LEICESTERSHIRE

JOINT STRATEGIC NEEDS ASSESSMENT

March 2012

Sexual Health

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1.1 INTRODUCTION

Sexual health is defined by the World Health Organisation as:-

> 'A state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled'. [1]

Good sexual health is an important part of physical and mental health and wellbeing. Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease.

NHS Leicestershire County and Rutland is responsible for ensuring sexual health services meet local population needs and to reduce health inequalities.

In 2011 Leicestershire County and Rutland undertook a detailed sexual health needs assessment which has formed the basis of the summary presented here.

1.2 KEY ISSUES AND GAPS

The key issues facing LCR with respect to sexual health are driven by the wide geographical area that the PCT covers. The landscape of rural areas with market towns surrounding the large urban centre covered by Leicester City PCT makes delivery of comprehensive and equitable sexual health services very difficult. This is further complicated by an incomplete knowledge of the sexual health needs across the patch to enable the PCT to design and develop services in the areas of greatest need.

The population at greatest need of sexual health services are those aged 15-24, and in LCR there are around 93,400 people in this age group.

In 2007-09 there were 1,139 conceptions to females aged 15 to 17 within Leicestershire County and 57 conceptions in Rutland. Leicestershire County has a rate of 31.6 conceptions per 1000 females aged 15-17 which is lower than the rate in England (40.2) or the East Midlands (39.2). There is variation in teenage conception rates within Leicestershire from 21.0 per 1000 females aged 15-17 in Harborough to 40.3 in North West Leicestershire.

58% of teenage conceptions in Leicestershire ended in abortion, this is higher than the England average of 50% (2008). The proportion of teenage conceptions that end in abortion also vary by district; from 43% in Melton to 65% in Blaby.

Emergency hormonal contraception (EHC) provided at 94 pharmacies across LCR. However, access to EHC is not equitable across the PCT as not all localities have a pharmacy providing EHC. Services should be available equitably to the whole population.

In 2009 there were 1,628 abortions to residents of Leicestershire County and Rutland. Abortion rates in LCR are significantly lower than the England average. In 2009, 70% of abortions for LCR women were carried out by 10 weeks gestation; this is lower than the national average of 74.4%. In 2009 in those under 25, 20% of abortions in NHS LCR were repeat abortions compared with 24.9% in England overall.

Chlamydia is the most commonly diagnosed sexually transmitted infection (STI) in the UK. In 2009/10 17,318 people aged 15-24 were screened for chlamydia through the National Chlamydia Screening Programme, and a further 3,410 were screened for chlamydia through other routes. 4.1% of those screened were diagnosed with Chlamydia, 3.7% of females and 5.1% of males. Positive diagnoses are lower than the England average for females (5.4%) but higher for males (4.7%).

The diagnosed prevalence of HIV in 2010 in Leicestershire County and Rutland is considered by the Health Protection Agency to be low[2] (0.59 per 1000 population aged 15-59) and is lower than the East Midlands average (1.12 per 1000 population aged 15-59). However, the number of residents accessing HIV related care in LCR has increased by 70% between 2006 and 2010, from 152 to 259.[2]

1.3 RECOMMENDATIONS FOR COMMISSIONING

In 2010 Leicestershire had a visit from the Teenage Pregnancy National Support Team. It should be ensured that work is continued to meet the recommendations highlighted in this report.

The three big challenges in sexual health in Leicestershire are:

- Increasing access to contraceptive services for the whole population, with targeted work for young people. This is necessary in order to have a direct impact on teenage pregnancy rates.

- Maintaining community sexual health provision, including condoms and pregnancy testing. This is in the context of changes to youth services and Connexions.

- Personal, social, health and economic education (PSHE) and sex and relationship education (PSE) are changing in light of OFSTED guidance and the formation of academies.

Further detail on commissioning recommendations for each aspect of sexual health are outlined below.

1.3.1 Births, abortion and teenage pregnancy

- Whilst good progress has been made to reduce the rate of teenage conception ongoing work is needed to ensure real change, particularly focusing on identified hot spot localities.
- Abortions, particularly repeat abortions, highlight issues in relation to contraceptive use. Contraceptive provision must be part of an integrated service pathway.

- There is a need to continually improve early access to abortion services. This improves choice for the type of abortion and reduces the risk of unintended complications linked to later terminations.

