UK resident man who had acquired the infection from Thailand²; later that year, two additional cases of infection with a strain of *N. gonorrhoeae* with ceftriaxone resistance and intermediate azithromycin resistance were detected in two women in different regions of England, both of whom had overlapping sexual networks with UK residents who had travelled to Ibiza, Spain.

This report has been compiled using routine STI data, the majority of which comes from specialist sexual health services.³ Chlamydia test and diagnosis data from community services are sourced from the CTAD Chlamydia Surveillance System.

Please see the link below for further details on chlamydia data from community services and for additional data on chlamydia testing coverage, positivity and diagnostic rates (for those aged 15-24 years).⁴ Diagnoses of all STIs made in specialist and non-specialist sexual health services are reported using the GUMCAD STI Surveillance System.

Burden and trend of new STIs

A total of 2,578 new STIs were diagnosed in residents of Wirral in 2018. It should be noted that if high rates of gonorrhoea and syphilis are observed in a population, this reflects high levels of risky sexual behaviour.

When interpreting trends, please note:

- Recent decreases in genital warts diagnoses are due to the protective effect of HPV vaccination, and are particularly evident in the younger age groups, offered the vaccine since the national programme began
- An increase in genital herpes diagnoses may be due to the use of more sensitive NAATs

Figure 2. Chart showing key STI indicators in Wirral UTLA compared to the rest of England

The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average, the diamond shows the average for the North West PHE Centre.

Compared to England:

- Better
- Similar
- Worse
- Lower
- Similar
- Higher
- Not compared



Indicator names	Period	UTLA count	UTLA value	England value	England lowest/worst	England highest/best
All new STI diagnosis rate / 100,000	2018	2,578	798.6	784.4	364.8	3,392.1
New STI diagnoses (exc chlamydia aged <25) / 100,000	2018	1,392	705.9	850.6	3,823.1	379.5
STI testing rate (exc chlamydia aged <25) / 100,000	2018	26,518	13,447.8	18,053.1	8,523.8	68,809.7
STI testing positivity (exc chlamydia aged <25) %	2018	759	2.9	2.3	1.3	4.0
Gonorrhoea diagnostic rate / 100,000	2018	199	61.6	98.5	870.9	17.7
Syphilis diagnostic rate / 100,000	2018	27	8.4	13.1	157.4	2.5
Genital warts diagnostic rate / 100,000	2018	370	114.6	100.1	258.9	50.8
Genital herpes diagnosis rate / 100,000	2018	173	53.6	59.0	166.6	20.0
Chlamydia diagnostic rate / 100,000	2018	1,694	524.8	384.4	176.0	1,387.1
Chlamydia diagnostic rate / 100,000 aged 25+	2018	524	225.4	212.5	1,227.5	74.1
Chlamydia detection rate / 100,000 aged 15-24	2018	1,149	3,429.6	1,974.9	1,053.5	5,756.9
Chlamydia detection rate / 100,000 aged 15-24 (male)	2018	377	2,167.8	1,335.8	543.0	4,415.0
Chlamydia detection rate / 100,000 aged 15-24 (female)	2018	747	4,636.6	2,619.8	1,233.6	7,035.3
Chlamydia proportion aged 15-24 screened	2018	8,555	25.5	19.6	9.4	48.7

Table 1. Rates per 100,000 population of new STIs in Wirral and England: 2017-2018

Diagnoses	2017	2018	% change 2017 to 2018*	Rank among 16 similar UTLAs†	Rank within England: 2018‡	Value for England: 2018
New STIs	684.3	798.6	16.7%	1	48	784.4
New STIs (exc chlamydia aged <25) ¹	661.3	705.9	6.7%	4	65	850.6
Chlamydia	437.1	524.8	20.1%	1	29	384.4
Gonorrhoea	55.8	61.6	10.6%	4	80	98.5
Syphilis	7.7	8.4	8.0%	5	72	13.1
Genital warts	109.4	114.6	4.8%	2	34	100.1
Genital herpes	48.0	53.6	11.6%	9	81	59.0

* Percent change not provided where the value in 2017 was 0. Calculated from unrounded values.

† These are Wirral and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from [CIPFA's Nearest Neighbours Model](#).

‡ Out of 150 upper-tier (county) local authorities in England, excluding those where values were suppressed due to small numbers. City of London and Isles of Scilly are always excluded. First rank has the highest value. Where the value was 0, ranks are based on order of local authority names.

¹ Population is restricted to those aged 15-64 years

Table 2. Number of new STIs by year, Wirral

Diagnoses	2012	2013	2014	2015	2016	2017	2018
New STIs	2,292	3,242	4,468	3,182	2,534	2,209	2,578
New STIs (exc chlamydia aged <25) ¹	1,297	2,217	3,312	1,893	1,392	1,304	1,392
Chlamydia	1,337	1,491	1,627	1,876	1,700	1,411	1,694
Gonorrhoea	127	141	125	118	125	180	199
Syphilis	8	3	6	23	16	25	27
Genital warts	427	535	510	468	328	353	370
Genital herpes	162	289	259	248	270	155	173

¹ Population is restricted to those aged 15-64 years

Figure 4. Rates per 100,000 population of new STIs excluding chlamydia in <25 years in 16 similar local authorities and the North West PHE Centre, compared to England: 2018

Similar refers to statistical nearest neighbours, derived from [CIPFA's Nearest Neighbours Model](#)

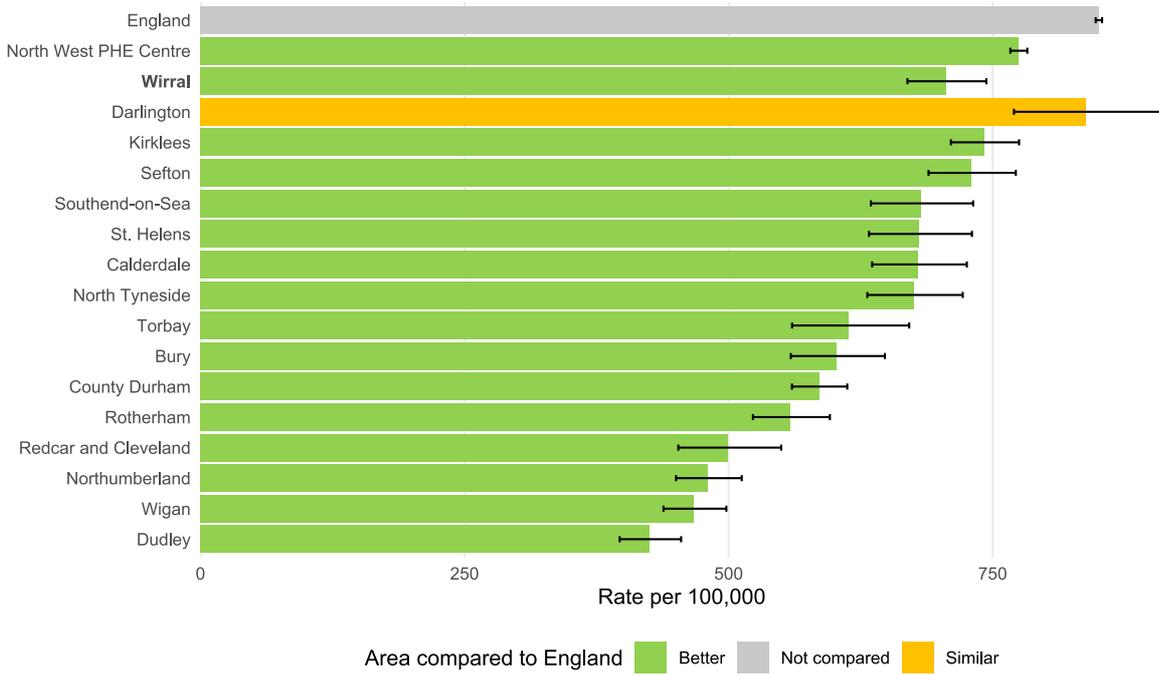


Figure 5. Rates per 100,000 population by diagnosis by year in Wirral compared to rates in the North West PHE Centre and England: 2012 to 2018

Please note the charts have different y axis scales.



Figure 6. Rates per 100,000 population of gonorrhoea in 16 similar local authorities and the North West PHE Centre, compared to England: 2018

Similar refers to statistical nearest neighbours, derived from [CIPFA's Nearest Neighbours Model](#)

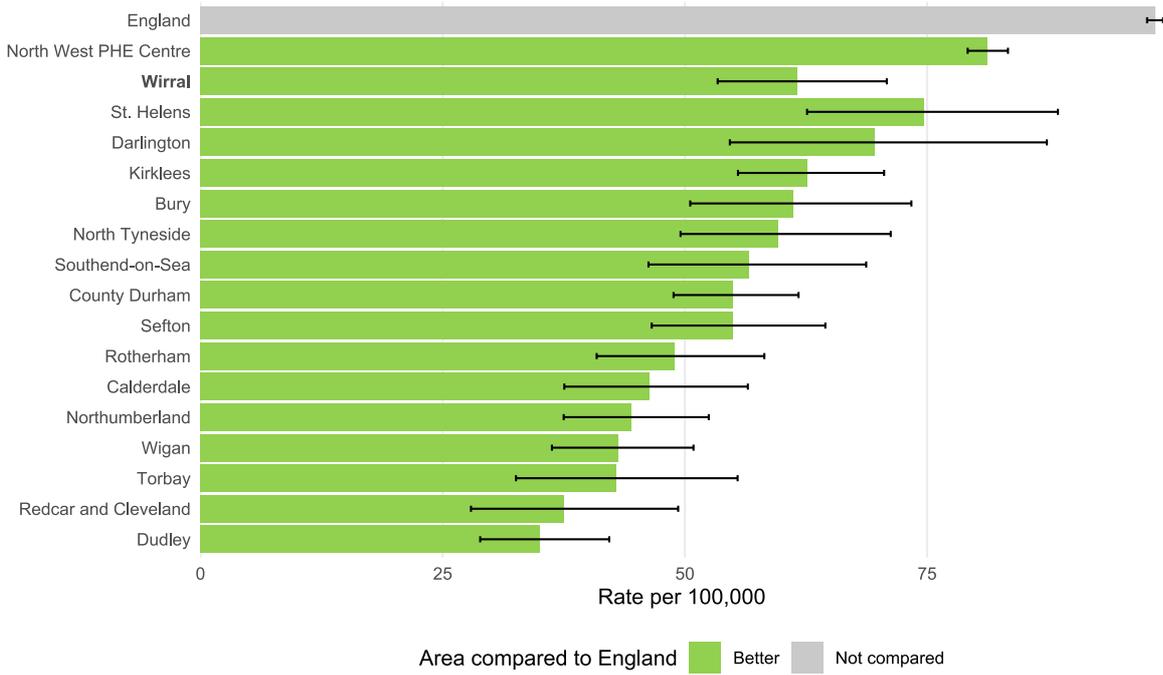
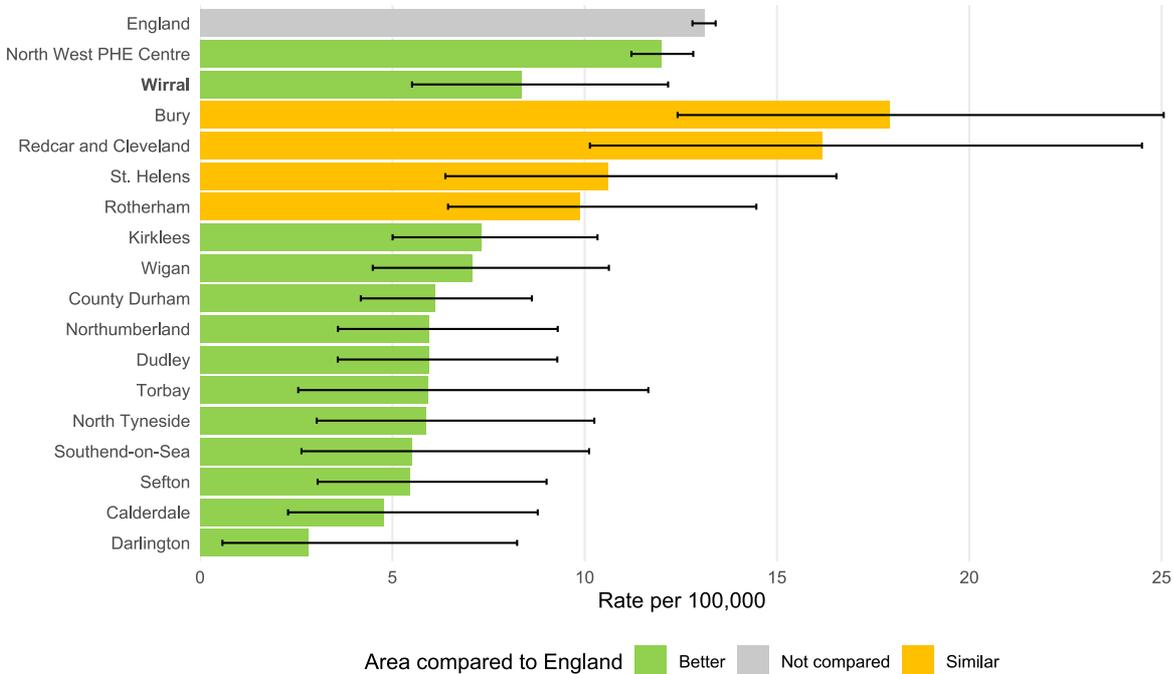


