# Sexual health

**Summary**

- The sexual health of the citizens of Hampshire is relatively good with teenage conception, HIV and acute sexually transmitted infections (STI) rates below national and regional averages.
- However STI rates have been increasing with an unequal impact on young people, men who have sex with men and people from certain minority ethnic groups.
- Left untreated, STIs can lead to a range of complications including infertility, ectopic pregnancy, disability, cancer and premature death.
- Unintended pregnancies can have a significant impact on both the physical and mental health of women and their children as well as on their educational outcomes and lifelong social and economic well-being.
- There are clear links between poor sexual health and the use of alcohol and drugs.
- Achieving good sexual health is complex and there are variations in the need for services and interventions for different individuals and groups. It is therefore essential that there is collaboration and integration to achieve improved outcomes.

**Recommendations**

*Under-18 conceptions*
- Continue the focused  action to reduce teenage conceptions

*Reproductive health*
- Improve access to contraception, including Long-Acting Reversible methods of contraception (LARC).

*Chlamydia diagnoses (15-24 year olds)*
- Work to achieve a chlamydia diagnostic rate of at least 2,300 per 100,000 young people aged 15-24.
- Emphasise the need for repeat testing, especially on change of sexual partner.

*Sexually transmitted infections*
- Maintain 48 hour access to STI testing and continue to improve partner notification rates
- Prevention efforts should be sustained and targeted at groups who are at the most risk

*People presenting with HIV at a late stage of infection*
- Improve awareness and diagnosis of primary HIV infection.
- Increase the uptake of HIV testing particularly for high-risk groups.
- Maintain the current high levels of HIV antenatal testing.
- Increase the availability and uptake of community-based HIV Point-of-Care Testing with high-risk groups

# Sexual health

## 1. Introduction

The consequences of poor sexual health can be serious. Many different factors influence relationships and safe sex including personal attitudes and beliefs; social norms; peer pressure; religious beliefs; culture; confidence and self-esteem; misuse of drugs and alcohol; and coercion and abuse.[1]

Sexually transmitted infections (STI) are increasing nationally and locally in men and women. Left untreated, sexually transmitted infections can lead to a range of complications including ectopic pregnancy, infertility, disability, cancer and premature death. Chlamydia is the most commonly diagnosed STI in the UK and in Hampshire and infection rates are substantially higher in young adults than in any other age group.

The number of people diagnosed with HIV in Hampshire continues to increase year on year and it is estimated that 25% of people with HIV remain undiagnosed and unaware of their infection. While there have been significant advances in treatment for HIV, which means that some people on treatment have a mortality risk identical to their HIV-negative peers[2], there is still no cure for HIV and late diagnosis (i.e. diagnosis after the point at which HIV treatment should have started) is associated with onward HIV transmission, high-levels of short-term mortality, poor prognosis and higher health and social care costs.

Unintended pregnancies can have a significant impact on both the physical and mental health of women and their children, their educational outcomes and lifelong social and economic status and well-being. About half of all pregnancies are unplanned[3] and there is increasing evidence that unplanned pregnancies are associated with poorer pregnancy, health and educational outcomes.[4] As well as it being an avoidable experience, abortions represent an avoidable cost to the NHS and can have immediate and long term serious consequences to the woman.

Poor sexual health is not evenly distributed within the population. There is a clear association with deprivation and social exclusion and a greater impact on young people, men who have sex with men and certain minority ethnic groups. There is also evidence of a clear link between poor sexual health and the use of alcohol and drugs.[5]

Recent decades have seen significant changes in what relationships people make, their sexual behaviour and how they choose to live their lives. While the age of first sexual experience has generally remained the same there are reported increases in both the total number of lifetime sexual partners and the numbers of people who report concurrent sexual partnerships. There has also been an increase in the

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[1] *A Framework for Sexual Health Improvement in England*, Department of Health, 2013

[2] Rodger AJ et al. Mortality in well controlled HIV in the continuous antiretroviral therapy arms of the SMART and ESPRIT trials compared with the general population. AIDS 27: 973-979, doi: 10.1097/QAD.0b013e32835cae9c, 2013.

[3] *A Framework for Sexual Health Improvement in England*, Department of Health, 2013.

[4] 'Effect of pregnancy planning and fertility treatment on cognitive outcomes in children at ages 3 and 5:longitudinal cohort study', Carson C et al, BMJ 2011; 343: d4473

[5] Bellis M et al, Contributions of Alcohol Use to Teenage Pregnancy, North West Public Health Observatory, 2009

numbers of people who report same-sex partners as well as increases in the number of people who report paying for sex.[6]

## 2. Level of need in the population

### 2.1 Sexually transmitted infections (STIs)
Left untreated, STIs can lead to a range of complications including ectopic pregnancy, infertility, disability, cancer and premature death. STIs are the main cause of infertility (particularly in women) and can also facilitate HIV transmission by increasing both HIV infectiousness and HIV susceptibility. There are well established links between certain types of human papillomavirus (HPV) with cervical, oral and genital cancers. Chlamydia is the most commonly diagnosed STI in England and in Hampshire followed by HPV (genital warts) and Herpes.

Both the total number and rates of STI diagnoses have increased significantly over the last 10 years alongside an increasing number of outbreaks of infections such as Syphilis and Lymphogranuloma Venereum (LGV). Gonorrhoea is becoming increasingly difficult to treat, as it can quickly develop resistance to antibiotics.

While part of this increase can be attributed to increased STI testing associated with the national chlamydia screening programme and the increased use of more sensitive diagnostic tests, the increase in STI diagnoses and rates is likely to be the result of high levels of unsafe sexual behaviour.

Figure 1 shows trends in the rates of the most commonly diagnosed STIs per 100,000 population since 2008. STI data prior to 2008 were reported by clinic rather than population (i.e. all diagnoses made at each clinic each quarter) which means that comparable rates at a local population level prior to 2008 are not available. However, it is clear from these data that Hampshire follows national trends with increasing STI rates, albeit just below national and regional rates.