1.3.2 Contraception

- It is essential that services are developed and provided in a way that is appropriate to the population. For example, young people's services must be provided in appropriate venues at accessible times and delivered in an effective way.
- As a rural area, it is often quite difficult to overcome access barriers, including geography, transportation, and communication. This is a major challenge for LCR PCT in relation to delivering sexual health services and needs to be considered when developing local services.
- The rurality of the PCT contributes to the complexity of service provision. It is essential that people are made aware of how to access the appropriate services for their needs.
- Access to Long-acting Reversible Contraception (LARC) and Emergency Hormonal Contraception (EHC) is not equitable across the PCT as not all GPs provide LARC and not all localities have a pharmacy providing EHC. Services should be available equitably to the whole population.
- Local research highlighted key issues with respect to education and awareness raising about the range of contraceptive options for young people as well as with developing tailored services to meet the needs of our younger populations.
- There is a need to ensure that there is a consistency of messages from contraceptive services about the risks of unprotected sex and that people at risk are able to access condoms.

1.3.3 Sexually transmitted infections

- The data for GUM has improved in recent years but is still lacking in consistency when drawing data from different sources. This makes it difficult to make decisions linked to the data that is available.
- It is essential that the contracts for providers for GUM reflect the national data collection for GUM and that this is monitored and data quality is addressed through the contracting route.
- The development of integrated sexual health services assists with delivery of sexual health services to meet needs in relation to both contraception and sexually transmitted infections.
- Chlamydia screening performance is lower than most other parts of the East Midlands. The latest target for Chlamydia screening focuses on prevalence rates. To achieve target there needs to be an increasing in the number of people screened and in the detection of Chlamydia. Increased screening through core services and targeting screening to reach those most at risk of Chlamydia will be the most cost effective model.
- Prevention of cervical cancer through the HPV vaccination is going well locally. However, there is no room for complacency with such an important public health issue and this immunisation programme must continue to improve population coverage rates.
- The numbers of people living with HIV continues to increase year on year. Services to support people living with HIV must ensure that people have the greatest opportunity for disability free living. Increased targeted community

testing and prevention activity is needed to improve early diagnosis, improve health outcomes and prevent risk of onward transmission.

- HIV services also need to address the needs of the groups disproportionately affected by HIV. In LCR these are men who have sex with men and black African communities.

1.3.4 HM Prison Services

- The PCT should explore ways to better identify and support the sexual health needs of prisoners. There will be an opportunity to improve our understanding of the sexual health needs of prisoners with the changes that have been made to the KC60 returns.
- It is essential that prisoners are given the same opportunity for health as other populations and services for prisoners need to be designed to ensure that they provide high quality health services across all elements of healthcare
- The Chlamydia screening programme needs to continue to be developed in all prisons, and in particular in Glen Parva
- The hepatitis B and C screening programmes need to continue to be developed as part of the prison performance and quality indicators
- Prisoners with HIV need access to appropriate services whilst in prison and support on leaving prison. The British Association for Sexual Health and HIV (BASHH) survey[3] will provide more detailed understanding of prisoners needs in this area

1.3.5 Sexual Violence

A National Support Team visit was undertaken in 2009 in relation to Sexual Assault Referral Centre (SARC). Key findings were reported to the range of agencies involved in the NST visit. In response to this visit a Project Manager conducted a review of services and developed recommendations for improving commissioning to meet minimum requirements for investigation, forensics, medical, child protection, prosecution and victim care.

1.3.6 Public perspective: behaviour and attitudes

- It is recommended that user views are used to inform service redesign across Leicestershire.
- The TellUs Survey indicates a need to improve the information that is provided in schools with respect to sex and relationships
- 'Learner Voice' research looked at young people's views of RSE (Relationships and Sex Education) in Leicester and Leicestershire. Overall students resoundingly prioritised two areas that they thought were essential in relation to RSE content. These were STIs and Contraception (predominantly condoms) with a clear message that 'Staying Safe' should be the overarching message.
- The Community Safer Sex Project has been evaluated and it is recommended that this project should continue to be developed as it delivers a high social return on investment
- The evaluation of the Loughborough GUM service highlighted that there was a need for an increase in capacity locally in GUM services. The increased capacity advocated an increase in the skill mix of the staff delivering services with a greater use of nurse-led sessions and level 2 sexual health services to increase overall capacity

- The needs assessment of contraceptive services highlighted that there was a need to review delivery and promotion of contraceptive services clinics to improve access and patient journey.