Figure 7. Rates per 100,000 population of syphilis in 16 similar local authorities and the North West PHE Centre, compared to England: 2018.

Similar refers to statistical nearest neighbours, derived from [CIPFA's Nearest Neighbours Model](#)



Chlamydia detection

The Public Health Outcome Framework (PHOF) includes an indicator to assess progress in controlling chlamydia in sexually active young adults under 25 years old: the annual detection rate among the resident 15-24 year old population. The detection rate reflects both coverage and the proportion testing positive at all sites, including sexual health services diagnoses as well as those made outside of sexual health services.

Since chlamydia is most often asymptomatic, a high detection rate reflects success at identifying infections that, if left untreated, may lead to serious reproductive health consequences. The detection rate is not a measure of prevalence. PHE recommends that local areas achieve a rate of at least 2,300 per 100,000 resident 15-24 year olds, a level which is expected to produce a decrease in chlamydia prevalence. Areas already achieving this rate should aim to maintain or increase it. Areas not currently achieving this rate should work towards it. High detection levels can only be achieved through the ongoing commissioning of high-volume, good quality screening services across primary care and sexual health services.

The chlamydia detection rate in 15-24 year olds in 2018 in Wirral was 3,430 per 100,000 population (1,149 positives out of 8,555 screened), higher than the 2,300 target. 25.5% of 15-24 year olds were tested for chlamydia, compared to 19.6% nationally. The detection rate per 100,000 and its rank in North West PHE Centre and England are shown in Table 3.

Table 3. Chlamydia detection rate per 100,000 population and percentage screened in 15-24 year olds in Wirral, the North West PHE Centre and England: 2018

	2017	2018	% change 2017 to 2018*	Rank among 16 similar UTLAs†	Rank within England: 2018‡	Value for England: 2018
Detection rate						
Total	2,650.6	3,429.6	29.4%	1	7	1,974.9
Women	3,389.0	4,636.6	36.8%	1	4	2,619.8
Men	1,834.3	2,167.8	18.2%	1	15	1,335.8
Percentage screened						
People aged 15- 24	24.9	25.5	2.5%	1	18	19.6

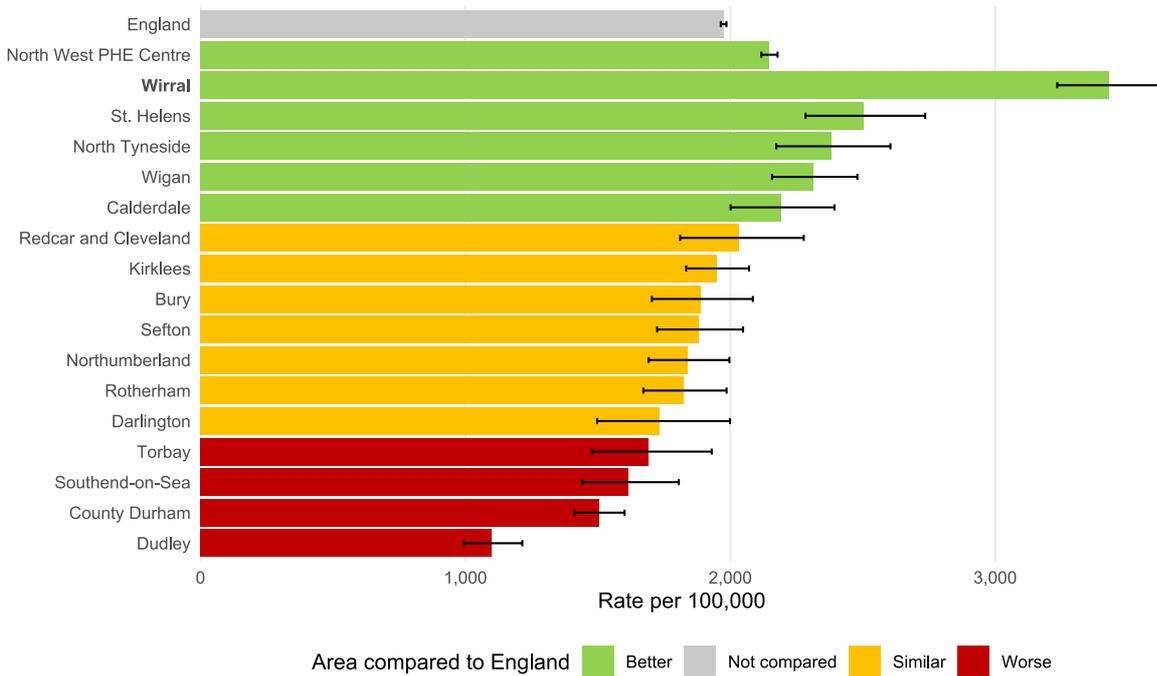
* Percent change proportional to the value in 2017, not a change in percentage points. Percent change not provided where the value in 2017 was 0. Calculated from unrounded values.

† These are Wirral and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from [CIPFA's Nearest Neighbours Model](#).

‡ Out of 150 upper-tier (county) local authorities in England, excluding those where values were suppressed due to small numbers. City of London and Isles of Scilly are always excluded. First rank has the highest value. Where the value was 0, ranks are based on order of local authority names.

Figure 8. Chlamydia detection rate per 100,000 population in 15-24 year olds in 16 similar local authorities and the North West PHE Centre, compared to England: 2018

Similar refers to statistical nearest neighbours, derived from [CIPFA's Nearest Neighbours Model](#)



In the five years from 2013 to 2018, there was a 28% increase in the chlamydia detection rate among 15-24 year olds in Wirral. From 2017, the increase was 29%.

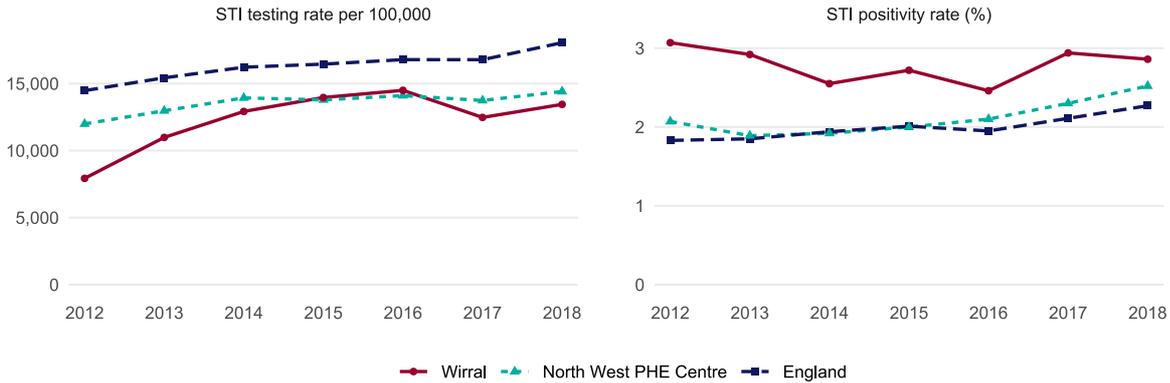
Figure 9. Chlamydia detection rate per 100,000 population in 15-24 year olds by year in Wirral, the North West PHE Centre and England



STI testing in sexual health services

In 2018 the rate of STI testing (excluding chlamydia in under 25 year olds) in sexual health services in Wirral was 13,448 per 100,000 aged 15 to 64 years, a 8% increase compared to 2017. This is worse than the rate of 18,053 per 100,000 in England in 2018. The positivity rate in Wirral was 2.9% in 2018, higher than 2.3% in England.

Figure 10. STI testing rate and positivity rate (excluding chlamydia in under 25 year olds) per 100,000 population aged 15-64 years by year in Wirral, the North West PHE Centre and England: 2012 to 2018



Other infections transmitted sexually

Other infections can be spread through sexual intercourse in addition to other routes, e.g. hepatitis B, hepatitis C and some infections are spread faecal-orally during sexual activity - termed sexually transmissible enteric infections (STEI) e.g. hepatitis A and *Shigella*.

In 2016 an outbreak of hepatitis A was identified among MSM in England and across Europe. Between July 2016 and April 2017 266 cases associated with the outbreak had been identified in England, 74% of these among MSM.⁵ This resulted in work to raise awareness of how to prevent infection through hygiene measures (e.g. washing hands after sex)⁶ and recommendations around hepatitis A vaccination of MSM attending sexual health services. This outbreak highlights how quickly and widely an infection can become established in at risk groups if prevention measures such as vaccination are not undertaken.

Over the last decade, the number of *Shigella* cases among MSM in England has increased. *Shigella* among MSM is an example of a STEI associated with higher risk behaviours, such as 'chemsex' and multiple partners. Most MSM cases present to primary care rather than sexual health services. PHE and other agencies undertook activity to raise awareness among MSM of *Shigella* and how to avoid it between Spring and Summer 2017 in London, Brighton and Manchester.⁷ Only a minority of MSM are thought to be aware of *Shigella* and how to avoid it.

In England, hepatitis B is most often acquired sexually. Where information on risk exposures was recorded on acute and probable acute cases of hepatitis B, the most commonly reported risk was heterosexual exposure (55%), followed by sex between men (15%).⁸ Vaccination can prevent infection and is recommended for MSM, for individuals with multiple sexual partners and for individuals who place themselves at risk through sexual activity when travelling to high prevalence countries. Following recent clusters of acute hepatitis B in men who did not initially disclose sex with men, an enhanced surveillance questionnaire for acute hepatitis B cases was developed in 2017 to improve completeness of risk factor information on cases with undisclosed risk factors to support targeted control and prevention measures.

Most people in England acquire hepatitis C through injecting drug use.⁹ However, MSM are also a risk group for hepatitis C transmission. MSM living with diagnosed HIV, especially those reporting high risk sexual practices, are disproportionately affected by hepatitis C compared to HIV-negative MSM; therefore guidance for hepatitis C screening has been targeted towards this group.