**Figure 1: Trends in STI diagnoses in Hampshire, 2008 to 2011**



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[6] http://www.natcen.ac.uk/study/natsal
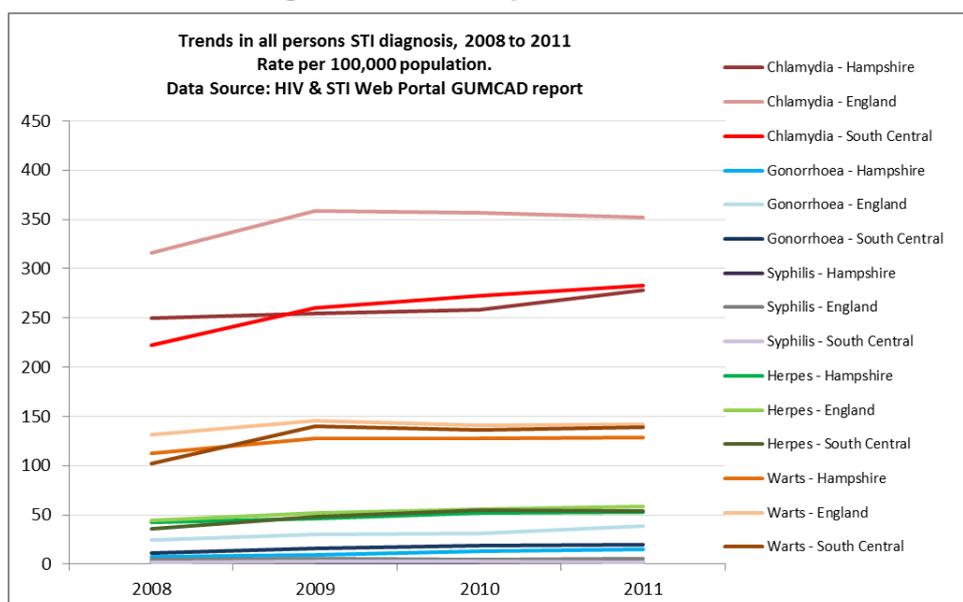
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There is considerable variation in the distribution of STIs across Hampshire's districts. Socio-economic deprivation is a known determinant of poor health outcomes and there are data which show a strong positive correlation between STI rates and the index of multiple deprivation (IMD) across England. However there are also many other factors which can influence STI rates including the local population profile by age, ethnicity and sexual orientation; the presence of a university, prison or military facility within an area; education, health awareness and health seeking behaviour (testing) in an area and the availability of and access to sexual health services.

The data in figure 2 indicate that the populations in most districts in Hampshire have STI rates significantly below the national average with the exception of Basingstoke and Deane, which had a rate which was slightly higher than the national rate in 2011 and Rushmoor and Gosport whose rates are in line with the national rate.

The 2012 Health Protection Agency "Local Authority Sexually Transmitted Infection Epidemiology" (LASER) reports included a national ranking for STI rates plus additional sexual health indicators by districts. The data include the percentage of STI diagnoses and the Chlamydia diagnosis rate in the 15-24 age group as well as the percentage of residents who received an HIV test as part of an STI screen. Basingstoke & Deane and Rushmoor were ranked in the second highest quintile for STI rates nationally.

**Figure 2: Rate of acute STIs by district in Hampshire, 2011**
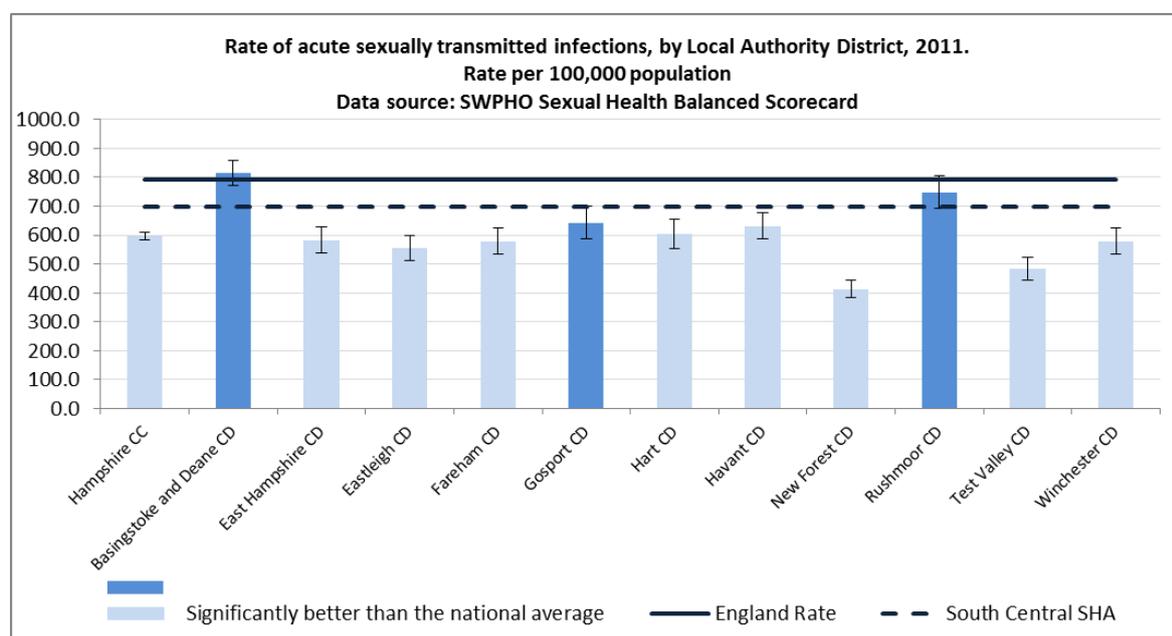


### 2.1.1 Young adults

Improved STI reporting since 2008 has enabled comparison between the rates of STIs in different age groups. These data are currently available for Hampshire and indicate the much higher rates of STIs in people aged 15-24 as well as slight increases in STI rates across almost all age groups. Adults aged under 25 years experience the highest rates of STIs. Nationally in GUM clinics in 2011, 66% of

chlamydia diagnoses, 56% of genital wart diagnoses, 57% of gonorrhoea diagnoses and 43% of genital herpes diagnoses were in people aged 15-24.