1.4 WHO'S AT RISK AND WHY

The consequences of poor sexual health can have a long-lasting and severe impact on people's lives. Poor sexual health can result in:-

- Unintended pregnancies and abortions;
- High teenage pregnancy rates with poorer educational, social, health and economic opportunities for teenage mothers and fathers;
- Poor psychological consequences of sexual coercion and abuse;
- Sexually Transmitted Infections (STIs) and HIV;
- Pelvic inflammatory disease, which can cause ectopic pregnancies and infertility;
- Cervical and other genital cancers;
- Hepatitis, chronic liver disease and liver cancer.

Nationally, prevalence of STIs is rising, with almost half a million new diagnoses in 2009 (excluding HIV). [4] HIV rates remain relatively high, with 2,760 new diagnoses in 2009, [5] and undiagnosed HIV is still a problem. It is estimated that around 26% people living with HIV are unaware of their infection. [6] This means they are unable to benefit from effective treatment and risk passing HIV on to others. In LCR the groups disproportionately affected by HIV are Men who have sex with Men and black African communities.

Poor sexual health also disproportionately affects young people. 15–24 year olds, particularly young women, continue to be the group most affected in the UK.[7] Of all 15–24 year olds diagnosed with an STI last year, around 1 in 10 will become re-infected within a year.[8] Teenage conceptions are at a 20-year low (38 cases per 1,000 under-18s), but the rate is still high when compared with Western Europe. [9]

1.5 THE LEVEL OF NEED IN THE POPULATION

Across Leicestershire County and Rutland in a 12 month period there are:

- 7,200 conceptions annually
- 418 under 18 conceptions, with 58% ending in abortion.
- 1,666 abortions annually
- 19,600 contacts at UHL family planning (NHS LCR and NHS Leicester City), 12,200 1st contacts
- 600 contacts for emergency hormonal contraception via Pharmacy scheme for under 25s
- Emergency hormonal contraception provided at 94 pharmacies across LCR
- Over 113,000 contraceptive items prescribed in a year
- Community safer sex project provided 8199 interventions through its condom service and 974 pregnancy tests
- 14,200 genito-urinary medicine clinic attendances annually, 74% of clients seen within 48 hours

- Chlamydia in 2009/10 – screened 17,318 people aged 15-24 through National Chlamydia Screening Programme and an additional 2,410 people through other routes
- HIV/AIDS prevalence - 235 cases in treatment services.
- Over 500 sexual assaults annually

1.6 CURRENT SERVICES IN RELATION TO NEED

It is essential that services are developed and provided in a way that is appropriate to the population. For example, young peoples' services must be provided in appropriate venues at accessible times and delivered in an effective way.

As a rural area, it is often quite difficult to overcome access barriers, including geography, transportation, and communication and rurality contributes to the complexity of service provision. This is a major challenge for LCR PCT in relation to delivering sexual health services and needs to be considered when developing local services. It is essential that people are made aware of how to access the appropriate services for their needs.

Access to LARC and EHC is not equitable across the PCT as not all GPs have signed up for LARC and not all localities have a pharmacy providing EHC. It is important to ensure that services are available equitably to the whole population.

Prescriptions for EHC have decreased between 2009 and 2010 by approximately 12%; the proportion of 16-18 year olds has decreased suggesting that this age group is using EHC less. However, it is not possible to say whether this indicates better use of other contraceptives or lack of use of contraception. The cost of LARC in Leicestershire County and Rutland is similar to the East Midlands average at £2,591 per 1000 women aged 15-44, however this is significantly higher than the England average.

The increased provision of LARC and oral contraception could increase risk of STIs. There is a need to ensure that there is a consistency of messages from contraceptive services about the risks of unprotected sex and that people at risk are able to access condoms.

In 2008/09 71.9% of first attendances at GUM clinics were seen within 2 working days, and in 2009/10 there was an increase in the percentage seen within 2 working days to 74.3%. The evaluation of the Loughborough GUM service highlighted that there was a need for an increase in capacity locally in GUM services. The increased capacity advocated an increase in the skill mix of the staff delivering services with a greater use of nurse-led sessions and level 2 sexual health services to increase overall capacity.