HIV

Free and effective antiretroviral therapy (ART) in the UK has transformed HIV from a fatal infection into a chronic but manageable condition. People living with HIV in the UK can now expect to have a near normal life expectancy if diagnosed promptly and they adhere to treatment.

In 2017, an estimated 101,600 (95% credible interval 99,300-106,400) people were living with HIV infection in the UK¹⁰ and the UNAIDS 90:90:90 targets¹¹ have been met. An estimated 92% of people living with HIV in the UK were diagnosed, 98% of those diagnosed were on treatment, and 97% of those on treatment were virally suppressed. Overall, 87% of people living with HIV in 2017 had an undetectable viral load and were unable to pass on their infection.

A decline in new HIV diagnoses among gay and bisexual men has been observed for the past two years in the UK, following an earlier fall in underlying new HIV infections in this group that began in 2012.¹² The reduction in transmission highlights that combination HIV prevention is working. Current key components of combination HIV prevention in the UK include: condom provision, pre-exposure prophylaxis (PrEP), expanded HIV testing and prompt initiation of treatment after diagnosis (treatment as prevention).

New HIV diagnoses in both black African and black Caribbean heterosexuals in the UK have been decreasing steadily over the past 10 years. However, declines have been observed for the first time among non-black African and non-black Caribbean heterosexual men.

Despite these promising data, significant challenges remain. Though HIV testing activity at sexual health services nationally has continued to increase in 2017, and despite over 1.1 million people being tested for HIV in 2017, there were still many missed opportunities for testing identified. Nearly 350,000 sexual health services attendees were not offered a test for HIV in 2017, despite being recorded as eligible for testing. This includes over 10,000 gay and bisexual men and over 10,000 black African heterosexual men and women. Furthermore, although HIV partner notification and testing has one of the highest positivity rates of all HIV testing activities, the number of people known to have tested at sexual health services as a result of partner notification in 2017 was low.

The number of HIV diagnoses made at a late stage of infection in England has decreased over the decade. Despite this decline, the proportion of late diagnoses remained high in 2017, particularly in black African heterosexual men and women and those aged over 50 years.

With progressive strengthening of combination prevention, HIV transmission, AIDS and HIV-related deaths could be eliminated in the UK. The recent encouraging changes are dependent upon sustained prevention efforts. Combination prevention needs to be replicated for all those at risk of acquiring of HIV, whoever they are and wherever they live.

Figure 11. Chart showing key HIV indicators in Wirral UTLA compared to the rest of England

The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average, the diamond shows the average for the North West PHE Centre.

Compared to England:

● Better ● Similar ● Worse ● Lower ● Similar ● Higher ○ Not compared



Indicator names	Period	UTLA count	UTLA value	England value	England lowest/worst	England highest/best
HIV diagnosed prevalence rate / 1,000 aged 15-59	2017	212	1.2	2.3	14.6	0.4
New HIV diagnosis rate / 100,000 aged 15+	2017	13	4.9	8.7	44.6	0.0
HIV late diagnosis (%)	2015 - 17	13	50.0	41.1	68.6	16.7
HIV testing coverage, total (%)	2018	3,539	45.9	64.5	29.0	84.8
HIV testing coverage, MSM (%)	2018	318	90.1	87.8	56.1	95.5
HIV testing coverage, women (%)	2018	1,891	36.5	55.2	20.2	83.2
HIV testing coverage, men (%)	2018	1,641	65.7	78.4	41.2	88.0

People living with diagnosed HIV

In 2017, the number of Wirral residents aged 15-59 years who were seen at HIV services (the prevalence of diagnosed HIV) was 212. The diagnosed prevalence per 1,000 residents aged 15-59 years was 1.2, better than 2.3 per 1,000 in England). The rank of Wirral was 102nd highest (out of 150 UTLAs). Since 2016, the increase in Wirral was 6%; in the 5 years since 2012, the increase was 38%.

Figure 12. Diagnosed HIV prevalence per 1,000 population aged 15-59 years by year in Wirral compared to rates in the North West PHE Centre and England: 2010 to 2017.

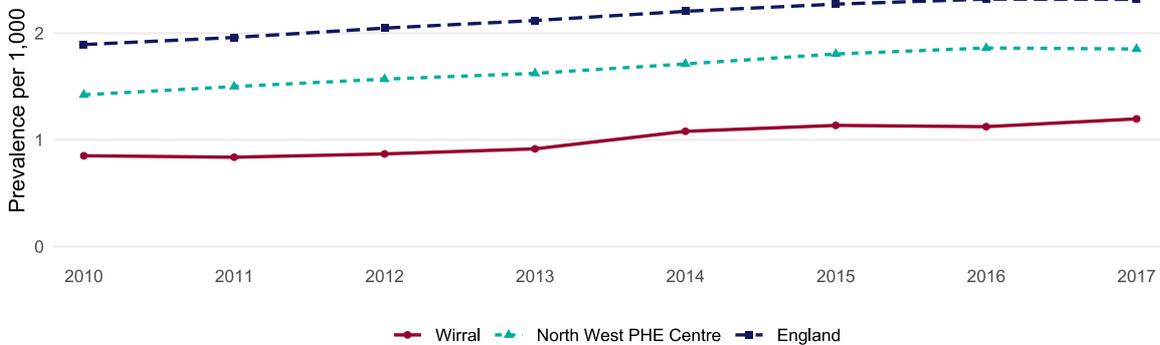
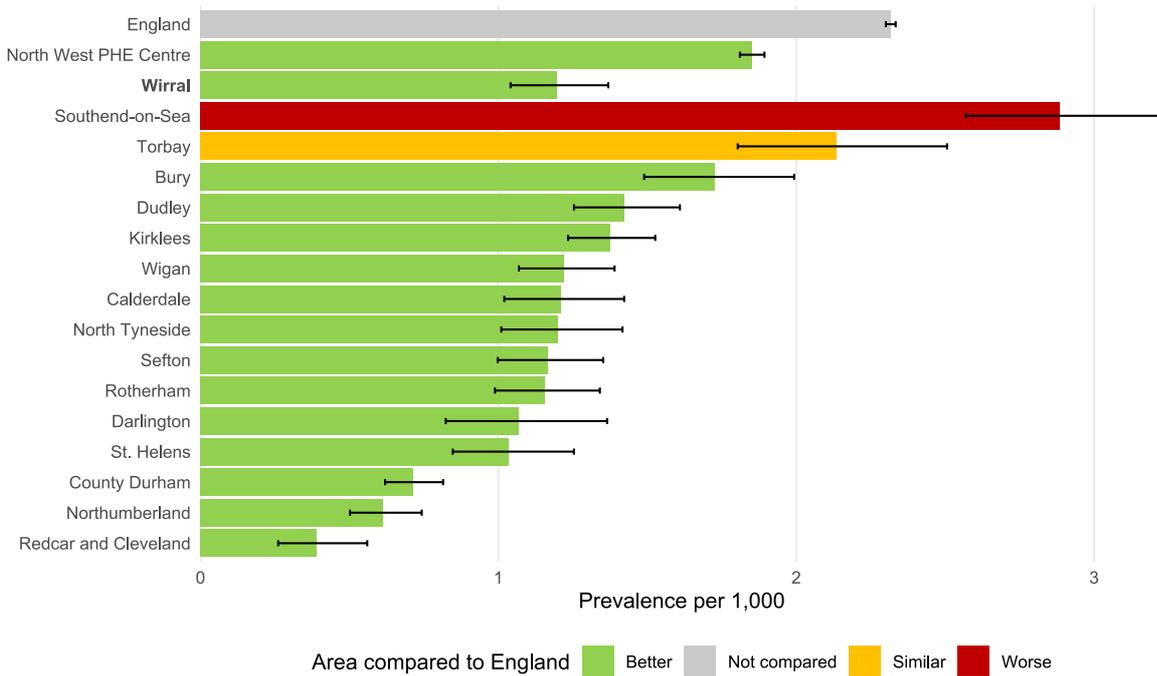


Figure 13. Diagnosed HIV prevalence per 1,000 population aged 15-59 years in 16 similar local authorities and the North West PHE Centre, compared to England: 2017

Similar refers to statistical nearest neighbours, derived from [CIPFA's Nearest Neighbours Model](#)



New HIV diagnoses

In 2017, the number of Wirral residents aged 15 years and older who were newly diagnosed with HIV was 13. The rate of new diagnoses per 100,000 residents was 4.9, better than the rate of 8.7 per 100,000 in England. This represented a 160% increase since 2016 and a 18% increase in the 5 years since 2012. The rank of Wirral for new the rate of HIV diagnoses was 96th highest (out of 150 UTLAs).

Figure 15. Rate of new HIV diagnoses per 100,000 population among people aged 15 years or above by year in Wirral compared to rates in the North West PHE Centre and England: 2011 to 2017.

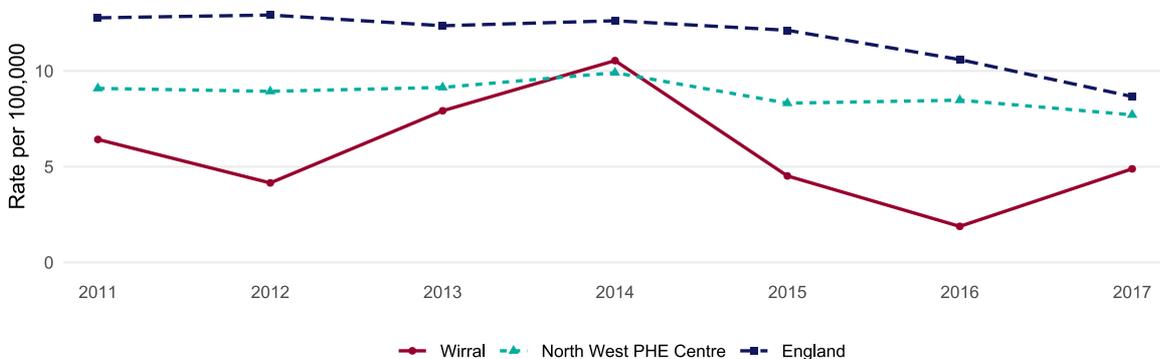
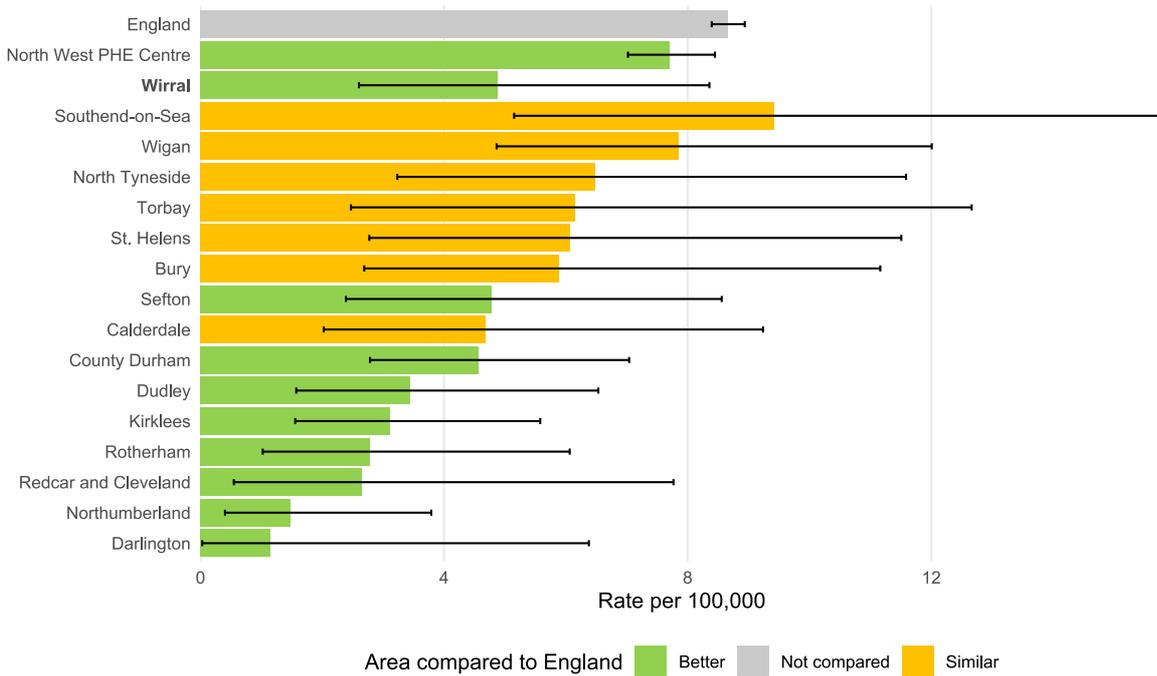