In 2011 over two thirds of all diagnosed STIs in Hampshire were in people aged 15-24, ranging from 55% in Basingstoke and Deane to 74% in Havant (table 1). The rates of STIs in females aged 15-19 appear to be twice as high as the rate in males aged 15-19. While this may be the result of increased STI testing (including chlamydia screening) in females in this age group, it could be an indicator that females in this age group are having more unprotected sexual relationships with slightly older men.

The data suggest that young people are more likely to become reinfected with STIs within a 12 month period, suggesting that some young people lack the knowledge, skills, confidence and/or motivation to negotiate safe sex and reduce their risks even after an STI episode. The 12 month reinfection rates in men and women aged 16-19 in Rushmoor, Basingstoke and Deane, Eastleigh, Gosport, Havant and Winchester are higher than the national average for all ages in both sexes (figure 3).

**Table 1: STI rates and rank by district in Hampshire, 2011**

| District | Rank for STI Rates (all ages) 2011 (out of 326 local authorities, first in the rank has the highest rates) | Acute STI rate (all ages) per 100,000 residents (2011) | % of acute STI diagnoses in young people aged 15-24 (2011) | Chlamydia diagnosis rate per 100,000 young people aged 15-24 (2011) | % of residents (all ages) accessing sexual health clinics who received a HIV test (2011) |
|---|---|---|---|---|---|
| **Basingstoke & Deane** | 74 | 813.3 | 55% | 1940.5 | 62% |
| **Rushmoor** | 98 | 745.8 | 64% | 1910.2 | 73% |
| **Gosport`** | 150 | 642.1 | 69% | 2385.4 | 60% |
| **Havant** | 158 | 630.8 | 74% | 2612.3 | 59% |
| **Hart** | 173 | 603.1 | 56% | 1571.8 | 71% |
| **East Hampshire** | 190 | 580.9 | 65% | 1898.6 | 63% |
| **Fareham** | 193 | 578.0 | 69% | 2340.2 | 65% |
| **Winchester** | 196 | 577.7 | 73% | 2078.1 | 48% |
| **Eastleigh** | 212 | 554.1 | 65% | 1971.5 | 54% |
| **Test Valley** | 255 | 482.1 | 67% | 1883.6 | 54% |
| **New Forest** | 293 | 411.3 | 61% | 1303.5 | 69% |

*Source: Health Protection Agency Local Authority Sexually Transmitted Infections Epidemiology Reports: 2011*

**Figure 3: Percentage of people with an acute STI who become reinfected within 12 months, 2009 to 2011**
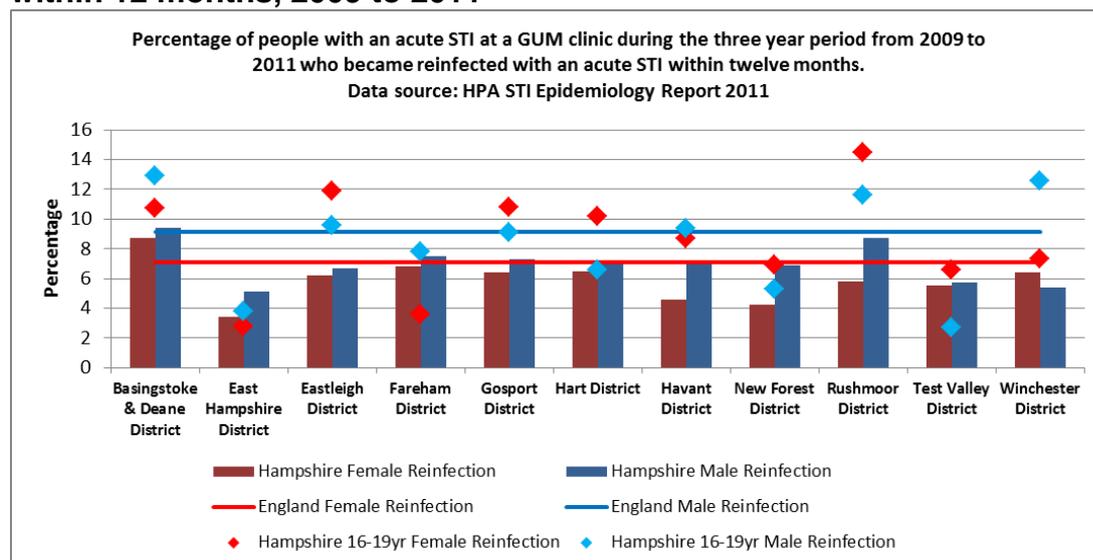


*Source: Health Protection Agency Local Authority Sexually Transmitted Infections Epidemiology Reports: 2011*

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

In England in 2011, where sexual orientation was recorded for men, 75% of syphilis diagnoses, 50% of gonorrhoea diagnoses, 15% of chlamydia diagnoses, 11% of genital herpes diagnoses and 8% of genital warts were among MSM. The number of diagnoses of STIs reported in MSM continues to rise. Nationally, between 2010 to 2011, the number of gonorrhoea diagnoses in MSM increased by 61%, chlamydia diagnoses by 48%, genital herpes diagnoses by 32%, syphilis diagnoses by 28% and genital warts diagnoses by 23%. A significant proportion of these diagnoses continue to be in younger people with 34% of genital wart diagnoses, 24% of gonorrhoea, 22% of genital herpes, 22% of chlamydia and 13% of syphilis diagnoses being in young men aged 15-24.