The national HPV immunisation programme protects girls against infection from two strains of HPV (which are associated with 70% of cervical cancers) by immunising girls aged 12-13 years (school year 8). A catch-up campaign for girls aged up to 18 was completed by the end of March 2011. LCR has higher uptakes of HPV vaccination within the routine cohort than England, East Midlands or Leicester City. During 2010/11 Leicestershire and Rutland achieved an uptake of 93.6% for dose 1, 93.3% for dose 2 and 92.6% for dose 3 delivered to girls aged 12-13 in school. Close partnership working with schools has greatly contributed to this.

The Community Safer Sex Project has been evaluated and it is recommended that this project should continue to be developed as it delivers a high social return on investment.

Sexual health services are provided in a range of settings and are structured into three levels of service. Level one services are the basic elements of sexual health services, provided through primary care and community settings. Level two services provide a wider range of care which may be undertaken by clinicians in primary care with a special interest in sexual health or by those providing additional elements of care not traditionally provided in their service. Level three services are specialist sexual health services. A range of provision at different levels allows people to benefit from opportunities to make choices about their sexual healthcare based on convenience and accessibility, availability of expertise or comprehensiveness of service.

1.7 PROJECTED SERVICE USE AND OUTCOMES IN 3-5 YEARS AND 5-10 YEARS

Abortions

Between 2002 and 2008. For NHS LCR the number of abortions has increased from 1400 per year to over 1600 per year. There has been a corresponding increase in the abortion rate. The increasing rate mirrors the increase in rate that has been experienced nationally. [10]

Teenage Conceptions

Between 1998 and 2008 the teenage pregnancy rate has decreased by 27% in Leicestershire and 19% in Rutland. The rate of reduction across LCR is higher than the progress that has been made in England overall. However, this progress is not sufficient to meet the 2010 targets and we need to improve performance in this area.

Contraception

Need and demand for contraceptive services will increase in line with population growth.

Sexually transmitted infections

Nationally, new episodes of Chlamydia are increasing every year, from 174 per 100,000 males in 2004 to 212 per 100,000 males in 2008. The PCT is working to improve diagnoses and treatment of Chlamydia and this is a key target for the next two years.

Nationally, new episodes of gonorrhoea have declined from 59.1 per 100,000 males in 2004 to 38.4 per 100,000 males in 2008.

Nationally, new episodes of syphilis remained static between 2006 and 2008 with a 2008 rate of 7.2 per 100,000 males and 0.9 per 100,000 females.

Nationally, new episodes of herpes have increased from 26.2 to 39.9 for males and 41.2 to 61.2 for females between 2006 and 2008.

The number of genital warts diagnosed in the UK population has continuously risen since records began in 1971. [11]

HPV

In the UK, a national HPV immunisation programme was introduced for all girls aged 12-13 years (school year 8) in autumn 2008. The national immunisation programme will protect girls against infection with HPV 16 and 18 (associated with 70% of cervical cancers).

HIV

The numbers of people living with HIV continues to increase year on year. Increased targeted community testing and prevention activity is needed to improve early diagnosis, improve health outcomes and prevent risk of onward transmission. In LCR, Men who have sex with Men and black Africans are disproportionately affected by HIV.

1.8 EVIDENCE OF WHAT WORKS

A new National Strategy for Sexual Health is due in spring 2012. There are a wealth of documents providing evidence of effectiveness and commissioning guidance for different aspects of sexual health. Key documents are included in references section.

Investment in sexual health services can deliver significant healthcare savings through preventing unintended pregnancies and reducing the transmission of sexually transmitted infections (STIs).[12]

1.9 USER VIEWS

It is important to recognise issues raised by users with respect to accessing services and to ensure that these are addressed in the development of locally responsive services.

The LARC research highlighted key issues with respect to education and awareness raising as well as with developing tailored services to meet the needs of our younger populations.

The TellUs Survey indicates a need to improve the information that is provided in schools with respect to sex and relationships.

Consultation has been conducted with young people in Hinckley and Bosworth on contraceptive services. The key issues raised by young people were that services need to be confidential and trustworthy. They also wanted to have the choice to access contraception anonymously.