Figure 16. New HIV diagnoses rate per 100,000 population aged 15 years and above in 16 similar local authorities and the North West PHE Centre, compared to England: 2017

Similar refers to statistical nearest neighbours, derived from [CIPFA's Nearest Neighbours Model](#)



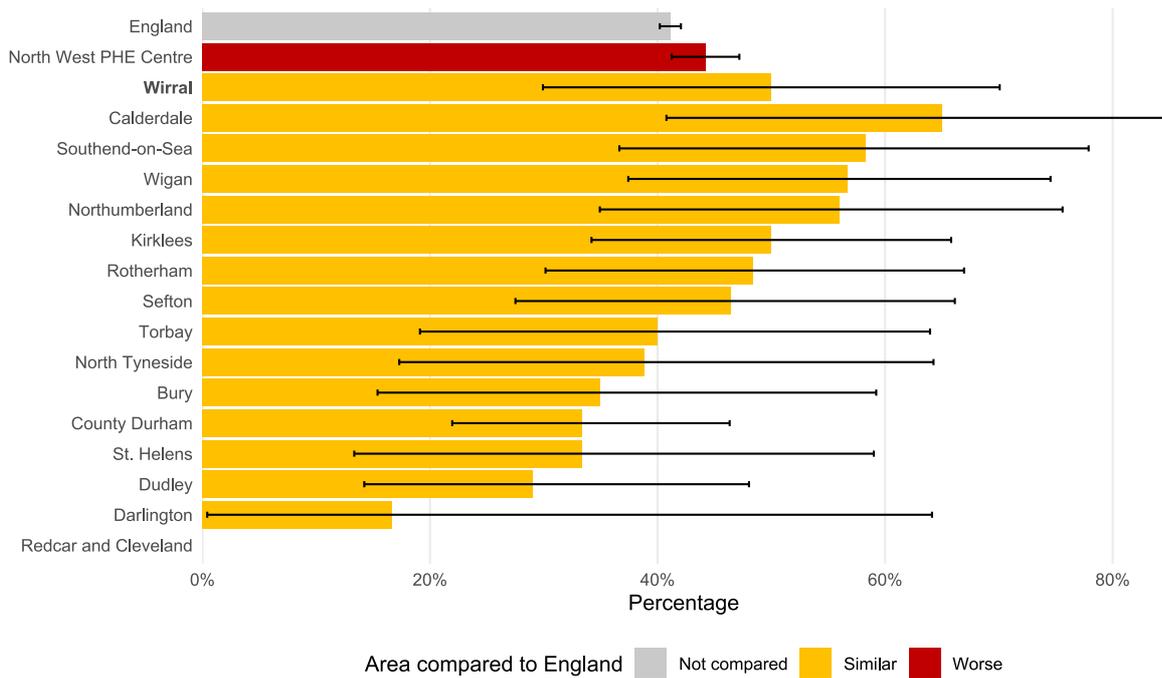
Late HIV diagnosis

Late diagnosis is the most important predictor of HIV-related morbidity and short-term mortality. It is a critical component of the PHOF, and monitoring is essential to evaluate the success of local HIV testing efforts. Diagnoses made at a late stage of infection are defined as having a CD4 cell count less than 350 cells per mm³ within three months of diagnosis.

In Wirral, the percentage of HIV diagnoses made at a late stage of infection in 2015 - 17 was 50.0% (95% CI 29.9 to 70.1), similar to 41.1% (95% CI 40.2 to 42.1) in England.

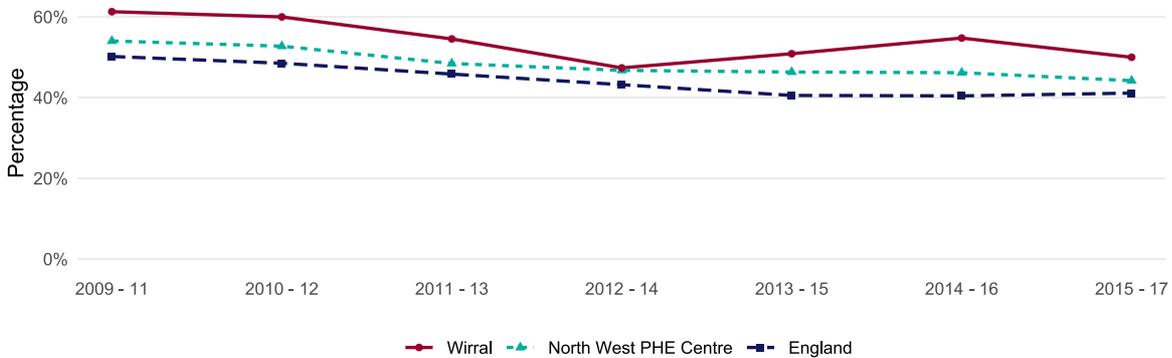
Figure 17. Percentage of late HIV diagnoses in 16 similar local authorities and North West PHE Centre, compared to England: 2015 - 17

Similar refers to statistical nearest neighbours, derived from [CIPFA's Nearest Neighbours Model](#)



Value suppressed for 1 local authority.

Figure 18. Percentage of late HIV diagnoses in Wirral compared to the North West PHE Centre and England: 2009-11 to 2015-17



HIV testing

In 2018, the percentage of eligible SHS attendees in Wirral who received an HIV test was 45.9%, worse than 64.5% for England. This represented a 30% decrease since 2017, and a 121% increase since 2013.

Table 4. Coverage of HIV testing among eligible patients at specialist SHSs Wirral, North West PHE Centre and England: 2018

	2017	2018	% change 2017 to 2018*	Rank among 16 similar UTLAs†	Rank within England: 2018‡	Value for England: 2018
Total	65.2	45.9	-29.6%	12	133	64.5
Women	55.7	36.5	-34.5%	12	131	55.2
Men	78.0	65.7	-15.8%	12	138	78.4
MSM	86.8	90.1	3.8%	7	43	87.8

When calculating these rates, eligibility for HIV testing is determined by reviewing previous HIV diagnosis and testing history for each patient. Those who are known to be HIV positive, based on their GUMCADv2 history, are not considered eligible for testing. Those who have been tested already are not considered eligible to be tested again until six weeks have passed (i.e. eligibility for testing occurs only once every six weeks).

* Percent change proportional to the value in 2017, not a change in percentage points. Percent change not provided where the value in 2017 was 0. Calculated from unrounded values.

† These are Wirral and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from [CIPFA's Nearest Neighbours Model](#).

‡ Out of 150 upper-tier (county) local authorities in England, excluding those where values were suppressed due to small numbers. City of London and Isles of Scilly are always excluded. First rank has the highest value. Where the value was 0, ranks are based on order of local authority names.

Reproductive health

Unplanned pregnancy

Unplanned pregnancies can end in abortion or maternity. Many unplanned pregnancies that continue will become wanted. However, unplanned pregnancy can cause financial, housing and relationship pressures and have impacts on existing children. Restricting access to contraceptive provision by age can therefore be counterproductive and ultimately increase costs.

The Third National Survey of Sexual Attitudes and Lifestyles (NATSAL-3), which was carried out in Britain in 2010-12, found that 16.2% of all pregnancies in the year before the study interview were unplanned. This survey found that:

- Pregnancies among 16-19 year olds accounted for 7.5% of the total number of pregnancies, but 21.2% of the total number that were unplanned.
- The highest numbers of unplanned pregnancies occur in the 20-34 year age group.
- 42% of the unplanned pregnancies ended in an abortion, 32% ended in a miscarriage and 25% went on to a full term pregnancy.

The survey included a pregnancy analysis of 5,686 women aged 16-44 years. The survey used a psychometrically-validated London Measure of Unplanned Pregnancy (LMUP), which assigned a score to each multiple choice answer, to questions on contraceptive use and intention of getting pregnant. The total score of 0-3 is categorised as unplanned, 4-9 as ambivalent and 10-12 as planned. The survey estimated that 54.8% (95% CI 50.3-59.2) of pregnancies were planned. The remaining 45.2% of pregnancies were described as 29.0% (95% CI 25.2-33.2) ambivalent and 16.2% (95% CI 13.1-19.9) unplanned.

Abortion

The total abortion rate, under 25 years repeat abortion rate, under 25 years abortions after a birth, and over 25 years abortion rates are indicators of lack of access to good quality contraception services and advice, as well as problems with individual use of contraceptive method.

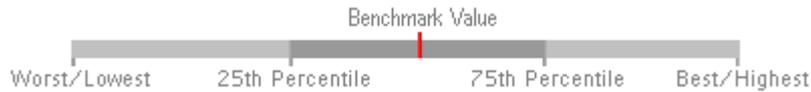
In Wirral the total number of abortions in 2017 was 1,236. The total abortion rate per 1,000 female population aged 15-44 years was 22.7, higher than the rate in England of 17.2 per 1,000. The rank (out of 149 UTLAs) within England for the total abortion rate was 15th highest.

Figure 19. Chart showing key abortion indicators in Wirral UTLA compared to the rest of England

The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average, the diamond shows the average for the North West PHE Centre.

Compared to England:

- Better
- Similar
- Worse
- Lower
- Similar
- Higher
- Not compared



Indicator names	Period	UTLA count	UTLA value	England value	England lowest/worst	England highest/best
Total abortion rate / 1,000	2017	1,236	22.7	17.2	26.4	10.7
Under 18s abortions rate / 1,000	2017	68	12.6	8.4	2.4	15.4
Over 25s abortion rate / 1,000	2017	701	18.2	15.0	23.8	9.0
Under 25s repeat abortions (%)	2017	149	27.9	26.7	39.0	13.9
Under 25s abortion after a birth (%)	2017	172	32.2	26.7	52.7	9.3

Table 5. Abortion figures in Wirral and England: 2017

	2016	2017	% change 2016 to 2017*	Rank among 16 similar UTLAs†	Rank within England: 2017‡	Value for England: 2017
Rates						
Total abortion rate / 1,000	21.5	22.7	5.2%	1	15	17.2
Under 18s abortions rate / 1,000	12.2	12.6	3.1%	2	15	8.4
Over 25s abortion rate / 1,000	17.9	18.2	1.7%	2	36	15.0
Percentages						
Under 25s repeat abortions (%)	30.9	27.9	-9.9%	6	58	26.7
Under 25s abortion after a birth (%)	33.9	32.2	-5.3%	10	39	26.7

* Percent change proportional to the value in 2016, not a change in percentage points. Percent change not provided where the value in 2016 was 0. Calculated from unrounded values.