**Table 2: Percentage of acute STIs in men who have sex with men in Hampshire's districts, 2009/11**

|  | % of acute STIs in men that were in MSM (2009-11) |
|---|---|
| **New Forest** | 11.0 |
| **Rushmoor** | 9.5 |
| **Eastleigh** | 9.2 |
| **Hart** | 8.7 |
| **Fareham** | 8.6 |
| **Gosport** | 8.5 |
| **Winchester** | 8.2 |
| **Test Valley** | 7.6 |
| **East Hampshire** | 7.0 |
| **Basingstoke & Deane** | 6.7 |
| **Havant** | 6.0 |

*Source: Health Protection Agency Local Authority Sexually Transmitted Infections Epidemiology Reports: 2011*

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Local data on STI rates in MSM are not readily available and there is likely to be under reporting due to poor recording of sexual orientation in clinics. The district LASER reports for 2011 include data on the proportion of acute STIs diagnosed among MSM for cases in men where sexual orientation was recorded between 2009 and 2011 (table 2).

### 2.1.3 Black and minority ethnic groups
Nationally in 2012, the highest rates of STI diagnoses were seen in people of Black ethnicity. Black African and black Caribbean communities in the UK are disproportionately affected by STIs. Black Africans in the UK are particularly affected by HIV, while black Caribbeans in the UK experience a higher burden of acute bacterial STIs, such as gonorrhoea, genital chlamydial infection and syphilis with a relatively lower burden of HIV. It is hoped that further analysis of the link between STIs and ethnicity at a local level will be available in due course.[7]

### 2.2 Specific STIs
### 2.2.1  Chlamydia
Chlamydia causes avoidable sexual and reproductive ill-health, including symptomatic acute infection and complications such as pelvic inflammatory disease (PID), ectopic pregnancy and tubal-factor infertility. Since chlamydia is most often asymptomatic, a high diagnosis rate reflects success at identifying infections that, left untreated, may lead to serious long term reproductive health consequences.

The chlamydia diagnosis rate among under 25 year olds is a measure of chlamydia control activities that represents infections tested (reducing risk of sequelae in those patients). Chlamydia screening is recommended for all sexually active people under 25 annually and with every partner change. Public Health England recommends that local authorities should aim for a diagnostic rate of at least 2,400 per 100,000 population in order to reduce the prevalence of chlamydia infection within their population

The crude rate of chlamydia diagnoses in Hampshire 15-24 year olds in 2011 was 1,975 per 100,000 compared to the national rate of 2,125. This is below the previously recommended diagnosis rate of 2,400 in 2011 (figure 4) which has now been reduced to 2,300 for the year 2013. Further action is required to increase the chlamydia diagnostic rate across Hampshire.

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[7] Public Health England Health Protection Report Volume 7 Number 23 Published on: 7th June 2013

**Figure 4: Chlamydia diagnostic rate by district in Hampshire, 2011**
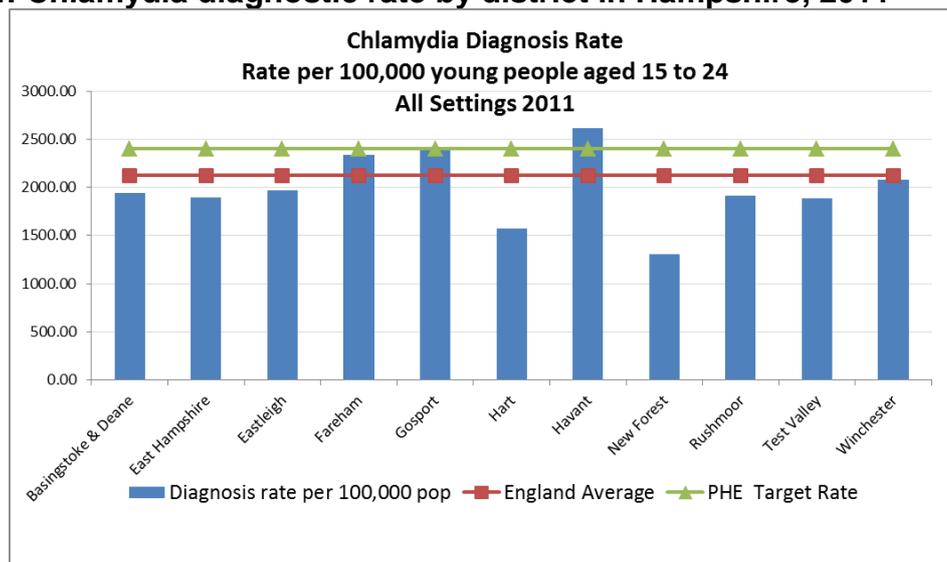


### 2.2.2 HIV

The prevalence of HIV in Hampshire is low at 0.8 per 1,000 population aged 15-59 in 2009, compared to the national rate which is not strictly comparable as it is form a different year, at 1.5 in 2011. Public Health England considers areas with a HIV prevalence greater than 2 per 1,000 population aged 15-59 as high rate areas and extended HIV testing at GP registration and all acute inpatient hospital admissions is recommended for these populations.
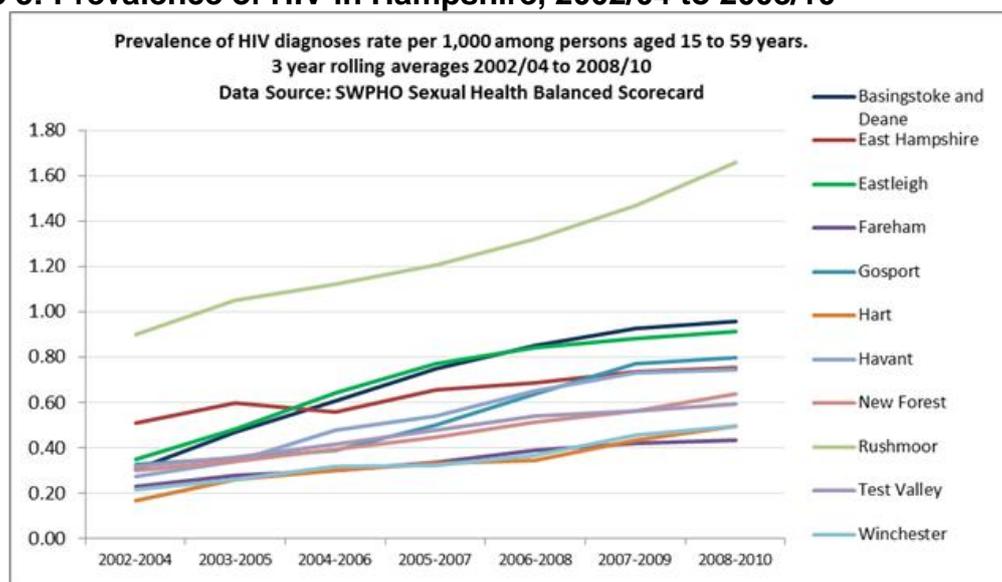
We have evidence that the prevalence of HIV in the population of Hampshire is increasing. Rushmoor has a three year rolling average rate of 1.66 in 2008-10, higher than the national average (figure 5). Data indicate that 756 Hampshire residents received HIV treatment and care in 2011, a significant increase from the 199 Hampshire residents in 2002. Furthermore it is estimated that 25% of all people with HIV in the UK remain undiagnosed which would suggest that the actual number of people living with HIV in Hampshire is closer to 945 individuals.