'Learner Voice' research looked at young people's views of RSE in Leicester and Leicestershire. Overall students resoundingly prioritised two areas that they thought were essential in relation to RSE content. These were STIs and Contraception (predominantly condoms) with a clear message that 'Staying Safe' should be the overarching message.

The needs assessment of contraceptive services highlighted that there was a need to review delivery and promotion of contraceptive services clinics to improve access and patient journey. The main areas for service improvements were opening hours, waiting

times and the need for more staff. Comments were also received regarding advertising, waiting room environment and the appointment system

However, overall satisfaction with contraceptive services was high, particularly in peripheral clinics. Key reasons patients gave for using the service related to accessibility; with convenience, geographic location to home or work and availability of walk in clinics most commonly stated. Friendliness of staff was another popular reason. Almost a quarter of service users had not gone to their GP due to the service not being available or not wanting to see their GP.

1.10 EQUALITY IMPACT ASSESSMENTS

This section is extracted from the Department of Health's Equality Impact Assessment of the Sexual Health Strategy 2010. [13] All policies and services, including those relating to sexual health, should be designed to meet the needs of the entire target population. This should include action to address inequalities, wherever relevant.

1.10.1 Age

In England, the age of consent for any form of sexual activity is 16 for both men and women, regardless of sexual orientation.

A factsheet, developed by FPA[14], indicated that in Great Britain the average (median) age at first heterosexual intercourse was 16 for both men and women. However, nearly a third of men and a quarter of women aged 16–19 had had heterosexual intercourse before they were 16.

England has a historically high rate of teenage pregnancy, and, although the rate is now falling, it remains the highest in Western Europe: in 2009, the conception rate among girls aged 15–17 was 38.2 per 1,000, down 18.1 per cent since 1998.

The Sexual Offences Act 2003 provides definitions of the various forms of sexual offences, including rape and sexual assault, and includes offences committed against those aged under 16. Sexual violence, assault and abuse have negative consequences on the sexual health of victims/survivors. These can include STIs, as well as unwanted pregnancy and gynaecological problems for female victims/survivors, and can lead to sexual risk-taking behaviour and re-victimisation.

Research studies relating to the under-18s have found that 21 per cent of girls and 11 per cent of boys experience some form of childhood sexual abuse. A third of 13–17-year-old girls suffer unwanted sexual acts in a relationship, including rape[15].

Research studies relating to those aged over 16 have found that 23 per cent of women and 3 per cent of men have experienced sexual abuse as an adult (aged 16–59). Five per cent of adult women and 0.4 per cent of adult men have been raped. Young adults are more likely to be sexually abused if they experienced sexual abuse as children. In addition, there is research, primarily from the USA, that identifies links between child sexual abuse and teenage pregnancy.[15]

1.10.2 Disability

Anyone who has been diagnosed with HIV is automatically covered by the Disability Discrimination Act.

Disabled people – like the rest of the population – can choose to have sexual relationships and can have a lesbian, bisexual, gay or heterosexual identity. Data on the sexual health of people with disabilities is limited. Disability is not currently included in any of the national datasets on sexual health, as the Information Standards Board (ISB) has not yet agreed a definition of disability.

In 2005, *Disability Now* carried out a survey of 1,115 disabled people[16]. The results of the survey were as follows:

- 85% of respondents had had sexual intercourse at some time;
- 68% of respondents had had sex since becoming disabled;
- 94% of respondents said they knew what safer sex was; and
- 27% had been sexually abused or exploited.

1.10.3 Gender

The sexual health needs of people will vary according to their gender, particularly as regards the provision of contraception and abortion services. However, people of all genders – including trans people – can be affected by STIs.

Women are disproportionately the victims/survivors of sexual violence and abuse, and such abuse is massively under-reported by both female and male victims/survivors.

Sex workers – like the rest of the population – form a diverse group, and their sexual and health behaviour will vary greatly. However, sex workers may have particular sexual health needs, and these are likely to differ according to their gender and personal circumstances

1.10.4 Race and Religion or belief

Religious and cultural views can influence attitudes towards abortion, contraception and sexual relationships. For example, pre-marital sex and same-sex relationships are prohibited by some religions. Some religions embrace trans people, whereas others do not. In addition, some religions require patients to be treated by a doctor or nurse of the same sex.