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‡ Out of 150 upper-tier (county) local authorities in England, excluding those where values were suppressed due to small numbers. City of London and Isles of Scilly are always excluded. First rank has the highest value. Where the value was 0, ranks are based on order of local authority names.

Figure 20. Abortion rates per 1,000 women by age in Wirral compared to the North West PHE Centre and England: 2012 to 2017

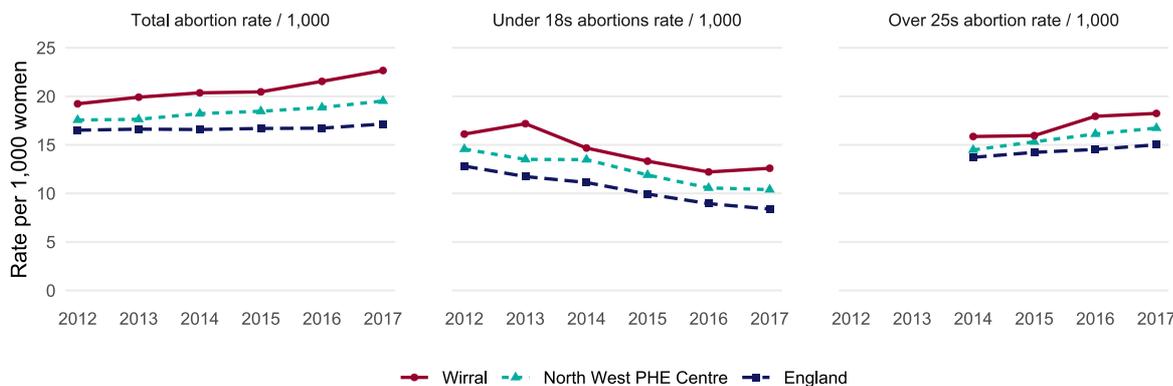


Figure 21. Characteristics of abortions over time in Wirral compared to the North West PHE Centre and England: 2012 to 2017

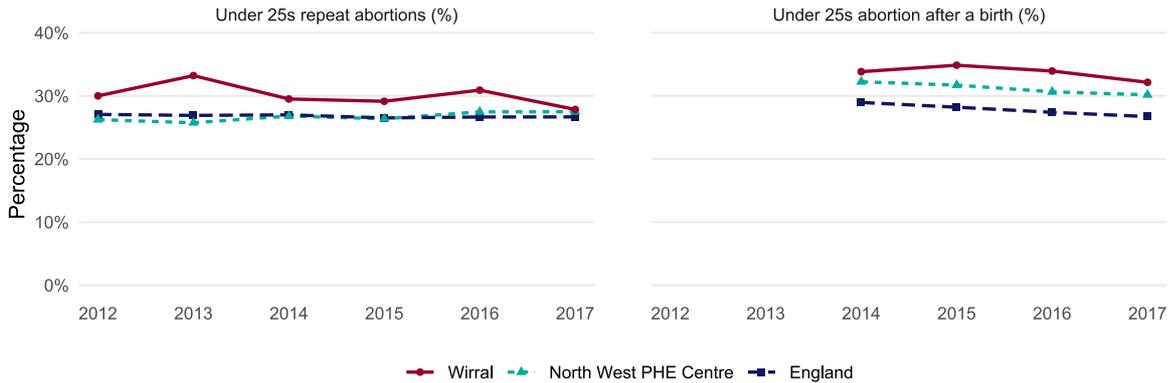
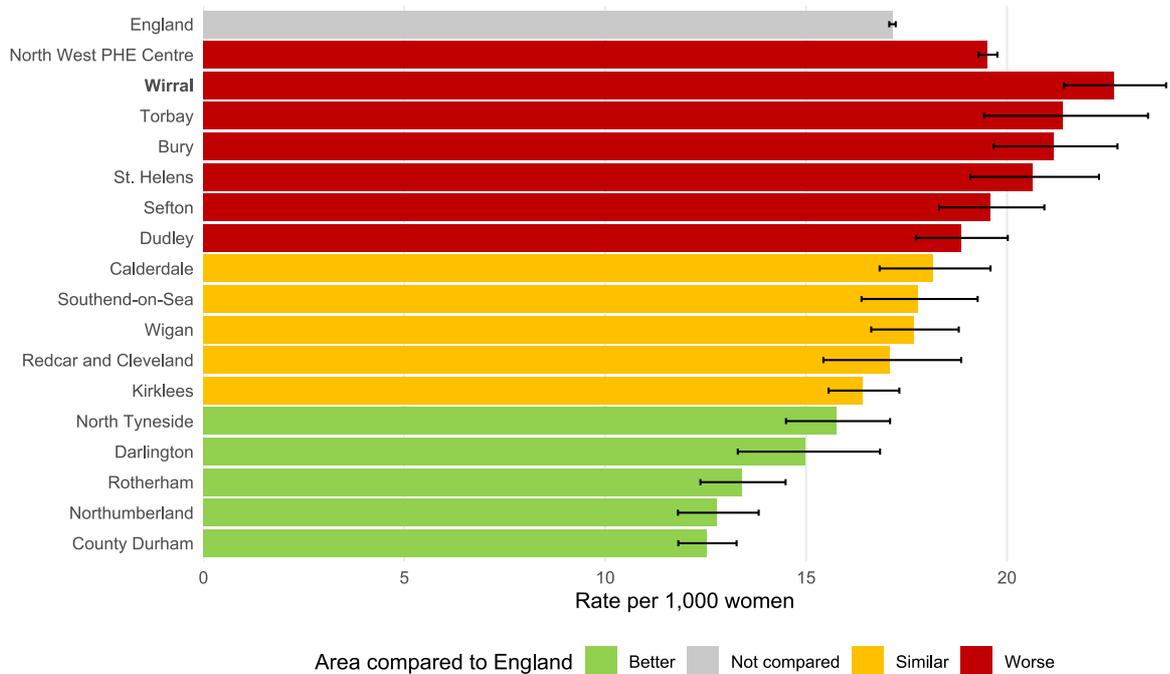


Figure 22. Abortion rate per 1,000 women in 16 similar local authorities and North West PHE Centre, compared to England: 2017

Similar refers to statistical nearest neighbours, derived from [CIPFA's Nearest Neighbours Model](#)



The earlier abortions are performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, is also cost-effective and an indicator of service quality.

In Wirral, the percentage of NHS-funded abortions that were under 10 weeks was 83.8% in 2017, better than the percentage in England of 76.6. The rank within England for this indicator was 5th highest (out of 149 UTLAs).

The choice of early medical abortion as a method of abortion is likely to have contributed to the increase in the overall England percentage of abortions performed at under 10 weeks gestation. Early medical abortion is less invasive than a surgical procedure and carries less risk as it does not involve

instrumentation or the use of anaesthetics. Medical abortions are also cheaper than surgical interventions.

However, women may prefer a surgical abortion under local or general anaesthesia/conscious sedation for a variety of reasons such as: wishing to avoid the experience of going through an induced pregnancy loss; intrauterine contraception can be fitted per procedure; only one visit would be required to the provider site for the procedure (medical abortions typically require two trips) which may be more feasible in terms of travel, work commitments, home caring responsibilities or financial implications.

There is also a new manual vacuum aspiration (MVA) technique which is a quicker and cheaper surgical procedure that does not require an anaesthetic.

The following indicator relating to the use of medical procedures will help to improve transparency at a local level on the extent of medical and surgical services available to women, and will thus be an indicator of patient choice. A very low or a very high percentage of medical abortions compared to other areas could be an issue for concern.

Among NHS-funded abortions in Wirral, the percentage of those under 10 weeks gestation that were performed using a medical procedure in 2017 was 90.9%, higher than the percentage in England of 79.4%. The rank within England for this indicator was 17th highest (out of 149 UTLAs).

Table 6. Abortion figures for Wirral and England: 2017

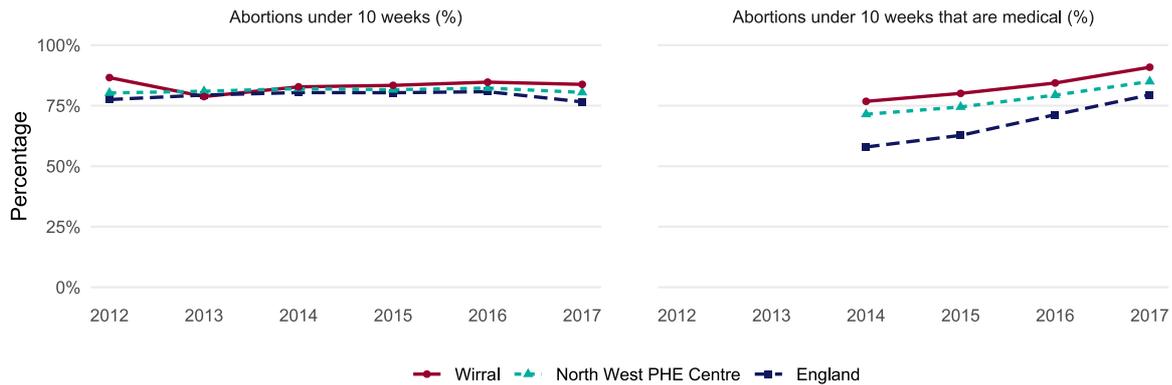
	2016	2017	% change 2016 to 2017*	Rank among 16 similar UTLAs†	Rank within England: 2017‡	Value for England: 2017
Abortions under 10 weeks (%)	84.7	83.8	-1.1%	1	5	76.6
Abortions under 10 weeks that are medical (%)	84.4	90.9	7.7%	7	17	79.4

* Percent change not provided where the value in 2016 was 0. Calculated from unrounded values.

† These are Wirral and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from [CIPFA's Nearest Neighbours Model](#).

‡ Out of 150 upper-tier (county) local authorities in England, excluding those where values were suppressed due to small numbers. City of London and Isles of Scilly are always excluded. First rank has the highest value. Where the value was 0, ranks are based on order of local authority names.

Figure 23. Early abortion over time in Wirral compared to the North West PHE Centre and England: 2012 to 2017



Teenage conception

Teenage pregnancy is a cause and consequence of education and health inequality for young parents and their children. Most recent data show that babies born to mothers under 20 years have a 30% higher rate of stillbirth than average and a 60% higher rate of infant mortality.¹³ Rates of low birthweight in younger mothers were 30% higher than average, and this inequality is increasing. Children born to teenage mothers have a 63% higher risk of living in poverty.¹⁴ Mothers under 20 years have a 30% higher risk of poor mental health 2 years after giving birth.¹⁵

This affects their own wellbeing, and their ability to form a secure attachment with their baby, recognised as a key foundation stone for positive child outcomes.¹⁶ Teenage mothers are more likely than other young people to not be in education, employment or training; and by the age of 30 years,¹⁷ are 22% more likely to be living in poverty than mothers giving birth aged 24 years or over.¹⁸ Young fathers are twice as likely to be unemployed aged 30 years, even after taking account of deprivation.¹⁹ Recent analysis of the Next Steps data shows that some of these poor outcomes, notably poor mental health, are also experienced by young parents up to the age of 25 years.²⁰

Since the introduction of the Teenage Pregnancy Strategy in 1999, England has achieved a 61.8% reduction in the under-18 conception rate between 1998 and 2017. The rate of 17.8/1,000 is currently at the lowest level since conception data was first recorded in 1969, with the greatest reductions in the most deprived areas. There has also been a doubling in the proportion of young mothers in education, training or employment.²¹ The success of the Strategy's approach has been recognised by the World Health Organization with the lessons being shared internationally with countries seeking to address high rates.²²

However, despite the significant progress, England's teenage birth rate remains higher than comparable Western countries,²³ and inequalities in the under-18 conception rate persist between and within local areas. Over a quarter of local

authorities have an under-18s conception rate significantly higher than the England average and 60% have at least one high rate ward. Further progress in both reducing the under-18s conception rate and improving the outcomes for young parents is central to improving young people's sexual health and narrowing the health and educational inequalities experienced by young parents and their children. Maintaining the downward trend is a priority in the Department of Health Framework for Sexual Health Improvement in England²⁴ and key to PHE priorities, including reducing health inequalities, ensuring every child gets the best start in life and improving sexual and reproductive health. The PHOF includes the under-18 conception rate and a number of other indicators disproportionately affecting young parents and their children.