Most HIV infections are contracted sexually, although there are other routes of transmission. Most HIV infection in diagnosed individuals in Hampshire is a result of unprotected sex between men who have sex with men (MSM) or heterosexual sex. Although the absolute number is small, some people are living with HIV in Hampshire who contracted it through injecting drug use, receipt of infected blood/blood products or through mother to child transmission.

HIV diagnoses in MSM continue to increase and are now at an all time high. The prevalence of HIV in MSM in the UK is estimated to be 47 per 1,000 while the prevalence of HIV in MSM in London may be as high as 1 in 10. There is some evidence that some MSM in Hampshire regularly travel to London to access the commercial gay scene which may significantly increase their risk of acquiring HIV infection through unprotected sex.

**Figure 5: Prevalence of HIV in Hampshire, 2002/04 to 2008/10**



Prevalence of HIV diagnoses rate per 1,000 among persons aged 15 to 59 years.
3 year rolling averages 2002/04 to 2008/10
Data Source: SWPHO Sexual Health Balanced Scorecard

The prevalence of HIV in the black African community in the UK is estimated to be 37 per 1,000. It is estimated that over half of the heterosexual men and women who were diagnosed with HIV in 2011 probably acquired their infection in the UK, compared to 27% in 2002.

Most heterosexual HIV infections in Hampshire are in black Africans. However, there has been an increase in diagnosed HIV infection in white women in Hampshire rising from 50 in 2007 to 85 in 2011. This may be associated with them having sexual relationships with men from countries with a high prevalence of HIV (table 3).

**Table 3: number of people diagnosed with HIV in Hampshire by ethnic group**

| Ethnic Group | 2007 | | | 2008 | | | 2009 | | | 2010 | | | 2011 | | | % change 2007 to 2011 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | Total | M | F | Total | M | F | Total | M | F | Total | M | F | Total | M | F | Total |
| White | 262 | 50 | 312 | 286 | 61 | 347 | 302 | 77 | 379 | 335 | 79 | 414 | 364 | 85 | 449 | 38.9 | 70.0 | 43.9 |
| Black-Caribbean | <5 | <5 | 7 | <5 | <5 | 8 | <5 | <5 | 6 | <5 | <5 | 5 | <5 | <5 | <5 | … | … | … |
| Black-African | 58 | 137 | 195 | 69 | 142 | 211 | 72 | 149 | 221 | 75 | 172 | 247 | 79 | 179 | 258 | 36.2 | 31 | 32.3 |
| Indian/Pakistani/ | <5 | <5 | <5 | <5 | <5 | <5 | <5 | <5 | <5 | <5 | <5 | <5 | <5 | <5 | <5 | … | … | … |
| Other^ | 16 | 13 | 29 | 16 | 14 | 30 | 17 | 18 | 35 | 19 | 17 | 36 | 22 | 16 | 38 | 37.5 | 23 | 31.0 |
| Not known | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | <5 | <5 | 0 | 0 | … |

Data Source: SOPHID 2011

**2.2.2.1 Late diagnosis of HIV**

Diagnosing people with HIV at an early stage in the course of the infection has a significant role in reducing HIV transmission. Most HIV transmission is from people with HIV who are not yet diagnosed and it is estimated that that about two thirds of MSM with HIV in the UK who are considered to be infectious are yet to be diagnosed.[8] Early diagnosis reduces onward transmission as there is evidence that

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[8] Brown A, Delpech V, Presanis A, Murphy G, Gill N: 'The threshold for an ART secondary prevention effect on HIV transmission among MSM has not been reached despite high treatment uptake', presentation at HPA Conference, Warwick University, 2012.

people tend to adapt their sexual behaviour following diagnosis[9] and effective treatment significantly reduces the risk of transmission by reducing an individual's level of infectiousness.[10] There is particular value in diagnosing HIV in the very early stages of infection, known as primary HIV infection, when most of the temporary symptoms appear, as this is when an individual is at their most infectious. Late diagnosis of HIV is the main predictor of HIV mortality and morbidity.

Nationally, about half of all adults newly diagnosed with HIV are diagnosed after the point at which treatment should have optimally been started (CD4 cell count below 350 cells). In Hampshire, 56.6% of new HIV diagnoses between 2009 and 2011 were diagnosed after this stage (figure 6).