It should never be assumed, however, that an individual who belongs to a specific religious group will necessarily be compliant with, or completely observant of, all the views and practices of that group.

1.10.5 Sexual orientation

There is little reliable data on the lesbian, gay and bisexual population. Sexual orientation is not currently included in the national census. However, in 2004, the

Department of Trade and Industry (DTI)[17] reviewed a range of research to develop an estimate that between 5 and 7 per cent of the population is lesbian, gay or bisexual.

As with everyone, women who have sex with women (WSW) and men who have sex with men (MSM) are socially and culturally diverse groups, and some of them may not self-identify as 'lesbian', 'gay' or 'bisexual'.

It is important to stress that people's sexual behaviour cannot be deduced from their sexual orientation. For example, a bisexual woman might only have sex with women, or a lesbian may have sex with men.

Lesbian, gay, bisexual and trans (LGBT) people may delay seeking help for a health problem and be less likely to access routine health screening because of a fear of encountering homophobic attitudes, a reluctance to disclose their sexual orientation to a healthcare worker and the lack of knowledge and awareness about LGBT health needs.

A Stonewall survey of 6,000 WSW[18] found that half had had negative experience of healthcare, including sexual healthcare, in the previous year, and a similar number felt unable to be open with their GP about their sexual orientation. Many WSW are likely to have unmet sexual health needs, and the Stonewall survey highlights the fact that there is considerable ignorance among healthcare workers about those needs. The Manual for Sexual Health Advisers[19] also points out that high percentages of WSW in all studies give a history of having previous or current sexual contact with men. The manual emphasises that an accurate sexual history is of vital importance in any assessment of risks and interventions.

1.11 UNMET NEED AND SERVICE GAPS

There is a need to reach groups of young people whose sexual health is particularly poor (due to increasing STIs and/ or unintended pregnancies) or those who are hard to reach. These include young people living in deprived areas, looked after young people, youth offenders, young people who are lesbian, gay or bisexual and those with additional support needs. For these young people additional support and a more targeted approach is required.

Research in the UK and in the other countries has shown that low socio-economic class, poor educational opportunities[20] and dropping out of school[21] are significant risk factors for teenage pregnancy.

Data from the Health Protection Agency (HPA) indicates a worrying increase in sexually transmitted infections with sexual health clinics reporting 482,700 new cases in 2009, which is an increase of around 12,000 on the previous year. The peak age for a sexually transmitted infection is 19-20 for women and 20-23 for men. Alarmingly, significant numbers of young people are returning to clinics. About 10% of the 15- to 24-year-olds treated for a sexually transmitted infection will be re-infected within a year.

1.12 CONCLUSIONS

Whilst sexual health in LCR is better than the national picture, there is no room for complacency. Improving service accessibility, prevention activity and continued improvement of relationships and sex education are vital to improve sexual health in Leicestershire. There is a need to focus on groups and localities at highest risk of poor sexual health, including young people, to reduce inequalities in sexual health.

The national changes to sexual health commissioning to be implemented in 2013 pose a challenge locally, particularly in the context of budgetary constraints. It will be important to focus on need and working in partnership to ensure that the transition stage and future commissioning is co-ordinated and informed by local need.

1.13 RECOMMENDATIONS FOR NEEDS ASSESSMENT WORK

More detailed needs assessment is required in relation to:

- STIs and contraception use. The new Genitourinary Medicine Clinic Activity Dataset (GUMCAD) and SHRAD national data collection will help to inform this.
- Sexual assault

1.14 CONSULTATION

Consultation is currently underway to seek the views of 16-24 year olds in relation to sexual health services.