International evidence identifies the provision of high quality, comprehensive relationships and sex education (RSE) linked to improved use of contraception as the areas where the strongest empirical evidence exists on impact on teenage pregnancy rates.^{25 26 27} RSE also has wider safeguarding and health benefits but to have impact, provision needs to reflect the internationally recognised effectiveness factors.^{28 29} From September 2020, new legislation requires all primary schools to provide relationships education, all secondary schools to provide relationships and sex education and both primary and secondary schools to provide health education, including puberty. Statutory guidance for schools was published in June 2019.³⁰ This includes specific reference to ensuring all secondary school pupils know about local services providing confidential SRH advice and care.

Contraceptive services need to be accessible and youth friendly to encourage early uptake of advice, with consultations that recognise and address any knowledge gaps about fertility and concerns about side effects, and support young people to choose and use their preferred method. An open and honest culture around sex and relationships is also associated with lower teenage pregnancy rates. Countries with more open approaches to young people's sexual health, as assessed by better RSE, more parental communication and more accessible contraceptive services, have lower conception rates.³¹

Measures to reduce teenage pregnancy need to be both universal and targeted. Although two-thirds of young people do not have sex before 16 years, by 20 years, 85% will have experienced vaginal intercourse,³² so all young people need good RSE and access to services to prevent early pregnancy and to look after their sexual health. Universal prevention programmes are also essential to reduce rates by a substantial margin.³³ Some young people, however, will be at greater risk of early pregnancy and require more intensive RSE and contraceptive support, combined with programmes to build resilience and aspiration, providing the means and the motivation to prevent early pregnancy. Reaching young people most in need involves looking at area and individual level associated risk factors. Child poverty and unemployment are the two area deprivation indicators with the strongest influence on under-18 conception rates.³⁴ At an individual level, the strongest associated factors for pregnancy before 18 years are free school meal eligibility, persistent school absence by age 14 years, poorer than expected academic progress between ages 11-14 years, and being looked after or a care

leaver.^{35 36 37} Other associated risk factors include first sex before 16 years, experience of sexual abuse or exploitation, alcohol, and experience of a previous pregnancy.^{38 39 40 41} As with Adverse Childhood Experiences, young people who have experienced a number of these factors will be at significantly higher risk.⁴² Local information on these risk factors, can be found, where available, on the [SRH profiles](#).

Teenagers are more likely to present late for abortion and to book late for antenatal care.⁴³ The higher risk of unplanned pregnancy, late confirmation of pregnancy and fear of disclosure, all contribute to delays in accessing abortion and maternity services.⁴⁴ Early pregnancy diagnosis, unbiased advice on pregnancy options and swift referral to maternity or abortion services are required to minimise delays.⁴⁵ Young people who have experienced pregnancy are also at higher risk of subsequent unplanned conceptions.⁴⁶ An estimated 12% of births conceived to under-20s are to young women who are already teenage mothers. Ten per cent of under-19s having an abortion have had one or more previous abortions, but this percentage varies significantly between local areas.⁴⁷ Advice on contraception during abortion or antenatal care and access to the chosen method immediately post pregnancy helps reduced unplanned conceptions.⁴⁸

Figure 24. Chart showing teenage conception indicators in Wirral UTLA compared to the rest of England

The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average, the diamond shows the average for the North West PHE Centre.

Compared to England:

● Better ● Similar ● Worse ● Lower ● Similar ● Higher ○ Not compared



Indicator names	Period	UTLA count	UTLA value	England value	England lowest/worst	England highest/best
Under 18s conception rate / 1,000	2017	111	20.5	17.8	43.8	6.1
Under 16s conception rate / 1,000	2017	23	4.4	2.7	10.6	0.0
Under 18s births rate / 1,000	2016	37	6.7	5.6	15.6	1.0
Teenage mothers	2017/18	30	1.0	0.7	2.1	0.2
Under 18s conceptions leading to abortion (%)	2017	71	64.0	52.0	27.8	81.0

In 2017, the under-18s conception rate per 1,000 females aged 15-17 years in Wirral was 20.5, similar to the rate of 17.8 per 1,000 in England. The decrease from 2016 was 22%. The rank within England for the under-18s conception rate was 53rd highest (out of 150 UTLAs). Between 1998 and 2017, the decrease in the under-18s conception rate in Wirral was 59%, compared to a 62% decrease in England.

Figure 25. Under-18s conception rate per 1,000 women in 16 similar local authorities and the North West PHE Centre, compared to England: 2017

Similar refers to statistical nearest neighbours, derived from [CIPFA's Nearest Neighbours Model](#)

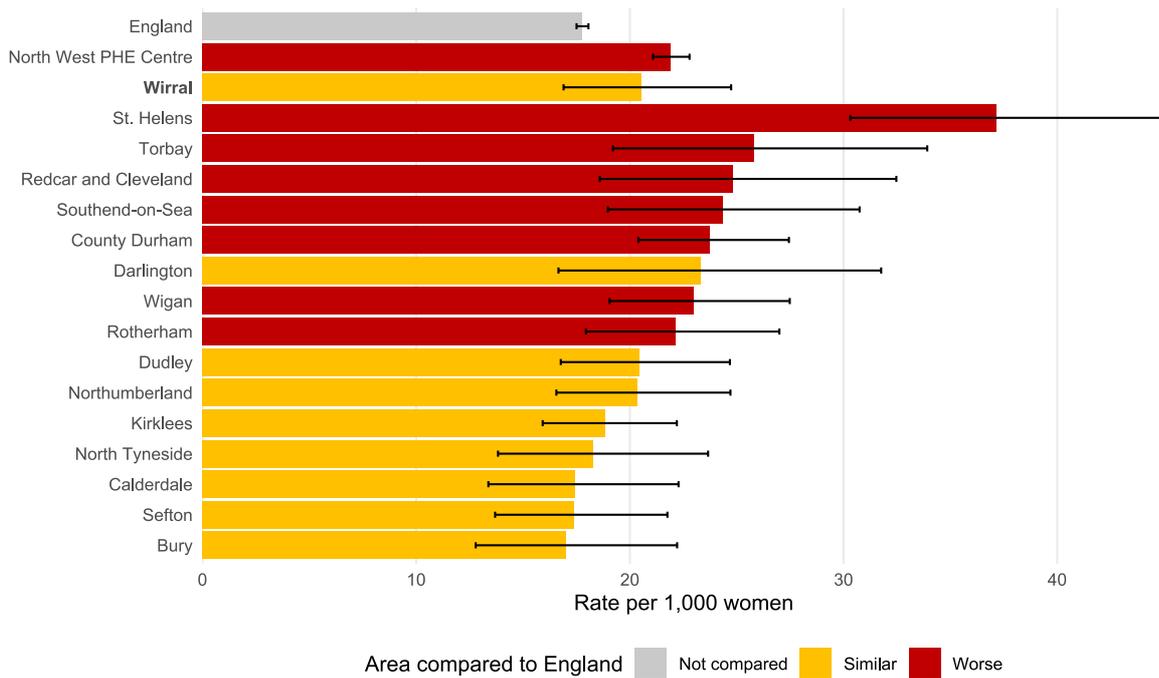
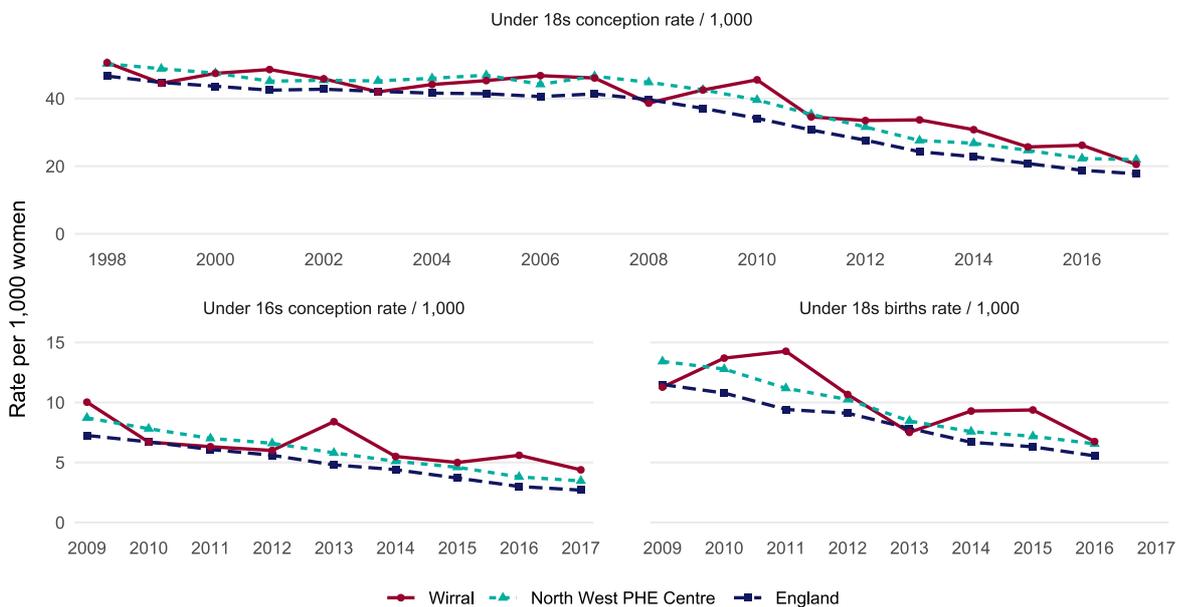


Figure 26. Rates of teenage conception and births over time in Wirral compared to the North West PHE Centre and England



Among the under-18 conceptions in Wirral, the percentage of those leading to abortion in 2017 was 64.0%, higher than the percentage in England of 52.0%. The rank for the percentage of conceptions leading to abortion in Wirral was 27th highest (out of 150 UTLAs).