The proportion of late diagnosis varies by sexual orientation, ethnicity and age. MSM are less likely to be diagnosed late compared to heterosexual men and women and older people are more likely to be diagnosed late compared to younger people.[11]

**Figure 6: People presenting with HIV at late stage of infection in Hampshire by district, 2008/10**
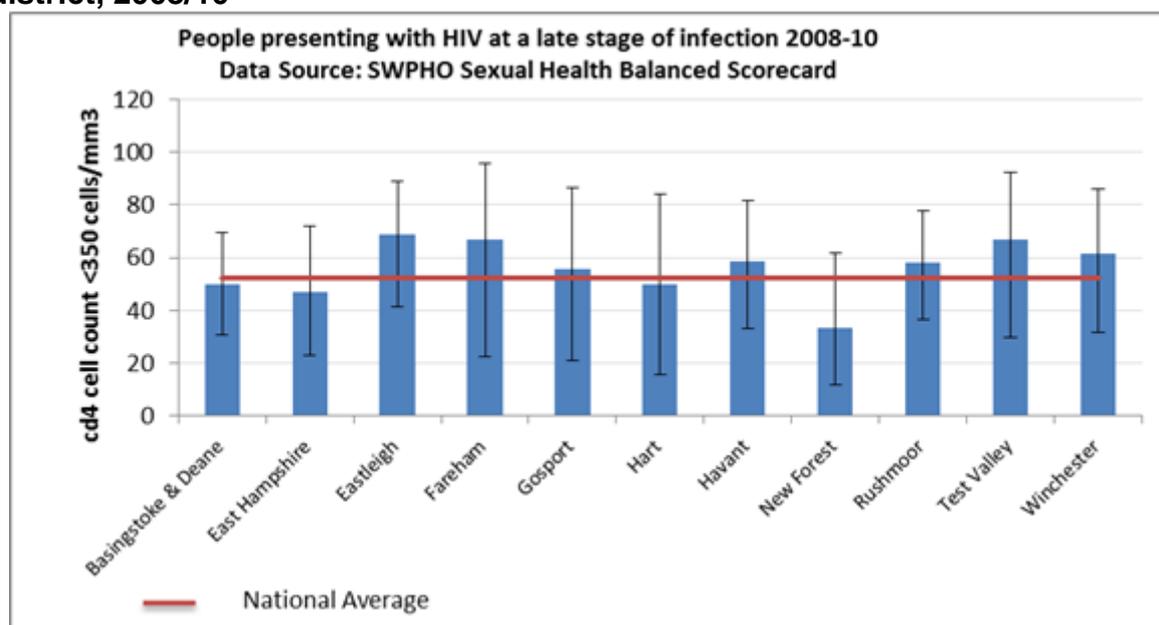


## 3.  Teenage conceptions

### 3.1 Under 18 conceptions

The under 18 conception rate is defined as the number of conceptions in women under the age of 18 per 1,000 of the female population aged 15-17 years. The under 18 conception rate nationally and in Hampshire is declining. There has been a 22.6% reduction in the three year rolling average teenage conception rate from 29.4 per 1,000 females aged 15-17 in 1998/00 (when the local implementation of the national

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[9] NAM: Preventing HIV, London, 2008; Fox J et al: 'Reductions in HIV transmission risk behaviour following diagnosis of primary HIV infection: a cohort of high-risk men who have sex with men', HIV Medicine, vol. 10, 2009.

[10] Position statement on the use of antiretroviral therapy to reduce HIV transmission BHIVA/EAGA January 2013

[11] Health Protection Agency, 2012, HIV in the United Kingdom: 2012 Report.

teenage pregnancy strategy began) to 25.8 per 1,000 in 2009/11. This represented a total of 1,847 under 18 conceptions in Hampshire between 2009 and 2011 (approximately 616 per year).

There is significant variation in the under 18 conception rate in young women across the county. The rates in Gosport and Havant are higher than the national average. In 2009/11 the lowest rate in Hampshire at 15.7 per 1,000 was seen in Hart, while the highest rate of 40.6 per 1,000 was seen in Havant, illustrating the well described link between teenage conception and deprivation. Eastleigh, Basingstoke & Deane and the New Forest see rates lower than the national rate.

Figure 4 provides information on the reduction in teenage conception rates by district. Rushmoor (-37.9%), Havant (-34.6%), Fareham (-26.4), Hart (-25.2%) and Basingstoke and Deane (-23.4%) have all seen bigger reductions in rates than the Hampshire average (-22.6%) between 1998/00 and 2009/11. There was an increase in the rate from 27.9 (1998/00) to 31.8 (2009/11) in Eastleigh. This equates to an increase of 54 conceptions from 220 in 1998/00 to 235 in 2009/11. More recently Eastleigh has seen a reduction in rates from 33.8 in 2008/10 to 31.8 in 2009/11 (table 4).

**Table 4: Numbers and rates of under 18 conceptions by Hampshire district, 2008/10 to 2009/11**

|  | Rate 08/10 | Rate 09/11 | No. of conceptions (08/10) | No. of conceptions (09/11) | Difference in number of conceptions between 08/10 & 09/11 | % Change in rate 98/00 & 09/11 | % Change in rate 08/10 & 09/11 |
|---|---|---|---|---|---|---|---|
| **Hampshire** | 29.4 | **25.8** | **2099** | **1847** | **252** | **-22.5%** | **-12.2%** |
| Basingstoke and Deane | 32.2 | **27.8** | 272 | **239** | **33** | **-23.4%** | **-13.7%** |
| East Hampshire | 23.6 | **18.6** | 161 | **129** | **32** | **-18.8%** | **-21.2%** |
| Eastleigh | 33.8 | **31.8** | 235 | **220** | **15** | **14.0%** | **-5.9%** |
| Fareham | 24.9 | **22.0** | 148 | **130** | **18** | **-26.4%** | **-11.7%** |
| Gosport | 47.1 | **40.6** | 203 | **179** | **24** | **-19.6%** | **-13.8%** |
| Hart | 17.1 | **15.7** | 86 | **77** | **9** | **-25.2%** | **-8.2%** |
| Havant | 43.0 | **36.5** | 282 | **239** | **43** | **-34.6%** | **-15.1%** |
| New Forest | 28.1 | **26.2** | 254 | **235** | **19** | **-19.4%** | **-6.8%** |
| Rushmoor | 29.5 | **24.6** | 154 | **130** | **24** | **-37.9%** | **-16.6%** |
| Test Valley | 28.5 | **24.9** | 187 | **164** | **23** | **-16.2%** | **-12.6%** |
| Winchester | 18.2 | **16.3** | 117 | **105** | **12** | **-21.6%** | **-10.4%** |

In 2009/11, 48.7% of under 18 conceptions in Hampshire ended in abortion which is lower than both the national rate (49.6%) and the South East regional rate (51.2%). In Hampshire, the districts with the lowest percentage of teenage conceptions ending in abortion were the more deprived districts, namely Gosport (40.7%), Basingstoke and Deane (42.0%), Havant (43.7%) and Rushmoor (44.4%), suggesting that teenagers in more deprived areas are more likely to continue with their pregnancy. This pattern is also need nationally.