1.15 KEY CONTACTS

Consultant in Public Health – Mike Sandys

Senior Public Health Manager – Janet Hutchins

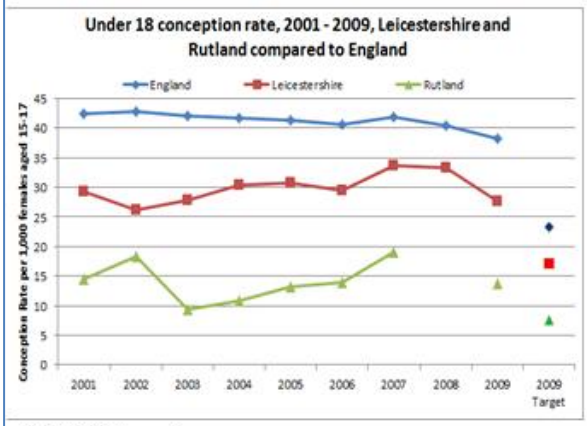
Teenage Pregnancy Co-ordinator – Katie Phillips

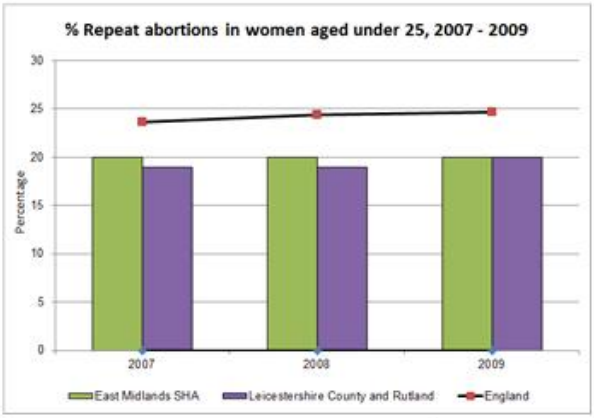
1.16 DATA FACTSHEETS

Sexual Health factsheet:

- Under 18 conception rate 2007-09 by district
- Repeat abortions in women aged under 25 years, 2007-09
- Leicestershire Teenage Pregnancy Hotspots and Services map
- Emergency hormonal contraception usage by age
- GP prescriptions for LARC
- HPV Vaccination data

JSNA Refresh 2012. Sexual health





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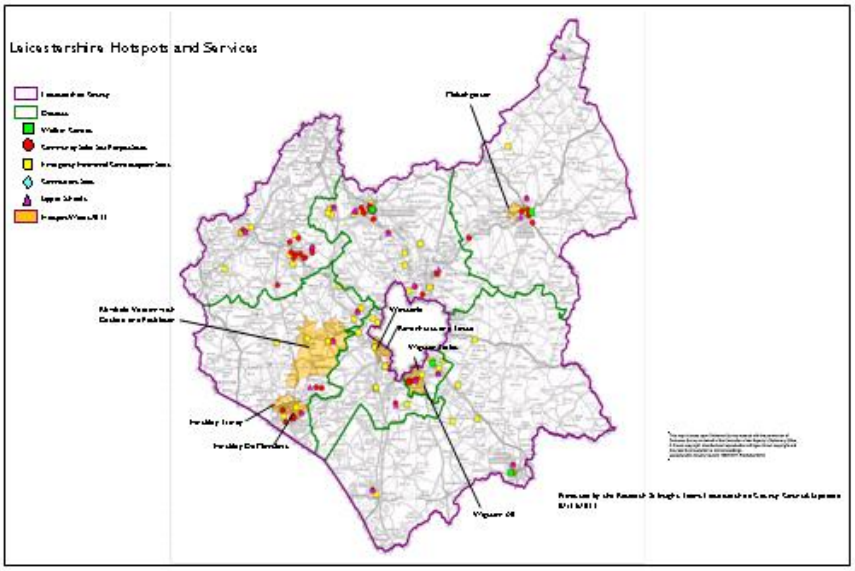