Figure 27. Percentage of under-18 conceptions leading to abortion over time in Wirral compared to the North West PHE Centre and England: 1998 to 2017

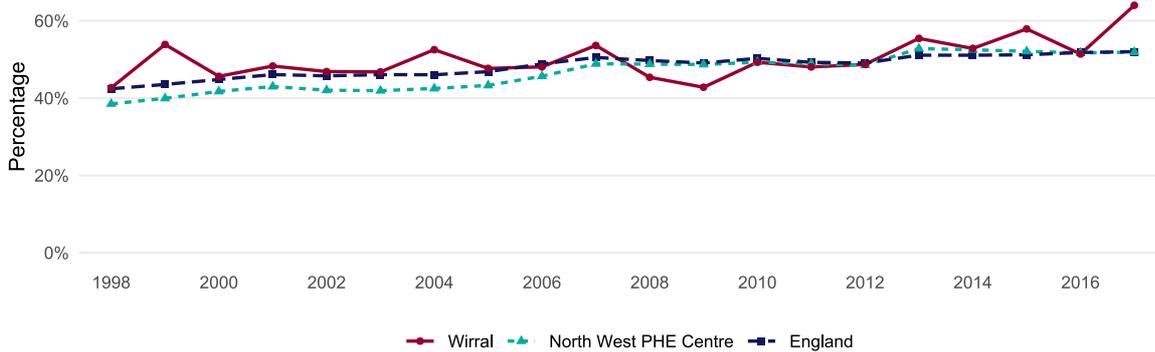


Figure 28. Percentage of births where the mother is aged under 18 over time in Wirral compared to the North West PHE Centre and England: 2010/11 to 2017/18

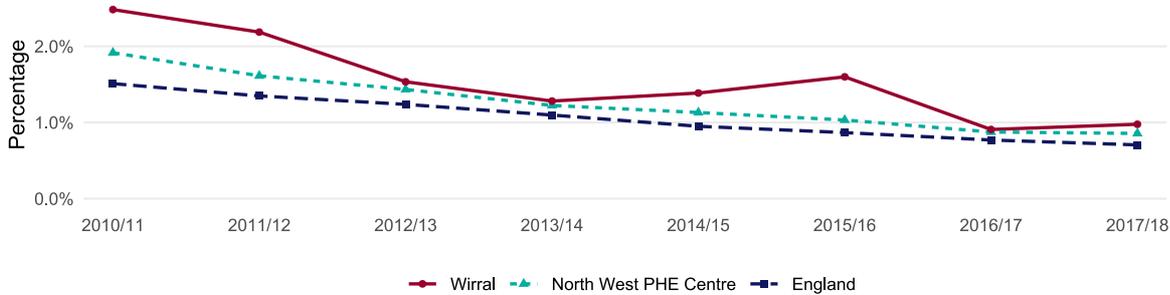


Table 7. Teenage conception and birth figures in Wirral and England: 2017

	2016	2017	% change 2016 to 2017*	Rank among 16 similar UTLAs†	Rank within England: 2017‡	Value for England: 2017
Under 18s conception rate / 1,000	26.2	20.5	-21.6%	9	53	17.8
Under 16s conception rate / 1,000	5.6	4.4	-21.6%	4	22	2.7
Under 18s conceptions leading to abortion (%)	51.4	64.0	24.5%	1	26	52.0

* Percent change not provided where the value in 2016 was 0. Calculated from unrounded values.

† These are Wirral and its 15 statistical nearest neighbours, excluding those where values were suppressed due to small numbers. First rank has the highest value. Nearest neighbours are derived from [CIPFA's Nearest Neighbours Model](#).

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Contraception

The government and the Faculty of Sexual and Reproductive Healthcare (FSRH) both highlight the importance of knowledge, access and choice for all women and men to all methods of contraception to help reduce unwanted pregnancies. Good contraception services have been shown to lower rates of teenage conceptions.

Contraception is widely available in the UK from a number of sources, and is provided free by the NHS for women and men of all ages. Contraception is available free of charge from: general practices, level 2 sexual and reproductive health (SRH) services, young person's clinics, NHS walk-in centres (emergency contraception only), some specialist sexual health services (emergency contraception and male condoms) and some pharmacists under a Patient Group Direction (usually only emergency contraception, condoms and chlamydia testing). Provision of contraception at the time of abortion is recommended practice and is almost always commissioned as part of this service; a significant proportion of this is thought to be the most effective long acting reversible contraception (LARC) methods (implants, intra-uterine systems [IUS] and intrauterine devices [IUD] but not injections).

Condoms are not prescribable on the NHS, and are therefore not available from prescription data from GPs. Condoms can be purchased from pharmacies, supermarkets, and other retailers and are free at sexual health services as well as for young people through condom distribution schemes. Around 85% of local authorities provide a c-card or other condom distribution scheme. Emergency hormonal contraception (levonorgestrel and ulipristal acetate) may be provided free through pharmacy depending on commissioning arrangements and is also available for over the counter purchase at some pharmacies and private clinics.

Currently, data on contraception provision are only centrally collected from specialist sexual health services, level 2 SRH services and some young person's clinics through the Sexual and Reproductive Health Activity Dataset (SRHAD) and from NHS prescription forms within primary care. Data sources used in this report are SRHAD and Prescribing Analysis Cost Tabulation (PACT). PACT data is available by number of prescriptions and is therefore a more useful indicator of use for LARC than short acting methods that require repeated prescription. However, there is no way of measuring method continuation, so the LARC data reflects method initiation only. The way in which this report presents total amount of contraception used in England should therefore be interpreted with care.

Attendance indicators provide a measure of young people's access to specialist contraceptive services. The indicators are split by sex and unique attendances because there are different patterns of service access and recording relating to each sex. Females access services more than males, and make more repeated visits in a year.

Figure 30. Chart showing key contraception indicators in Wirral UTLA compared to the rest of England

The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average, the diamond shows the average for the North West PHE Centre.

Compared to England:

● Better ● Similar ● Worse ● Lower ● Similar ● Higher ○ Not compared



Indicator names	Period	UTLA count	UTLA value	England value	England lowest/worst	England highest/best
Under 25s individuals attend specialist contraceptive services rate / 1,000 - Females	2017	5,990	371.8	142.0	6.4	397.9
Under 25s individuals attend specialist contraceptive services rate / 1,000 - Males	2017	1,411	81.1	15.5	0.5	81.1
Women choose injections at SRH Services (%)	2017	1,207	15.7	9.6	3.3	22.4
Women choose user-dependent methods at SRH Services (%)	2017	4,793	62.4	60.6	43.5	78.3
Women choose hormonal short-acting contraceptives at SRH Services (%)	2017	3,835	49.9	45.3	28.5	70.8
Under 25s choose LARC excluding injections at SRH Services (%)	2017	560	13.1	21.6	9.5	41.0
Over 25s choose LARC excluding injections at SRH Services (%)	2017	1,123	32.8	38.0	19.7	59.6
Total prescribed LARC excluding injections rate / 1,000	2017	2,435	44.6	47.4	7.0	85.8
GP prescribed LARC excluding injections rate / 1,000	2017	951	17.4	29.2	0.0	61.0
SRH Services prescribed LARC excluding injections rate / 1,000	2017	1,484	27.2	18.2	0.5	50.3

Attendance and service provision at sexual and reproductive health (SRH) clinics

Table 8. Attendance at specialist contraceptive services per 1,000 residents under 25 by gender, in Wirral and England: 2017

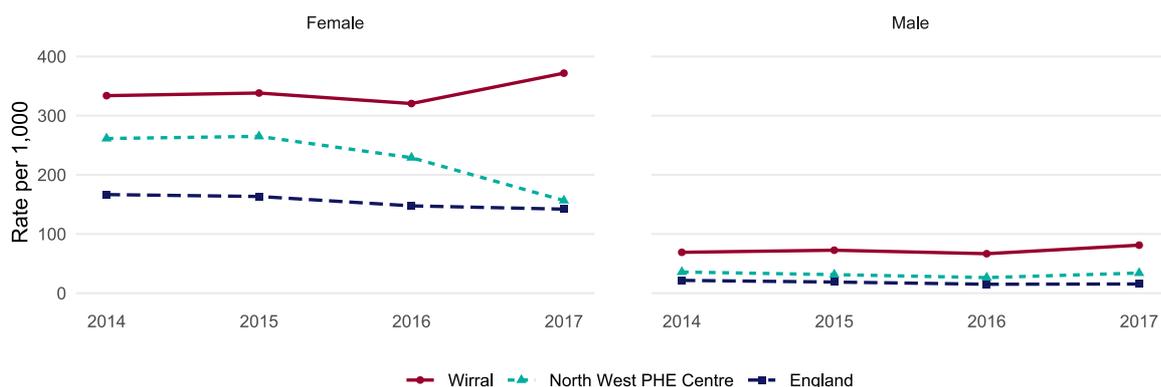
	2016	2017	% change 2016 to 2017*	Rank among 16 similar UTLAs†	Rank within England: 2017‡	Value for England: 2017
Under 25s individuals attend specialist contraceptive services rate / 1,000 - Females	320.4	371.8	16.0%	2	3	142.0
Under 25s individuals attend specialist contraceptive services rate / 1,000 - Males	66.7	81.1	21.7%	1	1	15.5

* Percent change not provided where the value in 2016 was 0. Calculated from unrounded values.

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Figure 31. Attendance at specialist contraceptive services among under 25s by gender, in Wirral compared to the North West PHE Centre and England: 2014 to 2017



Contraceptive care

Table 9. Women's choice of contraception at SRH services in Wirral and England: 2017

	2016	2017	% change 2016 to 2017*	Rank among 16 similar UTLAs†	Rank within England: 2017‡	Value for England: 2017
Women choose injections at SRH Services (%)	12.3	15.7	27.6%	4	14	9.6
Women choose user-dependent methods at SRH Services (%)	66.8	62.4	-6.6%	6	55	60.6
Women choose hormonal short-acting contraceptives at SRH Services (%)	52.4	49.9	-4.7%	5	33	45.3
Under 25s choose LARC excluding injections at SRH Services (%)	13.7	13.1	-4.4%	15	144	21.6
Over 25s choose LARC excluding injections at SRH Services (%)	30.2	32.8	8.6%	11	122	38.0

* Percent change proportional to the value in 2016, not a change in percentage points. Percent change not provided where the value in 2016 was 0. Calculated from unrounded values.

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Focus on long-acting reversible contraceptives (LARCs)

The total rate of long-acting reversible contraception (LARC) (excluding injections) prescribed in Wirral primary care, specialist and non-specialist sexual health services was 44.6 per 1,000 women aged 15-44 years in 2017, lower than the rate of 47.4 per 1,000 women in England.

The rate prescribed in primary care was 17.4 in 2017, lower than the rate of 29.2 in England. The rate prescribed in the other settings was 27.2 in 2017, higher than the rate of 18.2 in England.

Table 10. Rate of LARCs (excluding injections) prescribed per 1,000 women aged 15-44 years by setting, Wirral and England: 2017

	2016	2017	% change 2016 to 2017*	Rank among 16 similar UTLAs†	Rank within England: 2017‡	Value for England: 2017
Total prescribed LARC excluding injections rate / 1,000	38.0	44.6	17.5%	10	80	47.4
GP prescribed LARC excluding injections rate / 1,000	16.1	17.4	8.2%	10	98	29.2
SRH Services prescribed LARC excluding injections rate / 1,000	21.9	27.2	24.5%	6	24	18.2