### 3.2 Under 16 conceptions
In Hampshire 19% of conceptions in under 18 year olds are in females aged under 16. The under 16 conception rates are significantly lower than the England average and are decreasing in Hampshire. In 2009/11 the rate was 5.5 per 1,000 females

aged 13-15 compared to 6.0 per 1,000 in 2001/03, a reduction of 8.4%. There were 360 under 16 conceptions in 09/11 compared to 422 in 01/03. Young females in Gosport have the highest under 16 conception rate in Hampshire at 9.5 per 1,000 compared to Hart and Winchester with the lowest at 3.6 and 3.6 per 1,000. As the number of under 16 conceptions is small, the rates can vary dramatically from one reporting period to another with only a small change in actual numbers.

A higher proportion of under 16 conceptions end in abortion compared to under 18s. In 2009/11 62.6% (n=225) of under 16 conceptions ended in abortion in Hampshire with the highest percentage of under 16 conceptions ending in abortion (72.1%) seen in Eastleigh and the lowest in Gosport with 52.5%.

**3.3 Abortions**
The number of abortions in Hampshire has been decreasing. In 2011 there were 3,040 abortions in Hampshire compared to 3,306 in 2006. The age-standardised rate for women aged 15-44 in Hampshire has decreased slightly from 15 to 14 per 1,000 from 2006 and 2011. This is lower than the national average of 17.5 abortions per 1,000 women. The highest rate in Hampshire was seen for women aged 20-24 (26 per 1,000), followed by women aged 18-19 (25.0). The biggest rate reduction was seen in 18-19 year olds from 31 per 1000 in 2006 to 25 in 2011. The rate reduction among under 20s is partly due to concentrated work to reduce teenage conceptions in Hampshire over the last few years.

In Hampshire in 2011, 80% of all abortions were performed under 10 weeks gestation which is similar to the national average. The proportion of abortions under 10 weeks gestation is a good indicator of access to services with 70% and above signalling good access. 78.7% of abortions in under 18s in Hampshire were under 10 weeks compared to 70% nationally, indicating that there is good access to services in Hampshire.

**4. Projected service use and outcome in 3-5 years and 5-10 years**

In 2011 over two thirds of all diagnoses of STIs in Hampshire were in young people aged 15-24 with people of this age category representing the largest group accessing both specialist sexual & reproductive health and STI/GUM services.

The number of people aged 15-29 in Hampshire is estimated to reduce slightly,  by 3.66%, over the next 5 years (to 2018) but we are expecting to see a similar increase, a 3.17% growth in young people under the age of 15 who will in turn become sexually active, suggesting a static population for need of services. However, this population estimate when combined with changes in people's sexual behaviour; changes in the epidemiology of STIs; changes in the effectiveness of STI testing and treatment and changes in the uptake and use of more long-acting methods of contraception make projected sexual health service use challenging.

While we may see a reduction in the need for specialist contraception and abortion services, reductions in teenage conceptions and the increased uptake of LARC methods of contraception, we are also likely to see a sustained increase in need for STI and HIV services if the current levels of unsafe sex and HIV life expectancy are maintained.

## Sexual health

It is envisaged that both the prevalence of HIV and the number of Hampshire residents accessing HIV treatment and care will continue to increase due to the on-going transmission of HIV (new diagnoses); an increased focus on HIV testing (in order to reduce late diagnosis); and improved life expectancy as a result of early diagnosis and improved treatment and outcomes.

We are also likely to continue to see people living with HIV into old age, with an associated increase in the need for older people HIV- sensitive services to cater for residents with co-morbidities and complications of HIV infection, including hepatitis, liver disease, cardiovascular disease, cancer and HIV-related dementia.

### 5. Current services in relation to need

In 2009, NHS Hampshire started a three year process to redesign and re-procure sexual health services across Hampshire to meet the needs identified in the Hampshire Sexual Health Needs Assessment 2009. This led to commissioning a three-level integrated sexual health service delivered across a range of settings.

The service model seeks to improve access and reduce inequalities in sexual health by delivering a one-stop approach to local sexual health services in areas of greatest need, while at the same time reducing the number of appointments and distances that residents need to travel to manage their sexual health.

### 5.1 Level 3 Specialist Sexual Health Service
Solent NHS Trust provides a hub and spoke Level 3 sexual health service across Hampshire which it also provides to Portsmouth and Southampton local authorities. The Level 3 integrated sexual health service includes the following services as well as training and support for level 1 and 2 providers:

- HIV testing & treatment
- STI testing & treatment
- Chlamydia screening programme
- Contraception (including complex contraception and outreach services for young people)
- Termination of Pregnancy
- Vasectomy
- Psychosexual counselling
- Targeted HIV prevention and sexual health promotion

These services are delivered from a range of locations across Hampshire via a single point of access. Further information on this service is available at www.letstalkaboutit.nhs.uk.. The service started in January 2012 and saw over 74,000 residents (across all three local authorities) in 2012/13.

### 5.2 Level 2 Enhanced Sexual Health Services
To support the level 3 service, the County Council commissions a range of level 2 enhanced sexual health services from primary care providers. Level 2 enhanced sexual health services are services that are provided over and above the level 1 or core sexual health services that are commissioned by NHS England from general practice or community pharmacy.