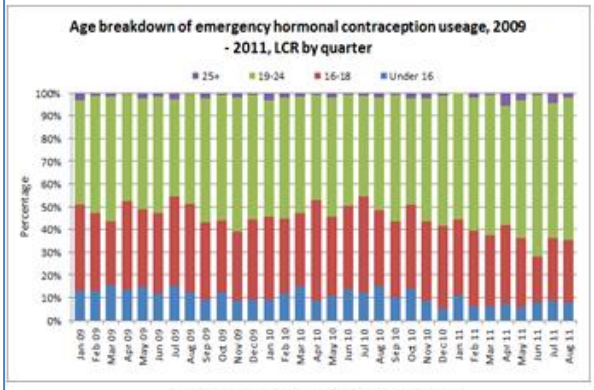

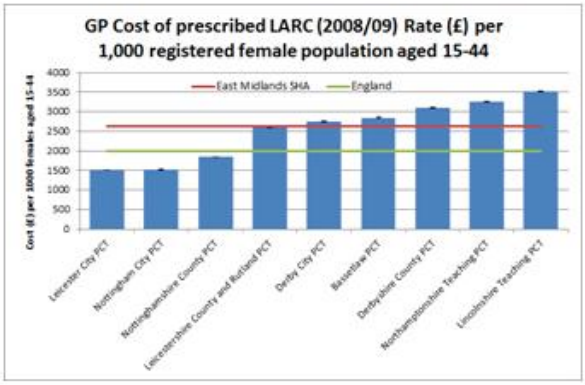

HPV Vaccination data 2008/09

	Routine Cohort (year 8)			
	Total number in routine cohort	Doses given since 1st Sept 2008		
		Dose 1 (%)	Dose 1 and 2 (%)	All 3 Doses (%)
England	303,361	88.1	86	80.1
East Midlands	25,831	90.9	89.3	76.9
Leicestershire County and Rutland	4,188	92	91.5	91

1.17 REFERENCES

[1] World Health Organization (2002) Defining Sexual Health: Report of a technical consultation on sexual health, 18-31January. Geneva, WHO
[2] Health Protection Agency (East Midlands). HIV in the East Midlands Annual Report 2010. December 2011.
[3] British Association for Sexual Health and HIV - http://www.bashh.org/news/627_results-of-bashh-survey
[4] Health Protection Agency (2010) Sexually Transmitted Infections, Annual Data Table 2009, www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/STIs/STIsAnnualData/
[5] Health Protection Agency (2010) New HIV Diagnoses, National Tables 2010 (2009 data), www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1252660002826
[6] Health Protection Agency (2010) HIV in the United Kingdom: 2010 Report.
[7] Health Protection Agency (2010) Sexually Transmitted Infections, Annual Data Table 2009, www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/STIs/STIsAnnualData/
[8] Our Health and Wellbeing Today: Department of Health; © Crown Copyright; 20 November 2010
[9] Organisation for Economic Co-operation and Development (OECD) (2009) Doing Better for Children, www.oecd.org/document/12/0,3343,en_2649_34819_43545036_1_1_1_37419, 00.html
[10] Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base http://www.nchod.nhs.uk or http://nww.nchod.nhs.uk
[11] HPA. General Information http://www.hpa.org.uk
[12] Choosing Health
[13] Equality Impact Assessment for National Sexual Health Policy: Prepared by the Sexual Health Policy team, Department of Health: January 2010
[14] http://www.fpa.org.uk/home
[15] Department of Health, Equality Impact Assessment for National Sexual Health Policy, 2010 - http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_111231.pdf
[16] Disability Now Sex Survey *Time to talk sex* (2005)
[17] http://www.bis.gov.uk/
[18] Prescription for Change - Lesbian and bisexual women's health check 2008: http://www.stonewall.org.uk/documents/prescription_for_change.pdf
[19] Society for Sexual Health Advisers (SSHA): http://www.ssha.info/resources/manual-for-sexual-health-advisers/
[20] National Statistics (2004) Census 2001 table: C0069 Mothers under 19 at birth (Commissioned by Teenage Pregnancy Unit, DfES)
[21] Hosie A, Dawson N (2005) The Education of Pregnant Young Women and Young Mothers in England. Bristol: University of Newcastle and University of Bristol

Key sexual health documents

- Health Economics of Sexual Health – a guide for Commissioning & Planning (Department of Health,2005)
- The Economics of Sexual Health (Family Planning Association, 2005)
- Recommended Standards for Sexual Health Services. (MedFASH, 2005) http://www.medfash.org.uk/publications/documents/Recommended_standards_for_NHS_HIV_services.pdf
- Recommended Standards for NHS HIV services (MedFASH, 2003) http://www.medfash.org.uk/publications/documents/Recommended_standards_for_NHS_HIV_services.pdf

- Clinical Guidelines CG30 Long-acting Reversible Contraception (NICE, 2005) http://www.nice.org.uk/CG030
- Public Health guidance: Prevention of STIs and under 18 Conceptions (NICE,2007) http://guidance.nice.org.uk/PH3
- Commissioning Services for Women and Children who experience abuse – a guide for health commissioners (DH, 2011) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125900