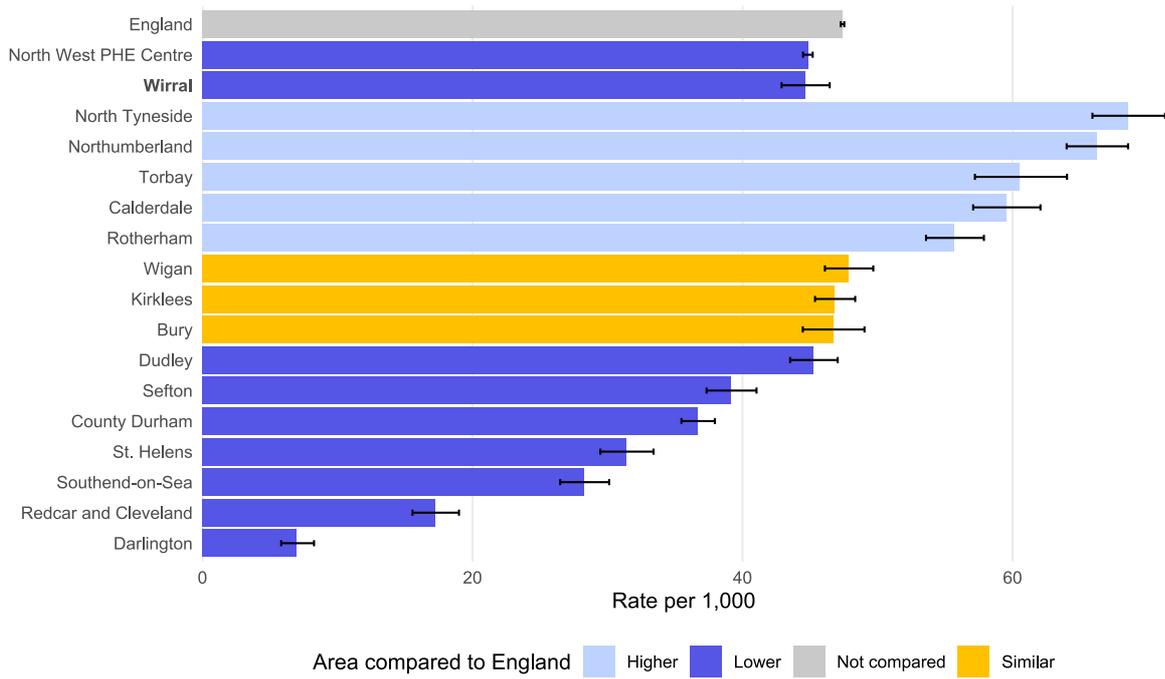
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Figure 33. Total rate of LARC (excluding injections) prescribed in primary care and in SRH services per 1,000 women aged 15-44 years in 16 similar local authorities and the North West PHE Centre, compared to England: 2017

Similar refers to statistical nearest neighbours, derived from [CIPFA's Nearest Neighbours Model](#)



National recommendations

- Local authorities are responsible for providing comprehensive, open access sexual health services. The prioritisation and provision of appropriate services can be shaped locally via Joint Strategic Needs Assessments, and guided by the PHOF⁴⁹ and Framework for Sexual Health Improvement.
- Local epidemiological STI, HIV, contraception, conception and abortion data can be employed to inform JSNAs, service commissioning and provision, and to make the case for prioritisation of sustained investment in prevention and control interventions, targeting populations most at risk.
- Statutory, high-quality relationship and sex education in secondary schools will equip young people with the skills to improve their sexual health and overall wellbeing. Relationships and sex education needs to include non-judgmental discussion of same-sex relationships. Personal, social and health education that addresses self-esteem is also crucial to all children's confidence and in building confident adults who take fewer risks (including sex, drugs and alcohol). Education should include information on how alcohol and drug use impacts on decisions about sex, including negotiation of safer sex. In March 2017, Government laid an amendment via the Children and Social Work Act (2017) to introduce compulsory relationships education in primary schools and compulsory relationships and sex education in secondary schools from September 2020. The legislation applies to all schools, including academies, free schools, faith schools and the independent sector. Statutory guidance for schools was published in June 2019.⁵⁰

STIs and HIV

- A sustained public health response is needed to reduce the transmission of HIV and STIs; based around early detection, successful treatment and partner notification, alongside promotion of condom use and health-care seeking. Open-access to sexual health services that provide rapid treatment and partner notification can reduce the risk of STI and HIV complications and infection spread.
- Local and national services for the prevention, diagnosis, treatment, and care of STIs need to be delivered to the general population as well as focus on groups with greater sexual health needs, including young adults, black ethnic minorities and MSM.
- There are several approaches to the prevention of HIV transmission and continued funding in prevention activities remains critical to control HIV.
- Correct and consistent condom use remains an extremely effective way to prevent STI and HIV transmission. The availability of condoms should be promoted through local services, including condom distribution schemes. Work to improve condom use should address the underlying factors that lead to risk taking behaviour, which may include low self-esteem and chemsex.

- Expanded HIV testing can reduce late diagnosis of HIV (a PHOF indicator), undiagnosed HIV infection and onward HIV transmission. NICE guidelines⁵¹ include recommendations for routine HIV testing in primary care and for people who are admitted to hospital based on whether services are in areas of high prevalence (between 2 and 5 cases of diagnosed HIV per 1,000 people aged 15-59 years) or extremely high prevalence (over 5 per 1,000). Sexual health services are advised to ensure that HIV tests are offered and recommended to all eligible attendees, especially MSM, black Africans and attendees born in countries with a diagnosed HIV prevalence >1%. MSM and black Africans should be encouraged to have frequent and regular HIV tests at sexual health services or other settings where HIV testing is offered, or by ordering self-sampling HIV kits on-line.⁵² As well as increasing awareness of HIV, efforts to reduce stigma and other socio-cultural barriers that prevent people from testing and seeking long-term care must be strengthened.
- Detection and treatment of chlamydia infection is central to chlamydia control activities. The PHOF includes a measure of chlamydia detection, with a recommendation that local areas achieve an annual detection rate of at least 2,300 per 100,000 15-24 year old population. Areas achieving or above the 2,300 detection rate are advised to aim to sustain or increase it, with areas not achieving this rate aiming to increase it. Local areas are advised to focus on those services that serve populations with the highest need, based on positivity. They should ensure that an effective, high quality patient pathway is in place with treatment and partner notification standards being met, re-testing after a positive diagnosis within 3 months of initial diagnosis, and screening annually and on change of sexual partner.
- Reducing gonorrhoea transmission and ensuring treatment-resistant strains of gonorrhoea do not persist and spread remains a public health priority. Prompt diagnosis and treatment according to national treatment guidelines, testing for antibiotic resistance and identifying and managing potential treatment failures effectively, are key to controlling infection.⁵³ High levels of gonorrhoea transmission are of particular concern given the emergence of extensively drug-resistant gonorrhoea. All patients diagnosed with gonorrhoea should have a sample taken for culture. All primary diagnostic laboratories should test gonococcal isolates for susceptibility to the recommended first-line antimicrobial (ceftriaxone) and refer suspected ceftriaxone resistant and high-level azithromycin-resistant isolates to PHE's national reference laboratory for confirmation and follow-up. Practitioners should ensure that all patients with gonorrhoea are treated and managed according to national guidelines, and should be alert to changes to the antimicrobials recommended for first-line use. Clinics should ensure that all patients receive a test-of-cure, and that their partners are contacted and tested. They should be vigilant to potential treatment failure for any STI in their patients and report suspected cases to PHE using the restricted access [HIV and STI web portal](#).
- Drug and alcohol services and sexual health service providers are advised to meet the specific needs of MSM involved in 'chemsex'. Joint working between alcohol and drug services and sexual health services should be established to

ensure an integrated approach to care, including specific treatment pathways for 'chemsex' according to need, hepatitis C testing and treatment and hepatitis B vaccination.⁵⁴

- As MSM are at increased risk of hepatitis A and B infection during sex, as demonstrated by recent outbreaks, sexual health services should offer MSM vaccination against hepatitis A and hepatitis B as per national guidelines.⁵⁵ Individuals diagnosed with hepatitis A and B should be offered testing for other STIs and HIV. Contact-tracing to offer testing and vaccination of close sexual contacts should also be provided by sexual health services.
- To prevent infections which are spread faeco-orally during sexual activity (termed sexually transmissible enteric infections) such as *Shigella*, sexual health providers are advised to support work to make MSM aware of how infections such as *Shigella* are transmitted and how to avoid infection.⁵⁶

Reproductive health

- Reducing the burden of unplanned pregnancy (whether this leads to maternity, miscarriage or abortion) requires a sustained public health response. This should be based around the following: marketing; easy access to high quality information for informed decision-making; easy access to the full range of contraception (particularly the most effective long-acting reversible contraception [LARC], the implant, intrauterine systems [IUS] and intrauterine device [IUD]) for pregnancy prevention; and accessible pregnancy testing with rapid referral to abortion services for unwanted pregnancy. These services should be delivered alongside promotion of safer sexual and health-care seeking behaviour.
- Every effort should be made to eliminate local barriers to pregnancy diagnosis, unbiased pregnancy options information, referral to maternity or abortion services and STI testing and contraception provision (which should be made available free and confidentially at easily accessible services). Alongside the effective clinical response, promoting safer sexual behaviour among individuals – including use of the most effective contraceptives, condom use and regular testing – remains crucial.
- Prevention programmes are also required for populations known to be at risk of exclusion from routine contraception, pregnancy testing and abortion provision. These include teenagers, the homeless and rootless, asylum seekers and refugees, those with mental health problems, women involved in the criminal justice system, victims of sexual violence, and those suffering from domestic abuse or from alcohol and drug problems.
- Unwanted pregnancies can be reduced by increasing knowledge, access, choice and provision of all methods of reversible and irreversible contraception, including the most effective LARC methods and emergency contraception, both oral-hormonal and the more effective IUD, for women of all ages and their partners.

- Contraception should be available through general practice and other services, including contraceptive, sexual health, pharmacy and young people's services as well as provided at the time of other treatments e.g. abortion and postnatal care, maternity and STI testing. Contraception should be provided free from any prescription charges.
- Local authorities are mandated to commission open access contraception advice and treatment services that meet the needs of their local population.
- LARC methods are more effective and cost-effective at preventing pregnancy than other hormonal methods and condoms. There are many opportunities after pregnancy to offer contraception, particularly long acting methods, such as in maternity, early pregnancy units and post abortion. Most women choose to go to their GP for contraception. Sexual health services tend to draw a younger and more deprived population. There has been a decline in the provision of LARC in General Practice over the last few years due to reduced capacity. Local systems are advised to make sure that their LARC provision effectively meets the need of their populations.
- The emergency contraception encounter is also an opportunity to provide an effective method of ongoing contraception. The Emergency IUD is the most effective method in preventing pregnancy in this situation and has the added advantage of providing ongoing contraception. Emergency contraception services need pathways in place to ensure referral to local services to provide access to the full choice of methods.
- For those women seeking an abortion, access to services at all gestations up to 24 weeks, as well as a choice of abortion methods, should be easily available and accessible.

Sexual and reproductive health messages for the public

- Make sure you choose a reliable method of contraception you are happy with before you start having (heterosexual) sexual relationships.
- For information about the range of contraceptive choices, visit [Sexwise](#). Sexwise provides inclusive, evidence-based information on contraception, pregnancy, sexually transmitted infections and sexual pleasure and wellbeing.
- Consistent and correct use of condoms can significantly reduce risk of STIs.
- Regular testing for HIV and STIs is essential for good sexual health.
- Everybody who is offered an HIV test by their healthcare professional is advised to accept the test so that if an HIV diagnosis is made, effective treatment can be started promptly.
- Anyone under 25 who is sexually active should be screened for chlamydia annually, and on change of sexual partner.
- Black ethnic minority men and women should have a regular STI screen, including an HIV test, if having condomless sex with new or casual partners.
- Gay, bisexual and other men who have sex with men (MSM)
 - MSM should test annually for HIV and STIs and every 3 months if having condomless sex with new or casual partners.
 - Ask about hepatitis A and hepatitis B vaccination at your next specialist sexual health service visit.
 - Shigella can cause severe diarrhoea and is caught from bacteria in faeces getting into your mouth during sex. There is a risk from rimming or giving oral sex after anal sex. To avoid it, wash your hands after sex, especially if you're fingering or handling used condoms and sex toys, and change condoms between anal and oral sex.
 - Ask your sexual health service where you can get support to reduce sexual health and other risks associated with recreational drug use. People who inject drugs are advised to use a full set of clean equipment for each injecting episode and make use of resources on the [Harm Reduction Works website](#) to keep themselves safe and reduce health harms.
- How to get an HIV test:
 - go to a STI clinic or a community testing site (<http://www.aidsmap.com/hiv-test-finder>)
 - ask your GP for an HIV test
 - request a self-sampling kit online (<https://www.test.hiv/>) or obtain a self-testing kit

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