Sexual health

### 5.2.1 Long-Acting Reversible Contraception (LARC) service
97% (143) of GP practices in Hampshire are commissioned to provide a LARC service which involves the fitting and removal of intrauterine contraceptive devices/systems (IUCDs/IUSs) and contraceptive implants. In 2011/12, LARC accounted for 28% of primary method of contraception, which was an increase from 18% in 2003/04. The LARC methods of contraception include the implant, the IUCD (often referred to as the coil), the IUS (the Mirena® coil is the IUS licensed for use in the UK) and the injectable contraceptive. LARC are the most effective methods of contraception and are described as non-user reliant methods, whereas oral contraception or condoms are user reliant methods

### 5.2.2 Emergency Contraception in Community Pharmacy
In 2012/13 124 of the 234 (53%) community pharmacies in Hampshire provided an Emergency Hormonal Contraception (EHC) Service. Trained pharmacists are able to administer emergency oral contraception free of charge supported by a Patient Group Direction (PGD). There were 7374 EHC consultations in Hampshire pharmacies in 2011/12, with EHC administered in 96% of consultations. A quarter of all EHC consultations in community pharmacy take place on a Monday.

### 5.2.3 Chlamydia Screening
Both GP practices and community pharmacies are commissioned to provide chlamydia screening for people aged 15-24 as part of the national chlamydia screening programme. In 2012 over 99% of GP practices in Hampshire provided this service generating 6151 screens with a positivity rate of 5.2%.

Just over 70 (30%) of community pharmacies provided this service in 2012 generating 139 screens with a positivity rate of 7.2%. This service is currently being extended to include more pharmacies as well as the provision of free condoms due to its ability to reach young people who may be at increased risk.

### 5.3 Level 1 Primary Care Services
General practices are also commissioned by NHS England to provide contraception including emergency hormonal contraception, cervical screening and opportunistic STI testing and treatment as part of the GP contract. Nationally, between 70-80% of contraceptives are distributed from general practice, with the remainder from community Contraceptive & Sexual Health (CASH) clinics. Oral contraception was the primary method of contraception used by 45% women attending community clinics and for the first time it was also the primary method used by females aged 15 (41%), pushing the use of male condoms into second place (36%). Oral contraception remains the most common method of contraception for women of all ages.

Community pharmacies also provide Level 1 sexual health services by dispensing oral contraception and selling condoms, EHC and pregnancy testing kits as well as signposting residents to more specialised sexual health services.

Details of all local sexual health services can be found on the dedicated sexual health website www.getiton.nhs.uk

## 6. User and provider views

Users, potential users and providers of services have been systematically involved in the development and implementation of plans to reduce teenage conceptions and improve sexual health in Hampshire using a variety of mechanisms. Over 1000 stakeholders were engaged in the redesign of local sexual health services by NHS Hampshire between 2009 and 2011. This included a public questionnaire which was completed by 1,046 Hampshire residents. The questionnaire sought to identify the views of local people on the new model as well as their preferences in relation to service locations and opening times. The findings were used to inform the development of the new model as well as the commissioning and delivery of current services.

## 7. Evidence of what works

There is evidence that sexual health outcomes can be improved by providing:[12]

- accurate, high-quality and timely information that helps people to make informed decisions about relationships, sex and sexual health;[13]
- preventative interventions that build personal resilience and self-esteem and promote healthy choices;[14]
- rapid access to confidential, open-access, integrated sexual health services in a range of settings, accessible at convenient times;[15]
- early, accurate and effective diagnosis and treatment of STIs, including HIV, combined with the notification of partners who may be at risk;[16] and
- joined-up provision that enables seamless patient journeys across a range of sexual health and other services. This will include community gynaecology, antenatal and HIV treatment and care services in primary, secondary and community settings.[17]

There is also evidence to support the identification of individuals at high risk of STIs and the delivery of structured one to one behaviour change interventions to reduce the transmission of STIs, and to reduce the rate of teenage conceptions, especially among vulnerable and at risk groups.[18] Action should also be taken to increase the offer, recommendation and uptake of HIV testing by black Africans and men who have sex with men (MSM) across a range of health and community settings  as well as regular repeat testing for those who have new or multiple partners.[19][20]

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[12] A Framework for Sexual Health Improvement in England, Department of Health, 2013.

[13] Kirby D, Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases, National Campaign to Prevent Teen and Unplanned Pregnancy, 2007

[14] Ibid

[15] 'Building the bypass – implications of improved access to sexual healthcare', Mercer C et al, Sexually Transmitted Infections 2012; 88: 9–15

[16] Ibid

[17] 'Integration of STI and HIV prevention, care and treatment into family planning services: a review of the literature', Church K and Mayhew SH, Studies in Family Planning 2009; 40(3): 171–86

[18] Prevention of sexually transmitted infections and under 18 conceptions, NICE public health intervention guidance 3, NICE 2007

[19] Increasing the uptake of HIV testing among black Africans in England, NICE public health guidance 33, NICE 2011

## 8. Recommendations

Achieving good sexual health is complex, and there are variations in the need for services and interventions for different individuals and groups. It is therefore essential that there is collaboration and integration between a broad range of organisations, including commissioning organisations, and services in order to deliver improved outcomes.

The importance of improving sexual health is acknowledged by the inclusion of three indicators in the Public Health Outcomes Framework (PHOF). These indicators have been prioritised, as each represents an important area of public health that needs sustained and focused effort in order to improve outcomes:
- under-18 conceptions;
- chlamydia diagnoses (15–24-year-olds); and
- people presenting with HIV at a late stage of infection.

### Under-18 conceptions
- Continue the focused action to reduce teenage conceptions.

### Reproductive Health
- Improve access to contraception, including Long-Acting Reversible methods of contraception (LARC).

### Chlamydia diagnoses (15-24 year olds)
- Work to achieve a chlamydia diagnostic rate of at least 2,300 per 100,000 young people aged 15-24.
- Emphasise the need for repeat testing, especially on change of sexual partner.

### Sexually transmitted infections
- Maintain 48 hour access to STI testing and continue to improve partner notification rates.
- Prevention efforts should be sustained and targeted at groups who are at the most risk.

### People presenting with HIV at a late stage of infection
- Improve awareness and diagnosis of primary HIV infection.
- Increase the uptake of HIV testing particularly for high-risk groups.
- Maintain the current high levels of HIV antenatal testing.
- Increase the availability and uptake of community-based HIV Point-of-Care Testing with high-risk groups.

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[20] Increasing the uptake of HIV testing among men who have sex with men, NICE public health guidance 34. NICE 2011